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RMDSENATE 10/13/2006

Arizona Supreme Court

TITLE XIX REPORT

Title XIX Task Force
Juvenile Justice Services Division
March, 1993

Administrative Office of the Courts

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INTRODUCTION

In November 1991, the Administrative Office of the Courts (AOC) entered into an Interagency Service Agreement (ISA) with the Arizona Department of Health Services (ADHS) to deliver behavioral health services to children in the juvenile justice system through the Arizona Health Care Cost Containment System (AHCCCS), the state's Medicaid (Title XIX) program. All the parties had high expectations that the new partnership between the state agencies and private sector providers would deliver better, more cost effective behavioral health services to children.

By Fall 1992, it had become painfully obvious to AOC administrators and others working within the children's behavioral health network that the Title XIX program was failing to live up to expectations, despite the best efforts of concerned staff and management. The anticipated increase of treatment resources had not materialized.

The seriousness of the lack of resources for juvenile treatment services was recognized by James E. McDougall, the Presiding Judge of the Maricopa County Juvenile Court, who expressed his disappointment in an article in the October 1992, issue of the Arizona Attorney, which later was reprinted in the Arizona Republic, November 29, 1992. Judge McDougall condemned the relative meaninglessness of the Title XIX program:

> "(Title XIX) funds have not worked as expected and, in this writer's opinion, they cannot be expected to do so in the future. It was hoped that with the availability of federal funds for the mental health treatment of indigent juveniles through Title XIX, more children would be able to access mental health services, both before and after their entry into the juvenile justice system, and that the savings realized would permit the juvenile system to spend more money on other worthwhile services, such as intensive probation. However the problems involved in determining eligibility and in getting needed services delivered on a timely basis have been so great as to render this source of funds practically useless."

The inability of the Title XIX network to deliver its entitlement benefits to youths in the juvenile justice system approached crisis proportions and challenged the integrity of state government. On September 29, 1992, Frank B. Sanders, Director, Juvenile Justice Services

Division, sent to Alethea Caldwell, Director, ADHS, a concept paper outlining the AOC's position regarding the AOC's continued participation in the Title XIX program. A follow-up meeting was held on October 7, 1992, with Director Caldwell and key staff to discuss the issues (Appendix II:1). Little progress was made.

On November 1, 1992, the lack of progress in resolving pressing operational issues with ADHS and the Regional Behavioral Health Authorities (RBHAs) led the AOC to place "...a moratorium on all new referrals into the Title XIX system except for those youth who [were deemed] clearly eligible by the Juvenile Court staff" (see Appendix II:2).

Simultaneously, the AOC organized the Title XIX Task Force to investigate and document the problems encountered with the Title XIX program, identify and analyze proposed solutions, and make recommendations to the AOC regarding one or more courses of action. Attorney George Logan was selected to lead the Task Force as a Management Consultant to the AOC. The membership of the Task Force was inclusive and representative of the various constituencies of the Title XIX system, i.e., state agencies, county probation offices, RBHAs, and providers. In addition to AOC and Juvenile Court staff, there were participants from AHCCCS, ADHS, Arizona Department of Economic Security (ADES), Arizona Department of Youth Treatment Rehabilitation (ADYTR), Community Organization for Drug Abuse, Mental Health and Alcoholism Services (CODAMA), and Pinal-Gila Behavioral Health Authority (PGBHA).

The entire staff of the AOC and Juvenile Courts are extremely appreciative of the time, expertise, and knowledge of each Task Force participant. Without their commitment and contribution this report would not have been possible.

OVERVIEW

The Arizona Constitution provides that the Superior Court shall sit as a juvenile court in the exercise of exclusive, original jurisdiction over juveniles who are deemed to be "delinquent", "incorrigible" or "dependent", and less than 18 years old. The focus of this report is limited to delinquent and incorrigible youths in the juvenile justice system as impacted by Title XIX funding.

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The Arizona juvenile justice system is county operated and state administered. Each of the state's fifteen counties has a juvenile division of the Superior Court. In FY 1991-92, the juvenile justice system processed more than 56,000 children through its courts. Understandably, Maricopa County had the largest share with more than 25,200 children, 45% of the entire population.

Consistent with contemporary mental health treatment theories, the Arizona juvenile justice system offers a broad continuum of behavioral health treatment, including emergency intervention, case management, inpatient, outpatient, residential, and group home services (Appendix II:3). All of these services are purchased from certified or licensed providers by the AOC. In FY 1991-92, the AOC spent $20,618,000 for treatment, a 27% increase over the FY 1990-91 expenditure of $15,054,175 (Appendix II:4).

BACKGROUND OF CHILDREN'S BEHAVIORAL HEALTH SERVICES

Arizona has been one of the fastest growing states in the nation for the last 20 years. It has ranked third in population growth since 1970, and is projected to have more than 5 million people by the year 2000. However, the state was minimally involved in providing behavioral health services to the general population until 1968 when the state legislature followed the federal lead and passed A.R.S. § 36-189, appropriating state funds for the State Subvention Program.[1]

Prior to FY 1987-88, no Subvention funds were allocated specifically for children's behavioral health services to the ADHS. In many instances, lack of treatment dollars in the behavioral health system forced families to turn to the courts for services.

> "It was not uncommon for parents to surrender custody of their children in order to obtain treatment for them. Children who were wards of the Court or of the State could receive behavioral health services funded by the Department of Corrections or by the Department of Economic Security."[2]

The Expanding Need for Behavioral Health Services

During FY 1987-88, the Legislature began to address this imbalance by appropriating almost $5M for a Children's Subvention Fund and mandating the development of a

comprehensive and coordinated behavioral health care system for children. Paralleling the expanding need for children's behavioral health services in programs administered by the executive branch was an unprecedented increasing demand for the same services in the juvenile courts. From FY 1987-88 to 1991-92, AOC expenditures for behavioral health services for delinquent youth doubled from $9M to over $18M.

In October 1990, AHCCCS complied with federal requirements to provide behavioral health services to children. "Medicaid funds were envisioned to be a vehicle toward the implementation of a 'comprehensive and coordinated' children's behavioral health system mandated in A.R.S.36-3421."[3] Title XIX began reimbursing the state for selected services provided to eligible children. The program was initiated on a fee-for-service basis and resulted in a significant increase in state expenditures notwithstanding the draw-down of federal matching funds. The legislature appropriated approximately $6.8M for state match for Title XIX during the first year. The appropriation has remained constant since then, even though the number of eligible children has risen dramatically. This increase was primarily attributable to the growing number of Medicaid eligible children who were in need of expensive, intensive residential or inpatient treatment and dramatic provider rate increases due to Title XIX requirements. Reliable estimates have placed the average monthly cost of services at $1,100-1,200 per child in the fee-for-service network.[4]

COST CONTAINMENT THROUGH CAPITATION AND MANAGED CARE

Arizona stands as a pioneer in development of public sector health maintenance organizations (HMOs). In 1980, the Legislature established AHCCCS as a unique Medicaid demonstration project for the delivery of a broad range of medical services to eligible citizens through enrollment in a prepaid capitated health plan. The successful use of the capitated model as an effective cost containment strategy had been proven in the private sector. Duplicating this success in the public sector was the primary objective of AHCCCS.

The cost containment theory of the capitated model is ingeniously simple. It combines the basic insurance principle of spreading the cost risk of medical treatment over a defined population with the practices of preventive medicine and the financial incentives generated by competitive bidding among providers.

For purposes of rate determination in a capitated system, the key variable affecting cost is the level of utilization of services by the designated population. Providers calculate service bids on the basis of estimates of treatment utilization by members of the group. The healthier the group members are, the lower the service utilization level will be, and consequently a lower capitation rate will be realized. Conversely, the higher the utilization level within the group, the higher the capitation rate will have to be to cover the costs of providing treatment.[5]

The Juvenile Courts Join Title XIX

In an effort to control its escalating costs of behavioral health services, the AOC agreed at the urging of the Legislature and ADHS to participate in AHCCCS, and thereby obtain Title XIX federal matching funds for eligible youth. In November 1991, an ISA was entered into with ADHS, the designated plan administrator.

Shortly after implementation of the ISA, significant problems surfaced regarding ADHS' non-compliance with ISA responsibilities to the AOC and the providers. These problems continued despite many attempts at resolution (Appendix II:5). The Regional Behavioral Health Authorities (RBHAs, then known as Entities) refused to accept referrals from the juvenile courts without parental consent. Other areas of ADHS' non-compliance included failing (1) to provide written procedures regarding maintaining and monitoring out-of-RBHA network placements, (2) to provide any evaluation/quality control reports, and (3) to bill AOC monthly and pay providers in a timely manner. In reaction to ADHS's defaults, providers began to complain and demand payment from the AOC.

Funding issues became so critical for ADHS in the Summer and Fall of 1992 that it began seeking a supplemental appropriation to meet its obligations. In August 1992, AHCCCS refused to process any ADHS claims for federal reimbursement because it did not have any state matching funds. Eventually, the financial crisis was mitigated when ADHS settled a lawsuit it had with a former Entity that yielded over $2M which it used as matching funds, along with internal transfers of other ADHS Subvention funds.[6] Notwithstanding these budgetary gymnastics, ADHS has conservatively projected an operating deficit of $3.9M for FY 1992-93 (Appendix II:6).

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Of particular concern to the AOC was the failure of ADHS to render timely accounting reports to reconcile expenditures. In November 1991, when the ISA was signed, AOC advanced $100,000 to ADHS to cover expenditures paid to providers for Title XIX behavioral health services rendered to juvenile court children between January and June 1992. ADHS agreed to submit a monthly accounting of charges against the advance until it was exhausted. It was not until May 13, 1992, that the first billing was submitted by ADHS for $53,882; the second billing for $90,426 was not submitted until August 10; the third billing was received on October 7 in the amount of $111,572; and the forth billing was received on November 4, for $244,801. It should be noted that the last three billings were submitted long after the close of the fiscal year and only after numerous written demands from the AOC and unpaid providers.

Notwithstanding the promises of the ADHS management to resolve the billing problems, there has been little change. As recently as December 1992 and January 1993, ADHS notified the AOC that there were $70,000 in claims that still had not been resolved, and $780,000 of claims which might not be paid due to untimeliness for FY 1991-92 (Appendix II:7). This billing problem is now exponentially compounded by the fact that, as of publication of this report (March 1993) ADHS has failed to submit the majority of bills for the first eight months of FY 1992-93, and has not fully paid all the Title XIX AOC claims for FY 1991-92.

The Principles of Managed Care

In order to cope with the population driven, rising health care costs, the state has moved in the direction of "managed care" to achieve greater cost efficiencies. The underlying assumption of managed care is that "costs are contained and quality is assured when the most appropriate level of service is delivered by the best qualified provider."[7] A managed care system operates on the principles of (1) identifying financially eligible clients, (2) certifying their medical need and determining the most appropriate level of service, and (3) having qualified providers deliver the authorized service.[8]

Pursuant to the U.S. Department of Health and Human Services, Health Care Financing Administration's (HCFA) mandate, AHCCCS and ADHS were required to convert the behavioral health fee-for-service program to a capitated HMO as the first stage of implementing its "managed care program" statewide. The enormous difficulty of this

daunting conversion process can not be overstated. The leadership of ADHS accepted the challenge of converting an on-going, statewide system with hundreds of providers serving thousands of children. ADHS' management and staff were commended by the Governor's Office for their "...commitment to transform a previously disparate system to one of managed care and accountability for services...."[9]

The Capitation Rate Structure

The capitation plan implemented by ADHS was radically different from the existing medical plans: "Unlike the AHCCCS medical health plans, the RBHAs do not have well children among their Medicaid-enrolled patients."[10]

While choosing to ignore the historical utilization data made available by providers, ADHS management developed an actuarial model to ascertain the capitation rate which it used to project utilization service levels. The theoretical data generated by this model became the basis for ADHS' recommendation of a capitation rate of $480.88 per child per month, including all administrative costs, case management, intake and treatment services. AHCCCS accepted this figure and submitted it to HCFA for approval.

An analysis by the AOC indicated that the capitation rate was based on data from July 1991 through December 1991, prior to the enrollment of AOC and ADYTR youths in the plan.[11] Moreover, after deducting the costs of administration, intake, and case management fees, only $175 remained for purchase of treatment services in the first month. In subsequent months this figure increases to $250 per month.[12]

The parsimonious nature of this capitation rate has been repeatedly and severely criticized by providers, advocates and various experts in the field of children's behavioral health services (Appendix II:12 and Appendix II:4).

In two federal lawsuits filed in the U.S. District Court for Arizona it has been alleged that the state has failed to provide "medically necessary" behavioral health services because of a deficient capitation rate. With the support of providers and advocates, Title XIX eligible children have sued AHCCCS and ADHS. See J.L., a minor, et.al. v. Leonard J. Kirschner, M.D., MPH, Director of the AHCCCS, CIV93-0263 PHX, U. S. District Court, District of

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Arizona, and J.K., a minor, et.al. v. Alethea Caldwell, Director of ADHS, first amended complaints, CIV91-261 TUC, U. S. District Court, District of Arizona.

The gravamen of the complaint in J.L. v. Kirschner is that the state failed to adhere to applicable federal regulations and state rules when it established the capitation rate, thereby rendering it invalid. Specifically, AHCCCS and ADHS are charged with excluding public input and ignoring historical cost data in setting the rate. Similarly, the complaint in J.K. v. Caldwell challenges the sufficiency of state funding for behavioral health services because eligible children are being limited or denied "medically necessary" treatment contrary to federal policy.

The uniqueness of AHCCCS as a statewide health care delivery system makes it impossible to find directly comparable programs in other states. However, research revealed several demonstration projects in other states involving Medicaid funded 1915(a) waiver programs which are structured as capitated models. The Robert Wood Johnson Foundation funds the National Program Office of the Mental Health Services Program for Youth in Washington, D.C. With technical assistance from the Washington Business Group on Health (WBG), the Foundation has funded eight, demonstration projects of five year duration in different states.

Family Matters, a quarterly newsletter, publishes progress reports on these projects. In the Spring 1992 issue, it is reported that the Multnomah County, Oregon, Partners' Project is funded at a capitation rate of $1,618 per month per child (Appendix II:9).

In a follow-up conversation, the WBG staff confirmed that two other projects also had significantly higher capitation rates than Arizona's. The Cuyahoga County, Ohio, Connections project is funded with a monthly capitated rate of $1,318, which is considered inadequate by its administrators to meet treatment costs. Program management is considering a rate increase. Lastly, the Family Mosaic project in San Francisco, California, which includes juvenile probation, is scheduled to convert its program to a capitated model in the Spring of 1993, with a capitation rate of $2,465 per month.

AHCCCS challenges the validity of any comparison with the demonstration projects. It points out that the capitation rates in the demonstration programs reflect their extremely small, selected populations with expensive, intensive behavioral treatment needs, without any

low utilization members. Notwithstanding these differences, a closer analysis suggests that the similarity of the treatment needs of AOC juvenile court youths, and the similarity of the continuum of services provided in these demonstration projects, are indicative of relevant parallel processes which clearly warrant further in depth investigation.

In response to this report, AHCCCS and ADHS have indicated the capitation rate is being reviewed.

Nationally, a trend is beginning to emerge. The linking of managed care with capitation is viewed as a preferred strategy for health care cost containment. However, contrary to what has been done in Arizona, other capitation rates are being established at realistic levels reflecting the actual costs of treatment of populations with high levels of service utilizations.

The EDS Billing and Payment System

A key part of the implementation plan included a fully automated on-line data processing system designed and operated by Electronic Data Systems (EDS) under an agreement to perform all program billings, collections, payments, fund transfers and related financial reports. Since implementation in November 1992, the EDS system has met with varying degrees of success. To its credit, EDS has been able to pay clean provider billings within seven days of filing. Compared to the existing system, this improvement is noteworthy. Most providers have been complimentary of the process and ADHS deserves high marks for this positive step.

Some providers have been critical and view the EDS' network as government-style progress. Initially the system generated a high number of rejected claims, exceeding 80% in some cases (Appendix II:10). This was primarily attributed to the combination of installing the system without sufficient user training and having excessively restrictive edits. Currently, the system requires all parties to submit accurate invoice information, including a Letter Of Authorization. For intensive services, these authorizations must be available before payment is generated. If not, payment is delayed or never made. Admittedly, these procedures need to be clarified in order to raise user satisfaction to an acceptable level.

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Regrettably, the EDS system has been limited to processing claims for services incurred after November 1, 1992. Thus, all prior fiscal year provider claims, some of which have been awaiting payment for as long as eight months, continue being processed through the existing manually intensive system. ADHS' management action taken to expedite payment of these claims, estimated to be more than $3M dollars, has produced only minimum results. This matter continues to be very frustrating to the AOC and of dramatic importance to the vitality of a significant number of members of the provider community.

FINANCIAL IMPACT OF TITLE XIX

As has been previously stated, the AOC has been participating in the Title XIX system since the ISA was agreed upon in November 1991. It was believed that by participating in the Title XIX program, AOC expenditures would be reduced for approved children thereby increasing the overall number of children who could be served through the Juvenile Treatment Services Fund.

The AOC anticipated that it would be able to purchase many of the same level of behavioral health services that it did with state-only funds, and Title XIX would contribute 62.5% of the cost. This was projected to produce a budget savings from January through June 1992 of over $2M dollars. These savings never materialized.

Provider Rates

Prior to participation in the Title XIX system, the AOC negotiated individual rates with providers based on services to meet the needs of the delinquent population. These rates were solicited through a Request for Proposal and contracting process. As the state agencies and behavioral health providers embraced the Title XIX system, concern was raised by the AOC with regard to the increasing provider rates. The AOC was assured the majority of children in out-of-home placement would meet the Title XIX criteria resulting in reimbursement by the federal government and, thereby, offsetting the rate increases. The concern of the AOC was premised on the fact that out-of-home placements consume the largest share of treatment funds.

Provider rates have significantly increased since FY 1990-91. The average rate negotiated by the AOC for an out-of-home placement in FY 1990-91 was $95.14 per day

(residential treatment and group home). During FY 1991-92, the AOC began to see significant rate increases and the emergence of a dual rate system for Title XIX and non-Title XIX services.

With the emergence of the Title XIX program, many providers chose to become Title XIX providers. During the two year period ending FY 1992-93, the average rate for an out-of-home placement in a Title XIX approved facility rose from $101.64 per day to $145.10 per day (Graph 1). This was a 43% rate increase to the AOC and in many cases to ADES and ADYTR as well. In comparison, for providers who chose not to contract with Title XIX, the average rate increased from $74.54 per day during 1990-91 to $83.72 per day during 1992-93. This was only a 12% increase during the same two year period (Graph 1).

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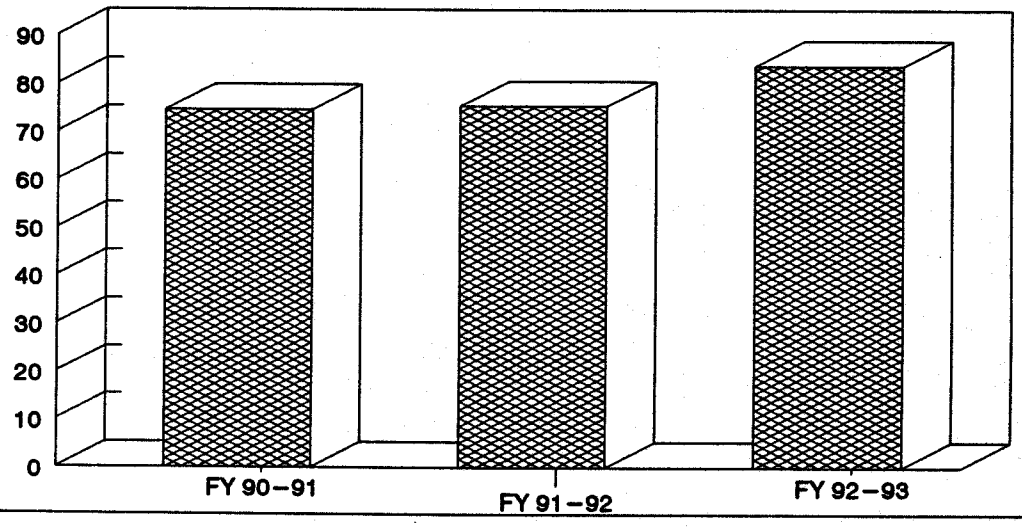
Title XIX/Non–Title XIX Provider Rate Comparison

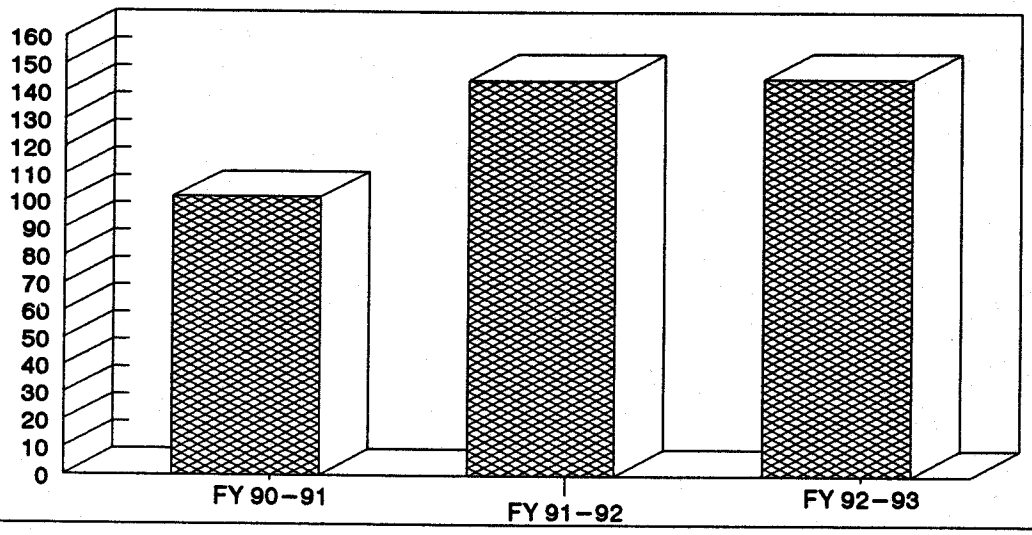
Non–Title XIX (provider did not become Title XIX approved)

AVERAGE RATE FY 90–91	AVERAGE RATE FY 91–92	AVERAGE RATE FY 92–93
$74.54	$75.30	$83.72



Title XIX (provider became Title XIX approved)

AVERAGE RATE FY 90–91	AVERAGE RATE FY 91–92	AVERAGE RATE FY 92–93
$101.64	$144.49	$145.10



GRAPH 1

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Title XIX Referrals

In January 1992, the first group of eligible AOC youths were referred to the RBHAs for Title XIX services. Although many youths fit the Title XIX financial eligibility, the majority were found clinically ineligible for services because of medical necessity. Medical necessity is defined by AHCCCS as:

> "...those covered services provided by a qualified service provider within the scope of their practice. Under state law or certification, whichever is applicable, medically necessary services are provided to prevent disease, disability and other adverse health conditions or their progression, or to prolong life."

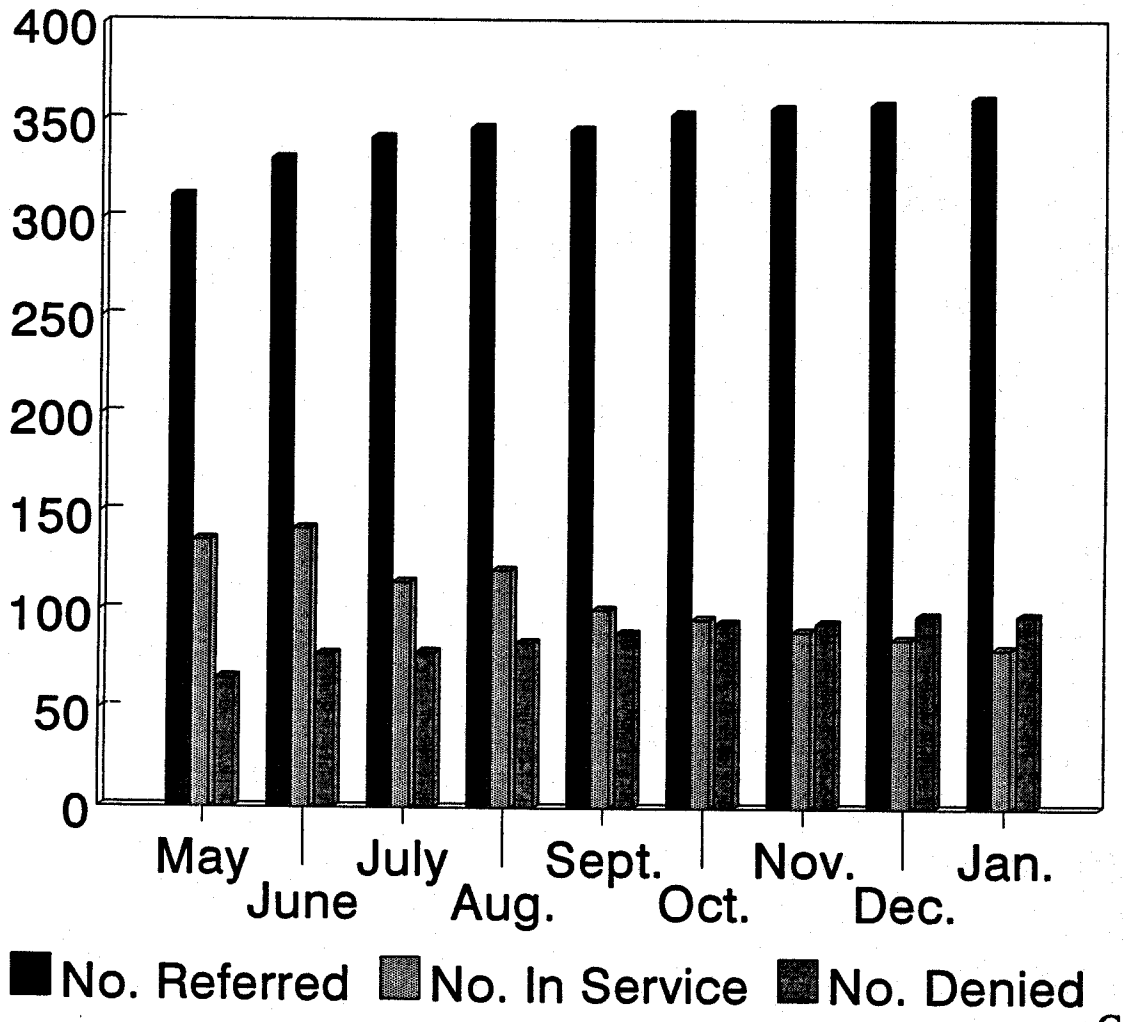
This definition, in and of itself, is vague, resulting in inconsistent interpretation by various behavioral health professionals to cope with financial constraints (Appendix II:11).

From January through April 1992, 312 juvenile court children were referred to the RBHAs. By May 1992, only 44% or 136 of the 312 youth referred remained both financially and clinically eligible for Title XIX reimbursement. Only 47 children were referred to the RBHAs between May and December, and by December the RBHAs denial rate had risen from 21% to 27% with the number of Title XIX youth in service dropping from 44% to 24% (Graph 2).

ADMINISTRATIVE OFFICE OF THE COURTS
TITLE XIX STATUS
Totals Per Month

MONTH	NUMBER * REFERRED	NUMBER IN SERVICE	NUMBER ** DENIED	PERCENT DENIED
January–April, 1992	312	---	---	---
May, 1992	312	136	66	21%
June, 1992	331	142	78	24%
July, 1992	342	115	79	23%
August, 1992	347	121	84	24%
September, 1992	346	101	89	26%
October, 1992	354	96	94	27%
November, 1992	357	90	94	26%
December, 1992	359	86	98	27%
January, 1993	362	81	98	27%

* Cumulative total
** "In process" and "terminated" not included



GRAPH 2

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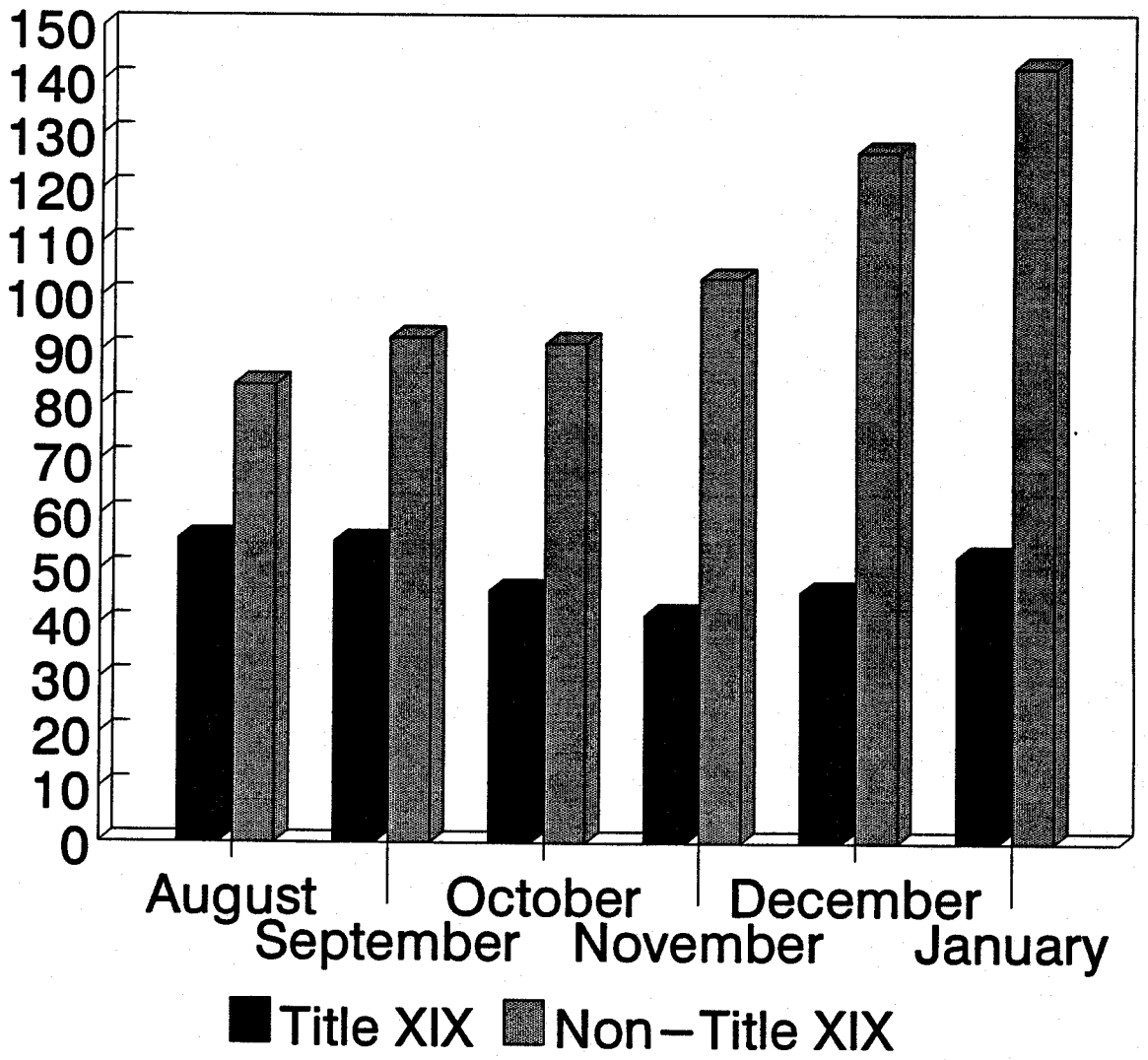
Average Daily Census

Since August 1992, the AOC has kept an average daily census for all juveniles in residential treatment. The average daily census is computed by totaling the census for each day of the month and dividing by the number of days in the month rounded to the nearest tenth of a day. The average number of Title XIX juveniles in residential treatment remained constant from August 1992 through January 1993 while the number of non-Title XIX juveniles rose dramatically because they were being rejected by Title XIX (Graph 3).

ADMINISTRATIVE OFFICE OF THE COURTS
Title XIX and Non–Title XIX Average Residential Daily Census

MONTH	TITLE XIX ELIGIBLE YOUTH	NON–TITLE XIX YOUTH
August, 1992	55.7	83.9
September, 1992	55.2	92.5
October, 1992	46.3	91.5
November, 1992	41.8	103.4
December, 1992	46.0	126.8
January, 1993	52.5	142.3
	297.5	640.4



GRAPH 3

Between May and December 1992, the AOC began to look at the numbers of denials being processed through the RBHA system and the excessive, time consuming activities performed by individual probation officers to process the children. This, in part, was due to concerns voiced by the courts regarding the cumbersome intake, lengthy decision making process, and strict interpretation of rules and regulations requiring parental consent. Rather than waiting for a RBHA to approve or deny a referral, the courts began to place children as necessary, following later with a Title XIX referral.

In February 1993, CODAMA began to take aggressive action to discharge children who they believed no longer fit the 'medical necessity' criteria due to their funding shortfall as a result of capitation (see Appendix II:11). The juvenile court was given a long list of children who would no longer be funded for their residential care under Title XIX, resulting in an increase of non-Title XIX expenditure for the courts. The current trend indicates the average daily census will significantly decrease for Title XIX eligible youth and increase for non-Title XIX funded youth during the next few months.

Expenditure Comparison

The total expenditures for AOC is difficult to assess, as the reconciliation with ADHS for AOC children in Title XIX funded services is not complete for the last fiscal year (1991-92). Graph 4 indicates Title XIX and non-Title XIX expenditures based on projections by each of the state's fifteen counties. As indicated, the Title XIX reimbursement began to drop in August 1992 and has continued to drop. It should be noted the Title XIX expenditures include all services to a Title XIX child including some non-Title XIX reimbursable services such as room and board, and personal clothing and allowance. Also in November 1992, when ADHS moved to a capitated system, the state match portion dropped to a percentage of the overall capitation rate and is no longer projected as a fee-for-service reimbursement. Again, these numbers are projections from the juvenile courts. The ADHS has reconciled once, since the start of this fiscal year for only a portion of services provided.

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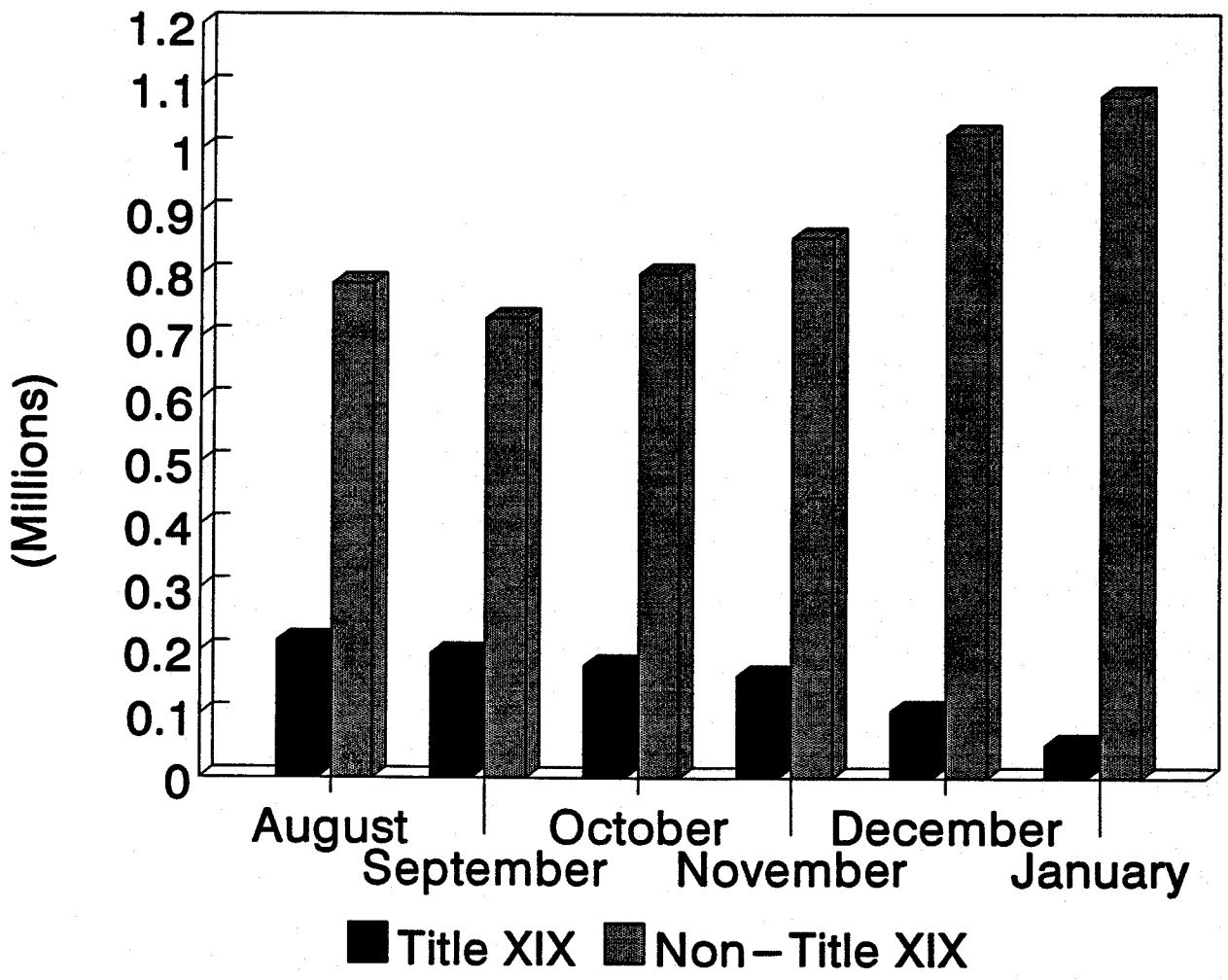
Title XIX Expenditure Comparison

MONTH	TITLE XIX * EXPENDITURE	NON–TITLE XIX EXPENDITURE
August, 1992	216,678.36	786,787.48
September, 1992	196,391.20	730,581.84
October, 1992	177,898.34	801,855.14
November, 1992	161,270.94	860,047.64
December, 1992	106,263.70	1,024,075.03
January, 1993	53,734.26	1,083,747.31
	$912,236.80	$5,287,094.44

* Includes room/board/personal clothing and allowance



GRAPH 4

Expenditures during November 1992 and December 1992 include room and board and personal clothing and allowance from July 1992 forward. Although the ISA requires ADHS to pay providers for room and board, personal clothing and allowance with reimbursement from the AOC, ADHS has not paid providers for these services to court children since July 1992. In December 1992, the AOC approached ADHS directly and made arrangements to pay providers for these costs and remove ADHS from this responsibility. Therefore, the Title XIX expenditures in November and December are inflated due to these payments. The amount of Title XIX reimbursement paid to providers has dramatically decreased during the year.

Average Cost of Behavioral Health Services for Juvenile Court Children

The AOC collected information from August 1992 to December 1992 to develop an average cost of treatment per youth per month. During this time period, there were an average of 113 youth participating in the Title XIX program with an average monthly treatment cost of $1,307 which is analogous to an AOC capitation rate. This did not include necessary non-Title XIX services, psychiatric medication and laboratory costs. The monthly cost to treat youth including room and board was $1,600. Again this cost excludes psychiatric medication laboratory tests and other non reimbursable costs (Graph 5).

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ADMINISTRATIVE OFFICE OF THE COURTS
Average Cost of Care for AOC Juveniles

The following treatment costs are average monthly costs. They do not include room and board, psychiatric medication or laboratory costs.

MONTH 1992	TITLE XIX EXPENDITURE	NO. OF CHILDREN IN SERVICE	AVERAGE COST PER CHILD
August	$175,839.00	139	$1,265.03
September	$156,781.00	115	$1,363.31
October	$143,610.00	110	$1,305.55
November	$136,425.00	103	$1,324.51
December	$125,790.00	98	$1,283.57

ADMINISTRATIVE OFFICE OF THE COURTS

Total Title XIX Costs without Room and Board

TOTAL TITLE XIX COSTS	$738,445.00
Average No. of Youth	113
Average Cost Per Child	$1,306.98

Total Title XIX Costs including Room and Board

TOTAL TITLE XIX COSTS	$903,928.00
Average No. of Youth	113
Average Monthly Costs	$1,599.87

* Does not include psychiatric medication or laboratory costs.

GRAPH 5

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Needless to say, AOC youth are a high risk population who require intensive services. The AHCCCS capitation rate of $480 per child per month, which was developed prior to AOC's participation in the Title XIX program, makes it impossible for the RBHA's to effectively cover the treatment costs of a pool of high risk youth who were not factored into the current rate. This results in a tug-of-war for dollars which pits judges and probation officers against behavioral health professionals in ongoing skirmishes over whether or not children meet the inconsistently defined medical necessity criteria.

Although many AOC youth legitimately do not meet the criteria for medical necessity, those who do have slowly been crowded out of the program or have been approved for limited services. The AOC must offset this service void, utilizing state dollars as the sole source to provide the necessary services even though these children remain financially eligible for Title XIX.

OPTIONS FOR ACTION

The Title XIX Task Force identified five possible options the AOC could pursue to resolve administrative and operational problems and maximize the benefits of the Title XIX program for the juvenile court children.

Options

I - Withdrawal completely from the Title XIX system;
II - Establish an AOC RBHA with a special capitation group;
III - Establish special capitation group within current RBHA network;
IV - Contract with each RBHA to establish AOC sub-RBHAs;
V - Amend the current ADHS-AOC ISA.

At the February 9, 1993 Task Force meeting, the participants discussed and evaluated Options I through IV. The results of these discussions are recorded in a "Pros" and "Cons" summary (Appendix II:12).

Strong support was voiced for Option I by juvenile court representatives. This proposal would allow the courts to return to their former practices without having to

coordinate treatment services with the various RBHAs. The return of total control to the courts makes this option extremely attractive, as the court would be able to expeditiously meet the needs of juvenile court children. Most importantly, the courts would be able to pay providers directly, without having to funnel funds through an intermediary (ADHS).

In reality, however, this option is the least acceptable because of its cost. In today's constrained fiscal environment, the courts must maximize utilization of state appropriations. Through Title XIX, the courts are able to get more than two federal dollars for each state dollar spent. Since approximately 25% of the court's 56,000 plus juvenile population may potentially meet Title XIX financial eligibility, fiscal prudence demands the courts capture Title XIX matching funds.

The benefits identified in support of Option II are also attractive from the courts' management perspective. The proposal calls for the AOC to establish and operate a self-contained RBHA for juvenile court children. A special capitation rate would be negotiated which would reflect the actual costs of treatment for this high service utilization group. The RBHA would function on a statewide basis with full management control in the hands of the AOC for intake, screening, evaluation, diagnosis, treatment and discharge.

The single overwhelming negative factor associated with an AOC RBHA is managing the enormous administrative requirements imposed by AHCCCS and federal regulations. A substantial up-front commitment of resources would be necessary to subsidize the RBHA's development. Also, because the juvenile court children constitute a relatively small pool of users, the benefits of cost savings derived from risk sharing in a large pool would be greatly diminished.

Option III, which is a variation of Option II, directs the AOC to establish a special capitated group for juvenile court children within the existing RBHA network. The major advantages identified are establishing a higher capitation rate sufficient to meet the service utilization levels of juvenile court children, eliminating competition with non-court children for services, and less administrative overhead than operating a separate RBHA.

The key benefit of both Option II and III is the having a special capitation rate, at a sufficiently high amount, that would allow adequate levels of treatment for juvenile court

children. The advantage of a separate capitation rate for the AOC is that only AOC funds would be used for federal match. For example, if the rate were fixed at $1200 per child per month, the AOC would contribute $400, drawing down a federal match of $800. Even though the amount is substantially higher than the current rate of $480, the state budget would not increase because juvenile court funds are separately appropriated. In addition, the state would receive the benefit of more federal dollars to treat juvenile delinquents.

The disadvantages of Option III are in the form of additional administrative and reporting requirements, and the minimized cost risk sharing inherent in a small capitated group. There was also concern that this could start a trend among all the agencies participating under the AHCCCS Title XIX program to establish special capitation groups, which would effectively destabilize the system.

Option IV is perhaps the most innovative approach presented. It proposes that the AOC enter into contracts with each of the existing RBHAs to become a sub-RBHA for juvenile court children only. Several substantial benefits flowing from this arrangement are the control and autonomy the court would enjoy, maximizing the draw down of Title XIX funds and eliminating case management duplication.

On the other hand, the negatives of Option IV are virtually the same as those identified with the other options. It creates another layer of bureaucracy, it separates court juveniles into a small pool with minimum cost-risk sharing, administrative overhead increases in managing six RBHA contracts, and the courts would assume responsibility for the financial risk providing services to juveniles in a managed care approach.

Option V which has been a principle focus of Task Force discussions, is amending the current ADHS-AOC ISA to best optimize the juvenile courts participation in the Title XIX system. The following items were frequently mentioned in the Juvenile Court Centers survey as needing to be changed (see Appendix II:13).

- A clear Title XIX Clinical Eligibility Criteria/Discharge Criteria needs to be established.

- Juvenile probation staff were particularly frustrated by the lack of communication from RBHA staff regarding treatment decisions involving their juveniles.

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- The intake, screening and diagnosis of referred juveniles was too slow and cumbersome. In many instances, the RBHA would not authorize treatment without parental consent, which clearly interferes with the Judges authority to order treatment. In many cases there are severe problems with the parents themselves. Having to require parental approval in these cases, makes little sense.

- Administratively, the claims process was identified as a disaster. The ADHS is unable to figure out which state agency is supposed to pay match on which child. The AOC can only estimate fiscal liability through projections, as ADHS submits claims for reimbursement many months after services are provided.

- Billing and collection procedures need to be renegotiated to reflect current operating procedures of Title XIX as a capitated plan. At the time the ISA was negotiated, the ADHS operated Title XIX as a fee-for-service plan, and EDS was not handling billings, collections, and third party payment functions.

The silent assumption underlying the viability of Options II, III, IV and V is that there will be a viable Title XIX network. Unfortunately the validity of this assumption is subject to question, in view of the history of behavioral health services in Arizona.

The provider network is in serious financial trouble resulting from ADHS' failure to pay claims in a timely manner. Many providers have carried delinquencies of substantial amounts for more than eight months, and have appealed to the AOC to intervene on their behalf with ADHS or pay them directly. On numerous occasions, the AOC has attempted to resolve this problem with ADHS without success.

There is no evidence or expectation that this situation will change at any time in the near future in view of the unresolved budget issues pending in the Legislature. "All indications are that there will be no increases for children's behavioral health services."[13]

CONCLUSIONS AND RECOMMENDATIONS

At the final meeting of the Task Force on March 4, 1993, the participants spent substantial time discussing the draft report. All participants were advised to submit their comments in writing so they could be included as part of the final report.

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Extensive discussion took place regarding Option V, which recommends the Juvenile Court's continue participating in the existing Title XIX program, on the condition that the AOC negotiate a new ISA with ADHS that resolves the various operational issues that now hinder delivery of full benefits to juvenile youths. The following are several crucial recommendations offered by participants to improve communication and coordination between the RBHAs and juvenile court staff.

- Require the RBHAs to include JPO staff as members of the clinical evaluation teams.
- Require the RBHAs to establish specialized units to deal with juvenile court youth.
- Institute a dispute resolution process whereby meaningful decisions can be obtained quickly to resolve differences between the RBHAs and juvenile courts.
- Develop a clear and workable definition of the term "medical necessity" that will be uniformly interpreted throughout the Title XIX network and will govern placements without regard to the RBHA's financial condition.
- Eliminate the requirement for parental consent as a precondition for enrollment of a juvenile court youth in the Title XIX program.
- Require the development of a more efficient intake and referral system and streamline the screening and diagnostic process which is duplicative of the juvenile courts'.
- Assure to everyone's satisfaction that ADHS is capable of performing all billing, collection and payment functions in a timely manner, utilizing the services of EDS.
- Assure that RBHA management be included in all negotiations between the AOC, ADHS and AHCCCS for effective implementation of the agreement.

Before the Task Force adjourned participants were asked to rank the options in order of preference. Ranking was done on a scale of 1-5 with 1 being most preferred and 5 being least preferred. Each option was ranked twice: (A) from the perspective of the Juvenile

Court, and (B) from the individual's personal perspective. The tabulation of the results reflected a clear consensus with the participants preferring the AOC to remain in the Title XIX network under a redrafted ISA. The next preferred option was to withdraw totally from the Title XIX system. The remaining three options, involving separate capitation groups and RBHA, were ranked very closely with minor statistical differences. The numerical values for the rankings are as follows:

	A	B
Option I - (Total withdrawal)	2.875 [2]	3.125 [3]
Option II - (AOC RBHA)	3.563 [5]	3.563 [5]
Option III - (AOC capitation)	3.25 [3]	3.188 [4]
Option IV - (RBHA sub-contract)	3.25 [3]	2.875 [2]
Option V - (Amended ISA)	1.842 [1]	1.579 [1]

In the final analysis, the AOC must pursue a course of action to achieve its stated goal of the rehabilitation of the youths who pass through the juvenile court system. For this to happen, the courts must be able to refer youths for treatment regardless of financial eligibility.

Title XIX had been viewed as the vehicle to increase services to juvenile delinquents through increased federal dollars. This never materialized because of provider rate increases and programmatic barriers. In addition, the cost of purchasing treatment on a fee-for-service basis had substantially escalated resulting in recommendation for a capitated system. Capitation was presented as a cost effective system that would allow the courts to continue to deliver the services it deemed necessary in a managed care network. Unfortunately, implementation of the system was defective and it has been unable to deliver the promised benefits of behavioral health services.

It is possible that in the near future, i.e., the next three to five years, the legislature will appropriate adequate funding for behavioral health services through Title XIX. However, until that funding materializes Arizona's program will continue to struggle and stumble because of its financial handicap without prospect of meeting its expectations.

This report concludes with the following recommendations:

1. The AOC should continue its current moratorium policy of limiting referrals of juveniles to Title XIX until such time as the program is adequately funded to the point where it can deliver the treatment services required to meet the needs of juvenile court youths.

2. The AOC should initiate negotiations with AHCCCS and ADHS to amend the ISA to increase the capitation rate and to remove the policy and operational barriers that have been identified in this report.

3. The AOC should seek an increase in the capitation rate that would support adequate levels of behavioral health treatment services for juvenile court youths.

4. The AOC should pursue the establishment of a separate RBHA if and when there is broader political support for the concept in the executive and legislative branches of government.

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FOOTNOTES

1. Dollars, Decisions & Dilemmas, pp. 9 (Appendix II:14).

2. D,D&D, pp. 14.

3. D,D&D, pp. 31.

4. D,D&D, pp. 15; also, Children's First: The Community's Design for Children's Behavioral Health Services (December 1992), pp. 10 (Appendix II:15).

5. D,D&D, pp. 30.

6. D,D&D, pp. 31.

7. D,D&D, pp. 38.

8. D,D&D, pp. 39.

9. Governor's Office Behavioral Health Task Force Report (November 2, 1992).

10. D,D&D, pp. 31.

11. Curt Bay memorandum of July 29, 1992 (Appendix II:8).

12. Dave Byers letter (Appendix II:2).

13. "Funding Folly." Arizona Republic Editorial, February 22, 1993.

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ANNOTATED BIBLIOGRAPHY

Dollars, Decisions & Dilemmas, (January 1993)

A compilation of various articles, and summaries regarding the Arizona Behavioral Health System presented at a conference sponsored by the Arizona Association of Behavioral Health Programs.

Community's Design for Children's Behavioral Health Services, (December 1992)

A study and recommendation for a comprehensive children's behavioral health system design for Pima County.

Governor's Office Behavioral Health Task Force Report, (November 1992)

A report presented to the Governor's Office from the Behavioral Health Task Force which examined the claims processing system, finance and financial reconciliation, and communication issues.

APPENDIX I

Title XIX Task Force Participants

RMDSENATE 10/13/2006

ADMINISTRATIVE OFFICE OF THE COURTS
TITLE XIX TASK FORCE MEMBERS

CANDANCE AHMANN
COCHISE COUNTY JUVENILE COURT

STAN ALEXANDER
ARIZONA DEPARTMENT OF ECONOMIC SECURITY

EILEEN BOND
ATTORNEY GENERAL'S OFFICE

DAN CADY
COCONINO COUNTY JUVENILE COURT

ANN KAEHLER-CAMPBELL
ARIZONA DEPARTMENT OF HEALTH SERVICES

KATHY DOUCETTE
COMMUNITY ORGANIZATION FOR DRUG ABUSE,
MENTAL HEALTH AND ALCOHOLISM SERVICES

TERRY FARRELL
YUMA COUNTY JUVENILE COURT

ELIZABETH GARCIA
PINAL-GILA BEHAVIORAL HEALTH AUTHORITY

ARGIE GOMEZ
ARIZONA DEPARTMENT OF YOUTH TREATMENT AND REHABILITATION

LANA TOMPKINS-HATTON
COCHISE COUNTY JUVENILE COURT

RODNEY JILG
ARIZONA DEPARTMENT OF HEALTH SERVICES

KAREN LEWIS
TRI-CITY BEHAVIORAL HEALTH SERVICES

LYNNE LIEBLING
PINAL COUNTY JUVENILE COURT

GEORGE LOGAN
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Jim Marvin
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Rosendo Morales, Jr.
Yuma County Juvenile Court

Tony Nicholson
Maricopa County Juvenile Court

Donna Noriega
Administrative Office of the Courts

Liz Powers
Arizona Health Care Cost Containment System

Linda Ruitenberg
Maricopa County Juvenile Court

Frank B. Sanders
Administrative Office of the Courts

Robert Schackner
Arizona Department of Health Services

Jamey Schultz
Administrative Office of the Courts

Aimee Schwartz
Arizona Department of Health Services

Dick Shapiro
Arizona Health Care Cost Containment System

Jerry Stogner
Pinal County Juvenile Court

Cathy Ryan-Stover
Prehab of Arizona, Inc.

Mike Ullery
Arizona Department of Youth Treatment and Rehabilitation

Myrtle Young
Cochise County Juvenile Court

APPENDIX II

Documents

RMDSENATE 10/13/2006

Supreme Court

STATE OF ARIZONA
ADMINISTRATIVE OFFICE OF THE COURTS

Stanley G. Feldman
Chief Justice

William L. McDonald
Administrative Director
of the Courts

September 29, 1992

Ms. Alethea Caldwell, Director
Arizona Department of Health Services
1740 West Adams
Phoenix, Arizona 85007

Dear Alethea:

Enclosed is the Concept Paper outlining our position with regard to Title XIX. I believe the next step is to begin implementation of the payment process. A meeting with AHCCCS, ADHS, and the AOC needs to occur rapidly.

If you have any questions, please do not hesitate to contact me at 542-9443.

Sincerely,

Frank

Frank B. Sanders, Director
Juvenile Justice Services Division

FBS/cmj
Attachment
cc: Donna Noriega

1501 WEST WASHINGTON STREET • PHOENIX, ARIZONA 85007-3327 • 602•542-9300

ARIZONA SUPREME COURT
ADMINISTRATIVE OFFICE OF THE COURTS
Title XIX Concept Paper

OVERVIEW:

The purpose of this document is to present a new position for the AOC with regard to participation in the Title XIX process. During the first year of participation in the Title XIX program, several problems arose requiring reconsideration. Recently, Arizona Department of Health Services (ADHS) and the Administrative Office of the Courts (AOC) met to discuss these areas which included capitation, Title XIX eligibility, provider payment, case management, intake, detention and clinical teams. A brief description of each follows:

1. The role of capitation. It was clarified that AOC does not fall under capitation as the AOC has the state match for children receiving Title XIX services.

2. The ability to pay providers directly for services to AOC children. Due to the problematic reconciliation process, provider confusion as to when to bill the AOC and when to bill ADHS, duplicate billings and no billings, providers of Title XIX services to AOC children were not paid in a timely manner.

3. The intake process for AOC children is lengthy and exclusionary resulting in many eligible children remaining unserved or dropping out.

4. Duplicate case management efforts exist for the period of time the child is Title XIX eligible. Within the AOC, the Probation Officer provides the case management activity for youth on probation.

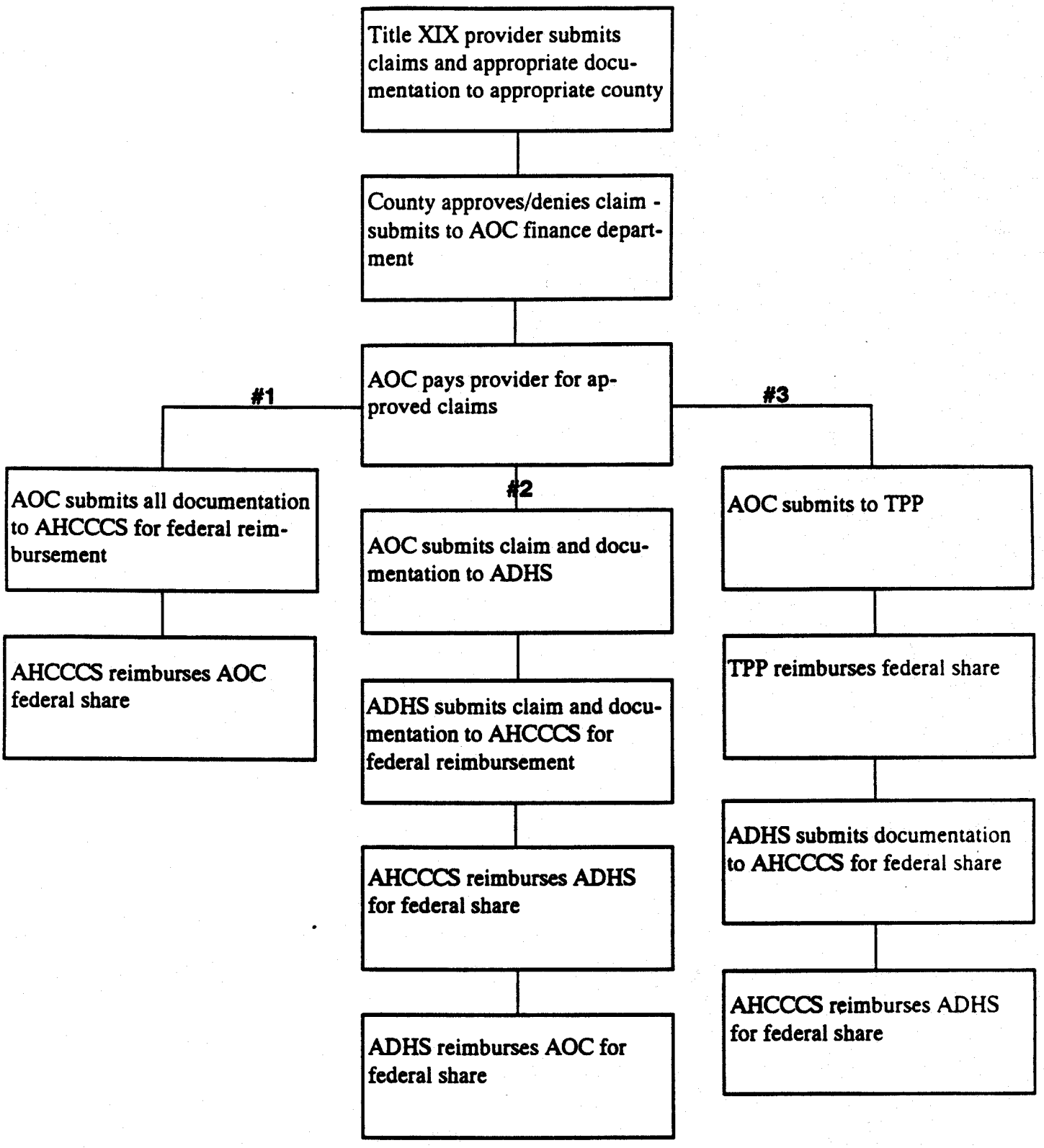
5. The issue of detention and whether children with behavioral health problems in detention on a temporary basis can retain their Title XIX eligibility and/or use their detention days toward the 30 day out-of-home rule for Title XIX eligibility.

During a subsequent meeting between ADHS and AOC, it was decided to prioritize the payment process to providers. The other identified issues would be phased in during the fiscal year.

PAYMENT PROCESS:

Currently, the AOC contracts directly with providers. Due to this contractual relationship, we have requested to begin with the November, 1992 billings, to pay providers directly for youth receiving Title XIX services and seek reimbursement for the federal share. Any claims for Title XIX services prior to November will be processed through the RBHA's existing procedure. There are three possibilities for AOC claim reimbursement for the federal share (diagram attached).

AOC/AHCCCS PAYMENT PROCESS



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Issues regarding each option:

Option 1: (This option is the preferred AOC reimbursement plan, if possible)

- Would eliminate encounter data to EDS.
- Payment would be quick for clean claims.
- Timely and cost effective process.
  - ✓ Can AOC receive direct Title XIX federal reimbursement from AHCCCS under A.R.S. §36-2900?
  - ✓ What would the liability for AOC be?
  - ✓ What type of interface would be needed regarding claims, denials, etc.?
  - ✓ Will there be any AHCCCS standards for payment by AOC?

Option 2:

- Would require a manual system for submission from ADHS to AHCCCS.
- Would eliminate encounter data to EDS.
- Possible lengthy reimbursement process dependent on staff time allocated to the process.

Option 3:

- Similar to Option 2, but the TPP reimburses federal share upfront.
- Would the TPP be able to pend payment to AOC and send on to AHCCCS for federal share?

Once received, the TPP could then reimburse AOC.

- How would this reimbursement occur? Transfer of funds, checks?

IMPLEMENTATION:

In order to begin paying provider claims by November 1, the following must occur rapidly:

	TASKS	TARGET DATE	RESPONSIBLE PARTY
1.	Submit paper to ADHS for submission to AHCCCS	week of 9/25	AOC/ADHS
2.	Meeting with ADHS/AHCCCS/EDS/ AOC finance • Discuss new billing procedures • Decide/begin implementation of new claim procedure	week of 9/28 (on hold by ADHS)	ADHS
3.	Apply for AHCCCS provider number	week of 10/4	AOC w/ADHS assist.
4.	Inform Juvenile Court Judges	10/9	AOC
5.	Meet with counties • Present new claim flow • Memo to providers re: new billing format	week of 10/11	AOC
6.	Meet with Codama/RBHAs • Prepare for transition • Work out procedure for agencies not contracted yet with AOC	week of 10/18	ADHS/AOC
7.	Begin new billing format	November	AOC

ONGOING ISSUES:

The remaining issues will require ongoing coordination with ADHS/AHCCCS and the RBHAs. During the next several months, we will continue to meet to implement these changes.

Detention:

Seek a final opinion on the detention situation. HCFA sent a response last spring but specific questions need to be addressed as follows:

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1. If a child is in detention as a protection to himself/herself or others and the court order specifically reads this way, can he retain his Title XIX?

2. Will DES allow the child's stay in detention as a protection to himself/others as the 30 day waiting period for out-of-home rule?

3. Research through JOLTS (Maricopa) the ability to get diagnosis/disposition and length of stay database.

Eligibility:

1. Work with DES to outstation workers at the juvenile court centers with high volume cases.

2. Try to increase the amount of children eligible for Title XIX including detention children.

Intake/Clinical Teams:

1. Develop an intake process concurrent with the evaluation done by the Probation Officer at intake.

2. Consider certification of current Probation Officers or contract with consultants to provide the intake function.

3. Consider execution of contracts between county clinical teams (psychologist and Masters level staff) and RBHA.

4. Consider a pilot in Pima and Maricopa Counties for alternative to the current RBHA clinical team. Consider working with Ron Adler/SAMHC to accomplish a separate pilot in Pima.

Case Management:

1. Work with each county to evaluate the ability of current P.O.s to provide case management services during Title XIX eligibility to youth within their care.

2. Consider pilot in Maricopa and Pima Counties.

Meeting with Alethea Caldwell
September 11, 1992

ISSUES FOR DISCUSSION

I. Title XIX and non-Title XIX

- Expanding our non-TXIX options.
- Establishing TXIX and non-TXIX rates with current providers.
- Who will establish the RBHA rate?
- When will the TXIX rates be negotiated?
- What licensing issues, if any prevent both TXIX and non-TXIX children in the same facilities?

II. Capitation

- How will capitation impact the AOC?

III. Intake Process

- Numerous barriers and lengthy intake process.
- What is the new RBHA role in terms of case management, case monitoring?
- Rationale for RBHA participation in the intake process.

IV. Provider Payment Issues

- Current demands from providers to pay TXIX bills.
- Has DHS paid AOC claims?

Supreme Court

Stanley G. Feldman
Chief Justice

STATE OF ARIZONA
ADMINISTRATIVE OFFICE OF THE COURTS

William L. McDonald
Administrative Director
of the Courts

November 6, 1992

Ms. Charline Franz
Governor's Office
1700 West Washington
Phoenix, Arizona 85007

Dear Charline:

This is a follow-up to your conversation with Bill McDonald on Friday, October 30, 1992, with regard to the Title XIX program. As Bill indicated, beginning November 1, 1992, the AOC has placed a moratorium on all new referrals into the Title XIX system except for those youth who we deemed clearly eligible by the Juvenile Court staff. We will also continue participating in the Title XIX system with those Title XIX children currently in service. During the moratorium, a task force will be formed to explore our options with Title XIX and to evaluate the overall cost effectiveness of participation in the program, as we now do or whether the Juvenile Courts should become a "RBHA like" entity, or other options that make the most sense. This period of moratorium will allow DHS to implement the Capitation program without the added complications of all Juvenile Court residential placements being referred to them.

As you know, this decision was made after extensive review. We have attached a copy of our position paper which outlines the issues, concerns and development of the task force. We believe this step will allow us to develop a continuum of care which meets the needs of our children and will allow us to more efficiently and cost effectively serve all the children that come to our attention.

Sincerely,

David K. Byers
Deputy Administrative Director

DKB/cmj
cc: Frank Sanders
Len Kirshner, AHCCCS
Charles Cowan, ADHS
John Arredondo, DYTR
Alethea Caldwell, DHS

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Title XIX Program

FEE FOR SERVICE VS. CAPITATION

OVERVIEW AND HISTORY

Beginning 11-1-92, the Title XIX program for children will change from a fee for service system to a capitated system. Under this new capitated program, AHCCCS will reimburse ADHS a set dollar amount for each child enrolled in the program each month. ADHS will then subcapitate each RBHA a specified amount per child per month. This monthly capitated amount is approximately $470.00 which includes both the federal dollars ($300.00) and the tate match dollars ($170.00). This capitated amount was estimated based on service utilization rates by Title XIX children during the six month period of 7-1-91 through 12-31-91. During the first month of service, this amount must cover an 8% administrative fee, intake fees and case management fees leaving approximately $175 for treatment services. In subsequent months of service, the monthly capitation amount must cover administrative and case management fees leaving a total of $250.00 per month for treatment services (federal and state combined).

Since 1-1-92, the AOC has participated in the fee for service Title XIX program. Services for children under this system were reimbursed from AHCCCS through ADHS based on established RBHA rates. Therefore, an approved Title XIX child in a residential program costing 4,000.00 per month would be reimbursed by AHCCCS for between 50-62% of the cost depending on the facility and the services provided.

Although it would appear that participating in the Title XIX program aided in reducing the AOC expenditures for approved children it, in fact, had an adverse affect on non-Title XIX children residing in the same facilities. Under the Title XIX program, facilities wishing to become certified to accept Title XIX eligible children were expected to adhere to rigid rules and regulations increasing costs substantially. Although participating as a Title XIX provider increased costs it also allowed for a higher rate structure which far exceeded what facilities had been paid prior to the Title XIX program. These new rates charged by these newly approved Title XIX facilities dramatically increased the expenditures for non-Title XIX AOC children in these same facilities. The overall loss to AOC by participating in the Title XIX program was approximately $240,000.

TITLE XIX UTILIZATION RATES

AOC has been participating in the Title XIX program since January 1, 1992. There have been approximately 350 referrals statewide to the RBHA of AOC Title XIX eligible children. As of August 31, 1992, 84 (24%) were denied services, 121 (34%) have been terminated from services, 21 (6%) are still in the intake process and 121 (34%) are receiving some type of service. Children accepted for service are assigned to one of four service models according to the intensity of services needed for the problem as follows:

Model A - children typically in Residential treatment JCAHO level 1 facilities (AOC has had 45 children in this model since January 1, 1992).

Model B - children in crisis/hospitalized (AOC has had 7 children since January 1, 1992).

Model C - children requiring intensive services of at least one year's duration; can include group home children, outpatients, children on medication only (AOC has had 69 children in this model since January 1, 1992).

Model D - children receiving individual, group or family treatment. This is a less intensive model (AOC has had no children in this model since January 1, 1992).

The majority of AOC children have required an intensive setting.

EFFECTS OF A CAPITATED SYSTEM

The AHCCCS/ADHS capitated demonstration model for mental health services for children will severely limit the RBHA's ability to utilize intensive out-of-home services (ie:residential and group home). The RBHA must balance the cost of children in residential treatment with large numbers of children in less costly services (group therapy/individual therapy). The effects of a capitated system on the AOC at this time are unknown. Obviously, the RBHA must severely limit the numbers of children in services such as residential treatment in order to balance their own budgets. Given this, it is difficult to project how AOC children needing intensive programs will be served.

The intake and eligibility process are lengthy and frustrating for probation officers. In many cases, children have been evaluated through the court system and recommendations have been made for services. Even in these cases 24% of the children are denied services because they do not meet specific criteria. With an even more rigid criteria for services, probation officers may end up spending countless hours referring children, sharing paperwork, getting children to and from appointments only to be told the child can only receive group or individual therapy under Title XIX funding.

The Title XIX process has taken away the courts discretion. The courts evaluate children in need of treatment and make decisions based on those evaluations. When appropriate, the courts will order children into treatment. This process has been rejected by the RBHA's and children are re-evaluated by additional professionals. In many cases, recommendations by the RBHA clinical teams are in direct opposition to the courts recommendations. Under capitation, this will become even more problematic as RBHA's institute tighter controls on intensive services.

The Title XIX system has also created significant difficulties with the provider community. Claims for Juvenile Court Children have not been paid by the Department of Health Services. The claims processing system will change to include a third party payor known as the EDS system. This system has just begun processing claims and the full extent of its ability to pay providers in a timely manner is unknown.

JUVENILE COURTS ARE ALREADY "STATE CAPITATED"

In 1991, there were 53,435 referrals to the Juvenile Courts. Each of the juvenile cases referred must be processed in some manner and services provided in varying degrees. Some children receive individual or family counseling, others are placed in community service programs, or day support programs. Still others need more extensive services such as supervised probation, intensive probation or residential care. Of the 53,435 referrals, only 250 or less than 1/2 % at any one time are placed in residential care.

Given the amount of $21,652,561 of state appropriated funds provided to the Juvenile Courts for treatment, only $405.21 is spent per child. This is our "State Capitated" amount.

DIRECTIONS AVAILABLE TO AOC

There are several possibilities available to AOC to deal with the current concerns regarding a capitated system.

1. Full Participation. Proceed with referrals into a capitated system with probation officers continuing to refer Title XIX children to the RBHA for intake and service designation. As the same concerns continue with lengthy intake, disagreement on service options, philosophical disagreements with regard to Court children needing treatment, this possibility would continue with no resolution of current concerns and issues. It would continue to limit the courts discretion in certain cases and would require participation in the EDS system.

2. No Participation. Totally drop out of the Title XIX system. Given the philosophical differences of why children need treatment as well as the difficulty accessing the system, this possibility would allow the AOC to have a totally non-Title XIX system and refer children based on the current criteria established by each county court for examining all treatment alternatives. The courts would have full discretion for deciding treatment alternatives and all claims would be paid by AOC with no exceptions.

3. Participate as a RBHA. Become a RBHA and receive sub-capitation from ADHS for intake, evaluation and service development for Title XIX children. This would require ensuring certification of probation officers, coordination with the EDS system for payment, development of clinical teams and adherence to the AHCCCS manual in areas such as quality assurance, grievance, etc.

RMDSENATE 10/13/2006

COURSE OF ACTION

Given the tenuous state of the capitated system, it is difficult to choose one of the above options without further evaluation and exploration. In order to make a reasonable decision with regard to participation or non-participation in the Title XIX program the following is a suggested course of action.

1. Participate in the Title XIX system with current Title XIX Children only. Place a temporary moratorium on all new referrals but continue participating in the Title XIX system with children currently in service.

2. Form a task force to make recommendations on the desired course of action for the AOC. Task force members will consist of:

   a. counties who are significantly affected by Title XIX/Capitation or who wish to participate.

   b. representatives from the provider community.

   c. a consultant (short term) to explore the EDS system as well as the cost-effectiveness of the Capitated system on the AOC.

   d. AOC JJSD staff members.

3. The charge of the task force will be to:

   a. Evaluate the outcome of the children currently in service under the capitated system.

   b. Explore the numbers eligible for Title XIX services. Consider evaluating one month of referrals into the juvenile court system. Of these referrals, how many children are Title XIX eligible. Of those with Title XIX eligibility, how many are referred to behavioral health treatment.

   c. Explore viability of the EDS system and the pros and cons with this system. Evaluate the EDS system and its ability to pay claims in a timely manner.

   d. Explore the administrative responsibilities of a RBHA and how/if becoming a RBHA is pragmatic for the AOC.

   e. Evaluate whether it is cost effective overall to participate in the Title XIX system.

4. The task force recommendations will be available no later than March 15, 1993.

Implementation of the moratorium will be November 1, 1992. The task force will be discussed and members decided upon at a Juvenile Administrative meeting on October 27, 1992. The first task force meeting will take place during the first week in November. At that time, specific objectives will be outlined to accomplish the charge of the task force.

11-6-92

RMDSENATE 10/13/2006

Principles for Mental Health Care in Health Care Reform

The following national organizations have endorsed the attached paper listing six key principles for mental health care in health care reform.

American Academy of Child and Adolescent Psychiatry
American Association for Marriage and Family Therapy
American Association for Partial Hospitalization
American Association of Pastoral Counselors
American Psychological Association
International Association of Psychosocial Rehabilitation Services
Federation of Families for Children's Mental Health
Mental Health Law Project
National Association of Protection and Advocacy Systems
National Association of Social Workers
National Association of State Mental Health Program Directors*
National Council of Community Mental Health Centers
National Mental Health Association

* subject to final membership approval

December 7, 1992

Principles for Mental Health Care in Health Care Reform

Mental health care must be viewed as an integral part of a national system of health care. The following principles emphasize the needs of individuals for mental health services within a reformed national care system.* The principles are not based on a particular payment system, although they assume that private health insurance will remain as a important form of securing benefits. The six principles are:

1. NON-DISCRIMINATION—People of all ages who have mental health needs and their families participate fully in the nation's health care system. Non-discrimination in the provision of health care means:

- Current health status is not a factor in determining coverage for medical and health related services. The health care system prohibits coverage exclusion or limitations based on ***pre-existing conditions.***
- Cost of coverage is based on the concept of broadly shared risk. That is, individual/family coverage costs are determined by ***community-wide usage*** rather than claims experience by small groups that exaggerate the impact of high service users.
- Health care coverage is portable and continuous. It is not dependent on a particular employment arrangement.
- Mental health services are available on the same terms and conditions as other medical and health related service, i.e., services are voluntarily sought and accepted.

2. COMPREHENSIVENESS—People who need mental health care regardless of age have coverage for a broad array of mental health and rehabilitation services delivered in culturally sensitive settings. These include:

- preventive services, e.g.: developmental and mental health screening and counseling to avoid and/or ameliorate illness;
- emergency services, including crisis intervention and crisis residential services;
- case management services;
- inpatient services;

RMDSENATE 10/13/2006

- outpatient services, including:
  —partial hospitalization,
  —psychotherapy and counseling,
  —medication management visits,
  —psychiatric rehabilitation,
  —day treatment for children and adolescents, and
  —family support services;
- prescription drugs.

3. CHOICE—The range of comprehensive services is based on individual need and informed choice. While recognizing the need to control unnecessary services, a consumer sensitive health care system will provide for consumer participation in treatment planning decisions, including selection of services, settings and providers.

4. EQUITY

a. SERVICE EQUITY—The provision of mental health services is not limited by artificial and arbitrary numbers of visits, days or procedures. Service equity means that the health care system:

- determines amount, duration and scope of services based on ***medical and psychological necessity*** in accordance with professional standards of reasonable care;
- ensures that services are delivered in the least restrictive environment able to meet the needs of the individual with minimal disruption to normal life style; and
- ensures the availability of appropriately trained personnel and services.

b. COST EQUITY—Individuals who have mental health care needs and their families do not spend a disproportionate share of their income and resources to obtaining services. Families do not have to select less-than-optimum services because of cost considerations. Cost equity means the health care system:

- limits expenses for participants through reasonable cost sharing requirements and overall limits on out-of-pocket costs;
- ensures adequate reimbursement for service providers; and
- does not discriminate in reimbursement rates between private and public providers.

5. EFFICIENCY—Health care financing policies contain incentives and reviews so that services are delivered in the lowest cost settings consistent with appropriate care (see Managed Care, below). An efficient health care system is one that:

- allocates resources in a reasoned way among preventive services, acute care, and rehabilitation services;
- undertakes reviews and evaluation to ensure that services are both cost efficient and effective; and
- reduces administrative complexity.

6. MANAGED CARE—The health care system employs managed care techniques to control unnecessary utilization through review of treatment and service plans while protecting the patient's right to quality care. The health care system also employs managed care devices such as: utilization review, prospective and capitated payments, preferred provider and negotiated performance-based contracting systems. An appropriate managed care organization:

- ensures an adequate range of high quality, individualized services appropriate to the needs of the patient;
- uses reviewers who are licensed or certified in the areas of health care they are reviewing;
- publishes in an accessible place and manner the review standards and criteria used in evaluating care plans;
- establishes arbitration or similar hearing arrangements to resolve appeals to the organization's decisions;
- ensures the confidentiality of patient-provider information;
- makes decisions quickly; and
- maximizes patient choice.

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* The population described in the paper consists of individuals who meet the diagnostic criteria for mental, emotional or behavioral disorders contained in the current edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association.

RMDSENATE 10/13/2006

JUVENILE PROBATION SERVICES FUND

CONTRACT SERVICES EXPENDITURE SUMMARY

FY 90-91

Service Category	FY 1990-91 Expenditure	Percentage of Total Expenditure
OUT-OF-HOME PLACEMENT:	$10,405,347	69.1%
Residential Treatment		
Sex Offender Residential Treatment		
Therapeutic Foster Care		
Family Foster Care		
Allowances		
Foster Home Recruitment, Training and Supervision		
Emergency Costs		
DAY TREATMENT & SUPERVISION:	2,315,861	15.4%
Day Treatment		
Non-Residential Rehabilitation or Supervision		
COUNSELING & TESTING:	1,125,987	7.5%
Counseling		
Sex Offender		
Drug Testing		
SHELTER CARE:	426,132	2.8%
EDUCATION:	364,662	2.4%
Drug/Alcohol		
Other Ancillary Problems		
Delinquency Prevention		
Community Service Supervision		
EVALUATION & ASSESSMENT:	416,186	2.8%
Psychosexual		
Sex Offender Assessment		
STATEWIDE TOTAL:	$15,054,175	100.0%

****

OUT-OF-HOME PLACEMENT:		
Residential Treatment:	$ 8,451,932	81.2%
Sex Offender Residential Trmt.:	704,547	6.8%
Therapeutic Foster Care:	644,011	6.3%
Family Foster Care:	400,276	3.8%
Foster Home Recruitment, Training and Supervision:	129,767	1.2%
Allowances:	62,419	.6%
Emergency Costs:	12,395	.1%
TOTAL:	$10,405,347	100.0%

JUVENILE PROBATION SERVICES FUND
UNITS OF SERVICE AND EXPENDITURE SUMMARY
FY 90-91

SERVICE PURCHASED	UNITS OF SERVICE	TOTAL EXPENDITURE	AVG COST PER UNIT	PERCENTAGE OF TOTAL EXPENDITURE
OUT-OF-HOME PLACEMENT		9,156,479		60.7
Residential Treatment (Days)	88,885	8,451,932	95.09	
Sex Offender Residential Treatment	3,617	603,293	166.79	
Inpatient Treatment	248	101,254	408.28	
DAY ~~TREATMENT~~				
Days	55,383	2,315,861	41.82	15.4
COUNSELING*		1,012,018		6.7
Hours	36,883	945,246	25.63	
Days	63	5,670	90.00	
Evaluations	33	5,413	164.03	
Sex Offender/Hours	855	55,689	65.13	
SHELTER CARE (Days)	7,630	426,132	55.85	2.8
THERAPEUTIC FOSTER CARE (Days)	14,433	644,011	44.62	4.3
EDUCATION*		364,661		2.4
Drug/Alcohol	1,847	245,062		
Other Ancillary Problems	1,984	74,170		
Delinquency Prevention	1,479	45,429		
FOSTER HOME RECRUITMENT		129,768		0.9
FAMILY FOSTER CARE (Days)	14,455	400,276	27.69	2.7
ALLOWANCES (Days) **		62,419		0.4
Clothing	33,102	27,187	0.82	
Personal	31,433	22,392	0.71	
Special		12,840		
EVALUATION AND ASSESSMENT		416,186		2.8
Hours	717	32,401	45.19	
Evaluations	1,111	300,031	270.05	
Prof. Reviews	9	1,415	157.22	
Psychosexual	292	66,308	227.08	
Sex Offender Assessment	28	16,031	572.54	
DRUG TESTING (Tests)	9,687	113,968	11.77	0.8
EMERGENCY COSTS				
Emergency Clothing		12,396		0.1
STATEWIDE TOTAL		15,054,175		100.0

* Many courts require that participants pay all or a portion of the cost for counseling and education classes. Units and amounts shown represent only those charged to and paid with state funds; the costs paid by participants are not included.

**Statistics are accumulated from allowances provided to juveniles residing in shelter care, therapeutic foster care, and family foster care. The statistics exclude last year's accumulation of allowance paid to juveniles in out-of-home placements. Out-of-home placement allowances are now included as part of the contracted daily rate for placement and are not billed for separately.

Units2

JUVENILE PROBATION SERVICES FUND
TREATMENT PORTION
FY 90-91

SERVICE PURCHASED	UNITS OF SERVICE	TOTAL EXPENDITURE	AVG COST PER UNIT	PERCENTAGE OF TREATMENT EXPENDITURE
OUT-OF-HOME PLACEMENT		9,156,479		65.9
Residential Treatment (Days)	88,885	8,451,932	95.09	
Sex Offender Residential Treatment	3,617	603,293	166.79	
Inpatient Treatment	248	101,254	408.28	
DAY TREATMENT				
Days	33,730	1,615,453	47.89	11.7
COUNSELING		786,427		5.7
Hours	16,070	719,895	44.80	
Days	63	5,670	90.00	
Evaluations	33	5,413	164.03	
Sex Offender/Hours	849	55,449	65.31	
THERAPEUTIC FOSTER CARE (Days)	14,433	644,011	44.62	4.6
SHELTER CARE (Days)	7,630	426,132	55.85	3.1
FOSTER HOME RECRUITMENT		129,768		0.9
FAMILY FOSTER CARE (Days)	14,455	400,276	27.69	2.9
ALLOWANCES (Days) **		62,419		0.5
Clothing	33,102	27,187	0.82	
Personal	31,433	22,392	0.71	
Special		12,840		
EVALUATION AND ASSESSMENT		409,820		3.0
Hours	717	32,401	45.19	
Evaluations	1,111	300,031	270.05	
Prof. Reviews	9	1,415	157.22	
Psychosexual	141	59,942	425.12	
Sex Offender Assessment	28	16,031	572.54	
DRUG TESTING (Tests)	9,657	113,605	11.76	0.8
EDUCATION*		109,562		0.8
Drug/Alcohol	749	11,731		
Other Ancillary Problems	1,633	68,707		
Delinquency Prevention	1,184	29,124		
EMERGENCY COSTS				
Emergency Clothing		12,396		0.1
STATEWIDE TOTAL		13,866,348		100.0

* Many courts require that participants pay all or a portion of the cost for counseling and education classes. Units and amounts shown represent only those charged to and paid with state funds; the costs paid by participants are not included.

**Statistics are accumulated from allowances provided to juveniles residing in shelter care, therapeutic foster care, and family foster care. The statistics exclude last year's accumulation of allowance paid to juveniles in out-of-home placements. Out-of-home placement allowances are now included as part of the contracted daily rate for placement and are not billed for separately.

Units1

JUVENILE PROBATION SERVICES FUND
PIC-ACT PORTION
FY 90-91

SERVICE PURCHASED	UNITS OF SERVICE	TOTAL EXPENDITURE	AVG COST PER UNIT	PERCENTAGE OF PIC-ACT EXPENDITURE
DAY/EVENING TREATMENT	21,653	700,407	32.35	59.0
EDUCATION*		255,100		21.5
Drug/Alcohol	1,098	233,332		
Other Ancillary Problems	351	5,463		
Delinquency Prevention	295	16,305		
COUNSELING		225,591		19.0
Hours	6,889	225,351	32.71	
Sex Offender (Hours)	6	240	40.00	
EVALUATION AND ASSESSMENT				
Psychosexual	151	6,366	42.16	0.5
DRUG TESTING (Tests)	30	363	12.10	0.0
STATEWIDE TOTAL		$1,187,827		100.0

* Many courts require that participants pay all or a portion of the cost for counseling and education classes. Units and amounts shown represent only those charged to and paid with state funds; the costs paid by participants are not included.

Units3

RMDSENATE 10/13/2006

TO: DONNAN AOC400 Donna Noreiga - AOC - Juvenile Justice
JAMEYS AOC400 Jamey Schultz

FROM: JAMEYS AOC400 Jamey Schultz

DATE: December 1, 1992
SUBJECT: Title XIX ISA Noncompliance by DHS

1. p. 4, IV.A.1)a). "Juvenile courts shall refer all Eligible Children to the appropriate RBHA." DHS is out of compliance because CODAMA will not accept a referral from anyone but a parent. Juvenile courts are to give CODAMA a "notification" that a parent may be making a referral.

2. p. 5, A)2)a). "DHS shall implement, maintain and monitor an appropriate inter-RBHA network to accommodate Eligible Children with regard to out-of-RBHA placement, out-of-RBHA emergency treatment and transfers. Within 30 days from the signing of this Agreement, DHS shall provide the Court with written procedures as to how such placements will be handled." Alethea Caldwell signed the ISA on July 31, 1992. I have not seen a copy of any such procedures.

3. p. 6, C)2)a). "DHS shall provide the Court with copies of the annual Structured Review of the RBHAs Report, Evaluation and Diagnosis Implementation Report at the time of completion." This report is due annually to AHCCCS on January 15, but I don't think the AOC has ever received a copy.

4. p. 7, E). "DHS shall provide the Court with a copy of the annual Structured Review of RBHAs Report, Quality of Care Report at the time of completion." This report is also due to AHCCCS annually on January 15, but I have never seen a copy of it.

5. p. 8, F)2)b). "DHS will assure that providers are reimbursed for non-Title XIX-reimbursable services in a timely manner." Many providers have sent us lists of unreimbursed claims for room and board--some many months old.

6. p. 8, F)3)c). "Each HCFA-1500 or UB-82 will have a Court invoice form attached, with the Court account code and fund source fields completed." DHS was compliant with this requirement until the last claims reconciliations were done on 11/3 and 11/4/92.

7. p. 9, 5)c). "DHS shall provide the Court a monthly reconciliation of the initial payment advance ($100,000) until the total advance amount has been used." The total advance was used to cover the first reconciliation and part of the second and is now completely spent, so there is no longer an obligation to provide us with monthly billings; however, before the advance was spent, DHS never provided the AOC a monthly billing. The ISA was in effect November 1, 1991, and DHS sent the AOC the first and second bills on 5/13/92 and 8/10/92, respectively.

The rest of the ISA requirements that have not been completed were to be joint activities of both DHS and the AOC.

ARIZONA DEPARTMENT OF HEALTH SERVICES

Office of the Director

FIFE SYMINGTON, GOVERNOR
ALETHEA O. CALDWELL, DIRECTOR

M E M O R A N D U M

TO: Peter Burns
Governor's Office of Strategic Planning and Budgeting

FROM: Alethea O. Caldwell
Director

DATE: December 7, 1992

SUBJECT: FY 93 Title XIX Children's Behavioral Health Funding

Attached is the analysis of the current year funding requirements for the Title XIX Children's Behavioral Health program. The analysis indicates a shortfall of $3,932,303 based on population rates included in the capitation application submitted to HCFA. The initial capitation roster from AHCCCS indicated less children receiving services then expected. This figure is expected to rise significantly as service authorizations for all Title XIX children are completed and entered into the system.

The Department has identified two possible means of funding this shortfall:

- Supplemental appropriation from the General Fund
- Transfer from other appropriated line items

Please let me know your preferred method of funding this shortfall and the Department will proceed accordingly.

AOC:MAS/ks

Attachment

cc: Charles Carbone
Charline Franz
Mark Stillion

The Department of Health Services is an Equal Opportunity Affirmative Action Employer.

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CHILDREN'S TITLE XIX
FORECAST OF MATCH REQUIREMENT
FISCAL YEAR ENDED JUNE 30, 1993

ESTIMATED 4 MONTH MATCH REQUIREMENT (7/1 - 10/31)	7,204,797
ESTIMATED 8 MONTH MATCH REQUIREMENT (11/1 - 6/30)	7,262,270
ESTIMATED 12 MONTH MATCH REQUIREMENT	14,467,067
ESTIMATED ADHS PORTION (1)	72.41%
ADHS LIABILITY	10,475,603
APPROPRIATION	6,543,300
DEFICIT	3,932,303

(1) PER GOVERNOR'S TASK FORCE REPORT

CHILDREN'S TITLE XIX
FORECAST OF MATCH REQUIREMENT *
4 MO. ENDED OCTOBER 31, 1992

RBHA	SERVICES	CASE MGT.	ADMIN.	TOTAL
CODAMA	9,648,000	2,667,990	771,840	13,087,830
ACCM	2,600,000	756,814	65,810	3,422,624
NARBHA	783,323	350,209	240,249	1,373,781
BHS -Yuma	200,952	79,832	28,832	309,616
PGBHA	409,435	212,935	83,166	705,536
SEABHS	560,000	162,000	80,000	802,000
TOTALS	14,201,710	4,229,780	1,269,897	19,701,387

ESTIMATED 4 MONTH COSTS	19,701,387
BLENDED MATCH RATE	36.57%
ESTIMATED 4 MONTH MATCH REQUIREMENT	7,204,797

FEDERAL/STATE CONTRIBUTION RATES:

	FEDERAL	STATE
JULY	62.61%	37.39%
AUGUST	62.61%	37.39%
SEPTEMBER	62.61%	37.39%
OCTOBER	65.89%	34.11%
BLENDED RATE	63.43%	36.57%

* BASED ON RBHA's ESTIMATES OF ACTIVITY FOR THE FIRST 4 MONTHS RECEIVED BY ADHS ON NOVEMBER 9, 1992.

RMDSENATE 10/13/2006

CHILDREN'S TITLE XIX
FORECAST OF MATCH REQUIREMENT
8 MO. ENDED JUNE 30, 1993

	EST. NO. OF ENROLLEES*	CAPITATION RATE	STATE SHARE	MONTHLY STATE COST
NOVEMBER	5,431	480.43	34.11%	890,003
DECEMBER	5,462	480.43	34.11%	895,083
JANUARY	5,493	480.43	34.11%	900,164
FEBRUARY	5,524	480.43	34.11%	905,244
MARCH	5,555	480.43	34.11%	910,324
APRIL	5,586	480.43	34.11%	915,404
MAY	5,617	480.43	34.11%	920,484
JUNE	5,648	480.43	34.11%	925,564
TOTALS	44,316			7,262,270

* As included in Capitation application to HCFA

ARIZONA DEPARTMENT OF HEALTH SERVICES

Office of the Director

FIFE SYMINGTON, GOVERNOR
ALETHEA O. CALDWELL, DIRECTOR

M E M O R A N D U M

TO: Mary Gill, Assistant Director/DAS
Department of Economic Security

Frank Sanders, Director
Juvenile Justice Services Division
Administrative Office of the Courts

FROM: Mark A. Stillion, Deputy Director/Chief Financial Officer

DATE: December 21, 1992

SUBJECT: Title XIX Children's Behavioral Health Services - FY 92

The Division of Behavioral Health Services (DBHS) has run a listing of claims that could potentially fall outside the nine month processing window; that total is $781,910.56. DBHS was not able to run the figure by State agency. They are attempting to do this!

I will keep you informed.

MAS/ks

cc: Alethea O. Caldwell
Charline Franz

ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF BEHAVIORAL HEALTH

Interoffice Memorandum

TO: Rodney Jilg, Ph.D.
Deputy Assistant Director,
Division of Behavioral Health

cc: Mabel Chen, M.D. Arizona Health Care
Cost Containment System (AHCCCS)

FROM: Curt Bay, Ph.D.
Project Manager, Research & Evaluation

RE: Children's Capitation

DATE: July 29, 1992

Calculation of the children's capitation rate is based on (a) Title XIX children's service utilization data collected during a recent six-month period, and (b) estimates of utilization for those services which are not currently covered, or if covered, not itemized within the current data collection system.

The data utilized for present purposes reflect Title XIX services provided during the period July 1, 1991 through December 31, 1991. It is believed that data for this period will provide the most stable estimate of service utilization during the first year of capitation. Utilization factors and capitated service costs for services currently covered by Title XIX are provided in Table I for the time period of interest.

These figures, with the following exceptions, were derived from data collected in the AHCCCS claims database as of June 2, 1992. Transportation cost was calculated from data provided by RBHA's in their quarterly reports for the six-month target period. Psychotherapy and group therapy services provided by psychologists and psychiatrists were not itemized. For purposes of estimating psychotherapy services provided by psychiatrists and psychologists (1A in Table I), it was assumed that 80% of psychotherapy would be provided by psychiatrists, and 20% by psychologists. For purposes of estimating group therapy services provided by psychiatrists and psychologists (2A in Table I), it was assumed that 90% of therapy would be provided by psychologists, and 10% by psychiatrists. The data reflect services provided to 5266 clients.

Itemized utilization data are not available for those services listed in Tables II and III. The assumptions utilized in calculating the figures provided are noted. Our best estimate of a per member per month cost, based on the data and assumptions used, is $438.06.

Family Matters

SPRING 1992

Published Quarterly by the Mental Health Services Program for Youth, a National Program of The Robert Wood Johnson Foundation

MHSPY, CASSP Meet in July

Important back-to-back meetings in Breckenridge, Colo., during July will provide intensive development and training opportunities for a wide range of children's service professionals.

Key program personnel from MHSPY's eight sites will meet July 17–18 to strategize on service capacity development, followed July 18–22 by the Child and Adolescent Service System's (CASSP) biannual training institutes.

MHSPY meeting participants will share their sites' experience in service capacity development; learn state-of-the-art strategies, particularly in the areas of individualized services and collaborative efforts with schools; and receive in-depth consultation for solving identified problems.

Continued on page 2

Photo by Rasheeda, age 10/Shooting Back, Inc.

Training Is a Key to Kentucky's Reform

The Kentucky legislature appropriated $19 million to expand the state's MHSPY model statewide. To help rapidly accomplish this sweeping reform of Kentucky's children's mental health system, an ambitious training program was developed.

When Kentucky's legislature funded the replication of the Bluegrass region's MHSPY model statewide, there was an immediate need to educate agency partners, service providers, and staff in the language and techniques of facilitation, coordination, collaboration, and team work.

This rapid growth of IMPACT (Interagency Mobilization for Progress in Adolescents' and Children's Treatment) created a large and diverse "blended family" of parents, practitioners, and service providers in five state government agencies. Many of the players not only were new

Continued on page 2

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Blended Funding

Oregon's Partners Pool Dollars for Flexible Services

Pooled dollars from five categorical agencies permit Multnomah County's Partners' Project to more fully utilize the wraparound process.

When funds for children's services are freed from the dictates of categorical programs, it becomes possible to design a service plan tailored to the unique needs and circumstances of a child and his or her family. This fundamental principle is nowhere better illustrated than in Multnomah County, Oregon, where five categorical agencies are pooling portions of their budgets to jointly finance flexible services.

These agencies, known as the Partners, are Portland Public Schools, the Centennial School District, the state Children's Services Division, the county mental health agency, the state Mental Health and Developmental Disabilities Services Division, and the state Office of Medical Assistance Programs.

How the Money Flows

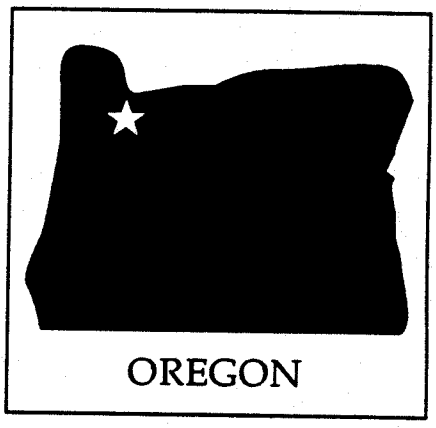
Each Partners' Project child has a Service Planning Team comprising his or her parent(s) and/or guardian, a managed care coordinator (as Partners' case managers are called), representatives from current service agencies, and significant others involved with the child. This team develops a plan of care which identifies and prioritizes services and supports for the child and family. The managed care coordinator then authorizes and coordinates the purchase of mental health services, within the parameters of the project service budget.

The county mental health agency, where the Partners' Project is based, receives a global rate of $1,618 every month for each child enrolled. The federal Medicaid program contributes approximately 62 percent of the rate for Medicaid-eligible children. The state match for Medicaid-eligible children and the full global rate is proportionately shared by the Partner agencies.

Individualized Care

With these flexible dollars, managed care coordinators finance individualized plans of care that include mental health services needed to stabilize the child with his or her family. Services may range from crisis respite to day treatment. In addition, the Partners' Project is able to fund added assistance for the child and family such as transportation assistance and music therapy. Since traditional services such as individual or family counseling in an office setting may be difficult for many families to access, Partners determines ways to provide and pay for services that would enable a child to be stabilized in his or her community.

About, 10 percent of the Partners funds finance



nontraditional mental health services and supports, such as in-home therapy, respite care, transportation, music therapy, recreational services, expert consultation, and concrete items such as a sleeping bag for a child to attend summer camp. Another 24 percent goes toward project administration and intensive case management and 9 percent pays for traditional outpatient therapy.

Continued on page 9

Mental Health Services Program for Youth Project Sites and Contacts

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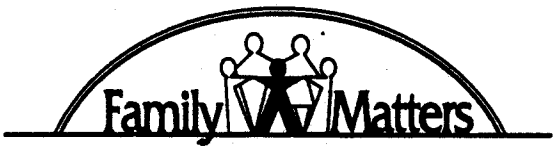

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RMDSENATE 10/13/2006

Supreme Court

Stanley G. Feldman
Chief Justice

STATE OF ARIZONA
ADMINISTRATIVE OFFICE OF THE COURTS

David K. Byers
Administrative Director
of the Courts

MEMORANDUM

TO: Title XIX Task Force

FROM: George Logan, Management Consultant
Juvenile Justice Services Division

DATE: February 9, 1993

SUBJ: ACCCA Member Survey

On January 21, 1993, pursuant to an invitation from Maria Hoffman the Executive Director of the Arizona Council of Centers for Children and Adolescents (ACCCA), I attended the monthly meeting in Casa Grande. ACCCA is an advocacy association of 46 non-profit agencies which provide children's mental and behavioral health services.

I explained to the members the purposes of the Title XIX Task Force and asked them to complete the attached survey and return it to me. Many of the members expressed concern over the confidentially of the forms and possible retaliation from the RBHAs because of negative or critical responses. To assure maximum confidentiality and honesty of responses, I agreed to accept anonymous responses.

Fifty questionnaires were distributed. Of the 13 returned 5 were anonymous. The results are as follows.

GL/lm
Attachment

1501 WEST WASHINGTON STREET • PHOENIX, ARIZONA 85007-3327 • 602•542-9300

ARIZONA SUPREME COURT
ADMINISTRATIVE OFFICE OF THE COURTS
JUVENILE JUSTICE SERVICES DIVISION
QUESTIONNAIRE RESULTS

---

1. Please note the adequacy of the amount of treatment authorized by RBHA (i.e., 6 counseling sessions, or 1 month RTC) for referred children for each type of service.

(a) Hospital

Very Satisfactory	Satisfactory	Unsatisfactory	No Answer
0	1	0	12

(b) Residential

Very Satisfactory	Satisfactory	Unsatisfactory	No Answer
0	0	6	7

(c) Day Support

Very Satisfactory	Satisfactory	Unsatisfactory	No Answer
0	1	4	8

(d) Out-patient

Very Satisfactory	Satisfactory	Unsatisfactory	No Answer
0	0	11	2

(e) If any are <u>unsatisfactory</u>, please briefly explain:

The treatment is greatly reduced for the subject population compared to the levels authorized prior to 7/1/92. We believe more issues are raised with the children than can be resolved.

Day Support - Dramatic cut in referral to partial day treatment program starting August 1992. Those children in programs, are being cut in number of days and/or terminated. Out-patient - Due to funding issues, children are being authorized bare minimum services. Heavy emphasis needing to be put on group services.

The RBHA has been authorizing only 1-2 sessions per month. This is not adequate to establish a therapeutic alliance with children.

Clientele are increasingly dysfunctional and services are being decreased, flexibility eliminated due to strictly financial constraints.

Rationing care for children with serious behavioral problems increases providers liability risk while failing to provide care based on clinical need.

(e) If any are unsatisfactory, please briefly explain: (Cont.)

In regards to residential treatment the amount of treatment authorized by RBHAs is resulting in a band-aid on a large wound. These children need long-term services outside the family unit to repair the deep problems that exist.

In regards to residential, day support and out-patient, has to do with the limited amount of approved services that consistently do not meet the client and family needs.

Residential - limit and stay - discharges done without complete input. Outpatient services - too limited to address problems.

Arbitrary reduction in support services is speech testing. M.D. visits based (and stated so) on economic issues only. No clinical consultation or even notice given.

Authorization for length of stay not related to acuity, diagnosis or response to treatment.

Doesn't meet requirements of court order needs of juvenile and their family not met with once a month session.

Adequate services are not being authorized due to financial considerations. Services are being cut without proper consultation with the clinician.

Medical necessity as established in treatment/service plan is ignored service level is solely determined by benefit package of $124/month/child. No notification to parent or agency of reduction in level of service prescribed in service plan approved by health plan as medical necessity.

2. What has been your experience in the following areas?

(a) Participation in intake, evaluation and diagnosis.

Very Satisfactory	Satisfactory	Unsatisfactory	No Answer
0	2	9	2

(b) Agreement with RBHA authorization for type of service.

Very Satisfactory	Satisfactory	Unsatisfactory	No Answer
0	4	9	0

(c) Agreement with RBHA for cost of service.

Very Satisfactory	Satisfactory	Unsatisfactory	No Answer
1	5	6	1

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(d) Communication with RBHA treatment staff.

Very Satisfactory	Satisfactory	Unsatisfactory	No Answer
0	9	4	0

(e) Communication with RBHA administrative staff.

Very Satisfactory	Satisfactory	Unsatisfactory	No Answer
4	1	8	0

(f) Accessibility to case manager.

Very Satisfactory	Satisfactory	Unsatisfactory	No Answer
0	7	6	0

(g) Agreement on termination of services.

Very Satisfactory	Satisfactory	Unsatisfactory	No Answer
0	3	10	0

3. What is the average length of time it takes to be paid from the date your bills are submitted to EDS?

(a)	**within 7 days**	2
(b)	**within 10 days**	5
(c)	**within 21 days**	5
(d)	**more than 90 days**	1
(e)	**within 21 - 90 days**	2

Comments:

Not yet paid for 5-6 months, payments are sporadic, have received some advances.

Problem is that LOAS are still lacking for many services already rendered.

If all the correct information is in the system.

We began using EDS in November and have had a recent response in regards to approved service plans since. Prior to November 1992 the answer would be within 21-90 days.

Dependent if RBHAs supply the proper documentation. If you have the LOA and it is correct then payments are very fast. This happens in less than 50% of the cases. Average 4-5 telephone calls to get proper LOA.

Comments: (Cont.)

Payment varies. EDS rejected 80% of claims during first 6 months. I still no clear or even unclear rules on how to bill for domestic violence services. CODAMA does not know how we should bill for domestic violence. CODAMA and EDS rules contradict one another.

We have been reconciling with the RBHA to date, not through EDS.

Within 7 - 10 days if prior authorization is in the system correctly. Never if prior authorization is not in EDS correctly.

4. Since implementation of managed care in November, 1992, have you altered your service delivery capacity by:

(a) increased services (y/n)?

Yes	No	No Answer
2	6	5

(b) decreased services (y/n)?

Yes	No	No Answer
8	2	3

(c) no change?

Answer	No Answer
1	6

Comments:

We have been gradually reducing our child serving staff due to reduced utilization. Prior to 7/1/92, we had 25 staff, now 6. We saw 350/week, now 25-30, depending on number of in-home.

Due to capitation, referrals have increased for least expensive services and decreased in partial care program and intensive in-home team services. Outpatient services have decreased in number across the board for all children.

Services to kids have gone down. CODAMA has stopped referring children even though they have informed us we are a PPO for screening and intake. Also Title 19 or Title 20 seem to cancel one another out - reducing services to kids.

Comments: (Cont.)

This has nothing to do with managed care. This is purely financial decisions driving the treatment services. The treatment is more expensive at all levels with less children receiving services.

This increase has to do with the addition of an intake screening service for eligibility. We have also add one outpatient therapist.

Our outpatient services have been greatly curtailed. Out ability to serve clients who do not qualify for Title XIX have also been impaired.

Anticipate severely diminished services.

Additional licensing requirements requires additional accountability and paperwork which increases costs.

Fewer services to more clients.

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CODAMA

PROJECTED REVENUE VS EXPENSES
FY 92-93 DECEMBER 1992
(Revised January 19, 1993)

Children's Title XIX:

Estimates Only

Revenue:	CLIENTS	RATE	UNITS	VALUE	IF 4000 CLIENTS
	2710	$463	per month	$1,254,730	1,852,000
Expenses:					
Inpatient	51	467/day	30/mo	714,510	
Residential	204	151/day	30/mo	924,120	
Group Home	138	122/day	30/mo	505,080	
Partial Care	77	78/day	16/mo	96,096	
Intensive Inhome	188	88/hr	16/mo	264,704	
Outpatient	2138	60/hr	4/mo	513,120	
				$3,017,630	
Case Management	1500	172/mo		258,000	
Administration		8%		100,378	
Total expenses per month				$3,376,008	
Deficit per month				< $2,121,278 >	< 1,524,008 >
Projected year end deficit (8 months)				< $16,970,224 >	

The client number of 2710 is believed to be under-reported by as much as 1000 clients due to new data system at ADHS, however it was the number being used for payment by ADHS.

CHILDREN/ADOLESCENT PLAN FOR REVENUE SHORTFALL

Critical Issue:

With the implementation of capitated funding of childrens' services, there is a significant revenue shortfall compared to expenses due to the following:

- $463 cap rate is lower than previous expenses of $1200 per month
- Case management has not reduced residential placements after 6 months even after discussion, but has increased placements by 50.
- Total number of XIX outpatient clients in EDS is less than previous enrollment (may be data error)
- No one has incentive to reduce costs other than CODAMA. (doctors, MCM, providers)... many have disincentives to reduce residential.

Goal:

Operate a childrens' program within financial limits, contractual requirements and standards of quality with managed care principles.

Objective 1:

Reduce the costs of care to that paid by ADHS, currently $463 per member per month for Title XIX children and $ per month for non-Title XIX children.

A. Reduce residential placements to 18.6 clients (daily static) per 1000 enrollees.

B. Reduce inpatient placements to 7.6 clients (daily static) per 1000 enrollees.

C. Reduce partial care and group home placements to 40 clients per 1000 enrollees.

D. Maintain outpatient care at $100.20 per month per enrollee unless the amount spent on other services decreases.

Objective 2:

Reduce case management to no more than 36% of all clients by March 1, 1993, or less than $73.40 including intake and transportation.

Objective 3:

Increase the Title XIX childrens' enrollment by 80% by June, 99% of which are outpatient early intervention children, 90% through group counseling settings.

Objective 4:

Examine all other revenue savings in other areas which can be utilized to subsidize the shortfall by February 1, 1993. Determine what has been obligated to-date for non-XIX and SEH funds.

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Objective 5:

Recoup all ADHS receivables from last year by March 1, 1993.

Action 1: Zita will prepare a report of all receivables for 1991-92 by December 21, 1992.

Action 2: Alan will notify ADHS of receivables by category and request payment and/or meeting to review by January 5, 1992.

Objective 6:

Develop immediate and ongoing communication with affected groups regarding managed care being implemented as described above.

Objective 7:

To assure that our revenue starting March, 1993, is sufficient to provide quality services to our clients.

Objective 8:

Establish a third party client copay collections team to maximize Medicare and other collections

Objective 9:

Establish a new non-Title XIX benefit package based on the new non-XIX capitated rate by February 1.

				CHILDREN CAPITATED RATE SCHEDULE			
					TITLE XIX		
SERVICE	UTILIZATION PER 1000 PER YEAR		UTIL PER MO	MO.COST	NET RATE	SERVICE ASSUMPTIONS	STATIC CLIENTS PER THOUSAND
inpatient	2155	days	180	$83.85	$76.64	30/month	7.6
JCAHO resid	7336	days	611	$92.32	$84.38	30/mo	18.6
partial care	12402	days	1033	$99.95	$91.35	16/mo	9
group home	in partial care			in PC		30/mo	30
E & D				$73.40	$73.40	7%	71
Case Mgmt	in E & D			in E&D		36%	360
transport	in E & D			in E&D		4/mo	48
psychotherapy	2812	hours	234	$22.43	$22.43	4 hr/mo	67
groups	7979	hours?	665	$10.37	$10.37	6 hr/ mo	110
psycho rehab	10000	hours	833	$10.00	$10.00	8 hr/mo	100
in-home	5043	hours	420	$25.71	$25.71	12 hr/mo	40
crisis	9	hours	0.7	$0.04	$0.04	1 hr/mo	0.7
med monitoring	354	qrter hr	30	$0.44	$0.44	1/4 hr /mo	30
medication	12720	Rx/lab	1060	$22.25	$22.25	intens- 2 Rx	560
						coordin- 1 Rx	
						all- 1 Lab	
gross capitation				$440.76	$424.30		
RBHA admin	8%			$38.22	$36.90		
total				$478.98	$461.20		
net capitation				$461.20	$461.20		
deficit/excess				-17.78	0		
1/25/93							

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TITLE XIX AOC OPTIONS

OPTION I - Total withdrawal from Title XIX system.

PROS

1. Allows courts to totally control treatment of its children.
2. Eliminates duplication of case management.
3. Allows courts to buy services at a cheaper cost (provider rate reduction).
4. Uninterrupted delivery of service regardless of 1) eligibility; 2) medical necessity; 3) social welfare; and 4) protection of community.
5. Very few kids impacted due to low numbers of current Title XIX AOC kids.
6. Eliminate ISA with ADHS.

CONS

1. Federal law requires you to make available Title XIX reimbursable services to eligible persons.
2. Less federal money over-all in the system.
3. Contrary to public policy re: maximizing federal financial participation.
4. Re-structuring of the AOC/JCC for clinical personnel would be necessary.
5. Problems with legislature for not participating in Title XIX.
6. Meds and labs would need to be purchased through JPSF or other fund source.

TITLE XIX AOC OPTIONS

OPTION II - Establish AOC RBHA with special capitation group.

PROS

1. Gives AOC control of everything, i.e., case management and financial activity (budgeting and spending).
2. One set of providers.
3. Cuts out duplication of so many individuals being involved in one case.
4. Permits coordination of all funding services and block grants.
5. Jolts could serve as tracking and case management system.
6. AOC kids would not have to compete with non-AOC kids for services.
7. Courts would justify own capitation rate.

CONS

1. Extensive AHCCCS manual requirements, e.g., financial and management reporting.
2. Substantial start up costs and assuming financial risk to live within capitation rate.
3. RBHA not cost effective if only a small percent of JPO kids qualify for Title XIX.
4. Long lead time involved to set up own RBHA - problems not solved quickly enough.
5. Logistical/geographical management problems of a statewide RBHA.
6. Need to coordinate with other RBHAs when kids transition out of court jurisdiction.
7. Small pool of AOC kids does not permit spreading risk over larger pool to reduce costs.
8. Less resources for other RBHAs.

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TITLE XIX AOC OPTIONS

OPTION III - Establish special capitation group within current Title XIX RBHA system.

PROS

1. Combined urban/rural pool provides a base for expanded rural services.
2. Higher capitation rate helps compensate for most needy population.
3. Higher capitation rate allows for more services.
4. Eliminates competition between AOC and non-AOC children for services.
5. More federal dollars flow into system.

CONS

1. Higher administrative costs - auditing, utilization reviews, financial reporting.
2. More state matching funds are necessary.
3. EDS would have to be modified for two different rates.
4. Problems of how to develop a rate.
5. Other state agencies would want to participate or duplicate.
6. Moving toward rate allocation and away from capitation.
7. Higher state share match.

RMDSENATE 10/13/2006

ARIZONA SUPREME COURT
ADMINISTRATIVE OFFICE OF THE COURTS
JUVENILE JUSTICE SERVICES DIVISION

Behavioral Health Survey Results

---

15 Responses - Those who responded:

Robert Castaneda, Gila County
Fred DuVall, Apache County
Candi Ahmann, Cochise County
Tony Nicholson, Maricopa County
Gordon Glau, Yavapai County
Jo Ann Miranda, Greenlee County
Irene Klim, Navajo County
Richard Tozer, La Paz County
Stev Crnkovich, Coconino County
Lynne Liebling, Pinal County
Richard Wilson, Pima County
Terry Farrell/Rosendo Morales, Yuma County
Robert Layton, Graham County
Jo Christensen, Santa Cruz County
Geraldine Lopez Forman, Mohave County

ARIZONA SUPREME COURT
ADMINISTRATIVE OFFICE OF THE COURTS
JUVENILE JUSTICE SERVICES DIVISION

Behavioral Health Survey Results

---

1. How well do you think the RBHA system has met your needs?

Very Satisfactory	Satisfactory	Fair	Poor	Very Poor
0	1	2	7	4

2. In general, how long does it typically take for the RBHA to complete an intake on your referral?

Less than 1 week	1-2 weeks	3-4 weeks	4 weeks or more
0	5	6	3

3. In general, during the past year, were you satisfied with the outcome of the intake, evaluation and diagnosis by the RBHA?

Yes	No	Don't know
4	7	3

4a. Timeliness of intake, evaluation and diagnosis

Very Satisfactory	Satisfactory	Fair	Poor	Very Poor
0	2	5	4	3

b. RBHA recommendations

Very Satisfactory	Satisfactory	Fair	Poor	Very Poor
0	3	6	3	2

c. RBHA attitude

Very Satisfactory	Satisfactory	Fair	Poor	Very Poor
1	3	5	3	2

d. RBHA communication

Very Satisfactory	Satisfactory	Fair	Poor	Very Poor
2	1	4	3	4

e. Case manager accessibility

Very Satisfactory	Satisfactory	Fair	Poor	Very Poor
1	4	5	2	2

f. Agreement on juveniles problems

Very Satisfactory	Satisfactory	Fair	Poor	Very Poor
0	3	7	1	3

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g. Ability to get juveniles in detention evaluated

Very Satisfactory	Satisfactory	Fair	Poor	Very Poor
1	1	3	5	4

h. Ability to get the amount of services believed necessary

Very Satisfactory	Satisfactory	Fair	Poor	Very Poor	Very, Very Poor
0	0	4	5	4	1

i. Ability to get timely accurate information

Very Satisfactory	Satisfactory	Fair	Poor	Very Poor
0	2	3	6	3

j. RBHA knowledge of behavioral health issues

Very Satisfactory	Satisfactory	Fair	Poor	Very Poor
1	1	8	1	2

5. In general, were you satisfied with the treatment services provided through the RBHA?

Yes	No	Unsure
1	7	6

6. Do you understand the TXIX eligibility process?

Yes	No	Uncertain
8	2	4

7. Do you understand medical necessity?

Yes	No	Uncertain
3	3	7

8. Do you understand the claims processing system?

Yes	No	Uncertain
2	4	8

9. Do you understand the system well enough to get a child crisis/psychiatric inpatient services?

Yes	No	Unsure
8	4	2

10. Between January 1, 1992 and November 1, 1992 how many juveniles did you refer for behavioral health services?

Title XIX:	549
Non-Title XIX:	3548

11. Between January 1, 1992 and November 1, 1992 how many juveniles were accepted by RBHA for Title XIX services?

253

12. How many juveniles have received psychiatric inpatient services since January 1992?

Title XIX:	38
Non-Title XIX:	47

13. What were the average number of inpatient days for all juveniles receiving psychiatric inpatient services since January 1992?

18 days

14. How many of the juveniles receiving psychiatric inpatient services since January 1992 were referred by a Regional Behavioral Health Authority?

17

15. A) Please identify the crisis service providers and inpatient psychiatric providers that your juvenile probation office uses. B) What type of crisis services do they offer to you?

A. Service Provider	B. Type of Service
West Yavapai Guidance Clinic	Outpatient, Detention Suicidal Issues
Verde Valley Guidance Clinic	Outpatient Suicidal Issues
Turning Point	Shelter Care
Maricopa Medical Center	In-Patient 72/Hour Evaluations
Arizona State Hospital	In-Patient Psychiatric Treatment
Numerous Outpatient Counselors	Family Counseling/In-Home Services
Arizona Baptist Children's Services	Crisis Shelter Provider
Youth ETC.	Crisis Shelter Provider
Florence Crittenton	Crisis Shelter Provider
Prehab of Arizona	Crisis Shelter Provider
Tumbleweed	Crisis Shelter Provider
Cochise Community Counseling	Crisis Intervention
Little Colorado Behavioral Health Center	Suicide Prevention, Family Crisis Intervention
Copper Mountain Behavioral Health	Crisis Intervention
Desert Vista Hospital	Inpatient Psychiatric
Arizona State Hospital	Inpatient Psychiatric
Rim Guidance Center	Crisis Intervention
In-House Counselors	Crisis Intervention at D-Home and walk-in 8am - 5pm
Superstition Mtn Mental Health Center	Crisis Intervention/Pre-petition
Copper Basin Behavioral Health	Crisis Intervention/Pre-petition
Behavioral Health Ag of Central Arizona	from 1-3/92, Crisis Intervention/Pre-petition
Desert Vista Hospital	Inpatient 72 hour Evaluation, if approved thru Pinal County Public Fiduciary
RBHA/La Paz	Monday - Friday, 8am to 5pm
Community Counseling	Counseling
Juvenile Detention	Lock-up
Never have used any providers	

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A. Service Provider (Cont.)	B. Type of Service
The Guidance Center	Psychiatric Crisis
Aspen Hills Hospital	Psychiatric Inpatient (no contract)
Arizona State Hospital	Adolescent Psychiatric Inpatient
Kingman Psychiatric Facility	Psychiatric Inpatient Evaluation
The Guidance Center	Psychiatric Evaluation
Graham Greenlee Counseling Center	Counseling
Jose M. Hernandez	Crisis Intervention
Pathways - Tucson	o-pat, in-pat
Desert Survivors (Closed)	
Mohave Mental Health	Psychiatrist
Tucson Psychiatric Institute	Secur Psy. Hospital
Family Center	Crisis Intervention
HKF Assoc.	Crisis Intervention
Kevin Tansy	Crisis Intervention
Tucson Psychiatric Institute	Psychiatric Evaluation
ATS - Crisis Teams	Psychiatric Assess

---

16. What are the procedures that the juvenile probation office uses to get crisis services or psychiatric inpatient services for a juvenile in respect to the following settings:

    (a) Detention
    (b) Residential placement
    (c) A parent's home
    (d) Shelter

---

17. Since January 1992 how many children have received psychiatric medication or psychiatric lab work?

Meds:	66
Labs:	8

---

18. What are the problem areas that must be changed for the juvenile court to participate in the Title XIX program?

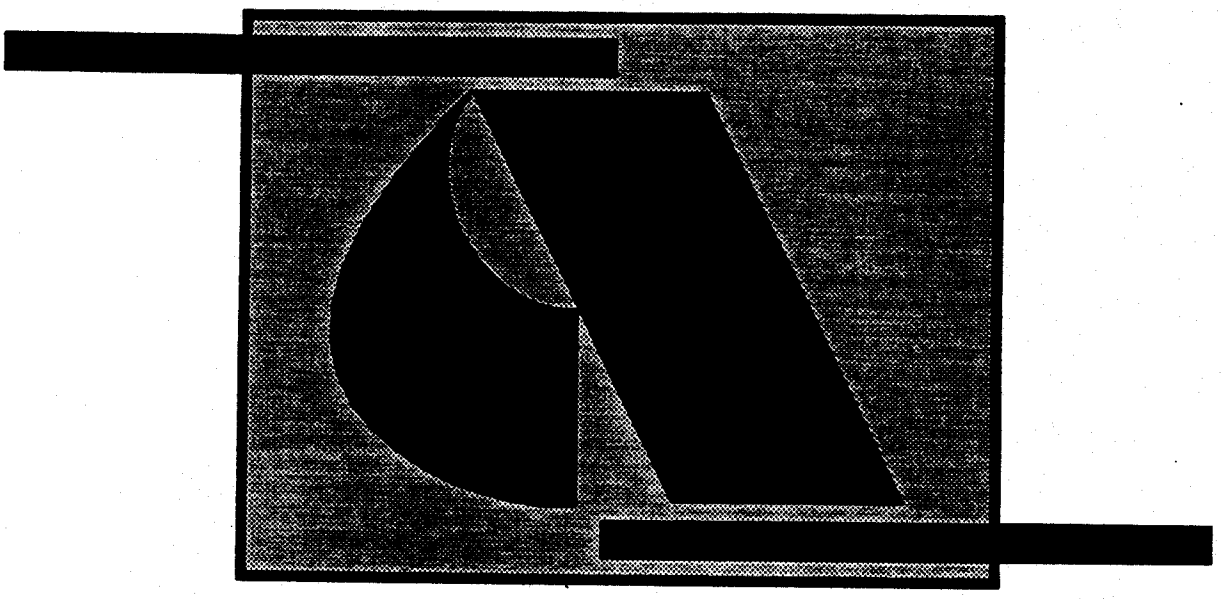
- Less paperwork and smoother processing.
- Referral and Eligibility procedures need to be more flexible and "user friendly." The system now is to complex and very confusing.
- An appeal system when the Entity and Juvenile Court disagree on treatment level.
- Title XIX must reorganize and become a part of the court process.
- More collaboration and joint decision making between RBHA and JPO.
- Services for those with non-medical necessity/non-indigent.
- Simplify and Re-educate.
- DHS must pay bills in a timely fashion.
- Providers must get paid.
- RBHA's have had high turnover within their agencies which causes management problems and inconsistencies in treatment.
- Allow direct referral to the Entity from the Juvenile Court instead of CMDP.
- Meet the needs of the children and not to the needs of Department Health Services.

- More understanding/participation by RBHA in Juvenile Court process.
- Opinions and assessments of JPO weigh heavier in decision-making process of treatment team.
- More kids need to be impacted too many are ineligible.
- RBHA's must provide appropriate treatment based on needs of child, and not based on dollars.
- All the "checks and balances" required by AHCCCS for clients to be able to receive treatment are overwhelming. Seems at times there are too many "hoops" to jump through. Clients loose eligibility to easily.
- Make all services available that are mandated by the law. Make PUPH's available to juveniles.
- Administrative costs of Title XIX must be reduced to allow sufficient funds to address the needs of the children eligible for Title XIX.
- Diagnosis not changed by RBHA to accommodate available funding. Juveniles suddenly get well and are removed from treatment when funding ends.
- Claims processing system is difficult to manage and track, needs to become more streamline, fewer forms, fewer steps.
- RBHA needs to provide psychiatric services to local Juvenile Detention Centers.
- Case management of TXIX juveniles must remain at the local level (JPO), we know our children best.
- Communication with RBHA's has to improve.
- RBHA's personnel's attitude has to change.
- RBHA's failure to work with JPO's as a team. It seemed in several cases they maintained an adversarial role.
- RBHA's be more responsive - return calls, etc.

RMTSENATE 10\13\0006

DOLLARS, DECISIONS & DILEMMAS

An Informative Seminar on Arizona's
Rapidly Changing Behavioral Health System



January 8, 1993
YWCA Conference Center, Phoenix

Sponsored by
The Arizona Association of Behavioral Health Programs

OVERVIEW

The State of Arizona is one of the fastest growing states in the nation. Since 1970, it has ranked third in population growth. It is projected that by the year 2000, Arizona will have more than 5 million people.

The foundation for Arizona's community-based behavioral health system of care was built in the 1960s and 1970s. At the time, there was little to no State involvement in the delivery of behavioral health services to members of the general population. The State funded the Arizona State Hospital (Phoenix) and the Southern Arizona Mental Health Center (Tucson) for the treatment of people with serious mental disorders.

Nor was there significant Federal involvement in the funding of behavioral health services. In 1963, Congress passed the Community Mental Health Centers Act, making possible direct funding grants to community mental health centers throughout the nation. There were two types of grants. One funded the construction of community centers; the other funded the staffing of these centers. These direct federal grants allowed for the start of community guidance and family counseling centers in a handful of Arizona communities including Flagstaff, Prescott, Phoenix, South Phoenix, Casa Grande, and Tucson. It is interesting to note that despite the sweeping intent of the Community Mental Health Centers Act, Congressional appropriations from the start funded fewer than one-tenth of the community mental health centers that were estimated to be needed at the time.

A number of community behavioral health agencies were founded in Arizona without federal grant monies. Here are just a few examples of how communities responded to local concerns:

- In Winslow, teen suicides prompted a minister and a school to generate community support for a counseling center in 1966. Today, Community Counseling Centers provides behavioral health services to citizens in Winslow, Holbrook and the White Mountain communities.
- In Prescott, a school superintendent, a lawyer and a doctor called a handful of other Prescott citizens together to come up with a way to serve the mental health needs of the community's children in 1966. Yavapai County donated an office; a merchant offered some paint; equipment was salvaged and operations began with a part-time nurse and a fly-in psychiatrist. Charitable funds and in-kind donations were eventually used to match state and federal funds as the non-profit agency known as West Yavapai Guidance Center grew to become the primary behavioral health resource for the west Yavapai community.
- In Phoenix, a number of recovering alcoholics took it upon themselves to start halfway houses for skid row alcoholics. After some time, Maricopa County began to send a visiting nurse to the facilities. Today, Maverick House is a residential treatment facility for chemical dependency in Glendale while the Guidepost, Crossroads, SOS, Casa De Amigas and Turning Point continue in downtown Phoenix.

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- In Yuma, an agency named Behavioral Health Services (BHS) was started in 1968 when a graduate school student began to counsel public inebriates from a small office in the basement of the courthouse. Later, the Yuma Women's Club and other community groups helped fund the expansion of counseling services. When a building in town was donated, the agency's board members offered their savings and property as collateral in order to fund improvements, making possible the city's first walk-in counseling center. Now, the family counseling center, a children's shelter and a group home are on the list of programs launched by BHS. Today, BHS is the regional administrator of behavioral health services for Yuma and La Paz counties and is still governed by many of its original board members.

In 1968, the Arizona State Legislature followed the federal lead and passed A.R.S. 36-189 which allowed the use of State funds for the purpose of supporting community behavioral health agencies. This was and still is known as the State Subvention Program. **The State Subvention Program is the framework for a unique partnership between private non-profit community agencies and government.** The distribution of subvention funds is guided by three principles.

1. **AVAILABLE SERVICES**
   On the principle that behavioral health services should be available to citizens in need of them, subvention funds are channeled to private not-for-profit agencies governed by boards of directors comprised of community representatives. Subvention funds make it possible for many communities, particularly in rural areas, to provide services they could not afford on their own. When services are available locally, citizens do not need to delay or defer treatment because of time and travel expenses and their risk of developing more serious problems is reduced.

2. **APPROPRIATE SERVICES**
   On the principle that behavioral health services should appropriately reflect local needs, community behavioral health agencies are required to match a portion of their subvention funding with locally generated monies. Having to generate financial support from community groups and businesses is one way local agencies are held accountable and responsive to community needs and concerns.

3. **AFFORDABLE SERVICES**
   On the principle that any service is more highly valued when it costs something, a sliding fee scale is used to charge clients for the services they receive. The fee is determined by the client's income and family size. The sliding fee scale ensures that services are affordable, but not necessarily free.

These principles of available, appropriate and affordable services are the foundation of Arizona's community-based system of behavioral health care.

THE COMMUNITY CONTINUUM OF CARE

Over the past thirty years, a continuum of services has evolved at the community level. Community behavioral health agencies today deliver a wide range of services, including residential and inpatient treatment. In the meantime, the Arizona State Hospital and other psychiatric hospitals serve as treatment facilities for the most seriously ill and/or dangerously ill citizens.

Community behavioral health services available on a sliding fee scale include:

- **CASE MANAGEMENT SERVICES**
  Identification & Outreach
  Screening & Evaluation
  Needs & Resource Assessment
  Treatment Planning & Ongoing Review
  Service Authorization
  Transportation
  Client Protection & Advocacy

- **OUTPATIENT SERVICES**
  Prevention & Early Intervention
  Crisis Intervention, Stabilization & Resolution
  Mobile Crisis Response
  Individual, Group & Family Counseling, in-home and clinic-based
  Support & Self-help Groups
  Mediation for adults and Peer Mediation Training for youth
  Partial Care, Respite Care & Day Care
  Medication Review & Maintenance

- **RESIDENTIAL SERVICES**
  Intensive 7-Day, 24-Hour Supervision
  Semi-Supervised Group Living
  Supervised Independent Living
  Supportive Housing & Specialized Home Care
  Respite Services
  Transitional Residential Group Home
  Detoxification & 30-60 Day Drug/Alcohol Treatment
  Short-Term Crisis Shelter & Treatment
  Therapeutic Foster Care (for youth)
  Therapeutic Group Home (for youth)

- **INPATIENT SERVICES**
  Psychiatric Health Facility (PHF)
  Re-Entry Facility (REF)

- **REHABILITATION SERVICES**
  Vocational Screening
  Vocational Training
  Job Placement and Support

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SUBVENTION FUND CATEGORIES

- Prevention and Early Intervention
- General Mental Health
- Substance Abuse (Drug and Alcohol)
- Children's Services
- Smi Services
- Domestic Violence Services

MORE ABOUT THE SIX SUBVENTION SERVICE GROUPS

PREVENTION & EARLY INTERVENTION SERVICES

This category of behavioral health services is one of the most important for its long range cost effectiveness, but competes with Domestic Violence for being the most under-invested today. Groups of people, often children, are targeted for Prevention & Early Intervention services when circumstances in their lives suggest that negative or harmful behaviors are being established and will become worse in the future. These circumstances are called "risk factors" and people "at-risk" include those who:

- Live in high poverty/high crime neighborhoods
- Observe chronic substance abuse in the family home
- Witness and/or are victims of domestic violence
- Live in families disrupted by death or divorce
- Are born to teenage mothers or are born with perinatal complications

Prevention & Early Intervention services are generally provided in non-clinical group settings through neighborhood centers, schools, churches and temples. These services focus on developing individual and group skills in the areas of problem identification, communication, and problem solving. Prevention programs also focus on preserving and strengthening families, often through services that promote and support the development of improved parenting skills.

The federal government requires that 20% of their block grants to states be used for prevention. In addition, the legislature has required that 20% of Children's subvention funds be dedicated to prevention services. Even so, Arizona ranked 46th for prevention funding in the most recent comparison of states, according to the 1991 edition of Alarming Trends.

When State behavioral health appropriations, federal block grants and Medicaid funds are combined, only 3.4% - **less than $8 million of a $226 million total** - is dedicated to prevention services this year, according to the Division of Behavioral Health Services.

GENERAL MENTAL HEALTH SERVICES

General mental health services are provided to individuals/couples/families undergoing adjustment to a major life event. The death of a friend or family member, divorce, unemployment, and parenting issues are examples of "life adjustments". Depression, eating disorders, and mild personality disorders can also be treated, in most cases, through the outpatient counseling format that is the backbone of general mental health services.

- According to the *Comprehensive Mental Health Services Plan* of 1989, the typical Arizonan receiving mental health services is an unmarried white woman in her late 20's who is employed full or part time.
- The Joint Legislative Budget Committee (JLBC) estimates that on any given day, an average of 24,900 Arizona adults are receiving general mental health services.

SUBSTANCE ABUSE SERVICES (alcohol and drug treatment)

According to the *Comprehensive Mental Health Services Plan* of 1989, the typical Arizonan receiving substance abuse services is in his or her late twenties/early thirties and only occasionally employed. Native Americans are significantly over represented in the population receiving alcohol abuse treatment - at 17% of the total compared to 5.4% of the general population.

- Substance abuse treatment services include detoxification, outpatient counseling, methadone treatment, residential treatment, and aftercare.
- Arizona has the highest waiting list in the nation for substance abuse treatment, according to a study conducted by the National Association of State Alcohol and Drug Abuse Directors in 1989.
- The JLBC estimates that a daily average of 19,400 Arizonans receive alcohol treatment services, while 8,600 receive drug treatment services.

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CHILDREN'S SERVICES

Prior to state fiscal year 1987-1988, there were no Subvention funds allocated specifically for children's services. Only a small amount of money was appropriated for the residential treatment of a portion of the state's Seriously Emotionally Handicapped (SEH) children.

It was not uncommon for parents to surrender custody of their children in order to obtain treatment for them. Children who were wards of the Courts or of the State could receive behavioral health services funded by the Department of Corrections or by the Department of Economic Security.

In 1988, the Arizona State Legislature began a Children's Subvention fund with an appropriation of nearly $3.5 million and enacted legislation that mandated the development of a comprehensive and coordinated system of care for children throughout local communities. This legislation was the result of unprecedented advocacy on behalf of children, fueled by a national report (*Care of the Seriously Mentally Ill: A Rating of State Programs*) that cited Arizona as spending less per capita on mental health than any other state and highlighted children's services as particularly deficient. The Behavioral Health Coalition that advocated for the children's legislation was led by the Arizona Council of Centers for Children and Adolescents and included other provider groups as well as business, union, church and community organizations. An ASU study entitled *Proposed Model For Comprehensive Services For Children* helped shape the resulting legislation.

In October 1990, Medicaid began to reimburse the State for certain services provided to eligible children. Additional State funds were appropriated to meet the required "match" on Medicaid reimbursements. Today, nearly 22% ($24.2 million) of the State's $111 million community behavioral health budget is dedicated exclusively to children's treatment services. An additional $30 million in Medicaid funds is anticipated this year for children's services.

- According to the *Comprehensive Mental Health Services Plan* of 1989, a profile of the typical seriously emotionally disturbed child is a male in his early teens, diagnosed as having serious emotional problems requiring special education before he was seven years old, has been psychiatrically hospitalized and requires medication for management of emotions or behavior. The most frequent behavior problems are assaultive behavior, acting out or impulsive behavior, hyperactivity, and suicidal tendencies.

- The more recent *Comprehensive Mental Health Services Plan* of 1991 estimates that five percent of all Arizona children and adolescents are seriously emotionally disturbed (SED) and 18.5% of all children and adolescents are considered behaviorally/emotionally disturbed (B/ED). Using a 1990 census total of 981,119 for children and adolescents under 18, the following reflects the estimated numbers of children in need of behavioral health services.

- 49,056 SED children + 181,507 B/ED children = 230,563 Total Children and Adolescents in need of behavioral health services
- Factors contributing to this high number include Arizona's neglect in serving this population, the constant movement of families into and out of Arizona, and the high rate of minority populations, according to the Plan cited above.
- A daily average of 9,000 children under 18 are currently receiving behavioral health services, according to the JLBC. Utilization reports from the Department of Health Services reflect that as of April 1992, 5500 were receiving for Medicaid coverage of some services.

Current treatment costs per child average $1100-1200 per month. In October 1992, the Arizona Department of Health Services instituted a capitated rate of $483 per child per month. The methodology used to establish this capitated rate is being challenged by community service agencies through the Department's administrative grievance process on the grounds that the rate does not reflect the level of service required to adequately serve Arizona's children in need. A more accurate capitated rate, according to some Association members, would be in the range of $800 per child per month.

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THE STATE - FEDERAL PARTNERSHIP: THE MEDICAID PROMISE

Presented by Senator Cindy Resnick

Senator Cindy Resnick is the Senate Minority Leader, the first woman to serve in this position in Arizona history. Senator Resnick has represented District 14 in Pima County since 1983. She was elected to the Senate in 1990 following four terms in the House of Representatives.

Senator Resnick is the acknowledged legislative expert on Arizona's Medicaid demonstration project, AHCCCS. She has helped guide the development of its managed care component and pushed to expand coverage to pregnant women and to children of the working poor. She is currently spearheading a legislative effort to bring universal access to health services.

Senator Resnick is the Chairman of the Health Committee for the National Conference of State Legislators. She is also an active member of her community and has been a board member of numerous local agencies. Over her ten year legislative career, Senator Resnick has received numerous honors and awards. She was most recently named Citizen of the Year by the University of Arizona Cancer Center, and Legislator of the Year by the Arizona Association of Homes for the Aging and the Arizona Association of Community Health Centers in recognition of her leadership on health issues.

"The history of the behavioral health system in Arizona has been somewhat tumultuous, with numerous changes and redirections. What is required now is a common vision with goals and objectives visibly supported by all involved - legislators, administrators, providers, consumers, families and advocates."
-- September 30, 1989, Arizona Comprehensive Mental Health Services Plan

ARIZONA'S EXPERIMENT WITH MEDICAID: AHCCCS

The Arizona Health Care Cost Containment System (AHCCCS) is Arizona's unique version of Medicaid. It was begun as an experiment to see if prepaid capitated health plans could provide a broad range of services to eligible citizens for less cost than traditional fee-for-service providers. As a demonstration project, AHCCCS was required to delay the implementation of certain mandated Medicaid services, behavioral health services among them.

People are determined to be eligible for AHCCCS based on age, income and/or financial situation (i.e. "spending down" to become eligible for AHCCCS when medical debts offset income or assets), and medical need guidelines. Eligibility standards for AHCCCS are composed of both federal and state requirements.

Depending on an individual's age, income and/or financial situation and medical need, their eligibility for AHCCCS is determined by their local County government, the Department of Economic Security, the AHCCCS Administration, or the Social Services Administration.

TABLE 4
AHCCCS CATEGORY, FUNDING AND ELIGIBILITY

Category	Funding Source	Eligibility Determination
MN/MI	County/State	County
ELIC		
SOBRA	Medicaid/State	County/DES
AFDC		DES
EAC	State	
SSI	Medicaid/State	SS Administration
ALTCS		AHCCCS Administration

MN/MI Medically Needy/Medically Indigent

ELIC Eligible Low Income Children

SOBRA Sixth Omnibus Budget Reconciliation Act

AFDC Aid to Families with Dependent Children

EAC Eligible Assistance Children

SSI Social Security Income

ALTCS Arizona Long Term Care System

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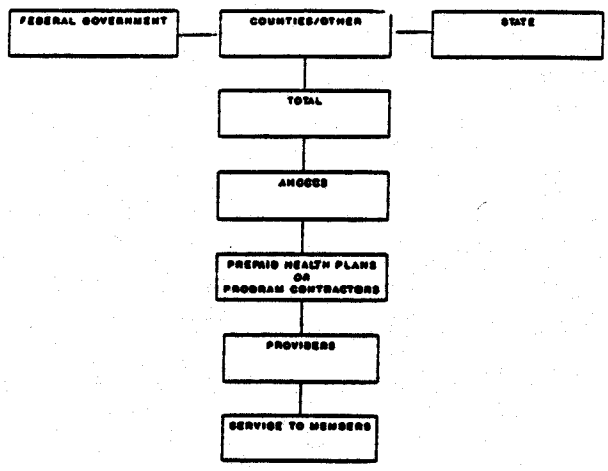
There are different eligibility standards for each of the AHCCCS categories. The largest AHCCCS category is AFDC. Citizens receiving AFDC comprise nearly half of all the Arizonans enrolled in AHCCCS. The second largest population in AHCCCS is the SSI population. People who qualify for AFDC, SSI, or SOBRA are **automatically** eligible for AHCCCS.

In the Medicaid/State categories, the State is required to "match" Medicaid funds. For every Medicaid dollar, the Medicaid contribution is roughly 62-cents, the State's match is 38-cents.

FIGURE 3
AHCCCS FLOW CHART



People who are determined to be eligible for AHCCCS are enrolled in a health plan and assigned to a Primary Care Physician. It is the responsibility of the physician to preserve the person's general well being, to provide routine health care, and to refer the patient to specialized treatment and/or services when necessary. Surgery, dialysis, and physical therapy are examples of specialized services which require prior authorization and referral from the primary care physician. Complex medical cases may involve planning and coordination of services by a treatment team that includes the primary care physician, various specialists, and a patient care coordinator or case manager.

CAPITATION

The AHCCCS Administration contracts with health plans on the basis of competitive bids. Health plans bid to provide medical and/or long term care services to some or all eligible populations on a capitated rate structure. If their bid for a certain population is selected, they are prepaid monthly at the capitated rate times the number of patients from that population who are enrolled in their health plan. The financial incentive for the health plan is to maintain the general well being of its patients so that the capitated rate covers the cost of services and then some. If the capitated rate is too low, or if a significant number of patients do not maintain or regain good health, the health plan is at risk to lose money.

The philosophy of AHCCCS health plans is similar to that of private sector Health Maintenance Organizations (HMOs) - to prevent illness and intervene early when it occurs. This philosophy is often at odds with the medical realities of AHCCCS-eligible citizens.

- Because the eligibility determination process is time-consuming and cumbersome, many people who are eligible don't enroll in the program until a serious illness or injury forces them to seek treatment.
- Because poor people in general are more ill than others, their medical condition when entering AHCCCS is often far from healthy, even when a medical emergency is not the reason for their enrollment. Even though Medicaid populations in Arizona have a lower number of hospitalization days than Medicaid populations in other states, they still require hospitalization at a rate higher than the general population.
- Many people who are in good health at the time of AHCCCS enrollment are at increased risk of injury or illness because of conditions related to their birth, environment or lifestyle. One example of an individual at increased medical risk, for instance, is a baby born to an adolescent mother who is unmarried and unemployed. Even if the child is born healthy, there are many risks inherent to the situation that may prevent continued good health.

Given these risks, however, not everyone who is enrolled in AHCCCS is ill or in immediate danger of becoming so. Healthy people, too, if they meet the financial eligibility criteria, can enroll in the program. And health plans receive the same rate of capitation for well patients as for ill or injured ones. This spreads the health plan's exposure to risk over a broad range that includes people who may see their physician once a year to patients who are terminally ill and in need of intensive medical and/or support services. Health plans must carefully weigh various patient trends against the utilization of services in order to submit a bid to AHCCCS that is competitive but that doesn't bankrupt the health plan.

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MEDICAID & CHILDREN'S SERVICES

In October 1990, Arizona entered into a new realm with the AHCCCS experiment. It began to draw down Medicaid funds for the reimbursement of certain behavioral health services provided to eligible children. Medicaid funds were envisioned to be a vehicle toward the implementation of a "comprehensive and coordinated" children's behavioral health system mandated in A.R.S. 36-3421.

Medicaid funds enter the state through AHCCCS, are disbursed under the management of the DHS Division of Behavioral Health Services to Regional Behavioral Health Authorities on a capitated basis, and are channeled to local service providers at contracted fee-for-service rates for which a ceiling has been established by the Division.

Unlike the AHCCCS medical health plans, the Regional Behavioral Health Authorities do not have well children among their Medicaid-enrolled patients. One criteria of the behavioral health system for all populations is that a person must be in need of services in order to qualify for them. Every person entering the behavioral health system has a need for some level of service.

During the first year of Medicaid draw down for children's services, the cost of providing behavioral health services to Medicaid-eligible children was significantly higher than expected. Among this population of children, for instance, fewer than 10 percent accounted for more than half of the Medicaid claims. This small number of the most poor and most ill children were also the most in need of intensive and expensive residential and/or inpatient services.

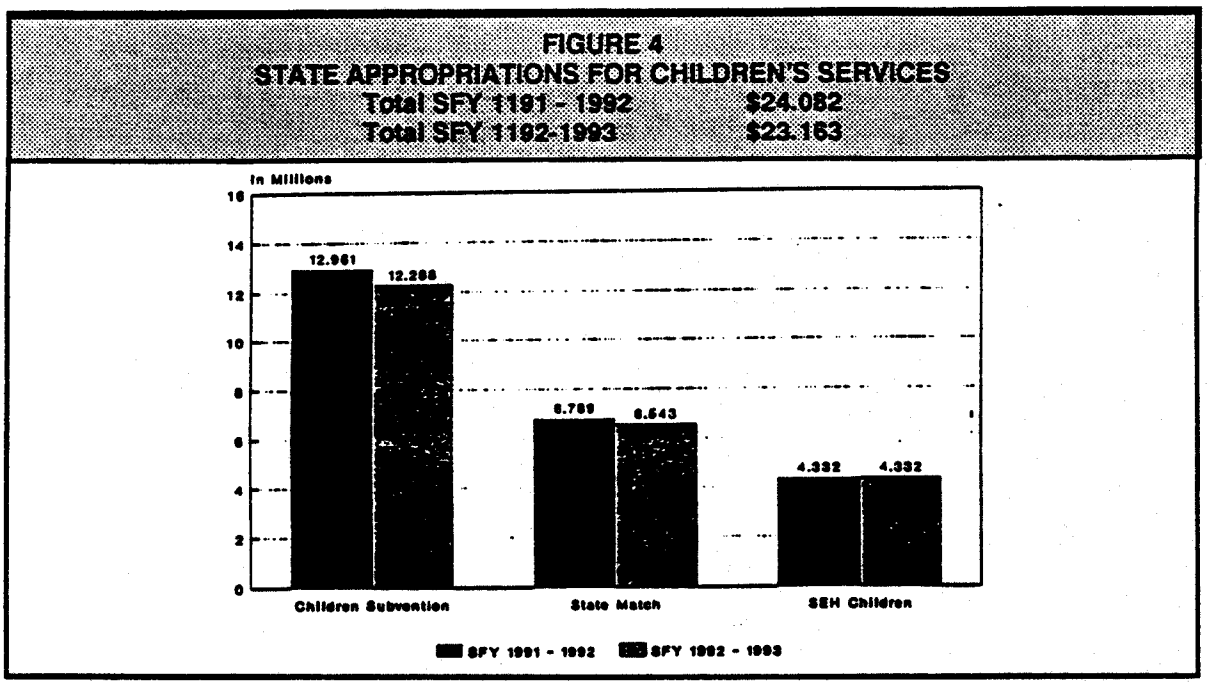
In order for the State to pay its unanticipated higher share of Medicaid match during fiscal year 1991, it transferred $3.5 million from the Children's Subvention fund into the Medicaid match account. This significantly reduced the number of children whose families could obtain services on a sliding fee scale through the state subvention program. Currently there are waiting lists comprised of children and their families who are in need of affordable community services.

One consequence of this situation is that an increased number of children will continue negative or damaging behavior until laws are broken and the Courts intervene. Another consequence is that the State will have to take custody of children who are neglected or abused in their family home. Either situation will guarantee the child receives behavioral health services. But both situations were among the original reasons that the Arizona State Legislature mandated a comprehensive continuum of children's services in the first place, so that children could receive appropriate services early, in the least restrictive setting possible, preferably while still in their own home.

This fiscal year, the JLBC is projecting that the Department of Health Services will once again fall short of its required Medicaid match. Though $ 6.5 million was appropriated for Medicaid match this year, the current use of services by Medicaid-eligible children will require an additional $4 million in match. This shortfall is based on the capitated

rate of $483 per child implemented in November, 1992. This year, however, the Legislature prohibited the Department of Health Services from using state subvention funds for Medicaid match, unless the transfer of funds is approved by the Joint Legislative Budget Committee.

It is interesting to note that State appropriations for Children's services actually decreased by nearly a million between last fiscal year and this year.



The total for 1993 increases by that missing million when the transfer of DES funds for Early Periodic Screening and Diagnostic Testing (EPSDT) of Medicaid-eligible children is considered.

It is, however, obvious that an increased commitment to Medicaid-eligible children has resulted in a decreased commitment to the vast majority of children in need of behavioral health care.

Though Medicaid-eligible children comprise only about **20%** of the total children's population, they account for more than **60%** of children receiving behavioral health services on any given day (5500 of 9,000 children) and about **67%** of the combined state funds, block grant funds and Medicaid funds dedicated to children's services (approximately $37.6 million for Medicaid compared to $18.9 million for subvention and SEH funding).

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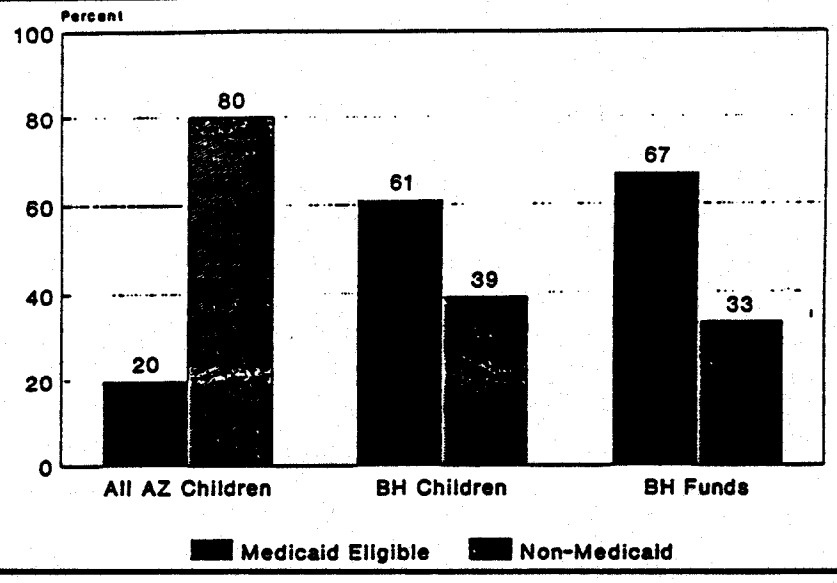
FIGURE 5
MEDICAID REPRESENTATION AMONG CHILDREN



MEDICAID AND SMI SERVICES

In November 1992, Arizona extended the AHCCCS experiment again. It began to draw down Medicaid funds for the delivery of behavioral health services to adults with a serious mental illness. Again, Medicaid funds were to propel the state closer to a "unified and comprehensive" system of care for this population as mandated by A.R.S. 36-550.

A capitated rate for SMI services of $589 per client per month was also implemented in November, 1992. As with the children's capitated rate, there is concern whether this rate is sufficient to provide all of the case management, treatment, housing, and other services required by the Department of Health Services under the terms of the Arnold vs Sarn Court Order.

Unlike the capitated rates for AHCCCS medical services, the capitated rates for Children's and SMI services were not established by competitive bid; they were proposed by the Division of Behavioral Health Services in consultation with AHCCCS and approved by the Health Care Finance Administration (HCFA) within the federal Health and Human Services agency.

This year, it is estimated Arizona will draw down $24 million in Medicaid funds for the delivery of Medicaid-covered services to adults with a serious mental illness.

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MEDICAID-ELIGIBLE POPULATIONS

It is important to remember that not everyone who is enrolled in AHCCCS is eligible for Medicaid-covered behavioral health services.

- The only AHCCCS children who are eligible are those who qualify for AHCCCS through AFDC, SOBRA or SSI eligibility requirements. These children are often referred to as "categorically" eligible. Another term used is Title XIX children. Medicaid is Title XIX.
- The only AHCCCS adults currently eligible for behavioral health services are those who have a serious mental illness **and** who are eligible for AHCCCS through AFDC, SOBRA or SSI requirements. Most adults with a serious mental illness who qualify for AHCCCS do so through SSI. However, currently less than half of the adults receiving SMI services meet the requirements for SSI.
- In February 1993, AHCCCS plans to implement Medicaid-covered behavioral health services for people 65 years and older who are enrolled in the Arizona Long Term Care System (ALTCS).
- In October 1993, ADHS plans to implement Medicaid-covered substance abuse and general mental health services for Medicaid-eligible adults - those who qualify for AHCCCS through AFDC, SOBRA or SSI.

MEDICAID COVERED SERVICES

When a TXIX-eligible child or adult receives behavioral health services, it does not necessarily follow that Medicaid will cover all of the services needed. For instance:

- If services are provided in a residential or inpatient facility that is accredited by the Joint Commission on the Accreditation of Hospitals (JCAHO), Medicaid will cover both treatment costs and the costs of room and board.
- However, if the services are provided in a less restrictive setting, such as a therapeutic group home, Medicaid will NOT cover the costs of room and board. Another funding source must be found to cover room and board, which can account for half or more of the total costs.
- Medicaid does not currently cover substance abuse education services.
- Medicaid does not currently cover residential substance abuse treatment, except for up to four days of detoxification.
- Medicaid does not cover services at which the Medicaid-eligible child is not present. If counseling for the parents is considered critical to the successful treatment of the child, another funding source must be found to cover these counseling costs. In other states, Medicaid does cover such services, but each state can design its own Medicaid benefit package and Arizona has not included this benefit.
- Medicaid does not cover vocational rehabilitation services for adults with a serious mental illness. This, too, is a Medicaid-covered service in other states.
- Once qualified for Medicaid through AFDC or SOBRA, children do not necessarily remain permanently Medicaid-eligible. A change in the family's situation, such as the part-time employment of a parent, can disqualify the family from AFDC or SOBRA. When this occurs, a child who is in residential or inpatient treatment can qualify for Medicaid on his or her own after 30 days in the facility. However, the child loses this Medicaid eligibility upon returning to the family home ... and loses Medicaid coverage of certain services if treatment is transferred to a less restrictive setting, such as a therapeutic group home. For many children, the best way to guarantee they can obtain needed services is to keep them for as long as possible in a residential or inpatient facility, even though this is in direct conflict to both clinical and legislative preference for treatment in the least restrictive setting possible.

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SYSTEM GROWING PAINS

Presented by
Jack Beveridge
and
Charles Carbone

Jack Beveridge has over 20 years experience in Arizona's behavioral health system and holds a Master's Degree in Psychology from Arizona State University. He began his career at the Arizona State Hospital in 1968, working with seriously mentally ill adults and their families. He later worked with a wide range of clients at the Phoenix South Community Mental Health Center. In 1974, Mr. Beveridge became the chief of community behavioral health programs for the Arizona Division of Behavioral Health Services and served in that capacity for nearly ten years. Mr. Beveridge is currently the executive director of the Pinal Gila Behavioral Health Association, one of the six regional behavioral health authorities in Arizona.

Charles Carbone is the deputy director of the DHS Division of Behavioral Health Services, a position equal to Mental Health Commissioner in other states. Mr. Carbone has managed both private and public sector behavioral health organizations in North Dakota, Michigan and Florida. From 1980 through August 1992, Mr. Carbone managed a variety of behavioral health programs for the state of Florida. His responsibilities included directing the state's administration of mental health and substance abuse services. He also prepared and implemented a plan to establish community-based services for Florida children and adolescents and was instrumental in that state's efforts to downsize its state hospitals.

"It is clear to the Task Force that continuing change is inevitable as Arizona improves the delivery and accountability of services provided. Change does not come without twists and curves - for real progress is almost never smooth."
-- October 21, 1992, Behavioral Health Task Force

SYSTEM DESIGN

Since October 1990, when Arizona began to draw down Medicaid funds for certain behavioral health services provided to eligible children, the entire behavioral health system has been in the process of becoming a "managed care" system.

This means that all funding sources - subvention, federal block grant and Medicaid - are to be applied under a managed care model. Here's why:

- Because Medicaid behavioral health dollars enter the state through AHCCCS, a managed care program, these Medicaid dollars are required to follow a number of federal and state "managed care" procedures.
- Because the Legislature was concerned that one system for Medicaid-eligible children and another for Subvention-eligible children would evolve, it mandated that all services for children are to be delivered through a "unified" system.
- With Medicaid now also covering some SMI services for eligible adults, and anticipated to cover some substance abuse and general mental health services in the near future, the Arizona Department of Health Services required Regional Behavioral Health Authorities to incorporate the principles of managed care in their 1992 bid proposals. Again, this was to promote a comprehensive and unified behavioral health system statewide.

Managed care is a term often used, but less often understood. Most simply stated, it is the theory that costs are contained and quality is assured when the most appropriate level of services is delivered by the best qualified provider.

In a managed care system, there are financial incentives to deliver the most appropriate services to people at the time they need them in order to avoid more expensive costs later. For an AHCCCS medical health plan that is prepaid a capitated rate for patients, applying the principles of managed care means:

- Teaching diabetics how to monitor and treat their sugar level to reduce the risk of diabetes-induced shock or coma
- Providing early and ongoing pregnancy care to reduce the risk of a premature birth
- Providing physical therapy to an accident victim to restore abilities and reduce the risk of long-term care

Similarly, a managed care behavioral health system should concern itself with:

- Teaching people with a bi-polar disorder how to monitor and manage their illness
- Providing early intervention to children at risk for unhealthy behaviors to reduce the risk of more costly intervention later
- Providing substance abuse treatment to an alcoholic to restore functioning and reduce the risk of long term health and employment problems

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- Providing substance abuse treatment to pregnant women in order to protect unborn children from drug exposure and addiction and related medical and learning problems

A managed care system is based on three major principles.

1. **Certified Need**
   On the principle that costs are contained when the most appropriate level of services is provided, a managed care system requires a clinical oversight component that evaluates the need for services, authorizes and coordinates the delivery of those services, and evaluates the effectiveness of the services on a case by case basis. The Regional Behavioral Health Authorities are responsible for directly providing or for overseeing the provision of these clinical case management services.

2. **Eligible Client**
   On the principle that one aspect of cost containment includes restrictions on who is eligible for care, a managed care system requires that clients meet eligibility standards before receiving services. Eligibility standards for Medicaid-covered services are both financial and medical; standards for Subvention-funded services are based on the individual's need as determined by clinical experts. The Regional Behavioral Health Authorities are responsible for monitoring client eligibility.

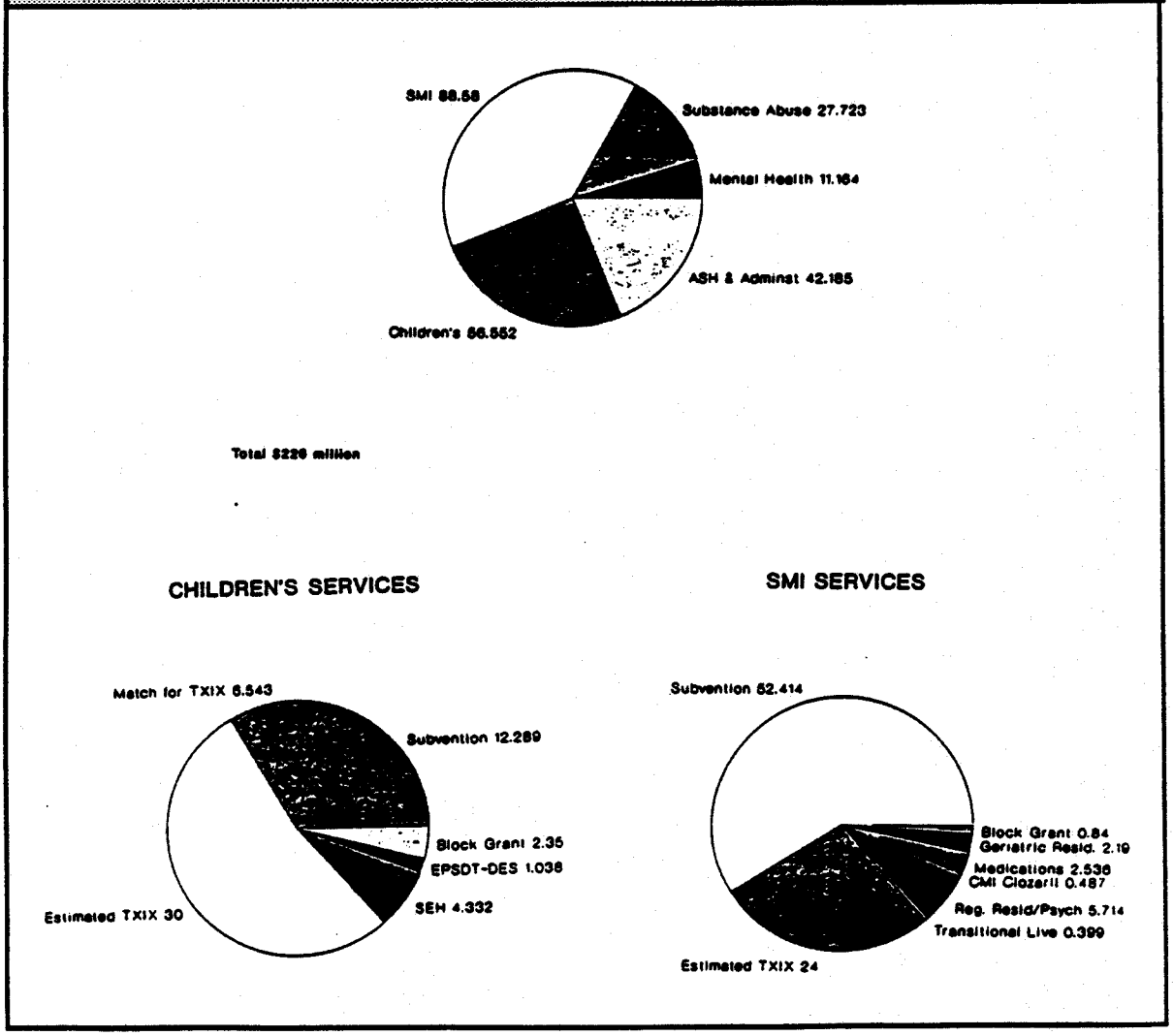
3. **Authorized Service Provider**
   On the principle that costs are contained and quality assured when services are delivered by qualified providers, community service agencies must meet licensure standards established and enforced by the Arizona Department of Health Services. Agency staff must be certified by the Arizona Board of Behavioral Health Examiners, or supervised by someone who is, if they provide therapeutic or clinical services. Agencies must also have a contract with the Regional Behavioral Health Authority to provide specific services to specific populations at contracted fee-for-service rates.

MANAGING A MANAGED CARE SYSTEM

Arizona's behavioral health system has undergone tremendous change in its attempt to become a managed care system. Some would say it has become an "over-managed" system. The effort to contain costs at the community service level has resulted in increased administrative oversight at the State level and increased case management responsibilities at the RBHA level.

In addition to the contractual, licensure, certification and clinical aspects of managed care, there is also more money to manage. This year, the Division of Behavioral Health Services will manage some $ 226 million in State, Medicaid and block grant funds. This is not one lump sum to be distributed at will. It is divided into more than a dozen spending categories, each with its own restrictions on the types of services it will fund for certain populations.

FIGURE 6
STATE & FEDERAL FUNDING



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Prior to July 1992, behavioral health funds were allocated to the Regional Behavioral Health Authorities by contract with the Division of Behavioral Health Services, then disbursed to community agencies in a prepaid method based on competitive bids among the agencies. This was similar to the way the AHCCCS Administration disburses funds to health plans.

July 1992 brought the implementation of a Third Party Payor (TPP) to the Arizona behavioral health system.

Here is how the system currently plans, provides and pays for behavioral health services.

1 A client is evaluated and a treatment plan is written.

In some rural regions, community agencies perform intake and evaluation and submit the treatment plan to their RBHA for review and authorization.

In other regions, the RBHA employs clinical teams that evaluate clients and write treatment plans.

In Maricopa County, a separate case management agency conducts evaluations and writes treatment plans for seriously ill children and adults.

2 The RBHA reviews the treatment plan, no matter who writes it.

3 The RBHA case manager electronically transmits the Service Authorization information to EDS, an automated claims and reimbursement system that is the third party payor for behavioral health services.

The service authorization contains information about the client, the client's diagnosis, the services that are authorized, and the agency that is authorized to deliver those services.

4 EDS electronically transfers a Letter of Authorization back to the RBHA.

5 The RBHA mails the Letter of Authorization to the authorized service provider.

6 Upon completing service delivery, the service provider electronically submits a claim to EDS for payment. Hard copy claims can also be submitted.

The provider's claim contains a Letter of Authorization number that ties the bill for services back to the original service authorization filed by the RBHA.

7 EDS checks the service authorization against the service claim, verifies that the agency is also authorized by State licensure and RBHA contract to provider the

services it is billing, and double-checks the agency's contracted rate for those services against the claim.

8 EDS sends an Explanation Of Benefits (EOB) to the provider.

This statement is prepared for all claims, whether they are approved or denied, usually a week or more after the claim is filed. The RBHA is not provided a copy of the EOB, making it difficult for the RBHA to be of assistance when a provider's claim is turned down.

9 EDS prepares checks in its Texas headquarters for approved claims and sends them to Phoenix.

10 EDS contacts the RBHAs to request transfers of cash to cover the checks.

11 EDS in Phoenix sends the checks to providers upon notification that the RBHA has transferred the money to cover it.

12 Each month, the Department of Health Services transfers a pre-determined capitated amount to the RBHAs, based on the number of eligible clients reported by EDS.

The amount transferred to the RBHA is to cover payments to service providers, case management costs, and the RBHA's administrative costs.

That's the simple overview. It hasn't worked quite so simply. Numerous problems with the EDS system itself, the accuracy of data input, delays in filing service authorizations, a changing service matrix (a definition of services and their claims value), and changes in the licensing of providers have resulted in a significant number and value of claims being denied ... significant delays in payment when claims are approved ... and in reduced ability to submit claims at all!

In December 1992, the Association of Behavioral Health Treatment Programs surveyed its members and determined that claims had been submitted for only **about half** of the total value of all services provided so far this year. And only half of that claims value had been paid! For every dollar of service value delivered, then, community service agencies had been paid only about 25-cents of it.

In the late Summer of 1992, the Department of Health Services authorized RBHAs to "advance", or prepay, providers in order to keep the community behavioral health system solvent. The Department is also attempting to make up payments owed to providers for services that were delivered last fiscal year.

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MORE ON MANAGED CARE

Mention has been made of staff certification, facility licensure, case management responsibilities, and the service matrix. Implementing the required changes in each of these areas has been frustrating, time-consuming and costly at every level of the system.

- Title XIX requires certification of provider staff. The Board of Behavioral Health Examiners was established in 1990. Professional therapists and clinicians are certified by this Board if they hold a Master's level degree in the discipline of Social Work, Marriage and Family Counseling, Counseling, or Substance Abuse Counseling. The Board also certifies Bachelor level social workers.

  The Board does not recognize Master's level degrees in the disciplines of Rehabilitation, Guidance and Counseling, or Psychology. Therapists and clinicians who hold degrees in these disciplines are categorized as technicians or para-professionals and can deliver services only under the supervision of a Board-certified individual, unless a specialized review by the Board results in their certification.

  The Division of Health Services is implementing a separate training and certification program for case managers.

- Title XIX requires that inpatient and 24-hour residential facilities meet the standards of the Joint Commission on the Accreditation of Hospitals (JCAHO). All behavioral health providers must meet the Behavioral Health Licensure Rules that were implemented by the State on October 23, 1992 after ten revisions. Providers that deliver SMI services must also meet the SMI Rules implemented on October 7, 1992.

  The Office of Behavioral Health Licensure is responsible for assuring that approximately 540 behavioral health service providers meet the licensure standards of treatment, care and safety set forth by Arizona statute and administrative code.

- The principles of managed care require that there be a "separation of power" between the case management agency and the service providing agency. Clinical review of treatment plans, prior authorization of services, and outcome evaluation are case management functions that are intended to promote cost containment by assuring each client receives no more and no less than needed.

  Case management, however, has traditionally included client-centered services that enable or support the client's ability to access and benefit from treatment. Transportation, for instance, is a case management service under this definition.

  There is ongoing discussion about the cost containment responsibilities of case management as it is now described, versus the care coordination responsibilities that have historically been assigned to case managers.

  Is it the case manager's primary responsibility to advocate for the client's access to all services that could be beneficial ... or is it the case manager's responsibility to

limit clients in general to only those services that can be purchased within the capitated rate? A balance is needed between the two.

- The Department of Health Services issues a Service Matrix that contains descriptions and codes used by providers when they submit a claim. Until recently, this Service Matrix was continually in flux. Wrote the Governor's Behavioral Health Task Force: "One glaring example [of poor to non-existent communication] can be found in the almost weekly dissemination of the Service Matrix, a document of some 60 pages which invariably is late and does not clearly indicate what specific changes occurred from the last matrix, resulting in providers scrambling to see if they can determine what changed and how it might impact billings."

  The existing service matrix is one example of "over-management". Breaking services and provider codes into smaller and more definitive pieces does not necessarily result in increased accountability, but it does increase complexity, confusion and cost.

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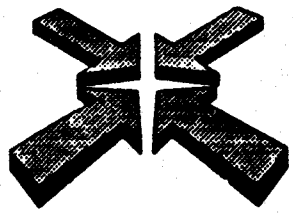
THE CHALLENGES OF MANAGED CARE

In addition to system changes in administrative oversight, case management, facility licensure, staff certification, and third party payment, there are many reasons why Arizona has had a difficult time accomplishing the true cost containment mission of a managed care system - to provide services early and in the least restrictive setting in order to prevent the need for more intensive and expensive treatment later.

- Allocated resources have consistently fallen short of a growing population's needs.
- When people do enter the behavioral health system, it is often in response to dire circumstances or extreme illness. Few people subscribe to annual behavioral health check ups. The intensity and length of treatment and support services required to stabilize and maintain behavioral health, particularly for Children's and SMI populations, drives up per client costs, consequently limiting the number of people who can be served with existing budgets and limiting the system's ability to aggressively deliver prevention and early intervention services.
- Unlike the AHCCCS managed care system for medical care that does enroll well people in health plans, no one enters the behavioral health system without a need for some level of service. This further reduces the system's ability to spread the financial risk of capitated rates across a broad spectrum of patients.
- Capitated rates are intended to reduce overall treatment costs but if capitated rates are too low, short term savings may result in increased long term costs. Capitation rates that are too low may also interfere with the system's ability to improve both capacity and quality as mandated for Children's and SMI populations.



Children First

The Community's Design for Children's Behavioral Health Services

EXECUTIVE SUMMARY

Arizona Center for Clinical Management

The Regional Behavioral Health Authority
for Pima County, Arizona

December 1992

"There is always one moment in childhood when the door opens and lets the future in." —Graham Greene

A Few Words on Funding

Despite changes in state funding mechanisms, members of the Children's Design Team designed "the system they want."

On November 1, 1992 the State of Arizona changed the way it funds behavioral health services for children. The state implemented a capitated system of care, in which it pays ACCM a set fee per month for every eligible child ACCM serves. The amount of money available per child per month to purchase needed services under the capitation system is only 25 percent of the previous amount authorized for those children enrolled in the system:

Prior to November 1, 1992:	As of November 1, 1992
Average cost of authorized services was $1,285 per month per child (based on data from May 1992).	ACCM receives $298 per child per month to purchase needed services.

The Team felt strongly that this reduced funding would not provide for the service system they envisioned. As a result, the Team members chose to plan for "the system they want" and to advocate for improved funding from the state to implement that system.

The Comprehensive System Design Effort

Goals of the overall system design effort: create a shared community philosophy about what we're trying to provide, for whom, and why

As noted above, the system design for children's behavioral health is just one phase of ACCM's broader system design effort. ACCM's goals in conducting this comprehensive system design are wide-ranging:

- To develop a shared community philosophy and system vision for behavioral health.
- To create ongoing relationships and trust.
- To develop specific recommendations regarding treatment philosophy, service arrays, resource allocations, and relationships necessary to implement an integrated behavioral health system for children and adults.

ACCM's community-based process can accomplish these goals because it brings together those who are most interested in and affected by the behavioral health system: consumers, providers, parents, the state, other service systems, and ACCM staff.

APPENDIX III

Interviewees/Contacts

RMDSENATE 10/13/2006

ADMINISTRATIVE OFFICE OF THE COURTS INTERVIEWEES/CONTACTS

The following is a list of individuals who were interviewed by George Logan, Management Consultant, with regard to the AOC Title XIX Report.

ARIZONA DEPARTMENT OF HEALTH SERVICES

Mr. Mark Stillion, Deputy Director-Chief Financial Officer
Office of the Director
Personal Interview January 14, 1993

DIVISION OF BEHAVIORAL HEALTH SERVICES

Mr. Charles P. Carbone, Assistant Director
Personal Interview February 1, 1993

Ms. Ann Kaehler-Campbell, Manager
Office of Children's Behavioral Health
Personal Interview December 2, 1992

AHCCCS

Mabel Chin, Deputy Director
Personal Interview February 5, 1993

REGIONAL BEHAVIORAL HEALTH AUTHORITY

Mr. Alan Flory, President
CODAMA
Personal Interview January 29, 1993

Ms. Nancy Newberry
ACCM
Personal Interview March 2, 1993

PROVIDERS AND PROVIDER ADVOCATES

Ms. Maria Hoffman, Executive Director
Arizona Council of Centers for Children and Adolescents
Personal Interview January 21, 1993

Mr. Hal Elliot, Director
San Pablo Treatment Center
Personal Interview January 21, 1993

OTHER

Ms. Linda Glenn
Office of the Monitor
Superior Court of Arizona
Personal Interview February 26, 1993

Ms. Eileen Bond, Assistant Attorney General
Office of the Attorney General
Personal Interview December 2, 1992

Ms. Linda Ruitenberg
Maricopa County Juvenile Court
Personal Interview February 9, 1993

Mr. Tony Nicholson
Maricopa County Juvenile Court
Personal Interview February 9, 1993

Mr. John Nuhn, Acting Manager
CMDP
Personal Interview December 29, 1992

Ms. Jane M. Hudson
Arizona Center for Law in the Public Interest
Personal Interview January 19, 1993

APPENDIX IV

Agency responses to DRAFT Title XIX Task Force Report

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

RMDSENATE 10/13/2006

FIFE SYMINGTON
Governor

LEONARD J. KIRSCHNER, M.D., M.P.H.
Director

RECEIVED
MAR 11 1993

MEMORANDUM

TO: George Logan, Management Consultant
Donna Noriega, Program Manager
Juvenile Justice Services Division

FROM: Dick Shapiro, Mental Health Coordinator
Liz Powers, Program and Projects Specialist II
Office of Policy and Intergovernmental Relations
Arizona Health Care Cost Containment System (AHCCCS)

SUBJECT: AOC TITLE XIX REPORT, DRAFT #1

DATE: March 5, 1993

Thank you for giving us the opportunity to review Draft #1 of the AOC Title XIX Report. AHCCCS supports the efforts of the Title XIX Task Force and AOC's interest and participation in the Title XIX program. We have completed our review of Draft #1 recognizing the executive summary, final conclusions, and appendices were not included. To ensure the accuracy of the AOC Title XIX Report, we request that you amend the report to include our responses as follows:

TITLE XIX CAPITATION (Page 4)

The report references two federal lawsuits filed against AHCCCS and ADHS regarding failure to provide "medically necessary services" because of a deficient capitation rate.

> ***It should be noted in the report that AHCCCS and ADHS are currently reviewing the capitation rate to determine if more current data still supports the capitation rate. In addition, ADHS has and continues to actively investigate allegations that medically necessary services are not being provided to Title XIX eligible children.***

801 East Jefferson · Phoenix, Arizona 85034 · (602) 234-3655
P.O. Box 25520 · Phoenix, Arizona 85002

FINANCIAL IMPACT OF CAPITATION (Page 4 - 6)

The report states the mental health capitation rate was developed radically different than the existing capitation rate paid to the AHCCCS Health Plans in that well children were not included in the risk pool.

> ***This is correct in terms of the capitation rate paid to the AHCCCS Health Plans. However, the mental health capitation rate is similar to the Arizona Long Term Care System (ALTCS) capitation rate in that the risk pool in the ALTCS program includes only Title XIX eligible individuals who are ill.***

The report states that the State ignored the historical data made available by providers.

> ***This is not correct, historical data was used in the development of the capitation rate.***

The report references several other mental health capitation projects in which the capitation rate is higher than the current ADHS Title XIX capitation rate.

> ***This information needs to be caveated, since in the absence of any detailed back-up information you are comparing apples and oranges. In order to know if the capitation rates are comparable one needs to understand the following: does the rate include only Title XIX eligible children; are non-Title XIX eligible children included; are the service packages the same; are only children with a mental health condition included, regardless of severity of the illness (e.g., nature of the risk pool); and what is the cost to deliver the services?***
>
> ***We contacted the project manager of the Connections Project in Cuyahoga, Ohio; the project planner of the Family Mosaic Project in San Francisco; and the Robert Wood Johnson Foundation which is funding these projects with the Multnomah County, Ohio program. We were advised that these "demonstration projects" focus primarily upon high risk, seriously emotionally disturbed children requiring intensive services. Each project has a very limited select population ranging from approximately 150 children in Oregon to a maximum projection of 300 children in San Francisco (when their program becomes operational). In addition, only a percentage of the children identified in each of these programs will be Title XIX eligible.***
>
> ***As a result of our conversations with Ohio, San Francisco, and the Robert Johnson Foundation, we recommend that this section be eliminated as it is misleading to the reader. Also, as noted earlier AHCCCS and ADHS are in the process of re-evaluating the Title XIX capitation rates.***

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FINANCIAL IMPACT OF TITLE XIX (Page 7)

This section should discuss the fact that Title XIX cannot pay for all of the services the courts may require. For example, there are often situations when residential services may not be medically necessary, however, the court may require either a residential placement or the extension of a residential treatment service that is no longer medically necessary.

- Only individuals meeting Title XIX eligibility and medical necessity criteria are covered under Title XIX.
- AOC is responsible for providing mental health services to non-Title XIX eligible individuals.

It is evident that AOC will need to have sufficient funds budgeted for all non-Title XIX individuals and non-Title XIX covered services. In addition, the issue of integrating the non-Title XIX needs of AOC with Title XIX will be a challenge that will need to be addressed in any of the options presented.

Average Daily Census (Page 8)

The report states that current trends indicate the average daily census will significantly decrease for Title XIX eligible youth and increase for non-Title XIX funded youth during the next few months.

> ***Because an individual is discharged from an inpatient facility does not necessarily mean they are no longer Title XIX eligible. Clearly, this will be a problem for those individuals who are Ribicoff eligible due to the fact that they are in an institutional setting. This however, is the nature of Title XIX which is limited to categorically eligible populations. Title XIX will not pay for services unless they are "medically necessary" regardless of which solution is adopted. If a child no longer needs institutional care, then under Title XIX they need to be discharged from the facility or Title XIX will not pay for the services of the individual in the institutional setting.***

OPTIONS FOR ACTIONS (Page 8 -11)

Option I

If AOC withdraws from the Title XIX program, AOC must provide the full array of Title XIX covered services to Title XIX eligible children with the State paying the entire cost of services provided. Denial of any medically necessary Title XIX covered service would constitute a violation by the State of Title XIX.

Options II and III

Special capitation groups and higher rates are not feasible as they would result in each unique population requesting special rates in effect producing a system which is no longer based upon a single risk pool with a cost effective capitation (i.e., cancellation of a managed care cost contained system).

Option IV

AHCCCS does not object to this option which would allow AOC to implement subcontracts with each RBHA. However, the subcontracts must comply with all federal and state requirements and the RBHAs must continue to operate within the prevailing capitation rates.

Option V

Instead of listing many of the concerns that have already been listed throughout the report, it would be more helpful if AOC identified how they would like to see the problems corrected within the context of the existing Title XIX program (e.g., AOC be a part of the intake process, AOC act as a case manager, etc.) A problem-resolution process should also be established within the AOC/ADHS ISA to expeditiously address problems as they arise.

AHCCCS recognizes that the implementation of the mental health program has been a challenging effort for all involved, especially to try and resolve all the issues and concerns identified in the AOC Title XIX report. The mental health program, however, is still relatively new to the State and as with any new program it takes time and experience to resolve all of the problems that arise. AHCCCS continues to be available to assist all parties in addressing changes needed to improve the program.

c: Mabel Chen, M.D.
Rodney Jilg

E:\Liz\Memos\Report.AOC

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
1717 W. Jefferson - P.O. Box 6123 - Phoenix, AZ 85005

Fife Symington
Governor

Charles E. Cowan
Director

RMDSENATE 10/13/2006

MAR 11 1993

RECEIVED
MAR 15 1993

George Logan
Management Consultant
Juvenile Services Division
Administrative Office of the Court
1501 West Washington
Phoenix, Arizona 85007

Dear Mr. Logan:

Thank you for the opportunity to provide comments to the AOC work group on Title XIX. Reports that I have received regarding the work group's efforts indicate that candid and open discussion was undertaken in an effort to lay out the issues that are faced by AOC and many of the other sister agencies with custodial responsibility.

As you know, in December of 1992, DES established a relationship with DHS and AHCCCS through a partnering session to open the lines of communication and provide a forum to identify all of the issues associated with Title XIX and the expected level of care that the children and families that we serve could expect. DES and DHS had contracted with one another through an ISA for behavioral health services, however, because of the rapid changes being made in the DHS system, it became obvious that there was a need for continuing dialogue to resolve issues as they arose.

To that end, a special work group was developed to outline all problems associated with the ISA both theoretically and operationally. Included in the work group were program staff from each agency, AHCCCS representatives and representatives of the RHBA's.

Prior to the partnering, the relationship between the agencies was strained due to philosophical differences in the meaning of "medical necessity" and to what extent DHS was required to provide the same level of services to the DES population based upon the mandates of the law. Social service advocates and providers do not agree with the medical based model of behavioral health care that has been developed by DHS and AHCCCS. In my opinion the disagreement is more a misunderstanding of the statutory mandates of Title XIX which do not encompass in totality the statutory mandates that agencies have with respect to the responsibility for providing services to unique populations such as foster care or juvenile services. Because of this misunderstanding, Title XIX was considered the panacea for behavioral health care. Custodial agencies were under the belief that the cost of providing services to the unique populations served would be shifted to DHS and AHCCCS under Title XIX. Of course as you know, a total cost shift is not possible. The System designed by DHS and AHCCCS was developed based upon a managed care, medical model for applicability to the general population of clients. It is my opinion that it does not and can not, as it is currently designed, provide for all of the needs of families and children in the child welfare system of the state.

Based upon the partnership with DHS, it is recognized and accepted that DES will have to maintain a provider network for services which are not Title XIX reimbursable and/or may not be deemed medically necessary. DES is working with the RHBAs and DHS to ensure continuity of care and to outline the specific responsibilities of the RHBAs and the DES case managers. The mission statement from our partnering session appropriately describes the current relationship. That mission statement reads:

> "We are committed, as partners, to develop joint leadership, planning and decision making for a comprehensive, culturally relevant service delivery system for children and families. We will create and maintain an open trusting and proactive environment. Through our mutual efforts, bureaucratic barriers will be eliminated and services will be more effective, efficient and accountable."

DES strongly recommends that before choosing an option, you explore developing a partnering relationship with DHS both separately to work out your individual issues and jointly with DES to ensure that we are all working toward the same goals. These issues are incredibly complex and it is extremely important that all of the players be a part of the process. Given the mandate of law for DHS to be the state behavioral health entity, it is impossible for AOC or any other agency to act in a vacuum. DES will support you in the decision that you make because we know it will be made with amply consideration of what is in the best interest of the population that you serve. DES will continue to advocate for a service delivery system within the state which is seamless and maximizes the use of federal dollars.

I would be happy to meet with you to discuss further the DES efforts and what can be accomplished through a relationship of open dialogue. I believe that Chip Carbone will echo my comments and encourage you to discuss this process with him. Please feel free to call my office at 542-3598, so that we may arrange a meeting time.

Sincerely,

Penny L. Willrich

Penny Ladell Willrich
Assistant Director
Division of Children &
Family Services

PLW:klc

bc: Dr. Linda Blessing
Stan Alexander
Frank Sanders
Donna Noriega
John Arredondo
Argie Gomez
Chip Carbone
Gregg Jacquin
Dr. Len Kirschner
Dr. Linda Redman
Peter Burns

RMDSENATE 10/13/2006

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
DIVISION OF CHILDREN AND FAMILY SERVICES

M E M O R A N D U M

TO: George Logan
Management Consultant
Juvenile Justice Services Division
Administrative Office of the Courts

DATE: March 8, 1993

FROM: Stan Alexander 942C
Acting Program Administrator
Comprehensive Medical
and Dental Program

SUBJECT: AOC Title XIX Task Force
(Comments regarding Title XIX AOC Options)

I have appreciated the opportunity to be a part of the AOC Task Force. The broad issue of a "unified" Children's Behavioral Health System (or Children's Mental Health System) and the seemingly inadequate Title XIX funding to help support that system has taken much time and energy over the past 32 months (since October 1, 1990). The AOC TXIX Task Force has provided yet another forum to discuss this issue. Perhaps one difference with this group is that the participation by a state agency in that system is being questioned. I need to state that the following comments are my own, and do not reflect DES policy.

Before addressing the options given to Task Force members at the March 4, 1993 meeting, I would first like to lobby for a slower and more inclusive approach. AOC is to be complimented for it's willingness to examine this issue. The ineffectiveness of the present system has been widely observed; but, largely denied, for far too long. The research and documentation that you have provided is professional and informational. The last draft gives a good basic overview of what it was like, what happened, and what it is like now. However, I do not believe that we can pretend to have fully addressed the problem in only 3-4 meetings of 2 hours duration, with inconsistent participation by necessary players. I would like to see much more discussion of the options, and attendant financial data regarding each of the options (i.e. just how much would it cost for AOC to institute option II).

I would also preface my choice of options with a question of "just what does constitute a unified mental health system"? Implicit in all the discussion is a belief that only via the current DHS RBHA system can Arizona fulfill the mandate of providing a "unified system". I submit that it might not be a huge stretch to expand that system from the current 6 RBHA's (who provide something less than "unified" services), to 7 or more by adding custodial state agencies that provide services to specific, special populations.

In my opinion, there are two (2) primary faults of the existing ADHS/RBHA system (notwithstanding the provider payment and other fiscal problems). One is the belief that you can establish standardized rules of treatment that do not allow for special populations. The second is that you can establish a single capitation rate for all of Arizona's children.

If all of society's children deserved the same treatment, there would be no AOC, DYTR, or DES/ACYF. Society has spoken loudly and often regarding their perception of these differences. The RBHA's have too often attempted to treat "state custody" children as if the pertinent state agency was a parent. Too often, I have heard the response "If this were a community child, we would now be releasing them to their parents------since you (AOC, DYTR, or DES) are the legal custodian, we expect you to take your child". But, the child often has no home to go to and thus placement issues, and medical necessity, and behavioral health vs mental health treatment, become obstacles to serving the best interests of the child. If the custodial agency child had the same needs as a community child, an agency would not be involved.

We must not pretend that we are in a real managed health care model. When capitation is only received for those members needing treatment, then it is not managed care. And when the custodial agency children (often those with the greatest need) are assessed the same capitation rate as custodial agency children, then it is even less of a managed care system. It is simply a "cost containment system".

In a system that has to operate within such limited financial constraints, the term "medically necessary" becomes a joke. "Medically necessary" is defined in the AHCCCS Mental Health Policy Manual as "those covered services provided by a qualified service provider within the scope of their practice. Under state law or certification, whichever is applicable, medically necessary services are

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provided to prevent disease, disability and other adverse health conditions or their progression, or to prolong life".

As you can see, this definition is rather loose. It becomes further complicated in decisions regarding if "medical necessity" is better addressed in an inpatient setting vs an outpatient setting; or if a child needs 1,2, 3, or 4 outpatient sessions per month.

I suspect that the real problem lies with the federal decision to funnel behavioral health treatment monies to the states via a medical model. It implies that necessary and therapeutic services are synonymous with "medically necessary" services. We are left with attempting to fit the real need (children's behavioral health services) into a service distribution system that is too narrow (medical model). This "medical" approach tends to place emphasis on treating a population that has symptoms (disease model) as opposed to treating high risk/exposed population (i.e. abused, neglected, delinquent, dependent) that will likely exhibit symptoms later (prevention model).

Therefore, I would cast my vote for option II (or some variation of this option), which "establishes an AOC RBHA with special capitation group". I don't believe that having 6 RBHA's that handle both community children and adjudicated children would be any less cumbersome than having 7 RBHA's (or 8 or 9). However, I would like to see more information regarding the cost of such an endeavor before totally committing to such a direction.

Under the present arrangement, custodial agencies have to either maintain an independent provider network to provide services that the RBHA's do not provide (i.e. non-medically necessary), or the RBHA's have to develop contracts with all providers that the custodial agencies need. It seems a little difficult to enforce such requirements upon private non-profit corporations, like the RBHA's. Nonetheless, we need a system that can provide needed treatment (TXIX or non-TXIX) to a child without having to change providers or settings as medical necessity changes.

It would seem that TXIX could be treated more as a funding source if the custodial agency acted as a RBHA. Then when TXIX medical necessity is no longer warranted, the agency would simply switch funding sources-------but, treatment would not be interrupted as often happens now.

Therefore, a solution may be to change our paradigm. A "unified mental health system" may come to mean that we all follow the same rules, same licensing requirements, monitored by the same state agency (ADHS), etc.; but, that existing RBHA's would be directly responsible for only "community children" and each custodial agency would be responsible for its respective children.

RMDSENATE 10/13/2006

Arizona Department of Health Services

Office of the Director

1740 W. Adams Street
Phoenix, Arizona 85007
(602) 542-1025
(602) 542-1062 FAX

FIFE SYMINGTON, GOVERNOR
DOUG CAMPOS-OUTCALT, MD, MPA
ACTING DIRECTOR

March 10, 1993

David K. Byers, Deputy Administrative Director
Arizona Supreme Court
Administrative Office of the Courts
1501 West Washington
Phoenix, AZ 85007-3327

Dear Mr. Byers:

Attached you will find the Department of Health Service's response to the Administrative Office of the Court's Draft #1 Title XIX Report.

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At the time the capitation rate was set, there was a limited amount of historical data available. None of the statistical analysis, other than the ones used by ADHS and AHCCCS for the current rate, have been actuarially tested.

Many of the AOC/ADHS IGA requirements were cumbersome administratively and clinically. In billing for services, the RBHAs were required to submit duplicate documentation.

Parental or guardian consent is always a requirement for non-emergency medical care.

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After the original AOC contribution of $ 100,000 was expended, ADHS continued to pay Title XIX and non-Title XIX claims on behalf of the AOC. These disbursements represented three-tenths of one percent (.003) of the Title XIX disbursements of 92-93.

Billings to the AOC were current as of February 17, 1992, nine days before the Logan report was circulated.

AHCCCS and ADHS implemented a capitated payment system in November 1992, because the Arizona Legislature mandated such a system. Much of the discussion has focused on the issue of Managed Care and capitation as we discuss mental health. It is unfair to focus either of these efforts on AHCCCS and ADHS when the public policy decision was made in large part by the Legislature when they asked for a comprehensive coordinated system for children. Moreover, the Behavioral Health community bought into this and was very much a part of the now criticized system. There

also needs to be a recognition that it is extremely difficult to start with/fee-for-service and then move to capitation after the program is running. Please reflect this discussion in the document.

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The "negative side" EDS comments are generally inaccurate. Letters of authorization are not currently required; the EDS processed claims effective July 1, 1992; and finally, most clean claims for services rendered prior to November 1, 1992, have been paid. George Logan's statement that nothing has been done to clean up $3 million in claims for the period is simply false.

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The statement that ADHS chooses to "ignore the historical utilization data most available by providers" is also false. ADHS used the most actuarially sound data it could find. Much of what was offered at the point in time when this setting of the rate was finished, was unusable. One common problem was that multiple fund sources were used to purchase Title XIX and non-Title XIX services. Another major issue was the tremendous over-utilization of residential treatment centers. The use of these very expensive facilities substantially affected practice patterns.

Pages 5-6 -

The other capitation programs are small, specialized, demonstration projects that have no comparability to what is happening in Arizona. The citing of these programs by Mr. Logan was misleading because it is well known that they only serve seriously mentally ill children. However, ADHS and AHCCCS have started a study based upon Arizona utilization which will provide a basis for determining the adequacy of the rate.

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The maximum rates that could be paid for services is higher than those the AOC historically paid. What the Logan report fails to mention is that these Title XIX services required a higher level of staffing and staff qualifications to meet the licensing requirements. Also, the AOC did not have to pay the maximum capped rate. It could have negotiated lower rates. Instead the AOC allowed its rates to increase by 31%.

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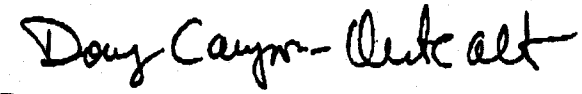
Clearly, the Courts and ADHS have different programmatic requirements. The Juvenile Courts must contend with public safety issues and social responsibilities for difficult youth. ADHS, with its Medicaid Program,

must ascertain when behavioral health services are medically necessary, and it must provide those services. If the AOC wants to offset some of its costs to Title XIX, it would need to work with the various RBHAs to establish cooperative working relationships. Historically, Juvenile Court Judges and staff have been able to operate independently.

Sincerely,



Doug Campos-Outcalt, MD, MPA
Acting Director

DCO:smo

cc: George Logan, Management Consultant
Arizona Supreme Court

RMDSENATE 10/13/2006

Supreme Court

Stanley G. Feldman
Chief Justice

STATE OF ARIZONA
ADMINISTRATIVE OFFICE OF THE COURTS

David K. Byers
Administrative Director
of the Courts

March 16, 1993

Mr. Jack Dillenberg, Acting Director
Arizona Department of Health Services
1740 West Adams Street
Phoenix, Arizona 85007

Dear Jack:

On March 10, 1993, Acting Director Doug Campos-Outcalt sent a response to George Logan, our Management Consultant regarding the Administrative Office of the Courts' (AOC) DRAFT Title XIX Task Force Report. In his response, Dr. Campos-Outcalt indicated "all billings to the AOC were current as of February 17, 1993" and "most clean claims prior to November 1992 have been paid". Unfortunately, both these statements are far from accurate.

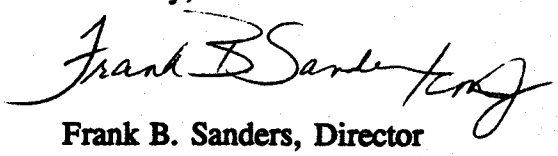
Since June 1992, the AOC has been requesting ADHS send billings to reconcile provider payment for services rendered to AOC juveniles for FY 91-92 and now FY 92-93, yet providers have not been fully paid. The AOC has received only one billing since July 1992, which included only a portion of services delivered to AOC juveniles. In addition, the AOC has not received any billing or reconciliation since the implementation of the capitated system. The AOC has been in touch with Mark Stillion and Gregg Jacquin from your department on a weekly basis regarding these billing concerns, therefore, I am unclear how ADHS would consider all the billings to be up-to-date.

Secondly, Dr. Campos-Outcalt indicated in his response that "letters of authorization are not currently required (for the EDS system)". Providers and RBHA staff have indicated letters of authorization are still needed for inpatient and residential services.

Lastly, Dr. Campos-Outcalt indicated the "AOC allowed its (provider) rates to increase by 31% and should have negotiated lower rates". The AOC attempted to negotiate lower provider rates on several occasions and wrote letters to both ADHS and AHCCCS requesting different rate structures within Title XIX programs only to be told that if providers dropped their rates for AOC youths they would suffer a rate decrease by HCFA. The providers were reluctant to lower rates after the HCFA response and the AOC was unwilling to sacrifice the provider community by issuing any ultimatum regarding rates.

Any assistance you can provide to clear up these misperceptions would be gladly appreciated. Thank you for your time and welcome to your new position.

Sincerely,



Frank B. Sanders, Director
Juvenile Justice Services Division

FBS/cmj
cc: David K. Byers