September 18, 2018

Re: Clinical Criteria for AHCCCS Behavioral Health Enrolled and Served Report

After administrative simplification occurred on July 1, 2016, the Arizona Health Care Cost Containment System (AHCCCS) re-evaluated the methodology utilized to calculate the rate of members who receive behavioral health services in our system. This re-evaluation included determining whether specific Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT), psychotropic medications, and the International Classification of Disease (ICD) procedural or diagnostic codes should be utilized.

AHCCCS determined that there were limitations to utilizing the procedural codes measurement. Although the Covered Behavioral Health Services Guide generally describes the procedural codes that are covered through the behavioral health benefit, other codes apart from these may be utilized for purposes of providing a behavioral healthcare service to a member. For example, a primary care provider (PCP) may utilize a general evaluation and management CPT code to manage a member's depression and thus we would want to capture this as a behavioral healthcare service when the principle/primary diagnosis is behavioral health in nature.

AHCCCS initially determined that by utilizing the principle/primary diagnosis on the billing claim, AHCCCS would be able to capture services provided by any provider type to calculate the behavioral healthcare service utilization. AHCCCS also developed a list of psychotropic medications that are primarily utilized for treating behavioral health conditions to augment the methodology.

As a starting point for determining which ICD principle/primary diagnoses were behavioral health in nature, AHCCCS utilized the AHCCCS Prepaid Medical Management Information System (PMMIS) reference file (RF) 724 "BHS Standard Service Set," herein referred to as the behavioral health diagnosis list. This list has historically defined which diagnoses are considered behavioral health in nature for purposes of determining payment responsibility in our traditionally carved-out service delivery model.

AHCCCS further refined its principle/primary diagnosis methodology by cross-walking the behavioral health diagnosis list with the product lines, health plans and providers that have historically served individuals with diagnoses on the list. Since claims with dementia or autism-related diagnostic codes as the primary/principle diagnosis were primarily paid by long term care system plans and supplied by their contracted providers, AHCCCS determined they should be excluded for the purposes of determining the behavioral healthcare service utilization rate. AHCCCS utilized this methodology for the behavioral health enrolled and served reports published for April, May, and June 2018.

Looking forward to 10/1/18 AHCCCS Complete Care (ACC) implementation, AHCCCS evaluated how the purpose of this behavioral health diagnosis list would change, as there will no longer be a separate entity responsible for payment of behavioral health services for the majority of AHCCCS members. Based on this foresight, AHCCCS determined that both autism and the dementia diagnoses should be included in the behavioral health diagnosis list, as this list would be utilized to determine which conditions are behavioral health in nature for purposes of administering the behavioral health benefit package. This new methodology was utilized for the behavioral health enrolled and served reports beginning July 2018 resulting in an anticipated increase in number of members served based on the expansion of diagnoses in the methodology utilized.

For the most current complete listing of ICD diagnoses that are classified as behavioral health conditions, please refer to the *AHCCCS Behavioral Health Diagnosis List*.