



Division of Behavioral Health Services

Individuals with a Serious Mental Illness (SMI)

FY 2015 Annual Report

Submitted Pursuant to A.R.S. §36-3415

[This Page Left Intentionally Blank]

Table of Contents

Executive Summary..... 4

I. Member Demographics..... 6

II. Service Utilization and Expenditures 9

III. Medical Necessity and Oversight Practices 11

IV. Tracking High Cost Beneficiaries 12

V. Mortality Trends..... 15

VI. Placement Trends..... 16

VII. Program Integrity 17

VIII. Access to Services 20

APPENDIX 23

Table of Figures

Table 1: FY 2015 SMI Member Enrollment Distribution6

Table 2: SMI Member Profile FY 2015 – Demographics.....7

Table 3: SMI Self-Report Gross Household Income – FY 20158

Table 4: Per Capita Expenditures by GSA and Eligibility.....9

Table 5: Comparison of FY 2013 to FY 2015 Per Capita Expenditures by GSA9

Table 6: Per Capita Expenditures by Service Type and Eligibility10

Table 7: Maricopa County SMI Individual Demographics by Eligibility and HCB Identification13

Table 8: Greater Arizona SMI Consumer Demographics by Eligibility and HCB Identification.....14

Table 9: SMI Member Mortality by Eligibility– FY 201515

Table 10: Title XIX SMI Average Length of Stay and Readmission Rates.....17

Table 11: Non-Title XIX SMI Average Length of Stay and Readmission Rates.....17

Table 12: FY 2015 Complaints in Access to Services Subcategories by Area and Eligibility21

Table 13: Utilization and Expenditures for AHCCCS-eligible HCB in Maricopa County by Service Type23

Table 14: Utilization and Expenditures for AHCCCS-eligible HCB in Greater Arizona by Service Type23

Table 15: Utilization and Expenditures for Non-AHCCCS-eligible HCB in Maricopa County by Service Type24

Table 16: Utilization and Expenditures for Non-AHCCCS-eligible HCB in Greater Arizona by Service Type24

Figure 1: SMI Mortality Trend from FY 2010 to FY 2015’16

Figure 2: Behavioral Health Performance Measures20

Figure 3: 26 Integrated Behavioral Health Performance Measures.....20

[This Page Left Intentionally]

Executive Summary

In accordance with the requisites outlined in Arizona Revised Statutes (A.R.S.) §36-3415, the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS, or Division), has completed a review of members diagnosed with a Serious Mental Illness (SMI) who received behavioral health services during State Fiscal Year (FY) 2015 (July 1, 2014 – June 30, 2015). This report summarizes selected areas of interest for this population, specifically: Demographics, Service Utilization and Expenditures, Medical Necessity Oversight Practices, Tracking of High Cost Beneficiaries, Mortality Trends, Placement Trends, Program Integrity and Access to Services. Highlights of this review include:

Demographics

- 81% of members with SMI were AHCCCS-eligible; an 8% increase from FY 2014.
- The majority (52%) of members with SMI resided outside of Maricopa County.
- Members with SMI were predominantly female (55.5%).
- The median age of members with SMI was 47.9 years.
- 13.4% of members with SMI reported being employed during the fiscal year.
- 3.8% of SMI members were homeless during FY 2015, similar to FY 2014.

Service Utilization¹ and Expenditures²

- Average per capita expenditures were \$11,107.12 for AHCCCS-eligible members and \$3,943.90 for Non-AHCCCS eligible members, showing an increase in per capita expenditures for both populations from FY 2014 (39% and 9%, respectively).
- Support, Medical, and Treatment Services were some of the most widely used services by this population.
- 26.7% of this population accessed Crisis Services at least once during the reporting period.

High Cost Beneficiaries

- 2.2% of the statewide population with SMI were identified as High Cost Beneficiaries (HCBs) using industry standard guidelines.
- The majority of HCBs were male (538, 57.5% male; and 398, 42.5% female).
- Comparable to FY 2014, a diagnosis of schizophrenia was more prevalent among HCBs (65%) than among the overall SMI population (29%).

Mortality Trends

- 270 of the 456 (59%) mortalities were of AHCCCS-eligible members with SMI and 186 (41%) were of Non-AHCCCS eligible members with SMI.
- Statewide mortality rate of DBHS SMI members has remained relatively stable in the past 5 years, with a high of 560 member mortalities in FY 2012 to a low of 456 in FY 2015.

Placement Trends

- Average Length of Stay (ALOS) at the end of Quarter 3 FY 2015 was higher for Behavioral Health Residential Facilities, when compared to FY 2014 data.
- ALOS for the end of Quarter 3 FY 2015 Facilities increased Statewide within Level I Behavioral Health Hospitals for both Medicaid and Non-Medicaid-eligible members with SMI.
- The readmission rate at the end of Quarter 3 FY 2015 remained stable from the previous year within Behavioral Health Residential Facilities for both Medicaid and Non-Medicaid-eligible members with SMI.

¹ Utilization figures are based on service encounter values as of July 31, 2015. Figures presented in this report were the most recent to-date at the time of analysis and are subject to change as additional encounters are submitted.

² For the purpose of this specific report, expenditures are defined as service encounters for those members with SMI who were enrolled and served during the reporting period (July 1, 2014-June 30, 2015) and is not tied to any other ADHS/DBHS reports.

[This Page Left Intentionally Blank]

The Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS, or Division) has conducted an assessment of members diagnosed with a Serious Mental Illness (SMI) who received behavioral health services during State Fiscal Year (FY) 2015 (July 1, 2014 – June 30, 2015). This review was conducted per the requisites outlined in Arizona Revised Statutes (A.R.S) §36-3415 for submission to the Joint Legislative Budget Committee, and includes information on the following areas of interest for both Medicaid and Non-Medicaid-eligible members: Demographics, Service Utilization and Expenditures, Medical Necessity Oversight Practices, Tracking of High Cost Beneficiaries, Mortality Trends, Placement Trends, Program Integrity and Access to Services.

I. Member Demographics

Enrollment and Eligibility

There were 41,876 members with an SMI diagnosis enrolled in the public behavioral health system in Fiscal Year (FY) 2015, within four Regional Behavioral Health Authorities (RBHAs). As presented in Table 1, the majority (52.3%) of the state's SMI population was enrolled in within the other Geographic Service Areas (GSA) across the state; the remaining 47.7% were enrolled in Maricopa County. For comparative purposes, this report explores differences between SMI members in Maricopa County (GSA 6) and those in Greater Arizona (GSAs 1-5).

Table 1: FY 2015 SMI Member Enrollment Distribution

County	Regional Behavioral Health Authority (Geographic Service Area)	Eligibility		Number of Enrolled Members with SMI	Percentage of Statewide SMI Population
		Title XIX	Non-TXIX		
Apache Coconino Mohave Navajo Yavapai	Northern Arizona Regional Behavioral Health Authority (NARBHA - GSA 1)	4,993	1,331	6,324	15.1%
La Paz Yuma	Cenpatico Behavioral Health Services of Arizona (GSA 2)	822	102	924	2.2%
Cochise Graham Greenlee Santa Cruz	Cenpatico Behavioral Health Services of Arizona (GSA 3)	873	136	1,009	2.4%
Gila Pinal	Cenpatico Behavioral Health Services of Arizona (GSA 4)	1,227	283	1,510	3.6%
Pima	Community Partnership of Southern Arizona (CPSA - GSA 5)	10,068	2,084	12,152	29.0%
Maricopa	Mercy Maricopa Integrated Care (GSA 6)	15,889	4,068	19,957	47.7%
Statewide		33,872	8,004	41,876	100.0%

The Division provides services to members who qualify for Title XIX or Title XXI benefits. These members are often referred to as being "AHCCCS-eligible" because their services are largely funded through the Arizona Health Care Cost Containment System, the state's Medicaid Authority. The majority (81%) of enrolled members with SMI were AHCCCS-eligible in FY 2015, an increase of 8% from FY 2014. The remaining 19.1% of enrollees were Non-AHCCCS eligible. Services for Non-AHCCCS-eligible members were funded using a combination of state, local and federal block grant dollars.

Table 2: SMI Member Profile FY 2015 – Demographics³

SMI Profile FY 2015		Maricopa County	Greater AZ	Statewide
Demographic population				
Total SMI Population		19,957	21,919	41,876
Median Age (Years)		47.98	47.98	47.98
Gender	Male	44.9%	44.1%	44.5%
	Female	55.1%	55.9%	55.5%
Race	White	85.2%	91.2%	88.3%
	Black	10.8%	4.1%	7.3%
	Native American	1.5%	2.3%	1.9%
	Asian	1.6%	0.6%	1.1%
	Hawaiian	0.2%	0.2%	0.2%
	Multiracial	0.7%	1.6%	1.2%
Ethnicity	Hispanic	15.2%	21.4%	18.4%
	Non-Hispanic	84.8%	78.6%	81.6%
Percent Attending School		12.8%	5.1%	8.7%
Percent Employed		14.2%	12.8%	13.4%
Percent with a Recent Arrest		1.9%	10.7%	6.5%
Percent Homeless		3.4%	4.2%	3.8%
Primary Substance Type	Alcohol	15.9%	18.6%	17.4%
	Marijuana	9.9%	9.4%	9.6%
	Methamphetamine	7.4%	7.0%	7.2%
	Heroin	2.6%	5.1%	3.9%
	Crack/Cocaine	2.8%	2.7%	2.7%
	Other Substances	2.6%	1.1%	1.8%
	No Substance Use	58.7%	56.1%	57.3%

Gender and Age

The SMI population is comprised of more women than men at both the state and national level.⁴ Statewide, 55.5% of members with an SMI diagnosis were female and 44.5% were male. The gender ratios of members with SMI residing in Greater Arizona and Maricopa County closely resemble the statewide proportions. Additionally, nearly one third (30.3%) of members with an SMI diagnosis were 31 to 45 years of age, 30.5% were 55 years of age or older, and 14.8% were 18 to 30 years old. Statewide, the median age of the enrolled SMI population in FY 2015 was 47.9 years. The median age of AHCCCS and Non-AHCCCS eligible members with SMI is identical to the statewide median age of 47.9 years.

Race and Ethnicity

Review of self-identified race and ethnicity data indicates that 88.3% of SMI members statewide were White, 7.3% were Black, 1.9% were Native American, and 1.2% identified with more than one racial designation. Additionally, 18.4% of members with SMI identified themselves as Hispanic/Latino.

³ The demographic data elements are limited due to missing data.

⁴ Substance Abuse and Mental Health Services Administration, (2012). *Behavioral Health, United States, 2012*, 36. HHS Publication No. (SMA) 13-4797. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Education and Employment

A larger proportion of Maricopa County members with SMI attended school or some form of vocational training program than those in Greater Arizona (12.8% and 5.1%, respectfully). However, statewide, there was a 4.8% decrease of SMI members who attended school or vocational training from FY 2014 to FY 2015. Approximately 13.4% of members with SMI reported being employed either full or part-time, with 14.2% of Maricopa County members and 12.8% of Greater Arizona's members employed.

Recent Arrests

Statewide, 6.5% of members with SMI had been recently arrested at the time of their last assessment. The proportion of male members with a recent arrest (8.5%) was nearly double that of their female counterparts (4.9%) at the statewide level. Statewide, 7.1% of AHCCCS-eligible SMI members had been recently arrested and 3.9% of Non-AHCCCS eligible members; this is a 3.1% increase for AHCCCS-eligible SMI members from FY 2014, compared to a 17.4% decrease for Non-AHCCCS eligible SMI members.

Homelessness

In FY 2015, 3.8% of members with an SMI diagnosis were homeless (Table 2); which is similar to the homeless population of FY 2014. Comparable proportions of members with SMI were homeless when compared by region and eligibility. A larger percentage of males than females were homeless (5.2% and 2.8%, respectively).

*Income***Table 3: SMI Self-Report Gross Household Income – FY 2015**

	Maricopa County	Greater AZ	Statewide
SMI w/Income Value (incl \$0.00)	3,815	14,149	17,964
<i>Income = \$0.00</i>	<i>2,006</i>	<i>5,159</i>	<i>7,165</i>
SMI with no income value reported	16,142	7,770	23,912
Total SMI	19,957	21,919	41,876

Beginning January 1, 2015, the Division instituted the requirement that providers collect gross monthly household income through the member demographic records. This information is collected directly from the members and it is self-reported. Of the total statewide SMI population, only 43% (17,964) have provided their self-reported gross monthly household income (Table 3); the remaining 25,411 (57%) member demographic records have yet to be updated. The Division will continue to collect this information from members during their initial and annual assessments.

For future reports, ADHS/DBHS will be evaluating alternate methods of collecting this demographic data field as well as engaging providers in cleaning the data elements in order to provide more accurate data.

II. Service Utilization⁵ and Expenditures⁶

This section details service utilization across categories and includes an analysis of total expenditures, per person expenditures and by service type or category.

Table 4: Per Capita Expenditures by GSA and Eligibility

SMI Profile FY 2015	Statewide					
	Title XIX		Non TXIX		All SMI	
	# Receiving Services	Per Capita	# Receiving Services	Per Capita	# Receiving Services	Per Capita
GSA 1 NARBHA	4,993	\$ 6,906.76	1,331	\$ 2,670.65	6,324	\$ 6,015.20
GSA 2 Cenpatico 2	822	\$ 14,944.34	102	\$ 6,534.39	924	\$ 14,015.97
GSA 3 Cenpatico 3	873	\$ 12,780.36	136	\$ 5,615.00	1,009	\$ 11,814.57
GSA 4 Cenpatico 4	1,227	\$ 11,499.69	283	\$ 3,093.23	1,510	\$ 9,924.18
GSA 5 CPSA - 5	10,068	\$ 5,805.15	2,084	\$ 2,575.00	12,152	\$ 5,251.20
Greater Arizona	17,983	\$ 7,255.93	3,936	\$ 2,852.26	21,919	\$ 6,465.16
GSA 6 Mercy Maricopa	15,889	\$ 15,465.86	4,068	\$ 5,000.13	19,957	\$ 13,332.54
Statewide	33,872	\$ 11,107.12	8,004	\$ 3,943.90	41,876	\$ 9,737.97

In FY 2015, the annual per capita expenditure, statewide, was \$11,107.12 for AHCCCS-eligible SMI members and \$3,943.90 for Non-AHCCCS eligible SMI members (Table 4). Mercy Maricopa served 19,957 members with SMI, expending \$13,332.54 per capita. Comparatively, the per-person annual expenditure for RBHAs within Greater Arizona was substantially less (\$6,867.38) for a greater number (21,919) of members.

Table 5: Comparison of FY 2013 to FY 2015 Per Capita Expenditures by GSA

SMI Profile FY 2013-2015	SMI - Statewide Annual Per Capita Expenditures					
	2013		2014		2015	
	# Receiving Services	Per Capita	# Receiving Services	Per Capita	# Receiving Services	Per Capita
GSA 1 NARBHA	5,574	\$ 6,305.26	6,026	\$ 5,217.91	6,324	\$ 6,015.20
GSA 2 Cenpatico 2	698	\$ 10,956.43	831	\$ 11,147.84	924	\$ 14,015.97
GSA 3 Cenpatico 3	774	\$ 10,360.44	863	\$ 9,803.32	1,009	\$ 11,814.57
GSA 4 Cenpatico 4	1,137	\$ 9,809.15	1,427	\$ 7,742.49	1,510	\$ 9,924.18
GSA 5 CPSA - 5	11,181	\$ 4,389.00	11,962	\$ 3,869.32	12,152	\$ 5,251.20
Greater Arizona	19,364	\$ 5,734.28	21,109	\$ 5,045.27	21,919	\$ 6,465.16
GSA 6 Mercy Maricopa	20,257	\$ 11,232.52	19,272	\$ 9,133.22	19,957	\$ 13,332.54
Statewide	39,621	\$ 8,545.36	40,381	\$ 6,996.26	41,876	\$ 9,737.97

In comparison to FY 2013, the number of all statewide members with SMI receiving services increased by 5.7% (2,255); although the annual per capita expenditure in FY 2014 showed a decrease by 18% (\$1,549.10) from FY 2013, the annual per capita increased by 14% (\$1,192.61) from FY 2013 to FY 2015 (Table 5). For Greater Arizona, the number of members receiving services increased by 13.2% (2,555) and the annual per capita expenditure also

⁵ Utilization figures are based on service encounter values as of July 31, 2015. Figures presented in this report were the most recent to-date at the time of analysis and are subject to change as additional encounters are submitted.

⁶ For the purpose of this specific report, expenditures are defined as service encounters for those members with SMI who were enrolled and served during the reporting period (July 1, 2014-June 30, 2015) and is not tied to any other ADHS/DBHS reports.

increased by 12.7% (\$730.88) from FY 2013 to FY 2015. For Maricopa County, there was a slight decrease (-1.5%) of the number of SMI members receiving services, and a significant increase of the annual per capita expenditure (18.7%, \$2,100.02).

Table 6: Per Capita Expenditures by Service Type and Eligibility

SMI Profile FY 2015	Statewide SMI Utilization and Expenditures					
	Title XIX		Non TXIX		All SMI	
	# Receiving Services	Per Capita	# Receiving Services	Per Capita	# Receiving Services	Per Capita
Support Services	33,499	\$ 3,666.00	7,824	\$ 1,598.52	41,323	\$3,274.55
<i>Case Management</i>	33,364	\$ 1,793.93	7,792	\$1,059.51	41,156	\$1,654.89
<i>Family Support</i>	732	\$ 426.99	135	\$159.17	867	\$385.29
<i>Peer Support</i>	11,704	\$ 934.30	2,735	\$579.67	14,439	\$867.13
<i>Personal Assistance</i>	2,977	\$ 5,247.74	208	\$1,497.24	3,185	\$5,002.81
<i>Respite Care</i>	154	\$ 2,255.87	11	\$4,228.39	165	\$2,387.37
Inpatient Services	7,826	\$ 5,432.56	481	\$715.57	8,307	\$5,159.43
Pharmacy	21,920	\$ 2,716.43	5,407	\$1,564.76	27,327	\$2,488.56
Rehabilitation Services	15,760	\$ 2,875.00	2,150	\$1,883.23	17,910	\$2,755.95
<i>Supported Employment</i>	8,660	\$ 1,925.87	941	\$2,198.90	9,601	\$1,952.63
<i>Health Promotion</i>	7,350	\$ 898.19	866	\$741.80	8,216	\$881.71
<i>Living Skills Training</i>	10,438	\$ 2,109.41	1,397	\$936.56	11,835	\$1,970.97
Residential Services	2,057	\$ 21,490.81	36	\$2,996.14	2,093	\$21,172.70
Treatment Services	24,823	\$ 914.91	4,158	\$385.41	28,981	\$838.94
Medical Services	28,352	\$ 923.01	6,402	\$497.88	34,754	\$844.69
Crisis Intervention	10,427	\$ 1,242.66	786	\$1,664.80	11,213	\$1,272.25
<i>Total</i>	33,872	\$ 11,107.12	8,004	\$3,943.90	41,876	\$9,737.97

Service utilization varies depending on funding eligibility (Table 6). For example, per capita expenditures for Non-AHCCCS eligible members with SMI utilizing Support Services were \$1,598.52; AHCCCS-eligible members with SMI utilized Support Services at \$3,666.00 per capita. Support Services include case management, peer support and personal assistance, three types of service that were widely-used by members with SMI.

Case management services are provided to enhance treatment effectiveness and include activities such as assistance in obtaining, monitoring and modifying services and communication/coordination of care. Nearly all (98.3%) members with an SMI diagnosis statewide utilized case management during the reporting period. Meanwhile, approximately 19.8% of members with SMI statewide utilized Inpatient Services (23.1% of AHCCCS-eligible members and 6.1% of Non-AHCCCS-eligible members, respectively).

Peer support services are designed to provide greater structure and intensity of services than is available through community-based recovery groups. Peer support refers to an individual who is, or has been, a recipient of behavioral health services and who currently provides behavioral health services to individuals enrolled in the public behavioral health system; One-third (34.5%) of members with SMI statewide utilized services in this sub-category.

Statewide, 27,327 of members with SMI were prescribed medications (Table 6 - Pharmacy) in FY 2015, at \$2,716.43 per capita for AHCCCS-eligible members (114% increase) and there was a 26% increase of the number of AHCCCS-eligible members from FY 2014 to FY 2015. The per capita for Non-AHCCCS eligible members was \$1,564.76, a 92% increase though there was an 11% decrease for the number of Non-AHCCCS eligible SMI members from FY 2014 to FY 2015.

III. Medical Necessity and Oversight Practices

This section discusses the activities performed by the Division to oversee medical necessity practices, including details about service authorization and denials, as well as RBHA practices in implementing medical necessity standards and timelines.

Prior Authorization requests and denials

The prior authorization (PA) process was developed to promote appropriate utilization of behavioral health services while effectively managing associated costs. Most behavioral health services do not require prior authorization.

Behavioral health services requiring prior authorization include:

- Non-emergency admissions to the Division of Licensing Services (DLS) Level I facility;
- Continued stay in a DLS Level I facility;
- Admission to and continued stay in a DLS Level II behavioral health residential facility for members under the age of 21 and
- All other level of care services that the RBHAs identify as requiring prior approval, as approved by ADHS/DBHS.

A decision to deny a prior authorization request must be made by the RBHA Medical Director or physician designee. Denial, reduction, limited authorization or termination of covered service(s) for AHCCCS-eligible and/or members with an SMI diagnosis must be accompanied by a Notice of Action. Statewide, there were a total of 11,409 Prior Authorization (PA) requests in FY 2015 for members with SMI, of which 767 were denied (6.7%).

The Division provides monitoring and oversight of RBHAs authorization for covered services by ensuring that prior authorizations from RBHAs meet the established AHCCCS guidelines on a monthly and quarterly basis. RBHAs submit monthly PA data reports, by GSA. In order to ensure consistent application of medical necessity criteria in pharmacy PA decisions, ADHS/DBHS adopted a statewide Medication List and Pharmacy Prior Authorization process on January 1, 2014. This approach will affect current patterns of PA pharmacy requests and actions (including denials).

RBHAs' PA processes are monitored during the Division's Annual Administrative Review. RBHAs must have qualified staff making medical necessity decisions, incorporate inter-rater reliability practices and apply standardized medical necessity coverage criteria when making medical necessity determinations. The RBHAs are placed on corrective action plans when failing to meet the above criteria at least 90% of the time. During FY 2015, one RBHA was found to be out of compliance and was placed on a corrective action plan (CAP), which is currently being enforced, for falling below the minimum performance score.

IV. Tracking High Cost Beneficiaries

High cost beneficiaries (HCB) are identified using industry-standard guidelines. High-level demographics and principal diagnoses are reported. SMI members identified as High Cost Beneficiaries were compared to the entire statewide SMI population. Appendix tables present HCB service utilization and expenditures by region and eligibility.

Methodology

Control chart utilization, also known as Statistical Process Control (SPC), was adopted as an effective evaluation tool for healthcare management in the 1990's to assess Total Quality Management (TQM)⁷. Control charts present data of interest at the mean, and at three standard deviations above (Upper Control Limit, UCL) and below the mean (Lower Control Limit).⁸ Cases found above the UCL are statistically assumed to be abnormal distributions (outliers) and warrant further research to determine possible abnormalities in care or, for the purposes of this report, hyper-utilization of services.

Use of a standard tool like the UCL to determine HCBs statistically identifies anomalies in order to gain insight into excessive variation of service utilization. Another purpose of identifying HCBs is to perform aggregate population profiling, then assess whether or not each individual with SMI is receiving medically necessary care.

Of the 41,876 members with SMI served statewide in FY 2015, there were a total of 936 members who met the criteria necessary to be classified as a High Cost Beneficiary within their eligibility group, a total of 2.2% of the statewide SMI population. This is a 17% increase of HCBs from FY 2013 (799 members), and closely resembles the HCB count from FY 2014 (937 members). Tables 7 and 8 depict the demographic profiles of members with SMI identified as HCB compared to all SMI statewide members by eligibility and region.

The ADHS/DBHS Office of Medical Management monitors over- and under- utilization of ADHS/DBHS covered services categories on a bi-annual basis. RBHAs must submit an analysis of recipient and provider level utilization of services, and their related plans to address identified problems on a standardized template described in the Bureau of Quality and Integration Specifications Manual. This template has sections for both member level and aggregate reporting for all nine adult coverage behavioral health service categories with aggregate breakouts for SMI utilization in all categories. ADHS/DBHS Utilization Management (UM) Specialists analyze RBHA covered service over-and under-utilization reports and present any trends or outliers to the Medical Management (MM)/UM Committee as a standing agenda item. The Committee assesses utilization activity and makes recommendations to address variances. Annually, during Administrative Review, ADHS/DBHS monitors RBHA over-and under-utilization policies and processes, as well as any interventions the RBHA may take to correct patterns of abuse or misuse of covered services.

RBHAs submit a quarterly pharmacy utilization report. ADHS/DBHS UM Specialists develop charts and graphs to analyze the pharmacy utilization data by GSA and statewide levels each quarter. Analyzed data includes the count of medication encounters per utilizing adult/child per month and the cost of medication encounters per utilizing adult/child per month. Pharmacy data is presented quarterly at the Pharmacy and Therapeutics (P&T) Committee, MM/UM Committee, and RBHA UM Coordinators Committee. Over- and under- utilization trends of medications is presented to the committee for further discussion and follow-up by the Office Chief of MM/UM or the Medical

⁷ Green, R. S. (1999). The application of statistical process control to manage global client outcomes in behavioral healthcare. *Evaluation and Program Planning*, 22, 199-210.

⁸ Standard Deviation definition - "A descriptive measure of dispersion; square root of the sum of the sum of squared deviations of each score from the mean, divided by the number of scores." Kantowitz, B. H., Roediger III, Henry. L., Elmes, D. G. (2001). *Experimental Psychology* (7th ed.). Belmont, CA: Wadsworth.

Director. Along with the implementation of a uniform pharmacy prior authorization process in FY2014, the pharmacy utilization reports received from the RBHAs are being modified into a comprehensive tracking and monitoring process that will allow the Division to identify psychotropic medication prescribing patterns as well as potentially problematic medication regimens for all members, including high-risk and special populations such as members with SMI.

Table 7: Maricopa County SMI Individual Demographics by Eligibility and HCB Identification

SMI Profile FY 2015 Demographic population		Maricopa County			
		TXIX		Non-TXIX	
		All SMI	HCB	All SMI	HCB
Total in Population		15,889	337	4,068	92
Median Age (Years)		45.8	43.9	55.5	53.6
Gender	Male	45.5%	54.0%	42.5%	47.8%
	Female	54.5%	46.0%	57.5%	52.2%
Race	White	83.9%	83.1%	90.4%	84.8%
	Black	11.8%	11.0%	6.9%	10.9%
	Native American	1.8%	2.1%	0.6%	1.1%
	Asian	1.6%	3.3%	1.5%	2.2%
	Hawaiian	0.2%	0.0%	0.2%	0.0%
	Multiracial	0.8%	0.6%	0.3%	1.1%
Ethnicity	Hispanic	15.9%	16.0%	12.3%	14.1%
	Not-Hispanic	84.1%	84.0%	87.7%	85.9%
Percent Attending School		12.7%	14.2%	13.0%	4.3%
Percent Employed		12.7%	5.3%	19.9%	12.0%
Percent with a Recent Arrest		2.2%	1.8%	0.9%	0.0%
Percent Homeless		4.0%	3.9%	1.3%	2.2%
Primary Substance Type	Alcohol	16.3%	16.6%	14.6%	17.4%
	Marijuana	11.0%	7.1%	5.5%	5.4%
	Methamphetamine	8.3%	11.3%	3.8%	12.0%
	Heroin	2.8%	3.3%	1.9%	0.0%
	Crack/Cocaine	3.1%	3.6%	1.6%	1.1%
	Other Substances	2.6%	3.0%	2.8%	3.3%
	No Substance Use	55.9%	55.2%	69.8%	60.9%
Axis I.1 Disorder Spectrum	Schizophrenia	35.2%	66.8%	27.8%	53.3%
	Bipolar	44.8%	20.5%	59.0%	33.7%
	Anxiety	3.8%	1.5%	3.8%	2.2%
	Depression	2.5%	1.2%	1.9%	2.2%
	All Other	13.8%	10.1%	7.6%	8.7%

Table 8: Greater Arizona SMI Consumer Demographics by Eligibility and HCB Identification

SMI Profile FY 2015 Demographic population		Greater Arizona			
		TXIX		Non-TXIX	
		All SMI	HCB	All SMI	HCB
Total in Population		17,983	426	3,936	81
Median Age (Years)		46.1	38.7	56.3	55.0
Gender	Male	44.3%	62.0%	43.2%	59.3%
	Female	55.7%	38.0%	56.8%	40.7%
Race	White	90.4%	84.3%	94.9%	96.3%
	Black	4.5%	5.4%	2.3%	1.2%
	Native American	2.6%	6.1%	0.8%	0.0%
	Asian	0.6%	0.9%	0.5%	0.0%
	Hawaiian	0.2%	0.5%	0.3%	0.0%
	Multiracial	1.7%	2.8%	1.2%	2.5%
Ethnicity	Hispanic	22.7%	26.5%	15.5%	22.2%
	Not-Hispanic	77.3%	73.5%	84.5%	77.8%
Percent Attending School		5.6%	8.0%	2.6%	0.0%
Percent Employed		12.1%	6.3%	16.1%	2.5%
Percent with a Recent Arrest		11.5%	12.0%	6.9%	9.9%
Percent Homeless		4.7%	7.5%	1.7%	3.7%
Primary Substance Type	Alcohol	18.5%	21.1%	19.1%	16.0%
	Marijuana	10.2%	11.0%	5.8%	6.2%
	Methamphetamine	7.7%	12.9%	3.7%	6.2%
	Heroin	5.6%	4.5%	2.6%	3.7%
	Crack/Cocaine	2.9%	1.2%	1.7%	3.7%
	Other Substances	1.1%	1.4%	0.9%	3.7%
	No Substance Use	53.9%	47.9%	66.1%	60.5%
Axis I.1 Disorder Spectrum	Schizophrenia	26.4%	57.5%	21.7%	50.6%
	Bipolar	49.3%	24.6%	58.7%	37.0%
	Anxiety	6.3%	1.9%	5.7%	2.5%
	Depression	2.2%	0.5%	2.5%	1.2%
	All Other	15.7%	15.5%	11.4%	8.6%

The demographic profile of High Cost Beneficiaries differed from the SMI population as a whole in several ways, including:

- Although the majority of members with SMI statewide were female (55.5%), 57.3% of SMI HCBs statewide were male. Across regions and eligibility a larger proportion of HCBs were male; Except in Maricopa County where Non-AHCCCS eligible male HCBs accounted for 47.8%.
- A substantially smaller proportion of both AHCCCS-eligible and Non-AHCCCS-eligible HCBs were employed.
- The Median ages of HCBs in both funding sources in Maricopa County were comparable to the overall SMI population within the AHCCCS- and Non-AHCCCS eligible members. Median ages of HCBs in Greater Arizona were variable between funding sources.
- A schizophrenia diagnosis was more prevalent among HCBs in both funding sources and regions than among all members with SMI which is comparable to FY 2014.

The service utilization profile of HCBs (Appendix: Tables 13-16) compared to the SMI population as follows:

- Only 19.8% of members with SMI statewide utilized inpatient services, compared to 54.5% of HCBs statewide.
- All HCBs (100%) statewide utilized support services during FY 2015, compared to 98.6% of SMI members statewide.
- A larger proportion of HCBs (85%) were prescribed medications, compared to 65% of SMI members statewide.

The Division requires contractors to track recipients that are high-cost users and conduct analysis to determine reasons for high utilization. Contractors must develop plans to intervene and reduce expenditures when appropriate. In some cases, a high-cost beneficiary may have a co-morbid diagnosis for which treatment is costly (e.g., cancer, transplants, HIV, etc.). However, a reduction in expenditures can often occur if less costly support services are provided. The Division will continue to monitor RBHA practices in identifying, analyzing and responding to high-cost utilization.

V. Mortality Trends

This Section examines the Division's members with Serious Mental Illness (SMI) mortality trends for state fiscal year (FY) 2015. Member mortality data were obtained from the Division's Bureau of Quality and Integration Quality of Care (QOC) database, the Quality Management System Portal (QMS – Portal). Mortality is examined in terms Cause of Death (COD). There were a total of 456 members with SMI mortalities reported for state fiscal year 2015.

Table 9: SMI Member Mortality by Eligibility– FY 2015

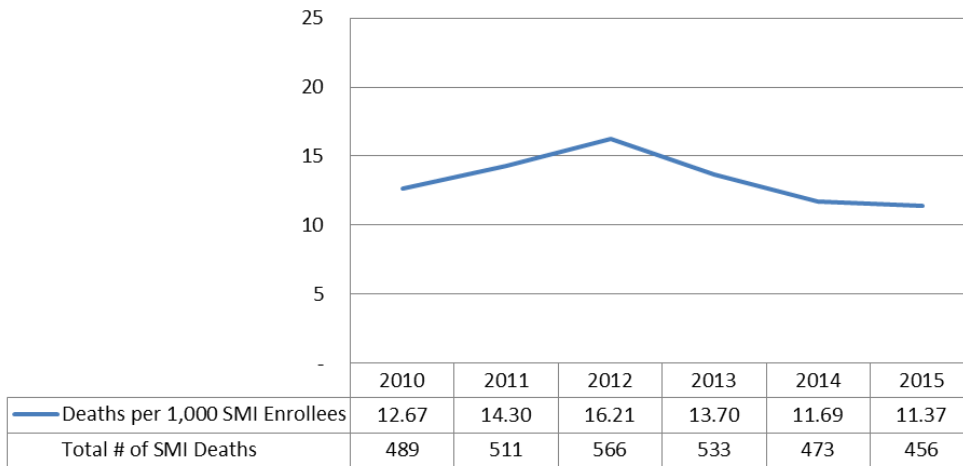
SMI Profile FY 2015 Statewide Cause of Death	Title XIX		Non TXIX		Total	
	# of Mortalities	% of TXIX Mortalities	# of Mortalities	% of Non TXIX Mortalities	Total # of Mortalities	% of Total SMI Mortalities
Accident	26	10%	9	5%	35	8%
Homicide	5	1%	2	1%	7	1%
Natural	104	39%	110	60%	214	47%
Suicide	18	7%	18	9%	36	8%
Unable to Determine	9	3%	2	1%	11	2%
Unknown	108	40%	45	24%	153	34%
Total	270	100%	186	100%	456	100%

As shown in Table 9, of the 456 FY 2015 mortalities within this group, 35 (8 %) were Accidents, 7 (1%) Homicides, 214 (47%) Natural deaths, 36 (8%) Suicides, 153 (34%) had an Unknown Cause, and 11 (2%) were classified as Unable to Determine. Because this report is written less than two months after the end of the fiscal year, the cause and manner of some deaths occurring toward year's end are as yet unknown because death certificates and autopsy reports have not been finalized. This explains the large number of mortalities with "Unknown" as the cause of death. According to the most recent ADHS/DBHS Annual Mortality Report, these SMI-specific trends mirror previous member mortality trends.

The DBHS Quality of Care (QOC) Office receives DBHS member mortality information via Incident Accident Death (IAD) reports submitted through the QM-Portal. The Cause of Death (COD) is usually listed as 'Unknown' initially, pending further investigation. When the investigation process is complete, the COD is changed from 'Unknown' to

a different COD in the QM-Portal (Natural, Accident, Suicide, Homicide, or Unable to Determine) as applicable. During FY 2015, 59% of all SMI deaths occurred in the Title XIX group, and 41% in the non-Title group.

Figure 1: SMI Mortality Trend from FY 2010 to FY 2015^{9,10}



Overall statewide counts and rates include all FY 2015 mortalities for members with SMI. As shown in Figure 1, the statewide mortality rate of DBHS SMI population has remained relatively stable in the past 5 years, with a 7% decrease from 489 member mortalities in FY 2010 to 456 in FY2015. Monthly SMI mortality (Title XIX and Non-Title XIX combined) totals in fiscal year 2014 ranged from 13 in October 2014 to 67 in June 2015. Non-Title XIX SMI mortalities peaked in February 2015 (20). The number of Title XIX SMI deaths was highest in May and June 2015 (53).

VI. Placement Trends

The Division routinely examines placement indicator trends (average length of stay, number of admissions and discharges, readmission rates within 30 days) for identifying normal variation in service utilization versus outliers. These data provide a perspective and comprehensive picture on overuse, underuse and misuse in all levels of care in order to improve healthcare utilization outcomes and in developing quality improvement policies.

Average length of stay (ALOS) and readmission rates for statewide members with an SMI diagnosis in Level I, Level I Sub-acute and Behavioral Health Residential Facility (BHRF) placements among both funding sources (AHCCCS-eligible and Non-AHCCCS-eligible) remained within minor acceptable variation as a result of random variability of high needs cases and low hospital discharge size. All data and variations are brought forth to the Division’s Utilization Management/Medical Management Committee on a quarterly basis for trending analysis and recommendations.

Level I facilities provide intensive inpatient treatment services with 24-hour supervision and medical support. Level I Sub-acute facilities provide 24-hour supervision with specialized treatment programming to persons not requiring on-site medical care. Within a BHRF, treatment services and psycho-social rehabilitation are provided in a structured residential setting.

⁹ Deaths per 1,000 member rate based on each year’s average monthly SMI enrollment, statewide.

¹⁰ FY 2015 average monthly SMI enrollment, statewide, did not include May 2015 and June 2015, as it was not yet available.

Statewide average length of stay and readmission rates for *AHCCCS-eligible* and *NON-AHCCCS-eligible* members with SMI placed in Level I, Level I Sub-Acute and BHRF placements for the first three quarters in FY 2015 were as follows¹¹:

- Average Length of Stay (ALOS) at the end of Quarter 3 FY 2015 was higher for Behavioral Health Residential Facilities, when compared to FY 2014 data.
- ALOS for the end of Quarter 3 FY 2015 Facilities increased Statewide within Level I Behavioral Health Hospitals for both Medicaid and Non-Medicaid-eligible members with SMI.
- The readmission rate at the end of Quarter 3 FY 2015 remained stable from the previous year within Behavioral Health Residential Facilities for both Medicaid and Non-Medicaid-eligible members with SMI.

Table 10: Title XIX SMI Average Length of Stay and Readmission Rates

Title XIX SMI	Q1		Q2		Q3	
	ALOS	Readmit Rate	ALOS	Readmit Rate	ALOS	Readmit Rate
Level I	11.5 days	15.6%	9.0 days	11.8%	12.7 days	15.2%
Level I Sub-Acute	6.8 days	12.3%	5.6 days	13.2%	5.9 days	12.4%
BH Residential Facility	40.4 days	23.3%	39.6 days	22.3%	46.1 days	28.1%

Table 11: Non-Title XIX SMI Average Length of Stay and Readmission Rates

Non-Title XIX SMI	Q1		Q2		Q3	
	ALOS	Readmit Rate	ALOS	Readmit Rate	ALOS	Readmit Rate
Level I	8.8 days	10.6%	8.7 days	15.6%	10.5 days	18.1%
Level I Sub-Acute	6.5 days	9.2%	7.1 days	13.4%	5.6 days	11.1%
BH Residential Facility	27.4 days	9.5%	37.4 days	22.7%	186.7 days	11.1%

VII. Program Integrity

In an effort to enhance the prevention and detection of health care fraud and program abuse, the Division has created a Bureau of Corporate Compliance (BCC), which is tasked with auditing and investigations. The BCC monitors all contractual obligations and applicable rules and regulations to ensure and promote robust program integrity. As part of its comprehensive Corporate Compliance Program, which is administered by the Corporate Compliance Officer within the BCC, the following internal procedures, workflows and tools were developed.

As required by the Deficit Reduction Act (DRA) of 2005, Title 42, U.S.C., §1396(a), the BCC provides all employees training regarding the False Claims Act, the Qui Tam Provisions and Federal Employee Whistleblower Protection Act, amongst other relevant areas. The Fraud and Program Abuse training commences with new employee orientation and annually thereafter.

BCC also records, tracks and trends all fraud and program abuse complaints; conducts fraud and program abuse awareness activities and fraud risk assessments; and all audit and review processes are in accordance with 42CFR 438.608, the Generally Acceptable Government Auditing Standards (GAGAS); ADHS/DBHS Accounting and Auditing Procedures Manual and the BCC Operations and Procedures Manual.

¹¹ The data on average length of stay and readmission rates for members with SMI for quarter four of FY 2015 was not available at the time of this report.

In addition to the above monitoring activities, the Division also conducts the Administrative Review, which meets the legal requirements of the Balanced Budget Act of 1997, and the contractual requirements between the Division and AHCCCS. The implementation of the Administrative Review provides additional monitoring to program performance and reviews the quality of processes to provide transparency and accountability.

Fraud Trend Analyses

This section discusses all fraud investigations conducted in FY 2015, pertaining to members both with and without an SMI diagnosis. There were 79 new cases (investigations) opened in State Fiscal Year 2015; 86 cases were closed during the fiscal year (18 of the closed cases were from the previous fiscal year). The sources of the 79 new cases were as follows: 58 were reported by RBHAs, Tribal RBHAs or Providers, with a breakdown as follows for the type of medium used to report the information: 34 were received in the BCC dedicated email, 8 received from the BCC hotline, 7 from a fax, 3 came via other email, 2 came from the new internet FWA Portal, and 4 came via U.S. Mail; there were also 16 allegations received from internal ADHS/DBHS email, most relating to member complaints; and 5 cases came from non-behavioral health sources which were forwarded to the appropriate entity (persons reporting SNAP fraud, WIC fraud, etc.). At the end of the fiscal year there were 11 open cases. Six cases were referred to AHCCCS-OIG by ADHS/DBHS during the fiscal year.

The audit summary for FY 2015 is as follows: Fifteen ride-along type audits were performed and completed. The total number of claims/encounters reviewed was 763, for a total value of \$250,533.82.

Pharmacy Lock-In Programs

Pharmacy Lock-in Programs is a program that may restrict a patient to filling all of his or her prescriptions at one pharmacy. The purpose of this program is to control duplicate and inappropriate drug therapies. CMS does not allow Medicare beneficiaries to be restricted to a particular pharmacy. In efforts to reduce the patterns of excessive and uncoordinated use of prescription drugs and other Medicaid benefits, the RBHAs have provided information surrounding their current efforts with participation in a Pharmacy Lock-In Program:

The Mercy Maricopa Integrated Care (GSA 6) Pharmacy Lock In Program's internal procedures and policies have remained the same as outlined for State Fiscal Year 2014. MMIC members may be referred to their Pharmacy Lock-In Program by the corporate pharmacy report, a medical record review, internal staff, the medical director, member report, PNO/Provider referral, health plan referral, or PCP referral, if they meet the criterion established by MMIC. Enrolled members are monitored by a MMIC care manager associate, who works closely with the physical health and behavioral health treatment team and community based case manager for all the MMIC plans and for the members who are treated in the General Mental Health/ Substance Abuse (GMH/SA) where the member receives their physical health care through an AHCCCS Acute Care Contractor, MMIC is establishing data sharing agreements and care coordination meetings to best serve the "non-integrate" AHCCCS population with the goal of coordinated, safe and effective outcomes. If the member changes providers, an update is done in the member's record and with the pharmacy. Reviews are completed annually to assess the need for continued enrollment. As of July 30, 2015, there are 263 members enrolled in the Pharmacy Lock-In Program. Since our last fiscal year the Pharmacy Lock-In program member participation has increased by over 500%. This increase was made possible by ensuring reports were completed on a monthly basis, which review various data points to identify increase in provider usage by member, Emergency Department entry and poisonings/overdoses. The substantial increase shown above makes it clear the program's effectiveness in decreasing member(s) abuse of controlled medication.

Cenpatico of Arizona (GSAs 2, 3, and 4), in cooperation the Pharmacy Benefit Manager US Script, work jointly to administer the pharmacy lock-down program to promote safe use of controlled substances for members. Requests for pharmacy lock-downs from Behavioral Health Medical Practitioners (BHMPs) and/or the Cenpatico utilization management staff are reviewed when received by the pharmacy director. An in-depth clinical review of pharmacy claims and the controlled substance prescription monitoring program are used to determine if the

member meets the approved lock-down criteria. If the member meets the criteria, both the prescriber and member are notified of the decision to lock the member to a specific pharmacy. Once locked, the member can only obtain controlled -substance prescriptions from the designated pharmacy for one year. The pharmacy lock-down will be continued [for an additional period of time] if requested; the prescriber and member will receive notification of the change. If it is determined by the prescriber that the member does not require pharmacy lock-down for an additional period of time, the prescriber and member will receive a letter informing them that they will no longer be required to receive controlled substances from that pharmacy. As of July 31, 2015 for FY 2015, Cenpatico has two (2) members enrolled in the Pharmacy Lock-Down Program. No trends have been identified during the past twelve (12) months).

Community Partnership of Southern Arizona's (CPSA – GSA 5) Pharmacy Restriction Program (also known as the Pharmacy Lock-In Program) continues the same process as SFY 2014. In terms of selection as candidates for the Pharmacy Restriction Program, Behavioral Health Medical Practitioners (BHMPs) choose members based on their clinical judgment; both the member or member's guardian and the BHMP determine the pharmacy selected. The pharmacy restriction is set for one year, unless otherwise requested by the BHMP. CPSA requires that the BHMP notify the member's physical health primary care provider of the restriction and the situation that led to the restriction. The BHMP fills out the "Pharmacy Restriction Request Form" (CPSA PM Form 3.14.25) to make the request. Upon review by the CPSA pharmacy staff, they enter the restriction into the Pharmacy Benefit Management (PBM) claim system. Therefore, CPSA always has readily available data as to members on Pharmacy Restrictions.

The numbers of CPSA members on the Pharmacy Restriction Program has historically been very low ($N < 20$); therefore, CPSA has noted a downward trend in the number of members being placed on pharmacy restrictions. Currently, CPSA has only seven members participating in a pharmacy restriction program. Two of these members are restricted as a result of benzodiazepine abuse as determined by their BHMP. The BHMP also placed the remaining five on pharmacy restrictions due to evidence of problematic use of multiple pharmacies and/or multiple physicians.

NARBHA (GSA 1) continues to not have a pharmacy lock-down program to report for FY 2015. Due to the rural nature of the region, many areas have limited choice already in pharmacies available to them, especially for evening/ night and weekend hours. Locking down the pharmacies may result in lapses in medications especially for members with limited transportation, weekend hospital discharges or travel out of the area. NARBHA encourages utilization of the same pharmacy for members by encouraging pharmacies that are on-site, co-located with behavioral health facilities, in the larger cities including Prescott, Cottonwood, Flagstaff, Kingman and Show Low.

VIII. Access to Services

With the launching of the Integrated Care RBHA Contract in Maricopa County late in the 2014 Contract Year, AHCCCS retired the Access to Care (ATC) performance measure and added seven (7) behavioral health measures (Figure 2) and twenty-six (26) acute medical measures (Figure 3). The seven behavioral health measures are statewide measures for the SMI, general mental health, substance abuse, and child populations. Due to inconsistency in submission of the data necessary for these measures, performance reporting has been delayed until complete data has been submitted.

Figure 2: Behavioral Health Performance Measures

Behavioral Health Performance Measures	
1	BH Inpatient Utilization (days/100,000 member months)
2	BH Emergency Department (ED) Utilization (visits/100,000 member years)
3	BH Hospital Readmissions
4	Follow-Up After Hospitalization for Mental Illness within <u>7</u> days
5	Follow-Up After Hospitalization for Mental Illness within <u>30</u> days
6	Access to Behavioral Health Provider within <u>7</u> days
7	Access to Behavioral Health Provider within <u>23</u> days

The twenty-six (26) Integrated Care Performance Measures are currently utilized only in Maricopa County. These measures will be rolled out to the Greater Arizona Integrated Plans (Health Choice Integrated Care in the northern region of the state, and Cenpatico Integrated Care in the south) beginning October 1, 2015. The twenty-six (26) measures (Figure 3) focus on the acute medical performance of the Integrated Care Plan, which provides medical care and services to those individuals with a diagnosis of a serious mental illness.

Figure 3: Integrated Behavioral Health Performance Measures

Integrated Behavioral Health Performance Measures			
1	Inpatient Utilization	14	Chronic obstructive pulmonary disease (COPD) admissions
2	Emergency Department (ED) Utilization	15	Congestive heart failure admissions
3	Hospital Readmissions	16	HIV/AIDS: Medical Visit
4	Adult Asthma Admission Rate	17	Annual monitoring for patients on persistent medications
5	Use of Appropriate Medications for People with Asthma	18	Timeliness of Prenatal Care (Hybrid)
6	Follow-up After Hospitalization within <u>7</u> Days	19	Postpartum Care Rate (Hybrid)
7	Follow-up After Hospitalization within <u>30</u> Days	20	Access to PCP
8	Comprehensive Diabetes Management: HbA1c Testing	21	Access to Behavioral Health Provider within <u>7</u> days
9	Comprehensive Diabetes Management: LDL-C Testing	22	Access to Behavioral Health Provider within <u>23</u> days
10	Comprehensive Diabetes Management: Eye Exam	23	EPSDT Participation
11	Flu Shots for Adults: Ages 50-64	24	Chlamydia Screening
12	Flu Shots for Adults: Ages 65+	25	Breast Cancer Screening
13	Diabetes Admissions, short-term complications	26	Cervical Cancer Screening (Hybrid)

There have been numerous changes throughout 2015 to the methodology of the Behavioral Health as well as to the Integrated Care performance measures. The reason for these changes has been to more closely align the measures to those of the Center for Medicare and Medicaid Services (CMS) and Health Plan Employer Data and Information Set (HEDIS). Because of the changes in methodology, it is not recommended that trends be determined or conclusions drawn at this time, regarding the quarterly performance measure results. An analysis should be completed for the 2016 SMI Report.

Complaint Data

Complaints can be filed by members or any party on behalf of members receiving behavioral health services. They can reflect any expression of dissatisfaction about the delivery of behavioral health services and can be filed directly with service providers, with the RBHAs, or with ADHS/DBHS.

Each RBHA is contractually required to maintain a complaint process that is easily accessible to behavioral health members, providers, and other stakeholders. They are further required to examine and assess their complaint data on a quarterly basis to identify trends and outliers to assist in identifying the need for and development of improvement strategies in the Division's service delivery system. Complaints referenced in this report are those that are reported to the Division via RBHA-submitted monthly complaint logs. Complaint data are reviewed in QM Committee meetings on a regular basis. Table 12 displays July 2014 to June 2015 *Access to Services* complaints received from or on behalf of AHCCCS-eligible (TXIX) and Non-AHCCCS-eligible (NTXIX) members with SMI.

Table 12: FY 2015 Complaints in *Access to Services* Subcategories by Area and Eligibility

Access to Services Complaint Subcategories	Greater Arizona		Maricopa County		Statewide	
	TXIX	NTXIX	TXIX	NTXIX	TXIX	NTXIX
No Provider to Meet Needs	42	6	70	7	112	13
Wait List	16	3	11	0	27	3
Timeliness	39	18	278	10	317	28
Office/ Appt. Wait Time	14	4	16	1	30	5
EOC Process	1	0	10	2	11	2
Authorization Process	26	4	46	5	72	9
Access to Services Total	138	35	431	25	569	60

Complaints are classified within one of seven complaint categories and are further stratified by complaint sub-categories. The complaint sub-categories for the *Access to Services* category are:

- No Provider to Meet Needs – Concerns with difficulty in receiving a service occurred as a result of the lack of a provider to meet the specific needs of the member;
- Timeliness – Concern that the service was not offered/provided within the required time frame;
- Office/Appointment Wait Time – Concern that the wait time for a scheduled appointment exceeds the maximum allowed wait time (45 minutes);
- Episode of Care Process – Concern that the ability to obtain medication or access a service is related to the behavioral health service activation (EOC) process;
- Authorization Process – Concern about prior authorization for services/medications or inability to access a service in a timely manner due to a lengthy prior authorization process.

Timeliness was the most common subcategory of complaints received from or on behalf of both AHCCCS-eligible and Non-AHCCCS-eligible members with SMI. The second highest number of complaints from, or on behalf of, both AHCCCS-eligible and Non-AHCCCS-eligible members with SMI were reported in the *No Provider to Meet Needs* subcategory.

Consumer Survey

On an annual basis, the Division, in collaboration with the T/RBHAs, administers two statewide surveys: the Mental Health Statistics Improvement Program (MHSIP) consumer survey (Adults); and the Youth Services Survey for Families (YSS-F) (Children). The survey's request independent feedback from AHCCCS-eligible adults and families of youth receiving services through Arizona's public behavioral health system; and seeks to measure consumers' perceptions in relation to the following domains: *General Satisfaction, Access to Services, Service*

Quality/Appropriateness, Participation in Treatment Planning, Outcomes, Cultural Sensitivity, and Improved Functioning and Social Connectedness.

Consumer Survey results are presented during the Executive QM Committee and the T/RBHA QM Committee. The critical information obtained from the survey is a major source for driving system improvements through RBHA contracts and QM Plans. T/RBHAs scoring less than 70% in any of the above mentioned domains are required to complete a corrective action plan (CAP) to address areas for system change opportunities. Survey outcomes are disseminated to stakeholders and members through the Performance Dashboard on the ADHS/DBHS website and submitted to national organizations as part of the federal grant requirements for use in national reporting and evaluation.

In April 2014, a change in the RBHA contractor for Maricopa County (GSA 6) occurred closely to the survey implementation timeframe, which resulted in the Maricopa County behavioral health members not participating in the FY 2014 survey. Since GSA 6 did not participate, the FY 2014 results were not weighted, as done in previous years. Since GSA 6 has the largest population base in the state, a direct comparison between FY 2013 and FY 2014 statewide results should be considered with caution. FY 2014 statewide domain scores show no statistically significant changes when compared to FY 2013 scores, with the exception of the *Social Connectedness* domain that increased 5 percentage points for the adult population.

The six questions presented on the Adult Consumer Survey that are aggregated to comprise the *Access to Services* domain are as follows:

- The location of services was convenient (parking, public transportation, distance, etc.).
- Staff were willing to see me as often as I felt it was necessary.
- Staff returned my call in 24 hours.
- Services were available at times that were good for me.
- I was able to get all the services I thought I needed.
- I was able to see a psychiatrist when I wanted to.

Fiscal year 2015 survey results will become after AHCCCS approval. The following is a summary of the 2014 survey results for the 1,664 RBHA-enrolled adult members that participated in the survey as well as a subset consisting of the 870 adults with SMI that participated.

Statewide Aggregate Adult Summary:

- The highest scoring domains for the adult participants were *Participation in Treatment Planning* and *Service Quality & Appropriateness*, both at 92% (both at 91% in 2013), and the lowest was *Improved Functioning* at 72% (71% in 2013);
- *Outcomes* scored 74%, an improvement of 2 percentage points as compared to 2013;
- *Social Connectedness* scored 82%, an improvement of 5 percentage points compared to 2013;
- The *Service Access* domain remained unchanged at 87% from FY 2013.
- The *General Satisfaction* domain decreased by 2 percentage points at 88%.

Statewide Youth Consumer Survey Summary:

- All domains remained the same or experienced increases in positive scores; none of which were statistically significant.

As per the Division contract with the RBHAs, satisfaction with service *Outcomes* on the Annual Consumer Survey is a performance incentive; of which a score of 70% or greater on the *Outcomes* domain of the Consumer Survey makes up 25% of the incentive award. Adult and youth survey results are evaluated independently, each contributing to half of the award. The Division believes that assisting members in the identification and tracking of treatment outcomes is imperative to improving behavioral health members' overall perception of the quality of services they receive.

APPENDIX

Table 13: Utilization and Expenditures for AHCCCS-eligible HCB in Maricopa County by Service Type

SMI Profile FY 2015 Service Categories and Sub-Categories	Maricopa County						
	TXIX HCB						
	# Receiving Services	Total Expenditures	Annual Per Capita	Percent of Population	Rate Per 1,000	Monthly Per Capita	Percent of Expenditures
Support Services	337	\$ 15,270,923.01	\$ 45,314.31	100.0%	1000.0	\$ 3,776.19	35.2%
<i>Case Management</i>	337	\$ 2,405,269.18	\$ 7,137.30	100.0%	1000.0	\$ 594.77	5.5%
<i>Family Support</i>	29	\$ 19,195.70	\$ 661.92	8.6%	86.1	\$ 55.16	0.0%
<i>Peer Support</i>	243	\$ 748,004.87	\$ 3,078.21	72.1%	721.1	\$ 256.52	1.7%
<i>Personal Assistance</i>	193	\$ 9,163,169.32	\$ 47,477.56	57.3%	572.7	\$ 3,956.46	21.1%
<i>Respite Care</i>	12	\$ 41,116.99	\$ 3,426.42	3.6%	35.6	\$ 285.53	0.1%
Inpatient Services	185	\$ 4,418,580.99	\$ 23,884.22	54.9%	549.0	\$ 1,990.35	10.2%
Rehabilitation Services	301	\$ 5,599,222.29	\$ 18,602.07	89.3%	893.2	\$ 1,550.17	12.9%
<i>Supported Employment</i>	171	\$ 800,683.67	\$ 4,682.36	50.7%	507.4	\$ 390.20	1.8%
<i>Health Promotion</i>	171	\$ 678,062.55	\$ 3,965.28	50.7%	507.4	\$ 330.44	1.6%
<i>Living Skills Training</i>	283	\$ 4,120,476.07	\$ 14,559.99	84.0%	839.8	\$ 1,213.33	9.5%
Residential Services	199	\$ 10,944,718.44	\$ 54,998.59	59.1%	590.5	\$ 4,583.22	25.3%
Pharmacy	274	\$ 5,215,463.37	\$ 19,034.54	81.3%	813.1	\$ 1,586.21	12.0%
Treatment Services	302	\$ 517,425.62	\$ 1,713.33	89.6%	896.1	\$ 142.78	1.2%
Crisis Intervention Services	213	\$ 585,427.32	\$ 2,748.49	63.2%	632.0	\$ 229.04	1.4%
Medical Services	336	\$ 788,897.32	\$ 2,347.91	99.7%	997.0	\$ 195.66	1.8%
Total	337	\$ 43,340,658.36	\$ 128,607.29	100.0%	1000.0	\$ 10,717.27	100.0%

Table 14: Utilization and Expenditures for AHCCCS-eligible HCB in Greater Arizona by Service Type

SMI Profile FY 2015 Service Categories and Sub-Categories	Greater Arizona						
	TXIX HCB						
	# Receiving Services	Total Expenditures	Annual Per Capita	Percent of Population	Rate Per 1,000	Monthly Per Capita	Percent of Expenditures
Support Services	426	\$ 6,030,709.39	\$ 14,156.59	100.0%	1000.0	\$ 1,179.72	18.8%
<i>Case Management</i>	426	\$ 2,829,115.03	\$ 6,641.12	100.0%	1000.0	\$ 553.43	8.8%
<i>Family Support</i>	31	\$ 11,542.59	\$ 372.34	7.3%	72.8	\$ 31.03	0.0%
<i>Peer Support</i>	297	\$ 779,822.40	\$ 2,625.66	69.7%	697.2	\$ 218.81	2.4%
<i>Personal Assistance</i>	132	\$ 733,113.52	\$ 5,553.89	31.0%	309.9	\$ 462.82	2.3%
<i>Respite Care</i>	35	\$ 75,072.24	\$ 2,144.92	8.2%	82.2	\$ 178.74	0.2%
Inpatient Services	278	\$ 8,540,154.91	\$ 30,719.98	65.3%	652.6	\$ 2,560.00	26.6%
Rehabilitation Services	342	\$ 3,269,986.08	\$ 9,561.36	80.3%	802.8	\$ 796.78	10.2%
<i>Supported Employment</i>	224	\$ 739,092.98	\$ 3,299.52	52.6%	525.8	\$ 274.96	2.3%
<i>Health Promotion</i>	211	\$ 266,341.25	\$ 1,262.28	49.5%	495.3	\$ 105.19	0.8%
<i>Living Skills Training</i>	290	\$ 2,264,551.85	\$ 7,808.80	68.1%	680.8	\$ 650.73	7.1%
Residential Services	279	\$ 9,703,045.68	\$ 34,777.94	65.5%	654.9	\$ 2,898.16	30.2%
Pharmacy	378	\$ 1,660,237.89	\$ 4,392.16	88.7%	887.3	\$ 366.01	5.2%
Treatment Services	379	\$ 694,031.02	\$ 1,831.22	89.0%	889.7	\$ 152.60	2.2%
Crisis Services	264	\$ 1,638,025.83	\$ 6,204.64	62.0%	619.7	\$ 517.05	5.1%
Medical Services	381	\$ 546,516.90	\$ 1,434.43	89.4%	894.4	\$ 119.54	1.7%
Total	426	\$ 32,082,707.70	\$ 75,311.52	100.0%	1000.0	\$ 6,275.96	100.0%

Table 15: Utilization and Expenditures for Non-AHCCCS-eligible HCB in Maricopa County by Service Type

SMI Profile FY 2015 Service Categories and Sub-Categories	Maricopa County						
	NTXIX HCB						
	# Receiving Services	Total Expenditures	Annual Per Capita	Percent of Population	Rate Per 1,000	Monthly Per Capita	Percent of Expenditures
Support Services	92	\$ 1,230,958.24	\$ 13,379.98	100.0%	1000.0	\$ 1,115.00	35.2%
Case Management	92	\$ 472,262.25	\$ 5,133.29	100.0%	1000.0	\$ 427.77	13.5%
Family Support	3	\$ 325.14	\$ 108.38	3.3%	32.6	\$ 9.03	0.01%
Peer Support	64	\$ 211,795.56	\$ 3,309.31	69.6%	695.7	\$ 275.78	6.1%
Personal Assistance	23	\$ 146,210.20	\$ 6,356.97	25.0%	250.0	\$ 529.75	4.2%
Respite Care	0	\$ -	\$ -	0.0%	0.0	\$ -	0.00%
Inpatient Services	18	\$ 8,682.39	\$ 482.36	19.6%	195.7	\$ 40.20	0.2%
Rehabilitation Services	79	\$ 1,383,981.90	\$ 17,518.76	85.9%	858.7	\$ 1,459.90	39.6%
Living Skills Training	67	\$ 199,652.23	\$ 2,979.88	72.8%	728.3	\$ 248.32	5.7%
Supported Employment	54	\$ 908,037.75	\$ 16,815.51	58.7%	587.0	\$ 1,401.29	26.0%
Health Promotion	52	\$ 276,291.92	\$ 5,313.31	56.5%	565.2	\$ 442.78	7.9%
Residential Services	6	\$ 6,492.30	\$ 1,082.05	6.5%	65.2	\$ 90.17	0.2%
Pharmacy	83	\$ 634,726.49	\$ 7,647.31	90.2%	902.2	\$ 637.28	18.2%
Treatment Services	63	\$ 39,453.88	\$ 626.25	68.5%	684.8	\$ 52.19	1.1%
Crisis Intervention Services	26	\$ 88,917.40	\$ 3,419.90	28.3%	282.6	\$ 284.99	2.5%
Medical Services	89	\$ 100,767.02	\$ 1,132.21	96.7%	967.4	\$ 94.35	2.9%
<i>Total</i>	92	\$3,493,979.62	\$37,978.04	100.0%	1000.0	\$ 3,164.84	100.0%

Table 16: Utilization and Expenditures for Non-AHCCCS-eligible HCB in Greater Arizona by Service Type

SMI Profile FY 2015 Service Categories and Sub-Categories	Greater Arizona						
	NTXIX HCB						
	# Receiving Services	Total Expenditures	Annual Per Capita	Percent of Population	Rate Per 1,000	Monthly Per Capita	Percent of Expenditures
Support Services	81	\$ 1,246,452.71	\$ 15,388.31	100.0%	1000.0	\$ 977.51	51.2%
Case Management	81	\$ 502,767.50	\$ 6,207.01	100.0%	1000.0	\$ 517.25	20.6%
Family Support	6	\$ 352.24	\$ 58.71	7.4%	74.1	\$ 4.89	0.01%
Peer Support	75	\$ 324,453.63	\$ 4,326.05	92.6%	925.9	\$ 360.50	13.3%
Personal Assistance	24	\$ 52,653.86	\$ 2,193.91	29.6%	296.3	\$ 182.83	2.2%
Respite Care	3	\$ 17,632.42	\$ 5,877.47	3.7%	37.0	\$ 489.79	0.7%
Inpatient Services	29	\$ 77,577.28	\$ 2,675.08	35.8%	358.0	\$ 222.92	3.2%
Rehabilitation Services	74	\$ 499,101.22	\$ 6,744.61	91.4%	913.6	\$ 562.05	20.5%
Living Skills Training	67	\$ 202,370.31	\$ 3,020.45	82.7%	827.2	\$ 251.70	8.3%
Supported Employment	45	\$ 246,173.69	\$ 5,470.53	55.6%	555.6	\$ 455.88	10.1%
Health Promotion	40	\$ 50,557.22	\$ 1,263.93	49.4%	493.8	\$ 105.33	2.1%
Residential Services	5	\$ 58,650.53	\$ 11,730.11	6.2%	61.7	\$ 977.51	2.4%
Pharmacy Services	60	\$ 105,872.81	\$ 1,764.55	74.1%	740.7	\$ 147.05	4.3%
Treatment Services	77	\$ 81,079.51	\$ 1,052.98	95.1%	950.6	\$ 87.75	3.3%
Crisis Services	41	\$ 300,162.86	\$ 7,321.05	50.6%	506.2	\$ 610.09	12.3%
Medical Services	72	\$ 66,092.09	\$ 917.95	88.9%	888.9	\$ 76.50	2.7%
<i>Total</i>	81	\$ 2,434,989.01	\$ 30,061.59	100.0%	1000.0	\$ 2,505.13	100.0%