August 31, 2022

The Honorable David Gowan
Chairman, Joint Legislative Budget Committee
1700 W. Washington
Phoenix, AZ 85007

Dear Senator Gowan:

Pursuant to A.R.S. 36-3415, AHCCCS is required to report annually to the Joint Legislative Budget Committee on each fiscal year's Medicaid and non-Medicaid behavioral health expenditures, including behavioral health demographics that include client income, utilization and expenditures, medical necessity oversight practices, tracking of high-cost beneficiaries, mortality trends, placement trends, program integrity and access to services.

If you have any questions regarding the attached report please feel free to contact me at (602) 417-4711.

Sincerely,

Jami Snyder
Director

cc: The Honorable Regina Cobb, Vice Chairman, Joint Legislative Budget Committee
Art Harding, Governor's Office, Director of Legislative Affairs
Matthew Gress, Director, Governor's Office of Strategic Planning and Budgeting
Richard Stavneak, Director, Joint Legislative Budget Committee

BEHAVIORAL HEALTH ANNUAL REPORT

FOR THE PERIOD:
STATE FISCAL YEAR (SFY) 2021
(JULY 1, 2020 – JUNE 30, 2021)

September 2022
Jami Snyder, Director

Background

ARS §36-3415 requires the following:

> *Behavioral health expenditures; annual report*
>
> *The administration shall report annually to the joint legislative budget committee on each fiscal year's Medicaid and non-Medicaid behavioral health expenditures, including behavioral health demographics that include client income, utilization and expenditures, medical necessity oversight practices, tracking of high-cost beneficiaries, mortality trends, placement trends, program integrity and access to services.*

As a result of administrative simplification, the merger of AHCCCS and the Arizona Department of Health Services' (ADHS) Division of Behavioral Health Services (DBHS) effective July 1, 2016, AHCCCS reviewed legislative report deliverables that were previously prepared by DBHS to determine the responsiveness of the information provided to the request, and to understand methodologies and data sources. AHCCCS determined that versions of the report previous to the merger due in accordance with §36-3415 were focused solely on information related to members with a Serious Mental Illness (SMI) designation. AHCCCS does not believe that limiting the report to members with an SMI designation aligns with the requirements in §36-3415 and thus AHCCCS revamped the report in its entirety beginning with the State Fiscal Year (SFY) 2017 report.

Pursuant to Laws 2022, Second Regular Session, Chapter 305, this report will continue to be issued annually; moving forward this will be issued as the §36-3415**(A)** report. In addition, AHCCCS will produce a new annual report under the newly-added subsection (B) that "shall be in a substantially comparable format as the fiscal year 2014-2015 annual report" submitted by ADHS/DBHS for members designated with an SMI. AHCCCS staff are currently evaluating the ability to identify and report the data mandated by the legislation to determine a delivery date for the first §36-3415(B) report, but will ensure that this report is submitted no later than September 1, 2023.

Beginning in contract year ending (CYE) 2019, with the implementation of the AHCCCS Complete Care (ACC) program, AHCCCS Managed Care Organizations (MCOs) provide fully integrated physical and behavioral health care for members with General Mental Health/Substance Use (GMH/SU) needs and members who are children (except children who are in foster care). Effective with CYE 2020, individuals with developmental disabilities transitioned to fully integrated health plans contracted with the Department of Economic Security/Division of Developmental Disabilities (DES/DDD) for acute care and behavioral health services. Members enrolled in the Comprehensive Medical and Dental Program (CMDP) were transitioned to an integrated product part way through SFY 2021, effective April 1, 2021. Under its new name, the Arizona Department of Child Safety – Comprehensive Health Plan (DCS CHP) delivers integrated physical and behavioral health services to its members. Thus these members received behavioral health services from Regional Behavioral Health Authorities (RBHAs) during the first three quarters of the reporting period covered by this report, and received behavioral health services from the integrated MCO for the remaining quarter. Therefore, while information in previous reports usually

reflected RBHA data only, information in this year's report is inclusive of behavioral health (BH) services provided under all contracts.

AHCCCS reports behavioral health service data as defined by clinical criteria determined by AHCCCS, instead of reporting behavioral health expenditures incurred only by RBHA payers for the reasons noted above. This reporting methodology was previously implemented for the Behavioral Health Enrolled and Served report that is produced on a monthly basis pursuant to §36-3405(D) as described in a memorandum available at the following link: Clinical Criteria for AHCCCS Behavioral Health Enrolled and Served Report.

Client Income

AHCCCS members who receive Medicaid services generally have household incomes near or below the Federal Poverty Level (FPL) and Federal Benefit Rate (FBR). Generally, the FBR standards change in January each year, and the FPL standards change no later than April each year. FPL and FBR standards used for the eligibility determinations in State Fiscal Year 2021 can be found at the following link: AHCCCS Medical Assistance Eligibility Policy 615: Income Eligibility.

In SFY 2021, 100 percent FBR for an individual was $9,528 a year and 100 percent FPL for an individual was $12,888 a year[1]. As noted in Table I, 47.7 percent of Medicaid (Title XIX) and Children's Health Insurance Program (CHIP – Title XXI) members determined by FPL were below 100 percent FPL. In addition, AHCCCS provides some limited, Non-Title XIX/XXI services to individuals not eligible for Medicaid/CHIP, who may have higher household incomes.

Table II on the following page provides the percentage of members determined by FBR. In SFY 2021, 72.6 percent of Medicaid and CHIP members determined by FBR were below 100 percent FBR.

[1] These numbers were miscalculated in the SFY 2020 report. One hundred percent FBR for an individual was $9,396 a year and one hundred percent FPL for an individual was $12,768 a year in SFY 2020.

Table I - SFY 2021 Medicaid & CHIP Members Determined by FPL

Federal Poverty Level	Percent
< 36% FPL	8.3%
≥ 36% and < 40% FPL	24.1%
≥ 40% and < 100% FPL	15.3%
≥ 100% and < 106% FPL	33.9%
≥ 106% and < 120% FPL	1.1%
≥ 120% and < 133% FPL	9.4%
≥ 133% and < 150% FPL	0.6%
≥ 150% and <185% FPL	5.2%
≥ 185% and < 200% FPL	1.8%
≥ 200% and < 250%FPL	0.3%
Grand Total	100%

Table II - SFY 2021 Medicaid & CHIP Members Determined by FBR

Federal Benefit Rate	Percent
< 100% FBR	72.6%
≥ 100% and < 300% FBR	27.4%
Total	100%

Utilization and Expenditures

The Medicaid and non-Medicaid behavioral health expenditures for SFY 2021 are provided in Tables III and IV. These expenditures are consistent with those reported in AHCCCS' SFY 2021 Behavioral Health Programmatic Expenditure Report, submitted in accordance with A.R.S. §36-3405. A link to that report is provided for reference: AHCCCS SFY 2021 Behavioral Health Programmatic Expenditure Report.

In this context, behavioral health services are defined as any service with a primary diagnosis code that is behavioral health related, or a pharmacy claim that is behavioral health related, as defined by AHCCCS clinical criteria.

Table III - Statewide Expenditures by Funding Source – SFY 2021

Total Behavioral Health Services Expenditures by Funding Source SFY 2021		
Funding	**Amount Paid**	**Percentage**
General Fund - Medicaid	$373,251,955	13.66%
Tobacco Tax Funds - Medically Needy Account	$35,565,800	1.30%
Tobacco Tax Funds - Proposition 204 Protection Account	$5,000,000	0.18%
Tobacco Tax Funds - Tobacco Litigation Settlement	$30,154,400	1.10%
TXIX and TXXI Medicaid Federal Grant Awards	$2,015,807,109	73.80%
Non-TXIX General Fund	$99,983,897	3.66%
Substance Abuse Services Fund	$2,250,200	0.08%
Federal Grant – MHBG	$19,608,451	0.72%
Federal Grant – SABG	$38,590,698	1.41%
Federal Grants (Opioid/Other)	$37,492,721	1.37%
County Funds	$71,845,968	2.63%
SMI Housing Trust Fund	$222,799	0.01%
Substance Use Disorder Funds	$1,165,919	0.04%
Other (Liquor Service Fees)	$583,823	0.02%
Total	**$2,731,523,740**	**100%**
TXIX/TXXI	*$2,459,779,264*	*90.05%*
Non-TXIX/TXXI	*$271,744,476*	*9.95%*

Table IV - Statewide Expenditures by Behavioral Health Category – SFY 2021

Members Served in FY 2021 by Behavioral Health Category*			
Behavioral Health Category	**TXIX/TXXI Funding**	**Non-TXIX/Non-TXXI Funding**	**Total**
Seriously Mentally Ill	$671,587,621	$133,688,093	$805,275,714
Children with Serious Emotional Disturbance	$421,042,249	$13,015,298	$434,057,548
Alcohol and Drug Abuse	$519,880,687	$51,799,592	$571,680,279
Other Mental Health	$847,268,707	$73,241,491	$920,510,198
Total	**$2,459,779,264**	**$271,744,475**	**$2,731,523,739**

**Table IV includes only Title XIX and Title XIX Funding Sources*

Medical Necessity Oversight Practices

AHCCCS requires that MCOs provide covered services to AHCCCS members in accordance with all applicable federal and state laws, the Arizona Section 1115 Waiver Demonstration, regulations, contract, and policy. In addition, services must meet mental health parity standards which generally require that limitations applied to mental health/substance use disorder benefits are no more restrictive than the limitations applied to medical conditions/surgical procedure benefits. Covered services must be medically necessary and be provided by a qualified provider.

AHCCCS contracts require MCOs to develop a comprehensive Medical Management (MM) Program that will assure the appropriate management of service delivery for members. Each MCO's MM Program is comprised of numerous required elements including but not limited to policies, procedures and criteria for the following activities that support medical necessity oversight:

- Prior authorization (PA) which promotes appropriate utilization of services, including behavioral health services, while effectively managing associated costs (though many behavioral health services do not require PA). A decision to deny a PA request must be made by a qualified health care professional with the appropriate clinical expertise in treating the member's condition or disease and will render decisions that:
    - Deny an authorization request based on medical necessity,
    - Authorize a request in an amount, duration, or scope that is less than what is requested, or
    - Exclude or limit services.

  A denial, reduction, limited authorization, or termination of a covered service requires that a Notice of Adverse Benefit Determination be issued to the member.

- Concurrent and retrospective review of utilization of services in institutional settings (e.g., hospitals, behavioral health residential facilities, etc.). AHCCCS policy outlines specific required criteria and elements that the MCO must include in policies and procedures. These reviews address medical necessity prior to a planned admission and determination of medical necessity for continued stay.

- MM utilization data analysis and data management focus on the utilization of services and detect both the under and over utilization of services. The MCO must review and evaluate the data findings and implement actions for improvement when variances are identified.

Oversight Activities

AHCCCS monitors and oversees MCO MM activities including, but not limited to, the review and approval of an annual MM plan submission, review of quarterly PA and denial data, and through Operational Reviews (OR) that audit the MCOs' compliance with established AHCCCS MM standards. The OR standards include, among other items, PA practices, concurrent and retrospective review practices, Notices of Adverse Benefit Determination practices, the maintenance of evidence-based practice guidelines, inter-rater reliability practices and drug utilization review program practices. During SFY 2021, AHCCCS

implemented a deliverable, associated with AHCCCS Medical Policy Manual (AMPM) 1021 Contractor Care Management, to ensure these activities were monitored specific to behavioral health data.

Prior to the SFY 2021 deliverable, and included in the SFY 2020 report, MCOs included physical health information within an ad hoc data submission, leading to larger reported numbers. AHCCCS provided further technical assistance to the MCOs to ensure that the deliverable was limited to behavioral health data. Due to the change in deliverable, this data is not comparable to prior reporting. AHCCCS will continue to monitor future deliverable submissions to ensure data integrity and will provide additional technical assistance as warranted. Table V offers data on the volume of behavioral health specific MCO MM oversight activities during SFY 2021.

Table V – Behavioral Health Medical Necessity Oversight Activities Fiscal Year 2021

Behavioral Health Medical Necessity Oversight Activity	SFY 2021
Prior Authorizations	4,588
Notice of Adverse Benefit Determinations (NOA)	5,479
Concurrent Reviews	29,652
Retrospective Reviews	6,680

Utilization Analysis

AHCCCS utilizes standardized performance measures to monitor the compliance of MCOs related to the delivery of care and services to members. Performance measures may focus on clinical and non-clinical areas including both physical and behavioral health measures; measures include utilization of services.

AHCCCS transitioned to calculating performance measures on a Calendar Year (CY) basis beginning with the CY 2020 performance measures. Table VI provides specific behavioral health utilization performance measures and outcome data for the CY 2020 measurement period (January 1, 2020 to December 31, 2020). CY 2020 is the most recent, completed data available for the ACC program, for members designated as SMI enrolled with the RBHAs, and for managed care enrolled members across all lines of business.

Table VI – CY 2020 AHCCCS Performance Measure Data – Utilization of Services

CY 2020 Behavioral Health Performance Measure Rates				
Performance Measure	2020 NCQA Medicaid Mean[1]	ACC Aggregate	SMI Aggregate	Statewide[2] Aggregate
Mental Health Utilization - Any Service (Total)	NA[3]	10.8%	85.5%	14.5%
Mental Health Utilization - Inpatient (Total)	NA[3]	1.1%	18.2%	1.6%
Mental Health Utilization - Intensive Outpatient/Partial Hospitalization (Total)	NA[3]	0.3%	13.6%	0.9%
Mental Health Utilization - Outpatient (Total)	NA[3]	10.0%	83.7%	13.6%
Mental Health Utilization - ED (Total)	NA[3]	0.1%	0.5%	0.1%
Mental Health Utilization - Telehealth (Total)	NA[3]	2.3%	20.1%	3.4%
Use of Pharmacotherapy for Opioid Use Disorder (Total)	NA[3]	42.7%	33.2%	52.3 %
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	60.1%	70.%	NA[4]	70.3%

[1] *NCQA Medicaid Mean retrieved from the State of Health Care Quality Report published by NCQA.*
[2] *Rates reflective of all managed care enrolled members meeting continuous enrollment criteria regardless of line of business.*
[3] *Measure does not have an NCQA Medicaid Mean.*
[4] *SMI does not include children and adolescents.*

Most of the utilization measures in Table VI utilization declined or remained flat when compared to the prior year, consistent with broader utilization trends as a result of the COVID-19 pandemic over the course of the federally declared Public Health Emergency beginning in March 2020. One notable exception was telehealth utilization, which is also consistent with state and national trends. Over the course of the COVID-19 pandemic, AHCCCS has added flexibilities to telehealth coverage and worked to expand telehealth covered services. AHCCCS will continue to monitor these outcomes to ensure availability and access to behavioral health services.

Beginning with its CYE 2021 contract amendments, AHCCCS transitioned to the use of national benchmark data (e.g., NCQA HEDIS Medicaid Mean and CMS Medicaid Median) to evaluate performance. In efforts to promote improvement in performance measure rates, AHCCCS requires Contractors to implement corrective action plans (CAPs) for measures not meeting the associated performance measure standards.

High-Cost Beneficiaries

AHCCCS requires MCOs to coordinate care for members with high behavioral and physical health needs and/or high costs. The MCO must identify members with high needs/high costs, plan interventions for addressing appropriate and timely care for these members, and report outcomes to AHCCCS. MCOs track interventions based on standardized criteria and report intervention summaries to AHCCCS within the annual plan submissions.

Beginning in CYE 2020, AHCCCS removed its prescriptive requirements for identifying high need/high-cost members and allowed MCOs to develop their own criteria to determine high-cost beneficiaries. MCOs took this opportunity to expand the diagnoses used to identify such members who could benefit from greater care coordination.

AHCCCS implemented a behavioral health specific deliverable associated with AHCCCS Medical Policy Manual (AMPM) 1021 during SFY 2021. MCOs identified and tracked 1,427 behavioral health high-cost beneficiaries in SFY 2021. As noted previously in this report, MCOs included physical health information within the data submission related to high-cost beneficiaries in the SFY 2020 report. This led to larger reported numbers. AHCCCS provided further technical assistance to the MCOs to ensure that the deliverable was limited to high-cost beneficiaries based only on behavioral health data. Due to the change to the high-cost beneficiaries deliverable, this data is not comparable to prior reporting. AHCCCS will continue to monitor future deliverable submissions to ensure data integrity and will provide additional technical assistance as warranted.

Mortality Trends

AHCCCS does not collect cause of death data and therefore is unable to attribute mortality rates to behavioral health causes versus physical health reasons. The ADHS Bureau of Public Health Statistics collects information on mortality rates across a variety of populations at the following link: ADHS Population Health and Vital Statistics For Death. In prior years' reporting, AHCCCS provided a summary of mortality statistics found on the ADHS website which were not limited to AHCCCS members. AHCCCS has determined that summarizing that statewide data is not responsive to the intent of this element of the report and is working to transition the Mortality Trends section in this and future reports.

Placement Trends

A number of behavioral health treatment settings exist for AHCCCS members. MCOs place a member in the least restrictive setting that is most appropriate to the level of care needed for the specific situation. These settings include[2]:

- Behavioral Health Residential Facility (BHRF)
  Residential services provided by a licensed behavioral health agency. These agencies provide a structured treatment setting with 24-hour supervision and counseling or other therapeutic activities for persons who do not require on-site medical services, under the supervision of an on-site or on-call behavioral health professional.

- Therapeutic Foster Care
  Therapeutic Foster Care services, formerly known as Home Care Training, to Home Care Client (HCTC) services, are provided by a behavioral health therapeutic home to a person residing in his/her home in order to implement the in-home portion of the person's behavioral health service plan. Therapeutic foster care services assist and support a person in achieving their service plan goals and objectives. It also helps the person remain in the community setting, thereby avoiding residential, inpatient, or institutional care.

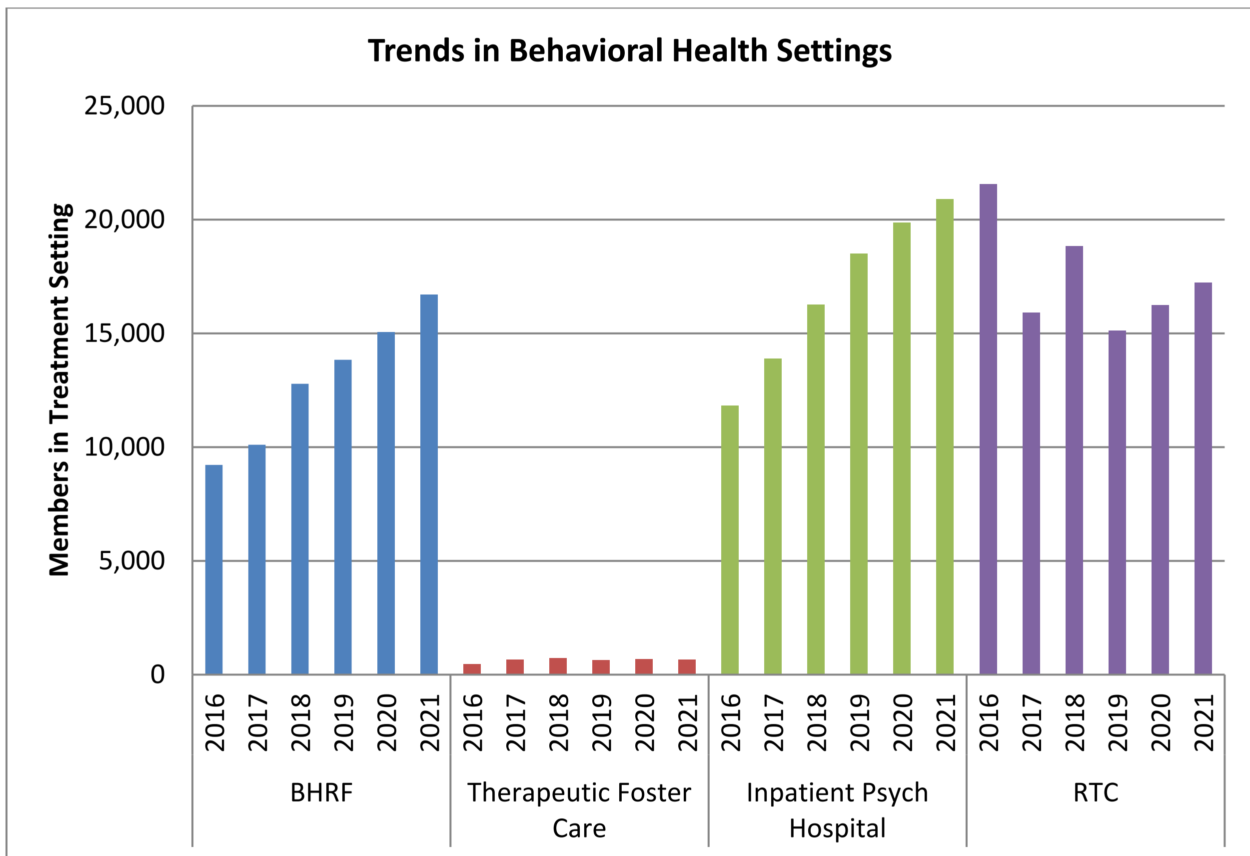
- Inpatient Psychiatric Hospital
  Inpatient services (including room and board) provided by a licensed behavioral health agency. These facilities provide a structured treatment setting with 24-hour supervision and an intensive treatment program, including medical support services.

- Residential Treatment Center (RTC)
  Inpatient psychiatric treatment, which includes an integrated residential program of therapies, activities, and experiences provided to persons who are under 21 years of age and have severe or acute behavioral health symptoms.

Chart I on the following page provides a six year history of behavioral health treatment settings for AHCCCS members. Data is provided on a CYE basis (October 1 through September 30 annually).

[2] More details regarding these treatment settings can be found in Chapter 300 of the AHCCCS Medical Policy Manual at https://www.azahcccs.gov/shared/MedicalPolicyManual

Chart I – Trends in Behavioral Health Settings



A combination of factors helps explain the trends in treatment settings over the last six years.

AHCCCS and its MCOs recognized the need for increasing network capacity for BHRF services and supported efforts by the provider community to add beds in this treatment setting. Some of the factors contributing to the need for additional beds include:

- Members leaving jail and transitioning to medically necessary behavioral health care in the community.
- Greater focus on treatment for opiate use disorder to reduce opioid prescription drug misuse and abuse.
- Programs targeting specialty populations in the children's system, for example youth with developmental delays exhibiting sexually maladaptive behaviors.
- Expansion for the inclusion of personal care services for members determined SMI, when appropriate.

Therapeutic foster care is utilized increasingly for members in need of a family setting for treatment. Training and education have been provided to the community regarding therapeutic foster care and how this unique service can provide therapeutic support in the least restrictive environment while still supporting the treatment needs of youth. The initiatives to expand community-based services to provide comprehensive support for youth and adults in settings supported by therapeutic foster care services appear to have led to increased utilization of this treatment setting.

Several factors contributed to the increased utilization of inpatient services across populations including, but not limited to:

- Collaboration with first responders, including expanded crisis intervention training to support police officers in getting members to treatment rather than sending members to jail.
- Concentrated efforts to reduce emergency department holds, which resulted in members obtaining inpatient care more quickly and enabling easier access to inpatient services.
- Greater focus on inpatient treatment for opiate use disorder to reduce opioid prescription drug misuse and abuse.
- Development of special needs units for youth with autism increasing the number of available behavioral beds in the community.
- Increased capacity to handle crisis-related treatment statewide.

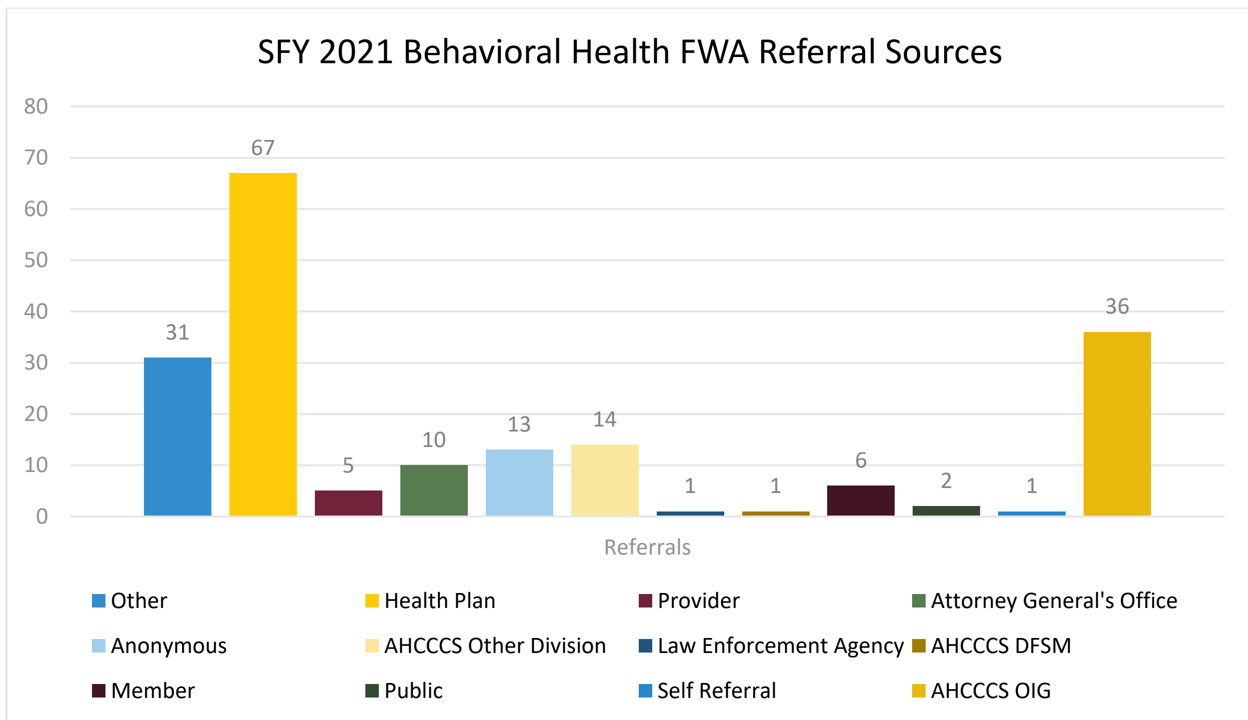
Program Integrity

The AHCCCS Office of the Inspector General (OIG) is the investigative arm of the State's Medicaid Agency, working jointly with federal, state, and local law enforcement to reduce and deter improper payments due to fraud, waste, and abuse (FWA). The OIG works in collaboration with the Medicaid Fraud Control Unit (MFCU), Arizona State Attorney General's Office (AGO), to ensure Medicaid funds are distributed and used as intended. Program Integrity activities include behavioral health services but do not target them separately due to the comprehensive nature of audits and responsive framework for investigations.

The OIG has worked collaboratively during SFY 2021 with internal AHCCCS subject matter experts, AHCCCS Division of Fee For Service Management, AHCCCS MCOs, and the ADHS Bureau of Residential Facilities Licensing to better understand the provision of behavioral health services unique to various AHCCCS populations, identify flags that should be reported for FWA, develop information sharing agreements, and facilitate joint agency discussions. Several of these partnerships have previously been established; however, OIG is consistently engaging and coordinating with these identified agencies for continued communication and partnership development.

Successful partnership activities have included the development of identifying overlapping behavioral health services between different provider types, highlighting unbundled services, comparing a singular date of service billed against services billed with date ranges, and utilizing information obtained during facility site visits that warrant referrals to the OIG.

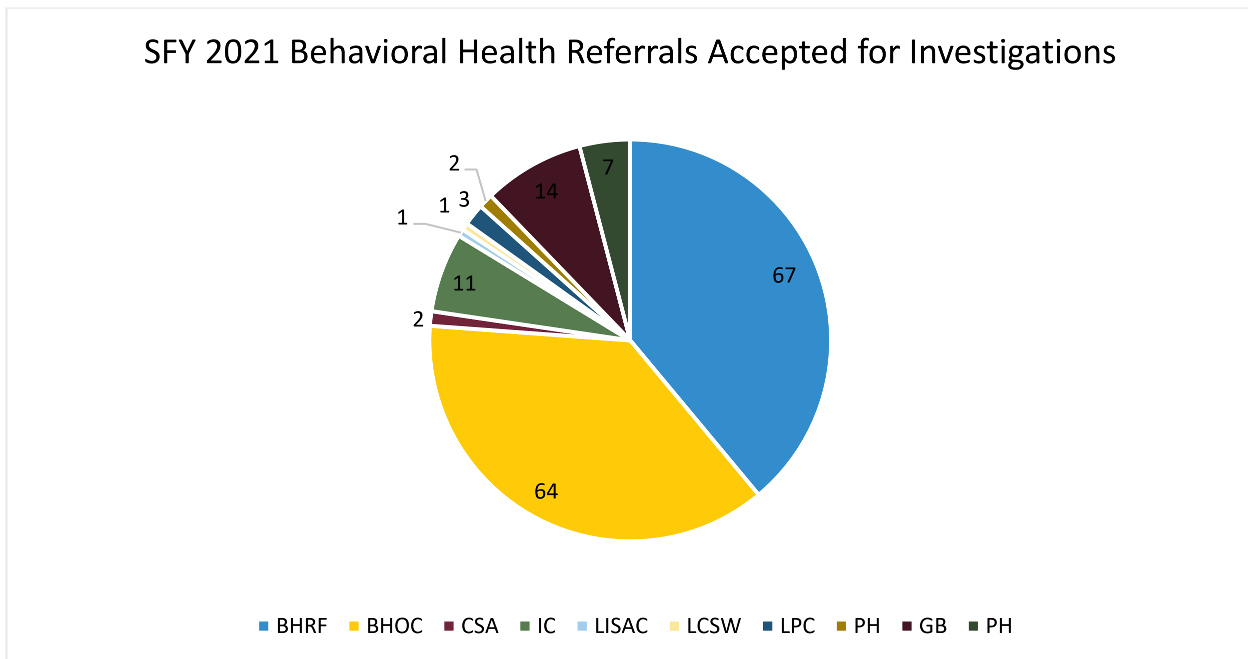
Chart II – SFY 2021 Behavioral Health Fraud Waste and Abuse Referral Sources



These unique partnerships identify different suspected FWA matters that fall into OIGs purview. As a result of these collaborations, the OIG has opened cases that encompass the provision of behavioral health services within the comprehensive audit and investigative framework. During SFY21, OIG opened investigations on:

- Behavioral Health Residential Facilities
- Behavioral Health Outpatient Clinic
- Community Service Agency
- Integrated Clinics
- Licensed Independent Substance Abuse Counselor
- Licensed Clinical Social Worker
- Licensed Professional Counselor
- Psychologist
- Group Billers
- Psychiatric Hospital

Chart III – SFY 2021 Behavioral Health Referrals Accepted for Investigation



Of the behavioral health referrals OIG received during SFY21, 15 of these referrals are joint cases with a Law Enforcement Agency. In accordance with 42 CFR § 455.23, OIG has initiated Credible Allegation of Fraud Payment Suspensions on 18 Behavioral Health Providers during SFY 21. Providers who receive these types of payment suspensions must meet requirements as outlined within the federal regulations.

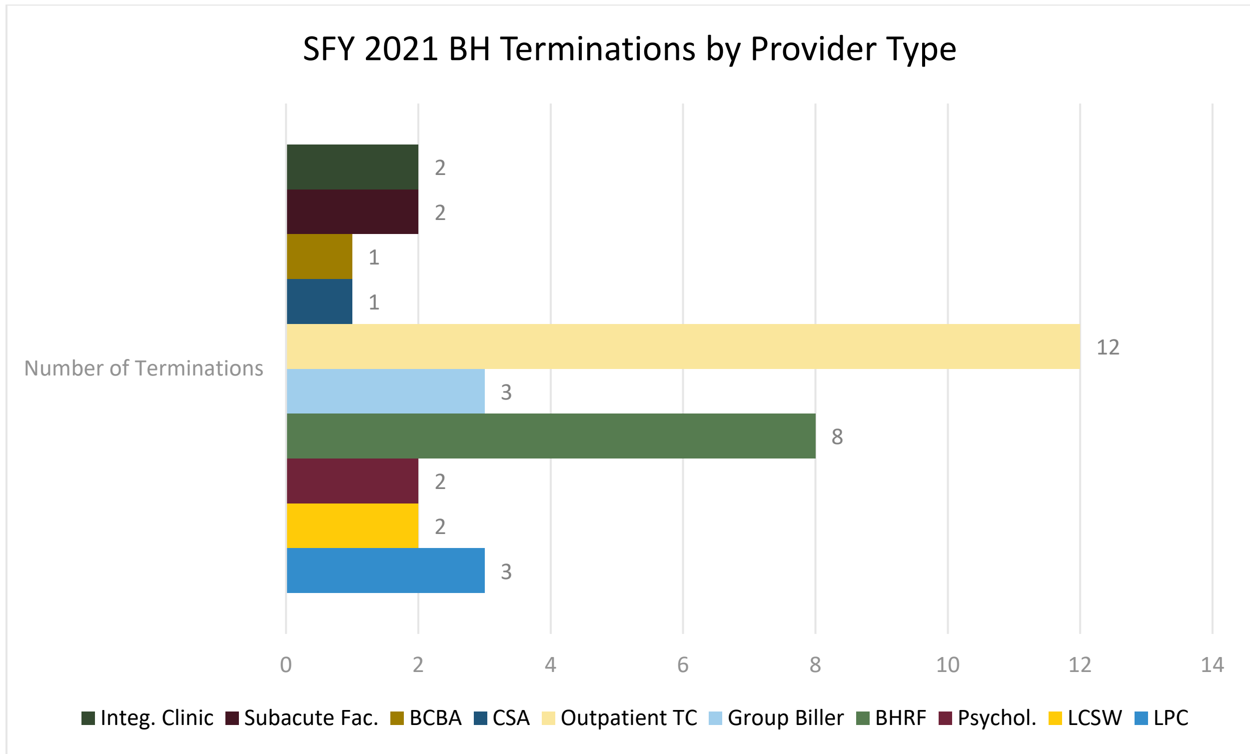
OIG Behavioral Health Cases in the news for investigations involving SFY 21 include:

- https://www.azag.gov/sites/default/files/docs/press-releases/2021/indictments/PHX_9842071_v1_P_2020_0158_SUN_VALLEY_SERVICES_TRUE_BILL_.pdf
- https://www.azag.gov/press-release/attorney-general-mark-brnovich-announces-13-individuals-and-14-related-business

Aside from these cases, the OIG can identify separate instances of recoveries and savings solely used for the provision of behavioral health services which are funded with Non-Title XIX funds. OIG achieved $5,019.55 in savings and recoveries of 3 NTXIX cases during SFY21.

Additional Program Integrity agency efforts include the collaboration with OIG and the AHCCCS Provider Enrollment (PEC) department. OIG syncs with PEC for a variety of actions, that include but are not limited to, provider terminations. During SFY 21, AHCCCS terminated Provider Participation Agreements with 36 different behavioral health providers. Providers are terminated for a multitude of reasons, such as; changes in licensure, request for voluntary termination, outdated paperwork, inactive statuses, OIG fraud findings, etc. The correct review and adequacy of our Provider Network is an integral and important program integrity function.

Chart IV – SFY 2021 Behavioral Health Terminations by Provider Type



Access to Services

Access to services and care is a pillar of the Medicaid program and is focused on members' ability to obtain quality health services in a timely manner in order to achieve optimal health outcomes. Access to care is measured by the availability, accessibility, and adequacy of services. AHCCCS has established standards and requirements for MCOs in order to ensure members are able to access quality services and care.

Network

AHCCCS requires MCOs to develop and maintain a comprehensive provider network that provides access to all services covered under the contract for all members. MCOs must also develop a provider Network Development and Management Plan that assures the provision of covered services and that is approved by AHCCCS. The Plan outlines the MCO's process to develop, maintain, and monitor an adequate provider network that is supported by written agreements and is sufficient to supply access to all services covered under the contract, while also satisfying all service delivery requirements.

AHCCCS maintains appointment availability and minimum network standards that must be met by the MCOs' contracted providers. Minimum network standards include minimum time or distance standards for various provider types, including Behavioral Health Outpatient and Integrated Clinics (for adult and

pediatric populations) and Crisis Stabilization facilities as outlined in the AHCCCS Contractor Operations Manual.

The MCOs submit their calculated compliance with these time and distance standards and AHCCCS validated these submissions through the External Quality Review Organization. When the validation finds the MCO fails to meet a time and distance standard, AHCCCS provides the MCO with a list of AHCCCS-registered providers in or near the county that are currently not in the MCO's network. Similar information is supplied to DES/DDD to assist it with its subcontracted MCOs. Continued failure to meet the standard can result in compliance action under the MCO's contract. Tables VII through XII on the following pages illustrate the validated findings for MCO performance against established network requirements for Behavioral Health Outpatient and Integrated Clinics (adult and pediatric populations), and Crisis Stabilization facilities in SFY 2021. The ACC MCOs are identified by an '(A)' in the tables below, the RBHAs by an '(R)', ALTCS-EPD MCOs with an (L), and DES/DDD subcontractors with a (D).

The time and distance data below represents performance during SFY 2021. During that time, AHCCCS changed the time and distance validation schedule from quarterly to every six months (April and October). Due to the timing of this transition, only the April 2021 validation occurred during SFY 2021. As a result of this, the percentages reported in tables VII to XII represent only that data.

Table VII - RBHA Behavioral Health Outpatient/Integrated Clinics (Adults)

RBHA Behavioral Health Outpatient/Integrated Clinics (Adults)			
SFY 2021			
County/Requirement	Mercy Care (R)	Health Choice Arizona (R)	Arizona Complete Health (R)
Maricopa - 90% within 15 min or 10 miles	98.8%		
Pima - 90% within 15 min or 10 miles			98.1%
Apache - 90% within 60 miles		97.3%	
Coconino - 90% within 60 miles		99.2%	
Gila - 90% within 60 miles		100%	
Mohave - 90% within 60 miles		100%	
Navajo - 90% within 60 miles		98.8%	
Yavapai - 90% within 60 miles		100%	
Yuma - 90% within 60 miles			99.7%
Pinal - 90% within 60 miles			100%
Cochise - 90% within 60 miles			100%
Santa Cruz - 90% within 60 miles			100%
Graham - 90% within 60 miles			100%
La Paz - 90% within 60 miles			100%
Greenlee - 90% within 60 miles			100%

Percent Compliant
90- 100%
80-89.9%
Under 80%
MCO Not in County

Table VIII - ACC Behavioral Health Outpatient/Integrated Clinics (Adults)

ACC Behavioral Health Outpatient/Integrated Clinics (Adults)							
SFY 2021							
County/Requirement	Mercy Care (A)	Health Choice Arizona (A)	Arizona Complete Health (A)	Banner UFC (A)	Care1st (A)	Molina Complete Care (A)	United Health Care (A)
Maricopa - 90% within 15 min or 10 miles	98.4%	98.6%	98.6%	99.2%	99.1%	98.4%	98.9%
Pima - 90% within 15 min or 10 miles			97%	97.4%			96.9%
Apache - 90% within 60 miles		83.5%			74.9%		
Coconino - 90% within 60 miles		97.7%			98.1%		
Gila - 90% within 60 miles	100%	100%	100%	100%	100%	100%	100%
Mohave - 90% within 60 miles		99.9%			99.9%		
Navajo - 90% within 60 miles		95.5%			94.0%		
Yavapai - 90% within 60 miles		100%			100%		
Yuma - 90% within 60 miles			998.8%	99.7%			
Pinal - 90% within 60 miles	100%	100%	100%	100%	100%	100%	100%
Cochise - 90% within 60 miles			100%	100%			
Santa Cruz - 90% within 60 miles			100%	100%			
Graham - 90% within 60 miles			100%	100%			
La Paz - 90% within 60 miles			100%	100%			
Greenlee - 90% within 60 miles			100%	100%			

Percent Compliant
90- 100%
80-89.9%
Under 80%
MCO Not in County

Table IX – ALTCS-EPD and DES/DDD Behavioral Health Outpatient/Integrated Clinics (Adults)

ALTCS EPD and DDD Behavioral Health Outpatient/Integrated Clinics (Adults)					
SFY 2021					
County/Requirement	Banner University (L)	Mercy Care (L)	United Health Care (L)	Mercy Care (D)	United Health Care (D)
Maricopa - 90% within 15 min or 10 miles	99.2%	99.0%	99.4%	97.4%	98.7%
Pima - 90% within 15 min or 10 miles	98.7%	98.5%		95.8%	98.3%
Apache - 90% within 60 miles			98.8%	57.1%	64.6%
Coconino - 90% within 60 miles			100%	88.9%	98.4%
Gila - 90% within 60 miles	100%	100%	100%	100%	100%
Mohave - 90% within 60 miles			100%	100%	100%
Navajo - 90% within 60 miles			100%	100%	97.5%
Yavapai - 90% within 60 miles			100%	100%	100%
Yuma - 90% within 60 miles	100%			100%	100%
Pinal - 90% within 60 miles	100%	100%	100%	100%	100%
Cochise - 90% within 60 miles	100%			100%	100%
Santa Cruz - 90% within 60 miles	100%			100%	100%
Graham - 90% within 60 miles	100%			100%	100%
La Paz - 90% within 60 miles	100%			100%	100%
Greenlee - 90% within 60 miles	100%			100%	100%

Percent Compliant
90- 100%
80-89.9%
Under 80%
MCO Not in County

Table X - ACC BH Outpatient/Integrated Clinics (Pediatric)

ACC BH Outpatient/Integrated Clinics (Pediatric)							
SFY 2021*							
County/Requirement	Mercy Care (A)	Health Choice Arizona (A)	Arizona Complete Health (A)	Banner UFC (A)	Care1st (A)	Molina Complete Care (A)	United Health Care (A)
Maricopa - 90% within 15 min or 10 miles	98.5%	98.9%	98.7%	99.2%	99.2%	98.3%	99.0%
Pima - 90% within 15 min or 10 miles			97.3%	97.4%			97.2%
Apache - 90% within 60 miles		84.5%			69.7%		
Coconino - 90% within 60 miles		96.1%			97.3%		
Gila - 90% within 60 miles	100%	100%	100%	100%	100%	100%	100%
Mohave - 90% within 60 miles		100%			99.9%		
Navajo - 90% within 60 miles		94.4%			90.3%		
Yavapai - 90% within 60 miles		100%			100%		
Yuma - 90% within 60 miles			99.9%	99.7%			
Pinal - 90% within 60 miles	100%	100%	100%	100%	100%	100%	100%
Cochise - 90% within 60 miles			100%	100%			
Santa Cruz - 90% within 60 miles			100%	100%			
Graham - 90% within 60 miles			100%	100%			
La Paz - 90% within 60 miles			100%	100%			
Greenlee - 90% within 60 miles			100%	100%			

** Not reported for the RBHAs due to data limitations on addresses for the children's population served by the RBHAs*

Percent Compliant
90.0- 100.0%
80.0-89.9%
Under 80.0%
MCO Not in County

Table XI – Access to Care ALTCS-EPD and DES/DDD BH Outpatient/Integrated Clinics (Pediatric)

ALTCS EPD and DDD Behavioral Health Outpatient/Integrated Clinics (Pediatric)					
SFY 2021					
County/Requirement	Banner University (L)	Mercy Care (L)	United Health Care (L)	Mercy Care (D)	United Health Care (D)
Maricopa - 90% within 15 min or 10 miles	96.8%	97.7%	100%	97.7%	98.9%
Pima - 90% within 15 min or 10 miles	93.9%	96.0%		94.4%	96.8%
Apache - 90% within 60 miles			100%	100%	73.3%
Coconino - 90% within 60 miles			100%	100%	95.5%
Gila - 90% within 60 miles		100%		100%	100%
Mohave - 90% within 60 miles			100%	100%	100%
Navajo - 90% within 60 miles			100%	100%	94.7%
Yavapai - 90% within 60 miles			100%	100%	100%
Yuma - 90% within 60 miles	100%			100%	99.7%
Pinal - 90% within 60 miles	100%	100%	100%	100%	100%
Cochise - 90% within 60 miles	100%			100%	100%
Santa Cruz - 90% within 60 miles	100%			100%	100%
Graham - 90% within 60 miles	100%			100%	100%
La Paz - 90% within 60 miles				100%	100%
Greenlee - 90% within 60 miles				100%	100%

Percent Compliant
90.0- 100.0%
80.0-89.9%
Under 80.0%
MCO Not in County
^ Less than 5 members in this population
0 Members in this population

Table XII – Access to Care Crisis Stabilization Facility

Crisis Stabilization Facility*			
SFY 2021			
County/Requirement	Mercy Care (R)	Health Choice Arizona (R)	Arizona Complete Health (R)
Maricopa - 90% within 15 min or 10 miles	99.3%		
Pima - 90% within 15 min or 10 miles			98.1%
Apache - 90% within 45 miles		99.5%	
Coconino - 90% within 45 miles		99.7%	
Gila - 90% within 45 miles		100%	
Mohave - 90% within 45 miles		99.1%	
Navajo - 90% within 45 miles		99.4%	
Yavapai - 90% within 45 miles		99.4%	
Yuma - 90% within 45 miles			99.7%
Pinal - 90% within 45 miles			100%
Cochise - 90% within 45 miles			99.6%
Santa Cruz - 90% within 45 miles			100%
Graham - 90% within 45 miles			100%
La Paz - 90% within 45miles			95.4%
Greenlee - 90% within 45 miles			100%

** This standard only applies to Regional Behavioral Health Authorities (RBHAs)*

Percent Compliant
90.0- 100.0%
80.0-89.9%
Under 80.0%
MCO Not in County

Appointment Availability

Appointment availability includes timeliness standards for access to urgent and routine care appointments for various services including but not limited to behavioral health provider appointments as follows:

Behavioral Health Provider Appointments:

a. Urgent need appointments as expeditiously as the member's health condition requires but no later than 24 hours from identification of need
b. Routine care appointments:
    i. Initial assessment within seven calendar days of referral or request for service,
    ii. The first behavioral health service following the initial assessment as expeditiously as the member's health condition requires but no later than 23 calendar days after the initial assessment, and
    iii. All subsequent behavioral health services, as expeditiously as the member's health condition requires but no later than 45 calendar days from identification of need.

Psychotropic Medications:

a. Assess the urgency of the need immediately, and
b. Provide an appointment, if clinically indicated, with a behavioral health medical professional within a timeframe that ensures the member a) does not run out of needed medications, or b) does not decline in his/her behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need.

MCOs are required on a quarterly basis to conduct provider appointment availability reviews to assess the availability of routine and urgent appointments for behavioral health appointments including tracking and trending the results. Plans have latitude in their methodologies to conduct these reviews. These reviews typically consist of contact with providers to obtain this information either through a phone survey or in-service meeting review of appointment schedules. As seen in the tables, some plans combine their reviews and apply them to more than one line of business, while others conduct and report their surveys separately.

While AHCCCS has established no compliance percentages for these standards, these results must be utilized by the MCO to address access to care concerns with providers not meeting the standards and to assure appointment availability in order to reduce unnecessary emergency department utilization. In its network planning process, each plan is required to compare its current year's appointment availability results to the previous year to identify network gaps. MCOs must also address when providers do not meet these timeframes and typically resurvey them the following quarter. AHCCCS met with representatives of United Health Care to address their performance in these measures and their data collection process. United Health Care made changes to its methodology to more accurately assess its performance and identify any root causes of poor performance. A preliminary review of the data indicates improvement; AHCCCS will continue to monitor these standards and take additional compliance action as necessary. Tables XIII and XIV on the following page shows the percentage of sampled providers meeting the timeframes during SFY 2021 for each ACC (A), RBHA (R), ALTCS-EPD (L) and ALTCS EPD plan (R) and DES/DDD subcontractor (D).

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Table XIII - RBHA and ACC - Appointment Availability

RBHA and ACC Plans % of Sampled Providers Meeting Standard SFY 2021 Average	Mercy Care (R)	Health Choice Arizona (R)	Arizona Complete Health (R)	Mercy Care (A)	Health Choice Arizona (A)	Arizona Complete Health (A)	Banner UFC (A)	Care1st (A)	Molina Complete Care (A)	United Health Care (A)
Urgent Need Appointments: As expeditiously as the member's health condition requires but no later than 24 hours from identification of need	100%	100%	100%	100%	100%	100%	89.7%	100%	100%	70.4%
Routine: Initial assessment within seven calendar days of referral or request for service	83.7%	100%	100%	80.8%	100%	100%	92.0%	99.5%	100%	74.6%
Routine: The first behavioral health service following the initial assessment as expeditiously as the member's health condition requires but for members aged 18 years or older, no later than 23 calendar days after the initial assessment	100%	100%	100%	99.8%	100%	100%	95.6%	98.2%	100%	71.3%
Routine: The first behavioral health service following the initial assessment as expeditiously as the member's health condition requires but for members under the age of 18 years old, no later than 21 calendar days after the initial assessment	100%	100%	100	100%	100%	100%	93.6%	98.5%	100%	71.3%
Routine - All subsequent behavioral health services, as expeditiously as the member's health condition requires but no later than 45 calendar days from identification of need	99.9%	100%	100%	100%	100%	100%	97%	98.7%	100%	71.3%
Referrals for Psychotropic Medications: Provide an appointment, if clinically indicated, with a Behavioral Health Medical Professional within a timeframe that ensures the member a) does not run out of needed medications, or b) does not decline in his/her behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need	100%	100%	100%	99.5%	100%	100%	96.9%	98.7%	100%	71.3%

Percent Compliant
90.0- 100.0%
80.0-89.9%
Under 80.0%

Table XIV - ALTCS-EPD and DES/DDD - Appointment Availability

ALTCS-EPD and DDD Plan % of Sampled Providers Meeting Standard					
SFY 2021 Average					
	Banner University (L)	Mercy Care (L)	United Health Care (L)	Mercy Care (D)	United Health Care (D)
Urgent Need Appointments: As expeditiously as the member’s health condition requires but no later than 24 hours from identification of need	89.7%	100%	70.4%	100%	70.4%
Routine: Initial assessment within seven calendar days of referral or request for service	92%	80.8%	74.6%	80.8%	74.6%
Routine: The first behavioral health service following the initial assessment as expeditiously as the member’s health condition requires but for members aged 18 years or older, no later than 23 calendar days after the initial assessment	95.6%	99.8%	71.3%	99.8%	71.3%
Routine: The first behavioral health service following the initial assessment as expeditiously as the member's health condition requires but for members under the age of 18 years old, no later than 21 calendar days after the initial assessment	93.6%	100%	71.3%	100%	71.3%
Routine - All subsequent behavioral health services, as expeditiously as the member’s health condition requires but no later than 45 calendar days from identification of need	97.1%	100%	71.3%	100%	71.3%
Referrals for Psychotropic Medications: Provide an appointment, if clinically indicated, with a Behavioral Health Medical Professional within a timeframe that ensures the member a) does not run out of needed medications, or b) does not decline in his/her behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need	96.9%	99.5%	71.3%	99.5%	71.3%

Percent Compliant
90.0- 100.0%
80.0-89.9%
Under 80.0%

Performance Metrics

AHCCCS utilizes performance metrics for monitoring MCO compliance related to the delivery of care and services to members. Measure areas include, among other activities, access to care.

Table XV provides specific behavioral health performance measures for the most recent, completed data available for the ACC program, for members designated as SMI enrolled with the RBHAs, and for managed care enrolled members across all lines of business: CY 2020.

Table XV – CY 2020 AHCCCS Performance Measure Data

CY 2020 Behavioral Health Performance Measure Rates				
Performance Measure	2020 NCQA Medicaid Mean[1]	ACC Aggregate	SMI Aggregate	Statewide[2] Aggregate
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 Day Follow-Up (Total) - NCQA	13.8%	17.7%	20.4%	19.6%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 Day Follow-Up (Total) - NCQA	20.2%	24.3%	30.1%	26.8%
Follow-Up After Emergency Department Visit for Mental Illness - 7 Day Follow-Up (Total) - NCQA	40.4%	47.6%	60.3%	53.2%
Follow-Up After Emergency Department Visit for Mental Illness - 30 Day Follow-Up (Total) - NCQA	54.4%	58.0%	75.2%	64.9%
Follow-Up After Hospitalization for Mental Illness - 7 Day Follow-Up (Total) - NCQA	39.4%	43.6%	65.8%	58.0%
Follow-Up After Hospitalization for Mental Illness – 30 Day Follow-Up (Total) - NCQA	58.9%	59.8%	82.1%	74.4%
Follow-Up Care for Children Prescribed Attention-Deficit/ Hyperactivity Disorder (ADHD) Medication – Initiation Phase	43.9%	56.1%	NA	61.7%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication – Continuation and Maintenance Phase	53.5%	66.7%	NA	71.1%

[1] *NCQA Medicaid Mean retrieved from the State of Health Care Quality Report published by NCQA*

[2] *Rates reflective of all managed care enrolled members meeting continuous enrollment criteria regardless of population/line of business*

Conclusion

SFY 2021 saw the final piece of integration of physical and behavioral health services for the full managed care membership with the April 2021 start of the DCS CHP contract. Integrating the delivery of physical and behavioral health care under the same MCO should result in improved attention on coordinated care and the delivery of behavioral health services. Ultimately, AHCCCS anticipates that this delivery system transformation effort will result in improved health outcomes for AHCCCS members with co-occurring physical and behavioral health issues.