

May 13, 2019

The Honorable Regina Cobb  
Chairman, Joint Legislative Budget Committee  
1700 W. Washington  
Phoenix, AZ 85007

Dear Representative Cobb:

Pursuant to A.R.S. 36-3415, AHCCCS is required 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 this report, please feel free to contact me at (602) 417-4711.

Sincerely,



Jami Snyder,  
Director

cc: The Honorable David Gowan, Arizona State Senate  
Christina Corieri, Governor's Office Senior Policy Advisor  
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) 2018  
(July 1, 2017 – June 30, 2018)

May 2018  
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 nonmedicaid 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/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 has determined that previous versions of the report due in accordance with §36-3415 were focused solely on information related to members determined to have a Serious Mental Illness (SMI). AHCCCS does not believe that limiting the report to members determined SMI aligns with the requirements in §36-3415 and thus AHCCCS revamped the report in its entirety beginning with last year's State Fiscal Year (SFY) 2017 report. As such, this report for the period of SFY 2018 will be comparable to the SFY 2017 report, but will not be comparable to previous §36-3415 reports.

### Behavioral Health Expenditures & Utilization

The Medicaid and non-Medicaid behavioral health expenditures for SFY 2018 are provided in Table I on the following page. These expenditures are consistent with those reported in AHCCCS' Behavioral Health Annual Report submitted December 28, 2018, in accordance with A.R.S. §36-3405. A link to that report is provided for reference:

[https://www.azahcccs.gov/shared/Downloads/Reporting/FY\\_2018\\_BH\\_FinancialProgrammaticReportFinal.pdf](https://www.azahcccs.gov/shared/Downloads/Reporting/FY_2018_BH_FinancialProgrammaticReportFinal.pdf)

Table I

<b>Total Behavioral Health Services Expenditures by Program FY 2018</b>		
<b>Funding</b>	<b>Amount Paid</b>	<b>Percentage</b>
Traditional Medicaid Services	1,192,957,400	47.90%
Proposition 204 Services	844,913,668	33.92%
ACA Adult Expansion	91,949,063	3.69%
CMDP	134,805,447	5.41%
Non TXIX Child	7,946,264	0.32%
Non TXIX SMI	148,315,412	5.96%
Non TXIX GMH/SA	43,144,061	1.73%
Non TXIX Crisis	16,407,231	0.66%
Non TXIX Prevention	10,259,225	0.41%
<b>Total</b>	<b>2,490,697,771</b>	<b>100.00%</b>

Source Data: AFIS

As described in the Annual Report, behavioral health expenditures included in this report represent payments made to the Regional Behavioral Health Authorities (RBHAs) and include integrated services for members determined SMI.

As part of the recently awarded AHCCCS Complete Care (ACC) contracts, <https://www.azahcccs.gov/shared/News/PressRelease/AHCCCSAwardsContractstoManagedCareOrganizations.html>, AHCCCS has moved toward a fully integrated delivery system and funding stream. Implemented Contract Year Ending (CYE) 2019, effective October 1, 2018, ACC Managed Care Organizations (MCOs) are paid one rate (referred to as a capitation rate) for managing both physical and behavioral health services for individual members. Thus the majority of AHCCCS members will no longer have their care split between one MCO for the coverage of physical health services, and a second MCO (i.e. RBHA) for the provision of behavioral health services.

Beginning with next year's Annual Report for SFY 2019, which will utilize CYE 2019 data incurred under the ACC contracts, AHCCCS will report behavioral health service data as defined by clinical criteria determined by AHCCCS, instead of reporting behavioral health expenditures incurred only by RBHA payers. The reporting of behavioral health utilization data will accompany the expenditure data for CYE 2019.

This new reporting methodology has already been implemented for the behavioral health enrolled and served report that is produced on a monthly basis pursuant to §36-3405(D). It is described in a memorandum available at the following link: <https://www.azahcccs.gov/shared/Downloads/MonthlyReports/BehavioralHealthEnrolledAndServedReports/FY2019/ClinicalCriteriaForBehavioralHealthEnrolledAndServedReport.pdf>

## Member Income

AHCCCS members who receive Medicaid services generally have household incomes near or below the Federal Poverty Level (FPL). The 2019 FPL for a family of 4 is \$25,750. Of Medicaid/CHIP members, 80.4% are below 100% FPL, 15.0% are between 100% and 138% FPL, and 4.6% are greater than 138% FPL; see Table II below. 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

Medicaid & CHIP Members by Poverty Category:

Poverty Threshold	AHCCCS Members
< 100% FPL	80.4%
100-138% FPL	15.0%
> 138% FPL	4.6%
Total	100.0%

## 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) of services which promotes appropriate utilization of services including behavioral health services while effectively managing associated costs. Most behavioral health services do not require prior authorization. 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 the amount, duration, or scope that is less than what is requested; or

- Excluded or limited 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, BH 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.

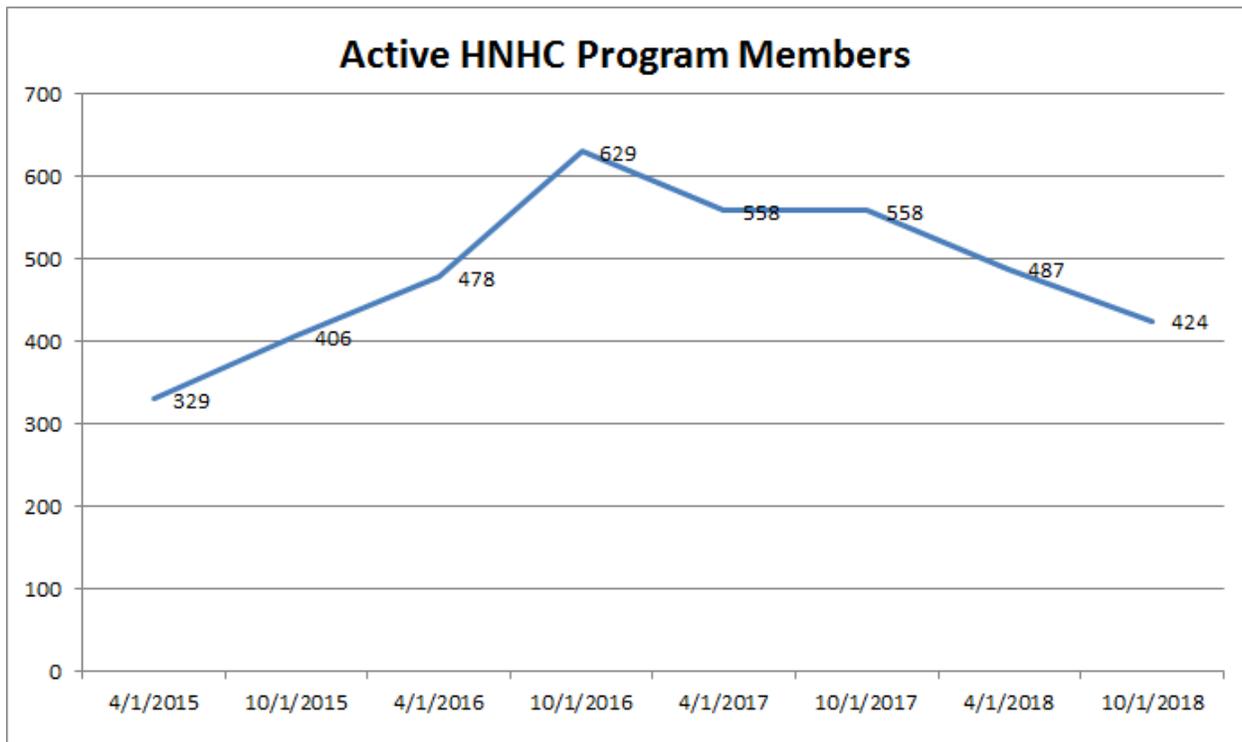
AHCCCS monitors and oversees MCO MM activities including but not limited to the review and approval of an Annual MM Plan submission, review of quarterly PA and denial data and through Operational Reviews (OR) that audit the MCOs' compliance with established AHCCCS MM standards. The OR standards include but are not limited to 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.

### Tracking Of 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.

The High Needs/High Cost (HN/NC) Program was developed by AHCCCS specifically to drive care coordination between MCOs and RBHAs for mutual members with complex behavioral and physical health needs. The Program provides standardized criteria which the MCOs and RBHAs utilize to identify members. The MCOs and RBHAs work together to identify and develop interventions to address appropriate and timely care for each member. AHCCCS provides oversight to an AHCCCS/MCO HN/HC workgroup that meets every 6 months to monitor outcomes and implement performance improvement. MCOs and RBHAs track interventions based on standardized criteria and report intervention summaries and member lists to AHCCCS. AHCCCS utilizes this data along with service level detail contained on member claims to monitor performance against a randomly selected control group. Chart I below identifies the number of members engaged in the Program since April 2015.

Chart I



### Mortality Trends

The Arizona Department of Health Services (ADHS), Bureau of Public Health Statistics, provides a great deal of information on mortality rates across a variety of populations at the following link: <http://pub.azdhs.gov/health-stats/menu/index.php?pg=deaths>. The most recent year of data available on ADHS' mortality webpage is for calendar year 2017. Following is a high level summary of 2017 mortality statistics found on the ADHS website, which are not limited to AHCCCS members.

Utilizing the ADHS statewide data, and focusing on mortality rates that are behavioral health related, the statistics indicate that suicide was the 8<sup>th</sup> leading cause of death in 2017 for Arizonans, with 1,304 reported, as well as the 8<sup>th</sup> leading cause of death for male Arizonans. For female Arizonans, suicide was the 11<sup>th</sup> leading cause of death.

The suicide rate increased from 17.7 per 100,000 in 2016 to 18.0 in 2017. While the suicide rate increased among both men and women in 2017, it increased more among females. Suicide posted a 3.3 times greater mortality risk for males (28.1/100,000) than for females (8.4/100,000).

Of note, American Indians in Arizona had the highest suicide rates: 26.2/100,000. White non-Hispanics were next with a rate of 22.1/100,000. Hispanics had the lowest suicide rate at 8.5/100,000. La Paz County reported the highest suicide rate of Arizona's 15 counties, with 46.2 suicides per 100,000.

Drug-related mortality reported by ADHS for 2017 grew by 9.0% over the prior year for Arizona residents. Table III provides the number of deaths reported as drug-related in 2016 and 2017.

Table III

Drug-Related Mortality by Category, Arizona Residents, 2016 & 2017			
Category	2016	2017	Change %
Abuse of psychoactive substances	133	98	-26.3%
Accidental poisoning by drugs	1,095	1,269	15.9%
Intentional self-poisoning by drugs/medicaments	133	140	5.3%
Undetermined intent of poisoning by drugs	100	85	-15.0%
<b>Total Drug-Related Deaths</b>	<b>1,461</b>	<b>1,592</b>	<b>9.0%</b>

The ADHS webpage includes much more detail regarding mortality rates based on age bands, counties and communities; the reader is encouraged to review these statistics for more information.

AHCCCS does not produce mortality statistics for members but does require MCOs to report data on unexpected deaths. For SFY 2018, MCOs reported 810 unexpected deaths among AHCCCS members.

### 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<sup>1</sup>:

- **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

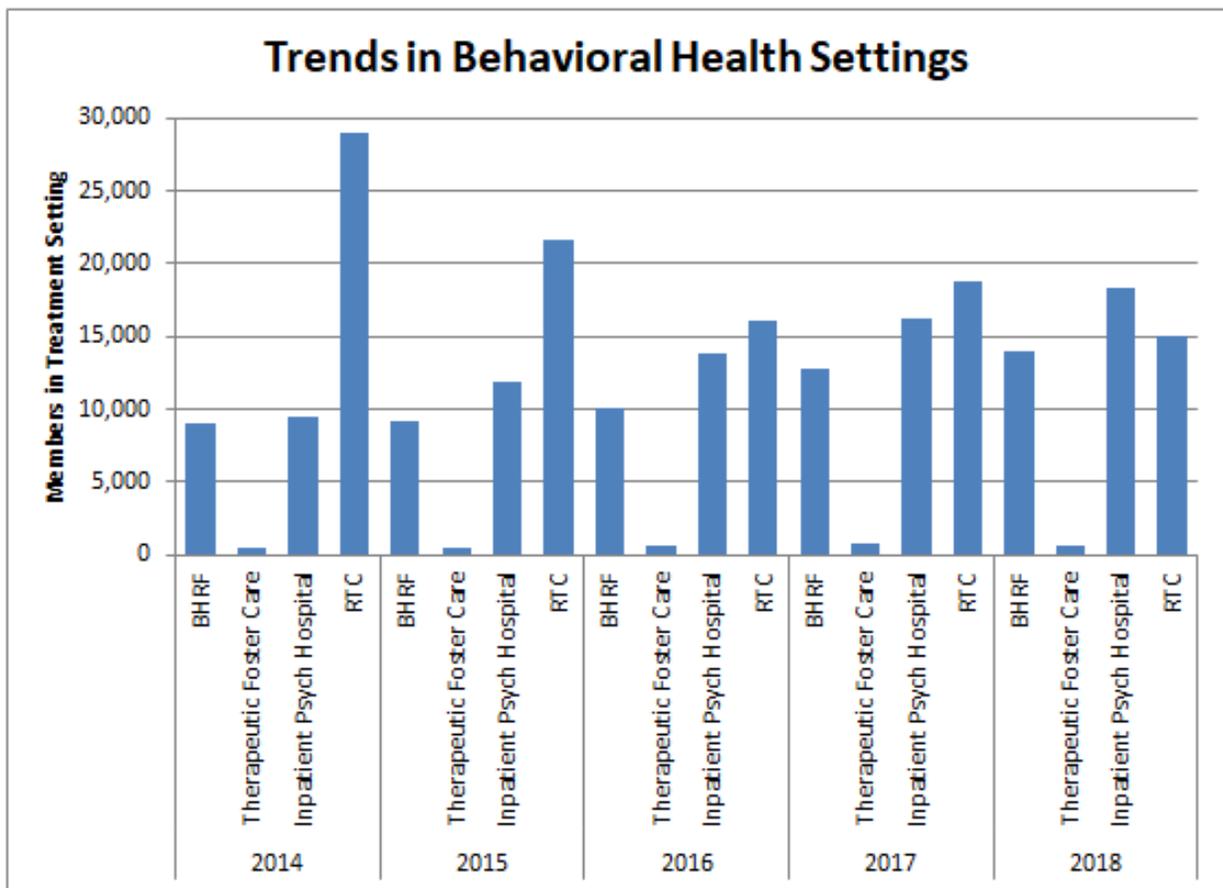
<sup>1</sup> More details regarding these treatment settings can be found in the AHCCCS Covered Behavioral Health Services Guide at <https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/covered-bhs-guide.pdf>

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 Level I 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 II below provides a four year history of behavioral health treatment settings for AHCCCS members. Data is provided on a contract year end (CYE) basis (October 1 through September 30 annually).

Chart II



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

AHCCCS and its RBHAs 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 has 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 a comprehensive support for youth and adults in settings supported by therapeutic foster care services appear to have led to increase 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.

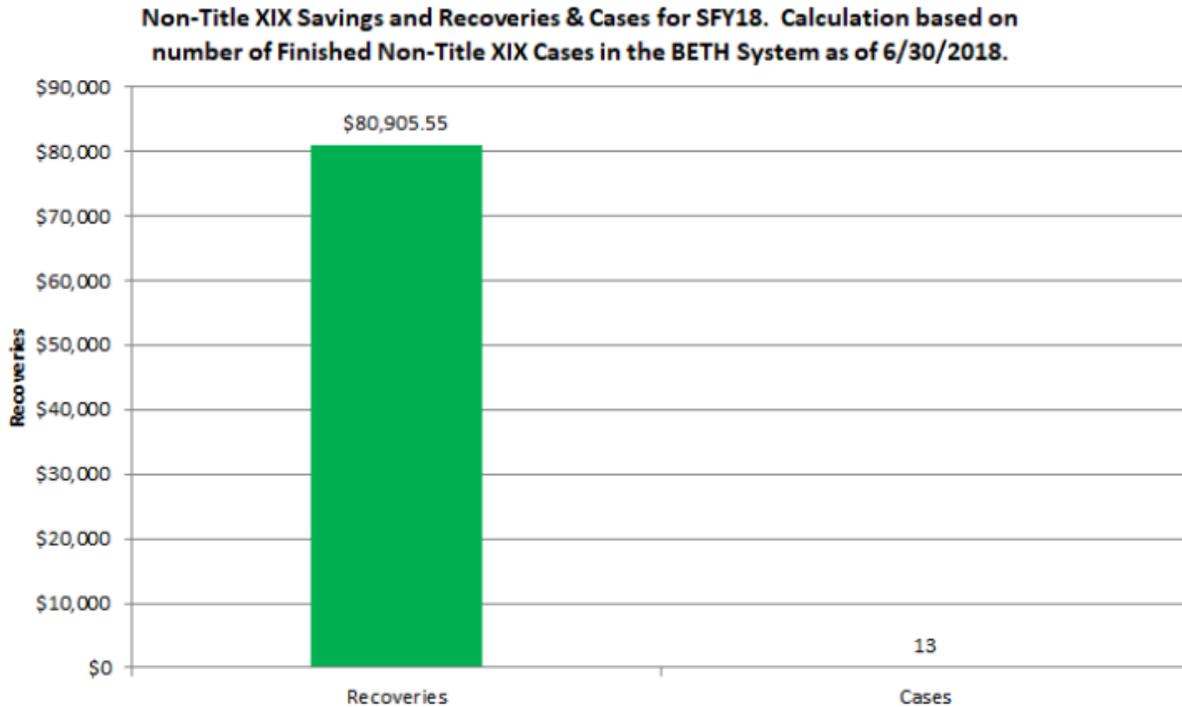
## Program Integrity

MCOs are required to have a mandatory Corporate Compliance Program that is designed to prevent, detect, and report fraud, waste and abuse and is supported by other administrative procedures including a Corporate Compliance Plan. The Program must meet all required contractual elements and is reviewed and approved by AHCCCS' Office of the Inspector General (OIG).

The AHCCCS OIG is responsible for the integrity of the AHCCCS program as well as handling reports of fraud and abuse of the AHCCCS program. The mission of the OIG is to prevent, detect, and recover improper payments due to fraud, waste, and abuse. AHCCCS currently does not have a tracking system that supports the provision of statistics for behavioral health cases only. However, OIG can report case recoveries by

fund type. Chart III shows the cases investigated by the OIG that contained Non-Title XIX (NTXIX) savings and recoveries in SFY 2018 (NTXIX funds are only used for the provision of behavioral health services).

Chart III



### 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 network and appointment availability standards that must be met by the MCOs’ contracted providers. Network standards for various provider types including Behavioral Health Outpatient settings, Integrated Clinics and Crisis Stabilization

facilities are outlined in the AHCCCS Contractor Operations Manual. MCOs are required to attest to minimum network requirement compliance. Table IV illustrates MCO performance against established network requirements for Behavioral Health Outpatient settings and Integrated Clinics as well as Crisis Stabilization facilities in CYE 2018.

Table IV

RBHA Network Standards			
Behavioral Health Outpatient and Integrated Clinics	CYE 2018 Average		
Requirement: 90% of membership lives within 15 min or 10 miles	MMIC Total*	HCIC Total*	CIC Total*
<i>Maricopa</i>	99.4%		
<i>Apache</i>		51.7%	
<i>Coconino</i>		98.3%	
<i>Gila</i>		95.0%	
<i>Mohave</i>		91.0%	
<i>Navajo</i>		70.0%	
<i>Yavapai</i>		95.0%	
<i>Pima</i>			96.4%
<i>Yuma</i>			98.6%
<i>Pinal</i>			91.9%
<i>Cochise</i>			91.8%
<i>Santa Cruz</i>			93.8%
<i>Graham</i>			59.1%
<i>La Paz</i>			66.4%
<i>Greenlee</i>			59.9%
Crisis Stabilization Facility - Maricopa and Pima	MMIC Total*		CIC Total*
Requirement: 90% of membership lives within 15 min or 10 miles			
<i>Maricopa</i>	99.4%		
<i>Pima</i>			92.3%
Crisis Stabilization Facility - All Other Counties		HCIC Total*	CIC Total*
Requirement: 90% of membership lives within 60 miles			
<i>Apache</i>		99.0%	
<i>Coconino</i>		99.3%	
<i>Gila</i>		100.0%	
<i>Mohave</i>		100.0%	
<i>Navajo</i>		91.3%	
<i>Yavapai</i>		100.0%	
<i>Yuma</i>			99.7%
<i>Pinal</i>			100.0%

<i>Cochise</i>			99.9%
<i>Santa Cruz</i>			100.0%
<i>Graham</i>			Not Reported**
<i>La Paz</i>			99.9%
<i>Greenlee</i>			99.9%

\* Totals are the average of 3 quarters. The deliverable was waived for Q418 due to ACC readiness and the implementation of new time and distance standards 15 days before the submission.

\*\* CIC did not report Graham county time and distance for this provider type during CYE 2018.

### *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 23 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. 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. Table V on the following page shows the percentage of providers meeting the availability standards by RBHA.

Table V

% of Providers Meeting Standard			
	CYE 2018 Average		
	MMIC Total	HCIC Total	CIC Total
<b>General BH Appt. Standards</b>			
<i>Urgent Need Appointments: As expeditiously as the member’s health condition requires but no later than 24 hours from identification of need</i>	97.9%	100.0%	95.3%
<i>Routine: Initial assessment within seven calendar days of referral or request for service</i>	95.7%	100.0%	94.2%
<i>Routine: 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</i>	98.2%	100.0%	98.0%
<i>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</i>	99.5%	100.0%	98.5%
<i>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</i>	99.4%	100.0%	98.3%

Key
90- 100%
80-89.9%
Under 80%

### Performance Measures

AHCCCS has developed and implemented 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. Areas include but are not limited to measures such as wellness and screening services, readmissions, utilization of services, and access to care. AHCCCS establishes Minimum Performance Standards (MPS) for each measure and MCOs must work to achieve at least the MPS. Table VI provides specific Behavioral Health Performance Measures and Outcome Data for CYE 2017.

Table VI

Performance Measure	CYE 2017 Minimum Performance Standard	CYE 2017 Medicaid Mean	SMI	GMH/SA
			CYE 2017 Aggregate	CYE 2017 Aggregate
Follow-Up After Hospitalization for Mental Illness - 7 Days	85%	37.0%	71.8%	48.1%
Follow-Up After Hospitalization for Mental Illness - 30 Days	95%	58.0%	87.7%	67.2%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	Baseline (GMH/SA Only)	3.0%	NA	1.0%
Mental Health Utilization - Any Service (Total)	Baseline	NA	90.1%	9.8%
Mental Health Utilization - Inpatient (Total)	Reported For Informational Purposes Only, Not in CYE 2017 Contract	NA	15.5%	0.9%
Mental Health Utilization - Intensive Outpatient/Partial Hospitalization (Total)	Reported For Informational Purposes Only, Not in CYE 2017 Contract	NA	14.6%	0.6%
Mental Health Utilization - Outpatient (Total)	Reported For Informational Purposes Only, Not in CYE 2017 Contract	NA	89.3%	9.5%

### Access to Care Report

In 2019, AHCCCS will produce an annual Access to Care Report which covers a wide variety of factors by which the Agency assesses member access to care. The completed reports for previous years can be found at the bottom of the webpage found at the following link: [https://www.azahcccs.gov/Plans\\_Providers/RatesAndBilling/FFS](https://www.azahcccs.gov/Plans_Providers/RatesAndBilling/FFS). The 2019 report will be posted to the same location upon completion.

## Conclusion

AHCCCS monitors the provision of behavioral health services to members through a variety of contractual requirements and by tracking and trending outcome measures. Through its oversight efforts, AHCCCS is able to identify challenges across a wide spectrum of areas and implement solutions in order to ensure access to medically necessary care. Interventions implemented by AHCCCS over the last several years range from minor adjustments in provider rates to major delivery system transformation initiatives.

The implementation of the ACC contracts on October 1, 2018, integrated physical and behavioral health care under the same MCO for the majority of AHCCCS members, and includes focused attention on the delivery of behavioral health care. 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.