September 11, 2020

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 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 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) 2019
(July 1, 2018 – June 30, 2019)

August 2020
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 the Arizona Health Care Cost Containment System (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 determined that versions of the report previous to the aforementioned merger 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 the State Fiscal Year (SFY) 2017 report. As such, this report for the period of SFY 2019 will be comparable to the SFY 2018 and SFY 2017 reports, but will not be comparable to previous §36-3415 reports.

Beginning with contract year ending (CYE) 2019, with the implementation of AHCCCS Complete Care (ACC) contracts, AHCCCS contracted Managed Care Organizations (MCOs) provide fully integrated physical and behavioral health (BH) care services for members with General Mental Health/Substance Use (GMH/SU) needs and Children (Child). Members enrolled in Comprehensive Medical and Dental Program (CMDP) and the Arizona Long Term Care System/Division of Developmental Disabilities program (ALTCS/DDD) continue to receive behavioral health services from Regional Behavioral Health Authorities (RBHAs). Therefore, while information in previous reports usually reflected RBHA data only, information in this year's report is inclusive of BH services provided under both ACC and RBHA contracts.

### Behavioral Health Expenditures & Utilization

The Medicaid and non-Medicaid behavioral health expenditures for SFY 2019 are provided in Table I on the following page. These expenditures are consistent with those

reported in AHCCCS' Behavioral Health Annual Report submitted December 17, 2019, in accordance with A.R.S. §36-3405. A link to that report is provided for reference:

https://www.azahcccs.gov/shared/Downloads/Reporting/2019BHSAnnualReport.pdf

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

Table I

| Total Behavioral Health Services Expenditures by Program FY 2019 | | |
|---|---|---|
| **Funding** | **Amount Paid** | **Percentage** |
| Traditional Medicaid Services | 1,053,119,340 | 42.93% |
| Proposition 204 Services | 904,632,751 | 36.86% |
| ACA Adult Expansion | 65,063,092 | 2.65% |
| CMDP | 133,088,952 | 5.43% |
| KidsCare | 18,809,023 | 0.77% |
| Medicaid Fee-for-Service | 37,968,240 | 1.55% |
| Non TXIX Child | 12,428,433 | 0.51% |
| Non TXIX SMI | 152,776,977 | 6.23% |
| Non TXIX GMH/SA | 47,381,738 | 1.93% |
| Non TXIX Crisis | 16,349,040 | 0.67% |
| Non TXIX Prevention | 11,509,437 | 0.47% |
| **Total** | **2,453,127,023** | **100.00%** |

As part of the ACC contracts, MCOs are paid one rate per member (referred to as a capitation rate) for managing both physical and behavioral health services for individual members. Thus the majority of AHCCCS members 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.

This report utilizes CYE 2019 data incurred under the ACC contracts and reports behavioral health service data as defined by clinical criteria determined by AHCCCS, instead of reporting behavioral health expenditures incurred only by RBHA payers. This new 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: https://www.azahcccs.gov/shared/Downloads/MonthlyReports/BehavioralHealthEnrolledAndServicedReports/FY2019/ClinicalCriteriaForBehavioralHealthEnrolledAndServedReport.pdf

## Member Income

AHCCCS members who receive Medicaid services generally have household incomes near or below the Federal Poverty Level (FPL). The 2020 FPL for a family of 4 is $26,200. Of Medicaid/CHIP members, 78.0% are below 100% FPL, 15.5% are between 100% and 138% FPL, and 6.5% 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 | 78.0% |
| 100-138% FPL | 15.5% |
| > 138% FPL | 6.5% |
| 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 other 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 lack of medical necessity;

  - Authorize a request in the 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 (NOA) 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.

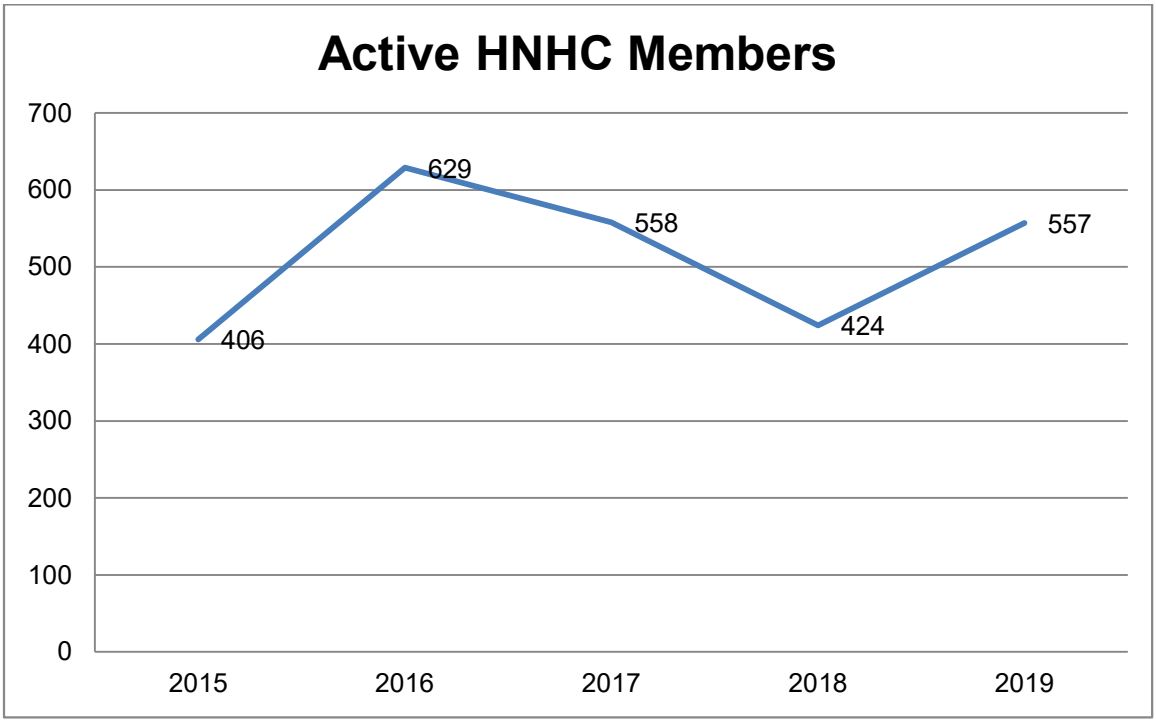
AHCCCS monitors and oversees MCO MM activities including but not limited to the review and approval of an Annual MM Plan submission, review of quarterly PA and denial data, and through Operational Reviews (OR) that audit the MCOs' compliance with established AHCCCS MM standards. The OR standards include but are not limited to PA practices, concurrent and retrospective review practices, NOA 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 prior to the ACC transition. Since the transition to integrated MCOs in 2018, the MCOs continue to identify, monitor, and intervene in order to provide appropriate and timely care to members with high needs and/or high costs who have physical and/or behavioral health needs. MCOs track interventions based on standardized criteria and report intervention summaries to AHCCCS within the annual plan submissions. Chart I on the following page identifies the number of members engaged in the Program since 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 the calendar year 2018. Following is a high-level summary of 2018 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 8th leading cause of death in 2018 for Arizonans, with 1,432 reported, as well as the 6th leading cause of death for male Arizonans. For female Arizonans, suicide was the 11th leading cause of death.

The suicide rate increased from 18.0 per 100,000 in 2017 to 19.5 in 2018, an increase of 8.3%. In 2018, firearms were the leading mechanism of suicide with 55.9% of all suicides using this mechanism. While the age-adjusted mortality rate for suicide increased among men by 12.1%, the suicide rate decreased among women by 7.1%. Arizona residents 10-14 years of age had the lowest age-specific suicide mortality rate while those 45-54, 55-64, and 65 and older years of age had the highest rates.

Of note, American Indians in Arizona had the highest suicide rates: 36.5/100,000. White non-Hispanics were next with a rate of 23.7/100,000. Asians had the lowest suicide rate

at 7.3/100,000. Gila County reported the highest age-adjusted suicide rate of Arizona's 15 counties, with 60.5 suicides per 100,000.

Drug-related mortality reported by ADHS for 2018 grew by 10.9% over the prior year for Arizona residents. Table III provides the number of deaths reported as drug-related in 2017 and 2018.

Table III

| Drug-Related Mortality by Category, Arizona Residents, 2017 & 2018 | | | |
|---|---|---|---|
| **Category** | **2017** | **2018** | **Change %** |
| Abuse of psychoactive substances | 98 | 113 | 15.3% |
| Accidental poisoning by drugs | 1,269 | 1,425 | 12.3% |
| Intentional self-poisoning by drugs/medicaments | 140 | 152 | 8.6% |
| Undetermined intent of poisoning by drugs | 85 | 75 | -11.8% |
| Total Drug-Related Deaths | 1,592 | 1,765 | 10.9% |

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 2019, MCOs reported 527 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[1]:

- 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.

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

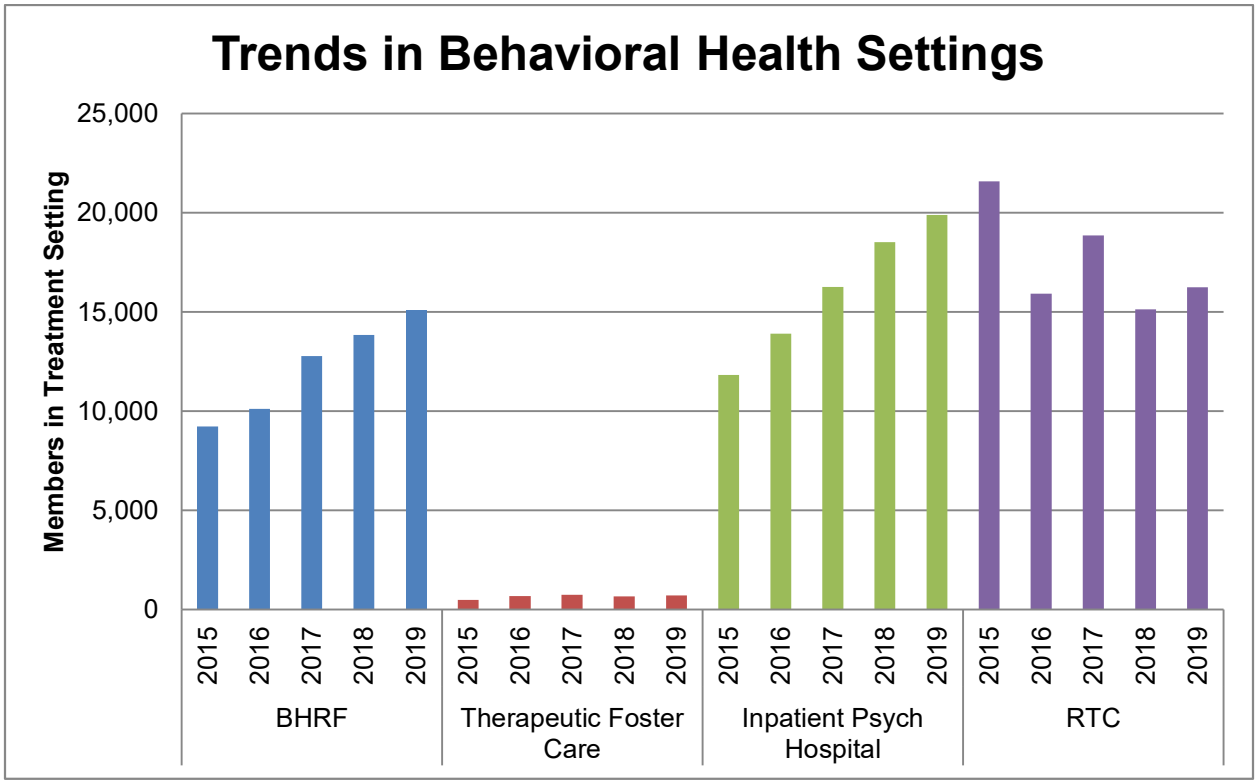
- Therapeutic Foster Care
  Therapeutic Foster Care services, formerly known as Home Care Training to Home Care Client (HCTC) services, are provided by a behavioral health therapeutic home to a person residing in his/her home in order to implement the in-home portion of the person's behavioral health service plan. Therapeutic foster care services assist and support a person in achieving his/her 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 provides a five year history of behavioral health treatment settings for AHCCCS members. Data is provided on a CYE basis (October 1 through September 30 annually).

Chart II



A combination of factors helps explain the trends in treatment settings over the last five 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 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 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:

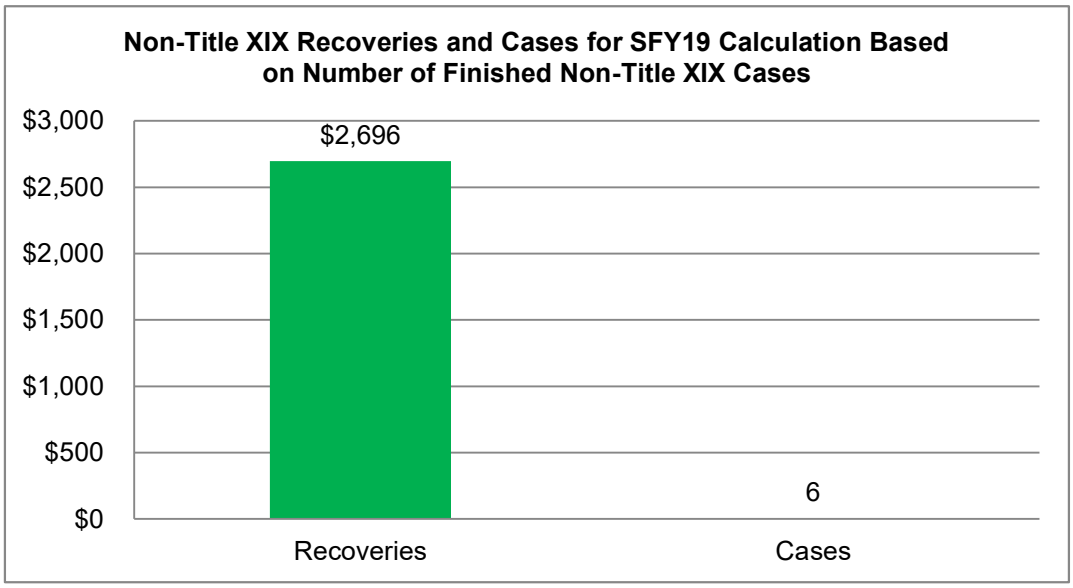
- Collaboration with first responders, including expanded crisis intervention training to support police officers in getting members to treatment rather than sending members to jail.
- Concentrated efforts to reduce emergency department holds, which resulted in members obtaining inpatient care more quickly 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

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. Recovery is the monies or funds that AHCCCS OIG retrieves from a Medicaid provider or member when an OIG investigation concludes that AHCCCS made improper payments due to a practice or trend of fraud, waste, and abuse by a Medicaid provider or member. Chart III shows the cases investigated by the OIG that contained Non-Title XIX (NTXIX) recoveries in SFY 2019 (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 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. Starting in CYE 2019, behavioral health services for most AHCCCS enrolled adults and children were transferred from the RBHAs to the ACC MCOs.

The MCOs submit their calculated compliance with these time and distance standards and, starting in CYE 2019, AHCCCS validates these submissions through a third party 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. Continued failure to meet the standard can result in compliance action under the MCO's contract. Tables IV through VI 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 CYE 2019. The ACC MCOs are identified by an '(A)' in the tables below, while the RBHAs are identified by an '(R)'.

Table IV

| Behavioral Health Outpatient/Integrated Clinics (Adults) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| CYE 2019 Average | | | | | | | | | | |
| **County/Requirement** | **Mercy Care (R)** | **Health Choice Arizona (R)** | **Arizona Complete Care (R)** | **Mercy Care (A)** | **Health Choice Arizona (A)** | **Arizona Complete Care (A)** | **Banner UFC (A)** | **Care1st (A)** | **Magellan Complete Care of AZ (A)** | **United Health Care (A)** |
| Maricopa - 90% within 15 min or 10 miles | 97.8% | | | 97.0% | 98.5% | 97.6% | 98.7% | 98.7% | 97.6% | 97.3% |
| Pima - 90% within 15 min or 10 miles | | | 98.1% | | | 97.5% | 97.2% | | | 96.7% |
| Apache - 90% within 60 miles | | 97.7% | | | 84.2% | | | 78.4% | | |
| Coconino - 90% within 60 miles | | 99.8% | | | 99.1% | | | 99.3% | | |
| Gila - 90% within 60 miles | | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Mohave - 90% within 60 miles | | 100.0% | | | 100.0% | | | 99.9% | | |
| Navajo - 90% within 60 miles | | 99.4% | | | 97.6% | | | 96.6% | | |
| Yavapai - 90% within 60 miles | | 100.0% | | | 100.0% | | | 99.9% | | |
| Yuma - 90% within 60 miles | | | 99.8% | | | 99.8% | 99.8% | | | |
| Pinal - 90% within 60 miles | | | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Cochise - 90% within 60 miles | | | 100.0% | | | 100.0% | 100.0% | | | |
| Santa Cruz - 90% within 60 miles | | | 100.0% | | | 100.0% | 100.0% | | | |
| Graham - 90% within 60 miles | | | 100.0% | | | 100.0% | 99.7% | | | |
| La Paz - 90% within 60 miles | | | 93.9% | | | 91.5% | 100.0% | | | |
| Greenlee - 90% within 60 miles | | | 100.0% | | | 100.0% | 99.9% | | | |

| Key |
|---|
| 90.0- 100.0% |
| 80.0-89.9% |
| Under 80.0% |
| MCO Not in County |

Table V

| BH Outpatient/Integrated Clinics (Pediatric) | | | | | | | |
|---|---|---|---|---|---|---|---|
| CYE 2019 Average* | | | | | | | |
| **County/Requirement** | **Mercy Care (A)** | **Health Choice Arizona (A)** | **Arizona Complete Care (A)** | **Banner UFC (A)** | **Care1st (A)** | **Magellan Complete Care of AZ (A)** | **United Health Care (A)** |
| Maricopa - 90% within 15 min or 10 miles | 97.2% | 98.8% | 97.7% | 98.9% | 99.0% | 96.9% | 97.3% |
| Pima - 90% within 15 min or 10 miles | | | 97.8% | 97.5% | | | 96.8% |
| Apache - 90% within 60 miles | | 86.1% | | | 72.3% | | |
| Coconino - 90% within 60 miles | | 98.7% | | | 98.9% | | |
| Gila - 90% within 60 miles | 100.0% | 100.0% | 99.6% | 100.0% | 100.0% | 100.0% | 100.0% |
| Mohave - 90% within 60 miles | | 100.0% | | | 99.9% | | |
| Navajo - 90% within 60 miles | | 97.6% | | | 94.7% | | |
| Yavapai - 90% within 60 miles | | 99.9% | | | 100.0% | | |
| Yuma - 90% within 60 miles | | | 99.9% | 99.9% | | | |
| Pinal - 90% within 60 miles | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Cochise - 90% within 60 miles | | | 100.0% | 100.0% | | | |
| Santa Cruz - 90% within 60 miles | | | 100.0% | 100.0% | | | |
| Graham - 90% within 60 miles | | | 100.0% | 99.7% | | | |
| La Paz - 90% within 60 miles | | | 91.8% | 100.0% | | | |
| Greenlee - 90% within 60 miles | | | 100.0% | 100.0% | | | |

** Not reported for the Regional Behavioral Health Authorities (RBHAs) due to data limitations on addresses for the children's population served by the RBHAs.*

| Key |
|---|
| 90.0- 100.0% |
| 80.0-89.9% |
| Under 80.0% |
| MCO Not in County |

Table VI

| Crisis Stabilization Facility<br>CYE 2019 Average** | | | |
|---|---|---|---|
| **County/Requirement** | **Mercy Care (R)** | **Health Choice Arizona (R)** | **Arizona Complete Care (R)** |
| Maricopa - 90% within 15 min or 10 miles | 98.5% | | |
| Pima - 90% within 15 min or 10 miles | | | 98.4% |
| Apache - 90% within 45 miles | | 99.0% | |
| Coconino - 90% within 45 miles | | 99.7% | |
| Gila - 90% within 45 miles | | 100.0% | |
| Mohave - 90% within 45 miles | | 99.7% | |
| Navajo - 90% within 45 miles | | 99.5% | |
| Yavapai - 90% within 45 miles | | 99.3% | |
| Yuma - 90% within 45 miles | | | 99.8% |
| Pinal - 90% within 45 miles | | | 100.0% |
| Cochise - 90% within 45 miles | | | 99.8% |
| Santa Cruz - 90% within 45 miles | | | 100.0% |
| Graham - 90% within 45 miles | | | 99.9% |
| La Paz - 90% within 45miles | | | 93.5% |
| Greenlee - 90% within 45 miles | | | 100.0% |

*** Standard only applies to Regional Behavioral Health Authorities (RBHAs)*

| Key |
|---|
| 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. 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. Metrics are used as a tool for MCOs to survey their providers against established timelines to spot potential network gaps. MCOs must address when providers do not meet these timeframes and typically resurvey them the following quarter. Table VII on the following page shows the percentage of providers meeting the timeframes for each ACC (A) and RBHA plan (R).

Table VII

| % of Providers Meeting Standard<br>CYE 2019 Average | Mercy Care (R) | Health Choice Arizona (R) | Arizona Complete Care (R) | Mercy Care (A) | Health Choice Arizona (A) | Arizona Complete Care (A) | Banner UFC (A) | Care1st (A) | Magellan Complete Care of AZ (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 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 87.2% | 100.0% | 91.8% | 75.7% |
| Routine: Initial assessment within seven calendar days of referral or request for service | 99.3% | 99.8% | 100.0% | 97.8% | 99.8% | 100.0% | 84.2% | 99.1% | 91.2% | 75.7% |
| 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 | 99.8% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 83.8% | 99.6% | 97.5% | 75.7% |
| 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 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 84.9% | 99.5% | 99.7% | 75.7% |
| 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 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 86.3% | 99.8% | 98.0% | 75.7% |

| Key |
|---|
| 90.0- 100.0% |
| 80.0-89.9% |
| Under 80.0% |

*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. AHCCCS requires Contractors to implement Corrective Action Plans (CAPs) for measures not meeting the MPS in an effort to promote improvement in performance measure rates. Table VIII provides specific Behavioral Health Performance Measures and Outcome Data for CYE 2018. Performance Measure rates are reflective of performance for the CYE 2018 measurement period (October 1, 2017 to September 30, 2018), in alignment with Federal Fiscal Year (FFY) 2019 reporting.

Table VIII

| | | | SMI | GMH/SU |
|---|---|---|---|---|
| **Performance Measure** | **CYE 2018 Minimum Performance Standard** | **CYE 2018 NCQA Medicaid Mean** | **CYE 2018 Aggregate** | **CYE 2018 Aggregate** |
| 7 Day Follow-Up After Hospitalization for Mental Illness (Total) - NCQA | 85% | 35.8% | 68.5% | 49.4% |
| 30 Day Follow-Up After Hospitalization for Mental Illness (Total) - NCQA | 95% | 56.8% | 85.6% | 67.1% |
| Use of Multiple Concurrent Antipsychotics in Children and Adolescents[1] | Baseline Measurement Year (GMH/SU Only) | 2.4% | NA | 0.8% |
| Mental Health Utilization - Any Service (Total) | Baseline Measurement Year | NA | 90.8% | 11.3% |
| Mental Health Utilization - Inpatient (Total) | *Reported for Informational Purposes Only* | NA | 16.6% | 1.1% |
| Mental Health Utilization - Intensive Outpatient/Partial Hospitalization (Total) | *Reported for Informational Purposes Only* | NA | 15.0% | 0.7% |
| Mental Health Utilization - Outpatient (Total) | *Reported for Informational Purposes Only* | NA | 89.9% | 10.9% |

| | | | | |
|---|---|---|---|---|
| Mental Health Utilization - ED (Total) | *Reported for Informational Purposes Only* | NA | 1.1% | 0.0% |
| Mental Health Utilization - Telehealth (Total) | *Reported for Informational Purposes Only* | NA | 6.6% | 0.7% |

[1] *Lower rate indicates better performance*

## 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.