AHCCCS
Arizona Health Care Cost Containment System

Douglas A. Ducey, Governor
Jami Snyder, Director

September 1, 2021

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 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 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) 2020
(July 1, 2019 – June 30, 2020)

September 2021
Jami Snyder, Director

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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.

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) continued to receive behavioral health services from Regional Behavioral Health Authorities (RBHAs) during the reporting period covered by this report. 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. 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:
https://www.azahcccs.gov/shared/Downloads/MonthlyReports/BehavioralHealthEnrolledAndServicedReports/FY2019/ClinicalCriteriaForBehavioralHealthEnrolledAndServedReport.pdf

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 2020 can be found at the following link: https://www.azahcccs.gov/resources/guidesmanualspolicies/eligibilitypolicy/epmplus/index.html#t=Policy%2FChapter_600_Income_Eligibility%2FMA0615.htm.

In SFY 2020, 100% FBR for an individual was $9,528 a year and 100% FPL for an individual was $12,888 a year. As noted in Table I, 43.6% of Medicaid (Title XIX) and Children's Health Insurance Program (CHIP – Title XXI) members determined by FPL were below 100% 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 provides the percentage of members determined by FBR. IN SFY 2020, 71.6% of Medicaid and CHIP members determined by FBR were below 100% FBR.

Table I - SFY 2020 Medicaid & CHIP Members Determined by FPL

Federal Poverty Level	Percent
< 36% FPL	9.4%
< 40% FPL	26.3%
< 100% FPL	43.6%
< 120% FPL	0.8%
< 133% FPL	12.7%
< 150% FPL	0.7%
<185% FPL	4.6%
< 200% FPL	1.8%
< 250%FPL	0.02%
Grand Total	**100.0%**

Table II - SFY 2020 Medicaid & CHIP Members Determined by FBR

Federal Benefit Rate	Percent
< 100% FBR	71.6%
< 300% FBR	28.4%
Total	**100.0%**

Utilization and Expenditures

The Medicaid and non-Medicaid behavioral health expenditures for SFY 2020 are provided in Tables III and IV. These expenditures are consistent with those reported in AHCCCS' SFY 2020 Behavioral Health Annual Report, submitted in accordance with A.R.S. §36-3405. A link to that report is provided for reference:
https://www.azahcccs.gov/shared/Downloads/Reporting/2021/FY2020BHAnnualReport.pdf

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 2020

Total Behavioral Health Services Expenditures by Funding Source SFY 2020		
Funding	**Amount Paid**	**Percentage**
General Fund - Medicaid	$383,749,984	14.90%
Tobacco Tax Funds - Medically Needy Account	$35,565,800	1.38%
Tobacco Tax Funds - Proposition 204 Protection Account	$5,000,000	0.19%
Tobacco Tax Funds - Tobacco Litigation Settlement	$30,154,400	1.17%
TXIX and TXXI Medicaid Federal Grant Awards	$1,865,739,262	72.42%
Non-TXIX General Fund	$97,993,106	3.80%
Substance Abuse Services Fund	$2,250,200	0.09%
Federal Grant Funds	$82,498,411	3.20%
County Funds	$68,783,375	2.67%
SMI Housing Trust Fund	$1,244,733	0.05%
Substance Use Disorder Funds	$3,306,849	13.00%
Other (Liquor Service Fees)	$58,715	0.00%
Total	**$2,576,344,835**	**100.00%**

Table IV - Statewide Expenditures by Program – SFY 2020

Total Behavioral Health Service Expenditures by Program FY 2020		
Funding	**Amount Paid**	**Percentage**
Traditional Medicaid Services	$ 1,036,203,510	40.21%
Proposition 204 Services	$ 992,913,930	38.54%
ACA Adult Expansion	$ 68,789,399	2.76%
CMDP	$ 142,692,100	5.54%
KidsCare	$ 22,821,399	0.89%
Medicaid Fee-for-Service	$ 56,789,107	2.20%
Non-TXIX Child	$ 9,737,237	0.38%
Non-TXIX SMI	$ 157,466,713	6.11%
Non-TXIX GMH/SA	$ 63,046,397	2.45%
Non-TXIX Crisis	$ 16,386,563	0.64%
Non-TXIX Prevention	$ 9,498,480	0.37%
Total	**$2,576,344,835**	**100.00%**

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. Table V offers data on the volume of numerous MCO MM oversight activities during SFY 2020.

Table V – Medical Necessity Oversight Activities Fiscal Year 2020

Medical Necessity Oversight Activity	SFY 2020
Prior Authorizations	52,177
Notice of Adverse Benefit Determinations (NOA)	2,910
Concurrent Reviews	72,641
Retrospective Reviews	24,241

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. Table VI provides specific behavioral health utilization performance measures and outcome data for CYE 2019 (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 – CYE 2019 AHCCCS Performance Measure Data – Utilization of Services

Population:		ACC	SMI	Statewide[1]
Performance Measure	**2019 NCQA Medicaid Mean[2]**	**CYE 2019 Aggregate**	**CYE 2019 Aggregate**	**CYE 2019 Aggregate**
Mental Health Utilization - Any Service (Total)	NA	12.1%	90.6%	14.8%
Mental Health Utilization - Inpatient (Total)	NA	1.2%	18.2%	1.7%
Mental Health Utilization - Intensive Outpatient/Partial Hospitalization (Total)	NA	0.7%	16.1%	1.1%
Mental Health Utilization - Outpatient (Total)	NA	11.7%	89.6%	14.4%
Mental Health Utilization - ED (Total)	NA	0.1%	1.1%	0.1%
Mental Health Utilization - Telehealth (Total)	NA	0.8%	7.6%	1.0%
Use of Pharmacotherapy for Opioid Use Disorder (Total)	NA	51.3%	43.3%	48.9%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	62.0%	70.7%	NA	70.5%

[1] *Rates reflective of all managed care enrolled members meeting continuous enrollment criteria regardless of line of business.*
[2] *NCQA Medicaid Mean retrieved from the State of Health Care Quality Report published by NCQA.*

Beginning in CYE 2021, AHCCCS will transition to the use of performance measure performance standards (PMPS) with official performance measure results evaluated based upon the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) Medicaid Mean or CMS Medicaid Median (for selected CMS Core Set-Only Measures), as identified by AHCCCS. AHCCCS will require Contractors to implement corrective action plans (CAPs) for measures not meeting the PMPS in efforts to promote improvement in performance measure rates.

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. MCOs identified and tracked **41,214** high-cost beneficiaries in SFY 2020. Due to the change in definition of high cost beneficiaries, this data is not comparable to prior reporting.

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: http://pub.azdhs.gov/health-stats/menu/index.php?pg=deaths. 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[1]:

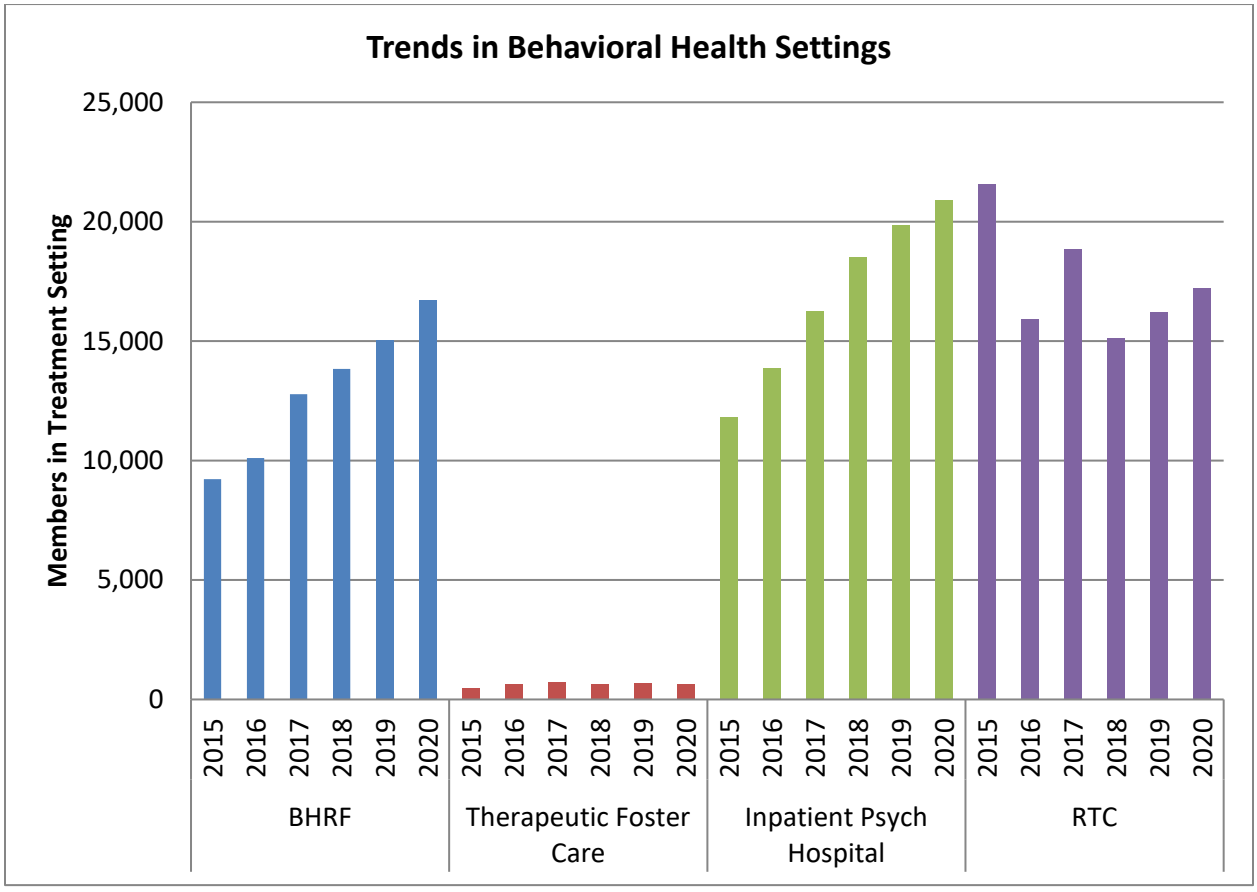
- *Behavioral Health Residential Facility (BHRF)*
  Residential services provided by a licensed behavioral health agency. These agencies provide a structured treatment setting with 24-hour supervision and counseling or other therapeutic activities for persons who do not require on-site medical services,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

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

- *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 I 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).

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.

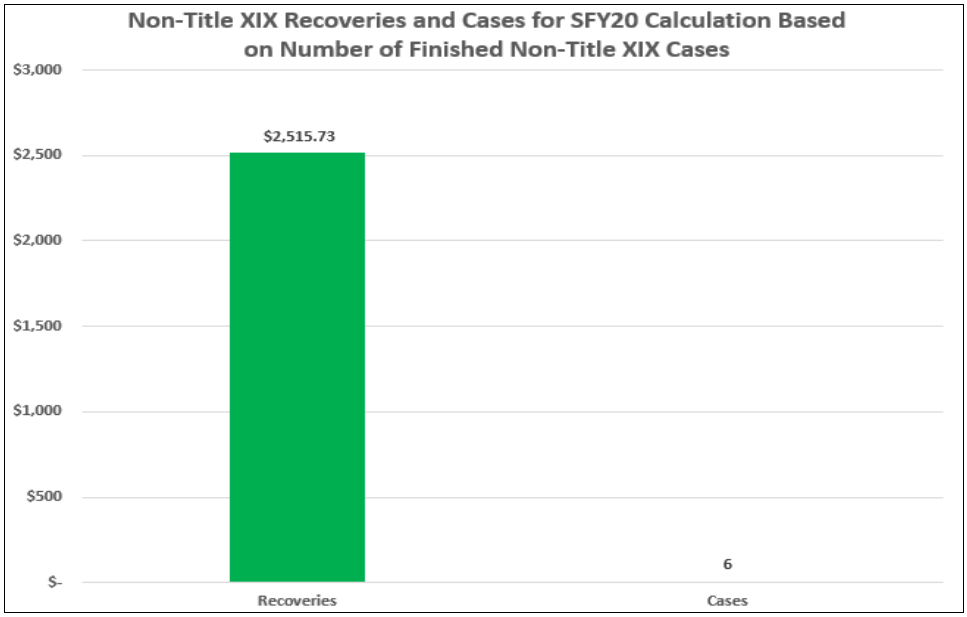
Program Integrity

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 2020 with internal AHCCCS subject matter experts, AHCCCS' MCOs, and the ADHS Bureau of Residential Facilities Licensing to better understand the provision of behavioral health services unique to various AHCCCS populations and to identify flags that should be reported for FWA. These identifiers aid in 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. As a result of these actions, the OIG has opened cases that encompass the provision of behavioral health services within the comprehensive audit and investigative framework. Some of these cases led the OIG to institute three Credible Allegation of Fraud Payment Suspensions, pursuant to 42 CFR § 455.23, for those cases that met the outlined criteria.

Aside from these cases, the OIG is able to identify separate instances of recoveries and savings solely used for the provision of behavioral health services which are funded with Non-Title XIX funds. Chart II shows the cases investigated by the OIG that contained Non-Title XIX recoveries in SFY 2020.

Chart II – Non-Title XIX Recoveries and Cases for SFY 2020



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, starting in CYE 2019, AHCCCS validated 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 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 CYE 2020. The ACC MCOs are identified by an '(A)' in the tables below, the RBHAs by an '(R)', ALTCS-EPD plans with an (L), and DES/DDD subcontractors with a (D).

The time and distance data below are an average of the percentage of members that meet the time and distance requirements in three quarters of CYE 2020. Quarter 4 reflected a transition period in AHCCCS' contract with its third-party organization; future validations will only be conducted twice a year rather than quarterly.

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

RBHA Behavioral Health Outpatient/Integrated Clinics (Adults)			
CYE 2020 Average			
County/Requirement	**Mercy Care (R)**	**Health Choice Arizona (R)**	**Arizona Complete Health (R)**
Maricopa - 90% within 15 min or 10 miles	98.6%		
Pima - 90% within 15 min or 10 miles			98.4%
Apache - 90% within 60 miles		96.4%	
Coconino - 90% within 60 miles		99.5%	
Gila - 90% within 60 miles		100%	
Mohave - 90% within 60 miles		100%	
Navajo - 90% within 60 miles		98.9%	
Yavapai - 90% within 60 miles		100%	
Yuma - 90% within 60 miles			99.8%
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%

Key
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)							
CYE 2020 Average							
County/Requirement	**Mercy Care (A)**	**Health Choice Arizona (A)**	**Arizona Complete Health (A)**	**Banner UFC (A)***	**Care1st (A)**	**Magellan Complete Care of AZ (A)**	**United Health Care (A)**
Maricopa - 90% within 15 min or 10 miles	98.3%	98.6%	98%	85.2%	98.8%	97.1%	98.1%
Pima - 90% within 15 min or 10 miles			97.6%	91.4%			97%
Apache - 90% within 60 miles		84.7%			99%		
Coconino - 90% within 60 miles		97.7%			100%		
Gila - 90% within 60 miles	100%	100%	100%	82.9%	100%	100%	100%
Mohave - 90% within 60 miles		100%			100%		
Navajo - 90% within 60 miles		95.8%			97.6%		
Yavapai - 90% within 60 miles		100%			100%		
Yuma - 90% within 60 miles			99.8%	99.7%			
Pinal - 90% within 60 miles	100%	100%	100%	100%	100%	100%	100%
Cochise - 90% within 60 miles			100%	99.7%			
Santa Cruz - 90% within 60 miles			100%	100%			
Graham - 90% within 60 miles			100%	97.8%			
La Paz - 90% within 60 miles			100%	33.9%			
Greenlee - 90% within 60 miles			100%	99.7%			

**During Q2 and Q3 of CYE 2020, the network data for Banner University did not include all network providers of this type, resulting in reduced calculated compliance with this standard.*

Key
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)					
CYE 2020 Average					
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	83.2%	98.9%	99.6%	97.3%	97.7%
Pima - 90% within 15 min or 10 miles	92.5%	96.2%		96.1%	97.9%
Apache - 90% within 60 miles			98.9%	50%	69.4%
Coconino - 90% within 60 miles			100%	87.8%	98.9%
Gila - 90% within 60 miles	83.4%	100%	100%	100%	100%
Mohave - 90% within 60 miles			100%	100%	99.7%
Navajo - 90% within 60 miles			100%	100%	97.4%
Yavapai - 90% within 60 miles			100%	100%	100%
Yuma - 90% within 60 miles	99.8%			100%	99.7%
Pinal - 90% within 60 miles	99.9%	100%	100%	100%	100%
Cochise - 90% within 60 miles	99.8%			100%	100%
Santa Cruz - 90% within 60 miles	100%			100%	100%
Graham - 90% within 60 miles	99.1%			100%	100%
La Paz - 90% within 60 miles	50.4%			100%^	100%
Greenlee - 90% within 60 miles	100%			100%	100%

**During Q2 and Q3 of CYE 2020, the network data for Banner University did not include all network providers of this type, resulting in reduced calculated compliance with this standard.*

Key
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)							
CYE 2020 Average*							
County/Requirement	**Mercy Care (A)**	**Health Choice Arizona (A)**	**Arizona Complete Health (A)**	**Banner UFC (A)****	**Care1st (A)**	**Magellan Complete Care of AZ (A)**	**United Health Care (A)**
Maricopa - 90% within 15 min or 10 miles	98.4%	98.9%	98.3%	85.9%	99.1%	97.3%	98.3%
Pima - 90% within 15 min or 10 miles			97.8%	91.1%			97%
Apache - 90% within 60 miles		86.1%			99.1%		
Coconino - 90% within 60 miles		97%			100%		
Gila - 90% within 60 miles	100%	100%	100%	82.9%	100%	100%	100%
Mohave - 90% within 60 miles		100%			99.9%		
Navajo - 90% within 60 miles		95.6%			95.8%		
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%	99.9%			
Santa Cruz - 90% within 60 miles			100%	100%			
Graham - 90% within 60 miles			100%	97.2%			
La Paz - 90% within 60 miles			100%	33.6%			
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.*

***During Q2 and Q3 of CYE 2020, the network data for Banner University did not include all network providers of this type, resulting in reduced calculated compliance with this standard.*

Key
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 DES/DDD Behavioral Health Outpatient/Integrated Clinics (Pediatric)					
CYE 2020 Average					
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	91.9%	97.7%	98.6%	97.7%	97.9%
Pima - 90% within 15 min or 10 miles	76.1%	95.2%		95%	96.4%
Apache - 90% within 60 miles			100%^	66.7%^	68.2%
Coconino - 90% within 60 miles			100%	100%	95.4%
Gila - 90% within 60 miles	66.7%^	100%^		100%	100%
Mohave - 90% within 60 miles			100%^	91.3%	100%
Navajo - 90% within 60 miles			100%^	100%^	94.4%
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%
Greenlee - 90% within 60 miles				100%	100%

**During Q2 and Q3 of CYE 2020, the network data for Banner University did not include all network providers of this type, resulting in reduced calculated compliance with this standard.*

Key
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 CYE 2020 Average*			
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			99.4%
Apache - 90% within 45 miles		100%	
Coconino - 90% within 45 miles		99.7%	
Gila - 90% within 45 miles		100%	
Mohave - 90% within 45 miles		99.3%	
Navajo - 90% within 45 miles		99.4%	
Yavapai - 90% within 45 miles		99.5%	
Yuma - 90% within 45 miles			99.8%
Pinal - 90% within 45 miles			100%
Cochise - 90% within 45 miles			99.8%
Santa Cruz - 90% within 45 miles			100%
Graham - 90% within 45 miles			100%
La Paz - 90% within 45miles			100%
Greenlee - 90% within 45 miles			100%

** This standard only applies to 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. 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. 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. Also, MCOs must address when providers do not meet these timeframes and typically resurvey them the following quarter. Tables XIII and XIV on the following pages show the percentage of providers meeting the timeframes for each ACC (A), RBHA (R), ALTCS-EPD (L) and DES/DDD plan (D).

Due to the public health emergency, AHCCCS waived the collection of this information during Q2 and Q3 of CYE 2020. As a result, the percentages in the tables reflect two quarters of data only.

Table XIII - RBHA and ACC - Appointment Availability

RBHA and ACC % of Providers Meeting Standard CYE 2020 Average										
	Mercy Care (R)	Health Choice Arizona (R)	Arizona Complete Health (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%	100%	100%	100%	100%	100%	78.6%	100%	98.1%	71%
Routine: Initial assessment within seven calendar days of referral or request for service.	99%	100%	100%	99.4%	100%	100%	84.6%	99%	99%	79%
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.	100%	100%	100%	99.5%	100%	100%	89%	97.8%	99.4%	63%
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%	85.7%	97.7%	99.7%	63%
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%	100%	100%	100%	100%	100%	91.8%	98.3%	99.7%	63%
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%	100%	100%	100%	91.2%	98.3%	99.2%	63%

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

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

ALTCS-EPD and DDD % of Providers Meeting Standard CYE 2020 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.	72%	100%	71%	100%	71%
Routine: Initial assessment within seven calendar days of referral or request for service.	81.9%	99.4%	79%	99.3%	79%
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.	89%	99.5%	63%	99%	63%
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.	85.7%	100%	63%	100%	63%
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.	91.2%	100%	63%	100%	63%
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.	90.1%	100%	63%	100%	63%

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

Performance Metrics

As noted previously in this report, 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 CYE 2019 (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 XV - CYE 2019 AHCCCS Performance Measure Data

Population:		ACC	SMI	Statewide[1]
Performance Measure	**2019 NCQA Medicaid Mean[2]**	**CYE 2019 Aggregate**	**CYE 2019 Aggregate**	**CYE 2019 Aggregate**
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 Day Follow-Up (Total) - NCQA	NA	19.7%	19.4%	19.5%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 Day Follow-Up (Total) - NCQA	NA	27.0%	30.8%	27.3%
Follow-Up After Emergency Department Visit for Mental Illness - 7 Day Follow-Up (Total) - NCQA	41.4%	47.9%	58.4%	51.9%
Follow-Up After Emergency Department Visit for Mental Illness - 30 Day Follow-Up (Total) - NCQA	55.6%	58.2%	78.7%	64.8%
Follow-Up After Hospitalization for Mental Illness - 7 Day Follow-Up (Total) - NCQA	36.2%	45.1%	68.6%	54.2%
Follow-Up After Hospitalization for Mental Illness – 30 Day Follow-Up (Total) - NCQA	56.9%	64.0%	85.4%	72.5%
Follow-Up Care for Children Prescribed Attention-Deficit/ Hyperactivity Disorder (ADHD) Medication – Initiation Phase	42.3%	58.5%	NA	59.6%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication – Continuation and Maintenance Phase	53.1%	66.0%	NA	66.9%

[1] Rates reflective of all managed care enrolled members meeting continuous enrollment criteria regardless of line of business.

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

Conclusion

SFY 2020 brings AHCCCS closer to the end of its 10-year journey to integrate physical and behavioral health services at the payer level. 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.