ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

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KATIE HOBBS
GOVERNOR

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February 4, 2026

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

Dear Senator Farnsworth:

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 Damien Carpenter, Chief Legislative Liaison, at (602) 396-0767.

Sincerely,

Virginia Rountree

Virginia Rountree
Director

cc: The Honorable David Livingston, Vice Chairman, Joint Legislative Budget Committee
Ben Henderson, Director, Governor's Office of Strategic Planning and Budgeting
Richard Stavneak, Director, Joint Legislative Budget Committee
Meaghan Kramer, Health Policy Advisor, Office of the Governor

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Behavioral Health Annual Report

For the Period:
State Fiscal Year (SFY) 2024
(July 1, 2023 – June 30, 2024)

October 2025

Background

Background

The Arizona Revised Statute § 36-3415 requires the following report regarding members who received behavioral health services:

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.

Pursuant to Laws 2022, Second Regular Session, Chapter 305, this report is issued annually as the § 36-3415(A) 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 children (except children in foster care). Effective CYE 2020, members with developmental disabilities transitioned to fully integrated health plans contracted with the Department of Economic Security/Division of Developmental Disabilities (DES/DDD) for acute care and behavioral health services. Members enrolled in the Comprehensive Medical and Dental Program (CMDP) were transitioned to an integrated product on April 1, 2021. Under the new name, the Arizona Department of Child Safety - Comprehensive Health Plan (DCS-CHP), delivers integrated physical and behavioral health services to its members. In alignment with the MCO integration of physical and behavioral health services, AHCCCS's FFS (Fee for Service) program, American Indian Health Program (AIHP), also integrated services allowing members to select AIHP for both physical and behavioral health. An exception to this was AIHP members with an SMI designation, in which case members were enrolled with an ACC-RBHA or a Tribal Regional Behavioral Health Authority (TRBHA). Beginning October 1, 2022, the American Indian Health Program (AIHP) fully integrated physical and behavioral health benefits for members including SMI designated members. The TRBHA continued to maintain responsibility for providing care coordination and case management for both GMH/SU and SMI members, through their Intergovernmental Agreements (IGAs) with the AHCCCS administration. As of June 2024, approximately 55% of AIHP members were assigned to one of the four TRBHAs – Gila River Tribe, Navajo Nation, Pascua Yaqui Tribe, and White Mountain Apache. An additional IGA for the delivery of crisis services is established with Colorado River Indian Tribes (CRIT).

AHCCCS operates primarily through a managed care system where members are established with a Primary Care Physician and Behavioral Health Home, and case management is provided as an administrative service. American Indians/Alaska Native have the option of an MCO or the AIHP, they are also able to receive services at any IHS or Tribal 638 facility regardless of their health plan of enrollment. While AIHP members receive their care primarily through IHS/Tribal 638 facilities, IHS/Tribal 638 facilities do not have administrative dollars to support case management functions. The American Indian Medical Home (AIMH) program is a care management model that puts AIHP members at the forefront of care and

creates an opportunity for case management and care coordination for AIHP members. IHS/Tribal 638 facilities that meet criteria can be established as an AIMH, where, through voluntary empanelment, AIHP members can benefit from additional services including primary care case management and twenty-four-hour access to the care team. While AIMHs must meet Primary Care Medical Home accreditation, AHCCCS' focus is on whole person care, meaning AIMHs are also responsible for helping to refer to and coordinate behavioral health services for empaneled members. In SFY 2024, there were 8 AIMHs, and approximately 29% of AIHP members were empaneled with an AIMH.

Additionally, AHCCCS has a partnership through an Interagency Service Agreement (**ISA) with the Arizona Department of Economic Security (ADES). The ISA** began on **April 1, 2022**, and will continue through **March 30, 2027**. The ISA formalizes a partnership between the Arizona Department of Economic Security (ADES) and the Arizona Health Care Cost Containment System (AHCCCS) to improve service delivery for Tribal Health Program (THP) members, including those with a Serious Mental Illness (SMI) designation.

Under this agreement, **ADES transferred oversight of key health services**—including acute physical health, behavioral health, and Children's Rehabilitation Services (CRS)—to AHCCCS. AHCCCS now manages prior authorizations and pays claims directly to providers on ADES's behalf.

AHCCCS also administers select Long Term Services and Supports (LTSS) for adults 21 and older, such as short-term skilled nursing, emergency alert systems, and habilitative therapies. ADES continues to manage other LTSS and support coordination.

This collaboration ensures **integrated care across physical health, behavioral health, and LTSS**, with both agencies working closely to coordinate services and improve outcomes for Arizona's tribal populations.

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

Member Income

AHCCCS members who receive Medicaid services generally have household incomes near or below the Federal Poverty Level (FPL) and Federal Benefit Rate (FBR). The FBR standards often change annually in January, and the FPL standards change no later than April each year. The FPL and FBR standards used for the eligibility determinations in State Fiscal Year (SFY) 2024 can be found on the AHCCCS website, under the Medical Assistance Eligibility Policy Manual.

In SFY 2024, 100% FBR for an individual was $11,316 a year and 100% FPL for an individual was $15,060 a year. As noted in Table I, 76.1% of Medicaid (Title XIX) and Children's Health Insurance Program (CHIP – Title XXI) members determined by FPL were below 106% FPL. In addition, AHCCCS provides Non-Title XIX/XXI services to qualifying individuals who are not eligible for Medicaid/CHIP and may have higher household incomes.

Table II presents the percentage of members determined by FBR. In SFY 2024, 69.5% of Medicaid and CHIP members determined by FBR were below 100% FBR.

Table I: Medicaid & CHIP Members Determined by FPL - SFY 2024

Federal Poverty Level	Percent
< 36% FPL	6.9%
≥ 36% and < 40% FPL	29.5%
≥ 40% and < 106% FPL	39.7%
≥ 106% and < 120% FPL	1.2%
≥ 120% and < 133% FPL	9.2%
≥ 133% and < 150% FPL	2.4%
≥ 150% and <185% FPL	7.8%
≥ 185% and < 200% FPL	3.0%
≥ 200% and < 250%FPL	0.4%
Grand Total	**100%**

**Codes for FPL bands are adjusted annually.*

Table II: Medicaid & CHIP Members Determined by FBR – SFY 2024

Federal Benefit Rate	Percent
< 100% FBR	69.5%
≥ 100% and < 300% FBR	30.5%
Total	**100%**

Utilization and Expenditures

The Medicaid (Title XIX/XXI) and non-Medicaid (Non-Title XIX/XXI) behavioral health expenditures for SFY 2024 are outlined in Tables III and IV. These expenditures are consistent with those reported in AHCCCS SFY 2024 Behavioral Health Programmatic Expenditure Report, submitted in accordance with A.R.S. § 36-3405.

AHCCCS is awarded federal block grant funding biannually in the form of the Mental Health Block Grant (MHBG) and the Substance Use, Prevention, Treatment, and Recovery Services (SUPTRS or Substance Use Block Grant, SUBG, previously known as the Substance Abuse Block Grant, or SABG). Allocated by the Substance Abuse and Mental Health Services Administration (SAMHSA) via the United States Department of Health and Human Services, block grant funding serves as a payor of last resort for services rendered to uninsured or underinsured qualifying members. The ACC-RBHAs and TRBHAs submit annual plans to AHCCCS that are incorporated into the Block Grant plans and discretionary grant applications submitted to SAMHSA. The ACC-RBHAs contract with behavioral health providers serving Arizona residents within their respective Geographic Service Areas (GSA) or Tribal land to ensure access to this funding across the state. The TRBHAs utilize the block grant funding to provide services to Title XIX and non-Title XIX members who

reside in their Tribal communities.

In this report, behavioral health services are defined as any service rendered to a member with a primary diagnosis code or a pharmacy claim that is behavioral health related, as defined by AHCCCS clinical criteria, including those qualifying as a serious mental illness (SMI), general mental health (GMH), serious emotional disturbance (SED), or substance use disorder (SUD) Expenditures data includes MCOs and Fee-For-Service (FFS) providers.

Medicaid Federal Grant Awards reported in Table III reflect an allocation of total payments based on the behavioral health proportional component of the total per member per month capitation rate. All other reported source amounts are actuals. Expenditures are reported on a cash basis that can result in timing differences between the receipt of funds and actual cash disbursements.

Table III - Statewide Expenditures by Funding Source – SFY 2024

Total Behavioral Health Services Expenditures by Funding Source FY 2024		
Funding	**Amount Paid**	**Percentage**
General Fund - Medicaid	$641,274,100	20.85%
Tobacco Tax Funds – Medically Needy Account	$35,565,800	1.16%
Tobacco Tax Funds –Proposition 204 Protection Account	$5,000,000	0.16%
Tobacco Tax Funds –Tobacco Litigation Settlement	$30,154,400	0.98%
TXIX and TXXI Medicaid Federal Grant Awards	$2,028,027,000	65.94%
Non TXIX General Fund	$104,304,400	3.39%
Substance Abuse Services Fund	$2,250,200	0.07%
Federal Grant - MHBG	$42,216,500	1.38%
Federal Grant - SABG	$64,935,300	2.11%
Federal Grants (Opioid/Other)	$36,665,000	1.19%
County Funds	$78,130,300	2.54%
SMI Housing Trust Fund	$423,300	0.01%
Substance Use Disorder Funds	$1,445,400	0.05%
Other (Liquor Service Fees)	$5,120,100	0.17%
Total	**$3,075,511,800**	**100%**
TXIX/TXXI	**$2,740,021,300**	**89.09%**
Non-TXIX/Non-TXXI	**$335,490,500**	**10.91%**

The reported expenditures in Table IV are a further allocation of the figures from Table III, based on the proportional use by service during the reporting period.

Table IV - Statewide Expenditures by Behavioral Health Category – SFY 2024*

Total Behavioral Health Services Expenditures by Behavioral Health Category FY 2024			
Behavioral Health Category	TXIX/TXXI Funding	Non-TXIX/ Non-TXXI Funding	Total
Seriously Mentally Ill	$748,300,145	$144,711,751	$893,011,896
Children with Severe Emotional Disturbance	$366,149,478	$21,725,642	$387,875,120
Alcohol and Drug Abuse	$685,571,541	$55,130,852	$740,702,393
Other Behavioral Health	$940,000,136	$113,922,256	$1,053,922,391
Total	**$2,740,021,300**	**$335,490,500**	**$3,075,511,800**

**Table IV includes only Title XIX/XXI and Non-Title XXI/XXI Funding Sources*

Medical Necessity Oversight Practices

AHCCCS requires that providers deliver medically necessary covered services to members in accordance with all applicable federal and state laws, regulations, contracts, policies, and the Arizona Section 1115 Waiver Demonstration. Services must meet mental health parity standards requiring that limitations applied to mental health/substance use disorder benefits be no more restrictive than limitations applied to medical conditions/surgical procedure benefits. All covered services must be medically necessary and delivered by a qualified provider.

AHCCCS contracts require Managed Care Organizations (MCOs) to develop a comprehensive Medical Management (MM) Program to ensure appropriate management of service delivery for members. Each MCO MM Program is comprised of numerous required elements including policies, procedures, and criteria for the following activities that support medical necessity oversight:

- **Prior authorization (PA)** - The PA process promotes appropriate utilization of services, including behavioral health services for a select and small number of service codes, while effectively managing associated costs. PA decisions are 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:
  - Approve the request,
  - Deny a request based on medical necessity,
  - Authorize a request in an amount, duration, or scope that is less than requested, or
  - Exclude or limit services.

Fee-For-Service (FFS) populations as specified within the PA Policy include Tribal ALTCS, TRBHA, the American Indian Health Program (AIHP), and DES DDD Tribal Health Program (DDD THP); excluding Federal Emergency Services Program (FESP). The PA Policy establishes the process by which AHCCCS DFSM applies FFS Prior Authorization (PA) requirements for covered services. The issuance of an authorization number does not guarantee payment. The documentation provided from the member's medical record shall support the diagnosis and treatment for which the authorization was issued, and the claim shall meet clean claims submission requirements.

A prior authorization (PA) may be issued provisionally if more documentation is needed to fully assess medical necessity for a service, admission, and/or length of stay. Once a final decision is made—approval

or denial—the provisional status is removed, and the provider is notified by letter. The AHCCCS Division of Fee-For-Service Management (DFSM) may request additional documentation if necessary to determine medical necessity.

"The Division of Fee-for-Service Management performs pre-payment reviews on all Federal Emergency Services claims, on American Indian Health Program claims that exceed established unit thresholds for common behavioral health codes, and on claims submitted by providers identified as non-compliant with AHCCCS policies."

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

- **MM utilization data analysis and data management** – MM uses analysis and management of data to focus on the utilization of services to detect both the under- and over-utilization of services. The MCO reviews and evaluates the data and implements actions for improvement when variances are identified.

Oversight Activities

AHCCCS monitors and oversees MCO MM activities through an Annual MM Program Plan, quarterly PA approval and denial data, and Operational Reviews (OR) that audit the MCOs' compliance with established AHCCCS MM Contract and Policy requirements. The ORs determine compliance with the following: PA, concurrent and retrospective review, Notices of Adverse Benefit Determination, evidence-based practice guidelines, inter-rater reliability, and member/prescriber drug utilization review.

Table V offers data on the volume of behavioral health specific MCO MM oversight activities during SFY 2024.

Table V – MCO Behavioral Health Medical Necessity Oversight Activities - SFY 2024

Behavioral Health Medical Necessity Oversight Activity	MCO SFY 2024
Prior Authorizations	6,297
Notice of Adverse Benefit Determinations (NOA)	424
Concurrent Reviews	10,525
Retrospective Reviews	180

Table – AIHP Behavioral Health Medical Necessity Oversight Activities - SFY 2024

Behavioral Health MedicalOversight Activity for AIHP	SFY2024
Prior Authorization (PA) Total	**208,261**
Behavioral Health PA	17,801
NEMT (Non-emergency medical transport) PA PA	97,168
Medical PA	93,292
Provider Training Total	**300**
Technical Assistance	48
General Provider Training	252
Pre- Payment Review	**166,987**

In State Fiscal Year 2024, AHCCCS conducted extensive oversight activities to ensure the quality and appropriateness of behavioral health services provided under the American Indian Health Program (AIHP). This oversight confirms compliance with AHCCCS contract and policy requirements.

A total of **208,261 prior authorization requests** were reviewed, reflecting the volume and complexity of care coordination. To support provider compliance and enhance service quality, AHCCCS delivered **300 training sessions.** Additionally, **166,987 claims underwent pre-payment review**, reinforcing fiscal accountability and ensuring services met medical necessity standards.

This data highlights AHCCCS's commitment to maintaining high standards of care and oversight for Arizona's tribal populations through rigorous review, provider education, and collaboration.

In State Fiscal Year 2024, AHCCCS DFSM expanded its Quality Management Unit (QM) with the development of Systemic Quality Management and Quality Assurance teams. Prior to the formation of these teams, QM focused on member-specific quality-of-care concerns and investigations. These teams extended the Unit's capacity to support and conduct systemic quality management activities and quality-of-care investigations. Systemic referrals may come from a variety of sources, including data reports, internal and external partners, members, providers, etc. In SFY 2024, Quality Management triaged 445 quality-of-care referrals, 64% of which required QM action such as on-site visit and investigation, Memos of Concern, Corrective Action Plans, etc. Additionally, QM was able to review and close 129-member specific cases during this period.

Utilization Analysis

AHCCCS utilizes standardized performance measures to monitor MCO compliance with delivery of care standards. Performance measures may focus on clinical and non-clinical measures for both physical and behavioral health services. In SFY 2024, the primary cost drivers for high needs/high cost (HNHC) behavioral health members were inpatient care, followed closely by residential services, due to the intensity and complexity of care required. Additionally, there was a notable increase in the utilization of counseling,

professional services and applied behavioral analysis indicating more engagement with outpatient and therapeutic supports reflected in the decrease in the concurrent and retrospective reviews.

Table VI provides the most recent behavioral health utilization performance measure data, for CY 2023 (January 1, 2023, to December 31, 2023). AHCCCS calculates performance measures on the previous Calendar Year (CY) to align with the most current available federal fiscal year performance standards. The Statewide Aggregate for Use of Pharmacotherapy for Opioid Use Disorder demonstrated an increase from 54% in 2022 to 54.2% in 2023. The Use of First-Line Psychosocial Care for Children and Adolescents prescribed Antipsychotics also increased from 68.2% in 2022 to 70.3% in 2023. Arizona performed above the NCQA Medicaid mean in the performance measures.

Table VI – AHCCCS Performance Measure Data – Utilization of Services[1]

CY 2023 Behavioral Health Performance Measure Rates				
Performance Measure	**2023 NCQA Medicaid Mean[1]**	**ACC Aggregate**	**SMI Aggregate**	**Statewide[2] Aggregate**
Use of Pharmacotherapy for Opioid Use Disorder	N/A	58.9%	44.7%	54.2%
Use of First-Line Psychosocial Care for Children and Adolescents prescribed Antipsychotics	57.9%	70.4%	N/A	70.3%

AHCCCS utilizes national benchmark data (e.g., NCQA HEDIS ® Medicaid Mean) to evaluate Contractors' performance. In efforts to promote improvement in performance measure rates, AHCCCS requires Contractors to implement corrective action plans (CAPs) for measures not meeting the associated benchmarks.

High-Cost Beneficiaries

AHCCCS requires that MCOs actively coordinate care with members demonstrating high behavioral and physical health needs and/or high utilization costs. The MCO must develop criteria to identify members with high needs/high costs (HNHC), 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 their annual plan submissions.

AHCCCS maintains a behavioral health specific deliverable associated with AHCCCS Medical Policy Manual (AMPM) 1021 – Contractor Care Management. MCOs identified and tracked 2,745 behavioral health high-cost beneficiaries in SFY 2024. AHCCCS will continue to monitor future deliverable submissions to ensure data integrity and will provide additional technical assistance as warranted.

AHCCCS also requires the TRBHAs, through Intergovernmental Agreements (IGAs), to coordinate care and provide case management services, including TRBHA members identified as High Needs High Cost (HNHC). The HNHC program works to ensure the TRBHAs are partnering with the appropriate IHS/Tribal 638

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

facilities and FFS providers for the coordination of care for shared members. AHCCCS DFSM and the TRBHAs work together on a regular basis to identify members for inclusion in the HNHC program. Monthly member staffings are conducted for the sharing of information to inform member care, ensure appropriate services are identified for members, and to provide technical assistance and resources to support the TRBHA's coordination for their members. In SFY 2024, AHCCCS DFSM and the TRBHAs identified and oversaw care for 173 HNHC members.

Mortality Trends

AHCCCS obtains mortality data via an inter-agency agreement with the Arizona Department of Health Services (ADHS), which are classified by Manner of Death (MOD). "Accident" deaths are defined as unintentional and occurred when there was no intent to cause harm or death. "Homicide" deaths are defined as death resulting from injuries inflicted by another person with the intent to cause fear, harm, or death. "Natural", which are defined by ADHS as having occurred due to a medical condition. And "suicide" is defined as death that is due to a self-directed intentional behavior where the intent is to die because of that behavior.

In SFY 2024, 32.9% of determined manner of deaths for Arizona's child population were considered the result of a natural cause or the result of a medical condition.

Table VII - Mortality Trends – Child

Member Manner of Death SFY2024	TXIX	%	NTXIX	%	All Child	%
Accident	85	17.5%	3	30.0%	88	17.7%
Homicide	27	5.5%	0	0.0%	27	5.4%
Natural Death	160	32.9%	3	30.0%	163	32.8%
Pending Investigation	3	0.6%	0	0.0%	3	0.6%
Suicide	12	2.5%	0	0.0%	12	2.4%
Undetermined	33	6.8%	0	0.0%	33	6.6%
Unknown	167	34.3%	4	40.0%	171	34.4%
Total	**487**	**100.0%**	**10**	**100.0%**	**497**	**100.0%**

According to the Arizona Child Fatality Review 2024 report[3], Arizona's child mortality rate has remained relatively stable since 2014. The male child mortality rate is consistently higher than the female child mortality rate and most child deaths occur between the ages of birth – 27 days as the result of natural causes.

Table VIII presents a statewide total of 22,248 mortalities of adult members identified as General Mental Health and/or having a substance use disorder (GMH/SU). Natural death was the highest manner of death for this population, accounting for 14,307 or 64.3% of all deaths in SFY 2024. Accidents accounted for 2,531 deaths or 11.4%. Suicide was the manner of death for 427, or 1.9% of the overall deaths for this population.

[3] https://www.azdhs.gov/documents/prevention/womens-childrens-health/reports-fact-sheets/child-fatality-review-annual-reports/cfr-annual-report-2024.pdf

Table VIII – Mortality Trends - General Mental Health/Substance Use (GMH/SUD)

Member Manner of Death SFY2024	TXIX	%	NTXIX	%	All GMH/SU	%
Accident	2,220	12.4%	311	7.2%	2,531	11.4%
Homicide	236	1.3%	15	0.3%	251	1.1%
Natural Death	11,495	64.2%	2812	64.7%	14,307	64.3%
Pending Investigation	67	0.4%	8	0.2%	75	0.3%
Suicide	348	1.9%	79	1.8%	427	1.9%
Undetermined	103	0.6%	19	0.4%	122	0.5%
Unknown	3435	19.2%	1100	25.3%	4,535	20.4%
Total	**17,904**	**100.0%**	**4,344**	**100.0%**	**22,248**	**100.0%**

Table IX demonstrates that of the 1,679 mortalities for adult members with a Serious Mental Illness (SMI) designation, the manner of death was natural death for 866 members which equated to 51.6% of deaths, and accidents accounted for 388 or 23.1% of deaths. Suicide was the manner of death for 54 or 3.2% of deaths for these members in SFY 2024.

Table IX - Mortality Trends – Members with a Serious Mental Illness (SMI)

Member Manner of Death SFY2024	TXIX	%	NTXIX	%	All SMI	%
Accident	335	24.2%	53	17.9%	388	23.1%
Homicide	16	1.2%	2	0.7%	18	1.1%
Natural Death	708	51.2%	158	53.4%	866	51.6%
Pending Investigation	6	0.4%	5	1.7%	11	0.7%
Suicide	40	2.9%	14	4.7%	54	3.2%
Undetermined	27	2.0%	6	2.0%	33	2.0%
Unknown	251	18.1%	58	19.6%	309	18.4%
Total	**1,383**	**100.0%**	**296**	**100.0%**	**1,679**	**100.0%**

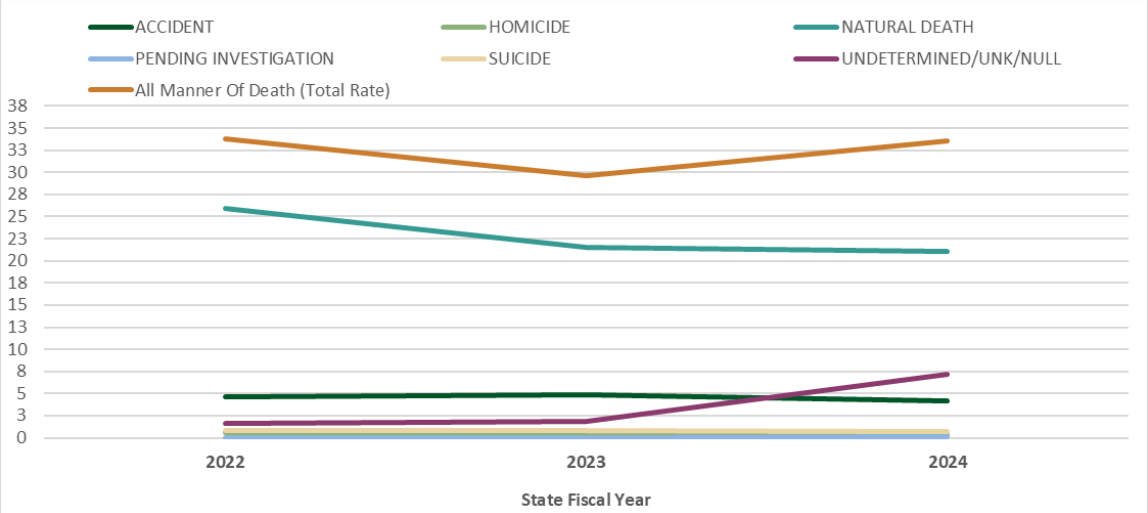
Table X illustrates statewide trends for death for all AHCCCS members receiving behavioral health services including Child, GMH/SU and SMI populations in SFY2024.

Table X - Mortality Trends – Statewide Behavioral Health Members

Statewide Manner of Death SFY2024	TXIX	%	NTXIX	%	All	%
Accident	2,640	13.4%	367	23.4%	3,007	12.3%
Homicide	279	1.4%	17	1.0%	296	1.2%
Natural Death	12,363	62.5%	2,973	66.6%	15,336	62.8%
Pending Investigation	76	0.4%	13	0.0%	89	0.4%
Suicide	400	2.0%	93	4.6%	493	2.0%
Undetermined	163	0.8%	25	3.3%	188	0.8%
Unknown	3,853	19.5%	1,162	1.1%	5,015	20.5%
Total	**19,774**	**100.0%**	**4,650**	**100.0%**	**24,424**	**100.0%**

Chart I and Table XI illustrate the mortality rate per 1,000 behavioral health members The natural death category demonstrated the highest rate per one thousand members for all behavioral health populations. Year over Year trends for mortality data based on manner of death demonstrate an increase in the total manner of death and those that are undetermined or unknown. AHCCCS will continue to monitor mortality and trends for these populations over time.

Chart I – SFY 2022-2024 BH Mortality Rate Per 1,000 - Manner of Death (MOD)[4]



[4] Mortality Rate denominator was adjusted to include all behavioral health members served during each SFY.

Table XI – SFY 2022-2024 BH Mortality Rate Per 1,000 - Manner of Death (MOD)

Mortality Rate per 1,000 BH Members	State Fiscal Year		
Manner of Death	2022	2023	2024
Accident	4.7	4.8	4.1
Homicide	0.6	0.6	0.4
Natural Death	26.0	21.5	21.1
Pending Investigation	0.0	0.0	0.1
Suicide	0.8	0.8	0.7
Undetermined/UNK/Null	1.7	1.8	7.2
All Manner of Death (Total Rate)	33.7	29.6	33.6
All Manner of Death (Total)	**23,315**	**21,535**	**24,424**

Placement Trends

A number of behavioral health treatment settings exist for members who qualify for AHCCCS or whose services are covered by state or federal grant funding. MCOs place a member in the least restrictive setting that is most appropriate for the level of care needed for the specific situation. These settings include[5]:

- Behavioral Health Residential Facility (BHRF):
  Residential services provided by an ADHS licensed behavioral health agency. These agencies provide a structured treatment setting with 24-hour supervision and counseling or other therapeutic activities under the clinical oversight of an on-site or on-call behavioral health professional for individuals experiencing behavioral health (including substance use) issues that limit their ability to be independent or causes the individual to require treatment to maintain or enhance independence.

- Therapeutic Foster Care:
  Therapeutic Foster Care services are a family-based placement option for individuals needing intensive support to remain in the community. Care is provided by a behavioral health therapeutic home to a member who is residing in their home 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 to assist the person to remain in a community setting, thereby avoiding residential, inpatient, or institutional levels of care.

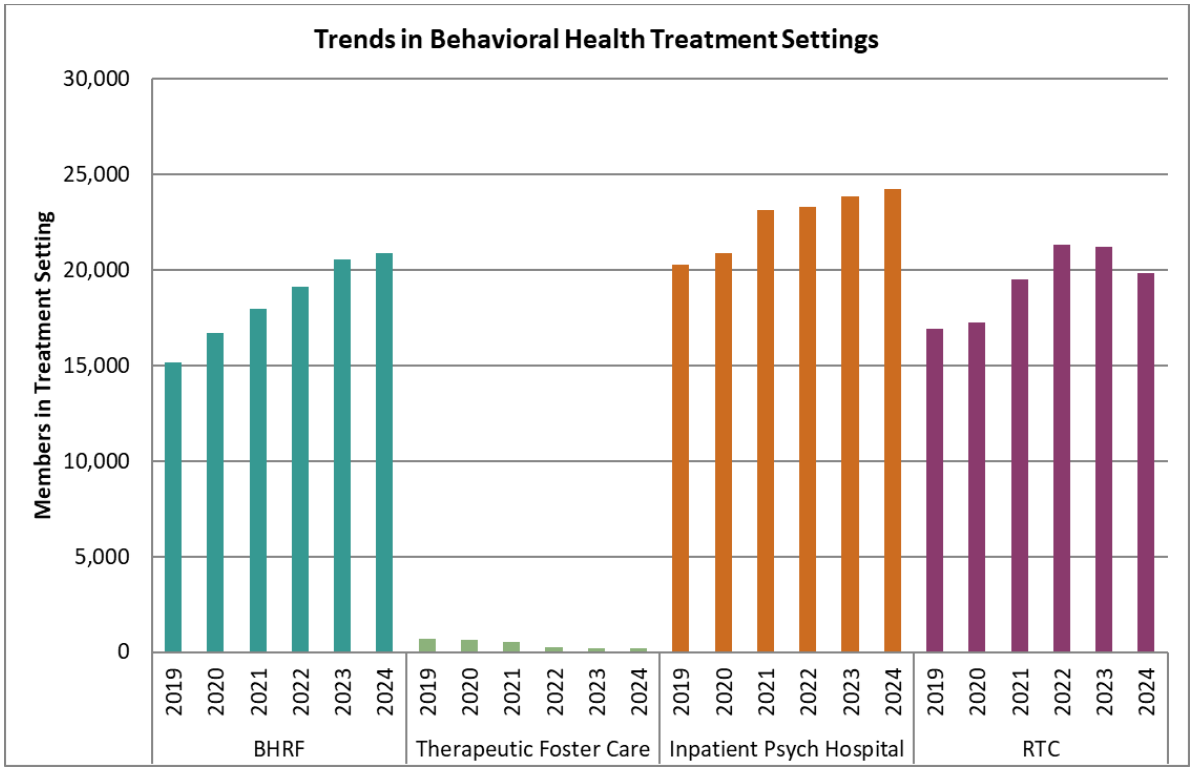
- Inpatient Psychiatric Hospitals:
  Inpatient services (including room and board) provided by an ADHS licensed behavioral health agency. These facilities provide a structured treatment setting with 24-hour supervision and an intensive treatment program, including medical support services.

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

[5] More details regarding these treatment settings can be found in Chapter 300 of the AHCCCS Medical Policy Manual.

Chart II provides a six-year history of behavioral health treatment settings for AHCCCS members. AHCCCS provides the data on a federal fiscal year / contract year basis (October 1 through September 30 annually).

Chart II – Trends in Behavioral Health Settings



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

Data reflects that an increasing number of members need both inpatient psychiatric hospital and BHRF level of care services. AHCCCS and its MCOs continue to recognize the ongoing need for increasing network capacity for BHRF services. AHCCCS supports efforts by the provider community to add beds in this treatment setting to meet the identified need. Some of the factors contributing to the need for additional BHRF admissions include:

- Members leaving jail and transitioning to medically necessary behavioral health care in the community to reduce recidivism by meeting the treatment needs for contributing mental health and substance use issues,
- Greater focus on substance use treatment, particularly for opioid use disorder to reduce opioid prescription drug misuse and abuse
- An overall increase in the severity of behavioral health symptoms warranting higher levels of care and extended support following hospitalization

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

- Ongoing collaboration with first responders, including expanded crisis intervention training to support police officers and emergency management service personnel (including 911

dispatchers) in diverting members to treatment for behavioral health related behaviors rather than a carceral setting,
- Continued focus on inpatient treatment for substance use disorders including opioid use disorder,
- Expanded capacity to identify individuals experiencing a behavioral health crisis (through 988 and national campaigns reducing the stigma related to seeking help),
- Increased access and management of crisis-related treatment statewide, including focus on specialized populations (children, adolescents, individuals with intellectual/developmental disabilities).
- An overall increase in the severity of behavioral health symptoms warranting higher levels of care for safety and stabilization

Program Integrity

Program integrity is an agency wide responsibility. Program integrity activities are meant to ensure that federal and state taxpayer dollars are spent appropriately on delivering quality, necessary care and preventing fraud, waste, and abuse from taking place. Within AHCCCS, several divisions have program integrity responsibilities; Division of Member and Provider Services (DMPS), Division of Fee for Service Management (DFSM), Division of Managed Care (DMC), the Office of General Counsel (OGC) and Office of the Inspector General (OIG) to name a few. The OIG responsibilities are specific to fraud, waste, and abuse.

OIG

OIG is specifically responsible for the integrity of the AHCCCS budget, approximately $21 billion in State Fiscal Year 2024, by preventing, detecting, and recovering improper payments due to Medicaid fraud, waste, and abuse. Fraud and abuse are both defined in Medicaid regulations (42 CFR 433.304 and 42 CFR 455.2). Fraud involves intentional deception, such as billing for services that were never provided. Abuse includes taking advantage of loopholes or bending the rules, such as improper billing practices. Waste, which is not defined in federal Medicaid regulations, includes inappropriate utilization of services and misuse of resources. An example would be duplication of tests that can occur when providers do not share information with each other. Waste is not a criminal or intentional act but results in unnecessary expenditures to the Medicaid program that might be prevented. At the end of SFY 2024, AHCCCS had 2,204,281 beneficiaries, 100,512 providers, 53 OIG investigators, and 7 Auditors with which to combat fraud, waste and abuse. OIG achieved $68.3 million in recoveries and $250.3 million in savings, totaling $318.6 million for the period.

OIG's program integrity activities continued its focus on behavioral health services due to the fraud presently occurring in Arizona during SFY 2024. OIG has continued to develop its previously reported behavioral health cases and investigations [see previous Behavioral Health Reports: SFY23, SFY22, SFY21, SFY20].

Credible Allegations of Fraud

Under 42 C.F.R. § 455.23 and the terms of the Provider Participation Agreement, AHCCCS may suspend payments to a provider if a Credible Allegation of Fraud (CAF) has been identified. Providers are informed

of the reason for their suspension in a Notice of CAF Suspension. CAF suspensions are based on preliminary findings of reliable indicia of fraud and may be lifted if AHCCCS determines there is no fraud occurring and/or good cause has been established under 42 C.F.R. § 455.23. Since first reporting the behavioral health fraud schemes for this report in SFY 2020, OIG has instituted more than 418 Credible Allegation of Fraud payment suspensions.

As a part of a CAF Suspension, a provider can submit written evidence to AHCCCS showing that good cause exists to remove the suspension in whole or in part. This includes written evidence or documents that would refute any evidence of fraud. The provider also has the option to request a state fair hearing if they disagree with the action specified in their Notice of Suspension. Finally, if the provider requests a state fair hearing, they may also request an informal settlement conference. OIG staff are extremely dedicated to each of these items and the correlating in-depth reviews necessary to perform these complex tasks. Good cause reasons must be reviewed by the Office of General Counsel (OGC) and presented and discussed by Executive Management. A state fair hearing may result in a hearing with the fraud investigator, supervisor, and sometimes other staff within various divisions of AHCCCS. This requires preparation for testimony, review of all relevant facts and issues surrounding the CAF, and then appearance and testimony at the hearing, which can take several hours to several days, depending on the case. If a provider submits documentation in which they feel OIG should consider refuting their CAF, this requires the investigator to review the documentation in relation to the evidence identified in the CAF and present it to the individuals responsible for CAF approval. This process is extremely laborious and can happen multiple times for each provider. As a result of these processes, 114 CAF's have been rescinded after providers submitted written evidence explaining their conduct. 115 Informal Settlement Conferences (ISC's) have been held between providers and OIG as part of the provider's appeal process and rights. During an ISC, a provider has the ability to present evidence to refute the action taken against them. OIG has also had 46 state fair hearings in which the result was that the suspension of payment action against the provider would remain in effect.

OIG has two main sections; Fraud Support and Recovery (FSRS) and Investigations. OIG Fraud Support and Recovery section is responsible for a variety of post pay audit functions, Deficit Reduction Act audits and compliance, Program Integrity Operational Review of AHCCCS Managed Care Organizations, collecting and processing payments for OIG cases, and several divisional administrative functions. OIG Investigations encompasses Provider and Member Compliance investigative teams, the OIG Forensic Accounting team, and participation in several agency cross collaborative projects.

Due to the volume of CAF suspensions and items requiring quick resolution by AHCCCS, OIG had to develop a global approach by which each case is reviewed for any and all agency administrative action. For example, identification of a provider's preliminary overpayment and/or calculation of any potential Civil Monetary Penalties would be part of the assessment. Additional actions include reviews for any terminations, exclusions, rescissions and/or removal from any AHCCCS systems. Any agency administrative action issued automatically includes appeal rights and other due process information.

Facility Site Visits

During SFY 2024, AHCCCS OIG completed site visits of 417 behavioral health facilities registered under the following provider types – B8 (Behavioral Health Residential Facilities), 77 (Behavioral Health Outpatient Clinics), IC (Integrated Clinics) and 01 (Group-Payment ID). Site visits involved a visual inspection of the property, including pictures, video and audio, when appropriate. Teams of at least two (2) investigators conducted the site visits using questionnaires designed to assist in uncovering Fraud, Waste and Abuse (FWA) and Quality-of-Care (QOC) concerns. Any QOC concerns uncovered during site visits were provided daily to the Deputy Inspector General and Deputy Assistant Director and ultimately submitted to the AHCCCS Quality Management team. Appropriate referrals were also made to other agencies (Arizona Department of Health Services, Arizona Attorney General's Office, local Police Departments, etc.), when applicable. Of the 417 behavioral health site visits completed, 162 had FWA concerns while 66 had QOC concerns.

Investigators also compiled a list of 597 AHCCCS providers and employees of AHCCCS providers who may have been inappropriately receiving Medical Assistance benefits and/or Supplemental Nutrition Assistance Program benefits. The list of 597 names was sent to AHCCCS OIG Member Compliance Section (MCS) for further investigation into possible beneficiary FWA.

Member AIHP Investigations

While conducting these site visits, investigators encountered members receiving behavioral health services under the American Indian Health Program (AIHP). In situations where preliminary evidence appeared to indicate members were inappropriately enrolled under AIHP or may have been transferred to AIHP without their consent, their information was forwarded to AHCCCS OIG's Member Compliance Section (MCS) for further investigation. MCS coordinated with the AHCCCS Office of Communications Advocacy Resolution and Enrollment (OCARE) to correct member enrollments who were transferred incorrectly from AHIP to a Managed Care Organization (MCO). MCS investigated a total of 126 instances of possible inappropriate AIHP transfers, and, in coordination with OCARE, reversed 70 members from AIHP to an MCO. These corrections ensure members are receiving proper care coordination and services within the MCOs to which they are correctly assigned.

OIG Fraud Support and Recovery

The OIG received 7,772 incoming referrals, scanned and archived 139,870 pages of documents, and generated 1,485 outgoing letters. Additionally, OIG collectors processed 1,618 payments totaling $10,604,252 from member and provider cases.

The OIG reviewed 548 provider audits conducted by Managed Care Organizations (MCO), of which 231 were exclusive to behavioral health. Four MCO Operational Reviews were conducted by OIG staff, to include behavioral health. OIG staff conducted 264 credit balance reviews performed by a contractor, to include behavioral health. The OIG completed 19 Deficit Reduction Act (DRA) audits and 209 beneficiary date of death (DoD) audits, 18 of which were behavioral health related. OIG confirmed that Solari, which is a contractor exclusive to behavioral health, completed 4,357 employee and 3,577 vendor exclusion checks. These were conducted monthly and were submitted and reviewed quarterly during SFY2024.

Additionally, OIG completed an FQHC (Federally Qualified Health Center) provider audit of a facility and their seven clinics.

OIG performed post payment audits on several areas which also included behavioral health providers.

- The Targeted Investments Program (TI 2.0) aligns with AHCCCS' strategic plan and Arizona's Section 1115 Waiver to support and incentivize providers to develop and enhance comprehensive whole person care systems that effectively address the social risk factors that adversely affect health. Eligible Medicaid provider organizations that meet certain benchmarks will receive financial incentives through managed care plans for developing infrastructure and protocols to optimize coordination of services designed to meet the member's acute, behavioral, and health-related social needs (HRSN) and address identified health inequities among their patient population.
    - 71 Targeted Investments (TI) audits were conducted, and the development of the TI 2.0 audit strategy began.
- The American Rescue Plan Act (ARPA) incentive program was initiated, and five audits were completed. 74 inpatient post payment audits were completed that resulted in $314,565 in recoupments identified.
- The Electronic Health Record (EHR) incentive program post pay audit was complete, finishing 5 audits during SFY 2024.

The OIG began performing non-criminal second level medical reviews of applicants applying to become AHCCCS Providers. In SFY 2024, OIG completed a review of 597 applicants. The Non-Criminal 2nd Level Medical reviews consisted of researching Arizona's MMIS system, the Arizona Corporation Commission (State business registry), the OIG case management system for past and current fraud, waste, and abuse investigations, AHCCCS terminated and suspended provider list, List of Excluded Individuals and Entities (LEIE), System for Awards Management (SAM), National Provider Identifier (NPI) registry, and the Arizona Department of Health Services (State Licensing), as well as other internal flags. OIG trained DMPS on how to conduct these same reviews during the provider registration processes. OIG continues to partner with DMPS and OGC to review any items or concerns.

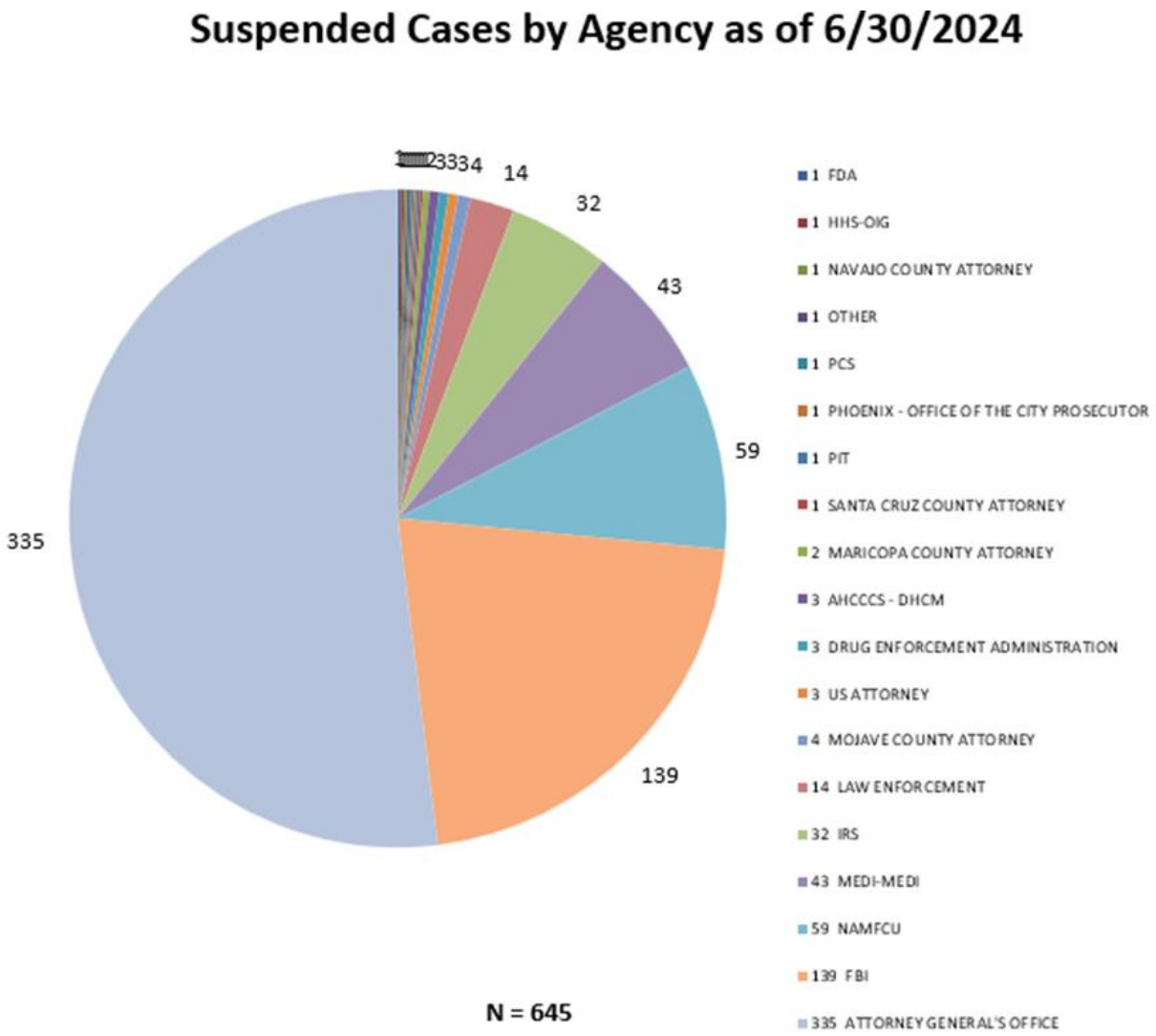
OIG Investigations

As of the end of SFY 2024, OIG had 1,051 active behavioral health related cases and 316 cases with various law enforcement agencies in suspended status. Also, as of the end of SFY 2024, OIG had completed 1,023 behavioral health related cases.

Of the 1,051 active cases:

- 283 are Behavioral Health Residential Facilities
- 400 are Behavioral Health Outpatient Clinics
- 82 are Integrated Clinics
- 100 are Group Providers
- 10 are Hotels
- 13 are Community Service Agencies
- 163 are other Provider Types

Chart III – Suspended Cases by Agency



OIG behavioral health cases in the news for investigations involving SFY 2024 include:

- Two Arizonans plead guilty to fraud targeting AHCCCS
- Mesa Business Owner Who Exploited the American Indian Health Plan Sentenced to Over 5 Years for AHCCCS Fraud
- Scammers took billions in taxpayer money through biggest fraud in Arizona history. Here's how
- Attorney General Mayes Announces Fraud Charges Against Owners and Biller of Behavioral Health Facility
- Valley man who AG says used fake degree to pose as psychologist sentenced to 1.5 years in prison
- San Tan Valley suspect accused of defrauding $55 million out of AHCCCS
- In a first, person convicted in massive Arizona Medicaid fraud scheme sentenced to prison time
- Man who made millions defrauding AZ's Medicaid in rehab scheme gets probation
- Arizona nurse facing new charges connected to targeting sober living home residents
- Seven Charged in Arizona as Part of the Department of Justice's 2024 National Health Care Fraud Enforcement Action

Internal Agency Collaboration

Internally, OIG has maintained its extensive cross divisional reporting with different AHCCCS divisions, including but not limited to; AHCCCS Division of Fee for Service Management (DFSM), AHCCCS Division of Managed Care (DMC), AHCCCS Division of Business and Finance (DBF), AHCCCS Information Services Division (ISD), and the AHCCCS Division of Member and Provider Services (DMPS). Subject matter experts' contributions from each of these areas have helped OIG perform comprehensive fact findings, gather evidence, and develop investigative leads.

OIG has continued to be an integral part of internal workgroups to further develop AHCCCS policies, including the AHCCCS Covered Behavioral Health Services Guide (CBHSG), the Coding and Benefits Review Committee (CBRC), and new provider type groups like Counseling Facilities (CF). OIG has also continued to offer feedback and guidance on policy updates that were undergoing revisions during SFY24.

In addition to the above items, OIG has worked with OGC to develop a state exclusion policy, which allows OIG to issue exclusion actions pursuant to A.R.S. § 36-2930.05 and A.A.C. § R9-22-1802. As a result of this, OIG has been able to issue state exclusions for providers who meet any basis in the authorities above.

OIG works closely with the Quality Management Team (QM) and frequently accompanies QM on provider site visits. Information from the site visit is used for a variety of issues to include health and safety, member safety, and fraud, waste and abuse issues. Working as a team and attending site visits together allows one visit rather than multiple visits for the various disciplines within AHCCCS.

As with other years, OIG continued to share its data throughout SFY24 with AHCCCS. Several training courses with AHCCCS divisions, AHCCCS vendors, and even CMS occurred with OIG sharing how it identifies aberrant billing behaviors or potential fraud.

As a result of the cross divisional reporting by OIG and other AHCCCS divisions, several key policy changes were made within AHCCCS during SFY 24 and into SFY 25:

- Effective with dates of service beginning February 17, 2023, provider types (77) Behavioral Health Outpatient Clinic and (IC) Integrated Clinics submitting claims to AHCCCS Division of Fee for Service Management must list a single claim line for each date of service equal to one (1) day of service, CPT/ HCPCS code and the total units for each line of service
- The rate for previous By-Report code H0015 - Alcohol and/or drug services; intensive outpatient is set at $157.86, effective 5/01/2023.
- Effective with claims received on and after May 3, 2023, Fee-For-Service providers billing more than 8 units of specific HCPCS codes in one day are required to provide the following documentation with the submission of the claim; a copy of the most recent comprehensive assessment, treatment plan, and the medical record documentation for the service billed on the service date.
- Effective June 9, 2023, a Provider Moratorium was issued for Behavioral Health Outpatient Clinic (77), Integrated Clinic (IC), Non-Emergency Medical Transportation (28), Community Service Agency (A3) and Behavioral Health Residential Facility (B8). The behavioral health provider moratorium concluded on December 9, 2024. Providers were instructed that any previously submitted applications from providers who were subject to the moratorium (prior to 12/09/2024) will be processed through the moratorium requirements and will require a moratorium

exemption form. While the behavioral health provider moratorium is no longer in effect, provider types identified as high-risk would still need to go through heightened provider enrollment requirements.

- Claims billed with the HCPCS code H2016 (Comprehensive Community Support Services, per diem) and H0038 (Self-Help/ Peer Services per 15 minutes) that are billed on the same date of service will automatically deny with the denial edit L237.4 "Service Not Allowed On The Same Day".
- Effective for dates of services beginning December 1, 2023, provider type B8 Behavioral Health Residential Facility (BHRF) must submit claims with Place of Service (POS) code 56 "Psychiatric Residential Treatment". This change will impact claims billed with HCPCS code H0018 only. This change applies to BHRF providers that are behavioral health and or substance use disorder providers.
- Intensive Outpatient Program (IOP) Coding Clarification:
    - A memo was sent to all contracted health plans to alert them of a concern regarding the use of H0015 and S9480 for Intensive Outpatient Program (IOP) services. AHCCCS became aware of a shift in these codes' utilization and concerns that providers billing S9480 do not meet the requirements for this level of service.
    - Providers billing S9480 for intensive outpatient psychiatric services must meet the minimum requirements as described below:
        - **A.** Treatment shall consist of a minimum of 9 hours of service per week, a minimum of 3 hours per day, conducted on at least 2 days and shall include, but is not limited to the following;
            - 1 session with the members treating Psychiatric Provider (Behavioral Health Medical Practitioner-BHMP) per week, and
            - 1-3 individual counseling sessions with a BHP, no less than 50 minutes in duration, per week, and
            - 2 group counseling sessions, no less than 50 minutes in duration, per week.
        - **B.** A BHMP shall be available on-site at least 80% of the time during IOP Program operation, and
        - **C.** BHP Caseloads shall not exceed 16 active members, and
        - **D.** Group sessions shall include no more than 8 members and be facilitated by a BHP, and
        - **E.** Intensive outpatient psychiatric services focused on the treatment of substance use and co-occurring disorders shall be consistent with the American Society of Addiction Medicine (ASAM) Criteria (3rd edition) level 2.1.
- Providers billing H0015 for intensive outpatient alcohol and/or drug services provide substance use disorder and cooccurring treatment, in alignment with ASAM Criteria, 3rd Edition, level 2.1, must meet the minimum requirements as described below:
    - A. Services may include individual and group counseling, medication management, family therapy, educational groups, occupational and recreational therapy, and peer support.
    - B. Services are provided in amounts, frequencies, and intensities appropriate to the treatment plan's objectives.
    - C. Treatment shall consist of a minimum of 9 hours of service a week, conducted for at least 3 hours a day and at least 3 days a week.

- Beginning October 2023, OIG began assisting DMPS with the Community Partner Assistor Organization (CPAO) Program. This consists of OIG reviewing applications for organizations and individuals, both of which participate in the CPAO program, as well as reviewing background

information to determine eligibility to participate in the program. OIG has reviewed over 100 Community Partner Assistor Organizations and 340 Community Partner Assistors. Reviewed results from OIG result in approvals or denials. Reasons for denials could include criminal background history discovered, conflict of interest identified, failure to disclose other items, unable to confirm employment/volunteer status, etc.

- Effective December 2023, Billing code H2016 and H0038 on the same day should deny.

Behavioral Health Services Billing and Coding H2016 and H0038
Same Day Billing Denial Edit L237.4

Claims billed with the HCPCS code H2016 (Comprehensive Community Support Services, per diem) H0038 (Self-Help/Peer Services per 15 minutes) that are billed on the same date of service will automatically deny with the denial edit **L237.4 "Service Not Allowed On The Same Day".**

Arizona Health Care Cost Containment (AHCCCS) for purposes of consideration for behavioral health services, per billing and policy may use American Medical Association Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS) or other procedure coding guidelines. References to CPT or other sources are for definition purposes only and do not imply any right to reimbursement.

- Effective February 6, 2024, billing multiple behavioral health per diem codes on the same date of service is not allowed.

February 6, 2024

Billing Clarification
Behavioral Health Per Diem Service Codes

The Division of Fee for Service Management of Arizona Health Care Cost Containment System is providing the following billing clarification for behavioral health services reimbursed on a per diem basis for members of the American Indian Health Program.

Per diem behavioral health services are reimbursed with a per-day bundled rate intended to cover all related routine behavioral health services. Billing multiple behavioral health per diem service codes on the same day is not allowed.

- As of March 1, 2024, date span billing for Behavioral Health Residential Facilities (BHRF) is prohibited.
- Clarification of Intensive Outpatient Program (IOP) H0015 and S9490 Intensive Outpatient PSYCHIATRIC Program dated March 25, 2024:

DATE: March 25, 2024

SUBJECT: Intensive Outpatient Program (IOP) Coding Clarification

This memo is being sent to all contracted health plans to alert you to a concern that has come to the attention of AHCCCS regarding the use of H0015 and S9480 for Intensive Outpatient Program (IOP) services. AHCCCS has become aware of a shift in the utilization of these codes and concerns that providers who are billing S9480 do not meet the requirements for this level of service.

Providers billing S9480 for intensive outpatient psychiatric services must meet the minimum requirements as described below:

A. Treatment shall consist of a minimum of 9 hours of service per week, a minimum of 3 hours per day, conducted on at least 2 days and shall include, but is not limited to the following;

i. 1 session with the members treating Psychiatric Provider (Behavioral Health Medical Practitioner-BHMP) per week, and
ii. 1-3 individual counseling sessions with a BHP, no less than 50 minutes in duration, per week, and
iii. 2 group counseling sessions, no less than 50 minutes in duration, per week.

B. A BHMP shall be available on-site at least 80% of the time during IOP Program operation, and
C. BHP Caseloads shall not exceed 16 active members, and
D. Group sessions shall include no more than 8 members and be facilitated by a BHP, and
E. Intensive outpatient psychiatric services focused on the treatment of substance use and co-occurring disorders shall be consistent with the American Society of Addiction Medicine (ASAM) Criteria (3rd edition) level 2.1.

Providers billing H0015 for intensive outpatient alcohol and/or drug services provide substance use disorder and co-occurring treatment, in alignment with ASAM Criteria, 3rd Edition, level 2.1, must meet the minimum requirements as described below:

A . Services may include individual and group counseling, medication management, family therapy, educational groups, occupational and recreational therapy, and peer support.
B. Services are provided in amounts, frequencies, and intensities appropriate to the objectives of the treatment plan.
C. Treatment shall consist of a minimum of 9 hours of services a week, conducted for at least 3 hours a day and at least 3 days a week.

- ID.me required for billers as of January 4, 2024:

AHCCCS Adds ID.me Security to Provider Portal

New feature will verify user identity

PHOENIX – Beginning Jan. 4, 2024, AHCCCS will implement another layer of security on its provider portal, AHCCCS Online, by requiring all users to register with ID.me.

ID.me is a federally-certified identity verification vendor specializing in digital identity protection. ID.me provides secure identity proofing, authentication, and group affiliation verification for government and businesses. It is a secure, online service available 24 hours a day and can be accessed on a computer, tablet, or smartphone. Many federal and state government agencies, including the Social Security Administration and the Arizona Department of Economic Security, rely on ID.me to ensure timely services while maintaining the integrity of public programs funded by taxpayers.

AHCCCS will use ID.me to verify user identity in the AHCCCS Online portal. This is one of many steps AHCCCS has taken this year to ensure program integrity and eliminate fraudulent Medicaid billing.

Upon logging in to AHCCCS Online on or after Jan. 4, users will see an additional screen and be asked to verify identity with an ID.me account. From that screen, they can log in to their existing ID.me account, or create one if they haven't already done so.

OIG Continued Projects

- OIG and the Arizona Department of Health Services (ADHS) worked collaboratively during SFY 2024. ADHS is an agency in the State of Arizona established to promote and protect public health and welfare through the operation of health-related programs within the state. The shared information and partnerships lead to the development of a memorandum of understanding (MOU) between our two agencies. While the executed MOU fell outside of the period for SFY 2022, the groundwork leading to this agreement started during this time and continued into SFY 2024. The development of information sharing between OIG and ADHS has proven essential and continues to expand. ADHS now sends closure information on all relevant licensure types to OIG in real time as they take place, which allows OIG to take immediate action and terminate providers who are no longer licensed and do not self-report those to AHCCCS.
    - In SFY 2024, due to the continued collaboration with ADHS, who reports license closures and revocations to AHCCCS, OIG terminated 183 providers for no longer being licensed, and failing to report their closures to AHCCCS. As a result, AHCCCS recognized significant savings of $146,071,511.
- During SFY 2024, OIG developed a partnership with the Arizona State Board of Nursing through an MOU to share investigative leads and referrals between the two agencies. This partnership has allowed the agencies to share information without concern of jeopardizing ongoing investigations.
- Aside from the focus of entities involved in potential behavioral health fraudulent items, OIG has repeatedly identified Behavioral Health Professionals (BHP) as being an integral part of the suspected fraud concerns. OIG identified a need to expand its manual licensing review project into different provider types that encompass BHPs. OIG Strikeforce investigators initiated a review of approximately 3,500 providers within three behavioral health provider types: 85 (Licensed Clinical Social Workers), 86 (Licensed Marriage and Family Therapists), and 87 (Licensed Professional Counselors). The review generated a list of 70 providers for termination, possible termination, recategorization and/or possible recoupment. The 70 providers were separated into the following four areas of concern:
    - Expired / suspended / revoked licenses
    - Out-of-state licensees performing services in Arizona and/or associated with non-638/IHS facilities, who provided services after the end of the Covid-19 Public Health Emergency
    - Associate-level licensees incorrectly registered (only independent-level licensees can register with AHCCCS)
    - Inactive licenses / miscategorized provider classifications / licensure restrictions not addressed

The evidence gathered by investigators is being prepared for presentation to AHCCCS' Executive Management team to appropriately effectuate the termination, exclude, or perform any other administrative actions, of any BHP who is deemed to be in violation of their Provider Participation Agreement. AHCCCS performs reviews to ensure access to care issues and member impacts are mitigated to the greatest extent possible.

External Partnerships

The Arizona Attorney General's Office, Health Care Fraud and Abuse Section (AZ AGO HCFA), the Federal Bureau of Investigation (FBI), the Internal Revenue Service Criminal Investigations Unit (IRS), the United

State Attorney Office (USAO), and the Health and Human Service Office of Inspector General (HHS OIG) have all participated in the joint fight against fraud, waste and abuse.

OIG staff are a crucial component to the law enforcement agencies working to combat the criminal components of the fraud enterprises within the behavioral health system. OIG staff have consistently provided partnerships on search warrants and operations that detected, uncovered, and prevented additional and on-going fraudulent activities. The specific knowledge of OIG staff was critical to support the investigative needs of the agency and assist law enforcement partners in these joint endeavors. SFY 2024 was truly an all-hands-on deck approach to help combat the fraud in the Arizona behavioral health system and protect the integrity of the AHCCCS system and taxpayer dollars from these fraudulent schemes. The support OIG staff provide is nowhere near the amount of investigative and prosecutorial efforts put forth by the law enforcement agencies below.

As it relates to behavioral health cases, from 01/01/2020 to current, Arizona has achieved the following results:

AZ AGO HCFA

- Indictments: 128 Persons and Entities
  - Of 128 indictments, there have been 60 convictions attributed to a direct case referral from AHCCCS OIG. The remaining 68 cases are moving through the adjudication process.
- Charges on these cases include, but are not limited to:
  - Fraud Schemes and Artifices
  - Consideration for referral of a patient (Patient Brokering)
  - Illegal Control of an Enterprise
  - Theft
  - Conspiracy
  - Forfeiture/Seizure: Approximately $136 Million + Real Property (i.e. residence, office building, vehicles, other assets pending values)
  - Approx $96 Million in Forfeiture
  - Approx $40 Million in Seizure

FBI

- Five (5) individual indictments with 2 convictions

IRS

- Four (4) individual indictments with 1 conviction

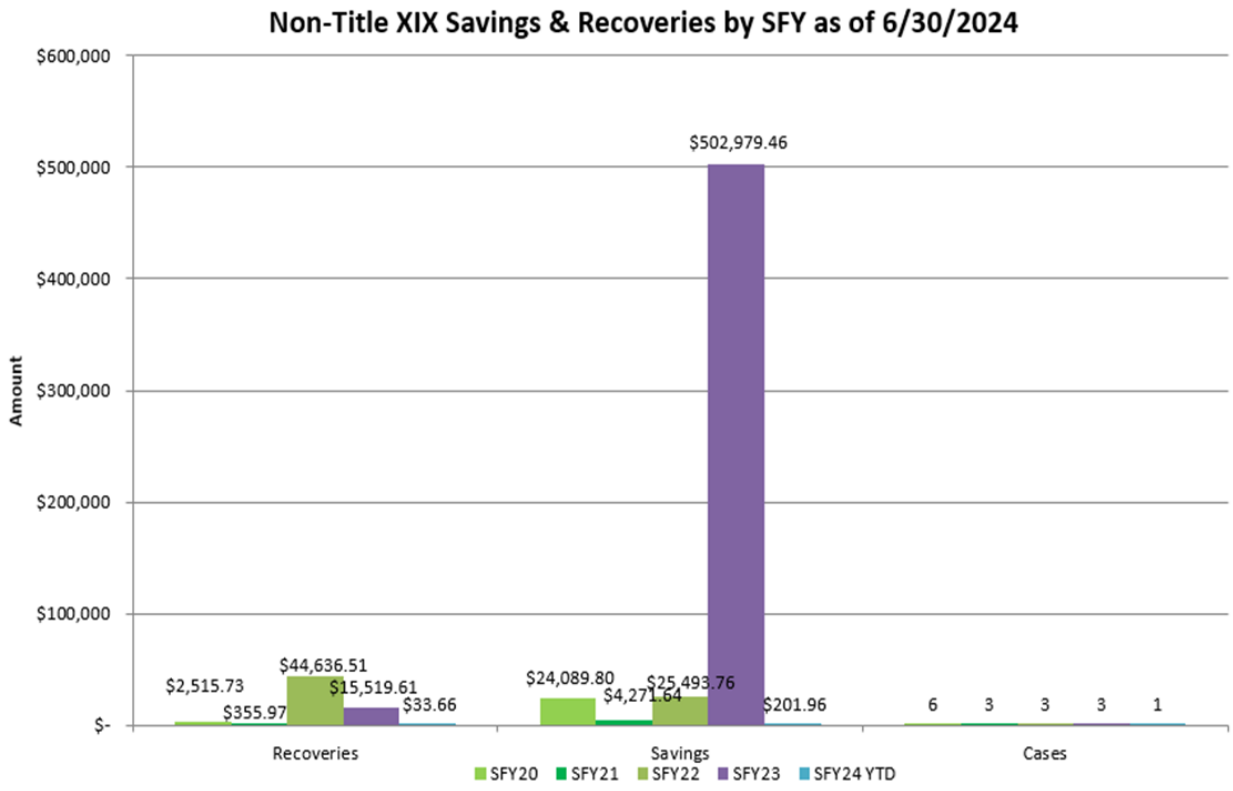
Aside from the joint investigations, AHCCCS OIG and AZ AGO HCFA have partnered to train CMS on how the fraud schemes are identified in the Arizona claims and encounter data for items such as ghost billing, duplicative and unbundled services, impossible service scenarios, and other highly suspected fraud patterns so that these items can be nationally identified.

Arizona has also proactively shared knowledge of the behavioral health fraud schemes on national platforms, such as a joint presentation by AHCCCS OIG and AZ AGO HCFA titled *Using Arizona's Financial Remedies, Including Asset Seizure and Forfeiture, In Public Agency Fraud Cases: Criminal, Civil, Administrative, Regulatory, and All Other Aspects.* AHCCCS OIG, AZ AGO HCFA, and HHS OIG also co-presented at the National Native American Law Enforcement Association Training Conference on

Unlicensed Fraud: Preying on our Vulnerable Community Members through Behavioral Health Exploitation.

The National Association of Medicaid Program Integrity (NAMPI) reaches an audience of all 50 states, U.S. territories, several federal audiences such as CMS, HHS OIG, and the Veterans Administration, MFCUs from different states, and a variety of national health plans. Arizona has, and continues to have, an active footprint in sharing information via this national platform since 2022 to ensure other states have awareness about the behavioral fraud schemes, patient impacts, and how they can partner with the different levels of law enforcement in their state structures. All of these agencies - AHCCCS OIG, AZ AGO HCFA, FBI, and IRS - have continually offered and participated in discussions with other states and groups about behavioral health fraud schemes.

Chart IV – Non-Title XIX Savings and Recoveries by SFY



In addition to Title XIX (Medicaid), AHCCCS also pays monies out through NTXIX (non-Medicaid) supplemental services. Most behavioral health services that are covered through Title XIX/XXI funding are also covered through Non-Title XIX/XXI funding including residential, counseling, case management, and support services, but may be limited to certain priority population members, as shown in AHCCCS Medical Policy Manual (AMPM) Exhibit 300-2B, and are not an entitlement. OIG achieved $201.96 in NTXIX savings and recoveries during SFY23. NTXIX is an area of focus OIG has identified for investigation and audit expansion activities.

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

ACC Behavioral Health Outpatient/Integrated Clinics (Adults)							
SFY 2024							
County/Requirement	Mercy Care (A)	Health Choice Arizona (A)	Arizona Complete Health - South (A)	Banner UFC (A)	Arizona Complete Health – North (A)	Molina Complete Care (A) *	United Health Care (A)
Maricopa - 90% within 15 min or 10 miles	99.0%	98.6%	99.3%	99.3%		62.7%	99.3%
Pima - 90% within 15 min or 10 miles			99.2%	97.2%			97.5%
Apache - 90% within 60 miles		88.1%			80.0%		
Coconino - 90% within 60 miles		97.8%			99.0%		
Gila - 90% within 60 miles	100%	100%	100%	100%		70.1%	100%
Mohave - 90% within 60 miles		100%			99.9%		
Navajo - 90% within 60 miles		86.0%			95.1%		
Yavapai - 90% within 60 miles		99.7%			100%		
Yuma - 90% within 60 miles			100%	100%			
Pinal - 90% within 60 miles	100%	100%	100%	100%		100%	100%
Cochise - 90% within 60 miles			100%	100%			
Santa Cruz - 90% within 60 miles			100%	100%			
Graham - 90% within 60 miles			100%	100%			
La Paz - 90% within 60 miles			100%	100%			
Greenlee - 90% within 60 miles			100%	99.7%			

**Molina: In CYE2024 Molina data included decreased numbers of providers used to measure the above standard compared to prior submissions. Molina indicated the reduction was a result of a coding error in how the system identifies providers, resulting in failure to report its complete network.*

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

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

ALTCS EPD and DDD Behavioral Health Outpatient/Integrated Clinics (Adults)					
SFY 2024					
County/Requirement	Banner University (L)	Mercy Care (L)	United Health Care (L)	Mercy Care (D)	United Health Care (D)
Maricopa - 90% within 15 min or 10 miles	99.6%	99.5%	98.2%	98.2%	99.1%
Pima - 90% within 15 min or 10 miles	98.1%	99.2%		96.9%	98.1%
Apache - 90% within 60 miles			95.2%	63.5%	66.8%
Coconino - 90% within 60 miles			93.6%	94.1%	81.4%
Gila - 90% within 60 miles	100%	100%	100%	100%	100%
Mohave - 90% within 60 miles			98.8%	100%	96.3%
Navajo - 90% within 60 miles			99.4%	100%	94.4%
Yavapai - 90% within 60 miles			100%	100%	99.9%
Yuma - 90% within 60 miles	100%			100%	100%
Pinal - 90% within 60 miles	100%	100%	100%	100%	100%
Cochise - 90% within 60 miles	100%			100%	100%
Santa Cruz - 90% within 60 miles	100%			100%	100%
Graham - 90% within 60 miles	100%			100%	100%
La Paz - 90% within 60 miles	100%			100%	100%
Greenlee - 90% within 60 miles	100%			100%	100%

Mercy Care DD: Mercy Care's data included substantially increased numbers of providers used to measure the above standard in comparison to previous submissions. Mercy Care indicated that it inadvertently included home office addresses in its report of service address, potentially influencing the validated compliance for the measured category.

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

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

ACC BH Outpatient/Integrated Clinics (Pediatric)							
SFY 2024							
County/Requirement	Mercy Care (A)	Health Choice Arizona (A)	Arizona Complete Health - South (A)	Banner UFC (A)	Arizona Complete Health - North(A)	Molina Complete Care (A)	United Health Care (A)
Maricopa - 90% within 15 min or 10 miles	99.0%	98.8%	99.3%	99.3%		70%	99.4%
Pima - 90% within 15 min or 10 miles			99.4%	97.2%			97.7%
Apache - 90% within 60 miles		88.9%			75.1%		
Coconino - 90% within 60 miles		96.5%			98.5%		
Gila - 90% within 60 miles	100%	100%	100%	100%		62.9%	100%
Mohave - 90% within 60 miles		100%			99.9%		
Navajo - 90% within 60 miles		95.1%			92.5%		
Yavapai - 90% within 60 miles		99.8%			100%		
Yuma - 90% within 60 miles			100%	100%			
Pinal - 90% within 60 miles	100%	100%	100%	100%		100%	100%
Cochise - 90% within 60 miles			100%	100%			
Santa Cruz - 90% within 60 miles			100%	100%			
Graham - 90% within 60 miles			100%	100%			
La Paz - 90% within 60 miles			100%	100%			
Greenlee - 90% within 60 miles			100%	99.6%			

^Molina: In CYE2024 Molina data included decreased numbers of providers used to measure the above standard compared to prior submissions. Molina indicated the reduction was a result of a coding error in how the system identifies providers, resulting in failure to report its complete network.

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

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

ALTCS EPD and DDD Behavioral Health Outpatient/Integrated Clinics (Pediatric)					
SFY 2024					
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	97.7%	98.5%	98.7%	98.2%	99.4%
Pima - 90% within 15 min or 10 miles	90.5%	91.2%		95.9%	95.8%
Apache - 90% within 60 miles			100%	100%	71.1%
Coconino - 90% within 60 miles			100%	100%	83.2%
Gila - 90% within 60 miles	100%	100%		100%	100%
Mohave - 90% within 60 miles			100%	96.7%	95.1%
Navajo - 90% within 60 miles			100%	94.5%	95.1%
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%

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

Table XVII – Access to Care Crisis Stabilization Facility

Crisis Stabilization Facility* SFY 2024			
County/Requirement	**Mercy Care (R)**	**Care 1st (R)**	**Arizona Complete Health (R)**
Maricopa - 90% within 15 min or 10 miles	99.4%		
Pima - 90% within 15 min or 10 miles			98.2%
Apache - 90% within 45 miles		96.2%	
Coconino - 90% within 45 miles		98.7%	
Gila - 90% within 45 miles	100%	100.0%	
Mohave - 90% within 45 miles		99.3%	
Navajo - 90% within 45 miles		99.5%	
Yavapai - 90% within 45 miles		99.4%	
Yuma - 90% within 45 miles			99.8%
Pinal - 90% within 45 miles	100%		100.0%
Cochise - 90% within 45 miles			99.7%
Santa Cruz - 90% within 45 miles			100.0%
Graham - 90% within 45 miles			99.5%
La Paz - 90% within 45miles			94.9%
Greenlee - 90% within 45 miles			100.0%

** This standard only applies to ACC-RBHAs*

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

Appointment Availability

Appointment availability includes timeliness standards for access to urgent and routine care appointments for various services including behavioral health provider appointments as follows:

Behavioral Health Provider Appointments:

1. Urgent need appointments as expeditiously as the member's health condition requires but no later than 24 hours from identification of need.
2. Initial assessment – Within seven calendar days after the initial referral or request for behavioral health services,
3. Initial appointment - Within timeframes indicated by clinical need:
    i) For members aged 18 years or older, no later than 23 calendar days after the initial assessment, and
    ii) For members under the age of 18 years old, no later than 21 days after the initial assessment.
4. 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:

1. Assess the urgency of the need immediately.
2. Provide an appointment, if clinically indicated, with a practitioner who can prescribe psychotropic medications within a timeframe that ensures the member:
    i) Does not run out of needed medications, or
    ii) Does not decline in their behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need.

AHCCCS requires MCOs to conduct provider appointment availability reviews regularly to assess member availability to routine and urgent appointments for behavioral health services. Starting in January 2023, AHCCCS revised MCO reporting from quarterly submissions to semi-annual submissions of these reviews.

These reviews typically consist of contact with providers to obtain information through a phone survey or in-person meeting review of appointment schedules. As displayed in the tables, some plans combine their reviews and apply them to more than one line of business, while others conduct and report their surveys separately.

The MCO must utilize the results to address access to care concerns and to assure appointment availability. In its network planning process, AHCCCS requires each plan to compare its current year's appointment availability results to the previous year to identify network gaps. MCOs must address when providers do not meet these timeframes and typically resurvey them the following quarter for compliance. Tables XVIII and XIX on the following pages display the percentage of providers meeting the timeframes for each ACC (A), ACC-RBHA, ALTCS-EPD (L) and ALTCS-EPD plan (R).

Table XVIII – ACC-RBHA and ACC – Appointment Availability

ACC-RBHA and ACC Plans % of Sampled Providers Meeting Standard SFY 2024 Average	Mercy Care (R)	Care1st (R)	Arizona Complete Health (R)	Mercy Care (A)	Health Choice Arizona (A)	Arizona Complete Health - South (A)	Banner UFC (A)	Arizona Complete Health - North(A)	Molina Complete Care (A)	United Health Care (A)
Urgent Need Appointments: As expeditiously as the member's health condition requires but no later than 24 hours from identification of need.	85.7%	81.7%	78.9%	85.7%	93.7%	78.9%	99.5%	81.7%	100.0%	96.9%
Initial assessment – Within seven calendar days after the initial referral or request for behavioral health services.	90.1%	84.9%	85.0%	90.0%	96.0%	85.0%	99.1%	84.9%	100.0%	95.0%
Initial appointment: For members aged 18 years or older, no later than 23 calendar days after the initial assessment.	85.8%	86.3%	86.1%	85.8%	97.5%	86.1%	99.3%	86.3%	100.0%	100%
Initial appointment: For members under the age of 18 years old, no later than 21 days after the initial assessment.	92.1%	78.5%	83.9%	92.1%	96.3%	83.9%	99.2%	78.5%	100%	96.6%
Subsequent behavioral health services: Within the timeframes according to the needs of the person, but no longer than 45 calendar days from identification of need.	92.9%	82.9%	82.0%	92.9%	97.9%	82.0%	100%	82.9%	100.0%	100%
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 their behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need.	93.8%	79.5%	81.5%	93.8%	95.7%	81.5%	100.0%	80.0%	100.0%	100%

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

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

ALTCS-EPD and DES/DDD Plan % of Sampled Providers Meeting Standard SFY 2024 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.	99.5%	85.7%	96.9%	75.2%	92.8%
Initial assessment – Within seven calendar days after the initial referral or request for behavioral health services	99.2%	90.1%	95.0%	83.5%	97.4%
Initial appointment: For members aged 18 years or older, no later than 23 calendar days after the initial assessment.	99.4%	85.8%	100%	84.3%	100%
Initial appointment: For members under the age of 18 years old, no later than 21 days after the initial assessment.	99.2%	92.1%	96.1%	83.5%	100%
Subsequent behavioral health services: Within the timeframes according to the needs of the person, but no longer than 45 calendar days from identification of need.	100%	92.9%	100%	84.3%	100.%
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 their behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need.	100.0%	93.8%	100%	84.3%	100%

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

Performance Metrics

AHCCCS utilizes performance metrics for monitoring MCO compliance related to the delivery of care and services to members.

Table XX provides specific behavioral health performance measures for the most recent, completed data available for the ACC program, for members designated as SMI enrolled with the ACC-RBHAs, and for managed care enrolled members across all lines of business for CY 2023. AHCCCS calculates performance measures on a Calendar Year (CY) to align with the most current federal fiscal year performance standards.

The access to care measures in Table XX continued to meet or exceed the NCQA Medicaid Mean despite the increase in Mean when compared to the prior year. AHCCCS will continue to monitor these outcomes to ensure availability and access to behavioral health services.

Table XX – CY 2023 AHCCCS Performance Measure Data[1,2]

CY 2023 Behavioral Health Performance Measure Rates				
Performance Measure	**2023 NCQA Medicaid Mean[1]**	**ACC Population**	**SMI Designated Population**	**Statewide Managed Care[2] Aggregate**
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 Day Follow-Up (Total) - NCQA	24.1%	29.7%	50.6%	31.9%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 Day Follow-Up (Total) - NCQA	35.5%	40.8%	69.7%	42.7%
Follow-Up After Emergency Department Visit for Mental Illness - 7 Day Follow-Up (Total) - NCQA	39.6%	44.9%	54.9%	51.5%
Follow-Up After Emergency Department Visit for Mental Illness - 30 Day Follow-Up (Total) - NCQA	54.1%	56.4%	72.0%	63.5%
Follow-Up After Hospitalization for Mental Illness - 7 Day Follow-Up (Total) - NCQA	38.5%	48.5%	69.0%	55.5%
Follow-Up After Hospitalization for Mental Illness – 30 Day Follow-Up (Total) - NCQA	59.1%	66.0%	84.0%	72.0%
Follow-Up Care for Children Prescribed Attention-Deficit/ Hyperactivity Disorder (ADHD) Medication – Initiation Phase	45.4%	58.3%	N/A	59.2%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication – Continuation and Maintenance Phase	52.1%	67.3%	N/A	68.2%

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

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

Conclusion

AHCCCS prioritizes the provision of high quality, integrated behavioral and physical health services through a Managed Care Organization (MCO) integrated delivery model. This integrated approach fosters a coordinated and cost-effective system of care designed to address the comprehensive health care needs of Arizonans benefiting from AHCCCS programs and services. Despite Arizona's historical challenges, AHCCCS has implemented a range of efforts aimed at enhancing service delivery, strengthening oversight mechanisms, and reinforcing monitoring requirements. These efforts reflect a sustained commitment to continuous quality improvement within Arizona's Medicaid program. Examples of efforts made and in progress include:

- Rewriting the Behavioral Health Clinical Chart Audit (BHCCA) to incorporate the concept of the Golden Thread, strengthening alignment between assessment, service planning, service delivery and outcome monitoring in addition to a stronger integration of member and family voice, cultural responsiveness, recovery-oriented principles and refocus on member engagement and outcomes.
- Revisions of multiple Arizona Medical Policy Manual policies to further define and direct service delivery including comprehensive behavioral health assessment, service and treatment planning, safety planning, clinical oversight, contractor and provider case management, and evidence-based practices.
- Revisions to the reintroduced Covered Behavioral Health Services Guide to promote understanding of service billing codes and programming/procedural expectations.
- Braiding Medicaid and grant funding to bolster crisis intervention services throughout the state but especially in rural/frontier geographic service areas
- Engagement in statewide fidelity audits of Assertive Community Treatment and actively partnering with ACC-RBHAs and providers to ensure service delivery occurs within fidelity standards in addition to targeting and remediating identified barriers or gaps in service delivery or access to care
- Continued implementation of the Housing and Health Opportunities (H20) Demonstration targeting positive health and wellbeing outcomes for members who are experiencing homelessness, are living with an SMI designation, and are living with an active chronic health condition or are currently in a correctional facility with a release date scheduled within 90 days or were released from a correctional facility within the last 90 days.
- Implementation planning for the juvenile justice requirement of the Consolidated Appropriations Act to provide eligible juveniles with community case management, assessment, and treatment planning up to 30 days prior to release from incarceration to enhance successful reintegration into the communities in which they reside and reduce the likelihood of recidivism

AHCCCS will continue to provide strategic guidance, robust oversight, and ongoing monitoring of integrated service delivery for our members. The agency will continue to analyze data and engage in collaborative efforts with our MCOs and provider networks to enhance health and wellbeing outcomes across the Medicaid population.