AHCCCS
Arizona Health Care Cost Containment System

Douglas A. Ducey, Governor
Thomas J. Betlach, Director

May 15, 2018

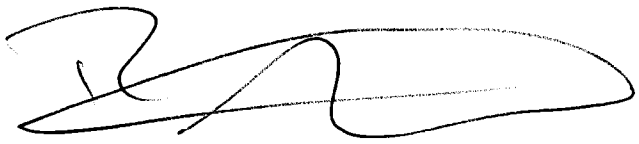
The Honorable John Kavanagh
Chairman, Joint Legislative Budget Committee
1700 West Washington
Phoenix, Arizona 85007

Dear Senator Kavanagh:

Pursuant to A.R.S. § 36-3415, the Arizona Health Care Cost Containment System 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.

If you have any questions regarding this report, please feel free to contact me at (602) 417-4776.

Sincerely,



Thomas J. Betlach,
Director

cc: The Honorable David Livingston, Arizona House of Representatives
Matthew Gress, Director, Governor's Office of Strategic Planning and Budgeting
Richard Stavneak, Director, Joint Legislative Budget Committee
Christina Corieri, Governor's Office Senior Policy Advisor

Behavioral Health Annual Report

For the Period:
State Fiscal Year (SFY) 2017
(July 1, 2016 – June 30, 2017)

May 2018
Thomas J. Betlach, Director

Background

ARS §36-3415 requires the following:

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

As a result of administrative simplification, the merger of AHCCCS and the Arizona Department of Health Services/Division of Behavioral Health Services (DBHS) effective July 1, 2016, AHCCCS is reviewing legislative report deliverables that were previously prepared by DBHS to determine the responsiveness of the information provided to the request, and to understand methodologies and data sources.

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

Behavioral Health Expenditures & Utilization

The Medicaid and non-Medicaid behavioral health expenditures for SFY 2017 are provided in Table I on the following page. These expenditures are consistent with those reported in AHCCCS' Behavioral Health Annual Report submitted December 29, 2017, in accordance with A.R.S. §36-3405. A link to that report is provided for reference: https://www.azahcccs.gov/shared/Downloads/Reporting/FY2017BHFinancialProgrammaticReportwithCoverLetter.pdf.

Table I

Statewide Expenditures by Program FY 2017

Total Behavioral Health Services Expenditures by Program FY 2017		
Funding	**Amount Paid**	**Percentage**
Traditional Medicaid Services	1,150,212,984	49.06%
Proposition 204 Services	720,697,332	30.74%
ACA Adult Expansion	79,004,313	3.37%
CMDP	172,511,172	7.36%
Medicaid Subtotal	2,122,425,801	90.53%
Non TXIX Child	7,451,372	0.32%
Non TXIX SMI	145,234,760	6.19%
Non TXIX GMH/SA	43,540,893	1.86%
Non TXIX Crisis	16,332,629	0.69%
Non TXIX Prevention	9,687,151	0.41%
Non TXIX Subtotal	222,246,805	9.47%
Total	**2,344,672,606**	**100.00%**

Source Data: AFIS

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

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

In order to meet reporting requirements and provide transparent expenditure data for physical versus behavioral health services under ACC contracts, AHCCCS has developed a cross divisional team of clinical, actuarial, and financial staff to model a

methodology to report these expenditures using service level detail contained on members' claims. This work is underway and will be utilized for future versions of this report, and the Annual Report provided pursuant to §36-3405, when CYE 2019 is reported.

The reporting of behavioral health utilization data will accompany the expenditure data for CYE 2019 when the new reporting methodology is implemented.

Member Income

AHCCCS members who receive Medicaid services generally have household incomes near or below the Federal Poverty Level (FPL). The 2018 FPL for a family of 4 is $25,100. Of Medicaid/CHIP members, 89.2% are below 100% FPL, 9.2% are between 100% and 138% FPL, and 1.6% are greater than 138% FPL; see Table II below. In addition, AHCCCS provides some limited, Non-Title XIX/XXI services to individuals not eligible for Medicaid/CHIP, who may have higher household incomes.

Table II

Medicaid & CHIP Members by Poverty Category:

Poverty Threshold	AHCCCS Members
< 100% FPL	89.2%
100-138% FPL	9.2%
> 138% FPL	1.6%
Total	100.0%

Medical Necessity Oversight Practices

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

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

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

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

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

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

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

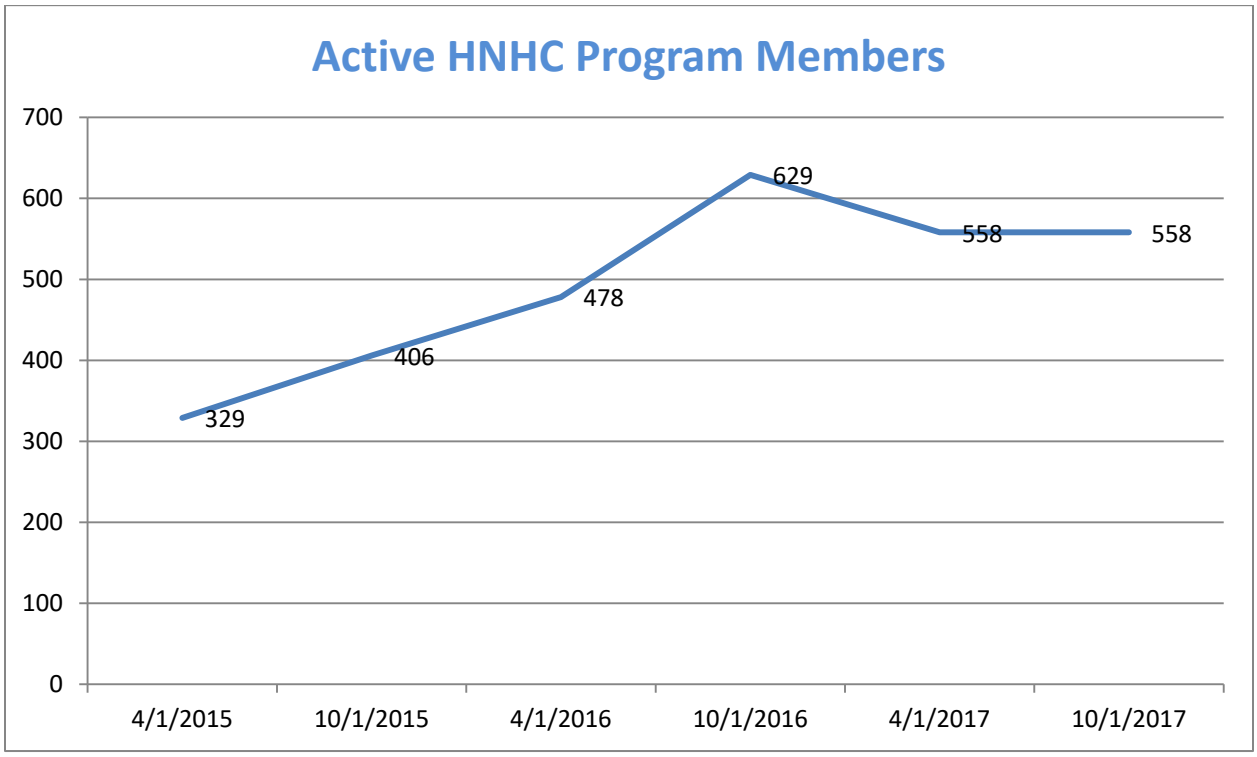
Tracking Of High-Cost Beneficiaries

AHCCCS requires MCOs to coordinate care for members with high behavioral and physical health needs and/or high costs. The MCO must identify members with high needs/high costs, plan interventions for addressing appropriate and timely care for these members and report outcomes to AHCCCS.

The High Needs/High Cost (HN/NC) Program was developed by AHCCCS specifically to drive care coordination between MCOs and RBHAs for mutual members with complex behavioral and physical health needs. The Program provides standardized criteria which the MCOs and RBHAs utilize to identify members. The MCOs and RBHAs work together to identify and develop interventions to address appropriate and timely care for each member. AHCCCS provides oversight to an AHCCCS/MCO HN/HC

workgroup that meets every 6 months to monitor outcomes and implement performance improvement. MCOs and RBHAs track interventions based on standardized criteria and report intervention summaries and member lists to AHCCCS. AHCCCS utilizes this data along with service level detail contained on member claims to monitor performance against a randomly selected control group. Chart I below identifies the number of members engaged in the Program since April 2015.

Chart I



Mortality Trends

The Arizona Department of Health Services (ADHS), Bureau of Public Health Statistics, provides a great deal of information on mortality rates across a variety of populations at the following link: http://pub.azdhs.gov/health-stats/menu/index.php?pg=deaths. The most recent year of data available on ADHS' mortality webpage is for calendar year 2016. Following is a high level summary of 2016 mortality statistics found on the ADHS website, which are not limited to AHCCCS members.

Utilizing the ADHS statewide data, and focusing on mortality rates that are behavioral health related, the statistics indicate that suicide was the 8th leading cause of death in 2016 for Arizonans, with 1,256 reported, as well as the 8th leading cause of death for male Arizonans. For female Arizonans, suicide was the 11th leading cause of death. The statistic rises to the 5th leading cause of death when limited to White, non-Hispanic males, and is also the 5th leading cause of death for males in a rural area when

comparing gender and urban/rural distinctions. American Indians had the highest rate of suicide among racial/ethnic groups.

Drug-related mortality reported by ADHS for 2016 grew by almost 10% over the prior year for Arizona residents. Table III provides number of deaths reported as drug-related in 2016.

Table III

Drug-Related Mortality By Category, Arizona Residents, 2016		
Abuse of psychoactive substances	133	9%
Accidental poisoning by drugs	1095	75%
Intentional self-poisoning by drugs	133	9%
Undetermined intent of poisoning by drugs	100	7%
Total	1461	100%

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

AHCCCS does not produce mortality statistics for members but does require MCOs to report data on unexpected deaths. For SFY 2017, MCOs reported 834 accidental deaths among AHCCCS members. Accidental deaths may be due to suicide, overdoses of illegal drugs or prescription drugs, and other reasons.

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]:

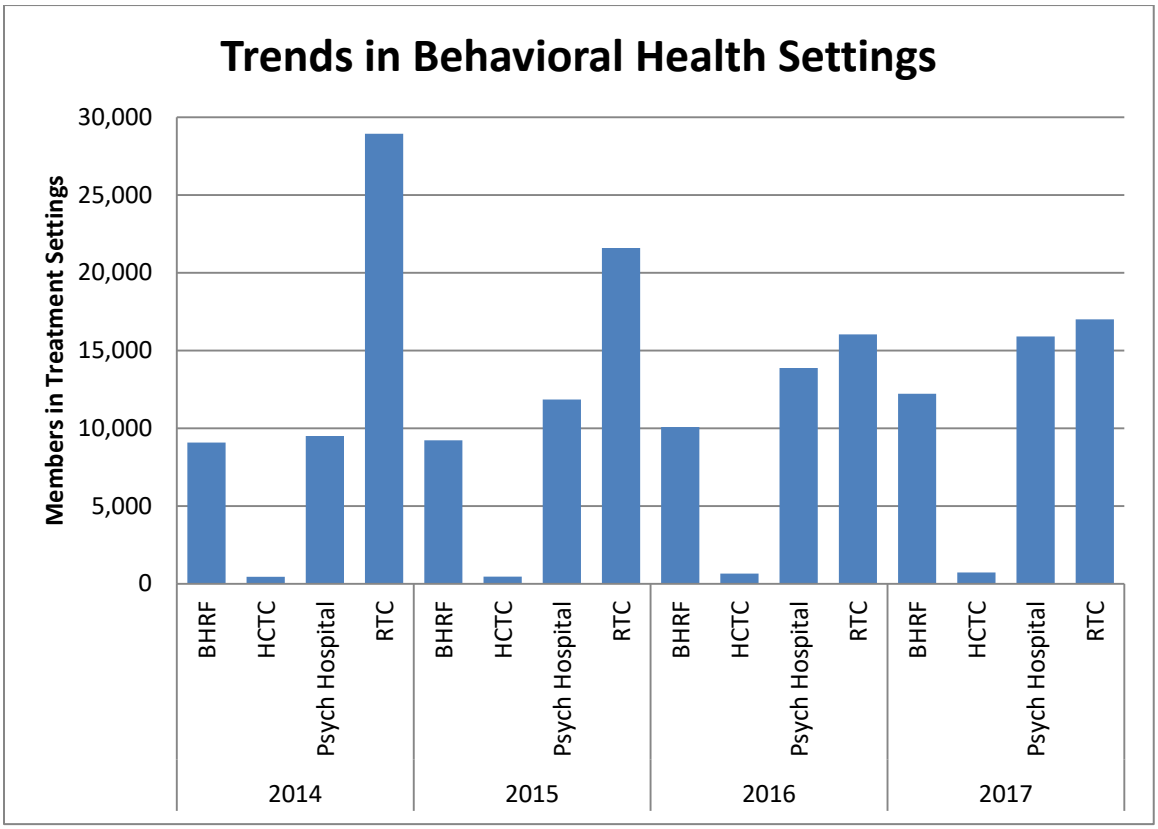
- Behavioral Health Residential Facility (BHRF)
  Residential services provided by a licensed behavioral health agency. These agencies provide a structured treatment setting with 24 hour supervision and counseling or other therapeutic activities for persons who do not require on-site medical services, under the supervision of an on-site or on-call behavioral health professional.
- Home Care Training to Home Care Client (HCTC)
  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. HCTC 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 Covered Behavioral Health Services Guide at https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/covered-bhs-guide.pdf

- Inpatient Psychiatric Hospital
  Inpatient services (including room and board) provided by a licensed Level I behavioral health agency. These facilities provide a structured treatment setting with 24 hour supervision and an intensive treatment program, including medical support services.
- Residential Treatment Center (RTC)
  Inpatient psychiatric treatment, which includes an integrated residential program of therapies, activities, and experiences provided to persons who are under 21 years of age and have severe or acute behavioral health symptoms.

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

Chart II



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

AHCCCS and its RBHAs recognized the need for increasing network capacity for BHRF services and supported efforts by the provider community to add beds in this treatment setting. Some of the reasons 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.

HCTC is utilized increasingly for members in need of a family setting for treatment. Training and education has been provided to the community regarding HCTC and how this unique setting can provide therapeutic support in the least restrictive environment while still supporting the treatment needs of youth. The initiatives to expand community based services to provide a comprehensive support for youth and adults in the HCTC setting appears to have led to increase utilization of this treatment setting.

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

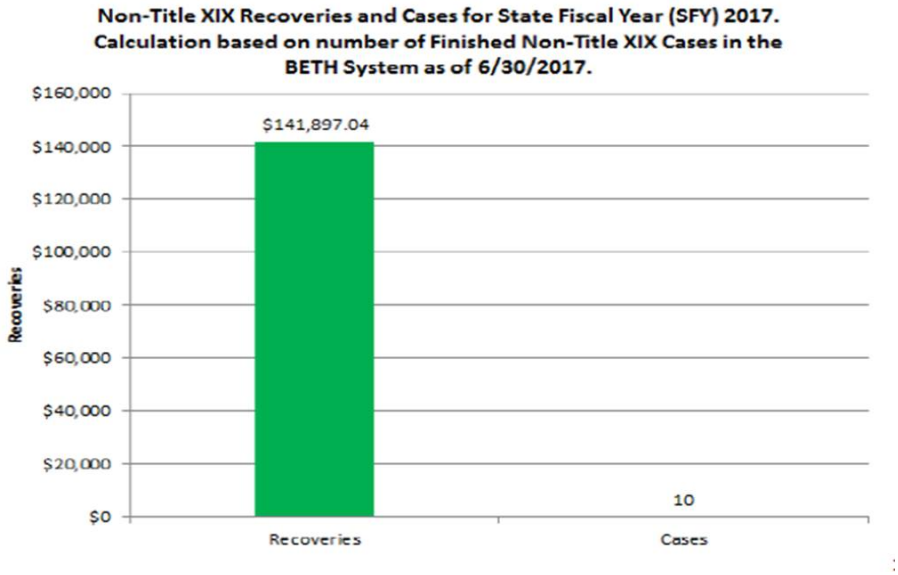
- Collaboration with first responders, including expanded crisis intervention training to support police officers in getting members to treatment rather than sending members to jail.
- Concentrated efforts to reduce emergency department holds, which resulted in members obtaining inpatient care more quickly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

Program Integrity

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

The AHCCCS OIG is responsible for the integrity of the AHCCCS program as well as handling reports of fraud and abuse of the AHCCCS program. The mission of the OIG is to prevent, detect, and recover improper payments due to fraud, waste, and abuse. AHCCCS currently does not have a tracking system that supports the provision of statistics for behavioral health cases only. However, OIG can report case recoveries by fund type. Chart III shows the cases investigated by the OIG that contained Non-Title XIX (NTXIX) savings and recoveries in SFY 2017 (NTXIX funds are only used for the provision of behavioral health services).

Chart III



Access to Services

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

Network

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

AHCCCS maintains network and appointment availability standards that must be met by the MCOs' contracted providers. Network standards for various provider types including Behavioral Health Outpatient settings, Integrated Clinics and Crisis Stabilization facilities are outlined in the AHCCCS Contractor Operations Manual. MCOs are required to attest to minimum network requirement compliance. Table IV illustrates MCO performance against established network requirements for Behavioral Health Outpatient settings and Integrated Clinics as well as Crisis Stabilization facilities in CYE 2017.

Table IV

RBHA Network Standards			
Behavioral Health Outpatient and Integrated Clinics	**CYE2017 Average**		
Requirement: 90% of membership within 15 min or 10 miles	**MMIC**	**HCIC**	**CIC**
Maricopa	99.3%		
Apache		51.5%	
Coconino		87.5%	
Gila		93.5%	
Mohave		71.3%	
Navajo		56.8%	
Yavapai		83.5%	
Pima			97.3%
Yuma			99.5%
Pinal			96.2%
Cochise			91.7%
Santa Cruz			94.3%
Graham			59.3%
La Paz			72.7%
Greenlee			58.8%
Crisis Stabilization Facility	MMIC		CIC
Requirement: 90% of membership within 15 min or 10 miles			
Maricopa	99.3%		
Pima			95.6%
Crisis Stabilization Facility		HCIC	CIC
Requirement: 90% of membership within 60 miles			
Apache		97.3%	
Coconino		100.0%	
Gila		100.0%	
Mohave		100.0%	
Navajo		90.0%	
Yavapai		100.0%	
Yuma			92.5%
Pinal			91.3%
Cochise			92.0%
Santa Cruz			95.8%
Graham			78.7%
La Paz			82.4%
Greenlee			49.8%

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

Behavioral Health Provider Appointments:

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

Psychotropic Medications:

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

MCOs are required on a quarterly basis to conduct provider appointment availability reviews to assess the availability of routine and urgent appointments for behavioral health appointments including tracking and trending the results. These results must be utilized by the MCO to address access to care concerns with providers not meeting the standards and to assure appointment availability in order to reduce unnecessary emergency department utilization. Table V on the following page shows the percentage of providers meeting the availability standards by RBHA.

Table V

% of Providers Meeting Standard			
	CYE 2017 Average		
	MMIC	HCIC	CIC
General BH Appt Standards			
Urgent need appointments: as expeditiously as the member's health condition requires but no later than 24 hours from identification of need	95.15%	92.31%	91.34%
Routine: Initial assessment within seven calendar days of referral or request for service	92.44%	97.85%	86.07%
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	92.81%	89.70%	92.26%
Routine: All subsequent behavioral health services, as expeditiously as the member's health condition requires but no later than 45 calendar days from identification of need	99.84%	89.70%	88.98%
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.	99.58%	100.00%	89.30%
Key			
90- 100%			
80-89.9%			
Under 80%			

Performance Measures

AHCCCS has developed and implemented performance measures to monitor the compliance of MCOs related to the delivery of care and services to members. Performance measures may focus on clinical and non-clinical areas including both physical and behavioral health measures. Areas include but are not limited to measures such as wellness and screening services, readmissions, utilization of services, and access to care. AHCCCS establishes Minimum Performance Standards (MPS) for each measure and MCOs must work to achieve at least the MPS. Table VI provides specific Behavioral Health Performance Measures and Outcome Data for CYE 2016.

Table VI
(Updated as of 04/13/2018)

Population			SMI	GMH/SA
Performance Measure	**CYE 2016 Minimum Performance Standards**	**CYE 2016 Medicaid Mean**	**Aggregate CYE 2016**	**Aggregate CYE 2016**
7 Day Follow-Up After Hospitalization for Mental Illness*	**50%**	**45.5%**	74.4%	51.5%
30 Day Follow-Up After Hospitalization for Mental Illness*	**70%**	**63.8%**	87.4%	69.0%
Mental Health Utilization - Inpatient (Total)	**Reported for Informational Purposes Only, Not in CYE 2016 Contract**	**NA**	13.9%	0.6%
Mental Health Utilization - Intensive Outpatient/Partial Hospitalization (Total)	**Reported for Informational Purposes Only, Not in CYE 2016 Contract**	**NA**	12.3%	0.4%
Mental Health Utilization - Any Service (Total)	**Reported for Informational Purposes Only, Not in CYE 2016 Contract**	**NA**	88.7%	7.6%
Mental Health Utilization - Outpatient/ED (Total)	**Reported for Informational Purposes Only, Not in CYE 2016 Contract**	**NA**	88.3%	7.5%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	**Reported for Informational Purposes Only, Not in CYE 2016 Contract**	**2.4%**	NA	1.1%

Access to Care Report
In 2018, AHCCCS will, for the fifth consecutive year, produce an annual Access to Care Report which covers a wide variety of factors by which the Agency assesses member access to care. The completed reports for 2014 through 2017 can be found at the bottom of the webpage found at the following link: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS. The 2018 report will be posted to the same location upon completion.

Conclusion

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

The implementation of the AHCCCS Complete Care (ACC) contracts on October 1, 2018, which will integrate physical and behavioral health care under the same MCO for the majority of AHCCCS members, will necessitate focused attention on the delivery of behavioral health care. Ultimately, AHCCCS anticipates that this delivery system transformation effort will result in improved health outcomes for AHCCCS members with co-occurring physical and behavioral health issues.