October 1, 2024

The Honorable John Kavanagh
Chairman, Joint Legislative Budget Committee
1700 W. Washington
Phoenix, AZ 85007

Dear Senator Kavanagh:

Pursuant to A.R.S. 36-3415, AHCCCS is required to report annually to the Joint Legislative Budget Committee on each fiscal year's Medicaid and non-Medicaid behavioral health expenditures, including behavioral health demographics that include client income, utilization and expenditures, medical necessity oversight practices, tracking of high-cost beneficiaries, mortality trends, placement trends, program integrity, and access to services.

If you have any questions regarding the attached report, please feel free to contact me at (602) 417-4711.

Sincerely,

Carmen Heredia
Director

cc: The Honorable David Livingston, Vice Chairman, Joint Legislative Budget Committee
Sarah Brown, Director, Governor's Office of Strategic Planning and Budgeting
Richard Stavneak, Director, Joint Legislative Budget Committee
Zaida Dedolph Piecoro, Health Policy Advisor, Office of the Governor

BEHAVIORAL HEALTH ANNUAL REPORT

FOR THE PERIOD:
STATE FISCAL YEAR (SFY) 2023
(JULY 1, 2022 – JUNE 30, 2023)

September 2024

Carmen Heredia, Director

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 members who are children (except children who are 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. Previous reports primarily reflected ACC with Regional Behavioral Health Agreement (ACC-RBHA) data only, information in this year's report is inclusive of behavioral health (BH) services provided under all contracts.

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.

Client Income

AHCCCS members who receive Medicaid services generally have household incomes near or below the Federal Poverty Level (FPL) and Federal Benefit Rate (FBR). 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 2023 can be found on the AHCCCS website, under the Medical Assistance Eligibility Policy Manual.

In SFY 2023, 100% FBR for an individual was $10,968 a year and 100% FPL for an individual was $14,580 a year. As noted in Table I, 30.9% of Medicaid (Title XIX) and Children's Health Insurance Program (CHIP – Title XXI) members determined by FPL were below 100% FPL. In addition, AHCCCS provides some limited, Non-Title XIX/XXI services to individuals not eligible for Medicaid/CHIP, who may have higher household incomes.

Table II presents the percentage of members determined by FBR. In SFY 2023, 70.3% of Medicaid and CHIP members determined by FBR were below 100% FBR.

Table I - Medicaid & CHIP Members Determined by FPL[1] - SFY 2023

Federal Poverty Level	Percent
< 36% FPL	8.7%
≥ 36% and < 40% FPL	30.8%
≥ 40% and < 106% FPL	39.3%
≥ 106% and < 120% FPL	1.3%
≥ 120% and < 133% FPL	9.8%
≥ 133% and < 150% FPL	0.8%
≥ 150% and <185% FPL	6.0%
≥ 185% and < 200% FPL	2.9%
≥ 200% and < 250%FPL	0.4%
Grand Total	**100.0%**

**Codes for FPL bands are adjusted annually.*

Table II - Medicaid & CHIP Members Determined by FBR - SFY2023

Federal Benefit Rate	Percent
< 100% FBR	70.3%
≥ 100% and < 300% FBR	29.7%
Total	**100.0%**

[1] Codes for FPL are adjusted manually

Utilization and Expenditures

The Medicaid (Title XIX/XXI) and non-Medicaid (Non-Title XIX/XXI) behavioral health expenditures for SFY 2023 are provided in Tables III and IV. These expenditures are consistent with those reported in AHCCCS' SFY 2023 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 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.

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. 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 2023

Total Behavioral Health Services Expenditures by Funding Source FY 2023		
Funding	**Amount Paid**	**Percentage**
General Fund - Medicaid	$834,178,051	15.59%
Tobacco Tax Funds – Medically Needy Account	$35,565,800	0.67%
Tobacco Tax Funds –Proposition 204 Protection Account	$5,000,000	0.09%
Tobacco Tax Funds –Tobacco Litigation Settlement	$30,154,400	0.56%
TXIX and TXXI Medicaid Federal Grant Awards	$4,132,407,303	77.25%
Non TXIX General Fund	$107,033,675	2.00%
Substance Abuse Services Fund	$2,250,200	0.04%
Federal Grant - MHBG	$27,344,494	0.51%
Federal Grant - SUPTRS	$59,176,233	1.11%
Federal Grants (Opioid/Other)	$37,708,143	0.71%
County Funds	$74,991,355	1.40%
SMI Housing Trust Fund	$963,953	0.02%
Substance Use Disorder Funds	$2,223,752	0.04%
Other (Liquor Service Fees)	$283,777	0.01%
Total	**$5,349,281,136**	**100.00%**
TXIX/TXXI	**$5,037,305,554**	**94.2%**
Non-TXIX/Non-TXXI	**$311,975,582**	**5.8%**

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 time period.

Table IV - Statewide Expenditures by Behavioral Health Category – SFY 2023*

Total Behavioral Health Services Expenditures by Behavioral Health Category FY 2023			
Behavioral Health Category	**TXIX/TXXI Funding**	**Non-TXIX/ Non-TXXI Funding**	**Total**
Seriously Mentally Ill	$921,562,385	$125,567,288	$1,047,129,673
Children with Severe Emotional Disturbance	$327,647,578	$21,829,084	$349,476,662
Alcohol and Drug Abuse	$2,107,410,387	$48,215,352	$2,155,625,739
Other Mental Health	$1,680,685,204	$116,363,858	$1,797,049,062
Total	**$5,037,305,554**	**$311,975,582**	**$5,349,281,136**

**Table IV includes only Title XIX and Title XIX Funding Sources*

Medical Necessity Oversight Practices

AHCCCS requires that providers deliver covered services to AHCCCS 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 be provided 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, while effectively managing associated costs (though many behavioral health services do not require PA). 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.

  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** - 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 focuses 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 2023.

Table V – MCO Behavioral Health Medical Necessity Oversight Activities - SFY 2023

Behavioral Health Medical Necessity Oversight Activity	SFY 2023
Prior Authorizations	4,007
Notice of Adverse Benefit Determinations (NOA)	1,642
Concurrent Reviews	18,225
Retrospective Reviews	398

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. Utilization increased from the previous year as data is reflective of all utilization for behavioral health services within CY 2023. Data for 2023 shows an increase for Prior Authorizations, NOA, Concurrent Review, and Retrospective reviews due to the increased activities related to fraud, waste and abuse. AHCCCS will continue to closely monitor deliverable submissions to ensure data integrity and will provide additional technical assistance as warranted.

Table VI provides the most recent behavioral health utilization performance measure data, for CY 2022 (January 1, 2022, to December 31, 2022). AHCCCS calculates performance measures on the Calendar Year (CY) to align with the most current available federal fiscal year performance standards.

Table VI – AHCCCS Performance Measure Data – Utilization of Services[2,3]

CY 2022 Behavioral Health Performance Measure Rates				
Performance Measure	2022 NCQA Medicaid Mean[1]	ACC Aggregate	SMI Aggregate	Statewide[4] Aggregate
Use of Pharmacotherapy for Opioid Use Disorder	27.50%	50.50%	47.00%	54.00%
Use of First-Line Psychosocial Care for Children and Adolescents prescribed Antipsychotics	57.30%	68.30%	N/A	68.20%

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 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.

Beginning in CYE 2020, AHCCCS removed its prescriptive requirements for identifying high need/high-cost members and allowed MCOs to develop their own criteria. MCOs took this opportunity to expand the diagnoses used to identify members who could benefit from greater care coordination.

AHCCCS implemented a behavioral health specific deliverable associated with AHCCCS Medical Policy Manual (AMPM) 1021 – Contractor Care Management during SFY 2023. MCOs identified and tracked 2,018 behavioral health high-cost beneficiaries in SFY 2023. AHCCCS will continue to monitor future deliverable submissions to ensure data integrity and will provide additional technical assistance as warranted.

[2] *The Mental Health Utilization (MPT) measure was retired by the AHCCCS measure steward; therefore, this measure (including all associated sub measure rates) is no longer included within this report.*

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

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

Mortality Trends

AHCCCS obtains member mortality data via an inter-agency agreement with the Arizona Department of Health Services (ADHS), which includes Manner of Death (MOD).

The majority (33.3%) of deaths for the entire child population were considered "Natural", which are defined by ADHS as having occurred due to a medical condition. "Accidental" deaths include an injury that occurred when there was no intent to cause harm or death. Per the ADHS Arizona Child Fatality Annual Report, 55% of child deaths were children under 1 year of age, with many of those attributable to prematurity or a congenital abnormality.[5]

Table VII - Mortality Trends – Child

Member Manner of Death SFY2023	TXIX	%	NTXIX	%	All Child	%
Accident	0	0.0%	107	21.4%	107	21.2%
Homicide	0	0.0%	43	8.6%	43	8.5%
Natural Death	1	25.0%	167	33.4%	168	33.3%
Pending Investigation	0	0.0%	1	0.2%	1	0.2%
Suicide	3	75.0%	32	6.4%	35	6.9%
Undetermined	0	0.0%	37	7.4%	37	7.3%
Unknown	0	0.0%	113	22.6%	113	22.4%
Total	**4**	**100%**	**500**	**100%**	**504**	**100%**

Table VIII presents a statewide total of 19,313 mortalities of adult members identified as General Mental Health and/or having a Substance Use Disorder (GMH/SUD). Natural death was the highest manner of death for this population, accounting for 14,437 or 74.8% of all deaths in SFY 2023. Accidents accounted for the second highest manner of death, 2,932 or 15.2%. Suicide was the manner of death for 493, or 2.6% of the overall deaths for this population.

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

Member Manner of Death SFY2023	TXIX	%	NTXIX	%	All GMH/SU	%
Accident	2,786	15.2%	146	14.1%	2,932	15.2%
Homicide	351	1.9%	7	0.7%	358	1.9%
Natural Death	13,656	74.7%	781	75.2%	14,437	74.8%
Pending Investigation	18	0.1%	0	0.0%	18	0.1%
Suicide	428	2.3%	65	6.3%	493	2.6%
Undetermined	164	0.9%	12	1.2%	176	0.9%
Unknown	872	4.8%	27	2.6%	899	4.7%
Total	**18,275**	**100%**	**1,038**	**100%**	**19,313**	**100%**

[5] ADHS Child Fatality Review 2023 Annual Report

Table IX demonstrates that of the 1,718 mortalities for adult members with a Serious Mental Illness (SMI) designation, the manner of death was natural death for 1,068 members which equated to 62.2% of deaths, and accidents accounted for 486 or 28.3% of deaths. Suicide was the manner of death for 57 or 3.3% of deaths for these members in SFY 2023.

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

Member Manner of Death SFY2023	TXIX	%	NTXIX	%	All SMI	%
Accident	427	30.3%	59	19.2%	486	28.3%
Homicide	17	1.2%	2	0.6%	19	1.1%
Natural Death	850	60.3%	218	70.8%	1,068	62.2%
Pending Investigation	0	0.0%	0	0.0%	0	0.0%
Suicide	46	3.3%	11	3.6%	57	3.3%
Undetermined	70	5.0%	18	5.8%	88	5.1%
Unknown	0	N/A	0	N/A	0	0.0%
Total	**1,410**	**100%**	**308**	**100%**	**1,718**	**100%**

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

Table X - Mortality Trends – Statewide Behavioral Health Members

Statewide Manner of Death SFY2023	TXIX	%	NTXIX	%	All SMI	%
Accident	573	23.4%	2,952	15.5%	3,525	16.4%
Homicide	24	1.0%	396	2.1%	420	2.0%
Natural Death	1,632	66.6%	14,041	73.6%	15,673	72.8%
Pending Investigation	0	0.0%	19	0.1%	19	0.1%
Suicide	114	4.6%	471	2.5%	585	2.7%
Undetermined	82	3.3%	219	1.1%	301	1.4%
Unknown	27	1.1%	985	5.2%	1,012	4.7%
Total	**2,452**	**100%**	**19,083**	**100%**	**21,535**	**100%**

Chart I and Table XI illustrate the mortality rate per 1000 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 remained fairly steady. Overall, the rate of member death has declined over the last three years. AHCCCS will continue to monitor mortalities for these populations over time.

Chart I – SFY 2021-2023 BH Mortality Rate Per 1,000 - Manner of Death (MOD)[6]

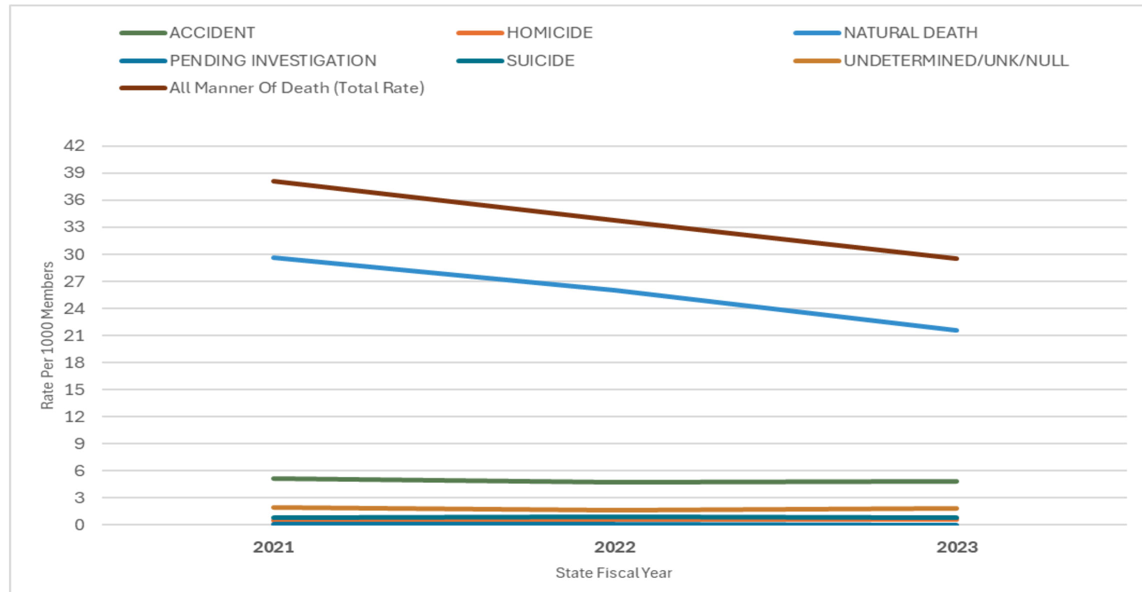


Table XI – SFY 2021-2023 BH Mortality Rate Per 1,000 - Manner of Death (MOD)

Mortality Rate per 1,000 BH Members	State Fiscal Year		
Manner of Death	**2021**	**2022**	**2023**
Accident	5.1	4.7	4.8
Homicide	0.6	0.6	0.6
Natural Death	29.6	26.0	21.5
Pending Investigation	0.0	0.0	0.0
Suicide	0.8	0.8	0.8
Undetermined/UNK/Null	2.0	1.7	1.8
All Manner of Death (Total Rate)	38.1	33.7	29.6
All Manner of Death (Total)	24,531	23,315	21,535

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 for the level of care needed for the specific situation. These settings include[7]:

- 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

[6] Mortality Rate denominator was adjusted to include all Behavioral Health members served during each SFY.
[7] More details regarding these treatment settings can be found in Chapter 300 of the AHCCCS Medical Policy Manual.

activities for persons who do not require on-site medical services, under the supervision of an on-site or on-call behavioral health professional.

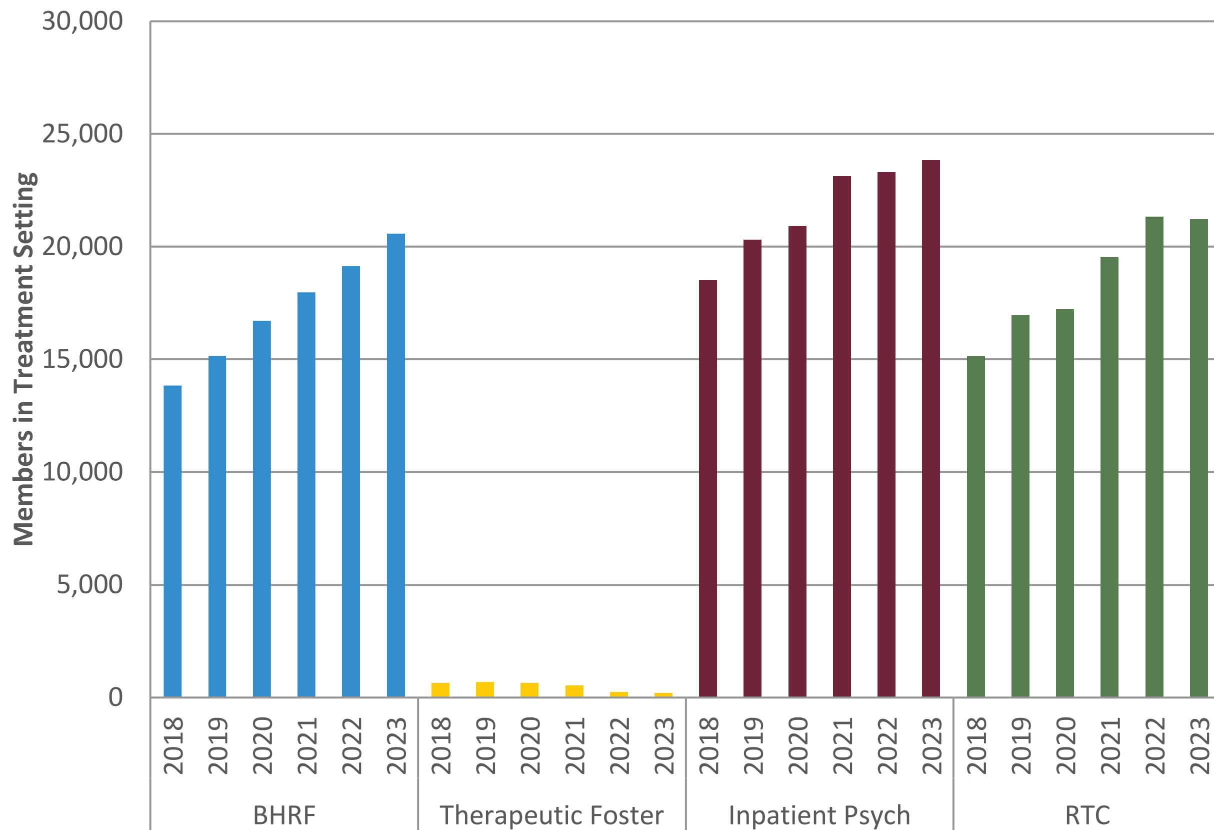
- Therapeutic Foster Care:
  Therapeutic Foster Care services, formerly known as Home Care Training, to Home Care Client (HCTC) services, care provided by a behavioral health therapeutic home to a person residing in their home in order to implement the in-home portion of the person's behavioral health service plan. Therapeutic foster care services assist and support a person in achieving their service plan goals and objectives. It also helps the person remain in the community setting, thereby avoiding residential, inpatient, or institutional care.

- Inpatient Psychiatric Hospital:
  Inpatient services (including room and board) provided by a 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.

Chart II provides a six-year history of behavioral health treatment settings for AHCCCS members. AHCCCS provides the data on a CYE 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.

AHCCCS and its MCOs recognize the need for increasing network capacity for BHRF services and supported efforts by the provider community to add beds in this treatment setting. Some of the factors contributing to the need for additional beds include:

- Members leaving jail and transitioning to medically necessary behavioral health care in the community,
- Greater focus on treatment for opiate use disorder to reduce opioid prescription drug misuse and abuse

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 getting members to treatment rather than sending members to jail,
- Concentrated efforts to expedite appropriate transfers and discharges from inpatient settings to more appropriate levels of care in the community,
- Continued focus on inpatient treatment for opiate use disorder to reduce opioid prescription drug misuse and abuse,

● Increased capacity to manage crisis-related treatment statewide, including focus on specialized populations (children, adolescents, individuals with intellectual/developmental disabilities).

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 Health Care Services (DHCS), 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, nearly $22 billion in State Fiscal Year 2023, 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 SFY23, AHCCCS had 2,411,057 beneficiaries, 120,566 providers, and 47 OIG investigators with which to combat fraud, waste and abuse. OIG achieved $68.3 million in recoveries and $250.3 million in savings, totaling $318.6m for the period.

OIG's program integrity activities included a developed focus on behavioral health services due to the fraud presently occurring in Arizona during SFY 2023. OIG has continued to develop its previously reported behavioral health cases and investigations [see previous Behavioral Health Reports: SFY22, SFY21, SFY20]. During SFY23, OIG opened investigations on:

- Behavioral Health Residential Facilities
- Behavioral Health Therapeutic Homes
- Behavioral Health Outpatient Clinics
- Group Billers
- Integrated Clinics
- Licensed Independent Substance Abuse Counselors
- Licensed Clinical Social Workers
- Licensed Professional Counselors

- Registered Nurse Practitioners
- Residential Treatment Center-Secure
- Hotels

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 412 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. And 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 their 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, 25 CAF's have been rescinded after providers submitted written evidence explaining their conduct. Also, OIG has had 25 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; Compliance and Investigations. OIG Compliance is responsible 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.

OIG Compliance

The OIG received 8,291 incoming referrals, scanned, and archived 243,075 pages of documents, and generated 1,468 outgoing letters. Additionally, OIG Collectors processed 1,557 payments totaling $10,582,635 from Member and Provider cases.

The OIG reviewed 763 provider audits conducted by Managed Care Organizations (MCO), of which 173 were exclusive to behavioral health. Six MCO Operational Reviews were conducted by OIG staff, to include Behavioral Health. OIG staff conducted 156 Credit Balance Reviews performed by a contractor, to include Behavioral Health. The OIG completed 14 Deficit Reduction Act (DRA) audits and 311 beneficiary Date of Death (DoD) audits, 23 of which were Behavioral Health related. OIG confirmed that Solari, which is a contractor exclusive to Behavioral Health, completed 640 employee and 567 vendor exclusion checks. These were conducted monthly and were submitted and reviewed quarterly during SFY 2023. Additionally, OIG completed an FQHC (FEDERALLY QUALIFIED HEALTH CENTER) provider audit of Valleywise and their ten clinics.

OIG performed post payment audits on several areas which also included Behavioral Health providers. Ten 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 OIG staff began developing the post payment audit strategy by researching the program and working with AHCCCS cross-divisional staff. One recoupment of program funds was made due to a change of ownership by OIG. There were 37 Inpatient post payment audits complete that resulted in $180,250.41 in recoupments identified.

OIG Investigations

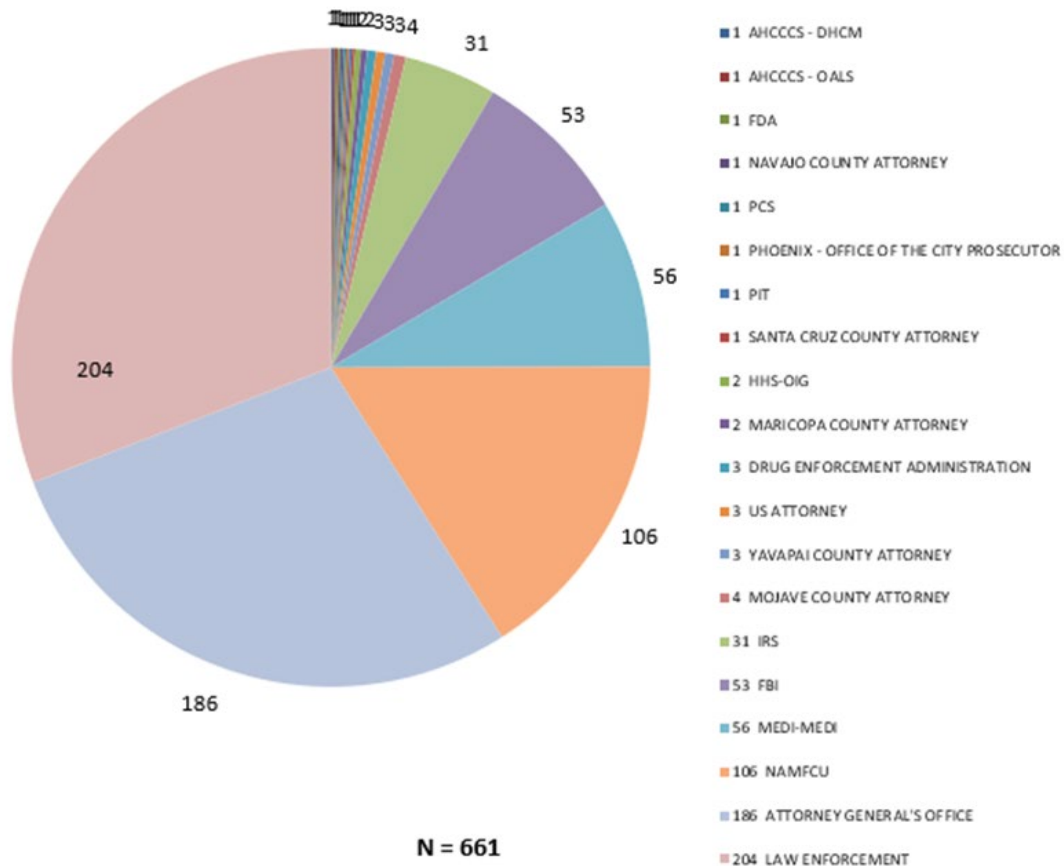
As of the end of SFY 23, OIG had 845 active behavioral health related cases and 332 cases with various law enforcement agencies in a suspended status. Also, as of the end of SFY 23, OIG had completed 309 behavioral health related cases.

Of the 845 active cases:

- 207 are Behavioral Health Residential Facilities
- 359 are Behavioral Health Outpatient Clinics
- 54 are Integrated Clinics
- 85 are Group Providers
- 8 are Hotels
- 5 are Community Service Agencies
- 127 are other Provider Types

Chart III – Suspended Cases by Agency

Suspended Cases by Agency as of 6/30/2023



OIG Behavioral Health cases in the news for investigations involving SFY23 include:

- Attorney General Mark Brnovich Announces 13 Individuals and 14 Related Business Entities Indicted in Alleged Massive Health Care Fraud Billing Scheme
- Mesa Woman Pleads Guilty to Fraud Targeting AHCCCS
- Chandler Couple Arrested for AHCCCS Fraud and Pandemic Loan Fraud
- Two Indicted for $9.4 Million Fraud Against AHCCCS's Insurance Program for Native Americans
- Arizona CEO and Accomplice Charged with Embezzling Millions of Dollars from Tribal Healthcare Provider
- New River Couple Arrested in Riverside, California for Fraud Targeting AHCCCS
- Attorney General Mayes Announces Fraud Charges Against Owners and Biller of Behavioral Health Facility
- Attorney General Mayes Announces Grand Jury Indictments of 10 Individuals in Alleged Patient Brokering Scheme
- Attorney General Mayes Announces Indictment for Alleged Patient Brokering
- Man arrested on suspicion of committing Medicaid fraud, running unlicensed facility in Chandler

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 Health Care Management (DHCM), 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.

As with other years, OIG continued to share its data throughout SFY23 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 23 and into SFY 24:

- Effective with dates of service beginning February 17, 2023, and forward, 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 any of the following 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.
    - Billing Codes:
        - H0004 (Behavioral Health Counseling and Therapy)
        - H0038 (Self-Help/Peer Services)
        - H2011 (Crisis Intervention Service)
        - H2014 (Skills Training and Development)
        - H2015 (Comprehensive Community Support Services)
        - H2017 (Psychosocial Rehabilitation Services)
        - H0025 (Behavioral Health Prevention Education Service)
        - H2027 (Psychoeducational Service)
        - S5150 (Unskilled Respite Care, Not Hospice)
        - T1016 (Case Management)
        - T1019 (Personal Care Services)
        - In addition, when billing more than 4 units of H0034 in one day, providers are required to provide documentation with the submission of the claim including a copy of the most recent comprehensive assessment, treatment plan, and the medical record documentation for the service billed on the service date.
- Multi-Systemic Therapy (MST) services. MST services for juveniles are provided by behavioral health providers who meet the standards to provide MST services. MST services may be submitted to AHCCCS (Arizona Health Care Cost Containment System) FFS under the code H2033. Providers

of this service must be trained and licensed by MST Services, Inc. in South Carolina which provides a training, support, and quality assurance system aimed at achieving targeted outcomes through treatment fidelity.

- Effective May 18, 2023, AHCCCS has made system updates to the AHCCCS Online Claims Submission system that restrict a provider's ability to bill on behalf of other providers. This change increases system integrity and reduces the risk of fraudulent billing.
- Effective June 9, 2023, Provider Moratorium Behavioral Health Outpatient Clinic (77), Integrated Clinic (IC), Non-Emergency Medical Transportation (28), Community Service Agency (A3) and Behavioral Health Residential Facility (B8). This moratorium was set to expire on December 9, 2023, but was extended to June 8, 2024.
- Effective with claims *submitted* on and after July 17, 2023, Fee-For-Service providers billing more than 2 units of hourly codes or 4 units of 15 minutes codes in the following list of HCPCS codes, on a single date of service, are required to provide the following documentation with the submission of the claim:
    - Comprehensive assessment:
        - **The member's most recent comprehensive behavioral health assessment,**
    - Treatment care plan:
        - **The treatment plan for the services billed,**
    - Consent to treat form:
        - **A signed copy of the member's consent to treatment for the services billed, and**
    - Records / Documentation:
        - **Medical record documentation for each claim line billed on the service date(s).**

Billing Codes (claims submitted on or after July 17, 2023, will be affected)

HCPCS	Description
H0006	Alcohol and/or drug service; case management, per 15 minutes,
H0036	Community psychiatric supportive treatment, face to face, per 15 minutes,
H2010	Comprehensive medication services, per 15 minutes,
H2012	Behavioral health day treatment, per hour,
T1002	RN services, per 15 minutes, and
T1003	LPN services, per 15 minutes.

HCPCS Codes Now Requiring Documentation When Billing More Than 8 Units

HCPCS	Description
H2019	Therapeutic behavioral health services, per 15 minutes,
H2025	Ongoing support to maintain employment, per 15 minutes

HCPCS Codes Now Requiring Documentation When Billing More Than 4 Units

Additionally, the documentation requirement on the following codes has changed when providers are submitting claims for more than 4 units on or after July 17, 2023.

HCPCS	Description
H0004	Behavioral Health Counseling and Therapy
H0038	Self-Help/Peer Services

H2011	Crisis Intervention, per 15 minutes-only billable for Crisis Mobile Team services, See (AMPM Policy 590 Behavioral Health Crisis Services and Care Coordination for requirements)
H2014	Skill Training and Development
H2015	Comprehensive Community Support Services
H2017	Psychosocial Rehabilitation Services
H2025	Behavioral Health Prevention Education Service
H2027	Psychoeducational Service
H5150	Unskilled Respite Care, Not Hospice
T1016	Case Management
T1019	Personal Care Services
H0034	Medication training and support, per 15 minutes

- 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 01, 2023, and after, Behavioral Health Residential Facility (BHRF), provider type B8" 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:
    - 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 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 services a week, conducted for at least 3 hours a day and at least 3 days a week.

<u>OIG Continued Projects</u>

- OIG instituted a manual licensure inspection project during SFY22 that has carried over into SFY23. OIG terminated 114 Outpatient Treatment Facilities registered with AHCCCS without current and appropriate licensure during SFY23 due to this review. These terminations resulted in $16,506,072.48 in savings to the AHCCCS program.

- OIG and the Arizona Department of Health Services (ADHS) worked collaboratively during SFY23. 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 an MOU between our two agencies. While the executed MOU fell outside of the period for SFY22, the groundwork leading to this agreement started during this time and continued into SFY23. 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.
    - Due to the collaboration with ADHS and within the various AHCCCS divisions, OIG and DFSM have terminated 729 providers and recognized significant savings. These numbers are in addition to the numbers reported for the Behavioral Health Outpatient Clinic licensing project but are also a running total of all terminations from 1/1/2022 to the end of SFY23. The savings above include various case outcomes such as settlements from providers Sun Valley Services, Babbitt Bowers Behavioral Health, Nevada First Choice, and Lutheran Indian Ministries, which were mentioned in the Arizona Attorney October 2021 press release.

OIG Temporary Structure Change

As directed by the Governor's Office and CEO Heredia, OIG restructured its OIG during SFY23. To address some of the investigative needs associated with behavioral health fraud, the OIG implemented a temporary taskforce referred to as the Strikeforce. The Strikeforce moved sixteen investigators from the OIG's Member Compliance Section (MCS) to bolster the ranks of the Provider Compliance Unit. Over six months, from April 2023 to October 2023, the investigators were split into three groups to work on various tasks associated with behavioral health fraud.

The largest project involved having the investigators conduct site visits / inspections of the following four provider types: B8 (Behavioral Health Residential Facilities), 77 (Behavioral Health Outpatient Clinics), IC (Integrated Clinics), and 01 (Group-Payment ID / Group Billers). Although the MCS investigators had considerable experience conducting field interviews, they received additional training through various courses and presentations to add an extra layer of safety. In addition to asking the providers over two dozen specifically formulated questions designed to root out fraud, waste and abuse, investigators also spoke with AHCCCS members during these site visits to ensure members were being treated appropriately, as well as to uncover any quality-of-care (QOC) issues that may exist. Additionally, the questionnaires / site inspection forms were supplemented with photographs, videos, and audio recordings, when appropriate. OIG shared all patient safety concerns with internal AHCCCS divisions.

Over several weeks, the investigators completed 599 site visits, which resulted in 444 site visits having documented concerns, including 137 QOC issues. QOC issues were slated for submission within 24 hours to stakeholders within AHCCCS and/or ADHS to ensure timely action was taken to protect vulnerable members. Site visit concerns included issues such as service addresses being non-operational or vacant, evidence of improper billing practices (duplicative billing practices between the B8 and 77/IC providers, false billing, billing for services not rendered), as well as a wide range of QOC concerns. Also, the site visits confirmed that many of the registered group billers with AHCCCS were type 77/IC providers rendering services, rather than non-rendering billing providers. The site visit questionnaires / inspection forms were routed to OIG investigators who already had open investigations, or they were reviewed to determine if opening a new case was appropriate for providers who were not already the subject of an open investigation. OIG has continued to share improper registration information with DMPS.

QOC concerns included issues such as members being provided treatment without behavioral health assessments or treatment plans, PHI and HIPAA (Health Insurance Portability and Accountability) issues, improper storage and security of medications, patient brokering, as well as onsite use of illegal or inappropriate drugs and alcohol. Additionally, the site visits revealed an extremely high number of members being billed for services under the American Indian Health Program (AIHP). Concerns notes, but are not limited to;

- Bringing Native Americans into Arizona from other states under false pretenses or against their will and applying for AHCCCS benefits.
- Allowing Native American members and other AHCCCS members who are receiving substance use treatment to continue using intoxicating substances, so the members do not get better, which allows the providers to continue billing AHCCCS for services.

- Housing Native American members in sober living homes that in some cases were not habitable.
- Forcing AHCCCS members out of the programs and into homelessness once their ability to bill AHCCCS had been exhausted.

OIG site visits identified additional concerns that some AHCCCS members enrolled in the AIHP did not qualify for the program because they were not Native Americans. Specifically, evidence was uncovered before and during the Strikeforce site visits that providers were helping members who were not Native American improperly register under the AIHP by providing false statements about their heritage. By enrolling members in the AIHP who should have been enrolled with Managed Care Organizations (MCO), providers could bill services at a higher rate. When Strikeforce investigators found members enrolled in the AIHP and had reason to believe they were not Native American, this information was also referred to the OIG's MCS for further investigation and proper disposition. The MCS investigated referrals alleging improper enrollment of members in the AIHP and worked with the AHCCCS Department of Member and Provider Services and Office of Communication Advocacy and Enrollment to switch improperly enrolled members from the AIHP to an appropriate MCO. As part of the OIG's work on the misclassification of AIHP members, AHCCCS has implemented more stringent policies when determining eligibility for the AIHP.

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

This project continues to be fully reviewed and researched prior to ensure correct and appropriate actions are taken.

<u>External Partnerships</u>

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. SFY23 was truly an all-hands-on deck approach to help combat the fraud in the BH system in Arizona and protect the integrity of the AHCCCS system and tax payor 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 1/1/2020 to current, Arizona has achieved the following results:

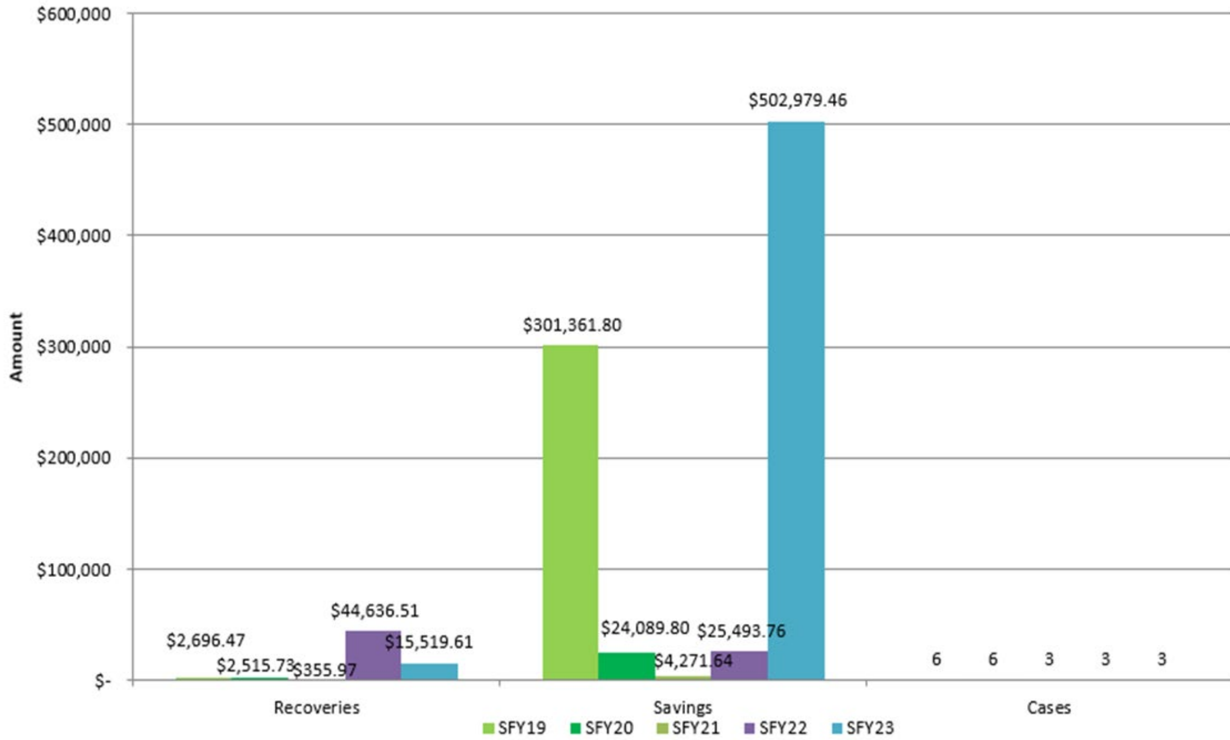
- AZ AGO HCFA
  - Indictments: 80 total
    - 54 Individuals and 29 Entities
    - Of these 80 cases, 43 have already pleaded, been sentenced, or settled, including a most recently guilty verdict by jury of 4 felony charges after a 3-week trial which resulted in a guilty verdict on all 4 counts.
  - 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
  - 6 individual indictments with 2 convictions
- IRS
  - 3 indictments

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 *A Comprehensive Approach to Stopping Behavioral Health Medicaid Fraud* and, an IRS presentation on, *The Role of IRS:CI in Healthcare Fraud Investigations* at the National Association of Medicaid Program Integrity (NAMPI). 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 $518,499.07 in NTXIX savings and recoveries during SFY23. NTXIX is an area of focus OIG has identified for investigation and audit expansion activities.

Access to Services

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

Network

AHCCCS requires MCOs to develop and maintain a comprehensive provider network. MCOs must develop a provider Network Development and Management Plan that assures the provision of covered services. The Plan outlines the process to develop, maintain, and monitor an adequate provider network, supported by written agreements, demonstrating sufficient access to all services covered under the contract.

MCOs' contracted providers must meet AHCCCS minimum network standards and appointment availability requirements. Network standards include minimum time or distance standards for various provider types including Behavioral Health Outpatient and Integrated Clinics (for adult and pediatric populations) and Crisis Stabilization facilities as outlined in the AHCCCS Contractor Operations Manual.

The MCOs report these time and distance standards, which AHCCCS validates through an External Quality Review Organization (EQRO). If the MCO fails to meet a time and distance standard, AHCCCS provides the MCO with a list of AHCCCS-registered providers in or near the county that are currently not in the MCO's network. Similar information is supplied to DES/DDD to assist it with its subcontracted MCOs. Continued failure to meet the standard can result in compliance action under the MCO's contract. Tables XII through XVII on the following pages illustrate the validated findings for the MCO performance against established network requirements for Behavioral Health Outpatient and Integrated Clinics (adult and pediatric populations), and Crisis Stabilization facilities. The ACC MCOs are identified by an '(A)' in the tables below, the ACC-RBHAs by an '(R)', ALTCS/EPD plans with an (L), and DES/DDD subcontractors with a (D).

The time and distance data below represents performance during State Fiscal Year 2023. During that time, there were several changes that impacted the results. Effective October 1, 2022, AHCCCS combined the Regional Behavioral Health Authority (RBHA) functions previously carried out under a separate RBHA contracting into three of its Acute Care Contractor (ACC) plans. These contractors are now termed 'ACC-RBHA' contractors. These Contracts were awarded to Arizona Complete Health, Mercy Care and Care1st Health Plan, which took over the responsibility for the Northern GSA from Health Choice Arizona. The data in these tables combine the results for these two contractors.

Additionally, the contract realigned the counties under the new ACC-RBHA contracts as of October 1, 2022. As a result, Gila and Pinal counties were realigned into the service area administered by Mercy Care. Therefore, the reporting for Gila and Pinal occurs under two RBHAs; the results for Gila County under Health Choice represents the first half the SFY (prior to the realignment), while the second half is reported under Mercy Care. Similarly, the result for Pinal County under Arizona Complete Health represents the first half of the SFY while the second is reported under Mercy Care.

Finally, AHCCCS incorporates telehealth into its time and distance standards for Behavioral Health Outpatient and Integrated Clinics (for adult and pediatric populations). AHCCCS considers an MCO in compliance with time and distance standards if 80% of members lived within a county's time and distance requirements if services via telehealth are available to members in the county.

Table XII – ACC-RBHA Behavioral Health Outpatient/Integrated Clinics (Adults)

ACC-RBHA Behavioral Health Outpatient/Integrated Clinics (Adults)			
SFY 2023			
County/Requirement	Mercy Care (R)	Health Choice Arizona/Care1st (R)	Arizona Complete Health (R)
Maricopa - 90% within 15 min or 10 miles	99.1%		
Pima - 90% within 15 min or 10 miles			98.0%
Apache - 90% within 60 miles		97.3%	
Coconino - 90% within 60 miles		99.2%	
Gila - 90% within 60 miles	100%	100%	
Mohave - 90% within 60 miles		99.9%	
Navajo - 90% within 60 miles		99.3%	
Yavapai - 90% within 60 miles		100%	
Yuma - 90% within 60 miles			99.3%
Pinal - 90% within 60 miles	100%		100%
Cochise - 90% within 60 miles			100%
Santa Cruz - 90% within 60 miles			100%
Graham - 90% within 60 miles			100%
La Paz - 90% within 60 miles			100%
Greenlee - 90% within 60 miles			100%

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

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

ACC Behavioral Health Outpatient/Integrated Clinics (Adults)							
SFY 2023							
County/Requirement	Mercy Care (A)	Health Choice Arizona (A)	Arizona Complete Health (A)	Banner UFC (A)	Care1st (A)	Molina Complete Care (A)	United Health Care (A)
Maricopa - 90% within 15 min or 10 miles	98.8%	97.7%	98.8%	99.2%		98.8%	98.9%
Pima - 90% within 15 min or 10 miles			97.0%	97.2%			96.2%
Apache - 90% within 60 miles		87.2%			79.0%		
Coconino - 90% within 60 miles		87.2%			98.2%		
Gila - 90% within 60 miles	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%
Mohave - 90% within 60 miles		97.5%			99.9%		
Navajo - 90% within 60 miles		95.3%			94.7%		
Yavapai - 90% within 60 miles		100.0%			100.0%		
Yuma - 90% within 60 miles			99.9%	99.7%			
Pinal - 90% within 60 miles	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%
Cochise - 90% within 60 miles			100.0%	100.0%			
Santa Cruz - 90% within 60 miles			100.0%	100.0%			
Graham - 90% within 60 miles			100.0%	100.0%			
La Paz - 90% within 60 miles			99.8%	100.0%			
Greenlee - 90% within 60 miles			99.7%	99.7%			

Indicates in compliance with October 1, 2022 Telehealth modification to time and distance standards

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 2023					
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	99.5%	99.4%	97.7%	98.0%	98.4%
Pima - 90% within 15 min or 10 miles	98.9%	98.6%		95.7%	97.1%
Apache - 90% within 60 miles			97.4%	64.6%	64.4%
Coconino - 90% within 60 miles			96.3%	90.8%	89.7%
Gila - 90% within 60 miles	100%	100%	100.0%	100.0%	100.0%
Mohave - 90% within 60 miles			98.7%	100.0%	96.9%
Navajo - 90% within 60 miles			99.6%	100.0%	95.9%
Yavapai - 90% within 60 miles			100.0%	100.0%	99.9%
Yuma - 90% within 60 miles	99.9%			100.0%	100.0%
Pinal - 90% within 60 miles	100.0%	100.0%	100.0%	100.0%	100.0%
Cochise - 90% within 60 miles	100.0%			100.0%	100.0%
Santa Cruz - 90% within 60 miles	100.0%			100.0%	98.9%
Graham - 90% within 60 miles	100.0%			100.0%	100.0%
La Paz - 90% within 60 miles	100.0%			100.0%	100.0%
Greenlee - 90% within 60 miles	100.0%			100.0%	100.0%

Indicates in compliance with October 1, 2022 Telehealth modification to time and distance standards

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 2023							
County/Requirement	Mercy Care (A)	Health Choice Arizona (A)	Arizona Complete Health (A)	Banner UFC (A)	Care1st (A)	Molina Complete Care (A)	United Health Care (A)
Maricopa - 90% within 15 min or 10 miles	98.8%	98.3%	98.9%	99.1%		98.6%	99.0%
Pima - 90% within 15 min or 10 miles			97.00%	97.2%			96.5%
Apache - 90% within 60 miles		82.2%			74.5%		
Coconino - 90% within 60 miles		82.5%			97.8%		
Gila - 90% within 60 miles	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%
Mohave - 90% within 60 miles		95.2%			99.9%		
Navajo - 90% within 60 miles		94.0%			91.2%		
Yavapai - 90% within 60 miles		100.0%			100%		
Yuma - 90% within 60 miles			100.0%	99.8%			
Pinal - 90% within 60 miles	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%
Cochise - 90% within 60 miles			100.0%	100.0%			
Santa Cruz - 90% within 60 miles			100.0%	100.0%			
Graham - 90% within 60 miles			100.0%	100.0%			
La Paz - 90% within 60 miles			100.0%	100.0%			
Greenlee - 90% within 60 miles			100.0%	99.7%			

Indicates in compliance with October 1, 2022 Telehealth modification to time and distance standards

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 2023					
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	97.2%	98.4%	98.1%	97.9%	98.7%
Pima - 90% within 15 min or 10 miles	87.9%	93.4%		93.6%	95.2%
Apache - 90% within 60 miles			100.0%		68.2%
Coconino - 90% within 60 miles			100.0%	100.0%	87.0%
Gila - 90% within 60 miles	100.00%	100.0%		100.0%	100.0%
Mohave - 90% within 60 miles			100.0%	96.7%	95.3%
Navajo - 90% within 60 miles			10.00%	94.5%	94.5%
Yavapai - 90% within 60 miles			100.0%	100.0%	100.0%
Yuma - 90% within 60 miles	100.0%			100.0%	100.0%
Pinal - 90% within 60 miles	100.0%	100.0%	100.0%	100.0%	100.0%
Cochise - 90% within 60 miles	100.0%			100.0%	100.0%
Santa Cruz - 90% within 60 miles	100.0%			100.0%	100.0%
Graham - 90% within 60 miles	100.0%			100.0%	100.0%
La Paz - 90% within 60 miles				100.0%	100.0%
Greenlee - 90% within 60 miles				100.0%	100.0%

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 2023			
County/Requirement	Mercy Care (R)	Health Choice Arizona (R)	Arizona Complete Health (R)
Maricopa - 90% within 15 min or 10 miles	99.5%		
Pima - 90% within 15 min or 10 miles			98.2%
Apache - 90% within 45 miles		97.3%	
Coconino - 90% within 45 miles		98.7%	
Gila - 90% within 45 miles	100.0%	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	100.00%		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. 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:
      a. For member aged 18 years or older, no later than 23 calendar days after the initial assessment, or
      b. Members under the age of 18 years old, no later than 21 days after the initial assessment.
   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:

1. Assess the urgency of the need immediately, and
2. Provide an appointment, if clinically indicated, with a behavioral health medical professional 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 the availability of routine and urgent appointments for behavioral health appointments. Starting in January 2023, AHCCCS revised MCO reporting from quarterly submissions to semi-annual submissions of these reviews. As a result, the data here represents three survey periods instead of SFY 2022's use of four periods.

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. 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 2023 Average										
	Mercy Care (R)	HCA/Care1st (R)	Arizona Complete Health (R)	Mercy Care (A)	Health Choice Arizona (A)	Arizona Complete Health (A)	Banner UFC (A)	Care1st (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.	100.0%	96.5%	96.3%	100.0%	98.0%	96.3%	100.0%	96.3%	100.0%	93.3%
Routine: Initial assessment within seven calendar days of referral or request for service.	100.0%	96.4%	97.1%	99.7%	98.9%	97.1%	99.5%	96.1%	100.0%	95.2%
Routine: Initial appointment within timeframes indicated by clinical need, but for members aged 18 years or older, no later than 23 calendar days after the initial assessment.	99.8%	97.4%	97.6%	100%	99.3%	97.6%	100.0%	97.3%	100.0%	96.7%
Routine: Initial appointment within timeframes indicated by clinical need, but for members under the age of 18 years old, no later than 21 days after the initial assessment.	100.0%	97.1%	99.5%	100.0%	99.5%	97.0%	100.0%	97.0%	100%	91.7%
Routine - All 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.	100.0%	96.5%	97.3%	100.0%	99.8%	97.3%	99.9%	96.3%	100.0%	98.3%
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.	99.9%	97.9%	97.3%	99.0%	99.5%	93.8%	100.0%	97.5%	100.0%	85.0%

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 2023 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.	100.0%	100.0%	93.3%	100.0%	93.3%
Routine: Initial assessment within seven calendar days of referral or request for service.	99.5%	99.7%	95.1%	99.2%	95.2%
Routine: Initial appointment within timeframes indicated by clinical need, but for members aged 18 years or older, no later than 23 calendar days after the initial assessment.	100.0%	100.0%	96.7%	100.0%	96.0%
Routine: Initial appointment within timeframes indicated by clinical need, but for members under the age of 18 years old, no later than 21 days after the initial assessment.	100.0%	100.0%	91.7%	100.0%	90.2%
Routine - All 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.	99.6%	100.0%	98.3%	100.0%	97.6.%
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%	99.0%	85.0%	99.2%	84.3%

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 2022. 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 2022 AHCCCS Performance Measure Data[1,2,3]

CY 2022 Behavioral Health Performance Measure Rates				
Performance Measure	2022 NCQA Medicaid Mean[1]	ACC Aggregate	SMI Aggregate	Statewide[2] Aggregate
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 Day Follow-Up (Total) - NCQA	25.0%	31.2%	56.8%	35.3%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 Day Follow-Up (Total) - NCQA	36.4%	40.9%	73.5%	46.8%
Follow-Up After Emergency Department Visit for Mental Illness - 7 Day Follow-Up (Total) - NCQA	41.5%	46.4%	57.1%	50.8%
Follow-Up After Emergency Department Visit for Mental Illness - 30 Day Follow-Up (Total) - NCQA	55.2%	56.6%	72.0%	63.1%
Follow-Up After Hospitalization for Mental Illness - 7 Day Follow-Up (Total) - NCQA	36.6%	46.5%	67.4%	59.0%
Follow-Up After Hospitalization for Mental Illness – 30 Day Follow-Up (Total) - NCQA	57.1%	63.2%	82.6%	75.5%
Follow-Up Care for Children Prescribed Attention-Deficit/ Hyperactivity Disorder (ADHD) Medication – Initiation Phase	43.6%	56.1%	N/A	57.6%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication – Continuation and Maintenance Phase	53.1%	66.6%	N/A	66.6%

[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/line of business.*

[3] *Note: Updated 10/16/2024 to reflect accurate data points.*

Conclusion

AHCCCS prioritizes access to quality, integrated physical and behavioral health care via a Managed Care Organization (MCO) integrated delivery system. Integrated systems of care provide a systemic and cost-effective approach to meeting the comprehensive health care needs of Arizonans benefiting from AHCCCS programs and services. While Arizona has recently faced challenges, numerous efforts related to improved service delivery, oversight, and monitoring activites and requirments have been implemented and the momentum for continued improvements is on-going. Examples of efforts made and in progress include:

- Revisions of multiple Arizona Medical Policy Manual policies to further define and direct service delivery including contractor and provider case management, evidence-based practices, Non-Title XIX/XXI funding utilization, and behavioral health residential facility operations.
- Reintroduction of the Covered Behavioral Health Services Guide to promote understanding of service billing codes and programming/procedural expectations.
- Continuous evaluation and improvement to the behavioral health audit tool, including revising the methodology to advance encapsulation of a comprehensive sample to thoroughly review provider compliance and analyze outcomes
- Braiding Medicaid and grant funding to expand crisis intervention services throughout the state but especially in rural/frontier geographic service areas
- Engagement in fidelity audits of Assertive Community Treatment and actively partnering with ACC-RBHAs and providers to ensure service delivery occurs within fidelity standards
- Utilization of grant funds to support the Arizona Perinatal Psychiatric Access Line allowing for medical and behavioral health providers access to consult with psychiatrists specializing in treatment options for this complex population
- 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.

AHCCCS will continue to provide guidance, oversight, and monitoring of integrated service delivery to our members in addition to analyzing data and collaborating with our MCOs and provider networks to improve health and wellbeing outcomes for all our members.