Arizona Health Care Cost Containment System
Review of Selected Behavioral Health Services

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Performance Audit

September 2022
Report 22-111

A Report to the Arizona Legislature

Lindsey A. Perry
Auditor General

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September 29, 2022

Members of the Arizona Legislature

The Honorable Doug Ducey, Governor

Ms. Jami Snyder, Director
Arizona Health Care Cost Containment System

Transmitted herewith is the Auditor General's report, *Arizona Health Care Cost Containment System—Review of Selected Behavioral Health Services*. This report is in response to a September 19, 2018, resolution of the Joint Legislative Audit Committee. The performance audit was conducted as part of the sunset review process prescribed in Arizona Revised Statutes §41-2951 et seq. I am also transmitting within this report a copy of the Report Highlights to provide a quick summary for your convenience.

As outlined in its response, the Arizona Health Care Cost Containment System agrees with the finding and plans to implement the recommendation. My Office will follow up with the Arizona Health Care Cost Containment System in 6 months to assess its progress in implementing the recommendation.

My staff and I will be pleased to discuss or clarify items in the report.

Sincerely,

Lindsey A. Perry

Lindsey A. Perry, CPA, CFE
Auditor General

Arizona Health Care Cost Containment System
Review of Selected Behavioral Health Services

AHCCCS reported providing behavioral health services to more than 583,000 members in fiscal year 2021 and has contracted for assessments of its behavioral health performance and various services but did not ensure all peer specialists met qualification and supervision requirements, potentially jeopardizing the quality of services provided to members

Audit purpose

To determine whether AHCCCS ensured peer specialists who provide services to AHCCCS members met qualification and supervision requirements and provide information about the AHCCCS Housing Program, behavioral health-related committees and work groups, and behavioral health-related reporting requirements.

Key findings

AHCCCS:

- Provides integrated physical and behavioral health services to its eligible members through a managed care system, including peer support services provided by peer specialists, such as helping members identify needs and recovery goals, and reported providing behavioral health services to more than 583,000 members at a cost of over $2.7 billion in fiscal year 2021.
- Has established various behavioral healthcare performance measures and contracts for independent assessments of these performance measures and the provision of other required behavioral health services, including services provided to members with a serious mental illness (SMI).
- Did not ensure that 21 of 23 peer specialists we reviewed met both State and federal qualification requirements to be a peer specialist and/or were supervised according to requirements, potentially jeopardizing the quality of peer support services provided to members.
- Has directed its contracted health plans to oversee the provision of peer support services provided by peer specialists but did not have a process for ensuring this oversight occurs.
- Provides housing rental subsidies to eligible AHCCCS members with an SMI and some members with a general mental health and/or substance use disorder through its Housing Program. As of March 2022, approximately 2,300 members were enrolled in the Housing Program, and an additional 4,134 members were on the Housing Program waitlist.
- Contracts with a Housing Administrator to manage and operate its Housing Program and has established performance measures for assessing Housing Administrator performance.
- Administers various committees, councils, task forces, and workgroups related to behavioral healthcare services.
- Provides several reports to the Legislature, Joint Legislative Budget Committee, and Governor that include information on behavioral healthcare expenditures and specific behavioral health areas/programs in response to statutory and session law requirements.

Key recommendation

- AHCCCS should develop and implement processes for monitoring its contracted health plans' oversight of peer specialists to help ensure they meet qualifications and receive supervision as required.

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INTRODUCTION

The Arizona Auditor General has released the second in a series of 3 audit reports of the Arizona Health Care Cost Containment System (AHCCCS) as part of AHCCCS' sunset review. This performance audit focused on AHCCCS' administration of certain behavioral health services and determined whether AHCCCS ensured peer and recovery support specialists (peer specialists) who provide services to AHCCCS members met qualification and supervision requirements and provides information about the AHCCCS Housing Program. The first audit determined whether AHCCCS complied with State and federal regulations and AHCCCS policies when disenrolling members from Medicaid and children's health insurance coverage.[1] The final audit report determined whether AHCCCS investigated fraud and abuse allegations within its time frame goals and provides responses to the statutory sunset factors.[2]

AHCCCS responsible for providing behavioral healthcare coverage to members

AHCCCS administers Arizona's Medicaid Program, which provides integrated physical and behavioral health services to eligible low-income individuals living in Arizona through a managed care system.[3,4,5] Specifically, AHCCCS contracts with the following health plans (contracted health plans):

- 7 Complete Care health plans that provide integrated healthcare coverage to approximately 2 million AHCCCS members in the State.
- 3 regional behavioral health authorities (RBHAs) that provide integrated healthcare coverage to members with a serious mental illness (SMI).[6,7]
- 4 Arizona Long Term Care System (ALTCS) health plans that provide healthcare services to members needing long-term care services.
- 1 health plan that provides integrated healthcare services to children involved with the State's foster care system.

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1 Arizona Auditor General Report 22-103 *Arizona Health Care Cost Containment System—Member Disenrollment Processes*.

2 Arizona Auditor General Report 22-112 *Arizona Health Care Cost Containment System—Performance Audit and Sunset Review.*

3 Medicaid is a healthcare coverage program administered and operated by states within federally established parameters. The federal government pays most Medicaid programs' costs. During fiscal year 2022, AHCCCS estimated that its revenues would total nearly $21.5 billion, including approximately $17.35 billion in federal Medicaid monies; nearly $2.73 billion in State monies, including $1.82 billion from the State General Fund and approximately $900 million from State agencies; and approximately $1.38 billion from other sources, such as county and tobacco tax revenues.

4 Prior to 2016, the Arizona Department of Health Services' (ADHS) Division of Behavioral Health Services was responsible for administering Medicaid and non-Medicaid behavioral health services. Laws 2015, Ch. 19, §9, transferred the administration of Medicaid and non-Medicaid behavioral health services from ADHS to AHCCCS.

5 AHCCCS also provides healthcare services, including behavioral health services, through a fee-for-service model, where AHCCCS pays healthcare providers directly for services.

6 An SMI is a chronic and long-term mental health condition that impacts a person's ability to perform day-to-day activities or interactions. According to AHCCCS' policies, individuals can request an assessment with a provider to receive an SMI designation. Members with an SMI do not need to be Medicaid eligible to receive healthcare services from AHCCCS.

7 AHCCCS also has intergovernmental agreements with 5 tribes and/or regional behavioral health authorities (TRBHA)—Colorado River Indian Tribes, Gila River, Navajo, Pascua Yaqui, and White Mountain Apache—to provide behavioral healthcare services to Native American members. Native American members with an SMI have the choice of enrolling with a RBHA or with a TRBHA for behavioral healthcare coverage.

AHCCCS members choose the contracted health plan in which they would like to enroll based on their county of residence and have the option to change their health plan once a year (see Figure 1).

Figure 1
AHCCCS contracted health plans by region[1]
As of August 2022
(Unaudited)

North region

Care 1st

Health Choice Arizona (includes RBHA)[2]

UnitedHealthcare Community Plan (ALTCS only)

Central region

Banner-University Family Care (includes ALTCS)

Health Choice Arizona

Arizona Complete Health-Complete Care Plan

Molina Healthcare

Mercy Care (includes ALTCS and RBHA in Maricopa County only)[3]

UnitedHealthcare Community Plan (includes ALTCS)

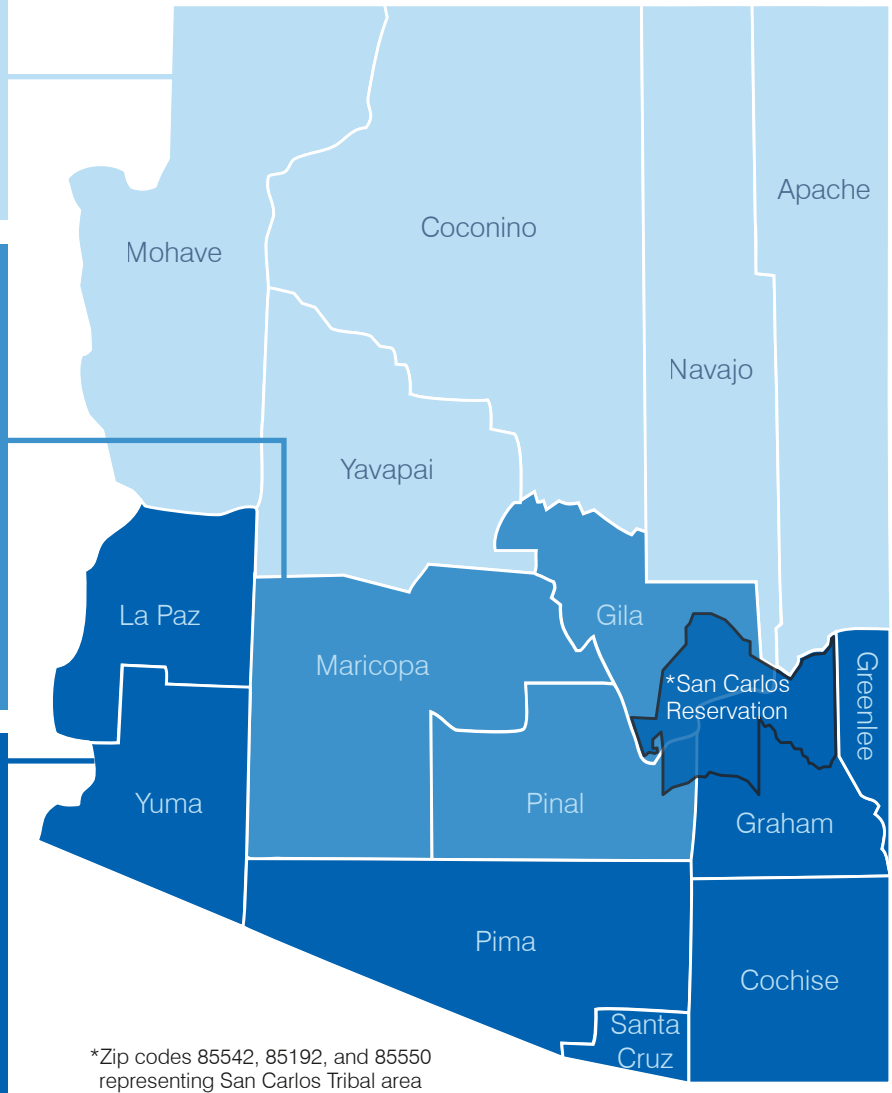
South region

Banner-University Family Care (includes ALTCS)

Arizona Complete Health-Complete Care Plan (includes RBHA)

Mercy Care—Pima County only (ALTCS only)

UnitedHealthcare Community Plan—Pima County only



*Zip codes 85542, 85192, and 85550 representing San Carlos Tribal area are included in the South region.

[1] Some contracted health plans provide services in more than 1 region. Additionally, AHCCCS contracts with the Arizona Department of Economic Security (ADES) Division of Developmental Disabilities to provide ALTCS services to individuals with developmental disabilities across all regions. AHCCCS also contracts with the Arizona Department of Child Safety Comprehensive Health Plan (DCS CHP) to provide services to children involved with the State's foster care system across all regions.

[2] RBHA members will transition their health plan coverage from Health Choice Arizona to Care 1st effective October 1, 2022.

[3] RBHA members residing in Pinal and Gila Counties will transition their health plan coverage to Mercy Care when it expands its coverage to include both counties effective October 1, 2022.

Source: Auditor General staff analysis of AHCCCS-contracted health plan service map.

AHCCCS requires each contracted health plan to develop and maintain an adequate provider network to provide physical and behavioral health services to enrolled members. As such, contracted health plans contract with primary care physicians and other medical specialists to provide physical health services and behavioral healthcare providers, such as psychologists and psychiatrists, to provide behavioral health services to their enrolled members. Behavioral health services provided to AHCCCS members include but are not limited to counseling, substance abuse treatment, and residential behavioral health services, such as services provided in a structured living environment.

Additionally, for their behavioral healthcare, members with an SMI have access to treatment and support resources, including an assigned case manager to help them coordinate healthcare services through the RBHAs. Some members with an SMI also have access to assertive community treatment (ACT), which consists of a team of providers that coordinate care if the member requires more individualized healthcare exceeding standard case management.[8] Further, members with an SMI also have access to permanent supportive housing, which includes rental subsidy support and other housing-related services. Specifically, through the AHCCCS Housing Program (Housing Program), members with an SMI can apply for housing rental support provided through housing subsidies to pay for the costs of leasing housing within the State.[9] In October 2021, AHCCCS contracted with a Statewide Housing Administrator to manage its Housing Program.[10] As of March 2022, approximately 2,300 AHCCCS members were enrolled in the Housing Program (see Questions and Answers, pages 15 through 21, for more information about the Housing Program).

Finally, as part of the previously mentioned behavioral health services, AHCCCS members have access to peer support services that are provided by credentialed peer specialists. Peer support services consist of supportive activities which include but are not limited to helping AHCCCS members with behavioral health treatment and recovery, including assisting AHCCCS members with identifying behavioral health needs and recovery goals and providing mentoring to help members understand behavioral health treatments and care options. As of December 2021, contracted providers reported employing 951 peer specialists to provide peer support services to members (see Finding 1, pages 11 through 14, for information and recommendations related to AHCCCS' lack of oversight related to peer support specialists).

AHCCCS reported providing behavioral health services to more than 583,000 members at a cost of over $2.7 billion in fiscal year 2021

In fiscal year 2021, AHCCCS' contracted health plans and behavioral healthcare providers provided behavioral health services to more than 583,000 AHCCCS members at a total cost of over $2.7 billion. Funding for behavioral health services comes from various sources including State General Fund monies, federal Medicaid monies, county monies, tobacco tax monies, and various federal grant monies, such as the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant. These monies were used to provide services to Medicaid members and individuals not qualified for Medicaid, including those with an SMI, children with serious emotional disturbance, members experiencing alcohol and drug abuse, and members with other mental health disorders (see Figure 2, page 4, for more information on behavioral health expenditures and members served).[11]

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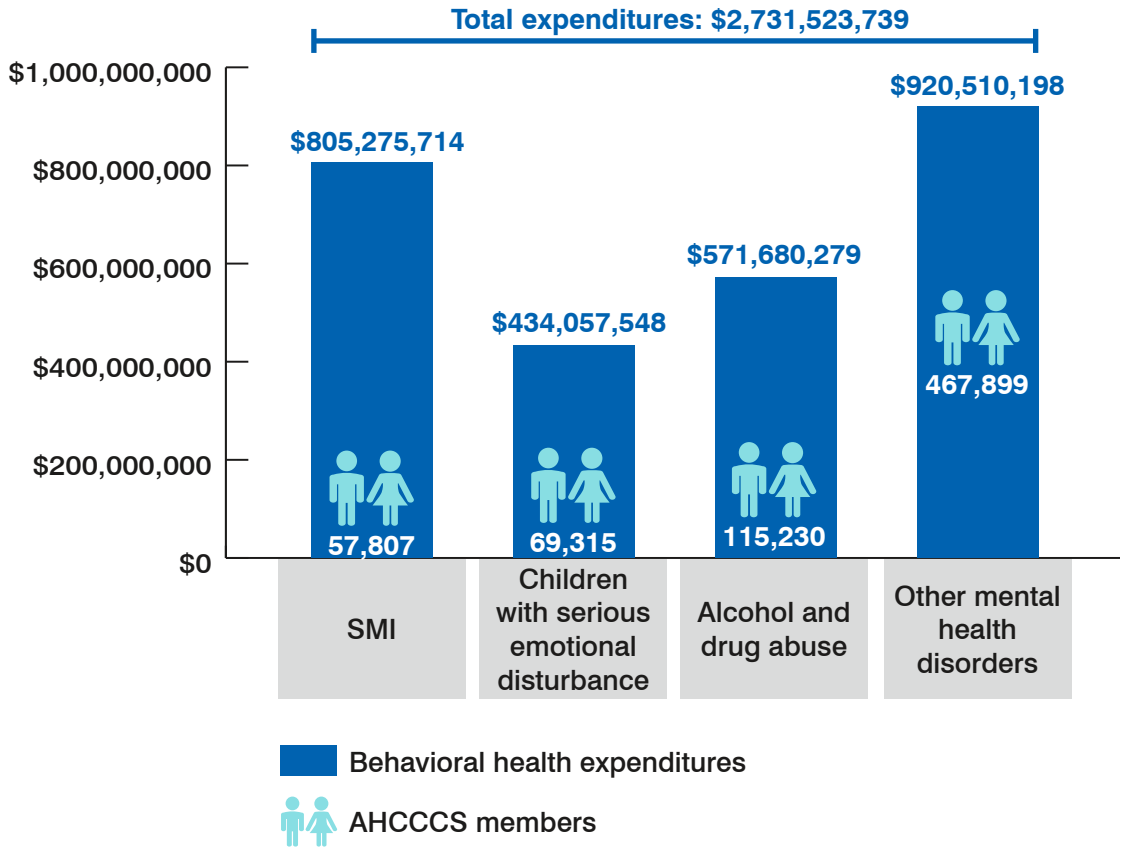
[8] Standard case management for members with an SMI includes a case manager who is responsible for locating, assessing, and monitoring healthcare services for the member. However, some members with an SMI may require an assertive community treatment team to help coordinate care.

[9] The Housing Program is available to eligible members with an SMI and some members with a general mental health and/or substance use disorder that have been identified as high cost/high needs. High cost/high needs refers to members who require more individualized behavioral healthcare services based on the complexity of their service needs, the cost of their service needs, utilization of services, and service history.

[10] Prior to contracting with the Statewide Housing Administrator, the Housing Program was administered by 3 separate RBHAs. Each RBHA was responsible for administering the Housing Program in its assigned counties.

[11] Children with serious emotional disturbance includes members up to age 18 who have a mental health condition that impacts their ability to participate in family, school, or community activities.

Figure 2
AHCCCS provided behavioral health services to more than 583,000 members with various behavioral health designations/diagnoses at an approximate cost of $2.7 billion[1]
Fiscal year 2021
(Unaudited)



[1] Includes expenditures for behavioral health services, such as counseling, substance abuse treatment, residential behavioral health services, peer support services, and housing subsidies.

Source: Auditor General staff review of AHCCCS. (2021). *Behavioral health services annual report, fiscal year 2021*. Phoenix, AZ. Retrieved 7/6/22 from https://www.azahcccs.gov/shared/Downloads/Reporting/2021/FY2021BehavioralHealthProgrammaticExpenditureReport.pdf.

AHCCCS has established various behavioral healthcare performance measures, reviews them, and contracts for independent assessment of them and provision of other required behavioral health services

Federal regulations require AHCCCS to establish standard performance measures for its contracted health plans and to collect contracted health plan performance measurement data related to the established performance measures.[12] AHCCCS uses standardized performance measures, including behavioral health-related performance measures, based on Centers for Medicare and Medicaid Services (CMS) Core Set measures and Healthcare Effectiveness Data and Information Set (HEDIS) measures established by the

[12] 42 Code of Federal Regulations (CFR) §438.330.

National Committee for Quality Assurance (NCQA), to evaluate contracted health plan performance.[13] See textbox for examples of behavioral health-related performance measures. Further, AHCCCS compares contracted health plan performance measure data to national benchmarks, such as the NCQA Medicaid Mean.[14] These national benchmarks serve as performance targets for AHCCCS' contracted health plans.

Examples of AHCCCS behavioral health-related performance measures:

- **Antidepressant medication management—**Percentage of members age 18 and older diagnosed with major depression who were treated with antidepressant medication and remained on an antidepressant medication for at least 84 and 180 days.
- **Followup after emergency department visit for alcohol and other drug abuse or dependence—**Percentage of emergency department visits for members age 18 and older with a principal diagnosis of alcohol or other drug abuse or dependence who had a follow-up visit for alcohol or other drug abuse or dependence within 7 and 30 days.
- **Followup after hospitalization for mental Illness—**Percentage of discharges for members age 18 and older who were hospitalized for mental illness or intentional self-harm who had a follow-up visit with a mental health provider within 7 and 30 days.
- **Initiation and engagement of alcohol and other drug abuse or dependence treatment—**Percentage of members age 18 and older with a new episode of alcohol or other drug dependence who received:
    - **Initiation of alcohol and other drug treatment—**Percentage of members who initiated treatment through inpatient alcohol and other drug admission, outpatient visit, intensive outpatient treatment or partial hospitalization, telehealth, or medication treatment within 14 days of diagnosis.
    - **Engagement of alcohol and other drug treatment—**Percentage of members who initiated treatment and who were engaged in ongoing alcohol and other drug treatment within 34 days of the initiation visit.

Source: Auditor General staff review of AHCCCS documents, CMS information, and Health Services Advisory Group (HSAG). (2022). *Contract year ending 2021 external quality review annual technical report for AHCCCS Complete Care and Department of Child Safety Comprehensive Health Plan*. Retrieved 7/25/2022 from https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-ACCandDCS-CHP.pdf.

As required by federal regulation, AHCCCS contracts with an external quality review organization, HSAG, to perform an annual external quality review.[15,16] This review includes validating contracted health plan performance related to the performance measures and presenting any findings on the quality, timeliness, and accessibility of contracted health plan-provided healthcare services, including behavioral health services. For example, the 2021 external quality review of AHCCCS' 7 Complete Care contracted health plans, which reports on measurement year 2020 performance, found that for the performance measure related to follow-up visits within 7 and 30 days after hospitalization for mental Illness, 5 of 7 contracted health plans met or exceeded the 2020 NCQA Medicaid Mean. HSAG also makes recommendations to contracted health plans and/or AHCCCS for improving performance and follows up on prior-year recommendations. For example, the 2020 external quality review recommended that AHCCCS work with its Complete Care contracted health plans to increase rates for the performance measure related to follow-up visits within 7 and 30 days after hospitalization

[13] According to CMS, HEDIS is a is a set of standardized performance measures designed to provide information for reliable comparison of health plan performance. Additionally, NCQA is a national independent nonprofit organization that is contracted by government entities and private sector clients to measure and improve the quality of healthcare services. NCQA collects data on behalf of CMS.

[14] In 2020, AHCCCS transitioned from using internally established minimum performance standards to national benchmarks.

[15] 42 CFR §438.364.

[16] HSAG, 2022.

for mental illness and the 2021 external quality review found that the Complete Care contracted health plans had addressed this recommendation.[17,18]

In addition to contracting for an external quality review, AHCCCS contracts for the following reviews and assessments of behavioral health services provided to members with an SMI:

- **Annual fidelity reviews that assess whether behavioral health services provided to members with an SMI meet SAMHSA standards—**The *Arnold v. Arizona Department of Health Services (commonly referred to as Arnold v. Sarn)* agreement requires the State to adopt national standards from SAMHSA and assess whether behavioral health service providers' delivery of services to members with an SMI meets these standards (see textbox for information on the *Arnold v. Sarn* lawsuit and agreement). SAMHSA standards include evidence-based practices for providing behavioral health services, such as supportive housing services, which help communities provide effective services for individuals with mental illness that produce specific, intended results. For example, a SAMHSA standard for supportive housing is ensuring individuals' housing is integrated into the community as opposed to clustering individuals with disabilities.

  AHCCCS contracts with the Western Interstate Commission for Higher Education (WICHE) to conduct annual fidelity reviews to assess how closely services expanded by the *Arnold v. Sarn* agreement in Maricopa County align with SAMHSA standards.[19] Specifically, the fidelity review scores how closely the following 4 service areas—ACT team, supportive employment, family and peer support, and supportive housing services—align with SAMHSA standards (see textbox, page 7, for fiscal year 2021 fidelity review results).[20]

Arnold v. Sarn lawsuit and agreement

A class action lawsuit filed against the State of Arizona in 1981 that alleged ADHS and Maricopa County did not provide a comprehensive community mental health system, as required by statute.[1,2] The parties reached an agreement in 2014 that required the State to expand services in 4 areas—ACT team, supportive employment, family and peer support, and supportive housing services—for individuals with an SMI in Maricopa County.[3] The agreement also required the State to adopt review tools to ensure the 4 service areas provided to members with an SMI meet standards established by SAMHSA.

[1] See *Arnold v. Arizona Dept. of Health Services*, 160 Ariz. 593, 775 P.2d 521 (1989).

[2] As previously reported, prior to 2016, ADHS was responsible for the oversight of Medicaid and non-Medicaid behavioral health services. Laws 2015, Ch. 19, §9, transferred the administration of Medicaid and non-Medicaid behavioral health services from ADHS to AHCCCS.

[3] According to AHCCCS, supportive employment services include job coaching, specialized job training, supervision, transportation, and other services to help members with an SMI attain and maintain competitive employment.

Source: Auditor General staff review of *Arnold v. Arizona Dept. of Health Services*, 160 Ariz. 593, 775 P.2d 521 (1989); Laws 2015, Ch. 19, §9; and AHCCCS information.

[17] HSAG, 2022; and HSAG. (2021). *Contract year ending 2020 external quality review annual report for AHCCCS Complete Care and Comprehensive Medical and Dental Program*. Retrieved 8/29/22 https://www.azahcccs.gov/Resources/Downloads/EQR/2020/CYE2020ExternalQualityReviewAnnualReportACCandCMDP.pdf.

[18] Although HSAG reported that AHCCCS' Complete Care contracted health plans had addressed this recommendation, the 2021 external quality review found that 2 of 7 contracted health plans had not met or exceeded the measurement year 2020 NCQA Medicaid Mean for the performance measure related to follow-up visits within 7 and 30 days after hospitalization for mental illness. Based on the 2021 external quality review, HSAG recommended that these 2 AHCCCS Complete Care contracted health plans conduct a root cause analysis to determine why members were not receiving timely follow-up care with a mental health provider and implement appropriate interventions.

[19] WICHE is an interstate agency that operates under a compact adopted by 15 states, including Arizona, and some U.S. Pacific territories. WICHE's behavioral health program provides consulting, technical assistance, research, and other resources to improve behavioral healthcare in the West.

[20] According to AHCCCS, service providers selected for fidelity review are based on changes in scores from the previous years, and providers with the most significant decline in their scores are prioritized for review. AHCCCS reported that, according to WICHE, providers should not go longer than 3 years without a review.

Fiscal year 2021 SAMHSA fidelity reviews

In fiscal year 2021, WICHE conducted fidelity reviews to assess 24 SMI service providers in Maricopa County as follows: 13 ACT teams, 4 supportive employment providers, 3 peer and family support providers, and 4 permanent supportive housing service providers. The reviews identified the following within each of the 4 service areas:

- **ACT team services—**The 13 ACT teams reviewed had operations that mostly aligned with SAMHSA standards for ACT teams. For example, SAMHSA standards recommend ACT teams provide 24-hour crisis service coverage to members with an SMI. The fidelity reviews found that all 13 ACT teams provided 24-hour crisis services. However, all 13 ACT teams did not meet the SAMHSA standard to spend an average of 2 hours or more a week with each member with an SMI.
- **Supportive employment services—**The 4 supportive employment service providers reviewed had operations that mostly aligned with SAMHSA standards for supportive employment services. For example, all 4 supportive employment service providers had supportive employment specialists with 25 or fewer clients as required by SAMHSA standards. However, all 4 supportive employment service providers did not meet the SAMHSA standard for employment specialists to spend 70 percent or more of their time providing services in the community.
- **Family and peer support services—**The 3 family and peer support service providers reviewed had operations that mostly aligned with SAMHSA standards. For example, SAMHSA standards recommend that service providers have a formal policy for addressing grievances and assessing customer satisfaction. The fidelity review found that all 3 family and peer support service providers had such a policy. However, the fidelity review found that 1 of 3 providers did not have a physical environment that fully aligned with SAMHSA standards.
- **Supportive housing services—**See Questions and Answers, pages 20 through 21, for more information on the supportive housing services fidelity review results.

Source: Auditor General staff review of SAMHSA documents and WICHE. (2021). *FY 2020-2021 (Year 7): Evidence based practices fidelity project quality improvement report*. Retrieved 7/8/22 from https://www.azahcccs.gov/AHCCCS/Downloads/ArnoldVSarn/AnnualReports/2021/WICHE_Year7YearEndReport.pdf.

- **An annual quality review of services provided to members with an SMI—**AHCCCS contracts with Mercer Health & Benefits (Mercer) to conduct an annual quality service review.[21] Separate from the fidelity reviews previously discussed, the purpose of this review is to identify strengths, service capacity gaps, and areas for improvement for members with an SMI who receive behavioral health services in Maricopa County. For example, the annual quality service review includes medical record reviews and interviews of a sample of members with an SMI to determine whether their needs are being identified and met by available behavioral health services, including those services expanded by the *Arnold v. Sarn* agreement.[22]

  The 2021 quality service review found that, for the sample of members reviewed, the most identified service needs were case management and medication management services.[23,24] Additionally, 90 percent of individual service plans reviewed had services that were based on members' needs.[25,26] However, 10 percent of members sampled did not have a current individual service plan and, according to Mercer,

[21] Mercer is a consulting firm that provides consulting services to government-funded health and welfare organizations.

[22] A need is defined as an issue or gap that is identified by a member or clinical team that requires a service or an intervention.

[23] Mercer. (2021a). *Quality service review 2021*. Retrieved 7/8/22 from https://www.azahcccs.gov/AHCCCS/Downloads/ArnoldVSarn/AnnualReports/2021/QualityServiceReviewReport2021.pdf.

[24] Mercer reported selecting a sample of 135 of 34,114 Maricopa County members with an SMI for review.

[25] An individual service plan is a plan, required for members with an SMI, developed by clinical teams and members that incudes services consistent with members' needs and preferences. This plan is required to have measurable goals and objectives that help evaluate members' progress toward attaining them.

[26] According to Mercer, 78 percent of members interviewed felt that services were based on their strengths and needs.

behavioral health services cannot be identified as needs if the individual service plan is missing or outdated. Further, Mercer found that individual service plans lacked strength-based objectives for 50 percent of members' individual service plans reviewed.[27] Mercer also found that case management, family support, crisis management, ACT team, and medication management services were consistently provided to members with an SMI after a need for the service was identified in the members' individual service plan. However, based on its review of documentation, Mercer found that peer support services, supportive employment services, and living skills training were not consistently provided to members with an SMI after a need was identified in the members' individual service plan.[28] Finally, Mercer found that for approximately 82 percent of members sampled, case management, peer support, family support, and living skills training were available to members within 15 days. Conversely, supportive housing and supportive employment services were identified as being the least available within 15 days and over 50 percent of members sampled reported that supportive housing services required more than 30 days to access.

- **An annual service capacity assessment of services provided to members with an SMI—**AHCCCS also contracts with Mercer to conduct an annual service capacity assessment that evaluates the utilization, need, availability, and provision of ACT team, family and peer support, supportive employment, and supportive housing services. Specifically, as part of this assessment, Mercer determines the extent to which members with an SMI use these specific services. For example, Mercer reported that 41 percent of members with an SMI received at least 1 unit of peer support during the calendar year 2020 time period as compared to 35 percent of members with an SMI that received at least 1 unit of peer support during the calendar year 2019 time period. See Table 1 for information on service utilization rates for these services in calendar year 2019 and 2020.

Table 1
Service utilization by members with an SMI in Maricopa County by service type[1]
Calendar years 2019 and 2020

	2019	2020	Change in service utilization
ACT team	6.6%	6.6%	-
Family support	5%	6%	1%
Peer support	35%	41%	6%
Supported employment	31%	34%	3%
Supported housing	15%	22%	7%

[1] According to Mercer, the service utilization rates are based on 34,451 and 35,114 members with an SMI in Maricopa County during calendar years 2019 and 2020, respectively.

Source: Auditor General staff review of Mercer. (2021b). *Priority mental health services 2021: Service capacity assessment*. Retrieved 7/7/2022 from https://www.azahcccs.gov/AHCCCS/Downloads/ArnoldVSarn/AnnualReports/2021/20211130AHCCCS_ServiceCapacityAssessment.pdf.

Examples of findings and recommendations from the 2021 service capacity assessment include the following for each area reviewed:[29]

- **ACT team services—**According to Mercer, the capacity of ACT team services appeared to be adequate to meet members' needs. However, it recommended analyzing service utilization trends and reviewing information such as jail-booking data and adverse incidents involving members with an SMI to identify members who could benefit from ACT teams. Mercer reported that the contracted health

[27] Strengths are defined as traits, abilities, resources, and characteristics that are relevant for and/or will assist members with their needs and objectives. Strengths can be identified by the members or clinical teams.

[28] Mercer reported that some members with an SMI received 1 or more of the reviewed services regardless of having a documented need.

[29] Mercer, 2021b.

plan responsible for delivering these services was in the process of developing a risk tool that includes incarceration and other relevant data to help identify high-risk members who may benefit from ACT team services.

- **Family and peer support services—**According to Mercer, family support services have relatively low utilization rates due to the lack of available or engaged family members, members choosing to not involve family members in treatment, and clinical teams not fully understanding and/or appreciating the benefits that family support services can provide. It recommended implementing training and supervision to ensure that clinical teams understand the appropriate application of family support services and recognize the value of family support services as an effective intervention.

  Additionally, Mercer found that various opportunities exist for members to access and participate in peer support services. According to Mercer, Maricopa County's peer support service utilization is considered a best practice benchmark. Mercer recommended that stakeholders examine changes in service delivery models and policies in response to the COVID-19 pandemic and retain practices that promote more efficient access to peer support services.

- **Supportive employment services—**According to Mercer, Maricopa County's supportive employment service-utilization rate is among the highest in a benchmark analysis of comparable systems across the nation. It recommended continuing efforts to promote the broader utilization of ongoing support to maintain employment. Mercer reported that the Maricopa County RBHA, provider network organizations, administrative entities, and supportive employment providers have partnered to co-locate supportive employment specialists. Additionally, it reported that clinical teams and these specialists meet regularly to integrate and coordinate services for members interested in obtaining and/or maintaining employment.

- **Supportive housing services—**According to Mercer, there are programs and adequate capacity of supportive services for individuals in need of housing, including a variety of support services and community resources to help individuals achieve and maintain integrated and independent housing. However, Mercer's participant focus group described the lack of affordable and safe housing for members as a crisis, noting rent increases and a perception that much of the available housing is not satisfactorily maintained and is unsafe.[30] Mercer recommended continuing to identify safe and affordable housing options for recipients through collaboration with community stakeholders, city and county housing authorities, and supportive housing providers.

AHCCCS reported that it requires the contracted health plan responsible for these services to work directly with service providers to implement improvement activities in response to these reviews and assessments. Additionally, AHCCCS reported that it meets quarterly with this contracted health plan to review its progress and services.[31] According to AHCCCS, it has also developed initiatives, such as policy and contract reviews, to address some of the findings from these reviews and assessments. See our performance audit and sunset review of AHCCCS for additional information and recommendations related to AHCCCS establishing policies and procedures to address findings and recommendations resulting from these reviews and assessments.[32]

[30] Mercer's service-capacity assessment includes focus groups with members, family members, case managers, and providers. Twenty-six stakeholders participated in the 2021 service-capacity assessment. As such, according to Mercer, focus group results should not be interpreted to be representative of the total population of potential focus group participants.

[31] According to AHCCCS, it also monitors individual member service delivery and adherence to health plan contract requirements.

[32] Arizona Auditor General report 22-112 *Arizona Health Care Cost Containment System—Performance Audit and Sunset Review*.

AHCCCS must submit several behavioral health-related reports to Legislature and Governor

AHCCCS must submit various reports to the Legislature pertaining to behavioral health, including several reports specific to members with an SMI. For example, a footnote in the General Appropriations Act requires AHCCCS to annually report to the Legislature on its progress in and cost of expanding behavioral health services for members with an SMI as part of the *Arnold v. Sarn* agreement. Also, Laws 2022, Ch. 305, requires AHCCCS to submit an annual report to the Legislature that includes demographic information on and outcome data related to members with an SMI, such as the percentage of members with an SMI who are incarcerated or homeless.[33] This report is similar to an annual report that ADHS provided to the Legislature prior to 2015 when it was responsible for administering Medicaid and non-Medicaid behavioral health services. Further, AHCCCS' Clinical Oversight Review Committee is required to submit an annual report to the Legislature and Governor that includes a summary of topics reviewed by the committee in the preceding year and any recommendations relating to quality performance metrics stemming from the committee's activities, which include reviewing data on behavioral health services for members receiving these services.[34] In addition, statute requires AHCCCS to submit various reports specific to behavioral health (see Table 2, Appendix B, pages b-2 through b-4, for AHCCCS' statutorily required behavioral health reports).

[33] Laws 2022, Ch. 305, is effective on September 24, 2022.

[34] The Clinical Oversight committee is composed of AHCCCS staff and is responsible for reviewing AHCCCS' provider clinical data, including data on behavioral health services, and quality performance metrics and makes recommendations to AHCCCS to improve clinical outcomes, performance, and member experiences.

AHCCCS did not ensure all peer specialists met qualification requirements, and some of these and other peer specialists were not supervised, potentially jeopardizing the quality of peer support services provided to members

State and CMS have established various qualification and supervision requirements for peer specialists

AHCCCS requires its contracted health plans to make available peer support services to members with behavioral health disorders to aid in their recovery. Peer support services consist of various supportive activities, including assisting AHCCCS members with identifying needs and recovery goals; accessing resources in the community, such as support groups and food assistance; exploring continued education and/or employment opportunities; and understanding and positively adapting to behavioral health challenges using coaching and role modeling. Research shows that peer support is effective for supporting recovery from behavioral health conditions and may provide a variety of benefits for members, such as an increased sense that treatment is meeting their needs, increased engagement in self-care and wellness activities, reduced hospital admission rates and use of inpatient services, and decreased substance use and depression.[35]

AHCCCS' contracted health plans contract with provider organizations that employ peer specialists to provide peer support services.[36] State and federal requirements outline several qualification and supervision requirements for peer specialists, including:[37]

- **Meeting experience, training and credential, and work and/or education qualification requirements—**Specifically:
    - **Lived experience and recovery from a mental health condition and/or substance use—**Self-identifying as an individual who has a lived experience of mental health conditions and/or substance use, for which they have sought help or care, and having an experience of long-term, sustainable recovery to share.

[35] SAMHSA. (2017). *Value of peers*. Rockville, MD. Retrieved 5/4/2022 from https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/value-of-peers-2017.pdf.

[36] Peer specialists may also provide other behavioral health services, such as case management or life skills, as determined by the provider.

[37] The State and federal requirements for the qualification and supervision of peer specialists are outlined by the following: AHCCCS Medical Policy Manual (AMPM) 963—Peer and Recovery Support Service Provision Requirements, AMPM 310-B—Title XIX/XXI Behavioral Health Service Benefit, AMPM 965—Attachment B—Documentation Standards, Arizona Administrative Code (AAC) R9-10-101 and R9-10-115, CMS State Medicaid Director Letter (#07-011), and the Arizona State Plan. The Arizona State Plan is an agreement between Arizona and the federal government that describes how Arizona will administer its Medicaid program.

- **Credentialed by peer support training program—**Being credentialed by an AHCCCS-approved peer support employment training program after completing training and passing a competency exam.[38,39]

- **Qualification as behavioral health paraprofessional, technician, or professional based on education and/or work experience—**Qualifying as a behavioral health paraprofessional (paraprofessional), behavioral health technician (technician), or behavioral health professional.[40] To qualify as a behavioral health paraprofessional or technician, a peer specialist must meet certain work and/or education requirements, such as having experience working in a behavioral health setting and/or completing post-high school behavioral health education, as determined and documented by the provider organization.

- **Receiving administrative and clinical supervision—**Receiving administrative and clinical supervision/oversight by a behavioral health professional. Depending on the peer specialist's qualifications as a paraprofessional or technician and employer, behavioral health professionals are required to provide oversight of peer specialists at least once during each 2-week period or for at least 4 hours per month. Oversight and supervision include monitoring the peer specialist to ensure services they provide are consistent with the health care institution's policies and procedures and, if applicable, the member's treatment plan; and providing ongoing review and guidance to improve the peer specialist's skills and knowledge related to the provision of behavioral health services.

Most peer specialists we reviewed did not meet both qualification and supervision requirements, potentially jeopardizing quality of services provided to AHCCCS members

As shown in Figure 3 (see page 13), our review of a random sample of 23 of 951 peer specialists reported as employed by contracted providers during the quarter of October 1, 2021 through December 31, 2021, found that 21 of 23 peer specialists lacked documentation demonstrating they met both State and federal qualification requirements to be a peer specialist and/or were not supervised according to requirements.[41] In other words, only 2 of 23 peer specialists we reviewed met both the qualification and supervision requirements that AHCCCS and the federal government have established for peer specialists who provide peer support services to members with behavioral health disorders to aid in their recovery. Specifically:

- **18 of 23 peer specialists did not receive required supervision, including 3 who also lacked documentation demonstrating they met all qualification requirements—**Our review of supervision-related documentation found that 18 of 23 peer specialists either did not receive any supervision or did not receive all required supervision during the 3-month time period we reviewed. This included 3 peer

[38] Peer support employment-training programs are provided by AHCCCS-registered providers who have submitted their training curriculum to AHCCCS for review and approval. AHCCCS approves peer support employment-training programs based on a program's compliance with all requirements specified in AMPM 963, such as the inclusion of all core curriculum elements in the training curriculum and the competency exam.

[39] Peer specialists must also annually complete at least 4 hours of continuing education relevant to peer support services.

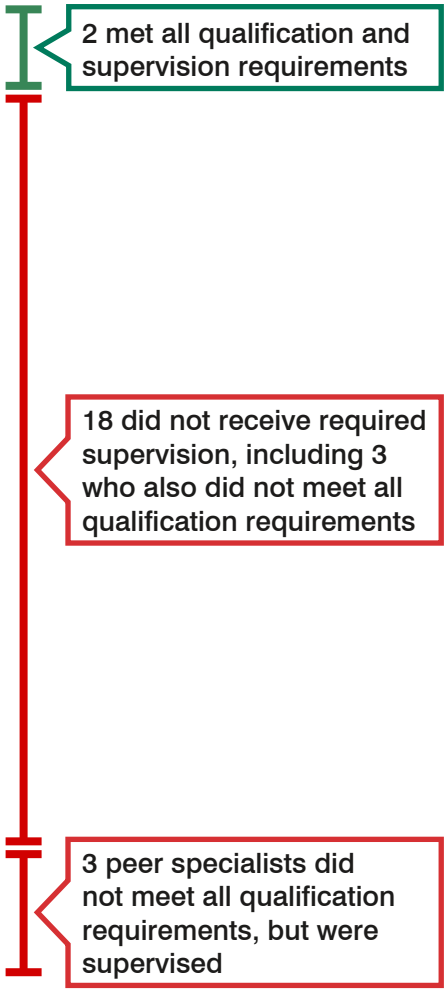
[40] Pursuant to AAC R9-10-101, a behavioral health paraprofessional or technician is an individual who provides services under a behavioral health professional's supervision or clinical oversight to a patient to address the patient's behavioral health needs, services that, if provided in a setting other than a health care institution, would be required to be provided by an individual licensed under Arizona Revised Statutes (A.R.S.) §§32-3251 through 32-3321; or health-related services. Additionally, behavioral health professional means an individual licensed under A.R.S. §§32-3251 through 32-3321, 36-501, 32-2061, 32-2091, or a registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or a registered nurse with a psychiatric-mental health nursing certification or 1 year of experience providing behavioral health services.

[41] Contracted health plans are required to provide AHCCCS with a quarterly report on all peer specialists employed by contracted providers. We reviewed a stratified random sample of 23 peer specialists from 951 peer specialists reported as employed on the contracted health plans' December 31, 2021, quarterly reports. Our sample was stratified across 10 providers that employ peer specialists that we judgmentally selected based on the providers' reported number of employed peer specialists. Although the quarterly report showed 951 employed peer specialists, we determined that the report included some errors, such as including some peer specialists who were not employed during the quarter. Although the report included these errors, we determined the report was reasonably accurate for audit purposes. See Appendix C, page c-1, for more information on our sample.

specialists who also did not meet all State and federal qualification requirements (see bullet on page 14 for more information). Specifically, the contracted providers lacked any documentation to show 11 peer specialists received supervision. Further, although the contracted providers had some documentation to show that 7 peer specialists received supervision, it was not at the required frequency or amount.

Figure 3
Most peer specialists we reviewed did not meet qualification and/or supervision requirements

Peer specialists	Qualification requirements			Supervision requirement
Count	Lived experience and recovery	Trained and credentialed	Education and/or work experience	Supervised
1	✓	✓	✓	✓
2	✓	✓	✓	✓
3	✓	✓	✓	✗
4	✓	✓	✓	✗
5	✓	✓	✓	✗
6	✓	✓	✓	✗
7	✓	✓	✓	✗
8	✓	✓	✓	✗
9	✓	✓	✓	✗
10	✓	✓	✓	✗
11	✓	✓	✓	✗
12	✓	✓	✓	✗
13	✓	✓	✓	✗
14	✓	✓	✓	✗
15	✓	✓	✓	✗
16	✓	✓	✓	✗
17	✓	✓	✓	✗
18	✓	✓	✗	✗
19	✓	✓	✗	✗
20	✓	✓	✗	✗
21	✓	✓	✗	✓
22	✓	✓	✗	✓
23	✓	✓	✗	✓



Source: Auditor General staff review of contracted providers' documentation related to qualification and supervision of 23 peer specialists.

According to State and federal requirements and recommended practices for peer support services, supervision helps to ensure peer specialists are meeting members' needs and providing quality services.[42] By not receiving required supervision, a peer specialist lacks ongoing training and feedback from a behavioral health professional to help ensure members' needs are met and quality services are provided. Further, peer specialists who provide peer support services with little to no oversight to members with behavioral health conditions could have negative consequences for members, such as a member being taught inappropriate or ineffective coping strategies or not identifying a member's need for additional behavioral health services. Lastly, some research indicates that providing supervision has been significantly related to improving member outcomes in behavioral health settings.[43]

- **Another 3 of 23 peer specialists lacked documentation demonstrating they met work or education requirements for qualification as a peer specialist—**Based on our review of work and education qualification documentation, another 3 peer specialists, for a total of 6 of 23 peer specialists we reviewed, did not have documentation demonstrating their qualification as a paraprofessional or technician, as required by the AMPM and the Arizona State Plan, and thus did not meet the qualifications to provide peer support services to AHCCCS members. According to rule, qualifications for peer specialists are based on the services the peer specialist is expected to provide and include the specific skills, knowledge, and experience necessary to provide those services.[44] By not ensuring that peer specialists meet required qualifications, the quality of peer support services provided to members may be compromised.

AHCCCS lacks oversight processes for peer support services

Although AHCCCS has directed its contracted health plans to oversee the provision of peer support services provided by peer specialists, it has not developed processes to ensure this oversight occurs. Specifically, the AMPM directs AHCCCS' contracted health plans to ensure their providers maintain documentation of peer specialists' qualifications and develop and make available to their providers policies and procedures specifying peer specialist-supervision monitoring and auditing/oversight activities. However, even though AHCCCS was able to obtain some peer specialist qualification documentation in response to our audit, it has not ensured that contracted health plans comply with these requirements. AHCCCS has processes for reviewing contracted health plans' compliance with federal and State regulations and their contractual obligations to AHCCCS in several areas at least once every 3 years, but these reviews do not include an assessment of contracted health plans' implementation of processes for ensuring their providers maintain required peer specialist qualification documentation and provide required peer specialist supervision.[45]

Recommendation

1. AHCCCS should ensure that peer specialists meet qualification requirements and are supervised as required by developing and implementing monitoring processes, such as assessing compliance with these requirements during its 3-year reviews of contracted health plans.

AHCCCS response: As outlined in its **response**, AHCCCS agrees with the finding and will implement the recommendation.

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[42] AAC R9-10-101; R9-10-115; AMPM 965—Attachment B—Documentation Standards; Arizona State Plan; and Jorgenson, J. & Schmook, A. (2014). *Enhancing the peer provider workforce: Recruitment, supervision, and retention*. Alexandria, VA: National Association of State Mental Health Program Directors. Retrieved 7/8/2022 from https://www.nasmhpd.org/content/enhancing-peer-provider-workforce-recruitment-supervision-and-retention.

[43] Choy-Brown, M. & Stanhope, V. (2018). The availability of supervision in routine mental health care. *Clinical Social Work Journal*, 46(4), 271-280.

[44] AAC R9-10-1006.

[45] 42 CFR §438.358(b)(iii) and AHCCCS' policies require AHCCCS to conduct a review of each contracted health plan at least once every 3 years.

AHCCCS Housing Program—Services provided, administration responsibilities, performance as of March 2022, and housing waitlist

Table of contents

Question 1: What is the AHCCCS Housing Program, and what services does it provide?

As discussed in the Introduction (see page 3), the AHCCCS Housing Program provides housing rental subsidies to qualifying AHCCCS members with an SMI and some members with a general mental health and/or substance use disorder (see textbox for AHCCCS' Housing Program mission). To apply for enrollment in the Housing Program, AHCCCS members must first receive a referral from their healthcare provider with a determination that the individual meets the Housing Program-eligibility requirements.[46] Upon receiving a housing referral, members can apply for the Housing Program and based upon their preference and treatment plan goals, may choose to be placed on the waitlist for 1 or both of the following 2 housing options:

AHCCCS Housing Program mission

To provide safe, high-quality, economically and programmatically sustainable housing with individualized support services to ensure stable housing for all eligible members as a foundation to improve their physical and behavioral health outcomes, well-being, and self-determination.

Source: Auditor General staff review of the *Housing Program Guidebook* (Guidebook). The Guidebook, which was finalized in July 2022, outlines responsibilities for Housing Program oversight and management.

- **Scattered Site Program—**Provides monthly housing subsidies to AHCCCS members to pay for the costs of leasing housing within the State. In this program, the AHCCCS member, with support from AHCCCS

[46] To be eligible for the Housing Program, an AHCCCS member must have an SMI designation or a general mental health and/or substance use disorder with high costs/needs, be at least 18 years old, be a U.S. citizen or have legal immigrant status, and have a housing need that has been documented by a healthcare provider or treatment team.

and its contracted Housing Administrator, is responsible to search for, identify, and secure housing that AHCCCS would then subsidize. As of March 2022, 1,482 AHCCCS members were enrolled in AHCCCS' Scattered Site Program.

- **Community Living Program—**Provides monthly housing subsidies for AHCCCS members to lease housing in dedicated units that have been designated for members with an SMI. These dedicated housing units are purchased or rehabilitated using Arizona SMI Housing Trust Fund monies granted by AHCCCS to provide permanent supportive housing to members with an SMI.[47] AHCCCS reported that, historically, the contracted RBHAs and housing providers identified potential housing projects and requested funding from AHCCCS for construction and rehabilitation costs. For approved projects, AHCCCS requires the awarded entity to sign an agreement requiring a restriction of the property's use to members with an SMI for a set number of years, which is determined by the type and amount of funding provided. AHCCCS reported that most restrictions extend for a period of 25 years.

  Some community living programs also offer on-site support services, including transportation and skills training. As such, a healthcare provider may recommend a member with an SMI for placement in a Community Living Program instead of the Scattered Site Program if they determine it is more appropriate for the member. As of March 2022, there were more than 200 community living sites housing 862 members.

After applying for housing through the Housing Program, the member is placed on a waitlist until housing can be secured, the member secures other permanent housing, voluntarily removes themselves from the list, or is determined inactive because they have not responded to the Housing Administrator (see Question 5, page 21, for information about the Housing Program waitlist). As of March 2022, approximately 2,300 AHCCCS members were enrolled in the Housing Program, and an additional 4,134 AHCCCS members were on the Housing Program's waitlist.

Housing Program subsidy amounts AHCCCS provides vary based on several factors but can include subsidies that cover up to the full rental amount for individuals with no income. To determine the housing subsidy amount, AHCCCS considers the size of the housing unit needed, the enrolled member's income, utility allowance, as applicable, and the payment standard—the maximum monthly assistance payment that should be provided to an eligible member—established by the U.S. Department of Housing and Urban Development's (HUD) Annual Fair Market Rent (FMR) schedule, and any adjustments to ensure rent reasonableness.[48] For example, AHCCCS may approve an adjustment to the payment standard for some circumstances, such as housing affordability and market conditions. Additionally, although a member's income does not impact their eligibility for the Housing Program and eligible members do not have a minimum rental contribution requirement, AHCCCS members with income contribute up to 30 percent of their income toward their rent, with the remaining rental cost subsidized through the Housing Program (see Figure 4, page 17, for information on how a member's subsidy amount is determined).[49] AHCCCS reported that in 2021, the average monthly subsidy provided to eligible members was $648 but could range from $50 to $2,392, depending on the factors described above.

To remain eligible for the Housing Program, AHCCCS members are required to recertify their Housing Program eligibility during the annual lease renewal period (see footnote 46, page 15, for Housing Program eligibility requirements).[50] Additionally, there is no limit on how long a member can continue to participate in the Housing

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[47] Supportive housing providers may include nonprofit organizations that provide supportive housing and supportive housing services, such as crisis planning and assisting members with employment.

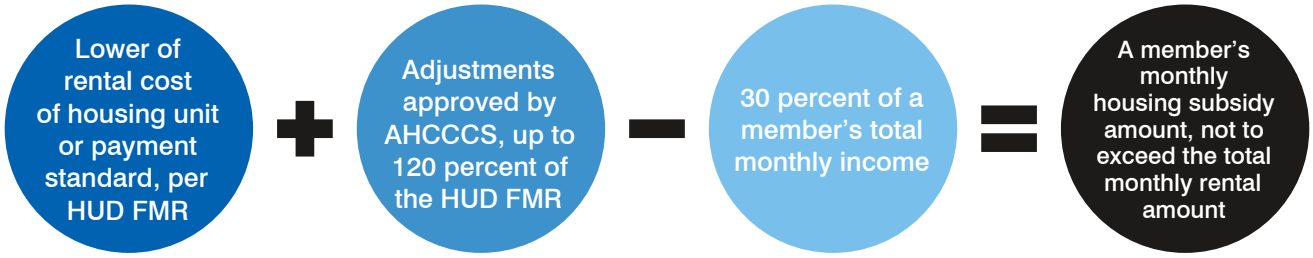
[48] For example, in fiscal year 2022, the HUD FMR payment standard for a 1-bedroom unit in the Phoenix-Scottsdale-Mesa area was $1,091.

[49] The expectation that employed members contribute up to 30 percent of their income toward rent is consistent with a similar HUD Housing Choice Voucher Program requirement. This HUD program provides rental subsidies to low-income individuals and requires participating individuals with an income to pay 30 percent of their income toward rent. The Guidebook requires the Housing Administrator to use the HUD Housing Choice Voucher participation-contribution policy to determine subsidy amounts.

[50] AHCCCS reported that most leases are for 12-month periods, and some may be longer, but also reported that it is renegotiating many of its lease agreements to ensure all lease agreements are for 12-month periods.

Program if they comply with their landlord's rules and lease agreement, and are annually recertified by the Housing Program.[51]

Figure 4
Housing subsidy equation



Source: Auditor General staff review of the *Housing Program Guidebook* and interview with AHCCCS staff.

Additionally, AHCCCS provides limited funding for other housing-related expenses, including emergency rental assistance, reimbursement to landlords for damages, and assistance with move-in costs or utility deposits. The Housing Administrator reported that between October 2021 and July 2022, it received 399 applications for other housing-related expenses and approved $480,568 for emergency rental assistance and assistance with move-in costs or utility deposits. Finally, AHCCCS reported it provides operational support for HUD's Continuum of Care Program, which includes monies for conducting housing inspections, administering landlord payments, and maintaining housing records.[52]

Question 2: How does AHCCCS pay for the Housing Program?

To cover the costs of its Housing Program, AHCCCS reported that between fiscal years 2018 and 2022, it received between approximately $29.8 million and $33.4 million annually from the following funds:

- **Supported Housing General Fund—**Monies may be used to provide rental subsidies and cover other housing-related expenses, such as utilities and move-in kits, specifically for members with an SMI who are non-Medicaid eligible and members with general mental health or substance use disorders who are Medicaid eligible. The Housing Program received approximately $5.3 million from this fund in fiscal year 2022.
- **SMI Housing Trust Fund—**According to A.R.S. §41-3955.01, monies are restricted solely for housing projects and rental assistance, such as rental subsidies, for members with an SMI. Housing projects may include the purchase and renovation of properties used to provide housing to members with an SMI. AHCCCS reported that between fiscal years 2018 and 2022, it has annually received approximately $2 million from this fund.
- **Non-Title XIX/XXI SMI General Fund—**Monies may be used to provide rental subsidies and cover other housing-related expenses, such as utility deposit payments, for members with an SMI. AHCCCS reported that the Housing Program received approximately $24.5 million from this fund in fiscal year 2022.

AHCCCS reported that it estimates 89.1 percent of its 2023 Housing Program monies will be used to provide rental subsidies, 3.7 percent for eviction prevention, with the remaining amount for other housing-related expenses, such as utility payments, member move-in assistance, and housing damages and maintenance expenses.

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[51] A member must notify the Housing Administrator if there is a change in their circumstances that may affect eligibility status. Failure to report a change or misreporting may lead to termination from the housing program.

[52] HUD's Continuum of Care program provides funding to nonprofit housing providers and state and local governments to provide housing to individuals experiencing homelessness.

Question 3: What are AHCCCS' and its contracted Housing Administrator's responsibilities for administering the Housing Program?

AHCCCS is responsible for the oversight, distribution of monies, and operation of the Housing Program, including ensuring that Housing Program monies are used for their intended purposes and in compliance with all federal, State, and local laws and regulations. To help meet these requirements, AHCCCS has contracted with a Housing Administrator to manage and operate its Housing Program. Specifically, effective October 2021, AHCCCS contracted with Arizona Behavioral Health Corporation (ABC) to operate as its Housing Administrator, with specific responsibilities for standardizing housing practices, such as managing the housing wait list and conducting housing-quality inspections, improving overall customer service and ensuring accountability for AHCCCS' housing resources. Prior to entering this contract, the Housing Program was administered by 3 separate Regional Behavioral Health Authorities (RBHAs) and, according to AHCCCS, had not established any standardized processes for operating the program. The Housing Administrator, with approval from AHCCCS, subcontracted with HOM, Inc. to make rental subsidy payments to landlords on behalf of eligible members and perform day-to-day Housing Program operations, such as recertifying members' program eligibility and assisting members with housing searches. AHCCCS and the Housing Administrator's responsibilities are outlined in the contract and Guidebook, which was developed after AHCCCS transitioned to a single Housing Administrator and finalized in July 2022. Some of the Housing Administrator's responsibilities include:

- **Managing a housing waitlist—**The Housing Administrator is contractually required to manage a waitlist for the Housing Program. AHCCCS and its Housing Administrator established a single State-wide waitlist for the Housing Program that includes AHCCCS members across the State and developed a standardized prioritization process for selecting members from the waitlist for available housing. According to the Guidebook, the standardized process should prioritize members for housing placement by considering several factors, including the member's screening tool outcomes, the individual's cost and need for healthcare services, whether the member has expressed a preference for 1 of the 2 housing program options, and the individual's homeless status.[53] Prior to the transition, AHCCCS reported that each of the 3 RBHAs managed their own housing waitlists and had their own processes for doing so (see Question 5, page 21, for more information about the housing waitlist).

- **Conducting housing-quality inspections—**The Housing Administrator is contractually required to inspect housing units prior to making them available for lease to eligible members, at the time of recertification, or as needed to ensure that housing units comply with federal housing-quality standards (see textbox for information about federal housing-quality standards). AHCCCS reported that it plans to develop procedures for periodically inspecting a sample of housing units to ensure they comply with federal housing-quality standards and that it would have these procedures in place by early 2023. Once implemented, these inspections are intended to allow AHCCCS to monitor the Housing Administrator's compliance with these requirements. Prior to transitioning to the Housing Administrator, the 3 RBHAs required their contracted housing providers to periodically inspect housing units to ensure they complied with federal housing-quality standards. However, AHCCCS reported that it did not have a process to monitor the RBHAs and housing providers to ensure these inspections were conducted and deficiencies were corrected.

Housing-quality standards

Federal regulations establish housing-quality performance requirements and acceptability criteria in 13 key areas related to housing, including interior air quality, water supply, and electricity. For example, housing units must have an appropriate public or private water supply that is sanitary and free from contamination. These standards apply to all housing units subsidized by the Housing Program.

Source: 24 CFR §982.401.

[53] AHCCCS providers may use the Vulnerability Index-Service Prioritization Decision Assistance Tool, a screening tool used by agencies serving homeless populations, to help prioritize services to those who are most vulnerable. For example, the tool includes various questions to assess an individual's needs, such as wellness, risk of exploitation, and housing situation. The Housing Administrator uses the screening tool results to prioritize housing placement for those who are most vulnerable.

- **Maintaining and reviewing participant files—**The Guidebook requires the Housing Administrator to maintain Housing Program participant files for each AHCCCS member, and similar to its housing unit-inspection plans, AHCCCS reported that beginning in 2023 it plans to periodically review a random sample of these files to ensure all required information is included, such as documentation verifying the member's housing eligibility and the member's applicable lease information.

- **Issuing subsidy payments to housing providers—**The Housing Administrator is contractually required to maintain financial systems, processes, and controls necessary to make timely and accurate subsidy payments to housing providers. AHCCCS also reported that it is requiring the Housing Administrator to transition to a standardized payment method for all Community Living Program housing providers that will separate costs for housing and costs for services when paying all housing providers, giving AHCCCS the ability to better track the use of Housing Program monies. Prior to the transition to the Housing Administrator, AHCCCS reported each of the RBHAs paid housing providers in different ways. For example, some RBHAs were making lump-sum payments to housing providers for all housing costs, including supportive services, which hindered AHCCCS' ability to assess how Housing Program monies were being used.

- **Reporting and monitoring Housing Program performance metrics and expenditures—**The Housing Administrator is contractually required to submit monthly expenditure reports to AHCCCS that include a leasing report summarizing all units under lease during the month broken out by geographical service area (region) and an expense reconciliation consisting of total rents owed, contributions from members enrolled in the program, and Housing Program payments for the month.[54] Additionally, the contract requires the Housing Administrator to submit a quarterly report to AHCCCS that includes a housing inventory, a narrative report on the status of the Housing Program, and performance metrics for key areas specified in the contract, such as the number of new members placed in housing; the number of members on the housing waitlist, the average time these members have been on the waitlist, and the number of members removed from the waitlist and the reasons why; the number of members leaving the program and the reasons for doing so; number of grievances and appeals; and housing retention rates (see Question 4 below for information on Housing Program performance metrics).

Since the transition to the Housing Administrator in October 2021, AHCCCS has also hired 2 new staff to work with its Housing Program Director to oversee the Housing Administrator and the performance of the Housing Program. Although it has yet to develop and implement policies and procedures for doing so, AHCCCS reported that the new staff will be responsible for conducting housing site inspections and participant file reviews and have been working to standardize the Housing Program, including standardizing lease terms and payment methods. See our performance audit and sunset review of AHCCCS for additional information and recommendations related to AHCCCS developing and implementing policies and procedures for overseeing the Housing program and its Housing Administrator's compliance with contract and Guidebook requirements.[55]

Question 4: How does AHCCCS assess Housing Program and Housing Administrator performance?

As mentioned in Question 3, the Housing Administrator is contractually required to submit a quarterly report to AHCCCS that includes several performance metrics, including the number of new AHCCCS members placed in housing, the number of AHCCCS members leaving the Housing Program and the reasons for doing so, and housing retention rates. For example, the Housing Administrator's reports submitted to AHCCCS for the quarters that ended in December 2021 and March 2022 indicated that a total of 109 members left the Housing Program during this time frame. Reported reasons for leaving included incarceration, failure to recertify, voluntary withdrawal from the Housing Program, or the need for a higher level of care, such as members with a severe physical disability who required enrollment in a long-term care facility. The quarterly reports must

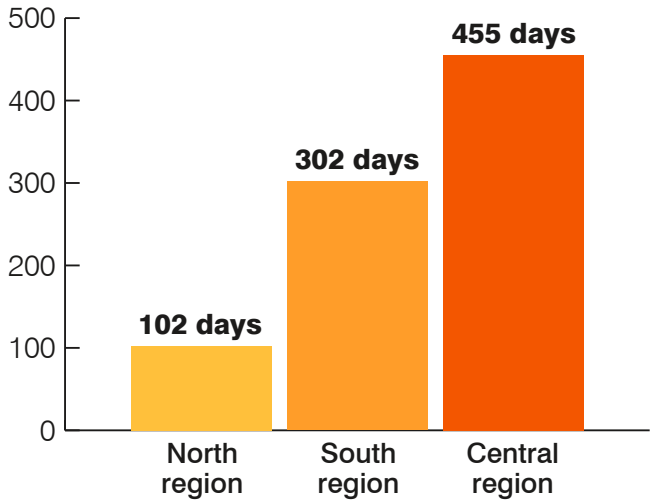
[54] AHCCCS separates the State into 3 service areas or regions: the North, Central, and South (see Introduction, page 2, for service area map).

[55] Arizona Auditor General report 22-112 *Arizona Health Care Cost Containment System—Performance Audit and Sunset Review*.

also include performance metrics related to the housing waitlist, including the number of housing referrals received during the reporting period, the number of AHCCCS members on the waitlist, and the average length of time spent on the waitlist. As of March 2022, eligible members spent an average of 404 days on the waitlist, although the average length of time on the waitlist can vary based on the region where the individual applied for housing (see Figure 5 for the waitlist times by region).

The Housing Administrator contract also requires AHCCCS and the Housing Administrator to establish and track Housing Program performance against benchmarks based on Section 8 Management Assessment Program (SEMAP) criteria.[56] This criteria includes several different performance measures that AHCCCS has incorporated into its Housing Administrator contract and that the Housing Administrator is required to track and quarterly report to AHCCCS, including the timeliness of annual housing-quality inspections, the timeliness of member income reexaminations, and the accuracy of rent determinations. AHCCCS reported that because of the lack of reporting on housing metrics from the RBHAs, it is collecting baseline data during the first year of the Housing Administrator contract to establish benchmarks based on SEMAP criteria. AHCCCS reported that beginning October 2022, it plans to require the Housing Administrator to begin reporting on its performance relative to the benchmarks AHCCCS will have established. See our performance audit and sunset review of AHCCCS for additional information and recommendations related to AHCCCS establishing these benchmarks, and tracking and reporting on Housing Administrator performance against the benchmarks.[57]

Figure 5
AHCCCS' housing waitlist times by region[1]
As of March 2022
(Unaudited)



[1] AHCCCS reported that these averages may not be completely accurate due to the lack of reporting on Housing Program metrics, such as waitlist information from the RBHAs prior to its transition to the Housing Administrator.

Source: Auditor General staff review of the Housing Administrator's March 2022 quarterly report.

Finally, the Guidebook specifies that the Housing Program must align with SAMHSA Permanent Supportive Housing Standards. As previously mentioned in the Introduction (see pages 6 and 7), in response to the 2014 *Arnold v. Sarn* agreement, the State is required to use SAMHSA review tools to assess program fidelity across 4 service areas, including supportive housing. Specifically, the *Arnold v. Sarn* agreement requires the State to conduct a fidelity review to assess whether behavioral health service providers' service delivery meets SAMHSA standards, including supportive housing providers. The fidelity review assesses 23 permanent supportive housing areas and provides a rating on how closely each area aligns with the SAMHSA Permanent Supportive Housing model.[58] Some of the areas reviewed include the extent to which the provided housing meets housing-quality standards, the extent to which members have a choice in housing, and the extent to which members have a choice in the housing services they receive.

The fiscal year 2021 fidelity review found that the 4 permanent supportive housing service providers in Maricopa County that were reviewed had operations that mostly aligned with the SAMHSA Permanent Supportive

[56] SEMAP is a HUD program that establishes criteria to assess housing agencies providing HUD housing vouchers across 14 key areas, including the timeliness of inspections and the accuracy of rent determinations.

[57] Arizona Auditor General report 22-112 *Arizona Health Care Cost Containment System—Performance Audit and Sunset Review*.

[58] The SAMHSA fidelity review assesses housing service providers in Maricopa County. Although many of the housing service providers included in the review provide housing services to members in the AHCCCS Housing Program, AHCCCS reported that some may also provide housing services to individuals in another supportive housing program such as Section 8. As such, the SAMHSA fidelity review is not limited to Scattered Site and Community Living Housing Programs.

Housing Model, such as the extent to which members have a choice in their housing unit and the extent to which the housing unit is integrated into the community.[59] However, the housing providers did not comply with some of the SAMHSA Permanent Supportive Housing Model areas. Specifically, all 4 housing service providers received low ratings regarding whether housing units complied with housing quality standards. For example, housing service providers reported that housing quality standard inspections were delayed due to the COVID-19 pandemic. See Introduction, page 9, for information on how AHCCCS reported addressing findings and recommendations from the fidelity reviews.

Question 5: How many AHCCCS members are on the Housing Program waitlist, and what is AHCCCS doing to increase housing capacity and reduce the number of members on the waitlist?

As previously mentioned in Question 1 (see page 16), as of March 2022, 4,134 AHCCCS members were on the waitlist for the Housing Program. With the October 2021 transition to using a Housing Administrator to manage the Housing Program, and to better understand members' housing needs and realize some administrative efficiencies, the various waitlists maintained by the RBHAs were combined and standardized to a single waitlist the Housing Administrator manages. According to AHCCCS, this should improve its ability to track housing needs across the State and should allow for some administrative savings, which can be used to provide additional housing capacity and monies for additional housing subsidies. As of August 2022, AHCCCS reported an estimated $1.5 million in administrative savings during the first year of the Housing Administrator contract.

Additionally, AHCCCS has taken steps to enhance the funding it would have available for housing-related services. Specifically, in May 2021, AHCCCS requested approval from CMS to be able to draw down federal monies and ultimately increase the amount of money available to provide members with housing and supportive services.[60] Although federal monies cannot be used to pay for housing subsidies, these monies can be used to provide housing-related services and supports. If approved, AHCCCS will be able to expand its provision of transitional housing services for individuals who are homeless or at risk of homelessness, such as security deposits, utility set-up fees, and essential furniture and appliances. AHCCCS also reported it would be able to provide additional housing services and supports, including home modification services to members who meet proposed eligibility criteria who currently do not have access to these services. However, the financial impact of this proposal has yet to be determined because the waiver request has yet to be approved. As of September 1, 2022, AHCCCS reported that it continues to negotiate the terms of its waiver request but has not received approval from CMS for this request.

[59] AHCCCS contracts with WICHE to conduct the fidelity review (see Introduction, footnote 19, page 6, for additional information about WICHE).

[60] AHCCCS requested an amendment to its 1115 Research and Demonstration waiver for these additional monies (see Appendix B, page b-1 for additional information about the waiver).

Auditor General makes 1 recommendation to AHCCCS

1. AHCCCS should ensure that peer specialists meet qualification requirements and are supervised as required by developing and implementing monitoring processes, such as assessing compliance with these requirements during its 3-year reviews of contracted health plans.

AHCCCS behavioral health-related committees, councils, task forces, and workgroups

AHCCCS administers various committees, councils, task forces, and workgroups (collectively referred to as groups) related to behavioral healthcare services.[61] According to AHCCCS, these groups include the:

- **Behavioral Health Planning Council—**This council is required by federal law and is responsible for monitoring, reviewing, and evaluating the allocation and adequacy of mental health services within the State and advocating for adults with an SMI, children with serious emotional disturbance, and other individuals with mental illnesses or emotional problems.[62] According to AHCCCS, this council's mission is to "advise the State in planning and implementing a comprehensive community-based behavioral and mental health system." The council meets monthly and includes representatives from AHCCCS; DCS; Arizona Department of Education (ADE); ADES; Arizona Department of Corrections, Rehabilitation and Reentry; federally recognized tribes; and individuals receiving behavioral healthcare services, including parents of children with a substance use disorder. In 2019, the council identified various system concerns and provided feedback to help address them. For example, the council identified that monies for primary prevention, which are used to help prevent substance abuse, such as raising awareness on the effects of alcohol and drug use, were being dedicated to teens and young adults. The council proposed that a portion of these monies be used to serve older age groups.

- **Behavioral Health Task Force—**AHCCCS, in collaboration with ADHS, established this task force to address behavioral health concerns stemming from the COVID-19 pandemic. The task force met regularly throughout the COVID-19 pandemic and last met in July 2022. As of August 2022, AHCCCS reported that this task force meets quarterly. The task force is composed of AHCCCS and ADHS staff and various healthcare stakeholders, including behavioral healthcare providers, health insurers, and representatives of provider and medical associations. According to AHCCCS, the task force assesses the impact of the COVID-19 pandemic on the State's behavioral health system, including evaluating data trends related to utilization of crisis services, deaths related to opioids and suicide, and the availability of behavioral health services. Further, this task force proposed initiatives in response to these trends, such as the Crisis Counseling Program, which provided individual and group counseling services to individuals impacted by the COVID-19 pandemic. According to AHCCCS, the Crisis Counseling Program was paid for with federal grant monies, and the federal grant was officially closed in March 2022.

- **Children's Behavioral Health Services Fund Quarterly Workgroup—**According to AHCCCS, it established this workgroup to develop policy templates and other guidance for schools referring uninsured or underinsured children to behavioral healthcare providers. AHCCCS reported that it meets quarterly with members from its contracted health plans, ADE, and community stakeholders to assess the administration of the Children's Behavioral Health Services Fund.[63] AHCCCS and ADE issued guidance, last updated

[61] AHCCCS reported that none of these groups are subject to State open meeting law requirements.

[62] 42 U.S. Code (USC) §300x–3 requires states to establish a planning council to be eligible for grant monies from SAMHSA for mental health services in accordance with 42 USC §300x.

[63] A.R.S. §36-3436 established the Children's Behavioral Health Services Fund to provide behavioral health services to uninsured or underinsured children referred by the schools.

in December of 2021, that included policy templates related to accessing monies from the Children's Behavioral Health Services Fund.

- **Justice Initiative Workgroup—**AHCCCS holds meetings with stakeholders from the justice system to discuss the challenges, successes, and best practices associated with assisting individuals involved in the justice system. According to AHCCCS, this workgroup meets quarterly and includes representatives from justice agencies, AHCCCS' contracted health plans, healthcare providers, and community-based organizations.

- **Maternal Mental Health Advisory Committee—**Established by Laws 2021, Ch. 54, §1, this committee is responsible for making recommendations to the Legislature regarding improvements for screening and treating maternal mental health disorders. The committee last met in January 2022 and has 4 subcommittees that each met at least once between February 2022 and April 2022. The committee includes representatives from AHCCCS' contracted health plans, ADHS, law enforcement agencies, hospitals, nonprofit organizations, and healthcare providers, including a psychiatrist and pediatrician. The committee is required to submit a report to the Legislature by the end of calendar year 2022 with recommendations for improving the screening and treatment of maternal mental health disorders. According to Laws 2021, Ch. 54, §1, the committee will terminate on June 30, 2023.

- **Mercy Care & AHCCCS Arnold Workgroup—**AHCCCS reported that this workgroup, established by AHCCCS, reviews information collected as part of the fidelity review related to the *Arnold v. Sarn* agreement. According to AHCCCS, the workgroup meets quarterly and is composed of AHCCCS employees and representatives from its contracted health plan, Mercy Care, that provides behavioral health services to members with an SMI in Maricopa County. AHCCCS reported that the data this workgroup reviews is included in the annual fidelity review (see Introduction, pages 6 through 7, and Questions and Answers, pages 20 through 21, for more information on the *Arnold v. Sarn* agreement and SAMHSA fidelity review).

- **Tribal Regional Behavioral Health Authority workgroups—**AHCCCS reported that it meets with the TRBHAs and/or tribes to discuss the delivery of behavioral health services to tribal communities, as required by most of its agreements with the TRBHAs and/or tribes (see Introduction, footnote 7, page 1, for more information about the TRBHAs). AHCCCS reported that these meetings occur quarterly.

- **Office of Individual and Family Affairs Advisory Council—**According to AHCCCS, its Office of Individual and Family Affairs (Office) Advisory Council meets to identify service needs, share educational resources, and discuss issues related to behavioral health and to hear from stakeholders, such as members and family members.[64] AHCCCS reported that this council meets monthly and is composed of representatives from AHCCCS' contracted health plans, peer organizations, healthcare providers, and community members. According to AHCCCS, in 2019, the council held planning sessions that included voting on priority areas for the Office during the following 3 years. The council proposed increasing activity in policy development and accountability by establishing processes to influence policy and professional development for peer and family support workers as the 2 top priority areas for the Office.

[64] The Office promotes recovery, resiliency, and wellness for individuals with mental health and substance use challenges. According to AHCCCS, this office builds partnerships with individuals, youth, communities, and organizations and collaborates with leadership and community members in the decision-making process at all levels of the behavioral health system.

AHCCCS behavioral health reporting requirements

AHCCCS has various statutory and session law requirements for reporting behavioral healthcare information to the Legislature, the Joint Legislative Budget Committee (JLBC), and the Governor. As shown in Table 2, see pages b-2 through b-4, these various reports' purposes are to provide behavioral health financial and expenditure information, information on contracted health plans' performance, and information on specific behavioral health areas/programs. These include the availability of inpatient psychiatric treatment for children and adult members, the total number of available inpatient psychiatric treatment beds, and information on AHCCCS' substance use disorder treatment programs, such as the number of members served for each substance use disorder treatment program.

AHCCCS is also required to regularly report on its performance to CMS. Specifically:

- As part of its Section 1115 Research and Demonstration waiver (see textbox for more information on the waiver), AHCCCS is required to submit quarterly and annual reports to CMS that include information on the status of AHCCCS programs and initiatives implemented under the waiver, such as information on outreach efforts for educating members, including members with an SMI, and community stakeholders on the services it provides. The reports also include healthcare utilization data and other quantitative information, including member enrollment and disenrollment numbers.
- AHCCCS is required to provide CMS with a Quality Strategy report and evaluation that CMS uses to evaluate the effectiveness of its Quality Strategy.[65] AHCCCS' Quality Strategy is required by federal regulations to include its network adequacy and availability of service standards.[66] AHCCCS is required to review and update its Quality Strategy at least once every 3 years, and is required to submit it to CMS for feedback if there are any significant changes to the Quality Strategy or within the State's Medicaid program.

1115 Research and Demonstration waiver

AHCCCS operates through a Section 1115 Demonstration waiver approved by CMS.[1] According to CMS, Section 1115 Research and Demonstration waivers give states additional flexibility to design their Medicaid program by waiving some federal Medicaid requirements. CMS reviews Demonstration waiver proposals to determine whether their stated objectives are aligned with those of Medicaid. According to CMS, it generally approves these waivers for a 5-year period, and they can be extended for an additional 3 to 5 years.

[1] According to the National Conference of State Legislatures, as of August 2019, 40 states, including Arizona, had at least one 1115 Research and Demonstration waiver approved by CMS.

Source: Auditor General staff review of information on the National Conference of State Legislatures, AHCCCS, and CMS websites.

[65] Federal regulations require state Medicaid agencies to draft and implement a quality strategy for assessing and improving the quality of healthcare services provided by its contracted health plans. AHCCCS' Quality Strategy outlines its goals and objectives for continuous healthcare quality improvement and summarizes its processes for monitoring and evaluating its contracted health plans performance.

[66] Federal regulations require state Medicaid agencies to develop network adequacy standards that require their contracted health plans to provide specific services, such as behavioral health services, to members enrolled in the contracted health plan considering various factors such as the distance members must travel to access these services. AHCCCS has established network adequacy standards that require its contracted health plans to establish provider networks that provide specific services to AHCCCS members within so many minutes or miles from the member's home.

Table 2
AHCCCS' required behavioral health reports
As of August 2022

Report name	Reporting requirement	Description	Submission date of last report
Annual Report: Substance Use Treatment Programs	A.R.S. §36-2023	An annual report, due to the Legislature and Governor by January 1 of each year, that provides information on AHCCCS' substance use disorder treatment programs, including the name, location, funding source, and number of members served for each substance use disorder treatment program.	January 18, 2022[1]
Arnold v. Sarn Report	Laws 2021, Ch. 408, §9	An annual report due to JLBC by June 30. The report includes information on AHCCCS' progress in implementing the *Arnold v. Sarn* lawsuit settlement and meeting all criteria specified in the 2014 *Arnold v. Sarn* stipulation agreement, such as its progress in expanding the 4 behavioral health service areas required by the agreement (see Introduction, page 6, for more information on the 4 behavioral health service areas). The report also includes information on the costs and funding sources for these services.	June 22, 2022
Behavioral Health Annual Report	A.R.S. §36-3415	An annual report provided to JLBC that includes information on behavioral health expenditures, range of member income, service utilization rates, and mortality and placement trends. The report also includes a summary of AHCCCS' contracted health plans' performance based on performance measures established in contracts (see Introduction, pages 4 through 6, for more information on AHCCCS' performance measures). Statute does not establish a due date for this report.	August 31, 2022
Behavioral Health Enrolled and Served Report	A.R.S. §36-3405	A monthly report to the Legislature and the Governor that is required to include the number of persons served, the units of service, and the amount of monies provided for member services for each RBHA, by Medicaid and non-Medicaid categories. The report should also include RBHA administration and case management expenses. Although AHCCCS' report includes the number of members served, it does not include the units of service and the amount of monies provided for member services for each RBHA, and RBHA administration and case management expenses.[2]	August 1, 2022
Behavioral Health Provider Reimbursement Rate Adequacy Report	A.R.S. §36-3403	A report submitted to JLBC every 5 years that provides the results of an independent study on the accuracy and appropriateness of Medicaid reimbursement rates to behavioral health providers.[3]	October 8, 2019[4]
Behavioral Health Services Annual Report	A.R.S. §36-3405	An annual report, due to the Legislature and Governor by January 1 of each year, that is required to provide information on behavioral health revenues and expenditures including a breakout of the total behavioral health service expenditures for the following service categories: SMI, alcohol and drug abuse, children with severe emotional disabilities, and domestic violence.[5]	January 4, 2022
Behavioral Health Services for Children in Legal Custody of the Department of Child Safety (DCS) Annual Report	A.R.S. §8-512.01	An annual report provided to the Governor, JLBC, and Legislature that summarizes the coordination and provision of behavioral health services, including crisis services, to children in DCS's legal custody and adopted children who are Medicaid eligible. Statute does not specify a recipient(s) or a due date for this report.	June 16, 2022

Table 2 continued

Report name	Reporting requirement	Description	Submission date of last report
Financial and Program Accountability Trends Report for Children enrolled in DCS CHP	Laws 2018, Ch. 152, §1	A semi-annual report due to the Legislature, Governor, JLBC Director, Governor's Office of Strategic Planning and Budgeting Director, and Secretary of State. The report includes information on the number of children enrolled in the DCS CHP by region and statewide, the percentage of enrolled members who received behavioral health services during the reporting period and monthly member utilization rates for the different types of behavioral health services provided by region and statewide. The report also includes the total monthly cost of services for each type of behavioral health service provided during the reporting period by region and statewide.[6]	March 22, 2022
Opioid Treatment Plan Summary Report and 24/7 Center of Excellence Standards	A.R.S. §§36-2907.14 and 36-2907.15	An annual report due to the Governor and the Legislature by January 15 of each year, that summarizes information reported by opioid treatment program providers receiving reimbursement from AHCCCS, such as the providers' plans for administering opioid treatment services.[7] The annual report also includes information about opioid treatment programs designated as 24/7 Access Points, including a list of all programs designated as 24/7 Access Points, a summary of the 24/7 Access Points' performance, and the standards for designating opioid treatment programs as 24/7 Access Points.[8]	January 18, 2022
Report of the Children's Behavioral Health Services Fund	A.R.S. §36-3436.01	An annual report submitted to the Legislature, Secretary of State, and Governor that provides information on the number of uninsured and underinsured students who received behavioral health services, based on referrals from schools, that are paid for by the Children's Behavioral Health Services Fund.	January 3, 2022
Report to the Director of JLBC Regarding Inpatient Psychiatric Treatment Availability	A.R.S. §36-2903.13	An annual report, due to JLBC by January 2, on the availability of inpatient psychiatric treatment for children and adolescents, and for adult members who receive services from the RBHAs. The report is required to include the total number of available inpatient psychiatric treatment beds and the occupancy rates for those beds, inpatient psychiatric treatment occupancy expenditures, the total number of members sent out of state for inpatient psychiatric treatment, and the prevalence of psychiatric boarding or holding psychiatric patients in emergency rooms for at least 24 hours before transferring to a psychiatric facility.[9]	January 3, 2022
SMI Housing Trust Fund Report	A.R.S. §41-3955.01	An annual report due to the Legislature by September 1. The report provides information on the status of the SMI Housing Trust Fund, including a summary of supportive housing facilities that received monies from the SMI Housing Trust Fund during the previous year, information on the cost and geographic location of each supportive housing facility, and the number of individuals benefiting from the operation, construction, and renovation of supportive housing facilities.	August 29, 2022
System Plan Annual Report	A.R.S. §36-3432	A report to the Legislature and Governor, due annually by November 1, on AHCCCS' system plan, which should provide information on the development and implementation of a comprehensive behavioral health service system for children, including identification of services, estimated number of members, and an appropriations request.	2017[10]

Table 2 continued

[1] Although this report is statutorily due by January 1 each year, AHCCCS reported it did not publish the report until January 18, 2022, due to a delay in its internal review process.

[2] AHCCCS reported that because it has integrated physical and behavioral health services, it cannot separately provide information on behavioral health administrative expenses. Additionally, it did not identify an AHCCCS report that includes information on case management expenses and members' units of service or provide an explanation for not reporting this required information. Finally, although the Behavioral Health Annual Report includes expenditure information per behavioral health category, this is an annual rather than monthly report. See Arizona Auditor General report 22-112 *Arizona Health Care Cost Containment System—Performance Audit and Sunset Review* for additional information and recommendations related to reporting requirements.

[3] AHCCCS is statutorily required to contract for an annual independent study on the adequacy and appropriateness of Medicaid reimbursement rates for behavioral health services and a full study is required to be completed at least every 5 years.

[4] Although this report is statutorily due by October 1, AHCCCS reported it did not publish the report until October 8, 2019, because of a delay in its internal review process.

[5] AHCCCS staff reported that behavioral health services for domestic violence are not separately reported, and the associated expenditures are included in the other service categories within the report.

[6] Laws 2018, Ch. 152, §1, requires AHCCCS to report on notices of action, which according to AHCCCS, involve not approving a service or stopping a service a member is receiving, and member appeals received during the reporting period. However, AHCCCS noted in its report that it collects data on notices of action for all populations and cannot separately provide information on notices of action for the DCS CHP population. AHCCCS reported that its State-wide integration of behavioral health services within DCS CHP should permit access to this data. Additionally, AHCCCS noted in its report that it does not have the capability to provide information on member appeals for the DCS CHP population because it is only notified of an appeal if a hearing is requested.

[7] Opioid treatment program providers receiving reimbursement from AHCCCS are required to annually submit a report to AHCCCS that includes a security plan, which includes patient management strategies designed to improve patient safety and reduce illegal opioid transactions; a neighborhood and stakeholder engagement plan, which outlines engagement efforts with neighborhood stakeholders to ensure the opioid treatment program is operating safely in the community; and a comprehensive plan for ensuring services meet federal standards. This information is summarized and included in AHCCCS' annual report to the Governor and the Legislature.

[8] AHCCCS and ADHS established standards for designating opioid treatment programs as 24/7 Access Points, including maintaining the capability to provide 24/7 medication assisted treatment services to members.

[9] AHCCCS' report includes information on available inpatient psychiatric treatment beds and the occupancy rates for those beds, inpatient psychiatric treatment occupancy expenditures, and number of members sent out of State for impatient psychiatric treatment. However, the report does not include information on the prevalence of psychiatric boarding or holding psychiatric patients in emergency rooms for at least 24 hours before transferring to a psychiatric facility. AHCCCS noted in its report that is working to standardize the reporting methodology to accurately report this information.

[10] AHCCCS reported that it has not submitted this annual report since 2017 because effective October 1, 2018, it integrated physical and behavioral health services and no longer maintained some information, such as the separate payment rate for behavioral health services for children, which AHCCCS reported it previously used to submit information. However, in response to our inquiries, AHCCCS reported it could work to determine how to address this reporting requirement. See Arizona Auditor General report 22-112 *Arizona Health Care Cost Containment System—Performance Audit and Sunset Review* for additional information and recommendations related to reporting requirements.

Source: Auditor General staff review of A.R.S. Title 36, Chapters 5, 18, 29, 34; A.R.S. §§8-512.01 and 41-3955.01; Laws 2021, Ch. 408, §9; Laws 2018, Ch. 152, §1; AHCCCS-provided reports and information; and AHCCCS reports available on its website at https://www.azahcccs.gov/Resources/Reports/state.html.

Scope and methodology

The Arizona Auditor General has conducted a performance audit of AHCCCS' administration of selected behavioral health services pursuant to a September 19, 2018, resolution of the Joint Legislative Audit Committee. The audit was conducted as part of the sunset review process prescribed in A.R.S. §41-2951 et seq.

We used various methods to address the audit's objectives. These methods included reviewing federal laws, regulations, and guidance documents; State statutes and rules; and AHCCCS' policies, procedures, and website. We also interviewed AHCCCS staff. In addition, we used the following specific methods to meet the audit's objectives:

- To determine whether AHCCCS ensured that its members were provided with peer support services by peer specialists that met State and federal qualification and supervision requirements, we reviewed a stratified random sample of 23 of 951 peer specialists reported as employed on the contracted health plans' December 31, 2021 quarterly reports.[67] The sample of 23 peer specialists was stratified across a sample of 10 of 55 providers that employ peer specialists that we judgmentally selected based on the providers' reported number of employed peer specialists, including 1 provider that reported employing more than 100 employed peer specialists, 1 provider that reported employing between 50 and 99 employed peer specialists, 3 providers that reported employing between 25 and 49 employed peer specialists, 3 providers that reported employing between 10 and 24 employed peer specialists, and 2 providers that reported employing 9 or fewer employed peer specialists.[68] Our work included reviewing qualification- and supervision-related documents, the AHCCCS Medical Policy Manual, rules, CMS State Medicaid Director Letter, and the Arizona State Plan. Additionally, we reviewed recommended practices and research for peer support services and supervision.[69]

- To provide information on the AHCCCS Housing Program, we reviewed AHCCCS' Housing Administrator Contract, AHCCCS' RBHA contracts, and the *AHCCCS Housing Program Guidebook*. We also interviewed AHCCCS staff and reviewed the Housing Administrator's quarterly reports. In addition, we reviewed federal regulations for housing quality standards, SAMHSA information, and HUD housing choice voucher participation contribution policies. Further, we reviewed AHCCCS' 1115 Research and Demonstration waiver request that was submitted in May 2021 and other Housing Program information.

- To identify AHCCCS behavioral health-related groups included in Appendix A, we requested a list of all committees, councils, task forces, and workgroups with a focus on behavioral health services from AHCCCS. We then worked with AHCCCS to identify the committees, councils, task forces, and workgroups

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[67] Contracted health plans are required to provide AHCCCS with a quarterly report on all peer specialists employed by contracted providers. Although the contracted health plans' December 31, 2021, quarterly report showed 951 employed peer specialists, we determined that the report included some errors, such as including some peer specialists who were not employed during the quarter. Although the report included these errors, we determined that it was reasonably accurate for audit purposes.

[68] At least 1 peer specialist was selected from each of the 10 providers in our sample.

[69] Choy-Brown, M. & Stanhope, V. (2018). The availability of supervision in routine mental health care. *Clinical Social Work Journal*, 46(4), 271-280; Jorgenson, J. & Schmook, A. (2014). *Enhancing the peer provider workforce: Recruitment, supervision, and retention*. Alexandria, VA: National Association of State Mental Health Program Directors. Retrieved 7/8/2022 from https://www.nasmhpd.org/content/enhancing-peer-provider-workforce-recruitment-supervision-and-retention; and SAMHSA. (2017). *Value of peers*. Rockville, MD. Retrieved 5/4/2022 from https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/value-of-peers-2017.pdf.

that were active as of August 2022. To obtain information about the committees, councils, task forces, and workgroups, we reviewed information on AHCCCS' website, meeting materials and agendas, federal laws, and information provided by AHCCCS staff. We also reviewed the fiscal year 2020-2021 Arizona Substance Abuse Treatment and Community Mental Health Services Block Grant application and AHCCCS' intergovernmental agreements with 5 tribal nations and/or TRBHAs for behavioral health services.

- To provide information on the statutory reporting requirements related to behavioral health services that are included in Appendix B, we reviewed A.R.S. Title 36, Chapters 5, 18, 29, and 34; §8-512.01; and §41-3955.01. Additionally, we reviewed Laws 2021, Ch. 408, §9, Laws 2018, Ch. 152, §1, and relevant reports provided by AHCCCS or available on its website. Further, to provide information on reports that AHCCCS is required to prepare and submit to CMS, we reviewed federal regulations and information on AHCCCS' website.

- To obtain information for the Introduction, we reviewed AHCCCS, CMS, SAMHSA, and NCQA information. In addition, we reviewed statute, session laws, and the *Arnold v Sarn* lawsuit and related agreement.[70] Further, we reviewed AHCCCS contracted health plan review and assessment reports related to service quality and/or behavioral health services.[71]

Our work on internal controls included reviewing AHCCCS' policies and procedures and, where applicable, testing its compliance with these policies and procedures. We reported our conclusions on applicable internal controls in Finding 1 and in the Questions and Answers sections of the report. We also assessed the reliability of the data AHCCCS provided and found it to be sufficiently reliable for our audit purposes.

We selected our audit sample to provide sufficient evidence to support our findings, conclusions, and recommendations. Unless otherwise noted, the results of our testing using these samples were not intended to be projected to the entire population.

We conducted this performance audit of AHCCCS in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We express our appreciation to the AHCCCS director and staff for their cooperation and assistance throughout the audit.

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[70] *Arnold v. Arizona Dept. of Health Services*, 160 Ariz. 593, 775 P.2d 521 (1989).

[71] Review and assessment reports we reviewed include: HSAG. (2022). *Contract year ending 2021 external quality review annual technical report for AHCCCS Complete Care and Department of Child Safety Comprehensive Health Plan*. Retrieved 7/25/2022 from https://www.azahcccs.gov/Resources/Downloads/EQR/2021/CYE2021ExternalQualityReviewAnnualReport-ACCandDCS-CHP.pdf; WICHE. (2021). *FY 2020-2021 (Year 7): Evidence based practices fidelity project quality improvement report*. Retrieved 7/8/22 from https://www.azahcccs.gov/AHCCCS/Downloads/ArnoldVSarn/AnnualReports/2021/WICHE_Year7YearEndReport.pdf; HSAG. (2021). *Contract year ending 2020 external quality review annual report for AHCCCS Complete Care and Comprehensive Medical and Dental Program*. Retrieved 8/29/22 https://www.azahcccs.gov/Resources/Downloads/EQR/2020/CYE2020ExternalQualityReviewAnnualReportACCandCMDP.pdf; Mercer. (2021a). *Quality service review 2021*. Retrieved 7/8/22 from https://www.azahcccs.gov/AHCCCS/Downloads/ArnoldVSarn/AnnualReports/2021/QualityServiceReviewReport2021.pdf; and Mercer. (2021b). *Priority mental health services 2021 Service capacity assessment*. Retrieved 7/7/2022 from https://www.azahcccs.gov/AHCCCS/Downloads/ArnoldVSarn/AnnualReports/2021/20211130AHCCCS_ServiceCapacityAssessment.pdf.

AHCCCS RESPONSE

September 28, 2022

Lindsey A. Perry
Auditor General
Office of the Auditor General
2910 North 44th Street, Suite 410
Phoenix, Arizona 85018

Dear Ms. Perry:

Enclosed is the Arizona Health Care Cost Containment System's response to the Auditor General's Performance Audit, detailing its review of selected behavioral health services.

I would like to express my appreciation to the Auditor General's office for its professionalism and collaborative approach throughout the audit process. As noted in the agency's response, AHCCCS has already begun to address the concerns identified.

Sincerely,

Jami Snyder
Director

Finding 1: AHCCCS did not ensure all peer specialists met qualification requirements, and some of these and other peer specialists were not supervised, potentially jeopardizing the quality of peer support services provided to members

Recommendation 1: AHCCCS should ensure that peer specialists meet qualification requirements and are supervised as required by developing and implementing monitoring processes, such as assessing compliance with these requirements during its 3-year reviews of contracted health plans.

Agency response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: AHCCCS has implemented policies and procedures to ensure providers comply with the AHCCCS Medical Policy Manual (AMPM 963 and AMPM 965), and the Arizona Department of Health Services' licensure requirements (A.A.C. R9-10). AHCCCS will establish and incorporate standards in the Managed Care Organization (MCO) operational review process to ensure the review of network providers' compliance with employment and supervision expectations for Peer and Recovery Support Specialists (PRSS). AHCCCS will also remind MCOs by written memo of the requirement that providers employing PRSS maintain their own policies detailing Behavioral Health Technician, Behavioral Health Paraprofessional, and Behavioral Health Professional qualifications as well as supervision requirements. This memo will be sent by November 2022.


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