ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES

Bureau of Quality & Integration Specifications Manual
Fiscal Year 2015
October 1, 2014 through September 30, 2015

Last Revision April 2015

BQ&I Specifications Manual
Table of Contents

Each Attachment below is included as an independent document within the Specifications Manual package. The chapters and attachments are listed together here for your awareness.

D10. Licensed Midwife Specialty Provider List
Attachment D10. Licensed Midwife Specialty Provider List Template

D11. Pregnant Women who Received Maternity Care from a Licensed Midwife Report
Attachment D11. Pregnant Women who Received Maternity Care from a Licensed Midwife Report.

Modified Chapters

Revision Date	Item	Reason for Revision
October 2013	Entire Specifications Manual and Attachments	Initial version
December 2013	Chapter and Attachment B4. Enrollee Grievance Report	The "Referred to QM" count is required for all worksheets and categories, not just Transportation. Use this format to report information starting on January 1, 2014.
December 2013	Chapter and Attachment B8. Quarterly Credentialing Report	Based upon correspondence from Kristin Frounfelker dated 11/14/13, two columns have been added to the template: (1) the "Number of completed applications received" (2) the "Completion Percentage" (contractual requirement). Use this format to report information starting with FY2014 Q1 (October through December 2013).
December 2013	Chapter B9. Performance Improvement Projects	An incorrect reference to "Section G" was changed to refer to the "FOCUS-PDSA MODEL."
December 2013	Chapter C4. SMI Eligibility Determination	Aggregate reporting of SMI Eligibility Determination has been replaced by member-level reporting in this chapter. Use this format to report information starting with FY2014 Q2 (January through March 2014).
March 2014	Chapter A1. How to Use this Specifications Manual	Reflects the addition of a RBHA providing integrated care to BHRs with SMI.
March 2014	Chapter A2. Enrolled in Episode of Care – Penetration Report	Updated to clarify current processing.
March 2014	Chapter A4. Eligible and Served –	New chapter describing the new Report generated by DBHS, available at the DBHS

	Penetration Report	website.
March 2014	Chapter B1.GSA Behavioral Health Service Plan	Updated to include the year for each quarter in the RBHA Timeline, updated the mailbox for receiving deliverables to the BQ&I mailbox, Updated to remove typo referencing BHSPv to read BHSP. Sampling methodology has been revised to discontinue dividing the 90% - 10% sample size by 4. Updated assessment scoring criteria to include BHT signature to be valid if BHP signs within 30 days after BHT/Assessor's signature. Updated to remove reference to Tribal BHSP onsite reviews.
March 2014	Chapter B2.GSA Behavioral Health Service Provision	Updated to include the year for each quarter in the RBHA Timeline.
March 2014	Chapter B3. GSA Behavioral Health Performance Measures and its Attachments B3a and B3c	Reflects these changes: For PM 1 adds Provider Type of 02 or 71 as inclusion criteria; For PM 2 changes "member months" to "member years"; For PM 3: changes the requested metric from "average adjusted probability" to "O/E Ratio (Observed Readmission Rate / Average Adjusted Probability)" For Table 2: addresses typographical errors; Language was added to clarify Access to BHP. These changes take effect with the April 15, 2014 submission.
March 2014	Chapter B5. Complaint Log and its Attachment	Updated to include the new RBHA contract ID; treatment settings updated to reflect licensing changes; definitions updated and codes added to include integrated care. Enrollment in DDD and CMDP is to be reported (see file layout). These changes take effect with the May 15, 2014 submission of April 2014 data.
March 2014	Chapter B12. GSA Integrated Care Performance Measures and Attachments	New chapter and attachments for integrated care monitoring and performance measures.
March 2014	Chapter B13. Incident, Accident, Death Report and Attachment	New chapter and attachment for the Incident, Accident, Death Report. Start using this Template on April 1, 2014.
March 2014	Chapter C1. Recipient	Updated to include the new template and

	and Provider Over- and Under-Utilization of Behavioral Health Services and Attachment	narrative requirements. Use this Template starting with the July 31, 2014 submission.
March 2014	Chapter C2. Length of Stay and Readmission	Report layout expanded to include levels of care for integrated care and new RBHA contract ID.
March 2014	Chapter C3. Prior Authorization	Report layout expanded to include integrated care services and new RBHA contract ID.
March 2014	Chapter C4. SMI Eligibility Determination	Updated to include the new RBHA contract ID and to clarify the inclusion criteria.
March 2014	Chapter C5. Outpatient Commitment Monitoring	Updated to include the new RBHA contract ID.
March 2014	Chapter C6. Pharmacy Utilization and Authorization, and Attachment	Updated to include new tabs in the reporting template and new narrative requirements. These changes have been discussed in the Pharmacy and Therapeutics Committee, and pilot data was submitted by the RBHAs on 2/14/14. Use this Template starting with the May 15, 2014 submission.
March 2014	Chapter C8. Transplant Log and Attachment	New chapter and attachment for the Transplant Log, required for integrated care.
March 2014	Chapter C9. HIV Specialty Provider List	New chapter and attachment for the HIV Specialty Provider List, required for integrated care.
March 2014	Chapter C10. Members on Provider and Pharmacy Restriction Snapshot Report and Template	New chapter and attachment for the Members on Provider and Pharmacy Restriction Snapshot Report.
March 2014	Section D Maternal and Child Health Chapters D1 thru D9 and Attachments	New section with EPSDT and Maternal-Child Health information and deliverables, required for integrated care.
September 2014	Chapter A1.	Updated to reflect current contract year.
September 2014	Chapter A3. Performance Incentives for Greater Arizona	Updated to reflect current contract year.
September 2014	Eligible and Served – Penetration Report	Deleted.
September 2014	Chapter B1. Behavioral Health	Updated to include H0002 as assessment code.

	Service Plan	Added detail on process for substitute assessment and requirement to include original sampled assessment when submitting a substitute assessment. Removed 5 day grace period for service plans; changed timeframes to bring the assessments closer to the BHSP period. Removed BHT signature; now only BHP signature will meet requirement for current/complete assessment. Added detail on Tribal process.
September 2014	Chapter B2. Behavioral Health Service Provision	Removed BHT signature, now only BHP signature will meet requirement. Removed 5 day grace period for service plans. Updated service matrix. Changed timeframes to bring the assessments closer to the BHSP period. Changed the date for running encounters to fall 6 months after the BHSP period.
September 2014	Chapter B3. GSA Behavioral Health Performance Measures and Attachments B3a, B3b, and B3C.	PM 1, 2, 3: Revised MPS and goals. PM 2: Changed "member years" to "member months". Table 1, PM 6 & 7: Added assessment code H0002. PM 6 & 7: Added code list to attachments. Updated Attachment B3a, GSA Behavioral Health PM Template. Updated Attachment B3c, Data Assumptions Removed EPSDT Participation from list of performance measures.
September 2014	B4. Grievance System Report	Deleted Enrollee Grievance Report and added specifications for new Grievance System Report
September 2014	B5. Complaint Log	Updated, definition, Report Frequency, Calculations for System wide Quarterly Performance Improvement Report, Timeline. Added complaint sub category other narrative requirement to the file specifications. Added "other" subcategory to each complaint

		category. Replaced Treatment setting codes with Aggrieved Provider Type codes. Updated descriptions for complaint category/subcategory code list, definitions for Resolution Reached code list and descriptions for Covered Behavioral Health Services code list.
September 2014	Attachment B5a-b. Quarterly Performance Improvement Report Template	Added language to Complaint Log analysis requirement.
September 2014	Quality of Care Concern Reporting	Deleted
September 2014	B8. Credentialing Denial Reporting Form and Attachment B8	New
September 2014	AHCCCS PIP:	Deleted Coordination of Care PIP (formerly B10) and added E-Prescribing PIP (B11).
September 2014	Chapter B12, GSA Integrated Care Performance Measures and Attachment B12a.	PM 1, 2, 3: Revised MPS and goals. PM 2: Changed "member years" to "member months". Table 1, PM 6 & 7: Added assessment code H0002. PM 6 & 7: Added code list to attachments. Updated Attachment B12a, GSA Integrated Care PM Template. Removed HIV/AIDS: Medical visit measure. Removed Access to PCP measure. Added two Cervical Screening measures. Added Chlamydia Screening measure. Removed "pending" from Persistent Medication monitoring measure. Removed CAHPS Health Plan Survey from measures.
September 2014	Chapter B13. Reporting Incidents, Accidents, and Deaths, Attachment B13a. and B13b.	Revised spec to include reference to Quality of Care & Peer Review Protocol (Attachment B13b.) Revised reporting form (Attachment B13a.)
September 2014	Chapter C2. Length of Stay and Readmission	Updated to include new RBHA Contractor id. Changed "same level of care" to "same or higher level of care".

September 2014	Chapter C3. Prior Authorization	Updated to include new RBHA Contractor id and added 2 edits to file layout.
September 2014	Chapter C4. SMI Eligibility Determination	Removed old Contractor id from file layout.
September 2014	Chapter C5. Outpatient Commitment (COT) Monitoring	Removed old Contractor id from file layout.
September 2014	Chapter C6. Pharmacy Utilization and Authorization and Attachment C6.	Updated to include integrated care services.
September 2014	C10. Members on Provider and Pharmacy Restriction Snapshot Report and Attachment C10.	Added DOB, AHCCCS ID, and CIS ID to fields to be reported in Attachment.
September 2014	Chapter D2. Sterilization	Updated to provide clarification.
September 2014	Chapter D7. Periodicity Schedules	Updated Exhibit number for Dental Periodicity Schedule at AHCCCS website link.
September 2014	Quarterly Performance Improvement Report Template	Removed Quality of Care Concern Summary Report from template and revised Complaint Log analysis.

| April 2015 | Chapter B1. GSA Behavioral Health Service Plan | Additional clarification made to the RBHA file submission process specifying the tabs in each excel spreadsheet that has to be populated.

The process of selecting members eligible for this measure was revised; T/RBHAs will provide DBHS with list of eligible members from which DBHS will pull samples.

Substitute assessments removed: only initial/core or updated assessments will be used for this measure.

The use of progress notes to supplement delays relating to entering service plan into the electronic health record on the same is no longer allowed. |
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| April 2015 | Chapter B3. GSA Behavioral Health Performance Measures and Attachments B3a and B3b | Updated the Minimum performance standards and goals for Performance Measures based on AHCCCS updates including per 1000 member months changed to per 100, 000 member months.

Added language requiring available data when not in service for the full reporting period.

Updated the reporting grid to match DBHS internal reporting data range time frames.

Removed H0002 assessment code from the Access to Care measures.

Updated Attachment B3a with the new AHCCCS template.

Updated Attachment B3b. ATC numerator service code list.

Updated Attachment B3c. to match rates and |

		changes made in the specifications.
April 2015	Chapter B4. Grievance System Report and Attachment B4a and B4b	Replaced link to AHCCCS GSR Attachment template with Attachment B4a. Added Attachment B4b to collect and report monthly member grievance data. Added Subcategory Late pick-up after Appointment to Attachment C (Transportation) of reporting template. Added direction regarding formatting of GSR Cover Letter.
April 2015	Chapter B5. Complaint Log and Attachment B5a	Deleted Code tables from spec; please refer to Attachment B5a. for codes. Added Complaint Category "Member Transportation" and 12 Subcategories to Code List on Attachment B5a.
April 2015	Chapter B8, Credentialing Denial Report Form and Attachment B8	Added requirement to report revocations of credentials. Added field "Date of Denial" to Attachment B8.
April 2015	(Former) Chapter B10, AHCCCS PIP: Reducing Readmissions	Removed.
April 2015	Chapter B11, PIP: Reduction of Member Appointment Wait Times – Behavioral Health Services	New PIP: Reduction of Member Appointment Wait Times was added
April 2015	Chapter B12, GSA Integrated Care Performance Measures and attachment B12	Updated the Minimum performance standards and goals for performance Measures based on including per 1000 member months changed to per 100, 000 member months on some standards. The Monitoring of Persistent Medications measure was Tabled for 2015 Comprehensive Diabetes LDL Screening was

		removed from the measures.
		Added language requiring available data when not in service for the full reporting period.
		Updated the reporting grid to match DBHS internal reporting data range time frames.
		Removed H0002 assessment code from the Access to Care measures.
		Updated Attachment B12 with the new AHCCCS template.
		Updated Attachment B3b. ATC numerator service code list.
April 2015	Chapter B13, Reporting IADs	Revised spec to reference IAD reporting through the QMS Portal and provided link for access. Deleted Attachments B13a and B13b.
April 2015	Chapter C1, Recipient and Provider Over-and Under-Utilization of Behavioral Health Services	Revised page 2 to "analyze top **5%** of service utilization".
April 2015	Chapter C2, Length of Stay and Readmission	Added Notification Date, Initial Review Date, and Days from Notification to Review to file layout. Added edit for DOB to file layout.
April 2015	Chapter C3, Prior Authorization	Added Wheelchair and Insulin Pump to Service list on file layout to be used by Integrated RBHAs only. Added clarification that the file should only contain pre-service authorization requests. Added edits for DOB and service codes on file layout.
April 2015	Chapter C4, SMI Determination	Expanded spec to include CRN. Added edit for DOB on file layout.
April 2015	Chapter C5, SMI	New specification.

	Determination Process (Maricopa County)	
April 2015	Chapter C6, Outpatient Treatment (Court Ordered Treatment) Monitoring	Added edit for DOB on file layout.
April 2015	Chapter C7, Pharmacy Utilization and Authorization Attachments	Revised to include reporting of pharmacy authorization and poly-pharmacy. Added Attachments C6b and C6c to be used as reporting templates as distributed to RBHAs November 2014.
April 2015	Chapter C8, Inter-Rater Reliability Testing	Added IRR testing to include service providers making SMI determinations.
April 2015	Chapter C12, Arizona State Hospital Discharge Report and Attachment C12	New specification and Attachment.

April 2015	Chapter C13, Adult and Children's Emergency Room Wait Times and Attachment C13	New specification and Attachment.
April 2015	Chapter C14, HCV Medication Monitoring and Attachment C14	New specification and Attachment.
April 2015	Chapter C15, Hospital Hold Report and Attachment C15	New specification and Attachment.
April 2015	D4. DBHS Maternity Care Risk Screening Guidelines	Modified Home Births and Births in free-standing Birth Centers section Modified the Maternity Care Provided by the Licensed Midwife section
April 2015	D6. DBHS Monthly Pregnancy and Delivery Report and attachment D6	Modified with new timeframes and instructions for submitting data sets with attachment D6. Attachment D6 was updated with additional fields and layout.
April 2015	D10. Licensed Midwife	New specification and Attachment.

	Specialty Provider List	
April 2015	D11. Pregnant Women Who Received Maternity Care from a Licensed Midwife Report	New specification and Attachment.

A. General

HOW TO USE THIS SPECIFICATIONS MANUAL

OVERVIEW

This Specifications Manual has been prepared by the ADHS/DBHS Bureau of Quality and Integration (BQ&I) and documents key information for Regional and Tribal Behavioral Health Authorities for use in FY2015. Included are reference materials and deliverables for Quality and Medical/Utilization Management. Each topic is detailed in its own chapter, with the footer listing the chapter number and name, revision date, and pagination. Required file layouts are included within the relevant chapter. If a chapter revision is necessary, the entire chapter will be updated, and distributed with the new revision date.

Use Adobe Reader to navigate through the document. Bookmarks have been established for each chapter and sections within the chapter.

Some topics have accompanying lists with information or templates used in file submission. For example, the Complaint Log file layout asks for codes of complaint categories and subcategories, among other details. The codes are listed in an attached Excel workbook for easy use in electronic file preparation. Excel workbook templates for submission of the GSA Behavioral Health Performance Measures Report, Quarterly Credentialing Report, Pharmacy data, Inter-rater Reliability Testing Report and others are provided as attachments to this Manual. Document templates are also included for the Quarterly Performance Improvement and Quarterly MM/UM Indicator Reports.

ORGANIZATION OF THE MANUAL

The Manual is divided into (A) General, (B) Quality Management, (C) Medical and Utilization Management, and (D) Maternal and Child Health sections. Attachments follow the chapter numbering scheme, for example, chapter B7 is the Quarterly Credentialing Report, and the associated template is labeled Attachment B7. See the Table of Contents for complete details.

AREAS OF SPECIAL FOCUS

Chapters and attachments with information required for submissions from Tribal Behavioral Health Authorities include:

A2. Enrolled in Episode of Care - Penetration Report
B1. Behavioral Health Service Plan
Attachment B1. Template for T-RBHA MBR BHSP List
B7. Quarterly Credentialing Report
Attachment B7. Quarterly Credentialing Report, page 1
B8. Credentialing Denial Reporting Form
Attachment B8. Credentialing Denial Reporting Form Template

These chapters and attachments are required only for Regional Behavioral Health Authorities for their recipients receiving integrated care:

B7. Quarterly Credentialing Report, Attachment page 2: Dental
B12. GSA Integrated Care Performance Measures
C9. Transplant Log
C10. HIV Specialty Provider List
D1. Pregnancy Termination
D2. Sterilization
D3. Report of Number of Pregnant Women who are HIV/AIDS Positive
D4. DBHS Maternity Care Risk Screening Guidelines
D5. Commercial Oral Nutritional Supplements
D6. DBHS Monthly Pregnancy and Delivery Report
D7. Periodicity Schedules
D8. Recommended Immunization Schedule
D9. EPSDT Tracking Forms
D10. Licensed Midfwife Speciality Provider List
D11. Pregnant Women who Received Maternity Care from a Licensed Midwife Report

All other chapters and attachments apply to all recipients served by those RBHAs, including those receiving integrated care.

ENROLLED IN EPISODE OF CARE - PENETRATION REPORT

DESCRIPTION

The Enrolled in Episode of Care - Penetration Report is prepared monthly by the Division of Behavioral Health Services, and contains behavioral health recipient enrollment and eligibility counts, along with penetration rates. The information is presented by eligibility group and behavioral health category statewide and by GSA/TRBHA.

ABBREVIATIONS

ADHS/DBHS – Arizona Department of Health Services/Division of Behavioral Health Services
AHCCCS – Arizona Health Care Cost Containment System
BHR – Behavioral Health Recipient
CIS – ADHS Client Information System
CMDP - Comprehensive Medical and Dental Plan
DUG – Demographic and Outcome Data Set User Guide
EOC – Episode of Care
GMH – General Mental Health
GSA – Geographical Service Area
OPI – Office of Performance Improvement
RBHA – Regional Behavioral Health Authority
SA – Substance Abuse
SMI – Seriously Mentally Ill
TRBHA – Tribal Regional Behavioral Health Authority

MINIMUM PERFORMANCE STANDARDS

Not applicable.

METHODOLOGY

The report is available through this link:
http://www.azdhs.gov/bhs/reports/monthly.htm

Population

People eligible for Title XIX/XXI Medicaid benefits are eligible to receive behavioral health services. There are also services available for those meeting state eligibility criteria. Behavioral health recipients with an open Episode of Care are counted as enrolled.

Eligibility and enrollment counts are reported by funding source, behavioral health category, and GSA/TRBHA.

Behavioral Health Category
- This is determined by the most current value within the Behavioral Health Category Code field in the Demographic Snapshot. The following age sub-definitions apply as determined by the behavioral health recipient's age at the end date of reference:
    - Child- age must be 0 to less than 18
    - SMI- Age must be 18 or greater
    - SA – Age must be 18 or greater
    - GMH- Age must be 18 or greater
    - CMDP- Age must be 0 to less than 18

Eligibility Segment
- An AHCCCS Eligibility (HIPAA 834) Behavioral Health eligibility segment is defined by a start and end date as defined by the HIPAA 834.

Eligibility Category (as defined by the HIPAA 834)
- This is determined by the value within the Contract Type field in the AHCCCS Eligibility Snapshot. The most recent segment will be used during the dates of reference. In order to determine CMDP Eligibility, the Contract Type value of "7" is used from the AHCCCS At-Risk Snapshot. CMDP eligibility supersedes any other eligibility category for behavioral health recipients who are less than 18 years of age.

Demographic Submissions (as defined by the Behavioral Health Assessment, DUG 6.0)
- 1- Initial Assessment- EOC Start
- 2- Subsequent Assessments- Full Assessment
- 3- Partial Update- Minor Change
- 4- Closing Assessment/EOC End
- 5- Start Crisis or Short Episode
- 6- End Crisis or Short Episode
- 9- Correct an error in previous transmission

Episode of Care (as defined by the Behavioral Health Assessment, DUG 6.0)
- An episode of care is that period between the beginning of treatment and the ending of services for the individual as marked by demographic submissions of "1" or "5" to start and "4" or "6" (crisis) to end.

Data Source

The report is generated from the ADHS/DBHS Client Information System (CIS).

Reporting Frequency

Monthly

Sampling

Not applicable.

Calculation

Penetration
- The percent of Medicaid eligible consumers, as determined by AHCCCS, having an open episode of care in the behavioral health system during the dates of reference. (Episode of Care/Eligible).

Timeline

Source data are aggregated 60 days after the month being reported to allow for submission lag. For example, the March report is created with data as of the end of May.

QUALITY CONTROL

Demographic information submitted by the T/RBHAs is monitored by DBHS through the Daily Demographic Acceptance Report. A 90% minimum acceptance rate must be maintained in order to continue submission of demographics to the production environment. Acceptance rates may be part of the T/RBHA's administrative review.

CONFIDENTIALITY PLAN

Preparation of the information for this report includes accessing "individually identifiable health information" as defined in HIPAA regulation 45 CFR 160.103 or "restricted personal identifying information" as defined in Arizona Strategic Enterprise Technology (ASET)/Statewide Information Security and Privacy Office (SISPO) Policy P900, Information Security Information Management, paragraph 4.1.10. Safeguards and controls, such as restricted access and agreement to protect confidential information, are contractual conditions in place to protect the identifying information that was accessed. All resulting publicly-reported data are aggregated at the GSA

and tribe level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information.

PERFORMANCE INCENTIVES FOR GREATER ARIZONA

DESCRIPTION

ADHS/DBHS uses a Performance Incentive System to encourage its Contractors to promote improved quality of care for Behavioral Health Recipients. Incentive payments earned for services delivered to BHRs are subject to the availability of funding. The incentives and financial reimbursements are based on the Contractor meeting or exceeding set performance targets. Additional incentives earning criteria can be referenced in the following documents:

- ADHS/DBHS Contractor Contracts
  - Cenpatico Behavioral Health of Arizona, Contract ADHS 13-033134 Amendment 22, Attachment D: Performance Incentives
  - Community Partnership of Southern Arizona, Contract HP032097-003 Amendment 21, Attachment D: Performance Incentives
  - Northern Arizona Regional Behavioral Health Authority, Contract HP032097-002 Amendment 26, Attachment D: Performance Incentives
- ADHS/DBHS Provider Manual
- ADHS/DBHS Program Support Procedures Manual

The term 'Contractor' is used throughout this specification to reference the following RBHAs currently awarded contracts with ADHS/DBHS for FY2015:

Cenpatico Behavioral Health of Arizona
Community Partnership of Southern Arizona
Northern Arizona Regional Behavioral Health Authority

ABBREVIATIONS

AHCCCS – Arizona Health Care Cost Containment System
ADHS/DBHS – Arizona Department of Health Services/Division of Behavioral Health Services
BHR – Behavioral Health Recipient
BQMO – Bureau of Quality Management Operations
CIS – Client Information System
ERE – Employee Related Expenses
FTE – Full-time Employee
GSA – Geographical Service Area
PCP – Primary Care Physician
RBHA – Regional Behavioral Health Authority
SMI – Seriously Mentally Ill
YSS-F – Youth Services Survey for Families

MINIMUM PERFORMANCE STANDARD

This contract period consists of four (4) quarters, from October 1, 2014 through September 30, 2015. ADHS/DBHS withholds 1% of a Contractor's combined Title XIX and Title XXI capitation payments for this contract period in each GSA and allocates this withheld Title XIX and Title XXI money to the Contractor if it meets the performance goals specified in the ADHS/DBHS and Greater Arizona RBHA contracts.

ADHS/DBHS has identified four (4) performance measures calculated for the fiscal year, with incentives paid for meeting or exceeding the performance measure goals. In order to earn the incentive for each of the performance measures, the measure-specific performance goal must be met before rounding the performance calculation. These performance measures are:

1. **Employment –** 26% of the total population served 18 years and older are employed. Using CIS data on the last day of each quarter of the fiscal year, for each of those quarters in which the goal is met, the Contractor earns one-fourth of the 25% incentive. The Contractor is responsible for accurate and timely submission of demographic data.

2. **Annual Assessment Updates** – 85% of the total number of enrolled members with an assessment have an assessment update within the past 12 months. Performance is measured separately for the following populations.
   a. SED and non-SED combined
   b. SMI, GMH, and SA combined

   Performance is measured annually using CIS data from the last day of the contract year. The Contractor is responsible for accurate and timely submission of demographic data. If the goal is met for SED and non-SED, the Contractor earns ½ of the 25% incentive. If the goal is met for SMI, GMH, and SA, the Contractor earns ½ of the 25% incentive.

3. **Consumer Satisfaction with Service Outcomes** – BHRs are satisfied or better with the behavioral health services they receive. Performance calculation is based on the results of the Outcomes portion of the ADHS/DBHS Consumer Survey for the contract period. The goal is that 70% or more of BHRs report that they are "satisfied" or better on the Outcomes domain in the youth and adult surveys. The Contractor will receive ½ of the incentive if the goal is met for the children's survey, and ½ of the incentive if the goal is met for the adult's survey.

4. **Title XIX Eligibility Ratio** – The goal is that 65% or more of enrolled SMI BHRs are also eligible for Title XIX services. Using CIS data on the last day of each quarter, for each of those quarters in which the goal is met, the Contractor earns one-fourth of the 25% incentive. The Contractor is responsible for accurate and timely submission of demographic data.

METHODOLOGY

Population

BHR populations are specified under the descriptions of each performance incentive measure.

Data Source

Employment - CIS

Annual Assessment Updates - CIS

Consumer Satisfaction – ADHS/DBHS 2014 Annual Consumer Survey: Questions 21-28 of the Adult tool and Questions 16-22 of the YSS-F tool.

Title XIX Eligibility Ratio – ADHS/DBHS Enrollment Penetration Report from CIS data.

Sampling

Not applicable.

Calculation

ADHS/DBHS will for the entire fiscal year calculate performance as follows:

1. Employment
   a. Using CIS Episode of Care data as of the last day of each quarter of the fiscal year, calculate the number of employed SMI/GMH/SA individuals.

      For NOMs Performance, Employment is determined by coding CIS Field 66 as follows: Values of 01, 02, 03, 04, 24, 25, and 27 = Employed; 08 = Unemployed; Blanks and 99 = System Missing; Else = Not in Labor Force (Missing)

      Numerator: Number of SMI/GMH/SA BHRs in an open Episode of Care who are employed on the last day of the quarter.
      Denominator: Number of SMI/GMH/SA BHRs in an open Episode of Care on the last day of the quarter.

   b. The Contractor will qualify for one-fourth of the total monies allocated for this incentive for each quarter of FY2014 that 26% or more of the total number of SMI/GMH/SA BHRs are considered employed.

2. Annual Assessment Updates

a. Using the CIS field "Assessment Date," from September 30, 2015, calculate the number of enrolled members with updated assessments for each of the following populations

   i. SED and non-SED
   ii. SMI, GMH, and SA

   Numerator: Number of members with a follow-up assessment completed within the past 12 months
   Denominator: Total number of enrolled members with an assessment for each of the above populations.

b. Performance will be separately assessed for SED and non-SED clients, and SMI, GMH and SA populations.

c. For each of the two population categories where 85% or more of the assessments are updated within the past 12 months, the Contractor will receive one-half of the incentive.

3. Satisfaction with Service Outcomes
   a. Develop an Outcomes domain score for each of the Contractor's Adult BHRs. For each BHR that responded to at least two-thirds of the domain questions, translate survey responses to a numerical score by obtaining each BHR's response to Questions 21 through 28 on the Adult tool associated with the ADHS/DBHS 2013 Annual Consumer Survey for the contract period. For each question in the domain, responses are converted to numerical scores as follows:
      i. Strongly Agree = 5
      ii Agree = 4
      iii. Neutral = 3
      v. Disagree = 2
      vi. Strongly Disagree = 1
   b. Calculate a domain average score for each adult BHR.
         Numerator: Total numeric scores for each BHR Questions 21 through 28
         Denominator: Number of valid responses to Questions 21 through 28 for each BHR

   The domain average should range between 1 and 5, with a domain average of greater than 3.5 indicating the BHR is satisfied under the Outcomes domain.
   c. The Contractor will qualify for the adult portion of the Satisfaction with Service Outcomes incentive if 70% or more of the BHRs have an Outcomes domain average of greater than 3.5.
   d. Develop an Outcomes domain score for each of the Contractor's child BHRs. For each BHR that responded to at least two-thirds of the domain questions, translate survey responses to a numerical score by obtaining each BHR's response to Questions 16 through 22 on the YSS-F tool associated with the ADHS/DBHS 2013 Annual Consumer Survey for the contract period. For each question in the domain, responses are converted to numerical scores as follows:
      i. Strongly Agree = 5
      ii. Agree = 4
      iv. Neutral = 3

      vii. Disagree = 2

      viii.   Strongly Disagree = 1

e. Calculate a domain average for each child BHR.

      Numerator: Total numeric scores for each BHR Questions 16 through 22

      Denominator: Number of valid responses to Questions 16 through 22 for each BHR

      The domain average should range between 1 and 5, with a domain average of greater than 3.5 indicating the BHR is satisfied under the Outcomes domain.

f. The Contractor will qualify for the child portion of the Satisfaction with Service Outcomes incentive if 70% or more of the BHRs have an Outcomes domain average of greater than 3.5.

4. <u>Title XIX Eligibility Ratio</u>

a. Using the Enrollment Penetration Report published the last day of each quarter of the contract period, ADHS/DBHS will:

    i. Identify the number of BHRs reported as SMI with an open episode of care in each GSA as of the last day of that quarter.

    ii. Identify the number of BHRs reported as Title TXIX SMI with an open episode of care in each GSA as of the last day of that quarter.

    iii. Develop a percentage for the quarter of the SMIs with an open episode of care that are Title XIX.

      Numerator: The number of Title XIX SMIs with an open episode of care

      Denominator: Total number of SMIs with an open episode of care

b. The Contractor will qualify for one-quarter of the total contract period monies withheld for this incentive for each of the quarters in which 65% or more of the total number of SMIs with an open episode of care are Title XIX eligible.

QUALITY CONTROL

Demographic information submitted by the RBHAs to ADHS/DBHS' Client Information System (CIS) is monitored by ADHS/DBHS through the Daily Demographic Acceptance Report. A 90% minimum acceptance rate must be maintained in order to continue submission of demographics to the production environment. Acceptance rates may be part of the RBHA's administrative review.

CONFIDENTIALITY PLAN

Preparation of the information for these performance incentives includes accessing "individually identifiable health information" as defined in HIPAA regulation 45 CFR 160.103 or "restricted personal identifying information" as defined in Arizona Strategic Enterprise Technology (ASET)/Statewide Information Security and Privacy Office (SISPO) Policy P900, Information Security Information Management, paragraph 4.1.10. Safeguards and controls, such as restricted access and agreement to protect confidential information, are contractual conditions in place to

protect the identifying information that was accessed. Publicly-reported data generated for these performance incentives are aggregated at the GSA level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information.

B. Quality Management

BEHAVIORAL HEALTH SERVICE PLAN

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DESCRIPTION
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All persons being served in the public behavioral health system must have a behavioral health assessment upon initial request for services and a written plan for services based upon the initial assessment. Service plans must be utilized to document services and supports that will be provided to the individual, based on behavioral health service needs and changes identified through the person's behavioral health assessment. Service plans must be updated as significant changes occur, and/or on an annual basis. This is a quarterly performance measure, which reviews the assessment and service plan to ensure that the needs and service recommendations identified in the assessment are reflected in the service plan. Assessments will be pulled for the quarter 3 months prior to the current BHSP measurement quarter to allow time for completion of the Behavioral Health Service Plan (BHSP). This chapter applies to the T/RBHAs and the Integrated RBHA.

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ABBREVIATIONS
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AAC – Arizona Administrative Code
ADHS/DBHS – Arizona Department of Health Services/Division of Behavioral Health Services

BHC – Behavioral Health Category
BHP – Behavioral Health Professional
BHR – Behavioral Health Recipient (referred to as "member" henceforth)
BHT - Behavioral Health Technician
BHSP – Behavioral Health Service Plan
BQI – Bureau of Quality and Integration
C/A – Child/Adolescent
CIS – ADHS Client Information System
CMDP – Comprehensive Medical and Dental Plan
CPT – Current Procedural Terminology
DCS – Department of Child Safety (formerly known as "Child Protective Services" (CPS)
DDD – Division of Developmental Disabilities
Funding Source – DDD, CMDP, Title XIX, Non-Title XIX, Title XXI
GMH – General Mental Health
GSA – Geographic Service Area
HCPCS – Health Care Procedure Coding Systems
HIPAA – Health Insurance Portability and Accountability Act
IRR – Inter-rater Reliability
MPS – Minimum Performance Standard

OPI – Office of Performance Improvement
PM – Performance Measure
RBHA – Regional Behavioral Health Authority
SA – Substance Abuse
SMI – Seriously Mentally Ill
TRBHA – Tribal Regional Behavioral Health Authority
T/RBHA – Tribal and Regional Behavioral Health Authority

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BHSP DEFINITIONS
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BHP - As specified in R9-10-101, an individual licensed under A.R.S. Title 32, whose scope of practice allows the individual to:

> a. Independently engage in the practice of behavioral health as defined in A.R.S. § 32-3251; or

> b. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. § 32-3251 under direct supervision as defined in A.A.C. R4-6-101.

BHT - As specified in R9-10-101, an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:
>   a. If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; and
>   b. Are provided with clinical oversight by a behavioral health professional.

Current Assessment
- An assessment completed during the 3 months prior to the Behavioral Health Service Plan quarter.
- The assessment must include:
  - Date, Begin and End time of the assessment,
  - Printed name, signature and professional credential of the BHP/BHT completing the behavioral health assessment
    - If a BHT completes the assessment; the assessment must also include a printed name, signature, professional credential, date and time of the BHP who reviewed the assessment information
- An Assessment completed by a BHT must be signed and dated by a BHP within 30 days to be eligible for review. The date of a completed assessment will be based on BHT/assessor signature with a 30 day grace period for BHP signature. If the BHP signature is not dated, or not dated within 30 days of assessment, it will be scored as not current.
- For an assessment to be current, it must be completed no more than 90 days **_prior_** to the service plan, or the same day as the service plan, (**_Any assessment created after the service plan_**

does not allow the service plan to be based on the assessment and therefore, the service plan would not be considered current.)

Current Service Plan
- • A service plan completed within 90 days of the initial or updated assessment, as identified by the signature and date of the BHT or BHP completing the service plan.
- • In the event that a BHT completes the service plan, a BHP must review and sign the service plan within 30 days of the member/guardian and one staff member's signatures. (See ADHS/DBHS Policy Manual # 105, Assessment and Service Planning: http://www.azdhs.gov/bhs/policy/documents/policies/bhs-policy-105.pdf
- • Signed and dated by the member/guardian and one staff member.

Telephonic/Telehealth Service Consent Guidelines for Assessments and Service Plans
- • Telehealth service appointments – Behavioral Health Professional (BHP), member/guardian, case manager, Department of Child Safety (DCS) worker are able to provider verbal consent re: service plans, treatment decisions, and placements.
- • Documentation of telephonic approval must be clearly identifiable in the medical record in a progress note or on a form specifically used for telephonic/telehealth service
- • Example of documentation: Telephonic/Telehealth Service consent received from XX (member/guardian, BHP, DCS Worker) on xx/xx/20xx at xxxx (time) for xx (service). Signature/date of the BHP
- • Upon next contact in which medical record is available for live signature, document must be updated with signature and date of individual who previously gave telephonic consent.

    **Option: forms can be faxed to the member/guardian/BHP/DCS Worker for signature. Signed forms must be faxed back within 3 working days. (This does NOT take the place of required documentation bullet #2 above).

Annual Updates to the Assessment and Service Plan
- • *Assessments must be completed, at a minimum, on an annual basis.* The update must include input from the member and family, if applicable, that:
- o records an historical description of the significant events in the member's life, and
- o describes how the member/family responded to the services/treatment provided during the past year

• The *service plan must be updated as goals are met and new goals are established.* , and must reflect the most current assessment.

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MINIMUM PERFORMANCE STANDARD
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Minimum: 85%
Goal: 95%

The MPS must be met each review period by each GSA for both the Child/Adolescent (C/A) and Adult populations.

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METHODOLOGY
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Population
Title XIX, Title XXI Child/Adolescent (up to age 21) and Adults (21+ years).

- Child/Adolescent Population

  ADHS/DBHS stratifies performance for the C/A population by GSA. In addition, ADHS/DBHS will ensure that a representative sample for each line of business (Title XIX, Title XXI, DDD, and CMDP) is drawn for each GSA.
  The following age bands may be used for ad hoc reporting:
  - 0 - 5.999
  - 6 - 11.999
  - 12 - 17.999
  - 18 - 20.999
- Adults

  ADHS/DBHS stratifies performance for Adults by GSA. In addition, ADHS/DBHS will ensure that a representative sample for each line of business (Title XIX SMI, Title XIX GMH/SA, Non-Title XIX SMI, DDD) is drawn for each GSA.

Overview
- DBHS no longer tracks "Episode of Care", which was previously used to identify members for this performance measure.

- DBHS attempted to use the assessment codes H0002 and H0031 to identify members who received an assessment service. Unfortunately, it was determined that these codes pulled **_all_** services that are considered "assessments", and not just the Initial/Core or Annual assessment.

- A "work-around" was developed for CY14 whereby all H0002 and H0031 assessments that occurred during the 3 months prior to the BHSP quarter were pulled and if the assessment was found to be other than an Initial/Core or Annual assessment, the RBHA was required to submit a "substitute" core assessment for that member that occurred within the 12 months prior to the BHSP quarter.

- The use of "substitute" assessments caused numerous problems for the T/RBHAs as well as for the OPI Quality Analysts.

- For CY15, DBHS is changing the method by which the Assessments (Initial/Core and Annual) are identified and for which the Service Plans will be reviewed. Refer to **Sample Source** below.

Review Frequency

RBHAs every three months; TRBHAs twice in the (IGA) contract year.

- o **Sample Source – RBHA and TRBHA - The** T/RBHAs will provide DBHS with an Excel document containing all members who received either an Initial/Core or Annual Assessment in the three (3) months prior to the Service Plan Review quarter using the template provided as Attachment B1a. (RBHA) or B1b. (TRBHA). DBHS will take a random sample of members provided by the T/RBHAs and forward the sample to the T/RBHA. The T/RBHA will return the same Excel document to DBHS, adding the Provider name for each sampled member along with chart documentation. See **Required Documents to Submit for Review** and **Process** sections below for details. The review of RBHA information is completed by DBHS OPI staff on a quarterly basis for the RBHAs, and semi-annually for the TRBHAs. The content is scored according to objective criteria to determine the percentage of Service Plans meeting compliance with the performance measure

Sampling

Samples are drawn randomly at the GSA or tribe level using at least a 90% confidence level with a 10% error rate for the Child/Adolescent and Adult populations. Additional samples will be requested for DBHS inter-rater reliability testing. BHSP results for these members will not be included in the scored sample for this PM.

Required Documents to Submit for Review

•The current/most recent service plan that directly relates to the core. (Service plan is required to be completed within 90 days of the core/annual assessment.)

The DBHS sample spreadsheet – RBHAs must complete the Provider column.).

Timeline - RBHA

RBHA BHSP Quarter	**Assessment Quarter** Dated (2014-2015)	**BHSP Quarter** Dates (2014-15)	**RBHA ELIGIBLE LIST TO DBHS**	**DBHS RANDOM SAMPLE LIST TO RBHA**	**RBHA FILE TO DBHS**
*Q1 10/01-12/31	July 1 – September 30, 2014	October 1– December 31, 2014	June 15, 2015	June 30, 2015	July 30, 2015
*Q2 01/01-03/31	October 1 – December 31, 2014	January 1 – March 31, 2015	July 15, 2015	July 30, 2015	August 30, 2015

*Q3 04/01-06/30	January 1– March 31, 2015	April 1 – June 30, 2015	August 15, 2015	August 30, 2015	September 30, 2015
*Q4 07/01-09/30	April 1– June 30, 2015	July 1 – September 30, 2015	November 15, 2015	November 30, 2015	December 30, 2015

If the day the file must be reported to ADHS/DBHS falls upon a weekend or holiday, it will be due the next business day.

Process - RBHA (Q3 and Q4 only)

1) 45 Days Following the RBHA BHSP Quarter
Via the Sherman server, with e-mail notification to DBHS, each RBHA will submit an Excel workbook having two tabs: one tab is the list of C/A members that had received an initial/core assessment or updated assessment during the "Assessment Quarter Dated" column in the table above. The other tab is the sample of Adult members that had received an initial/core assessment or updated assessment during the "Assessment Quarter Dated" column in the table above. See Attachment B1a for prescribed format.

2) 60 Days Following the RBHA BHSP Quarter
Via the Sherman server with an email notification to the RBHA, DBHS will provide a copy of the initial Excel Spreadsheet and tabs with C/A and Adult members in the respective tab. The spreadsheet will contain a randomly selected sample that is also selected by BH Category and Funding Source using a 90% confidence level with a 10% error rate where possible. If the eligible population is too small for a 90/10 sample, DBHS may select the entire population (e.g., Adult DDD).

3) 30 Days Following the "DBHS RANDOM SAMPLE LIST TO RBHA" (see table above)
Via the Sherman server with e-mail notification to ADHS/DBHS (BQI.Deliverables@azdhs.gov), the RBHA provides ADHS/DBHS with the completed Excel spreadsheet, including Provider name, as well as the required documents for completion of the review (see Electronic Record Submission Format below).

Timeline – TRBHA

Semi-Annual Review Period - TRBHA

TRBHA BHSP Period (2014-15)	TRBHA Assessment Review Period (2014-15)	TRBHA file to DBHS (2015)	DBHS file to TRBHA (2015)
Q1-2 October 1, 2014 – March 31, 2015	April 1 2014– September 30, 2014	May 15	June 15
Q3-4 April 1 2015 – September 30, 2015	October 1, 2014 – March 31, 2015	November 15	December 15

**TRBHA completed submission of assessment and service plan due to DBHS 30 days from the date that DBHS returns the file to the TRBHA.

Process - TRBHA
 1. **45 Days** Following the TRBHA BHSP Period

Via the Sherman server, with e-mail notification to the DBHS, each TRBHA provides DBHS with a with an Excel workbook having two tabs: one is the C/A recipients and the other is the Adult recipients who **received an assessment 6 months prior** to the **BHSP period** (see example in above table). See Attachment B1b for prescribed format.

 2. **30 days** following the receipt of the TRBHA file

DBHS will provide the TRBHAs with the list of members for which the assessment and service plan documentation must be submitted.

 3. **30 days** following the receipt of the DBHS file,

The TRBHAs, via the Sherman server with e-mail notification to ADHS/DBHS (BQI.Deliverables@azdhs.gov) provides ADHS/DBHS with the completed Excel spreadsheet, as well as the required documents for completion of the review (see Electronic Record Submission Format below).

Electronic Record Submission Format
• All documents must be submitted in PDF format.
• All documents relating to each member must be submitted in one document folder (e.g. all of 'Mary Smith's' documents need to be combined in one document). No more than one member's documents may be in one PDF document/folder.
• Each document must be labeled with the member's name (which must match the name as listed on the DBHS spreadsheet).
• Each section of each document must be identified by topic (e.g. Assessments, Service Plans, Progress Notes).
• All pages submitted must be legible and complete (crooked pages causing missing information or signatures will not be given credit; acronyms unique to the provider or T/RBHA must be spelled out).
• All scanned pages must be rotated in the same direction.
• All documents must be placed in folders labeled by population (e.g., T19 Children, Adults), BH Category and Funding Source, and GSA (for applicable RBHAs only).
• For information submitted at the Sherman server
      o All files must be zipped prior to placement on the Sherman server.
      o All submissions must be placed into the RBHA specific folder on the Sherman server.
      o Once submissions are complete, the RBHA must send email notification to ADHS/DBHS BQI.Deliverables@azdhs.gov and the BHS Compliance mailbox (BHSCompliance @azdhs.gov).

Scoring Criteria
Assessment:
In order to be scored and considered current, the assessment must:

- Be signed by the BHP completing the assessment, or co-signed by a BHP within 30 days of the BHTs signature .
- Include the date of assessment next to signature
- Ensure that the assessment falls within the previous 3 months of the Behavioral Health Service Plan Review Period for core or annual assessments

The reason(s) for the assessment not to be scored as current are as follows:
- BHP signature date over 30 days
- Illegible
- Incomplete/Missing pages
- No BHP signature (printed name, signature and professional credential)
  - o In the event that a BHT completes the service plan, a BHP must review and sign the service plan.
- Not dated (Date, Begin and End time of the assessment)
- Scanning/technical issue
- Not following telephonic consent guidelines

Service Plan:

The service plan is scored if both the assessment and service plan are considered current. A current service plan contains the following elements:
- Submitted service plan is based upon a current (core/initial or annual) assessment
- Submitted service plan is signed by member/guardian AND one staff member
- Includes date of service plan next to signature

- If completed by a BHT, BHP must review and sign Service Plan within 30 days of member/guardian/BHT signatures.

* The date of the service plan is based on the date of the BHT or BHP completing the service plan. The member, parent, and/or guardian must also sign and date the service plan.

** Individuals must be sure to sign the service plan on the correct lines based upon their role/identity.

*** Credentials must follow signatures of BHT/BHP as applicable.

The reason(s) for the service plan not be included or not be considered/scored as current are as follows:
- Assessment not current
- Service plan completed more than 90 days after the assessment
- Service plan completed prior to the assessment
- Illegible
- Incomplete/Missing pages
- No member/guardian signature
- No BHP signature (printed name, signature and professional credential)
  - o In the event that a BHT completes the service plan, a BHP must review ,sign, and date review of the service plan.
- Not dated
- Not found
- Scanning/technical issue

- BHP did not review and sign/date the Service Plan
- BHP did not review and sign/date the Service Plan within 30 days of BHT/member/guardian signatures

In addition, the following criteria must be met to pass this measure:
- a) The most recent service plan must be current and must be based on the assessment.
- b) The service plan must incorporate the needs and service recommendations identified in the assessment.
- c) The service plan contains objectives to address the identified needs of the member and/or family if applicable.
- d) The service plan contains services based on the needs of the individual and/or family if applicable.

4. OPI will not accept record disputes on BHSP scores.

Calculation
Numerator: Number of sampled member records with a current and complete assessment and a service plan that incorporates the needs and service(s) identified in the assessment.
Denominator: Total number of member records in the sample.

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QUALITY CONTROL
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T/RBHAs submit documentation containing current and accurate data regarding service plans and assessments. This information is validated through the quarterly reviews.

ADHS/DBHS OPI staff perform inter-rater reliability reviews at least annually, to ensure consistency of scoring.

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CONFIDENTIALITY PLAN
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Preparation of the information for this performance measure includes accessing "individually identifiable health information" as defined in HIPAA regulation 45 CFR 160.103 or "restricted personal identifying information" as defined in Arizona Strategic Enterprise Technology (ASET)/Statewide Information Security and Privacy Office (SISPO) Policy P900, Information Security Information Management, paragraph 4.1.10. Safeguards and controls, such as restricted access and agreement to protect confidential information, are contractual conditions in place to protect the identifying information that was accessed. Publicly-reported data generated for this performance measure are aggregated at the GSA and tribe level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information.

BEHAVIORAL HEALTH SERVICE PROVISION

DESCRIPTION

This performance measure determines the percent of members who receive the services recommended in their service plans, based on encounters that have been submitted for provided services. This chapter applies to RBHAs only; TRBHAs are not included in this measure.

ABBREVIATIONS

AAC – Arizona Administrative Code
ADHS/DBHS – Arizona Department of Health Services/Division of Behavioral Health Services
AHCCCS – Arizona Health Care Cost Containment System
BH Category – GMH/SA, SMI
BHP – Behavioral Health Professional
BHSP – Behavioral Health Service Plan
BHSPv – Behavioral Health Service Provision
BHT – Behavioral Health Tech
BIS – Bureau of Information Systems
BQI – Bureau of Quality and Integration
C/A – Child/Adolescent
CIS – ADHS Client Information System
CMDP – Comprehensive Medical and Dental Plan
CPT – Current Procedural Terminology
DDD – Department of Developmental Disabilities
Funding Source – DDD, CMDP, Title XIX, Non-Title XIX, Title XXI
GMH – General Mental Health
GSA – Geographical Service Area
HCPCS – Health Care Procedure Coding Systems
HIPAA – Health Insurance Portability and Accountability Act
IRR – Inter-rater Reliability
MPS – Minimum Performance Standard
OPI – Office of Performance Improvement
PM – Performance Measure
RBHA – Regional Behavioral Health Authority
SA – Substance Abuse
SMI – Seriously Mentally Ill
TRBHA – Tribal Regional Behavioral Health Authority

DEFINITIONS

Current Service Plan

- A service plan completed within 90 days of the initial or updated assessment, as identified by the signature date. Note that all service plans completed by a BHT must be reviewed and signed by a BHP within 30 days. (See ADHS/DBHS Policy Manual # 105, Assessment and Service Planning: http://www.azdhs.gov/bhs/policy/documents/bhs-policy-105.pdf).

- Signed and dated by the member/guardian and a BHT or BHP

Telephonic Consent Guidelines for Assessments and Service Plans
- Telehealth service appointments – Behavioral Health Provider (BHP), member/guardian, case manager, Department of Child Safety (DCS) worker are able to provider verbal consent re: service plans, treatment decisions, and placements.
- Documentation of telephonic approval must be clearly identifiable in the medical record in a progress note or on a form specifically used for telephonic/telehealth service
- Example of documentation: Telephonic/Telehealth Service consent received from XX (member/guardian, BHP, DCS Worker) on xx/xx/20xx at xxxx (time) for xx (service). Signature/date of the BHP.
- At the time in which the medical record is available for live signature, document must be updated with signature and date of individual who previously gave telephonic consent.

  **Option: forms can be faxed to the member/guardian/BHP/DCS Worker for signature. Signed forms must be faxed back within 3 working days. (This does NOT take the place of required documentation bullet #2 above).

MINIMUM PERFORMANCE STANDARD

Minimum: 85%
Goal: 95%

The MPS must be met every review period by each GSA, for both the Child/Adolescent and Adult populations.

METHODOLOGY

Population
Title XIX, Title XXI Child/Adolescent (up to age21) and Adults (21+ years) are included in this measure. Tribes are not evaluated on this measure. ADHS/DBHS stratifies performance by GSA.

As this Performance Measure utilizes the sample data for the Behavioral Health Service Plan (BHSP) measure, population criteria will be the same as stated in the BHSP specification (Chapter B1).

Review Frequency
Every three months.

Sample Source
The same sample used for the Behavioral Health Service Plan (BHSP) performance measure will be used for this measure.

The **denominator** for Behavioral Health Service Provision (BHSPv) includes all member records in the randomly selected BHSP sample.

BHSPv is based on encounters for behavioral health services within the ADHS Client Information System (CIS) that have been initially submitted through AHCCCS.

Sampling
Sampling specific to this measure is not applied. All members randomly selected for the BHSP sample are used for this measure.

Timeline

Quarter	Contract Year Quarter 2014-15	Assessment Review Period 2014-15	DBHS Encounter Processing Dates 2015 - 16
Q1	Oct 1 - Dec 31, 2014	July 1 - Sept 30, 2014	August 2015
Q2	Jan 1 - March 31, 2015	Oct 1 - Dec 31, 2014	October 2015
Q3	April 1 - June 30, 2015	Jan 1 - March 31, 2015	December 2015
Q4	July 1 - Sept 30, 2015	April 1 - June 30, 2015	February 2016

Calculation

ADHS/DBHS determines performance on this measure using the documentation submitted by the RBHAs for the Behavioral Health Service Plan performance measure along with encounters submitted for behavioral health services. Service Plans for all members selected for the BHSP measure are reviewed; the service codes/description name found in the Behavioral Health Services Guide and recommended in the service plan are matched to CPT and HCPCS codes in CIS encounter data. To meet compliance, all covered services recommended in the service plan must have corresponding dates of service on or after the date the service plan was completed.

Numerator: Number of members in the denominator who received all the services in their most recent service plan.

Denominator: Number of member records randomly selected for the BHSP measure.
The rate for this measure will be calculated by dividing the number of members who received all of the services recommended in their most recent service plan as documented through encounter data by the total number of members selected for the BHSP measure.

Note:
1. Encounters are eligible for inclusion in this measure if the service was provided on the service plan completion date or within the following six months.
2. To ensure accuracy of the results of this performance measure, it is *imperative* that BHPs developing the Service Plan with the member and/or parent/guardian include the *code and the service description* located in the Behavioral Health Covered Services Guide (http://www.azdhs.gov/bhs/documents/covserv/covered-bhs-guide.pdf). A matrix of allowable Procedure Codes by Provider Type is also available at the following link: http://www.azdhs.gov/bhs/documents/covserv/AppendixB2.pdf.   The attached list is a compilation of the *__most common__* codes that have been used for this measure by the RBHAs in the past (see **Attachment B2. Commonly Used Procedure Codes**). This list is by no means exhaustive.

3. OPI will be tracking and trending:
    a. Services included on the service plan for which no encounter has been found in the system
    b. Services not included on the service plan but which have been encountered in the system

4. OPI will not accept record disputes on BHSPv scores.

QUALITY CONTROL

RBHAs perform quarterly data validation studies of their contractors to verify that the services received by members are documented in the medical record appropriately, and are reported to the RBHA in an accurate and timely manner. ADHS/DBHS receives summary reports of the data validation studies.

As part of the corporate compliance plan, the DBHS Office of Audit and Evaluation conducts provider audits to determine whether the documentation in the medical record supports the billing submitted in the claim or encounter.

CONFIDENTIALITY PLAN

Preparation of the information for this performance measure includes accessing "individually identifiable health information" as defined in HIPAA regulation 45 CFR 160.103 or "restricted personal identifying information" as defined in Arizona Strategic Enterprise Technology (ASET)/Statewide Information Security and Privacy Office (SISPO) Policy P900, Information Security Information Management, paragraph 4.1.10. Safeguards and controls, such as restricted access and agreement to protect confidential information, are contractual conditions in place to protect the identifying information that was accessed. Publicly-reported data generated for this performance measure are aggregated at the GSA level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information.

GSA BEHAVIORAL HEALTH PERFORMANCE MEASURES

DESCRIPTION

Following are the GSA behavioral health performance measures.

Measure	MPS	Goal	Methodology	Comments
BH Inpatient Utilization (days/100,000 member months)	TBD	TBD	HEDIS - IPU (Inpatient Utilization)	The PM rate will be reflective of an aggregate rate of days per 100,000 member months.
BH Emergency Department (ED) Utilization (visits/100,000 member years)	TBD	TBD	HEDIS - AMB (Ambulatory Care)	Only the ED visit portion of the methodology will be utilized for PM evaluation. The PM rate will be reflective of an aggregate rate of visits per 100,000 member years.
BH Hospital Readmissions	TBD	TBD	Adult Core, though for all members, including those under the age of 18	The ratio of the observed readmission rate to the average adjusted probability will serve as the reported PM rate. The PM rate will be reflective of an aggregate rate for all age groups included in the measure. Use the commercial risk tables outlined in HEDIS for this measure.
Follow-Up After Hospitalization for Mental Illness (within 7 days)	50%	80%	Adult Core, though for all members, including those under the age of 18	Intentionally left blank.
Follow-Up After Hospitalization for Mental Illness (within 30 days)	70%	90%	Adult Core, though for all members, including those under the age of 18	Intentionally left blank.
Access to Behavioral Health Provider within 7 days	75%	85%	See below.	While this is not a new measure, the service list that is used to determine the numerator has been revised to ensure timely and appropriate member care is being delivered.
Access to Behavioral Health Provider within 23 days	90%	95%	See below.	While this is not a new measure, the service list that is used to determine the numerator has been revised to ensure timely and appropriate member care is being delivered.

These measures will be calculated using data from Regional Behavioral Health Authorities (RBHAs). These results will be shared with the RBHAs, and corrective action will be expected

from the RBHA if these measures fail to meet the MPS. All measures will have aggregate results, as well as results by three specific member populations (CMDP, and DDD). It is expected that AHCCCS Acute, DDD, and CMDP Contractors will work with RBHAs to coordinate care and achieve performance standards for these measures if population-specific barriers are identified.

Rates by GSA for each measure for each member population will be compared with the MPS specified in the contract in effect during the measurement period. Minimum Performance Standards in the CYE 2015 contract apply to results calculated by DBHS for the CFY 2015 measurement period.

ABBREVIATIONS

AHCCCS – Arizona Health Care Cost Containment System
AMB – Ambulatory Care HEDIS measure
BH – Behavioral Health
BHP – Behavioral Health Provider
CMDP – Comprehensive Medical and Dental Program
CMS – Centers for Medicare and Medicaid Services
DDD – Division of Developmental Disabilities
EPSDT – Early Periodic Screening, Diagnosis, and Treatment
HEDIS – Healthcare Effectiveness Data and Information Set
IPU – Inpatient Utilization HEDIS measure
MPS – Minimum Performance Standard
PM – Performance Measure
RBHA – Regional Behavioral Health Authority

GENERAL METHODOLOGY

Use the reference in the Methodology column above for details of each measure; most are available at the AHCCCS web site:
http://azahcccs.gov/reporting/quality/performancemeasures.aspx
See below for the methodology of the Access to Behavioral Health Provider measures.

Allowable gaps will follow the established methodology. If an option for a Medicaid gap exists, use that specification.

While measures may be from the Adult Core Set, they will be reflective of all members served, including members under the age of 18. The EPSDT Participation measure applies only to members under the age of 21.

If RBHAs did not provide services during the entire reporting period, data will be submitted for the months in the period for which they do have data. (e.g. If the RBHA has only been in operation for 3 months and does not have 12 months of data, data will be submitted for the three months in the rolling period for which they do have data.)

Timeline
Use this schedule of review periods for the FY2015 contract year.

Reporting Quarter	DBHS Processing Dates	Data Range (12 Rolling Months, 3 month lag)*
Q1 2015	Jan 1, 2015	Oct 2013 - Sept 2014
Q2 2015	Apr 1, 2015	Jan 2014 - Dec 2014
Q3 2015	Jul 1, 2015	Apr 2014 - Mar 2015
Q4 2015	Oct 1, 2015	Jul 2014 - Jun 2015
Q1 2016	Jan 1, 2016	Oct 2015 - Sept 2015

REPORTING

Please see Attachment **B3a. GSA Behavioral Health Performance Measures Report Template** for reporting requirements, including the calculations, reporting frequency, and reporting timeline.

ACCESS TO BEHAVIORAL HEALTH PROVIDER METHODOLOGY

The Access to Behavioral Health Provider performance measure determines the percent of AHCCCS members who have received an initial behavioral health assessment visit and who have received a follow up visit with a behavioral health professional (BHP) within 7 and/or 23 days (separate measures) of the initial visit.

Operational Definitions:
1)   Assessment
- The ongoing collection and analysis of a person's medical, psychological, psychiatric, and social condition in order to initially determine if a behavioral health disorder exists and if there is a need for behavioral health services and on an ongoing basis ensure that the person's service plan is designed to meet the person's (and family's) current needs and long-term goals. The assessment date is obtained from encounter data.

Assessment code
- Encounters with the H0031 Assessment Code will be used to identify a member who has had an assessment within the review period. Any member with the H0031 Assessment Code who has not had a service within the previous 12 months of the review period will be considered an "active" member for this measure.

2) Encounter
A record of a service rendered by a registered AHCCCS provider to an AHCCCS enrolled member.

3) Access to BHP
- A service provided to the member by a Behavioral Health Provider that is included in the list of codes located in Attachment B3b, on or after the date of the initial assessment, as identified by the Assessment Code of H0031 (see Assessment Code above) and is obtained from encounter data. The only codes used to identify service(s) rendered within 7 and/or 23 days of the assessment are located in: **Attachment B3b. Access to Behavioral Health Provider Numerator Service Codes.**

- Services captured in encounters for the 7 day Access to Behavioral Health Provider measure will be duplicated in the 23 day measure.

Calculation – 7 day measure

Denominator: Total number of records identified with the Assessment Code of H0031 within the review period that have not had any behavioral health service within the 12 months prior to the review period.

Numerator: Total number of records in the denominator identified as having received a service that is located in Attachment B3b. Access to Behavioral Health Provider Numerator Service Codes provided by a BHP within 7 days of the assessment.

Calculation – 23 day measure

Denominator: Total number of records identified with the Assessment Code of H0031 within the review period who have not had any behavioral health service within the 12 months prior to the review period..

Numerator: Total number of records in the denominator identified as having received a service that is located in Attachment B3b. Access to Behavioral Health Provider Numerator Service Codes provided by a BHP within 23 days of the assessment.

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QUALITY CONTROL

RBHAs are responsible for verifying the accuracy of the data submitted for these measures and may be required to submit verification to ADHS/DBHS upon request. ADHS/DBHS may identify a random sample of behavioral health recipients and require that the RBHA submit documentation for validation purposes or perform such validation through on-site visits.

CONFIDENTIALITY PLAN

Preparation of the information for this report includes accessing "individually identifiable health information" as defined in HIPAA regulation 45 CFR 160.103 or "restricted personal identifying information" as defined in Arizona Strategic Enterprise Technology (ASET)/Statewide Information Security and Privacy Office (SISPO) Policy P900, Information Security Information Management, paragraph 4.1.10. Safeguards and controls, such as restricted access and agreement to protect confidential information, are contractual conditions in place to protect the identifying information that was accessed. All resulting publicly-reported data are aggregated at the GSA and tribe level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information.

GRIEVANCE SYSTEM REPORT

DESCRIPTION

The Grievance System Report contains data regarding claim disputes, authorization requests, TXIX/XXI appeals, and member grievances (complaints) received by the RBHA, and for Integrated RBHAs includes Member Medicare D-SNP Appeals.   The RBHA must generate and submit the Grievance System Report with an accompanying cover letter (email is not an accepted form of cover letter) that summarizes the data from each content area, explains significant trending in either direction (positive or negative), and explains any interventions implemented as a result of identified issues for each Attachment. The Grievance System Report includes:

1. Cover Letter (http://www.azahcccs.gov/commercial/Downloads/OperationsReporting/GrievanceSystemReportCoverLetter.doc)
2. Claim Dispute Report (Attachment A)
3. Authorization Request and Appeal Report (Attachment B)
4. Member Grievance Reports (Attachments C, D, E, and F)
5. Member Medicare D-SNP Appeals Report (Attachment G for RBHAs providing Integrated Care)
6. Monthly Member Grievance Tracking Template

DEFINITIONS

ADHS/DBHS – Arizona Department of Health Services/Division of Behavioral Health Services
AHCCCS – Arizona Health Care Cost Containment System
BQ&I – Bureau of Quality and Integration
EOC – Episode of Care
GSA – Geographic Service Area
HIPAA – Health Insurance Portability and Accountability Act
RBHA – Regional Behavioral Health Authority

MINIMUM PERFORMANCE STANDARD

Not applicable.

METHODOLOGY

Population
Data is reported for Title XIX/XXI members with an open EOC during the reporting month.

Reporting Frequency
The Report is submitted monthly by RBHAs to ADHS/DBHS.

Data Source
RBHA Claim Disputes, Requests for Hearing, Prior Authorizations, Appeals, Member Grievances (Complaint Log Descriptions)
http://www.azahcccs.gov/commercial/Downloads/OperationsReporting/GrievanceSystemReportingGuide.pdf

Sampling
Not applicable. Report includes all RBHA Claim Dispute, Requests for Hearing, Prior Authorization, Appeal, and Member Grievance activity during the report period.
http://www.azahcccs.gov/commercial/Downloads/OperationsReporting/GrievanceSystemReportingGuide.pdf

Calculation
Refer to AHCCCS Grievance System Reporting Guide and template for details:
http://www.azahcccs.gov/commercial/Downloads/OperationsReporting/GrievanceSystemReportingGuide.pdf
http://www.azahcccs.gov/commercial/ContractorResources/manuals/GrievanceSystemReportingGuide.aspx

Timeline
The Report is due the 30th day of each month for the previous month. RBHAs submit the Grievance System Report (Cover Letter and Attachments A-G) via email to ADHS/DBHS:
BQI.Deliverables@azdhs.gov, Kara.Burke@azdhs.gov, and BHSCompliance@azdhs.gov .

If the submission due date falls on a weekend or holiday, it is due the following working day.

Process
The RBHA is required to utilize the Cover Letter template located here:
http://www.azahcccs.gov/commercial/Downloads/OperationsReporting/GrievanceSystemReportCoverLetter.doc. Please ensure the body of the Cover Letter is written uniformly in standard sentence case Times New Roman 12 font.

In addition to a summary of the data, positive and negative trends, and interventions for each section, the cover letter must include:
1. An explanation of claim disputes that have not been resolved within 30 days as identified in Attachment A;
2. A narrative that identifies the reason(s) for the Contractor initiated settlement(s) identified in Attachment A, Section C. Request for Hearing Summary;
3. A definition of new categories identified in Attachment A, Section D. Categorical Trending Analysis;
4. An explanation of member appeals that have not been resolved within 30 days as identified in Attachment B;

5. A narrative that identifies the reason(s) for the Contractor initiated settlement(s) identified in Attachment B, Section H. Expedited Appeals;
6. An explanation of delayed resolutions (those more than 90 days from receipt) as identified in Attachments C, D, E, and F, Member Grievance Reports;
7. An explanation of all member grievances categorized as "other" on Attachments C, D, E, and F, Member Grievance Reports; and
8. For RBHAs providing Integrated Care: Service level detail on the appeals that were upheld and overturned, including a description of the action which is appealed as identified in Attachment G, MA-D-SNP Member Pre-Service Appeals Report.

RBHAs should refer to Attachment B4a. to report Attachments A-F. RBHAs providing integrated care must also submit Attachment G.

The Member Grievance section of the report includes attachments C, D, E, and F. The attachments will be populated with the designated ADHS Complaint Log Categories by corresponding Subcategories and Covered Service Type as follows.

- Attachment C - Transportation. Include *all* subcategories on this attachment as reflected in the ADHS complaint category: Transportation.
- Attachment D - Medical Service Provision. Include *all* subcategories on this attachment as reflected in these ADHS categories: Clinical decisions Related to Service, Client Rights, and Coordination of Care.
- Attachment E - Contractor Service. Include *all* subcategories on this attachment as reflected in these ADHS Complaint Categories: Customer Service, Information Sharing, and Financial.
- Attachment F – Access to Care. Include *all* subcategories on this attachment as reflected in the ADHS Complaint Category: Access to Services.

All complaint subcategories must be included on the corresponding attachments. Categories for which no complaint was resolved within the reporting month will be marked as zero, "0." For each row reflecting a "0" in the Resolved column, the Average Time to Resolve column should be noted as N/A.

RBHAs will complete Attachment B4b. to collect month-to-month member grievance data received to aid in the analysis of trends. This attachment will be submitted to ADHS/DBHS as part of the overall Grievance System Report.

Please defer to the reporting frequency and timelines in this document and in the ADHS/RBHA contract schedule of deliverables as they differ from the reporting timeframes defined in the AHCCCS Grievance System Reporting Guide.

QUALITY CONTROL

Monthly files submitted by the RBHAs and processed at ADHS/DBHS electronically are checked programmatically for data errors. Errors are identified as erroneous or missing data in any of the required fields. Files containing errors are returned to the RBHA for correction. Errors are recorded and tracked by ADHS/DBHS. RBHAs are subject to corrective action, up to and including sanctions if the error rate exceeds 5% in any field for two consecutive quarters.

CONFIDENTIALITY PLAN

The information submitted in cover letter and attachments A-G must not include "individually identifiable health information" as defined in HIPAA regulation 45 CFR 160.103 or "restricted personal identifying information" as defined in Arizona Strategic Enterprise Technology (ASET)/Statewide Information Security and Privacy Office (SISPO) Policy P900, Information Security Information Management, paragraph 4.1.10. Safeguards and controls, such as restricted access and agreement to protect confidential information, are contractual conditions in place to protect that information. All publicly-reported data generated from this information are aggregated at the GSA/RBHA level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information.

COMPLAINT LOG

DESCRIPTION

The Complaint Log contains all complaints received by RBHAs pertaining to Title XIX/XXI and Non-Title XIX/XXI Children and Adults receiving or seeking to receive services. Complaints may be lodged by persons who are or are not receiving health services, including family members, providers, and community stakeholders. Complaints may also be received by ADHS/DBHS Customer Service.

RBHAs submit analysis of complaints received, identifying trends with plans to address them.

ADHS/DBHS uses the term complaint interchangeably with member grievance as a grievance is defined in 42 CFR 438.400 et seq.: an expression of dissatisfaction with any aspect of care, other than the appeal of actions, including but not limited to concerns about the quality of care or services provided, aspects of interpersonal relationships with service providers, and lack of respect for recipients' rights.

Refer to ADHS Policy 1802, Complaint Resolution,
at: http://www.azdhs.gov/bhs/policy/documents/policies/bhs-policy-1802.pdf

ABBREVIATIONS

ADHS/DBHS – Arizona Department of Health Services/Division of Behavioral Health Services
BHC – Behavioral Health Category
C/A – Child / Adolescent
CMDP – Comprehensive Medical and Dental Program
DDD – Division of Developmental Disabilities
EOC – Episode of Care
GMH – General Mental Health
GSA – Geographic Service Area
HIPAA – Health Insurance Portability and Accountability Act
SA – Substance Abuse
SAPT – Substance Abuse Prevention and Treatment
SED – Seriously Emotionally Disturbed
SMI – Seriously Mentally Ill
RBHA –Regional Behavioral Health Authority/Regional Behavioral Health Authority

MINIMUM PERFORMANCE STANDARD

Not applicable.

METHODOLOGY

Population
All complaints are to be reported. To clarify, if someone expresses multiple complaints during the same contact, every complaint is recorded, tracked, and reported.

ADHS/DBHS stratifies performance for the C/A population by the following age bands for potential ad hoc reporting:
- 0 -5.999
- 6 -11.999
- 12 - 17.999
- 18 - 20.999

Complaint data is stratified by C/A and adults, funding source, BHC, and GSA.

Data Source
RBHA complaint/member grievance logs.

Reporting Frequency
Complaint log data are reported monthly.

Data analysis of all complaints received involving Title XIX/XXI and non-Title XIX/XXI persons receiving or seeking services is submitted quarterly in the Quarterly Performance Improvement Report. This report incorporates a monthly analysis and summary of system wide complaint data, trends and interventions.

Data analysis of Title XIX/XXI specific complaint data is submitted and analyzed monthly as part of the Grievance System Report.

Data analysis of complaints involving SMI, XIX/XXI Integrated members is submitted quarterly by the Integrated RBHA in the Grievance/Complaint Report – SMI Data.

Sampling
Not applicable.

Calculation for the system wide Quarterly Performance Improvement Report. (Calculations for other complaint/member grievance reporting requirements are specified with the relevant report.)

Use the following to calculate rates per thousand for analysis, stratified by population as appropriate.

Numerator: Total Number of all complaints filed during the reporting quarter X 1000

Denominator: Total Number of Members with an open EOC

Timeline
1. RBHA-submitted comma delimited text files (Complaint logs) are due to ADHS/DBHS the 15th of the month for complaints received during the previous month. These files shall adhere to the attached Complaint Log File Layout Specifications found at the end of this Chapter.

2. The RBHA aggregates and analyzes Title XIX/XXI complaint data on a monthly basis and submits to ADHS/DBHS via the Grievance System Report.   This report is due 30 days after the end of the month to be reported.

3. The RBHA aggregates and analyzes all complaint data on a quarterly basis and submits to ADHS/DBHS via the Quarterly Performance Improvement Report Template. This report is due the 30th of the month following the last day of the reporting quarter.

4. The Integrated RBHA aggregates and analyzes integrated physical and behavioral health complaint data on a quarterly basis and submits this to ADHS/DBHS as part of the Grievance/Complaint Report – SMI Data. This report is due 15 days after the end of each quarter.

If the day the report must be submitted to ADHS/DBHS falls upon a weekend or holiday, it will be due the following business day.

QUALITY CONTROL

Monthly files submitted by the RBHAs and processed at ADHS/DBHS electronically are checked programmatically for data errors. Errors are identified as erroneous or missing data in any of the required fields. Files containing errors are returned to the RBHA for correction. Errors are recorded and tracked by ADHS/DBHS. RBHAs are subject to corrective action, up to and including sanctions if the error rate exceeds 5% in any field for two consecutive quarters.

Complaints reported in Complaint Logs are reviewed in conjunction with grievance system deliverables to allow for a more comprehensive view of the service delivery system.

CONFIDENTIALITY PLAN

The information submitted in Complaint Logs includes "individually identifiable health information" as defined in HIPAA regulation 45 CFR 160.103 or "restricted personal identifying information" as defined in Arizona Strategic Enterprise Technology (ASET)/Statewide Information Security and Privacy Office (SISPO) Policy P900, Information Security Information Management, paragraph 4.1.10. Safeguards and controls, such as restricted access and agreement to protect confidential information, are contractual conditions in place to protect that information. All publicly-reported data generated from this information are aggregated at the GSA/RBHA level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information.

FILE SPECIFICATIONS

Comma delimited text file.
File Name:
COMPLAINT_LOG_FYyyyy_MMM_rr.TXT (yyyy=Fiscal Year, MMM=Month Name (3
characters), r=2 DIGIT RBHA ID)
Example: COMPLAINT_LOG_FY2015_JAN_02.TXT

Field Name	Definition	Format	Remarks
RBHA_ID	RBHA ID number	Text: 2 characters	"02"=Cenpatico GSA 2 "32"=Cenpatico GSA 3 "22"=Cenpatico GSA 4 "26"=CPSA "15"=NARBHA "37" = MMIC
LAST_NAME	Complaint subject's last name.	Text: 15 characters	
FIRST_NAME	Complaint subject's first name.	Text: 15 characters	
CLIENT_ID *	BHS client id	Text: 10 characters	
DOB	Complaint subject's Date of Birth	Text: yyyymmdd 8 characters	
COMPLAINT_DATE	The date the RBHA was contacted with the complaint.	Text: yyyymmdd 8 characters	
RESOLUTION_DATE	The date resolution was reached.	Text: yyyymmdd 8 characters If Resolution is Pending, use 20990101	
ELIGIBILITY	Status of the complaint subject's Title XIX/XXI eligibility at the time of the complaint.	Text: (1 character) Y/N	Y = Yes N = No
SPECIAL POPULATION	Complaint subject's enrollment with DDD or CMDP at the time of the complaint	Numeric	1 = Not enrolled with DDD or CMDP 2 = Enrolled with DDD 3 = Enrolled with CMDP
COMPLAINT_CATEGORY	Defined Complaint Category Code	Text: See Complaint Categories and Subcategories table on Attachment B5a**	
COMPLAINT_SUB_CATEGORY	Defined Complaint Sub-category Code	Text: See Complaint Categories and Subcategories table on Attachment B5a **	
COMPLAINT_SOURCE	Defined Code for person or entity making the complaint. (Complaint Source)	Text: See Complaint Source table on Attachment B5a**	
RESOLUTION_REACHED	Defined Code for type of resolution	Text: See Resolution Reached table on Attachment B5a**	
COVERED_SERVICE_CAT	Covered Service Category Code related to complaint	Text: See Covered Services table on Attachment B5a for Behavioral or Physical Health service, as appropriate**	
COVERED_SERVICE_SUB_CAT	Covered Service Sub-Category Code related to complaint	Text. See Covered Services table on Attachment B5a for Behavioral or Physical Health service, as appropriate**	

Field Name	Definition	Format	Remarks
AGGRIEVED_PROVIDER_TYPE	Provider type code related to complaint.	Text: See Aggrieved Provider Type table on Attachment B5a**	
PROGRAM_TYPE	Adult SAPT, GMH, SA, SMI, Child, SED, Not Receiving BH Services	Numeric	1=Adult SAPT 2= GMH 3= SA 4= SMI 5= Child 6= SED 7= Not Receiving BH Services
AGE_GROUP	Complaint subject's Age Group	Numeric	1 = 0 – 5.999 2 = 6 – 11.999 3 = 12 – 17.999 4 = 18 – 20.999 5 = 21 and over
COMMUNICATION NEEDS	Code for Communication needs required to participate in complaint process	Text: See Communication Needs table on Attachment B5a**	
COMPLAINT SUB CATEGORY OTHER	Brief narrative explanation if Complaint sub category is "Other"	Text: 80 characters	NA if Not Applicable (Complaint is not reported under Complaint Sub category "Other"

Error Edits
- The RBHA number in the file name must match the RBHA ID field value.
- The Year_Month value must be a valid year and month, and fall within the reporting period listed in the file name.
- All fields from the tables that follow this File Specification must have a valid value (no blanks).
- Complaint Subcategory code must be a code that begins with the corresponding Category code.

* Not required if Complaint Subject is not receiving services or a Client id has not been assigned yet.
**Use Code provided. See the Complaint Log Descriptions Code List tables that follow.

NATIONAL OUTCOME MEASURES (NOMs)

DESCRIPTION

ADHS/DBHS compiles and analyzes Behavioral Health Recipients' (BHRs) demographic outcome data from begin Episode of Care (EOC) through update or end EOC annually. The information is used to document and compare outcomes across populations and GSAs over multiple review periods (fiscal years) to ascertain positive or negative trends in service outcomes.

ABBREVIATIONS

ADHS/DBHS – Arizona Department of Health Services/Division of Behavioral Health Services
BHC – Behavioral Health Category
BHR – Behavioral Health Recipient
CIS – Client Information Systems
EOC – Episode of Care
GSA – Geographical Service Area
HIPAA – Health Insurance Portability and Accountability Act
RBHA – Regional Behavioral Health Authority
TBHA – Tribal Behavioral Health Authority

METHODOLOGY

Population
BHRs with an open EOC during the reporting fiscal year, except for those receiving services through a TBHA, are included in this analysis.

Data Source
ADHS CIS.

Review Frequency
The measures are calculated annually.

Record Selection
BHRs eligible for this measure (denominator) had an open EOC during the reporting fiscal year. No sample is drawn. Data are based on all BHRs with an open EOC during the reporting fiscal year who have begin EOC data and update or end EOC data in CIS. The population number (N)

may change with each measure based on the availability of demographic data for both begin EOC and update or end EOC data for the required field. The data are analyzed (by GSA and BHC). If update <u>and</u> end EOC data are available in CIS, the most recent EOC demographic will be used.

Calculation

NOMs outcome data is calculated and reported by the following:
1. Statewide adults – number of adults reported by all GSAs combined
2. Statewide children and adolescents – number of children and adolescents reported by all GSAs combined
3. Statewide combined populations – sum of number of adults reported by all GSAs combined and number of children and adolescents reported by all GSAs combined
4. GSA Combined populations
5. Adults by Behavioral Health Category

For each of the five outcome stratifications under "Reporting", NOMs are calculated as follows:

Employment

For NOMs Performance, Employment is determined by coding CIS Field 66 as follows: Values of 01, 02, 03, 04, 24, 25, and 27 = Employed; 08 = Unemployed; Blanks and 99 = System Missing; Else = Not in Labor Force (Missing)

Numerator: Number of BHRs employed at begin EOC.
Denominator: Number of BHRs with complete begin EOC data and an update or end EOC data in CIS with valid employment field descriptors for both the begin EOC date and the update or end EOC data.

Numerator: Number of BHRs employed at update or end EOC, whichever record is most recent submission.
Denominator: Number of BHRs with complete begin EOC data and an update or end EOC data in CIS with valid employment field descriptors for both the begin EOC data and the update or end EOC data.

The difference in percentage from begin EOC to update or end EOC is described as positive (+) or negative (-) percent change from begin EOC status.

Educational Participation

For NOMs Performance, Educational Participation is determined by coding CIS Field 67 as follows: Values of Y = In School; N = Not in School; Blanks = System Missing

Numerator: Number of BHRs identified as attending a school or vocational program in the Education data field at begin EOC.
Denominator: Number of BHRs with complete begin EOC data and an update or in CIS with valid education field descriptors for both the begin EOC data and the update or end EOC data.

Numerator: Number of BHRs identified as attending a school or vocational program in the Education data field at update or end EOC, whichever record is most recent submission.
Denominator: Number of BHRs with complete begin EOC data and an update in CIS with valid education field descriptors for both the begin EOC data and the update or end EOC data.

The difference in percentage from begin EOC to update or end EOC is described as positive (+) or negative (-) percent change from begin EOC status.

Housing
For NOMs Performance, Housing Status is determined by coding CIS field 69 as follows: Blank and 08= System Missing; 07 = Homeless; Else = Not Homeless

Numerator: Number of BHRs identified in the Primary Residence data field as Not Homeless at begin EOC.
Denominator: Number of BHRs with complete begin EOC data and an update in CIS with valid housing field descriptors for both the begin EOC data and the update or end EOC data.

Numerator: Number of BHRs identified in the Primary Residence data field as Not Homeless at update or end EOC, whichever record is most recent submission.
Denominator: Number of BHRs with complete begin EOC data and an update in CIS with valid housing field descriptors for both the begin EOC data and the update or end EOC data.

The difference in percentage from begin EOC to update or end EOC is described as positive (+) or negative (-) percent change from begin EOC status.

Criminal Activity

For NOMs Performance, Criminal Activity is determined by coding CIS Field 71 as follows: 0 = No Recent Arrest; 1 thru 31 = Recently Arrested; Else = System Missing
Numerator: Number of BHRs arrested at begin EOC.
Denominator: Number of BHRs with complete begin EOC data and an update in CIS with valid criminal activity field descriptors for both the begin EOC data and the update or end EOC data.

Numerator: Number of BHRs arrested at update or end EOC, whichever record is most recent submission.

Denominator: Number of BHRs with complete begin EOC data and an update in CIS with valid criminal activity field descriptors for both the begin EOC data and the update or end EOC data.

The difference in percentage from begin EOC to update or end EOC is described as positive (+) or negative (-) percent change from begin EOC status.

Substance Abstinence or Reduction in Use

For NOMs Performance, client must have a valid primary substance type (CIS Field 72 is not equal to '0001') in both the initial and update/closure demographic record.

Abstinence is indicated by a value of '1', '6', '7', or '8' in the SA_FREQ_1 (CIS 73) field (Blank = System Missing).

Reduction in use is measured as follows: If Update_SA_FREQ_1 < Intake_SA_FREQ_1 **Or** If Update_SA_FREQ_1 AND Intake_SA_FREQ_1 are equal to '1' = Reduced or No Use During Episode; If Update_SA_FREQ_1 > Intake_SA_FREQ_1 = Increase in Use.

Numerator: Number of BHRs with a valid Primary Substance abstinent at begin EOC.
Denominator: Number of BHRs with a valid Primary Substance with complete begin EOC data and an update or end EOC in CIS.

Numerator: Number of BHRs with a valid Primary Substance abstinent at update or end EOC, whichever record is most recent submission.
Denominator: Number of BHRs with a valid Primary Substance with complete begin EOC data and an update or end EOC in CIS.

The difference in percentage from begin EOC to update or end EOC is described as positive (+) or negative (-) percent change from begin EOC status.

Statistical Analysis

ADHS/DBHS conducts testing to a 95% standard for statistically significant changes in performance on all measurement sets. A standard two tailed T test, or Chi Square depending on variability in denominator size, is conducted on each data set to assess for significant changes from Measurement 1 (first review period) to Measurement 2 (second review period). As needed, based on individual contractor performance, ADHS/DBHS conducts an analysis of variance (ANOVA) across Contractors to identify statistically significant variance in Contractor performance in order to identify areas for process and performance improvement.

Timeline
1. Quarter 2 following close of reporting Fiscal Year
ADHS/DBHS analyzes CIS data to establish the BHRs eligibility.

2.   Quarter 3 following close of reporting Fiscal Year
The final report is completed and distributed at this time. The information is used for internal monitoring of systems and posted on the ADHS/DBHS dashboard at this link:
http://www.azdhs.gov/bhs/dashboard/index.htm

QUALITY CONTROL

Demographic information submitted by the RBHAs is monitored by DBHS through the Daily Demographic Acceptance Report. A 90% minimum acceptance rate must be maintained in order to continue submission of demographics to the production environment. Acceptance rates may be part of the RBHA's administrative review.

CONFIDENTIALITY PLAN

Preparation of the information for this report includes accessing "individually identifiable health information" as defined in HIPAA regulation 45 CFR 160.103 or "restricted personal identifying information" as defined in Arizona Strategic Enterprise Technology (ASET)/Statewide Information Security and Privacy Office (SISPO) Policy P900, Information Security Information Management, paragraph 4.1.10. Safeguards and controls, such as restricted access and agreement to protect confidential information, are contractual conditions in place to protect the identifying information that was accessed. All resulting publicly-reported data are aggregated at the GSA level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information.

QUARTERLY CREDENTIALING REPORT

DESCRIPTION

This deliverable reports aggregated credentialing information, including counts of completed applications and credentialed providers, as well as the times to determine and load provider IDs for encounter processing. Data are reported for initial, provisional, and organizational credentialing, as well as re-credentialing. The report is submitted by all T/RBHAs to DBHS.

ABBREVIATIONS

ADHS/DBHS – Arizona Department of Health Services/Division of Behavioral Health Services
AHCCCS – Arizona Health Care Cost Containment System
RBHA – Regional Behavioral Health Authority
TBHA – Tribal Behavioral Health Authority
T/RBHA – Tribal/Regional Behavioral Health Authority

MINIMUM PERFORMANCE STANDARD

N/A

METHODOLOGY

Population
Providers who completed any credentialing activities within the quarter are included. The second page of the template, which includes information about dental/oral health providers, is only required from T/RBHAs providing integrated care.

Reporting Frequency
This report is submitted to ADHS/DBHS every quarter.

Data Source
This information is drawn from T/RBHA credentialing databases and processes.

Sampling
Sampling is not used for this report.

Calculation

Attachment B7 of this Specifications Manual is a template for the Report.

Because TBHAs do not load provider IDs for further processing, only the first six columns of the table are filled out by TBHAs.

The re-credentialing process is typically triggered by an event such as the approach of the three year mandatory re-credentialing time period. The date the T/RBHA initiates the re-credentialing process is the anchor date. The date that the T/RBHA receives all of the documents necessary to complete the re-credentialing process is considered the end date of the re-credentialing process. The process should be completed within six (6) months of the re-credentialing process initiation date.

It is not expected that RBHAs complete the fields that specify the number of days to load the provider into the claims system in the re-credentialing row on the form because providers that are being re-credentialed will already be loaded into the RBHA's system. Therefore, the fields are shaded.

Facility information is initially entered in the Organizational Credentialing row, and thereafter in the Re-credentialing row.

Timeline

The report is due to ADHS/DBHS 30 days after the end of every quarter.

QUALITY CONTROL

This information is validated during the DBHS/BQ&I annual Administrative Reviews with the RBHAs and TBHAs.

CONFIDENTIALITY PLAN

Safeguards and controls, such as restricted access and agreement to protect confidential information, are contractual conditions in place to protect any identifying information that was accessed. Publicly-reported data generated for this report are aggregated at the T/RBHA level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information.

CREDENTIALING DENIAL REPORTING FORM

DESCRIPTION

The Credentialing Denial Reporting Form is to be utilized by T/RBHA Credentialing Committees to report to the DBHS Office of Quality of Care any Individual or Organizational Providers who have been denied credentialing or re-credentialing status for any reason as well as any revocations of credentials. The form is also used to report denials to any temporary or provisional credentialing for Individual Providers.

ABBREVIATIONS

NPI- National Provider Identifier
PMMIS- Prepaid Medical Management Information System
T/RBHA- Tribal/Regional Behavioral Health Authority

DEFINITIONS

Credentialing/Re-credentialing- Is the process of obtaining, verifying and assessing information (e.g., validity of the license, certification, training and/or work experience) to determine whether a behavioral health professional or a behavioral health technician has the required credentials to provide behavioral health services to persons enrolled in the ADHS/DBHS behavioral health system. It also includes the review and primary source verification of applicable licensure, accreditation and certification of behavioral health providers.

Individual/Organizational Provider- A person or entity that contracts with a T/RBHA to provide covered services directly to members.

NPI- The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers.

Organizational Provider-

PMMIS- AHCCCS' primary source of detailed financial information. PMMIS is a grouping of subsystems which includes: Finance, Claims, Encounters, Reinsurance, Recipient, Health Plan, and others.

Temporary/Provisional Credentialing- Temporary/Provisional Credentialing is used when it is in the best interest of members that providers be available to provide care prior to completion of the entire credentialing process. The T/RBHA has 14 calendar days from receipt of a complete application to render a decision regarding temporary or provisional credentialing.

T/RBHA- Means a reference to both RBHAs and Tribal RBHAs. A RBHA is an organization under contract with ADHS that administers covered behavioral health services in a geographically

specific area of the state. A Tribal RBHA is a Native American Indian tribe under an Inter-Governmental Agreement (IGA) with ADHS to coordinate the delivery of behavioral health services to eligible and enrolled persons who are residents of the Federally-recognized Tribal Nation that is the party to the Agreement.

MINIMUM PERFORMANCE STANDARD

The T/RBHA is expected to notify DHBS Office of Quality of Care within 24 hours of a denial of credentialing, re-credentialing, or revocation of credentialing of an Individual Provider or an Organizational Provider.

METHODOLOGY

Using the Credentialing Denial Reporting Form, complete the following steps:

1. Enter the T/RBHA name and date of report.

2. Enter the Official name of the Individual or Organizational Provider that was denied credentialing.

3. Enter the National Provider Identifier (NPI) number. The NPI will consist of 9 numeric digits followed by one numeric check digit.

4. Enter the address of the Provider who was denied credentialing or re-credentialing. The Provider Address should be the one utilized in PMMIS.

5. Enter the telephone number of the Provider who was denied credentialing or re-credentialing. The Provider Telephone number should be the one utilized in PMMIS.

6. Enter the reason the Provider was denied credentialing or re-credentialing. The reason for denial should be descriptive, including date of notification of denial to provider.

7. Enter the date the decision to deny or revoke credentialing or re-credentialing was rendered.

8. Multiple entries may be submitted on the same reporting form if they fall within the same reporting period (same day).

9. Email the reporting form as an attachment via secure email to BHSQMO@azdhs.gov and cc the Office Chief of the DBHS Office of Quality of Care. Place in subject line of email [Credentialing Denial (Name of T/RBHA) mmddyyyy]

PERFORMANCE IMPROVEMENT PROJECTS

OVERVIEW

DBHS requires its Contractors to participate in Performance Improvement Projects (PIPs) selected by the DBHS or mandated by AHCCCS. DBHS may also mandate that a PIP be conducted by a Contractor or group of Contractors, according to standardized methodology developed by DBHS.

DESIGN

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1. PIPs are designed, through ongoing measurement and intervention, to achieve:

   a. Demonstrable improvement, sustained over time, in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction
   b. Demonstrable improvement that meets or exceeds Minimum Performance Measures set forth by the PIP, and that the improvement is sustained over a period of time.
   c. Correction of significant systemic problems
   d. Clinical focus topics may include the following:
      i. Primary, secondary, and/or tertiary prevention of acute conditions
      ii. Primary, secondary, and/or tertiary prevention of chronic conditions
      iii. Care of acute conditions
      iv. Care of chronic conditions
      v. High-risk services, and
      vi. Continuity and coordination of care.
   e. Non-clinical focus topics may include the following:
      i. Availability, accessibility and adequacy of the Contractor's service delivery system
      ii. Cultural competency of services
      iii. Interpersonal aspects of care (i.e., quality of provider/member encounters), and
      iv. Appeals, grievances, and other complaints.

2. PIP methodologies are developed according to C.F.R. 438.240, Quality Assessment and Performance Improvement Program for Medicaid Managed Care Organizations as well as evidence based approaches to conducting Performance Improvement Projects as determined by the Office of Performance Improvement. The protocol for developing and conducting PIPS is found in the FOCUS-PDSA Model section below.

DATA COLLECTION METHODOLOGY

Assessment of the Contractor's performance on the selected measures will be based on systematic, ongoing collection and analysis of accurate, valid and reliable data, as collected and analyzed by DBHS. Contractors may be directed to collect all or some of the data used to measure performance. In such cases, qualified personnel must be used to collect data and the Contractor must ensure inter-rater reliability if more than one person is collecting and entering data. Contractors must submit specific documentation to verify that indicator criteria were met.

MEASUREMENT OF DEMONSTRABLE IMPROVEMENT

1. The Contractor must initiate interventions that result in significant demonstrable improvement, sustained over time, in its performance for the performance indicators being measured. Improvement must be evidenced in repeated measurements of the indicators specified for each PIP undertaken by the Contractor.

2. Contractors must strive to meet a benchmark level of performance defined in advance by DBHS for all Performance Improvement Projects.

3. A Contractor will have demonstrated improvement when:

   a. It meets or exceeds the DBHS's overall average for the baseline measurement if its baseline rate was below the average and the increase is statistically significant

   b. It shows a statistically significant decrease if its baseline rate was at or above the DBHS overall average for the baseline measurement, and the intent of the PIP was to reduce rates to achieve improvement in health outcome.

   c. It is the highest performing (benchmark) plan in any re-measurement and maintains or improves its rate in a successive measurement.

4. A Contractor will have demonstrated sustained improvement when:

   a. The Contractor maintains or increases the improvements in performance for at least one year after the improvement in performance is first achieved.

   b. The Contractor must demonstrate how the improvement can be reasonably attributable to interventions undertaken by the organization (i.e., improvement occurred due to the project and its interventions, not another unrelated reason).

TIMEFRAMES

1. The PIP begins on a date, established by DBHS, and will correspond to the contract year or a timeframe otherwise set by the DBHS at the beginning of the PIP. Baseline data will be collected and analyzed at the beginning of the PIP.

2. During the first year of the PIP, the Contractor will implement interventions to improve performance, based on an evaluation of barriers to care/use of services and evidence-based approaches to improving performance, as well as any unique factors such as its membership, provider network, or geographic area(s) served. DBHS may provide baseline data by Contractor, and may provide additional data, which may assist Contractors in refining interventions.

3. Contractors should utilize a Find-Organize-Clarify-Understand- Select- Plan-Do-Study-Act (FOCUS-PDSA) cycle, to manage the problem identification process and to test interventions quickly and refine them as necessary. It is expected that the PDSA section of the FOCUS-PDSA process will be implemented in as short a time frame as practical based on the PIP topic. See the description of the FOCUS-PDSA cycle included below.

4. DBHS will conduct annual measurements to evaluate Contractor performance, and may conduct interim measurements, depending on the resources required to collect and analyze data.

5. A Contractor's participation in the PIP will continue until demonstration of significant improvement and the improvement has been sustained for one year.

REPORTING REQUIREMENTS

1. Contractors will report to DBHS quarterly interventions, analysis of interventions and internal measurements, changes or refinements to interventions and actual or projected results from repeated measurements. Contractors must use the DBHS PIP Reporting Template (see Attachment B9. PIP Reporting Template)

2. Contractors will report to DBHS annually their interventions, analysis of interventions and internal measurements, changes or refinements to interventions and actual or projected results from repeated measurements.

3. Contractors must use the DBHS PIP Reporting Template (see Attachment B9. PIP Reporting Template) to submit the annual reports, which are due with the Contractor's annual quality management plan and evaluation.

FOCUS-PDSA MODEL

The FOCUS-PDSA model is an extension of the PDSA model and integrates the problem identification stage of performance improvement into the PDSA model. FOCUS-PDSA stands for:

F = Find a problem
O = Organize a team
C = Clarify the problem
U = Understand a problem
S = Select an intervention
P = Plan
D = Do
S = Study
A = Act

Step 1: F = Find a Process or Problem to Improve
The first step in the FOCUS-PDSA model is to identify and very clearly define a specific process or problem to improve. This is usually the performance gabs identified in the DBHS PIP proposal or, the purpose of the PIP which is usually outlined in AHCCCS mandated PIPs.

Step 2: O = Organize a Team
The second step in the FOCUS-PDSA model is to organize a team that is familiar with the performance improvement process or the problem under investigation.

Step 3: C = Clarify Current Knowledge of the Process
A team cannot improve a process or problem until the team fully understands and agrees on what the current process or problem is. This can be a challenge when dealing with an interdisciplinary team.

This third step in the FOCUS-PDSA model is aimed at bringing every member of the team on the same level of understanding by clarifying and agreeing on the current knowledge of processes. The goal is to answer questions such as, "Is the problem clearly understood?" or "Are the related processes clearly understood?" In addition certain terminology or concepts should be clarified and agreed upon at this stage.

Step 4: U = Understand the sources and causes of variations (Problems)

The key to solving a problem is to fully understand it. This is where background study of the situation and a quantitative and qualitative analysis of the problem are performed. The group should research and brainstorm on the possible causes of the problem then, perform a quantitative and qualitative analysis of the current problem.

Three analytical tools are useful here; Process Mapping, Pareto Analysis and Root Cause Analysis.

a- Process Mapping is a structural analysis of a process flow. It is a graphic representation of a process that allows an observer to walk through a whole process and to see it in its entirety. This helps distinguish how work is actually done from how it should be done.

b- The Pareto Analysis helps the team to understand the magnitude of each cause or barrier of the problem. It looks into the number of causes to the problem, determines which cause has the greatest effect on the performance, and which causes can be resolved with the available resources. Where reliable data is available the Pareto chart should be used to understand differences in barriers.

c- The Root Cause Analysis is used to identify the root causes of the barriers; it enables the team to make a distinction between the symptoms of the problem and the true causes of the problem. Here, the Fishbone or Ishikawa diagram is useful

Step 5: S = Select the Improvement or Intervention

Based on the team's knowledge of the performance improvement process and the root causes to the problem identified in Step 4, the team should proceed to designing an intervention. It is likely that several alternatives for solving the problem exist hence more than one intervention may be necessary.

Choosing sound solutions requires a good list of options. Careful reflection on team's available resources and desired outcome should be carried. Outcome measures and indicators of progress should be considered when designing any intervention

Implementing an Intervention (PDSA)

The PDSA is the next phase of the FOCUS-PDSA Model and it focuses on how to manage an intervention. Once a team has identified the right interventions to implement, the following steps must be taken:

Step 6: P = Plan How to Implement the Intervention and Test the Changes

In this step, the team should develop a strategic plan on how to carry out the intervention chosen in step 5. The strategic plan should include; the activities or actions to be taken, what the desired outcomes of the interventions are, how will progress be measured and documented, who will be responsible for what actions, what strategies will be used, and

when will the intervention begin and end. At best, it is important to draw up a complete strategic plan and if possible include a work breakdown structure. This is useful in establishing that the improvement is reasonably attributable to interventions undertaken by the team.

Step 7: D = Do. Implement the Plan

Once a concise and realistic plan has been developed, the team can begin implementation. In the seventh step the team carries out the steps of the plan. The plan should have a way of measuring progress and should be treated as a living document-changes can be made to accommodate unforeseen contingencies. However, the team must use a worksheet to document any changes to the plan during its implementation.

Step 8: S = Study the Results of the Implementation

After the intervention has been implemented and sufficient time has been provided for the intervention to take effect, the team should review the results of the intervention. At the planning stage, the team had decided on a measurement criteria as well as the desired outcome of the intervention. In this stage, the team should use trend diagrams to observe and analyze changes during and after the intervention, use control charts to analyze the stability of the trends and test for rate and statistical significance of the change. The main goal in this stage is to evaluate the effectiveness of the intervention and to decide if the intervention should be retained, refined, or abandoned

Step 9: A = Act to maintain Improvement or refine the intervention

The purpose of Step 9 of the FOCUS-PDSA model is to take action on the findings obtained in the study stage. If the intervention brought about the desired change, the team must seek to sustain the change for a period of time determined by the DBHS. If the intervention failed to bring about the desired change, it should either be refined based on lessons learned or abandoned entirely. Sustaining improving means institutionalizing the improvement and monitoring results over time.

PROTOCOL ACTIVITY AND IMPLEMENTATION

PROTOCOL ACTIVITY	HOW THE PROTOCOL IS IMPLEMENTED
STEP 1: F = Find the problem or process to improve For DBHS designed PIPS, This is usually performance gaps identified due to contractors not meeting minimum performance standards. For AHCCCS designed PIPS, these are areas or aspects of health outcomes where improvements on the current baseline data are desired.	For most DBHS designed PIP, the problem will be stated. Such PIPs will often be based on performance measures for which the contractor has demonstrated continuous under performance over a given period of time. For AHCCCS designed PIPs this step is usually stated in the PIP proposal or methodology. Contractors must use the FOCUS section of the FOCUS-PDSA model to appropriately identify areas of improvement
STEP 2: O = Organize a Team PIPs require a series of processes and activities to be carried out. This often involves more than one person and sometimes may need more than one department. It is important to put together a team of people who understand both the performance improvement process and the area of improvement	Identify those responsible for implementing the PIP and create a functional group with a clear objective. Be sure to include people with knowledge of what needs to be improved. It may require the presence of some members of another department
STEP 3: C = Clarify the current knowledge of the process A team cannot improve a process or problem until the team fully understands and agrees on what the current process or problem is. This can be a challenge when dealing with an interdisciplinary team. The third step in the FOCUS-PDSA model is aimed at bringing every member of the team on the same page by clarifying and agreeing on the current knowledge of processes. The goal is to answer questions such as, "Is the problem clearly understood?" or "Are the related processes clearly understood?" In addition certain terminology or concepts should be clarified and agreed upon at this stage.	Set up team meeting and have everyone state what in their opinion the problem is. Obtain a consensus on what the problem is and what processes are involved. Be sure to document the discussion and state the resolution for future references

PROTOCOL ACTIVITY	HOW THE PROTOCOL IS IMPLEMENTED
STEP 4: U = Understand the sources and causes of variations (Problems) The key to solving a problem is to fully understand it. This is where background study of the situation and a quantitative and qualitative analysis of the problem are performed. The group should research and brainstorm on the possible causes of the problem then, perform a quantitative and qualitative analysis of the current problem	Put together a group or have the entire team analyze the current problem. This will include; identifying the source of the problem, the nature of the problem, the magnitude of the problem and the root causes of the problem. Three analytical tools are useful here; A process map, the Pareto analysis and the Root Cause Analysis. See description of the FOCUS-PDSA model for detail explanations on the three analytical tools.
STEP 5: S = Select the Improvement or Intervention Based on the team's knowledge of the performance improvement process and the root causes to the problem identified in Step 4, the team should proceed to designing an intervention. It is likely that several alternatives for solving the problem exist hence more than one intervention may be necessary.	This is one of the most important stages of a performance improvement project and it is important to get it right. Have the team reflect on the type of intervention that will improve the current situation. The root cause should help in identifying targets for the intervention. Consider the objective of the PIP, the feasibility of the intervention, implementation time frame and the cost benefit ratio of the intervention. Choose the most feasible and outcome effective intervention(s) to implement.
Implementing an intervention (PDSA) The PDSA is the next phase of the FOCUS-PDSA Model and it focuses on how to manage an intervention. Once a team has identified the right interventions to implement, the following steps must be taken:	The PDSA is not intended for the entire project but specifically, for the intervention stage of the project.

PROTOCOL ACTIVITY	HOW THE PROTOCOL IS IMPLEMENTED
STEP 6: P = Plan on how to Implement the Improvement and Test the Changes In this step, the team should develop a strategic plan on how to carry out the intervention chosen in step 5. The strategic plan should include; the activities or actions to be taken, what the desired outcome of the interventions are how will progress be measured and documented, who will be responsible for what actions, what strategies will be used, and when will the intervention begin and end. At best, it is important to draw up a complete strategic plan and if possible include a work breakdown structure. This is useful in establishing that the improvement is reasonably attributable to interventions undertaken by the team	Draw a strategic plan of all activities that will be carried out to complete each intervention. State them as clear and chronologically as possible. Identify who does what, and when and if possible, do a Work Breakdown Structure to clarify tasks, timelines and responsible persons. Include milestones as measurement criteria for the improvement process. A well-drawn plan should eliminate redundant activities and visually portray the course of action
STEP 7: D = Do. Implement the Plan Once a concise and realistic plan has been developed, the team can begin implementation. In the seventh step the team carries out the steps of the plan. The plan should have a way of measuring progress and should be treated as a living document- changes can be made to accommodate unforeseen contingencies. Use a worksheet to document any changes to the plan during its implementation	Take action on all what has been planned. It is important to follow the plan as best as possible. If changes are unavoidable, it must be a concerted action and it should be documented. It will become useful if the intervention needs to be redesigned or refined.
STEP 8: S = Study the Results of the Implementation After the intervention has been implemented and sufficient time has been provided for the intervention to take effect, the team should review the results of the intervention.	At the planning stage, the team had decided on a measurement criteria as well as the desired outcome of the intervention. In this stage, the team should use trend diagrams to observe and analyze changes during and after the intervention, use control charts to analyze the stability of the trends and test for rate and statistical significance of the change. The main goal in this stage is to evaluate the effectiveness of the intervention and to decide if the intervention should be retained, refined, or abandoned. The test for statistical significance for PIPs is conducted using chi-square.

PROTOCOL ACTIVITY	HOW THE PROTOCOL IS IMPLEMENTED
STEP 9: A = Act to sustain improvement, refine or abandon intervention The purpose of Step 9 of the FOCUS-PDSA model is to take action on the findings obtained in the study stage. If the intervention brought about the desired change, the team must seek to sustain the change for a period of time. If the intervention failed to bring about the desired change, it should either be refined based on lessons learned or abandoned entirely. Sustaining improving means institutionalizing the improvement and monitoring results over time.	Significant changes observed as a result of a PIP should be sustained over a period of time before the PIP is closed. If the PDSA model was well structured, and changes obtained were associated to the intervention implemented, replicating the steps will likely lead to stable variations over a long period of time. Using basic control charts will identify special cause variations

Arizona Health Care Cost Containment System (AHCCCS)
Acute-care, ALTCS E/PD, ALTCS DDD, AIHP, DBHS, and Integrated Care Plans
Performance Improvement Project:
E-Prescribing

Creation Date: January 2014
Implementation Date: October 1, 2014

Background:

The development of health information technology, including electronic prescribing (e-prescribing) was meant to improve the quality of healthcare for patients as well as efficiency for providers. E-Prescribing is a clinicians' ability to electronically send an accurate, error-free and understandable prescription directly to a pharmacy from the point-of-care. Thus, clinicians can safely and efficiently manage patients' medications while reducing the risk for errors. Additional benefits include reducing phone calls between clinicians and pharmacies and providing patient convenience by avoiding additional trips to pharmacies to drop off prescriptions.

A National Ambulatory Medical Care Survey identified that 880.5 million visits were made to a physician's office in 2001 and 61.9 percent of these visits resulted in a clinician prescribing at least one medication.[1] Data continues to show preventable errors in utilizing the standard handwritten paper method to communicate a medication between a prescriber and a pharmacy.

A Cornell medical school study found that clinicians make seven times fewer errors, decreasing from 42.5 per 100 prescriptions to 6.6 per 100 prescriptions after one year, when using an electronic system rather than writing prescriptions by hand. [2] This includes completely eliminating illegibility errors, which were at a rate of 87.6 per 100 prescriptions and identifying that two in five handwritten prescriptions within community practices had errors.[2] Prescribing errors occur at a much higher rate within community based settings, demonstrated by a study that found a 27.8 percent error rate in a community setting versus 11 percent in an academic-affiliated primary care clinic.[3]

Adverse drug events can impact both patients and hospitals. The Agency for Healthcare Research and Quality has identified that 770,000 injuries occur each year from adverse drug events resulting in hospitalizations and/or deaths and can cost hospitals up to 5.6 million per year.[4] Another study found the average length of stay at a hospital as a result of an adverse drug reaction is 6.69 days and estimates individual cost to be over $2,000.00 per event.[5] Sending a clear and legible prescription electronically can reduce mistakes related to medication types, dosages, and member information. This can also assist pharmacies in identifying potential problems related to medication management and identifying potential reactions members may encounter, especially for those taking multiple medications.

The perception of both clinicians and pharmacy staff is imperative to the continuation and success of e-prescribing. The National Institute of Health confirms the value of e-prescribing for patient safety among clinicians within a study concluding that 78 percent of clinicians felt that e-prescribing was better than other methods of use.[6] Pharmacist and pharmacy technicians also reported several strengths to e-prescribing including: quick access to prescriptions, consistency in prescription formatting and legibility.[7]

Purpose:
The purpose of this Performance Improvement Project is to increase the number of prescribers electronically prescribing prescriptions and to increase the percentage of prescriptions which are submitted electronically in order to improve patient safety.

AHCCCS Goal
In alignment with the payment reform e-prescribing initiative, the goal is to increase therefore the goal is to demonstrate a statistically significant increase in the number of providers submitting electronic prescriptions and the number of electronic prescriptions submitted then sustains the increase for one year.

Measurement Period
Baseline Measurement: October 1, 2013 through September 30, 2014
First Re-measurement: October 1, 2015 through September 30, 2016
Second Re-measurement: October 1, 2016 through September 30, 2017

Study Question
What is the number and percent, overall and by Contractor, of AHCCCS-contracted providers which prescribe at least one prescription electronically? What is the number and percent, overall and by Contractor, of total prescriptions prescribed electronically by AHCCCS-contracted prescribers?

Population
This study will include members in the following populations:
- ALTCS Elderly and Physically Disabled (E/PD) members, ages 0-64 and 65+
- ALTCS Developmentally Disabled (DD) members, ages 0-64 and 65+
- Acute-care members - Medicaid, ages 0-64 and 65+
- Acute-care members - KidsCare, ages 0-18
- Comprehensive Medical and Dental Program (CMDP) members, ages 0-19
- Children's Rehabilitative Services members, aged 0-20 and 21+
- DBHS members, aged 0-64 and 65+
- DBHS Integrated members, aged 18-64 and 65+
- American Indian Health Plan members, aged 0-64 and 65+

Population Exclusions
The sample frame will exclude:
- Members with no medications prescribed
- Prescriptions designated as refills of an existing prescription

Population Stratification
The population will be stratified by Contractor. The population will also be stratified by age groups*:
- 0 through 20 years old
- 21 through 64 years old
- 65 years and older

* Note: Each Contractor's performance will be evaluated based on its aggregate rate for the Medicaid population for this indicator. Data will be evaluated for the 65+ population before final results are shared; if it is determined that sufficient Medicare data has not been received to support the age-band reporting, that population group will not be included in the performance rate.

Sample Frame:
There will be no sample frame for this study. All prescribers and prescriptions that meet the criteria will be evaluated to determine the measure rates.

Sample Selection:
Not applicable.

Indicator Criteria

Indicator 1:   The percent (overall and by Contractor) of AHCCCS-contracted providers who prescribed at least one electronic prescription.

Indicator 2:   The percent (overall and by Contractor) of prescriptions prescribed by an AHCCCS contracted provider sent electronically.

Numerator

Indicator 1:   The number of providers in the denominator who sent at least one prescription electronically to a pharmacy during the measurement period

Indicator 2:   The number of prescriptions in the denominator which were sent electronically to a pharmacy during the measurement period

Denominator

Indicator 1:   The total number of providers contracted with AHCCCS who prescribed at least one prescription using any method during the measurement period

Indicator 2:   The total number of prescriptions sent to a pharmacy using any method during the measurement period

Data Sources:
AHCCCS administrative data will be used to identify indicator data. AHCCCS will collect prescription origination information from its encounter system. It is important to note, only approved adjudicated claims and encounters are included in this study.

For the purposes of defining an e-prescribed prescription, AHCCCS will be looking at those prescriptions generated through a computer-to-computer electronic data interchange protocol, following a national industry standard and identified by Origin Code 3.

Data Collection:
This study will be conducted via administrative review of the data sources listed above.

Confidentiality Plan:
AHCCCS and its Contractors maintain compliance with the Health Insurance Portability and Accountability Act (HIPAA) requirements. Only AHCCCS employees who analyze data for this project will have access to study data. Requested data are used only for the purpose of performing health care operations, oversight of the health care system, or research. Member names are never identified or used in reporting.

Quality Assurance Measures:
Data files will be thoroughly reviewed prior to detailed validation to ensure that all study perimeters are accurate and complete. Once rates have been established, AHCCCS will track and trend data to ensure consistency with internal data and similar aligned initiatives. Additionally external reports will be evaluated to determine rate alignment for comparative purposes.

Data Validation:
The Data Validation Studies examines professional encounters and facility encounters. These studies compare paid claims files by the Contractors and encounters sent to AHCCCS by the Contractors. The studies produce an overall accuracy rate based on receipt, accuracy and timeliness. These studies are prepared for Contractors under ALTCS, acute care and behavioral health contract types in accordance with RFP specifications listed in the programmatic contract procurement process.

The sample frame will be validated to ensure that members meet criteria for inclusion in the study and that data collected from administrative sources (e.g., AHCCCS encounters) meet numerator and denominator criteria. These data will be validated through review of a random sample of members included in the denominator as well as those not selected for the denominator and a random sample of numerator data.

Analysis Plan:
The data will be analyzed in the following ways:
- The numerator will be divided by the denominator to determine the indicator rate.
- Results will be analyzed as a statewide aggregate and by individual Contractor.
- Results will be analyzed by urban and rural county groups.
- Results may be analyzed by member race/ethnicity; i.e. Caucasian, African American, Hispanic Asian/Pacific Islander, Native American/American Eskimo, and Other/Unknown, as well as any other stratifications deemed appropriate.

Comparative Analysis:
For the purpose of comparative analyses, the following will be considered when applicable and meaningful to future improvement:
- Results will be compared with prior years to identify changes and trends.
- Results by placement will be compared with each other.
- Rural and urban area results will be compared to identify any significant disparities in geographic area types.
- Individual Contractor results will be compared with each other, the statewide aggregate, and the AHCCCS goal.

- Results may be compared by other stratifications as deemed appropriate (i.e. age, race/ethnicity, gender).
- Results will be compared to the results of any other comparable studies, if available.
- In the future, differences between overall baseline study results and overall remeasurement results will be analyzed for statistical significance and relative change.

Limitations:
None noted at this time.

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3. *Ambulatory prescribing errors among aommunity-based providers in two states.* **Abramson, Erika L, et al., et al.** s.l. : BMJ Group, 2012, Jamin, Vol. 19, pp. 644-648.

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7. *Retail pharmacy staff perceptions of design strengths and weaknesses of electronic prescribing.* **Odukoya, Olufunmilola and Chui, Michelle A.** 6, s.l. : BMJ Group, 2012, Jamin, Vol. 19.

For general questions regarding this methodology, please contact Jakenna Lebsock, Quality Improvement Manager, at 602-417-4229 or at Jakenna.Lebsock@azahcccs.gov. For technical questions regarding this methodology, please contact Lucy Valenzuela, Data/Research Analyst, at 602-417-4753 or lucy.valenzuela@azahcccs.gov.

ARIZONA DIVISION OF BEHAVIORAL HEALTH SERVICES (DBHS)
2015 PERFORMANCE IMPROVEMENT PROJECT (PIP):
REDUCTION OF MEMBER APPOINTMENT WAIT TIMES – BEHAVIORAL HEALTH SERVICES

BACKGROUND

The wait time for patients to receive a health care appointment has clinical implications, including risk of decompensation and suicide, as well as resource ramifications. Within the behavioral health setting, timely appointments are critical to establishing and maintaining optimal patient care. An excessive delay between a request for services and being seen by a mental health provider can lead to a delay in diagnosis and treatment, as well as increased utilization of crisis and inpatient services. Customer satisfaction and rapport can also be negatively impacted.

Studies have shown that delayed appointments impact the likelihood that people will keep their scheduled appointments. A Queens College study found that 90% of people kept their appointment if the appointment was scheduled with a one-day delay. Significantly fewer people, 35%, kept the appointment when it was scheduled with a 15-day delay[1]. Timely appointments are critical to maximizing kept appointments, which aids in the prevention of wasted resources and negative consequences to the member resulting from delayed treatment.

The wait time between scheduling an appointment and the date of the appointment significantly impacts the no-show rate within the related communities of substance abuse[2] and outpatient pediatrics[3]. Patients were more likely to no-show dependent on the wait time and were less likely to remember to contact the office prior to the schedule appointment if there was a conflict in their schedule. Researchers suggest that shortened wait times provide the immediate positive feedback and reinforcement that patients need to assist them in initiating the recovery process[2].

The Los Angeles County Access Improvement Project used a quality improvement model to increase their access to care utilizing existing resources at an outpatient community mental health center[4]. The 18-month improvement project resulted in significantly reduced time between the intake appointment and psychiatric evaluation. The no-show rate was also dramatically reduced from 52% to 18%, which saved the clinic an estimated cost of $44,200 per year in billable psychiatric time. Among the other benefits to the improvements in care access were significant decreases in hospitalization rates, fewer complaints from clients, and an increase in staff morale and office efficiency[4].

For this study, DBHS will define member appointment wait time as the number of days between a referral for a service and the actual appointment date for that service.

PURPOSE

The purpose of this Performance Improvement Project is to decrease member appointment wait time for Intake, Assessment, Behavioral Health Medical Professional (BHMP), and any related outpatient requested behavioral health service available to AHCCCS enrolled members. The reduction of the wait time is aimed at improving overall service delivery for members, reduce utilization of crisis services, emergency room services, hospitalizations, and re-hospitalizations while promoting increased access to outpatient services. The ability to access and utilize behavioral health services in a timely manner will reduce the overall medical and behavioral health costs associated with behavioral health services.

DBHS GOAL

There currently is no benchmark in Arizona for member appointment wait times for behavioral health services. The goal, therefore, is to demonstrate a statistically significant reduction in member appointment wait times for behavioral health services, and sustain this reduction for a minimum of one year.

MEASUREMENT PERIODS

Baseline Measurement: April 1, 2015, through March 30, 2016

First Re-measurement: April 1, 2016, through March 30, 2017

Second Re-measurement: April 1, 2017, through March 30, 2018

DEFINITIONS

Referral –Any oral, written, faxed, or electronic request for behavioral health services made by any member, or member's legal guardian, family member, an AHCCCS health plan, primary care provider, hospital, jail, court, probation and parole officer, tribal government, Indian Health Services, school, or other governmental or community agency. The request for services should facilitate action by the outreached entity and initiate identification and coordination towards service delivery.

Intake/Enrollment—The collection by appropriately trained T/RBHA/provider staff of basic information about a Non- Title XIX/XXI eligible member to ensure verification in the ADHS/DBHS system for Title XIX/XXI AHCCCS eligibility to determine the need for any copayments.

Assessment – The ongoing collection and analysis of a person's medical, psychological, psychiatric and social conditions in order to initially determine if a health disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensure that the person's service plan is designed to meet the person's (and family's) current needs and long term goals.

Assessment/Evaluation and Screening—Gathering and assessment of historical and current information which includes face-to-face contact with the person and/or the person's family or other informants, or group of individuals resulting in a written summary report and recommendations.

Other Professional Services—As outlined in the ADHS/DBHS covered services guide this includes but is not limited to codes and definitions found in the following sections;

- Treatment Services
- Other Professional
- Rehabilitation Services
- Medical Services
- Support Services
- Behavioral Health Day Programs
- Preventions Services

BHMP Appointment (Medical Management) – Assessment and management services that are provided by a licensed medical professional to a person as part of their medical visit for ongoing treatment purposes. Includes medication management services involving the review of the effects and side effects of medications and the adjustment of the type and dosage of prescribed medications.

STUDY QUESTION

What is the number of members (per 1000) by Contractor that meets or exceeds the standards for appointment timeliness as stated in ADHS DBHS Policy and Procedures Manual (Policy 102, Appointment Standards and Timeliness of Service) and (Policy 103, Referral and Intake Process) for each of the following;

- Intake/Assessment appointments
- BHMP (Medical Management) appointments
- Initial Other Professional Service appointments

POPULATION, EXCLUSIONS, AND STRATIFICATIONS

This sample frame/study will include the following populations:

DBHS/Regional Behavioral Health Authority (RBHA) enrolled members all ages, all behavioral health categories, all AHCCCS enrollment types except Non-Title XIX members. The sample frame will exclude:

- Tribal and fee-for-service members will be excluded due to the inability to accurately collect complete data on these populations.
  - The population will be stratified by Contractor for reporting purposes.

SAMPLE SELECTION

No sample will be selected; data reported will include the entire population that meets the sample frame criteria.

INDICATOR CRITERIA

Indicator 1:   The percentage of referrals initiated that had no identifying CPT code for Intake/Assessment, BHMP appointments, or Other Professional Service appointments.

Indicator 2:   The percentage of Intake/Assessment appointments completed within 7 business days of the routine requests/referrals.

99241	99242	99243	99244	99245	H0001	H0002
H0031	H0031 HK	90791	90792			

Indicator 3:   The percentage of BHMP appointments completed within 23 calendar days of the Intake/Assessment (if the Intake/Assessment concludes that psychotropic medications should be considered or if the member/guardian requested a BHMP appointment).

CPT Codes "BHMP Appointment (Medical Management)":

99201	99202	99203	99204	99205	99241	99242

99243	99244	99245	99304	99305	99306	99307
99308	99309	99310	99318	99324	99325	99326
99327	99328	99341	99342	99343	99344	99345
99354	99355	99499				

Indicator 4:   The percentage of Other Professional Service appointments (as defined above to include any services captured under "Other Professional Services" by ADHS-DBHS Covered Behavioral Health Services Guide) completed within 23 calendar days of the Intake/Assessment (if the Intake/Assessment concludes that a specialized service is appropriate or if the member/guardian requested said service).

CPT/HCPCS Codes "Other Professional Services":

90791	90792	90832	90833	90834	90836	90837
90838	90845	90870	90875	90876	90880	90846
90847	90849	90853	90899	90901	96101	96102
96103	96110	96111	96116	96118	96119	96120
97532	99199	H0004	H0004 HR	H0004 HQ	H0015	H0036
H0036 TF	H0037	H0038	H0038 HQ	H0046	H2012	H2014 HK
H2014 HQ	H2015	H2016	H2017	H2019	H2019 TF	H2020
H2027	H2033	S5109 HB	S5109 HC	S5109 HA	S5150	S5151
S5110	T1019	T1020				

Indicator 5: The number of days an "Other Professional Service" appointment is completed after referral from the treatment team or member/guardian requesting the service.

90791	90792	90832	90833	90834	90836	90837
90838	90845	90870	90875	90876	90880	90846
90847	90849	90853	90899	90901	96101	96102
96103	96110	96111	96116	96118	96119	96120
97532	99199	H0004	H0004 HR	H0004 HQ	H0015	H0036
H0036 TF	H0037	H0038	H0038 HQ	H0046	H2012	H2014 HK
H2014 HQ	H2015	H2016	H2017	H2019	H2019 TF	H2020
H2027	H2033	S5109 HB	S5109 HC	S5109 HA	S5150	S5151
S5110	T1019	T1020				

NUMERATOR

Indicator 1: The number of referrals initiated that had no identifying CPT code for Intake/Assessment, BHMP appointments, or Other Professional Service appointments.

Indicator 2: The number of Intake/Assessment appointments completed within 7 business days of the routine requests/referrals.

Indicator 3:   The number of BHMP appointments completed within 23 calendar days of the Intake/Assessment (if the Intake/Assessment concludes that psychotropic medications should be considered or if the member/guardian requested a BHMP appointment).

Indicator 4: The number of Other Professional Service appointments completed within 23 calendar days of the Intake/Assessment (if the Intake/Assessment concludes that a specialized service is appropriate or if the member/guardian requested said service).

Indicator 5: The number of days an "Other Professional Service" appointment is completed after referral from the treatment team or member/guardian requesting the service.

DENOMINATOR

Indicator 1: The total number of referrals

Indicator 2: The number routine requests/referrals.

Indicator 3: The number of Intake/Assessments that conclude that psychotropic medications should be considered or where the member/guardian requested a BHMP appointment.

Indicator4: The number of Intake/Assessments that conclude that a specialized service is appropriate or where the member/guardian requested said service.

Indicator 5: NA

CONFIDENTIALITY PLAN

DBHS continues to work in collaboration with Contractors to maintain compliance with the

Health Insurance Portability and Accountability Act (HIPAA) requirements. DBHS maintains the following security and confidentiality protocols:

- To prevent unauthorized access, the sample member file is maintained on a secure, password-protected computer shared network folder.
- Only DBHS employees who work on the project have access to member-specific study data.
- All employees and Contractors are required to sign confidentiality agreements.
- Requested data are used only for the purpose of performing health care operations, oversight of the health care system, or research.
- Member names are never identified or used in reporting.
- Upon completion, all study information will remain in the shared network folder.

DATA SOURCES

Baseline - RBHAs will be asked to collect and present data to DBHS to provide baseline data.

Re-measurement year 1 –

Re-measurement year 2 -

DATA COLLECTION PROCESS

RBHAs will be issued a State Wide data request along with information for the Performance Improvement Project to capture member information related to dates of request for Referral, Intake/Assessment, BHMP, and additional Other Professional Services. RBHAs will be capturing the date of request, date(s) of appointments offered, date of scheduled appointment, and date of ACTUAL appointment.

RBHAs will calculate the number of no shows for initial scheduled appointments (Intake/Assessment, BHMP, and Other Professional Service), number of patient cancelations (for initial Intake/Assessment, BHMP, and Other Professional Service), and number of contractor cancelations (for initial Intake/Assessment, BHMP, and Other Professional Service).

DATA VALIDATION

Data validation will be performed to ensure that all data used to calculate results are from the appropriate records and meet the denominator and numerator criteria. DBHS staff will validate data against recipient and encounter data in CIS, with the use of two member detail reports:

- A random sample of members who had appointments during the measurement period.
- A random sample of members who had requested appointments during the measurement period.

LIMITATIONS

Other unidentified factors besides Contractor interventions may falsely influence results. Relying on subjective rather than objective data (RBHA reports versus claims/encounters) may impact the accuracy of results.

ANALYSIS PLAN

Rates will be analyzed and reported by individual Contractor as well as by a statewide aggregate. A statistical software package will be utilized to calculate all medians and/or mean values, and to calculate statistical significance of changes between measurements.

COMPARATIVE ANALYSIS

Results will be compared to the results of any other comparable studies, if available. Comparative analysis also will include:
- Individual Contractors to the statewide average
- All other stratifications as deemed appropriate
  - Differences between overall baseline study results and overall re-measurement results will be analyzed for statistical significance and relative change.

REPORT FORMAT

The report will include the use of the FOCUS-PDSA reporting template located in the DBHS Specifications Manual. In addition, a written analysis will include, but not be limited to, the methodology used, narrative summary of analysis findings, limitations, recommendations and the analysis results displayed in appropriate charts, tables and graphs.

- Results will be reported by individual Contractor and statewide aggregate.
- Results will be reported to AHCCCS, who may publish the results on the AHCCCS website; and to external organizations as appropriate.

REFERENCES

[1] Watanabe-Rose, M. and Sturmey, P. (2008). The effects of appointment delay and reminders on appointment-keeping behavior. *Behavior and Social Issues, 17*, 161-168.

[2] Festinger, D.S., Lamb, R.J., Kirby, K.C., and Marlowe, D.B. (1996). The accelerated intake: A method for increasing initial attendance to outpatient cocaine treatment. *Journal of Applied Behavior Analysis, 29*, 387-398.

[3] Ross, L.V., Friman, P.C., and Christophersen, E.R. (1993). An appointment-keeping improvement package for outpatient pediatrics: Systematic replication and component analysis. *Journal of Applied Behavior Analysis, 26*, 461-467.

[4] Williams, M.E., Latta, J., Conversano, P. (2008). Eliminating the wait for mental health services. *The Journal of Behavioral Health Services & Research, 35*(1), 107-114.

GSA INTEGRATED CARE PERFORMANCE MEASURES

DESCRIPTION

Following are the GSA performance measures for integrated care.

Measure	MPS	Goal	Methodology	Comments
1. Inpatient Utilization *(days/100,000 member months)*	TBD	TBD	HEDIS - IPU (Inpatient Utilization): Administrative	The PM rate will be reflective of an aggregate rate of days per 100,000 member months (ages 20+).
2. Emergency Department (ED) Utilization *(visits/100,000 member months)*	TBD	TBD	HEDIS - AMB (Ambulatory Care): Administrative	Only the ED visit portion of the methodology will be utilized for PM evaluation. The PM rate will be reflective of an aggregate rate of visits per 100,000 member months (ages 20+).
3. Plan All-Cause Hospital Readmissions *(within 30 days of discharge)*	TBD	TBD	Adult Core: Administrative	The ratio of the observed readmission rate to the average adjusted probability will serve as the reported PM rate. The PM rate will be reflective of an aggregate rate for all age groups included in the measure. Use the commercial risk tables outlined in HEDIS for this measure.
4. Adult Asthma Admission Rate *(discharges/100,000 member months)*	TBD	TBD	Adult Core: Administrative	The PM rate will be reflective of an aggregate rate for all age groups included in the measure. The number of discharges for asthma per 100,000 member months aged 40 and older during the measurement period.
5. Use of Appropriate Medications for People with Asthma	86%	93%	HEDIS: Administrative	This measure will follow HEDIS methodology and will include members age 18-64. The PM rate will be reflective of an aggregate rate for all age groups included in the measure.
6. Follow-up After Hospitalization (all cause) within 7 Days	50%	80%	Adult Core: Administrative	This measure will be for both mental health and physical health discharge diagnoses. The PM rate will be reflective of an aggregate rate for all hospitalizations.
7. Follow-up After Hospitalization (all cause) within 30 Days	70%	90%	Adult Core: Administrative	This measure will be for both mental health and physical health discharge diagnoses. The PM rate will be reflective of an aggregate rate for all hospitalizations.

Integrated care performance measures, continued

Measure	MPS	Goal	Methodology	Comments
8. Comprehensive Diabetes Management: HbA1c Testing	77%	89%	Adult Core: Hybrid	Intentionally left blank.
9. Comprehensive Diabetes Management: Eye Exam	49%	68%	HEDIS - CDC (Comprehensive Diabetes Care): Hybrid	Intentionally left blank.
10. Flu Shots for Adults: Ages 18-64	75%	90%	AHCCCS: Administrative	PM rate will be reflective of the number of members within the age group that received a flu shot during the study period. DBHS will utilize administrative and ASIIS data for this measure calculation.
1. Flu Shots for Adults: Ages 65+	75%	90%	AHCCCS: Administrative	PM rate will be reflective of the number of members within the age group that received a flu shot during the study period. DBHS will utilize administrative and ASIIS data for this measure calculation.
13. Diabetes Admissions, short-term complications *(discharges/100,000 member months)*	TBD	TBD	Adult Core: Administrative	The PM rate will be reflective of an aggregate rate for all age groups included in the measure. The number of discharges for diabetes short-term complications per 100,000 member months aged 18 and older during the measurement period
14. Chronic obstructive pulmonary disease (COPD) admissions *(discharges/100,000 member months)*	TBD	TBD	Adult Core: Administrative	The PM rate will be reflective of an aggregate rate for all age groups included in the measure. The number of discharges for COPD per 100,000 member months aged 40 and older during the measurement period
15. Congestive heart failure admissions *(discharges/100,000 member months)*	TBD	TBD	Adult Core: Administrative	The PM rate will be reflective of an aggregate rate for all age groups included in the measure. The number of discharges for CHF per 100,000 member months aged 18 and older during the measurement period

Integrated care performance measures, continued

Measure	MPS	Goal	Methodology	Comments
16. Annual monitoring for patients on persistent medications: Combo Rate **Tabled for CYE2015**	**75%**	**80%**	Adult Core: Administrative	PM rate will be reflective of the percentage of Medicaid enrollees age 18 and older who received at least 180 treatment days of ambulatory medication therapy for select therapeutic agents during the measurement period and who received annual monitoring for the therapeutic agent in the measurement period.
17. Timeliness of prenatal care — prenatal care visit in the first trimester or within 42 days of enrollment	80%	90%	Children's Core: Hybrid	Intentionally left blank.
18. Postpartum Care Rate	64%	90%	HEDIS: Hybrid	Intentionally left blank.
20. Access to Behavioral Health Provider (encounter for a visit) within **7** days	75%	85%	AHCCCS: Administrative	Intentionally left blank.
21. Access to Behavioral Health Provider (encounter for a visit) within **23** days	90%	95%	AHCCCS: Administrative	Intentionally left blank.
21. EPSDT Participation	68%	80%	CMS 416 will be used: Administrative	Line 10
Miscellaneous Monitoring				
1. Adult Access to Preventive Care	75%			
2. Chlamydia Screening	63%	70%	Adult Core: Administrative	PM rate will be reflective of the percentage of Medicaid- enrolled women ages 21 to 24 who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.
3. Breast Cancer Screening	50%	60%	Adult Core: Administrative	PM rate will be reflective of the percentage of Medicaid- enrolled women ages 50 to 74 who received a mammogram to screen for breast cancer during the study period.
4. Cervical Cancer Screening: Women Aged 21-64 With a Cervical Cytology Performed Every Three (3) Years	64%	70%	Adult Core: Administrative	PM rate will be reflective of the percentage of Medicaid-enrolled women ages 21 to 64 who were screened for cervical cancer using cervical cytology performed every 3 years.
5. Cervical Cancer Screening: Women Aged 30-64 with a Cervical Cytology/Human	64%	70%	Adult Core: Administrative	Percentage of Medicaid-enrolled women ages 30 to 64 who were screened for cervical cancer using cervical cytology/human papillomavirus (HPV) co-

Papillomavirus (HPV) Co-Testing Performed Every Five (5) Years				testing performed every 5 years.
6. Members Cared for under Enhanced Payment Models	TBD	TBD	TBD	TBD

Rates by RBHA for each measure will be compared with the MPS specified in the contract in effect during the measurement period; performance standards in the CYE 2015 contract apply to results calculated by DBHS for the CYE 2015 measurement period. If RBHAs did not provide services during the entire reporting period, data will be submitted for the months in the period for which they do have data. (e.g. If the RBHA has only been in operation for 3 months and does not have 12 months of data, data will be submitted for the three months in the rolling period for which they do have data.)

In addition to the performance measures, report the counts and rates related to the following topics. (See Attachment B12. GSA Integrated Care Performance Measures Report Template for details.)

- EPSDT Monitoring
    - EPSDT Tracking Forms
    - Dental Measures (CMS Mandates)
    - EPSDT Provider Outreach
    - EPSDT Member Outreach
- Adult Monitoring
    - Provider Outreach
    - Member Outreach
- Miscellaneous Monitoring

ABBREVIATIONS

AAP – Adults' Access to Preventive/Ambulatory Health Services
AHCCCS – Arizona Health Care Cost Containment System
AMB – Ambulatory Care HEDIS measure
BH – Behavioral Health
BHP – Behavioral Health Provider
CAHPS – Consumer Assessment of Healthcare Providers and Systems
CDC – Comprehensive Diabetes Care
CMDP – Comprehensive Medical and Dental Program
CMS – Centers for Medicare and Medicaid Services
DDD – Division of Developmental Disabilities
ED – Emergency Department
EPSDT – Early Periodic Screening, Diagnosis, and Treatment
GSA – Geographical Service Area
HEDIS – Healthcare Effectiveness Data and Information Set

IPU – Inpatient Utilization HEDIS measure
MPS – Minimum Performance Standard
PCP – Primary Care Provider
PM – Performance Measure
RBHA – Regional Behavioral Health Authority
TBD – To Be Determined

GENERAL METHODOLOGY

Use the reference in the Methodology column above for details of each measure; most are available at the AHCCCS web site:
http://azahcccs.gov/reporting/quality/performancemeasures.aspx
See below for the methodology of the Access to Behavioral Health Provider measures.

Allowable gaps will follow the established methodology. If an option for a Medicaid gap exists, use that specification.

While measures may be from the Adult Core Set, they will be reflective of all members served.

Timeline
Use this schedule of review periods for the CY2015 contract year.

Reporting Quarter	DBHS Processing Dates	Data Range (12 Rolling Months, 3 month lag)*
Q1 2015	Jan 1, 2015	Oct 2013 - Sept 2014
Q2 2015	Apr 1, 2015	Jan 2014 - Dec 2014
Q3 2015	Jul 1, 2015	Apr 2014 - Mar 2015
Q4 2015	Oct 1, 2015	Jul 2014 - Jun 2015
Q1 2016	Jan 1, 2016	Oct 2014 - Sept 2015

* If the measure requires a 24, 36 or 60 month timeframe (e.g. Cervical Cancer screening) the data range is adjusted to go back according to the specification requirement and ending with the last month listed in the date range above

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REPORTING

Please see Attachment **B12. GSA Integrated Care Performance Measures Report Template** for reporting requirements, including the calculations, reporting frequency, and reporting timeline.

ACCESS TO BEHAVIORAL HEALTH PROVIDER METHODOLOGY

The Access to Behavioral Health Provider performance measure determines the percent of AHCCCS members who have received an initial behavioral health assessment visit and who have received a follow up visit with a behavioral health professional (BHP) within 7 and/or 23 days (separate measures) of the initial visit.

Operational Definitions:
1)   Assessment
- The ongoing collection and analysis of a person's medical, psychological, psychiatric, and social condition in order to initially determine if a behavioral health disorder exists and if there is a need for behavioral health services and on an ongoing basis ensure that the person's service plan is designed to meet the person's (and family's) current needs and long-term goals. The assessment date is obtained from encounter data.

   Assessment code
- Encounters with the H0031 Assessment Code will be used to identify a member who has had an assessment within the review period. Any member with the H0031 Assessment Code who has not had a behavioral health service within the 12 months prior to the review period will be considered for the measure an "active" member for this measure.

2)   Encounter
   A record of a service rendered by a registered AHCCCS provider to an AHCCCS enrolled member.

3)   Access to BHP
- A service provided to the Member by a Behavioral Health Provider that is included in the list of codes located in Attachment B3b, on or after the date of the initial assessment, as identified by the Assessment Code of H0031 (see Assessment Code above) and is obtained from encounter data. The only codes used to identify service(s) rendered within 7 and/or 23 days of the assessment are located in: At**tachment B3b. Access to Behavioral Health Provider Numerator Service Codes.**

- Services captured in encounters for the 7 day ATC measure will be duplicated in the 23 day measure.

Calculation – 7 day measure
Denominator: Total number of records identified with the Assessment Code of H0031 within the review period that has not had any behavioral health service within the 12 months prior to the review period.

Numerator: Total number of records in the denominator identified as having received a service that is located in **Attachment B3b. Access to Behavioral Health Provider Numerator Service Codes** provided by a BHP within 7 days of the assessment.

Calculation – 23 day measure

Denominator: Total number of records identified with the Assessment Code of H0031 within the review period that has not had any behavioral health service within the 12 months prior to the review period.

Numerator: Total number of records in the denominator identified as having received a service that is located in **Attachment B3b. Access to Behavioral Health Provider Numerator Service Codes** provided by a BHP within 23 days of the assessment.

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QUALITY CONTROL

RBHAs are responsible for verifying the accuracy of the data submitted for these measures and may be required to submit verification to ADHS/DBHS upon request. ADHS/DBHS may identify a random sample of behavioral health recipients and require that the RBHA submit documentation for validation purposes or perform such validation through on-site visits.

CONFIDENTIALITY PLAN

Preparation of the information for this report includes accessing "individually identifiable health information" as defined in HIPAA regulation 45 CFR 160.103 or "restricted personal identifying information" as defined in Arizona Strategic Enterprise Technology (ASET)/Statewide Information Security and Privacy Office (SISPO) Policy P900, Information Security Information Management, paragraph 4.1.10. Safeguards and controls, such as restricted access and agreement to protect confidential information, are contractual conditions in place to protect the identifying information that was accessed. All resulting publicly-reported data are aggregated at the GSA and tribe level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information.

REPORTING INCIDENTS, ACCIDENTS, AND DEATHS

DESCRIPTION

Significant events, such as accidents, injuries, allegations of abuse, human rights violations, and deaths require careful examination and review to ensure the protection of behavioral health recipients. ADHS/DBHS, as well as other federal and state agencies, requires the prompt reporting of significant events involving persons receiving services within the public behavioral health system. Providers are responsible for reporting incidents, accidents, and deaths of behavioral health recipients through the QMS Portal.

The QMS Portal is intended for the use of providers reporting IADs to T/RBHAs. This system is administered by the ADHS – Division of Behavioral Health Services (ADHS/DBHS). Access to the QMS Portal is at: https://app.azdhs.gov/QMPortal/WF_Public_Default.aspx

The QMS Portal has links for:

- **Registration Guide**

- **QuickStart - Creating an IAD**

- **Current Build Release Notes**

- **Technical Assistance**

ABBREVIATIONS

ADHS – Arizona Department of Health Services
BHR – Behavioral Health Recipient
BQ&I – Bureau of Quality and Integration
DBHS – Division of Behavioral Health Services
GSA – Geographic Service Area
HIPAA – Health Insurance Portability and Accountability Act
QM – Quality Management
RBHA – Regional Behavioral Health Authority
TBHA – Tribal Behavioral Health Authority
T/RBHA – Tribal/Regional Behavioral Health Authority

QUALITY CONTROL

RBHAs are responsible for verifying the accuracy of the data submitted for this reporting and may be required to submit verification to ADHS/DBHS upon request. ADHS/DBHS may identify a random sample of behavioral health recipients and require that the RBHA submit documentation for validation purposes or may perform such validation through on-site visits.

CONFIDENTIALITY PLAN

Preparation of the information for this report includes accessing "individually identifiable health information" as defined in HIPAA regulation 45 CFR 160.103 or "restricted personal identifying information" as defined in Arizona Strategic Enterprise Technology (ASET)/Statewide Information Security and Privacy Office (SISPO) Policy P900, Information Security Information Management, paragraph 4.1.10. Safeguards and controls, such as restricted access and agreement to protect confidential information, are contractual conditions in place to protect the identifying information that was accessed. All resulting publicly-reported data are aggregated at the GSA and tribe level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information.

C. Medical and Utilization Management

RECIPIENT AND PROVIDER OVER- AND UNDER-UTILIZATION

OF BEHAVIORAL HEALTH SERVICES

DESCRIPTION

This report contains RBHA data reporting and analysis of recipient and provider over-and under-utilization of behavioral health services, and their related plans to address identified problems.

ABBREVIATIONS

BHC – Behavioral Health Category
BHR - Behavioral Health Recipient
C/A – Child/Adolescent
CIS - Client Information Systems
DBHS - Division of Behavioral Health Services
GSA – Geographical Service Area
HIPAA – Health Insurance Portability and Accountability Act (of 1996)
MM/UM - Medical Management/Utilization Management
RBHA - Regional Behavioral Health Authority

METHODOLOGY

Population
All Title XIX/XXI and Non-Title XIX/XXI BHRs are included.

BHRs are stratified by BHC, age group, special population, and funding source.

Title XIX/XXI BHR age groups are stratified as follows:

Child/Adolescent (C/A)
- 0-5.999
- 6-11.999
- 12-17.999
- 18-20.999
- 0-17.999 Non TXIX Children

Title XIX and Title XXI C/As are combined.

Adult
- 21 and older

- 18 + Non TXIX/XXI

Data Source
RBHA recipient and provider utilization data.

Sampling
Not applicable.

Reporting Frequency
Twice a year.

Timeline

Review Period	RBHA Reports Due
October 1 to March 31	July 31
April 1 to September 30	January 31

If the day the file must be reported to ADHS/DBHS falls upon a weekend or holiday, it will be due the following business day. The report due dates were chosen to allow a 90-day lag for encounter submission and an additional month for analysis.

The RBHA is expected to review utilization at an individual recipient and provider level. The RBHA will use the Over- and Underutilization Report Template (Attachment C1. Over - and Underutilization of BH Services Template) to report and analyze the top 5% of service utilization against total utilization per service category to identify individuals who are utilizing services significantly more than other behavioral health recipients. The RBHA will also examine the most- and least-heavily used services to ascertain trends and patterns of use by provider and service type. The RBHA will report its analysis of trends and activities to address the over- and under-utilization that it has identified.

Label the submission file "*yyyymmdd*_OUUtilization_*nn*", where *yyyymmdd* is the year, month, and day that the report is due, and *nn* is the contractor ID. For example, MMIC's submission due on July 31, 2015 will be labeled 20150731_OUUtilization_37. The completed Over- and Underutilization Report Template will be submitted to ADHS/DBHS on the dates indicated above by way of the Sherman server, or through SharePoint submission with email notification of delivery to BQ&I Deliverables and BHS Contract Compliance.

QUALITY CONTROL

RBHAs perform quarterly data validation studies of their contractors to verify that the services received by BHRs are documented in the medical record appropriately, and are reported to the RBHA in an accurate and timely manner. ADHS/DBHS receives summary reports of the data validation studies.

As part of the corporate compliance plan, the DBHS Office of Audit and Evaluation conducts provider audits to determine whether the documentation in the medical record supports the billing submitted in the claim or encounter.

CONFIDENTIALITY PLAN

Preparation of the information for this report includes accessing "individually identifiable health information" as defined in HIPAA regulation 45 CFR 160.103 or "restricted personal identifying information" as defined in Arizona Strategic Enterprise Technology (ASET)/Statewide Information Security and Privacy Office (SISPO) Policy P900, Information Security Information Management, paragraph 4.1.10. Safeguards and controls, such as restricted access and agreement to protect confidential information, are contractual conditions in place to protect the identifying information that was accessed. All resulting publicly-reported data are aggregated at the GSA/RBHA level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information.

LENGTH OF STAY AND READMISSIONS

DESCRIPTION

RBHAs submit member-level demographic, service date, and readmission information for any members discharged from an inpatient, residential, or HCTC provider during the report month. In addition, RBHAs providing integrated care submit member-level demographic, service date, and readmission information for any member discharged from acute inpatient, inpatient skilled nursing, inpatient rehabilitation, and inpatient hospice.

The section of the Quarterly MM/UM Indicator Report regarding length of stay and readmissions includes a summary of the quarter's data including total discharges for each level of care and timeliness of initial reviews; analysis; and identification of trends with the RBHA's plans to address negative trends.

ABBREVIATIONS

ADHS/DBHS – Arizona Department of Health Services/Division of Behavioral Health Services
AHCCCS – Arizona Health Care Cost Containment System
BHR – Behavioral Health Recipient
CIS – ADHS's Client Information System
CMDP – Comprehensive Medical and Dental Program
COE – Court Ordered Evaluation
DDD – Division of Developmental Disabilities
GSA – Geographic Service Area
HCTC - Home Care Training To Home Care Client
HIPAA - Health Insurance Portability and Accountability Act
LOS - Length of Stay
MM/UM – Medical Management/Utilization Management
RBHA – Regional Behavioral Health Authority
RTC – Residential Treatment Center
TPL – Third Party Liability

METHODOLOGY

Population
Information about any member who has been discharged from a behavioral inpatient, residential, or HCTC provider during the report period is included in this report. RBHAs providing integrated care must also include acute inpatient, inpatient skilled nursing, inpatient rehabilitation, and inpatient hospice providers. Consult the Covered Services Guide to determine

the provider types associated with each level of care. The following fields are to be reported for each discharged member. At the end of the Chapter are file layout details with additional information.

1. RBHA ID
2. Year of the recipient's discharge
3. Month of the recipient's discharge
4. Recipient's CIS ID
5. Recipient's AHCCCS ID, if applicable
6. Recipient's last name
7. Recipient's first name
8. Recipient's date of birth
9. Level of care from which the recipient was discharged
10. Date of discharge
11. Date of admission for that discharge
12. Total length of stay in days for this inpatient/residential stay
13. Date of notification of stay
14. Date of initial review of stay
15. Number of days between date of notification and date of initial review
16. Number of RBHA-authorized days in this stay
17. COE this stay?
18. Was this member readmitted to the same or higher level of facility within 30 days (regardless of payer)? Include admissions for COE. Changes in payer source during one contiguous admission (ex: TXIX/XXI to COE) should not be counted as a discharge/readmission if the member remains in the same level of care during the period of COE. RBHAs providing integrated care should report readmissions within 30 days to any acute care facility including both behavioral and non-behavioral sites.
19. Date of the readmission to the same or higher level of facility that occurred within 30 days of the discharge.

Based on the BHR identifying information submitted by the RBHA, this additional information will be retrieved from the DBHS CIS system for use in analysis.

1. Recipient's Behavioral Health Category: determined based on the member's eligibility on the day of discharge.
2. Age band for this recipient: calculated by subtracting the member's Date of Birth from the day of discharge.
3. Recipient's funding source: determined based on the member's eligibility on the day of discharge.
4. Health plan subpopulation, if applicable (for example DDD or CMDP): determined based on the member's eligibility on the day of discharge.

Data Source
RBHA behavioral inpatient/residential/HCTC tracking logs and CIS.

RBHAs providing integrated-care will also use non-behavioral inpatient tracking logs and CIS.

Reporting Frequency
Data are reported monthly. Analysis is submitted quarterly.

Sampling
Not applicable.

Calculation

Length of Stay:
Report the number of days for each stay in a facility (LOS) for every discharge during this report month, regardless of when the recipient was admitted to the facility. Follow these guidelines:

1. Do not include the day of discharge in the count of LOS days.
2. Do not include same-day discharges (an admission and discharge occurring within the same 24-hour period) in the count of LOS days or number of discharges/clients discharged.
3. If a BHR is readmitted to the same level of care within 24 hours of discharge, exclude that discharge and consider it to be one stay.

For example, if a member is admitted to a Level I facility on June 21 and discharged on July 3, this 12 day-LOS would be included in the July report.

Days from notification to review:
Report the number of days from the date the RBHA received notification of the inpatient admission to the date of initial utilization review of the stay. If the initial review is completed on the same day as the date of notification, a "0" may be reported.

Readmissions:
If a BHR is discharged during the report month, indicate those having a subsequent readmission to the same or higher facility level within 30 days. Note that the readmission may occur in the month following the report month. If a BHR is readmitted to the same level of care within 24 hrs of discharge, exclude that discharge and consider it to be one stay.

For example, if a member was discharged from a Level I Sub-acute facility on July 25, then readmitted to the same or higher facility level on August 5, the readmission would be included in the July report.

The Readmission Rate would be calculated as follows.
   Numerator: Number of members readmitted to a same or higher level facility within 30 days.
   Denominator: Number of member discharges from a facility.

Timeline

Data are reported to ADHS/DBHS 45 days after the reporting month via a comma delimited text file with double quotes around each field (file layout attached), submitted at the ADHS/DBHS Sherman Server.

Quarterly analysis is submitted to ADHS/DBHS 60 days after the final reporting month for the quarter using the MM/UM Indicator Report template (see attachment).

If the day the file must be reported to ADHS/DBHS falls upon a weekend or holiday, it will be due the following business day.

QUALITY CONTROL

Monthly files submitted by the RBHAs and processed at ADHS/DBHS electronically are checked programmatically for data errors. Errors are identified as erroneous or missing data in any of the required fields. Files containing errors are returned to the RBHA for correction. Please be aware that ADHS requires each RBHA to submit complete and correct deliverables by the due date. Any resubmissions that result from incorrect procedures or data from the RBHA that arrive after the original due date are considered out of compliance. ADHS reserves the right to take formal action including requirement of a corrective action plan or the assessment of financial sanctions for repeated instances of incorrect submissions.

RBHAs are responsible for verifying the accuracy of the data submitted for this measure and may be required to submit verification to ADHS/DBHS upon request. ADHS/DBHS may identify a random sample of behavioral health recipients and require that the RBHA submit documentation for validation purposes or perform such validation through on-site visits. RBHAs must demonstrate a minimum performance score of 90% data accuracy at time of validation. Scores of less than 90% will require a corrective action plan to improve data accuracy.

CONFIDENTIALITY PLAN

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information that was accessed. All resulting publicly-reported data are aggregated at the GSA/RBHA level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information.

FILE SPECIFICATIONS

Comma delimited text file with double quotes around each field, such as *"158888","15","2013"***.**
ALL FIELDS ARE REQUIRED TO BE REPORTED, INCLUDING ZERO VALUES
File Name:
LOS_READMITS_FYyyyy_Mnn_rr.TXT (yyyy=FISCAL Year, nn=MONTH NUMBER within the FISCAL YEAR, rr=2 Digit RBHA ID)
Example: LOS_READMITS_FY2015_M03_02.TXT for December 2014 for GSA 2.

Field Name	Definition	Format	Remarks
Record Number	Unique record identifier for each line in the file	6 Characters	Example: 000001
RBBA ID	2 Digit RBHA Contractor ID	2 Characters	"02" = Cenpatico GSA 2 "32" = Cenpatico GSA 3 "22" = Cenpatico GSA 4 "26" = CPSA GSA 5 "15" = NARBHA "37" = MMIC "77"=MMIC Integrated
Year	Calendar year in which the discharge occurred	Numeric	YYYY Example: 2013
Month	Calendar month in which the discharge occurred	Numeric	MM Example: 12
Recipient's CIS ID	The unique CIS identifier for the recipient.	10 Characters	Example: 1234567890
Recipient's AHCCCS ID, if applicable	The unique AHCCCS identifier for the recipient.	9 Characters	Example: A12345678
Recipient's last name	The last name of the recipient	20 Characters maximum	Example: Smith
Recipient's first name	The first name of the recipient	20 Characters maximum	Example: Jane
Date of Birth	Recipient's date of birth	yyyymmdd	Example: 19950716
Level of Care	Type of facility/service at which this recipient received care during the report timeframe.	Numeric	1 = Behavioral Health Hospital Facility 2 = Behavioral Health Inpatient Facility RTC 3 = Behavioral Health Inpatient Facility Sub-acute 4 = Behavioral Health Residential Facility 5 = HCTC 6 = All Inpatient Acute Hospital Beds (Medical/Surgical, Telemetry, Obstetrics, Intensive Care) 7 = Skilled Nursing Facility 8 = Inpatient Hospice 9 = Inpatient Rehabilitation
Discharge Date	Date of discharge for this recipient. The discharge date must be in this reporting period.	yyyymmdd	Example: 20131218
Admission Date	Date of admission for the previous line's discharge for this recipient.	yyyymmdd	Example: 20131210
Length of Stay	Total length of stay in days for this inpatient/residential stay.	Numeric	Example: 8
Notification Date	Date the RBHA received initial notification of the admission on the previous line for this recipient	yyyymmdd	Example: 20131211
Initial Review Date	Date the RBHA conducted the first review of the reported admission for this recipient	yyyymmdd	Example: 20131212
Days from notification to review	The number of days between RBHA receiving notification of the inpatient admission and completion of the initial utilization review of the stay.	Numeric	Example: 1

Field Name	Definition	Format	Remarks
Number of RBHA-authorized days in this stay	Days of the total for this stay that were authorized by the RBHA	Numeric	Example: 6
COE this stay?	Was there a court-ordered evaluation during this stay?	Numeric	1= Yes 2= No
Readmission?	Was this recipient readmitted to the same level facility within 30 days of discharge (regardless of payer)? Include COE admissions.	Numeric	1 = Yes 2 = No
Readmission date within 30 days of this stay's discharge.	Date this recipient was readmitted to the same level of facility within 30 days of this stay's discharge	yyyymmdd or NULL if there was no readmission	Example: 20140102
Edits: *** The Record Number value must be unique and cannot be duplicated.** *** The RBHA number in the file name must match the RBHA ID field value.** *** The Year value must be a valid year and fall within the reporting period listed in the file name.** *** The Month value must be a valid month between 01 and 12 and fall within the reporting period listed in the file name.** *** The Date of Birth cannot be greater than the reporting period.** *** The admission date must be before the discharge date.** *** Readmission date must be after the discharge date**			

PRIOR AUTHORIZATION

DESCRIPTION

The Prior Authorization report contains member-level data detailing prior authorization requests received by the RBHA for certain services during the reporting month. Included are recipient identifying information, as well as a description of that member's prior authorization request(s) and associated disposition(s).

The section of the Quarterly MM/UM Indicator Report regarding prior authorizations includes a summary of the quarter's data, analysis, and identification of trends with the RBHA's plans to address negative trends.

Please note that reporting of pharmacy Prior Authorization information is required for *Chapter C6. Pharmacy Utilization and Authorization,* in addition to the reporting requirements of this Chapter.

ABBREVIATIONS

ADHS/DBHS – Arizona Department of Health Services/Division of Behavioral Health Services
AHCCCS – Arizona Health Care Cost Containment System
BHR – Behavioral Health Recipient
CIS – Client Information System
CMDP – Comprehensive Medical and Dental Program
DDD – Division of Developmental Disabilities
ECT – Electroconvulsive Therapy
GSA – Geographical Service Area
HCTC- Home Care Training To Home Care Client
HIPAA- Health Insurance Portability and Accountability Act
MM/UM – Medical Management/Utilization Management
RBHA – Regional Behavioral Health Authority
RTC – Residential Treatment Center

METHODOLOGY

Population

Prior authorizations for all recipients are to be reported. This report should not include authorizations granted upon concurrent review of emergent inpatient hospitalizations. The following fields are to be reported for each member for whom a prior authorization was received during the report month. At the end of the Chapter are file layout details with additional information.

1. RBHA ID
2. Year of the Prior Authorization request
3. Month of the Prior Authorization request
4. Recipient's CIS ID
5. Recipient's AHCCCS ID, if applicable
6. Recipient's last name
7. Recipient's first name
8. Recipient's date of birth
9. Date the Prior Authorization request was received
10. The service requested
11. The request type
12. Date the Prior Authorization decision was made
13. Was the request completed timely?
14. Was the request initially submitted as expedited, then changed to standard?
15. The outcome of the request.

Based on the BHR identifying information submitted by the RBHA, this additional information will be retrieved from the DBHS CIS system for use in analysis.

1. Recipient's Behavioral Health Category: determined based on the member's eligibility on the date the Prior Authorization request was received.
2. Age band for this recipient: calculated by subtracting the member's Date of Birth from the date the Prior Authorization request was received.
3. Recipient's funding source: determined based on the member's eligibility on the date the Prior Authorization request was received.
4. Health plan subpopulation, if applicable (for example DDD or CMDP): determined based on the member's eligibility on the date the Prior Authorization request was received.

Data Source
RBHA Authorization tracking logs and CIS.

Reporting Frequency
Data are reported monthly. Analysis is reported quarterly.

Sampling
Not applicable.

Calculation
Member level data are used in the following calculations of approval and denial rates.

Authorization Approval Rates
    Numerator: Number of prior authorization requests approved of those received this report period for a Level of Care or Service
    Denominator: Number of prior authorization requests received this report period for the Level of Care or Service

Authorization Denial Rates
    Numerator: Number of prior authorization requests denied of those received this report period
    for a Level of Care or Service
    Denominator: Number of prior authorization requests received this report period for the Level
    of Care or Service

Timeline
Data are reported to ADHS/DBHS on the 30th day of the month for the previous month's
authorizations via comma delimited text files with double quotes around each field, submitted at the
ADHS/DBHS Sherman Server. Decisions made after the last day of the previous month should also
be included.

Quarterly analysis is submitted to ADHS/DBHS in the electronic Quarterly MM/UM Indicator
Report template 60 days after the final month of the reporting quarter. The Report template is an
attachment to this Specifications Manual.

If the day the file must be reported to ADHS/DBHS falls upon a weekend or holiday, it will be due
the following business day.

QUALITY CONTROL

Files submitted by the RBHAs and processed at ADHS/DBHS electronically are checked
programmatically for data errors. Errors are identified as erroneous or missing data in any of the
required fields. Files containing errors are returned to the RBHA for correction. Please be aware
that ADHS requires each RBHA to submit complete and correct deliverables by the due date. Any
resubmissions that result from incorrect procedures or data from the RBHA that arrive after the
original due date are considered out of compliance. ADHS reserves the right to take formal action
including requirement of a corrective action plan or the assessment of financial sanctions for
repeated instances of incorrect submissions.

RBHAs are responsible for verifying the accuracy of the data submitted for this measure and may
be required to submit verification to ADHS/DBHS upon request. ADHS/DBHS may identify a
random sample of behavioral health recipients and require that the RBHA submit documentation for
validation purposes or perform such validation through on-site visits. RBHAs must demonstrate a
minimum performance score of 90% data accuracy at time of validation. Scores of less than 90%
will require a corrective action plan to improve data accuracy.

CONFIDENTIALITY PLAN

Preparation of the information for this report includes accessing "individually identifiable health
information" as defined in HIPAA regulation 45 CFR 160.103 or "restricted personal identifying
information" as defined in Arizona Strategic Enterprise Technology (ASET)/Statewide Information
Security and Privacy Office (SISPO) Policy P900, Information Security Information Management,
paragraph 4.1.10. Safeguards and controls, such as restricted access and agreement to protect

confidential information, are contractual conditions in place to protect the identifying information that was accessed. All resulting publicly-reported data are aggregated at the GSA/RBHA level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information.

FILE SPECIFICATIONS

Comma delimited text file with double quotes around each field, such as *"158888","15","2013".*
ALL FIELDS ARE REQUIRED TO BE REPORTED, INCLUDING ZERO VALUES

File Name:
AUTH_REQ_FYyyyy_Mnn_rr.TXT (yyyy=FISCAL YEAR, nn=MONTH NUMBER within the FISCAL YEAR, rr=2DIGIT RBHA ID)
Example: AUTH_REQ_FY2015_M03_02.TXT for December 2014 from Cenpatico GSA 2

Field Name	Definition	Format	Remarks
Record Number	Unique record identifier for each line in the file	6 Characters	Example: 000001
RBHA ID	2 Digit RBHA Contractor ID	2 Characters	"02" = Cenpatico GSA 2 "32" = Cenpatico GSA 3 "22" = Cenpatico GSA 4 "26" = CPSA GSA 5 "15" = NARBHA "37" = MMIC "77"=MMIC Integrated
Year	Calendar year in which the Prior Authorization request was received	Numeric	YYYY Example: 2013
Month	Calendar month in which the Prior Authorization request was received	Numeric	MM Example: 12
Recipient's CIS ID	The unique CIS identifier for the recipient.	10 Characters	Example: 1234567890
Recipient's AHCCCS ID, if applicable	The unique AHCCCS identifier for the recipient.	9 Characters	Example: A12345678
Recipient's last name	The last name of the recipient	20 Characters maximum	Example: Smith
Recipient's first name	The first name of the recipient	20 Characters maximum	Example: Jane
Date of Birth	Member's date of birth	yyyymmdd	Example: 19950716
Date of Request	The date prior authorization request was received.	yyyymmdd	Example: 20131216
Service	The service requested.	Numeric	1 = Planned Behavioral Health Hospital Facility 2 = Behavioral Health Inpatient Facility RTC 3 = Behavioral Health Inpatient Facility Sub-acute 4 = Behavioral Health Residential Facility 5 = HCTC 6 = Behavioral Pharmacy 7 = ECT 8 = Non-Behavioral Pharmacy 9 = Non-Emergent Inpatient 10 = Inpatient Hospice 11 = Inpatient Skilled Nursing 12 = Inpatient Rehabilitation 13 = Outpatient Surgery 14 = Home Health Care 15 = In Home Hospice 16 = Physical Therapy 17 = Occupational Therapy

Field Name	Definition	Format	Remarks
Service, continued	The service requested.	Numeric	18 = Speech Therapy 19 = Cardiac Therapy 20 = Pulmonary Rehab 21 = MRI 22 = MRA 23 = Angiography 24 = PET Scan 25 = Discogram/Myelogram 26 = 3D Imaging 27 = Durable Medical Equipment excluding wheelchairs 28 = Infusion Therapy 29 = Orthotics 30 = Prosthetics 31 = Sleep Studies 32 = Hearing 33 = External Feeding Supplies 34 = Dental 35 = Pain Management 36 = Non-Contracted Facility 37 = Non-Contracted Provider 38 = Allergy Testing & Treatment 39 = Immunological Testing & Treatment 40 = Genetic Testing 41 = Transplant Services 42 = Pregnancy/Obstetrics 43 = Family Planning 44 = Sterilization 45 = Pregnancy Termination 46 = Chiropractic 47= Wheelchair 48 = Insulin Pump
Request Type	The type of prior authorization request.	Numeric	1 = Standard, No Extension 2 = Standard with Extension 3 = Expedited, No Extension 4 = Expedited with Extension
Date of Decision	The date the prior authorization decision was made.	yyyymmdd	Example: 20131224
Completed Timely	Was the request completed timely? (14 calendar days for standard, 3 business days for expedited; an extension to either a standard or expedited request is 14 calendar days)	Numeric	1 = Yes 2 = No
Expedited Changed to Standard	Was the request initially submitted as an expedited request, and then changed to a standard request?	Numeric	1 = Yes 2 = No
Approved or Action Type	The outcome of the request, either approval or reason for denial.	Numeric	1 = Request approved 2 = Not approved: Not a Covered Benefit/Benefit Exhausted 3 = Not approved: Not Medically Necessary 4 = Not approved: Out of Network Provider 5 = Not approved: Not Enough Information to Make a Decision 6 = Not approved: System/Program issues
Edits:	*The Record Number value must be unique and cannot be duplicated. * The RBHA number in the file name must match the RBHA ID field value. * The Year value must be a valid year and fall within the reporting period listed in the file name. * The Month value must be a valid month between 01 and 12, and fall within the reporting period listed in the file name. * The Date of Birth cannot be greater than the reporting period. * Service codes 8-46 can only be associated with RBHA ID 77 * Service codes 8-46 must only be used when the Behavioral Health Category is 2-SMI		

SMI ELIGIBILITY DETERMINATION

DESCRIPTION

This report includes member-level information regarding determinations of Serious Mental Illness (SMI) eligibility for Behavioral Health Recipients (BHRs). Included are the outcome of the member's evaluation request, and the number of days between the request and evaluation.

ABBREVIATIONS

ADHS/DBHS – Arizona Department of Health Services/Division of Behavioral Health Services
AHCCCS – Arizona Health Care Cost Containment System
BHR - Behavioral Health Recipient
BQ&I – Bureau of Quality and Integration
CIS – ADHS's Client Information System
CMDP – Comprehensive Medical and Dental Program
DDD – Division of Developmental Disabilities
GSA – Geographical Service Area
HIPAA – Health Insurance Portability and Accountability Act (of 1996)
MM/UM – Medical Management/Utilization Management
Non-SMI – Behavioral health recipients determined not to have a serious mental illness
RBHA – Regional Behavioral Health Authority
SMI – Serious Mental Illness

METHODOLOGY

Population
Report all members who have had an SMI eligibility determination during the report period or for whom a requested evaluation was withdrawn during the report period. Please include the following fields in the submission. At the end of the Chapter are file layout details with additional information.

1. RBHA ID
2. Year in which the SMI evaluation determination was made or request withdrawn
3. Month in which the SMI evaluation determination was made or request withdrawn
4. Recipient's CIS ID
5. Recipient's AHCCCS ID, if applicable
6. Recipient's last name
7. Recipient's first name
8. Recipient's date of birth

9. Date the SMI evaluation request was received
10. Time the SMI evaluation request was received if the source of the request is inpatient
11. Source of request (inpatient or other)
12. Date the SMI evaluation was completed
13. Time the SMI evaluation was completed if the source of the request is inpatient
14. Date the SMI determination was made or request withdrawn
15. Result of the determination request
16. The number of days from the date of request to the evaluation
17. Did the member consent to an extension, and if so, for how long?
18. Was the extension used?

Based on the BHR identifying information submitted by the RBHA, this additional information will be retrieved from the DBHS CIS system for use in analysis.

1. Recipient's Behavioral Health Category: determined based on the member's eligibility on the last day of the reporting period.
2. Age band for this recipient: calculated by subtracting the member's Date of Birth from the last day of the reporting period.
3. Recipient's funding source: determined based on the member's eligibility on the last day of the reporting period.
4. Health plan subpopulation, if applicable (for example DDD): determined based on the member's eligibility on the last day of the reporting period.

This report will be generated internally for GSA 6 due to the new SMI determination process.

Data Source
RBHA SMI Eligibility Determination tracking logs and CIS.

Reporting Frequency
Data and analysis are reported quarterly.

Calculation
The information in this report will be used for analysis using these formulae.

Rates of SMI and Non-SMI Determinations
Determined SMI
Numerator: Number of BHRs determined SMI
Denominator: Total number of SMI Determinations
Determined Non-SMI
Numerator: Number of BHRs determined Non-SMI
Denominator: Total number of SMI Determinations

Rates for Denial Reasons
Denied due to non-qualifying diagnosis
Numerator: Number of BHRs determined Non-SMI due to non-qualifying diagnosis
Denominator: Total number of BHRs determined Non-SMI
Denied due to functional impairment
Numerator: Number of BHRs determined Non-SMI due to not meeting the functional criteria
Denominator: Total number of BHRs determined Non-SMI

Time-Related Calculations
Average Number of Days from Request for SMI determination to Evaluation
Numerator: Total number of days to conduct routine evaluations after initial requests
Denominator: Total number of SMI Evaluation Requests
Percent of Recipients Pended for 20-day Extension
Numerator: Number of BHRs Pended for 20-day Extension
Denominator: Number of SMI Evaluations
Percent of Recipients Pended for 90-day Extension
Numerator: Number of BHRs Pended for 90-day Extension
Denominator: Number of SMI Evaluations

Timeline
Data are reported to ADHS/DBHS 30 days post-quarter via a comma delimited text file (File Specifications Attached) submitted to the ADHS/DBHS Sherman Server.

Quarterly analysis is submitted to ADHS/DBHS through the electronic Quarterly MM/UM Indicator Report template due 60 days post quarter.

If the day the file must be reported to ADHS/DBHS falls upon a weekend or holiday, it will be due the following business day.

QUALITY CONTROL

Quarterly files submitted by the RBHAs and processed at ADHS/DBHS electronically are checked programmatically for data errors. Errors are identified as erroneous or missing data in any of the required fields. Files containing errors are returned to the RBHA for correction. Please be aware that ADHS requires each RBHA to submit complete and correct deliverables by the due date. Any resubmissions that result from incorrect procedures or data from the RBHA that arrive after the original due date are considered out of compliance. ADHS reserves the right to take formal action including requirement of a corrective action plan or the assessment of financial sanctions for repeated instances of incorrect submissions.

RBHAs are responsible for verifying the accuracy of the data submitted for this measure and may be required to submit verification to ADHS/DBHS upon request. ADHS/DBHS may identify a random sample of behavioral health recipients and require that the RBHA submit documentation for validation purposes or perform such validation through on-site visits. RBHAs must demonstrate a minimum performance score of 90% data accuracy at time of validation. Scores of less than 90% will require a corrective action plan to improve data accuracy.

CONFIDENTIALITY PLAN

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FILE SPECIFICATIONS

Comma delimited text file with double quotes around each field, such as *"158888","15","2013"***.**

ALL FIELDS ARE REQUIRED TO BE REPORTED, INCLUDING ZERO VALUES

File Name:
SMI_ELIG_FYyyyy_Qn_rr.TXT (yyyy=FISCAL YEAR, n=QUARTER NUMBER OF THE FISCAL YEAR, rr=2DIGIT RBHA ID)
Example: SMI_ELIG_FY2014_Q3_02.TXT for April through June 2014 from Cenpatico GSA 2

Field Name	Definition	Format	Remarks
Record Number	Unique record identifier for each line in the file	6 Characters	Example: 000001
RBHA ID	2 Digit RBHA Contractor ID	2 Characters	"02" = Cenpatico GSA 2 "32" = Cenpatico GSA 3 "22" = Cenpatico GSA 4 "26" = CPSA GSA 5 "15" = NARBHA "37" = MMIC
Year	Calendar year in which the determination was made or the request was withdrawn	Numeric	YYYY Example: 2014
Month	Calendar month in which the determination was made or the request was withdrawn	Numeric	MM Example: 05
Recipient's CIS ID	The unique CIS identifier for the recipient.	10 Characters	Example: 1234567890
Recipient's AHCCCS ID, if applicable	The unique AHCCCS identifier for the recipient.	9 Characters	Example: A12345678
Recipient's last name	The last name of the recipient	20 Characters	Example: Smith
Recipient's first name	The first name of the recipient	20 Characters	Example: Jane
Recipient's date of birth	Member's date of birth	Yyyymmdd	Example: 19850422
Date request received	The date the request for evaluation was received.	Yyyymmdd	Example: 20140510
Time request received	The time the request for evaluation was received if the source of the request is inpatient.	HH:MM (using 24 hour clock) or null	Example: 15:30
Source of request	The source of the evaluation request.	Numeric	1 = Inpatient 2 = Other
Date SMI evaluation complete	The date the SMI evaluation was completed, or it may be null if the request was withdrawn.	Yyyymmdd or null	Example: 20140512
Time SMI evaluation complete	The time the SMI evaluation was completed, or it may be null if the request was withdrawn if the source of the request is inpatient.	HH:MM (using 24 hour clock) or null	Example: 13:30
Date of determination or request withdrawn	The date the SMI determination was made or that the request was withdrawn.	Yyyymmdd	Example: 20140512

Field Name	Definition	Format	Remarks
Determination Outcome	The result of the determination request.	Numeric	1 = No determination made (the request was withdrawn) 2 = Determined SMI 3 = Not SMI due to Diagnosis 4 = Not SMI due to Functional Impairment
Days Request to Evaluation	The number of days from the date request received to the date of evaluation complete.	Numeric	Example: 2
Consent for Extension	Did the member consent to an extension?	Numeric	1 = No 2 = Yes, a 20-day extension 3 = Yes, a 90-day extension 4 = Unable to provide consent
Extension Used	Was the extension used?	Numeric	1 = No 2 = Yes, a 20-day extension was used 3 = Yes, a 90-day extension was used 4 = N/A

Edits:
*The Record Number value must be unique and cannot be duplicated.
* The RBHA number in the file name must match the RBHA ID field value.
* The Year value must be a valid year and fall within the reporting period listed in the file name.
* The Month value must be a valid month between 01 and 12, and fall within the reporting period listed in the file name.
* The Date of Birth cannot be greater than the report period.
* If the source of request is 1-Inpatient then there must be a time value represented in the Time request received and Time SMI evaluation completed sections.

SMI DETERMINATION FILE PROCESSING

DESCRIPTION

Effective January 1, 2014, the Department of Health Services has contracted with an independent third-party vendor to review and complete the determination process for individuals in Maricopa County under evaluation for a qualifying Serious Mental Illness (SMI). Accordingly, the contents of this section of the Client Information System's File Layout and Specification Manual apply only to the Regional Behavioral Health Authority (RBHA) assigned to administer services within Maricopa County, and the contracted third-party SMI vendor. Additionally, information contained within this document is meant to detail the Determination Process from an information technology and data exchange perspective and should not be misconstrued or used in a manner which would infer any form of clinical or programmatic directive.

Effective October 1, 2015 the Department of Health Services has contracted with an independent third-party vendor to review and complete the determination process for individuals in the state of Arizona under evaluation for a qualifying Serious Mental Illness (SMI). Accordingly, the contents of this section of the Client Information System's File Layout and Specification Manual apply to all Regional Behavioral Health Authorities (RBHAs) assigned to administer services, and the contracted third-party SMI vendor. Additionally, information contained within this document is meant to detail the Determination Process from an information technology and data exchange perspective and should not be misconstrued or used in a manner which would infer any form of clinical or programmatic directive.

ABBREVIATIONS

ADHS/DBHS – Arizona Department of Health Services/Division of Behavioral Health Services
AHCCCS – Arizona Health Care Cost Containment System
BHR - Behavioral Health Recipient
BQ&I – Bureau of Quality and Integration
CIS – ADHS's Client Information System
CMDP – Comprehensive Medical and Dental Program
DDD – Division of Developmental Disabilities
GSA – Geographical Service Area
HIPAA – Health Insurance Portability and Accountability Act (of 1996)
MM/UM – Medical Management/Utilization Management
Non-SMI – Behavioral health recipients determined not to have a serious mental illness
RBHA – Regional Behavioral Health Authority
SMI – Serious Mental Illness

MINIMUM PERFORMANCE STANDARD

Minimum: TBD
Goal: TBD

METHODOLOGY

Population
All members having an SMI assessment completed and sent to the independent third-party vendor for SMI determination.

Reporting Frequency
Daily.

Data Source
Fixed width flat files.

Sampling
None

Calculation
None

Timeline
Daily

DAILY STATUS FILES

The Department of Health Services generates a series of status files on a nightly basis and provides these files to the SMI Vendor and the Maricopa County Regional Behavioral Health Authority. This process is critical, as it ensures the RBHA is aware of all determinations either in progress, or completed by the SMI Vendor – which allows the RBHA to effectively communicate with the appropriate SMI clinic and coordinate care for the member.

OPEN NOT YET SUBMITTED DETAIL FILE

File Name: *OPENNOTSUBMITTEDXXYYMMDD.DAT* - ('XX' indicates the Contractor ID)
A fixed-width file identifying all cases that have been initiated by the SMI Vendor, but have not been finalized and submitted. This is a rolling report, i.e. cases will appear on this file continuously until they are submitted to ADHS. This file is provided to both the SMI Vendor and the RBHA via Secure FTP.

Fixed Width Layout:

Field	Spaces
CASE ID	10
CIS ID	10 (can be Null)
AHCCCS ID	9 (can be Null)
Last Name	20
First Name	20
Case Creation Date	8 (YYYYMMDD)
Days Open	4
Evaluator First Name	20
Evaluator Last Name	20
Case Creator	30

SUBMITTED CASE ACTIVITY (VENDOR FILE)

File Name: *SMI-SUBMITTEDXXYYMMDD.DAT* - ('XX' indicates the Contractor ID)
A fixed-width flat file listing all cases submitted by the SMI Vendor during the date in the file name. Cases submitted after 5:00 pm will be included in the next daily file. This is a daily activity report provided to the SMI Vendor via Secure FTP for reconciliation and case tracking purposes.

Field	Spaces
CASE ID	10
CIS ID	10 (can be Null)
AHCCCS ID	9 (can be Null)
Last Name	20
First Name	20
Case Creation Date	8 (YYYYMMDD)
Determination Date	8 (YYYYMMDD)
Determination Result	1
Case Submitter	30

SUBMITTED CASE ACTIVITY (RBHA FILE)

File Name: *SMI-STATUSXXYYMMDD.DAT* - ('XX' indicates the Contractor ID)
A fixed-width flat file listing all cases submitted by the SMI Vendor during the date in the file name. Cases submitted after 5:00 pm will be included in the next daily file. This is a daily activity report provided to the RBHA via Secure FTP for reconciliation and case tracking purposes. This file contains more information that that supplied to the SMI vendor, as the RBHA must take further action once notified of a member's change in SMI Status, including assigning that member to a provider clinic, and providing ADHS with an updated demographic record reflecting the member's assessment information.

Fixed-Width Layout:

Field	Spaces	Definition	Notes
CASE ID	10		
RBHA ID	2		
CIS ID	10		Can be Null
AHCCCS ID	9		Can be Null
Last Name	20		
First Name	20		
Date of Birth	8 (YYYYMMDD)		
Referring Provider	30		
Evaluation Date	8 (YYYYMMDD)		
Determination Result	1	'S' – SMI 'G' – GMH/SA 'W' – Case Withdrawn	
Denial Reason	1	'1' – SMI '2' – Diagnosis Criteria not met '3' – Functional Criteria not met '4' – Neither Diagnosis nor Functional Criteria met	
Determination	8		
AXIS I.1	6	DSM-IV-TR	
AXIS I.2	6	DSM-IV-TR	Can be Null
AXIS I.3	6	DSM-IV-TR	Can be Null
AXIS I.4	6	DSM-IV-TR	Can be Null
AXIS I.5	6	DSM-IV-TR	Can be Null
AXIS II.1	6	DSM-IV-TR	Can be Null
AXIS II.2	6	DSM-IV-TR	Can be Null
AXIS V	3	DSM-IV-TR	
Assessor – First	10		
Assessor – Last	20		
BHMP – First	10		
BHMP – Last Name	20		
EOC Status	1	'1' – Open EOC with Maricopa Contractor '2' – Open EOC with Non-Maricopa Contractor '3' – No Open EOC Null – No EOC History on Record for Member	Can be Null
EOC Start Date	8		Can be Null
Current MHC (Demo)	1	'S' – SMI 'G' or 'M' – Non-SMI Adult 'C' or	Can be Null
Trans_1 ECN	15		Can be Null
Days Open	4	Number of Days Since Submittal to Portal	
In Appeal	1	'Y' – Case in Appeal (see OGA Database) 'N' – No Open Appeal	
Preferred Clinic	35		Can be Null
Reason for Preference	55		Can be Null

APPENDED ID FLAT FILE(RBHA FILE)

File Name: *SMI-IDAPPENDXXYYMMDD.DAT* - ('XX' indicates the Contractor ID)
A fixed-width flat file listing all cases submitted by the SMI Vendor in which the member had no CIS or AHCCCS ID at the time of original submission. The ID has since been generated and appropriately linked to the member in question. This file is provided to both the SMI Vendor and the RBHA via Secure FTP and includes only those cases in which the member ID has been identified within the most recent processing cycle.

Fixed Width Layout:

Field	Spaces
CASE ID	10
CIS ID	10
AHCCCS ID	9 (can be Null)
Last Name	20
First Name	20
Determination Date	8 (YYYYMMDD)

RBHA RESPONSIBILITIES

Once a case has been submitted to the SMI Portal the RBHA is responsible for ensuring that the member's status in CIS is appropriately updated. This includes successfully uploading a demographic record to ADHS reflecting the member's mental health category (please see the Demographic and Outcomes Data Set Users Guide for more details); additionally, if the member is non-Medicaid eligible, the RBHA will must transmit an 834 enrollment add or change record to AHCCCS with the correct mental health category documented (please see Chapter 2 of this manual on Enrollment).

QUALITY CONTROL

Daily files submitted by the independent third-party vendor are processed at ADHS/DBHS electronically are checked programmatically for data errors. Errors are identified as erroneous or missing data in any of the required fields. Files containing errors are returned to the independent third-party vendor & RBHA for correction. Please be aware that ADHS requires each RBHA to submit complete and correct deliverables by the due date. Any resubmissions that result from incorrect procedures or data from the RBHA that arrive after the original due date are considered out of compliance. ADHS reserves the right to take formal action including requirement of a corrective action plan or the assessment of financial sanctions for repeated instances of incorrect submissions.

RBHAs are responsible for verifying the accuracy of the data submitted to the independent third-party vendor for this measure and may be required to submit verification to ADHS/DBHS upon request. ADHS/DBHS may identify a random sample of behavioral health recipients and require that the RBHA submit documentation for validation purposes or perform such validation through on-site visits. RBHAs must demonstrate a minimum performance score of TBD data accuracy at time of validation. Scores of TBD will require a corrective action plan to improve data accuracy.

CONFIDENTIALITY PLAN

Preparation of the information for this report includes accessing "individually identifiable health information" as defined in HIPAA regulation 45 CFR 160.103 or "restricted personal identifying information" as defined in Arizona Strategic Enterprise Technology (ASET)/Statewide Information Security and Privacy Office (SISPO) Policy P900, Information Security Information Management, paragraph 4.1.10. Safeguards and controls, such as restricted access and agreement to protect confidential information, are contractual conditions in place to protect the identifying information that was accessed. All resulting publicly-reported data are aggregated at the GSA/RBHA level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information.

OUTPATIENT COMMITMENT (COURT ORDERED TREATMENT) MONITORING

DESCRIPTION

This report contains member-level information about BHRs receiving Court Ordered Treatment (COT), including demographic and monitoring elements associated with the court order.

ABBREVIATIONS

ADHS/DBHS – Arizona Department of Health Services/Division of Behavioral Health Services
AHCCCS – Arizona Health Care Cost Containment System
BHMP - Behavioral Health Medical Practitioner
BHP – Behavioral Health Professional
BHR – Behavioral Health Recipient
CIS – Client Information System
COT – Court Ordered Treatment
DDD – Division of Developmental Disabilities
HIPAA – Health Insurance Portability Accountability Act (of 1996)
MM/UM – Medical Management/Utilization Management
RBHA – Regional Behavioral Health Authority

MINIMUM PERFORMANCE STANDARD

Not applicable.

METHODOLOGY

Population
All members age 18 and older receiving court ordered treatment (COT) are included in this report. The following fields are to be submitted. At the end of the Chapter are file layout details with additional information.

1. RBHA ID
2. The report year
3. The report month
4. Recipient's CIS ID
5. Recipient's AHCCCS ID, if applicable
6. Recipient's last name
7. Recipient's first name

8. Recipient's date of birth
9. Is this court order new or is it an active court order from the previous month?
10. Start date for this current court order
11. End date for this current court order†
12. COT Reason
13. Recipient's re-hospitalization status and reason if re-hospitalized
14. Last date of re-hospitalization this report month
15. Was the recipient incarcerated during this report month?
16. Last date of incarceration this report month
17. Did the court order expire during this month?
18. Was the recipient seen by the BHMP for a review not less than 30 days prior to the expiration of any treatment portion of the court order?
19. Recipient transferred to the Indian Health Service during the report month?
20. Was the recipient considered non-compliant* during this report month?
21. Was the court order amended due to non-compliance?
22. RBHA contact person and contact information

†As noted in ARS 36-540, an order to treat in most situations may not exceed 365 days. Court ordered treatment ends at 11:59 PM on the last full day of COT. The expiration date is used in determining the date for reviews at least 30 days prior to expiration:
- Given that there are 365 days in a non-Leap Year, one year of treatment with a start date of 9/28/12 would expire at 12:00 a.m. on 9/28/13.
- Given that there are 366 days in a Leap Year, one year of treatment with a start date of 9/28/11 would expire at 12:00 a.m. on 9/27/12.
- For the purposes of COT data validation audits only, the RBHA shall note the county-specific extenuating circumstances when a court order expiration date exceeds 365 days.

*"Non-compliant" is defined as:
- *BHR has missed two or more unexcused office appointments with the case manager, BHP, or BHMP within the last 30 days.*
- *BHR is not available for two or more pre-scheduled residential visits with a team member within a 15 day period*
- *BHR refuses to accept medications for behavioral health disorder as determined by the BHMP for more than 7 days without a reasonable excuse (i.e., medication side-effects, a medical contraindication as determined by a medical provider, unable to refill prescription due to events beyond the BHR's control).*

Based on the BHR identifying information submitted by the RBHA, this additional information will be retrieved from the DBHS CIS system for use in analysis.

1. Recipient's Behavioral Health Category: determined based on the member's eligibility on the last day of the reporting period.

2. Age band for this recipient: calculated by subtracting the member's Date of Birth from the last day of the reporting period.
3. Recipient's funding source: determined based on the member's eligibility on the last day of the reporting period.
4. Health plan subpopulation, if applicable (for example DDD): determined based on the member's eligibility on the last day of the reporting period.

Data Source
RBHA Court Ordered Treatment tracking logs and CIS.

Reporting Frequency
This information is submitted monthly. Analysis is submitted quarterly on the Quarterly MM/UM Indicator Report.

Calculation
N/A

Timeline
Data are collected by the RBHA and reported to ADHS/DBHS on the 10th day of each month or the first business day thereafter via a comma delimited text file with double quotes around each field (file specifications attached), submitted at the ADHS/DBHS Sherman Server.

Quarterly analysis is submitted to ADHS/DBHS via the electronic Quarterly MM/UM Indicator Report template due 60 days post quarter.

If the day the file must be reported to ADHS/DBHS falls upon a weekend or holiday, it will be due the following business day.

QUALITY CONTROL

Monthly files submitted by the RBHAs and processed at ADHS/DBHS electronically are checked programmatically for data errors. Errors are identified as erroneous or missing data in any of the required fields. Files containing errors are returned to the RBHA for correction. Please be aware that ADHS requires each RBHA to submit complete and correct deliverables by the due date. Any resubmissions that result from incorrect procedures or data from the RBHA that arrive after the original due date are considered out of compliance. ADHS reserves the right to take formal action including requirement of a corrective action plan or the assessment of financial sanctions for repeated instances of incorrect submissions.

RBHAs are responsible for verifying the accuracy of the data submitted for this measure and may be required to submit verification to ADHS/DBHS upon request. ADHS/DBHS may identify a random sample of behavioral health recipients and require that the RBHA submit documentation for validation purposes or perform such validation through on-site visits.

CONFIDENTIALITY PLAN

Preparation of the information for this report includes accessing "individually identifiable health information" as defined in HIPAA regulation 45 CFR 160.103 or "restricted personal identifying information" as defined in Arizona Strategic Enterprise Technology (ASET)/Statewide Information Security and Privacy Office (SISPO) Policy P900, Information Security Information Management, paragraph 4.1.10. Safeguards and controls, such as restricted access and agreement to protect confidential information, are contractual conditions in place to protect the identifying information that was accessed. All resulting publicly-reported data are aggregated at the GSA/RBHA level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information.

FILE SPECIFICATIONS

Comma delimited text file with double quotes around each field, such as *"158888","15","2013"*.
ALL FIELDS ARE REQUIRED TO BE REPORTED, INCLUDING ZERO VALUES

File Name:
COT_FYyyyy_Mnn_rr.TXT (yyyy=FISCAL YEAR, nn=MONTH NUMBER within the FISCAL
YEAR, rr=2DIGIT RBHA ID)
Example: COT_FY2015_M03_02.TXT for December 2014 from Cenpatico GSA 2

Field Name	Definition	Format	Remarks
Record Number	Unique record identifier for each line in the file	6 Characters	Example: 000001
RBHA ID	2 Digit RBHA Contractor ID	2 Characters	"02" = Cenpatico GSA 2 "32" = Cenpatico GSA 3 "22" = Cenpatico GSA 4 "26" = CPSA GSA 5 "15" = NARBHA "37" = MMIC
Year	Calendar report year	Numeric	YYYY Example: 2013
Month	Calendar report month	Numeric	MM Example: 12
Recipient's CIS ID	The unique CIS identifier for the recipient.	10 Characters	Example: 1234567890
Recipient's AHCCCS ID, if applicable	The unique AHCCCS identifier for the recipient.	9 Characters	Example: A12345678
Recipient's last name	The last name of the recipient	20 Characters maximum	Example: Smith
Recipient's first name	The first name of the recipient	20 Characters maximum	Example: Jane
Date of Birth	Recipient's date of birth	yyyymmdd	Example: 19950716
New or Existing Court Order	Is this recipient's court order new or is it an active court order from the previous month(s)?	Numeric	1 = New Court Order 2 = Active Court Order from Previous Month
Court Ordered Treatment Start Date	Start date for this current court order	yyyymmdd	Example: 20130706
Court Ordered Treatment End Date	End date for this current court order	yyyymmdd	Example: 20140705

Field Name	Definition	Format	Remarks
COT Reason	The reason for the Court Ordered Treatment	Numeric	1 = Danger to Self (DTS) 2 = Danger to Others (DTO) 3 = Gravely Disabled (GD) 4 = Persistently and Acutely Disabled (PAD) 5 = DTS / DTO 6 = PAD / DTS 7 = PAD / DTO 8 = GD / DTS 9 = GD / DTO 10 = PAD / GD 11 = DTS / DTO / PAD 12 = DTS / DTO / GD 13 = DTO / GD / PAD 14 = DTS / GD / PAD 15 = DTS / DTO / PAD / GD
Re-hospitalization	Identify this recipient's re-hospitalization status via revocation (primary psychiatric reason for the recipient)	Numeric	1 = Not re-hospitalized 2 = Re-hospitalized for DTS 3 = Re-hospitalized for DTO 4 = Re-hospitalized for GD 5 = Re-hospitalized for PAD
Re-hospitalization Date	Last date the recipient was re-hospitalized this report month	yyyymmdd or NULL if there was no re-hospitalization	Example: 20131215
Incarcerated	Was this recipient incarcerated during the reporting month?	Numeric	1 = Yes 2 = No
Incarceration Date	Last date the recipient was incarcerated this report month	yyyymmdd or NULL if there was no incarceration	Example: 20131202
Court Order Expired	Did this recipient's Court Order Expire during the reporting month?	Numeric	1 = Yes 2 = No
COT Review	Was this recipient seen by the BHMP for a review not less than 30 days prior to the expiration of any treatment portion of the court order?	Numeric	1 = Yes 2 = No 3 = Non applicable/court order not expiring during the report month
Transferred to IHS	Was this recipient's COT transferred to Indian Health Services during the report month?	Numeric	1 = Yes 2 = No
Non-compliant	Did this recipient miss 2 or more unexcused appointments with the CM, BHP or BHMP within the previous 30 days/was not available for 2 or more pre-scheduled visits with a team member within a 15-day period, or refuse to accept medication for more than 7 days without a reasonable excuse?	Numeric	1 = Yes 2 = No
Court Order Amended Due to Non-compliance	Was this recipient's court order revoked/amended as a result of treatment non-compliance?	Numeric	1 = Yes 2 = No 3 = Not applicable/BHR has been compliant with treatment
RBHA Contact Person	The RBHA contact person for this BHR's court ordered treatment.	30 Characters maximum	Jane Smith
RBHA Contact Telephone Number	The contact person's telephone number.	20 Characters maximum	Example: 123-456-7890
RBHA Contact Email Address	The contact person's email address.	40 Characters maximum	Jane.Smith@RBHA.org

Edits:	*The Record Number value must be unique and cannot be duplicated.
	* The RBHA number in the file name must match the RBHA ID field value.
	* The Year value must be a valid year and fall within the reporting period listed in the file name.
	* The Month value must be a valid month between 01 and 12, and fall within the reporting period listed in the file name.
	* The Date of Birth cannot be greater than the reporting period.

PHARMACY UTILIZATION AND AUTHORIZATION MONITORING REPORTS

DESCRIPTION

This section describes three separate report templates that will report cost, count, poly-pharmacy oversight and pharmacy prior authorization information regarding prescribed behavioral medications for members. RBHAs providing integrated care will also separately report the cost, count, and authorization information regarding prescribed non-behavioral medications for members 18+ receiving physical health care in addition to the reporting of behavioral medications for all members. Analysis of medication data is also submitted.

Please note that reporting of pharmacy prior authorization information is required for *Chapter C3. Prior Authorization*, in addition to the reporting requirements of this Chapter.

ABBREVIATIONS

ADHS/DBHS – Arizona Department of Health Services/Division of Behavioral Health Services
BHC – Behavioral Health Category
BHR – Behavioral Health Recipient
BQ&I – Bureau of Quality and Integration
CMDP – Comprehensive Medical and Dental Program
DDD – Division of Developmental Disabilities
HIPAA – Health Insurance Portability Accountability Act (of 1996)
MM/UM – Medical Management Utilization Management
RBHA – Regional Behavioral Health Authority
SMI – Seriously Mentally Ill

METHODOLOGY

Population
Title XIX/XXI Child/Adolescents and Adults and Non-Title XIX/XXI adults are included in this report.

Utilization data are reported for number of medications prescribed, costs per BHC and by top ten for Child/Adolescents and Adults. Title XIX/XXI totals are inclusive of DDD and CMDP populations. Additionally, integrated RBHAs will provide non-behavioral health medication information for members 18+ receiving physical health care. Age groups are stratified as follows:

Child/Adolescent
- 0 – 5.999
- 6 – 11.999
- 12 – 17.999
- 18 – 20.999

Adults
- 21 – 54.999
- 55 and over

Authorization data are reported for the top three medications requested by prior authorization, as well as the total number of medications requested by prior authorization for the reporting period. The information is reported by BHC with subpopulations for DDD and CMDP. In addition to reporting behavioral health medications requested, integrated RBHAs will separately report non-behavioral health medications requested for members 18+ receiving physical health care. BHCs are stratified as follows:

Child/Adolescent
- 0 – 17.999

Adults
- 18+ SMI
- 18+ GMH/SA

BHRs receiving DDD or CMDP funding are stratified by age and BHC for both reports.

Poly-Pharmacy Monitoring data is reported for intra-class poly-pharmacy as well as inter-class poly-pharmacy for members eligible and served during the reporting period. The information is reported by BHC with subpopulations for DDD and CMDP. BHCs are stratified as follows:

Child/Adolescent
- 0 - 5.999
- 6 - 11.999
- 12 - 17.999
- 18 - 20.999 (for CMDP enrolled members)

Adults
- 18 - 20.999
- 21 - 66.999
- 67+

BHRs receiving DDD or CMDP funding are stratified by age and BHC for both reports.

Data Source
RBHA Pharmacy data

Reporting Frequency
Data and analysis are submitted quarterly.

Sampling
Not applicable.

Calculation

Average number of behavioral medications prescribed per member
Numerator = Number of behavioral medications.
Denominator = Number of BHRs prescribed behavioral medications.

Average Cost per BHR
Numerator = Sum of the total dollar value of all behavioral medication encounters.
Denominator = Number of BHRs prescribed behavioral medications.

Top 10
Cost = Sum of the total dollar value by drug name of behavioral medication encounters.
Count = Count by drug name of all behavioral medication encounters.

Additionally for RBHAs providing integrated care for members receiving that care:

Average number of non-behavioral medications prescribed per member
Numerator = Number of non-behavioral medications.
Denominator = Number of members prescribed non-behavioral medications.

Average Cost per BHR
Numerator = Sum of the total dollar value of all non-behavioral medication encounters.
Denominator = Number of BHRs prescribed non-behavioral medications.

Top 10
Cost = Sum of the total dollar value by drug name of non-behavioral medication encounters.
Count = Count by drug name of all non-behavioral medication encounters.

Timeline

RBHA Pharmacy Utilization and Authorization Monitoring Reports data are reported to ADHS/DBHS 45 days post-quarter in the attached Templates.

Quarterly analysis is submitted to ADHS/DBHS through the electronic Quarterly MM/UM Indicator Report Template (attached) due 60 days post quarter.

If the day the file must be reported to ADHS/DBHS falls upon a weekend or holiday, it will be due the following business day.

QUALITY CONTROL

RBHAs are responsible for ensuring the accuracy and completeness of submitted information and may be required to submit verification upon ADHS/DBHS' request. RBHAs are required to perform data validation studies quarterly on their providers in accordance with the established schedules. Quarterly Data Validation reports are scored as part of the RBHA's yearly Administrative Review.

CONFIDENTIALITY PLAN

Preparation of the information for this report includes accessing "individually identifiable health information" as defined in HIPAA regulation 45 CFR 160.103 or "restricted personal identifying information" as defined in Arizona Strategic Enterprise Technology (ASET)/Statewide Information Security and Privacy Office (SISPO) Policy P900, Information Security Information Management, paragraph 4.1.10. Safeguards and controls, such as restricted access and agreement to protect confidential information, are contractual conditions in place to protect the identifying information that was accessed. All resulting publicly-reported data are aggregated at the GSA/RBHA level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information.

INTER-RATER RELIABILITY TESTING

DESCRIPTION

This report contains results of Contractor inter-rater reliability (IRR) testing for all qualified service providers making initial and continuous medical necessity as well as serious mental illness (SMI) determinations, and corrective action plan details for any staff not meeting the minimum acceptable score according to each Contractor's policy.

ABBREVIATIONS

ADHS - Arizona Department of Health Services
BHR - Behavioral Health Recipient
CAP - Corrective Action Plan
HIPAA - Health Insurance Portability and Accountability Act
IRR - Inter-rater Reliability
MPS - Minimum Performance Score
RBHA - Regional Behavioral Health Authority

MINIMUM PERFORMANCE SCORE

Minimum: As determined by each Contractor's policy.

The minimum performance score (MPS) must be met each review period, according to the standard set by each Contractor, for all staff making medical necessity as well as serious mental illness (SMI) determinations, including the Medical Director.

METHODOLOGY

Population
Inter-rater reliability testing scores are reported for all staff making medical necessity determinations who were tested within the current review period. Each staff member must be tested within three months of hire or transfer into the position, and then annually thereafter. Include in the report any re-testing that occurs due to Corrective Action Plans (CAPs).

Data Source
RBHA IRR logs

Sampling
Not applicable.

Calculation
Contractor staff must receive an inter-rater reliability test MPS of at least the minimum score as defined in the Contractor's policy in order to make medical necessity determinations. Inter-rater reliability testing is conducted using the following methodology:
- Clinician's scores are calculated based on the percentage of concurrence among reviewers.
- In the instance that a clinician scores less than the minimum percentage, the clinician will be placed on a corrective action plan and will be re-tested per the individual's CAP.
- If the clinician fails to achieve the MPS following a re-test, the clinician shall be held from making medical necessity determinations until the MPS is achieved.

Contractors must include the following information on the IRR Testing Report (See attached Template):
- Clinician's last name
- Clinician's first name
- Clinician's credentials
- Clinician's position/title
- Clinician's date of hire or date transferred to current position
- Clinician's three (3) month post-hire Inter-rater Reliability testing date*
- Clinician's three (3) month post-hire Inter-rater Reliability testing score*
- Clinician's annual testing date*
- Clinician's annual testing score*
- Re-test date if less than the minimum percentage*
- Re-test score if less than the minimum percentage*
- Specific/measurable CAP interventions for all test scores less than the minimum percentage

*If conducted during current review period.

Reporting Frequency
Bi-annually

Time Line

Review Period	RBHA Reports Due
October 1 to March 31	April 30
April 1 to September 30	October 30

Testing results are reported to ADHS 30 days post-review period via the required ADHS IRR Testing Reporting Template (see Attachment), and posted to the ADHS Sherman Server. An email notification of the post shall be sent to BQ&I Deliverables and BHS Contract Compliance.

If the day the file must be reported to ADHS falls upon a weekend or holiday, it will be due the following working day.

QUALITY CONTROL

Files submitted by the Contractors are checked for data errors. Errors are identified as erroneous or missing data in any of the required fields. Files containing errors are returned to the Contractor for correction. Errors are recorded and tracked by ADHS, and are subject to corrective action, up to and including sanctions.

Contractors are responsible for verifying the accuracy of the data submitted for this measure and may be required to submit verification to ADHS upon request. ADHS may identify a random sample of staff IRR testing results and require that the Contractor submit documentation for validation purposes or perform such validation through on-site visits.

CONFIDENTIALITY PLAN

Preparation of the information for this report includes accessing "individually identifiable health information" as defined in HIPAA regulation 45 CFR 160.103 or "restricted personal identifying information" as defined in Arizona Strategic Enterprise Technology (ASET)/Statewide Information Security and Privacy Office (SISPO) Policy P900, Information Security Information Management, paragraph 4.1.10. Safeguards and controls, such as restricted access and agreement to protect confidential information, are contractual conditions in place to protect the identifying information that was accessed. All resulting publicly-reported data are aggregated at the GSA/RBHA level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information.

TRANSPLANT LOG

DESCRIPTION

This report contains brief information about member transplant activity, and is submitted quarterly to DBHS from RBHAs providing integrated care. It is a cumulative report for the contract year. See **Attachment C8. Transplant Log Template**.

ABBREVIATIONS

ADHS – Arizona Department of Health Services
BHR – Behavioral Health Recipient
BQ&I – Bureau of Quality and Integration
DBHS – Division of Behavioral Health Services
GSA – Geographic Service Area
HIPAA – Health Insurance Portability and Accountability Act
RBHA – Regional Behavioral Health Authority

METHODOLOGY

Population
Include in this report all BHRs receiving integrated care who have transplant activity.

Reporting Frequency and Timeline
The report is due 7 days after each quarter. If the day the file must be reported to ADHS/DBHS falls upon a weekend or holiday, it will be due the following business day.

Data Source
RBHA records.

Submission Notes
1. If there is no transplant activity in a quarter, submit the report indicating there is no activity.
2. Highlight all the new activity each month in yellow.
3. The Log is cumulative for a contract year. The Log due October 7 for the contract year October 1 through September 30 must list all members with transplant activity during the contract year.
4. The Log submitted for a new contract year must have all non-active members removed (such as members who expired, terminated eligibility, or are no longer a transplant candidate).
5. Submit the information using the template in Attachment C9. Label your submission "FY*yy*Q*q*_TransplantLog_*nn*" where *yy* is the fiscal year, *q* is the report quarter, and *nn* is the RBHA's contract ID. For example, MMIC's Log holding information for July through September 2014 will be named "FY14Q4_TransplantLog_37".

Contents
The following information is reported.
1. Member Name (Last, First)
2. AHCCCS ID
3. Transplant Type
4. Transplant Center
5. Date of Transplant
6. Date of Death
7. Comments

QUALITY CONTROL

Please be aware that ADHS requires each RBHA to submit complete and correct deliverables by the due date. If the log is incomplete or password protected, it will not be accepted and the RBHA will be in violation of timely submission. Any resubmissions that result from incorrect procedures or data from the RBHA that arrive after the original due date are considered out of compliance. ADHS reserves the right to take formal action including requirement of a corrective action plan or the assessment of financial sanctions for repeated instances of incorrect submissions.

RBHAs are responsible for verifying the accuracy of the data submitted in this report and may be required to submit verification to ADHS/DBHS upon request. ADHS/DBHS may identify a random sample of behavioral health recipients and require that the RBHA submit documentation for validation purposes or perform such validation through on-site visits.

CONFIDENTIALITY PLAN

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HIV SPECIALTY PROVIDER LIST

DESCRIPTION

Any Regional Behavioral Health Authority providing integrated care is required to submit a list of HIV providers to DBHS annually. This information is used to evaluate network adequacy.

ABBREVIATIONS

ADHS – Arizona Department of Health Services
BHR – Behavioral Health Recipient
BQ&I – Bureau of Quality and Integration
DBHS - Division of Behavioral Health Services
GSA – Geographic Service Area
HIPAA – Health Insurance Portability and Accountability Act
RBHA – Regional Behavioral Health Authority

METHODOLOGY

Reporting Frequency and Timeline
The list is required annually, due on November 1. If the day the file must be reported to ADHS/DBHS falls upon a weekend or holiday, it will be due the following business day.

Data Source
RBHA records

Contents
Include this information in the list, using Attachment C10. HIV Specialty Provider List Template.
1. Provider name
2. Address
3. Phone number

Label the file with the list as "*yyyy*_HIVSpecialtyProviderList_*nn*" where *yyyy* is the year in which you are submitting the list and *nn* is the RBHA's contract ID. For example, MMIC's List submitted on November 1, 2014 will be titled "2014_HIVSpecialityProviderList_37".

QUALITY CONTROL

Please be aware that ADHS requires each RBHA to submit complete and correct deliverables by the due date. Any resubmissions that result from incorrect procedures or data from the RBHA

that arrive after the original due date are considered out of compliance. ADHS reserves the right to take formal action including requirement of a corrective action plan or the assessment of financial sanctions for repeated instances of incorrect submissions.

RBHAs are responsible for verifying the accuracy of the data submitted for this information and may be required to submit verification to ADHS/DBHS upon request.

CONFIDENTIALITY PLAN

Preparation of the information for this report includes accessing "individually identifiable health information" as defined in HIPAA regulation 45 CFR 160.103 or "restricted personal identifying information" as defined in Arizona Strategic Enterprise Technology (ASET)/Statewide Information Security and Privacy Office (SISPO) Policy P900, Information Security Information Management paragraph 4.1.10. Safeguards and controls, such as restricted access and agreement to protect confidential information, are contractual conditions in place to protect the identifying information that was accessed. All resulting publicly-reported data are aggregated at the GSA/RBHA level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information.

MEMBERS ON PROVIDER AND PHARMACY RESTRICTION SNAPSHOT REPORT

DESCRIPTION

This report contains a list of all members who are actively restricted to one provider, to one pharmacy, or to both one provider and one pharmacy during the review period, or whose restriction has ended during the review period.

ABBREVIATIONS

BHR - Behavioral Health Recipient
CIS - Client Information Systems
DBHS - Division of Behavioral Health Services
GSA – Geographical Service Area
HIPAA – Health Insurance Portability and Accountability Act (of 1996)
MM/UM - Medical Management/Utilization Management
RBHA - Regional Behavioral Health Authority

METHODOLOGY

Population
Information about any member who has been actively restricted to one provider, to one pharmacy, or to both one provider and one pharmacy during the review period or whose restriction has ended during the review period. The following fields are to be reported in the template for each restricted member.

1. Recipient's last name
2. Recipient's first name
3. DOB
4. AHCCCS ID
5. CIS ID
6. Recipient's assigned provider agency
7. Date that restriction began
8. Date that restriction ended (please mark N/A if member is still currently restricted)
9. Reason for member restriction or reason for end of member's restriction

Data Source
RBHA recipient and provider utilization data.

Sampling
Not applicable.
Reporting Frequency
Twice a year.

Timeline

Review Period	RBHA Reports Due
March 1 to March 14	March 15
September 1 to September 15	September 15

If the day the file must be reported to ADHS/DBHS falls upon a weekend or holiday, it will be due the following business day.

The RBHA is expected to report the information using *Attachment C11. Members on Provider and Pharmacy Restriction Template*. Label the Excel workbook "*yyyymmdd_*PPRestriction_*nn*" where *yyyymmdd* is the due date's year, month, and day, and *nn* is the contractor ID. For example, the workbook submitted by MMIC for September 15, 2014 would be 20140915_PPRestriction_37. Submit the file by way of the Sherman server or through secure email to BQ&I Deliverables and BHS Contract Compliance.

QUALITY CONTROL

RBHAs perform quarterly data validation studies of their contractors to verify that the services received by BHRs are documented in the medical record appropriately, and are reported to the RBHA in an accurate and timely manner. ADHS/DBHS receives summary reports of the data validation studies.

As part of the corporate compliance plan, the DBHS Office of Audit and Evaluation conducts provider audits to determine whether the documentation in the medical record supports the billing submitted in the claim or encounter.

CONFIDENTIALITY PLAN

Preparation of the information for this report includes accessing "individually identifiable health information" as defined in HIPAA regulation 45 CFR 160.103 or "restricted personal identifying information" as defined in Arizona Strategic Enterprise Technology (ASET)/Statewide Information Security and Privacy Office (SISPO) Policy P900, Information Security Information Management, paragraph 4.1.10. Safeguards and controls, such as restricted access and agreement to protect confidential information, are contractual conditions in place to protect the identifying information that was accessed. All resulting publicly-reported data are aggregated at the

GSA/RBHA level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information.

ARIZONA STATE HOSPITAL DISCHARGE REPORT

DESCRIPTION

Integrated RBHAs must supply all insulin dependent diabetic members with the same brand and model blood glucose monitoring device and supplies with which the member demonstrated competency while in the facility. Care must be coordinated with the AzSH prior to discharge to ensure that all supplies are authorized and available to the member upon discharge.

In the event that a member's mental status renders him/her incapable or unwilling to manage his/her medical condition and the member has a skilled medical need, the Integrated RBHA must arrange ongoing medically necessary nursing services in a timely manner.

This report details the Integrated RBHAs discharge planning for diabetic members discharging from the AzSH.

ABBREVIATIONS

ADHS/DBHS – Arizona Department of Health Services/Division of Behavioral Health Services
AHCCCS – Arizona Health Care Cost Containment System
AzSH - Arizona State Hospital
CIS – ADHS's Client Information System
RBHA – Regional Behavioral Health Authority

METHODOLOGY

Population
Include in this report information about any diabetic member who has been discharged from the AzSH during the reporting month.

1. Recipient's last name
2. Recipient's first name
3. Recipient's date of birth
4. Recipient's CIS ID
5. Recipient's AHCCCS ID, if applicable
6. Date of Discharge
7. Blood Glucose Monitoring Supplies Brand and Model while hospitalized
8. Blood Glucose Monitoring Supplies Brand and Model Received at Discharge
9. Date Member Received Discharge Blood Glucose Monitoring Supplies
10. If member is unable/unwilling to participate in blood glucose management, name of skilled nursing provider

11. Date skilled nursing services are scheduled to begin

Data Source
RBHA behavioral inpatient tracking logs and CIS.

Reporting Frequency
Data are reported monthly.

Submission Notes
1. If there is no discharge activity in a month, submit the report indicating there is no activity.
2. Submit the information using the template in Attachment C12. Label your submission "FY*yy*M*m*_AzSHDCReport_*nn*" where *yy* is the fiscal year, *m* is the report month, and *nn* is the RBHA's contract ID. For example, MMIC's Log holding information for July 2015 will be named "FY15M10_AzSHDCReport_37".

Timeline
The report is due to ADHS/DBHS 7 days after the reporting month on the reporting template, submitted at the ADHS/DBHS SharePoint Site with email notification to BQ&I Deliverables and BHS Contract Compliance.

If the day the file must be reported to ADHS/DBHS falls upon a weekend or holiday, it will be due the following business day.

QUALITY CONTROL

Monthly reports submitted by the RBHAs and reviewed at ADHS/DBHS electronically. Errors are identified as erroneous or missing data in any of the required fields. Files containing errors are returned to the RBHA for correction. Please be aware that ADHS requires each RBHA to submit complete and correct deliverables by the due date. Any resubmissions that result from incorrect procedures or data from the RBHA that arrive after the original due date are considered out of compliance. ADHS reserves the right to take formal action including requirement of a corrective action plan or the assessment of financial sanctions for repeated instances of incorrect submissions.

RBHAs are responsible for verifying the accuracy of the data submitted for this measure and may be required to submit verification to ADHS/DBHS upon request. ADHS/DBHS may identify a random sample of behavioral health recipients and require that the RBHA submit documentation for validation purposes or perform such validation through on-site visits. RBHAs must demonstrate a minimum performance score of 90% data accuracy at time of validation. Scores of less than 90% will require a corrective action plan to improve data accuracy.

CONFIDENTIALITY PLAN

Preparation of the information for this report includes accessing "individually identifiable health information" as defined in HIPAA regulation 45 CFR 160.103 or "restricted personal identifying information" as defined in Arizona Strategic Enterprise Technology (ASET)/Statewide Information Security and Privacy Office (SISPO) Policy P900, Information Security Information Management, paragraph 4.1.10. Safeguards and controls, such as restricted access and agreement to protect confidential information, are contractual conditions in place to protect the identifying information that was accessed. All resulting publicly-reported data are aggregated at the GSA/RBHA level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information.

Adult and Children's Emergency Room Wait Times

DESCRIPTION

RBHAs must monitor ED utilization for members presenting with behavioral crises, including wait times for transition to behavioral health placements and discharge with OP services.

ABBREVIATIONS

ADHS/DBHS – Arizona Department of Health Services/Division of Behavioral Health Services
AHCCCS – Arizona Health Care Cost Containment System
BHC - Behavioral Health Category
CIS – ADHS's Client Information System
CMDP - Comprehensive Medical and Dental Program
COT - Court Ordered Treatment
DCS - Department of Child Safety
DDD - Division of Developmental Disabilities
DES - Department of Economic Security
ED - Emergency Department
GMH - General Mental Health
OP - Outpatient
RBHA – Regional Behavioral Health Authority
SMI - Serious Mental Illness

METHODOLOGY

Population
Include in this report information about any member who has experienced an ED wait time in excess of 48 hours prior to transfer to a behavioral health placement or discharge with OP services.

1. Date of 1st Report of Member in ED
2. Time of 1st Report
3. Members Last Name
4. Members First Name
5. Members DOB
6. Members CIS ID
7. Members AHCCCS ID/Plan Number
8. Funding Source
9. BHC
10. Special Population

11. COT Status upon Presentation to ED
12. Insurance Carrier(s)
13. Hospital
14. Date Medically Cleared
15. Time Medically Cleared
16. Date Member Placed in BH Facility or discharged with OP Services
17. Time Member Placed in BH Facility or discharged with OP Services
18. Hours in ED
19. RBHA Coordination Activities to Facilitate Placement or Wrap Around Services
20. RBHA Coordination Activities to Facilitate Placement or Wrap Around Services

Data Source
RBHA behavioral emergency room/crisis tracking logs and CIS.

Reporting Frequency
Data are reported monthly.

Submission Notes
1. If there is no ED hold activity in excess of 48 hours in a month, submit the report indicating there is no activity.
2. Submit the information using the template in Attachment C13. Label your submission "FY*yy*M*m*_EDWaitTime_*nn*" where *yy* is the fiscal year, *m* is the report month, and *nn* is the RBHA's contract ID. For example, MMIC's Log holding information for July 2015 will be named "FY15M10_EDWaitTime_37".

Timeline
The report is due to ADHS/DBHS on the 10th day of each month for the prior month on the reporting template, submitted at the ADHS/DBHS Sherman Server or SharePoint Site with email notification to BQ&I Deliverables and BHS Contract Compliance.

If the day the file must be reported to ADHS/DBHS falls upon a weekend or holiday, it will be due the following business day.

QUALITY CONTROL

Monthly reports submitted by the RBHAs and reviewed at ADHS/DBHS electronically. Errors are identified as erroneous or missing data in any of the required fields. Files containing errors are returned to the RBHA for correction. Please be aware that ADHS requires each RBHA to submit complete and correct deliverables by the due date. Any resubmissions that result from incorrect procedures or data from the RBHA that arrive after the original due date are considered out of compliance. ADHS reserves the right to take formal action including requirement of a corrective action plan or the assessment of financial sanctions for repeated instances of incorrect submissions.

RBHAs are responsible for verifying the accuracy of the data submitted for this measure and may be required to submit verification to ADHS/DBHS upon request. ADHS/DBHS may identify a random sample of behavioral health recipients and require that the RBHA submit documentation for validation purposes or perform such validation through on-site visits. RBHAs must demonstrate a minimum performance score of 90% data accuracy at time of validation. Scores of less than 90% will require a corrective action plan to improve data accuracy.

CONFIDENTIALITY PLAN

Preparation of the information for this report includes accessing "individually identifiable health information" as defined in HIPAA regulation 45 CFR 160.103 or "restricted personal identifying information" as defined in Arizona Strategic Enterprise Technology (ASET)/Statewide Information Security and Privacy Office (SISPO) Policy P900, Information Security Information Management, paragraph 4.1.10. Safeguards and controls, such as restricted access and agreement to protect confidential information, are contractual conditions in place to protect the identifying information that was accessed. All resulting publicly-reported data are aggregated at the GSA/RBHA level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information.

HCV Medication Monitoring

DESCRIPTION

Integrated RBHAs must report prior authorization requests for brand name HCV medications including information pertaining to request decisions as a whole, appeals and administrative hearings for denials as well as treatment outcomes for approvals.

ABBREVIATIONS

ADHS/DBHS – Arizona Department of Health Services/Division of Behavioral Health Services
AHCCCS – Arizona Health Care Cost Containment System
HCV - Hepatitis C Virus
RBHA – Regional Behavioral Health Authority

METHODOLOGY

Population
Include in this report aggregate data related to designated brand name HCV medication requests for integrated members.

1. Prior Authorizations
   a. Received
   b. Approved
   c. Denied
   d. Withdrawn or closed
2. Appeals
   a. Received
   b. Overturned
   c. Denied
   d. Withdrawn or closed
3. Administrative Law Judge Hearings
   a. Scheduled or postponed
   b. Withdrawn or closed
   c. Determination upheld
   d. Determination overturned
4. Outcomes
   a. Treatment Discontinuations
      i. Discontinued at 4 weeks due to detectable viral load
      ii. Lost to follow-up
      iii. Adverse event due to hepatitis C regimen

iv. Other
b. Treatment Completions
    i. Undetectable viral load at 12 weeks post treatment completion
    ii. Detectable viral load at 12 weeks post treatment completion
    iii. Undetectable viral load at 24 weeks post treatment completion

Data Source
RBHA prior authorization and grievance and appeals tracking logs.

Reporting Frequency
Data are reported monthly.

Submission Notes
1. Data is reported for ALL HCV medication activity for the month being reported.
2. As outcome information becomes available, it will also be reported in the month received.
3. Submit the information using the template in Attachment C14. Label your submission "FY*yy*M*m*_HCVMedMonitoring_*nn*" where *yy* is the fiscal year, *m* is the report month, and *nn* is the RBHA's contract ID. For example, MMIC's Log holding information for July 2015 will be named "FY15M10_HCVMedMonitoring_37".

Timeline
The report is due to ADHS/DBHS on the 10th day of each month for the prior month on the reporting template, submitted at the ADHS/DBHS SharePoint Site with email notification to BQ&I Deliverables and BHS Contract Compliance.

If the day the file must be reported to ADHS/DBHS falls upon a weekend or holiday, it will be due the following business day.

QUALITY CONTROL

Monthly reports submitted by the RBHAs and reviewed at ADHS/DBHS electronically. Errors are identified as erroneous or missing data in any of the required fields. Files containing errors are returned to the RBHA for correction. Please be aware that ADHS requires each RBHA to submit complete and correct deliverables by the due date. Any resubmissions that result from incorrect procedures or data from the RBHA that arrive after the original due date are considered out of compliance. ADHS reserves the right to take formal action including requirement of a corrective action plan or the assessment of financial sanctions for repeated instances of incorrect submissions.

RBHAs are responsible for verifying the accuracy of the data submitted for this measure and may be required to submit verification to ADHS/DBHS upon request. ADHS/DBHS may identify a random sample of behavioral health recipients and require that the RBHA submit documentation for validation purposes or perform such validation through on-site visits. RBHAs must demonstrate a minimum performance score of 90% data accuracy at time of validation. Scores of less than 90% will require a corrective action plan to improve data accuracy.

CONFIDENTIALITY PLAN

Preparation of the information for this report includes accessing "individually identifiable health information" as defined in HIPAA regulation 45 CFR 160.103 or "restricted personal identifying information" as defined in Arizona Strategic Enterprise Technology (ASET)/Statewide Information Security and Privacy Office (SISPO) Policy P900, Information Security Information Management, paragraph 4.1.10. Safeguards and controls, such as restricted access and agreement to protect confidential information, are contractual conditions in place to protect the identifying information that was accessed. All resulting publicly-reported data are aggregated at the GSA/RBHA level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information.

Hospital Hold Report

DESCRIPTION

The integrated RBHA for GSA 6 must report total hours its petition screening agencies are on hospital hold for each month.

ABBREVIATIONS

ADHS/DBHS – Arizona Department of Health Services/Division of Behavioral Health Services
GSA - Geographic Service Area
RBHA – Regional Behavioral Health Authority

METHODOLOGY

Population
Include in this report provider level data for each petition screening agency.

1. Agency
2. Date hold began
3. Time hold began
4. Date hold ended
5. Time hold ended
6. Total hold time in minutes
7. Summary of hold activity

Data Source
RBHA provider tracking logs.

Reporting Frequency
Data are reported monthly.

Submission Notes
1. Data is reported for all hold activity for the month being reported.
2. Submit the information using the template in Attachment C15. Label your submission "FY*yy*M*m*_HospitalHold_*nn*" where *yy* is the fiscal year, *m* is the report month, and *nn* is the RBHA's contract ID. For example, MMIC's Log holding information for July 2015 will be named "FY15M10_HospitalHold_37".

Timeline
The report is due to ADHS/DBHS on the 10th day of each month for the prior month on the reporting template, submitted at the ADHS/DBHS SharePoint Site with email notification to BQ&I Deliverables and BHS Contract Compliance.

If the day the file must be reported to ADHS/DBHS falls upon a weekend or holiday, it will be due the following business day.

QUALITY CONTROL

Monthly reports submitted by the RBHAs and reviewed at ADHS/DBHS electronically. Errors are identified as erroneous or missing data in any of the required fields. Files containing errors are returned to the RBHA for correction. Please be aware that ADHS requires each RBHA to submit complete and correct deliverables by the due date. Any resubmissions that result from incorrect procedures or data from the RBHA that arrive after the original due date are considered out of compliance. ADHS reserves the right to take formal action including requirement of a corrective action plan or the assessment of financial sanctions for repeated instances of incorrect submissions.

RBHAs are responsible for verifying the accuracy of the data submitted for this measure and may be required to submit verification to ADHS/DBHS upon request. ADHS/DBHS may identify a random sample of behavioral health recipients and require that the RBHA submit documentation for validation purposes or perform such validation through on-site visits. RBHAs must demonstrate a minimum performance score of 90% data accuracy at time of validation. Scores of less than 90% will require a corrective action plan to improve data accuracy.

CONFIDENTIALITY PLAN

Preparation of the information for this report includes accessing "individually identifiable health information" as defined in HIPAA regulation 45 CFR 160.103 or "restricted personal identifying information" as defined in Arizona Strategic Enterprise Technology (ASET)/Statewide Information Security and Privacy Office (SISPO) Policy P900, Information Security Information Management, paragraph 4.1.10. Safeguards and controls, such as restricted access and agreement to protect confidential information, are contractual conditions in place to protect the identifying information that was accessed. All resulting publicly-reported data are aggregated at the GSA/RBHA level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information.

D. Maternal and Child Health

PREGNANCY TERMINATION

DESCRIPTION

The ADHS/DBHS Medically Necessary Pregnancy Termination Policy 206 details the conditions in which pregnancy termination is covered for BHRs receiving integrated care. There are additional considerations related to administration of Mifepristone (also known as Mifeprex or RU-486) for intrauterine pregnancy termination. See the ADHS/DBHS Medically Necessary Pregnancy Termination Policy 206 for conditions and requirements specific to Mifepristone use.

The Monthly Pregnancy Termination Report (Attachment D1a) documents the number of pregnancy terminations performed each month. If no pregnancy terminations were performed during the report month, the RBHA must submit the Monthly Report indicating there were no terminations as attestation.

For RBHA-authorized pregnancy terminations, the following documentation must be provided with the monthly report for each terminated pregnancy:

1. A copy of the completed Certificate of Necessity for Pregnancy Termination (Attachment D1b), signed by RBHA Medical Director or designee in addition to the clinical information that supports the medical necessity for the procedure.

2. A copy of the completed Verification of Diagnosis by Contractor for Pregnancy Termination Request (Attachment D1c).

3. A copy of the clinical information that verifies the diagnosis/condition that confirms that medical necessity criteria have been met.

4. A copy of documentation confirming that pregnancy termination occurred.

5. A copy of the official incident report in cases of rape or incest.

Pregnancy terminations must be prior-authorized except in cases of medical emergencies; in that case, the provider must submit documentation of medical necessity to the RBHA within two working days from the day on which the pregnancy termination procedure was performed.

ABBREVIATIONS

ADHS – Arizona Department of Health Services
BHR – Behavioral Health Recipient
BQ&I – Bureau of Quality and Integration
DBHS – Division of Behavioral Health Services
HIPAA – Health Insurance Portability and Accountability Act
RBHA – Regional Behavioral Health Authority

METHODOLOGY

Population
BHRs receiving integrated care who have undergone pregnancy termination procedure(s).

Reporting Frequency and Timeline
The Monthly Pregnancy Termination Report is due to ADHS/DBHS on the 15th day after the report month; if there were no pregnancy terminations in the month, the report must be submitted reflecting zero terminations. If the submission due date falls on a weekend or holiday, it is due the following business day.

The Report template is included as **Attachment D1a. Monthly Pregnancy Termination Report**.

For each approved pregnancy termination on the report, include the following supporting documentation.

- **Attachment D1b. Certificate of Necessity for Pregnancy Termination**
- **Attachment D1c. Verification of Diagnosis by Contractor for Pregnancy Termination Request**
- Clinical reports and medical documentation supporting the justification for pregnancy termination
- A copy of the official incident report when rape or incest is involved

Title the file with the report as "*yyyymm_nn_*DBHSPregnancyTermination", where *yyyymm* reflects the calendar year and month being reported, and *nn* is the RBHA contract ID. For each set of supporting documentation, label the files with a prefix of "*yyyymm_nn_s_*" where *yyyymm* and *nn* are defined as above, and *s* is the entry number in which the BHR appears on the Report. For example, supporting documentation for the first person appearing on the June 2014 Report for MMIC will have "201406_37_1_" as the prefix for the associated file names.

Submit the Report and supporting documentation via the ADHS/DBHS FTP server or by secured email to ADHS/DBHS BQ&I Deliverables and BHS Contract Compliance.

Data Source
RBHA pregnancy termination records.

QUALITY CONTROL

Please be aware that ADHS requires each RBHA to submit complete and correct deliverables by the due date. Any resubmissions that result from incorrect procedures or data from the RBHA that arrive after the original due date are considered out of compliance. ADHS reserves the right

to take formal action including requirement of a corrective action plan or the assessment of financial sanctions for repeated instances of incorrect submissions.

RBHAs are responsible for verifying the accuracy of the data submitted for this measure and may be required to submit verification to ADHS/DBHS upon request. ADHS/DBHS may identify a random sample of behavioral health recipients and require that the RBHA submit documentation for validation purposes or perform such validation through on-site visits.

CONFIDENTIALITY PLAN

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STERILIZATION

DESCRIPTION

The ADHS/DBHS Family Planning Services Policy 203 details the criteria to be met for a behavioral health recipient (BHR) to be sterilized. The BHR's consent for sterilization must be documented (see Attachment D2a. Sterilization Consent Form), with a copy of the consent form provided to the person and another copy maintained as a part of the recipient's medical record. RBHAs providing integrated care are required to submit a monthly Sterilization Report to DBHS (see Attachment D2b. Sterilization Reporting Form) with supporting medical necessity documentation regarding members under the age of 21 years who have been sterilized.

ABBREVIATIONS

ADHS – Arizona Department of Health Services
BHR – Behavioral Health Recipient
BQ&I – Bureau of Quality and Integration
DBHS - Division of Behavioral Health Services
GSA – Geographic Service Area
HIPAA – Health Insurance Portability and Accountability Act
RBHA – Regional Behavioral Health Authority

METHODOLOGY

Population
This documentation applies to the sterilization of BHRs receiving integrated care.

Consent Form Timeline
See the ADHS/DBHS Family Planning Services Policy 203 for information about the timeline for Consent for Sterilization (Attachment D2a).

Sterilization Reporting Frequency and Timeline
The Sterilization Report (Attachment D2b).
is submitted monthly and documents the number of sterilizations performed for integrated members under the age of 21 years of age during the month. The report must include clinical information documenting the justification/necessity for sterilization of an integrated member under 21 years of age.

Confirmatory testing, a hysterosalpingogram, will need to be documented in the report if and when a Hysteroscopic tubal sterilization is performed.

The Report is due from the RBHAs to DBHS no later than the 15th day of the following month after either the date of service or the date of confirmatory testing (if required). If the submission due date falls on a weekend or holiday, it is due the following business day.

Title the file with the report as "*yyyymm_nn_*DBHSSterilization", where *yyyymm* reflects the calendar year and month being reported, and *nn* is the RBHA contract ID. For each set of supporting documentation, label the files with a prefix of "*yyyymm_nn_s_*" where *yyyymm* and *nn* are defined as above, and *s* is the entry number in which the BHR appears on the Report. For example, supporting documentation for the first person appearing on the June 2014 Report for MMIC will have "201406_37_1_" as the prefix for the associated file names.

Submit the Sterilization Report and supporting documentation via the ADHS/DBHS FTP server or by secured email to ADHS/DBHS BQ&I Deliverables and BHS Contract Compliance.

Data Source
RBHA records

QUALITY CONTROL

Please be aware that ADHS requires each RBHA to submit complete and correct deliverables by the due date. Any resubmissions that result from incorrect procedures or data from the RBHA that arrive after the original due date are considered out of compliance. ADHS reserves the right to take formal action including requirement of a corrective action plan or the assessment of financial sanctions for repeated instances of incorrect submissions.

RBHAs are responsible for verifying the accuracy of the data submitted for this measure and may be required to submit verification to ADHS/DBHS upon request. ADHS/DBHS may identify a random sample of behavioral health recipients and require that the RBHA submit documentation for validation purposes or perform such validation through on-site visits.

CONFIDENTIALITY PLAN

Preparation of the information for this report includes accessing "individually identifiable health information" as defined in HIPAA regulation 45 CFR 160.103 or "restricted personal identifying information" as defined in Arizona Strategic Enterprise Technology (ASET)/Statewide Information Security and Privacy Office (SISPO) Policy P900, Information Security Information Management, paragraph 4.1.10. Safeguards and controls, such as restricted access and agreement to protect confidential information, are contractual conditions in place to protect the identifying information that was accessed. All resulting publicly-reported data are aggregated at the GSA/RBHA level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information.

REPORT OF NUMBER OF PREGNANT WOMEN WHO ARE HIV/AIDS POSITIVE

DESCRIPTION

A count of pregnant women receiving integrated care who have been identified as being HIV/AIDS positive is submitted to ADHS in this report.

ABBREVIATIONS

ADHS - Arizona Department of Health Services
AIDS – Acquired Immune Deficiency Syndrome
BQ&I – Bureau of Quality and Integration
DBHS – Division of Behavioral Health Services
GSA – Geographical Service Area
HIPAA – Health Insurance Portability and Accountability Act
HIV – Human Immunodeficiency Virus
RBHA – Regional Behavioral Health Authority

METHODOLOGY

Population
New cases of pregnant women receiving integrated care through Title XIX who have been identified as HIV/AIDS positive are reported.

Reporting Frequency and Timeline
This report is submitted to DBHS semiannually. The count of new cases identified from October 1 through March 31 is due April 15; the count for April 1 through September 30 is submitted October 15. If the submission due date falls on a weekend or holiday, it is due the following business day.

Label the report "*yyyymmdd_nn_*NumberPregnantWomen", where *yyyymmdd* reflects the calendar year, month, and day of the report, and *nn* is the RBHA contract ID.

Submit the Report via the ADHS/DBHS FTP server or by secured email to ADHS/DBHS BQ&I Deliverables and BHS Contract Compliance.

Data Source
RBHA records.

Methodology
Submit only new cases identified during the reporting period, not a cumulative count. Please refer to the ADHS/DBHS Maternity Health Services Policy 202 for information about Maternal Care Services.

QUALITY CONTROL

Please be aware that ADHS requires each RBHA to submit complete and correct deliverables by the due date. Any resubmissions that result from incorrect procedures or data from the RBHA that arrive after the original due date are considered out of compliance. ADHS reserves the right to take formal action including requirement of a corrective action plan or the assessment of financial sanctions for repeated instances of incorrect submissions.

RBHAs are responsible for verifying the accuracy of the data submitted for this measure and may be required to submit verification to ADHS/DBHS upon request. ADHS/DBHS may identify a random sample of behavioral health recipients and require that the RBHA submit documentation for validation purposes or perform such validation through on-site visits.

CONFIDENTIALITY PLAN

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This report is a submission of the count of members meeting the criteria; no member-identifying information is included.

DBHS MATERNITY CARE RISK SCREENING GUIDELINES

This information is based on Exhibit 410-2 AHCCCS Maternity Care Risk Screening Guidelines, with effective date 10/2/2013.

HOME BIRTHS AND BIRTHS IN FREESTANDING BIRTH CENTERS

The following are not considered low-risk deliveries by DBHS and are not appropriate for planned homebirths or births in freestanding birthing centers. These include members with:

1. Age less than 16 years regardless of parity, primiparous over 40 years of age or multiparous over 45 years of age

2. Previous uterine surgery or cesarean section

3. Drug addiction, current use of drugs, or therapy for drug abuse

4. <u>Current</u> severe psychiatric illness or severe psychiatric illness evident during assessment of recipient's preparation for birth

5. Significant hematological disorders/coagulopathies/hemolytic disease

6. History of severe postpartum bleeding, of unknown cause, which required transfusion

7. Isoimmunization, including evidence of Rh sensitization/platelet sensitization

8. Congenital heart defects or cardiovascular disease causing functional impairment

9. Chronic or severe hypertension, eclampsia (current or previous pregnancy)

10. History or current diagnosis of deep venous thrombosis or pulmonary embolism

11. Significant pulmonary disease/disorder (including active tuberculosis)

12. Renal, or collagen-vascular disease

13. Significant endocrine disorders including pre-existing diabetes (type I or type II)

14. Hepatic disorders including uncontrolled intrahepatic cholestasis of pregnancy and/or abnormal liver function tests

15. Neurologic disorders or active seizure disorders

16. Positive HIV antibody test

17. Active syphilis, gonorrhea or hepatitis, until treated and recovered

18. Primary genital herpes simplex infection in first trimester or active genital herpes at onset of labor

19. Previous placenta previa, current placental abnormalities, or significant 3rd trimester bleeding

20. Known multiple gestation

21. Abnormal presentation after 36 weeks gestation

22. Gestational age >34 weeks with no prenatal care

23. Pelvis that will not safely allow a baby to pass through during labor

24. Cancer affecting site of delivery or previous breast surgery for malignancy

25. Other significant deviations from normal as assessed by the provider

MATERNITY CARE PROVIDED BY THE LICENSED MIDWIFE

Transfer of care is indicated for, but not limited to, the following maternal and newborn-related conditions:

MATERNAL (Refers to the antepartum, intrapartum, and postpartum care of the mother)

1. Prematurity or labor beginning before 36 weeks gestation

2. Gestation beyond 42 weeks

3. Presence of ruptured membranes without onset of labor within 24 hour

4. Abnormal fetal heart rate below120 beats per minute or above 160 beats per minute

5. Presence of thick meconium, blood-stained amniotic fluid or abnormal fetal heart tone;

6. Umbilical cord prolapse

7. Non-bleeding placenta retained more than 24 hours

8. Consistent non-attendance at prenatal visits, lack of available support in the home for first three postpartum days, unsafe location for delivery

9. Postpartum hemorrhage of greater than 500 cc in the current pregnancy

10. Anaphylaxis or shock

11. Uterine prolapse or inversion

12. Sustained maternal vital sign instability and/or shock

13. Maternal seizure

14. Respiratory distress

15. Development of any of the conditions listed in previous section of
HOME BIRTHS AND BIRTHS IN FREESTANDING BIRTH CENTERS

16. Other significant deviations from normal as assessed by the provider

Licensed midwives are required to use professional judgment in assessing and determining the need for implementation of appropriate transfer of care in cases of adverse situations.
NEWBORN (Refers to the infant's care during the first 24 hours following birth)

1. Birth weight less than 2000 grams

2. Pale blue or gray color after ten minutes

3. Excessive edema

4. Major congenital anomalies

5. Respiratory distress

6. Cardiac abnormalities or irregularities

7. Prolonged glycemic instability

8. Neonatal seizure

9. Other significant deviations from normal as assessed by the provider

Licensed midwives are required to use professional judgment in assessing and determining the need for implementation of appropriate transfer of care in cases of adverse situations.

COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS FOR EPSDT MEMBERS

DESCRIPTION

To obtain prior authorization from the RBHA, the behavioral health recipient's primary care provider or attending physician must submit the Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (Attachment D5).

ABBREVIATIONS

ADHS/DBHS – Arizona Department of Health Services/Division of Behavioral Health Services
BHR – Behavioral Health Recipient
BQ&I – Bureau of Quality and Integration
EPSDT – Early Periodic Screening, Diagnosis, and Treatment
HIPAA – Health Insurance Portability and Accountability Act
RBHA – Regional Behavioral Health Authority

METHODOLOGY

Population
This form is completed for prior authorization of oral nutritional feedings for BHRs younger than 21 years of age receiving integrated care.

Reporting Frequency
As needed.

QUALITY CONTROL

This form is submitted by the primary care provider or attending physician to the RBHA.

CONFIDENTIALITY PLAN

Preparation of the information for this report includes accessing "individually identifiable health information" as defined in HIPAA regulation 45 CFR 160.103 or "restricted personal identifying information" as defined in Arizona Strategic Enterprise Technology (ASET)/Statewide Information Security and Privacy Office (SISPO) Policy P900, Information Security Information Management paragraph 4.1.10. Safeguards and controls, such as restricted access and agreement to protect confidential information, are contractual conditions in place to protect the identifying information that was accessed.

DBHS MONTHLY PREGNANCY AND DELIVERY REPORT

DESCRIPTION

RBHAs providing integrated care submit a monthly report with information about member pregnancies and deliveries.

ABBREVIATIONS

ADHS - Arizona Department of Health Services
AHCCCS – Arizona Health Care Cost Containment System
BQ&I – Bureau of Quality and Integration
DBHS – Division of Behavioral Health Services
EDC – Estimated Date of Confinement
GSA – Geographical Service Area
HIPAA – Health Insurance Portability and Accountability Act
RBHA – Regional Behavioral Health Authority

METHODOLOGY

Population
Include pregnant women receiving integrated care through Title XIX on this Report.

Reporting Frequency and Timeline
The Report is due monthly, 15 days after month end. If the submission due date falls on a weekend or holiday, it is due the following business day.

Label the report "*yyyymm_nn_*DBHSPregnancyDelivery", where *yyyymm* reflects the calendar year and month being reported, and *nn* is the RBHA contract ID.

Submit the Report via the ADHS/DBHS FTP server or by secured email to ADHS/DBHS BQ&I Deliverables and BHS Contract Compliance.

Data Source
RBHA data files.

Contents
Complete the Attachment D6. DBHS Pregnancy and Delivery Report Template with new or updated information regarding the member's pregnancy and/or delivery. Include the following information.

Fields Due 30 days after first prenatal visit (submitted in the next consecutive report:
- Unique ID - Must be a unique number that will not be duplicated in future months. Cannot use Member identifiable information as ID: same member may have another pregnancy during timeframe tracked on report.
- Report Period – Submission Report Month
- Member FName - Text
- Member_LName - Text
- AHCCCS ID - AHCCCS ID
- Member DOB – DD/MM/YYYY
- EDC / Due Date - DD/MM/YYYY
- Date of 1st Scheduled Prenatal visit - DD/MM/YYYY
- Date of Actual First Prenatal Visit - DD/MM/YYYY
- Prenatal within 1st trimester – Y= Yes N=No (176 to 280 days prior to delivery or EDC)
- Member Assigned OB Case Mgmt – Y= Yes N=No

Fields due 30 days after the delivery date (submitted in the next consecutive report):
- Total Number of Prenatal Visits -
- Date of Delivery – DD/MM/YYYY If baby is lost during pregnancy, please fill in with "Deceased" to allow the additional fields to be blank.
- Birth Weight (grams) – Number in grams
- Low Birth weight? - Y= Yes N=No (<2500 grams)
- Very Low Birth weight? - Y= Yes N=No (<1500 grams)
- Delivery date >=39 wks - Y= Yes N=No
- Delivery date >=37 wks - Y= Yes N=No
- Cesarean Section - Y= Yes N=No
- C Section Medically necessary - Y= Yes N=No

Fields due 90 days after delivery date (submitted in the next consecutive report:
- Date of Postpartum Visit - DD/MM/YYYY (if there is a date must answer Screened for Postpartum Depression)
- Postpartum Visit Date is 21-56 days after Delivery - Y= Yes N=No
- Screened for Postpartum Depression - Y= Yes N=No (If yes must answer Referred for Postpartum Depression)
- Referred for Postpartum Depression - Y= Yes N=No (If yes must have Date of Post Partum Depression Counseling Visit)
- Date of Post Partum Depression Counseling Visit

If pregnancy is discovered after an event has occurred, use NA for all dates and mark question fields 'No' for events that <u>did not</u> occur. All fields are required up to the event and must be completed in the next subsequent report.

All fields required for each event must be completed as instructed. However, a cover letter and explanation for fields left blank must be included in the cover letter. Any blanks and all missing fields are considered errors and the report will be rejected.

Please use a deceased or termination code for a pregnancy that ends as a termination, stillbirth or infant expired and fill out all remaining fields with that code.

QUALITY CONTROL

Please be aware that ADHS requires each RBHA to submit complete and correct deliverables by the due date. Any resubmissions that result from incorrect procedures or data from the RBHA that arrive after the original due date are considered out of compliance. ADHS reserves the right to take formal action including requirement of a corrective action plan or the assessment of financial sanctions for repeated instances of incorrect submissions.

RBHAs are responsible for verifying the accuracy of the data submitted for this measure and may be required to submit verification to ADHS/DBHS upon request. ADHS/DBHS may identify a random sample of behavioral health recipients and require that the RBHA submit documentation for validation purposes or perform such validation through on-site visits.

CONFIDENTIALITY PLAN

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PERIODICITY SCHEDULES

DESCRIPTION

ADHS/DBHS follows the periodicity schedules as mandated by AHCCCS. This chapter provides a link to the required schedules, which are exhibits in Chapter 400 of the AHCCCS Medical Policy Manual (AMPM).

ABBREVIATIONS

ADHS – Arizona Department of Health Services
AHCCCS – Arizona Health Care Cost Containment System
DBHS – Division of Behavioral Health Services

METHODOLOGY

The AMPM is available at this link:

http://www.azahcccs.gov/shared/MedicalPolicyManual/MedicalPolicyManual.aspx

Use Exhibit 430-1 for EPSDT, Vision, and Hearing & Speech Periodicity Schedules.

Use Exhibit 431-1 for the Dental Periodicity Schedule.

RECOMMENDED IMMUNIZATION SCHEDULE

DESCRIPTION

ADHS/DBHS follows the recommended immunization schedule as mandated by AHCCCS. This chapter provides a link to the required schedule, which is at the CDC website.

ABBREVIATIONS

ADHS – Arizona Department of Health Services
AHCCCS – Arizona Health Care Cost Containment System
CDC – Centers for Disease Control and Prevention
DBHS – Division of Behavioral Health Services

METHODOLOGY

The required immunization schedule is available at this link:

http://www.cdc.gov/vaccines/schedules/index.html

EPSDT TRACKING FORMS

DESCRIPTION

ADHS/DBHS requires use of the EPSDT Tracking Forms mandated by AHCCCS. This chapter provides a link to the required Forms, which are Appendix B of the AHCCCS Medical Policy Manual (AMPM).

ABBREVIATIONS

ADHS – Arizona Department of Health Services
AHCCCS – Arizona Health Care Cost Containment System
DBHS – Division of Behavioral Health Services

METHODOLOGY

The AMPM is available at this link:

http://www.azahcccs.gov/shared/MedicalPolicyManual/MedicalPolicyManual.aspx

Use Appendix B for the EPSDT Tracking Forms.

LICENSED MIDWIFE SPECIALTY PROVIDER LIST

DESCRIPTION

Any Regional Behavioral Health Authority providing integrated care is required to submit a list of licensed midwife providers to DBHS annually. This information is used to evaluate network utilization and adequacy for the integrated RBHA services.

ABBREVIATIONS

ADHS – Arizona Department of Health Services
BHR – Behavioral Health Recipient
BQ&I – Bureau of Quality and Integration
DBHS - Division of Behavioral Health Services
GSA – Geographic Service Area
HIPAA – Health Insurance Portability and Accountability Act
RBHA – Regional Behavioral Health Authority

METHODOLOGY

Reporting Frequency and Timeline
The list is required annually, due on November 1. If the day the file must be reported to ADHS/DBHS falls upon a weekend or holiday, it will be due the following business day.

Data Source
RBHA records
RBHA Network

Contents
Include this information in the list, using Attachment D10. Licensed Midwife Specialty Provider List Template.

1. Provider name
2. Address
3. Phone number

Label the report with RBHA Contractor's Name, Reporting Period (Date reporting), Name and contact number of Individual Completing the Report.

QUALITY CONTROL

Please be aware that ADHS requires each RBHA to submit complete and correct deliverables by the due date. Any resubmissions that result from incorrect procedures or data from the RBHA that arrive after the original due date are considered out of compliance. ADHS reserves the right to take formal action including requirement of a corrective action plan or the assessment of financial sanctions for repeated instances of incorrect submissions.

RBHAs are responsible for verifying the accuracy of the data submitted for this information and may be required to submit verification to ADHS/DBHS upon request.

CONFIDENTIALITY PLAN

Preparation of the information for this report includes accessing "individually identifiable health information" as defined in HIPAA regulation 45 CFR 160.103 or "restricted personal identifying information" as defined in Arizona Strategic Enterprise Technology (ASET)/Statewide Information Security and Privacy Office (SISPO) Policy P900, Information Security Information Management paragraph 4.1.10. Safeguards and controls, such as restricted access and agreement to protect confidential information, are contractual conditions in place to protect the identifying information that was accessed. All resulting publicly-reported data are aggregated at the GSA/RBHA level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information

PREGNANT WOMEN WHO RECEIVED MATERNITY CARE FROM A LICENSED MIDWIFE REPORT

DESCRIPTION

Maternity care and coordination services provided by licensed midwives for enrolled integrated RBHA members are covered services. In addition, members who choose to receive maternity services from this provider type must meet eligibility and medical criteria specified in DBHS Maternity Care Risk Screening Guidelines provided in the DBHS Specifications manual-Section D.4. Licensed midwives are required to use professional judgment in assessing and determining the need for implementation of appropriate transfer of care in cases of adverse situations in which the health or safety of the mother or newborn are determined to be at risk.

Licensed midwife services may be provided only to members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated. The member must sign and date the ADHS Bureau of Special Licensing INFORMED CONSENT MIDWIFERY SERVICES form indicating that the member has been informed, both orally and in writing, and the member understands the scope of maternity care and delivery services that will be provided by the licensed midwife, as described in R9-16-108 and R9-16-109.

Any Regional Behavioral Health Authority providing integrated care is required to submit a quarterly report for all pregnant members who received maternity care from a licensed midwife provider to DBHS. This information is used to monitor and evaluate utilization and adherence of licensed midwives scope of services per licensing rules.

ABBREVIATIONS

ADHS – Arizona Department of Health Services
BHR – Behavioral Health Recipient
BQ&I – Bureau of Quality and Integration
DBHS - Division of Behavioral Health Services
GSA – Geographic Service Area
HIPAA – Health Insurance Portability and Accountability Act
RBHA – Regional Behavioral Health Authority

METHODOLOGY

Reporting Frequency and Timeline
The report is quarterly and due on the 15th of the month following the end of the quarter. If the day the file must be reported to ADHS/DBHS falls upon a weekend or holiday, it will be due the following business day.

Data Source

RBHA records
RBHA Claims

Contents
Include this information in the report, using Attachment D11. Pregnant Women who Received Maternity Care from a Licensed Midwife Report Template

1. Dates of Service (mm/dd – mm/dd/yyyy)
2. Member Name (Last name, First name)
3. Member AHCCCS ID#
4. Member DOB (*mm/dd/yyyy*)
5. Name and TIN # of Licensed midwife
6. Maternity care services provided by licensed midwife (*Yes or No*)
7. Baby delivered by licensed midwife (*Yes or No*)
8. Consent (*signed and dated by member indicating the member has been informed and understands the scope of services that will be provided by the license midwife*)
9. Supportive documentation certifying the risk status of the member's pregnancy (Refer to Specifications Manual D.4 the ADHS/DBHS Maternity Care Risk Screening Guidelines).
10. If the member's care was transferred for maternity care and/or delivery of newborn, to an integrated physician within the member's integrated RBHA network, the RBHA must provide all supportive documentation why the member's care was transferred to an integrated RBHA physician. (Explain why midwife services ended and include the midwife's Emergency Action plan)

Label the report with RBHA Contractor's Name, Reporting Period (Date reporting), Name and contact number of Individual Completing the Report.

QUALITY CONTROL

Please be aware that ADHS requires each RBHA to submit complete and correct deliverables by the due date. Any resubmissions that result from incorrect procedures or data from the RBHA that arrive after the original due date are considered out of compliance. ADHS reserves the right to take formal action including requirement of a corrective action plan or the assessment of financial sanctions for repeated instances of incorrect submissions.

RBHAs are responsible for verifying the accuracy of the data submitted for this information and may be required to submit verification to ADHS/DBHS upon request.

CONFIDENTIALITY PLAN

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information" as defined in Arizona Strategic Enterprise Technology (ASET)/Statewide Information Security and Privacy Office (SISPO) Policy P900, Information Security Information Management paragraph 4.1.10. Safeguards and controls, such as restricted access and agreement to protect confidential information, are contractual conditions in place to protect the identifying information that was accessed. All resulting publicly-reported data are aggregated at the GSA/RBHA level. This Specifications Manual contains no individually identifiable health information or restricted personal identifying information