mercy care

Mercy Care Complete Care
Mercy Care Developmental Disabilities and Department of Child Safety
Comprehensive Health Plan



Visit: **www.MercyCareAZ.org**

Mercy Care (MC) Provider Manual
Chapter 200 – Mercy Care Complete Care (MCCC), Mercy Care DD (MC DD) and Mercy Care DCS Comprehensive Health Plan (DCS CHP) – Plan Specific Terms

MC Chapter 1 – Mercy Care Complete Care/Mercy Care DD/Mercy Care DCS CHP Overview
- 1.00 – MCCC/MC DD/MC DCS CHP Overview

MC Chapter 2 – Covered and Non-Covered Services
- 2.00 – Coverage Criteria
- 2.01 – Covered Services
- 2.02 – Non-Covered Services

MC Chapter 3 – Behavioral Health
- 3.00 – Behavioral Health Overview
- 3.01 – Behavioral Health Provider Types
- 3.02 – Alternative Living Arrangements
- 3.03 – Emergency Services
- 3.04 – Case Management Caseload Ratio Guidelines
- 3.05 – Behavior Analysis Services
- 3.06 – Behavioral Health Consults
- 3.07 – Behavioral Health Screening
- 3.08 – Behavioral Health Appointment Standards
- 3.09 – Behavioral Health Provider Coordination of Care Responsibilities
- 3.10 – DDD Coordination of Care
- 3.11 – DD Members with an SMI Designation, Provider Requirements
- 3.12 – PCP Coordination of Care
- 3.13 – General and Informed Consent
- 3.14 – Family Involvement
- 3.15 – Members with Diabetes and the Arizona State Hospital
- 3.16 – Pre-Petition Screening, Court Ordered Evaluation and Court Ordered Treatment
- 3.17 – Behavioral Health Treatment Plans and Daily Documentation
- 3.18 – SMI Eligibility Determination and SED Identification
- 3.19 – Reporting of Seclusion and Restraint
- 3.20 – Out of State Treatment for Behavioral Health
- 3.21 – Behavioral Health Assessment and Service Planning Overview

3.22 – Assessments
3.23 – Minimum Elements of the Behavioral Health Assessment
3.24 – MC DCS CHP Psychiatric Acute Care and Behavioral Health Inpatient (BHIF) Services - Outpatient and Inpatient Assessments
3.25 - Children's Behavioral Health Residential Facility (BHRF) and Children's Behavioral Health Inpatient Facility (BHIF) Requirements
3.26 – Provider Submits a Complex Case Request
3.27 – Update to Assessment and Service Plan
3.28 – Transfer Assessment
3.29 – Housing for Individuals Determined to have Serious Mental Illness (SMI for Central GSA
3.30 – Employment & Rehabilitation Services for Individuals Determined to be Eligible for Title XIX/XXI Behavioral Health Service Benefit
3.31 – Collection of Demographic and Clinical Data Timeframes
3.32 – Behavioral Health Fee Schedule

MC Chapter 4 – General Mental Health/Substance Use (GMH/SU)
4.00 – About General Mental Health/Substance Use (GMH/SU)
4.01 – Funding
4.02 – Referral and Intake Process
4.03 – Outreach, Engagement, Reengagement and Closure
4.04 – Serious Mental Illness Determination
4.05 – Special Populations
4.06 – Crisis Intervention Services
4.07 – Training Requirements

MC Chapter 5 – Pharmacy Management
5.00 – Pharmacy Management Overview
5.01 – Updating the Preferred Drug Lists (PDLs)
5.02 – Notification of PDL Updates
5.03 – Prior Authorization Required
5.04 – Over the Counter (OTC) Medications

5.05 – Generic vs. Brand
5.06 – Diabetic Supplies
5.07 – Injectable Drugs
5.08 – Exclusions
5.09 – Family Planning Medications and Supplies
5.10 – Behavioral Health Medications
5.11 – Request for Non-PDL Drugs
5.12 – Discarded Physician-Administered Medications

MC Chapter 6 – Peer and Family Support Services and Partnership Requirements with Peer-Run and Family-Run Organizations
6.00 – Peer and Family Support Services and Peer and Family Run Organizations
6.01 – Incorporating Peer and Family Voice and Choice in Integrated Care

MC Chapter 7 – Dental and Vision Services
7.00 – Dental Services
7.01 – Dental Covered Services
7.02 – Vision Services

MC Chapter 8 – Grievances, Appeals and Claim Disputes - Reserved

MC Chapter 9 – Provider Requirements for Specific Programs and Services
9.00 – Provider Requirements for Specific Programs and Services

MC Chapter 10 – Quality Management
10.00 – Provider Monitoring

MC Chapter 1 – Mercy Care Complete Care/Mercy Care DD/Mercy Care DCS CHP Overview

1.00 – MCCC/MC DD/MC DCS CHP Overview

Mercy Care (MC) is a local Arizona health plan serving people enrolled in Medicaid, Medicare, and other government-sponsored health care programs since 1985. We are committed to walking alongside children, adults, seniors, people with disabilities and others facing serious health challenges to support their health, independence, and quality of life. We are Arizona-led, pairing local accountability and relationships with national expertise, technology, analytics, and support.

MC provides services to the Arizona Medicaid populations including:

- **AHCCCS Complete Care**: Members select the managed care plan to administer their benefits. MCCC is contracted in Maricopa, Pinal, and Gila Counties to provide covered services to enrolled members and integrates both their behavioral health and physical health needs.
- **Children's Rehabilitative Services (CRS):** Arizona's Children's Rehabilitative Services (CRS) program provides medical and behavioral health care, treatment, and related support services to Arizona Health Care Cost Containment System (AHCCCS) members who meet the eligibility criteria and completed the application to be enrolled in the CRS program and have been determined eligible.
- **Division of Developmental Disabilities Long Term Care program:** Members are enrolled through the Arizona Department of Economic Security/Division of Developmental Disabilities (DDD). DDD is a Medicaid program administered by AHCCCS through the Department of Economic Security (DES). MCCC and MC DD are contracted with DDD to provide integrated physical and behavioral health benefits and limited Long-Term Services and Supports (LTSS) including:
    - Custodial nursing facilities
    - Emergency alert services
    - Physical therapy for members aged twenty-one (21) and older
    - Augmentative and Alternative Communication (AAC) services, supplies, and accessories.

  DDD members are in the following counties:
    - Apache
    - Cochise
    - Coconino
    - Gila
    - Graham
    - Greenlee

    - La Paz
    - Maricopa
    - Mojave
    - Navajo
    - Pima
    - Pinal
    - Santa Cruz
    - Yavapai
    - Yuma
- **MC Department of Child Safety Comprehensive Health Plan (MC DCS CHP):** The MC Department of Child Safety Comprehensive Health Plan (MC DCS CHP) is a statewide program administered by the Department of Child Safety (DCS). MC DCS CHP is the health plan for Arizona's children and youth placed in out-of-home care and leverages the relative strengths and expertise of the Department of Child Safety (DCS) and MC Members are enrolled with MC DCS CHP by their custodial agency (the agency that placed them in out-of-home care). DCS is contracted directly with AHCCCS to provide covered services for Medicaid eligible children in foster care and accordingly holds ultimate decision-making authority and accountability for the services and population covered.
  Custodial agencies are:
    - Department of Child Safety (DCS)
    - Arizona Department of Juvenile Corrections (ADJC)
    - Administrative Office of the Court/Juvenile Probation Office (AOC/JPO)
- **General Mental Health and Substance Use (GMH/SU):** General Mental Health and Substance Use (GMH/SU) services are provided to adult members aged 18 and older who have been determined to have an illness in this category. These individuals do not have a serious mental illness. General mental health disorders may include, but are not limited to, anxiety or depression. Substance use services are also provided for members using one or more substances or have a dependency on a substance that causes harm to themselves or others. Additionally, services are also available for members dealing with both general mental health concerns and substance use at the same time known as co-occurring disorders.
- **KidsCare:** AHCCCS offers health insurance through KidsCare for eligible children (under age 19) who are not eligible for other AHCCCS health insurance. For those who qualify, there are monthly premiums. Please review the KidsCare webpage on the AHCCCS website for additional information.

MC collaborates with other governmental/state agencies. The collaboration is guided through collaborative protocols and/or Memos of Understanding (MOUs). These documents can be found in the **Availity** portal.

MC Chapter 2 – Covered and Non-Covered Services

2.00 – Coverage Criteria

Except for emergency care, all covered services must be medically necessary and provided by a primary care provider or other qualified provider. Benefit limits apply.

Each line of business has specific covered and non-covered services. Participating providers are required to administer covered and non-covered services to members in accordance with the terms of their contract and member's benefit package.

Disclosure Statement: The presence of a rate in the fee schedule does not guarantee payment; the service must be covered by AHCCCS to be considered payable.

2.01 - Covered Services

Covered Services for all members include:

- AHCCCS-approved organ and tissue transplants and related prescriptions (limitations apply);
- Behavioral health services;
- Care to stabilize you after an emergency;
- Chiropractic services;
- Dialysis;
- Doctor office visits, including specialist visits;
- Durable medical equipment and supplies; For DD members this will include augmentative communication devices.
- Emergency care;
- Emergency eye exam and lens post cataract surgery;
- Family planning services and supplies;
- Foot and ankle services;
- Health risk assessments and screenings for members aged 21 years of age and over
- Home health services (such as nursing and home health aide);
- Hospice;
- Hospital care;
- Incontinence briefs to avoid or prevent skin breakdown, with limitations;
- Inpatient rehabilitation services, including occupational, speech and physical therapy; Laboratory, radiology, and medical imaging;
- Maternity care (prenatal, labor and delivery, postpartum);
- Medical foods;

- Medically necessary and emergency transportation. Providers may arrange medically necessary non-emergent transportation for MC members by calling Member Services at 602-263-3000 or 800-624-3879;
- Medications on MC's list of covered medicines. Members with Medicare will receive their medications through Medicare Part D;
- Nursing home, when used instead of hospitalization, up to 90 days a year;
- Outpatient Rehabilitation services, including occupational, speech, physical and respiratory therapy (limitations apply) for patients older than age 21;
- Speech therapy;
- Respiratory therapy;
- Routine immunizations;
- Urgent care; and
- Wellness exams and preventive screenings.

Additional covered services for members under age 21:

- Acute services for DDD Members enrolled in CRS.
- Adaptive aids (DD members only); Chiropractic services;
- Conscious sedation;
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services;
- Identification, evaluation, and rehabilitation of hearing loss;
- Incontinence briefs, with limitations;
- Medically necessary personal care. This may include help with bathing, toileting, dressing, walking and other activities that the member is unable to do for medical reasons;
- Medically necessary practitioner visits to member's home (DD members only);
- Outpatient speech, occupational and physical therapy;
- Routine preventive dental services, including oral health screenings, cleanings, fluoride treatments, dental sealant, oral hygiene education, X-rays, fillings, extractions, and other therapeutic and medically necessary procedures;
- Vision exams, prescriptive lenses, frames for eyeglasses as well as the replacement and repair of eyeglasses; and
- Well visits (MC does not limit the number of well visits for members under 21 years of age).

DCS members are required to receive a medical exam that meets EPSDT requirements and a dental assessment within 30 days of entering out-of-home placement and annually after that.

Additional services for Qualified Medicare Beneficiaries (QMB):

- Any services covered by Medicare but not by AHCCCS
- Chiropractic services

- Outpatient occupational therapy

For additional information on EPSDT, Family Planning, and Maternity Care, refer to **MC Provider Manual Chapter 100 – General Terms, Chapter 5 – Early and Periodic Screening, Diagnostic and Treatment (EPSDT), Chapter 7 – Family Planning, and Chapter 8 – Maternity Care Services.**

Limited and Excluded Services

The following services are not covered for adults 21 years and older. (If a member is a Qualified Medicare Beneficiary, we will continue to pay their Medicare deductible and coinsurance for these services.)

BENEFIT/SERVICE	SERVICE DESCRIPTION	SERVICE EXCLUSIONS OR LIMITATIONS
Percussive vests	This vest is placed on a person's chest and shakes to loosen mucous.	AHCCCS will not pay for percussive vests. Supplies, equipment maintenance (care of the vest) and repair of the vest will be paid for.
Bone-anchored hearing aid	A hearing aid that is put on a person's bone near the ear by surgery. This is to carry sound.	AHCCCS will not pay for Bone-Anchored Hearing AID (BAHA). Supplies, equipment maintenance (care if the hearing aid) and repair of any parts will be paid for.
Lower limb microprocessor controlled joint/ prosthetic	A device that replaces a missing part of the body and uses a computer to help with the moving of the joint.	AHCCCS will not pay for a lower limb (leg, knee, or foot) prosthetic that includes a microprocessor (computer chip) that controls the joint.
Routine dental services	Covered routine dental services.	$1,000 limit routine dental services per contract year for DDD ALTCS members.
Emergency dental service	Emergency treatment for pain, infection, swelling and/or injury	Emergency dental services are covered for members under the age of 21. Covered emergency dental services for members 21 years of age and older are limited to problem focused exam, required X-rays, jaw fractures, biopsies, and medically necessary anesthesia.
Transplants	A transplant is when an organ or blood cells are moved from one person to another.	Approval is based on the medical need and if the transplant is on the "covered" list. Only transplants listed by AHCCCS as covered will be paid for.

Occupational and Physical Therapy	Exercises taught or provided by a physical therapist to make you stronger or help improve movement	Outpatient Occupational Therapy services are covered for members under the age of 21, when medically necessary. Outpatient Occupational Therapy services are covered for members, 21 years of age and older as follows: • 15 OT visits per benefit year for restoring a skill or level of function and maintaining that skill or level of function once restored, and • 15 OT visits per benefit year for acquiring a new skill or a new level of function and maintaining that skill or level of function once acquired. Outpatient physical therapy visits are limited to 15 habilitative/15 rehabilitative for a total of 30 visits for the continued care for one diagnosis per contract year (10/1– 9/30). For dual eligible members, the health plan is responsible for paying the Medicare cost of share limited to 15 habilitative/15 rehabilitative for a total of 30 visits for the continued care for one diagnosis per contract year (10/1-09/30). Outpatient PT is not covered as a maintenance program.

Orthotic Devices

Orthotic devices for members under the age of 21 are provided when prescribed by the member's primary care provider, attending physician or practitioner.

Orthotics devices for members who are 21 years of age and older:

MC covers orthotic devices for members who are 21 years of age and older when the orthotic is medically necessary as the preferred treatment based on Medicare Guidelines, along with the following criteria:

- The orthotic costs less than all other treatments and surgical procedures to treat the same condition; and
- The orthotic is ordered by a physician or primary care practitioner (nurse practitioner or physician assistant).

Repairs or Adjustments of Purchased Equipment:
Reasonable repairs or adjustments of purchased equipment are covered for all members over and under the age of 21 to make the equipment serviceable and/or when the repair cost is less than renting or purchasing another unit. The component will be replaced if at the time authorization is sought and documentation is provided to establish that the component is not operating effectively.

DDD Covered Services

MC offers all physical health, behavioral health, Children's Rehabilitative, and limited Long-Term Support Services (PT for members ages 21 and over, Custodial nursing facility, Emergency alert systems, and Augmentative and Alternative Communication Devices).

DDD offers Long-Term Support Services, Support Coordination (Case Management), and Habilitative Therapy Services.

Qualified vendors may be used to provide some services such as Home and Community Based Services (HCBS):

- Attendant Care
- Direct Care Services
- Employment Services
- Habilitation
- Home Health Aide
- Home Health Nurse
- Homemaker Services
- Home Modification Services
- Licensed Health Aide
- Respite (up to 600 hours/year based on assessed needs)
- Residential Services
- Respiratory Therapy
- Support Coordination
- Therapies: Occupational, Physical, and Speech
- Transportation

For MC DD, the following chart illustrates Integrated Care Services that are covered by MC Long Term Care versus Long Term Care Services that are covered by DDD.

Integrated Care Services (Covered by MC)	Long Term Care Services (Covered by DDD)
Care Management	Support Coordination/Case Management
Physical Health	Attendant Care
Behavioral Health including SMI	Habilitation
Skilled and Custodial Nursing Facility	Day Treatment and Training
Life Alert	Employment Services
Dental	Home Health Aide
Augmentative and Alternative Communication Devices	Out of Home Placements
>21 Hab/Rehab Physical Therapy	Home Maker
Rehabilitative Therapies	Habilitative Therapy (Speech, Occupation & Physical)
Home Nursing – short term	Home Nursing – long term
Behavioral Health Respite	Respite
Applied Behavior Analysis	Home Modification
Behavioral Health Residential Facility	Licensed Health Aide
<21 Vision	Respiratory Therapy
DME Installation	

Providers unsure of these responsibilities can obtain guidance by calling MC member services, assigned MC Network Management Representative, DDD customer service, DDD OIFA team or the DDD Support Coordinator.

All behavioral health services are provided through MC contracted providers.

Member Handbook

MC is responsible for the **Member Handbook**, available on our website by line of business. The MC Member Handbook applies to ACC members, including GMHSU, non-DCS CHP, CRS, DDD and MC DCS CHP members. Member handbooks can be found at the following links:

- **MC ACC-RBHA**
- **MC DCS CHP**
- **MC DD**

GMU/SU members will no longer receive the ACC-RBHA handbook, as the benefits for those members may be different. It is also important to note that these members may be enrolled in one of several health plans, so it is imperative providers ensure the corresponding handbook is offered to each member.

The Member Handbook is provided to all members in their welcome letter that contains their member ID card. MC also notifies members annually that they can request a printed copy of the Member Handbook by contacting MC Member Services.

For those members who do not have internet access, please direct them to contact:

- MC Member Services at 602-263-3000/800-624-3879

Per AHCCCS ACOM Chapter 400, Policy 406 – Member Handbook and Provider Directory, Member Handbooks must be distributed to members receiving services as follows:

- Provide the Member Handbook to each member/guardian/designated representative or household within 12 Business Days of receipt of notification of the enrollment date to members receiving physical health care services.

Documentation of receipt of the member handbook should be filed in the member's record, if given to a member by a provider.

- Member Handbooks will be available and accessible on the MC website under each line of business in the Member's section in the Materials and forms section. The Member Handbook is available in English, Spanish, Arabic and Vietnamese.
- Members receiving healthcare services have the right to request and obtain a Member Handbook at least annually. MC notifies members of their right to request and obtain a Member Handbook at least annually by publishing this information using notices or newsletters accessible on MC's website.
- AHCCCS may require MC to revise the Member Handbook and distribute it to all current members if there is a significant program change. AHCCCS determines if a change qualifies as significant.

Member Handbooks are reviewed annually, and updated by MC sooner, if needed.

2.02 – Non-Covered Services

Non-covered services include:

- Services from a provider who is NOT contracted with MC (unless prior approved by the Health Plan)
- Cosmetic services or items;
- Personal care items such as combs, razors, soap etc.;
- Any service that needs prior authorization that was not prior authorized;
- Services or items given free of charge, or for which charges are not usually made;
- Services of special duty nurses, unless medically necessary and prior authorized;
- Physical therapy that is not medically necessary;
- Routine circumcisions;

- Services that are determined to be experimental by the health plan medical director;
- Pregnancy termination and termination counseling, unless medically necessary, pregnancy is the result of rape or incest, or if physical illness related to the pregnancy endangers the health of the mother;
- Health services if you are in prison or in a facility for the treatment of tuberculosis;
- Experimental organ transplants, unless approved by AHCCCS;
- Sex change operations;
- Reversal of voluntary sterilization;
- Medications and supplies without a prescription;
- Treatment to straighten teeth, unless medically necessary and approved by MC;
- Prescriptions not on our list of covered medications, unless approved by MC; and
- Physical exams for qualifying for employment or sports activities;

Other Services that are Not Covered for Adults (age 21 and over)

- Hearing aids, including bone-anchored hearing aids.
- Cochlear implants;
- Microprocessor controlled lower limbs and microprocessor-controlled joints for lower limbs;
- Percussive vests;
- Routine eye examinations for prescriptive lenses or glasses;
- Routine dental services and emergency dental services, unless related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw;
- Chiropractic services (except for Medicare QMB members); and
- Outpatient speech therapy (except for Medicare QMB members)

MC Chapter 3 – Behavioral Health

3.00 - Behavioral Health Overview

Comprehensive mental health and substance use (behavioral health) services are available to MC members. A direct referral for a behavioral health evaluation can be made by any health care professional in coordination with the member's assigned PCP and MC care manager. MC members may also self-refer for a behavioral health evaluation. The level and type of behavioral health services will be provided based upon a member's strengths and needs and will respect a member's culture. Behavioral health services include:

- Behavior management (personal care, family support/home care training, peer support)
- Behavioral health case management services
- Behavioral health nursing services
- Emergency behavioral healthcare
- Emergency and non-emergency transportation
- Evaluation and assessment
- Individual, group and family therapy and counseling
- Inpatient hospital services
- Non-hospital inpatient psychiatric facilities services (Level I residential treatment centers and sub-Acute facilities)
- Lab and radiology services for psychotropic medication regulation and diagnosis
- Opioid Agonist treatment
- Partial care (supervised, therapeutic, and medical day programs)
- Psychosocial rehabilitation (living skills training; health promotion; supported employment services)
- Psychotropic medication
- Psychotropic medication adjustment and monitoring
- Respite care (with limitations)
- Rural substance use transitional agency services
- Screening
- Therapeutic Foster Care (TFC)

3.01 - Behavioral Health Provider Types

Several main provider types typically provide behavioral health services for MC members. These may include, but are not limited to, the following licensed agencies or individuals:

- Outpatient behavioral health clinics
- Psychiatrists
- Psychologists
- Certified psychiatric nurse practitioners
- Licensed clinical social workers

- Licensed professional counselors
- Licensed associate counselors
- Licensed marriage and family therapists
- Licensed substance use counselors
- Residential treatment facilities
- Behavioral health group homes, Levels II and III.
- Partial hospital programs
- Substance use programs

Behavioral Health Residential Facilities (BHRF)

The BHRF level of care requires prior authorization, including all modified services. The initial authorization for BHRF is valid up to 60 days. A request for continued stay authorization will be coordinated telephonically by the rendering provider to the assigned concurrent reviewer prior to the last day of the expiration of the current authorization.

- For modified services in a BHRF the following criteria applies:
    a) Personal Care Service (PCS) TF modifier: follow AMPM 320-V and provide a documented medical diagnosis with clear clinical rationale demonstrating the need for additional support to complete activities of daily living (ADLs).
    b) Enhanced Staffing (up to 24 hours) TG modifier:
        1. Verbally Abusive or Threatening Behavior (Repeated verbal aggression or threats directed at staff or peers);
        2. Physically Aggressive or Impulsive Behavior (Physical aggression or impulsivity toward others that may require safety holds or staff intervention);
        3. Property Destruction (Minor destruction of property necessitating staff involvement);
        4. Elopement Risk (Consistent attempts to leave the facility, often related to psychiatric symptoms (e.g., psychosis, auditory hallucinations, cognitive impairment). Elopement behaviors directly linked to psychiatric illness, posing potential harm to the member. Member must be willing to remain at the facility and engage in treatment.);
        5. Uncooperative with Care (Refusal to participate in care or treatment activities);
        6. Noncompliance with Rules or Policies (Unwillingness to engage in program activities with peers, requiring separate monitoring or support);
        7. Noncompliance with Medical Recommendations (Behaviors such

as medication refusal, cheeking or hoarding medications, bringing illegal substances from the community, or poor management of medical conditions);

8. Self-Harm Risk (Non-Acute): Increased verbalizations or gestures of self-harm that require enhanced staff observation but do not necessitate a higher level of care. May occur during waking or all hours; and/or
9. Neurodevelopmental or Cognitive Support Needs (Due to psychotic disorders, cognitive impairments, language or processing delays, or Autism Spectrum Disorder, the member requires enhanced staffing to support activities of daily living (ADLs) and self-care).

c) 1:1 Staffing CR modifier: This level requires an additional staff member dedicated solely to the member 24/7. The member must have a recent history in a higher level of care (e.g., inpatient, BHRF) or have utilized the TG Tiered service for enhanced staffing, and demonstrate one or more of the following:

1. Chronic Risk of Harm to Self or Others: Ongoing behaviors that pose a risk of harm to self or others, Increased verbalizations or gestures of self-harm, which are unlikely to be safely managed with enhanced staffing at a BHRF and necessitate continuous staff presence within line of sight, though not requiring a higher level of care;
2. While in a higher level of care, the member consistently required close staff monitoring or frequent interventions;
3. History of Severe Physical Aggression or Impulsivity: Recent incidents of physical aggression or impulsivity toward others that were not safely managed, indicating a need for staff to remain within line of sight at all times;
4. Persistent Aggressive or Destructive Behavior: Ongoing verbal or physical aggression, or property destruction, that has not responded to standard interventions even with enhanced staffing. May include behaviors requiring safety holds;
5. Self-Harm Risk Requiring Line-of-Sight Supervision: Increased verbalizations or gestures of self-harm that necessitate continuous staff presence within line of sight, though not requiring a higher level of care; and/or
6. Psychiatric-Driven Behaviors Requiring Intervention: Behaviors directly related to a psychiatric diagnosis that have required increased intervention but do not meet criteria for a higher level

of care.

The above criteria are to be used for authorizing and continued use of modifiers for members who meet behavioral health medical necessity for a BHRF. Concurrent Reviews will occur at a more frequent cadence to ensure member's needs are being met and criteria is met. When Members no longer demonstrate needs for the modifier during concurrent review, modifiers will be removed and rate will revert to standard BHRF rate as long as member meets criteria for continued BHRF stay.

The TG and CR modifiers are not intended for use throughout the entire duration of treatment. The Utilization Management (UM) team will require the BHRF provider to submit specific goals that the enhanced staffing or 1:1 support will address, along with the intended outcomes. This information should demonstrate how the member will progress to a point where the modifier is no longer necessary and treatment can continue at the standard BHRF level of care.

3.02 - Alternative Living Arrangements

MC also includes the following alternative living arrangements:

- **Behavioral Health Level II and III** – these settings provide behavioral health treatment with 24-hour supervision. Services may include on-site medical services and intensive behavioral health treatment programs.
- **Traumatic Brain Injury Treatment Facility** – this setting provides treatment and services for people with traumatic brain injuries.

3.03 - Emergency Services

Prior authorization is not required for emergency services. In an emergency, members should go to the nearest emergency department. Emergency medical services are provided for the treatment of an emergent physical or behavioral health condition. MC is also responsible for post-stabilization services related to that emergency condition. Post-stabilization care services are covered services related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition, or under the circumstances described in 42 CFR §438.114€, to improve or resolve the member's condition.

Behavioral health crisis services are available to MC members and can be accessed through the Arizona Statewide Crisis Phone Line at 844-534-4673. Crisis mobile teams may also be dispatched through the crisis lines.

General Requirements

To meet the needs of individuals in communities throughout Arizona, MC will ensure that the following crisis services are available:

- Telephone Crisis Intervention Services:
  - Telephone crisis intervention and NurseLine services, including a toll-free number, available 24 hours per day, seven days a week: 844-534-4673; toll free 800-631-1314; or TTY/TTD toll free 800-327-9254.
  - Answer calls within three (3) telephone rings (equivalent to 18 seconds), with a call abandonment rate of less than three (3%) percent.
  - Offer interpretation or language translation services to members who do not speak or understand English and for the deaf and hard of hearing.
  - Mobile Crisis Intervention Services
  - Mobile crisis intervention services are available 24 hours per day, seven days a week.
  - Mobile crisis teams will respond within one (1) hour to a psychiatric crisis in the community in Maricopa and Pima Counties and 90 minutes in all other counties.

You may also access our **Crisis/State Only Memberships Services Guide** for additional information regarding crisis services.

3.04 – Case Management Caseload Ratio Guidelines

The caseload ratios for children in High Needs Case Management are for a full High Needs Case Manager FTE (1.0) of high needs children is between 1:25. HNCM who carry a full caseload are not to be assigned additional duties unrelated to individual specific case management for more than 10% of their time.

3.05 – Behavioral Analysis Services

Behavior Analysis Services are an AHCCCS covered benefit for individuals with Autism Spectrum Disorder (ASD) and other diagnoses as justified by medical necessity. Behavior Analysis Services are designed to accomplish one or more of the following:

- Increase functional skills
- Increase adaptive skills (including social skills)
- Teach new behaviors
- Increase independence and/or reduce or eliminate behaviors that interfere with behavioral or physical health

Behavior Analysis Services are prescribed or recommended in specific dosages, frequency, intensity, and duration by a qualified Behavioral Health Professional as the result of an assessment of the member, the intensity of the behavioral targets, and complexity and range of treatment goals. Providers cannot require a set number of therapy hours as a precondition for participating in ABA services. Providers work in collaboration with the parent/caregiver or health care decision maker and clinical team on development of treatment goals taking into consideration other treatment modalities. Providers should gather and analyze complex

information to develop a comprehensive picture of the members' needs to effectively guide treatment and promote coordination of care. The ABA provider should be aware of medical conditions that may affect behavior from the PCP at the onset of services and should inform the PCP/parent/caregiver/healthcare decision maker of any potential underlying medical conditions based on environmental observations.

Please refer to the **MC Claims Processing Manual** available on the MC website for additional information on how to bill for these services. You may also refer to the Behavioral Health Services Billing Matrix under the **Medical Coding Resources** page on the AHCCCS website for more information regarding required coding information, including covered settings., modifiers for behavior analysis trainee billing, or other billing/coding information.

Behavioral Analysis providers are required to submit prior authorization for Adaptive Behavior **Treatments** (CPT Codes 97153-97158). Adaptive Behavior **Assessments** (CPT Codes 97151 and 97152) will not require authorization. Service(s) rendered without authorization may be denied for payment. For Behavioral Analysis services a specific prior authorization form has been developed for initial and re-authorization of services. To access the form and a list of required clinical documentation, visit our website under **Forms** named **Prior Authorization for ABA Services**. Prior authorization, if determined medically necessary, is approved for a maximum of 6 months, re-authorization will be required for continued service delivery.

Provider Qualifications

Behavior Analysis Services shall be directed and overseen by Licensed Behavior Analysts (LBA) and supported, where applicable, by Behavior Analysis Trainees and/or Behavior Technicians. The Licensed Behavior Analyst is responsible for training Behavior Analysis Trainees and Behavior Technicians to implement assessment and intervention protocols with members. The Licensed Behavior Analyst is responsible for all aspects of clinical direction, supervision, and provider-level case management.

Ongoing case supervision is necessary to the success of ABA services. Case supervision is generally proportional to treatment dosage but is separate and distinct from direct treatment hours. Case supervision encompasses direct and indirect activities, such as data analysis and protocol modification. The number of direct treatment hours received by patients is commonly used to determine the number of case supervision hours necessary to adequately oversee ABA services. Although the number of case supervision hours provided must be responsive to individual patient needs, one to two hours of case supervision for every 10 hours (1-2:10) of direct treatment is the general standard of care.

The Licensed Behavior Analyst shall be responsible for ensuring that the extent, kind, and quality of the Behavior Analysis Services the Behavior Analysis Trainee and Behavior Technician perform are consistent with his or her training and experience.

The Licensed Behavior Analyst shall be responsible for Behavior Analysis Trainee and Behavior Technician compliance with this Policy and Arizona state rules and regulations including those provisions set forth in A.R.S. §32-2091.

Behavioral Analysis Assessments

Behavioral Analysis Services shall be based upon assessment(s) that include Standardized and/or Non-Standardized instruments through both direct and indirect methods.

- Standardized instruments and procedures include, but are not limited to, behavior checklists, rating scales, and adaptive skill assessment instruments that comprise a fixed set of items and are administered and scored in a uniform way with all members (e.g., Pervasive Developmental Disabilities Behavior Inventory, Brigance Inventory of Early Development, Vineland Adaptive Behavior Scales).
- Non-standardized instruments and procedures include, but are not limited to, curriculum-referenced assessments, stimulus preference assessment procedures, and other procedures for assessing behaviors and associated environmental events that are specific to the individual member and their behaviors.

Service Administration

Behavior Analysis Services shall be rendered in accordance with an individualized behavior analysis treatment plan which shall:

- Be developed by a Behavior Analyst, based upon and assessment completed of the member and their behaviors as described above.
- Be person-centered and individualized to the member's specific needs.
- Specify the setting(s) in which services will be delivered.
- Identify the modality by which the service will be delivered (whether in person or via telehealth, or in group of individual setting, or combination thereof).
- In-person service delivery is preferred unless the member, parent, or health care decision maker requests telehealth or if telehealth is medically necessary to meet member needs. If the member, parent or health care decision maker requests telehealth, the provider must clearly document the reason along with the service that will be delivered, and that the member is actively able to participate in treatment. If telehealth is not appropriate to meet the member's individual needs, the provider will assist with a smooth transition to another MC ABA provider who has the skill and competency to meet the member's needs.
- Identify the baseline levels of target behaviors.

- Specify long- and short-term objectives that are defined in observable. measurable, and behavioral terms.
- Specify the criteria that will be used to determine treatment progress and achievement of objectives.
- Include assessment and treatment protocols for addressing each of the target behaviors.
- Clearly identify the schedule of services planned and roles and responsibilities for service delivery.
- Include frequent review of data on target behaviors.
- Include adjustments of the treatment plan and/or protocols by the Behavior Analyst as needed based upon the review of data, including recommendations for treatment intensity and duration based upon the member's response to treatment.
- Include training, supervision, and evaluation of procedural fidelity for BCaBA s Behavior Analysis Trainees, and Behavioral Technicians implementing treatment protocols.
- Include training and support to enable parents and/or other caregivers, if applicable, to participate in treatment planning and treatment plan implementation.
- Include care coordination activities involving the member's team in order to assist in the generalization and maintenance of treatment targets. This shall include the Child and Family Team (CFT) or Adult Recovery Team (ART) for members enrolled with MC and may include the Health Care Decision Maker, Primary Care Provider (PCP), school, medical specialists, behavioral health prescribers, Division of Developmental Disabilities (DDD), Department of Child Safety (DCS) and/or other state-funded programs, and others as applicable.
- The treatment plan must allow time for additional modalities the member may need including but not limited to school or educational program through the Arizona Department of Education, medical/specialty appointments, respite, speech, language, and occupational therapy, along with behavioral health services, etc. Providers must ensure the member, parent/caregiver or health care decision maker is in agreement with the recommended treatment plan and have adequate time outside ABA therapy to address non-medical factors that may affect the health and well-being of the member.
- Discharge and transition criteria should be measurable, realistic, and individualized for the member in treatment. The criteria for moving through a transition plan and discharging members should be documented at the initiation of services and refined and modified throughout the treatment process based on ongoing evaluation of skills and needs. Transition and discharge planning should be conducted in collaboration with the patient, family, and other professionals involved in the member's CFT/ART or other meetings as applicable.
- Result in progress reports at minimum, every six months. Progress reports shall include, but are not limited to the following components:
    - Member Identification;

- Background Information (family dynamics, school placement, cultural considerations, prenatal and/or developmental history, medical history, sensory, dietary, and adaptive needs, sleep patterns, and medications);
- Assessment Findings (i.e., social, motor, and self-help skills, maladaptive behaviors, and primary caregiver concerns);
- Outcomes (measurable objectives progress towards goals, clinical recommendations, treatment dosage, family role and family outcomes, and nature of family participation); and
- Care Coordination (transition statement and individualized discharge criteria).

- Be consistent with applicable professional standards, certification board requirements and the ethical code related to the practice of behavior analysis as well as Arizona Medicaid laws and regulations, Arizona state Behavior Analyst licensure laws and regulations (A.R.S. §32-2091).

3.06 - Behavioral Health Consults

Behavioral Health consults are required by AHCCCS on all MC members who receive behavioral health services. Behavioral Health Consults are done between a MC Care Manager and a behavioral health provider-based case manager reviewing the behavioral health provider's progress notes and treatment plan to determine continued medical necessity of the services. Per AHCCCS guidelines, the following items are required for the Behavioral Health Consultations Process:

- Consults must take place quarterly for long-term care members that are receiving behavioral health services and 30 days after a referral for behavioral health services is made.
- Behavioral health consultations must be reviewed face-to-face with, and the outcome signed by a master's Level Behavioral Health Clinician.

MC behavioral health prescriber will send a letter to the member's PCP regarding the member's treatment and psychotropic medication regime.

3.07 - Behavioral Health Screening

- Members should be screened by their PCP for behavioral health needs during routine or preventive visits.
- Behavioral health screening by PCPs is required at each well visit for members under age 21.

3.08 - Behavioral Health Appointment Standards

- Urgent care appointments within 24 hours from identification of need.
- Routine care appointments:

- Initial assessment within seven days of referral.
- The first behavioral health service following the initial assessment within the timeframe indicated by the behavioral health condition, but:
  - For members aged 18 years or older, no later than 23 calendar days after the initial assessment;
  - For members under the age of 18 years old, no later than 21 days after the initial assessment; and
  - All subsequent behavioral health services, as expeditiously as the members' health condition requires but no later than 45 days from identification of need.

Behavioral health appointments standards for DCS CHP members and adopted children:

- Integrated Rapid Response – when a child enters out-of-home placement within the timeframe indicated by the behavioral health condition, but no later than 72 hours after notification by DCS that a child has been or will be removed from their home.
- Screening and Evaluation – within seven calendar days after the initial referral or any subsequent initial request for behavioral health services.
- Initial appointment – within timeframes indicated by clinical need, but no later than 21 calendar days after any screening and evaluation.
- Subsequent Behavioral Health Services – within the timeframes according to the needs of the person, but no later than 21 calendar days from any screening and assessment.

For additional information on behavioral health services for persons in the legal custody of DCS and adopted children in accordance with A.R.S. §8-512-1, refer to ACOM Policy 449.

3.09 - Behavioral Health Provider Coordination of Care Responsibilities

It is critical that a strong communication link be maintained with behavioral health providers including:

- PCPs and other interested parties such as DDD and DCS for Youth in DCS Care (if the guardian and MC have the paperwork)
- Public Fiduciary Department (if documentation is provided identifying the Public Fiduciary Department as the member's guardian)
- Veterans Office (when guardian)
- Children's schools (participation in the ISP with parental or guardian consent)
- The court system (when completing paperwork for all court ordered treatments or evaluations)
- Department of Developmental Disabilities (DDD)
- Other providers not described above

Information can be shared with the other party that is necessary for the member's treatment. This process begins once a member is identified as meeting medical necessity for seeing a behavioral health provider by the behavioral health coordinator. Information can be shared with other parties with written permission from the member or the member's guardian.

Coordination of Care with Qualified Residential Treatment Facilities (QRTP)

For children/youth who are placed in a Department of Child Safety funded Qualified Residential Treatment Facility (QRTP), the Provider must ensure the following is implemented:

- The Provider will engage in care coordination to assist with organized transition planning:
  - A CFT is to occur within a QRTP within the 10th working day following admission.
  - Reducing the behaviors which led to the admission and/or repair and strengthening of previous community-based services should be the primary focus of the Individualized Service Plan and targeted treatment goals, developed in conjunction with the QRTP.
- To promote collaboration with the child and family, and to ensure the timely access of community-based services post-transition, Child and Family Teams should be convened at a minimum once a month, or as clinically indicated for the duration of the treatment.
- QRTP transition planning will be coordinated with the CFT and must begin at the time of admission.
- Transition will contain, as appropriate:
  - Covered services to support the youth and caregiver.
  - Community and natural support elements to support the youth and caregiver.
  - Transition caregiver identified and incorporated into the CFT.
- Transition plans must be reviewed at each CFT meeting and modified according to the child's anticipated needs.
- Transition services must be engaged in advance of transition and have an identified provider and start date.
- Minimum monthly Child and Family Team meetings to occur one time a month for at least 6 months after transition from a QRTP.

Coordination of Care with Schools and Behavioral Health Providers

For children/youth who are referred by schools for behavioral health services, the behavioral health provider must ensure the following:

- The students and families are made aware of their right to select the location in which the students will receive services.
- The acceptance of the **AHCCCS School-based Universal Referral Form** to refer Arizona students for services.
- Providers will track all referrals from schools and their outcomes including situations where referred students are transferred to other agencies due to capacity issues. Providers will share this information with MC upon request.

- There is communication back to the school districts in situations where referred students are transferred to other agencies due to capacity issues.
- To share information to the extent permitted by law and authorized by the member or Health Care Decision Maker (HCDM) as specified in AMPM Policy 940.
- For children who receive special education services, including those in the custody of DCS, include information and recommendations contained in the Individualized Education Program (IEP) during the assessment and service planning process (refer to AMPM 320-O).
- Shall participate with the school in developing the child's IEP and partner in the implementation of behavioral health interventions, ensuring appropriate coordination of care occurs.
- Invite teachers and other school staff to participate in the CFT if agreed to by the child and HCDM.
- Understand the IEP requirements as described in the Individuals with Disabilities Education Act (IDEA) and residential special education placement as defined in ARS 15-761 et seq.
- Support accommodations for students with disabilities who qualify under Section 504 of the Rehabilitation Act of 1973.
- Ensure that transitional planning occurs prior to and after discharge of an enrolled child from any out-of-home placement as it pertains to the school/education setting.
- Provider staff will encourage the use of the **AHCCCS School Feedback Form** to promote feedback acquisition for the purpose of addressing barriers to behavioral health in school service provision.
- The provider shall share information with their MC enrolled members on the resources available on school campuses and any provider programming offered including those programs offered during school breaks.

Transition from Child to Adult Services

Planning for the transition into the adult behavioral health system must begin for any young adult involved in behavioral health care when the young adult reaches the age of 16. Planning must begin immediately for young adults entering behavioral health care who are 16 years or older at the time they enter care.

A transition plan that starts with an assessment of self-care and independent living skills, social skills, work, and education plans, earning potential and psychiatric stability must be incorporated into the young adult's Individual Service Plan (ISP).

Elements Addressed as Part of Young Adult's Transition Plan

Not all young adults transfer to the adult Serious Mental Illness (SMI) or General Mental Health/Substance Use (GMH/SU) system, but for young adults who do, providers must ensure a

smooth transition. To accomplish a smooth transition, providers must develop a clear and explicit process and procedure that will ensure and support the delivery of children's and adult services during the transition period. Providers must ensure that adult system staff attend and are part of the Child and Family Team (CFT) during the four to six months prior to the child turning 18 to provide information and be part of the service planning, development and coordination effort that needs to take place so the individualized needs of that young adult can be met on the day they turn 18 years of age. Providers must also ensure that any coordination efforts that remain after a young adult turns 18 are appropriately handled by the children's provider. This may include attendance at intakes, level of care admissions, and/or support to the young adult in successfully connecting to the adult provider.

Some of the elements to be addressed by the CFT and/or Behavioral Health Provider as part of a transition plan include:

- Identifying the young adult's behavioral health needs into adulthood.
- Identifying personal strengths that will assist the young adult when he/she transitions to the adult system.
- Identifying staff who will coordinate services after the young adult reaches age 18, including any changes in the behavioral health provider, clinical team, guardian, or family involvement.
- Identifying and collaborating with other involved state agencies and stakeholders to jointly establish a behavioral health service plan and prevent duplication of services.
- Establish how the transition will be implemented.
- Planning for where the young adult will reside upon turning 18 and how he/she will support him/herself. If an SMI eligibility determination is made, consider initiating a referral for housing, if needed.
- Identifying the need for referrals to and assistance with applications for Supplemental Security Income (SSI)P, Rehabilitation Services Administration (RSA), SMI eligibility determination, Title XIX and Title XXI eligibility, housing, guardianship, training programs, etc. In addition, the team and/or behavioral health provider should assist in gathering necessary information to expedite these applications/determinations when the time comes to apply, including obtaining medical and school records to substantiate these needs. The team and/or behavioral health provider begin to develop a timeline and task list for when appointments are needed.
- Identifying the need for transportation to appointments and other necessary activities.
- Identifying special needs that the young adult may have and/or whether the young adult will require special assistance services.
- Identifying whether the young adult has appropriate life skills, social skills, and employment or education plans.

- Taking necessary action if the young adult is not eligible for Title XIX or Title XXI benefits and/or Social Security Disability Income (SSDI) and is not determined to meet criteria for SMI services. Identifying supports needed to be in place for a successful transition.
- Following guidelines established in **AHCCCS Clinical Guidance Tool Practice Protocol, Transition to Adulthood**.
- Meeting the provisions of the JK Settlement Agreement and the Arizona Vision and 12 Principles.

The services that have been planned, developed, and provided for the young adult can continue to be provided after the young adult has turned 18 years of age, if continuation of these services is the choice of the young member when he/she reaches the age of majority. Providers shall properly encounter and receive payment for the provision of services of staff involved, including adult system staff.

Providers are responsible for the provision of services for Title XIX/XXI eligible members 18 years of age through 20 years of age (who are still a part of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program) regardless of their designation as SMI or GMH/SU. Services include care management services and all other covered services that the member's treatment team determines to be needed to meet individualized needs.

Child Transition to Adult Services – Year Prior

When a young adult receiving behavioral health services reach the age of 17, behavioral health providers must determine whether the young adult is potentially eligible for services as an adult with a Serious Mental Illness. If so, behavioral health providers must refer the young adult for an SMI eligibility determination if applicable.

When a young adult receiving behavioral health services reaches age 17.5, the CFT and/or the behavioral health provider must:

- Submit the SMI Packet Evaluation if applicable.
- Assist the young adult and/or family or guardian in applying for potential benefits (e.g., SSI, food stamps, etc.).
- Assist the young adult and/or family in determining whether an application for title XIX or Title XXI benefits is to be submitted; if the young adult and/or family is already delible, determine if eligibility will continue for the young adult once he/she turns 18; if young adult's current eligibility will not continue, assist the family in completing the re-application process.
- Assist the young adult and/or family to schedule their first well-visit with a PCP to occur on or after their 18th birthday (an EPSDT visit is synonymous with a well-visit).

- Address any new authorization requirements for sharing protected health information due to the young adult turning 18 to ensure that the clinical team can continue to share information.
- Ensure that the young adult's behavioral health category assignment is changed. Once the young adult's behavioral health category assignment has been changed, ongoing behavioral health service appointments must be provided according to the timeframes for routine appointments.
- Upon turning 18 years of age, if the member is not eligible for services as a member determined to have a Serious Mental Illness or the member has been determined ineligible for Title XIX or Title SSI services, behavioral health providers can continue to provide behavioral health services.

3.10 – DDD Coordination of Care

Providers strive toward effective coordination of services with members receiving services through DDD Arizona Long Term Care (ALTCS) by:

- Working in collaboration with DDD staff and service providers involved with the member. All efforts should be made to include the support coordinator and any additional relevant stakeholders in the development of the service plan that identifies behavioral health needs and risk.
- Child and Family Team (CFT)/ Adult Recovery Team (ART) and DDD meetings should be combined whenever possible that best meets the time and place for the member and/or guardian's needs.
- Incorporating information and recommendations in the Individual or Family Support Plan (ISP~~)~~ Behavior Treatment Plan developed by DDD staff, when appropriate, while developing the member's Person-Centered Service Plan (PCSP);
- Clinic shall provide a copy of the approved behavioral health service plan, medication sheet, and at risk crisis plan (ARCP) to the support coordinator.
- Clinic and DDD staff will provide notification of significant changes to the member's circumstances.

In order to properly coordinate care for MC DD members there may be times when Division staff contacts a provider requesting information to coordinate care. This may include coordination of service or management of health care and related services by one or more providers, including the coordination or management of health care by a provider with a third party, consultation between providers relating to a patient or the referral of a patient for care from one provider to another.

The Health Insurance Portability and Accountability Act (HIPAA) governs how Covered Entities (CEs) protect and secure Protected Health Information (PHI). HIPAA also provides regulations that describe the circumstances in which CEs are permitted to use and disclose PHI for certain

activities without first obtaining an individual's authorization. These circumstances include treatment and health care operations related to members services and should be the minimum amount necessary to achieve the disclosure purpose. Please note, this memorandum does not include disclosure of Part 2, HIV, or communicable disease related data and information as these have added privacy protections under federal or state law.

DDD Eligibility Criteria

If a clinical team, provider, guardian, or family member determines a member may be eligible for DES/DDD services based upon the member having one of the following diagnoses:

- Cognitive/Intellectual Disability (I/DD)
- Autism Spectrum Disorder
- Cerebral Palsy
- Epilepsy
- Down Syndrome

It is strongly preferred that a referral to DDD be made to ensure the member has access to appropriate supports and services. The referring party should attempt to obtain and gather the following information prior to calling the DDD's Customer Service Line office at 844-770-9500. The application may be submitted by email at **DDDapply@azdes.gov**, dropped off in person at any DDD office, or mailed in.

Age 3 to 6

To qualify for Division of Developmental Disabilities services, a person aged 3 years to 6 years must:

- Voluntarily apply,
- Be an Arizona resident, and
- Either have or be at-risk for developing one of these qualifying developmental disabilities:
    - Autism Spectrum Disorder
    - Cerebral Palsy
    - Intellectual (Cognitive) Disability
    - Epilepsy
    - Down Syndrome

A developmental assessment, provided by a medical professional or school evaluator trained in childhood development, can be used to identify a developmental delay that could lead to a developmental disability.

Professionals trained in early childhood development include:

- Licensed Physician, such as a Family Physician or Neonatologist
- School Psychologist

- Early Childhood Education Specialist
- Nurse Practitioner
- Physician's Assistant
- Licensed Psychologist
- Pediatrician including Developmental Pediatrician
- Neurologist
- Clinical Geneticist

Other Accepted Disabilities

- Spina Bifida with Arnold Chiari Malformation
- Periventricular Leukomalacia
- Chromosomal Abnormalities with high risk for Intellectual Disability
- Post-Natal Traumatic Brain Injury (such as Shaken Baby Syndrome or near drowning)
- Hydrocephaly
- Microcephaly
- Disorders due to drugs or alcohol (Such as Fetal Alcohol Syndrome)
- Birth weight under 1000 grams with neurological impairment.

Age 6 – Adult

To qualify for Division of Developmental Disabilities services, a person aged 6 years to adulthood must:

- Voluntarily apply,
- Be an Arizona resident, and
- Be diagnosed with a qualifying developmental disability which developed before the age of 18 and is likely to continue indefinitely, and
- Also have significant limitations in daily life skills related to the disability (see the following Daily Life Skills and Substantial Functional Limitations section).

Qualifying Diagnosis Requirements

Cerebral Palsy

A licensed physician with expertise in diagnosing neurological disorders, such as a neurologist, or specialist in rehabilitation medicine, shall diagnose cerebral palsy. The physician shall submit a report to the Department documenting the diagnosis of cerebral palsy and include available medical records supporting the diagnosis.

Epilepsy

A physician specializing in neurology shall diagnose epilepsy.

- The physician specializing in neurology shall submit a report to the Department documenting the active diagnosis of epilepsy and include the following:
    - Electroencephalogram (EEG) report;

    - A description of the nature and frequency of the seizures, including current anti-seizure medication; and
    - Confirmation of the ongoing nature of the disorder.
- If the records of a neurological evaluation cannot be obtained or a diagnosis is not made by a physician specializing in neurology, the Division Medical Director shall review the available medical records to confirm a diagnosis of epilepsy.

Autism Spectrum Disorder

A psychiatrist, neurologist, licensed psychologist, or developmental pediatrician who has expertise in diagnosing autism shall make an autism diagnosis. A pediatrician who has completed specialized training approved by the Department in the diagnosis of autism may also make an autism diagnosis. The psychiatrist, neurologist, licensed psychologist, developmental pediatrician, or pediatrician with specialized training shall submit a diagnostic report regarding the individual documenting the presence of diagnostic criteria for autism, including the presence of the required number of symptoms of autism based on current guidelines established by the American Psychiatric Association.

Intellectual (Cognitive) Disabilities

A licensed psychologist trained to perform psychological evaluations utilizing standardized, culturally appropriate, and psychometrically sound measures shall diagnose cognitive/intellectual disability by considering the following:

- Other mental disorders identified in current guidelines established by the American Psychiatric Association, including Schizophrenia, Bipolar Disorder, Attention Deficit Hyperactivity Disorder, and Substance Abuse;
- Significant disorders related to language or language differences;
- Physical factors, including sensory impairments, motor impairments, acute illness, chronic illness, and chronic pain;
- Testing performed during an acute inpatient hospitalization;
- Educational or environmental deprivation; and
- Psychosocial factors.

Down Syndrome

- A Licensed Primary Care Physician, Developmental Pediatrician, Neonatologist, or Clinical Geneticist shall diagnose Down Syndrome.
- The physician shall submit the diagnostic prenatal or postnatal genetic testing results and a report to the Department documenting how the practitioner came to the diagnosis based on the diagnostic prenatal or postnatal genetic testing.

<u>Daily Life Skills and Substantial Functional Limitations</u>

In addition to being diagnosed with at least one developmental disability, the person must show significant limitations in daily life skills due to their qualifying diagnosis in three (3) of the following. (Note: The age of the person is taken into consideration when identifying significant limitations in daily life skills.)

Receptive and Expressive Language

- Cannot communicate with others.
- Cannot communicate effectively without the assistance of others or a mechanical device.

Learning

The person cannot participate in age-appropriate learning without assistance.

Self-Direction

- The person needs assistance with making decisions that affect their well-being.
- Does not have safety awareness skills.
- Needs help with personal finances.

Self-Care

- Needs significant help with bathing, toileting, tooth brushing, dressing, and grooming (taking care of themselves).
- Or the time to complete self-care activities takes so long it affects attendance or success in school, employment, or other activities of daily living.

Mobility

- Fine and motor skills are impaired.
- The person needs assistance from a mechanical device like a wheelchair or a walker to move from place to place.
- The time it takes for the person to move takes so long that it affects keeping a job or completing activities of daily living.

Capacity for Independent Living

- The person needs daily supervision to help with health and safety.
- This includes completing household chores, preparing simple meals, using microwaves or other household equipment, using public transportation and shopping for food and clothing.

Economic Self-Sufficiency

- Can’t perform tasks to keep a job.
- The person is limited in what they can earn.

- Considering all expenses and the disability, the person earns below federal poverty level.

Eligibility Re-determination

"Re-determination" is the process when the Division of Developmental Disabilities (DDD) looks at the information we have about you or your child and decides if you or your child continues to be eligible or need DDD services. During the **re-determination process**, you or your child will continue to receive supports and services. Re-determination will happen when your child reaches age six and eighteen.

Members determined eligible for DDD Arizona Long Term Care Services (ALTCS) will receive integrated behavioral health and physical. For members deemed ineligible for ALTCS, the member will continue to be enrolled under the AHCCCS Complete Care (ACC) plan.

For members deemed ineligible for ALTCS, the member will enroll under the ACC-RBHA.

3.11 - DD Members with an SMI Designation, Provider Requirements

Clinic Transfers - Transfer Guidelines

Clinic guardian requests a transfer to a new site and/or agency for members with the dual designation of SMI and DD. In accordance with the 9 Guiding Principles of member empowerment and self-determination, personal preference is given the utmost consideration, and the member or guardian must agree with the transfer.

- In cases where the member or guardian/designated representative would like to transfer.
- Members are to be transferred to the new ACC-RBHA Health Home at the same level of care (ACT, Intensive, Supportive, Connective, Navigator), upon agreement from the member, unless the member will be moving/stepping down from an ACT team. The receiving ACC-RBHA Health Home is not able to refuse/reject the intra-RBHA transfer to the same level of care.
- If the request for transfer is due to lack of services or dissatisfaction, clinical leadership at the transferring agency will meet with the member or guardian to discuss and attempt to resolve.
- Outpatient Transfers between and to ACT teams (ex: supportive to ACT, ACT to ACT and ACT to FACT) are expected to be completed in less than twenty-one (21) days from the time the receiving ACT team receives the transfer request. The ACT team should screen members within two weeks of them receiving the outpatient referral to ensure they meet ACT criteria. If the member meets ACT Criteria and the transfer is not complete in the 21-day timeline, **smimemberservicesrequest@mercycareaz.org** should be contacted. For Inpatient Level 1 referrals, Newly Determined SMI ACT referrals, referral waitlist, and transfer protocols, please refer to the **ACT Operational Manual**.

- Transfers between ACT teams are expected to be completed in less than twenty-one (21) days from the time the receiving clinic receives the transfer request. If the transfer is not complete in the 21-day timeline, **smimemberservicesrequest@mercycareaz.org** should be contacted.

Transfer Process

The clinical director/site administrator of the referring clinic will ensure that documentation is prepared and delivered to the receiving clinic within 7 days after the Release of Information is signed. All transfer activities will be documented in the medical record.

The member, designated representative, or guardian and OHR (if applicable) will be notified of the transfer referral by the referring clinic with the intention that the receiving clinic assign the member to a clinical team within the required timeframes. This will be documented in the medical record.

The referring clinic shall prepare a transfer packet to include the following medical record information:

- Transfer of care cover sheet
- Part E (Annual Assessment)
- Part D
- AUD
- ARCP
- Medical sheet
- Last three doctor notes
- Last three progress notes
- Face sheet
- COT/Special Assistance or guardianship paperwork
- A progress note indicating a conversation with the member or member's guardian/designated representative with the transfer request.
- Last psychiatric evaluation
- Labs from the past year
- EKG from the past year, if applicable
- Medication lists for the past year and current medication list to include medical and physical health medications.
- Progress notes for the past year (last 3 progress notes):
    - The clinical director/single point of contact from the transferring agency will place a personal telephone call to the clinical director/single point of contact receiving the case and will discuss any special needs or circumstances involving

the individual such as court ordered treatment, court ordered evaluations and/or special treatment needs.

- The referring clinic shall ensure the member has adequate transportation and/or other special circumstances needed i.e., interpreter services to the initial appointment at the receiving clinic.
- The referring clinic must attend the initial appointment to ensure proper coordination.
- The member's medical record must be delivered by the referring clinic by the time of the initial appointment at the receiving clinic.
- The referring and receiving clinics shall log all medical record tracking information and make the necessary changes to the clinical team affiliations in the electronic medical record to ensure the member is appropriately designated to the desired agency/clinic.
- In all cases in which a member is being treated with medication, the transferring agency/clinic shall ensure a 30-day supply (from the date of transfer) is given to the member prior to the change in clinics. Should this be a concern based on clinical indicators, the clinical team will ensure that the member can obtain medications while waiting for the transfer. The receiving agency/clinic is responsible for ensuring a medication management appointment is scheduled within 30 days of the date of transfer so that medications are not disrupted. The referring clinic must ensure the member's medications are delivered to the receiving clinic, if applicable.
- If member chooses to transfer to an integrated clinic, the clinical team must coordinate care with the transferring PCP to ensure the individual has at least 30 days of medical medications. The receiving integrated clinic is responsible for ensuring a medication management appointment is scheduled within 30 days of the date of transfer so that medications are not disrupted.
- The receiving agency clinic shall schedule an initial appointment for the member within 45 calendar days for supportive and connective level members and 21 days for ACT members If the transfer timelines are not met and **smimemberservicesrequest@mercycareaz.org** should be contacted.
- Within 3 days of receiving the transfer request, the receiving clinic shall contact the referring clinic's clinical director to:
  - Provide the date and time of the initial appointment for transfer;
  - Provide the date and time of the initial appointment with the newly assigned BHMP (this may occur on the same date as the transfer); and by the transfer packet documentation or arranges a prescriber-to-prescriber call if needed.

If the member chooses to transfer to an integrated clinic, the ART will need to assist the member in changing their PCP assignment.

If there are any concerns, questions, conflicts, etc., regarding the transfer process, the smimemberservicesrequest@mercycareaz.org should be utilized for resolution if not able to resolve between the two agencies.

Outreach, Engagement, Reengagement and Closure (only applicable to Central GSA)

Outreach, engagement, reengagement, and closure guidelines are below for DD SMI (only applicable to Central GSA); Northern and Southern GSA outreach, engagement, reengagement, and closure guidelines are determined by clinical need of the member.

Re-engagement

DD SMI Behavioral Health Service Providers must attempt to re-engage members in an episode of care that have withdrawn from participation in the treatment process prior to the successful completion of treatment, refused services or failed to appear for a scheduled service. All attempts to reengage members who have withdrawn from treatment, refused services, or failed to appear for a scheduled service must be documented in the comprehensive clinical record.

If the above activities are unsuccessful, the behavioral health provider must make further attempts to reengage members determined to have a Serious Mental Illness (SMI), pregnant substance abusing females, or any member determined to be at risk of relapse, decompensation, deterioration or a potential harm to self or others. Further attempts may include contacting the member or member's legal guardian face to face or contacting natural supports who the member has given permission to the provider to contact. If the member appears to meet clinical standards as a danger to self, danger to others, persistently and acutely disabled or gravely disabled the provider must determine whether it is appropriate, and make attempts as appropriate, to engage the member to seek inpatient care voluntarily. If this is not a viable option for the member and the clinical standard is met, initiate the pre-petition screening or petition for treatment process.

Behavioral Health providers must attempt to re-engage members in an episode of care that have:

- Withdrawn from participation in the treatment process prior to the successful completion of treatment (Including Residential Treatment)
- Refused services or
- Failed to appear for a scheduled service (NO SHOW POLICY)

All attempts to reengage members who have withdrawn from treatment, refused services, or failed to appear for a scheduled service must be documented in the

comprehensive clinical record. The behavioral health provider must attempt to reengage the member with a minimum of three (3) separate outreach attempts by:

- Communicating in the member's preferred language
- Contacting the member or the member's legal guardian (if applicable) by telephone, at times when the member may reasonably be expected to be available (e.g., after work or school)
- Telephonic completed within 24 business hours and
- Another telephonic within 72 business hours
- Another telephonic within 10 business days
- If unable to reach member telephonically, member's emergency contact (if identified) should be outreached within 10 business days for members with history of DTO/DTS behaviors.
- Sending a letter to the current or most recent address requesting contact once three (3) separate outreach attempts at personal contact are unsuccessful, except when a letter is contraindicated due to safety concerns (e.g., domestic violence) or confidentiality issues. The provider will note safety or confidentiality concerns in the progress notes section of the clinical record and include a copy of the letter sent in the comprehensive clinical record.
- If unable to reach telephonically, an outreach letter is to be sent within 12 business days.
- Contacting the member or the member's legal guardian (if applicable) face-to-face if telephone contact and outreach letter is insufficient to locate the member or determine acuity and risk and doing so does not pose as undue burden to the provider organization.
- If unable to reach telephonically or with outreach letter, face to face attempted within 21 business days; unless the face-to-face attempt poses a potential safety risk for the member, staff members, or undue burden to the provider organization. This justification must be documented in member's clinical record; in order to receive sufficient credit.

All attempts to reengage members determined to have a Serious Mental Illness (SMI), pregnant substance abusing women/teenagers, or any member determined to be at risk of relapse, decompensation, deterioration or harm to self or others must be clearly documented in the comprehensive clinical record.

No Show Policy (all regions)

For all members receiving DDD and SMI services, the provider must attempt telephonic contact with member, within 24 hours, following any missed appointment. If the provider is unable to reach telephonically, a face to face/home visit is completed within 72 hours, following missed appointment.

For all members receiving Children's Behavioral Health Services, the provider must attempt a telephonic contact, within 24 hours. If they are unable to reach the member/guardian, an attempt to make telephonic or face to face contact should be made again within 72 hours and should follow the steps outline under the reengagement section.

For children in the custody of DCS receiving behavioral health services, contact the DCS Specialist or the DCS Supervisor to inform them of the need for assistance in re-engaging the member and the DCS out-of-home placement (e.g., foster home, kinship, or group home). If unsuccessful, contact the MC Child Welfare Single Point of Contact at **DCS@MercyCareAZ.org** to assist with reengagement. For MC DCS CHP Youth who have been in services under six months, and all re-engagement attempts have been unsuccessful, please contact the MC ACC-RBHA Child Welfare Single Point of Contact at **DCS@MercyCareAZ.org**.

Follow-Up After Significant and/or Critical Events (all regions)

During business hours, unless safety needs dictate immediate inpatient or sub-acute/crisis assessment, members should be seen at the ACC-RBHA Health Home prior to admitting to a psychiatric inpatient or sub-acute/crisis setting. The member should be assessed by a BHMP and/or triaged by an RN at the ACC-RBHA Health Home first.

For DD and ACC members, the clinical team must visit the member in the inpatient setting, for physical and behavioral health, within 72 business hours and continue to visit once a week, and a telephonic discussion with the attending psychiatrist/physician must take place within the first 24 business hours of admission. Behavioral health providers must also document activities in the clinical record and conduct follow-up activities to maintain engagement within the following timeframes:

- Discharged from inpatient services in accordance with the discharge plan and within 7 days or no later than 30 days;
- Involved in a behavioral health crisis, including but not limited to discharge from a crisis setting, within timeframes based upon the member's clinical needs, but no later than 72 business hours;
- Refusing prescribed psychotropic medications within timeframes based upon the member's clinical needs and individual history; and
- Released from local and county jails and detention facilities within 72 hours.

Additionally, for members to be released from inpatient care, behavioral health providers must help establish priority prescribing clinician appointments to ensure client stabilization, medication adherence, and to avoid re-hospitalization.

For DD SMI members in the central GSA, if the member has a behavior health hospitalization, the discharge policy is as follows:

- The BHMP appointment must be scheduled within 5 business days following discharge.
- Home visit must be completed within 5 days following discharge.
- Face to face visits must be scheduled each week for 4 weeks following discharge (weekly face to face is monitored by 7-day intervals).
- RN appointment must be scheduled within 10 days following discharge.
- The 30-day face to face visit includes development of the "30-day discharge staffing note".

Hospital follow up protocol outside of the central GSA for DD SMI Members should be completed according to their clinical need, but a follow up appointment needs to be scheduled with BHMP no later than 7 days for psychiatric hospitalization.

The expectation for non-ACT adult DD SMI members being discharged from 23.9 observation/crisis is for the clinical team to contact the member within 24 business hours and see the BHMP within 72 business hours. The expectation for non-ACT adult members being discharged from an emergency room/department is for the clinical team to contact the member within 24 business hours and see the BHMP and/or PCP within 5 actual days or sooner if clinically indicated. For ACT adult DD SMI members being discharged from 23.9 observation/crisis or an emergency room/department, it is expected that the clinical team will contact the member within 24 actual hours and see the BHMP within 72 actual hours.

Case Management (only applicable to Central GSA)

Contact Guidelines are listed below for DD SMI.

Level of Care	Face-to-Face Contact Guideline	Home Visit Contact Guideline
Connective	Quarterly; Every 90 days	Yearly; Every 365 days
Supportive	Monthly; Every 30 days	Quarterly; Every 90 days
ACT	4 contacts every 7 days for high fidelity clinical indication. Minimum of 1 contact every 7 days but team should provide face-to-face services dependent on the member's individual need.	

Targeted minimum thresholds for performance in each of these areas are identified as:

- Connective and Supportive have an expected compliance to the target of 80%; and
- ACT, being aligned with SAMHSA fidelity scores, is targeted to meet, or exceed 3.1 average face to face meeting per week on a monthly average.

Caseload Ratios for DD SMI Members

Central, Northern, and Southern GSA providers must be in compliance with caseload ratios outlined in AMPM 570 and DDD Medical Policy Manual 570.

ACT maximum caseload is 12 members per ACT team Case Manager/Specialist, per policy. ACT members cannot be part of a blended caseload.

For non-blended caseloads, the maximum ceiling is 42 members for Supportive level of care and 98 members for Connective level of care. Blended caseloads (combination of members assigned to Supportive and Connective levels of care) have a maximum ceiling of 294 points. This is based on each member on Supportive level of care being assigned 7 points and each member on Connective level of care being assigned 3 points. Health homes for members with SMI are subject to contract enforcement if 294 points is exceeded for both blended and non-blended (Supportive and Connective) caseloads and 90% of Case Manager caseloads per health home/stand-along ACT team (not per agency) need to be in compliance with the aforementioned standards.
*Caseload ratio flexibilities and approval of a blended caseload are subject to DDD/AHCCCS approval.

3.12 - PCP Coordination of Care

The PCP will be informed of the member's behavioral health provider so that communication may be established. It is very important that PCPs develop a strong communication link with the behavioral health provider. PCPs are expected to exchange any relevant information such as medical history, current medications, diagnosis, and treatment within 10 business days of receiving the request from the behavioral health provider.

Where there has been a change in a member's health status identified by a medical provider, there should be coordination of care with the behavioral health provider within a timely manner. The update should include but is not limited to; diagnosis of chronic conditions, support for the petitioning process, and all medication prescribed.

The PCP should also document, and initial signifying review receipt of information received from a behavioral health provider who is treating the member. All efforts to coordinate on care on behalf of the member should be documented in the member's medical record.

EPSDT provider shall refer any physical and behavioral screenings with positive results to the appropriate provider for follow-up diagnosis, and treatment. Referrals must occur in a timely manner. PCPs must coordinate care between providers to ensure treatment is initiated within 60 days of the screening services and/or referral request. MC also requires that providers, when appropriate, communicate the final disposition of each referral to the referral source within 30 days of the member receiving an initial assessment.

3.13 – General and Informed Consent

Each member has the right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment. It is important for members seeking behavioral health services to agree to those services and be made aware of the service options and alternatives available to them as well as specific risks and benefits associated with these services.

General Consent is a one-time agreement to receive certain services, including but not limited to behavioral health services that is usually obtained from a member during the intake process at the initial appointment, and is always obtained prior to the provision of any behavioral health services. General consent must be obtained from a member's behavioral health recipient's or legal guardian's signature.

Informed Consent is an agreement to receive behavioral health services before the provision of a specific treatment that has associated risks and benefits. Informed consent is required to be obtained from a member or legal guardian prior to the provision of the following services and procedures:

- Complementary and Alternative Medicine (CAM),
- Psychotropic medications,
- Electro-Convulsive Therapy (ECT),
- Use of telemedicine,
- Application for a voluntary evaluation,
- Research,
- Admission for medical detoxification, an inpatient facility, or a residential program (for members determined to have a Serious Mental Illness), and
- Procedures or services with known substantial risks or side effects

MC recognizes two primary types of consent for behavioral health services: general consent and informed consent.

Prior to obtaining informed consent, an appropriate behavioral health representative, as identified in R9-21-206.01(c), must present the facts necessary for a member to make an informed decision regarding whether to agree to the specific treatment and/or procedures. Documentation that the required information was given, and that the member agrees or does not agree to the specific treatment, must be included in the comprehensive clinical record, as well as the member/ guardian's signature when required.

In addition to general and informed consent for treatment, state statute (A.R.S. §15-104) requires written consent from a child's parent or legal guardian for any behavioral health survey, analysis, or evaluation conducted about a school-based prevention program.

The intent of this section is to describe the requirements for reviewing and obtaining general, and informed consent, for members receiving services within the behavioral health system, as well as consent for any behavioral health survey or evaluation in connection with an AHCCCS school-based prevention program.

General Requirements

- Any member aged 18 years and older, in need of behavioral health services must give voluntary general consent to treatment, demonstrated by the member's or legal guardian's written or electronic signature on a general consent form prior to the delivery of behavioral health services or refusal of treatment.
- For members under the age of 18, the parent, legal guardian, or a lawfully authorized custodial agency (including foster care givers A.R.S. 8.514.05(C)) must give general consent to treatment, demonstrated by the parent, legal guardian, or a lawfully authorized custodial agency representative's written or electronic signature on a general consent form prior to the delivery of behavioral health services or refusal of treatment.
- Any member aged 18 years and older or the member's legal guardian, or in the case of members under the age of 18, the parent, legal guardian, or a lawfully authorized custodial agency, after being fully informed of the consequences, benefits, and risks of treatment, has the right not to consent to receive behavioral health services.
- Any member aged 18 years and older or the member's legal guardian, or in the case of members under the age of 18, the parent, legal guardian or a lawfully authorized custodial agency has the right to refuse medications unless specifically required by a court order or in an emergency.
- Providers treating members in an emergency are not required to obtain general consent prior to the provision of emergency services. Providers treating members pursuant to court order must obtain consent, as applicable, in accordance with A.R.S. Title 36, Chapter 5.
- All evidence of informed consent and general consent to treatment must be documented in the comprehensive clinical record per the **AHCCCS AMPM Policy 940**.
- MC must develop and make available to providers policies and procedures that include any additional information or forms.
- A foster parent, group home staff, foster home staff, relative, or other person or agency who is caring for a child currently in out-of-home placement may give consent for:
    - Evaluation and treatment for emergency conditions that are not life threatening.
    - Routine medical and dental treatment and procedures, including Early Periodic Screening Diagnosis and Treatment (EPSDT) services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (A.R.S. §8-514.05(C)).

    - Testing for the presence of the human immunodeficiency virus (HIV).
- Examples of behavioral health services in which foster, or kinship can consent to include:
    - Assessment and service planning,
    - Counseling and therapy,
    - Rehabilitation services,
    - Medical Services,
    - Psychiatric evaluation,
    - Psychotropic medication,
    - Laboratory services,
    - Support Services,
    - Case Management,
    - Personal Care Services,
    - Family Support,
    - Peer Support,
    - Respite,
    - Sign Language or Oral Interpretive Services,
    - Transportation,
    - Crisis Intervention Services,
    - Behavioral Health Day Programs.
- To ensure timely delivery of services, consent for intake and routine behavioral health services may be obtained from either the foster caregiver or the Department of Child Safety Specialist (DCSS) whomever is available to do so immediately upon request (A.R.S. § 8-514.05(C)).
- A foster parent, group home staff, foster home staff, relative, or other person or agency who is caring for a child in out-of-home placement shall not consent to:
    - Medical/physical health services:
        - General Anesthesia,
        - Surgery,
        - Testing for the presence of the human immunodeficiency virus,
        - Blood transfusions,
        - Abortions.
    - Behavioral health services:
        - Inpatient psychiatric acute services
        - BHIF residential treatment centers
        - Behavioral health residential facility (BHRF) services
        - Therapeutic foster care
- Foster or kinship caregivers may not consent to terminate behavioral health treatment. The termination of behavioral health treatment requires Department of Child Safety (DCS) consultation and agreement.

- A Foster parent, group home staff, foster home staff, relative, or other personal agency cannot refuse to consent for treatment for medically recommended services.
- If the foster or kinship caregiver disagrees on the behavioral health treatment being recommended through the Child and Family Team (CFT), the CFT including the foster or kinship caregiver and DCS case worker should reconvene and discuss the recommended treatment plan. Only DCS can refuse consent to medically recommended behavioral health treatment.

General Consent

Administrative functions associated with a member's enrollment do not require consent, but before any services are provided, general consent must be obtained.

MC will make available to providers any form used to obtain general consent to treatment.

Informed Consent

- In all cases where informed consent is required by this policy, informed consent must include at a minimum:
    - The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions,
    - Information about the member's diagnosis and the proposed treatment, including the intended outcome, nature and all available procedures involved in the proposed treatment,
    - The risks, including any side effects, of the proposed treatment, as well as the risks of not proceeding,
    - The alternatives to the proposed treatment, particularly alternatives offering less risk or other adverse effects,
    - That any consent given may be withheld or withdrawn in writing or orally at any time. When this occurs, the provider must document the member's choice in the medical record;
    - The potential consequences of revoking the informed consent to treatment, and
- A description of any clinical indications that might require suspension or termination of the proposed treatment. Documenting Informed Consent:
    - Members, or if applicable the member's parent, guardian, or custodian, shall give informed consent for treatment by signing and dating an acknowledgment that he or she has received the information and gives informed consent for the proposed treatment.
    - When informed consent is given by a third party, the identity of the third party and the legal capability to provide consent on behalf of the member, must be established. If the informed consent is for psychotropic medication or

telemedicine and the member, or if applicable, the member's guardian refuses to sign an acknowledgment and gives verbal informed consent, the medical practitioner shall document in the member's record that the information was given, the member refused to sign an acknowledgment and that the member gives informed consent to use psychotropic medication or telemedicine.

- When providing information that forms the basis of an informed consent decision for the circumstances identified above, the information must be:
    - Presented in a manner that is understandable and culturally appropriate to the member, parent, legal guardian, or an appropriate court; and
    - Presented by a credentialed behavioral health medical practitioner or a registered nurse with at least one year of behavioral health experience. It is preferred that the prescribing clinician provide information forming the basis of an informed consent decision. In specific situations in which it is not possible or practicable, information may be provided by another credentialed behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience.
- Psychotropic Medications, Complementary and Alternative Treatment and Telemedicine:
    - Unless treatments and procedures are court ordered, providers must obtain written informed consent, and if written consent is not obtainable, providers must obtain oral informed consent. If oral informed consent is obtained instead of written consent from the member, parent, or legal guardian, it must be documented in written fashion. Informed consent is required in the following circumstances:
        - Prior to the initiation of any psychotropic medication or initiation of Complementary and Alternative Treatment (CAM). The use of **AMPM 310-V – Prescription Medications – Pharmacy Services, Attachment A – Informed Consent for Psychotropic Medication Treatment** is recommended as a tool to review and document informed consent for psychotropic medications, and
        - Prior to the delivery of behavioral health services through telemedicine.
    - Electro-Convulsive Therapy (ECT), research activities, voluntary evaluation and procedures or services with known substantial risks or side effects.
    - Written informed consent must be obtained from the member, parent, or legal guardian, unless treatments and procedures are under court order, in the following circumstances:
        - Before the provision of (ECT),
        - Prior to the involvement of the member in research activities, and
        - Prior to the delivery of any other procedure or service with known substantial risks or side effects.

- Written informed consent must be obtained from the member, legal guardian, or an appropriate court prior to the member's admission to any medical detoxification, inpatient facility or residential program operated by a behavioral health provider.
- MC DCS CHP and MC are not required to obtain written approval from a member before requesting the member's medical record from the PCP or any other organization or agency. MC may obtain a copy of a member's medical records without written approval of the member if the reason for such request is directly related to the administration of the MC DCS CHP program. MC DCS CHP shall be afforded access to all members' medical records whether electronic or paper within 7 business days of receipt of request or more quickly if necessary.
- If informed consent is revoked, treatment must be promptly discontinued, except in cases in which abrupt discontinuation of treatment may pose an imminent risk to the member. In such cases, treatment may be phased out to avoid any harmful effects.
- Informed Consent for Telemedicine:
    - Before a health care provider delivers health care via telemedicine, verbal or written informed consent from the member or their health care decision maker must be obtained. Refer to the AHCCCS AMPM Policy 320-I for additional detail.
    - Informed consent may be provided by the behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience. When providing informed consent, it must be communicated in a manner that the member and/or legal guardian can understand and comprehend.
    - Exceptions to this consent requirement include:
        - If the telemedicine interaction does not take place in the physical presence of the member;
        - In an emergency in which the member or the member's health care decision maker is unable to give informed consent; or
        - To the transmission of diagnostic images to a health care provider serving as a consultant or the reporting of diagnostic test results by that consultant.

Special Requirements for Children

- In accordance with A.R.S. §36-2272, except as otherwise provided by law or a court order, no person, corporation, association, organization or state-supported institution, or any individual employed by any of these entities, may procure, solicit to perform, arrange for the performance of or perform mental health screening in a nonclinical setting or mental health treatment on a minor without first obtaining consent of a parent or a legal custodian of the minor child. If the parental consent is given through telemedicine, the health professional must verify the parent's identity at the site where the consent is given. This section does not apply when an emergency exists that requires

a person to perform mental health screening or provide mental health treatment to prevent serious injury to or save the life of a minor child.

- Non-Emergency Situations
    - In cases where the parent is unavailable to provide general or informed consent and the child is being supervised by a caregiver who is not the child's legal guardian (e.g., grandparent) and does not have power of attorney, general and informed consent must be obtained from one of the following:
        - Lawfully authorized legal guardian,
        - Foster parent, group home staff, or another person with whom the DCS has placed the child, or
        - Government agency authorized by the court.
- If someone other than the child's parent intends to provide general and, when applicable, informed consent to treatment, the following documentation must be obtained and filed in the child's comprehensive clinical record:

INDIVIDUAL/ENTITY	DOCUMENTATION
Legal guardian	Copy of court order assigning custody
Relatives	Copy of power of attorney document
Another person/agency	Copy of court order assigning custody
DCS Placements (for children removed from the home by DCS), such as: • Foster parents • Group home staff • Foster home staff • Relatives • Other person/agency in whose care DCS has placed the child	None required (see note)

NOTE: If behavioral health providers doubt whether the individual bringing the child in for services is a person/agency representative in whose care DCS has placed the child, the provider may ask to review verification, such as documentation given to the individual by DCS indicating that the individual is an authorized DCS placement. If the

individual does not have this documentation, then the provider may also contact the child's DCS case worker to verify the individual's identity.

- For any child who has been removed from the home by DCS, the foster parent, group home staff, foster home staff, relative or other person or agency in whose care the child is currently placed may give consent for the following behavioral health services:
    - Evaluation and treatment for emergency conditions that are not life threatening, and
    - Routine medical and dental treatment and procedures, including early periodic screening, diagnosis and treatment services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (including behavioral health services and psychotropic medications).
    - Any minor who has entered a lawful contract of marriage, whether that marriage has been dissolved subsequently, any emancipated youth or any homeless minor may provide general and, when applicable, informed consent to treatment without parental consent (A.R.S. §44-132).
- Emergency Situations
    - In emergencies involving a child in need of immediate hospitalization or medical attention, general and, when applicable, informed consent to treatment is not required.
    - Any child, 12 years of age or older, who is determined upon diagnosis of a licensed physician, to be under the influence of a dangerous drug or narcotic, not including alcohol, may be considered an emergency and can receive behavioral health care as needed for the treatment of the condition without general and, when applicable, informed consent to treatment.

At times, involuntary treatment can be necessary to protect safety and meet needs when a member, due to mental disorder, is unwilling or unable to consent to necessary treatment. In this case, a court order may serve as the legal basis to proceed with treatment. However, capacity to give informed consent is situational, not global, as a member may be willing and able to give informed consent for aspects of treatment even when not able to give general consent. Members should be assessed for capacity to give informed consent for specific treatment and such consent obtained if the member is willing and able, even though the member remains under court order.

Consent for Behavioral Health Survey or Evaluation for School-Based Prevention Programs

- Written consent must be obtained from a child's parent or legal guardian for any behavioral health survey, analysis, or evaluation conducted about a school-based prevention program administered by AHCCCS.
- AMPM Exhibit 320-Q-2, Substance Abuse Prevention Program and Evaluation Consent must be used to gain parental consent for evaluation of school-based prevention

programs. Providers may use an alternative consent form only with the prior written approval of AHCCCS. The consent must satisfy all the following requirements:
    - Contain language that clearly explains the nature of the screening program and when and where the screening will take place;
    - Be signed by the child's parent or legal guardian; and
    - Provide notice that a copy of the actual survey, analysis, or evaluation questions to be asked of the student is available for inspection upon request by the parent or legal guardian.
- Completion of AMPM Exhibit 320-Q-2, Substance Abuse Prevention Program and Evaluation Consent applies solely to consent for a survey, analysis, or evaluation only, and does not constitute consent for participation in the program itself.

3.14 - Family Involvement

Family involvement in a member's treatment is an important aspect in recovery. Studies have shown members who have family involved in their treatment tend to recover quicker, have less dependence on outside agencies, and tend to rely less on emergency resources. Family is defined as any person related to the member biologically or appointed (stepparent, guardian, and/or power of attorney). Treatment includes treatment planning, participation in counseling or psychiatric sessions, providing transportation or social support to the member. Information can be shared with other parties with written permission from the member or the member's guardian.

3.15 - Members with Diabetes and the Arizona State Hospital

- Members with diabetes who are admitted to the Arizona State Hospital (herein AzSH) for behavioral health services will receive training to use a glucometer and testing supplies during their stay at AzSH.
- Upon discharge from AzSH, PCPs must ensure these members are issued the same brand and model of glucometer and supplies that they were trained to use during their AzSH admission.
- MC's behavioral health coordinator will notify the PCP of the member's discharge from AzSH and provide information on the brand and model of equipment and supplies that should be continued to be prescribed.
- The MC behavioral health coordinator will work with AzSH to ensure the member has enough testing supplies to last until an office visit can be scheduled with the provider.
- In the event the member's mental status renders them incapable or unwilling to manage their medical condition and that condition requires skilled medical care, the MC behavioral health coordinator will work with AzSH and the PCP to obtain an appropriate placement for additional outpatient services.

- For re-authorization for continued behavioral health services, contact the member's provider-based case manager, and fax the Behavioral Health Treatment Plan and progress notes requesting continued authorization. Be sure to include the services to be delivered, frequency of services to be delivered and duration of services provided.
- ALWAYS verify member eligibility prior to the provision of services.

3.16 – Pre-Petition Screening, Court Ordered Evaluation and Court Ordered Treatment

At times, it may be necessary to initiate civil commitment proceedings to ensure the safety of a person, or the safety of other persons, due to a member's mental disorder when that member is unable or unwilling to participate in treatment. In Arizona, state law permits any responsible person to apply for pre-petition screening when another member may be, because of a mental disorder:

- A danger to self (DTS);
- A danger to others (DTO);
- Persistently or acutely disabled (PAD); or
- Gravely disabled (GD)

If the person who is the subject of a court ordered commitment proceeding is subject to the jurisdiction of an Indian tribe rather than the state, the laws of that tribe, rather than state law, will govern the commitment process.

Pre-petition screening includes an examination of the person's mental status and/or other relevant circumstances by a designated screening agency. Upon review of the application, examination of the person and review of other pertinent information, a licensed screening agency's medical director or designee will determine if the person meets criteria for DTS, DTO, PAD, or GD because of a mental disorder.

If the pre-petition screening indicates that the person may be DTS, DTO, PAD, or GD, the screening agency will file an application for a court ordered evaluation. Based on the immediate safety of the member or others, an emergency admission for evaluation may be necessary. Otherwise, an evaluation will be arranged for the person by a designated evaluation agency within timeframes specified by state law.

Based on the court ordered evaluation, the evaluating agency may petition for court ordered treatment on behalf of the member. A hearing, with the member and his/her legal representative and the physician(s) treating the member, will be conducted to determine whether the member will be released and/or whether the agency will petition the court for court ordered treatment. For the court to order ongoing treatment, the person must be determined, because of the evaluation, to be DTS, DTO, PAD, or GD. Court Ordered Treatment (COT) may include a combination of inpatient and outpatient treatment. Inpatient treatment

days are limited contingent on the member's designation as DTS, DTO, PAD, or GD. Members identified as:

- DTS may be ordered up to 90 inpatient days per year;
- DTO and PAD may be ordered up to 180 inpatient days per year; and
- GD may be ordered up to 365 inpatient days per year.

If the court orders a combination of inpatient and outpatient treatment, a mental health agency will be identified by the court to supervise the person's outpatient treatment. Before the court can order a mental health agency to supervise the person's outpatient treatment, the agency medical director must agree and accept responsibility by submitting a written treatment plan to the court.

At every stage of the pre-petition screening, court ordered evaluation, and court ordered treatment process, a person will be provided an opportunity to change his/her status to voluntary. Under voluntary status, the person is no longer considered to be at risk for DTS/DTO and agrees in writing to receive a voluntary evaluation.

County agencies and MC contracted agencies responsible for pre-petition screening and court ordered evaluations must use the following forms prescribed in **9 A.A.C. 21, Article 5** for persons determined to have a Serious Mental Illness; agencies may also use the following forms AHCCCS Forms found under the **AHCCCS Medical Policy Manual, Section 320-U**, for all other populations:

- Application for Involuntary Evaluation
- Application for Voluntary Evaluation
- Application for Emergency Admission for Evaluation
- Petition for Court Ordered Evaluation
- Petition for Court Ordered Treatment Gravely Disabled Person
- Affidavit
- Special Treatment Plan for Forced Administration of Medications

In addition to court ordered treatment because of civil action, an individual may be ordered by a court for evaluation and/or treatment upon:

1) Conviction of a domestic violence offense; or
2) Upon being charged with a crime when it is determined that the individual is court ordered to treatment, or programs, because of being charged with a crime and appears to be an "alcoholic."

Licensing Requirements

Behavioral health providers who are licensed by the Arizona Department of Health Services/Division of Public Health Licensing Services as a court ordered evaluation or court ordered treatment agency must adhere to ADHS licensing requirements.

Pre-Petition Screening

Pinal County

Pinal County contracts with Horizon Health and Wellness and CPR to complete Pre-Petition Screening within Pinal County. These services can be accessed by calling Nursewise at 1-866-495-6735.

Gila County

In Gila County, Community Bridges Inc. is the designated screening agency; however other behavioral health agencies may be granted permission upon request to the Gila County Attorney's Office. Community Bridges, Inc. can be contacted at 1-877-931-9142.

Maricopa County

There is an intergovernmental agreement between Maricopa County and AHCCCS for the management, provision of, and payment for Pre-Petition Screening and Court Ordered Evaluation. AHCCCS in turn contracts with MC for these pre-petition screening and court ordered evaluation functions. MC is required to coordinate provision of behavioral health services with the member's contractor responsible for the provision of behavioral health services.

The pre-petition screening includes an examination of the member's mental status and/or other relevant circumstances by a designated screening agency. The designated screening agency must follow these procedures:

- The pre-petition screening agency must help, if needed, to the applicant in the preparation of the application for court ordered evaluation (see Application for Involuntary Evaluation).
- Any behavioral health provider that receives an application for court ordered evaluation (see Application for Involuntary Evaluation) must immediately refer the applicant for pre-petition screening and petitioning for court ordered evaluation to the designated pre-petition screening agency or county facility.

Filing of Non-Emergent Petitions

This provides instruction to the provider-based case manager and Pre-Petition Team relative to AAC and ARS requirements, not intended to be instructive to provider/community members.

- The Clinical Team or Pre-Petition Team will staff the application for involuntary evaluation (Application for Involuntary Evaluation and Pre-Petition Screening Report) with a psychiatrist. The psychiatrist need never have met the person to decide whether

to move forward with a Petition for COE. The psychiatrist will:

- Review the application, pre-petition screening report, and any other collateral information made available as part of the pre-petition screening to determine if it indicates that there is reasonable cause to believe the allegations of the applicant for the COE.
- Prepare a Petition for COE and file the petition if the psychiatrist determines that the member, due to a mental disorder, which may include a primary diagnosis of dementia and other cognitive disorders, is DTS, DTO, PAD or GD. The **Petition for Court Ordered Evaluation** documents pertinent information for COE;
- If the psychiatrist determines that there is reasonable cause to believe that the member, without immediate hospitalization, is likely to harm him/her or others, the psychiatrist must coordinate with the UPC, RRC-W or CPEC and ensure completion of the **Application for Emergency Admission for Evaluation** and take all reasonable steps to procure hospitalization on an emergency basis.

- Pre-petition screens, application, and petition for Inpatient or Outpatient Court Ordered Evaluation can be filed on a non-emergent basis at the MIHS Desert Vista Campus Legal Office, 570 West Brown Road, Mesa, AZ 85201, and 480-344-2000. This involves all Persistently or Acutely Disabled (PAD) and Gravely Disabled (GD) petitions. Danger to Self (DTS) and Danger to Others (DTO) petitions that do not require immediate intervention can also be filed on a non-emergent basis. Please use the following forms for filing the non-emergent petition: **Petition for Court Ordered Evaluation** and **Application for Involuntary Evaluation**.
- Eight copies and the original Petition for Court Ordered Evaluation, Application for Involuntary Evaluation, Pre-Petition Screening Report, and the Police Mental Health Detention Information Sheet, must be submitted by the behavioral health member's provider-base case manager or the pre-petition team to the Legal Department at Maricopa Integrated Health System (MIHS) Desert Vista Campus for review by the County Attorney, preparation of the Detention Order, and filing with the Superior Court. These documents must be filed within 24 hours of completion, excluding weekends and holidays.
- Once the petition is filed with the court, the Legal Department at MIHS Desert Vista Campus Delivers the Detention Order to the Police Department to have the behavioral health member brought to the UPC, RRC or CPEC for evaluation. NOTE: The **Petition for Court Ordered Evaluation** and **Police Mental Health Detention Information Sheet**) expires 14 days from the date the judge signs off on the order for COE.
- One of the eight copies of petition documents shall be stored by the behavioral health member's provider-based case manager or the pre-petition team in a secure place (such as a locked file cabinet) to ensure the behavioral health member's confidentiality. A petition for involuntary evaluation may not be stored in the medical record if the behavioral health member has not been court ordered to receive treatment.

Emergent Filing

In cases where it is determined that there is reasonable cause to believe that the member is in such a condition that without immediate hospitalization, he/she is likely to harm himself/herself or others, an application for emergency admission can be filed. Only applications indicating Danger to Self and/or Danger to Others can be filed on an emergent basis and shall be filed at the Urgent Psychiatric Care (UPC), 1201 S 7th Ave, Ste 150 Phoenix, AZ 85007; 602-416-7600; Response Recovery Center- (RRC, 11361 N. 99th Ave, Ste 402, Peoria AZ 85345, 602-636-4605; or Community Psychiatric Emergency Center (CPEC), 358 E. Javelina, Mesa, AZ 85210, 480-507-3180. MC contracts with the UPC, RCC, and CPEC to assist the applicant in preparing the **Application for Emergency Admission for Evaluation** when an emergent evaluation is requested and can also assist when an Application for Court Ordered Evaluation on a non-emergent basis is needed due to the person not meeting criteria for an emergency admission.

Emergent process

The applicant is a person who has, based on personal observation, knowledge of the behavioral health member's behavior that is danger to self or danger to others. The applicant shall complete the **Application for Emergency Admission for Evaluation** with assistance of UPC/RRC/CPEC/CBI West Valley Access Point (WVAP) staff and include:

- The applicant must have seen or witnessed the behavior or evidence of mental disorder.
- The applicant, as a direct observer of dangerous behavior, may be called to testify in court if the application results in a petition for COE.
- Upon receipt of the Application for Emergency Admission for Emergency Evaluation (MH-104) the UPC, RRC or CPEC admitting officer will begin the assessment process to determine if enough evidence exists for an emergency admission for evaluation. If there is enough evidence to support the emergency admission for evaluation and the member does not require medical care beyond the capacity of UPC, RRC or CPEC, then the UPC, RRC or CPEC staff will immediately coordinate with local law enforcement for the detention of the member and transportation to UPC, RRC or CPEC.
- If the Application for Emergency Admission for Evaluation is accepted by the UPC, RRC or CPEC admitting officer and the member requires a level of medical support not available at the UPC, RRC or CPEC, then within 24 hours the UPC, RRC or CPEC admitting officer will coordinate admission to the MIHS Psychiatric Annex. If admission to the MIHS Psychiatric Annex cannot be completed within 24 hours of the Application for Emergency Admission for Evaluation being accepted by the UPC, RRC or CPEC admitting officer, then the MC ACC-RBHA Medical Director must be notified.
- An **Application for Emergency Admission for Evaluation** may be discussed by telephone with a UPC, RRC or CPEC admitting officer, the referring physician, and a police officer to facilitate transport of the member to be evaluated at a UPC, RRC or CPEC.

- A member proposed for emergency admission for evaluation may be apprehended and transported to the UPC, RRC or CPEC by police officials through a written **Application for Emergency Admission for Evaluation** faxed by the UPC, RRC or CPEC admitting officer to the police.
- A 23-Hour Emergency Admission for Evaluation begins at the time the behavioral health member is detained involuntarily by the Admitting Officer at UPC, RRC or CPEC who determines there is reasonable cause to believe that the member, because of a mental disorder, is a DTS or DTO and that during the time necessary to complete prescreening procedures the member is likely, without immediate hospitalization, to suffer harm or cause harm to others.
- During the emergency admission period of up to 23 hours the following will occur:
    - The behavioral health member's ability to consent to voluntary treatment will be assessed.
    - The behavioral health member shall be offered and receive treatment to which he/she may consent. Otherwise, other than calming talk or listening, the only treatment administered involuntarily will be for the safety of the individual or others, i.e., seclusion/restraint or pharmacological restraint in accordance with A.R.S. §36-513.
    - UPC/RRC/CPEC may contact the County Attorney prior to filing a petition if it alleges that a member is DTO.
    - If the behavioral health member is determined to require a court ordered evaluation, then the petition for COE will be filed with the court within 24 hours of admission (not including weekends or court holidays). If the behavioral health member does not meet the criteria for an application for emergency admission but is determined to meet criteria for PAD and/or GD, UPC, RRC-W or CPEC will notify and offer to assist the applicant of the non-emergent process.

Court Ordered Evaluation

If the pre-petition screening indicates that the member may be DTS, DTO, PAD, or GD, the screening agency will file an application for a court ordered evaluation. The procedures for court ordered evaluations are outlined below:

MC and its subcontracted behavioral health provider must follow these procedures:

- A member being evaluated on an inpatient basis must be released within seventy-two hours (not including weekends or court holidays) if further evaluation is not appropriate, unless the member makes application for further care and treatment on a voluntary basis;
- A member who is determined to be DTO, DTS, PAD, or GD because of a mental disorder must have a petition for court ordered treatment prepared, signed, and filed by MC's medical director or designee; and

- Title XIX/XXI funds must not be used to reimburse court ordered evaluation services.

MC encourages the utilization of outpatient evaluation on a voluntary or involuntary basis. MC is not responsible to pay for the costs associated with Court Ordered Evaluation outside of the limited "medication only" benefit package available for Non-Title XIX members determined to have SMI, unless other prior payment arrangements have been made with another entity (e.g., county, hospital, provider).

Court Ordered Outpatient Evaluation

- After the pre-petition screening, if the member is refusing a voluntary evaluation and the psychiatrist determines the member is safe to go through an Outpatient Court Ordered Evaluation, then the provider-based case manager or pre-petition team will deliver the original Application for Involuntary Evaluation, **Pre-Petition Screening Report**, and **Petition for Court Ordered Evaluation** to the Legal Department at Maricopa Integrated Health System(MIHS) Desert Vista Campus for review by the County Attorney, preparation of the service order, and filing with the Superior Court.
- Once the petition is filed with the court, the Legal Department at MIHS Desert Vista delivers the service order to the police department to have the member served legal notice of the date/time/location of the outpatient evaluation. One of the eight copies of the petition documents shall be stored by the member's provider-based case manager or PAD team in a secure place (such as a locked file cabinet) to ensure the behavioral health member's confidentiality. A petition for involuntary evaluation may not be stored in the medical record if the behavioral health member has not been court ordered to receive treatment.
- The MIHS Legal Department will arrange for an outpatient Court Ordered Evaluation and notify the provider-based case manager or Pre-Petition Team of the date and time of the evaluation.
- If the Outpatient COE is scheduled to take place at Desert Vista, the provider-based case manager will arrange for transportation for the member to and from the Outpatient COE and will provide any documents requested by the psychiatrists conducting the evaluation. If the member is not enrolled at an Integrated/Behavioral Health Home, the MC Court Liaison will assist the member in arranging transportation.
- If the two evaluating psychiatrists do not believe that the member needs COT, then the MIHS Legal Department will forward the physicians' affidavits to the provider-based case manager or Pre-Petition Team with an explanation that the member has been determined not to need COT.
- If the two evaluating psychiatrists completing the Outpatient Court Ordered Evaluation determine the member needs COT, then the two physician's **Affidavit and social** work report will be delivered to the MIHS Legal Department within 1 business day of the evaluation. The MC Court Liaison will then file a Petition for Court Ordered Treatment

with the Maricopa County Superior Court within 2 business days.

Voluntary Evaluation

Any MC contracted behavioral health provider that receives an application for voluntary evaluation must immediately refer the member to the facility responsible for voluntary evaluations.

Voluntary Inpatient or Outpatient Evaluation

- If the individual agrees to a voluntary evaluation, complete the **Application for Voluntary Evaluation** and review with a psychiatrist.
- If the psychiatrist determines that a voluntary evaluation is appropriate, then a decision as to whether the evaluation is to take place on an inpatient or outpatient basis will be made by the psychiatrist.
- If the psychiatrist determines an inpatient voluntary evaluation is necessary, the provider-based case manager or PAD Team is to arrange for a voluntary admission to UPC, RRC, or CPEC, for the evaluation to take place, assist the member in signing in and deliver the original notarized **Application for Voluntary Evaluation** to the UPC, RRC, or CPEC Coordinator.
- If the psychiatrist determines an outpatient voluntary evaluation is acceptable, then the provider-based case manager or PAD Team will deliver the original, notarized **Application for Voluntary Evaluation** to the MIHS Legal Department. An outpatient evaluation will then be scheduled at Desert Vista Hospital, and the provider-based case manager or PAD Team will be responsible for notifying the member of the date and time of the evaluation, provide transportation to and from the evaluation, and provide any documentation requested by the physician's conducting the evaluation.
- The voluntary outpatient or inpatient assessment must include evaluation by two psychiatrists and the involvement of either two social workers, or one social worker and one psychologist, who shall complete the outpatient treatment plan. The voluntary psychiatric evaluation shall include determination regarding the existence of a mental disorder, and whether, because of a mental disorder, the individual meets one or more of the standards. The psychiatric evaluation must also include treatment recommendations. The psychiatrists completing the outpatient psychiatric evaluations will submit a written affidavit to the MIHS Legal Department regarding their findings.
- If the psychiatrists do not believe that the member needs COT, then the MIHS Legal Department will forward the physicians' affidavits to the provider-based case manager or PAD Team with an explanation that the member has been determined not to need COT.
- If the psychiatrists completing the voluntary inpatient evaluation or voluntary outpatient evaluation determine the member needs COT, then the two physician's **Affidavit** and a social work report will be delivered to the MIHS Legal Department within

1 business day of the evaluation. The MC contracted behavioral health provider must follow these procedures:

- The evaluation agency must obtain the individual's informed consent prior to the evaluation (see **Application for Voluntary Evaluation** and provide evaluation at a scheduled time and place within five days of the notice that the member will voluntarily receive an evaluation;
- For inpatient evaluations, the evaluation agency must complete evaluations in less than seventy-two hours of receiving notice that the member will voluntarily receive an evaluation; and
- If a behavioral health provider conducts a voluntary evaluation service as described in this chapter, the comprehensive clinical record must include:
    - A copy of the **Application for Voluntary Evaluation**;
    - A completed informed consent form; and
    - A written statement of the member's present medical condition.

In Maricopa County, MC contracts with Valleywise for inpatient Court Ordered Evaluations and Outpatient Court Ordered Evaluations when the county does not contract with MC for court ordered evaluations. In counties outside of Maricopa County, the county (not MC) contracts with the evaluating agency. COE is available to all people in the state of Arizona regardless of health plan enrollment.

Court Ordered Treatment Following Civil Proceedings under A.R.S. Title 36

Based on the court ordered evaluation, the evaluating agency may petition for court- ordered treatment. The behavioral health provider must follow these procedures:

- Upon determination that an individual is DTS, DTO, GD, or PAD, and if no alternatives to court ordered treatment exist, the medical director of the agency that provided the court ordered evaluation must file a petition for court ordered treatment (see **Petition for Court Ordered Treatment**);
- Any behavioral health provider filing a petition for court ordered treatment must do so in consultation with the member's clinical team prior to filing the petition;
- The petition must be accompanied by the affidavits of the two physicians who conducted the examinations during the evaluation period and by the affidavit of the applicant for the evaluation (see **Affidavit** and attached addenda);
- A copy of the petition, in cases of grave disability, must be mailed to the public fiduciary in the county of the patient's residence, or the county in which the patient was found before evaluation, and to any member nominated as guardian or conservator; and
- A copy of all petitions must be mailed to the superintendent of the Arizona State Hospital.

Responsibility of the Outpatient Agency Appointed to Supervise and Administer the Court Order for Treatment

For ACC members on COT, the Outpatient Agency appointed by the court to supervise and administer COT is responsible for filing status reports as ordered by the court. These are typically ordered at 45 days, 180 days, and 305 days after COT start date. Status review hearings where a team member must appear may also be ordered by the court.

The Outpatient Agency will schedule members on COT to see a Behavioral Health Medical Professional (BMHP) at least once every 30 days. If a member does not attend a scheduled appointment, the clinical team will attempt to locate the member and re-schedule the appointment within one (1) business day. If the member cannot be engaged, then clinical team will discuss options for engagement and options for amending the COT to bring the member to inpatient or sub-acute facility for assessment.

Members placed on a Title 36 Court Order for Treatment (Civil) after being found Non-Competent/Not Restorable in a Criminal Matter may have as part of the Title 36 COT a "Notice of Noncompliance" attached at the time the person is placed on the Title 36 COT. (This is also known as a Rule 11 COT)

Members on a Rule 11 COT require special treatment and tracking by the Outpatient Agency. ARS §36-544 requires the Outpatient Agency that supervises and administers the Title 36 COT to file a notice with the court and prosecuting attorney within five (5) days of a members unauthorized absence from Title 36 Court Ordered treatment and request the court toll (suspend) the treatment order for the period the patient is absent. "Unauthorized absence' means:

- The member is absent from an inpatient treatment facility without authorization; or
- The member is no longer living in a placement or residence specified by the treatment plan and has left without authorization; or
- The member left or failed to return **to the county or state without authorization.**

Additionally, the statue requires the Outpatient Agency to:

- Use information and other resources available to the agency to facilitate efforts to locate and return the patient to treatment.
- File a status report every sixty (60) days specifying the information and resources used to facilitate the member's return to treatment; and
- Notify the court of the patient's return to treatment.

After 180 days, the Outpatient Agency may petition the court to terminate the order for treatment. The court may either terminate the treatment order or require additional outreach.

If a Notice of Noncompliance appears in the Court Order for Treatment or Minute Entry, the Outpatient Agency must report any noncompliance with the treatment order.

If the medical director intends to release a patient from a Rule 11 COT prior to the expiration of the COT, he/she must provide at least a ten (10) day notice to the court, prosecuting attorney, and any relative or victim of the patient who filed a demand for notice.

If the medical director decides not to renew a Rule 11 COT or the Application for Renewal was not filed on time, at least a ten (10) day notice of the pending expiration date of COT shall be provided to the court and prosecuting agency.

Judicial Review and COT Renewal Timelines/Forms

Judicial Review

Pursuant to ARS§36-546 each member Court Ordered Treatment must be provided with a Notice of the Right to Judicial Review 60 days after the start of COT and every 60 days thereafter. Any member of the clinical team can provide this notice and must document in a progress note the date and time notice was provided. The notice of right to judicial review can be completed verbally and/or with a form developed by the provider for this purpose. If the member does request Judicial Review, below is the timeline and paperwork that will need to be submitted:

- Member signs request for Judicial Review which is then signed by a member of the clinical team and notarized. The member does not need to make this request in person. Request for Judicial Review can be made on the phone and staff person receiving the phone call will complete the Request for Judicial Review form on behalf of the member and note that the request was made by phone on the form and in a progress note in the medical record.
- The Psychiatric Report for Judicial Review must be completed by a psychiatrist signed and notarized and filed with the court within 72 hours (not including weekends or court holidays) of the request for judicial review (please also note that the date of the MD signature MUST match the date of the notarization, or it will be rejected).
- The original Request for Judicial Review and Psychiatric Report for Judicial Review must be filed with the court within 72 hours of the Request for Judicial Review.
- If the court orders a full hearing for the Judicial Review the medical director of the treating agency shall provide the member's attorney with a copy of the member's medical records at least 24hr prior to the hearing.

Application for COT Renewal

Pursuant to section ARS §36-538, within ninety days before the expiration of a court order for treatment, the medical director of the mental health treatment agency shall conduct an annual review of a patient who has been found to have a grave disability or a persistent or acute

disability and who is undergoing court-ordered treatment to determine whether the continuation of court-ordered treatment is appropriate and to assess the needs of the patient for guardianship or conservatorship, or both. The annual review shall consist of the mental health treatment and clinical records contained in the patient's treatment file. The mental health treatment agency shall keep a record of the annual review. If the medical director believes that a continuation of court-ordered treatment is appropriate, the medical director of the mental health treatment agency shall appoint one or more psychiatrists to carry out a psychiatric examination of the patient. In any proceeding conducted pursuant to this section, a patient has the right to have an analysis of the patient's mental condition by an independent evaluation pursuant to section 36-538. The annual review is required whether or not the court has ordered a final status report.

All renewal paperwork must be submitted to the provider agency court coordinator **NO LATER** than 45 days prior to the expiration of COT. If the Final Status Report states that renewal is requested, the following paperwork will need to be submitted:

- A Final Status Report stating that renewal is requested and can be signed by a psychiatrist or Nurse Practitioner.
- Psychiatric Report for Annual Review of COT must be completed by a psychiatrist, signed, and notarized (please note that the date of the psychiatrist's signature MUST match the date of the notarization, or it will be rejected).
- ***ORIGINAL*** Psychiatric Report for Annual Review of COT must be delivered to the provider agency court coordinator as copies cannot be filed with the court.
- Two witness statements for those who will be attending a hearing if one should be set. (The witness statements aren't notarized so these can be scanned and emailed, preferably at the same time.)

**Please note that both psych reports must be completed by an MD. A NP or PA CANNOT complete these, nor is co-signing permitted.*

Members who are Title XIX/XXI Eligible and/or Determined to have Serious Mental Illness (SMI)

When a member referred for court ordered treatment is Title XIX/XXI eligible and/or determined or suspected to have a Serious Mental Illness, MC will:

- Conduct an evaluation to determine if the member has a Serious Mental Illness in accordance with **Chapter 3 – Behavioral Health, Section 3.18 – SMI Eligibility Determination and SED Identification** in this manual, and conduct a behavioral health assessment to identify the member's service needs in conjunction with the member's clinical team, as described in **Chapter 3 – Behavioral Health, Section 3.21 – Behavioral Health and Service Planning Overview** in this manual
- Provide necessary court ordered treatment and other covered behavioral health services in accordance with the member.

- Member's needs, as determined by the member's clinical team, the behavioral health member, family members, and other involved parties.
- Perform, either directly or by contract, all treatment required by A.R.S. Title 36, Chapter 5, Article 5 and 9 A.A.C. 21, Article 5.

Transfer from one behavioral health provider to another

A member ordered by the court to undergo treatment can be transferred from one behavioral health provider to another behavioral health provider if:

- The member does not have a court appointed guardian;
- The medical director of the receiving behavioral health provider accepts the transfer; and
- The consent of the court for the transfer is obtained, as necessary.
- In order to coordinate a transfer of a member under court ordered treatment to ALTCS or another ACC-RBHA, the behavioral health member's clinical team will coordinate with the MC Court Advocacy Department at MercyCareNetworkManagement@mercycareaz.org.
- To coordinate a transfer of a member under COT from one Integrated/Behavioral Health Home to another, the behavioral health member's current psychiatrist will discuss the transfer with the receiving psychiatrists. If both Integrated/Behavioral Health Homes agree that the transfer is appropriate, the receiving psychiatrist will then provide a Letter of Intent to Treat to the Integrated/Behavioral Health Home Court Coordinator of the sending Integrated/Behavioral Health Home. The Integrated/Behavioral Health Home Court Coordinator will then prepare a motion to transfer treatment provider, review with Integrated/Behavioral Health Home attorney, and file with the court. The member's care will not be transitioned to the receiving Integrated/Behavioral Health Home until the new treatment provider is reflected on the COT.

Court Ordered Treatment for Members Charged with or Convicted of a Crime

MC providers may be responsible for providing evaluation and/or treatment services when an individual has been ordered by a court due to:

- Conviction of a domestic violence offense; or
- Upon being charged with a crime when it is determined that the individual is court ordered to treatment, or programs, because of being charged with a crime and appears to be an "alcoholic."

Domestic Violence Offender Treatment

Domestic violence offender treatment may be ordered by a court when an individual is convicted of a misdemeanor domestic violence offense. Although the order may indicate that the domestic violence (DV) offender treatment is the financial responsibility of the offender under **A.R.S. §13-3601.01**, MC will cover DV services with Title XIX/XXI funds when the member

is Title XIX/XXI eligible, the service is medically necessary, required prior authorization is obtained if necessary, and/or the service is provided by an in-network provider. For Non-TXIX/XXI eligible member's court ordered for DV treatment, the individual can be billed for the DV services.

Court ordered substance use evaluation and treatment

Substance use evaluation and/or treatment (i.e., DUI services) ordered by a court under **A.R.S. §36-2027** is the financial responsibility of the county, city, town, or charter city whose court issued the order for evaluation and/or treatment. Accordingly, if MC receives a claim for such services, the claim will be denied with instructions to the provider to bill the responsible county, city, or town.

Court Ordered Treatment for American Indian Tribal Members in Arizona

Arizona tribes are sovereign nations, and tribal courts have jurisdiction over their members residing on reservation. Tribal court jurisdiction, however, does not extend to tribal members residing off the reservation or to state court ordered evaluation or treatment ordered because of a behavioral health crisis occurring off reservation.

Although some Arizona tribes have adopted procedures in their tribal codes, which are like Arizona law for court ordered evaluation and treatment, each tribe has its own laws which must be followed for the tribal court process. Tribal court ordered treatment for American Indian tribal members in Arizona is initiated by tribal behavioral health staff, the tribal prosecutor or other member authorized under tribal laws. In accordance with tribal codes, tribal members who may be a danger to themselves or others and in need of treatment due to a mental health disorder are evaluated and recommendations are provided to the tribal judge for a determination of whether court ordered treatment is necessary. Tribal court orders specify the type of treatment needed.

Additional information on the history of the tribal court process, legal documents and forms as well as contact information for the tribes, MC liaison(s), and tribal court representatives can be found on the AHCCCS web page titled, **Tribal Court Procedures for Involuntary Commitment - Information Center**.

Since many tribes do not have treatment facilities on reservation to provide the treatment ordered by the tribal court, tribes may need to secure treatment off reservation for tribal members. To secure court ordered treatment off reservation, the court order must be "recognized" or transferred to the jurisdiction of the state.

The process for establishing a tribal court order for treatment under the jurisdiction of the state is a process of recognition, or "domestication" of the tribal court order (see **A.R.S. §12-136**).

Once this process occurs, the state recognized tribal court order is enforceable off reservation. The state recognition process is not a rehearing of the facts or findings of the tribal court. Treatment facilities, including the Arizona State Hospital, must provide treatment, as identified by the tribe, and recognized by the state. **A.R.S. §12-136 Domestication or Recognition of Tribal Court Order** is a flow chart demonstrating the communication between tribal and state entities.

MC providers must comply with state recognized tribal court orders for Title XIX/XXI and Non-Title XIX SMI members. When tribal providers are also involved in the care and treatment of court ordered tribal members, MC and its providers must involve tribal providers to ensure the coordination and continuity of care of the members for the duration of court ordered treatment and when members are transitioned to services on the reservation, as applicable.

This process must run concurrently with the tribal staff's initiation of the tribal court ordered process to communicate and ensure clinical coordination with the MC. This clinical communication and coordination with MC are necessary to assure continuity of care and to avoid delays in admission to an appropriate facility for treatment upon state/county court recognition of the tribal court order. The Arizona State Hospital should be the last placement alternative considered and used in this process.

A.R.S. §36-540(B) states, "The Court shall consider all available and appropriate alternatives for the treatment and care of the patient. The Court shall order the least restrictive treatment alternative available." MC will partner with American Indian tribes and tribal courts in their geographic service areas to collaborate in finding appropriate treatment settings for American Indians in need of behavioral health services.

Due to the options American Indian/Alaskan Native member have regarding their health care, enrollment for AHCCCS eligible American Indian/Alaskan Native members with an SMI designation may occur through a T/RBHA, ACC-RBHA or American Indian Health Program (AIHP). American Indian/Alaskan Native members who are enrolled with a federally recognized tribe are also entitled to receive health care from an Indian Health Service facility and/or a Tribal 638 facility in addition to the services received through their AHCCCS health plan.

3.17 - Behavioral Health Treatment Plans and Daily Documentation

Behavioral Health Treatment Plan

A Behavioral Health Treatment Plan must be developed and reviewed/updated annually on each MC member, and as needed should a change in the member's condition requires a modification to the treatment plan. The treatment plan should include strengths, measurable goals and presenting behavioral issues. For the behavioral issues, list recommended behavioral

interventions to be utilized. Amended/renewed plans should indicate goals achieved or barriers interfering with success and recommendations to address this.

Daily Documentation

Daily documentation is required to reflect MC member's behaviors and issues that occur. This should include frequency of behaviors, frequency and type of staff interventions required throughout the day, and the member's level of responsiveness to interventions/redirections.

3.18 – SMI Eligibility Determination and SED Eligibility Identification

General Requirements

This chapter applies to:

- Members who are referred for, request or have been determined to need an eligibility determination for Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) Identification;
- Members who are enrolled as a member determined to have a SMI or SED for whom a review of the determination is indicated; and
- MC subcontracted providers and the MC designee.

A qualified assessor must complete all SMI and SED evaluations. If the qualified assessor is a Behavioral Health Technician the evaluation must be reviewed, approved, and signed by a Behavioral Health Professional.

All children and adolescents from birth up to 18 years of age shall be evaluated for SED eligibility by a qualified clinician if the individual or their Health Care Decision Maker (HCDM) makes such a request, and the individual has or is believed to have a qualifying diagnosis pending assessment or evaluation. An evaluation is required to occur no later than seven (business) days after a request is made.

All members must be evaluated for SMI eligibility by a qualified assessor, and have an SMI eligibility determination made by Solari, if:

- The member requests an SMI determination;
- HCDM, who is authorized to consent to inpatient treatment makes a request on behalf of the member;
- An Arizona Superior Court issues an order instructing that a member is to undergo a SMI evaluation/determination; or
- The member has both a qualifying SMI diagnosis and functional impairment because of the qualifying diagnosis.

The SMI eligibility determination record must include all the documentation that was considered during the review including but not limited to current and/or historical treatment

records. The record may be maintained in either hardcopy or electronic format. MC will develop and make available to providers any requirements or guidance on SMI eligibility determination record location and/or maintenance.

Computation of time for SMI eligibility determination is as follows:

- Evaluation date with a qualified clinician = day zero (0), regardless of time of the evaluation.
- Determination due date = Three (3) business days from day zero (0), excluding weekends and holiday.
- The final determination is required three (3) business days from day 0, not 3 business days from the date of submission to MC or designee. Providers that contract with MC must submit the SMI evaluation to the designees as soon as practicable, but no later than 11:59 p.m. on the next business day following the evaluation. **MC or designee will have at least two (2) business days to complete the SMI determination.**

Completion Process of Initial SMI Eligibility Determination or SED Identification

Upon receipt of a referral for, a request, or identification of the need for an SMI determination or SED Identification, the behavioral health provider or designated Department of Corrections' staff member will schedule an appointment for an initial meeting with the member and a qualified assessor. This shall occur no later than 7 days after receiving the request or referral.

During the initial meeting with the member by a qualified assessor, the assessor must:

- Make a clinical assessment whether the member is competent enough to participate in an assessment;
- Obtain general consent from the member or, if applicable, the member's HCDM to conduct an assessment; and
- Provide to the member and, if applicable, the member's HCDM, the information required in **R9-21-301(D) (2)**, a client rights brochure, and the appeal notice required by **R9-21- 401(B)**.

If during the initial meeting with the member the assessor is unable to obtain sufficient information to determine whether the applicant is SMI or SED, the assessor must:

- Request additional information to decide whether the member is SMI or SED and obtain an authorization for the release of information, if applicable
- For SMI, initiate an assessment including completion of the **AHCCCS Medical Policy Manual 320-P Eligibility Determination for Individuals with Serious Mental Illness** and **AHCCCS Medical Policy Manual 550 Serious Emotional Disturbance Identification**.

Criteria for SMI Eligibility Determination

The determination of SMI requires both a qualifying SMI diagnosis and functional impairment because of the qualifying diagnosis.

Functional Criteria for SMI Determination

To meet the functional criteria for SMI, a member must have, because of a qualifying SMI diagnosis, dysfunction in at least one of the following four domains, as described below, for most of the past twelve months or for most of the past six months with an expected continued duration of at least six months:

- **Inability to live in an independent or family setting without supervision** – Neglect or disruption of ability to attend to basic needs. Needs assistance in caring for self. Unable to care for self in safe or sanitary manner. Housing, food, and clothing must be provided or arranged for by others. Unable to attend to most basic needs of hygiene, grooming, nutrition, medical and dental care. Unwilling to seek prenatal care or necessary medical/dental care for serious medical or dental conditions. Refuses treatment for life threatening illnesses because of behavioral health disorder.
- **A risk of serious harm to self or others** – Seriously disruptive to family and/or community. Pervasively or imminently dangerous to self or others' bodily safety. Regularly engages in assaultive behavior. Has been arrested, incarcerated, hospitalized or at risk of confinement because of dangerous behavior. Persistently neglectful or abusive towards others in the member's care. Severe disruption of daily life due to frequent thoughts of death, suicide, or self-harm, often with behavioral intent and/or plan. Affective disruption causes significant damage to the member's education, livelihood, career, or personal relationships.
- **Dysfunction in role performance** – Frequently disruptive or in trouble at work or at school. Frequently terminated from work or suspended/expelled from school. Major disruption of role functioning. Requires structured or supervised work or school setting. Performance significantly below expectation for cognitive/developmental level. Unable to work, attend school, or meet other developmentally appropriate responsibilities; or
- **Risk of Deterioration** – A qualifying diagnosis with probable chronic, relapsing, and remitting course. Co-morbidities (like mental retardation, substance dependence, personality disorders, etc.). Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors (life-threatening or debilitating medical illnesses, victimization, etc.). Other (past psychiatric history; gains in functioning have not solidified or are a result of current compliance only; court-committed; care is complicated and requires multiple providers; etc.).

The following reasons shall not be enough in and of themselves for denial of SMI eligibility:

- An inability to obtain existing records or information.
- Lack of a face-to-face psychiatric or psychological evaluation

Member with Co-occurring Substance Use

For members who have a qualifying SMI diagnosis and co-occurring substance use, for purposes of SMI determination, presumption of functional impairment is as follows:

- For psychotic diagnoses (i.e., bipolar I disorder with psychotic features, delusional disorder, major depression, recurrent, severe, with psychotic features, schizophrenia, schizoaffective disorder, and psychotic disorder NOS) functional impairment is presumed to be due to the qualifying psychiatric diagnosis;
- For other major mental disorders (i.e., bipolar disorders, major depression, and obsessive-compulsive disorder), functional impairment is presumed to be due to the psychiatric diagnosis, unless:
    - The severity, frequency, duration, or characteristics of symptoms contributing to the functional impairment cannot be attributed to the qualifying mental health diagnosis; or
    - The assessor can demonstrate, based on a historical or prospective period of treatment, that the functional impairment is present only when the member is abusing substances or experiencing symptoms of withdrawal from substances.
- For all other mental disorders not covered above, functional impairment is presumed to be due to the co-occurring substance use unless:
    - The symptoms contributing to the functional impairment cannot be attributed to the substance use disorder; or
    - The functional impairment is present during a period of cessation of the co-occurring substance use of at least thirty (30) days; or
    - The functional impairment is present during a period of at least ninety (90) days of reduced use unlikely to cause symptoms or level of dysfunction.

SMI Eligibility Determination for Inmates in the Department of Corrections (DOC)

An SMI eligibility designation/determination is done for purposes of determining eligibility for community-based behavioral health services. The Arizona Department of Health Services recognizes the importance of evaluating and determining the SMI eligibility for inmates in the Department of Corrections (DOC) with impending release dates to appropriately coordinate care between the DOC and the community based behavioral health system. Inmates of DOC **pending release within 6 months**, who have been screened or appear to meet the diagnostic and functional criteria, **will now be permitted to be referred** for an SMI eligibility evaluation and determination. Inmates of DOC whose release date exceeds 6 months are not eligible to be referred for an SMI eligibility evaluation and determination.

SMI Eligibility Determination for Children Transitioning into the Adult System

When the adolescent reaches the **age of 17.5** and the Child and Family Team (CFT) believes that the youth may meet eligibility criteria as an adult with a Serious Mental Illness (SMI), the TRBHA and their subcontracted providers must ensure the young adult receives an eligibility

determination as outlined in the **AHCCCS Medical Policy Manual 320-P Eligibility Determination for Individuals with Serious Mental Illness** and **AHCCCS Medical Policy Manual 550 Serious Emotional Disturbance Identification.**

If the youth is determined eligible, or likely to be determined eligible for services as a member with a Serious Mental Illness, the adult behavioral health services provider-based case manager is then contacted to join the CFT and participate in the transition planning process. **After obtaining permission from the HCDM**, **it is the responsibility of the children's behavioral health service provider to contact and invite the adult behavioral health services provider-based case manager to upcoming planning meetings.** Additionally, the children's provider must track and report the following information to MC, CFT transition date (date the adult and children's provider attended a CFT) and adult intake date. When more than one TRBHA and/or behavioral health service provider agency is involved, the responsibility for collaboration lies with the agency that is directly responsible for service planning and delivery.

If the young adult is not eligible for services as a member with a Serious Mental Illness, it is the responsibility of the children's behavioral health provider, through the CFT, to coordinate transition planning with the adult GMH/SU provider. The importance of securing representation from the adult service provider in this process cannot be overstated, regardless of the member's identified behavioral health category assignment (SMI, General Mental Health, Substance Use). The children's behavioral health provider should be persistent in its efforts to make this occur.

For additional guidance regarding the Transition to Adulthood Process for youth determined SMI prior to turning 18, see **AHCCCS Medical Policy Manual 587 – Transition to Adulthood.**

Functional Criteria for SED Identification

To meet the functional criteria for SED, an individual shall have impairment due to a qualifying SED diagnosis, in at least one of the following domains, for most of the past three months with an expected continued duration of at least three months:

a. Seriously disruptive to family and/or community which can include, but is not limited to any of the following:
    - Pervasively or imminently dangerous to self or other's bodily safety.
    - Regularly engages in assaultive behavior.
    - Has been arrested, incarcerated, hospitalized or is at risk of confinement because of dangerous behavior.
    - Persistently neglectful or abusive toward others.
    - Severe disruption of daily life due to frequent thoughts of death, suicide, self-harm, often with behavioral intent and/or plan.

- Affective disruption causes significant damage to the individual's education or personal relationships.

b. Dysfunction in role performance which can include, but is not limited to any of the following:
   - Frequently disruptive or in trouble at home or at school. Frequently suspended/expelled from school.
   - Major disruption of role functioning.
   - Requires structured or supervised school setting.
   - Performance significantly below expectation for cognitive/developmental level.
   - Unable to attend school or meet other developmentally appropriate responsibilities.

c. Child and Adolescent Level of Care Utilization System (CALOCUS) recommended level of care 2, 3, 4, 5, or 6.

d. Risk of deterioration:
   - A qualifying diagnosis with probably chronic, relapsing, and remitting course.
   - Co-morbidities (e.g., developmental/intellectual disability, Substance Use Disorder (SUD), personality disorders).
   - Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors (e.g., life-threatening or debilitating medical illnesses, victimization).
   - Other (e.g., past psychiatric history, gains in functioning have not solidified or are a result of current compliance only, court-committed, care is complicated and requires multiple providers)

Children with Co-occurring Substance Use

For purposes of SED identification, presumption of functional impairment is as follows for individuals with co-occurring substance use:

1. For psychotic diagnoses other than substance-induced psychosis (bipolar I disorder with psychotic features, delusional disorder, major depression, recurrent, severe, with psychotic features, schizophrenia, schizoaffective disorder, and any other diagnosis of persistent psychotic disorder), functional impairment is presumed to be due to the qualifying mental health diagnosis.
2. For other qualifying psychiatric disorders, functional impairment is presumed to be due to the psychiatric diagnosis, unless:
   a. The severity, frequency, duration, or characteristics of symptoms contributing to the functional impairment cannot be attributed to the qualifying mental health diagnosis, or
   b. The assessor can demonstrate, based on a historical or prospective period of treatment, that the functional impairment is present only when the individual is

actively using substances or experiencing symptoms of withdrawal from substances. In order to make such identifications, the assessor shall first look at a period of either 30 days or longer of abstinence, or 60 days or longer of reduced use that is less than the threshold expected to produce the resulting symptoms and disability and establish that the symptoms and resulting disability were no longer present after the 30 or 60 day period and/or no longer required mental health treatment to prevent recurrence of symptoms.

3. A diagnosis of substance-induced psychosis only be made if both of the following conditions are present:
    a. There is no psychosis present before a period of substance use that is of sufficient type, duration, and intensity to cause psychotic symptoms, and
    b. The psychosis remits completely (not partially) after a period of abstinence of 30 days or less.
4. Continuation of new onset psychotic symptoms after a 30-day period of abstinence requires a presumptive diagnosis of persistent psychotic disorder.
5. For persistent psychosis of undetermined onset, the absence of clear remission of psychosis during a period of abstinence of 30 days or less should be considered presumptive evidence of a persistent psychotic disorder for SED identification purposes.
6. For individuals who are not able to attain or maintain a period of abstinence from substance use, who continue to use substances and/or do not experience consecutive days of abstinence, this is not a disqualifier to initiate the SED identification process. Some individuals will not meet the 30-day period of abstinence. This does not preclude them from the SED assessment or identification process.

Completion of SED Eligibility Identification

If a child is identified by the provider as meeting criteria for SED, the provider shall submit the following elements into the DUGless Portal. To submit an SED identification request in DUGless, the provider shall:

- Search for the member under the Supplemental Data section of the portal.
- Indicate whether they are submitted an SED identification (Yes) or removal (No) request.
- The provider the following member information:
    - AHCCCS ID
    - First and Last Name
    - Date of Birth
    - Effective Date of SED Identification

- CALOCUS Level of Care Score 1-6 (use 99 for members under age 6 or FFS members, specifically AIHP/TRBHA/FES, if CALOCUS is not available)
- SED Qualifying Diagnosis – The SED qualifying Diagnosis from the AHCCCS SED qualifying diagnoses list published on the **AHCCCS Medical Coding page** of the AHCCCS website.

Please note: a request cannot be made through the DUGless portal if the child or adolescent does not have active enrollment with an AHCCCS contracted health plan. Providers must confirm or establish enrollment prior to requesting an SED Identification or removal.

A member is required to have an AHCCCS ID prior to submission. If the member is identified as SED, AHCCCS Online will reflect the Behavioral Health Code change to "Z" within 3 business days. Please refer to the **AHCCCS SED FAQ** and the **DUGless Portal Guide** for further information on the request submission.

Completion Process of Final SMI Eligibility Determination

The licensed psychiatrist, psychologist, or nurse practitioner designated by Solari must make a final determination as to whether the member meets the eligibility requirements for SMI status based on:

- A face-to-face assessment or reviewing a face-to-face assessment by a qualified assessor.
- A review of current and historical information, if any, obtained orally or in writing by the assessor from collateral sources, and/or present or previous treating clinicians.

The following must occur if the designated reviewing psychiatrist, psychologist, or nurse practitioner has not conducted a face-to-face assessment and has a disagreement with the current evaluating or treating qualified behavioral health professional or behavioral health technician (that cannot be resolved by oral or written communication):

- **Disagreement regarding diagnosis:** Determination that the member does not meet eligibility requirements for SMI status must be based on a face-to-face diagnostic evaluation conducted by a designated psychiatrist, psychologist, or nurse practitioner. The resolution of (specific reasons for) the disagreement shall be documented in the member's comprehensive clinical record.
- **Disagreement regarding functional impairment:** Determination that the member does not meet eligibility requirements must be based upon a face-to-face functional evaluation conducted by a designated psychiatrist, psychologist, or nurse practitioner. The psychiatrist, psychologist, or nurse practitioner shall document the specific reason(s) for the disagreement in the member's comprehensive clinical record.

If there is enough information to determine SMI eligibility, the member shall be provided written notice of the SMI eligibility determination within three (3) business days of the initial meeting with the qualified assessor.

Issues Preventing Timely Completion of SMI Eligibility Determination

The time to initiate or complete the SMI eligibility determination may be extended no more than 20 days if the member agrees to the extension and:

- There is substantial difficulty in scheduling a meeting at which all necessary participants can attend.
- The member fails to keep an appointment for assessment, evaluation, or any other necessary meeting.
- The member is capable of but temporarily refuses to cooperate in the preparation of the completion of an assessment or evaluation.
- The member or the member's HCDM and/or designated representative requests an extension of time.
- Additional documentation has been requested but has not yet been received.
- There is insufficient functional or diagnostic information to determine SMI or SED eligibility within the required time periods.

Solari

Solari must:

- Document the reasons for the delay in the member's eligibility determination record when there is an administrative or other emergency that will delay the determination of SMI status.
- Not use the delay as a waiting period before determining SMI status or as a reason for determining that the member does not meet the criteria for SMI eligibility (because the determination was not made within the time standards).

Situations in which Extension is due to Insufficient Information for SMI Determination

- Solari shall request and obtain the additional documentation needed e.g., current, and/or past medical records) and/or perform or obtain any necessary psychiatric or psychological evaluations.
- The designated reviewing psychiatrist, psychologist, or nurse practitioner must communicate with the member's current treating clinician, if any, prior to the determination of SMI, if there is insufficient information to determine the member's level of functioning.
- Eligibility must be determined within three days of obtaining enough information, but no later than the end date of the extension.

If the individual refuses to grant an extension, SMI eligibility must be determined based on the available information. If SMI eligibility is denied, the member will be notified of his/her appeal rights and the option to reapply).

If the evaluation or information cannot be obtained within the required period because of the need for a period of observation or abstinence from substance use to establish a qualifying mental health diagnosis, the member shall be notified that the determination may, with the agreement of the member, be extended for up to 60 (calendar) days. This is a 60-day period of abstinence, or reduced use from drug and/or alcohol use to help the reviewing psychologist make an informed decision regarding SMI eligibility.

Notification of SMI Eligibility Determination

If the eligibility determination results in approval of SMI status, the SMI status must be reported to the member in writing, including notice of his/her right to appeal the decision.

If the eligibility determination results in a denial of SMI status, Solari shall include in the notice above:

- The reason for denial of SMI eligibility
- The right to appeal
- The statement that Title XIX/XXI eligible members will continue to receive needed Title XIX/XXI covered services. In such cases, the member's behavioral health category assignment must be assigned based on criteria.

Re-enrollment or Transfer

If the member's status is SMI or SED at disenrollment, or upon transfer from another TRBHA, the member's status shall continue as SMI or SED upon re-enrollment, opening of a new episode of care, or transfer.

Review of SMI Eligibility Determination

A review of SMI eligibility made by Solari for individuals currently enrolled as a member with an SMI Designation may be initiated by MC or behavioral health provider:

- As part of an instituted, periodic review of all members determined to have a SMI.
- When there has been a clinical assessment that supports that the member no longer meets the functional and/or diagnostic criteria.
- An individual currently enrolled as a member with an SMI, or their legally authorized representative, upon their request.

A review of the determination may not be requested by MC or behavioral health provider within six months from the date an individual has been determined SMI eligible.

If, because of such review, the member is determined to no longer meet the diagnosis and functional requirements for SMI, MC must ensure that:

- Services are continued depending on Title XIX/XXI eligibility, or other MC service/ priorities.
- Written notice of the determination made on review with the right to appeal is provided to the affected member with an effective date of 30 days after the date the written notice is issued.

Verification of SMI Eligibility Determinations

When a TRBHA or its contracted providers are required to verify SMI Eligibility for individuals who have previously been determined SMI, but cannot locate the member's original SMI determination documentation, or when the SMI determination is outdated (more than 10 years old as required by AHCCCS for eligibility/enrollment for benefits), **Serious Mental Illness Determination Verification** must be completed.

- The form does not replace Serious Mental Illness Determination but enables the MC and providers to "verify" a member's current SMI eligibility.

The form must be completed by a licensed psychiatrist, psychologist, or nurse practitioner, and then submitted to MC for approval. MC is responsible for monitoring and validating the forms. MC must keep copies of the validated Serious Mental Illness Determination Verification form in the member's record.

SMI Decertification

There are two established methods for removing a SMI designation, one clinical and the other an administrative option, as follows:

1. **Integrated/Behavioral Health Home Removal**
    - A member who has an SMI designation or a member working with an individual from the member's clinical team may request an Integrated/Behavioral Health Home Removal. An Integrated/Behavioral Health Home Removal is a determination that a member who has a SMI designation no longer meets SMI criteria. If, as a result of a review, the member is determined to no longer meet the diagnostic and/or functional requirements for SMI status:
        - The Determining Entity shall ensure that written notice of the determination and the right to appeal is provided to the affected member with an effective date of 30 days after the date the written notice is issued.
        - MC ACC-RBHA must ensure that services are continued in the event an appeal is filed timely, and that services are appropriately transitioned as part of the discharge planning process.
2. **SMI Administrative Removal**

- A member who has a SMI designation may request a SMI Administrative Removal if the member has not received behavioral health services for a period of six (6) months.
- MC will evaluate the member's request and review data sources to determine the last date the member received a behavioral health service. MC will inform the member of changes that may result with the removal of the member's SMI designation. Based upon review, the following will occur:
    - In the event the review finds that the member has received behavioral health services within the previous six (6) months, the member will be notified that they may seek decertification of their SMI status through the Clinical Decertification process.
    - In the event the review finds that the member has received behavioral health services within the prior six (6) months, the member will be notified that they may seek removal of their SMI status through the Clinical Removal process.

SED Decertification

MC or the contracted behavioral health providers may request a removal of an individual's SED identification:

- As part of an instituted, periodic review of all individuals designated to have an SED.
- When there has been a clinical assessment that supports that the individual no longer meets the functional and/or diagnostic criteria.
- As requested by an individual who has been determined to meet SED eligibility criteria, or their HCDM.

The removal of SED identification shall occur when the provider's comprehensive assessment determines that the member no longer meets the diagnostic and/or functional limitation criteria for SED identification.

In the event removal of SED identification is warranted, the provider shall:

1. Revise the member's following information in the DUGless Portal:
    a. CALOCUS score with date. For a child under the age of six, 99 shall be entered as the CALCOUS assessment tool is not validated for this age. 99 shall also be entered for FFS members as the tool is recommended, but not required, and
    b. An SED identification entered as "no" option The "no" option indicates that the child is no longer identified SED.
2. The provider shall communicate the assessed diagnostic change and/or functional limitation changes and CALOCUS score (if applicable) resulting in the removal of the SED identification to the member and HCDM and document this communication.

A review of the eligibility may not be requested within the first six months from the date an individual has been identified as SED eligible.

Based upon review of the individual's request and clinical data provided, removal of SED behavioral health category will occur if:

- The individual is an enrolled member and has not received any behavioral health service within the previous six months; or
- The individual is determined to no longer meet the diagnostic and/or functional requirements for SED designation.

If it is determined that the member no longer meets SED criteria, the Behavioral Health Home must complete appropriate coordination between the BHMP/PCP of the member's choice in order to eliminate any gaps in care for the member. All coordination must be appropriately documented in the member's medical record, and it is the sending provider.

SMI Integrated Behavioral Health Home Transfer Protocol

- Once CRN determines the SMI removal, CRN sends an email to the SMI health home indicating the specific member status of removal.
- As soon as the SMI health home receives notification that a member has completed and been approved for SMI removal, the SMI health home will immediately begin working with the member to determine where the member wants to transfer their services.
- The Integrated/Behavioral Health Home must complete appropriate coordination between a GMH/SU provider(s) or BHMP/PCP of the member's choice to eliminate any gaps in care for the member.
- The transfer of services from the Integrated/Behavioral Health Home to the GMH/SU provider(s) or alternative BHMP/ PCP must be completed in less than thirty (30) days from the time the Integrated/Behavioral Health Home is notified the member is determined to no longer meet SMI criteria.
- All coordination must be appropriately documented in the member's medical record.
- It is the sending provider's responsibility to gather a release of information from the member and transfer all applicable records to the receiving provider.
- If a member is not currently receiving services from an Integrated/Behavioral Health Home but is T19, the Integrated/Behavioral Health Home that the member was paneled to under the Navigator level of care is responsible for completing the transfer of the member.
- If a member does not want to transfer to a GMH/SU provider or BHMP/PCP or refuses to sign a release of information for a receiving provider, the Integrated/Behavioral Health Home will complete appropriate outreach and engagement which requires two outreach attempts.

- The Integrated/Behavioral Health Home will offer the member the opportunity to obtain their medical records (see **MC Provider Manual Chapter 100, Chapter 4 – Provider Responsibilities, Section 4.19 – Member's Medical Record**) if the member declines further assistance with the transfer process.
- If the member is unable to be contacted or declines obtaining their records, the Integrated/Behavioral Health Home must retain the original or copies of the member's medical records for at least six (6) years after the last date the member receives medical or health care services from the provider.

MC Transfer Protocol

MC member transition process, in coordination with Arizona Health Care Cost Containment System (AHCCCS), helps to ensure that members' healthcare continues without interruption or delay when there is a change of health plans. When an individual has been approved for SMI removal, MC, as the relinquishing Contractor, will complete and transmit the Enrollment Transition Information (ETI) form to the appropriate parties no later than 10 business days from receipt of AHCCCS notification. MC's transition coordinator will also notify the receiving health plan's transition coordinator to ensure that the member's services are appropriately transferred.

Paneling of Members with GMH/SU

All members enrolled in MC and Non-Title XIX SMI eligibility plans are paneled to a Behavioral Health Home (BHH) once behavioral health services are initiated within identified paneling organizations. Members will be re-paneled, as appropriate to paneling organizations that are the primary catalyst of behavior health services. Members entering behavioral health services via emergency and/or crisis services will be paneled according to member preference and geographical location. If member preference is unavailable, the member is paneled to an ABHC based on geographic proximity. Paneling to an ABHC is aligned to member eligibility. Members are not paneled to an ABHC during gaps in enrollment or while eligible in a plan other than Integrated or Non-Title XIX SMI.

Paneling of Members with SED

All members with SED Identification are paneled to a Children's Behavioral Health Home (BHH) within 5 days of MC receiving notification from AHCCCS. Members are assigned to BHH based on available claims data. In the absence of claim data, members are geo-assigned based on BHH proximity to their residence. MC also considers a member's title status when issuing assignments to ensure only MHBG-SED subrecipient providers are assigned Non-Title XIX/XXI membership.

Paneling of Members with SMI

All members enrolled in MC and Non-Title XIX SMI eligibility plans are paneled to a Behavioral Health Home (BHH). MC panels newly enrolled members to an ABHC based on member preference. If member preference is unavailable, the member is paneled to an ABHC based on geographic proximity. Paneling to an ABHC is aligned to member eligibility. Members are not paneled to an ABHC during gaps in enrollment or while eligible in a plan other than Integrated or Non-Title XIX SMI. For more information regarding Non-Title XIX, please review our **Non-Title Enrollment Reference Guide.**

There are numerous scenarios where members determined with SMI may be enrolled in a plan other than Integrated or Non-Title XIX SMI.

- **Opt-Out Request –** A member determined SMI, who is currently enrolled in an ACC-RBHA, may opt out of receiving physical health services from the ACC-RBHA and be transferred to an Acute Care Contractor for his/her physical health services if one or more of the applicable opt out criteria are satisfied. Members who meet the opt-out criteria will continue to receive behavioral health services through MC RBHA.
- **Recent Determination –** There is a 14-day transitional period for a change in health plan for Medicaid members determined with SMI.

In addition to being paneled to an ABHC, members receiving services through Assertive Community Treatment (ACT) teams must be paneled to an ACT Team. MC does not panel newly enrolled members to ACT teams.

Integrated/Behavioral Health Homes and ACT teams are required to manage their panels through the Member Paneling tool available in Availity. Panel changes submitted through the Member Paneling tool are processed nightly and loaded directly into the MC RBHA provider information systems.

IHH Health Homes, Integrated Behavioral Health Homes and ACT teams that fail to manage their panels are subject to corrective action, loss or reduction of incentives and sanctions.

3.19 – Reporting of Seclusion and Restraint

Definitions

Drug Used as a Restraint: Means a pharmacological restraint as used in A.R.S. §36-513 that is not standard treatment for a client's medical condition or behavioral health issue and is administered to:

- Manage the client's behavior in a way that reduces the safety risk to the client or others;
- Temporarily restrict the client's freedom of movement as defined in A.A.C. R-21-101(26).

Mechanical Restraint: Means any device, article or garment attached or adjacent to a client's body that the client cannot easily remove and that restricts the client's freedom of movement or normal access to the client's body, but does not include a device, article, or garment:

- Used for orthopedic or surgical reasons; or
- Necessary to allow a client to heal from a medical condition or to participate in a treatment program for a medical condition as defined in A.A.C. R9-21-101(44).

Personal Restraint: Means the application of physical force without the use of any device for the purpose of restricting the free movement of a client's body, but for a behavioral health agency licensed as a Level 1 RTC or a Level 1 sub-acute agency according to A.A.C. R9-10-102 does not include:

- Holding a client for no longer than 5 minutes;
- Without undue force, to calm or comfort the client; or
- Holding a client's hand to escort the client from area to another as defined in A.A.C. R9-21-101(50).

Seclusion: Means the involuntary confinement of a behavioral health member in a room or an area from which the member cannot leave.

Seclusion of Individuals Determined to Have a Serious Mental Illness: Means the restriction of a behavioral health member to a room or area using locked doors or any other device or method which precludes a member from freely exiting the room or area or which a member reasonably believes precludes his/her unrestricted exit. In the case of an inpatient facility, the grounds of the facility, or a ward of the facility does not constitute seclusion. In the case of a community residence, restricting a behavioral health member to the residential site, according to specific provisions of an Individual Service Plan or court order, does not constitute seclusion.

Reporting to MC ACC-RBHA

Licensed behavioral health facilities and programs, including out-of-state facilities, authorized to use seclusion and restraint must report each occurrence of seclusion and restraint and information on the debriefing after the occurrence of seclusion or restraint to MC ACC-RBHA's Quality Management Department within five (5) calendar days of the occurrence. The individual reports must be submitted on the **Policy 962, Attachment A, Seclusion and Restraint Individual Reporting Form.** This form is available on MC ACC-RBHA's website.

If a use of seclusion or restraint requires face-to-face monitoring, a report detailing face-to-face monitoring is submitted to MC ACC-RBHA Quality Management (QM) along with the Policy 962, Attachment A, Seclusion and Restraint Individual Reporting Form. The face-to-face monitoring form must include the requirements as per A.A.C. R9-21-204**.**

Each subcontracted licensed Level 1 Behavioral Health Inpatient Facility must also report the total number of occurrences of the use of seclusion and restraint for MC ACC-RBHA members that occurred in the prior month to MC ACC-RBHA QM the 5th calendar day of the month. If there were no occurrences of seclusion and restraint for MC ACC-RBHA members during the reporting period, the report should so indicate.

All documentation related to a single seclusion or restraint submission, including all required supporting records and the 962 Attachment, **must be consolidated into one complete PDF document prior to submission**. Submissions containing multiple separate attachments will be considered non-compliant and will not be accepted for review.

To maintain consistency, all seclusion and restraint reported events for MC ACC-RBHA members are to be submitted via email directly to MercyCareSandR@MercyCareAZ.org or via fax to 1-855-224-4908.

3.20 – Out of State Treatment for Behavioral Health

General Requirements

When MC considers an out-of-state treatment for a child or young adult, the following conditions apply:

- The Child and Family Team (CFT) or Adult Recovery Team (ART) will consider all applicable and available in-state services and determine that the services do not adequately meet the specific needs of the member; and additionally, a minimum of three in-state facilities must decline to accept the member;
- The member's family/guardian (not including those not under guardianship between 18 and under 21 years of age) agrees with the out-of-state treatment;
- The out-of-state treatment facility is registered as an AHCCCS provider; and is willing to accept AHCCCS rates or enter into a Single Case Agreement (SCA) with MC;
- The out-of-state treatment facility meets the Arizona Department of Education Academic Standards;
- A plan for the provision of non-emergency medical care must be established; and
- If a member has been placed out-of-state secondary to an emergency, unforeseen event, or by a third-party liability insurance, MC must address all above conditions as soon as notification of the out-of-state treatment is received.

Conditions before Referral for Out-of-State Placement

Documentation in the clinical record must indicate the following conditions have been met before a referral for an out-of-state treatment is made:

- All less restrictive, clinically appropriate treatment interventions have either been provided or considered by the CFT or ART and found not to meet the member's needs;

- The CFT or ART has been involved in the service planning process and agrees with the out-of-state treatment;
- The CFT or ART has determined how they will remain active and involved in service planning once the out-of-state treatment has occurred;
- The CFT or ART develops a proposed Individual Service Plan that includes a discharge plan that has been developed that addresses the needs and strengths of the member;
- All applicable prior authorization requirements have been met;
- The Arizona Department of Education has been consulted to ensure that the educational program in the out-of-state placement meets the **Arizona Department of Education Academic Standards** and the specific educational needs of the member;
- Coordination has occurred with other state agencies involved with the member, including notification to the DDD Medical Director when the individual is enrolled DD eligible;
- The member's AHCCCS Health Plan Behavioral Health Coordinator or health care provider has been contacted and a plan for the provision of any necessary non-emergency medical care has been established and is included in the comprehensive clinical record. The Behavioral Health Home in coordination with the family/legal guardian will coordinate with the AHCCCS Health Plan to decide and document all contacts and arrangements;
- MC Health Plan Coordinator will send notification of the pending out-of-state transition with the admission date and facility to the appropriate Health Plan AHCCCS Behavioral Health Coordinator.
- Cultural considerations have been explored and incorporated into the ISP; and
- If a member has been placed out-of-state secondary to an emergency or unforeseen event, MC must address all above conditions as soon as notification of the out-of-state placement is received.

The Individual Service Plan (ISP)

For a member placed out-of-state, the ISP developed by the CFT, or ART must require that:

- Discharge planning is initiated at the time of request for prior authorization or notification of admission (if placed prior by TPL or another state agency), including:
    - The measurable treatment goals being addressed by the out-of-state placement and the criteria necessary for discharge back to in-state services;
    - The planned or proposed in-state residence where the member will be returning;
    - The recommended services and supports required once the member returns from the out-of-state placement;
    - What needs to be changed or arranged to accept the member for subsequent in-state treatment that will meet the member's needs;
    - How effective strategies implemented in the out-of-state treatment will be transferred to the member's subsequent in-state treatment;

    - The actions necessary to integrate the member into family and community life upon discharge; and
    - The CFT or ART actively reviews the member's progress with clinical staffing occurring at least every 30 days. Clinical staffing must include the staff of the out-of-state facility.
- The member's family/guardian is involved throughout the duration of the treatment. This may include family counseling in member or by teleconference or video-conference;
- The CFT or ART must ensure that essential and necessary health care services are provided in coordination with the member's medical health plan; Home passes are allowed as clinically appropriate. Please refer to **AMPM Chapter 200 – Behavioral Health Practice Tools** for more guidance. For youth in Department of Child Safety (DCS) custody, home passes must be determined only in close collaboration with DCS.

Initial Notification to AHCCCS Office of Management

Prior authorization must be obtained before making a referral for out-of-state treatment, in accordance with MC criteria. MC requires their providers assist with supplying the information required on the form and with providing copies of supporting clinical documentation.

Process for Initial Notification to MC

For behavioral health providers contracted with MC, the provider is required to coordinate with MC the intent to make a referral for out-of-state treatment as follows:

- For children/adolescent and adults under the age of 21, the Behavioral Health Home Clinical Leadership is expected to follow guidelines regarding Securing Services and Prior Authorization**.**

If a child/adolescent or adult under age 21 is approved for an inpatient treatment, and all in-state inpatient providers have been exhausted:

- The Behavioral Health Home Clinical Leadership will coordinate with applicable key stakeholders (i.e., DCS, JPO, and DDD) and verify they agree for an out-of-state placement. If there is disagreement, which cannot be resolved, the Behavioral Health Home Clinical Leadership may contact MC for assistance in resolution.
- The MC Care Management Department will review the form and forward by secure email to the AHCCCS Office of Medical Management at **MedicalManagement@azahcccs.gov** for review and approval prior to placing the child or young adult.
- When the out-of-state treatment is approved AHCCCS, MC will notify the Behavioral Health Home Clinical Leadership and direct them to complete the out of state placement process.
- MC will identify out-of-state AHCCCS registered providers and send referrals to the

provider and case management team.
- Once the accepting facility is identified, MC will facilitate a Single Case Agreement (SCA) and coordination transportation.

Periodic Updates to AHCCCS Office of Medical Management

In addition to providing initial notification, updates are required to be submitted every 30 days to AHCCCS regarding the member's progress in meeting the identified criteria for discharge from the out-of-state treatment. The 30-day update timelines will be based upon the date of admission to the out-of-state treatment as reported by MC to AHCCCS. The update will include a review of progress, CFT participation, evaluation of the discharge plan and availability of services based on the member's needs.

MC reviews the form for completeness and submits it to the AHCCCS Office of Medical Management.

Additionally, MC must submit notification to AHCCCS within forty-eight (48) hours of MC being notified when an out-of-state treatment is discontinued.

3.21 – Behavioral Health Assessment and Service Planning Overview

MC supports a model for assessment, service planning, and service delivery that is individualized, member-centered, strength-based, inclusive of family and/or natural supports, culturally and linguistically appropriate, and clinically sound.

The model incorporates the concept of a "team," established for each member receiving behavioral health services. For children, this team is the Child and Family Team (CFT) and for adults, this team is the Adult Recovery Team (ART).

At a minimum, the functions of the CFT and ART include:

- Ongoing engagement of the member, family and other formal and informal supports who are significant in meeting the behavioral health needs of the member, including their active participation in the decision-making process and involvement in treatment;
- An assessment process is conducted to elicit information on the strengths, needs and goals of the individual member and his/her family, identify the need for further or specialty evaluations, and support the development and updating of a service plan which effectively meets the member's/family's needs and results in improved health outcomes;
- Continuous evaluation of the effectiveness of treatment through the CFT and ART process, the ongoing assessment of the member, and input from the member and his/her team resulting in modification to the service plan, if necessary;

- Provision of all covered services as identified on the service plan, including assistance in accessing community resources, as appropriate and, for children, services which are provided in accordance with the Arizona Vision and 12 Principles, and for adults, services which are provided in accordance with the 9 Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems;
- Ongoing collaboration, including the communication of appropriate clinical information, important to achieving positive outcomes (e.g., primary care providers, school, child welfare, juvenile or adult probation, other involved service providers);
- Oversight to ensure continuity of care by taking the necessary steps (e.g., clinical oversight, development of facility discharge plans, or after-care plans, transfer of relevant documents) to assist members who are transitioning to a different treatment program, (e.g., inpatient to outpatient setting), changing behavioral health providers and/or transferring to another service delivery system (e.g., out-of-area, out-of-state or to an Arizona Long Term Care System (ALTCS) Contractor); and
- Development and implementation of transition plans prior to discontinuation or modification of behavioral health services.

For additional information regarding the Child and Family Team practice refer to **AHCCCS AMPM 580 – Child and Family Team**.

The Twelve (12) Principles for Children's Service Delivery are as follows:

1. Collaboration with the child and family
2. Functional outcomes
3. Collaboration with others
4. Accessible services
5. Best practices
6. Most appropriate setting
7. Timeliness
8. Services tailored to the child and family
9. Stability
10. Respect for the child and family's unique cultural heritage
11. Independence
12. Connection to natural supports

The Nine (9) Guiding Principles for Adults are as follows:

1. Respect
2. People choose their services
3. Focus on the whole person and natural supports
4. Independence
5. Integration, collaboration, participation in community

6. Partnership between individuals, staff, family members, and natural supports
7. People define their own successes
8. Services are strength-based, flexible and responsible
9. Hope

The Health Homes and Primary Behavioral Health Providers shall coordinate with Specialty Behavioral Health Providers as specified by policy. The Specialty Behavioral Health Providers shall complete assessments and develop treatment plans that are clinically appropriate within their scope of practice, as specified in A.A.C. Title 9, Chapter 10 and as specified by policy. The Specialty Behavioral Health Providers shall coordinate with Health Homes and Primary Behavioral Health Providers to obtain copies of comprehensive assessment and other clinical documentation as specified within AHCCCS Medical Policy Manual **320-O Behavioral Health Assessment, Service and Treatment Planning**.

The behavioral health comprehensive assessments and service plans shall be updated at minimum once annually or may be updated more often as medically necessary, based on clinical needs or upon significant life events including but not limited to:

- A change in housing location or status including loss of housing,
- Death of a family member or friend,
- Change in family structure (e.g., divorce, separation, placement disruption, birth or loss of a child/children),
- Hospitalization (including physical heath, behavioral health crisis stabilization, observation, or inpatient),
- Major illness of the member, their family member, or person of importance,
- Change in level of care,
- Incarceration,
- Any event that may cause a disruption of normal life activities, including a crisis event, based on a member's identified perspective and need, and
- Any change in diagnosis/es as determined by a licensed BHP or Behavioral Heath Medical Professional (BHMP).

For members with an SMI designation, a special assistance assessment shall be completed in accordance with AMPM Policy 320-R.

For members under the legal custody of the Arizona Department of Child Safety (DCS), assessment, service and/or treatment planning shall be coordinated as necessary, based on the child's assigned health plan (e.g., ALTCS E/PD, CHP or DES DDD).

3.22 – Assessments

All individuals being served in the public behavioral health system must have a behavioral health assessment upon an initial request for services. For individuals who continue to receive behavioral health services, updates to the assessment must occur at least annually. For Health Homes and Primary Behavioral Health Providers, behavioral health services may not be provided prior to the completion of a comprehensive assessment and the development of a service plan, with the exception of interim behavioral health services identified in the comprehensive assessment. Interim behavioral health services must begin immediately to prevent harm to a member and documentation of medical necessity including why the service(s) cannot be postponed until a formal service plan meeting shall be maintained in the member record.

Behavioral health assessments must be utilized to collect necessary information that will inform providers of how to plan for effective care and treatment of the individual.

MC does not mandate that a specific assessment tool or format be used by requires certain minimum elements. Assessment of substance use disorders and related levels of service provision using the ASAM Criteria (most current edition) for assessment, service planning, and level of care placement for members who have SUD or co-occurring mental health and SUD.

Providers must collect and submit all required demographic information in accordance with the criteria outlined in the AHCCCS DUGless User Guide (DUG).

The initial and annual assessment must be completed by a behavioral health professional (BHP) or behavioral technician (BHT) under the clinical oversight of a BHP, who is trained on the minimum elements of a behavioral health. If an assessment is conducted and documented by a BHT, a BHP must review and sign the assessment information that was documented by the BHT within 72 hours of the BHT signature.

3.23 - Minimum Elements of the Behavioral Health Assessment

MC has established the following minimum elements that must be included in a comprehensive behavioral health assessment and documented in the comprehensive clinical record.

An assessment shall include an evaluation of the member's:

a. Presenting concerns
b. Information on the strengths and needs of the member and their family
c. Current and past behavioral health treatment, current and past medical conditions and treatment
d. History of physical, emotional, psychological or sexual trauma at any stage of life, if applicable

e. Family behavioral health and medical history
f. History of other types of trauma (e.g., environmental, natural disasters, etc.)
g. Current and past substance use related disorders, if applicable
h. Status of basic needs, or Health Related Social Needs (HRSN)
    i) Living environment
    ii) Educational and vocational training
    iii) Employment (paid or volunteer activities)
    iv) Interpersonal, social and cultural skills
i. Developmental history
j. Criminal justice history
k. Public (e.g., unemployment, food stamps) and private resources (e.g., faith-based, natural supports)
l. Legal status (e.g., present or absence of an HCDM) and apparent capacity (e.g., ability to make decisions or complete daily living activities)
m. Language and communication capabilities
n. Risk assessment of the member
o. Mental status of the member
p. Summary of clinician's impressions and observations
q. Recommendations of member needs and next steps
r. Diagnostic impressions of the qualified clinician
s. Identification of the need for further or specialty evaluations
t. Other information that is determined to be relevant
u. Diagnosis(es) using current DSM or most recent revision
    i) Diagnosis(es) may only be given by a licensed BHP or BHMP within their scope of practice.

Additional assessment components:

a. An assessment may also include, but is not limited to:
    i) A psychiatric evaluation
    ii) A psychological evaluation
    iii) A crisis assessment
    iv) Standardized assessment to address specific needs (e.g., depression, anxiety, need for HRSN) or identify recommended levels of care, or
    v) Specific assessments by specialty behavioral health providers to meet the member's specific treatment needs
b. If a standardized assessment tool is used (e.g., CALOCUS, ASAM CONTINUUM, LOCUS), results shall be shared and discussed with the member's team including ART/CFT. Differences in recommended level of care shall be addressed with the member and the team to reach a determination on next steps for the member's treatment plan.

c. Children birth through five: Refer to AHCCCS AMPM Policy 581 for information on Early Childhood Service Intensity Instrument (ECSII)
d. Children six through 17: CALOCUS shall be completed during the initial assessment and updated at least every six months or more often as clinically appropriate.
e. Children ages 11 through 17 who have an identified Substance Use Disorder and may need treatment services: A standardized screening/assessment tool may be used to evaluate potential treatment recommendations but must be normed to the member's age.
f. Members ages 18 and up who have an identified Substance Use Disorder and may need treatment services: ASAM criteria shall be used to evaluate adults for substance use level of care recommendations. ASAM CONTINUUM may be used if available but is not required.

Additional assessment requirements:

a. REQUIRED FOR ALL TITLE XIX/XXI MEMBERS: Primary Care Provider (PCP) name and contact information.
b. REQUIRED FOR ALL TITLE XIX/XXI MEMBERS: Involvement with other agencies (e.g., Department of Child Safety, Probation).
c. ONLY REQUIRED FOR CHILDREN AGED 0 TO 5: Developmental screening for children aged 0-5 with a referral for further evaluation by the child's Primary Care Provider (PCP), the Arizona Early Intervention Program (AzEIP) for children aged 0-3, or the public-school system for children aged 3-5 when developmental concerns are identified.
d. ONLY REQUIRED FOR CHILDREN AGED 6 TO 18: Child and Adolescent Level of Care Utilization System (CALOCUS) Score and Date.
e. ONLY REQUIRED FOR CHILDREN AGED 6 TO 18: Strength, Needs and Culture Discovery Document.
f. ONLY IF INDICATED: Seriously Mentally Ill Determination (for members who request SMI determination or have an SMI qualifying diagnosis) in accordance with Chapter 3 – Behavioral Health, Section **3.18 – SMI Eligibility Determination and SED Identification** in this manual.
g. ONLY REQUIRED FOR MEMBERS DETERMINED SMI: Special Assistance assessment in accordance with **MC Provider Manual Chapter 100 – General Terms, Chapter 18 – Grievance System, Member Rights**, and Claim Disputes and **AHCCCS AMPM Policy 320-R – Special Assistance for Members with Serious Mental Illness**.

Safety Planning

A safety plan provides a written method for potential crisis support or intervention that identifies needs and preferences that are most helpful in the event of a crisis. A safety plan shall be developed in accordance with the Vision and Guiding Principles of Children's System of Care

and the Nine Guiding Principles of the Adult System of Care, as specified in AMPM Policy 100. Safety plans shall be trauma informed, with a focus on safety and harm reduction.

The development of a safety plan shall be completed in alignment with the member's service and treatment plan, and any existing behavior plan if applicable (e.g., Functional Behavioral Assessment [FBA], DES/DDD Behavior Treatment Plan [BTP]). The development of a safety plan shall be considered when any of the following clinical indicators are identified in a member's treatment, service, or behavior plan:

a. Justice involvement
b. Previous psychiatric hospitalizations
c. Out-of-home placements:
d. Special health care needs
e. History of, or presently under Court Ordered Treatment (COT)
f. History or present concern of Danger to Self/Danger to Others (DTS/DTO)
g. Members with an SMI designation
h. Members identified as high risk/high needs and/or
i. Children aged six through 17 with a CALOCUS Level 4, 5, or 6

Safety plans shall be updated annually, or more frequently if a member meets one or a combination of the above criteria, or if there is a significant change in the member's needs. A copy of the safety plan shall be distributed to the outpatient team members that assisted with development of the safety plan.

Safety plans shall be updated annually, or more frequently if a member meets one or a combination of the above criteria, or if there is a significant change in the member's needs. A copy of the safety plan shall be distributed to the outpatient team members that assisted with development of the safety plan.

A safety plan does not replace or supplant a Mental Health Power of Attorney or behavior plan but rather serves as a complement to these existing documents.

Essential Elements

A safety plan shall establish goals to prevent or ameliorate the effects of a crisis and shall specifically address:

a. Techniques for establishing safety, as identified by the member and/or HCDM, DR, as well as members of the CFT or ART,
b. Realistic interventions that are most helpful or not helpful to the individual and their family members/responsible person or support system,
c. Consideration of physical limitations, comorbid conditions, or other unique needs the member may have that would aid in reduction of symptoms,

d. Guiding the support system toward ways to be most helpful to members and their families,
e. Multi-system Involvement,
f. Adherence to COT (if applicable),
g. Necessary resources to reduce the chance for a crisis or minimize the effects of an active crisis for the member.

This may include, but is not limited to:

a. Clinical (support staff/professionals), medication, family, friends, HCDM and/or DR, environmental,
b. Notification to and/or coordination with others, and
c. Assistance with and/or management of concerns outside of crisis (e.g., animal care, children, family members, roommates, housing, financials, medical needs, schoolwork).

For members referred for or identified as needing ongoing psychotropic medications for a behavioral health condition, the assessor must establish an appointment with a licensed medical practitioner with prescribing privileges. If the assessor is unsure regarding a member's need for psychotropic medications, then the assessor must review the initial assessment and treatment recommendations with his/her clinical supervisor or a licensed medical practitioner with prescribing privileges.

Members with substance use disorders, primarily opioid addiction, may be appropriately referred to Medication Assisted Treatment (MAT). MAT services are a combination of medications and counseling/behavioral therapies to provide a "whole patient" approach to the treatment of substance use disorders. MC contracts with network providers to specifically prescribe and/or dose medications to normalize brain chemistry, block the euphoric effects of alcohol and opioids, relieve physiological cravings, and normalize body functions without the negative effects of the used drug. MC members may solely receive behavioral health services from contracted MAT providers; members may also receive behavioral health services from one agency and receive MAT services from another provider. Providers involved are required to provide care coordination to optimize treatment outcomes for these members.

Food Insecurities

In addition to the AHCCCS minimum requirements for the comprehensive assessment, MC has additional elements that must be documented in the comprehensive clinical record as they relate to members residing in a limited supermarket access zip code.

As health care professionals, we need to assess member need and the HRSN that may be impacting the member's level of engagement, health, and treatment plan. The United States Department of Agriculture (USDA) makes a clear and explicit distinction between food

insecurity and hunger. “Food insecurity – the condition assessed in the food security survey and represented in USDA food security reports – is a household - level economic and social condition of limited or uncertain access to adequate food. Hunger is an individual-level physiological condition that may result from food insecurity.” (Source: https://www.ers.usda.gov/data-products/food-security-in-the-united-states/.)

Every member must be evaluated for food Insecurity and proximity to a limited supermarket access zip code. Often our members cannot access the health care and food they need when they need it. Many of our members live in limited supermarket access areas or “food deserts” and are uncertain as to where their next meal will come from or where they will obtain food for themselves and their families. Therefore, it’s important to assess where our members are obtaining their food and how often. The question below can be used to evaluate member food insecurity:

In the past 12 months, have you been uncertain as to where to access your next meal? Uncertainty would be defined as unable to articulate or develop a plan as to how they will access food for themselves or their family.

Some examples would include:

- Not having access to available funds for food;
- Inability to find transportation to secure food and food related items;
- Outreaching friends/family members for assistance has proven to be unsuccessful;
- Unable to locate food access through community programs/resources;
- Difficulty with budget planning, etc.

.

The USDA survey could be used as a guide to the assessment questions as you assess food insecurity. Those questions can be found at https://www.ers.usda.gov/data- products/food-security-in-the-united-states/.

If a member replies yes to the question above, they would be identified as food insecure or having a food insecurity. If a member identifies as being food insecure and they live in a limited supermarket access area, additional measure should be taken to address the members need. Limited supermarket access or LSA is identified within designated areas in the Phoenix Metro area. The identification of the zip codes is set forth by the 2014 reinvestment funds LSA analysis tool found on www.policymap.com/maps. This is a useful tool to decipher whether someone lives in an LSA. Refer to data available under the ‘Quality of Life’ on this website.

If a person is identified as being food insecure and/or living in an LSA, the treatment team must assist the member by adding this designation to the treatment plan and assist the member with

identifying resources independently to obtain food on a regular basis. Examples of interventions that may be used to address this are as follows:

- Connecting them with DES and DHS to enroll them into Federal Nutrition programs like SNAP and WIC
    - Transportation by bus
- Local food pantry that can provide free groceries (a map of all pantries is available at www.azfoodbanks.org).
    - Budget planning
    - Referral for permanent supportive housing/peer support
    - Locating or identifying the hours of a Fresh Express (fresh food vending services) or community gardens.

Service Planning

All individuals being served in the public behavioral health system must have a written plan for services upon an initial request for services and periodic updates to the plan to meet the changing behavioral health needs for individuals who continue to receive behavioral health services. The service plan shall be developed and administered by the health home, primary behavioral health provider acting as a member's health home for those not formally assigned to a health home. MC does not mandate a specific service planning tool or format. Service plans must be utilized to document services and supports that will be provided to the individual, based on behavioral health service needs identified through the member's behavioral health assessment. The service plan shall be updated at least once a yar and anytime a member experiences a significant life event.

If a member is in immediate or urgent need of behavioral health services, an interim service plan may need to be developed to document services until a complete service plan is developed. If interim behavioral health services are utilized the service or treatment plan shall be completed accordingly as specified in A.A.C. Title 9, Chapter 10 and A.A.C. Title 9 Chapter 21. A complete service plan, however, must be completed no later than 7 days after the initial appointment.

The behavioral health member, his/her guardian (if applicable), advocates (if assigned) must be included in the development of the service plan. In addition, family members, Health Care Decision Maker (HCDM), agency representatives, and other involved parties, as applicable, may be invited to participate in the development of the service plan. Behavioral health providers must coordinate with the member's health plan, PCP or others involved in the care or treatment of the individual, as applicable, regarding service planning recommendations.

The service plan must be documented in the comprehensive clinical record in accordance with **MC Provider Manual Chapter 100 – General Terms, Chapter 4 – Provider Responsibilities,**

Section 4.19 – Member's Medical Records, be based on the current assessment, and contain the following elements:

- The member/family vision that reflects the needs and goals of the member/family;
- Identification of the member's/family's strengths;
- Goals and objectives. The goals and objectives shall be individualized, measurable and reflect the member's definition of achievement.
-
- The services recommended to address all identified needs based on the comprehensive assessment, including the frequency and duration of each covered service identified in the Behavioral Health Services Matrix (B2 Matrix) and in alignment with AMPM Policy 310.
- Specific strategies and methods for treating the needs identified in the assessment;
- Who is responsible for providing each service and/or treatment component identified in the assessment (changes in specialty providers do not warrant an immediate revision of the service plan prior to the initiation of services by the new provider, however, shall be thoroughly documented and the service plan updated as soon as is practicable to reflect responsibility);
- An identified timeframe/schedule for accomplishing the goals and objectives;
- Court Ordered Treatment (COT) specific requirements and goals (if applicable);
- Crisis contact information for any risks identified in the comprehensive assessment;
- A safety plan of action for support or intervention, that identifies a person's needs and preferences which are most helpful to them in the event of escalating circumstances that may lead to a crisis and compromise safety:
    - The safety plan shall be developed with the member and, if applicable, the HCDM, and
    - The safety plans shall be trauma informed with a focus on safety and harm reduction.
- Additional relevant documents from other service providers or entities involved in the member's care (e.g., education, probation, housing services;
- The member's mental health status and progress, including changes in functioning;
- The signature of the member/guardian and the date it was signed;
- Documentation of whether the member/guardian agrees with the plan;
- The signature of a clinical team member and the date it was signed;
- The signature of the member providing Special Assistance, for members determined to have Serious Mental Illness who are receiving Special Assistance (See **Section 2.13** – Special Assistance for Members Determined to have a Serious Mental Illness); and
- The Service Plan Rights Acknowledgement Template dated and signed by the member or guardian, the member who filled out the service plan and a BHP if a BHT fills out the service plan.

If a member is identified as being food insecure and/or food insecure and living in an LSA, the treatment team must assist the member by adding this designation to the treatment plan and assist the member with identifying resources independently to obtain food on a regular basis. Examples of interventions that may be used to address this are as follows:

- Bus training to a nearby grocery store;
- Budget planning;
- Referral for permanent supportive housing/peer support;
- Locating or identifying the hours of a food express (fresh food vending services) truck, or community gardens.

Service plans must be completed by BHPs or BHTs who are trained on the behavioral health service plan and meet requirements in **MC Provider Manual Chapter 100 – General Terms, Chapter 4 – Provider Responsibilities, Section 4.40 – Credentialing/Recredentialing**.

For SMI members, the ART must have a monthly meeting at minimum (for any treatment plans due that month) with case manager's staff and present members' ISP goals. Members, HCDM, designated representatives, and guardians should be given the option of attending this meeting in person to review the team's recommendations. If the member/HCDM declines to attend in person, the case manager or designated staff should contact the member/HCDM within 5 business days to see if they are agreeable to putting the recommendations in the treatment plan. If they are not agreeable, the case manager should attempt to resolve any issues and utilize the assistance of the clinic peer support specialist in engagement and to assist in resolution.

The behavioral health member and/or their parent/guardian must be provided with a copy of their plan. Questions regarding service plans or member rights should be directed to MC's customer service line at 800-564-5465.

Treatment Planning – Specialty Providers

Treatment planning is focused on specific interventions and therapeutic strategies to address the symptoms of a diagnosed condition by a specialty behavioral health provider, including inpatient and crisis providers. A treatment plan is a written plan of specific physical and/or behavioral health services and therapeutic interventions that the provider will provide to the member based on a current assessment of treatment need(s). Treatment planning may occur with more than one outpatient provider based on the member's identified need. The goals and interventions identified in the treatment plan must be based on the member's diagnosis(es) and standards of practice for the behavioral health treatment of individuals with that diagnosis. The treatment plan shall identify:

- The frequency and duration of each identified intervention. Interventions provided through covered services shall be documented as listed in the Behavioral Health Services Matrix (B2 Matrix) and in alignment with AMPM Policy 310-B.
- The specific strategies and methods for treating the needs identified in the most current comprehensive assessment.
- The goals and objectives shall be individualized, measurable and reflect the member's definition of achievement. Interventions and therapeutic strategies shall be correlated with identified needs based on the provider's assessment as well as evidence-based standards of practice for the treatment of the member's diagnosis(es) and presentation.
- A schedule for accomplishing the goals and objectives.
- The member's mental health status and progress including changes in functioning.
- The specialty behavioral health providers providing services as part of a treatment team shall provide assessments, treatment plans and progress notes to the member's health home, primary behavioral health provider acting as the member's health home pursuant to AMPM Policy 940. A member may have multiple treatment plans based on individual clinical needs.

Contact Guidelines for Children in the Custody of DCS

The Children's Behavioral Health Home (BHH) must initiate and document a minimum of one (1) contact each month for all children with DCS CHP coverage for a period of at least six (6) months from the date of behavioral health enrollment unless services are declined by the legal guardian (DCS), or the child is no longer in DCS custody. If the child has identified needs that may benefit from more frequent behavioral health services, the BHH must engage the child as frequently as is necessary to meet the needs.

Minimum elements of the service plan for Non-Title XIX/XXI members determined to have SMI that do not have an assigned Care Manager

Service plans for Non-Title XIX/XXI members determined to have SMI who do not have an assigned Care Manager can be incorporated into the psychiatric progress notes completed by the BHP if the treatment goals reflect the needs identified on the assessment, are clearly documented, and summarize the progress made. The BHP must document when a clinical goal has been achieved and when a new goal has been added.

Additionally, Non-Title XIX/XXI members determined to have SMI, who do not have an assigned Care Manager shall have the option of accessing peer support services to assist them in developing a peer-driven, self-developed proposed service plan to be shared with their BHP for approval, adoption, and implementation. These peer-driven, self-developed service plans are not required to contain all minimum elements as outlined above for those that have assigned Care Managers; however, they should consider the member-specific needs for and expected benefits from community-based support services including, but not limited to supported

employment, peer support, family support, permanent supportive housing, living skills training, health promotion, personal assistance, and respite care. Peer-driven, self-developed proposed service plans should also address natural supports that can be leveraged and strengthened as well as outline crisis prevention approaches (e.g., warm line availability) and how the emergence of a potential crisis will be addressed.

These services should be incorporated into the peer-driven, self-developed proposed service plan as appropriate. It is recommended that a standardized process be used to develop peer-driven, self-developed proposed service plans.

Additionally, the peer-driven, self-developed proposed service plan must be reviewed with and approved by the BHP and maintained in the medical record. Progress and outcomes related to the approved peer-driven, self-developed service plan must be tracked and documented by the BHP.

Appeals or Service Plan Disagreements

Every effort should be taken to ensure that the service planning process is collaborative, solicits and considers input from each team member and results in consensus regarding the type, mix and intensity of services to be offered. If a member and/or legal or designated representative disagree with any aspect of the service plan, including the inclusion or omission of services, the team should make reasonable attempts to resolve the differences and actively address the member's and/or legal or designated representative's concerns.

3.24 – MC DCS CHP Psychiatric Acute Care and Behavioral Health Inpatient (BHIF) Services - Outpatient and Inpatient Assessments

The following guidelines are required per ARS 8-272, Psychiatric Acute Care Services; Outpatient and Inpatient Assessments:

a. If a child exhibits behavior that indicates the child may suffer from a mental disorder or is a danger to self or others, an entity may request that the child receive an outpatient assessment or inpatient assessment.
b. A psychologist, psychiatrist or physician shall conduct an outpatient assessment at a time and place that is convenient for the psychologist, psychiatrist or physician and the child. At the conclusion of the outpatient assessment, the psychologist, psychiatrist, or physician shall recommend that the child be either:
    i) Provided with outpatient treatment services.
    ii) Admitted to a psychiatric acute care facility for inpatient assessment or inpatient psychiatric acute care services.
    iii) Provided with residential treatment services.
c. Discharged to the entity without further psychological or psychiatric services because the child does not suffer from a mental disorder, is not a danger to self or others or is

not a child with a persistent or acute disability or grave disability. A psychologist, psychiatrist or physician shall conduct an inpatient assessment within seventy-two (72) hours after a child is admitted to an inpatient assessment facility, excluding weekends and holidays. At the conclusion of the inpatient assessment, the psychologist, psychiatrist, or physician shall recommend that the child be either:

i) Admitted to a psychiatric acute care facility for inpatient psychiatric acute care services.
ii) Discharged to an entity and provided with outpatient treatment services.
iii) Provided with residential treatment services.
iv) Discharged to the entity without further psychological or psychiatric services because the child does not suffer from a mental disorder, is not a danger to self or others or is not a child with a persistent or acute disability or grave disability.

d. Within twenty-four hours after a child is admitted for an inpatient assessment, excluding weekends and holidays, the entity shall file a motion for approval of admission for inpatient assessment court. The motion shall include all the following:
   i) The name and address of the juvenile inpatient assessment facility.
   ii) The name of the psychologist, psychiatrist or physician who is likely to perform the inpatient assessment.
   iii) The date and time the child was admitted to the inpatient assessment facility.
   iv) A short statement explaining why the child needs an inpatient assessment.
e. An entity that files a motion under subsection D of this section shall provide a copy of the motion to all the parties and their attorneys. The court shall rule on the motion without response from any party, except that any party may request a hearing to review the child's admission for an inpatient assessment. If the court grants a hearing, the court shall set the hearing on an accelerated basis.
f. If the psychologist, psychiatrist, or physician who performed the outpatient assessment or inpatient assessment of the child recommends that the child receive inpatient acute care psychiatric services, the entity may file a motion for inpatient psychiatric acute care services with the juvenile court. Within 72 hours of Admission, a **Statement from the Medical Director/ Designee of Inpatient Psychiatric Acute Care Hospital (CSO-1364B)** must be provided by the medical provider stating that the facility's services are appropriate to meet the child's needs. The motion shall include all the following:
   i) A copy of the written report of the results of the inpatient assessment or outpatient assessment, including:
      - The reason inpatient psychiatric acute care services are in the child's best interests.
      - The reason inpatient psychiatric acute care services are the least restrictive available treatment.
      - A diagnosis of the child's condition that requires inpatient psychiatric acute care services.

- The estimated length of time that the child will require inpatient psychiatric acute care services.

ii) A **Statement from the Medical Director/ Designee of Inpatient Psychiatric Acute Care Hospital (CSO-1364B)** must be provided by the medical provider stating that the facility's services are appropriate to meet the child's needs.

g. As soon as practicable after the filing of a motion under subsection D or F of this section, the court shall appoint an attorney for the child if an attorney has not been previously appointed. The court may also appoint guardian ad litem for the child.

h. If a motion is filed pursuant to subsection F of this section, the court shall hold a hearing on the motion within seventy-two hours after the motion is filed, excluding weekends and holidays. If the child has been admitted for an inpatient assessment, the child may remain at the inpatient assessment facility until the court rules on the motion.

i. If a child is admitted for an inpatient assessment and an entity fails to file a motion pursuant to and within the time limit prescribed in subsection F of this section, the child shall be discharged from the inpatient assessment facility.

j. If the court approves the admission of the child for inpatient psychiatric acute care services, the court shall find by clear and convincing evidence that both:

i) The child is suffering from a mental disorder or is a danger to self or others and requires inpatient psychiatric acute care services.

ii) Available alternatives to inpatient psychiatric acute care services were considered, but that inpatient psychiatric acute care services are the least restrictive available alternative.

k. The court shall review the child's continuing need for inpatient psychiatric acute care services at least every sixty days after the date of the treatment order. The medical provider must complete the **60 Day Review of Residential/ Psychiatric Treatment Services, CSO-1361A** addressing the child's continuing need for inpatient psychiatric acute care services. This form is filled out at least every 60 days after the date of the treatment order. The inpatient psychiatric acute care facility shall the report to the court at least five days before the review and shall provide copies of the progress report to all the parties, including the child's attorney and guardian ad litem. On its own motion or on the motion of a party, the court may hold a hearing on the child's continuing need for inpatient psychiatric acute care services. If requested by the child, the court shall hold a hearing unless the court has held a review hearing within sixty days before the child's request. If requested by the child, the court may hold a hearing at any time for good cause shown. The progress report shall make recommendations and shall include at least the following:

i) The nature of the treatment provided, including any medications and the child's current diagnosis.

ii) The child's need for continued inpatient psychiatric acute care services, including the estimated length of the services.

iii) A projected discharge date.
iv) The level of care required by the child and the potential placement options that are available to the child on discharge.
v) A statement from the medical director of the inpatient psychiatric acute care facility or the medical director's designee as to whether inpatient psychiatric acute care services are necessary to meet the child's mental health needs and whether the facility that is providing the inpatient psychiatric acute care services to the child is the least restrictive available alternative.

l. On its own motion or on the motion of a party, the court may hold a hearing on the child's continuing need for inpatient psychiatric acute care services. If requested by the child, the court shall hold a hearing unless the court has held a review hearing within sixty days before the child's request. If requested by the child, the court may hold a hearing at any time for good cause shown. The progress report shall make recommendations and shall include at least the following:
    i) The nature of the treatment provided, including any medications and the child's current diagnosis.
    ii) The child's need for continued inpatient psychiatric acute care services, including the estimated length of the services.
    iii) A projected discharge date.
    iv) The level of care required by the child and the potential placement options that are available to the child on discharge.
    v) A statement from the medical director of the inpatient psychiatric acute care facility or the medical director's designee as to whether inpatient psychiatric acute care services are necessary to meet the child's mental health needs and whether the facility that is providing the inpatient psychiatric acute care services to the child is the least restrictive available alternative.

m. If a child is transferred from an inpatient psychiatric acute care facility to another inpatient psychiatric acute care facility, no new inpatient assessment or outpatient assessment is required. Unless the court orders otherwise due to an emergency, an entity shall file a notice of transfer with the juvenile court at least five days before the transfer of the child. The notice shall include all the following:
    i) The name and address of the facility to which the child is being transferred and the date of the transfer.
    ii) A statement from the medical director of the receiving inpatient psychiatric acute care facility or the medical director's designee that the receiving facility is an appropriate facility to meet the child's mental health needs and that it is the least restrictive available alternative.
    iii) A statement that the entity has contacted the child's attorney or guardian ad litem and whether the child or the child's attorney or guardian ad litem opposes the transfer.

n. Any party may request a hearing to review the transfer of a child to another inpatient psychiatric acute care facility pursuant to subsection L of this section.
o. Within fifteen days after a child is discharged, the inpatient psychiatric acute care facility shall prepare a discharge summary. Within twenty days after a child is discharged, an entity shall file a notice of discharge with the juvenile court. The notice shall include:
    i) A statement of the child's current placement.
    ii) A statement of the mental health services that are being provided to the child and the child's family.
    iii) A copy of the discharge summary that is prepared by a mental health professional.
p. When possible, the child's attorney shall communicate with the child within twenty-four hours after a motion is filed pursuant to subsection D or F of this section, excluding weekends and holidays. The child's attorney shall discuss treatment recommendations and shall advise the child of the child's right to request a hearing. The child's attorney or designee shall attend all court hearings related to the child's inpatient assessment or inpatient psychiatric acute care services and shall be prepared to report to the court the child's position on any recommended assessments or treatment. The child may attend any hearing unless the court finds by a preponderance of the evidence that allowing the child to attend would not be in the child's best interests.
q. Section 8-273 applies if residential treatment services are recommended after an inpatient assessment or outpatient assessment or any inpatient psychiatric acute care treatment. Section 8-341.01 applies if a child who is adjudicated delinquent or incorrigible and who is subject to the jurisdiction of the juvenile court requires residential treatment services. Section 41-2815 applies if a child who is committed to the department of juvenile corrections requires residential treatment services. If the inpatient assessment recommends Behavioral Health Inpatient Facility Services:
    i) Within 72 hours of Admission, the recommendation and assessments must be documented with either **Inpatient Assessment Report (CSO-1364A)**, if recommendation made from inpatient setting or **Outpatient Assessment Report (CSO-1363A)**, if recommendation made from outpatient setting.
    ii) Within 72 hours of Admission, the **Statement from Medical Director/Designee of Residential Treatment Center (BHIF-RTC) (CSO-1364C)** must be provided by the medical provider stating that the facility's services are appropriate to meet the child's mental health needs.
    iii) If the child remains in a BHIF for at least 60 days or longer, the medical provider must complete **60 Day Review of Residential/Psychiatric Treatment Services (CSO-1361A)**); and the BHIF must submit provide a written progress report.
r. Section 8-273 applies if residential treatment services are recommended after an inpatient assessment or outpatient assessment or any inpatient psychiatric acute care treatment. Section 8-341.01 applies if a child who is adjudicated delinquent or

incorrigible and who is subject to the jurisdiction of the juvenile court requires residential treatment services. Section 41-2815 applies if a child who is committed to the department of juvenile corrections requires residential treatment services.

s. Information and records that are obtained or created during any assessment, examination or treatment are subject to the confidentiality requirements of section 36-509, except that information and records may be provided to the department of juvenile corrections pursuant to section 8-341.

t. For the purposes of this section, "child" means a person who is under eighteen years of age or, if the juvenile court has retained jurisdiction over the person pursuant to section 8-202, subsection H, under nineteen years of age and who is either:
    i) Found to be dependent or temporarily subject to court jurisdiction pending an adjudication of a dependency petition.
    ii) In the temporary custody of the department pursuant to section 8-821.
    iii) Detained in a juvenile court detention facility.
    iv) Committed to the department of juvenile corrections.
    v) 5. Found to be delinquent and subject to probation supervision.

3.25 – Children's Behavioral Health Residential Facility (BHRF) and Children's Behavioral Health Inpatient Facility (BHIF) Requirements

If a children's Behavioral Health Residential Facility (BHRF) or children's Behavioral Health Inpatient Facility (BHIF), has bed space available and a child/adolescent is prior authorized for treatment, the BHRF or BHIF may not deny treatment if:

- The behavioral health needs are within the scope of services provided.
- The placement does not disrupt the environment of the treatment program, including the behavioral needs of other residents of the behavioral health program.
- The child/adolescent condition is a behavioral health condition.
- The child/adolescent requires medication management for a chronic physical health condition.

If a children's BHRF or BHIF denies treatment of a child who has referred the children's Behavioral Health Facility must:

- Document the specific clinical reason for denying treatment of the child/adolescent.
- Notify MC of the reason for the denial within 24 hours after the decision has been made.
- When possible, work collaboratively with MC and the Behavioral Health Home (BHH) to explore alternative placements or additional supports that may facilitate a successful placement of the child/adolescent. These efforts should be documented.

3.26 - Provider Submits a Complex Case Request

In the event a provider determines a need for an action, they may complete a **Complex Case Review Form** available under **Forms** on the MC website and submit it to MC Medical Management at **ComplexCase@MercyCareAZ.org** for review. For additional guidance see Provider Manual, Title XIX/XXI Notice and Appeal Requirements, subsection Complex Case Requests. Medical Management staff will evaluate the request to determine if it requires a notice. If a notice is required, MC will issue the NOA in accordance with ACOM 414, Notice of Adverse Benefit Determination and Notices of Extension for Service Authorizations.

In cases that a member determined to have a Serious Mental Illness and/or legal or designated representative disagree with some or all of the Non-Title XIX/XXI covered services included in the service plan, the member and/or legal or designated representative **must** be given a **Notice of Decision and Right to Appeal (For Individuals With a Serious Mental Illness)** available under **Forms** on the MC website by the behavioral health representative on the team.

In either case, the member and/or legal or designated representative may file an appeal within 60 days of the action.

3.27 - Update to Assessment and Service Plan

Behavioral health assessments, service, and treatment plans shall be updated at minimum, once annually or more often as necessary, based on clinical needs and/or upon significant life events including but not limited to:

a. Moving, or a change in housing location or status,
b. Death of a family member or friend,
c. Change in family structure (e.g., divorce, separation, adoption, placement disruption),
d. Hospitalization,
e. Major illness of the member, their family member, or person of importance,
f. Change in level of care,
g. Incarceration, and
h. Any event that may cause a disruption of normal life activities, based on a member's identified perspective, and need.

Additionally, SMI Direct Care Clinics' targeted thresholds for ISP and Assessments are identified as 85% per clinic/stand-alone ACT team (not per agency).

3.28 - Transfer Assessment

If an assessment has been completed by another provider, or prior to behavioral health outpatient treatment, or if the OTC has a medical record for the patient that contains an assessment that was completed within 12 months before the date of the patient's current admission, the following requirement is applicable (per A.A.C. R9-10-1011),

a. The patient's assessment information is reviewed and updated if additional information is identified that affects the patient's assessment, and
b. The review and update of the patient's assessment information is documented in the patient's medical record within 48 hours after the review is completed.

3.29 – Housing for Individuals Determined to have Serious Mental Illness (SMI) for Central GSA

AHCCCS, along with MC have worked collaboratively to ensure a variety of housing options and supportive services are available to assist members determined to have a Serious Mental Illness (SMI) live as independently as possible. Recovery often starts with safe, decent, and affordable housing so that individuals can live, work, learn, and participate fully in their communities. Safe, stable, and familiar living arrangements are critical to a member's ability to benefit from treatment and supportive services.

For DD members who have been determined to have SMI and who can live independently, there are several programs accessed through the AHCCCS Housing Program (AHP) administrator to support independent living, including rental subsidies and project-based housing that combines housing services with other ACC-RBHA covered behavioral health services.

MC believes in permanent supportive housing and has adopted the SAMHSA model for permanent supportive housing services. The 12 Key Elements of SAMHSA Permanent Supportive Housing are:

- Tenants have a lease in their name, and, therefore, they have full rights of tenancy under landlord-tenant law, including control over living space and protection against eviction.
- Leases do not have any provisions that would not be found in leases held by someone who does not have a psychiatric disability.
- Participation in services is voluntary, and tenants cannot be evicted for rejecting services.
- House rules, if any, are like those found in housing for people who do not have psychiatric disabilities and do not restrict visitors or otherwise interfere with a life in the community.
- Housing is not time-limited, and the lease is renewable at tenants' and owners' option.
- Before moving into Permanent Supportive Housing, tenants are asked about their housing preferences and are offered the same range of choices as are available to others at their income level in the same housing market.
- Housing is affordable, with tenants paying no more than 30 percent of their income toward rent and utilities, with the balance available for discretionary spending.
- Housing is integrated. Tenants can interact with neighbors who do not have psychiatric disabilities.

- Tenants have choices in the supportive services that they receive. They are asked about their choices and can choose from a range of services, and different tenants receive different types of services based on their needs and preferences.
- As needs change over time, tenants can receive more intensive or less intensive supportive services without losing their homes.
- Supportive services promote recovery and are designed to help tenants choose, get, and keep housing.
- The provision of housing and the provision of supportive services are distinct.

All members with an SMI diagnosis can apply for housing subsidies through the AHCCCS Housing Program (AHP) administrator. A housing subsidy is not required for a member to receive supportive housing services.

MC Housing Requirements

State Funded Supportive Housing Programs for Central GSA

MC complies with the following requirements to effectively manage limited housing funds by providing supportive housing services to enrolled individuals:

- MC and its subcontracted providers must not actively refer, or place individuals determined to have SMI in a homeless shelter, licensed supervisory care homes, unlicensed board and care homes, or other similar facilities.
- MC does not use supportive housing allocations for room and board charges in residential treatment settings (Level II and Level III facilities). However, MC may allow residential treatment settings to establish policies, which require that members earning income contribute to the cost of room and board.
- MC encourages its subcontracted providers to seek donations for necessary move-in/home furnishing items whenever possible. MC does not use supportive housing allocations or other funding received from AHCCCS (including block grant funds) to purchase furniture.
- For appeals related to supportive housing services, MC and its subcontracted providers must follow the requirements in **MC Provider Manual Chapter 100 - General Terms, Chapter 18 – Grievance System, Member Rights, and Claim Disputes, Section 18.03 – Serious Mental Illness (SMI) Member Appeal Resolution Process**.
- Housing related grievances and requests for investigation for members determined to have SMI must be addressed in accordance with **MC Provider Manual Chapter 100 - General Terms, Chapter 18 – Grievance System, Member Rights, and Claim Disputes, Section 18.02 – Serious Mental Illness (SMI) Member Appeal Resolution Process**.

Other MC Housing Requirements

- MC ensures its subcontracted providers are assisting members with securing or maintaining permanent housing placement when a part of the member's service

planning.

- MC coordinates with the AHP Administrator for prioritization of housing referrals, service coordination and required reporting. See **AHCCCS AMPM Chapter 1710 – AHCCCS Housing Program**.
- MC submits a quarterly Housing Deliverable and periodic reports on housing services to AHCCCS, as outlined in the AHCCCS/MC contract.
- MC collaborates with subcontracted providers and AHCCCS on the utilization of SMI Housing Trust Fund-Capital Projects.
- MC manages the Non-Title XIX/XXI funding for the Transitional Living and FlexCare Programs for the housing/facility related costs, including block leasing of housing units. MC oversees the application and referral processes, and monitors exit destinations for these programs.
- MC provides education and training to subcontracted providers on housing options and resources, included evidence-based practices related to housing services.
- MC has an agreement with the Housing and Health Opportunities (H2O) Administrator for the sharing of information and coordination of care.
- MC has a dedicated Housing Specialist designated as the subject matter expert on housing and housing resources.

Federal Programs and Assistance

The US Department of Housing and Urban Development (HUD) provides funding for adults who are homeless and disabled. On May 20, 2009, President Obama signed into law a bill to reauthorize HUD's McKinney-Vento Homeless Assistance Programs. The bill, known as the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act, made numerous changes to HUD's homeless assistance programs:

- Significantly increases resources to prevent homelessness.
- New incentives will place more emphasis on rapid re-housing, especially for homeless families.
- The existing emphasis on creating permanent supportive housing for people experiencing chronic homelessness will continue, and families have been added to the definition of chronically homeless.
- Rural communities will have the option of applying under a different set of guidelines that may offer more flexibility and more assistance with capacity building.

HUD published the HEARTH Continuum of Care (CoC) Program interim rule on July 31, 2012, and it became effective August 31, 2012. Changes made include codifying the Continuum of Care process, expanding the definition of homelessness, and focusing selection criteria more on performance. The purpose of the CoC Homeless Assistance Program is to reduce the incidence of homelessness in CoC communities, by assisting homeless individuals and families in quickly

transitioning to self-sufficiency and permanent housing, as authorized under Title IV of the McKinney–Vento Homeless Assistance Act.

The HEARTH Act consolidates the programs formerly known as the Supportive Housing Program (SHP), the Shelter Plus Care (S+C) Program, and the Section 8 Moderate Rehabilitation for Single Room Occupancy (SRO) Program into one grant program: The Continuum of Care program.

MC works in collaboration with the Arizona Department of Housing (ADOH) and AHCCCS and the three Continuums of Care to ensure the revised requirements of the HEARTH Act are met, allowing Arizona to maximize the HUD Continuum of Care Homeless Assistance Programs awarded throughout the State.

MC and its subcontracted providers awarded HUD funding are required to participate in the Homeless Management Information System (HMIS), a software application designed to record and store client-level information on the characteristics and service needs of homeless members. The HMIS is used to coordinate care, manage program operations, and better serve clients.

Federal HUD Housing Choice Voucher Program

- Tenants pay 30% of their adjusted income towards rent.
- Vouchers are portable throughout the entire country after one year.
- Permanent housing is obtainable for individuals following program rules.
- The program is accessed through local Public Housing Authorities through a waiting list.
- Initial screening is conducted by the Public Housing Authority; however, the final decision is the responsibility of the landlord.
- A Crime Free - Drug Free Lease Addendum is required.

3.30 - Employment & Rehabilitation Services for Individuals Determined to be Eligible for Title XIX/XXI Behavioral Health Service Benefit

All individuals have an opportunity to obtain a community-based job that matches their skills, interests, and preference with proper support to maintain the job. MC has a variety of employment and rehabilitation services available to assist members in moving toward self-sufficiency and community integration. MC has a network of employment and rehabilitation service providers to meet the employment and rehabilitation needs of members determined to be eligible for Title XIX/XXI Behavioral Health Service Benefits and are competent in providing a range of employment services including Supported Employment.

See **AHCCCS Contractor Operations Manual Policy 447 Employment**, **AHCCCS Medical Policy Manual 1240-J - Employment Services**, and **Division policy DDD MPM 1240-J**.

For members enrolled in DDD transitioning to adulthood, it is important to include discussions related to employment, education, recreation, and social needs as part of the planning for adulthood.

MC has adopted Employment First principles related to service planning and delivery.

- Employment is expected outcome for all working aged Arizonans who have disabilities.
- Individuals who have disabilities will have access to competitive integrated work settings.
- Individuals receive information to help them make informed decisions about employment, including, but not limited to, the following:
    - Employment supports and services,
    - Knowledge about the value of employment on the individual's quality of life,
    - Understanding of how work affects public benefits and resources so that employment remains an option without fear of losing essential benefits,
    - Focus on an individual's strengths, interests, and preferences.
    - Consider appropriate supports and services such as supported and customized employment and assistive technology.
- Long-term supports and services, if needed, are made available for the individual to be successful in the workplace.

Employment and rehabilitation services include the provision of educating, coaching, training, and demonstrating skills, to remediate/prevent existing/anticipated functional deficits. Please refer to the AHCCCS Medical Policy Manual AMPM Chapter 300, Policy **310-B - Title XIX/XXI Behavioral Health Service Benefit** for additional details.

Rehabilitation Services include:

- Skills Training and Development and Psychosocial Rehabilitation Living Skills Training, Cognitive Rehabilitation
- Behavioral Health Prevention/Promotion Education and Medication Training and Support (Health Promotion)
- Supported Employment [Psychoeducational Service (Pre-Job Training and Job Development)
- Ongoing Support to Maintain Employment (Job Coaching and Employment Support).

Prevocational and Employment related services available through MC are distinct from vocational services available through RSA/VR program.

For additional information including staff competencies required for service delivery and range of services available see **AHCCCS Employment Policy ACOM 447** and **AMPM 1240-J**, and **Division Policy DDD MPM 1240-J**.

The **Vocational Rehabilitation (VR) program** provides a variety of services to persons with disabilities, with the goal to prepare for, enter into, or retain employment. Additional VR program details can be found on the ADES website under Vocational Rehabilitation.

Members enrolled in DDD services please note: MC will coordinate with the assigned DD Support Coordinator to avoid duplication of employment support services. The Division similarly offers LTSS employment supports. To avoid the duplication of efforts, the member's Support Coordinator and Planning Team shall determine the service provider that best meets the member's needs for employment support. The determination and coverage responsibility will be documented in the member's Planning Document. Members' Support Coordinators are responsible for making any Vocational Rehabilitation referrals. MC will coordinate with the DDD Support Coordinator to support the member's connection to RSA.

Members enrolled in DDD living with an SMI designation please note: MC works collaboratively with Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA) in the Central GSA. MC and DES/RSA have mutually developed collaborative protocols to ensure effective and efficient provision of comprehensive rehabilitative and employment support services for individuals determined eligible for SMI services to achieve increased independence or gainful employment. The Statewide Collaborative Protocol with ADES/RSA defines the respective roles and responsibilities of each party. The **Statewide Collaborative Protocols** established through the Interagency Service Agreement (ISA) between AHCCCS and ADES/RSA apply statewide.

Prevocational and Employment related services available through MC are distinct from vocational services available through ADES/RSA. Please refer to the AHCCCS Covered Behavioral Health Services Guide on the **AHCCCS Medical Coding Resources page** for additional details. U

NOTE: For those that are eligible for DDD/ALTCS additional employment support services may be available. To learn more visit **DDD Services & Supports**.

3.31 - Collection of Demographic and Clinical Data Timeframes

Demographic and clinical data will be collected starting at the first date of service. A demographic record must be collected within 45 days of the first service and submitted to AHCCCS within 55 days. Additional clinical data may be collected at subsequent assessment and service planning meetings with the member (e.g., education, vocation) as well as during

periodic and annual updates. Demographic and clinical data recorded in the member's behavioral health medical record must match the demographic file on record with AHCCCS.

Specific Data Elements

Effective October 1, 2018, providers are required to submit demographic data directly to AHCCCS. Information on specific data elements is available at: **https://www.azahcccs.gov/PlansProviders/Demographics/.**

Use of Demographic and Clinical Data

Behavioral health providers are encouraged to utilize demographic and clinical data to improve operational efficiency and gain information about the members who receive behavioral health services. Providers may consider:

- Utilizing and integrating collected demographic data into the member's assessments;
- Monitoring the nature of the provider's behavioral health member population; and
- Evaluating the effectiveness of the provider's services towards improving the clinical outcomes of members enrolled in the AHCCCS system.

Technical Assistance with Demographic and Clinical Data Submission

At times, technical problems or other issues may occur in the electronic transmission of the clinical and demographic data from the behavioral health provider to the AHCCCS.
Any questions about the portal or the data fields in the portal should be submitted to DHCM/DAR Information Management/Data Analytics Unit (IMDAU) Manager, Angela Aguayo at Angela.Aguayo@azahcccs.gov and should also include Lori Petre at Lori.Petre@azahcccs.gov, Data Analysis and Research Manager for DHCHM/DAR. If there are any technical issues with the portal contact Customer Support at either ISDCustomerSupport@azahcccs.gov or 602-417-4451.

3.32 – Behavioral Health Fee Schedule

In 2018, MC amended several behavioral health provider contracts to include a new ***MC ACC Behavioral Health Fee Schedule***. This fee schedule only includes select codes. While the contract language indicates that the below select codes can be found in the Provider Manual, in the contract itself, it indicates that this applies to AHCCCS Complete Care (ACC) and Division of Developmental Disability (DDD). This fee schedule does not apply to the MC Fee Schedule or the MC RBHA Fee Schedule.

MC ACC BEHAVIORAL HEALTH CODE LIST

Table 1 – Select MC ACC Behavioral Health Codes for covered services
MC Select ACC BH Covered Codes
General Mental Health & Substance Use (GMHSU)*

CODE	CODE	CODE	CODE
H0001	H0002	H0004-HQ, HR, HS	H0015
H0020-HG	H0025	H0031, H0031-HK	H0034
H0036, H0036-TF	H0037	H0038 H0038-HK, HQ	H2010
H2012	H2014-HK, HQ	H2017	H2020
H2025	H2026	H2027	H2033
S5140-HB, HC S5145-HA	S5110	S5150	S5151
T1002	T1003	T1016-HN, HO	T1019
T1020			

Table 2 – Select MC ACC Behavioral Health Psychiatric Codes for covered services
MC Select ACC BH Covered Codes
Psychiatry Care, Testing & Treatment performed by an MD or DO*

CODE	CODE	CODE	CODE
90791	90792	90832	90833
90834	90836	90837	90838
90846	90847	90849	90853
90870	90876	90887	90889

MC Chapter 4 – General Mental Health/Substance Use (GMH/SU)

4.00 – About General Mental Health/Substance Use (GMH/SU)

MC's integrated system joins both physical and behavioral health services together to treat all aspects of our members' health care needs under one plan. MC encourages more coordination between providers within the same network which can mean better health outcomes for our members.

4.01 – Funding

Special Populations

MC receives some funding for behavioral health services through the Federal Substance Use Block Grant (SUBG). SUBG funds are used to provide substance use services for Non-Title XIX/XXI eligible members. As a condition of receiving this funding, certain populations are identified as priorities for the timely receipt of designated behavioral health services. Currently, not all network contracted providers receive SUBG Block Grant funding. Providers who do receive these funds must follow the requirements found in this chapter. For all other contracted behavioral health providers that do not currently receive these funds, the following expectations do not apply.

Substance Use Block Grant (SUBG) Populations

The following populations are prioritized and covered under the SUBG funding:

First: Pregnant females who use drugs by injection;
Then: Pregnant females who use substances;
Then: Teenagers who use substances;
Then: Other injection drug users;
Then: Substance-using females with dependent children, including those attempting to regain custody of their children; and
Finally: All other members in need of substance use treatment.

Response Times for Designated Behavioral Health Services under the Substance Use Block Grant (SUBG) (based on available funding)

- **WHEN:** Behavioral health services provided within a timeframe indicated by clinical need, but no later than 48 hours from the referral/initial request for services.
- **WHAT:** Any needed covered behavioral health service, including admission to a residential program if clinically indicated. If a residential program is temporarily unavailable, an attempt shall be made to place the member within another provider agency facility, including those in other geographic service areas. If capacity still does not exist, the member shall be placed on an actively managed wait list, and interim services must be provided until the individual is admitted. Interim services include

counseling/education about HIV and Tuberculosis (including the risks of transmission), the risks of needle sharing and referral for HIV and TB treatment services if necessary, counseling on the effects of alcohol/drug use on the fetus and referral for prenatal care.

- **WHO:** Pregnant women/teenagers referred for substance use treatment (includes pregnant injection drug users and pregnant substance users) and Substance-using females with dependent children, including those attempting to regain custody of their children.
- **WHEN:** Behavioral health services provided within a timeframe indicated by clinical need but no later than 14 days following the initial request for services/referral. All subsequent behavioral health services must be provided within timeframes according to the needs of the member.
- **WHAT:** Includes any needed covered behavioral health services. Admit to a clinically appropriate substance use treatment program (can be residential or outpatient based on the member's clinical needs); if unavailable, interim services must be offered to the member. Interim services shall minimally include education/interventions about HIV and tuberculosis, and the risks of needle sharing and must be offered.
- within 48 hours of the request for treatment.
- **WHO:** All other injection drug users.

Governor's Office – Substance Use Disorder Funds (SUDS)

In a Special Session of the Legislature, members of the Arizona House and Senate Legislature unanimously passed the Arizona Opioid Epidemic Act, which Governor Ducey signed into law on January 26, 2018. The Arizona Opioid Epidemic Act provides funding for treatment, improves oversight and enforcement tools, and extends life-saving resources to law enforcement, first responders, and community partners on the ground.

MC receives funding from the Arizona Health Care Cost Containment System (AHCCCS) under a state allocation toward Substance Use Disorder Services (SUDS). The goal of SUDS:

1. Increase outreach and identification of under and uninsured individuals with OUD.
2. Increase navigation to OUD treatment.
3. Increase utilization of OUD treatment services.

Eligibility

The SUDS funding is passed on to sub-recipient providers to provide services **for underinsured and uninsured** Arizonans *with* opioid use disorders (OUD) residing in Maricopa County. Providers are required to conduct enrollment verification and screening for alternative forms of insurance coverage per the Provider Manual, prior to encountering GO-SUDS Funding. *AHCCCS requires that GO-SUDS-funded providers use the allocation as a payor of last resort and after SUBG funds have been exhausted.*

Not all network contracted providers receive GO-SUDS Funding. Current contracted GO-SUDS providers can be found by calling MC Member Services at **602-586-1841**, toll free at **1-800-564-5465** or TTY/TDD: **711** to get connected to care. Representatives are available 24 hours a day, 7 days a week.

GO-SUDS Funds are encounterable dollars for individuals diagnosed with Opioid Use Disorder. To encounter these funds, *providers must utilize a **U8 modifier** in conjunction with covered services claims identified on the AHCCCS Code list for GO SUDs fund.*

4.02 – Referral and Intake Process

Behavioral Health Referral and Intake Process

To facilitate a member's access to behavioral health services in a timely manner, MC maintains an effective process for the referral and intake for behavioral health services that includes:

- Communicating to potential referral sources the process for making referrals (e.g., centralized intake at MC, identification of providers accepting referrals);
- Collecting enough basic information about the member to determine the urgency of the situation and subsequently scheduling the initial assessment within the required timeframes and with an appropriate provider;
- Adopting a welcoming and engaging manner with the member and/or member's legal guardian/family member;
- Ensuring that intake interviews are culturally appropriate and delivered by providers that are respectful and responsive to the member's cultural needs;
- Keeping information or documents gathered in the referral process confidential and protected in accordance with applicable federal and state statutes, regulations, and policies;
- Informing, as appropriate, the referral source about the final disposition of the referral; and
- Conducting intake interviews that ensure the accurate collection of all the required information and ensure members who have difficulty communicating because of a disability or who require language services are afforded appropriate accommodations to assist them in fully expressing their needs.

Responding to Referrals

Follow-Up

When a request for behavioral health services is initiated but the member does not appear for the initial appointment, the provider must attempt to contact the member and implement engagement activities consistent with **Chapter 4 – General Mental Health/Substance Use (GMH/SU), Section 4.03 – Outreach, Engagement, Reengagement and Closure** in this manual.

MC or provider will also attempt to notify the entity that made the referral.

Documenting and Tracking Referrals

MC or subcontracted provider will document and track all referrals for behavioral health services including, at a minimum, the following information:

- Member's name and, if available, AHCCCS identification number;
- Name and affiliation of referral source;
- Date of birth;
- Type of referral (immediate, urgent, routine);
- Date and time the referral was received;
- If applicable, date and location of first available appointment and, if different, date and location of actual scheduled; and
- Final disposition of the referral.

Intake

Behavioral health providers must conduct intake interviews in an efficient and effective manner that is both "member friendly" and ensures the accurate collection of all the required information necessary for enrollment into the system or for collection of information for AHCCCS eligible individuals who are already enrolled. The intake process must:

- Be flexible in terms of when and how the intake occurs. For example, to best meet the needs of the member seeking services, the intake might be conducted over the telephone prior to the visit, at the initial appointment prior to the assessment and/or as part of the assessment; and
- Make use of readily available information (e.g., referral form, AHCCCS eligibility screens, Department of Child Safety related documentation) to minimize any duplication in the information solicited from the member and his/her family.

During the intake, the behavioral health provider will collect, review, and disseminate certain information to members seeking behavioral health services. Examples can include:

- The collection of contact information, insurance information, the reason the member is seeking services and information on any accommodations the member may require to effectively participate in treatment services (i.e., need for oral interpretation or sign language services, consent forms in large font, etc.).
- The collection of required demographic information and completion of client demographic information sheet, including the behavioral health member's primary/preferred language;
- The completion of any applicable authorizations for the release of information to other parties;
- The dissemination of a Member Handbook to the member;
- The review and completion of a general consent to treatment;

- The collection of financial information, including the identification of third-party payers and information necessary to screen and apply for AHCCCS health insurance, when necessary;
- Advising Non-Title XIX/XXI members determined to have a Serious Mental Illness (SMI) that they may be assessed a co-.
- The review and dissemination of MC's Notice of Privacy Practices (NPP) and the AHCCCS HIPAA Notice of Privacy Practices (NPP) located at; and
- The review of the member's rights and responsibilities as a member of behavioral health services, including an explanation of the appeal process.

The member and/or family members may complete some of the paperwork associated with the intake, if acceptable to the member and/or family members.

Behavioral health providers conducting intakes must be appropriately trained, approach the member and family in an engaging manner, and possess a clear understanding of the information that needs to be collected.

Integrated Care Specific Referral and Intake Guidelines

It may be necessary for an MC member to be referred to another provider for medically necessary services that are beyond the scope of the member's PCP. For those services, providers only need to complete the **Specialist Referral Form** available under **Forms** on the MC website and refer the member to the appropriate MC Participating Health Provider (PHP). MC's website includes a provider search function for your convenience.

There are two types of referrals:

- Participating providers (particularly the member's PCP) may refer members for specific covered services to other practitioners or medical specialists, allied healthcare professionals, medical facilities, or ancillary service providers.
- Member may self-refer to certain specialists for specific services, such as an OB/GYN, family planning, or substance use treatment.

Referrals must meet the following conditions:

- The referral must be requested by a participating provider and be in accordance with the requirements of the member's benefit plan (covered benefit).
- The member must be enrolled in MC on the date of service (s) and eligible to receive the service.
- If MC's network does not have a provider to perform the requested services, members may be referred to out of network providers if:
    - The services required are not available within the MC's network.
    - MC prior authorizes the services.

If out of network services are not prior authorized, the referring and servicing providers may be responsible for the cost of the service. The member may not be billed if the provider fails to follow MC's policies. Both referring and receiving providers must comply with MC policies, documents, and requirements that govern referrals (paper or electronic) including prior authorization. Failure to comply may result in delay in care for the member, a delay or denial of reimbursement or costs associated with the referral being changed to the referring provider.

Referrals are a means of communication between two providers servicing the same member. Although MC encourages the use of its referral form, it is recognized that some providers use telephone calls and other types of communication to coordinate the member's medical care. This is acceptable to MC if the communication between providers is documented and maintained in the member's medical records.

Referring Provider's Responsibilities

- Confirm that the required service is covered under the member's benefit plan prior to referring the member.
- Confirm that the receiving provider is contracted with MC.
- Obtain prior authorization for services that require prior authorization or are performed by a non-PHP.
- Complete a Specialist Referral Form available under **Forms** on the MC website and mail or fax the referral to the receiving provider.

Receiving Provider's Responsibilities

PHPs may render services to members for services that do not require prior authorization, and that the provider has received a completed referral form (or has documented the referral in the member's medical record). The provider rendering services based on the referral is responsible to:

- Schedule and deliver the medically necessary services in compliance with MC's requirements and standards related to appointment availability.
- Verify the member's enrollment and eligibility for the date of service. If the member is not enrolled with MC on the date of service, MC will not render payment regardless of referral or prior authorization status.
- Verify that the service is covered under the member's benefit plan.
- Verify that the prior authorization has been obtained, if applicable, and includes the prior authorization number on the claim when submitted for payment, inform the referring provider of the consultation or service by sending a report and applicable medical records to allow the referring provider to continue the member's care.

Period of Referral

Unless otherwise stated in a provider's contract or MC documents, a referral is valid for the full extent of the member's care starting from the date it is signed and dated by the referring provider, if the member is enrolled and eligible with MC on the date of service.

Maternity Referrals

Referrals to Maternity Care Health Practitioners may occur in two ways:

- A pregnant MC member may self-refer to any MC contracted Maternity Care Practitioner.
- The PCP may refer pregnant members to a MC contracted Maternity Care Practitioner.

At a minimum, Maternity Care Practitioners must adhere to the following guidelines:

- Coordinate the members maternity care needs until completion of the postpartum visits.
- Per the ACOG, the members initial postpartum visit shall take place within the first 3 weeks postpartum. Any follow-up postpartum visits shall be done within the first 12 weeks of the delivery. For members that are high-risk or experienced complications, the initial visit should be completed within one week of delivery.
- When necessary, refer members to other practitioners in accordance with the MC referral policies and procedures.
- Schedule return visits for members with uncomplicated pregnancies consistent with the ACOG standards:
    - Through twenty-eight weeks of gestation – every four weeks.
    - Between twenty-nine- and thirty-six-weeks' gestation every two weeks.
    - After the thirty sixth week – once a week.
    - Members in the second trimester – 14 calendar days.
    - Members in third trimester – within three business days.
    - High-risk Members – within three business days of identification or immediately when an emergency condition exists.

Ancillary Referrals

All practitioners and providers must use and/or refer to MC contracted ancillary providers.

Member Self-Referrals

MC members can self-refer to participating providers for the following covered services:

- Family Planning Services and supplies
- OB/GYN Services
- Dental Services for Members Ages 18 through 20 years old
- Vision services for Members Ages 18 through 20 years old
- Behavioral Health Services

EPSDT Referral Requirements

- EPSDT provider must follow the referral requirements outlined in the AMPM 430 EPSDT Policy. Some of the referral requirements are outlined below and additional details can also be found in the EPSDT section of this provider manual**.**
- Referrals must be documented in the members medical record as well as on any submitted EPSDT forms**.**
- Providers shall document referrals made to resources within the community such as AzEIP, Early Head Start/Head Start, Home Visitation Programs, and Raising Special Kids**.**
- EPSDT members shall be referred to a dentist or dental home no later than one year old**.** The referral can happen sooner if the member has a tooth that has erupted.
- For medically necessary nutrition therapy referrals, see the details outlined in section 5.04 – Nutritional Assessment and Nutrition Therapy of this provider manual.
- For all EPSDT physical and behavioral screenings with positive results, providers shall refer members for follow-up diagnosis, and treatment in a timely manner. Treatment is to be initiated within 60 days of screening services.
- For members with an elevated blood lead level that have lost AHCCCS eligibility, they must be referred to a low-cost or no-cost clinic for follow-up testing and treatment.
- Refer a member to care management when a physical or behavioral health need is identified.
- Refer appropriate members under three years of age with developmental disabilities requiring early intervention therapy services to AzEIP. AzEIP referrals must follow the criteria outlined in the AMPM 430 Attachment C and Attachment D. Additional details can also be found in the AzEIP section of this provider manual.
- Refer appropriate members to The Department of Economic Security (DES) Division of Developmental Disabilities (DDD) to access services and support for individuals with developmental disabilities, such as Autism, Cerebral Palsy, Down Syndrome. Epilepsy, or intellectual disabilities. Additional details can also be found in the DDD Eligibility Criteria section of this provider manual.

Children's Direct Support and Specialty Provider Referrals

Expectations:

- The Child and Family Team determine if a service from a Direct Support Provider (DSP) or a Specialty Provider is recommended.
- The CFT typically helps to identify the MC contracted provider(s) who are able to provide the needed Direct Support or Specialty service.
- The CFT Facilitator and/or HNCM will complete the **Request for Direct Support or Specialty Provider Services** form, available under **Forms** on the MC website, and will send the form with the following documents to the identified provider agencies:
    - CFT service plan/CFT Notes;

- Strengths Needs and Cultural Discovery (ages 6-17);
- Current assessment or most recent annual update;
- Crisis/Support Plan;
- Most recent CALOCUS;
- Current Psychiatric Notes and Evaluation (if applicable); and
- Intensive Support and Rehabilitation Services (formally MMWIA) Prioritization Form for Intensive Support and Rehabilitation Services referrals.

- Upon receipt of the referral form and the documents listed above, the Direct Support or Specialty Provider will review the information and determine if they are able to accept the referral.
- The Direct Support or Specialty Provider will communicate if they are able to accept or if they need to decline the referral to the CFT Facilitator and/or HNCM within 3 business days from the receipt of a routine referral:
  - If the referral is accepted the guardian will be notified; and
  - The Direct Support or Specialty Provider will assess to determine next steps and for treatment needs.
- For children, DSP and Specialty services are to be provided within 21 days of identification on the child's Individual Service Plan/CFT.
- Every Monday, Direct Support and Specialty Providers will send "Referral Capacity Report" indicating the number of available referrals that can be accepted for the current week, this will also include Spanish- speaking capacity to the Children's System of Care Administrator, by e-mailing **DSP_SpecialtyProviders@MercyCareAZ.org**.

Integrated Rapid Response Referrals for Children

Expectations:

- A child is removed from their home and placed in DCS Custody.
- DCS, law enforcement, or other individuals including the out-of-home placement or adoptive parent make a DCS Integrated Rapid Response Referral. DCS provides appropriate documentation (generally a Temporary Custody Notice and/or Notice to Provider to Solari - Crisis Response Network (Solari - CRN) within 24 hours of the child's removal.
- Solari – CRN verifies the Integrated Rapid Response Referral is complete and dispatches the referral to an Integrated Rapid Response provider based on the location of the DCS out of home caregiver.
- DCS, law enforcement, or other individuals including the out-of-home placement or adoptive parent make a DCS Integrated Rapid Response Referral. DCS provides appropriate documentation (generally a Temporary Custody Notice and/or Notice to Provider to Crisis Response Network (CRN)) within 24 hours of the child's removal.
- The caregiver will be contacted by an Integrated Rapid Response Team Clinician, and the team will be dispatched within the first 72 hours of a child being referred to Integrated

Rapid Response. If the child has immediate behavioral health needs, the assessment/crisis team will be dispatched within 2 hours of being notified.

- The Integrated Rapid Response provider will follow the Integrated Rapid Response outreach and closure protocol when scheduling an appointment with the out-of-home caregiver:
    - Email **DCS@mercycareaz.org** if unable to confirm DCS assigned staff, child's location or custody status.
    - Complete three documented attempts to outreach Caregiver.
    - Phone calls at different times of the day.
    - Email (copy DCS)
    - Attempt to visit residence when possible.
    - Letter
- Completed and documented attempts to contact DCSS and supervisor
    - Separate phone calls to DCSS and Supervisor
    - One email to both including efforts made to complete IRRA and dates/times of attempts.
    - If no response, email **DCS@MercyCareAZ.org** to engage MC to reach out to DCS and DCS CHP SOCC team (do not close until the response is complete and DCS PM agrees with closure)
- Escalation after attempts
    - Send final request to PM, DCSS, DCS Supervisor AND DCS CHP - **CHPSystemofCare@AZDCS.GOV**, and MC **DCS@MercyCareAZ.org**. The subject line should be titled: IRRA final outreach – (include PI#). If no response, send closure letter to the dedicated DCS CHP mailbox **CHPSystemofCare@AZDCS.GOV**, DCS PM, DCSS, DCS Supervisor and copy.
- A referral will be made to an Integrated Rapid Response Provider to complete the behavioral health assessment and developmental screening and Physical Health Screening.
- Out of County of Jurisdiction Dispatches
    - IRR providers must contact the selected Children's Behavioral Health Home (BHH) in the Court of Jurisdiction and DCS within 24 hours of receiving the IRR dispatch. The contact will include the assigned staff completing the IRR Assessment and their contact information.
    - If no BHH in the Court of Jurisdiction is selected by DCS on the IRR referral, Solari-CRN will suggest a randomly selected BHH in the Court of Jurisdiction when dispatching the referral.
- The Integrated Rapid Response Provider will coordinate the selection of a PCP with the out-of-home caregiver, including scheduling an initial wellness visit with the PCP within 30 days of the removal date, if possible;
- If during the Physical Health Screening, any acute concerns are indicated or noticed, the

member/caregiver should be referred to the ER/Urgent Care for evaluation.

- During the Physical Health Screening, if the member's condition is not acute, but has healthcare needs that must be met prior to the initial PCP appointment, then contact the PCP/ordering provider to resolve the needs. If the PCP/Provider is not known or is unable to meet the need in the required time, support the caregiver to connect with the MC provider available to address the need prior to the initial PCP appointment.
- The Integrated Rapid Response Assessment, including the completed Physical Health Screening form, will be sent by email to the DCS Specialist, DCS Program Supervisor and to MC Integrated Care Management.
- The Integrated Rapid Response Team will assess youth ages 8 and above to determine if it is appropriate to distribute DCS approved age appropriate and developmentally appropriate materials and resources about sexual abuse, child sex trafficking, and exploitation. The Integrated Rapid Response Team will distribute the approved materials to those youth assessed as appropriate to receive the information.
- If an Integrated Rapid Response referral is not submitted or the Integrated Rapid Response Team is not dispatched within this timeframe, DCS, law enforcement, or individuals including the out-of-home placement or adoptive parent may contact the MC Designated DCS Point of Contact at **DCS@MercyCareAZ.org**.
- A developmental screening and assessment will be completed. The developmental checklist and warning signs will be provided to caregivers. For children aged 0-3, if any developmental concerns are noted, complete a referral to the Arizona Early Intervention Program (AzEIP).
- Integrated Rapid Response Team will assess to determine if high needs care management (HNCM) services are recommended.
- The Integrated Rapid Response Team will make a referral, based on the youth's acuity (or the need for HNCM) and guardian's preference for an intake appointment with a BHH to complete the comprehensive assessment. If the guardian does not have a provider preference and the youth does not need HNCM, the youth will be referred by the Integrated Rapid Response Team to a BHH based geographic access, specialty services, and an algorithm.
- The referral will be emailed to the identified BHH by the DCS Rapid Response Team. The identified provider information will be provided to the guardian.
- The BHH will contact the DCS Specialist and/or DCS out-of-home placement to set up an intake to begin services. If unable to contact the DCS out-of-home placement, the BHH will contact the DCS Specialist to set up an intake to begin services.
- The BHH will notify DCS Rapid Response Team within 7 days of the referral of the status of the referral and/or the completed intake date.
- The BHH will follow the ABHC 7-day Intake outreach and closure protocol when scheduling an initial intake after the Integrated Rapid Response assessment:
    - Complete 3 documented attempts to outreach Caregiver

        - Phone calls at different times of the day
        - Email (copy DCS)
        - Attempt to visit residence when possible
        - Letter
    - Completed and documented attempts to contact DCSS and supervisor
        - Separate phone calls to DCSS and Supervisor
        - One email to both including efforts made to complete IRRA and dates/times of attempts
    - Escalation after attempts
        - Staff with BHH leadership
        - BHH leadership outreaches DCS PM, DCSS, DCS supervisor
        - If no resolution, send closure letter to the dedicated DCS CHP System of Care mailbox **CHPSystemofCare@AZDCS.GOV**, DCS PM, DCSS, DCS Supervisor and copy **DCS@mercycareaz.org.** Subject line: BHH 7-day Intake closure - (include PI#)

4.03 – Outreach, Engagement, Reengagement and Closure

Outreach

The behavioral health system must provide outreach activities to inform the public of the benefits and availability of behavioral health services and how to access them. MC will disseminate information to the general public, other human service providers, school administrators and teachers and other interested parties regarding the behavioral health services that are available to eligible members.

Outreach activities conducted by MC may include, but are not limited to:

- Participation in local health fairs or health promotion activities
- Involvement with local schools
- Routine contact with AHCCCS Health Plan behavioral health coordinators and/or primary care providers
- Development of homeless outreach programs
- Development of outreach programs to members who are at risk, are identified as a group with high incidence or prevalence of behavioral health issues or are underserved.
- Publication and distribution of informational materials
- Liaison activities with local and county jails, county detention facilities, and local and county DCS offices and programs
- Routine interaction with agencies that have contact with substance abusing pregnant females.
- Development and implementation of outreach programs that identify members with co-morbid medical and behavioral health disorders and those who have been determined to have a Serious Mental Illness (SMI) within MC's geographic service area, including

members who reside in jails, homeless shelters, county detention facilities or other settings.
- Provision of information to mental health advocacy organizations
- Collaboration and coordination of outreach with tribal nations and tribal communities within the Central Arizona ACC-RBHA geographic service area.

Engagement

MC or their subcontracted providers will actively engage the following in the treatment planning process:

- The member and/or member's legal guardian
- The member's family/significant others, if applicable and amenable to the member
- Other agencies/providers as applicable

Behavioral health providers must provide services in a culturally competent manner in accordance with MC's Cultural Competency Plan. Additionally, behavioral health providers must:

- Provide a courteous, welcoming environment that provides members with the opportunity to explore, identify and achieve their personal goals.
- Engage members in an empathic, hopeful, and welcoming manner during all contacts.
- Provide culturally relevant care that addresses and respects language, customs, and values and is responsive to the member's unique family, culture, traditions, strengths, age, and gender.
- Provide an environment in which members from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices in the context of negotiating treatment options.
- Provide care by communicating to members in their preferred language and ensuring that they understand all clinical and administrative information (see **MC Provider Manual Chapter 100 – General Terms, Chapter 4 – Provider Responsibilities, Section 4.28 – Cultural Competency, Health Literacy and Linguistic Services**).
- Be aware of and seek to gain an understanding of members with varying disabilities and characteristics.
- Display sensitivity to, and respect for, various cultural influences and backgrounds (e.g., ethnic, racial, gender, sexual orientation, socio-economic class, and veteran status)
- Establish an empathic service relationship in which the member experiences the hope of recovery and is considered to have the potential to achieve recovery while developing hopeful and realistic expectations.
- Demonstrate the ability to welcome the member, and/or the member's legal guardian, the member's family members, others involved in the member's treatment and other service providers as collaborators in the treatment planning and implementation

process.

- Demonstrate the desire and ability to include the member's and/or legal guardian's viewpoint and to regularly validate the daily courage needed to recover from persistent and relapsing disorders.
- Assist in establishing and maintaining the member's motivation for recovery.
- Provide information on available services and assist the member and/or the member's legal guardian, the member's family, and the entire clinical team in identifying services that help meet the member's goals.
- Provide the member with choice when selecting a provider and the services they participate in
- At Risk Crisis Plans will address managing any change in a client's health, medical status, or behavior that is not immediately and obviously life-threatening (such as a heart attack, a seizure or immediate danger to self or others), but is nevertheless seriously concerning and may also include any significant and concerning change in a client's health, medical status, or behavior

Reengagement

Reengagement For GMH/SU members, to include DD members without and SMI designation, the reengagement policy is as follows:

Behavioral health providers must attempt to re-engage members in an episode of care that have withdrawn from participation in the treatment process prior to the successful completion of treatment, refused services or failed to appear for a scheduled service. All attempts to reengage members who have withdrawn from treatment, refused services, or failed to appear for a scheduled service must be documented in the comprehensive clinical record. The behavioral health provider must attempt to reengage the member with a minimum of three (3) separate outreach attempts by:

- Communicating in the member's preferred language
- Contacting the member or the member's legal guardian by telephone, at times when the member may reasonably be expected to be available (e.g., after work or school)
- Whenever possible, contact the member or the member's legal guardian (if applicable) face-to-face, if telephone contact is insufficient to locate the member or determine acuity and risk.
- Sending a letter to the current or most recent address requesting contact once three (3) separate outreach attempts at personal contact are unsuccessful, except when a letter is contraindicated due to safety concerns (e.g., domestic violence) or confidentiality issues. The provider will note safety or confidentiality concerns in the progress notes section of the clinical record and include a copy of the letter sent in the comprehensive clinical record.

For GMH/SU and MC DCS CHP members, if the member had a hospitalization during the review period, the discharge policy is as follows:

- BHMP appointment must be scheduled within 5 business days following discharge. Please Note: If the child is receiving case management services only from a High Needs Case Management provider, there must be evidence of the High Needs Case Manager (HNCM) coordinating with the Behavioral Health Home providing medication monitoring services to set up a BHMP appointment within the required timeframe.
- Behavioral Health providers must have telephonic or face to face contact with the member within 24 business hours of crisis episode or discharge.
- A face-to-face visit must be completed within 5 business days following discharge.
- Telephonic contact must be made each week for 4 weeks following discharge (weekly contact is monitored by 7-day intervals).

MC behavioral health providers are expected to:

- Involve the member, their parent/guardian/responsible person, their families, or significant others in transition or aftercare planning;
- For extenuating circumstances involving crisis calls, follow up within 24 hours and if the member is unreachable, initiate a welfare check that could include utilizing law enforcement services, family members and significant others as designated by the member;
- Commence discharge planning at the time of intake;
- Within 24 hours of notification of admission and after the initial concurrent review, the clinical team contacts the inpatient social worker to schedule discharge planning staffing;
- Within 72 hours of notification of admission and after the initial concurrent review has occurred, the clinical team coordinates with a MC Care Coordinator to provide an initial discharge plan;
- Involve the member, parent/guardian, and/or family members in the selection of aftercare providers and appointment times, and make sure that aftercare appointments meet established access standards;
- Formalize discharge planning in writing with a discharge summary and follow up actions clearly indicated with scheduled aftercare appointments;
- Ensure members have enough medications or a prescription to last until the follow-up BHP appointment. This includes coordination with the inpatient treating physician and may include prior authorization requests to the MC;
- Within 72 hours of discharge, a BHMP completes a face-to-face comprehensive evaluation of the member and addresses any medication and/or treatment issues;
- Implement a multi-disciplinary team approach which includes the following:
    - A home visit within 5 days of discharge to identify environmental issues that may

need interventions to prevent hospital readmission.

- Weekly face-to-face contact after discharge for at least four consecutive weeks intended to identify causes, which led to the hospitalization and assess the member's ability to engage in their own wellness and transition successfully to community care. *
- A Clinical Team Nurse will schedule an appointment within 10 days of discharge to ensure behavioral health members understand medications, dosages, side effects and any medication changes post discharge. **
- 30-day post discharge face to face to formally review the discharge transition to determine if the member is at risk for readmission; assess the level of care needed; and develop a written action plan to maintain independence in the community.

*The face to face, weekly, requirement is enough, if the member is going into residential treatment, following discharge and the clinical and discharge team indicates that weekly face to face contact does not need to occur. This decision must be documented in either the hospital discharge plan and/or discharge staffing note.

** If the children's provider does not have an RN employed, there must be evidence in the BHMP note ensuring the member/guardian understands medications, dosages, side effects and any medication changes post discharge.

For Children members, the reengagement policy is as follows:
Children's Behavioral Health Providers shall ensure re-engagement attempts are made with members who have withdrawn from participation in the treatment process prior to the successful completion of treatment; refused services; or failed to appear for a scheduled service based on a clinical assessment of need. All attempts to reengage members shall be documented in the comprehensive clinical record.

The Children's Behavioral Health Provider shall attempt to re-engage the member by:

- Communicating in the member's preferred language,
- Completing at least three outreach attempts utilizing the strategies listed below:
  - Contacting the member/guardian/designated representative by telephone at times when the member may reasonably be expected to be available (e.g., after work or school),
  - For children in the custody of DCS, the provider must contact the DCS Specialist or the DCS Supervisor to inform them of the need for assistance in re-engaging the member and the DCS out-of-home placement (e.g., foster home, kinship or group home).

- When possible, contact the member/guardian/designated representative face-to-face if telephone contact is insufficient to locate the member or determine acuity and risk, and,
- Sending a letter to the current or most recent address requesting contact if all attempts at personal contact are unsuccessful, except when a letter is contraindicated due to safety concerns (e.g., domestic violence) or confidentiality issues. The provider will note safety or confidentiality concerns in the progress notes section of the clinical record and include a copy of the letter sent in the comprehensive clinical record.

If the above activities are unsuccessful, Children's Behavioral Health providers shall ensure further attempts are made to re-engage children identified as SED, pregnant teenagers with substance use disorder, and any member determined to be at risk of relapse, decompensation, deterioration or a potential harm to self or others based on the member's clinical needs. Further attempts shall include at a minimum: contacting the member/guardian/designated representative face-to-face and contacting natural supports for whom the member has given permission to the provider to contact. All attempts to re-engage these members shall be clearly documented in the comprehensive clinical record.

Children's Behavioral Health Providers shall ensure activities are documented in the clinical record, and follow-up activities are conducted to maintain Engagement within the following timeframes:

- Discharged from inpatient services, in accordance with the discharge plan and within seven days of the member's release to ensure member stabilization, medication adherence, and to avoid re-hospitalization;
- Involved in a behavioral health crisis within timeframes based upon the member's clinical needs, but no later than seven days;
- Refusing prescribed psychotropic medications within timeframes based upon the member's clinical needs and history; and
- Changes in the level of care

For DCS CHP Youth who have been in services under six months, and all re-engagement attempts have been unsuccessful, please contact the MC ACC-RBHA Child Welfare Single Point of Contact at **DCS@MercyCareAZ.org**.

For members receiving General Mental Health/Substance Use services, behavioral health providers must also document activities in the clinical record related to coordination of care upon admission and with discharge planning, and conduct follow-up activities to maintain engagement including:

- Discharge from inpatient services in accordance with the discharge plan within

7 days of discharge upon notification;
- Involved in a behavioral health crisis within timeframes based upon the member's clinical needs, but no later than 7 days upon notification;
- Ensure members have enough medications or a prescription to last until the follow-up BHMP appointment, as applicable and upon notification. This includes coordination with the inpatient treating physician;
- Refusing prescribed psychotropic medications within timeframes based upon the member's clinical needs and individual history;
- Involve the member, their parent/guardian, their families, or significant others in transition or aftercare planning; and
- Released from local and county jails and detention facilities within 7 days upon notification.

Additionally, for members to be released from these settings, behavioral health providers must help establish priority prescribing clinician appointments, as applicable, to ensure client stabilization, medication adherence, and to avoid re-hospitalization.

Should members receiving GMH/SU services with recurrent hospitalizations meet specific criteria as being at 'high risk', additional navigator assistance services may be available through specifically funded providers through the Comprehensive Community Health Program. Navigators assist members with engagement and coordination of care.

Ending an Episode of Care for Member in Behavioral Health System

Under certain circumstances, it may be appropriate or necessary to dis-enroll a member or end an episode of care from services after reengagement efforts described in ***Reengagement*** have been expended except for members designated as SMI, TXIX or Non-Title XIX. Ending the episode of care can occur due to clinical or administrative factors involving the enrolled member. The episode of care can be ended for both Non-Title XIX and Title XIX individuals, but Title XIX eligible individuals no longer in an episode of care for behavioral health services remain enrolled with AHCCCS. When a member is dis-enrolled or has an episode of care ended, notice and appeal requirements may apply.

For children in the custody of DCS who have been enrolled with a Behavioral Health Home for less than 6 months, the Behavioral Health Home must elevate closure reasons of 'Treatment Completed', 'Lack of Contact', or 'Declined Further Services' to the MC Child Welfare Single Point of Contact at **DCS@MercyCareAZ.org** prior to ending the Episode of Care.

Clinical Factors

Treatment Completed:

A member's episode of care must be ended upon completion of treatment. A Non-Title XIX member would also be dis-enrolled at treatment completion. Prior to ending the episode of care or dis-enrolling a member following the completion of treatment, the behavioral health provider and the member or the member's legal guardian must mutually agree that behavioral health services are no longer needed.

Further Treatment Declined:
A member's episode of care must be ended if the member or the member's legal guardian decides to refuse ongoing behavioral health services. A Non-Title XIX member would also be dis-enrolled from services except for members designated as SMI, TXIX or nontitle XIX. Prior to ending the episode of care or dis-enrolling a member for declining further treatment or moving a member to a Patient Navigator, the behavioral health provider must ensure the following:

- All applicable and required reengagement activities described in *Reengagement* have been conducted and clearly documented in the member's comprehensive clinical record; and
- The member does not meet clinical standards for initiating the pre-petition screening or petition or petition for treatment process.
- Upon receiving a request from a DCS Specialist or representative for a child in the custody of DCS to discontinue services and/or dis-enroll a foster child, the behavioral health provider will conduct a Child Family Team (CFT) meeting to determine if this is clinically sound. If the child has been enrolled with the Behavioral Health Home for less than 6 months, the Behavioral Health Home must elevate the request to decline further treatment to MC Child Welfare Single Point of Contact at DCS@MercyCareAZ.org.

Lack of Contact:
A member's episode of care may be ended if MC or behavioral health provider is unable to locate or contact the member after ensuring that all applicable and required re- engagement activities described in ***Reengagement*** have been conducted.

A Non-Title XIX individual would also be dis-enrolled from services.

Administrative Factors:
Eligibility/Entitlement Information Changes Including:

- Loss of Title XIX/XXI eligibility, if other funding is not available to continue services; and
- Members who become or are enrolled as elderly or physically disabled (EPD) under the Arizona Long Term Care System (ALTCS) must be dis-enrolled after ensuring appropriate coordination and continuity of care with the ALTCS program contractor. (Not applicable for developmentally delayed ALTCS members ALTCS/DD whose behavioral health treatment is provided through the TRBHA system.)

Behavioral health providers may dis-enroll Non-Title XIX/XXI eligible members for non-payment of assessed co-payments per **MC Provider Manual Chapter 100 – General Terms, Chapter 4 – Provider Responsibilities, Section 4.33 - Copayments** under the following conditions:

- The member is not eligible as a member determined to have a Serious Mental Illness (SMI); and
- Attempts at reasonable options to resolve the situation, (e.g., informal discussions) do not result in resolution. All efforts to resolve the issue must be documented in the member's comprehensive clinical record, in accordance with **MC Provider Manual Chapter 100 – General Terms, Chapter 4 – Provider Responsibilities, Section 4.33 – Copayments**.

Out-of-State Relocations:
A member's episode of care must be ended for a member who relocates out-of-state after appropriate transition of care. A Non-Title XIX individual would also be dis-enrolled. This does not apply to members placed out-of-state for purposes of providing behavioral health treatment.

Inter-TRBHA Transfers:
A member who relocates to another TRBHA and requires ongoing behavioral health services must be closed from one TRBHA and transferred to the new TRBHA. Services must be transitioned.

Children in the Custody of DCS:
Inter-ACC-RBHA transfers are not to be initiated if an AHCCCS-eligible child is in the custody of DCS, remains with the same court of jurisdiction and moves to a different county due to the location of an out-of-home placement (e.g., foster home, kinship, or group home).

Arizona Department of Corrections Confinements:
A member aged 18 or older must be dis-enrolled upon acknowledgement that the member has been placed in the long-term control and custody of a correctional facility.

Children Held at County Detention Facilities:
A child who was served by MC prior to detainment in a county detention facility will remain in an active episode of care if the child remains Title XIX/XXI eligible. MC and contracted providers must check the AHCCCS Pre-paid Medical Management Information System (PMMIS) to ensure Title XIX/XXI eligibility prior to the delivery of each behavioral health service to a child who is held in a county detention facility.

Inmates of Public Institutions:

AHCCCS has implemented an electronic inmate of public institution notification system developed by the AHCCCS Division of Member Services (DMS). If a member is eligible for AHCCCS covered services during the service delivery period, MC is obligated to cover the services regardless of the perception of the member's legal status.

For AHCCCS to monitor any change in a member's legal status, and to determine eligibility, providers need to notify AHCCCS via e-mail if they become aware that an AHCCCS eligible member is incarcerated. AHCCCS has established email addresses for this purpose. Please note that there are two separate e-mail addresses based on the member's age. For children less than 18 years of age, please use **DMSJUVENILEincarceration@azahcccs.gov**. For adults aged 18 years and older, please use **DMSADULTIncarceration@azahcccs.gov.**

Notifications must include the following member information:

- AHCCCS ID;
- Name;
- Date of Birth;
- Incarceration date; and
- Name of public institution where incarcerated.

Please note that providers ***do not*** need to report members incarcerated with the Arizona Department of Corrections.

Deceased Members:
A member's episode of care must be ended following acknowledgement that the member is deceased, effective on the date of the death. The Non-Title XIX individual would be dis-enrolled from the system.

Crisis Episodes:
For members who are enrolled because of a crisis episode, the member's episode of care would end if the following conditions have been met:

- The behavioral health provider conducts all applicable and required reengagement activities and such attempts are unsuccessful; or
- The behavioral health provider and the member or the member's legal guardian mutually agrees that ongoing behavioral health services are not needed; a Non-Title XIX individual would be dis-enrolled from the system.

One-Time Consultations:
For members who are in the system for a one-time consultation, the member's episode of care may be ended if the behavioral health provider and the member or the member's legal

guardian mutually agrees that ongoing behavioral health services are not needed. The Non-Title XIX individual would also be dis-enrolled.

Serving Members Previously Enrolled in Behavioral Health System

Some members who have ended their episode of care or were dis-enrolled may need to re-enter the behavioral health system. The process used is based on the length of time that a member has been out of the behavioral health system.

For members not receiving services for less than one year:

- If the member has not received a behavioral health assessment in the last year, conduct a new behavioral health assessment and revise the member's service plan as needed. If the member has received a behavioral health assessment in the last year and there has not been a significant change in the member's behavioral health condition, behavioral health providers may utilize the most current assessment. Review the most recent service plan (developed within the last year) with the member, and if needed, coordinate the development of a revised service plan with the member's clinical team.
- If the member presents at a different TRBHA or provider, obtain new general and informed consent to.
- If the member presents at a different TRBHA or provider, obtain new authorizations to disclose confidential information, as applicable.

For members not receiving services for one year or longer:

- Conduct a new intake, behavioral health assessment and service plan.
- Continue the member's SMI status if the member was previously determined to have a Serious Mental Illness (SMI)
- Obtain new general and informed consent to treatment.
- Obtain new authorizations to disclose confidential information, as applicable.

4.04 – Serious Mental Illness Determination

General Requirements

This section applies to:

- Members who are referred for, request or have been determined to need an eligibility determination for Serious Mental Illness (SMI);
- Members who are enrolled as a member determined to have a SMI for whom a review of the determination is indicated; and
- MC, subcontracted providers, and the MC designee.

A qualified assessor must complete all SMI evaluations. If the qualified assessor is a Behavioral Health Technician the evaluation must be reviewed, approved, and signed by a Behavioral Health Professional.

Completion Process of Initial SMI Eligibility Determination

Upon receipt of a referral for, a request, or identification of the need for an SMI determination, the behavioral health provider or designated Department of Corrections' staff member will schedule an appointment for an initial meeting with the member and a qualified assessor. This shall occur no later than 7 days after receiving the request or referral.

During the initial meeting with the member by a qualified assessor, the assessor must:

- Make a clinical assessment whether the member is competent enough to participate in an assessment;
- Obtain general consent from the member or, if applicable, the member's guardian to conduct an assessment; and
- Provide to the member and, if applicable, the member's guardian, the information required in **R9-21-301(D) (2)**, a client rights brochure, and the appeal notice required by **R9-21- 401(B)**.

If, during the initial meeting with the member, the assessor is unable to obtain enough information to determine whether the applicant is SMI, the assessor must:

- Request the additional information to decide whether the member is SMI and obtain an authorization for the release of information, if applicable; and
- Initiate an assessment including completion of the **Serious Mental Illness Determination**.

Criteria for SMI Eligibility Determination

The determination of SMI requires both a qualifying SMI diagnosis and functional impairment because of the qualifying diagnosis.

Functional Criteria for SMI Determination

To meet the functional criteria for SMI, a member must have, because of a qualifying SMI diagnosis, dysfunction in at least one of the following four domains, as described below, for most of the past twelve months or for most of the past six months with an expected continued duration of at least six months:

- **Inability to live in an independent or family setting without supervision** – Neglect or disruption of ability to attend to basic needs. Needs assistance in caring for self. Unable to care for self in safe or sanitary manner. Housing, food, and clothing must be provided or arranged for by others. Unable to attend to most basic needs of hygiene, grooming, nutrition, medical and dental care. Unwilling to seek prenatal care or necessary medical/dental care for serious medical or dental conditions. Refuses treatment for life threatening illnesses because of behavioral health disorder.
- **A risk of serious harm to self or others** – Seriously disruptive to family and/or

community. Pervasively or imminently dangerous to self or others' bodily safety. Regularly engages in assaultive behavior. Has been arrested, incarcerated, hospitalized or at risk of confinement because of dangerous behavior. Persistently neglectful or abusive towards others in the member's care. Severe disruption of daily life due to frequent thoughts of death, suicide, or self-harm, often with behavioral intent and/or plan. Affective disruption causes significant damage to the member's education, livelihood, career, or personal relationships.

- **Dysfunction in role performance** – Frequently disruptive or in trouble at work or at school. Frequently terminated from work or suspended/expelled from school. Major disruption of role functioning. Requires structured or supervised work or school setting. Performance significantly below expectation for cognitive/developmental level. Unable to work, attend school, or meet other developmentally appropriate responsibilities; or
- **Risk of Deterioration** – A qualifying diagnosis with probable chronic, relapsing and remitting course. Co-morbidities (like mental retardation, substance dependence, personality disorders, etc.). Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors (life-threatening or debilitating medical illnesses, victimization, etc.). Other (past psychiatric history; gains in functioning have not solidified or are a result of current compliance only; court-committed; care is complicated and requires multiple providers; etc.).

The following reasons shall not be enough in and of themselves for denial of SMI eligibility:

- An inability to obtain existing records or information; or
- Lack of a face-to-face psychiatric or psychological evaluation.

Member with Co-Occurring Substance Use

For members who have a qualifying SMI diagnosis and co-occurring substance use, for purposes of SMI determination, presumption of functional impairment is as follows:

- For psychotic diagnoses (bipolar I disorder with psychotic features, delusional disorder, major depression, recurrent, severe, with psychotic features, schizophrenia, schizoaffective disorder, and psychotic disorder NOS) functional impairment is presumed to be due to the qualifying psychiatric diagnosis;
- For other major mental disorders (bipolar disorders, major depression, and obsessive-compulsive disorder), functional impairment is presumed to be due to the psychiatric diagnosis, unless:
    - The severity, frequency, duration, or characteristics of symptoms contributing to the functional impairment cannot be attributed to the qualifying mental health diagnosis; or
    - The assessor can demonstrate, based on a historical or prospective period of treatment, that the functional impairment is present only when the member is abusing substances or experiencing symptoms of withdrawal from substances.

- For all other mental disorders not covered above, functional impairment is presumed to be due to the co-occurring substance use unless:
    - The symptoms contributing to the functional impairment cannot be attributed to the substance use disorder; or
    - The functional impairment is present during a period of cessation of the co-occurring substance use of at least thirty (30) days; or
    - The functional impairment is present during a period of at least ninety (90) days of reduced use unlikely to cause the symptoms or level of dysfunction.

SMI Eligibility Determination for Inmates in the Department of Correction (DOC)

An SMI eligibility designation/determination is done for purposes of determining eligibility for community-based behavioral health services. The Arizona Department of Health Services recognizes the importance of evaluating and determining the SMI eligibility for inmates in the Department of Corrections (DOC) with impending release dates to appropriately coordinate care between the DOC and the community based behavioral health system. Inmates of DOC **pending release within 6 months**, who have been screened or appear to meet the diagnostic and functional criteria, **will now be permitted to be referred** for an SMI eligibility evaluation and determination. Inmates of DOC whose release date exceeds 6 months are not eligible to be referred for an SMI eligibility evaluation and determination.

SMI Eligibility Determination for Children Transitioning into the Adult System

When the adolescent reaches the **age of 17.5** and the Child and Family Team (CFT) believes that the youth may meet eligibility criteria as an adult with a Serious Mental Illness (SMI), the TRBHA and their subcontracted providers must ensure the young adult receives an eligibility determination as outlined in the **AHCCCS Medical Policy Manual 320-P Serious Mental Illness Determination.**

If the youth is determined eligible, or likely to be determined eligible for services as a member with a Serious Mental Illness, the adult behavioral health services provider-based case manager is then contacted to join the CFT and participate in the transition planning process. **After obtaining permission from the parent/guardian**, **it is the responsibility of the children's behavioral health service provider to contact and invite the adult behavioral health services provider-based case manager to upcoming planning meetings.** Additionally, the children's provider must track and report the following information to MC, CFT transition date (date the adult and children's provider attended a CFT) and adult intake date. When more than one TRBHA and/or behavioral health service provider agency is involved, the responsibility for collaboration lies with the agency that is directly responsible for service planning and delivery.

If the young adult is not eligible for services as a member with a Serious Mental Illness, it is the responsibility of the children's behavioral health provider, through the CFT, to coordinate

transition planning with the adult GMH/SU provider. The importance of securing representation from the adult service provider in this process cannot be overstated, regardless of the member's identified behavioral health category assignment (SMI, General Mental Health, Substance Use). The children's behavioral health provider should be persistent in its efforts to make this occur.

For additional guidance regarding the Transition to Adulthood Process for youth determined SMI prior to turning 18, see **AHCCCS Clinical Guidance Tool Transition to Adulthood Practice Protocol.**

Completion Process of Final SMI Eligibility Determination

The licensed psychiatrist, psychologist, or nurse practitioner designated by Solari must make a final determination as to whether the member meets the eligibility requirements for SMI status based on:

- A face-to-face assessment or reviewing a face-to-face assessment by a qualified assessor; and
- A review of current and historical information, if any, obtained orally or in writing by the assessor from collateral sources, and/or present or previous treating clinicians.

The following must occur if the designated reviewing psychiatrist, psychologist, or nurse practitioner has not conducted a face-to-face assessment and has a disagreement with the current evaluating or treating qualified behavioral health professional or behavioral health technician (that cannot be resolved by oral or written communication):

- Disagreement regarding diagnosis: Determination that the member does not meet eligibility requirements for SMI status must be based on a face-to-face diagnostic evaluation conducted by a designated psychiatrist, psychologist, or nurse practitioner. The resolution of (specific reasons for) the disagreement shall be documented in the member's comprehensive clinical record.
- Disagreement regarding functional impairment: Determination that the member does not meet eligibility requirements must be based upon a face-to-face functional evaluation conducted by a designated psychiatrist, psychologist, or nurse practitioner. The psychiatrist, psychologist, or nurse practitioner shall document the specific reason(s) for the disagreement in the member's comprehensive clinical record.

If there is enough information to determine SMI eligibility, the member shall be provided written notice of the SMI eligibility determination within three (3) business days of the initial meeting with the qualified assessor.

Issues Preventing Timely Completion of SMI Eligibility Determination

The time to initiate or complete the SMI eligibility determination may be extended no more than 20 days if the member agrees to the extension and:

- There is substantial difficulty in scheduling a meeting at which all necessary participants can attend;
- The member fails to keep an appointment for assessment, evaluation, or any other necessary meeting;
- The member is capable of, but temporarily refuses to cooperate in the preparation of the completion of an assessment or evaluation;
- The member or the member's guardian and/or designated representative requests an extension of time;
- Additional documentation has been requested, but has not yet been received; or
- There is insufficient functional or diagnostic information to determine SMI eligibility within the required time periods.

Solari must:

- Document the reasons for the delay in the member's eligibility determination record when there is an administrative or other emergency that will delay the determination of SMI status; and
- Not use the delay as a waiting period before determining SMI status or as a reason for determining that the member does not meet the criteria for SMI eligibility (because the determination was not made within the time standards).

Situations in which Extension is due to Insufficient Information:

- Solari shall request and obtain the additional documentation needed e.g., current and/or past medical records) and/or perform or obtain any necessary psychiatric or psychological evaluations;
- The designated reviewing psychiatrist, psychologist, or nurse practitioner must communicate with the member's current treating clinician, if any, prior to the determination of SMI, if there is insufficient information to determine the member's level of functioning; and
- SMI eligibility must be determined within three days of obtaining enough information, but no later than the end date of the extension.

If the member refuses to grant an extension, SMI eligibility must be determined based on the available information. If SMI eligibility is denied, the member will be notified of his/her appeal rights and the option to reapply).

If the evaluation or information cannot be obtained within the required time because of the need for a period of observation or abstinence from substance use to establish a qualifying

mental health diagnosis the member shall be notified that the determination may, with the agreement of the member, be extended for up to 90 (calendar) days.

Notification of SMI Eligibility Determination

If the eligibility determination results in approval of SMI status, the SMI status must be reported to the member in writing, including notice of his/her right to appeal the decision.

If the eligibility determination results in a denial of SMI status, Solari shall include in the notice above:

- The reason for denial of SMI eligibility (**Serious Mental Illness Determination**);
- The right to appeal; and
- The statement that Title XIX/XXI eligible members will continue to receive needed Title XIX/XXI covered services.

Re-Enrollment or Transfer

If the member's status is SMI at disenrollment, or upon transfer from another TRBHA, the member's status shall continue as SMI upon re-enrollment, opening of a new episode of care, or transfer.

Review of SMI Eligibility Determination

A review of SMI eligibility made by Solari for individuals currently enrolled as a member with a SMI may be initiated by MC or behavioral health provider:

- As part of an instituted, periodic review of all members determined to have a SMI; or
- When there has been a clinical assessment that supports that the member no longer meets the functional and/or diagnostic criteria.
- An individual currently enrolled as a member with a SMI, or their legally authorized representative, upon their request.

A review of the determination may not be requested by MC or behavioral health provider within six months from the date an individual has been determined SMI eligible.

If, because of such review, the member is determined to no longer meet the diagnosis and functional requirements for SMI status, MC must ensure that:

- Services are continued depending on Title XIX/XXI eligibility, MC service priorities and any other requirements.
- Written notice of the determination made on review with the right to appeal is provided to the affected member with an effective date of 30 days after the date the written notice is issued.

Verification of SMI Eligibility Determinations

When a TRBHA or its contracted providers are required to verify SMI Eligibility for individuals who have previously been determined SMI, but cannot locate the member's original SMI determination documentation, or when the SMI determination is outdated (more than 10 years old as required by AHCCCS for eligibility/enrollment for benefits), **Serious Mental Illness Determination Verification** must be completed.

- The form does not replace Serious Mental Illness Determination but enables the MC and providers to "verify" a member's current SMI eligibility.

The form must be completed by a licensed psychiatrist, psychologist, or nurse practitioner, and then submitted to MC for approval. MC is responsible for monitoring and validating the forms. MC must keep copies of the validated Serious Mental Illness Determination Verification form in the member's record.

4.05 - Special Populations

MC receives Federal grants and State appropriations to deliver behavioral health services to special populations in addition to Federal Medicaid (Title XIX) and the State Children's Health Insurance Program (Title XXI) funding. The grants are awarded by a federal agency and made available to AHCCCS. AHCCCS then disburses the funding throughout Arizona for the delivery of covered behavioral health services in accordance with the requirements of the fund source.

Substance Use Block Grant (SUBG)

The SUBG supports primary prevention services and treatment services for member with substance use disorders. It is used to plan, implement, and evaluate activities to prevent and treat substance use. Grant funds are also used to provide early intervention services for HIV and tuberculosis disease in high-risk substance users. This section is intended to present an overview of the major Federal grants that provide AHCCCS and the public behavioral health system with funding to deliver services to member who may otherwise not be eligible for covered behavioral health services.

Coverage and Prioritization

SUBG funds are used to ensure access to treatment and long-term recovery support services for (in order of priority):

- Pregnant women/teenagers who use drugs by injection;
- Pregnant women/teenagers who use substances;
- Other member who use drugs by injection;
- Substance using women and teenagers with dependent children and their families, including females who are attempting to regain custody of their children; and
- All other clients with a substance use disorder, regardless of gender or route of use, (as funding is available).

Members must indicate active substance use within the previous 12-month period to be eligible for SUBG funded services.

Choice of Substance Use Providers

Members receiving substance use treatment services under the SUBG have the right to receive services from a provider to whose religious character they do not object.

Behavioral health subcontractors providing substance use services under the SUBG must notify members of this right. Members must document that the member has received notice in the member's comprehensive clinical record.

If a member objects to the religious character of a behavioral health provider, the provider must refer the member to an alternative provider within 7 days, or earlier when clinically indicated, after the date of the objection. Upon making such a referral, providers must notify MC of the referral and ensure that the member contacts the alternative provider.

Upon making a referral, the provider will notify MC's General Mental Health/Substance Use Administrator by calling 800-564-5465.

Available Services

The following services must be made available to Substance Use Block Grant (SUBG) special populations, as clinically identified and appropriate: Behavioral health providers must provide specialized, gender-specific treatment and recovery support services for females who are pregnant or have dependent children and their families in outpatient/residential treatment settings. Services are also provided to mothers who are attempting to regain custody of their children. Services must treat the family as a unit. As needed, providers must admit both mothers and their dependent children into treatment. The following services are provided or arranged as needed:

- Referral for primary medical care for pregnant females
- Referral for primary pediatric care for children
- Gender-specific substance use treatment
- Therapeutic interventions for dependent children

MC is required to ensure the following issues do not pose barriers to access to obtaining substance use treatment:

- Childcare
- Case management
- Transportation

MC is required to publicize the availability of gender-based substance use treatment services for females who are pregnant or have dependent children. Publicizing will include at a minimum the posting of fliers at each site notifying the right of pregnant females and females with dependent children to receive substance use treatment services at no cost.

Subcontracted providers must notify MC if, based on moral or religious grounds, the provider elects not to provide or reimburse for a covered service.

Providers may call MC at 800-564-5465 with questions regarding specialty program services for women and children.

Interim Services for Pregnant Women/Injection Drug Users (Non-Title XIX/XXI only)

The purpose of interim services is to reduce the adverse health effects of substance use, promote the health of the individual, and reduce the risk of transmission of disease. Provision of interim services must be documented in the client's chart as well as reported to MC through the online waitlist. Interim services are available for Non-Title XIX/XXI priority populations who are maintained on an actively managed wait list. Title XIX/XXI eligible members who also meet a priority population type may not be placed on a wait list (see **Chapter 3 – Behavioral Health, Section 3.08 – Behavioral Health Appointment Standards** of this manual). The minimum required interim services include education that covers:

- Prevention of and types of behaviors which increase the risk of contracting HIV, Hepatitis C and other sexually transmitted diseases;
- Effects of substance use on fetal development;
- Risk assessment/screening;
- Referrals for HIV, Hepatitis C, and tuberculosis screening and services; and
- Referrals for primary and prenatal medical care.

SUBG Reporting Requirements

Providers must promptly submit information for Priority Population Members (Pregnant Women, Women with Dependent Children, and Intravenous Drug Users) who are waiting for placement in a Residential Treatment Center, to the MC SUBG Waitlist System, or in a different format upon written approval by MC.

- Title XIX/XXI members may not be added to the wait list.
- Priority Population Members must be added to the wait list if MC or its providers are not able to place the member in a Residential Treatment Center within the timeframes prescribed.
    - For pregnant females, the requirement is within 48 hours, for women with dependent children the requirement is within 5 calendar days, and for all IVDUs the requirement is within 14 calendar days.
- Non-Title XIX/XXI members may be added to the waitlist if there are no available

services.

Other SUBG Requirements

MC is required to designate:

- A lead substance use treatment coordinator who will be responsible for ensuring MC compliance with all SUBG requirements;
- A women's treatment coordinator;
- An opiate treatment coordinator
- A prevention services administrator; and
- An HIV early intervention services coordinator

HIV Early Intervention Services

Because members with substance use disorders are considered at high risk for contracting HIV-related illness, the SUBG requires HIV intervention services to reduce the risk of transmission of this disease.

In Maricopa County, Terros, Inc., provides HIV early intervention services at substance use programs, case management sites for the seriously mentally ill, and community events, and operates a drop-in center. To contact this program, please call 602-685-6000.

Eligibility for HIV Early Intervention Services

- Services are provided exclusively to populations with substance use disorders.
- HIV services may not be provided to incarcerated populations.

Requirements for Providers Offering HIV Early Intervention Services

HIV early intervention service providers who accept funding under the SUBG must provide HIV testing services.

Behavioral health providers must administer HIV testing services in accordance with the Clinical Laboratory Improvement Amendments (CLIA) requirements, which requires that any agency that performs HIV testing must register with CMS to obtain CLIA certification. However, agencies may apply for a CLIA Certificate of Waiver which exempts them from regulatory oversight if they meet certain federal statutory requirements. Many of the Rapid HIV tests are waived. Available for your review is a complete list of waived Rapid HIV tests listed on the **CDC website**. Waived rapid HIV tests can be used at many clinical and non-clinical testing sites, including community and outreach settings. Any agency that is performing waived rapid HIV tests is considered a clinical laboratory.

Any provider planning to perform waived rapid HIV tests must develop a quality assurance plan, designed to ensure any HIV testing will be performed accurately. (Please click to see the Centers for Disease Control Quality Assurance Guidelines.)

HIV Education and Pre/Post-test Counseling: The HIV Prevention Counseling training provided through MC must be completed by MC HIV Coordinators, provider staff, and provider supervisors whose duties are relevant to HIV services. Staff must successfully complete the training with a passing grade prior to performing HIV testing.

MC HIV Coordinators and provider staff delivering HIV Early Intervention Services for the SUBG must attend an HIV Early Intervention Services Webinar issued by MC on an annual basis, or as indicated by AHCCCS. The Webinar will be recorded and made available by MC. New staff assigned to duties pertaining to HIV services must view the Webinar as part of their required training prior to delivering any HIV Early Intervention Services reimbursed by the SUBG.

HIV early intervention service providers cannot provide HIV testing until they receive a written HIV test order from a licensed medical doctor, in accordance with **A.R.S. §36-470**. HIV rapid testing kits must be obtained from the Office of Tobacco and Chronic Disease.

HIV early intervention service providers must actively participate in regional community planning groups to ensure coordination of HIV services.

Reporting Requirements for HIV Early Intervention Services

For every occurrence in which an oral swab rapid test provides a reactive result, a confirmatory blood test must be conducted, and the blood sample sent to the Arizona State Lab for confirmatory testing. Therefore, each provider who conducts rapid testing must have capacity to collect blood for confirmatory testing whenever rapid testing is conducted.

The number of the confirmatory lab slip will be retained and recorded by the provider. This same number will be used for reporting in the Luther database. The HIV Early Intervention service provider must establish a Memorandum of Understanding (MOU) with their local County Health Department to define how data and information will be shared.

Providers must use the Luther database to submit HIV testing data after each test administered.

Monitoring Requirements for HIV Early Intervention Services

MC is required to collect monthly progress reports from subcontracted providers and submit quarterly progress reports to AHCCCS.

Site visits to providers offering HIV Early Intervention Services must be conducted bi-annually. The AHCCCS HIV Coordinator, MC HIV Coordinator, provider staff, and supervisors relevant to HIV services must be in attendance during staff visits. A budget review and description/justification for use of funding must be made available by the provider as part of the site visit.

Minimum Performance Expectations

MC is expected to administer a minimum of 1 test per $600 in HIV funding.

Delivery Considerations Services to Substance Use Block Grant (SUBG) Populations

SUBG treatment services must be designed to support the long-term treatment and substance-free recovery needs of eligible members. Specific requirements apply regarding preferential access to services and the timeliness of responding to a member's identified needs. Providers funded with SUBG funding must coordinate non-emergency transportation to covered SUBG services.

Restrictions use of Substance Use Block Grant (SUBG)

The State shall not expend SUBG Block Grant funds on the following activities:

- To provide inpatient hospital services, except for detox services;
- To make cash payments to intended members of health services;
- To purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
- To satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds (Maintenance of Effort);
- To provide financial assistance to any entity other than a public or nonprofit private entity;
- To provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug use and the risk that the public will become infected with the etiologic agent for AIDS;
- To pay the salary of an individual through a grant or other extramural mechanism at a rate more than **Executive Level I of the Executive Salary Schedule** for the award year; and
- To purchase treatment services in penal or correctional institutions of the State of Arizona.

Room and Board (H0046-SE) services funded by the SUBG are limited to children/adolescents with a Substance Use Disorder (SUD), and adult priority population members (pregnant females, females with dependent children, and intravenous drug users with a SUD).

Mental Health Block Grant (MHBG)

The MHBG provides funds to establish or expand an organized community-based system of care for providing Non-Title XIX mental health services to children with serious emotional disturbances (SED) and adults with serious mental illness (SMI). These funds are used to:

- Carry out the State plan contained in the application;
- Evaluate programs and services, and;
- Conduct planning, administration, and educational activities related to the provision of services.

Coverage and Prioritization

The MHBG provides Non-Title XIX/XXI behavioral health services to adults with SMI and children with SED.

The MHBG must be used:

- To ensure access to a comprehensive system of care, including employment, housing, case management, rehabilitation, dental, and health services, as well as mental health services and supports;
- To promote participation by consumer/survivors and their families in planning and implementing services and programs, as well as in evaluating State mental health systems;
- To ensure access for underserved populations, including people who are homeless, residents of rural areas, and older adults;
- To promote recovery and community integration for adults with SMI and children with SED;
- To provide for a system of integrated services to include:
    - Social services;
    - Educational services;
    - Juvenile justice services;
    - Substance use services;
    - Health and behavioral health services; and
    - To provide for training of providers of emergency health services regarding behavioral health.

Restrictions on Use of MHBG Funds

The State shall not expend MHBG funds on the following activities:

- To provide inpatient hospital services; except for detox services
- To make cash payments to intended members of health services;
- To purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
- To satisfy any requirement for the expenditure of non-Federal funds as a condition for

the receipt of Federal funds (Maintenance of Effort);
- To provide financial assistance to any entity other than a public or nonprofit private entity;
- To provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug use and the risk that the public will become infected with the etiologic agent for AIDS;
- To pay the salary of an individual through a grant or other extramural mechanism at a rate more than **Executive Level I of the Executive Salary Schedule** for the award year; and
- To purchase treatment services in penal or correctional institutions of the State of Arizona Room and Board services funded by the MHBG are limited to children with SED.

Room and Board services funded by the MHBG are limited to children with SED.

4.06 – Crisis Intervention Services

A crisis event is self-defined and determined by the individual experiencing the situation. An individual is in crisis if the individual finds they lack the skills or are unable to cope with a situation or event that is impacting them. Crisis services are immediate and unscheduled behavioral health services provided to an individual to address an acute behavioral issue affecting the individual. Crisis services are required to be recovery-oriented, person-focused, with the goal of stabilizing the individual as quickly as possible to assist then in returning to their baseline of functioning. Crisis intervention services are provided in a variety of settings, such as hospital emergency departments, face-to-face at a member's home, over the telephone, via telehealth (inclusive of services provided via text, chat, and phone) or in the community without duplicating or replacing existing behavioral health services available at that location. These intensive and time limited services may include screening, (e.g., triage and arranging for the provision of additional crisis services) assessing, evaluating, or counseling to stabilize the situation, medication stabilization and monitoring, observation and/or follow-up to ensure stabilization, and/or other therapeutic and supportive services to prevent, reduce or eliminate a crisis. All interventions are required to be offered in a clinically and culturally appropriate manner that respects the preferences of the individual in crisis, while recognizing the need to maintain safety.

General Requirements

To meet the needs of individuals in communities throughout Arizona, MC will ensure that the following crisis services are available:

- Telephone Crisis Intervention Services:
    - Telephone crisis intervention and NurseLine services, including a toll-free number, available 24 hours per day, seven days a week: 844-534-4673; toll free

800-631-1314; or TTY/TTD toll free 800-327-9254.
    - Answer calls within three (3) telephone rings (equivalent to 18 seconds), with a call abandonment rate of less than three (3%) percent.
    - Offer interpretation or language translation services to members who do not speak or understand English and for the deaf and hard of hearing.
    - Mobile Crisis Intervention Services
    - Mobile crisis intervention services available 24 hours per day, seven days a week;
    - Mobile crisis teams will respond within an average of one (1) hour to a psychiatric crisis in Maricopa and Pima Counties and within an average of 90 minutes in all other counties.
    - If a two-member team responds, one member may be a Behavioral Health Technician, including a peer or family member, provided he/she has supervision and training as currently required for all mobile team members.
- 23-hour crisis observation/stabilization services, including detoxification services.
- Up to 72 hours of additional crisis stabilization as funding is available for mental health and substance use related services.
- Work collaboratively with local emergency departments and first responders.

Psychiatric Emergencies for Adults

Community Bridges- Community Psychiatric Emergency Center
358 E. Javelina Ave.
Mesa, AZ 85210
Phone: 877-931-9142

Community Bridges- West Valley Access Point
824 N. 99th Ave
Avondale, AZ 85323

Community Bridges- Casa Grande
675 E. Cottonwood Lane, Ste 140
Casa Grande, AZ 85122

Connections AZ Urgent Psychiatric Care Center (UPC)
1201 S. 7th Ave., Ste. 150
Phoenix, AZ 85007
Phone: 602-416-7600

Recovery Response Center (formerly Recovery Innovations Psychiatric Recovery Center (META) West (PRC-West))
11361 N 99th Ave., Ste. 402

Peoria, AZ 85345
Phone: 602-650-1212, then press 2

Community Bridges Central City Addiction Recovery Center (CCARC)
2770 E. Van Buren St.
Phoenix, AZ 85008
Phone: 877-931-9142

Community Bridges East Valley Addiction Recovery Center (EVARC)
506 S. Bellview
Mesa, AZ 85204
Phone: 877-931-9142

Mind 24/7 - Metro
10046 N. Metro Parkway
Phoenix, AZ 85051
Phone: 844-MIND247

Mind 24/7 - Higley
1138 S. Higley Rd
Mesa, AZ 85206

Management of Crisis Services

The ACC-RBHA in the north, central, and south is responsible for the oversight of crisis service delivery within Arizona. Crisis services are available across the state for all who may be experiencing a behavioral health crisis. MCLTC coordinates with the managed care organizations who oversee crisis service delivery in all three regions Arizona for follow up after crisis.

- Allocate and manage funding to maintain the availability of required crisis services for the entire fiscal year;
- Work collaboratively with local hospital-based emergency departments to determine whether a MC -funded crisis provider should be deployed to such locations for crisis intervention services;
- Work collaboratively with local inpatient hospitals to determine whether and for how many hours such locations are used for crisis observation/stabilization services; and
- When Non-Title XIX/XXI eligible individuals are receiving crisis services and require medication, MC will use the generic medication formulary identified in the Non-Title XIX SMI benefit.

Whenever possible, Crisis Services are to be delivered within the community at the least restrictive level of care available.

Outreach to Service Members, Veterans, and their Families

MC will partner with community organizations which provide care and support to service members, veterans, and their families. Using a collaborative approach, MC will identify members who may benefit from outreach regarding available programs and services and shall develop and implement outreach activities which inform members and their families of the benefits available and how to access those services. This includes communicating and disseminating information on how to access Veterans Affairs services.

Providers may access additional online training to better understand the needs of veterans, service members, and their families through PsychArmor Institute**.** Please use this **link** to create an account. When you login, there will be a list of pre-populated/suggested courses on your profile, but you may also access a full list of courses by clicking on the "courses" tab at the top of your screen.

MC and its providers will work with the AHCCCS-Approved Statewide Veteran Resource Provider (Be Connected) and their network of community organizations that provide care and support for service members, veterans, and their families.

Information to Members: MC and its providers will develop and implement outreach activities in coordination with the AHCCCS-Approved Statewide Veteran Resource Provider to inform members and families through handbooks, websites, and online provider searches of the benefits available and how to access those services.

Referrals to the AHCCCS-Approved Statewide Veteran Resource Provider: MC and its providers will work with the AHCCCS-Approved Statewide Veteran Resource Provider to determine an appropriate number of referrals per month based on the number of members who need assistance.

Staff Training: MC and its providers will work with the AHCCCS-Approved Statewide Veteran Resource Provider to train staff on the available community resources and appropriate actions to take to ensure members are afforded the ability to effectively access these resources.

General Mental Health/Substance Use (GMH/SU) Member Contact in Sub-Acute and Inpatient Facilities

Upon finding out that a client has been admitted to an inpatient level of care:

- Behavioral health providers must attempt to speak with the sub-acute or inpatient provider daily.
- Behavioral health providers must actively participate in the client's discharge planning and should make plans for follow up activities once the client is discharged (actual

discharge planning should begin to occur at the time of admission).

Behavioral health providers must also document activities in the clinical record and conduct follow-up activities to maintain engagement within the following timeframes:

- Community Based MC Contracted Behavioral Health Providers must have telephonic or face to face contact with member within 24 hours of crisis episode or discharge.
- Member to see prescriber within 7 days of discharge.

4.07 – Training Requirements

MC leadership's expectation is that all contracted General Mental Health/Substance Use providers are knowledgeable about the Substance Use Block Grant (SUBG). This includes providers having SUBG posters and materials available in waiting areas, and to be able to speak to uninsured and underinsured individuals who may need treatment or providing a referral for treatment.

MC Chapter 5 – Pharmacy Management

5.00 - Pharmacy Management Overview

Prescription drugs may be prescribed by any authorized provider, such as a PCP, attending physician, dentist, etc. Prescriptions should be written to allow generic substitution whenever possible and signatures on prescriptions must be legible for the prescription to be dispensed. The **Preferred Drug List (PDL)** on our Pharmacy webpage, also referred to as a Formulary, identifies the medications selected by AHCCCS and the Pharmacy and Therapeutics Committee (P&T Committee) that are clinically appropriate to meet the therapeutic needs of our members in a cost-effective manner.

Step Therapy is a form of automated prior authorization whereby one (1) or more prerequisite drugs, which may or may not be in the same drug class, must be tried first before a step therapy medication will be approved. Drugs that require step therapy are identified on the formulary with "ST".

Certain drugs on the MC formulary have quantity limits and are identified on the formulary with "QLL".

Step therapy and quantity level limits are developed based upon evidence-based guidelines, well-designed controlled clinical trials in peer-reviewed medical literature, drug compendia, and FDA-approved product labeling and conform to nationally recognized standards.

Prescriptions that exceed the quantity limit or do not meet step therapy requirements will require prior authorization before the prescription can be filled at the point of sale.

5.01 - Updating the Preferred Drug Lists (PDLs)

MC's PDLs are developed, monitored, and updated by AHCCCS and the P&T Committee. The P&T Committee continuously reviews the PDLs and medications are added or removed based on objective, clinical, and scientific data. Considerations include efficacy, side effect profile, and cost and benefit comparisons to alternative agents, if available.

Key considerations:

- Therapeutic advantages outweigh cost considerations in all decisions to change PDLs. Market share shifts, price increases, generic availability, and varied dosage regimens may affect the actual cost of therapy.
- Products are not added to the list if there are less expensive, similar products on the formulary.
- When a drug is added to the PDL, other medications may be deleted.

- Participating physicians may request additions or deletions for consideration by the P&T Committee. Requests should include:
    - Basic product information, indications for use, its therapeutic advantage over medications currently on the PDL.
    - Which drug(s), if any, the recommended medication would replace in the current PDL.
    - Any published supporting literature from peer reviewed medical journals.

All PDL requested additions should be sent to:

Aetna Medicaid Administrators LLC
Mercy Care Corporate Director of Pharmacy
4750 S. 44th Place, Ste 150
Phoenix, AZ 85040

5.02 - Notification of PDL Updates

MC will not remove a medication from the PDL without first notifying providers and affected members. MC will provide at least 30 days' notice of such changes. MC is not required to send a hard copy of the PDL each time it is updated, unless requested. A memo may be used to notify providers of updates and changes and may refer providers to view the updated PDL on the MC website. Please click on the link to the access the most current **PDL** which is located on our website. This list may be printed by a provider at any time, if needed. Providers may contact their **Network Management Representative** to request a hard copy of the PDL be mailed to them as well. MC may also notify providers of changes to the PDL via direct letter. MC will notify members of updates to the PDL via direct mail and by notifying the prescribing provider, if applicable.

5.03 - Prior Authorization Required

Prior authorization is required:

- If the drug is not included on the PDL.
- If the prescription requires compounding.
- For injectable medications dispensed by the physician and billed through the member's medical insurance, please call to initiate prior authorization for the requested specialty medication:
    - **MC: 602-263-3000 or toll-free 800-624-3879**
    - **MC ACC-RBHA: 602-586-1841 or toll-free 800-564-5465**
- For injectable medications dispensed by the physician and billed through the member's medical insurance, please call 602-263-3000 or toll-free 800-624-3879 to initiate prior authorization for the requested specialty medication.
- For medication quantities which exceed recommended doses.

- For specialty drugs which require certain established clinical guidelines be met before consideration for prior authorization.
- For certain medications on the PDL that are noted as requiring prior authorization or step therapy**.**

In instances where a prescription is written for drugs not on the PDL, the pharmacy may contact the prescriber to either request a PDL alternative or to advise the prescriber that prior authorization is required for non-PDL drugs. Please see **Chapter 5 – Pharmacy Management, Section 5.11 – Request for Non-PDL Drugs** in this manual for additional information.

Decision and Notification Standards

MC makes pharmacy prior authorization decisions and notifies prescribing practitioners/providers, and/or members in a timely manner, according to the standards defined below:

- MC makes decisions within 24 hours of the receipt of all necessary information.
- MC notifies requesting prescribing providers by fax, phone, or electronic communication of the approved decisions within 24 hours of receipt of the submitted request for prior authorization.
- A request for additional information is sent to the prescriber by fax within 24 hours of the submitted request when the prior authorization request for a medication lacks enough information to render a decision. A final decision will be rendered within seven business days from the initial date of the request.
- If an authorization is denied, MC notifies members and practitioners and/or providers regarding how to initiate an expedited appeal at the time they are notified of the denial.
- MC *will fill a*t *least* a 4-day supply of a covered outpatient prescription drug in an emergent situation.

5.04 - Over the Counter (OTC) Medications

A limited number of OTC medications are covered for MC members. OTC medications require a written prescription from the physician that must include the quantity to be dispensed and dosing instructions. Members may present the prescription at any MC contracted pharmacy. OTCs are limited to the package size closest to a 30-day supply when filled at a retail pharmacy and up to a 90-day supply when filled at CVS mail order pharmacy. Please refer to the Formulary (Covered Medication List for more information.

5.05 - Generic vs. Brand

Generic medications represent a considerable cost savings to the health care industry and Medicaid program. As a result, generic substitution with A-rated products is mandatory unless the brand has been specifically authorized or as otherwise noted. In all other cases, brand names are listed for reference only.

5.06 - Diabetic Supplies

Diabetic supplies are limited to a 30-day supply (to the nearest package size) with a prescription when filled at a retail pharmacy and up to a 90-day supply when filled at CVS mail order pharmacy.

5.07 - Injectable Drugs

The following types of injectable drugs are covered when dispensed by a licensed pharmacist or administered by a participating provider in an outpatient setting and may require prior authorization:

- Immunizations when administered by a pharmacy in a retail pharmacy
- Chemotherapy for the treatment of cancer
- Medication to support chemotherapy for the treatment of cancer
- Glucagon emergency kit
- Hemophilia medications including Ceprotin and Stimate Nasal Spray which must be filled at CVS Specialty Pharmacy.
- Insulin; Insulin syringes
- Immunosuppressant drugs for the post-operative management of covered transplant services
- Rhogam

5.08 - Exclusions

The following items, by way of example, are not reimbursable by MC:

- DESI drugs (those considered less than effective by the FDA)
- Non-FDA approved agents
- Rogaine
- Any medication limited by federal law to investigational use only
- Medications used for cosmetic purposes (e.g., alopecia, actinic keratosis, vitiligo)
- Non-indicated uses of FDA approved medications without prior approval by MC
- Lifestyle medications (such as medications for sexual dysfunction)
- Medications used for anti-obesity/weight loss
- Medications used for fertility

5.09 - Family Planning Medications and Supplies

Aetna Medicaid Administrators LLC administers the family planning benefit for MC that includes:

- Over-the-counter items related to family planning (condoms, foams, etc.) are covered and do not require prior authorization. However, the member must present a written

prescription to the pharmacy including the quantity to be dispensed. A supply for up to 30 days is covered.

- Injectable medications, administered in the provider's office, such as Depo-Provera, will be reimbursed at the MC Fee Schedule, unless otherwise stated in the provider's contract.
- Oral contraceptives provided through the pharmacy are covered for MC members, through Aetna Medicaid Administrators LLC.

Family Planning claims should be mailed to:

Mercy Care Family Planning
P.O. Box 982978
El Paso, TX 79998-2978

For additional information on Family Planning Provider responsibilities refer to the **MC Provider Manual, Chapter 100 – General Terms, Chapter 7 – Family Planning.**

5.10 - Behavioral Health Medications

PCP Medication Management Services: In addition to treating physical health conditions, MC will allow PCPs to treat behavioral health conditions within their scope of practice. PCPs who treat members with behavioral health conditions may provide medication management services including prescriptions, laboratory, and other diagnostic tests necessary for diagnosis, and treatment. For PCPs prescribing medications to treat SUDs, the PCP must refer the member to a behavioral health provider for the psychological and/or behavioral therapy component of the MAT model and coordinate care with the behavioral health provider.

***Transfer of Care*:** For members transitioning from a BHMP to a PCP or from a PCP to a BHMP: PCPs and BHMPs shall coordinate the care and ensure that the member has a sufficient supply of medication(s) to last through the date of the member's first appointment with the PCP or BHMP.

Psychotropic Medication: Prescribing and Monitoring

Psychotropic medication will be prescribed by a psychiatrist who is a licensed physician, or a licensed nurse practitioner, licensed physician assistant, or physician trained or experienced in the use of psychotropic medication; that has seen the client and is familiar with the client's medical history or, in an emergency, is at least familiar with the client's medical history.

When a client on psychotropic medication receives a yearly physical examination, the results of the examination will be reviewed by the physician prescribing the medication. The physician will note any adverse effects of the continued use of the prescribed psychotropic medication in the client's record.

Whenever a prescription for medication is written or changed, a notation of the medication, dosage, frequency or administration, and the reason the medication was ordered or changed will be entered in the client's record.

Assessments

Reasonable clinical judgment, supported by available assessment information, must guide the prescription of psychotropic medications. To the extent possible, candidates for psychotropic medications must be assessed prior to prescribing and providing psychotropic medications. Psychotropic medication assessments must be documented in the member's comprehensive clinical record. Behavioral health medical providers (BHMPs) can use assessment information that has already been collected by other sources and are not required to document existing assessment information that is part of the member's comprehensive clinical record. At a minimum, assessments for psychotropic medications must include:

- An adequately detailed medical and behavioral health history;
- A mental status examination;
- A diagnosis;
- Target Symptoms;
- A review of possible medication allergies;
- A review of previously and currently prescribed psychotropic medications including any noted side effects and/or potential drug-drug interactions;
- Current medications prescribed by the PCP and medical specialists;
- Current over the counter (OTC) medications, including supplements:
- For sexually active females of childbearing age, a review of reproductive status (pregnancy); and
- For post-partum females, a review of breastfeeding status;

Annual reassessments must ensure that the provider prescribing psychotropic medication notes in the client's record:

- The reason for the use of the medication and the effectiveness of the medication;
- The appropriateness of the current dosage;
- All medication (including medications prescribed by the PCP and medical specialists, OTC medications, and supplements) being taken and the appropriateness of the combination of the medications; and
- Any side effects such as weight gain and/or abnormal/involuntary movements if treated with an anti-psychotic medication.

Informed Consent

Informed consent must be obtained from the member and/or legal guardian for each psychotropic medication prescribed. When obtaining informed consent, the BHP

must communicate in a manner that the member and/or legal guardian can understand and comprehend. It is preferred that the prescribing clinician provide information forming the basis of an informed consent decision. In specific situations in which this is not possible or practicable, information may be provided by another credentialed behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience.

The comprehensive clinical record must include documentation of the essential elements for obtaining informed consent. Essential elements for obtaining informed consent for medication are contained within the **Informed Consent for Psychotropic Medication Treatment.** The use of this form is recommended as a tool to document informed consent for psychotropic medications. If Informed Consent for Psychotropic Medication Treatment is not used to document informed consent, the essential elements for obtaining informed consent must be documented in the member's individual comprehensive clinical record in an alternative fashion.

Psychotropic Medication Monitoring

Psychotropic medications are known to affect health parameters. Depending on the specific psychotropic medication(s) prescribed, these parameters must be monitored according to current national guidelines, considering individualized factors. At a minimum, these must include:

- **Heart Rate and Blood Pressure:** On initiation of any medication, follow up at week 12, and at least annually thereafter or more frequently as clinically indicated.
- **Weight/Body Mass Index (BMI):** On initiation of any medication, follow up at week 4, 8, 12, each visit and at least annually thereafter.
- **Abnormal Involuntary Movements (AIMS):** On initiation of any antipsychotic medication, follow up at week 12, and at least every six months thereafter or more frequently as clinically indicated.
- **Fasting glucose:** On initiation of any medication affecting this parameter, follow up at week 12, and at least annually thereafter or more frequently as clinically indicated.
- **Lipids:** On initiation of any medication affecting this parameter, at week 12, and at least annually thereafter or more frequently as clinically indicated.
- **Complete Blood Count (CBC):** On initiation of any medication affecting this parameter and at least annually thereafter or more frequently as clinically indicated.
- **Liver function:** On initiation of any medication affecting this parameter and at least annually thereafter or more frequently as clinically indicated.
- **Lithium level:** Within one week of initiation of lithium or significant change in dose, follow up at 6 months, and at least annually thereafter or more frequently as clinically indicated.
- **Thyroid functions:** On initiation of lithium, at 6 months, at any significant change in dose, and at least annually thereafter, or more frequently as clinically indicated.

- **EKGs**: On initiation of any medication affecting the QT interval, then as clinically indicated.
- **Renal function:** On initiation of lithium, follow up at 3 months, 6 months, at any significant change in dose, and at least annually thereafter or more frequently as clinically indicated.
- **Valproic acid level:** Within one week of initiation of valproic acid or divalproex or significant change in dose and at least annually thereafter or more frequently as clinically indicated.
- **Carbamazepine level:** Within one week of initiation of carbamazepine or significant change in dose and at least annually thereafter or more frequently as clinically indicated.
- **Review of all Medications**, including medications prescribed by the PCP and medical specialists, OTC medications, and supplements at least annually or more frequently as clinically necessary.
- **Children** are more vulnerable than adults about developing several antipsychotic induced side effects. These included higher rates of sedation, extrapyramidal side effects (except for akathisia), withdrawal dyskinesia, prolactin elevation, weight gain and at least some metabolic abnormalities. (Journal of Clinical Psychiatry 72:5 May 2011)

Polypharmacy

Commonly used psychotropic medication combinations include the following: medication combinations used to treat multiple disorders in the same patient, medication combinations that offer unique treatment advantages for a single disorder, and medication combinations to address side effects of an effective agent (**Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents J. AM. ACAD. CHILD ADOLESC. PSYCHIATRY, 48:9, SEPTEMBER 2009**).

MC recognizes two types of polypharmacy: intra-class polypharmacy and inter-class polypharmacy. Below are MC's expectations regarding prescribing multiple psychotropic medications to a member being treated for a behavioral health condition:

- **Intra-class Polypharmacy:** Defined as more than two medications prescribed at the same time within the same class, other than for cross-tapering purposes. The member's medical record must contain documentation specifically describing the rationale and justification for the combined use.
- **Inter-class Polypharmacy:** Defined as more than three medications prescribed at the same time from different classes of medications for the overall treatment of behavioral health disorders. The medical record must contain documentation specifically describing the rationale and justification for the combined use.

- **Polypharmacy in Children aged Birth to Five:** Defined as use of more than one psychotropic medication at a time (see Practice Guidelines for Children: Birth to Five Years of Age).

Reporting Requirements

MC has established system requirements for monitoring the following:

- Adverse drug reactions;
- Adverse drug event; and
- Medication errors.

The above-mentioned events are identified, reported, tracked, reviewed, and analyzed by MC.

An incident report must be completed for any medication error, adverse drug event and/or adverse drug reaction that results in harm and/or emergency medical intervention.

Spravato

Spravato® is a specialty prescription medication, used along with an antidepressant, taken by mouth to treat:

- Adults with treatment-resistant depression (TRD)
- Depressive symptoms in adults with major depressive disorder (MDD) with suicidal thoughts or actions.

If a patient requires treatment with this specialty drug, please send/refer them to a Spravato Clinic. Please click on the link for available locations.

5.11 - Request for Non-PDL Drugs

A participating or nonparticipating practitioner/provider acting on behalf of a member is to obtain prior authorization from MC before prescribing or obtaining medications that are not listed in the Formulary/PDL or the member's prescription drug benefit. MC will require the practitioner/ provider to submit the MC Pharmacy Prior Authorization request form and all the necessary supporting medical documentation (e.g., pertinent medical records, completed Federal Drug Administration [FDA] Med Watch form).

The prescribing provider is responsible for submitting authorization requests for non-formulary drugs to the Pharmacy Prior Authorization unit by phone, fax, or electronic PA (ePA), and is responsible for providing medical information necessary to review the request.

Pharmacy Prior Authorization will accept drug-specific information necessary for the authorization review from the prescribing practitioner. MC will inform the member and provider of authorization approvals or denials by written notice.

Any new drugs that are approved by the FDA will be considered through AHCCCS and the P&T Committee review process for addition to MC formulary, and would be made available as a non-formulary drug, requiring PA, upon their availability in the marketplace

To support routine Non-Formulary pharmacy authorization decisions, MC uses guidelines based on FDA-approved indications, evidence-based clinical literature, recognized off-label use supported by peer-reviewed clinical studies, and member's benefit design, which are applied based on individual members. MC also uses the **AHCCCS Fee-For-Service Pharmacy Prior Authorization Criteria**.

The AHCCCS Fee-For-Service Prior Authorization Criteria for Non-Preferred Drugs is used to evaluate authorization requests for which there are not specific guidelines. A request may be authorized if any of the following conditions are met:

- Drug is deemed to be medically necessary AND
- At least three (3) formulary drugs (when available) in the same therapeutic category have been utilized for an adequate trial and have not been effective OR
- Formulary drugs in the same therapeutic category are contra-indicated OR
- There is no therapeutic alternative listed on the Formulary

5.12 – Discarded Physician-Administered Medications

Discarded federally and state reimbursable physician-administered medications shall not be billed to MC. A.A.C. R9-22-209(C) provides that pharmaceutical services are covered only if they are prescribed. The unused portion of a physician administered drug is not covered because it's not medically necessary or prescribed.

A.R.S. §36-2918(A)(1) prohibits a person from making a claim for an item or service that the person knows or has reason to know was not provided as claimed.

A.R.S. §36-2918(A)(3)(b) prohibits a person from submitting a claim for items and services that substantially exceed the needs of the patient.

MC Chapter 6 – Peer and Family Support Services and Partnership Requirements with Peer-Run and Family-Run Organizations

6.00 – Peer and Family Support Services and Peer and Family Run Organizations

Peer and family services are a vital part of member- and family-centered care. When you put a member and their family at the center of their care, the individual's voice is strengthened, and recovery and resiliency can remain the primary focus for all involved in the care for loved ones experiencing mental illness. Behavioral, physical, peer and family support providers shall share the same mission to place the member's whole-health needs more than anything else, as the focal point of care.

Peer support services usually operate in conjunction with clinical services which amplify the benefits of treatment by engaging peers in services they might otherwise not accept, offering ongoing support and psychosocial rehabilitation, and encouraging peers to stay in treatment and services by sharing their stories of recovery. Peer support activities could include, but are not limited to, developing formal and informal supports, instilling confidence, assisting in the development of goals, and/or serving as an advocate, mentor, or facilitator for resolution of issues and skills necessary to enhance and improve the health of a member with emotional, behavioral, or co-occurring disorders.

Family support services are directed toward the restoration, enhancement, or maintenance of the family functioning to increase the family's ability to effectively interact and care for the person in the home and community. Parent/family support activities could include, but are not limited to, assisting the family to adjust to the individual's needs, developing skills to effectively interact and/or guide the individual, understanding the causes and treatment of behavioral health concerns, understanding, and effectively utilizing the system, and/or planning long term care for the individual and the family.

Peer and family support services are a valuable addition to traditional care, and these services are known to contribute to improved outcomes in employment, education, housing stability, satisfaction, self-esteem, medication adherence, and decrease in the need for more costly services, such as hospitalizations. Peer and family-provided services help to foster recovery, increase treatment and service engagement, reduce acute care use, and improve quality of life.

Peer and family run organizations are a SAMHSA evidence-based practice, referred to as a Consumer Operated Service Provider. Peer and family run organizations utilize the principles of peer and family support, are administratively controlled, and operated by individuals with lived experience and offer a wide variety of services including recovery focused support groups, life enhancement skills, goal setting, and socialization and community building with others in recovery. Any agency interested in meeting the requirements of the Consumer Operated

Service Provider who wish to be recognized as a peer and/or family run organization (PRO and/or FRO) may submit a request to MC that will be submitted to AHCCCS to review and determine if the provider meets the definition of a PRO and/or FRO.

Peer and family services are available to all MC members and their families within the health home setting as well as at community-based supportive service organizations, such as a peer run and/or family run organization. Based on member's choice, a member may receive peer support services at their health home and/or at a supportive service provider; however, the service must be identified on the member's individualized service plan. Regarding family support services, a family member may receive family support services at the member's health home and/or at a supportive service provider, if indicated on the member's service plan and the member agrees.

Trainers of peer/recovery support specialists, and individuals seeking training and/or employment as a peer and/or recovery support specialist shall:

- Self-identify as an individual who:
    - Has lived experience of mental health conditions and/or substance use for which they have sought support, and
    - Has an experience of sustained recovery to share
- Qualify as a behavioral health paraprofessional, behavioral health technician, or behavioral health professional.

Individuals meeting the above criteria may be credentialed as a peer and/or recovery support specialist by completing training and passing a competency exam through an AHCCCS/OIFA approved Peer Support Employment Training Program. Individuals are credentialed by the agency operating the Peer Support Employment Training Program.

The training agency program operators shall utilize AMPM 963: Attachment B to determine if applicants are qualified for admission and shall admit only individuals completing and fulfilling all requirements of Attachment B. Final determination for admission rests with the credentialing program operator. The training agency program operators shall maintain a record of issued credentials. If there are regional, agency or culturally specific training requirements exclusive to the training agency, the additional requirements shall not prevent recognition of a PRSS credential issued. The PRSS credentialed process is not a service.

Credentialing is required statewide to deliver peer support services. A list of training programs can be accessed by reaching out to **oifateam@mercycareaz.org.**

The OIFA Team has authority to request and review both new and existing PSETP materials upon request. A member of the OIFA Team would contact the program developer and request

the materials to be submitted within 2 weeks to the oifateam@mercycareaz.org. Should the OIFA Team have feedback on further developing or enhancing their curricula, written feedback will be provided within 2 weeks, and a follow-up meeting will be scheduled to review recommendations and discuss any enhancements. Prospective and current PSETPs interested in recommendations and input from the OIFA Team may also request additional review and oversight through contact with oifateam@mercycareaz.org.

Provider agencies rendering peer support services to any AHCCCS member including fee for service members shall maintain documentation evidencing that all actively employed peer/recovery support specialists have met the required qualifications and credentialing. All providers of peer/recovery support services are required to complete and submit quarterly reports to the OIFA Team utilizing AMPM Policy 963: approved AHCCCS portal.

Peer Support Employment Training Programs (PSETPs) are approved through AHCCCS/OIFA. PSETPs shall include core elements addressed in AMPM Policy 963: Section H. Additional resources for development of curriculum can be found by contacting oifateam@mercycareaz.org. PSETPs are required to send all credentialed individuals who completed and passed their training program to AHCCCS/ OIFA via email at oifa@azahcccs.gov utilizing AMPM Policy 963: Attachment C and must retain copies of Attachment C that may be made available to MC OIFA upon request. Individuals credentialed in another state shall submit their credential to AHCCCS/OIFA via oifa@azahcccs.gov.

Individuals employed as a peer and/or recovery support specialist (PRSS) shall have adequate access to continuing education relevant to peer support. PRSS shall obtain a minimum of four hours of Continuing Education and Ongoing Learning relevant to Peer Support, per year with at least one hour covering ethics and boundaries related to the practice of peer support. Agencies employing peer and/or recovery support specialists shall provide supervision by individuals qualified as behavioral health technicians or behavioral health professionals. Supervision shall require that supervisors of peer supports be established to be conducive to a sound support structure for peer supports, including establishing a process for reviewing, monitoring, and training the peer support on a regularly occurring basis as deemed appropriate by the provider. Supervision shall be documented and inclusive of both clinical and administrative supervision. Supervisors of peer and/or recovery support specialists shall have adequate access to continuing education relevant to the provision of peer support services and supervision of peer and/or recovery support specialists.

Trainers of credentialed parent/family support specialists and individuals seeking training and/or employment as a credentialed parent/family support specialist shall:

a. Self-identify as an individual who has lived experience as a primary natural support for an adult with emotional, behavioral health or substance abuse needs OR as a parent or

primary caregiver with lived experience who has raised or is currently raising a child with emotional, behavioral health and/or substance use disorders

b. Qualify as a behavioral health paraprofessional, behavioral health technician, or behavioral health professional.

Individuals meeting the above criteria may be credentialed as a parent/family support specialist by completing training and passing a competency exam through an AHCCCS/OIFA approved Credentialed Parent/Family Support Training Program. Individuals are credentialed by the agency operating the Credentialing Parent/Family Support Training Program. A list of training programs can be accessed by reaching out to **oifateam@mercycareaz.org**.

Provider agencies rendering credentialed family support services to any AHCCCS member including fee for service members shall maintain documentation evidencing that of all actively employed credentialed parent/family support specialists that have met the required qualifications and credentialing. All providers are required to complete and submit biannual reports to the OIFA Team utilizing AMPM Policy 964: approved AHCCCS portal.

The OIFA Team has authority to request and review both new and existing CPFSP materials upon request. A member of the OIFA Team would contact the program developer and request the materials to be submitted within 2 weeks to the **oifateam@mercycareaz.org**. Should the OIFA Team have feedback on further developing or enhancing their curricula, written feedback will be provided within 2 weeks, and a follow-up meeting will be scheduled to review recommendations and discuss any enhancements. Prospective and current CPFSPs interested in recommendations and input from the OIFA Team may also request additional review and oversight through contact with **oifateam@mercycareaz.org**. Additional resources for development of curriculum can be found by contacting **oifateam@mercycareaz.org.**

CPFSPs are required to send all credentialed individuals completing their training program to AHCCCS/OIFA. Individuals credentialed in another state shall submit their credential to AHCCCS/OIFA through their employing provider.

Individuals employed as a credentialed parent and/or family support specialist shall have a minimum of 8 hours of continuing education relevant to parent and/or family support with at least one hour covering ethics and boundaries related to the practice of family support.

Agencies employing credentialed parent and/or family support specialists shall provide supervision by individuals qualified as behavioral health technicians or behavioral health professionals. Supervision shall require that supervisors of credentialed parents and/or family supports be established to be conducive to a sound support structure for family supports, including establishing a process for reviewing, monitoring, and training the family support on a

regularly occurring basis as deemed appropriate by the provider. Supervision shall be documented and inclusive of both clinical and administrative supervision. Supervisors of parent and/or family support specialists shall have adequate access to continuing education relevant to the provision of family support services and best practices in providing supervision to credentialed parent/family support providers.

6.01 – Incorporating Peer and Family Voice and Choice in Integrated Care Service Delivery

Advisory Councils

All behavioral health providers must establish and maintain an Advisory Council made up of members receiving services at a provider's clinic, family members, clinic leadership, and clinic staff.

The purpose of the Advisory Council is to give individuals receiving services and their family members the opportunity to participate in organizational decision making and have regular dialogue with their clinics. The clinics of contracted providers are required to organize and hold an Advisory Council, making available to clinic members and family members a formal platform and opportunity to offer meaningful input, recommendations, and participate in decision-making and service planning with clinic leadership and staff in a comfortable and collaborative environment.

Advisory Councils will be held monthly for a minimum of one hour. The clinic is responsible for promoting their Advisory Council, ensuring members and family members are aware of the purpose of the advisory council and the time and location of each month's meeting. Each clinic will be required to post the time and location of their monthly advisory council through signage in a dedicated area of their main lobby and/or on a virtual platform, i.e., clinic website, social media pages, etc. in addition to other appropriate methods to inform members and their families of each upcoming council meeting. Required attendance for each monthly advisory council will be at least 2 clinic members actively receiving clinic services and a minimum of 1 family member. Vested community partners and stakeholders are also allowed to attend and are welcomed to present information and resources appropriate to members and family members in attendance. A member of clinic leadership must be present at all Advisory Councils. A clinic's Advisory Council will consist of a Chair, Co-Chair, and a Facilitator. The Chair and Co-Chair positions can only be held by clinic members and/or family members and these roles, in collaboration with the Facilitator, will lead their respective clinic's Advisory Council meetings. The Advisory Council Facilitator position is reserved only for a member of clinic staff and will be responsible for the organization of the Advisory Council in collaboration with the council's Chair and/or Co-Chair and notation of the findings and discussions during each Advisory Council meeting. Notetaking duties can be delegated to another clinic staff member, if necessary.

Each clinic will be entrusted with the responsibility of reviewing member feedback, making recommendations for improvement, and documenting these findings in detail in the meeting minutes. Monthly meeting minutes must be posted on or directly under their advisory council signage located in the clinic lobby for public consumption for those who were unable to attend. Minute meetings may also be distributed digitally to clinic members and their families at the discretion and guidance from clinic leadership. All Advisory Council participants are required to sign the sign-in sheet, this includes members, clinic staff, and any community partners. Meeting minutes and sign-in sheets will be retained and distributed to the MC Office of Individual and Family Affairs by the fifteenth of the following month.

When applicable, the MC Office of Individual and Family Affairs will provide technical assistance in the development and sustainment of a clinic's Advisory Council. The Office of Individual and Family Affairs will be available to provide Advisory Councils with support and participate in meetings when appropriate.

Peer, Youth and Family Engagement and Participation

Committee Involvement and Participation

MC encourages all members and their families to become involved in a way that is comfortable to them and allows them to voice concerns, provide input, make recommendations, and participate in decision-making. All committee participants will be provided with a description of their rights, roles and responsibilities as described below.

Individual and Family Rights

- Participate in dialogue and discussions as an equal participant;
- Have input valued and respected by other committee member and participants;
- Receive information in a time frame that allows for the review of materials prior to the meeting;
- Receive adequate notice of scheduled meetings;
- Have questions answered in a respectful manner;
- Have opportunities to attend trainings on their roles and responsibilities, reviewing data, or other topics that will support their meaningful participation on the committee;
- Make recommendations that are equally considered by the committee;
- Participate in workgroups or subcommittees, as needed and appropriate;
- Participate equally in decision-making by the committee; and
- Have access to an MC staff member to support their participation in the committee through coaching and technical assistance.

Peer, Youth, and Family Roles

- Participate in the review of all quality improvement measures and performance indicators;

- Participate in the review of community facing educational and marketing materials;
- Participate in monitoring service delivery and development;
- Provide input on the quality of services provided to the community;
- Assist in identifying gaps in services;
- Identify community needs and work with committee members to develop recommendations to fill those needs;
- As a committee participant, submit to the MC Governance Committee recommendations regarding ways to improve the delivery of mental health and substance use services;
- Provide advice and consultation regarding development of new models of service delivery;
- Observe, report, and participate in strategic planning; and
- Share insights and information about their experiences in ways that others can learn from them.

Peer, Youth, and Family Responsibilities

- Participate in scheduled trainings;
- Attend meetings;
- Inform the committee lead if unable to attend a meeting;
- Stay informed about issues impacting the behavioral health delivery system
- Review all materials presented within specified time frames;
- Provide thoughtful input;
- Work toward fulfilling the committee/workgroup's objectives;
- Carry out individual assignments within specified timeframes;
- Focus on the best interests of the behavioral health delivery system;
- Consult with consumers, providers, and ACC-RBHA staff to develop a better understanding of differing viewpoints, as well as the potential impact of service proposals on the greater community;
- Deal with one another and the greater community in ways that respect the dignity and worth of all members; and
- Encourage communication that clarifies intent

Engagement and Involvement of Members and Family Members in Service Planning and Delivery

To ensure the inclusion of peer and family members, MC's contracted service providers are responsible for carrying out the activities that comprise effective engagement and involvement of members and family members in service planning and service delivery. The contracted providers are responsible for facilitating the building of rapport and encouragement of

individuals to include others, such as family members, relatives, and other natural supports in the process.

Behavioral health services will be done in an effective and recovery-oriented fashion and delivered through a strength-based assessment and service planning approach. The model incorporates the concept of a "team", established for each member receiving behavioral health services.

For children, this team is the Child and Family Team (CFT) and for adults, this team is the Adult Recovery Team (ART). At a minimum, the functions of the Child and Family Team and Adult Recovery Team include initial and ongoing engagement of the member, family and others who are significant in meeting the behavioral health needs of the member, including their active participation in the decision-making process and involvement in treatment.

The team process emphasizes a family friendly, culturally sensitive, and clinically sound model that focuses on identification of the member and family strengths. The process includes engagement and input from those members being served, as well as their family and significant others, and focuses on identifying the member's and team member's preferences.

MC requires the following from subcontractors and providers:

- The ability to welcome and engage family members in the member's service planning and service delivery as full partners in the planning, delivery, and evaluation of services and supports;
- Demonstration of the ability to include family members viewpoint in the service planning and service delivery processes;
- Encourage and engage family members to participate, be active and respected as part of the member's team;
- During the assessment process, establish that the service assessment and service planning process is viewed as a partnership and is a team approach;
- During the Individual Service Plan (ISP) development, the assessor will identify the unique strengths, needs and preferences of the member, family/caregiver and identified team members. The needs (and associated services) identified in the ISP will be tailored to the unique strengths, values and beliefs of each individual member and their family, and will be updated as members progress toward recovery and their goals evolve;
    - All Individual Service Planning (ISP) and development with children is completed collaboratively with the child's parent and/or primary caregiver;
    - Development and prioritization of ISP goals are not focused solely on the child, but include the parent, caregiver, and the needs of the family as a whole;
- All ISP should consider the inclusion of community and natural supports;

- Providers are required to adhere to **AHCCCS Clinical Guidance Tool Family and Youth Involvement in the Children's Behavioral Health System**.
- Provide support to family members to assist in eliminating barriers preventing them from actively participating on the member's team, and;
- Establish a mechanism that will provide family support be accessible to families to help engage the family and to help the individual best utilize their natural support network;
- Establish partnerships with peer-run and family-run organizations to co-facilitate trainings on peer- and family-professional partnerships, and;
- Partner with peer and family-run organizations in the delivery of training on peer-to-peer and family-to-family roles for Peer and Parent/Family Support Provider roles employed in the system.

MC requires providers to demonstrate documentary evidence to show participation of at least one peer, youth or family during the interview process when hiring for all direct services staff positions. MC requires affiliated providers to have at least one peer/recovery support specialist assigned on each adult recovery team.

MC Chapter 7 – Dental and Vision Services

7.00 - Dental Overview

Liberty Dental Plan

Liberty Dental Plan administers dental benefits for MC. Liberty Dental Plan has administrative oversight for the following responsibilities:

- Credentialing
- Patient Management
- Prior Authorization
- Claims
- Customer Service Calls from Providers
- Appeals

MC will administer the following for our members:

- Grievances
- Customer Service Calls from Members

Dentists will bill on the ADA form with the dental service codes and dental claims with dates of service on or after January 1, 2026, need to be sent to Liberty Dental Plan at the following claims address:

Liberty Dental Plan
Attention: Claims
P.O. Box 401086
Las Vegas, NV 89140

For electronic claims submissions, Liberty Dental Plan works directly with the following Clearinghouses:

DentalXchange (800-576-6412)
Vyne Dental (463-218-6519)

You can contact your software vendor to make certain that they have Liberty Dental Plan listed as the payer and claim mailing address on your electronic claim. Your software vendor will be able to provide you with any information you may need to ensure that submitted claims are forwarded to Liberty Dental Plan. Liberty Dental Plan's Payer ID is CX083.

If you have additional questions regarding your claims for Liberty Dental Plan, you may contact them directly at 888-352-7924. They will be happy to assist you.

You may also utilize their Interactive Voice Response (IVR) system 24 hours a day, 7 days a week that provides up-to-date information regarding member eligibility, claim status, and much more. Benefits associated with this program and more detailed information regarding Liberty Dental Plan can be found in their Provider Reference Guide on-line at **https://www.libertydentalplan.com/Resources/Documents/AZ-Provider-Reference-Guide.pdf**

Billing for Medical Services

- Physicians performing general anesthesia will bill on the CMS 1500 form with the appropriate CPT/HCPCS codes.
- Ambulatory Surgical Centers will bill on the CMS 1400 form with the appropriate CPT/HCPCS codes and modifiers.
- Outpatient facility surgical services will be billed on the UB-04 with appropriate revenue codes and CPT/HCPCS codes.

Medical claims need to be submitted to:

Mercy Care
Claims Department
P.O. Box 982975
El Paso, TX 79998-2975

7.01 – Dental Covered Services

Dental Screening/Dental Treatment for members under 21

More information regarding Dental Screening/Dental Treatment for members under 21 is available under the **MC Provider Manual Chapter 100 – General Terms, Chapter 5 – Early and Periodic Screening, Diagnostic and Treatment (EPSDT)**.

The following dental services/dental treatments are covered for members under age 21:

- Oral health screenings
- Cleanings
- Fluoride treatments
- Dental sealant
- Oral hygiene education
- X-rays
- Fillings
- Extractions
- Other therapeutic and medically necessary procedures

- Routine dental services

Two (2) routine preventive dental visits are covered per year. Visits to the dentist must take place within six months and one day after the previous visit. The first dental visit should take place by one year of age, or by the time the child has at least one tooth that is visible. Members under 21 years of age do not need a referral for dental care.

Benefits covered for members under age 21 are in accordance with AHCCCS' **Exhibit 431, Attachment A - AHCCCS Dental Periodicity Table**. Benefits are also outlined in the Liberty Dental Plan Provider Reference Guide available at **https://www.libertydentalplan.com/Resources/Documents/AZ-Provider-Reference-Guide.pdf**

MC assigns all members under 21 years of age to a dental home. A dental home is where the member and a dentist work together to best meet dental health needs. Having a dental home builds trust between the member and the dentist. It is a place where the member can get regular, ongoing care, not just a place to go when there is a dental problem. A "dental home" may be an office or facility where all dental services are provided in one place. Members can choose or change their assigned dental provider.

Emergency Dental Services for Members 21 Years of Age and Older

Members 21 years of age or older have a $1,000 annual emergency dental benefit per health plan year. The annual benefit plan year runs from October 1 - September 30. Medically necessary emergency dental care and extractions are covered for persons aged 21 years and older who meet the criteria for a dental emergency. A dental emergency is an acute disorder of oral health resulting in severe pain and/or infection because of pathology or trauma.

Emergency dental services* include:

- Emergency oral diagnostic examination (limited oral examination - problem focused);
- Radiographs and laboratory services limited to the symptomatic teeth;
- Composite resin due to recent tooth fracture for anterior teeth;
- Prefabricated crowns, to eliminate pain due to recent tooth fracture only;
- Recementation of clinically sound inlays, onlays, crowns, and fixed bridges;
- Pulp cap, direct or indirect plus filling;
- Root canals and vital pulpotomies when indicated for the treatment of acute infection or to eliminate pain;
- Apicoectomy performed as a separate procedure, for treatment of acute infection or to eliminate pain, with favorable prognosis;
- Immediate and palliative procedures, including extractions if medically necessary, for relief of pain associated with an oral or maxillofacial condition;

- Tooth reimplantation of accidentally avulsed or displaced anterior tooth, with favorable prognosis;
- Temporary restoration which provides palliative/sedative care (limited to the tooth receiving emergency treatment);
- Initial treatment for acute infection, including, but not limited to, periapical and periodontal infections and abscesses by appropriate methods;
- Preoperative procedures and anesthesia appropriate for optimal patient management; and
- Cast crowns limited to the restoration of root canal treated teeth only.

*Emergency dental services do not require prior authorization.

Dental services that are **not** covered:

- Diagnosis and treatment of TMJ - except to reduce trauma
- Maxillofacial dental services that are not needed to reduce trauma
- Routine restorative procedures and routine root canal therapy
- Bridgework to replace missing teeth
- Dentures

Covered dental services not subject to the $1,000 emergency dental limit include:

- Extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck, or head.
- Members who require medically necessary dental services before getting a covered organ or issue transplant**:
    - Treatment for oral infections
    - Treatment of oral disease, including dental cleanings, treatment of periodontal disease, medically necessary extractions, and simple restorations.

**These services are covered only after a transplant evaluation determines that the member is a candidate for organ or tissue transplantation.

Anesthesia related to the emergency dental services also falls under the annual $1,000 benefit.

Emergency dental codes are covered only if they meet the criteria of emergent treatment per AHCCCS policy. For additional details regarding this benefit, we are including the following links to the AHCCCS Medical Policy Manual:

- **AHCCCS AMPM Policy 310 – D1 - Dental Services for Members 21 Years of Age and Older**
- **AHCCCS AMPM Policy 310 – D2 - Arizona Long Term Care System Adult Dental Services**

As per Arizona Medicaid Section 1115 Demonstration Waiver extension, effective 10/14/2022, the $1,000 dental services limits for American Indian and Alaskan Native (AI/AN) members 21 years of age and older receiving services for medically necessary diagnostic, therapeutic, and preventive dental services at IHS and 638 Tribal facilities are eliminated.

Services performed outside of the IHS/638 Tribal facilities remain limited to the $1000 Emergency Dental Benefit for members 21 years of age and over.

MC will continue to reimburse for medically necessary services that are eligible for 100 percent Federal reimbursement and that are provided by an IHS or 638 tribal facilities to Title XIX members enrolled with MC.

Effective April 1, 2023, American Indian/Alaskan Native MC members over the age of 21 years with an SMI designation have an Enhanced Tribal Dental Benefit which covers preventive oral health care procedures in addition to the Emergency Dental Benefit. American Indian/Alaskan Native MC members over 21 with an SMI designation do not need to do anything to receive this benefit and may continue to see the same dentist. American Indian/Alaskan Native members who qualify for this benefit who have questions or need help may contact MC Member Services at 602-263-3000 or 1-800-624-3879 (TTY 711).

Informed Consent for Dental Treatment

Informed consent is a process by which the provider advises the recipient/recipient's representative of the diagnosis, proposed treatment and alternative treatment methods with associated risks and benefits of each, as well as the associated risks and benefits of not receiving treatment.

Informed consents for oral health treatment include:

- A written consent for examination and/or any preventive treatment measure, which does not include an irreversible procedure, as mentioned below. This consent is completed at the time of initial examination and is updated at each subsequent six-month follow-up appointment.
- A separate written consent for any irreversible invasive procedure, including but not limited to, dental fillings, pulpotomy, etc. In addition, a written treatment plan must be reviewed and signed by both parties, as described below, with the member/member's representative receiving a copy of the complete treatment plan.

All providers will complete the appropriate informed consents and treatment plans for AHCCCS members as well as provide quality and consistent care, in a manner that protects and is easily understood by the member and/or member's representative.

This requirement extends to all mobile unit providers. Consents and treatment plans must be in writing and signed/dated by both the provider and the patient or patient's representative. Completed consents and treatment plans must be maintained in the member's chart and subject to audit.

For more information on dental consent requirements, refer to **AHCCCS AMPM Policy 431-Dental**, **AHCCCS AMPM 310 D1 - Dental Services for Members 21 Years of Age and Older,** and **AHCCCS AMPM 310 D2 - Arizona Long Term Care System Adult Dental Services**

Notification Requirements for Charges to Members

Providers will provide medically necessary services within the $1,000.00 allowable amount. If medically necessary services are greater than $1,000.00, the provider may perform the services after the following notifications take place.

In accordance with A.A.C. R9-22-702 (Charges to Members), the provider must inform/explain to the member both verbally and in writing in the member's primary language that the dental service requested is not covered and exceeds the $1,000 limit. If the member agrees to pursue the receipt of services:

- The provider must supply the member a document describing the service and the anticipated cost of the service.
- Prior to service delivery, the member must sign and date a document indicating that he/she understands that he/she will be responsible for the cost of the service to the extent that it exceeded the $1,000 limit.

7.02 – Vision Services

Vision Overview

MC covers eye and optometric services provided by qualified eye/optometry professionals within certain limits based on member age and eligibility.

Coverage for Members (Under Age 21)

- Any abnormal vision screening, such as a vision screening of 20/60 or greater, shall result in a referral to Nationwide for further examination and possible provision of glasses.
- Medically necessary emergency eye exam and treatment is covered.
- Ocular photo screening with interpretation and report, bilateral is covered for children ages three through six as part of the visit due to challenges with a child's ability to cooperate with traditional chart-based vision screening techniques. Ocular photo screening is limited to a lifetime coverage limit of one.

- Automated visual screening is for vision screening only. It is not covered when used to determine visual acuity for purposes of prescribing glasses or other corrective devices.
- Prescriptive lenses and frames are provided to correct or ameliorate defects, physical illness, and conditions.
- Frames for eyeglasses as well as the replacement and repair of eyeglasses are also covered without restrictions when they are used to correct or ameliorate conditions discovered during vision screenings.
- Contact lenses are not a covered benefit.
- Cataract surgery and treatment for medical conditions of the eye after cataract surgery.

For more information, please review the AHCCCS AMPM Policy 430 – EPSDT.

Nationwide Referral Instructions

Nationwide is MC's contracted vendor for all vision services, including diabetic retinopathy exams. Members requiring vision services should be referred by the PCP's office to a Nationwide provider listed on MC's website. The member may call Nationwide directly to schedule an appointment.

Coverage for Adults (21 years and older)

Eye examinations must be performed by PCPs during a member well visit as appropriate to age according to **AHCCCS EPSDT Periodicity Schedule (AHCCCS AMPM 430-Attachment A)** using standardized visual tools.

- Emergency eye care, which meets the definition of an emergency medical condition, is covered.
- Medically necessary vision examination and optometry services are covered unless it is for prescriptive lenses. Eye examinations for prescriptive lenses are not covered.
- Treatment of medical conditions of the eye after cataract surgery.
- Prescriptive lenses are only covered if they are the sole visual prosthetic device used by the member after a cataract extraction. (**AMPM Policy 310-JJ - Orthotics and Prosthetics**).
- Cataract removal is covered if certain criteria is met. For more information on the criteria needed, please review the **AHCCCS AMPM Chapter 300 - Exhibit 300-1 - AHCCCS Covered Benefits with Special Circumstances**.

Dental and Vision Community Resources for Adults

AHCCCS benefits do not include routine dental and vision services for adults. However, there are community resources available to help members obtain routine dental and vision care. For more information, call MC's Member Services at 602-263-3000 or 800-624-3879.

MC Chapter 8 – Grievances, Appeals and Claims Disputes - Reserved

This chapter is reserved. Information in this section was moved to MC Provider Manual Chapter 100 - General Terms, Chapter 18.

MC Chapter 9 – Provider Requirements for Specific Programs and Services

9.00 – Provider Requirements for Specific Programs and Services

Provider Requirements for Specific Programs and Services are contractual documents for providers and lines of business that outline provider responsibilities and expectations that may not be included otherwise in their contract or in the Provider Manual. These providers must comply with all requirements outlined in their Provider Requirements for Specific Programs and Services. These documents can be found in **Availity**.

MC Chapter 10 – Quality Management

10.00 – Provider Monitoring

Provider Monitoring is responsible for monitoring provider services and service sites per AHCCCS AMPM 910-Attachment A requirements.

Please see MC Provider Manual Chapter 100 General Terms, Section 12.03 – Provider Monitoring for audit information and compliance standards.