mercy care

Mercy Care Long Term Care



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Mercy Care Provider Manual
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MCLTC Chapter 1 – Mercy Care Long Term Care Overview

1.00 – Mercy Care Long Term Care Overview

Mercy Care 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.

MCLTC provides services to the Arizona Medicaid populations including:

- **Arizona Long Term Care System (herein ALTCS):** AHCCCS offers services for individuals who require nursing home or in-home care and integrates both their behavioral health and physical health needs. These services are offered through the *Arizona Long Term Care System (ALTCS)*. This program is intended for individuals who are age 65 or older, blind or have a disability (at any age) and need ongoing services at a nursing facility level of care. Those who qualify do not have to reside in a nursing home. Many ALTCS members live in their own homes or an assisted living facility and receive needed in-home services. ALTCS members are in the following counties:
    - Maricopa
    - Gila
    - Pima
    - Pinal
- **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 acute care services. DDD members are in the following counties:
    - Apache
    - Cochise
    - Coconino
    - Gila
    - Graham
    - Greenlee
    - La Paz
    - Maricopa
    - Mojave
    - Navajo
    - Pima
    - Pinal

    - Santa Cruz
    - Yavapai
    - Yuma
- **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.

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.

MCLTC Chapter 2 – Network Provider Service Delivery Requirements

2.00 – MCLTC Overview

The MCLTC program includes additional requirements and benefits compared to the MC (herein MC) Acute line of business. Providers are contractually obligated to adhere to and comply with all terms of the plan and provider contract, including all requirements described in this manual in addition to all federal and state regulations governing the plan and the provider. MC may or may not specifically communicate such terms in forms other than the contract and this provider manual. While this manual contains basic information about the Arizona Health Care Cost Containment System (AHCCCS), providers are required to fully understand and apply AHCCCS requirements when administering covered services.

MCLTC members are eligible for:

- Home and Community Based Services
- Alternative Residential Settings
- Residential Skilled Nursing Facilities (SNF) – For additional information please review the **MC Claims Processing Manual, Chapter 6 - Skilled Nursing Facility Claims** on the MC website.

Below is a list of services specific to the MCLTC program:

MCLTC Services Table

Type of Service	Description
Adult Day Health Care	Health care and personal services as part of an adult day center. This may include meals, health checks, and therapies.
Adult Foster Care	This setting provides room and board, supervision, and care for up to four residents.
Assisted Living Center	This setting provides care in a single or shared apartment, and includes kitchen, bathroom, and private sleeping areas.
Assisted Living Home	This setting provides room and board, supervision, and care for up to 10 people.
Alternative Living Settings	ALTCS offers other types of living arrangements for members. These types of settings provide supervisory services, personal care, or directed

	care, and are licensed or certified. Members are not required to pay Room and Board for these settings.
Attendant Care Services	A trained person from a certified caregiver agency provides services in the member's home such as personal care, housekeeping, and meal preparation.
Emergency Alert System	Equipment that provides 24-hour access to emergency help.
Habilitation	This service provides training in independent living skills.
Home Delivered Meals	Healthy meals are prepared and brought to a member's home.
Home Health Service	This service provides nursing, home health aide, and therapy in the member's home.
Homemaker	This service is designed to assist with household jobs like cleaning, shopping, or running errands.
Home Modification	This service makes adaptive changes to the home to increase the member's independence.
Hospice Care	Services that help members who need health care and emotional support during the final stages of life.
Licensed Health Aide (LHA)	An LHA is a licensed individual who is a family member or legal guardian providing services to a single ALTCS enrolled member who is 21 years of age, consistent with the patient's plan of care.
Nursing Facility	Nursing facilities provide room, board and nursing services for members who need these services all of the time.
Personal Care	This service offers help with eating, bathing, toileting, and dressing.
Private Duty Nursing	Nursing services for members who need more individual and continuous care.
Respite	This service provides personal care to provide a member's family and other informal caregiver(s) a rest. This service can be provided in the member's home, assisted living facility or skilled nursing home.

Self-Directed Attendant Care	This program is for members who want to oversee their attendant caregiver service. Members using this service will hire/fire, train, and oversee their own caregivers. Members have more control in this program. They can hire anyone that has the basic skills needed, give work, and make schedules within the weekly service hours, which are determined by meeting with a case manager.
Spouse Attendant Care	A spouse can become a member's paid attendant caregiver while s/he is living at home. State guidelines must be followed, so please speak to an MCLTC case manager regarding Spouse Attendant Care.

2.01 – MCLTC Program Contractor Changes

MCLTC has a transition coordinator to assist with all program contractor changes. All MCLTC members have the option of changing program contractors during their annual enrollment choice month. AHCCCS sends a packet of information to each member prior to their annual enrollment choice about how to change program contractors and the dates by which their choice must be communicated to AHCCCS. Members may also change program contractors at other times if the circumstance meets AHCCCS criteria such as:

- Moving to another county
- Moving to another program contractor to maintain continuity of medical care, or
- Residing in a facility that no longer contracts with their current program contractor.

In these situations, the member's case manager will put together a packet of information, and the transition coordinator will send it to the requested program contractor. If the requested program contractor grants the request, a transition date is determined and AHCCCS is notified and makes the change.

2.02 - Home and Community Based Services (HCBS)

All Home and Community Based providers who provide attendant care, housekeeping, personal care, and respite care are required by AHCCCS to complete a monthly MCLTC Provider Non-Provision of Services Log for critical services. Your Network Relations Specialist/Consultant is available for initial and ongoing training.

A gap in critical services is defined as the difference between the number of hours of home care worker critical services scheduled in each member's HCBS care plan and the hours of scheduled type of critical service that are delivered to the member.

Critical services received in the member's home are inclusive of tasks such as bathing, toileting, dressing, feeding, transferring to or from bed or wheelchair, and assistance with similar daily activities. Types of critical services include:

- Attendant care, including spouse attendant care
- Personal Care
- Homemaker
- In-home respite

Please refer to **AHCCCS AMPM Chapter 1200, Arizona Long Term Care System Services and Settings for Members Who Are Elderly and/or have Physical Disabilities and/or have Developmental Disabilities** in the AHCCCS Medical Policy Manual (AMPM) for additional Home and Community Based Services information.

2.03 - Agency with Choice Providers

The following provisions apply to all Agency with Choice Providers:

An authorized representative of the Provider must sign a Member's Service Plan if present at the service plan meeting. Regardless of whether Provider signs the Service Plan, by acceptance of this Agreement, Provider agrees to its roles and responsibilities in implementing the Service Plan, which it will perform in accordance with the terms of the Service Plan, this Agreement and applicable law.

2.04 - Attendant Care Services - Interruption in Service

There may be times when an interruption in service may occur due to an unplanned hospital admission for the member. Please refer to AMPM 1240-A Direct Care Services, regarding when attendant care can be billed for members that are inpatient. The allowance is limited to ensure smooth transitions from the acute care setting to preserve the individual's functional abilities and not for routine attendant care.

2.05 - Attendant Care Modifiers

AHCCCS requires the use of specific codes/modifiers for attendant care as follows:

Attendant Care:

Non-Family: S5125-No modifier
Family Non-Resident: S5125-U4
Family Resident: S5125-U5
Spouse: S5125-U3

Agency with Choice

Non-Family: S5125-U7
Family Non-Resident: S5125-U4U7
Family Resident: S5125-U5U7
Spouse: S5125-U3U7

Self-Directed Attendant Care

Non- Family: S5125-U2
Family Non-Resident: S5125-U2U4
Family Resident: S5125-U2U5

Skilled Self-Directed Attendant Care

Non-Family: S5125-U6
Family Non-Resident: S5125-U6U4
Family Resident: S5125-U6U5

Example:
During a six-month time frame the member is receiving 20 hours per week of Family Non-Resident attendant care and 10 hours per week of Non-Family attendant care for a total of 30 hours per week.

The attendant care agency needs to pay attention to how many units are allotted for each of these two specific care categories. Billing with incorrect modifiers and units could result in claims being pended and denied for no units available. The attendant care agency must bill in accordance with the authorized services and units.

If there is a change in care during the authorized period, i.e., the Non-Family attendant care worker starts to work more than 10 hours per week (on a consistent basis), the attendant care agency must contact the MCLTC case manager to correct the authorization and adjust the units to reflect the change in care. If this happens for only one occurrence, the agency does not need to contact the case manager, but if a major change is needed to the original authorization, the attendant care agency would need to work with the MCLTC case manager to correct the authorization. This will alleviate potential claims from pending or being denied.

2.06 – Attendant Care Out of Area Care

For members wishing to take vacations or otherwise leave the area temporarily, MCLTC would like to address the issue of paid Attendant Care Caregivers providing services outside of Maricopa and Pima Counties. MCLTC does not authorize services at a specific location provided the member resides in Maricopa or Pima County. Services are authorized to the requesting attendant care agency based on the member's evaluation by Case Management. It is up to the individual agency to decide their policy

regarding out-of-county care with paid caregivers. This includes family attendants. MCLTC does not recognize any difference between family attendants and non-family attendants. Both are paid employees of the agency, and all Department of Labor regulations apply to them equally.

If your agency does decide to allow out-of-county services, please keep a few key points in mind:

- How will your agency ensure the safety of the member?
- How will your agency deal with a gap in coverage and provide a replacement caregiver if needed?
- How will your agency ensure that the authorized care has been provided by the paid caregiver?
- This could also affect your workers compensation and raise other legal concerns. If this is in question your organization should seek qualified legal advice.

If an agency decides not to allow out-of-county services, MCLTC will respect that decision, and it will not affect your relationship with MCLTC in any way.

If an agency does decide to allow out-of-county services, each occurrence will need to be reviewed by the member's Case Manager to ensure continuity of care and correct services are provided prior to the planned departure.

2.07 – Direct Care Worker Database

AHCCCS maintains an online database which tracks the testing records of Direct Care Workers (DCWs) serving Arizona Long Term Care System members living in their own homes. DCW and DCW Trainer testing records are portable or transferrable from one employer to another.

The online database serves as an administrative support tool for DCW agencies and Approved Direct Care Worker Training and Testing Programs (Approved Programs). Per AHCCCS:

- DCW agencies will use the online database to manage a list of employees and search for testing records of prospective/new employees.
- Approved Programs will use the online database to manage a list of trainers and to input DCW or DCW Trainer testing records.

Please refer to the following to the **Welcome to the AHCCCS DCW and DCW Trainer Testing Records Online Database** for further information.

PHPs must develop policies and procedures for, and begin conducting background checks of Direct Care Workers (DCWs), that comply with the following standards:

- At the time of hire/initial contract and every three years thereafter, conduct a nationwide criminal background check that accounts for criminal convictions in Arizona.
- At the time of hire/initial contract and every year thereafter, conduct a search of the Arizona Adult Protective Services Registry.

- Prohibit a DCW from providing services to ALTCS members if the background check results contain:
    - Convictions for any of the offenses listed in A.R.S. §41-1758.03(B) or (C), or
    - Any substantiated report of abuse, neglect or exploitation of vulnerable adults listed on the Adult Protective Services Registry pursuant to A.R.S. §46-459.
- Upon hire/initial contract and annually thereafter, obtain a notarized attestation from the DCW that he/she is not:
    - Subject to registration as a sex offender in Arizona or any other jurisdiction
    - Awaiting trial on or been convicted of committing or attempting, soliciting, facilitating, or conspiring to commit any criminal offense listed in A.R.S. §41-1758.03(B) or (C), or any similar offense in another state or jurisdiction.
- Require DCWs to report immediately to the agency if a law enforcement entity has charged the DCW with any crime listed in A.R.S. §41-1758.03(B) or (C).
- Require DCWs to report immediately to the agency if Adult Protective Services has alleged that the DCW abused, neglected, or exploited a vulnerable adult.
- Agencies may choose to allow exceptions to the background requirements for DCWs providing services to family members only. If the agency allows a DCW to provide services under this exception, the agency shall:
    - Notify the ALTCS member in writing that the DCW does not meet the background check standards and therefore otherwise would not normally be allowed to provide services, and
    - Obtain consent from the ALTCS member to allow the DCW to provide services despite the findings of the background check.
- Agencies are prohibited from allowing exceptions to the Adult Protective Services Registry screening requirements for DCWs providing services to family members only.

PHPs are required to comply with Fingerprint Clearance Card requirements outlined in A.R.S. Title 41, Chapter 12, Article 3.1. Providers may use a DCW's Fingerprint Clearance Card as evidence of complying with the criminal background check required by this Policy; however, the agency must still comply with the obligation to check the Arizona Adult Protective Services Registry. DCWs are prohibited from providing services to ALTCS members if the DCW is precluded from receiving a Fingerprint Clearance Card or has a substantiated report of abuse, neglect, or exploitation of vulnerable adults listed on the Adult Protective Services Registry pursuant to A.R.S. §46-459.

2.08 – Electronic Visit Verification (EVV)

Electronic Visit Verification (EVV) replaces the Non-Provision of Service Log. For detailed information and requirements by AHCCCS, please visit their **Electronic Visit Verification web page.** This web page contains important information that providers will need to know about this process.

2.09 - Prior Period Coverage for Home and Community Based Services (HCBS)

"Prior Period Coverage" for an HCBS member refers to HCBS in place prior to enrollment with MCLTC (during the Prior Period Coverage period). Services were previously provided by another AHCCCS plan.

Prior Period eligibility dates are determined by AHCCCS. The MCLTC case manager will perform a retrospective assessment to determine the medical necessity of services, along with determination that the services previously delivered were provided by a registered AHCCCS provider in the most cost-effective manner.

If the MCLTC case manager determines that the services are covered, reimbursement will be made to the provider.

2.10 - Case Manager Responsibilities

Each MCLTC member is assigned to a case manager. The case manager is responsible for working with the member's PCP to coordinate and authorize the provision of medically necessary services for the member. The case manager is also the member's advocate and works to facilitate the member's care.

The MCLTC case manager authorizes medically necessary services, providing information about room and board to providers and members, and assisting members with coordination of appropriate services.

The MCLTC case manager is the primary point of contact for providers when there are issues or questions about a member. Providers must also contact the MCLTC case manager whenever there are changes in a member's health status.

2.11 - Service Authorizations

The following table illustrates Acute and HCBS services provided to MCLTC members that require PCP orders and/or authorization by the program contractor.

NOTE: The MCLTC case manager only authorizes long-term care services, not medical services. Medical service authorization procedures are outlined in **MC Provider Manual Chapter 100 – General Terms, Chapter 13 – Referrals and Authorizations.**

MCLTC Service Authorization Table

Service	**PCP Orders**	**Program Contractor Authorization**
Acute Hospital Admission (Non-Medicare Admission)	X	X
Adult Day Health Services		X
Assisted Living Facility		X
Attendant Care		X
Behavioral Health Services		X
DME/Medical Supplies	X	X
Emergency Alert	X	X
Habilitation		X
Home Delivered Regular Meals • 1500-1800 Calorie Diabetic • Low Sodium 2gm • Diabetic/Low Sodium	 X X X	 X X X
Home Health Agency	X	X
Home Modifications	X	X
Homemaker Services		X
Hospice Services (HCBS & Institutional – Non-Medicare)	X	X
ICF/MR	N/A	N/A
Medical Care Acute Services	X	X
Nursing Facility Services	X	X
Personal Care		X
Respite Care (In-Home)		X
Respite Care (Institutional)	X	X
Therapies	X	X
Transportation		X

2.12 – MCLTC Alternative Residential Settings

MCLTC offers different types of medically necessary alternative residential settings for eligible members. These different types of settings provide supervisory services, personal care, or direct care, and are delivered by licensed or certified facilities. Members are required to pay room and board fees in these settings. The MCLTC case manager will assess the member's need for the appropriate type of setting.

MCLTC Service Types

Setting	Description
Adult Foster Care	This setting includes up to 4 residents. The owner of the home must live in the home and provide the care.
Adult Therapeutic Home Care	Provides behavioral health and ancillary services for a minimum of 1 and a maximum of 3 people.
Child Therapeutic Home Care	Provides services by homes licensed with DES as a professional foster care home.
Assisted Living Home	This setting provides care and supervision for up to 10 people.
Assisted Living Center	This setting provides resident rooms or residential units and services to 11 or more residents. Three meals are provided in the main dining hall. Personal care and medication monitoring is provided as needed.

Please refer to MC Provider Manual Chapter 100 General Terms, Section 12.03 for Provider Monitoring QM requirements.

2.13 - Provider Requirements for Assisted Living Facilities

Assisted Living Home and Assisted Living Center Requirements

- The provider of an Assisted Living Facility must collect room and board fees from the member. Room and board is the amount the MCLTC member pays each month for the cost of food and/or shelter.
- MCLTC does not pay the member's room and board cost when the member is in an alternative setting. MCLTC's room and board agreement identifies the level of payment for the setting, placement date, and room and board amount the member must pay and is determined by the MCLTC case manager at the time of placement.
- The room and board agreement is used for all alternative settings. The amount of room and board will periodically change based on a member's income.
- The Room and Board Agreement form is completed at least once a year or more often if there are changes in income.
- Payment issued to the provider is always the contracted amount minus the member's room and board.
- All assisted living placements are required to give notice to a resident to terminate placement per R9-10-207 (G). Residents in assisted living placement are not required to give notice when discharging from the assisted living placement.
- For Adult Foster Care, Foundation for Senior Living is billed for all Adult Foster Care services provided in Maricopa County. For all other alternative living arrangement settings, MCLTC should be billed directly.

- PHP shall notify MCLTC in writing immediately if a change in location of the Assisted Living Home or Assisted Living Center is being considered. MCLTC Care Management will communicate with members and their representatives to determine whether a location change is in their best interest.
- PHP will notify MCLTC in writing immediately if an ownership change is being considered. MCLTC will decide if a contract with the new owner will be offered. To be considered for a contract, a new owner must be licensed by Arizona Department of Health Services (ADHS), have an AHCCCS Provider Identification number and have proof of required liability insurance.
- PHP shall maintain in full force and effect and be always covered throughout the term of their MCLTC contract by (a) professional liability (malpractice) insurance which covers all acts of omissions of PHP in providing or arranging for Covered Assisted Living Home Services under their MCLTC contract, and (b) general liability insurance. The terms and limits of such insurance coverage shall be subject to MCLTC approval; provided, however PHP shall maintain in full force and effect and be always covered throughout the term of this Agreement by (a) professional liability (malpractice) insurance which covers all acts and omissions of PHP in providing or arranging for covered services under their MCLTC contract, and (b) general liability insurance. The general liability policy shall have limits of liability of not less than One Million Dollars ($1,000,000) per occurrence, and an annual aggregate of Two Million Dollars ($2,000,000). Failure to secure and maintain such professional liability and general liability insurance coverage shall constitute a material breach of PHP's contract with MCLTC.
- PHP must ensure MC staff always have immediate access to the member and member's records.

Assisted Living Home Requirements

- PHP must obtain written authorization from the MCLTC case manager who is the sole authorizing agent for placement and level of care prior to admission. Covered Assisted Living Home services, not prior authorized will not be reimbursed.
- PHP shall maintain member case records with information that includes, but is not limited to:
    - Member's name and MCLTC identification number;
    - Member's relative name(s) address(es) and phone number(s);
    - Emergency contact name and phone number
    - Member's primary care provider address and phone number;
    - Member's current medications and pharmacy phone number; and
    - Member's guardian, grantee of power of attorney, or healthcare decision maker, as applicable.
- PHP shall maintain policies and procedures specific to the management and organization of PHP, which include but are not limited to an admission agreement; personnel policies and staffing ratios; house standards; medication dispensing and home furnishings and repairs. PHP shall submit copies of policies and procedures to MCLTC (i) annually, (ii) as developed, and (iii) as the policies and procedures are revised.

- All deposits paid prior to MCLTC enrollment date must be refunded to the member or member's power of attorney designee **immediately**.
- If the member is eligible for Prior Period Coverage (PPC), PHP is encouraged to bill MCLTC for this prior period time and refund the member the MCLTC rates for this prior period time.
- All assisted living placements are required to give notice to a resident to terminate placement per R9-10-207 (G). Residents in assisted living placement are not required to give notice when discharging from the assisted living placement.
- All private agreements with members cease on the effective enrollment date of the member with MCLTC. Following MCLTC enrollment, the MCLTC contract and the MCLTC Room & Board Placement Agreement should control. All private and previous agreements with an MCLTC member are canceled.
- PHP shall not charge members for any item(s) or service(s) which are covered under their MCLTC contract or the AHCCCS Medical Policy Manual.
- PHP shall arrange for or provide recreational and social activities on a regular basis designed to maintain or improve skills for members.
- PHP will report to MCLTC case manager all member emergency room visits, hospitalizations, observation bed admissions, significant events, incidents, accidents, and expirations within twenty-four (24) hours of the occurrence.
- PHP must provide shampoo, hand soap, toilet paper, laundry detergent, gloves, wipes, chux, or any other personal care items for each resident.

Assisted Living Center Requirements

- PHP shall ensure that each new PHP staff completes an orientation within ten (10) days from the date of employment which includes, but is not limited to, orientation to the characteristics and needs of Assisted Living Center members; promotion of member dignity, independence, self-determination, privacy, choice, and rights; and instruction on the development and implementation of treatment plans.
- PHP shall ensure that each staff member completes a minimum of six (6) hours of ongoing training every twelve (12) months and includes but is not limited to promoting dignity, independence, self-determination, privacy, choice, and rights; fire, safety, and emergency procedures; and assistance in self-administration of medications.
- PHP must obtain written authorization from the MCLTC. Care Management is the sole authorizing agent for placement and level of care of MCLTC members in an Assisted Living Center, Behavioral Health Assisted Living or in an Assisted Living Alzheimer's Unit.
- Upon admission, there must be documentation/evidence that the member is free from infectious tuberculosis. Annual testing is to be completed and documented in the member's medical record.
- PHP will report to MCLTC case manager all member emergency room visits, hospitalizations, observation bed admissions, and expirations within twenty-four (24) hours of the occurrence.

- There must always be staff member(s) on duty who speak and read English (fluently), twenty-four (24) hours per day, three hundred sixty-five (365) days per year.
- PHP must provide shampoo, hand soap, toilet paper, laundry detergent, gloves, wipes, chux, or any other personal care items for each resident.
- One (1) staff member certified in CPR must be always on duty.
- All deposits paid prior to MCLTC enrollment date must be refunded to the member or member's power of attorney designee **immediately**.
- If the member is eligible for Prior Period Coverage (PPC), PHP is encouraged to bill MCLTC for this prior period and to refund the member the MCLTC rates for this time frame.
- All private agreements with members cease on the effective enrollment date of the member with MCLTC. Following MCLTC enrollment, the MCLTC contract and the MCLTC Room & Board Placement Agreement should control. All private and previous agreements with an MCLTC member are canceled.
- All assisted living placements are required to give notice to a resident to terminate placement per R9-10-207 (G). Residents in assisted living placement are not required to give notice when discharging from the assisted living placement.
- PHP shall maintain member case records with information that includes, but is not limited to:
    - Member's name and MCLTC identification number;
    - Member's relative name(s) address(es) and phone number(s);
    - Emergency contact name and phone number
    - Member's primary care provider address and phone number;
    - Member's current medications and pharmacy phone number; and
    - Member's guardian, grantee of power of attorney, or healthcare decision maker, as applicable
- PHP shall maintain policies and procedures required by applicable law which are specific to the management and organization of PHP, which include, but are not limited to admission agreements, personnel policies and staffing ratios, house standards, medication dispensing, and home furnishings and repairs. PHP shall submit copies of its policies and procedures to MCLTC:
    - Upon request
    - When new policies and procedures are implemented
    - When existing policies and procedures are revised by PHP.
- PHP shall maintain policies and procedures specific to a member's personal needs allowance according to applicable law; PHP shall submit such policies to MCLTC upon request.
- PHP shall not charge members for any item(s) or service(s) which are covered under their MCLTC contract or the AHCCCS Medical Policy Manual.
- PHP shall collect the room and board amount determined by the MCLTC case manager from the member.
- PHP shall maintain in full force and effect and be always covered throughout the term of their MCLTC contract by (a) professional liability (malpractice) insurance which covers all acts of omissions of PHP in providing or arranging for covered Assisted Living Home Services under

their MCLTC contract, and (b) general liability insurance. The terms and limits of such insurance coverage shall be subject to MCLTC approval; provided, however PHP shall maintain in full force and effect and be always covered throughout the term of their contract by (a) professional liability (malpractice) insurance which covers all acts and omissions of PHP in providing or arranging for covered services under their MCLTC contract, and (b) general liability insurance. The general liability policy shall have limits of liability of not less than One Million Dollars ($1,000,000) per occurrence, and an annual aggregate of Two Million Dollars ($2,000,000). Failure to secure and maintain such professional liability and general liability insurance coverage shall constitute a material breach of PHP's contract with MCLTC.

Additional Requirements for Assisted Living Alzheimer's Units

- PHP shall provide a designated unit secured by locked or electronically controlled doors (a wander guard-type system alone does not meet this requirement).
- PHP shall be staffed with the following ratios: (these staffing ratios exclude facility directors, administrative, clerical and maintenance staff).
    - One (1) staff to ten (10) members from 6:00 am – 2:00 pm
    - One (1) staff to ten (10) members from 2:00 pm – 10:00 pm
    - One (1) staff to twenty (20) members from 10:00 pm – 6:00 am

  Example: If PHP has thirty-eight (38) members, PHP is required to have three (3) full-time staff and then the fourth (4^{th}) staff would be required to work 6 hours and 40 minutes of the 8-hour shift during the hours of 6:00 am to 10:00 pm.
- All staff newly assigned to work on the unit must receive two (2) hours of in-service training prior to providing care to members with GCI. Training must include, but is not limited to:
    - Understanding members with GCI; and
    - How to work with members with GCI.
- All staff on the unit must attend a minimum of one (1) hour every month of in-service education addressing the special needs of members with GCI such as those with Alzheimer's disease and related disorders. Training must take place and be documented within thirty (30) days.
    - Off-site in-service education may be included to meet this requirement.
    - Topics for in-service sessions are to include, but are not limited to:
        - Charting and documentation;
        - Understanding persons with GCI;
        - How to work with persons with GCI;
        - Providing services to members based on individual needs;
        - How to maximize independence for persons with GCI;
        - Member rights;
        - Appropriate verbal and non-verbal interaction with members;
        - Pharmacological and physical restraints and their use;
        - Facility protocol to manage/locate members who wander;

  - Activities of daily living as part of the activity program;
  - Fall prevention;
  - Cultural diversity; and
  - Using hospice for members with advanced GCI.
- PHP must have activity staff programming ten (10) hours a week. PHP must offer activities that are appropriate for persons with GCI seven (7) days a week.
- PHP must have buildings and furnishings that are designed for the member's safety.
- PHP facilities must be designed to maximize comfort for the member's physical environment, personal and shared space, demonstrate a balance of sensory stimuli that are calming and soothing; and other sensory stimuli that are pleasantly stimulating and engaging.
- PHP shall maintain in full force and effect and be always covered throughout the term of their MCLTC contract by (a) professional liability (malpractice) insurance which covers all acts of omissions of PHP in providing or arranging for Covered Assisted Living Home Services under their MCLTC contract, and (b) general liability insurance. The terms and limits of such insurance coverage shall be subject to MCLTC approval; provided, however PHP shall maintain in full force and effect and be always covered throughout the term of this Agreement by (a) professional liability (malpractice) insurance which covers all acts and omissions of PHP in providing or arranging for covered services under their MCLTC contract, and (b) general liability insurance. The general liability policy shall have limits of liability of not less than One Million Dollars ($1,000,000) per occurrence, and an annual aggregate of Two Million Dollars ($2,000,000). Failure to secure and maintain such professional liability and general liability insurance coverage shall constitute a material breach of PHP's contract with MCLTC.

2.14 - Provider Requirements for Adult Foster Care Home

- For Adult Foster Care Homes in Maricopa County, Foundation for Senior Living is billed for all Adult Foster Care services.
- PHP must obtain written authorization from the MCLTC case manager who is the sole authorizing agent for placement and level of care prior to admission. Covered Assisted Living Home services not prior authorized, will not be reimbursed.
- PHP must provide shampoo, hand soap, toilet paper, laundry detergent, gloves, wipes, chum, or any other personal care items for each resident.
- All deposits paid prior to MCLTC enrollment date must be refunded to the member or member's power of attorney designee **immediately**.
- If the member is eligible for Prior Period Coverage (PPC), PHP is encouraged to bill MCLTC for this prior period time and to refund the member the MCLTC rates for this prior period time.
- All private agreements with members cease on the effective enrollment date of the member with MCLTC. Following MCLTC enrollment, the MCLTC contract and the MCLTC Room and Board Placement Agreement should control. All private and previous agreements with an MCLTC member are canceled.

- PHP shall notify MCLTC in writing within five (5) business days of PHP changes that include, but are not limited to a change in location, services, licensing, or ownership.
- Referrals for specific covered Adult Foster Care services must be initiated and obtained by the member's primary care provider and/or the MCLTC case manager. Services not authorized by MCLTC will not be reimbursed.
- PHP shall maintain member case records with information that includes at a minimum the following:
    - Member's name and ALTCS identification number;
    - Member's relative(s) name(s), address(es), and phone number(s);
    - Member's emergency contact(s) name(s), address(es), and phone number(s);
    - Member's primary care provider address and phone number;
    - Member's current medications and pharmacy phone number;
    - Member's guardian, grantee of power of attorney, or healthcare decision maker, as applicable.
- PHP shall maintain policies and procedures specific to advanced directives according to applicable law and MCLTC Policies. PHP must also provide education to PHP staff and subcontractors regarding advance directives.
- PHP shall maintain policies and procedures required by applicable law specific to the management and organization of PHP, which includes, but is not limited to an admission agreement; personnel policies and staffing ratios; house standards; medication dispensing; and home furnishings and repairs. PHP must submit copies of policies and procedures to MCLTC upon request.
- PHP shall not charge Members for any item(s) or service(s) which are covered under this Agreement by AHCCCS or Medicare.
- PHP shall maintain policies and procedures specific to Member's personal needs according to applicable law and submit them to MCLTC upon request.
- Nursing care services may be provided by PHP if such PHP is a nurse licensed by the State of Arizona to provide covered Adult Foster Care Services according to applicable law. PHP shall keep a record of nursing services rendered and obtain prior authorization according to MCLTC Policy and Provider Manual.
- PHP shall arrange for or provide recreational and social activities on a regular basis designed to maintain or improve skills to members.
- PHP will report to MCLTC case manager all member emergency room visits, hospitalizations, observation bed admissions, significant events, incidents, accidents, and expirations within twenty-four (24) hours of the occurrence.
- PHP shall maintain in full force and effect and be always covered throughout the term of their MCLTC contract by (a) professional liability (malpractice) insurance which covers all acts of omissions of PHP in providing or arranging for Covered Assisted Living Home Services under their MCLTC contract, and (b) general liability insurance. The terms and limits of such insurance coverage shall be subject to MCLTC approval; provided, however PHP shall maintain in full force

and effect and be always covered throughout the term of this Agreement by (a) professional liability (malpractice) insurance which covers all acts and omissions of PHP in providing or arranging for covered services under their MCLTC contract, and (b) general liability insurance. The general liability policy shall have limits of liability of not less than One Million Dollars ($1,000,000) per occurrence, and an annual aggregate of Two Million Dollars ($2,000,000). Failure to secure and maintain such professional liability and general liability insurance coverage shall constitute a material breach of PHP's contract with MCLTC.

- PHP must ensure MC staff always has immediate access to the member and member's records.

2.15 - Provider Requirements for Skilled Nursing Facilities (SNFs)

Skilled Nursing Facilities (SNFs) provide services to members that need consistent care, but do not have the need to be hospitalized or require daily care from a physician. Many SNFs provide additional services or other levels of care to meet the special needs of members. SNFs are responsible for making sure that members residing in their facility are seen by their PCP in accordance with the following intervals:

- For initial admissions to a nursing facility, members must be seen once every 30 days for the first 90 days, and at least once every 60 days thereafter.
- Members that become eligible while residing in a SNF must be seen within the first 30 days of becoming eligible, and at least once every 60 days thereafter.

Additional nursing facility visits are provided as medically necessary and appropriate.

Providers may also refer to the **MC Claims Processing Manual, Chapter 6 – Skilled Nursing Facility Claims** available on the MC website**.** The Claims Processing Manual includes helpful information regarding the following:

- Billable Days
- Share of Cost
- Patient Trust Accounts
- Behavioral Health Services
- Therapy Authorizations
- Claims
- Claims Payment and Submission
- Discharge from a SNF
- Information and Services offered by MCLTC for SNF
- Provider Claim Disputes and Member Appeals

Covered services delivered to eligible members in accordance with a PHP's contract include the following:

- MCLTC is not responsible to pay for any otherwise covered services rendered to MCLTC members prior to the date the MCLTC member becomes enrolled by the State Agency with

MCLTC (except with respect to certain newborns pursuant to the State Agency regulations) or after the MCLTC member loses eligibility or otherwise is dis-enrolled from MCLTC.

- The per diem payment for ALTCS members includes over-the-counter medications. The PHP must use MCLTC contracted pharmacies and durable medical equipment companies for non-Medicare and MCA members who are on a custodial stay in the facility.
- MCLTC should be billed for co-payments for MCLTC members who have Fee for Service Medicare and a Prescription Drug Program or who are on a Medicare Advantage Program, which is not MCA.
- MC shall reimburse PHP for covered therapy services on a fee for service basis. MC will update internal payment systems in response to additions, deletions, and changes of this nature.
- PHP will report to MCLTC case manager all significant changes in condition, incidents, accidents, and expirations within twenty-four (24) hours of the occurrence.

Levels of Care

The appropriate level of care will be determined by the MCLTC case manager, utilizing the AHCCCS/ALTCS Uniform Assessment Guidelines.

In the event PHP disagrees with the level of care authorized, the PHP may request an administrative review by MCLTC. In the event PHP disagrees with the decision following the administrative review, PHP may request a second administrative review. The second review request must be made in writing to the MCLTC care management supervisor within thirty (30) days of the determination of the first administrative review. In the event the original level of care is upheld, the decision is final and not subject to further review by MCLTC. In the event the original level of care is overturned during the administrative review process, CMCLTC will adjust the level of care in accordance with the date of the PHP's initial level of care notification.

Levels of care are listed in the table below:

Level of Care	**Revenue Codes**
Sub-Acute Care Level III	0193
Sub-Acute Care Level IV (Ventilator care)	0194
Hospital Bed Hold	0185
Therapeutic Bed Hold	0183

- Level of care changes authorized by MCLTC will be effective on the day of evaluation. Level of care changes may be retroactive to the date of phone or fax notification to the Nursing Facility, but not prior to the date of notification.
- Covered Therapy Services are not included in the MCLTC member per diem rate, except where specified. PHP shall arrange or provide covered therapy services, for MCLTC members residing in its facility. For additional information regarding referrals and authorizations, please refer to

MC Provider Manual, Chapter 100 – General Terms, Chapter 13 – Referrals and Authorizations in this provider manual.

Requirements for Specialty Rates

Custodial levels of care are determined according to the AHCCCS Universal Assessment Tool for Acuity Determinations.

These levels are NOT for placements that are Medicare funded by MCA. RUG rates are used for MCA members whose care meets the Medicare criteria for RUG rates.

PHPs providing specialty levels of care must meet the requirements identified below, in accordance with their contract:

Sub-Acute

Level III - Intensive Sub-Acute. This includes any combination of the following:

- complex wound care/decubitus
- total parenteral nutrition or tracheotomy care
- or any therapy up to 3 hours per day (PT/OT/ST)

An RN charge nurse is required to be on the station where Level III members are located 24 hours a day. This level of care is authorized by the MCLTC concurrent review nurse. Daily documentation in the medical chart of continued need for sub-acute level of care is required.

PHP must notify MCLTC staff within 24 hours of when a member no longer requires sub-acute level of care services.

High Respiratory

- Ensure that all respiratory therapy personnel must be licensed by the State of Arizona.
- Strive to utilize regularly designated nursing and respiratory staff for the care of members in need of respiratory services. If nursing pool must be used, ensure that these temporary personnel have training in respiratory care and the ability to manage equipment currently in use in the facility.
- Maintain a 1:5 ratio of Therapist/Technician to MCLTC members in need of respiratory services for each eight (8) hour shift.
- Provide oversight by a licensed pulmonologist.
- Designate one (1) Registered Respiratory Therapist (RPT) as the Respiratory Director, who will oversee all respiratory duties and who will work no less than (40) hours per week.
- Designate one (1) Registered Nurse for each (8) hour shift who will oversee all nursing duties for members requiring respiratory services for that period.
- Individuals admitted for respiratory services may be weaning from a ventilator, require

multiple respiratory treatments, or have a tracheostomy requiring frequent respiratory therapy monitoring.

Ventilator

- Ensure that all respiratory therapy personnel are licensed by the State of Arizona.
- Strive to utilize regularly designated nursing and respiratory staff for the care of members in need of respiratory services. If nursing pool must be used, ensure that these temporary personnel have training in respiratory care and the ability to manage equipment currently in use in the facility.
- Maintain a 1:5 ratio of Therapist/Technician to MCLTC member in need of respiratory services for each eight (8) hour shift.
- Provide oversight by a licensed pulmonologist.
- Designate one (1) Registered Respiratory Therapist (RPT) as the Respiratory Director who will oversee all respiratory duties and who will work no less than (40) hours per week.
- Designate one (1) Registered Nurse for each (8) hour shift who will oversee all nursing duties for Members requiring respiratory services for that period.
- Provide care for members who are on a ventilator.
- Provide care for members on BiPap with a back-up breath rate.
- Maintain respiratory therapy notes of member's condition, including daily documentation of heart rate, breathe sounds and any medical condition, during and after respiratory procedures, including response to treatment and how many hours of ventilator usage each day.
- Notify the MCLTC case manager or Concurrent Review Nurse within 24 hours of the initiation of ventilator/BiPap treatment and/or ventilator weaning.
- Provide the services of a licensed pulmonologist who will:
    - Conduct a physical examination and complete medical history as it pertains to ventilator services on each newly admitted MCLTC ventilator dependent member within seven (7) days of admittance, when ordered by the MCLTCPCP.
    - Perform routine on-site visits which include evaluation for potential weaning and appropriate diagnosis and treatment on each MCLTC ventilator dependent member when ordered by the MCLTCPCP.
    - Re-evaluate, at least annually, each MCLTC ventilator dependent member to review continued prospects of weaning the member from dependency on the ventilator.
    - Visit and evaluate MCLTC ventilator dependent members at least every thirty (30) days.
    - Ensure that appropriate discharge orders accompany member when leaving the ventilator unit including a discharge summary from the ventilator unit which includes input from the nursing facility pulmonologist and a plan for any on-going treatments, including respiratory treatments.
    - Provide education and training for ventilator dependent members and their

families when appropriate to increase member's functioning and self-sufficiency.
  - Evaluate member's ability to provide self-care and/or family's ability to care for the member.
  - Provide on-going nursing and therapy consultation and training to promote the development of the member's ability to provide self-care and the family's ability to care for the member.
  - Provide training on maintenance of equipment and nursing care to members who are discharging home.
  - Maintain adequate documentation that reflects the member's/family's ability to provide care.
  - Coordinate with MCLTC case manager or Concurrent Review Nurse regarding DME, supplies, home nursing and other follow-up care that may be needed for members who are discharging to the community.

Staff Assisted Dialysis

- To qualify for staff assisted dialysis level of care, members must be unable to attend outpatient dialysis due to their medical condition.
- PHP must provide medical documentation to the MCLTC case manager substantiating need for staff assisted dialysis in lieu of outpatient dialysis prior to admission to the facility at the staff assisted dialysis level of care.
- Perform dialysis treatment as ordered by a nephrologist.
- Evaluate and monitor the member's condition on an on-going basis.
- Inform the member's PCP and nephrologist of relevant diagnostic study results within 72 hours of receipt of results; and report adverse results within 24 hours of receipt of results.
- Administer medications and perform other treatments/diagnostic studies as ordered by the nephrologist.
- Provide all services, supplies, items, and equipment and ESRD related laboratory tests covered under the composite/service rates necessary to perform dialysis treatments.
- Approval of requests to provide staff assisted dialysis services beyond the initially authorized time frame is dependent on PHP's submission of medical documentation supporting member's need for ongoing staff assisted dialysis.

Global Cognitive Impairment (GCI) Program

- Provide a safe and secure nursing home environment for MCLTC members who have been assessed by the MCLTC case manager as needing this environment due to exhibition of problematic wandering to a degree that endangers the member and other nursing home residents and who cannot be safely managed in a traditional nursing home unit.
- Provide secure living area indoors and outdoors by means of locks (a wander guard type system alone will not meet this requirement) and/or electronically controlled access. Secured areas will be large enough to permit members space to walk, while remaining in

sight of the nursing station. Mirrors or video monitors may be used to assist visual supervision of members.

- Provide dining area on the secured unit or nearby with staffing to supervise members going to and returning from meals. If possible, the dining area will be separate from that of the other units in the facility. If not possible, meals for the unit will be scheduled at different times than those of the other units.
- Maintain a 3.0 NHPPD (Nursing Hours per Patient Day) minimum staffing level on the unit.
- All staff newly assigned to work on the unit will receive two (2) hours of in-service training prior to working with the GCI members. The subjects will include understanding members with GCI and how to provide care to members with GCI.
- All staff on the unit will attend a minimum of one (1) hour every month of in-service education addressing the special needs of GCI members such as those with Alzheimer's disease and related disorders and how to provide care for them.
- The unit will have an activity program which offers activities that are appropriate for persons with GCI, including at least one planned activity per day in the Wandering Unit.
- Develop a facility protocol to manage wandering members which includes:
- Identify potential wanderers to all staff to enable recognition of members who may be found off the wandering unit.
- Compile a file of member photographs that can be used to identify members to police in the event a resident elopes from the facility.
- Develop an intercom code or other procedure to alert all staff when a member is temporarily off the wandering unit.
- Assign responsibility to each employee for an area of the facility to search in the event of an alert for a wandering member.
- In the event of complete but unsuccessful search for a wandering member, notify police and MCLTC case manager no later than 30 minutes from the time the Member was identified as missing from the unit.

Bariatric

Bariatric services are reserved for individuals that have a very poor prognosis for weight loss. These members will typically exhibit a body mass index (BMI) that is severe enough to make care difficult due to the individual's inability to change position, ambulate, or transfer without hands on assistance from three or more nursing home staff. Additional care requirements specifically related to the member's morbid obesity must be evident in the facility documentation prior to approval of a bariatric level of care.

- The facility will be required to provide medical documentation supporting the need for a bariatric level of care to the MCLTC case manager prior to admission and prior to continued authorization.
- Documentation of care planning and ongoing efforts to affect member weight loss must be provided to the MCLTC case manager prior to continued authorization for this level

of care.

- PHP shall provide the following:
  - Additional nutritional counseling to assist member with appropriate caloric needs.
  - Physical, occupational, or restorative therapies tailored to the member.
  - Demonstrate an ongoing multidisciplinary approach to weight loss.
  - Provide all services, medications, supplies, and bariatric equipment necessary including a bariatric bed to maintain the member at the bariatric level of care (excludes customized DME).

Hospital Bed Hold

Bed holds require authorization by MCLTC staff. PHP must notify the MCLTC case manager within 24 hours of hospital admission if there is a request for a hospital bed hold. There is a maximum of twelve (12) days that may be authorized per member, per contract year (October 1- September 30).

Therapeutic Bed Hold

Bed holds require authorization by MCLTC staff. There is a maximum of nine (9) days that may be authorized per member, per contract year (October 1- September 30).

Respite

Respite placement in a nursing facility is authorized by MCLTC staff according to AHCCCS requirements. The purpose is to provide an interval of rest and/or relief to a family member or other unpaid person caring for the member, and to improve the emotional and mental well-being of the member. There is a maximum of 25 respite days per contract year (October 1-September 30) provided member has not used respite in any other setting during the contract year.

Requirements for All Behavioral Health Specialty Placements

Participating Healthcare Provider (PHP) shall provide all the following services to MCLTC members in Behavioral Health Specialty Placements:

- Psychiatric nursing care services
- Rehabilitative services
- Restorative services
- Overall management and evaluation of a member's Care Plan/Service Plan
- Overall management and evaluation of a member's Behavioral Treatment Plan
- Observation and assessment of a member's changing condition
- One-on-one services for short durations

The Behavioral Health Program Team is comprised of:

- Member

- Healthcare Decision Maker (HCDM)
- MC Behavioral Health Case Manager
- Special Assistant, if applicable
- Clinical Program Director qualified as a Behavioral Health Professional (BHP) by definition:
    - An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:
        - Independently engage in the practice of behavioral health as defined in A.R.S. § 32-3251, or
        - Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. § 32-3251 under direct supervision as defined in A.A.C. R4-6-101
    - A psychiatrist as defined in A.R.S. § 36-501
    - A psychologist as defined in A.R.S § 32-2061
    - A physician
    - A behavioral analyst as defined in A.R.S. § 32-2091
    - A registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or
    - A registered nurse
        - A psychiatric mental health nursing certification, or
        - One (1) year of experience providing behavioral health services
- Behavioral Health Program Coordinator
- Other clinical staff involved in the member's clinical care

PHP will report to MCLTC all changes to the member's needs, ensuring that Behavioral Health Specialty Placement remains appropriate and the least restrictive environment.

PHP will develop a process to timely communicate scheduled member staffings to the MCLTC Behavioral Health Case Manager.

Training

- PHP shall provide a minimum of forty (40) hours of on-the-job training for new staff in the Behavioral Health Specialty Placement covering the services provided in the setting.
- During the didactic in-service requirements during which the new staff observes and participates, new staff are not to be left alone or responsible for direct member care.
- PHP will also ensure there is ongoing monthly training related to behavioral health, at a minimum of one (1) hour per month for all staff.

Documentation

- PHP shall comply with MCLTC documentation requirements that include but are not limited to**:**

    - PHP shall complete daily behavioral documentation on all MCLTC members in a Behavioral Health Specialty Placement.
    - Behavioral documentation should reflect the target behaviors addressed in the member's Behavioral Treatment Plan and include a detailed description of the behavior(s), intervention(s) used, and the outcome.
    - PHP shall maintain a system to track the increase and decrease of targeted behaviors.
    - Medication monitoring with frequent laboratory testing, as applicable.
    - Behavioral Treatment Plans must be developed and implemented for all members residing in Behavioral Health Specialty Placements. This guides treatment and ensures that everyone responds to behaviors consistently.
- PHP shall provide documentation upon request from MCLTC.
- A guiding principle of the ALTCS program is that members live in the most integrated/least restrictive environment. MCLTC uses documentation regularly to support/justify placement type and level of care (LOC).
- If behavioral documentation does not support the member's current placement type/level of care (LOC), the MCLTC Behavioral Health Case Manager will work with the member/HCDM and PHP to locate an alternate/least restrictive setting for the member.

Additional Requirements for Behavioral Health Skilled Nursing Facility Program

Behavioral Health High Acuity Unit

In addition to the above requirements, PHPs must meet the requirements for Behavioral Health High Acuity Unit, as follows:

- PHP shall provide residents with staff supervision twenty-four (24) hours per day.
- PHP shall provide a designated unit secured by locked or electronically controlled doors (a Wander Guard type system alone does not meet this requirement).
- The designated unit must have secured gates and have a fence no less than six (6) feet high and be designed in such a manner as to ensure the staff's ability to observe and supervision members directly always.
- PHP shall prove a secure outdoor area separate from any outdoor area utilized by other facility residents.
- The secure outdoor area must be available to members twenty-four (24) hours per day.
- All MCLTC members in Behavioral Health High Acuity units will have a private room.
- PHP shall provide attendants for off-site appointments.
- The Behavioral Health High Acuity Unit shall be staffed with:
    - One (1) licensed nurse (RN or LPN) every shift for every fifteen (15) High Acuity members. If census increases to sixteen (16) and above, another licensed nurse shall be added for sixteen (16) hours/day. There shall be a minimum of one (1) licensed nurse dedicated to each unit.
    - Day Shift: One (1) CNA to two and a half (2.5) members

- PM Shift: One (1) CNA to two and a half (2.5) members
- Night Shift: One (1) CNA to four (4) members
- Activity personnel a minimum of eight (8) hours/day including weekends

These hours are to be dedicated exclusively to the members in the Behavior Health High Acuity Unit and shall be maintained at the same rate for all residents including those who are not on MCLTC.

Behavioral Health Standard Unit

In addition to the above requirements, PHPs must meet the requirements for Behavioral Health Standard Unit, as follows:

- All MCLTC members will have no more than two (2) members to a room.
- The Behavioral Health Standard Unit shall be staff with:
  - One (1) licensed nurse (RN or LPN) every shift for twenty (20) Standard members. If census increases to twenty-one (21) and above, another licensed nurse shall be added for sixteen (16) hours/day.
  - Day Shift: One (1) CNA to four (4) members
  - PM Shift: One (1) CNA to four (4) members
  - Night Shift: One (1) CNA to six (6) members
  - Activity personnel a minimum of eight (8) hours/day including weekends

These hours are to be dedicated exclusively to the members in the Behavioral Health Standard Unit and shall be maintained at the same rate for all members including those who are not on MCLTC.

Behavioral Health Step-Down Unit

PHPs must meet the requirements for Behavioral Health Step-Down Unit, as follows:

- All MCLTC members will have no more than two (2) members to a room.
- The Behavioral Health Step-Down Unit shall be staffed with:
  - One (1) licensed nurse (RN or LPN) every shift for every twenty (2) Step-Down members. If census increases to twenty-one (21) and above, another licensed nurse shall be added for sixteen (16) hours/day.
  - Day Shift: One (1) CNA to six (6) members
  - PM Shift: One (1) CNA to six (6) members
  - Night Shift: One (1) CNA to eight (8) members
  - Activity personnel a minimum of eight (8) hours/day including weekends

These hours shall be dedicated exclusively to the members in the Behavioral Health Step-Down Unit and shall be maintained at the same rate for all residents including those who are not on MCLTC.

Requirements for Behavioral Health Assisted Living Programs

- PHP shall ensure the Behavioral Health Assisted Living Program is secured and monitored.

- PHP must meet minimum staffing ratios worked by licensed personnel and caregivers, as follows:
    - Day Shift: Two (2) staff to ten (10) members
    - PM Shift: One (1) staff to ten (10) members
    - Night Shift: One (1) staff to ten (10) members

  These staffing ratios shall be dedicated exclusively to the members in Behavioral Health Assisted Living Programs and shall be maintained at the same rate for all residents including those who are not on MCLTC.
- All MCLTC members will have no more than two (2) members to a room.
- PHP shall provide members with daily recreational; community and/or social activities designed to maintain or improve physical and social interaction.
- PHP shall provide services including but not limited to psychosocial rehabilitation; skills training and development that are designed to help develop skills necessary to carry out goals specified in the member's treatment plan and promote independence.

Behavioral Health Global Cognitive Impairment (GCI) Programs

In addition to the above requirements, PHP must meet the requirements for Behavioral Health Global Cognitive Impairment (GCI) Programs as follows:

- PHP shall provide residents with staff supervision twenty-four (24) hours per day.
- The program must have secured gates and have a fence no less than six (6) feet high and be designated in such a manner as to ensure the staff's ability to observe and supervise members directly always.
- PHP shall ensure the program is secured by locked or electronically controlled doors (a Wander Guard type systems alone does not meet this requirement).
- PHP shall provide a secure outdoor area separate from any outdoor area utilized by other facility residents.
- The secure outdoor area must be available to members twenty-four (24) hours per day.
- PHP shall ensure programs are designed to maximize comfort for the member's physical environment, personal and shared space, demonstrate a balance of sensory stimuli that are calming and soothing; and other sensory stimuli that are pleasantly stimulating and engaging.
- PHP must offer activities that are appropriate for persons with GCI.
- PHP will ensure there is ongoing monthly training related to the special needs of members with GCI, at a minimum of one (1) hour per month for all staff**.**

2.16 - Contract Terminations – Nursing Facilities and Alternative Residential Settings

The below process defines the relationship between MCLTC, a Nursing Facility (NF) and/or an Alternative Residential Setting (ARS) following the termination of a contract between these entities, regardless of which entity terminates the contract or the reason for contract termination. The following process delineates how MCLTC, NF and/or ARS will collaborate to provide for the needs of the members residing in the facility at the time of contract termination.

Member/Resident Options when a NF and/or ARS Contract is Terminated

Affected members residing in a NF and/or ARS at the time of a contract termination may continue to reside in that facility until their open enrollment period, at which time they must either choose an available Contractor that is contracted with the facility or move to a setting that is contracted with their current Contractor.

A meeting between the Contractor, NF, and/or ARS and AHCCCS will be held prior to the effective date of the contract termination to plan all aspects related to the change in contract status and impact on members and representatives.

MCLTC in collaboration with the NF and/or ARS and AHCCCS must develop a member/ representative communication plan. The purpose of the communication plan is to provide affected or impacted members and/or their representatives with consistent information regarding the contract termination. The Contractor must receive approval of their member/ representative communication plan from the Division of Health Care Management Operations Unit. The plan must be submitted to AHCCCS within five business days of the termination decision. All member communications must be consistent with guidelines found in the AHCCCS ACOM Policy 404.

Reimbursement

- **Nursing Facilities**
  MCLTC shall reimburse the NF at the previously contracted rates or the AHCCCS fee for service schedule rates, whichever are greater. Should AHCCCS increase its fee schedule, MCLTC shall reimburse the NF at the greater of the increased AHCCCS fee for service schedule rates or MCLTC's previously contracted rates. Should AHCCCS reduce its fee schedule, LCT shall reduce its previously contracted rates by the same percentage and pay the greater of the adjusted rates.

  If MCLTC had in place a provision for subacute, specialty care or add-on rates at the time of the contract termination, then MCLTC shall apply those rates. Should AHCCCS adjust its fee schedule, then MCLTC will adjust its subacute or add-on rate(s) by the average adjustment to the NF fee schedule rates.
- **Alternative Residential Settings**
  MCLTC shall reimburse the ARS at the previously contracted rate. Should AHCCCS adjust its HCBS Fee Schedule rates, MCMCLTC will adjust its ARS rates by the average percentage that the HCBS Fee Schedule rates are adjusted.

Quality of Care

If MCLTC or other entity, such as Arizona Department of Health Services (ADHS) Licensure or AHCCCS identify instances where the overall quality of care delivered by an NF or ARS places residents in

immediate jeopardy, the Contractor will inform members/representatives of the problems and offer members alternative placement. Members may have the option to continue to reside in the NF or ARS.

In some cases, ADHS or AHCCCS may require that MCLTC find new placements for members. In such cases, the Contractor shall work with the members/HCDM to identify an appropriate placement that meets the needs of the member. AHCCCS may require MCLTC to increase monitoring of facilities identified as having health or safety issues until AHCCCS is assured that the issues have been resolved or members have been transitioned to a placement setting that can meet their needs.

In the event of a bankruptcy or foreclosure order of an NF or ARS, MCLTC must notify the MC Quality Management Department (QM) within 24 hours. QM will investigate the concern, act with the provider, and make any necessary reports to external entities and AHCCCS.

Admissions/Discharges/Readmissions

- NFs or ARSs are not required to accept new admissions of members who are enrolled with a non-contracted Contractor.
- NFs are required to otherwise follow admission, readmission, transfer, and discharge rights as per 42 CFR 438.12.
- The Contractor may authorize bed hold days up to the allowed limit (Short Term Hospitalization Leave – 12 days and Therapeutic – nine days) as required by Chapter 100 of the AHCCCS AMPM.

2.17 – Employment Services

All individuals have an opportunity to obtain a community-based job that matches their skills, interests and preference and proper support to maintain the job. MC works to ensure a variety of employment and rehabilitation services are available to assess Long-Term Care LTC members move toward self-sufficiency and community integration. MC has a network of employment and rehabilitation service providers to meet the rehabilitation needs of members.

Employment planning is a team effort, driven by the member, through informed choice including education on the intended benefit of participating in a Vocational Rehabilitation program. Person-centered employment planning is key in this process and occurs with members interested in gaining or maintaining employment. LTC Case Managers can assist members connect to employment services or support to meet the identified goal. See the **AHCCCS Covered Behavioral Health Services Guide** for further information.

For members transitioning to adulthood beginning at the age of 16 or sooner. It is important to include discussions related to employment, education, recreation, and social needs as part of the planning for adulthood. Engaging with members about employment and employment related goals should be occurring with all members of working age.

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

- Employment is the expected outcome for all working aged Arizonans who have disabilities.
- Individuals who have disabilities 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 support 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 strength, interests, and preferences, and
    - Consideration of appropriate supports and services such as supported and customized employment and assistive technology.
- Long-term support and services, if needed, are available for the individual to be successful in the workplace.

ALTCS members have access to pre-employment services, to prepare for engagement in meaningful work-related activities, or services necessary to achieve full-or part-time competitive integrated employment. This includes self-employment and post-employment (job coaching) services, to support maintaining current employment.

Settings where employment services are provided are integrated community work settings. An integrated work setting is a worksite that's located in a community setting such as residential, business, social, or educational environments.

Please refer to **AHCCCS AMPM 1240-J** and **Division Policy DDD MPM 1240-J** for further details regarding facility-based services and standards for integrated work settings.

ALTCS members are educated on the following:

- Arizona Disability Benefits 101 (DB101)
- Rehabilitation Services Administration/Vocational Rehabilitation (RSA/VR)
- Community employment resources, including ARIZONA@WORK
- AHCCCS Freedom to Work (Medicaid Buy-In)

It is important to know members in facility-based, congregate employment programs prior to **March 17, 2023**, may continue to receive those services without having a goal of working outside of the facility. However, providers must continually assess and offer services geared toward these members obtaining a competitive job in the community.

Rehabilitation services include:

- Skills Training and Development and Psychosocial Rehabilitation, and Cognitive Rehabilitation
- Behavioral Health Prevention/Promotion Education and Medication Training and Support (Health Promotion)
- Supported Employment - Psychoeducational Service (Pre-Job Training and 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 the RSA/VR program.

Please refer to the **AHCCCS Covered Behavioral Health Services Guide** for additional information.

MC employment services for ALTCS members aligns with **AHCCCS AMPM 1240-J**, **AHCCCS ACOM Policy 447** on Employment, and **DDD MPM 1240-J**. These policies outline the competencies required to provide Employment and Rehabilitation services include the provision of educating, coaching, training, and demonstrating skills to remediate/prevent existing/anticipated functional deficits.

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 ALTCS 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 and Pima County. 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.

Prevocational and employment related services available through MC are distinct from vocational services available through ADES/RSA.

MCLTC Chapter 3 – Covered Services

3.00 – Coverage Criteria

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

3.01 - Covered Services

Long term care covered services and benefits:

- Nursing home care
- Home and Community Based Services
  - Adult day health care
  - Attendant care (includes spouse attendant care and self-directed care)
  - Community transitional service
  - Habilitation (includes day treatment and training)
  - Home delivered meals
  - Home health services
  - Homemaker services
  - Home modifications
  - Hospice
  - Personal care services
  - Respite and group respite care
- Alternative residential settings
  - Adult foster care
  - Adult and child developmental home
  - Assisted living home
  - Assisted living center
  - Behavioral health facility
  - Substance abuse transitional facility
  - Therapeutic home care - adult and child
  - Traumatic brain injury home

Medical covered services and benefits:

- Audiology services, including evaluation and treatment of hearing loss
- Behavioral health services and settings
- Breast reconstruction after a mastectomy
- Care to stabilize you after an emergency
- Chiropractic services
- Diabetes care including A1C and LDL screenings, and eye exam for diabetes-related care
- Doctor office visits, including specialists and primary care providers
- Durable medical equipment such as crutches, walkers, wheelchairs, and blood glucose monitors
- Emergency medical care
- Family planning services and supplies such as contraceptives, testing, and treatment for sexually transmitted infections (STIs)
- Foot and ankle services such as treatment for foot pain or preventive diabetic foot care
- Health risk assessments and screening such as blood pressure testing, mammography, and colon cancer screenings
- Hospital care, including inpatient medical care, observation, and outpatient medical care
- Incontinence briefs to avoid or prevent skin breakdown, with limitations
- Kidney dialysis
- Laboratory and X-rays, including blood work
- Limited vision services, for members over 21 years of age, including: emergency eye care and some medically necessary vision services such as cataract removal
- Maternity care (prenatal, labor and delivery, postpartum)
- Medical foods, with limitations
- Medical supplies such as catheters and oxygen
- Medically necessary transportation to and from required medical services; emergency transportation
- Medications on MCLTC's list of covered medicines - members with Medicare will receive their medications from Medicare Part D
- Nutritional assessments, including evaluation and dietary recommendations
- Orthotics to support or brace weak joints or muscles
- Outpatient surgery and anesthesia
- Prescriptive lenses after cataract surgery
- Rehabilitation services, including occupational, speech, physical and respiratory therapy (limitations apply) for patients older than age 21
- Routine immunizations, such as flu shots
- Urgent care services – when you need care today, or within the next couple of days
- Wellness exams and preventive screenings

Additional covered services for children (under age 21):

- Dental homes are covered for members under 21 years of age. A "dental home" is an office or facility where all dental services are provided in one location.
- Two (2) routine and preventive dental visits are covered per year for members under the age of 21.
- Visits to the dentist must take place within six (6) months and one (1) day after the previous visit. Services include oral health screenings, cleanings, fluoride treatments, dental sealants, oral hygiene education, X-rays, fillings, extractions, and other medically necessary procedures and therapeutic and emergency dental services.
- Routine and emergency vision services are covered for members under 21. Vision services include exams and prescriptive lenses, frames, and replacement and repair of eyeglasses.
- Well visits including checkups and immunizations. MC does not limit the number of well visits for members under 21 years of age.
- Chiropractic services.
- Conscious sedation.
- Incontinence briefs, with limitations.
- Additional services for Qualified Medicare Beneficiaries (QMBs).
- Any service covered by Medicare but not by AHCCCS

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 benefits/services: for members 21 years or older:

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
Chiropractic services	Hands on therapy for spinal manipulation or adjustment	Excluded except for QMB members
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.
Dental and emergency dental service	Emergency services are those times that you need care immediately like a bad infection in your mouth or pain in your teeth or jaw.	There is limited coverage for dental services for members with cancer of the jaw, neck, or head and for members who are pre-transplant candidates. Coverage for emergency dental services for members 21 years of age or older is limited to services that physicians are generally competent to perform. Exclusions include services such as dental cleanings, routine dental exams, dental restorations, and root canals. Diagnosis and treatment of TMJ is not covered except for reduction of trauma.
Transplants	A transplant is defined as the transfer of an organ or blood cells 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, Physical and Speech Therapies	Exercises taught or provided by a physical therapist to make you stronger or help improve movement.	Coverage for out-patient physical therapy visits is limited to 15 visits to re-learn a skill and 15 visits to learn a new skill per contract year (October 1 - September 30). Coverage for members who have Medicare is limited to payment of copays for 15 visits. Members who have Medicare should contact the health plan for help in determining coverage.
Respite care	Respite care is offered as a temporary break for caregivers to take time for themselves.	The number of respite hours available to adults and children receiving ALTCS benefits or behavioral health services is 600 hours within a 12-month period. The 12 months will run from October 1 through September 30 of the next year.

Member Handbook

MCLTC is responsible for the **Member Handbook**.

The MCLTC Member Handbook applies to MCLTC and DDD members also receive the member handbook produced by the contractor who delivers their physical health benefits.

The member handbook is provided to all members in their welcome letter that contains their member ID card. MCLTC 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 (Long Term Care and DDD physical)

Per AHCCCS ACOM 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. A hard copy of the MCLTC Member Handbook **is** provided and reviewed by MCLTC's Case Manager with the MCLTC member.

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 easily accessible on the MCLTC website (**Member Handbook**). The Member Handbook is available in English and Spanish.
- Members receiving healthcare services have the right to request and obtain a Member Handbook at least annually. MCLTC 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 MCLTC's website.
- AHCCCS may require MCLTC 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 MCLTC sooner, if needed.

3.02 – Non-Covered Services

- Services from a provider who is NOT contracted with MCLTC (unless prior approved by MCLTC)
- 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
- Abortions and abortion 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 MCLTC
- Prescriptions not on MCLTC's list of covered medications, unless approved by MCLTC
- Diapers solely for personal hygiene
- 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

- Microprocessor controlled lower limbs and microprocessor-controlled joints for lower limbs
- Percussive vests
- Routine eye examinations for prescriptive lenses or glasses
- Chiropractic services (except for Medicare QMB members)

3.03 – Long Term Care Services (Covered by DDD)

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 MCLTC 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

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.

MCLTC Chapter 4 – Behavioral Health

4.00 - Behavioral Health Overview

Comprehensive mental health and substance abuse (behavioral health) services are available to MCLTC 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 case manager. MCLTC 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 care
- Behavioral health nursing services
- Case management 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)
- Screening

4.01 - Behavioral Health Provider Types

Several main provider types typically provide behavioral health services for MCLTC 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 marriage and family therapists
- Licensed substance abuse counselors
- Residential treatment facilities
- Behavioral health group homes, Levels II and III.
- Partial hospital programs
- Substance abuse 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.

4.02 - Alternative Living Arrangements

MCLTC 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.

4.03 – Case Management Caseload Ratio Guidelines

Caseload Ratios for children in High Needs Case Management (HNCM)

The caseload ratios for children in High Needs Case Management is a caseload ratio of between 1:8 and 1:25, with 1:15 being the desired target.

4.04 - 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 for MCLTC members. If a member is experiencing a behavioral health crisis, please contact the Arizona Statewide Behavioral Health Crisis Line at 844-534-4673.

During a member's behavioral health emergency, the crisis line clinician may telephonically support the person in crisis or may also dispatch a behavioral health mobile crisis team to the site of the member to de-escalate the situation and evaluate the member for behavioral health services. All medically necessary services are covered by the ACC-RBHA in that region.

4.05 – 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 health 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 them 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, MCLTC 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 or Text: 4HOPE (44673); 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 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.

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 Avenue
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 Road
Mesa, AZ 85206

Connections Health Solutions – Crisis Response Center
2802 E. District Street
Tucson, AZ 85714

The Guidance Center

2187 N. Vickey Street
Flagstaff, AZ 86004

Psychiatric Emergencies for Children/Adolescent

MIND 24/7 – Higley
1138 S. Higley Road
Mesa, AZ 85206

MIND 24/7 – Metro
10046 N. Metro Parkway
Phoenix, AZ 85051

Connections Health Solutions- Crisis Response Center
2802 E. District Street
Tucson, AZ 85714

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.

For Emergency Applications (to mobilize the CRISIS TEAM to evaluate a member) please contact: Arizona Statewide Crisis Phone Line 844-534-4673 or Text: 4HOPE (44673)

At Risk Crisis Plans should include information that can be useful to support the person in crisis, including any natural supports, coping skills, medical information that may be useful, and any other information that can help crisis responders and first responders.

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 MCLTC 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.

4.06 - Behavioral Health Consults

Behavioral health consults are required by AHCCCS on all MCLTC members who receive behavioral health services to review that all behavioral health needs are appropriate and to refer to new behavioral health services if needed. Behavioral health consults are done between an MCLTC case manager and a licensed behavioral health clinician by reviewing the behavioral health provider's treatment plan, facility progress notes, and medication administration record (MAR). 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 through Microsoft Teams or by phone, and the outcome signed by a licensed master's level behavioral health clinician.

MCLTC behavioral health prescriber will send a letter to the member's PCP regarding the member's treatment and psychotropic medication regime for coordination of medical and psychiatric medications.

4.07 - 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.

4.08 – Behavioral Analysis Service

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; and
- 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.

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.

Provider Qualifications

Behavior Analysis Services shall be directed and overseen by Behavior Analysts and supported, where applicable, by Behavior Analysis Trainees and/or Behavior Technicians.

The Behavior Analyst is responsible for training Behavior Analysis Trainees and Behavior Technicians to implement assessment and intervention protocols with members. The Behavior Analyst is responsible for all aspects of clinical direction, supervision, and provider-level case management.

The 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 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.

Behavior Analysis Assessments

Behavior 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).
- 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 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, Department of Child Safety (DCS) and/or other state-funded programs, and others 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 and guidelines relating to the practice of behavior analysis as well as Arizona Medicaid laws and regulations and Arizona state Behavior Analyst licensure laws and regulations (A.R.S. §32-2091).

4.09 - Behavioral Health Appointment Standards

MCLTC routinely monitors providers for compliance with appointment standards. Behavioral health appointment standards for both physical and behavioral health providers:

- Urgent need appointments – as expeditiously as the member's health condition requires but no later than 24 hours from identification of need,
- Initial assessment – within seven calendar days after the initial referral or request for behavioral health services,
- Initial appointment – within timeframes indicated by clinical need:
    - For members aged 18 years or older, no later than 23 calendar days after the initial assessment, and

    - For members under the age of 18 years, no later than 21 days after the initial assessment.
- Subsequent behavioral health services – within the timeframes, according to the needs of the person, but no longer than 45 calendar days from identification of need.

4.10 - 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 DCS (if the guardian/caregiver and MCLTC have the paperwork)
- Public Fiduciary Department (if documentation is provided identifying the Public Fiduciary Department as the member's guardian/caregiver)
- Veterans Office (when documentation is provided by the guardian/caregiver)
- Children's schools (participation in the ISP with parental or guardian/caregiver consent)
- The court system (when completing paperwork for all court ordered treatments or evaluations)
- 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 DCS funded QRTP, the Provider must ensure that 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 ISP 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 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 CFT 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.
- 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 Individual 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 sills, work, and education plans, earning potential and psychiatric stability must be incorporated into the young adult's ISP.

4.11 - 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.

4.12 - Prior Authorization Requirements and Process

Outpatient behavioral health services do not require referrals or prior authorization for outpatient services. Subacute Residential Treatment for SUD and BH requires prior authorization.

4.13 – 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

MCLTC 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 in reference to 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 signature on a general consent form, before receiving behavioral health services.
- 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 signature on a general consent form prior to the delivery of 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, 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.
- Contractors and TRBHAs 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 in whose care a child is currently placed may give consent for:
    - 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 (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)).
- 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)).
- Foster or kinship caregivers can consent to evaluation and treatment for routine medical and dental treatment and procedures, including behavioral health services. 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,
    - Care Management,
    - Personal Care Services,

  - Family Support,
  - Peer Support,
  - Respite,
  - Sign Language or Oral Interpretive Services,
  - Transportation,
  - Crisis Intervention Services,
  - Behavioral Health Day Programs.
- A foster parent, group home staff, foster home staff, relative, or other person or agency in whose care a child is currently placed shall not consent to:
  - General Anesthesia,
  - Surgery,
  - Testing for the presence of the human immunodeficiency virus,
  - Blood transfusions,
  - Abortions.
- 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.
- 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 Specialist 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.

MCLTC 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,
- Prior to the provision of a voluntary evaluation for a member. The use of AMPM Exhibit 320-Q-1, Application for Voluntary Evaluation is required for members determined to have a Serious Mental Illness and is recommended as a tool to review and document informed consent for voluntary evaluation of all other populations, 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.
- 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 written or verbal 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
Other 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,
    - 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).
    - Testing for the presence of the human immunodeficiency virus.
- Emancipated Minor
    - In the event the child is an emancipated minor, evidence of an emancipation shall be required, except in emergency situations under A.R.S. §12-2453,
    - 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 in reference to 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.

4.14 - Family Involvement

Family involvement in a member's treatment is an important aspect of 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.

4.15 - 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.
- MCLTC'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 MCLTC behavioral health coordinator will work with AzSH to ensure the member has sufficient 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 MCLTC 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 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.

4.16 – 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 as specified in A.A.C. R9-21-501 and A.R.S. § 36-520, when the 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 a Native American tribe rather than the state, the laws of that tribe, rather than state law, will govern the commitment process.

If, in the time it would take to complete a pre-petition screening, the member is likely to come to harm or harm others (even in not at the moment danger to self or danger to others) the applicant can go to any evaluating agency that accepts emergency admissions and complete an Application for Emergency Admission for Evaluation when the member, because of a mental disorder is DTS, DTO, PAD, or GD and is unwilling or unable to participate in voluntary evaluation and treatment.

Pre-petition screening includes an examination of the person's mental status and/or other relevant circumstances by a designated screening agency. The pre-petition screening agency, upon receipt of the application, shall determine the need for continued evaluation and immediately act as prescribed, not to exceed 48 hours of the filing of the application for court ordered evaluation excluding weekends and holidays as specified in A.R.S. § 36- 520. Upon reviewing the application for court ordered evaluation, examination of the person and review of other pertinent information, a licensed pre-petition screening agency's medical director or designee will determine if the person meets criteria for a Court Ordered Evaluation as 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 pre-petition 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, as the result of a mental disorder, to be DTS, DTO, PAD, or GD. Court-Ordered Treatment (COT) may include a combination of inpatient and outpatient treatment with the outpatient component not to exceed one year.

Inpatient treatment days can be used consecutively or non-consecutively and 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 letter of intent to treat and 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/PAD/GD and agrees in writing to receive voluntary evaluation and/or treatment.

County agencies and MC ACC-RBHA 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:

- 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, and/or programs, because of being charged with a crime and appears to have a substance use disorder.

Licensing Requirements

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

Pre-Petition Screening

Maricopa County

There is an intergovernmental agreement (IGA) 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 MCLTC for these pre-petition screening and court ordered evaluation functions. MCLTC 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 pre-petition screening agency must follow these procedures:

- The pre-petition screening agency must provide 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. In Maricopa County the EMPACT PAD Team which can be reach at: **padreferrals@lafrontera-empact.org.**
- If the member meets criteria for an Application for Emergency Admission for Evaluation as DTS/DTO/PAD/GD, and in the time, it would take to complete a pre-petition screening the person is likely to be a danger to self or others (even if not an immediate danger at the moment), then the applicant can go to any involuntary crisis facility in Maricopa County to complete the application. The Application for Emergency Admission can be initiated by police, crisis teams, family members, or anyone who has knowledge of the alleged behavior(s) as specified in A.R.S. § 36-524. In addition, there must be two witnesses available to verify the

member's behavior once it goes to court.

The evaluating agencies that accept applications for emergency admission in Maricopa County are:

Connections Health Solutions Urgent Psychiatric Care (UP)
1207 S. 7th Ave, Unit 150
Phoenix, AZ 85007
(602) 416-7600

Community Bridges Inc. (CBI):
CBI CPEC
358 E. Javelina, Ste 102
Mesa, AZ 85210
1-877-931-9142

CBI West Valley
824 N. 99th Ave, Ste 109
Avondale, AZ 85323
1-877-931-9142

Recovery Innovations International (RI)
11361 N. 99th Ave, Ste 402
Peoria, AZ 85345
602-650-1212

Pima County

Application for Emergency Admission

If, in the time it would take to complete a pre-petition screening, the member is likely to come to harm or harm others (even if not at the moment an immediate danger to self or danger to others) the applicant can initiate an Application for Emergency Admission when the member, because of a mental disorder is DTS, DTO, PAD, or GD and is unwilling or unable to participate in voluntary evaluation and treatment.

The Application for Emergency Admission can be initiated by police, crisis teams, family members, or anyone who has knowledge of the alleged behavior(s) as specified in A.R.S. § 36-524. In addition, there must be two witnesses available to verify the member's behavior once it goes to court.

To initiate the Emergent petition the petitioner would call Tucson Police Department (TPD) if it warrants a call to 911 or call Southern Arizona Mental Health Corporation (SAMHC) to dispense the

Mobile Acute Services (MAC team). TPD calls the Solari statewide crisis line to triage, and to find out which evaluating hospital has an opening. The MAC team would coordinate with TPD and Solari.

For Non-Emergency Applications for Court Ordered Evaluation

Community Bridges, Inc.
Phone: 520-617-5500
Address: 250 S. Toole, Tucson, AZ 85701

The evaluating hospitals are:

Sonora Behavioral Health
6050 N. Corona Rd. Bldg. 3
Tucson, AZ 85704
520-469-8700

Palo Verde Hospital
2695 N. Craycroft Rd.
Tucson, AZ 85712
520-324-3522

University of Arizona Medical Center-South Campus
Abrams Annex 2800 E. Ajo Way
Tucson, AZ 85713
520-626-5582

Pre-Petition Screening in Pima County- Non-Emergent (PAD/GD)

Non-Emergent Petitions are facilitated by the Community Bridges pre-petition screening team. Any party can submit an Application for Court Ordered Evaluation by calling SAMHC at 520-617-0043 or 520-618-8694. Two witnesses must be available to verify the individual's behavior if a petition for Court Ordered Treatment is eventually filed and there is a COT hearing scheduled. A person may only be petitioned for Court Ordered Evaluation in Pima County if he/she is a resident of Pima County and/or if the behavior in question occurred in Pima County. A person must also be suffering from a mental disorder and meet the legal definition of DTS, DTO, GD, or PAD.

Pinal County

Non-Emergent pre-petition screening

In Pinal County, the county is responsible for pre-petition screening and Court Ordered Evaluation. 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 pre-petition screening agency must follow these procedures:

The pre-petition screening agency must provide 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. In Pinal County contact the Solari Statewide Crisis line to being the non-emergent pre-petition screening process.

Application for Emergency Admission (Emergent process)

If, in the time it would take to complete a pre-petition screening, the member is likely to come to harm or harm others (even if not at the moment an immediate danger to self or danger to others) the applicant can initiate an Application for Emergency Admission when the member, because of a mental disorder is DTS, DTO, PAD, or GD and is unwilling or unable to participate in voluntary evaluation and treatment.

The Application for Emergency Admission can be initiated by police, crisis teams, family members, or anyone who has knowledge of the alleged behavior(s) as specified in A.R.S. § 36-524. In addition, there must be two witnesses available to verify the member's behavior once it goes to court.

For people who exhibit petitionable behaviors in Pinal County, an Application for Emergency Admission can be filed at one of two CBI locations contracted with the county to complete Court Ordered Evaluation:

Community Bridges Inc. (CBI) Casa Grande
675 E. Cottonwood Lane
Casa Grande AZ, 85122

Community Bridges Inc. (CBI) CPEC
358 E. Javelina
Mesa, AZ 85210

Gila County

In Gila County, the county is responsible for pre-petition screening and Court Ordered Evaluation. 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 pre-petition screening agency must follow these procedures:

- The pre-petition screening agency must provide 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. In Gila County contact the Solari Statewide Crisis line to being the application for emergency admission (emergent) and non-emergent pre-petition screening process.

Filing of Non-Emergent Applications for Court Ordered Evaluation in Maricopa County

This provides instructions to the Case Manager and Pre-Petition Team relative to AAC and ARC requirements, not intended to be instructive to provider/community members.

Non-emergency Process

For behavioral health members receiving MCLTC Psychiatric services, the following steps will be completed by the Clinical Team.

- For residents of Maricopa County, the EMPACT pre-petition team will complete these steps for petitions for COE. Any responsible individual may apply for a COE of a member who is alleged to be, because of a mental disorder, a danger to self or to others, persistently, or acutely disabled, or gravely disabled and who is unwilling or unable to undergo a voluntary evaluation.

  For Maricopa County residents not enrolled with a MCLTC Psychiatric Provider service, an applicant contacts Empact at 480-784-1514 EXT 1158 and requests a PAD or GD application be completed on an identified member in the community. An applicant can also go in person to AZ Connections, 1201 S 7th Ave., Ste. 150, Phoenix, AZ 85007, CPEC, 358 E. Javelina, Ste. 101, Mesa, AZ 85210, or CBI West Valley, 824 N. 99th Ave, Ste. 109, Avondale, AZ 85323 1-877-931-9142.
- To begin the non-emergent process, the Pre-Petition team shall receive the referral and will contact the applicant to assist the applicant in completion of the Application for Involuntary Evaluation when a non- emergency COE is requested.
- For MCLTC enrolled behavioral health members, the Clinical Team shall assist the applicant in the completion of the application and evaluation when a non-emergency COE is requested. If at any time during the process the behavioral health member is determined to be in imminent danger of harming self or others, AZ Connections, CBI CPEC, or CBI West Valley will be contacted for assistance in evaluation and possible application for an emergency admission.
- For all MCLTC enrolled or non-enrolled members, pre-petition screening must be attempted within forty-eight (48) hours, excluding weekends and holidays, of completion of the application. Pre-petition screening process includes informing the individual that an application for evaluation (Application for Involuntary Evaluation) has been completed, explaining the

individual's rights to voluntary evaluation, reviewing the allegations, and completing a mental status examination. The Pre-Petition Screening Report is a detailed report of the information obtained during the assessment. This report must be completed by someone other than the applicant. If the member does consent to a voluntary evaluation the Application for Voluntary Evaluation shall be used.

- During the pre-petition screening, at least three attempts to contact the member should be completed. If attempts at contacting the member are unsuccessful and screening is not possible, screening staff will review this information with a psychiatrist or psychiatric nurse practitioner. The screening agency shall prepare a report giving reasons why the screening was not possible, including opinions/conclusions of staff members who attempted to conduct pre-petition screening.
- If the member does not consent to a voluntary outpatient evaluation or voluntary inpatient evaluation or when a voluntary evaluation is not appropriate as determined by the evaluating psychiatrist or psychiatric nurse practitioner, the involuntary process shall continue.
- 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 or psychiatric nurse practitioner. The psychiatrist/NP need never have met the person to decide regarding whether to move forward with a Petition for COE. The psychiatrist/NP 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 GCI and other cognitive disorders, is DTS, DTO, PAD or GD. The documents contain pertinent information for COE;
- If the psychiatrist/NP determines that there is reasonable cause to believe that the member is likely to harm him/her or others in the time it would take to complete the non-emergent process, the psychiatrist/NP must coordinate with the UPC, RRC-W,CBI CPEC, or CBI West Valley 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 Valley Wise Roosevelt Campus 2619 E. Pierce, Phoenix, AZ 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, Application for Involuntary Evaluation, Pre-Petition Screening, Witness List, and Police Worksheet.
- Three copies and the original Petition for Court-Ordered Evaluation, Application for Involuntary Evaluation, Pre-Petition Screening Report, witness list, and the Police Mental Health Detention Information Sheet, must be submitted by the behavioral health member's Case Manager or the

pre-petition team to the Legal Department at Valley Wise Roosevelt 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 packet is filed with the court, the Legal Department at Valley Wise delivers the Detention Order to the Police Department to have the member brought to the UPC, RRC, CBI West Valley, or CBI CPEC for evaluation. NOTE: The Petition for Court Ordered Evaluation and Detention Order signed by the judge expires 14 days from the date the judge signs off on the order for COE.
- A copy of petition documents shall be stored by the behavioral health member's 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 in the time it would take to complete the non-emergent process, he/she is likely to harm himself/herself or others, an application for emergency admission can be filed. Applications indicating Danger to Self, Danger to Others, Persistently or Acutely Disabled, or Gravely disabled 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; Recovery Innovations - (RRC, 11361 N. 99th Ave., Ste. 402, Peoria AZ 85345, 602-636-4605; or CBI Community Psychiatric Emergency Center (CPEC), 358 E. Javelina, Mesa, AZ 85210, 480-507-3180 or CBI West Valley 824 N. 99th Ave, Ste 109 Avondale, AZ 85323 1-877-931-9142 ACC-RBHA contracts with the UPC, RCC, and CBI 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

If the member meets criteria for an Application for Emergency Admission for Evaluation as DTS/DTO/PAD/GD, and in the time, it would take to complete a pre-petition screening the person is likely to be a danger to self or others (even if not an immediate danger at the moment), then the applicant can go to any involuntary crisis facility in Maricopa County to complete the application. The Application for Emergency Admission can be initiated by police, crisis teams, family members, or anyone who has knowledge of the alleged behavior(s) as specified in A.R.S. § 36-524. In addition, there must be two witnesses available to verify the member's behavior once it goes to court.

- The applicant must have knowledge of the behavior and evidence of mental disorder.
- The applicant may be called to testify in court if the application results in a petition for COE or petition for COT.
- Upon receipt of the Application for Emergency Admission for Emergency Evaluation (MH-104)

the UPC, RRC, CPEC, or CBI West Valley 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, CPEC, or CBI West Valley, then the crisis facility, which is a licensed evaluating agency, staff will immediately coordinate with local law enforcement for the detention of the member and transportation to the crisis facility.

- If the Application for Emergency Admission for Evaluation is accepted by the UPC, RRC, CPEC or CBI West Valley admitting officer and the member requires a level of medical support not available at the crisis facility, then within 24 hours the admitting officer will coordinate admission to the Valley Wise Psychiatric Annex. If admission to the Valley Wise Psychiatric Annex cannot be completed within 24 hours of the Application for Emergency Admission for Evaluation being accepted by the crisis facility, then the MCLTC Medical Director must be notified.
- An Application for Emergency Admission for Evaluation may be discussed by telephone with a crisis facility/evaluating agency admitting officer, the referring physician, and a police officer to facilitate transport of the member to be evaluated at the crisis facility/ evaluating agency.
- A member proposed for emergency admission for evaluation may be apprehended and transported to the crisis facility/evaluating agency by police officials through a written Application for Emergency Admission for Evaluation faxed by the crisis facility/evaluating agency 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 crisis facility/evaluating agency who determines there is reasonable cause to believe that the member, because of a mental disorder, is a DTS, DTO, PAD, or GD and that during the time necessary to complete prescreening procedures the member is likely, without hospitalization, to suffer harm or cause harm to others.
- During the emergency admission period of up to 23 hours the following will occur:
- The member's ability to consent to voluntary treatment will be assessed.
- The 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.**
- The crisis facility/evaluating agency may contact the County Attorney prior to filing a petition if it alleges that a member is DTO.
- If the 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, then the crisis facility/evaluating agency will notify the applicant and MCLTC Case Manager 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:

MCLTC 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 MCLTC's medical director or designee; and
- Title XIX/XXI funds must not be used to reimburse court-ordered evaluation services.

MCLTC encourages the utilization of outpatient evaluation on a voluntary or involuntary basis. MCLTC 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 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 Valley Wise Roosevelt 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 Valley Wise 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 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 Valley Wise Legal Department will arrange for an outpatient Court Ordered Evaluation and notify the 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 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 MCLTC Court Liaison will assist the member in arranging transportation.
- If the two evaluating psychiatrists do not believe that the member needs COT, then the Valley Wise Legal Department will forward the physicians' affidavits to the 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 MCLTC Court Liaison will then file a Petition for Court Ordered Treatment with the Maricopa County Superior Court within 2 business days.

Voluntary Evaluation

Any MCLTC 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 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 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 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 Valley Wise Legal Department regarding their findings.
- If the psychiatrists do not believe that the member needs COT, then the Valley Wise Legal Department will forward the physicians' affidavits to the 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 Valley Wise Legal Department within 1 business day of the evaluation. The MCLTC 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.

When the county does not contract with the MCLTC for court-ordered evaluations MCLTC contracts with Valley Wise for inpatient Court-Ordered Evaluations and Outpatient Court-Ordered Evaluations

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.
- Any evaluating agency 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.
- A copy of the petition, in cases of grave disability or when a member is already a ward of the public fiduciary, 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 and for those petitioned as GD or already a ward of the public fiduciary, must be sent to the office of the public fiduciary. A copy of the petition will also be sent to a person's private guardian if one is in place.

For MCLTC members who are already under Court Ordered Treatment under A.R.S. Title 36, MCLTC is responsible for tracking the status of the member's treatment and reports to the Mental Health Court, as necessary. As such, treating providers must notify MCLTC of any treatments. Members need to be involved in treatment planning and member/guardian needs to sign the inpatient service plan. If a member is on COE or COT, there needs to be evidence of an attempt and documentation if member refuses.

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

For members who are under Court Ordered Treatment through the Mental Health Court, MCLTC is responsible for tracking the status of the member's treatment and reports to the Mental Health Court, as necessary. As such, treating providers must notify MCLTC of any treatments.

The treating provider 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 COT after finding of Not Competent/Not Restorable in a Criminal Matter (Rule 11 COT)

Members placed on COT after having been found not competent and not restorable (Rule 11) require special treatment and tracking by the MCLTC. ARS §36-544 requires the MCLTC to file a notice with the court and prosecuting attorney within five (5) days of a members unauthorized absence from 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 MCLTC 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, MCLTC 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, MCLTC must report any noncompliance with the treatment order.

If the MCLTC 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. 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.
- 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 or designee 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:

- Psychiatric Affidavit Examiner 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).
- Psychiatric Affidavit Examiner for Annual Review of COT will be kept at the psychiatrist's office, and a copy will be placed in the member's medical record.
- 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.)

4.17 – SMI Eligibility Determination

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);
- Members who are enrolled as a member determined to have a Qualifying SMI Diagnosis and Functional Impairment due to that diagnosis for whom a review of the determination is indicated; and
- MCLTC, subcontracted providers and the MCLTC 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.

All members must be evaluated for SMI eligibility by a qualified assessor, and have an SMI eligibility determination made by the Crisis Response Network, if the member:

- Requests an SMI determination;
- A guardian/legal representative 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
- 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. MCLTC will develop and make available to providers any requirements or guidance on SMI eligibility determination record location and/or maintenance.

Computation of time is as follows:

- Evaluation date with a qualified clinician = day zero (0), regardless of the time of the evaluation.
- Determination due date = Three (3) business days from day zero (0), excluding weekends and holidays.
- The final determination is required three (3) business days from day 0, not 3 business days from the date of submission to MCLTC or designee. Providers that contract with MCLTC 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. **MCLTC, or designee, will have at least two (2) business days to complete the SMI determination.**

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 sufficient 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
- Initiate an assessment including completion of the **AHCCCS Medical Policy Manual 320-P 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 sufficient 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 Abuse

For members who have a qualifying SMI diagnosis and co-occurring substance abuse, 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 abuse 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 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 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 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 case manager to upcoming planning meetings. Additionally, the children's provider must track and report the following information to MCLTC, 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/SA 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 Abuse). 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 Crisis Response Network 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 sufficient 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
- There is insufficient functional or diagnostic information[1] to determine SMI eligibility within the required time periods.

Solari Crisis & Human Services

Solari Crisis & Human Services 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

- The Crisis Response Network 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
- SMI eligibility must be determined within three days of obtaining sufficient 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 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 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.

[1] Insufficient diagnostic information shall be understood to mean that the information available to the reviewer is suggestive of two or more equally likely working diagnoses, only one of which qualifies as SMI, and an additional piece of existing historical information or a face-to-face psychiatric evaluation is likely to support one diagnosis more than the other(s).

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

- The reason for denial of SMI eligibility (**Serious Mental Illness Determination**)
- 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 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 Crisis Response Network for individuals currently enrolled as a member with a SMI may be initiated by MCLTC 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 a SMI, or their legally authorized representative, upon their request

A review of the determination may not be requested by MCLTC 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, MCLTC must ensure that:

- Services are continued depending on Title XIX/XXI eligibility, or other MCLTC 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 MCLTC 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 MCLTC for approval. MCLTC is responsible for monitoring and validating the forms. MCLTC 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 Decertification***
   - 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 Decertification. An Integrated Behavioral Health Home Decertification is a determination that a member who has a SMI designation no longer meets SMI criteria. If, because 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.
     - MCLTC 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 Decertification***
   - A member who has a SMI designation may request a SMI Administrative Decertification if the member has not received behavioral health services for a period of two or more years.
     - Upon receipt of a request for Administrative Decertification, MCLTC shall direct the member to contact AHCCCS DHCM Customer Service.
     - AHCCCS will evaluate the member's request and review data sources to determine the last date the member received a behavioral health service. AHCCCS will inform the member of changes that may result in the removal of the member's SMI designation. Based upon review, the following will occur:
       - In the event the member has not received a behavioral health service within the previous two years, the member will be provided with AMPM Exhibit 320-P-3. This form must be completed by the member and returned to AHCCCS.
       - In the event the review finds that the member has received behavioral health services within the prior two-year period, the member will be notified that they may seek decertification of their SMI status through the Clinical Decertification process.

Integrated/Behavioral Health Home Transfer Protocol

- Once CRN determines the SMI decertification, CRN sends an email to the Integrated/Behavioral Health Home indicating the specific member status of decertification.
- As soon as the Integrated/Behavioral Health Home receives notification that a member has completed and been approved for SMI decertification, the Integrated/Behavioral 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/SA provider(s) or BHMP/PCP of the member's choice to eliminate any gaps in care for the member.
- The transferring of services from the Integrated/Behavioral Health Home to the GMH/SA 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/SA 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 – General Terms, Chapter 4 – Provider Responsibilities, Section 4.19 – Member's Medical Records**) 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 (see **MC Provider Manual, Chapter 100 – General Terms, Chapter 4 – Provider Responsibilities, Section 4.19 – Member's Medical Records**).

MCLTC Transfer Protocol

MCLTC 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 decertification, MCLTC, 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. MCLTC'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 SMI

MCLTC panels newly enrolled members to a BHH based on member preference or keeping their community psychiatric provider. If member preference is unavailable, the PCP or case manager can help with some options in the community or on geographic proximity and 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.

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

- **Native American –** Native American members have choice and may opt-out of enrollment in an integrated plan.
- **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. MCLTC 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 Provider Intake on **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.

4.18 – Out of State Treatment for Behavioral Health

General Requirements

When MCLTC 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;
- 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 MCLTC;
- The out-of-state treatment facility meets the Arizona Department of Education Academic Standards; and
- A plan for the provision of non-emergency medical care must be established.
- If a member has been placed out-of-state secondary to an emergency, unforeseen event, or by a third-party liability insurance, MCLTC 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 (BHH) or Psychiatric provider in coordination with the family/legal guardian will coordinate with the AHCCCS Health Plan to decide and document all contacts and arrangements;
- MCLTC 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,

MCLTC 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 health plan; Home passes are allowed as clinically appropriate and in accordance with AHCCCS Guidelines. 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

MCLTC is required to obtain approval from the AHCCCS Office of Medical Management prior to an out-of-state treatment and upon discovering that a MCLTC member is in an out-of-state treatment using **AHCCCS Exhibit 450-1, Out-of-State Placement Form**. Prior authorization must be obtained before making a referral for out-of-state treatment; in accordance with MCLTC criteria. MCLTC requires their providers to assist with supplying the information required on the form and with providing copies of supporting clinical documentation.

Process for Initial Notification to MCLTC

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

For children/adolescent and adults under the age of 21, the Assigned Behavioral Health Clinic Clinical Leadership or MCLTC BH Team 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 or MCLTC BH Team will coordinate with applicable key stakeholders (i.e., DCS, JPO, and DDD) and verify they agree to an out-of-state placement. If there is disagreement, which cannot be resolved, the Behavioral Health Home clinical leadership or MCLTC BH Team may contact MCLTC for assistance in resolution.
- When the Behavioral Health Home Clinical Leadership or MCLTC BH Team and key stakeholders agree on the treatment, the Behavioral Health Home Clinical Leadership or the MCLTC BH Team will complete the **AHCCCS Exhibit 450-1, Out-of-State Placement Form** and submit to the MCLTC Utilization Management Department via secure e-mail to ChildrensDischargePlanning@MercyCareAZ.org within 2 business days for identifying the need for out-of-state treatment.
- The MCLTC 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, MCLTC will notify the Behavioral Health Home Clinical Leadership or MCLTC BH Team and direct them to complete the out of state placement process.
- MCLTC will identify out-of-state AHCCCS registered providers and send referrals to the provider and care management team.
- Once the accepting facility is identified, MCLTC 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 Behavioral Health Home Clinical Leadership will complete the **AHCCCS Exhibit 450-1, Out-of-State Placement Form** and submit to the MCLTC UM Department via secure e-mail to ChildrensDischargePlanning@MercyCareAZ.org no later than 5 business days before the 30-day update is due to AHCCCS. The 30-day update timelines will be based upon the date of admission to the out-of-state treatment as reported by MCLTC 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.

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

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

4.19 – Behavioral Health Assessment and Service Planning Overview

MCLTC 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 Practice Protocol Child and Family Team Practice**.

4.20 – 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. MCLTC will disseminate information to the 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 MCLTC 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 MCLTC'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
- Development and coordination of outreach programs to Native American tribes in Arizona to provide services for tribal members

Engagement

MCLTC 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
- For members with a Serious Mental Illness who are receiving Special Assistance, the member (guardian, family member, advocate or other) designated to provide Special Assistance

Behavioral health providers must provide services in a culturally competent manner in accordance with MCLTC'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 with members in their preferred language and ensuring that they understand all clinical and administrative information.
- 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

For SMI Members, the reengagement policy is as follows:

RBHA Health Homes must attempt to re-engage members in an episode of care that has 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 ACC-RBHA Health Home must attempt to reengage the member assigned to a Supportive or Connective level of care for eight (8) weeks minimum, with three (3) outreach attempts in weeks 1 and 2 and more intensive outreach if clinically indicated; two (2) outreach attempts in weeks 3 and 4 and more intensive outreach if clinically indicated; one outreach attempt in weeks 5-8 and more intensive outreach if clinically indicated. One (1) of the outreach attempts per week must be conducted in the community.

For members assigned to an ACT level of care, the ACT team must attempt to reengage the member for eight (8) weeks minimum, with four (4) outreach attempts per week. Two (2) of the four (4) outreach attempts per week are to be conducted in the community and are performing street outreach. More intensive outreach if clinically indicated individualized to the member's needs and, for example, could range from four (4) attempts each week to multiple attempts each day.

If there are safety concerns, the behavioral health provider should assess for petition-able behavior, such as persistently and acutely disabled (PAD), danger to self (DTS), danger to others (DTO), grave disability (GD). The MCLTC Health Home should develop their own detailed policies outlining the consistency and methods of outreach and should include but is not limited to:

- Communicating in the member's preferred language.
- Contacting the assigned LTC Case Manager regarding any safety issues.
- 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) within 24 hours.
- Whenever possible, contact the member or the member's legal guardian 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 the outreach process has begun, informing the member of the outreach process, except when a letter is contraindicated due to safety concerns (e.g., domestic violence) or confidentiality issues. The ACC-RBHA Health Home 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.
- Sending a letter to the current or most recent address requesting contact within 72 hours once 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 MCLTC Health Home 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.
- Checking the inpatient census (each provider has identified employees who have access to a

real time inpatient census through MC).
- Checking the Health Information Exchange.
- Calling the emergency contact, involved family members.
- Calling other supports such as pharmacy, primary care physician, payee, advocate, special assistance, probation officer, parole officer, day program, therapists.
- Checking the legal system.
- Calling the morgue.
- Street outreach such as home visit/potential known whereabouts.
- Members on Court Ordered Treatment (COT) should not be moved to a lower level of care even after outreach has been completed.
- For members determined to have a Serious Mental Illness who are receiving Special Assistance, contacting the designated person providing Special Assistance for his/her involvement in member's reengagement efforts.
- No Show Policy
- For all members receiving Serious Mental Illness (SMI) services, the provider must attempt a 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. Please see previous section regarding options to reengage members.

For children receiving Behavioral Health services, 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:

a. Communicating in the member's preferred language;
b. Contact the LTC Case Manager regarding coordination of care;
c. 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);
d. 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);
e. When possible, contacting the member/guardian/designated representative face-to-face if telephone contact is insufficient to locate the member or determine acuity and risk; and
f. 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, 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.

For children in the custody of DCS receiving behavioral health services, if attempts to contact the DCS Specialist or the DCS Supervisor is unsuccessful, contact the MC ACC-RBHA Child Welfare Single Point of Contact at DCS@MercyCareAZ.org to assist with reengagement. For DCS CHP 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.

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:

a. 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;
b. Involved in a behavioral health crisis within timeframes based upon the member's clinical needs, but no later than seven days;
c. Refusing prescribed psychotropic medications within timeframes based upon the member's clinical needs and history; and
d. Changes in the level of care

For SMI Behavioral Health Service Providers:
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. The SMI Behavioral Health Service 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 member's assigned LTC Case Manager for coordination of care

- Contacting the member, member's behavioral health clinical team 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, member's behavioral health clinical team or the member's legal guardian 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 SMI Behavioral Health Service 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 members determined to have a Serious Mental Illness who are receiving Special Assistance for his/her involvement in member's reengagement efforts

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.

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 a harm to self or others must be clearly documented in the comprehensive clinical record.

No Show Policy

For all members receiving Serious Mental Illness (SMI) services, the provider must attempt a telephonic contact with member, within 24 hours, following any missed appointment. Provider will contact the LTC Case Manager regarding the missed appointment and if they have been unable to reach the member to reschedule so they can assist in contacting the member. These timeframe requirements are the minimum; based on the member's needs, more outreaches may be clinically indicated.

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 or adopted children 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 LTC Case Manager and MC ACC-RBHA Child Welfare Single Point of Contact at DCS@MercyCareAZ.org to assist with re-engagement. For DCS CHP Youth who have been in service 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

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 SMI non-ACT 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 clinical team should be present at discharge and complete clinically appropriate home visits and discharge follow-up (please see below for specific timeframe requirements);
- Involved in a behavioral health crisis within timeframes based upon the member's clinical needs, with minimum contact within 24 hours (please see below regarding specific BHMP required timeframes for appointments);
- 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.
- For children removed from their parent or guardian by the Department of Child Safety (DCS), within 72 hours of notification from DCS.

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 SMI members, if the member has a hospitalization in a behavioral health inpatient setting, the discharge policy is as follows:

- The BHMP appointment must be scheduled within 72 business hours following discharge.
- Daily contact must be made with the member during the 5 business days after a psychiatric hospitalization. One of these contacts must be a face-to-face visit with the member.
- 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.
- PCP appointment must be scheduled within 30 days following discharge.
- The 30-day face to face visit includes development of the "30-day discharge staffing note".

For SMI members, if the member has a hospitalization in a medical/physical health inpatient setting, the discharge policy is as follows:

- The BHMP appointment must be scheduled within 30 days following discharge.
- The PCP appointment must be scheduled within 7 days or sooner if indicated following discharge.

The expectation for non-ACT adult 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.

Outreach to Service Members, Veterans, and Families

MC will partner with community organizations which provide care and support for service members, veterans, and families. Utilizing 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 families of the benefits available and how to access those services. MC will train staff on the available community resources and appropriate actions to take to ensure members are afforded the ability to be connected to these resources. 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 the full list of courses by clicking on the "courses" tab at the top of your screen.

4.21 - 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.

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.

The assessment of substance use disorders and related levels of service provision using the current 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.

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.

4.22 - Minimum Elements of the Behavioral Health Assessment

MCLTC 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:

- Presenting concerns;
- Information on the strengths and needs of the member and their family;
- Current and past behavioral health treatment, current and past medical conditions, and treatment;
- History of physical, emotional, psychological, or sexual trauma at any stage of life, if applicable;
- History of other types of trauma (e.g., environmental, natural disasters, etc.);
- Current and past substance use related disorders, if applicable;
- Health Related Social Needs (HRSN):
    - Living environment
    - Educational and vocational training
    - Employment
    - Interpersonal, social, and cultural skills
- Developmental history;
- Criminal justice history;
- Public (e.g., unemployment, food stamps) and private resources (e.g., faith-based, natural supports);
- Legal status (e.g., presence or absence of a HCDM) and apparent capacity (e.g., ability to make decisions or complete daily living activities);
- Need for special assistance; and
- Language and communication capabilities;

Additional components of the assessment shall include:

- Risk assessment of the member;
- Mental status examination of the member;
- A summary of clinician's impressions, and observations;
- Recommendations for next steps;
- Diagnostic impressions of the qualified clinician;
- Identification of the need for further or specialty evaluations

Additional assessment requirements:

- **REQUIRED FOR ALL TITLE XIX/XXI MEMBERS:** Primary Care Provider (PCP) name and contact information.
- **REQUIRED FOR ALL TITLE XIX/XXI MEMBERS:** Involvement with other agencies (e.g., Department of Child Safety, Probation, Division of Developmental Disabilities).
- **ONLY REQUIRED FOR CHILDREN AGED 0 TO 5:** Birth to Five Assessment to be completed within 90 days of intake, with a minimum of 2 documented observations to occur within a 45-60-day period and the first observation to occur within 21 days of intake. Recommendations for treatment to be reviewed with the Guardian/Primary Caregiver and Stakeholders within a Child and Family Team meeting. 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.
- **ONLY REQUIRED FOR CHILDREN AGED 6 TO 18:** Child and Adolescent Service Intensity Instrument (CASII) Score and Date.
- **ONLY REQUIRED FOR CHILDREN AGED 6 TO 18 WITH CASII SCORE OF 4 OR HIGHER:** Strength, Needs and Culture Discovery Document.
- **ONLY IF INDICATED:** Seriously Mentally Ill Determination (for members who request SMI determination or have an SMI qualifying diagnosis.
- 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

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. MCLTC 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. MCLTC 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.

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 Plan). 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:

- Justice involvement;
- Previous psychiatric hospitalizations;
- Out-of-home placements:
    - Home and Community Based Service (HCBS) settings (e.g., assisted living facility)
    - Nursing facilities
    - Group home settings
- Special health care needs;
- History of, or presently under Court Ordered Treatment COT;
- History or present concern of Danger to Self/Danger to Others (DTS/DTO);
- Members with a SMI designation;
- Members identified as high risk/high needs; and/or
- Children ages six through 17 with a CALOCUS Level of 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.

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:

- Techniques for establishing safety, as identified by the member and/or HCDM, DR, as well as members of the CFT or ART;
- Realistic interventions that are most helpful or not helpful to the individual and their family members/responsible person or support system;
- Consideration of physical limitations, comorbid conditions, or other unique needs the member may have that would aid in reduction of symptoms;
- Guiding the support system toward ways to be most helpful to members and their families,
- Multi-system Involvement;
- Adherence to COT (if applicable);
- 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:

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

4.23 - 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 MCLTC 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, MCLTC 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).**

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

4.24 - 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:

- Moving, or a change in housing location or status,
- Death of a family member or friend,
- Change in family structure (e.g., divorce, separation, adoption, placement disruption),
- Hospitalization,
- Major illness of the member, their family member, or person of importance,
- Change in level of care,
- Incarceration, and
- 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).

4.25 - Transfer Assessments

- 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 current admission, the following requirement is applicable (per A.A.C. R9-10-1011):
- The patient's assessment information is reviewed and updated if additional information is identified that affects the patient's assessment; and
- 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.

4.26 – Housing for Individuals Determined to have Serious Mental Illness (SMI)

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 MCLTC 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 they 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, MC Provider Manual, Chapter 100 – General Terms, Chapter 18 – Grievance System, Member Rights, and Claim Disputes, Section 18.02 – Serious Member Illness (SMI) Member Grievance Resolution Process**.

Other MC Housing Requirements

- MC ensures its subcontracted providers are assisting members with securing or maintaining permanent housing placement as 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 Policy 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 at 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.

4.27 – 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 MCLTC

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 MCLTC'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 MCLTC's website.

If a use of seclusion or restraint requires face-to-face monitoring, a report detailing face-to-face monitoring is submitted to MCLTC's 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 MCLTC members that occurred in the prior month to MCLTC QM the 5th calendar day of the month. If there were no occurrences of seclusion and restraint for MCLTC members during the reporting period, the report should so indicate.

All documentation related to a single seclusion or restraint submission, including all required supporting documents 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 MCLTC members are to be submitted via email directly to **MercyCareSandR@MercyCareAZ.org** com or via fax to 1-855-224-4908.

MCLTC 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. 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:
  - **MCCC/MC DD/MCLTC: 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 **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 **Provider Drug 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 **AHCCCS AMPM 310-V Attachment A - 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.

MCLTC 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 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 to further develop or enhance 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/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 through their employing provider 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:

- 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
- Qualify as a behavioral health paraprofessional, behavioral health technician, or behavioral health professional.

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 hours covering ethics and boundaries related to the practice of family support.

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 of all actively employed credentialed parent/family support specialists that have met the required qualifications and credentialing. All providers are required to complete quarterly reports utilizing AMPM Policy 964: approved AHCCCS portal.

Credentialed Parent/Family Support Training Programs (CPFSPs) are approved through AHCCCS/OIFA. CPFSPs shall include core elements addressed in AMPM Policy 964: Section E.

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 to further develop or enhance 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 16 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 and 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.

MCLTC Chapter 7 – Dental and Vision Services

7.00 - Dental Services

Liberty Dental Plan

Liberty Dental Plan administers dental benefits for MCLTC. Liberty Dental Plan has administrative oversight for the following responsibilities:

- Credentialing
- Patient Management
- Prior Authorization
- Claims
- Customer Service Calls from Providers
- Appeals

MCLTC 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 855-352-7924. 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 1500 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 Long Term Care
  Claims Department
  P.O. Box 982975
  El Paso, TX 79998-2975

Dental Screening/Dental Treatment for members under 21

More information regarding Dental Screening/Dental Treatment for members under 21 is available in **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. 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 AMPM Policy 431-Attachment A – AHCCCS Dental Periodicity Schedule. 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 detail regarding this benefit, we are including the following link to the AHCCCS Medical Policy Manual:

- **AHCCCS AMPM 310 – D1 – Dental Services for Members 21 Years of Age and Older**

In addition, in accordance with A.R.S. §36-2939, MCLTC members aged 21 or older may receive medically necessary dental benefits up to $1,000 per member per contract year (October 1st to September 30th) for diagnostic, therapeutic and preventive care, including dentures. The services described in the above emergency dental AMPM Policy 310-D1 do not count towards the ALTCS $1,000 limit.

- **AHCCCS AMPM 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, and the additional $1000 for dental services for members on ALTCS.

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 facility to Title XIX members enrolled with MC.

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 alternate 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 copy of the complete treatment plan.

All providers will complete the appropriate informed consents and treatment plans for AHCCCS members as well as to 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 Ch 431-Dental Policy**, **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 $1,000.00 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 $1,000.00 limit.

7.01 - Vision Services

Vision Overview

MCLTC covers eye and optometric services provided by qualified eye/optometry professionals within certain limits based on member age and eligibility.

Coverage for Children (Under Age 21)

- 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.
- 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 430-EPSDT policy.

Nationwide Referral Instructions

Nationwide is MCLTC's contracted vendor for all vision services, including diabetic retinopathy exams. Members requiring vision services should be referred by their PCP's office to a Nationwide provider listed on MCLTC's website. The member may call Nationwide directly to schedule an appointment.

Coverage for Adults (21 years and older)

- 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 medically 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.

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 MCLTC's Member Services at 602-263-3000 or 800-624-3879 (toll-free).

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

This chapter is reserved. Information in this section was moved to MC Provider Manual Chapter 100 - General Terms, Chapter 18.

MCLTC 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**.

9.01 – Provider Requirements for ALTCS Person Centered Service Plan (PCSP)

Mercy Care ALTCS network providers play a critical role in supporting members through a comprehensive, person-centered service planning process. Providers, including, but not limited to primary care providers PCP, specialists and caregiver agencies are expected to actively collaborate with the member, their HCDM, Designated Representative (DR) and the MC ALTCS Case Manager (CM) to ensure that service planning is meaningful, individualized and aligned with AHCCCS requirements.

The expectations below outline the required provider engagement standards:

- Participation in PCSP meetings when requested by the member, their HCDM or DR.
    - This may include attending scheduled PCSP meetings (in person, phone, or virtual) and/or contributing clinical, functional, and quality of life information necessary to support member-directed planning.
        - AHCCCS requires that members choose who participates in the planning meeting and have the opportunity to provide input on location and format. Members may request provider participation in planning meetings. Providers must honor these preferences when involvement is requested.
        - Participation supports AHCCCS' person-centered standards, which require provider collaboration in assessing needs, identifying supports, and ensuring the plan reflects the member's preferences strengths, and goals.
        - Providers must supply accurate and timely information needed to develop or update the PCSP. This includes:
            - Updates on ADLs/IADLs, health changes, behavioral health status, and significant events as applicable.
            - Information that supports required PCSP elements, including the member profile, medical supports, risk factors, and progress toward goals.
            - Submission of requested materials with CM specified timelines to ensure timely PCSP development, review, and ongoing service coordination.
        - PCSPs must include member-driven, measurable goals and outcomes based on the person-centered assessment. Providers are expected to:
            - Provider observations and recommendations that support measurable and achievable goals consistent with the members' preferences.

MCLTC 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.