mercy care

Mercy Care ACC - RBHA



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Mercy Care Provider Manual
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ACC-RBHA Chapter 1 – Mercy Care ACC-RBHA Overview

1.00 – About Mercy Care ACC-RBHA

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. MC ACC-RBHA's effective date is 10/1/2022. MC ACC-RBHA covers the Central GSA in the following counties:

- Maricopa County
- Pinal County
- Gila County

MC ACC-RBHA provides services to the Arizona Medicaid populations that include:

- **Serious Mental Illness:** Persons who, because of a "mental disorder" (as defined in A.R.S. §36-501), exhibit emotional or behavioral functioning that is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. In these persons, mental disability is severe and persistent, resulting in a long-term limitation of their functional capacities for primary activities of daily living such as interpersonal relationships, homemaking, self-care, employment, and recreation, as defined in A.R.S. §36-550 diagnosed in persons 18 years and older.
- **Crisis:** A crisis 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.
- **Grants:** Behavioral health members may be covered under grants such as:
    - **Substance Use Block Grant (SUBG)** is a Formula Grant, which supports treatment services for Title XIX/XXI and Non-Title XIX/XXI members with substance use disorders (SUD) and primary substance use and misuse prevention efforts. The SUBG is used to plan, implement, and evaluate activities to prevent and treat substance abuse disorders. Grant funds are also used to provide Early Intervention Services for HIV and tuberculosis disease in high-risk individuals who use substances. SUBG funds are only to be used for allowable services identified in AMPM Exhibit 300-2B for priority populations within AMPM 320-T1 Block Grants and Discretionary Grants.

- **Mental Health Block Grant (MHBG**) is allocated from SAMHSA to provide mental health services to Title XIX/XXI and Non-Title XIX/XXI adults with an SMI determination, Title XIX/XXI, and Non-Title XIX/XXI children with an SED determination, and Title XIX/XXI and Non-Title XIX/XXI individuals in need of FEP services. MHBG funds are only to be used for allowable services identified in AMPM Exhibit 300-2B.
- **State Opioid Response Grant (SOR)** are federal dollars intended for Increasing infrastructure and access to treatment for Non-Title XIX/XXI individuals with Opioid Use or Stimulant Use Disorder. Select providers are subcontracted to coordinate care, offer recovery support services and prevention activities to reduce the prevalence of OUDs and opioid-related overdose deaths.

The State of Arizona has chosen MC ACC-RBHA, a locally owned and operated non-profit health plan, as the AHCCCS Complete Care - Regional Behavioral Health Agreement (ACC-RBHA) for Maricopa County.

Under contract with MC ACC-RBHA, providers are expected to follow the contents of this provider manual, MC ACC-RBHA Policies and Procedures as well as fulfill the scope of the contract terms. MC ACC-RBHA maintains a Network Management department for providers to ask questions and request technical assistance as well as to discuss contractual and program changes.

For more information about MC ACC-RBHA, its departments and their functions, please visit **www.MercyCareAZ.org**.

MC ACC-RBHA is dedicated to providing its members with access to care for their behavioral and medical health (integrated care) needs. Our focus is on the whole-member and uses a holistic approach to care. We want to know our members' goals, use their strengths, and understand their needs. We know how to provide access to high-quality, integrated care to people who have complex needs and work with the community and local health care providers to ensure those needs are met.

The Arizona Health Care Cost Containment System (herein AHCCCS) has developed expectations for MC ACC-RBHA's Provider Manual, which includes content specific to our geographic service areas (GSA) and communities. The MC ACC-RBHA Provider Manual describes public behavioral and integrated care health system requirements for any entity that directly provides behavioral health/integrated care services. These entities may include:

- Behavioral health/integrated care contracted and non-contracted providers, including those that provide emergency and post-stabilization services;
- Behavioral health/integrated care prevention services providers; and

- MC ACC-RBHA itself.

The MC ACC-RBHA Provider Manual is applicable to defined populations that may access public behavioral health/integrated care services. These populations include:

- Behavioral health members receiving emergency/crisis services;
- Non-Title XIX members determined to have a Serious Mental Illness;
- Members receiving services through the Substance Use Block Grant (SUBG); Mental Health Block Grant (MHBG); or Governor's Office Substance Use Disorder funds.
- Non-enrolled members participating in AHCCCS prevention sponsored activities;
- Non-enrolled members participating in AHCCCS HIV Early Intervention services;
- Other populations based on the availability of funding and the prioritization of available funding.

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 ACC-RBHA 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 MC ACC-RBHA as well as AHCCCS requirements, providers are required to fully understand and apply these requirements when administering covered services.

Please refer to the **AHCCCS** website for further information regarding AHCCCS regulations.

1.01 – Overview of the Arizona Public Behavioral Health System

AHCCCS is the single state Medicaid Agency to administer behavioral health benefits for members who are Title XIX and Title XXI eligible.

MC ACC-RBHA, in turn, subcontracts with community providers that administer behavioral health programs and services for children and adults and their families. MC ACC-RBHA is responsible for the oversight of the administration of behavioral health services for several populations funded through various sources.

Arizona state law requires MC ACC-RBHA to administer community-based treatment services for adults who have been determined to have a Serious Mental Illness.

The Substance Abuse and Mental Health Services Administration (SAMHSA) provides funding to AHCCCS through two block grants:

- The Substance Use Block Grant (SUBG) funds a variety of substance abuse services and specialized addiction treatment programs for priority populations outlined within the **AMPM 320-T1.**

- The Mental Health Block Grant is allocated from SAMHSA to provide mental health services to Title XIX/XXI and Non-Title XIX/XXI adults with a Serious Mental Illness (SMI) determination, Title XIX/XXI and Non-Title XIX/XXI children with a Serious Emotional Disturbance (SED) identification, and Title XIX/XXI and Non-Title XIX/XXI individuals in need of First Episode Psychosis (FEP) services.

MC ACC-RBHA administers other federal, state and locally funded behavioral health services. Individuals can get more information about **AHCCCS** programs by visiting their website. Please click the link to access.

1.02 – Overview of Mercy ACC-RBHA

MC ACC-RBHA System Principles

All healthcare services must be delivered in accordance with AHCCCS system principles. AHCCCS supports a healthcare system that includes:

- Easy access to care;
- Behavioral health member and family involvement;
- Collaboration with the Greater Community;
- Effective innovation;
- Expectation for improvement; and
- Cultural competency.

Easy Access to Care

- Accurate information is readily available that informs healthcare members, families, and stakeholders how to access services;
- The healthcare network is organized in a manner that allows for easy access to behavioral health/integrated care services; and
- Services are delivered in a manner, location and timeframe that meet the needs of healthcare members and their families.

Behavioral Health Member and Family Involvement

- Behavioral health members and families are active participants in behavioral health delivery system design, prioritization of behavioral health resources and planning for and evaluating the services provided to them; and
- Behavioral health members, families, and other parties involved in the member and family's lives are central and active participants in the assessment, service planning and delivery of behavioral health services and connection to natural supports.

Collaboration with the Greater Community

- Stakeholders including general medical, child welfare, criminal justice, education, Veterans Affairs Administration, and other social service providers are actively engaged

in the planning and delivery of integrated services to behavioral health members and their families;
- Relationships are fostered with stakeholders to maximize access by healthcare members and their families to needed resources such as housing, employment, medical and dental care, and other community services; and
- Providers of healthcare services collaborate with community stakeholders to assist healthcare members and families in achieving their goals.

Effective Innovation

- Healthcare providers are continuously educated in the application of evidence-based practices;
- The services system recognizes that substance abuse, mental health, and physical health disorders are inextricably intertwined, and integrated substance abuse and mental health evaluation and treatment are the community standard;
- Interested healthcare members and families are provided training and supervision to be retained as providers of peer support services; and
- Implementation of the Adverse Childhood Experiences (ACEs) Interface train-the trainer model, inclusive of unique cultural perspectives of our members such as American Indian/Alaska Natives (AI/AN), requiring clinical staff who complete assessments to be trained on ACEs, and have ACE scores included in the evaluation of treatment needs.

Expectation for Improvement

- Services are delivered with the explicit goal of assisting people to achieve or maintain success, recovery, gainful employment, success in age-appropriate education, return to or preservation of adults, children and families in their own homes, avoidance of delinquency and criminality, self-sufficiency, and meaningful community participation;
- Services are continuously evaluated, and modified if they are ineffective in helping to meet these goals; and
- Healthcare providers instill hope that achievement of goals is possible even for the most disabled.

Integration of Primary Health and Behavioral Healthcare

MC ACC-RBHA utilizes an integrated care approach to positively affect the health and quality of life of our high-risk members diagnosed with a SMI, based on member-defined strengths, needs, and preferences. We weave physical, behavioral, and psychosocial support needs together to improve member outcomes, enhance quality of life, and reduce racial and ethnic health disparities associated with SMI, as well as disparities based on racial and ethnic backgrounds.

MC ACC-RBHA has adopted two models of integration for members with serious mental illness. These models are intended to provide a comprehensive array of physical and mental health care services, as well as health prevention and promotion services.

Model: Integrated Health Home (IHH)

An integrated health home is a place where members receive whole-member oriented care for their needs including primary care, behavioral health care, general counseling services, care coordination, specialty health service referral, medication management, health promotion, prevention, wellness services, member and family health education services (e.g., chronic disease management, healthy lifestyle, etc.), evidence-based programs (e.g., supported employment, peer support services, etc.), care management and outreach services.

Providers of integrated care must operate as a team that functions as the single-point of whole-health treatment and care for all a member's health care needs. Co-location or making referrals without coordinating care through a team approach does not equate to integrated care. Integrated teams include (at a minimum) a PCP, BHP, Registered Nurse (RN), or Licensed Practical Nurse (LPN under the supervision of an RN), care manager, medical assistant, team member to lead care coordinating, team member to lead wellness activities, housing specialist or housing point of contact, vocational coordinator, and peer.

Integrated health home includes wellness programming for earlier identification and intervention that reduces the incidence and severity of serious physical and mental illness using tools such as the HRA, disease registries, etc. IHH goals include improved member's experience of care and individual health outcomes.

Integrated Health Home Requirements

The following are additional requirements for Integrated Health Home (IHH) providers.

1. **Integrated Care Training –** All IHHs must have (at a minimum) one Master Trainer in the Connecting Minds curriculum. All staff (administrative staff, clinical, care managers, allied health, supervisors, etc.) working with an IHH must complete all four modules of the Connecting Minds**:** Inter-professional Collaboration for Whole Health (Connecting Minds) training within eight (8) months of hire within an IHH.
2. **Interdisciplinary Team Meetings (IDT) –** Providers, within an IHH, must attend weekly IDT meetings and use the skills and format from the Connecting Minds training.
3. **Daily Huddles** – Providers, within IHHs, are required to huddle daily using the daily huddle skills provided in the Connecting Minds training.
4. **Integrated Individual Service Plan (IISP) –** Providers within an IHH are required to complete an IISP for all members using a format with all the required elements as outlined in the Connecting Minds training.
5. **Integrated Dual Disorder Treatment (IDDT) -** IDDT will be available to all members

through IHHs and will be monitored for fidelity practices.

Additionally, the Data Collection Instrument (DCI) is required for all T19 members enrolled in an Integrated Health Home (IHH). The DCI is to be completed within 30 days of a member's enrollment in an IHH, and annually thereafter. For the IHH, please be advised that the DCI only needs to be completed for T19 members enrolled in the integrated model on site (opting into see physical and behavioral health at the clinic). IHH's targeted thresholds for the DCI is identified as 85% per IHH (not per agency).

Use of Terms

An attempt was made to use consistent terminology throughout the Provider Manual to the best extent possible. Members receiving healthcare services are referred to as "behavioral health members" or simply as "members."

Revisions to Provider Manual

Policies established as medical policies are updated annually or more frequently, if changes are necessary. Other sections of the Provider Manual are updated on an ongoing basis, but at a minimum, sections will be reviewed every year. For information or changes that must be communicated immediately, AHCCCS issues Policy Clarification Memorandums under their **Guides and Manuals for Health Plans and Providers** web page for both behavioral health and physical health providers. MC ACC-RBHA incorporates any changes made by AHCCCS into their provider manual as soon as it is received.

Healthcare providers and others may provide comments and request for revisions to the Provider Manual. Healthcare providers and other interested members should contact the MC ACC-RBHA Network Management at 800-564-5465 to provide input and requests for updates.

- Providers should note that policy revisions will be available both on **MC ACC-RBHA's website**, and via email to all contracted providers.
- Provider Notices: Notices to providers regarding changes in program policy or procedures will also be distributed via e-mail to contracted providers and posted to MC's website under **Notices** on the MC website.

ACC-RBHA Chapter 2 – Network Provider Service Delivery Requirements

2.00 – SMI Determination and SED Eligibility Evaluation

General Requirements

This chapter applies to:

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

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

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

- Requests an SMI determination or SED evaluation;
- A Health Care Decision Maker (HCDM) who is authorized to consent to inpatient treatment makes a request on behalf of the member;
- An Arizona Superior Court issues an order instructing that a member is to undergo a SMI evaluation/determination; or
- Has both a qualifying SMI or SED diagnosis and functional impairment because of the qualifying diagnosis.

The SMI determination or SED eligibility evaluation record must include all the documentation that was considered during the review including but not limited to current and/or historical treatment records. The record may be maintained in either hardcopy or electronic format. MC ACC-RBHA will develop and make available to providers any requirements or guidance on SMI or SED eligibility determination record location and/or maintenance.

Computation of time is as follows:

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

evaluation. MC ACC-RBHA or designee will have at least two (2) business days to complete the SMI determination.

Completion Process of Initial SMI Determination or SED Eligibility Evaluation

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 HCDM to conduct an assessment; and
- Provide to the member and, if applicable, the member's HCDM, the information required in **R9-21-301(D) (2)**, a client rights brochure, and the appeal notice required by **R9-21- 401(B)**.

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

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

Issues Preventing Timely Completion of SMI or SED Eligibility Evaluation

The time to initiate or complete the SMI determination or SED eligibility evaluation 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 of the member's HCDM and/or designated representative requests an extension of time.
- Additional documentation has been requested but has not yet been received.
- There is insufficient functional or diagnostic information to determine SMI or SED

eligibility within the required time periods.

SMI 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 Eligibility Determination for Individuals with Serious Mental Illness** and **AHCCCS Medical Policy Manual 550 Serious Emotional Disturbance Identification.**

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

If the young adult is not eligible for services as a member with a Serious Mental Illness, it is the responsibility of the children's behavioral health provider, through the CFT, to coordinate transition planning with the adult GMH/SU provider. The importance of securing representation from the adult service provider in this process cannot be overstated, regardless of the member's identified behavioral health category assignment (SMI, General Mental Health, Substance 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 Medical Policy Manual 587 – Transition to Adulthood.**

Completion Process of Final SMI Eligibility Determination

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

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

The following must occur if the designated reviewing psychiatrist, psychologist, or nurse practitioner has not conducted a face-to-face assessment and has a disagreement with the

current evaluating or treating qualified behavioral health professional or behavioral health technician (that cannot be resolved by oral or written communication):

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

If there is 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.

Solari

Solari must:

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

Situations in which Extension is due to Insufficient Information

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

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

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

Notification of SMI Eligibility Determination

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

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

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

Re-enrollment or Transfer

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

Review of SMI Eligibility Determination

A review of SMI eligibility made by Solari for individuals currently enrolled as a member with a SMI Designation may be initiated by MC ACC-RBHA 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 MC ACC-RBHA or behavioral health provider within six months from the date an individual has been determined SMI eligible.

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

- Services are continued depending on Title XIX/XXI eligibility, or other MC ACC-RBHA

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 MC ACC-RBHA for approval. MC ACC-RBHA is responsible for monitoring and validating the forms. MC ACC-RBHA must keep copies of the validated Serious Mental Illness Determination Verification form in the member's record.

SMI Removal

MC Member Services will inform the member of changes that may result with the removal of the member's SMI designation and how to contact the AHCCCS contractor assigned to manage the process outside of MC. There are two established methods for removing an SMI designation, one clinical and the other an administrative option, as follows:

1. SMI Clinical Removal
    - A member who has an SMI designation or an individual from the member's clinical team may request an SMI Clinical Removal. An SMI Clinical Removal is a determination that a member who has an SMI designation no longer meets SMI criteria. If, as a result of a review, the person is determined to no longer meet the diagnosis 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 person with an effective date of 30 days after the date the written notice is issued.
        - Members filing an appeal should be referred back to the AHCCCS contractor assigned to manage this process outside of MC.
        - Providers must discuss with members the potential impact of removing an SMI designation on the member's eligibility for entitlements.
2. SMI Administrative Removal
    - A member who has an SMI designation may request an SMI Administrative

Removal if the member has not received behavioral health services for a period of six (6) months.

- The AHCCCS contractor assigned to manager this process outside of MC will evaluate the member's request and review data sources to determine the last date the member received a behavioral health service.
- Denial of an SMI Administrative Removal is not appealable, and members should be referred back to the AHCCCS contractor assigned to manage this process outside of MC.
- Members wishing to file a grievance if their administrative SMI removal is denied, should be referred back to the AHCCCS contractor outside of MC assigned to handle that process.
- Providers must discuss with members the potential impact of removing an SMI designation on the member's eligibility for entitlements.

If the determining entity makes a decision that the member no longer meets SMI criteria, the RBHA Health Home must complete appropriate coordination between a GMH/SU provider(s), or BHMP/PCP of the member's choice in order to eliminate any gaps in care for the member. The transferring of services from the RBHA Health Home to the GMH/SU provider(s) or alternative BHMP/ PCP must be completed in less than thirty (30) days from the time the RBHA 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, and 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. Upon assessment for removal with the BHMP, the clinical team will begin to coordinate care with the next provider of the member's choice.

ACC-RBHA Health Home Transfer Protocol

- Once CRN determines the SMI decertification, CRN sends an email to the ACC-RBHA Health Home indicating the specific member status of decertification.
- As soon as the ACC-RBHA Health Home receives notification that a member has completed and been approved for SMI decertification, the ACC-RBHA Home Health will immediately begin working with the member to determine where the member wants to transfer their services.
- The ACC-RBHA Health Home must complete appropriate coordination between a GMH/SU provider(s) or BHMP/PCP of the member's choice to eliminate any gaps in care for the member.
- The transferring of services from the ACC-RBHA Health Home to the GMH/SU provider(s) or alternative BHMP/PCP must be completed in less than thirty (30) days

from the time the ACC-RBHA 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 ACC-RBHA Health Home but is T19, the ACC-RBHA Health Home that the member was paneled to under the Navigator level of care is responsible for completing the transfer of the member.
- If a member does not want to transfer to a GMH/SU provider or BHMP/PCP or refuses to sign a release of information for a receiving provider, the ACC-RBHA Health Home will complete appropriate outreach and engagement which requires two outreach attempts.
- The ACC-RBHA Health Home will offer the member the opportunity to obtain their medical records (see **MC Provider Manual, Chapter 100 – General Terms, 4.0 – 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 ACC-RBHA 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 4.0 – Provider Responsibilities, Section 4.19 – Member's Medical Records**).

Paneling of Members with SMI

If member preference is unavailable, the member is paneled to an ACC-RBHA Health Home based on geographic proximity. Paneling to an ACC-RBHA Health Home is aligned to member eligibility. Members are not paneled to an ACC-RBHA Health Home 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 ACC-RBHA Health Home, members receiving services through Assertive Community Treatment (ACT) teams must be paneled to an ACT Team.

ACC-RBHA 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 provider information systems.

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

SED Identification

Functional Criteria for SED Identification

To meet functional criteria for SED, an individual shall have, because of a qualifying SED diagnosis, dysfunction in at least one of the following four domains, as specified below, for most of the past six months, or for most of the past three months with an expected continued duration of at least three months:

- Seriously disruptive to family and/or community. Pervasively or imminently dangers 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 toward others. Severe disruption of daily life due to frequent thoughts of death, suicide, self-harm, often with behavioral intent and/or plan. Affective disruption causing significant damage to individuals' education or personal relationships.
- Dysfunction in role performance. Frequently disruptive or in trouble at home or at school. Frequently suspended/expelled from school. Major disruption of role functioning. Requires structured or supervised school setting. Performance significantly below expectation for cognitive/developmental level. Unable to attend school or meet other developmentally appropriate responsibilities.
- Child or Adolescent Level of Care Utilization System (CALOCUS) recommended level of care 4, 5, or 6.
- Risk of deterioration:
    - A qualifying diagnosis with probably chronic relapsing, and remitting course.
    - Co-morbidities (e.g., developmental/intellectual disability, Substance Use Disorder (SUD), personality disorders).
    - Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors (e.g., life-threatening, or debilitating illnesses, victimization).
    - Other (e.g., past psychiatric history, gains in functioning have not solidified or are a result of current compliance only, court-committed, care is complicated and requires multiple providers).

The following reasons shall not be sufficient in and of themselves for denial of SED eligibility:

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

Individuals with Co-Occurring Substance Abuse

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

1. For psychotic diagnoses other than substance-induced psychosis (bipolar I disorder with psychotic features, delusional disorder, major depression, recurrent, severe, with psychotic features, schizophrenia, schizoaffective disorder, and any other diagnosis of persistent psychotic disorder), functional impairment is presumed to be due to the qualifying mental health diagnosis.
2. For other qualifying psychiatric disorders, functional impairment is presumed to be due to the psychiatric diagnosis, unless:
    a. The severity, frequency, duration, or characteristics of symptoms contributing to the functional impairment cannot be attributed to the qualifying mental health diagnosis, or
    b. The assessor can demonstrate, based on a historical or prospective period of treatment, that the functional impairment is present only when the individual is actively using substances or experiencing symptoms of withdrawal from substances. In order to make such identifications, the assessor shall first look at a period of either 30 days or longer of abstinence, or 60 days or longer of reduced use that is less than the threshold expected to produce the resulting symptoms and disability and establish that the symptoms and resulting disability were no longer present after the 30 or 60 day period and/or no longer required mental health treatment to prevent recurrence of symptoms.
3. A diagnosis of substance-induced psychosis can only be made if both of the following conditions are present:
    a. There is no psychosis present before a period of substance use that is of sufficient type, duration, and intensity to cause psychotic symptoms, and
    b. The psychosis remits completely (not partially) after a period of abstinence of 30 days or less.
4. Continuation of new onset psychotic symptoms after a 30-day period of abstinence requires a presumptive diagnosis of a persistent psychotic disorder.
5. For persistent psychosis of undetermined onset, the absence of clear remission of psychosis during a period of abstinence of 30 days or less should be considered presumptive evidence of a persistent psychotic disorder for SED identification purposes.
6. For individuals who are not able to attain or maintain a period of abstinence from substance use, who continue to use substances and/or do not experience consecutive

days of abstinence, this is not a disqualifier to initiate the SED identification process. Some individuals will not meet the 30-day period of abstinence. This does not preclude them from the SED assessment or identification process.

Submitting Formal Notification of SED Identification

Formal notification of SED identification to AHCCCS is submitted through the Demographic User Guide (DUG) via the DUGless portal.

To enter information into the DUGless Portal, the member must have an AHCCCS ID. If the AHCCCS ID is not available or the member is not actively enrolled, providers must work with the appropriate ACC-RBHA Contractor or TRBHA (for Non-Title XIX/XXI eligibility cases) to establish eligibility records. The provider should coordinate with the designated ACC-RBHA Contractor or TRBHA to obtain the AHCCCS ID and initiate enrollment, allowing the provider to complete the SED identification process in the DUGless Portal.

When a provider identifies a child as meeting SED criteria, they must enter the following three components into the DUGless Portal:

1. If a child is identified by the provider as meeting criteria for SED, the provider shall submit the following three elements into the DUGless Portal:
    a. The SED qualifying diagnosis from the SED qualifying diagnoses list published on the AHCCCS Medical Coding Page of the AHCCCS website,
    b. CALOCUS score with date. For a child under the age of six, 99 shall be entered as CALOCUS is not validated for this age category. 99 shall also be entered for FFS members as the CALOCUS tool is recommended but not required, and
    c. SED identification - Selection of “yes” or “no” option. The “yes” option indicates that the child is identified SED. The “no” option is in the removal of the SED identification process as described below.
2. The provider shall communicate the SED qualifying diagnosis and CALOCUS score (if applicable) resulting in the SED identification to the member and HCDM and document this communication in the medical record.
3. The provider is required to reassess the member and update the CALOCUS at least every six months or more often as clinically indicated and shall submit updated results into the DUGless Portal as described above at the time of re-assessment. 4. The providers shall complete a DUGless Portal entry for members up to the age of 18 for SED identification even when the member has completed an SMI determination at age 17.5 years to ensure SED identification through age 18. Refer to **AHCCCS AMPM Policy 320-P - Eligibility Determinations for Individuals with Serious Mental Illness (SMI)**.

SED Identification Removal

MC or the contracted behavioral health providers may request a review of an individua's SED designation from the determining entity:

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

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

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

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

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

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

Paneling of Members with SED

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

2.01 – Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage and Low Subsidy Program

Behavioral health services for members who are not currently Title XIX/XXI eligible/enrolled

Behavioral health providers must help individuals apply for Arizona public programs, including Medicaid (Title XIX/XXI), Medicare Savings Programs, Nutrition Assistance, Cash Assistance and Medicare Part D, before delivering Non-Title XIX/XXI behavioral health services. Non-Title funds are the payer of last resort and cannot be used for premiums, deductibles, or most copays, with limited exceptions such as Medicare Part B cost-sharing for members with an SMI designation.

Providers are required to verify eligibility, complete screenings through Health-e-Arizona Plus, assist with documentation and support enrollment in Medicare Part D and Extra Help, Individuals who are not eligible for Medicaid may still qualify for services through federal grants, and crisis or emergency services may begin immediately without prior verification.

State law requires individuals to participate in the screening process; refusal makes them ineligible for state-funded behavioral health services, and providers must document refusals and follow required steps before ending services.

Title XIX/XXI Screening and Eligibility Process

There are three steps involved in screening for Title XIX/XXI eligibility:

- First, verify the member's Title XIX or Title XXI eligibility.
- Next, for those members who are not Title XIX or Title XXI eligible; screen for potential Title XIX or other eligibility.
- Finally, as indicated by the screening tool, assist members with applications for a Title XIX or other eligibility determination.

Step #1-Accessing Title XIX/XXI or Other Eligibility Information

Contracted providers who need to verify the eligibility and enrollment of an AHCCCS member can use one of the alternative verification processes 24 hours a day, 7 days a week. These processes include:

- **AHCCCS web-based verification (Customer Support 602-417-4451):** This website allows the providers to verify eligibility and enrollment. To use the website, providers must create an account before using the applications. To create an account, click on the link and follow the prompts. Once the providers have an account, they can view eligibility and claim information (claim information is limited to FFS). Batch transactions are also available. There is no charge to providers to create an account or view transactions. For technical web-based issues, contact AHCCCS Customer Support at 602-417-4451, Monday – Friday 7:00 a.m. to 5:00 p.m.
- **AHCCCS contracted Medical Electronic Verification Service (MEVS):** The AHCCCS member card can be "swiped" by providers to automatically access the AHCCCS' Prepaid

Medical Management System (PMMIS) for up-to-date eligibility and enrollment. For information on MEVS, contact the MEVS vendor - Emdeon at 800-444-4336.

- **Interactive Voice Response (IVR) system IVR**: Allows unlimited verification information by entering the AHCCCS member's identification number on a touch-tone telephone. This allows providers access to AHCCCS' PMMIS system for up-to-date eligibility and enrollment. Maricopa County providers may also request a faxed copy of eligibility for their records. There is no charge for this service. Providers may call IVR within Maricopa County at 602-417-7200 and all other counties at 800-331-5090.
- **Medifax:** Medifax allows providers to use a PC or terminal to access the AHCCCS' PMMIS system for up-to-date eligibility and enrollment information. For information on EVS, contact Emdeon at 800-444-4336.
- If a member's Title XIX or Title XXI eligibility status still cannot be determined using one of the above methods, the provider must:
    - Call MC ACC-RBHA Member Services at 800-564-5465 for assistance during normal business hours (8:00 am through 5:00 pm, Monday-Friday); or
    - Call the AHCCCS Verification Unit. Callers from outside Maricopa County can call 800-331-5090 or call 602-417-7200 in Maricopa County. When calling the AHCCCS Verification Unit, the provider must be prepared to provide the verification unit operator the following information:
        - Provider's identification number;
        - The member's name, date of birth, AHCCCS identification number and social security number (if known); and
        - Dates of service(s)

Step #2-Interpreting Eligibility Information

A provider will access important pieces of information when using the eligibility verification methods described in Step #1 above. The **AHCCCS Reference Subsystem Codes and Values** include a key code index that may be used by providers to interpret AHCCCS eligibility key codes and/or AHCCCS rate codes. MC ACC-RBHA must ensure that providers have access to and are familiar with the codes as they may help indicate provider responsibility for the delivery of Title XIX/XXI covered services.

- If Title XIX or Title XXI eligibility status and behavioral health provider responsibility is confirmed, the behavioral health provider must provide any needed covered behavioral health services in accordance with the **AHCCCS Medical Policy Manual, Policy 310-B – Title XIX/XXI Behavioral Health Service Benefit**.
- There are some circumstances whereby a member may be Title XIX eligible, but the AHCCCS behavioral health system is not responsible for providing covered behavioral health services. This includes members enrolled as elderly or physically disabled (EPD) under the Arizona Long Term Care System (ALTCS) Program and members eligible for family planning services only through the Sixth Omnibus Reconciliation Act (SOBRA)

Extension Program. A member who is Title XIX eligible through ALTCS must be referred to his/her ALTCS care manager to arrange for provision of Title XIX behavioral health services. However, ALTCS-EPD individuals who are determined to have Serious Mental Illness (SMI) may also receive Non-Title XIX SMI services from MC ACC-RBHA.

- If the member is not currently Title XIX eligible, proceed to step #3 and conduct a screening for Title XIX or other eligibility.

Step #3-Screening for Title XIX or Other Eligibility

The behavioral health provider must screen all Non-Title XIX/XXI members using the **Health-e Arizona PLUS** online application:

- Upon initial request for behavioral health services;
- At least annually or during each Federal Health Insurance Marketplace open enrollment period thereafter, if still receiving behavioral health services; and
- When significant changes occur in the member's financial status.

A screening is not required at the time an emergency service is delivered but must be initiated within 5 days of the emergency service if the member seeks or is referred for ongoing behavioral health services.

To conduct a screening for Title XIX or other eligibility, MC ACC-RBHA or provider meets with the member and completes AHCCCS eligibility screening through the **Health-e Arizona PLUS** online application for all Non-Title XIX members. Documentation of AHCCCS eligibility screening must be included in a comprehensive clinical record upon completion after initial screening, annual screening, and screening conducted when a significant change occurs in a financial status (see **MC Provider Manual Chapter 100 – General Terms, Chapter 4 – Provider Responsibilities, Section 4.19 – Member's Medical Records**).

MC ACC-RBHA will assist providers with contact information to obtain HEAPlus assistor modules and training from AHCCCS.

Once completed, the screening tool will indicate that the member is potentially AHCCCS eligible.

Pending the outcome of the Title XIX or other eligibility determination, the member may be provided services in accordance with **MC Provider Manual Chapter 100 – General Terms, Chapter 4 – Provider Responsibilities, Section 4.33 - Copayments**.

Upon the final processing of an application, it is possible that a member may be determined ineligible for AHCCCS health insurance. If the member is determined ineligible for Title XIX or Title XXI benefits, the member may be provided behavioral health services in accordance with

MC Provider Manual, Chapter 100 – General Terms, MC Chapter 4 – Provider Responsibilities, Section 4.33 - Copayments.

If the screening tool indicates that the member does not appear Title XIX or any other AHCCCS eligibility, the member may be provided behavioral health services in accordance with **MC Provider Manual Chapter 100 – General Terms, Chapter 4 – Provider Responsibilities, Section 4.33 - Copayments**. However, the member may submit the application for review by DES and/or AHCCCS *regardless* of the initial screening result. Additional information requested and verified by DES/AHCCCS may result in the member receiving AHCCCS eligibility and services after all.

AHCCCS requires MC ACC-RBHA to document and report the number of applicant screenings completed by providers for Title XIX SMI and Federal Health Insurance Marketplace eligibility. The reporting must include the following elements:

- Number of applicants to be screened for AHCCCS eligibility
- Number of applicant screenings for AHCCCS eligibility completed
- Number of applicant screenings for AHCCCS eligibility to be completed
- Number of AHCCCS eligible applicants because of the screening
- Number of applicants to be screened for health coverage via the Federal Health Insurance Marketplace
- Number of applicant screenings for health coverage via the Federal Health Insurance Marketplace completed
- Number of applicant screenings for health coverage via the Federal Health Insurance Marketplace to be completed
- Number of applicants eligible for health coverage via the Federal Health Insurance Marketplace because of the screening

By the fifth day of each month, providers must submit via e-mail the data shown above in a Microsoft Excel spreadsheet to **providerdeliverables@aetna.com**. If the fifth of the month falls on a weekend, the data should be submitted on the previous Friday. Providers can consult with their assigned MC ACC-RBHA Network Relations specialist/consultant if technical assistance is needed.

Medicare Part D Prescription Drug Coverage and Low-Income Subsidy (LIS) Eligibility

Members must report if they are eligible or become eligible for Medicare, as it is considered third party insurance. See **Chapter 13 – Service Authorizations, Section 13.05 – Third Party Liability** (**TPL**) of this manual regarding how to coordinate benefits for members with other insurance including Medicare. If a behavioral health/integrated care member is unsure of Medicare eligibility, MC ACC-RBHA or providers may verify Medicare eligibility by calling 800-MEDICARE (800-633-4227), with a behavioral health/integrated care member's permission and

required member information. Once a member is determined Medicare eligible, MC ACC-RBHA or providers must offer and aid Part D enrollment and the LIS application upon a behavioral health/integrated care member's request.

Enrollment in Part D

All members eligible for Medicare must be encouraged and assisted in enrolling in a Medicare Part D plan to access Medicare Part D Prescription Drug coverage. Enrollment must be in a Prescription Drug Plan (PDP), which is fee-for-service Medicare plan or a Medicare Advantage Prescription Drug Plan (MA-PD), which is a managed care Medicare plan. Upon request, MC ACC-RBHA or provider must assist Medicare eligible members in selecting a Part D plan. CMS developed web tools to assist with choosing a Part D plan that best meets the member's needs. The web tools can be accessed at the **Medicare** website**.** For additional information regarding Medicare Part D Prescription Drug coverage, call Medicare at 800-633-4227 or the Arizona State Division of Aging and Adult Services at 602-542-4446 or toll free at 800-432-4040.

Applying for the Low-Income Subsidy (LIS)

The LIS is a program in which the federal government pays all or a portion of the cost sharing requirements of Medicare Part D on behalf of the member. If MC ACC-RBHA or provider determines that a member may be eligible for the LIS (see **Social Security Administration (SSA)** website by clicking on the link for income and resource limits), MC ACC-RBHA or provider must offer to assist the member in completing an application. Applications can be obtained and submitted through the following means:

- **On-line** – click on the link to access their website;
- By calling 800-772-1213;
- In member at an SSA local office; or
- By mailing a paper application to the SSA.

MC ACC-RBHA and their contracted providers must educate and encourage Non-Title SMI members to apply for health coverage from a qualified health plan using the application process located at the **Federal Health Insurance Marketplace** and help for those choosing to enroll during open enrollment periods and qualified life events. Members enrolled in a qualified health plan through the Federal Health Insurance Marketplace may continue to be eligible for Non-Title XIX covered services that are not covered under the Federal Health Insurance Marketplace plan.

Refusal to Participate with Screening and/or Application Process for Title XIX, Other AHCCCS Eligibility or Enrollment in a Part D Plan

On occasion, a member may decline to participate in the AHCCCS eligibility screening and application process or refuse to enroll in a Medicare Part D plan. In these cases, MC ACC-RBHA

or provider must actively encourage the member to participate in the process of screening and applying for AHCCCS health insurance coverage or enrolling in a Medicare Part D plan.

Arizona state law stipulates those members who refuse to participate in the AHCCCS screening and eligibility application process or to enroll in a Medicare Part D plan are ineligible for state funded services (see **A.R.S. §36-3408**). As such, individuals who refuse to participate in the AHCCCS screening and eligibility application or enrollment in Medicare Part D, if eligible, will not be enrolled with MC ACC-RBHA during their initial request for behavioral health/integrated care services or will be dis-enrolled if the member refuses to participate during an annual screening. The following conditions do not constitute a refusal to participate:

- A member's inability to obtain documentation required for eligibility determination;
- A member is incapable of participating because of their mental illness and does not have an HCDM; and
- A member who is enrolled in a qualified health plan through the Federal Health Insurance Marketplace and refuses to take part in the AHCCCS screening and application process will not be eligible for Non-Title XIX/XXI SMI funded services.

Special Considerations for Members Determined to have a Serious Mental Illness (SMI)

If a member is eligible for or requesting services as a member determined to have a SMI, is unwilling to complete the eligibility screening or application process for Title XIX or to enroll in a Part D plan and does not meet the conditions above, behavioral health provider must request a clinical consultation by a Behavioral Health Medical Professional (e.g., Single Point of Contact) by contacting the member's assigned care manager or therapist and ensuring that the member is fully informed of the option and potential consequences of failing to enroll in a Part D plan. Prior to the termination of behavioral health services for members determined to have a SMI who have been receiving behavioral health services and subsequently decline to participate in the screening/referral process, MC ACC-RBHA must provide written notification of the intended termination using **Notice of Decision and Right to Appeal.** (See **MC Provider Manual Chapter 100 - General Terms, Chapter 18 – Grievance System, Member Rights, and Claim Disputes, Section 18.03 – Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)**.

Members who Refuse to Cooperate with AHCCCS Eligibility and/or Application Process or do not Enroll in Part D Plan

MC ACC-RBHA or behavioral health provider must inform the member who they can contact in the behavioral health system for an appointment if the member chooses to participate in the eligibility and/or application process in the future. Maricopa County behavioral health members should contact MC ACC-RBHA for assistance at 800-564-5465.

2.02 – Additional Behavioral Health Appointment Availability Information

For your reference, the AHCCCS Contractors' Operation Manual outlines requirements regarding access to care. For children receiving behavioral health services, the member must be seen within seven (7) calendar day for an intake assessment and within 21 calendar days for ongoing appointment. The appointment standards for members in legal custody of the Department of Child Safety and adopted children are intended to monitor and report appointment accessibility and availability.

If an AHCCCS-eligible child in the custody of DCS or an adoptive child does not receive services within these 7 and/or 21 calendar day timeframes, DCS, the out-of-home placement (e.g., foster home, kinship or group home) or adoptive parent may contact the MC ACC-RBHA Child Welfare Single Point of Contact at DCS@MercyCareAZ.org and the AHCCCS Customer Service line at 602-364-4558. DCS, the out-of-home placement or adoptive parent may then contact any AHCCCS-registered providers directly, regardless of whether they are a part of the MC ACC-RBHA provider network.

Providers shall not solely offer open access appointments and must include offering specific appointment times for intakes and ongoing services.

Appointment Availability and Timeliness of Service

- Members must be offered an appointment within the required 7 business days.
- During business hours, phone calls are answered by referral and intake staff or routed to other staff if the referral and intake staff are unavailable.
- Members should not go to voice mail during business hours.
- If a mystery shopper calls and gets a voicemail at an agency, this will count against the agency.
- Refrain from directing members solely to MC's Member Services.

If an appointment cannot be offered within the required 7 business days:

- Warm transfer the member to MC ACC-RBHA Member Services (**800-564-5465**) so a timely appointment can be found with another service provider.
- Do not tell members to call back on a different day to schedule an appointment.
- Do not tell members to call back later because there are no appointments available.
- Members who are Title 19 and Title 21 must never be placed on a "waiting list" for any Title 19/21 covered behavioral health services.
- Providers who are unable to deliver medically necessary covered behavioral health services for Title 19 or Title 21 members must ensure timely and adequate coverage of these services with another service provider.

Appointment Availability Standards for Behavioral Health Providers for Non-Hospitalized Members

Immediate Appointment Availability

- **WHO:** All members requesting assistance unless determined not to be eligible. At the time of determination that an immediate response is needed, a member's eligibility and enrollment status may not be known. Behavioral health providers must respond to all members in immediate need of behavioral health services until the situation is clarified that the behavioral health provider is not financially responsible.
- **WHAT**: Services can be telephonic or face-to-face; the response may include any medically necessary covered behavioral health service.
- **WHEN:** Behavioral health services provided within a timeframe indicated by behavioral health condition, but no later than 2 hours from identification of need or as quickly as possible when a response within 2 hours is geographically impractical.

Urgent Appointment Availability - All Other Requests

- **WHO:** Referrals for hospitalized members not currently TRBHA enrolled, all Title XIX/XXI eligible members and all Non-Title XIX/XXI members determined to have a Serious Mental Illness.
- **WHAT:** Includes any medically necessary covered behavioral health service.
- **WHEN:** Behavioral health services provided within a timeframe indicated by behavioral health condition but no later than 24 hours from identification of need.

Routine Appointment Availability

- **WHO:** All Title XIX/XXI members, all Non-Title XIX/XXI members determined to have a Serious Mental Illness, and all members referred for determination as a member with a Serious Mental Illness.
- **WHAT:** Includes any allowable assessment service as identified in the **AHCCCS Medical Policy Manual, Policy 320-O– Behavioral Health Assessments, Service and Treatment Planning**.
- **WHEN:** Appointment for initial assessment with a BHP or *behavioral health technicians* (as defined in 9 A.A.C. 10) must meet the MC ACC-RBHA's credentialing requirements to provide assessment and evaluation services within 7 business days of referral or request for behavioral health services.
- **WHO:** All MC ACC-RBHA members.
- **WHAT:** Includes any medically necessary covered behavioral health service including medication management and/or additional services.
- **WHEN:** Routine care appointments:
    - Initial assessment within seven calendar days of referral or request for service,
    - The first behavioral health service following the initial assessment as expeditiously as the member's health condition requires but no later than 23

calendar days after the initial assessment or sooner if there are critical medication needs for the member, and
- All subsequent behavioral health services, as expeditiously as the member's health condition requires but no later than 45 calendar days from identification of need.

Note: Standards for members receiving services as part of Substance Use Block Grant (SUBG) funding are in **Section 2.12, Services with Special Circumstances – Non-Title XIX/XXI Behavioral Health Services Benefit**.

Urgent Referral for Child in DCS Custody

- **WHO:** Upon notification from DCS that a child has been or will imminently be taken into the custody of DCS, regardless of the child's Title XIX or Title XXI eligibility status.
- **WHAT:** Includes medically necessary covered behavioral health services.
- **WHEN:** Behavioral Health services must be provided within a timeframe indicated by behavioral health condition but no later than 72 hours after notification by DCS, the out-of-home placement or adoptive parent that a child has been or will be removed from their home. If the child has immediate needs, the assessment/crisis team will be dispatched within 2 hours of being notified.

For Behavioral Health and Initial Physical Health Appointments for Members in Legal Custody of the Department of Child Safety (DCS)

Integrated Rapid Response when a child enters out-of-home placement within timeframe indicated by the behavioral health condition, but no later than 72 hours after notification by DCS, the out-of-home placement (e.g., foster home, kinship, or group home) or adoptive parent that a child has been or will be removed from their home. The purpose for this urgent response is to:

- Identify immediate safety needs and presenting problems of the child, to stabilize behavioral health crises and to be able to offer immediate services the child may need.
- Complete a Physical Health Screening and coordinate the selection of a PCP with the out-of-home caregiver, including scheduling an initial wellness visit with the PCP within 30 days of the removal date, if possible.
- If during the Physical Health Screening, any acute concerns are indicated or noticed, the member/caregiver should be referred to the ER/Urgent Care for evaluation.
- During the Physical Health Screening, if the member's condition is not acute, but has healthcare needs that must be met prior to the initial PCP appointment, then contact the PCP/ordering provider to resolve the needs. If the PCP/Provider is not known or is unable to meet the need in the required time, support the caregiver to connect with the MC provider available to address the need prior to the initial PCP appointment.
- The Integrated Rapid Response Assessment, including the completed Physical Health

Screening form, will be sent by email to the DCS Specialist, DCS Program Supervisor and to MC Integrated Care Management.

- Provide behavioral health services to each child with the intention of reducing the stress and anxiety that the child may be experiencing and offering a coherent explanation to the child about what is happening and what can be expected to happen in the near-term.
- Provide outreach and engagement with the biological family if permission is provided by DCS HCDM.
- Provide needed behavioral health services to each child's new caregiver, including guidance about how to respond to the child's immediate needs in adjusting to foster care, behavioral health symptoms to watch for and report, assistance in responding to any behavioral health symptoms the child may exhibit, and identification of a contact within the behavioral health system.
- Initiate the development of the CFT for each child (see **Child and Family Team Practice Protocol**); and
- Provide the DCS Specialist with findings and recommendations for medically necessary covered behavioral health services for the initial Preliminary Protective Hearing, which occurs within 5 to 7 business days of the child's removal.
- Provide the DCS Specialist and the DCS out-of-home placement (e.g., foster home, kinship, or group home) with contact information for the Behavioral Health Home (BHH) assigned to provide an intake for the child within seven calendar days of the Rapid Response assessment.
- Initial assessment within seven calendar days after referral request Initial assessment within seven calendar days after referral or request for behavioral health services.
- Initial appointment within timeframes indicated, by clinical need, but no later than 21 calendar days after the initial assessment.
- Subsequent behavioral health services within the timeframes according to the needs of the member, but no longer than 21 calendar days from the identification of need.

The appointment standards for members in legal custody of the Department of Child Safety and adopted children are intended to monitor and report appointment accessibility and availability.

Additional information may be found by reviewing our **Collaborative Protocol with the Department of Child Safety** available in the **Availity** portal.

Referral for Psychotropic Medications

- **WHEN:** Assess the urgency of the need immediately. If clinically indicated, provide an appointment with a BHMP within a timeframe indicated by clinical need, but no later than 30 business days from the referral/initial request for services and no later than 21 business days from the referral/initial request for services for youth who are in the

custody of Department of Child Safety or adopted children.

- **WHAT:** Screening, consultation, assessment, medication management, medications, and/or lab testing services as appropriate.
- **WHO:** All Title XIX/XXI eligible members, all Non-Title XIX/XXI members enrolled with a TRBHA, all members determined to have a Serious Mental Illness and any member in an emergency or crisis.

Referral for Specialty and Other Identified Service Needs

- **WHEN:** Assess the urgency of the need immediately. If clinically indicated, submit referrals within a timeframe indicated by clinical need but no longer than 7 days for adult SMI members, also services should be implemented no later than 30 business days from the initial request for services and no later than 21 business days from the initial request for services for youth who are in the custody of Department of Child Safety or adopted children.
- **WHAT:** Specialty and other identified service needs include but are not limited to requests for counseling, day programs and temporary hotel assistance.
- **WHO:** All Title XIX/XXI eligible members, all Non-Title XIX/XXI members enrolled with a TRBHA, all members determined to have a Serious Mental Illness and any member in an emergency or crisis.

All Initial Assessments/Treatment Recommendations Indicate Need for Psychotropic Medication

- **WHEN:** The initial assessment and treatment recommendations must be reviewed by a BHMP within a timeframe based on clinical need.
- **WHAT:** Screening, consultation, assessment, medication management, medications, and/or lab testing services as appropriate.
- **WHO:** All Title XIX/XXI eligible members, all Non-Title XIX/XXI members enrolled with a TRBHA, all members determined to have a Serious Mental Illness and any member in an emergency or crisis.

Referrals for Hospitalized Members

Behavioral health providers must quickly respond to referrals pertaining to eligible members not yet enrolled in the TRBHA or Title XIX/XXI eligible members who have not been receiving behavioral health services prior to being hospitalized for psychiatric reasons and members previously determined to have a SMI. Upon receipt of such a referral, the following steps must be taken:

Referrals for Members with SMI

For referrals of Title XIX/XXI eligible members and members previously determined to have a SMI: Initial face-to-face contact, an assessment and disposition must occur within 24 hours of the referral/request for services.

For referrals of members referred for eligibility determination of Serious Mental Illness:

- Initial face-to-face contact and an assessment must occur within 7 business days of the referral/request for services. Determination of SMI eligibility must be made within timeframes;
- Upon the determination that the member is eligible for services and the member needs continued behavioral health services, the member must be enrolled, and the effective date of enrollment must be no later than the date of first contact; and
- MC will assign the member to a clinic within 24 hours, and the provider is required to initiate contact within 7 business days (or on the day of notification if the member is COE/COT) to schedule an initial appointment.

Wait Times

AHCCCS has established standards so that members presenting for scheduled appointments do not have to wait unreasonable amounts of time. Unless a behavioral health provider is unavailable due to an emergency, a member appearing for an established appointment must not wait for more than 45 minutes.

Behavioral health providers arranging for, or providing non-emergency transportation services for members must adhere to the following standards:

- A member must not arrive sooner than one hour before his/her scheduled appointment; and
- A member must not have to wait for more than one hour after the conclusion of his/her appointment for transportation home or to another pre-arranged destination.

Other Requirements

All referrals from a member's primary care provider (PCP) requesting a psychiatric evaluation and/or psychotropic medications must be accepted and acted upon in a timely manner according to the needs of the member, and the response time must help ensure that the member does not experience a lapse in necessary psychotropic medications, as described above.

Title XIX and Title XXI members must never be placed on a "wait list" for any Title XIX/XXI covered behavioral health service. If the MC ACC-RBHA network is unable to provide medically necessary covered behavioral health services for Title XIX or Title XXI members, it must ensure timely and adequate coverage of needed services through an alternative provider until a network provider is contracted. In this circumstance, MC ACC-RBHA must ensure coordination

with respect to authorization and payment issues. If a covered behavioral health service is temporarily unavailable to a Title XIX/XXI eligible member, the behavioral health provider must adhere to the following procedures:

- Select an appropriate MC ACC-RBHA contracted provider.
- Confirm that the MC ACC-RBHA contracted provider can deliver the needed covered service;
- Confirm the MC ACC-RBHA contracted provider can meet the timeliness of the needed service; and
- Coordinate the referral.
- If no MC ACC-RBHA contracted provider can meet the timeliness of the needed service, behavioral health members must be referred to a provider outside of MC ACC-RBHA's network:
    - Select an appropriate non-contracted provider (AHCCCS);
    - Confirm that the non-contracted provider can deliver the needed covered service;
    - Confirm the non-contracted provider can meet the timeliness of the needed service;
    - Call MC ACC-RBHA at 800-564-5465 to request a prior authorization; and
    - Coordinate the referral.

For Title XIX/XXI individuals in inpatient or behavioral health residential facilities who are discharge-ready but there are no discharge services available within the MC ACC-RBHA contracted provider network:

- Select an appropriate non-contracted provider (AHCCCS);
- Confirm that the non-contracted provider can deliver the needed covered service;
- Providers can access information related to outpatient treatment appointment and residential bed availability by calling MC ACC-RBHA at 800-564-5465;
- Confirm that non-contracted provider can meet the timeliness of the needed service;
- Call MC ACC-RBHA at 800-564-5465 to request a prior authorization; and
- Coordinate the referral.

If no non-contracted provider can deliver the needed service or meet the timeliness of the needed service, the individual may remain at the facility until necessary discharge services are arranged.

2.03 – Referral and Intake Process

Where to Send Referrals

Providers can be found on our website by using the "Find a Provider" search.

Referrals for Second Opinion

Title XIX/XXI health care members are entitled to a second opinion. Upon a Title XIX/XXI eligible healthcare member's request or at the request of the treating physician, MC ACC-RBHA must provide for a second opinion from a healthcare professional within the network or arrange for the healthcare member to obtain one outside the network when an in-network provider is not available, at no cost to the member.

Referrals to Providers

Providers (not including CSAs) may complete their own Assessment and Treatment plan to begin services. The provider must document attempts made to obtain the current assessment and service plan from the referring agency in the member record. The provider is required to coordinate care with the adult recovery team on an ongoing and regular basis.

Referrals Initiated by Department of Child Safety (DCS) Pending Removal of a Child

Upon notification from the Department of Child Safety (DCS) that a child has been, or is at risk of being taken into the custody of DCS, behavioral health providers are expected to respond in an urgent manner (for additional information see **MC Provider Manual Chapter 100 – General Terms, Chapter 4 – Provider Responsibilities, Section 4.02 - Appointment Availability Standards,** **Child and Family Team Practice Protocol** and **The Unique Behavioral Health Service Needs of Children, Youth, and Families involved with the DCS Practice Protocol**).

Accepting Referrals

Providers are required to accept referrals for behavioral health services 24 hours a day, 7 days a week. The following information will be collected from referral sources:

- Date and time of referral;
- Information about the referral source including name, telephone number, fax number, affiliated agency, and relationship to the member being referred;
- Name of member being referred, address, telephone number, gender, age, date of birth and, when applicable, name and telephone number of parent or HCDM;
- Whether or not the member, parent or HCDM is aware of the referral;
- Transportation and other special needs for assistance due to impaired mobility, visual/hearing impairments or developmental or cognitive impairment;
- Accommodations due to cultural uniqueness and/or the need for interpreter services;
- Information regarding payment source (i.e., AHCCCS, private insurance, Medicare, or self-pay) including the name of the AHCCCS health plan or insurance company;
- Name, telephone number and fax number of AHCCCS primary care provider (PCP) or another PCP as applicable;
- Reason for referral including identification of any potential risk factors such as recent hospitalization, evidence of suicidal or homicidal thoughts, pregnancy, and current supply of prescribed psychotropic medications;
- Medications prescribed by the member's PCP or other medical professional including

the reason the medication is being prescribed; and
- Names and telephone numbers of individuals the member, parent or HCDM may wish to invite to the initial appointment with the referred member.

Don't Delay - Act on a referral regardless of how much information you have. While the information listed above will facilitate evaluating the urgency and type of practitioner the member may need to see, timely triage and processing of referrals must not be delayed because of missing or incomplete information.

When psychotropic medications are a part of an enrolled member's treatment or have been identified as a need by the referral source, behavioral health providers must respond as outlined in **MC Provider Manual, Chapter 100 – General Terms, Chapter 4 – Provider Responsibilities, Section 4.02 Appointment Availability Standards**.

Referral sources may use any written format, or they may contact MC ACC-RBHA and providers orally by calling 800-564-5465.

In situations in which the member seeking services or his/her family member, HCDM, or significant other contacts MC ACC-RBHA or provider directly about accessing behavioral health services, MC ACC-RBHA or provider will ensure that the protocol used to obtain the necessary information about the member seeking services is engaging and welcoming.

When an SMI eligibility determination is being requested as part of the referral or by the member directly, MC ACC-RBHA and providers must conduct an eligibility determination for SMI in accordance with **MC Provider Manual Chapter 200 – MCCC, MC DD, DCS CHP, Chapter 4 – General Mental Health/Substance Use, Section 4.04 - Serious Mental Illness Determination.**

Responding to Referrals

Follow-Up

When a request for behavioral health services is initiated but the member does not appear for the initial appointment, the provider must attempt to contact the member and implement engagement activities consistent with **Chapter 2 – Network Provider Service Delivery Requirements, Section 2.04 - Outreach, Engagement, Reengagement, and Closure** of this manual.

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

Final Dispositions

Within 30 days of receiving the initial assessment, or if the member declines behavioral health services, within 30 days of the initial request for behavioral health services, MC ACC-RBHA or provider must notify the following applicable referral sources of the final disposition:

- AHCCCS health plans;
- AHCCCS PCPs;
- Department of Child Safety and adoption subsidy;
- Arizona Department of Corrections;
- Arizona Department of Juvenile Corrections;
- Administrative Offices of the Court;
- Arizona Department of Economic Security/Rehabilitation Services Administration; and
- Arizona Department of Education and affiliated school districts.

The final disposition must include:

- The date the member was seen for the initial assessment; and
- The name and contact information of the provider who will assume primary responsibility for the member's behavioral health care, or
- If no services will be provided, the reason. When required, authorization to release information will be obtained prior to communicating the final disposition to the referral sources referenced above.

Children's System of Care Referral Process

Routine Referrals

Expectations:

- MC ACC-RBHA Member Services Department will gather the following basic information from the HCDM:
    - Obtains caller/requestor information - name, relationship to the member receiving services, address, and phone number;
    - Obtains member demographic information; name, address, phone, date of birth; and
    - AHCCCS eligibility will be confirmed.
- The Member Service Representative will establish if the HCDM has a provider preference. If the HCDM does not have a provider preference, the youth will be referred to a Behavioral Health Home (BHH) based on geographic access, specialty services, and an algorithm.
- The Member Service Representative will advise parent/HCDM of Behavioral Health Homes in an area that meets the child's needs, and the HCDM will select the Behavioral Health Home.
- The Member Service Representative will warmly transfer the call to the identified Behavioral Health Home. Prior to the warm transfer of the HCDM, the Member Service Representative will advise the Behavioral Health Home of service type requested,

parent/HCDM name, member name, address, date of birth, and AHCCCS ID number. The Behavioral Health Home will gather any additional information from the caller and schedule an intake appointment within 7 days.

Direct Support and Specialty Provider Referrals

Expectations:

- The Child and Family Team determine if a service from a Direct Support Provider (DSP) or a Specialty Provider is recommended.
- The CFT typically helps to identify the MC ACC-RBHA contracted provider(s) who are able to provide the needed Direct Support or Specialty service.
- The CFT Facilitator and/or HNCM will complete the **Request for Direct Support or Specialty Provider Services** form, under **Forms** on the MC website, and will send the form with the following documents to the identified provider agencies:
    - CFT service plan/CFT Notes;
    - Strengths Needs and Cultural Discovery (ages 6-17);
    - Current assessment or most recent annual update;
    - Crisis/Support Plan;
    - Most recent CALOCUS;
    - Current Psychiatric Notes and Evaluation (if applicable); and
    - Intensive Support and Rehabilitation Services (formally MMWIA) Prioritization Form for Intensive Support and Rehabilitation Services referrals.
- Upon receipt of the referral form and the documents listed above, the Direct Support or Specialty Provider will review the information and determine if they are able to accept the referral.
- The Direct Support or Specialty Provider will communicate if they are able to accept or if they need to decline the referral to the CFT Facilitator and/or HNCM within 3 business days from the receipt of a routine referral:
    - If the referral is accepted the HCDM will be notified; and
    - The Direct Support or Specialty Provider will assess to determine next steps and for treatment needs.
- Every Monday, Direct Support and Specialty Providers will send "Referral Capacity Report" indicating the number of available referrals that can be accepted for the current week, this will also include Spanish- speaking capacity to the Children's System of Care Administrator, by e-mailing **DSP_SpecialtyProviders@MercyCareAZ.org**.

  For children in the custody of DCS, DSP and Specialty services are to be provided within 21 days of referral.

Emergent Referrals

Process:

- Hospital notifies MC ACC-RBHA Member Services at 800-564-5465 of a youth that is currently inpatient without an open episode of care with a Behavioral Health Home.
- If the youth will not be discharged within 24 hours, MC ACC-RBHA will refer to a High Needs Care Management (HNCM) provider utilizing an identified algorithm.
- The referral is documented and forwarded to the MC ACC-RBHA Children's Discharge Planning (CDP) team.
- The CDP team will forward the emergent referral to the assigned HNCM provider as well as to the referring hospital.
- The HNCM provider will perform the assessment within 24 hours of receipt of the referral.
- If the youth will be discharged in less than 24 hours, or is in a 23-hour observation unit, the Member Services Representative will provide the name of the HNCM provider closest to the member's address or a preferred provider and warm transfer to that provider.
- The HNCM provider must attempt to set up the appointment and see the member within 24 hours.

Eligibility Screening and Supporting Documentation

Members who are not already AHCCCS eligible must be asked to bring supporting documentation to the screening interview to assist the behavioral health provider in identifying if the member could be AHCCCS eligible (see **Chapter 2 – Network Provider Service Delivery Requirements, 2.01 Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage and Low Subsidy Program** of this manual). Explain to the member that the supporting documentation will only be used for assisting the member in applying for AHCCCS health care benefits. Let the member know that AHCCCS health care benefits may help pay for behavioral health services. Ask the member to bring the following supporting documentation to the screening interview:

- Verification of gross family income for the last month and current month (e.g., paycheck stubs, social security award letter, retirement pension letter)
- Social security numbers for all family members (social security cards if available)
- For those who have other health insurance, bring the corresponding health insurance card (e.g., Medicare card)

For all applicants, documentation to prove United States citizenship or immigration status and identity (see **Chapter 14 – Contract Compliance, Section 14.01 – Verification of U.S. Citizenship or Lawful Presence for Public Behavioral Health Benefits** of this manual)**.**

- For those who pay for dependent care (e.g., adult or child daycare), proof of the amount paid for the dependent care
- Verification of out-of-pocket medical expenses

Intake

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

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

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

- The collection of contact information, insurance information, the reason the member is seeking services and information on any accommodations the member may require to effectively participate in treatment services (i.e., need for oral interpretation or sign language services, consent forms in large font, etc.).
- The collection of required demographic information and completion of client demographic information sheet, including the behavioral health member's primary/preferred language;
- The completion of any applicable authorizations for the release of information to other parties;
- The dissemination of a Member Handbook to the member;
- The review and completion of a general consent to treatment;
- The collection of financial information, including the identification of third-party payers and information necessary to screen and apply for AHCCCS health insurance, when necessary;
- Advising Non-Title XIX/XXI members determined to have a Serious Mental Illness (SMI) that they may be assessed a co-payment.
- The review and dissemination of MC ACC-RBHA's Notice of Privacy Practices (NPP) and the AHCCCS HIPAA Notice of Privacy Practices (NPP)**;** and
- The review of the member's rights and responsibilities as a member of behavioral health services, including an explanation of the appeal process.

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

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

Integrated Care Specific Referral and Intake Guidelines

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

There are two types of referrals:

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

Referrals must meet the following conditions:

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

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

Referrals are a means of communication between two providers servicing the same member. Although MC ACC-RBHA encourages the use of its referral form, it is recognized that some providers use telephone calls and other types of communication to coordinate the member's

medical care. This is acceptable to MC ACC-RBHA if the communication between providers is documented and maintained in the member's medical records.

Referring Provider's Responsibilities

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

Receiving Provider's Responsibilities

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

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

Period of Referral

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

Maternity Referrals

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

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

Practitioner.

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

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

Ancillary Referrals

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

Member Self-Referrals

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

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

When a member self refers for any of the above services, providers rendering services must adhere to the same referral requirements as described above.

EPSDT Referral Requirements

EPSDT providers must follow the referral requirements outlined in the **AMPM 430 EPSDT Policy**. Additional details on EPSDT Referrals can also be found in the EPSDT section of the **MC Provider Manual Chapter 100 – General Terms, Chapter 5 – Early and Periodic Screening, Diagnostic and Treatment (EPSDT):**

- Referrals must be documented in the members' medical record as well as on any submitted EPSDT Forms.
- Providers shall document referrals made to resources within the community such as AzEIP, Early Head Start/Head Start, Home Visitation Programs, and Raising Special Kids.
- Members under 21 years old shall be referral to a dentist if the oral health screening shows the members has cavities or if the member has not been seen by a dentist.
- EPSDT providers shall refer any physical and behavioral screenings with positive results to the appropriate provider for follow-up, diagnosis, and treatment. Referrals must occur in a timely manner, and treatment is to be initiated within 60 days of the screening services and/or referral request.
- MC requires that providers, when appropriate, communicate the final disposition of each referral to the referral source within 30 days of the member receiving an initial assessment.
- Refer a member to care management when a physical or behavioral health need is identified.

2.04 – Outreach, Engagement, Reengagement and Closure

Outreach

The behavioral health system must provide outreach activities to inform the public of the benefits and availability of behavioral health services and how to access them. MC ACC-RBHA 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 MC ACC-RBHA may include, but are not limited to:

- Participation in local health fairs or health promotion activities
- Involvement with local schools
- Routine contact with AHCCCS Health Plan behavioral health coordinators and/or primary care providers
- Development of homeless outreach programs
- Development of outreach programs to members who are at risk, are identified as a group with high incidence or prevalence of behavioral health issues or are underserved
- Publication and distribution of informational materials
- Liaison activities with local and county jails, county detention facilities, and local and county DCS offices and programs
- Routine interaction with agencies that have contact with substance abusing pregnant

females
- Development and implementation of outreach programs that identify members with co-morbid medical and behavioral health disorders and those who have been determined to have a Serious Mental Illness (SMI) within MC ACC-RBHA's geographic service area, including members who reside in jails, homeless shelters, county detention facilities, or other settings
- Provision of information to mental health advocacy organizations
- Collaboration and coordination of outreach with tribal nations and tribal communities within the Central Arizona ACC-RBHA geographic service areas.

Engagement

MC ACC-RBHA or their subcontracted providers will actively engage the following in the treatment planning process:
- The member and/or member's HCDM
- 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 (HCDM, family member, advocate or other) designated to provide Special Assistance

Behavioral health providers must provide services in a culturally competent manner in accordance with MC ACC-RBHA'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 HCDM, 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 HCDM'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 HCDM, 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 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 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 petitionable behavior, such as persistently and acutely disabled (PAD), danger to self (DTS), danger to others (DTO), grave disability (GD). The ACC-RBHA Health Home should develop their own detailed policies outlining the consistency and methods of outreach and should include but not limited to:

- Communicating in the member's preferred language.
- Contacting the member or the member's HCDM 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, contacting the member or the member's HCDM 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 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.
- 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, 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.
    - Please see No Show Policy or below for additional detail.

If a provider has completed the required eight-week outreach process for Non-Title 19 members with SMI, and unable to connect with the member, Providers should close the members services after staffing with lead psychiatrist to ensure it is clinically appropriate to close the member, and additional outreach is not needed. Providers can email the **pcpalignmentsupdates@mercycareaz.org** address to request member closure after assessing for clinical appropriateness. Per AHCCCS Guidelines, if a member is closed, Providers are required to send the member a Notice of Decision (NOD) in a timely manner prior to closing services.

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. Contacting the member/HCDM/designated representative by telephone at times when the member may reasonably be expected to be available (e.g., after work or school);
c. 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);
d. When possible, contacting the member/HCDM/designated representative face-to-face if telephone contact is insufficient to locate the member or determine acuity and risk; and
e. 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/HCDM/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 the member, member's behavioral health clinical team or the member's

HCDM by telephone, at times when the member may reasonably be expected to be available (e.g., after work or school)

- Whenever possible, contacting the member, member's behavioral health clinical team or the member's HCDM 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 HCDM 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. If the provider is unable to reach telephonically, a face to face/home visit is completed within 72 hours, following missed appointment. 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/HCDM, 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 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 actual 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 actual hours.
- For children removed from their parent or HCDM 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 actual hours following discharge.
- Home visit must be completed within 5 days 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 actual hours. The expectation for non-ACT adult members being discharged from an emergency room/department is for the clinical team to contact the member within 24 business hours and see the BHMP and/or PCP within 5 actual days or sooner if clinically indicated. For ACT adult members being discharged from 23.9 observation/crisis or an emergency room/department, it is expected that the clinical team contact the member within 24 actual hours and see the BHMP within 72 actual hours.

Outreach to Service Members, Veterans, and their Families

MC Care 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 Care 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.

2.05 – Emergency Services

Prior authorization is not required for emergency services. In an emergency, members should got 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(e) to improve or resolve the member's condition.

MC ACC-RBHA covers behavioral health emergency services for MC ACC-RBHA 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 a 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 MC ACC-RBHA.

2.06 – Crisis Intervention Services

A crisis event is self-defined and determined by the individual experiencing the situation. An individual is in crisis if the individual finds they lack the skills or are unable to cope with a

situation or event that is impacting them. Crisis services are immediate and unscheduled behavioral health services provided to an individual to address an acute behavioral issue affecting the individual. Crisis services are required to be recovery-oriented, person-focused, with the goal of stabilizing the individual as quickly as possible to assist 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.

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

General Requirements

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

- Telephone Crisis Intervention Services:
  - Telephone crisis intervention and NurseLine services, including a toll-free number, available 24 hours per day, seven days a week: 844-534-4673; toll free 800-631-1314; or TTY/TTD toll free 800-327-9254.
- Mobile Crisis Intervention Services
  - Mobile crisis intervention services available 24 hours per day, seven days a week;
  - Mobile crisis teams will respond within an average of one (1) hour to a psychiatric crisis in Maricopa and Pima Counties and within an average of 90 minutes in all other counties.

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
844-MIND247

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

Psychiatric Emergencies for Children/Adolescents

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

Management of Crisis Services

MC Care ACC-RBHA is responsible for the oversight of crisis service delivery within the central region in Arizona. Crisis services are available across the state for all who may be experiencing a behavioral health crisis. MC ACC-RBHA coordinate with the managed care organizations who oversee crisis service delivery in northern and southern Arizona for follow up after crisis.

According to AHCCCS, crisis management modifiers are as follows:

Service	Population	Setting	Codes	Modifiers	Responsible Party
Crisis services within the first 24 hours	Medicaid, KidsCare, and State Only	All providers/settings permitted to bill these codes except observation and stabilization units	H2011, S9484, S9485	ED, GT, H9, U8	ACC-RBHA
Crisis services within first 24 hours	Medicaid, KidsCare, and State Only	Observation and stabilization units	S9484, S9485, H0031, H0038, 90791, T1002, T1016	32, ET, GT, H9, U8	ACC-RBHA
Crisis phones	Medicaid, KidsCare, and State Only	Telephonic	H0030	ET	ACC-RBHA
Assessments	Medicaid, KidsCare	ED/Medical Floor	H0031, 90791, 90792	GQ, H9, U8, U9, V1	Plan of Enrollment

For Maricopa County residents not enrolled with a MC ACC-RBHA health home, the applicant may contact MC ACC-RBHA Customer Service Line at 800-564-5465. Other ways to connect to care include:

- Calling the statewide crisis phone line at 844-534-4673 who may also be able to dispatch a mobile team
- Calling La Frontera-EMPACT PAD Team at 480-784-1414 ext. 1158
- Applicants may also go in-person to one of these crisis facilities: UPC, RRC, CPEC, or WVAP

2.07 – Behavioral Analysis Services

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

- Increase functional skills;
- Increase adaptive skills (including social skills);
- Teach new behaviors; 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 Claims page 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).

2.08 – Assessment and Service Planning

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

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

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

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

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

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

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

The 9 Guiding Principles for Adults are as follows:
1. Respect
2. People choose their services
3. Focus on the whole person and natural supports
4. Independence

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

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.

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

Providers must collect and submit all required demographic information in accordance with the criteria outlined in the **AHCCCS DUGless User Guide (DUG)** and **Chapter 15.00 -Enrollment, Disenrollment and Other Data Submission** of this manual.

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 assessment and meets requirements in **MC Chapter 100 – General Terms, Chapter 4 – Provider Responsibilities, Section 4.40 – Credentialing and Recredentialing**. 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.

RBHA Health homes should assess a member's level of care management annually at minimum, but as often as clinically indicated, to ensure the member is connected to the correct level of care management based upon their needs. Additionally, RBHA health homes should assess case management level of care, upon any significant events in the members life such as hospitalization, loss of job, and emergency room visit to ensure they are connected to the appropriate level of care.

Minimum Elements of the Behavioral Health Assessment

MC ACC-RBHA has established the following minimum elements that must be included in a comprehensive behavioral health assessment and documented in the comprehensive clinical record, in accordance with **MC Provider Manual Chapter 100 – General Terms, Chapter 4 – Provider Responsibilities – Section 4.19 – Member's Medical Records**.

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, including but not limited to Adverse Childhood Experiences (ACEs) scores, 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, and
    - 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).
- ONLY REQUIRED FOR CHILDREN AGED 0 TO 5: Developmental screening for children aged 0-5 with a referral for further evaluation by the child's Primary Care Provider (PCP), the Arizona Early Intervention Program (AzEIP) for children aged 0-3, or the public-school system for children aged 3-5 when developmental concerns are identified.
- ONLY REQUIRED FOR CHILDREN AGED 6 TO 18: Child and Adolescent Level of Care Utilization System (CALOCUS) Score and Date.
- ONLY REQUIRED FOR CHILDREN 6 TO 18: 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).
- ONLY REQUIRED FOR MEMBERS DETERMINED SMI: Special Assistance assessment.

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, in accordance with **MC Provider Manual Chapter 100 – General Terms, Chapter 4 – Provider Responsibilities, Section 4.02 – Appointment Availability Standards**. If the assessor is unsure regarding a member's need for psychotropic medications, then the assessor must review the initial assessment and treatment recommendations with his/her clinical supervisor or a licensed medical practitioner with prescribing privileges.

Members with substance use disorders, primarily opioid addiction, may be appropriately referred to Medication Assisted Treatment (MAT). MAT services are a combination of medications and counseling/behavioral therapies to provide a "whole patient" approach to the treatment of substance use disorders. MC ACC-RBHA 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 abused drug. MC ACC-RBHA 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 (see **MC Provider Manual Chapter 100 – General Terms, Chapter 14 – Billing Encounters and Claims, Section 14.08 – MC as Secondary Insurer**).

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 (HBS) 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 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).

Food Insecurities

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

As health care professionals, we need to assess member need and the HRSN that may be impacting the member's level of engagement, health, and treatment plan. The United States Department of Agriculture (USDA) makes a clear and explicit distinction between food insecurity and hunger. "Food insecurity – the condition assessed in the food security survey and represented in USDA food security reports – is a household-level economic and social condition of limited or uncertain access to adequate food. Hunger is an individual-level physiological condition that may result from food insecurity." (Source: **https://www.ers.usda.gov/data-products/food-security-in-the-united-states/.**

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

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

Some examples would include:

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

- Difficulty with budget planning, etc.

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

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

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

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

Service Planning

All individuals being served in the public behavioral health system must have a written plan for services upon an initial request for services and periodic updates to the plan to meet the changing behavioral health needs for individuals who continue to receive behavioral health services. MC ACC-RBHA does not mandate a specific service planning tool or format. Service plans must be utilized to document services and supports that will be provided to the individual, based on behavioral health service needs identified through the member's behavioral health assessment.

If a member is in immediate or urgent need of behavioral health services, an interim service plan may need to be developed to document services until a complete service plan is developed. A complete service plan, however, must be completed no later than 7 days after the initial appointment.

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

The service plan must be documented in the comprehensive clinical record in accordance with **MC Provider Manual Chapter 100 – General Terms, Chapter 4 – Provider Responsibilities, Section 4.19 – Member's Medical Records**, be based on the current assessment, and contain the following elements:

- The member/family vision that reflects the needs and goals of the member/family;
- Identification of the member's/family's strengths;
- Measurable objectives and timeframes to address the identified needs of the member/family;
- Identification of the specific services to be provided and the frequency with which the
- services will be provided;
- The signature of the member/HCDM and the date it was signed;
- Documentation of whether the member/HCDM agrees with the plan;
- The signature of a clinical team member and the date it was signed;
- The signature of the member providing Special Assistance, for members determined to have Serious Mental Illness who are receiving Special Assistance (See Section 2.16 – Special Assistance for Members Determined to have a Serious Mental Illness (SMI) of this manual); and
- The Service Plan Rights Acknowledgement Template dated and signed by the member or HCDM, the member who filled out the service plan and a BHP if a BHT fills out the service plan.

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

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

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

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

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

Minimum Elements of the Service Plan for Non-Title XIX/XXI Members Determined to have SMI that do not have an Assigned Care Manager

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

Additionally, Non-Title XIX/XXI members determined to have SMI, who do not have an assigned Care Manager shall have the option of accessing peer support services to assist them in developing a peer-driven, self-developed proposed service plan to be shared with their BHP for approval, adoption, and implementation. These peer-driven, self-developed service plans are not required to contain all minimum elements as outlined above for those that have assigned Care Managers; however, they should consider the member-specific needs for and expected benefits from community-based support services including, but not limited to supported employment, peer support, family support, permanent supportive housing, living skills training, health promotion, personal assistance, and respite care. Peer-driven, self-developed proposed service plans should also address natural supports that can be leveraged and strengthened as well as outline crisis prevention approaches (e.g., warm line availability) and how the emergence of a potential crisis will be addressed.

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

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

Appeals or Service Plan Disagreements

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

Provider Submits a Complex Case Request

In the event a provider determines a need for an action, they may complete a **Complex Case Review Form** available under **Forms** on the MC website and submit it to MC ACC-RBHA Medical Management at **ComplexCase@MercyCareAZ.org** for review. For additional guidance see Provider Manual, **MC Provider Manual Chapter 100 - General Terms – Chapter 18 – Grievance System, Member Rights, and Claim Disputes**, Title XIX/XXI Notice and Appeal Requirements, subsection Complex Case Requests. Medical Management staff will evaluate the request to determine if it requires a notice. If a notice is required, MC ACC-RBHA 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 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)** by the behavioral health representative on the team.

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

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, health home's targeted thresholds for ISP and Assessments are identified as 85% per health home/stand-alone ACT team (not per agency).

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 patient's 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.

2.09 – Clinical Guidelines

MC RBHA has outlined our clinical guidelines which can be found under Clinical Guidelines on the MC website. Behavioral health clinical guidelines can also be found on the AHCCCS website under Clinical Guidance Tools. MC ensures members are assigned and have access to a clinical team as described in A.A.C. R9-21-101. There are minimum expectations for RBHA Health Homes to include the following individuals:

Supportive/Connective Level of Care

- 1 Psychiatrist (BHMP)
- 1 Registered Nurse
- 1 Rehabilitation Specialist
- 1 Peer Support Specialist (per health home)
- 1 Clinical Coordinator (Team Leader)
- Case Managers (amount based on established clinical targets and maximum ceiling)

- 1 Clinical Director licensed as a Behavioral Health Professional in the State of Arizona

RBHA Health Home executive leadership, regional, vice president, or CEO level staff are required to review the RBHA at a Glance contact grid on a monthly basis and attest that all information regarding individuals listed on the contact grid are correct, including job titles and contact information. Providers are required to notify their network representative and systems of care team of any changes to key staff on the RBHA at a Glance contact grid as soon as possible, but no later than 3 business days from the change.

MC requires that providers ensure a supervisor-to-provider case manager ratio be established that is conducive to providing consistent, quality supervision by a qualified supervisor. The ratio of Clinical Coordinators (Team Leader) to Case Managers is not to exceed 1 Clinical Coordinator (Team Leader) overseeing 12 Case Managers. The qualified Clinical Coordinators (Team Leader) shall be able to effectively support case managers, regardless of their job title, including establishing a process for routine review and monitoring supervisor staff assignments or the need for reassignments in order to adhere to MC's designated 1:12 supervisor-to-case manager ratio. If applicable, MC shall ensure that provider case manager supervisors have adequate time to train and review the work of newly hired provider case managers as well as provide support and guidance to established provider case managers.

RBHA Health Homes are required to provide case managers with dedicated time each workday to complete documentation responsibilities and maintain compliance with documentation standards.

Clinical Oversight and Supervision

In addition to already stated licensure requirements of 2 hours of clinical oversight of Behavioral Health Technician (BHT)/Behavioral Health Paraprofessional (BHPP) staff per month, a supplementary 2 hours of direct one-on-one clinical oversight must take place monthly with their direct supervisor for any clinical staff that has direct contact with members.

Behavioral Health Paraprofessionals (BHPPs) that provide services in the public behavioral health system, shall receive supervision by a Behavioral Health Professional (BHP). Behavioral Health Technicians (BHTs) that provide services in the public behavioral health system shall receive clinical oversight by a BHP.

In addition to possessing the requisite licenses and other qualifications, BHPs providing clinical oversight of BHTs shall have demonstrated competence in delivering the same or similar services to members of comparable acuity and intensity of service needs as the BHTs they supervise. BHPs providing clinical oversight of BHTs shall also demonstrate the following key competencies:

- Demonstrated knowledge of the relevant best clinical practices and policies that guide the services being provided,
- Demonstrated knowledge of the policies and principles governing ethical practice,
- Demonstrated ability to develop individualized BHT competency development goals and action steps to accomplish these goals, and
- Demonstrated ability to advise, coach, and directly model behavior to improve interpersonal and service delivery skills.

Personal Medicine

Dr. Pat Deegan founded Personal Medicine, she teaches us that Personal Medicine are the things we do to get well and stay well. Personal Medicine supports recovery-oriented practice, is evidence-based, and has been shown to increase activation which leads to more robust health outcomes. The practice of Personal Medicine meets SAMHSA's criteria for recovery-based practice and the core competencies of peer support.

Each clinical team is required to have a certified personal coach (CPMC), and the Rehabilitation specialist is designated to be the CPMC. Rehabilitation Specialists are required to be certified in Personal Medicine and need to complete annual recertification. Any exceptions need written approval by MC Care. Rehabilitation Specialists need to become a Certified Personal Medicine Coach (CPMC) within 120 days after starting their new role. See Provider Requirements for Specific Programs and Services on Availity for additional information on the role of the Rehabilitation Specialist. Each provider should have one Personal Medicine Coach Champion who can train others unless otherwise designated by MC. Personal Medicine is a required domain goal on each member's Individual Service Plans however if a member declines to have a personal medicine goal that can simply be stated in the personal medicine domain as the practice encourages member empowerment, choice, and personal wisdom.

Providers are required to coordinate and get approvals of the CPMC trainings of their staff with MC's Adult System of Care which can be reached at the following for this initiative PersonalMedicine@MercyCareAZ.org. If there is a lack of appropriate coordination or if the rehabilitation specialist fails to pass their certification successfully, the providers may be held responsible for the cost of the training not approved by MC or for the certification cost.

2.10 – Serious Mental Illness Removal

SMI Removal

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

1. **Integrated/Behavioral Health Home Removal**
    - A member who has an SMI designation or a member working with an individual from the member's clinical team may request an Integrated/Behavioral Health

Home Removal. An Integrated/Behavioral Health Home Removal is a determination that a member who has a SMI designation no longer meets SMI criteria. If, as a result of a review, the member is determined to no longer meet the diagnostic and/or functional requirements for SMI status:

- The Determining Entity shall ensure that written notice of the determination and the right to appeal is provided to the affected member with an effective date of 30 days after the date the written notice is issued.
- MC ACC-RBHA must ensure that services are continued in the event an appeal is filed timely, and that services are appropriately transitioned as part of the discharge planning process.

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

ACC-RBHA Health Home Transfer Protocol

- Once CRN determines the SMI decertification, CRN sends an email to the ACC-RBHA Health Home indicating the specific member status of decertification.
- As soon as ACC-RBHA receives notification that a member has completed and been approved for SMI decertification, the ACC-RBHA Health Home will immediately begin working with the member to determine where the member wants to transfer their services.

- The ACC-RBHA Health Home must complete appropriate coordination between a GMH/SU provider(s) or BHMP/PCP of the member's choice to eliminate any gaps in care for the member.
- The transferring of services from the ACC-RBHA Health Home to the GMH/SU provider(s) or alternative BHMP/ PCP must be completed in less than thirty (30) days from the time the ACC-RBHA 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 ACC-RBHA Health Home but is T19, the ACC-RBHA Health Home that the member was paneled to under the Navigator level of care is responsible for completing the transfer of the member.
- If a member does not want to transfer to a GMH/SU provider or BHMP/PCP or refuses to sign a release of information for a receiving provider, the ACC-RBHA Health Home will complete appropriate outreach and engagement which requires two outreach attempts.
- The ACC-RBHA Health Home will offer the member the opportunity to obtain their 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 ACC-RBHA Health Home must retain the original or copies of the member's medical records for at least six (6) years after the last date the member receives medical or health care services from the provider.

MC ACC-RBHA Transfer Protocol

MC ACC-RBHA 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, MC ACC-RBHA, as the relinquishing Contractor, will complete and transmit the Enrollment Transition Information (ETI) form to the appropriate parties no later than 10 business days from receipt of AHCCCS notification. MC ACC-RBHA'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

All members enrolled in the MC ACC-RBHA and Non-Title XIX SMI eligibility plans are paneled to an ACC-RBHA Health Home. MC ACC-RBHA panels newly enrolled members to an ACC-RBHA Health Home based on member preference. If member preference is unavailable, the member is paneled to a health home based on geographic proximity. Paneling to an ACC-RBHA Health Home is aligned to member eligibility. Members are not paneled to an ACC-RBHA Health Home during gaps in enrollment or while eligible in a plan other than Integrated or Non-Title XIX SMI.

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

- Opt-Out Request – A member determined SMI, who is currently enrolled in an ACC-RBHA, may opt out of receiving physical health services from the ACC-RBHA and be transferred to an Acute Care Contractor for his/her physical health services if one or more of the applicable opt out criteria are satisfied. Members who meet the opt-out criteria will continue to receive behavioral health services through MC ACC-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 ACC-RBHA Health Home, members receiving services through Assertive Community Treatment (ACT) teams must be paneled to an ACT Team. MC ACC-RBHA does not panel newly enrolled members to ACT teams.

RBHA 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 ACC-RBHA provider information systems.

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

2.11 – General and Informed Consent

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 HCDM's signature on a general consent form, before receiving behavioral health services.

For members under the age of 18, the parent, HCDM, or a lawfully authorized custodial agency must give general consent to treatment, demonstrated by the parent, HCDM, 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 HCDM, or in the case of members under the age of 18, the parent, HCDM, 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 HCDM, or in the case of members under the age of 18, the parent, HCDM 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 following forms:

- Consent to Treatment Form
- Informed Consent for Psychotropic Medication Treatment (English/Spanish) (available under **AHCCCS Medical Policy Manual, 310-V – Prescription Medications – Pharmacy Services, Attachment A – Informed Consent for Psychotropic Medical Treatment)**

General Consent

Administrative functions associated with a behavioral health member's enrollment do not require consent, but before any services are provided, general consent must be obtained. General consent is usually obtained during the intake process and represents a member, or if under the age of 18, the member's parent, HCDM, or lawfully authorized custodial agency representative's written agreement to participate in and to receive non-specified (general) behavioral health services.

Informed Consent Required Information

In all cases where informed consent is required by this chapter, informed consent must include at a minimum:

- Behavioral health 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 client's parent, HCDM, 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 to 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 HCDM 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 client refused to sign an acknowledgment and that the client gives informed consent to use psychotropic medication or telemedicine.

Providing Informed Consent

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, HCDM, or an appropriate court; and
- Presented by a credentialed behavioral health 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 that are not possible or practicable, information may be provided by another credentialed behavioral health 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 HCDM, 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/ Services with Known Substantial Risks or Side Effects

Written informed consent must be obtained from the member, parent, or HCDM, 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 the Application for Voluntary Evaluation, available under **Forms** on the MC website, 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.
- Coordination of care with the outpatient Behavioral Health Medical Provider is required.
- Member has been prescreened by anesthesiologist.
- Relative contraindications include:
    - Space occupying lesions of the brain
    - High intracranial pressure
    - Unstable or severe cardiovascular disease
    - Recent myocardial infarction
    - Recent cerebral infarction
    - Retinal detachment
    - High anesthesia risk
    - Significant medical risk
    - Unstable musculoskeletal injuries (particularly spinal)
- Medical clearance required checklist:
    - Complete medical/ surgical history
    - Physical examination completed in last thirty (30) days
    - Required Basic laboratory work:
        - CBC with differential
        - Chemistry panel
        - TSH, drug blood levels
        - UA
        - UDS
        - UPT urine pregnancy test
        - Iron studies (as applicable)
    - EKG (within 30 days and reviewed by your medical consultant)
    - If female, please provide negative UPT (last 7 days) or if pregnant provide documentation of consult and evaluation by OB/GYN
    - Medical consultant review and clearance opinion on the nature of unstable or

serious medical conditions
- As indicated (e.g., osteoporosis, osteopenia, history of skull spinal trauma) X-Rays of the Spine- Lateral X-rays of the dorso-lumbar spine to rule out any spine fracture, before giving ECT — Skull X-Rays - Anteroposterior and lateral view of skull to screen intracerebral pathology before ECT.

BHMP Note: You are required to have the member assigned to a behavioral health provider in the network prior to discharge. If the member is not currently assigned to a BHMP, please call Member Services 1-800-564-5465 for assistance in locating a provider.

If this is a request for ongoing ECT, coordination of care is required with the outpatient community mental health provider.

Health Information Exchange
Consent for participation in the H.I.E. is received at the clinics, typically during intake. Members have the option to opt in or out of the Health Information Exchange at any time by contacting their clinic and updating their consent documentation.

Additional Provisions
Written informed consent must be obtained from the member, HCDM, 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.

Revocation of Informed Consent
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.

Special Requirements for Children
In accordance with **A.R.S. §36-2272**, except as otherwise provided by law or a court order, no member, 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 the written or oral 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 does not apply when an emergency exists that requires a member to perform mental health screening or provide mental health treatment to prevent serious injury or to 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 HCDM (e.g., grandparent) and does not have power of attorney, general and informed consent must be obtained from one of the following:

- Lawfully authorized HCDM;
- Foster home, group home, kinship, or another member/agency with whom the Department of Child Safety (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
HCDM	Copy of court order assigning custody
Relatives	Copy of power of attorney document
Another member/agency	Copy of court order assigning custody
DCS out-of-home placements (for children removed from the home by DCS), such as: Foster home, group home, kinship, other member/agency in whose care DCS has placed the child	Copy of Notice to Provider – Educational and Medical (DCS Form FC-069)

For any child who has been removed from the home by DCS, the foster home, group home kinship caregiver or other member or agency in whose care the child is currently placed can consent to evaluation and treatment for routine behavioral health services.

Examples of behavioral health services in which DCS out-of-home placements 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

DCS must consent to inpatient psychiatric acute care services, behavioral health residential treatment services (Behavioral Health Inpatient Facility – BHIF), therapeutic group homes (Behavioral Health Residential Facility – BHRF), and Therapeutic Foster Care (TFC).

Any minor who has entered a lawful contract of marriage, whether that marriage has been dissolved subsequently 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 emergency situations 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.

Informed Consent During Involuntary 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 an individual may be willing and able to give informed consent for aspects of treatment even when not able to give general consent. Individuals should be assessed for capacity to give informed consent for specific treatment and such consent obtained if the individual is willing and able, even though the individual 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 HCDM for any behavioral health survey, analysis or evaluation conducted about a school-based prevention program administered by AHCCCS.

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 MC ACC-RBHA. The written 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 HCDM; 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 HCDM.

Completion of the **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.

2.12 – SMI Patient Navigator

The SMI Patient Navigator is a position within the ACC-RBHA Health Homes service structure to ensure that all members designated as SMI or Title XIX have an ACC-RBHA Health Home. NTXIX members are not eligible for the SMI Patient Navigator level of care. The SMI Patient Navigator staff shall screen members for service needs and based on the needs identified, conduct an assessment and treatment plan outlining necessary support services and outreach and engagement from the ACC-RBHA Health Home.

Navigator position details and contact requirements

- BHT level staff member who demonstrates competency in assessments, engagement, and outreach;
- The SMI Patient Navigator shall complete an annual screening and the MC ACC-RBHA Health Risk Assessment (HRA);
- The SMI Patient Navigator shall provide engagement and assistance to the members in navigating and connecting to behavioral health services;
- Members assigned to a SMI Patient Navigator shall receive outreach within 90 days upon assignment and at minimum annually thereafter; and
- Caseload will be 1-250;

All members assigned or receiving SMI Patient Navigator Services shall be screened with a provider identified screening tool and the HRA at a minimum annually. Upon completion of the screening and agreement to participate in active services, the consent to treat, assessment and treatment plan will be completed. When determining if a member needs care management services or continued SMI Patient Navigator services, the clinical team should consider the following upon completion of the screening:

- Should the screening tool or member themselves indicate a need to continue Navigator services, the member will be engaged to complete a basic treatment plan that reflects this level of service along with completion of consents and assessment;
- Should the member's needs warrant care management, the assessment and treatment plan should indicate service level need and a transition to care management should occur within regularly outlined access to care requirements; and
- There may be circumstances in which the member indicates needs that warrant crisis service utilization, which will proceed as standard crisis protocol.
- Members that received Special Assistance or are Court Ordered for Treatment (COT) should not be moved to a Navigator level of care.

Example of process:

1. Screen the member using the screening tool:
    a. If the member is interested in care management, complete consents, assessment, and plan:
        i. Determine if higher level of care warranted:
            1. Supportive;
            2. Connective; or
            3. Continued Navigator
    b. If member is unable to be contacted:
        i. Continue to reach out 3 times;
        ii. Send a certified letter;
        iii. Attempt one face to face contact - use of BHPPs could be applicable; and
        iv. Connect with the PCP.

Members previously designated as SMI but may no longer require care management may be assigned to a SMI Patient Navigator to ensure continued behavioral health service connection. Movement from care management to an SMI Patient Navigator shall be determined through an assessment with the BHMP when assessing level of care. Should the member need care management, the SMI Direct Care clinic will transition the member to the appropriate level of care management to meet the member's needs. Additionally, if a member is receiving psychiatrist services, specifically medications, the member needs to be on a connective level of care, at minimum, and cannot be on a navigator level of care.

Closure of an SMI member's episode of care will occur for the following reasons. All others will remain at the Navigator level of Care Management:

- Member is NTXIX, not engaging in services, and treatment has completed appropriate 8-week outreach/reengagement (please see **Chapter 2, Section 2.04 – Outreach, Engagement, Reengagement and Closure** of this manual).

- Member is NTXIX, requests and is determined clinically eligible to close and team has assessed if the member meets decertification criteria.
- Incarceration in prison (after 3 months' stay).
- Member moved out of state and move was completed with coordinated efforts from treatment team.
- Member moved out of Central GSA ACC-RBHA, and inter-ACC-RBHA transfer/move was completed with coordinated efforts from the treatment team.
- Member has requested decertification (last resort and should be thoroughly discussed with member by treatment team).
- Member moved to ALTCS.
- Member's Death.

In the above scenarios, the member will remain on a clinic's roster until the eligibility updates are provided via AHCCCS to MC ACC-RBHA. Once the eligibility updates are received, the clinic's roster will be updated accordingly.

2.13 – 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 a member may be, because of a mental disorder:

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

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

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 of 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 review of the application, for court ordered evaluation examination of the person and review of other pertinent information, a licensed screening agency's medical director or designee will determine if the person meets criteria for 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 during the evaluation, to be DTS, DTO, PAD, or GD as the result of a mental disorder. Court-Ordered Treatment (COT) may include a combination of inpatient and outpatient treatment. Outpatient treatment will not exceed one year. Inpatient treatment days can be consecutive or non-consecutive 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 written letter of intent to treat and 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/DT/PAD/GD and agrees in writing to receive a 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, or programs, because of being charged with a crime and appears to be an “alcoholic”.

Licensing Requirements

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

Pre-Petition Screening

PINAL COUNTY

Pinal County contracts with Horizon Health and Wellness and CPR to complete Pre-Petition Screening within Pinal County. These services can be accessed by calling the Solari Statewide Crisis Line at 844-534-4673.

GILA COUNTY

Gila County contracts with Community Bridges Inc. as the designated screening agency; however other behavioral health agencies may be granted permission upon request to the Gila County Attorney's Office. Community Bridges, Inc. can be contacted at 1-877-931-9142 or through the Solari Statewide Crisis Line 844-534-4673.

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 MC ACC-RBHA for these pre-petition screening and court ordered evaluation functions. MC ACC-RBHA 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 this is the member's assigned SMI Health Home or if not connected to an SMI Health Home, the EMPACT PAD Team which can be reach at: **padreferrals@lafrontera-empact.org**.

Filing of Non-Emergent Petitions

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

Non-emergent Process

For behavioral health members receiving MC ACC-RBHA Clinic Services, the following steps will be completed by the Clinical Team.

- For all other residents of Maricopa County (not enrolled with a MC ACC-RBHA), the 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 other, 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 MC Care ACC-RBHA Health Home, an applicant contacts the Solari Crisis Line 800-631-1314 and requests assistance with an applicable for court ordered evaluation. An applicant can also go in person to UPC, RRC, CPEC, or CBI West Valley Access Point 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. All other steps, when applicable, will be the same as for MC ACC-RBHA Clinic enrolled behavioral health members.
- For MC ACC-RBHA Clinic 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, UPC, RRC, or CPEC will be contacted for assistance in evaluation and possible application for an emergency admission.

- For all MC ACC-RBHA Clinic 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 behavioral health member should be completed. If attempts at contacting the behavioral health member are unsuccessful and screening is not possible, screening staff will review this information with a physician. 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 behavioral health 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, 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. The psychiatrist need never have met the person to decide regarding whether to move forward with a Petition for COE. The psychiatrist will:
    - Review the application, pre-petition screening report, and any other collateral information made available as part of the pre-petition screening to determine if it indicates that there is reasonable cause to believe the allegations of the applicant for the COE.
    - Prepare a Petition for COE and file the petition if the psychiatrist determines that the member, due to a mental disorder, which may include a primary diagnosis of dementia and other cognitive disorders, is DTS, DTO, PAD or GD. The Petition for Court Ordered Evaluation documents pertinent information for COE;
    - If the psychiatrist determines that there is reasonable cause to believe that the member, without immediate hospitalization, is likely to harm him/her or others, the psychiatrist must coordinate with the UPC, RRC-W or CPEC and ensure completion of the Application for Emergency Admission for Evaluation and take all reasonable steps to procure hospitalization on an emergency basis.
- Pre-petition screens, application, and petition for Inpatient or Outpatient Court Ordered

Evaluation can be filed on a non-emergent basis at the Desert Vista Campus Legal Office, 570 West Brown Road, Mesa, AZ 85201, and 480-344-2000. This involves all Persistently or Acutely Disabled (PAD) and Gravely Disabled (GD) petitions. Danger to Self (DTS) and Danger to Others (DTO) petitions that do not require immediate intervention can also be filed on a non-emergent basis. Please use the following forms for filing the non-emergent petition: Petition for Court Ordered Evaluation and Application for Involuntary Evaluation.

- Eight copies and the original Petition for Court-Ordered Evaluation, Application for Involuntary Evaluation, Pre-Petition Screening Report, and the Police Mental Health Detention Information Sheet, must be submitted by the behavioral health member's Care Manager or the pre-petition team to the Legal Department at Desert Vista Campus for review by the County Attorney, preparation of the Detention Order, and filing with the Superior Court. These documents must be filed within 24 hours of completion, excluding weekends and holidays.
- Once the petition is filed with the court, the Legal Department at MIHS Desert Vista Campus Delivers the Detention Order to the Police Department to have the behavioral health member brought to the UPC, RRC or CPEC for evaluation. NOTE: The Petition for Court Ordered Evaluation and Police Mental Health Detention Information Sheet) expire 14 days from the date the judge signs off on the order for COE.
- One of the eight copies of petition documents shall be stored by the behavioral health member's 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 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 for emergency admission. If the member meets criteria for an Application for Emergency Admission for Evaluation as DTS/DTO/PAD/GD, and. 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.

MC 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 admission for 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.

The involuntary crisis facilities that are evaluating agencies and accept applications for emergency admission in Maricopa County are: **Connections Health Solutions Urgent Psychiatric Care (UPC)** 1207 S. 7th Ave Unit 150 Phoenix, AZ 85007 (602) 416-7600; **Community Bridges Inc. (CBI) CPEC,** 358 E. Javelina Ste 102 Mesa, AZ 85210 480-507-3180, **CBI West Valley** 824 N. 99th Ave Ste 109 Avondale, AZ 85323 1-877-931-9142, and **Recovery Innovations International (RI),** 11361 N. 99th Ave Ste 402, Peoria, AZ 85345, 602-636-4605.

Gila County

Contact the Solari Statewide Crisis line to be connected to an evaluating agency that accepts applications for emergency admission.

Pinal County

Pinal county contracts with Community Bridges Inc (CBI) as evaluating agencies. An applicant can present at CBI Community Psychiatric Emergency Center (CPEC), 358 E. Javelina, Mesa, AZ 85210, 480-507-3180 or CBI Casa Grande 675 E. Cottonwood Ln, Casa Grande AZ 85122 520-426-0088 to complete an Application for Emergency Admission.

Emergent process

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

- The applicant must have knowledge of the behavior and evidence of mental disorder as specified in A.R.S. § 36-524.
- The applicant may be called to testify in court if the application results in a petition for COE.
- Upon receipt of the Application for Emergency Admission for Emergency Evaluation (MH-104) the crisis facility/evaluating agency 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 crisis facility/evaluating agency, then the crisis facility/evaluating agency staff will immediately coordinate with local law enforcement for the detention of the member and transportation to the crisis facility/evaluating agency.
- If the Application for Emergency Admission for Evaluation is accepted by the crisis facility/evaluating agency admitting officer and the member requires a level of medical support not available at the crisis facility/evaluating agency, then within 24 hours the

crisis facility/evaluating agency admitting officer will coordinate admission to the Valleywise Maricopa Behavioral Psychiatric Annex. If admission to the MIHS Psychiatric Annex cannot be completed within 24 hours of the Application for Emergency Admission for Evaluation being accepted by the UPC, RRC or CPEC admitting officer, then the MC ACC-RBHA Medical Director must be notified.

- An Application for Emergency Admission for Evaluation may be discussed by telephone with a crisis facility/evaluating admitting officer, the referring physician, and a police officer to facilitate transport of the member to be evaluated at a 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 admitting officer to the police.
- A 23-Hour Emergency Admission for Evaluation begins at the time the behavioral health member is detained involuntarily by the Admitting Officer at 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 immediate hospitalization (even if not currently DTS/DTO behaviors at that moment),to suffer harm or cause harm to others as specified in A.R.S. § 36-524.
- During the emergency admission period of up to 23 hours the following will occur:
    - The behavioral health member's ability to consent to voluntary treatment will be assessed.
    - The behavioral health member shall be offered and receive treatment to which he/she may consent. Otherwise, other than calming talk or listening, the only treatment administered involuntarily will be for the safety of the individual or others, i.e., seclusion/restraint or pharmacological restraint in accordance with A.R.S. § 36-513.
    - Crisis facility/evaluating agency may contact the County Attorney prior to filing a petition if it alleges that a member is DTO.
    - If the behavioral health member is determined to require a court ordered evaluation, then the petition for COE will be filed with the court within 24 hours of admission (not including weekends or court holidays). If the behavioral health member does not meet the criteria for an application for emergency admission but is determined to meet criteria for PAD and/or GD, crisis facility/evaluating agency will notify and offer to assist the applicant of the non-emergent process.

Court-Ordered Evaluation

If the pre-petition screening indicates that the member may be DTS, DTO, PAD, or GD, or the crisis facility/evaluating agency determines during an emergency admission that the member

may be DTS, DTO, PAD, or GD the pre-petition screening agency or in case of emergency admission crisis facility/evaluating agency will file an application for a court-ordered evaluation. The procedures for court-ordered evaluations are outlined below:

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

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

MC ACC-RBHA encourages the utilization of outpatient evaluation on a voluntary or involuntary basis. MC ACC-RBHA 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, and witness list to the Legal Department at Valley Wise Roosevelt 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. A copy of the petition documents shall be stored by the member's Care 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 ACC RBHA Health Home, the MC ACC-RBHA 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 Care 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 Valley Wise Legal Department within 1 business day of the evaluation. The MC ACC-RBHA Court Liaison will then file a Petition for Court Ordered Treatment with the Maricopa County Superior Court within 2 business days.

Voluntary Evaluation

Any MC ACC-RBHA 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 Care 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 Valley Wise 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 Care 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 MC ACC-RBHA 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 MC ACC-RBHA for court-ordered evaluations MC ACC-RBHA 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 (see Petition for Court-Ordered Treatment);
- Any behavioral health provider filing a petition for court-ordered treatment must do so in consultation with the member's clinical team prior to filing the petition;
- The petition must be accompanied by the affidavits of the two physicians who conducted the examinations during the evaluation period and by the affidavit of the

applicant for the evaluation (see Affidavit and attached addenda);
- A copy of the petition, in cases of grave disability, must be mailed to the public fiduciary in the county of the patient's residence, or the county in which the patient was found before evaluation, and to any person nominated as HCDM or conservator; and
- A copy of all petitions must be mailed to the superintendent of the Arizona State Hospital.

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

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

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

Members need to be involved in treatment planning and member/HCDM need to sign the inpatient service plan. If a member is on COE, there needs to be evidence of an attempt and documentation if member refused.

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

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

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

Additionally, the statue requires the Outpatient Agency to:

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

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

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

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

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

Judicial Review and COT Renewal Timelines/Forms

Judicial Review

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

- Member signs request for Judicial Review which is then signed by a member of the clinical team and notarized. The member does not need to make this request in person. Request for Judicial Review can be made on the phone and staff person receiving the phone call will complete the Request for Judicial Review form on behalf of the member and note that the request was made by phone on the form and in a progress note in the medical record.
- The Psychiatric Report for Judicial Review must be completed by a psychiatrist signed and notarized and filed with the court within 72 hours (not including weekends or court holidays) of the request for judicial review (please also note that the date of the MD signature MUST match the date of the notarization, or it will be rejected).

- The original Request for Judicial Review and Psychiatric Report for Judicial Review must be filed with the court within 72 hours of the Request for Judicial Review.
- If the court orders a full hearing for the Judicial Review the medical director of the treating agency shall provide the member's attorney with a copy of the member's medical records at least 24hr prior to the hearing.

Application for COT Renewal

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

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

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

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

When a member referred for court-ordered treatment is Title XIX/XXI eligible and/or

determined or suspected to have a Serious Mental Illness, MC ACC-RBHA will:

- Conduct an evaluation to determine if the member has a Serious Mental Illness, and conduct a behavioral health assessment to identify the member's service needs in conjunction with the member's clinical team; and
- Provide necessary court-ordered treatment and other covered behavioral health services in accordance with the member
- Member's needs, as determined by the member's clinical team, the behavioral health member, family members, and other involved parties and
- Perform, either directly or by contract, all treatment required by A.R.S. Title 36, Chapter 5, Article 5 and 9 A.A.C. 21, Article 5.

Transfer from one behavioral health provider to another

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

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

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

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

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

Domestic Violence Offender Treatment

Domestic violence offender treatment may be ordered by a court when an individual is convicted of a misdemeanor domestic violence offense. Although the order may indicate that the domestic violence (DV) offender treatment is the financial responsibility of the offender under **A.R.S. §13-3601.01**, MC ACC-RBHA will cover DV services with Title XIX/XXI funds when the member is Title XIX/XXI eligible, the service is medically necessary, required prior authorization is obtained if necessary, and/or the service is provided by an in-network provider. For Non-TXIX/XXI eligible member's court ordered for DV treatment, the individual can be billed for the DV services.

Court-Ordered Substance Abuse Evaluation and Treatment

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

Court-Ordered Treatment for American Indian Tribal Members in Arizona

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

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

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

Since many tribes do not have treatment facilities on reservation to provide the treatment ordered by the tribal court, tribes may need to secure treatment off reservation for tribal

members. To secure court ordered treatment off reservation, the court order must be "recognized" or transferred to the jurisdiction of the state.

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

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

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

This process must run concurrently with the tribal staff's initiation of the tribal court ordered process to communicate and ensure clinical coordination with the MC ACC-RBHA. This clinical communication and coordination with the MC ACC-RBHA is necessary to assure continuity of care and to avoid delays in admission to an appropriate facility for treatment upon state/county court recognition of the tribal court order. The Arizona State Hospital should be the last placement alternative considered and used in this process **A.R.S. §36-540(B)** states, "The Court shall consider all available and appropriate alternatives for the treatment and care of the patient. The Court shall order the least restrictive treatment alternative available." MC ACC-RBHA will partner with American Indian tribes and tribal courts in their geographic service areas to collaborate in finding appropriate treatment settings for American Indians in need of behavioral health services.

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

Benefits Available to American Indian/Alaskan Native ACC-RBHA Members

American Indian/Alaskan Native members with an SMI designation who are enrolled with the MC Care ACC-RBHA have access to the added benefits of wearable health technology (FitBit) and traditional healing. If an American Indian/Alaskan Native ACC-RBHA enrolled member would like to have a FitBit, a FitBit Request form is available to each Integrated Health Home and may be submitted to SMIMemberServicesRequest@mercycareaz.org. For American Indian/Alaskan Native ACC-RBHA enrolled members who want to receive traditional healing that is unique to their tribal culture, a $300 annual benefit is available to cover the cost needed to receive it. A Traditional Healing Services Request form is available to each Integrated Health Home and may submitted to TribalRelations@mercycareaz.org.

2.14 – 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 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 in providing supportive housing services to enrolled individuals:

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

Other MC Housing Requirements

- MC ensures its subcontracted providers are assisting members with securing or maintaining permanent housing placement when a part of the member's service planning.
- MC coordinates with the AHP Administrator for prioritization of housing referrals, service coordination, and required reporting. See **AHCCCS AMPM 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 as the subject matter expert on housing and housing resources.

Federal Programs and Assistance

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

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

HUD published the HEARTH Continuum of Care (CoC) Program interim rule on July 31, 2012, and it became effective August 31, 2012. Changes made include codifying the Continuum of

Care process, expanding the definition of homelessness, and focusing selection criteria more on performance. The purpose of the CoC Homeless Assistance Program is to reduce the incidence of homelessness in CoC communities, by assisting homeless individuals and families in quickly transitioning to self-sufficiency and permanent housing, as authorized under Title IV of the McKinney–Vento Homeless Assistance Act.

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

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

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

Federal HUD Housing Choice Voucher Program

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

2.15 - Services with Special Circumstances - Non-Title XIX/XXI Behavioral Health Services Benefit

Substance Use Block Grant (SUBG)

MC Care receives funding for behavioral health services through the Federal Substance Use Block Grant (SUBG). SUBG funds are used to provide substance use services for Non-Title XIX/XXI eligible members and select state-only services for Title XIX/XXI individuals meeting grant eligibility criteria. As a condition of receiving this funding, certain populations are identified as priorities for the timely receipt of designated behavioral health services. Currently, not all network contracted providers receive SUBG Block Grant funding. Current contracted SUBG providers can be found here or by calling MC Member Services at **602-586-1841**, toll free

at **1-800-564-5465** or TTY/TDD: **711** to get connected to care. Representatives are available 24 hours a day, 7 days a week.

Substance Use Block Grant (SUBG) Priority Populations

The following populations are prioritized and covered under the Substance Use Block Grant (SUBG) funding:

- **First:** Pregnant women/teenagers who use drugs by injection;
- **Then:** Pregnant women/teenagers with an SUD
- **Then:** Other persons who use drugs by injection
- **Then:** Women and teenagers with a SUD, with dependent children and their families, including women who are attempting to regain custody of their children, and
- **Finally:** All other individuals with a SUD, regardless of gender or route of use, (as funding is available).

Eligibility

All members receiving SUBG-funded services are required to have a Title XIX/XXI eligibility screening completed and documented in the medical record at the time of intake and annually thereafter.

SUBG is specifically allocated to provide services that are not otherwise covered by Title-XIX/XXI funding. This includes SUD treatment and supportive services for Members who do not qualify for Title XIX/XXI eligibility. Members shall indicate active substance use within the previous 12-months to be eligible for SUBG services. This includes individuals who were incarcerated and reported using while incarcerated. The 12-month standard may be waived for individuals:

- On medically necessary methadone maintenance upon assessment for continued necessity, and/or
- Incarcerated for longer than 12 months that indicate substance use in the 12 months prior to incarceration.

Members shall not be charged a copayment for SUD treatment or supportive services funded by the SUBG. Sliding scale fees established regarding room and board do not constitute a copayment.

Providers must complete an eligibility determination screening for all members who are not identified as being currently enrolled with AHCCCS using the subscriber version of the HealtheArizona PLUS. An eligibility screening will be conducted:

- Upon initial request for behavioral health services;
- At least annually thereafter, if still receiving behavioral health services; and
- When significant changes occur in the member's financial status.

There are two eligibility SUBG benefits in which a member may qualify for:

- **Non-titled Enrollment**
  - Appropriate when a member has no current insurance coverage.
  - Enrollment remains open until insurance information changes

- **Crisis/State Only Segmentation**
  - Appropriate when a member is active with a Non-MC AHCCCS Complete Care (ACC) Plan
  - State-only segments remain open for 30 days,
  - Crisis segments remain open for 72 hours.

For more information regarding this, please review our **Non-Title Enrollment Reference Guide**.

Response Times

Designated Behavioral Health Services under the SUBG (based on available funding):

- **WHEN:** Intakes must be provided within 48 hours from the referral/initial request for services.
- **WHAT:** Any needed covered behavioral health service, including admission to a residential program if clinically indicated. If the treatment identified is temporarily unavailable, an attempt shall be made to place the member within another provider agency facility, including those in other geographic service areas. If capacity still does not exist, the member shall be placed on the AHCCCS SUBG Priority Population wait list in the Quality Management (QM) Portal and interim
services must be provided until the individual is admitted. Interim services are described in the section “Interim Services for Pregnant Women/Injection Drug Users.”
- **WHO:** Pregnant women/teenagers referred for substance use treatment (includes pregnant injection drug users and pregnant substance users) and substance-using females with dependent children, including those attempting to regain custody of them children.
- **WHEN:** Behavioral health services provided within a timeframe indicated by clinical need but no later than 14 days following the initial request for services/referral. All subsequent behavioral health services must be provided within timeframes according to the needs of the member.
- **WHAT:** Includes any needed covered behavioral health services. Admit to a clinically appropriate substance use treatment program (can be residential or outpatient based on the member’s clinical needs); if unavailable, interim services must be offered to the member. Interim services are described in the section “Interim Services for Pregnant Women/Injection Drug Users.”
- **WHO:** Other Priority Populations

SUBG Reporting Requirements

Providers shall immediately submit Priority Population Members (pregnant women, women with dependent children, and people who inject drugs) to the AHCCCS SUBG Priority Population Waitlist in the AHCCCS Quality Management (QM) Portal when treatment cannot be initiated within the required timeframes.

- Title XIX/XXI members may not be added to the waitlist.
- Priority Population Members shall be added to the waitlist when treatment services, regardless of level of care, cannot be provided within the timeframes established in AHCCCS Medical Policy Manual (AMPM) 320-T1:
    - Pregnant women: within 48 hours of the request for services;
    - Women with dependent children: within 5 calendar days of the request for services; and
    - People who inject drugs: within 14 calendar days of the request for services.
- Non-Title XIX/XXI members may be added to the waitlist when no treatment capacity is available.

Before placing a member on the waitlist, providers shall attempt placement with another provider agency, including providers in other geographic service areas, when appropriate. If treatment remains unavailable, the provider shall immediately add the member to the AHCCCS SUBG Priority Population Waitlist and provide and document required interim services until the member is admitted to treatment.

Interim Services for Pregnant Women and People Who Inject Drugs (Non-Title XIX/XXI Only)

The purpose of interim services is to reduce the adverse health effects of substance use, promote individual health, and reduce the risk of disease transmission.

Provision of interim services must be documented in the member's clinical record and reported through the AHCCCS SUBG Priority Population Waitlist. At a minimum, interim services shall include education and/or referrals addressing:

- Prevention of HIV, hepatitis C, and other sexually transmitted infections;
- Behaviors associated with increased risk of disease transmission;
- Effects of substance use on fetal development;
- Risk assessment and screening;
- HIV, hepatitis C, and tuberculosis testing and treatment services; and
- Primary and prenatal medical care.

In accordance with 45 CFR 96.126, any program receiving funding under the grant and that treats individuals for intravenous substance use, upon reaching 90% of its capacity to admit individuals to the program, notify the ACC-RBHA and AHCCCS within seven days via the AHCCCS Quality Management (QM) Portal.

Mercy Care will monitor provider utilization of the AHCCCS SUBG Priority Population Waitlist, including timely waitlist submission and documentation of required interim services, and will provide technical assistance as needed.

Choice of Substance Use Providers

Members receiving substance use treatment services under the SUBG have the right to receive services from a provider to whose religious character they do not object. Behavioral health subcontractors providing substance use services under the SUBG must notify members of this right using the **AHCCCS AMPM Policy 320-T1 - Block Grants and Discretionary Grants**, Attachment A. Providers must document that the member has received notice in the member's comprehensive clinical record.

If a member objects to the religious character of a behavioral health provider, the provider must refer the member to an alternative provider within seven (7) days, or earlier when clinically indicated, after the date of the objection. Providers shall utilize available resources, including the Mercy Care SUBG Provider Resource website, to identify and provide alternative referral options. Providers shall complete and maintain Attachment A documentation in the member's clinical record and maintain a log of all Charitable Choice referrals.
Upon making a referral, providers must notify Mercy Care by submitting an email to **Grants@MercyCareAZ.org** with the subject line **"Charitable Choice Referral."** The notification shall include, at a minimum:

- The name of the requesting provider agency;
- The date the member requested an alternative provider;
- The alternative provider agency to which the member was referred; and
- Confirmation that Attachment A was completed and provided to the member.

Providers must ensure that the member is connected with the alternative provider and maintain documentation of the referral. Referral logs and supporting documentation shall be made available to Mercy Care and AHCCCS upon request.

Available Services

The following services must be made available to SUBG special populations, as clinically identified and appropriate.

Behavioral health providers must provide specialized, gender-specific treatment and recovery support services for females who are pregnant or have dependent children and their families in outpatient/residential treatment settings. Services are also provided to mothers who are attempting to regain custody of their children. Services must treat the family as a unit. As needed, providers must admit both mothers and their dependent children into treatment. The following services are provided or arranged as needed:

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

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

- Childcare
- Care management
- Transportation

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

To encounter these funds, *providers must utilize a **U7 modifier*** in conjunction with allowable services identified for priority populations within AMPM Exhibit 300-2b.

Providers who receive and expend SUBG pregnant and parenting women dollars shall employ staff that are trained and experienced in evidence-based and culturally appropriate practices for children and families and implement such practices in the provision of SUBG treatment and recovery services to pregnant and parenting women/teenagers.

If the provider does not have the ability/capacity to employ staff with the training and experienced outlined in the requirements above, then the provider shall establish a service agreement with at least one partner agency/organization that employs such staff to ensure appropriate comprehensive services are provided to pregnant and parenting women/teenagers and their dependent children.

MC maintains training offerings (in the Relias Learning Management System) that support compliance with required standards related to child and adolescent development, trauma-informed care, and behavioral health best practices. Current learning resources address foundational topics such as early childhood development, adverse childhood experiences, children's mental health, secure attachment, parenting and family dynamics, trauma-informed approaches, and culturally response care for diverse youth populations.

These trainings are designed to support staff knowledge and skill development across the continuum of care and align with expectations for serving children, adolescents, and transition-age youth. Course content is periodically reviewed and updated to ensure continued relevance and alignment with regulatory and clinical practice requirements.

Restrictions Use of Substance Use Block Grant (SUBG)

SUBG Funds may not be expended on the following activities:

- Inpatient hospital services;
- Physical health care services including payment of copays, unless otherwise specified for Priority Populations;
- Cash payments to intended recipients of health services;
- Purchase or improvement of land, purchase, construct, or permanently improve any building or facility except for minor remodeling with written approval from AHCCCS;
- Purchase of major medical equipment;
- To satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds;
- Provision of financial assistance (grants) to any entity other than a public or non-profit private entity
- Provision of hypodermic needles or syringes for illegal drug use, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug use and the risk that the public will become infected with the etiologic agent for Acquired Immune Deficiency Syndrome (AIDS);
- Payment of salary of an individual through a grant or other extramural mechanism at a rate more than Level I of the Executive Salary Schedule for the award year, see https://grants.nih.gov/grants/policy/salcap_summary.htm;
- Purchase of treatment services in penal or correctional institutions in the State of Arizona;
- Flex funds purchases; or
- Sponsorship for events and conferences.

SUBG Outreach Requirements

SUBG providers shall carry out outreach activities to encourage individuals in need of treatment to undergo such treatment. Providers shall use outreach models that are scientifically sound, or if no models are available which are applicable to the local situation, use an approach which reasonably can be expected to be an effective outreach method.

Additional information & Resources

- Mercy Care Crisis/State-only Membership Services Online
- AHCCCS Frequently Asked Questions for SUBG & MHBG
- AMPM 320-T1
- AMPM Exhibit 300-2B
- AMPM 650
- Non-Title Enrollment Reference Guide

Mental Health Block Grant (MHBG)

The MHBG is allocated from SAMHSA to provide mental health services to Title XIX/XXI and Non-Title XIX/XXI adults with a Serious Mental Illness (SMI) determination, Title XIX/XXI, and Non-Title XIX/XXI children with a Serious Emotional Disturbance (SED) identification, and Title XIX/XXI and Non-Title XIX/XXI individuals in need of First Episode Psychosis (FEP) services.

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

MHBG funds are only to be used for allowable services identified in AMPM Exhibit 300-2B for:

- Non-Title XIX/XXI eligible Members determined SMI, SED or individuals experiencing FEP.
- Non-Title XIX/XXI services for Title XIX/XXI Members meeting the same criteria.

To encounter these funds, *providers must utilize a **UB modifier*** in conjunction with allowable services identified for priority populations within **AMPM Exhibit 300-2B**.

Members shall not be charged a copayment for mental health treatment or supportive services funded by the MHBG. Sliding scale fees established regarding room and board do not constitute a copayment.

Eligibility Requirements

All Members receiving MHBG-funded services are required to have a Title XIX/XXI eligibility screening completed and documented in the medical record at the time of intake and annually thereafter.

- The MHBG is specifically allocated to provide services that are not otherwise covered by Title-XIX/XXI funding. This includes mental health treatment and supportive services for Members who do not qualify for Title XIX/XXI eligibility; and

Effective October 1, 2023, to be eligible for an SED determination an individual must have a qualifying diagnosis and functional impairment caused by the qualifying diagnosis. (For qualifying Diagnosis see AMPM 320-P). The process will include the following steps:

1. An evaluation with a qualified clinician occurs no later than seven business days after a request is made, unless there is a current (less than six months old) evaluation that supports the qualifying diagnosis and functional impairment.
2. The qualified clinician sends the required paperwork (assessment) to the Solari Crisis & Human Services.

3. Solari Crisis & Human Services completes the determination within three, 20, or 60 days, depending on each individual case.
4. Solari Crisis & Human Services will send notice, in writing, to the individual with the results of the eligibility determination and information on how to receive services (when applicable). Solari Crisis & Human Services will also notify Arizona Health Care Cost Containment System (AHCCCS) and/or the individual's commercial/private health insurer, the Tribal Regional Health Authority (TRBHA), Tribal Arizona Long Term Care System (ALTCS) Case Manager, ACC-RBHA, and the member's provider.

To meet the SED functional impairment criteria, an individual shall have, as a result of a qualifying SED diagnosis, dysfunction in at least one of the four domains listed below for most of the past six months, or for most of the past three months with an expected continued duration of at least three months.

1. 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 is at risk of confinement because of dangerous behavior. Persistently neglectful or abusive towards others. 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 individual's education or personal relationships.
2. Dysfunction in role performance. Frequently disruptive or in trouble at home or at school. Frequently suspended/expelled from school. Major disruption of role functioning. Requires structured or supervised school setting. Performance significantly below expectation for cognitive/developmental level. Unable to attend school or meet other developmentally appropriate responsibilities.
3. Child and Adolescent Level of Care Utilization System (CALOCUS) recommended level of care 4, 5, or 6.
4. Risk of deterioration. A qualifying diagnosis with probable chronic, relapsing, and remitting course, comorbidities (e.g., developmental/intellectual disability, substance use disorder, personality disorders), persistent or chronic factors such as social isolation, poverty, extreme chronic stressors (e.g., life-threatening or debilitating medical illnesses, victimization), or other (e.g., past psychiatric history, gains in functioning have not solidified or are a result of current compliance only, court-committed, care is complicated and requires multiple providers).

If a child is in need of an SED determination, the parent/HCDM may call their primary care provider (PCP), their established behavioral health provider, their health plan (AHCCCS or commercial/private insurer), or their school to request an SED eligibility determination. If the child is uninsured/underinsured resident of Gila, Maricopa, or Pinal counties, the HCDM can contact MC ACC-RBHA Member Services at 602-586-1841, toll free at 800-564-5465 or

TTY/TDD: 711 to get connected to care. Representatives are available 24 hours a day, 7 days a week.

MHBG funds cannot be utilized for the following:

- Inpatient services;
- Physical health care services including payment of copays;
- General Prevention efforts;
- To make cash payments to intended recipients of health services;
- Purchase or improvement of land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
- To satisfy any requirement for the expenditure of non-Federal funds as a condition or the receipt of Federal funds;
- Provision of financial assistance to any entity other than a public or nonprofit private entity;
- Provision of hypodermic needles or syringes so for illegal drug use, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug use and the risk that the public will become infected with the etiologic agent for AIDS;
- Payment of salary of an individual through a grant or other extramural mechanism at a rate more than Level I of the Executive Salary Schedule for the award year (see National Institutes of Health (NIH) Grants & Funding Salary Cap Summary);
- Purchase of treatment services in penal or correctional institutions of the State of Arizona;
- Flex fund purchases;
- Sponsorship for events and conferences; or
- Childcare Services.

2.16 – Special Assistance for Members Determined to have a Serious Mental Illness (SMI)

MC ACC-RBHA and subcontracted providers must identify and report to the AHCCCS Office of Human Rights (OHR) members determined to have a Serious Mental Illness (SMI) who meets the criteria for Special Assistance. If the member's Special Assistance needs appear to be met by an involved family member, friend, designated representative, or HCDM, MC ACC-RBHA or behavioral health provider must still submit a notification to the OHR. MC ACC-RBHA, subcontracted providers, and AHCCCS Office of Grievance and Appeals (OGA) must ensure that the member designated to provide Special Assistance is involved at key stages.

General Requirements

Criteria for Identifying Need for Special Assistance

A member who has been determined to have a SMI needs Special Assistance if he or she is unable to do any of the following:

- Communicate preferences for services;
- Participate effectively in individual service planning (ISP) or inpatient treatment;
- Discharge planning (ITDP); or
- Participate effectively in the appeal, grievance, or investigation processes;

AND the member's limitations are due to any of the following:

- Cognitive ability/intellectual capacity (such as cognitive impairment, borderline intellectual functioning, or diminished intellectual capacity);
- Language barrier (an inability to communicate, other than the need for an interpreter/translator); or
- Medical condition (including, but not limited to traumatic brain injury, dementia, or severe psychiatric symptoms).

A member who is subject to a general HCDM has been found to be incapacitated under **A.R.S. §14-5304** and therefore automatically satisfies the criteria for Special Assistance. Similarly, if MC ACC-RBHA or its subcontracted provider recommends a member with a SMI for a general HCDM or an HCDM is in the legal process (in accordance with **R9-21-206** and **A.R.S. §14-5305**), the member automatically satisfies the criteria for Special Assistance.

The existence of any of the following circumstances for an individual should prompt MC ACC-RBHA and its subcontracted provider to review the individual's need more closely for Special Assistance:

- Residence in a 24-hour setting;
- Limited HCDM; or
- MC ACC-RBHA or its subcontracted provider is recommending and/or pursuing the establishment of a limited HCDM; or
- Existence of a serious medical condition that affects his/her intellectual and/or cognitive functioning (such as dementia, traumatic brain injury (TBI), etc.)

Member Qualified to Make Special Assistance Determinations

The following may deem a member to need Special Assistance:

- A qualified clinician providing treatment to the member;
- A care manager of MC ACC-RBHA or subcontracted provider;
- The member's clinical team;
- MC ACC-RBHA;
- A program director of a subcontracted provider;
- The Deputy Director of AHCCCS; or

- A hearing officer assigned to an appeal involving a member determined to have an SMI.

Screening for Special Assistance

MC ACC-RBHA's subcontracted providers must screen whether members determined to have a SMI need Special Assistance on an ongoing basis. Minimally this screening must occur at the following stages:

- Assessment and annual updates;
- Development of or update to the Individual Service Plan (ISP);
- Upon admission to a psychiatric inpatient facility;
- Development of or update to the Inpatient Treatment and Discharge Plan (ITDP);
- Initiation of the grievance or investigation processes;
- Filing of an appeal; and
- Existence of a condition which may be a basis for a grievance, investigation, or an appeal, and/or the member's dissatisfaction with a situation that could be addressed by one or more of these processes.

Documentation

MC ACC-RBHA's subcontracted providers shall document in the clinical record each time a member is screened for Special Assistance, indicating what factors were considered and the conclusion reached. If it is determined that the member is in need of Special Assistance, they must notify the AHCCCS Office of Human Rights (OHR) by completing Part A of the Special Assistance Notification through the AHCCCS QM portal as noted in **AMPM 320-R Special Assistance for Members with Serious Mental Illness**.

Before notifying OHR, MC ACC-RBHA's subcontracted providers shall check if the member is already identified as in need of Special Assistance. A notation of Special Assistance designation should already exist in the clinical record. However, if it is unclear, subcontracted providers must review MC ACC-RBHA data or contact MC ACC-RBHA to inquire about status. MC ACC-RBHA maintains a database on members in need of Special Assistance and share data with subcontracted providers on a regular basis, at a minimum quarterly.

Notification to Office of Human Rights

If the member is not correctly identified as Special Assistance, MC ACC-RBHA's subcontracted providers must notify the Office of Human Rights (OHR) within five working days of identifying a member in need of Special Assistance. If the member's Special Assistance needs require immediate assistance, the notification must be submitted immediately, with a notation indicating the urgency**.** MC ACC-RBHA and subcontracted providers should inform the member of the notification and explain the benefits of having another member involved who can provide Special Assistance, if able. If the member is under an HCDM or one is in process, the documentation of such must also be submitted to OHR. However, if the documentation is not

available at the time of OHR notification the notification should be submitted within the required timeframes, followed by submittal of the HCDM documentation.

The Office of Human Rights (OHR) administration (Office Chief or Lead Advocate) reviews the notification to confirm that a complete description of the necessary criteria is included. In the event necessary information is not provided, OHR contacts the staff member submitting the notification to obtain clarification. The OHR responds to the MC ACC-RBHA subcontracted provider, by completing Part B within five working days of receipt of notification and any necessary clarifying information from MC ACC-RBHA. If the need for Special Assistance is urgent, the OHR will respond as soon as possible, but generally within one working day of receipt of the notification form**.**

The notification process is complete only when OHR returns the notification, with Part B completed, to the MC ACC-RBHA subcontracted providers. The MC ACC-RBHA subcontracted providers should follow up with the OHR if no contact is made or Part B is not received within five working days.

OHR designates which agency/member will provide Special Assistance when processing the notification. When the agency/member provides Special Assistance changes, OHR will need to process an "updated Part B" to document the change. In the event the member or agency currently identified as providing Special Assistance is no longer actively involved, MC ACC-RBHA or subcontracted provider must notify OHR. If an OHR advocate is also assigned, notification to the advocate is enough.

Members No Longer in Need of Special Assistance

The MC ACC-RBHA subcontracted provider must notify the OHR within ten days of an event or a determination that an individual is no longer in need of Special Assistance using Part C of the notification through the QM portal, noting:

- The reasons why Special Assistance is no longer required;
- The effective date;
- The name, title, phone number, and e-mail address of the staff member completing the form; and
- The date the form is completed.

The following are instances that should prompt MC ACC-RBHA's subcontracted provider to submit a Part C:

- The original basis for the member meeting Special Assistance criteria is no longer applicable and the member does not otherwise meet criteria; The subcontracted provider must first discuss the determination with the member or agency providing Special Assistance to obtain any relevant input; this includes when a member is

determined to no longer be a member with a SMI (proper notice and appeal rights must be provided and the period to appeal must have expired);
- The member dies;
- The member's episode of care is ended with MC ACC-RBHA (Non-Title XIX member with a SMI will also be dis-enrolled) and the member is not transferred to another TRBHA;
- Submission of a Part C is not needed when a member transfers to another TRBHA, as the Special Assistance designation follows the member.

The MCCACC-RBHA subcontracted providers must first perform all required re-engagement efforts, which includes contacting the member providing Special Assistance, per **Chapter 2 – Network Provider Service Delivery Requirements, Section 2.04 – Outreach, Engagement, Reengagement and Closure** of this manual, proper notice and appeal rights must be provided and the time to appeal must have expired.

Upon receipt of the Part C documentation, the OHR administration reviews the content to confirm accuracy and completeness and send it back to the agency that submitted it, copying MC ACC-RBHA or its subcontracted provider.

Requirements of MC ACC-RBHA and Providers

The MC ACC-RBHA subcontracted providers must maintain open communication with the member/agency (HCDM, family member, friend, OHR advocate, etc.) assigned to meet the member's Special Assistance needs. Minimally, this involves providing timely notification to the member providing Special Assistance to ensure involvement in the following stages:

- ISP planning and review: Including any instance when the member decides about service options and/or denial/modification/termination of services; (service options include not only a specific service but also potential changes to provider, site, doctor, and care manager assignment); and
- ISP development and updates;
- ITDP planning: Which includes any time the member is admitted to a psychiatric inpatient facility and involvement throughout the stay and discharge;
- Appeal process: Includes circumstances that may warrant the filing of an appeal, so all notices of action (NOAs) or notices of decisions (NODs) issued to the member/HCDM must also be copied to the member designated to meet Special Assistance needs; and
- Investigation or grievance: Includes circumstances when initiating a request for investigation/grievance may be warranted.

If such procedures are delayed ensuring the participation of the member providing Special Assistance, the MC ACC-RBHA subcontracted provider must document the reason for the delay in the clinical record and ensure that the member receives the needed services in the interim.

MC ACC-RBHA's subcontracted providers shall provide relevant details to the receiving entity and when applicable, care manager when a member in need of Special Assistance is:

- Admitted to an inpatient facility;
- Admitted to a residential treatment setting; or
- Transferred to a different TRBHA, care management provider site or care manager.

Subcontracted providers must periodically review whether the member's Special Assistance needs are being met by the member or agency designated to meet those needs. If a concern arises, the MC ACC-RBHA subcontracted provider should initially address the problem with the member providing Special Assistance. If the issue is not promptly resolved, they must take further action to address the issue, which may include contacting the OHR administration for assistance.

Confidentiality

MC ACC-RBHA and subcontracted providers shall grant access to clinical records of members in need of Special Assistance to the OHR in accordance with all federal and state confidentiality laws.

Human Rights Committee (HRCs) and their members shall safeguard the monthly list that contains the names of those members in need Special Assistance regarding any Protected Health Information (PHI). HRCs must inform MC ACC-RBHA in writing of how it will maintain the confidentiality of the Special Assistance lists. If HRCs request additional information that contains PHI that is not included in the monthly report, they must do so in accordance with the requirements set out in ***Disclosures to Human Rights Committee.***

Office of Grievance and Appeals Reporting Requirements

Upon receipt of a request for investigation, grievance, or an appeal, MC ACC-RBHA OGA must review whether the member is already identified as in need of Special Assistance.

If so, the MC ACC-RBHA OGA must ensure that:

- A copy of the request for investigation or grievance is sent to OHR within five days of receipt of the request. MC ACC-RBHA OGA must also forward a copy of the final grievance/investigation decision to the OHR within five days of issuing the decision.
- The results of the Informal conference (IC) regarding appeals are sent to OHR. MC ACC-RBHA OGA shall also forward a copy of any subsequent notice of hearing.

Documentation and Reporting Requirements

MC ACC-RBHA's subcontracted providers must maintain a copy of any applicable documentation submitted to AHCCCS OHR in the member's comprehensive clinical record. In the event a member was identified as no longer needing Special Assistance and a Part C of the

notification form was completed, MC ACC-RBHA and subcontracted providers must maintain a copy of the Notification of Member in Need of Special Assistance in the comprehensive clinical record.

MC ACC-RBHA's subcontracted providers must also clearly document in the clinical record (i.e., in the assessment, ISP, ITDP, face sheet) and care management/client tracking system if an individual is identified as Special Assistance, the member assigned currently to provide Special Assistance, the relationship, contact information of phone number and mailing address.

To support MC ACC-RBHA and OHR in maintaining accurate and up-to-date information on members in need of Special Assistance, subcontracted providers are required to follow MC ACC-RBHA's quarterly procedures for data updates about currently identified/active members in need of Special Assistance.

MC ACC-RBHA must share Special Assistance data with its subcontracted providers that provide care management to individuals determined to have a SMI and verify that a process exists at each care management provider to ensure this data is accessible by front-line provider staff (at a minimum quarterly). MC ACC-RBHA must also establish a process with such providers to obtain quarterly updates on individuals currently identified as Special Assistance to support the MC ACC-RBHA quarterly data updates process with the OHR.

Other Requirements

The Human Rights Committees (HRC) must make periodic visits to individuals in need of Special Assistance placed in residential settings to determine whether the services meet their needs, and their satisfaction with their residential environment. MC ACC-RBHA provides training for all appropriate staff on the requirements related to Special Assistance. Subcontracted providers are required to train their staff on the requirements related to Special Assistance.

2.17 – Arizona State Hospital (AzSH)

Admissions

To ensure that individuals are treated in the least restrictive and most appropriate environment that can address their individual treatment and support their needs, the criteria for clinically appropriate admissions to AzSH are as follows:

- The behavioral health member must not require acute medical care beyond the scope of medical care available at AzSH.
- MC ACC-RBHA or other referral source has made reasonably good-faith efforts to address the individual's target symptoms and behaviors in an inpatient setting(s).
- MC ACC-RBHA and other referral source have completed Utilization Review of the potential admission referral, and it is recommending admission to the AzSH as necessary

and appropriate, and as the least restrictive option available for the member given his/her clinical status.

- When a community provider agency or other referral source believes that a civilly committed or voluntarily admitted adult is a candidate to be transferred from another Level I Behavioral Health treatment facility for treatment at AzSH, the agency will contact the MC ACC-RBHA AzSH Liaison to discuss the recommendation for admission to AzSH. MC ACC-RBHA will initiate the MC ACC-RBHA AzSH Review Process. MC ACC-RBHA must agree with the other referral source that a referral for admission to AzSH is necessary and appropriate. If the candidate is not TRBHA enrolled, MC ACC-RBHA will initiate an SMI determination and the enrollment process prior to application or at the latest within twenty-four (24) hours of admission pursuant to **MC Provider Manual Chapter 200 – MCCC, MC DD, DCS CHP, Chapter 3 – Behavioral Health, Section 3.08 – Behavioral Health Appointment Standards** to AzSH. The enrollment date is effective the first date of contact by MC ACC-RBHA. MC ACC-RBHA will also complete a Title XIX application once TRBHA enrollment is completed. For all non-TRBHA enrolled Tribal behavioral health members, upon admission to AzSH, the hospital will enroll the member, if eligible in the AHCCCS American Indian Health Program (AIHP).
- For TRBHA (Tribal RBHA only) enrolled behavioral health members, MC ACC-RBHA must also agree with the referring agency that admission to AzSH is necessary and appropriate, and MC ACC-RBHA must prior authorize the member's admission (see **Chapter 13 – Service Authorizations, Section 13.00 - Securing Services and Prior Authorization** of this manual).
- MC ACC-RBHA and/or other referral sources must contact the AzSH Admissions Office and forward a completed packet of information regarding the referral to the Admissions Office and if determined to be SMI and previously assessed as requiring Special Assistance, then the existing Special Assistance form should be included in the package. If the form has not been completed, please refer to **Chapter 2 – Network Provider Service Delivery Requirements, Section 2.16 - Special Assistance for Members Determined to have a Serious Mental Illness (SMI)** of this manual for further instructions.
- The Admissions Office confirms receipt of the complete packet and notifies the referral source of missing or inadequate documentation within two business days of receipt. AzSH cannot accept any member for admission without copies of the necessary legal documents.
- For T-XIX enrolled members, the **Certification of Need (CON)**, available under **Forms** on the MC website, should be included in the application for admission. MC ACC-RBHA needs to generate a Letter of Authorization (LOA) or issue a denial. The LOA should be provided to the AzSH Admissions Department with the application for admission to AzSH.

- MC ACC-RBHA is responsible for notifying AzSH's Admissions Office of any previous court ordered treatment days utilized by the behavioral health member. Behavioral health members referred for admission must have a minimum of forty-five (45) inpatient court ordered treatment days remaining to qualify for admission. The behavioral health member's AHCCCS eligibility will be submitted by MC ACC-RBHA to the AzSH Admissions Office with the admission application and verified during the admission review by the AzSH Admissions Office. The AzSH Admissions Office will notify (AHCCCS) Member Services of the behavioral health member's admission to AzSH and any change in health plan selection, or if any other information is needed.
- The Chief Medical Officer or Acting Designee will review the information within two (2) business days after receipt of the completed packet and determine whether the information supports admission and whether AzSH can meet the behavioral health member's treatment and care needs.
- If the AzSH Chief Medical Officer or Acting Designee determines that the behavioral health member does not meet criteria for admission, the Chief Medical Officer or Acting Designee will provide a written statement to the referral source. If the admission is denied, the AzSH Admissions Office will send the denial statement to the referral source.
- If the admission is approved, the Admissions Office will send the acceptance statement from the Chief Medical Officer or Acting Designee to the referral source.
- A Court Order for transfer is not required by AzSH when the proposed behavioral health member is already under a Court Order for treatment with forty-five (45) remaining inpatient days. However, in those jurisdictions in which the court requires a court order for transfer be issued, the referring agency will obtain a court order for transfer to AzSH.
- If a Court Order for transfer is not required, the AzSH Admissions Office will set a date and time for admission. It is the responsibility of the referring agency to make the appropriate arrangements for transportation to AzSH.
- When AzSH is unable to admit the accepted behavioral health member immediately, the behavioral health member will be placed on a MC ACC-RBHA list for AzSH. If the behavioral health member's admission is pending, the referral agency must provide AzSH with a clinical update in writing, including if any alternative placements have been explored while pending, and if the need for placement at AzSH is still necessary prior to admission is requested.

Adult Members under Civil Commitment

The behavioral health member must have a primary diagnosis of Mental Disorder (other than Cognitive Disability, Substance Abuse, Paraphilia-Related Disorder, or Antisocial Personality Disorder) as defined in **A.R.S. §36-501**, which correlates with the symptoms and behaviors precipitating the request for admission, and be determined to meet DTO, DTS, GD, or PAD criteria as the result of the mental disorder.

The behavioral health member is expected to benefit from proposed treatment at AzSH (**A.R.S. §36-202**). The behavioral health member must have completed 25 days of mandatory treatment in a local mental health treatment agency under T-36 Court Ordered Treatment (COT), unless waived by the court as per **A.R.S. §36-541** or, if PAD, waived by the Chief Medical Officer of AzSH.

AzSH must be the least restrictive alternative available for treatment of the member (**A.R.S. §36-501**) and the less restrictive long-term level of care available elsewhere in the State of Arizona to meet the identified behavioral health needs of the behavioral health member.

The behavioral health member must not suffer more serious harm from proposed care and treatment at AzSH (see **A.A.C. R9-21-507(B) (1)**).

Hospitalization at AzSH must be the most appropriate level of care to meet the member's treatment needs, and the member must be accepted by the Chief Medical Officer for transfer and admission (**A.A.C. R9-21-507(B)(2)**).

Treatment and Community Placement Planning

AzSH will begin treatment and community placement planning immediately upon admission, utilizing the Adult Clinical Team model.

All treatment is patient-centered and is provided in accordance with AHCCCS-established five principles of member-centered treatment for adult behavioral health members determined to have Serious Mental Illness (SMI).

Behavioral health members shall remain assigned to their original provider network throughout their admission unless the member initiates a request to transfer to a new clinic site or treatment team.

For members who are admitted under the services of an ACT team the member should be stepped down to a supportive level of care within the same provider network. The member would remain under supportive level of care with the same provider network while at AzSH and reassessed for ACT services during discharge planning. ACT level of care to supportive level of care should occur if a member has been at AzSH for 60 days and expected to remain at AzSH beyond 60 days. For members who are admitted to AzSH with a planned stay of less than 60 days these members should remain on the ACT team. Current treatment team should treat each case individually and assess all areas of the members treatment needs prior to making a change from ACT level of care to supportive level of care.

- Consideration of comprehensive information regarding previous treatment approaches, outcomes, and recommendations/input from MC ACC-RBHA and other outpatient community treatment providers is vital.
- Representative(s) from the outpatient treatment team are expected to participate in treatment planning throughout the admission to facilitate enhanced coordination of care and successful discharge planning.
- Treatment goals and recommended assessment/treatment interventions must be carefully developed and coordinated with the outpatient providers (including MC ACC-RBHA, ALTCS Health Plan, other provider(s), the behavioral health member's HCDM, family members, significant others as authorized by the behavioral health member and Advocate/designated representative whenever possible.
- The first ITDP meeting, which is held within 10 days of the behavioral health member´s admission, should address specifically what symptoms or skill deficits are preventing the behavioral health member from participating in treatment in the community and the specific goals/objectives of treatment at AzSH. This information should be used to establish the treatment plan.
- The first ITDP meeting should also address the discharge plan for reintegration into the community. The behavioral health member's specific needs for treatment and placement in the community, including potential barriers to community placement and successful return to the community, should be identified and discussed.

AzSH will provide all treatment plans to the responsible agency. The responsible agency should indicate review of an agreement/disagreement with the treatment plan on the document. Any disagreements should be discussed as soon as possible and resolved as outlined in **9 A.A.C. 21**.

Treatment plans are reviewed and revised collaboratively with the Adult Clinical Team at minimum every 60 days, depending upon the behavioral health member's treatment progress.

Any noted difficulties in collaboration with the outpatient provider treatment teams will be brought to the attention of MC ACC-RBHA to be addressed. MC ACC-RBHA AzSH Liaison will monitor the participation of the outpatient team and assist when necessary. AZSH liaison will refer all SMI TXIX members to MC ACC-RBHA Management team for care coordination activities once discharge planning is noted.

Through the Adult Clinical Team, AzSH will actively address the identified symptoms and behaviors which led to the admission and link them to the community rehabilitation and recovery goals whenever possible. AzSH will actively seek to engage the behavioral health member and all involved parties to establish understandable, realistic, achievable, and practical treatment, discharge goals, and interventions.

While in AzSH and depending upon the behavioral health member's individualized treatment needs, a comprehensive array of evaluation and treatment services are available and will be utilized as appropriate and as directed by the behavioral health member's treatment plan and as ordered by the behavioral health member's treating psychiatrist.

Recertification of Need (RON)

The AzSH Utilization Manager is responsible for the recertification process for all Title XIX/XXI eligible members and is the contact for AzSH for all MC ACC-RBHA continued stay reviews.

All MC ACC-RBHA decisions regarding the approval or denial for continued stay will be rendered prior to the expiration date of the previous authorization and upon receipt of the RON for those behavioral health members. MC ACC-RBHA authorization decisions are based on review of chart documentation supporting the stay and application of the AHCCCS Level Continued Stay criteria. If continued stay is approved, MC ACC-RBHA sends a LOA to the AzSH Utilization Management Department with the completed RON and updated standard nomenclature diagnosis codes (if applicable). Denials will be issued upon completion of the denial process described in **Chapter 13 – Service Authorizations, Section 13.00 – Securing Services and Prior Authorization** of this manual.

Adult Members on Conditional Release from the Arizona State Hospital (AzSH) include but are not limited to coordination with AzSH for the following:

- Active discharge planning.
- Participation in the development of conditional release plans.
- Member outreach and engagement to ensure compliance with the approved conditional release plan. Each area of the plan needs to be actively reviewed and monitored for compliance by the responsible agency.
- At minimum, the member must receive weekly care management contact.
- The team must notify MC ACC-RBHA and the Psychiatric Security Review Board (PSRB) immediately of non-compliance for any portion of the conditional release plan.
- The team must outline steps taken to support the member in meeting the release requirements and immediately remediate any identified concerns.
- Outpatient staffing to review progress must be completed at least monthly.
- Care Coordination activities must be completed with member's treatment team and providers of both physical and behavioral health services.
- Weekly updates must be communicated to MC ACC-RBHA.
- Monthly comprehensive status reports need to be completed and submitted to MC ACC-RBHA, the PSRB and AHCCCS.

Through the active coordination by the Adult Clinical Team and with MC ACC-RBHA oversight, the goal is to ensure enough support is provided to members on conditional release and to ensure that the member remains in compliance with their conditional release plan.

Transition to Community Placement Setting

The behavioral health member is ready for community placement and is placed on the Discharge Pending List when the following criteria are met:

- The agreed upon discharge goals set at the time of admission with MC ACC-RBHA have been met by the behavioral health member.
- The behavioral health member presents no imminent danger to self or others due to psychiatric disorder. Some behavioral health members, however, may continue to exhibit occasional problematic behaviors. These behaviors must be considered on a case-by-case basis and do not necessarily prohibit the member from being placed on the Discharge Pending List. If the behavioral health member is psychiatrically stable and has met all treatment goals but continues to have medical needs, the behavioral health member remains eligible for discharge/community placement.
- All legal requirements have been met.

Once a behavioral health member is placed on the Discharge Pending List, MC ACC-RBHA must immediately take steps necessary to transition the behavioral health member into community-based treatment as soon as possible. MC ACC-RBHA has up to thirty (30) days to transition the behavioral health member out of AzSH. MC ACC-RBHA's outpatient treatment team should identify and plan for community services and supports with the member's inpatient clinical team 60–90 days out from the member's discharge date. This will allow enough time to identify appropriate community covered behavioral health services.

When the behavioral health member has not been placed in a community placement setting within 30 days, a quality of care concern will be initiated by MC ACC-RBHA.

Adult Members Adjudicated Guilty Except Insane (GEI) on Conditional Release from the Arizona State Hospital (AzSH)

Requirements include, but are not limited to coordination with AzSH and MC ACC-RBHA for the following:

- Active discharge planning.
- Participation in the development of conditional release plans
- Member outreach and engagement to ensure compliance with the approved conditional release plan. Each area of the plan needs to be actively reviewed and monitored for compliance by the responsible agency.
- At minimum, the member must receive weekly care management contact.
- The team must notify MC ACC-RBHA and the Psychiatric Security Review Board (PSRB)

immediately of non-compliance for any portion of the conditional release plan.
- The team must outline steps taken to support the member in meeting the release requirements and immediately remediate any identified concerns.
- Outpatient staffing to review progress must be completed at least monthly.
- Care Coordination activities must be completed with member's treatment team and providers of both physical and behavioral health services.
- Weekly updates must be communicated to MC ACC-RBHA.
- Monthly comprehensive status reports need to be completed and submitted to MC ACC-RBHA, the PSRB and AHCCCS.

Through the active coordination by the Adult Clinical Team and with MC ACC-RBHA oversight, the goal is to ensure enough support is provided to members on conditional release and to ensure that the member remains in compliance with their conditional release plan.

Other Contractual Considerations

AzSH acknowledges that it and its providers have an independent responsibility to provide mental health and/or dual diagnosis substance abuse services, including covered services, to eligible members and that coverage or payment determinations by MC ACC-RBHA does not absolve AzSH or its providers of responsibility to render appropriate services to eligible members.

AzSH must render and must ensure that contracted providers render covered services in a quality and cost-effective manner pursuant to MC ACC-RBHA applicable standards and procedures and in accordance with generally accepted medical standards and all applicable laws and regulations.

AzSH shall not discriminate against any eligible member based on race, color, gender identity, sexual orientation, age, religion, national origin, handicap, health status, or source of payment in providing services under this chapter.

AzSH agrees to identify and initiate appropriate referrals to Children's Rehabilitation Services (CRS) for all eligible members aged 18 up to the age of twenty-one (21) years whose condition is identified as an eligible CRS diagnosis.

AzSH further agrees to comply with AHCCCS policies regarding appropriate referrals to the AHCCCS/ALTCS programs.

Under the HIPAA regulations, confidential information must be safeguarded pursuant to **42 C.F.R. Part 431(F)**, **A.R.S. §§ 36-107**, **36-509**, **36-2903**, **41-1959**, **46-135**, **A.A.C. R9-22**, and any other applicable provisions of state or federal law.

MC ACC-RBHA will abide by and cooperate with complaint, grievance, and appeal process maintained to fairly and expeditiously resolve eligible member's, provider's, and AzSH's concerns pertaining to any service provided; issues related to this chapter; and/or allow an eligible member, provider, or AzSH to appeal a determination that a service is not medically necessary; and to resolve SMI eligible member allegations of rights violations under the AHCCCS rules (**A.A.C. R9-21**) for SMI eligible members.

Denial Process

All decisions by MC ACC-RBHA to deny authorization for admission or continued stay must be made to the AzSH Utilization Manager via phone and followed by fax. The denial letter must specify the reason(s) for denial specifically applying MC ACC-RBHA level of care criterion to each case.

The AzSH Utilization Manager will request to appeal MC ACC-RBHA decision in writing and document the date and time the formal appeal was requested in the behavioral health member's utilization management file.

Claims, Billing and Reimbursement

Claims

MC ACC-RBHA will coordinate and reimburse medical care for eligible members who are inpatient at the Arizona State Hospital according to ACOM Policy 432 and AMPM Policy 1020.

AzSH agrees to file claims for covered services in the form and manner required by MC ACC-RBHA.

AzSH agrees to cooperate with MC ACC-RBHA in providing any information reasonably requested in connection with claims and in obtaining necessary information relating to coordination of benefits, subrogation, verification of coverage, and health status.

All claims will be submitted on a UB04 form or electronically.

The billing amount will be the filed program rate for the program in which the behavioral health member resides. The payment amount will be the lesser of the published amount in the B2 matrix or the program rate.

MC ACC-RBHA provides the name and address to which claims are to be sent in writing to the AzSH Finance Department and any changes thereof.

Time Frames

The claim will be submitted to MC ACC-RBHA within five (5) months after the date of service.

Payment by MC ACC-RBHA will be made within thirty/ninety (30/90) days upon receipt of clean claims. This standard will be based on the Center for Mental Health Services (CMS) requirement that 90% of clean claims be paid in thirty (30) days and 99% in ninety (90) days.

An explanation of any denials will be received from the MC ACC-RBHA within thirty/ninety (30/90) days of the MC ACC-RBHA receiving the initial claim submission.

Resubmissions will be provided to MC ACC-RBHA within thirty (30) days of the receipt of the denial.

Availability of Funds

Payments made by MC ACC-RBHA to AzSH, and the continued authorization of covered services are conditioned upon the receipt of funds by AHCCCS, and in turn, the receipt of funds to MC ACC-RBHA from AHCCCS authorized for expenditure in the manner and for the purposes provided in this chapter.

MC ACC-RBHA must not be liable to AzSH for any purchases, obligations, or cost of services incurred by AzSH in anticipation of such funding.

Indemnification

MC ACC-RBHA agrees to indemnify and to hold AzSH harmless from any costs, claims, judgments, losses, damages, or expenses, including attorneys' fees, which AzSH incurs because of the negligent acts or omissions of the MC ACC-RBHA, MC ACC-RBHA employees, agents, directors, trustees, and/or representatives.

AzSH agrees to indemnify and to hold MC ACC-RBHA harmless from any costs, claims, judgments, losses, damages, or expenses, including attorneys' fees, which the MC ACC-RBHA incurs because of the negligent acts or omissions of AzSH, AzSH employees, agents, directors, trustees, and/or representatives.

MC ACC-RBHA External Medical Record Review

MC ACC-RBHA utilization review specialists may obtain information from the health record of the AzSH patient to review the utilization of the hospital's services. All procedures as outlined in this chapter will follow standards set forth by the Joint Commission; the Centers for Medicare and Medicaid Services; and all federal, state, and local laws, rules, and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

2.18 – Employment and Rehabilitation 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 has a variety of employment and rehabilitation services available to assist members move toward self-sufficiency and community integration. Employment and rehabilitation service providers are available to meet the employment and rehabilitation needs of members determined to be eligible for Title XIX/XXI Behavioral Health Service Benefit and are competent in providing a range of employment services including Supported Employment.
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 strengths, interests, and preferences,
    - 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.

AHCCCS **ACOM Policy 447** and **AMPM 1240-J** outline the competencies required to provide employment and rehabilitation services and include the provision of educating, coaching, training, and demonstrating skills to remediate/prevent existing/anticipated functional deficits.

Rehabilitation Services include:

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

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.

MC works collaboratively with the Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA). MC and ADES/RSA have mutually developed collaborative protocols to ensure effective and efficient provision of comprehensive rehabilitative and employment support services for individuals determined eligible for SMI services to achieve increased independence or gainful employment.

The Statewide Collaborative Protocol with ADES/RSA defines the respective roles and responsibilities of each party. The Statewide Collaborative Protocols established though the Interagency Service Agreement (ISA) between AHCCCS and ADES/RSA applies statewide.

Prevocational and employment related services are available through MC ACC-RBHA are distinct from vocational services available through RSA/VR. Please refer to the AHCCCS Covered Behavioral Health Services Guide for additional details including billing limitations related to prevocational and employment support services.

ACC-RBHA Chapter 3 – Additional Mercy Care ACC-RBHA Provider Responsibilities

3.00 – Provider Selection

Within the MC ACC-RBHA provider network, there are five behavioral health service delivery systems organized by population and/or service array. These systems include services for:

- Adults with a serious mental illness;
- Children/adolescents;
- Prevention; and
- Crisis services.

Additionally, for adults with serious mental illness the development and monitoring activities includes healthcare primary care physicians, contracted specialists, ancillary healthcare providers, and hospital facilities.

Providers and groups of providers who are interested in joining the MC ACC-RBHA provider network should fax a letter of interest to our Network Management Department at 860-975-3201. Based on the identified needs within the network, applicants will receive written notification within 30 days of their letter of interest with MC ACC-RBHA's decision. In the event a provider or group is excluded or denied, they will be provided with a reason as to why their application to join the network was not approved.

3.01 – Health Information Exchange

MC ACC-RBHA maintains a state-of-the-art health information exchange (HIE) that will facilitate the exchange of near-real time clinical information across all providers involved in the member's care. Communication between members of the treatment team will be supported by our state-of-the art health information exchange (HIE), which allows behavioral health and physical health providers to share clinical information such as assessments, treatment plans, medication information, and service notes in near real time. Our HIE connects every member of the care team across specialties, regardless of organizational boundaries, in a secure manner with technological sophistication to support integration.

MC ACC-RBHA's HIE is used to facilitate the exchange of real-time member and quality information between our entire network as well as system partners who provide services to our members. MC ACC-RBHA's downloadable technology is available to all care providers. Our HIE connects every member of the care team regardless of organizational boundaries and technological sophistication so that care can be effectively coordinated around a common member. This application runs on a platform on which users can select and run a variety of applications, like downloading applications on a smartphone.

Providers are granted access to the HIE by being a member of the MC ACC-RBHA network of providers. Once connected, the provider office will have access to the system and the ability to grant access to those within their organization that have a clinical need to access the patient information and ensure those granted access are following HIPAA rules and regulations and any agreement set forth by MC ACC-RBHA.

MC ACC-RBHA complies with all requirements of federal and state confidentiality statues, rules, and regulations, including HIPAA Privacy and Security, as well as those requirements specific to behavioral health records to protect medical records and any other personal health information that may identify a particular member or subset of members. Consent for participation in the HIE is received at the clinics, typically during intake.

MC ACC-RBHA regularly collaborates with system stakeholders. This is a key element of our efforts to transform and enhance the delivery of services via strong partnerships across the entire system through seamless coordination, information sharing, problem solving, and continuous quality improvement. For that reason, we strive to work cooperatively and collaboratively to provide a delivery system that is fully integrated, patient-centered and focused on quality. We demonstrate our commitment through our accessibility, engagement, and follow-through.

3.02 – Psychiatric Visit Information

The **Psychiatric Visit Information Form,** available under **Forms**, on the MC website is intended to be an information gathering tool, for families/ foster families/ group home staff to fill out prior to a Behavioral Health Medical Practitioner (BHMP) appointment. It is not mandatory but will give the BHMP updated information on any changes/updates affecting the member.

3.03 – Case Management Contact Guidelines

Contact Guidelines for Title XIX/Non-Title XIX SMI Members

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

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

- Connective and Supportive have an expected compliance to the target of 80%; and

- ACT, being aligned with SAMHSA fidelity scores, is targeted to meet, or exceed 3.1 average face to face meeting per week on a monthly average.

According to contact guidelines and clinical necessity, when scheduling SMI members for future BHMP, RN, or PCP appointments, Behavioral Health/Integrated ACC-RBHA Health Home staff must ensure that the member is able to schedule an appointment while the member is at the health home after completing the previous BHMP, RN, or PCP appointment.

Contact Guidelines for Children in the Custody of DCS

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

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

Caseload Ratios for Title XIX/Non-Title XIX SMI Members

Established Clinical Targets for ACT, Supportive and Connective for Provider Case Management Caseload Ratios		
Level of Care	***Individual Caseload Size**	**Caseload Size Per Prescriber**
Assertive Community Treatment (ACT)	12 Members	100 Members
Supportive Teams	30 Members	200-250 Members
Connective Teams	70 Members	350 Members

*Providers are responsible for submitting accurate caseload ratios data.

Clinical team size should range from 250-300 members total.

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

For non-blended caseloads, the maximum ceiling is 42 members for Supportive level of care

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

*Caseload ratio flexibilities and approval of a blended caseload are subject to AHCCCS approval.

Targeted thresholds for caseload ratios are identified as 90% per health home/stand-alone ACT team (not per agency).

3.05 – Intra-RBHA Clinic Transfers

Transfer Guidelines

- The health home and/or agency shall implement a transfer for members needing specialized services which are unable to be provided by the current health home, team, and/or agency, or when the member or HCDM requests a transfer to a new site and/or agency. In accordance with the 9 guiding principles of member empowerment and self-determination, personal preference is given the utmost consideration, and the member or HCDM must agree with the transfer.
- In cases where the member or HCDM would like to transfer to an integrated DCC or specialized DCC.
- If the request for transfer is due to lack of services or dissatisfaction, clinical leadership at the transferring agency will meet with the member or HCDM to discuss and attempt to resolve.
- Agencies will respect the member's or HCDM's choice and voiced request to transfer services to another agency.
- Members are to be transferred to the new ACC-RBHA Health Home at the same level of care (ACT, Intensive, Supportive, Connective, Navigator), upon agreement from the member, unless the member will be moving/stepping down from an ACT team. The receiving ACC-RBHA Health Home is not able to refuse/reject the intra-RBHA transfer to the same level of care.
- If transferring from an integrated health home, discussion and documentation should occur for choice of PCP with the member. The integrated health home shall assist member in choosing the PCP from MC ACC-RBHA website. The integrated health home will outreach to the new identified PCP to include discussion about member care, transfer of medical records, and ensuring the PCP is aware of behavioral health home

information. An appointment with the outside PCP will be made in partnership with the member. The integrated health home will ensure the member has a supply of medical medications that will last until the PCP appointment.

- If transferring to an integrated health home, the member must agree to the PCP located at the integrated health home. The member must sign the consent form agreeing with receiving services from the PCP as well as the BHMP at the integrated health home. The BH clinical team will ensure the member has a supply of medical medications until the transfer appointment at the integrated health home.
- If special assistance is being provided by the Office of Human Rights (OHR) for the member, they must be notified prior to the transfer.
- Agencies will respond to the transfer request within seven (7) business days as evidenced by sending all necessary documents to be transferred to the receiving health home/care management team. The referring agency health home shall enter a progress note in the member's medical record indicating a transfer packet request was delivered and note any deficiencies, if any, in the packet.
- If the medical record documentation is incomplete or not current, the referring agency will make every attempt to complete/update the documentation by the time of the transfer. Transfers will not be delayed due to incomplete documentation or documentation from another source of medical record i.e., NextGen. All transfer activities should be documented in the member's medical record.
- If the member is refusing to engage with the transferring agency, outreach documentation is needed to explain the reason for the refusal and ongoing efforts to engage the member in completing the documentation prior to the transfer.
- Transfers between and to supportive teams and connective teams are expected to be completed in less than forty-five (45) days from the time the receiving health home receives the transfer request. If the transfer is not complete in the 45-day timeline, **smimemberservicesrequest@MercyCareAZ.org** should be contacted for assistance and notification of the delay.
- Outpatient Transfers between and to ACT teams (ex: supportive to ACT, ACT to ACT and ACT to FACT) are expected to be completed in less than twenty-one (21) days from the time the receiving ACT team receives the transfer request. The ACT team should screen members within two weeks of the receiving the outpatient referral to ensure they meet ACT criteria. If the member meets ACT Criteria and the transfer is not complete in the 21-day timeline, **smimemberservicesrequest@MercyCareAZ.org** should be contacted. For Inpatient Level 1 referrals, Newly Determined SMI ACT referrals, referral waitlist and transfer protocols please refer to the **ACT Operational Manual.**
- Transfers between ACT teams are expected to be completed in less than twenty-one (21) days from the time the receiving health home receives the transfer request. If the transfer is not complete in the 21-day timeline, **smimemberservicesrequest@MercyCareAZ.org** should be contacted.

- If the referring agency concludes that the requested transfer should not take place because of the member's "clinical instability" and/or it would not be in the best clinical interest of the member, the agency chief medical officer can request approval from MC ACC-RBHA's Medical Director to delay the transfer until the risk is ameliorated. The smimemberservicesrequest@MercyCareAZ.org mailbox can be utilized to start this process. The MC ACC-RBHA Medical Director shall issue a decision to the agency within five (5) business days. If the transfer request of the member is rejected, the clinical team shall notify all members making the request as to why the request was denied and of the member's right to appeal the decision.
- Violent and/or threatening behaviors may result in legal action that prevents the member from continuing to receive services at their current agency health home. If there is any question regarding "clinical instability" from the receiving health home, the SMI member services mailbox should be utilized.
    - It is expected that these members be managed within their current network and that alternate health homes within that network should be able to immediately meet all the member's needs.
    - If the member refuses continued treatment at the current network and requests transfer, they shall be offered health home selection from the agency health home map.
    - The "clinical instability" guidelines above may apply.
    - Regular time frames for transfers will apply.
- If there is a delay regarding a member's pending transfer due to a health home's temporary lack of capacity, once the health home resumes accepting referrals transfers, they will be scheduled in order of the original request date of the packet referral. Under these circumstances, any member unable to transfer to a site initially requested will be offered the option of transferring to an alternative open health home based on the member's preference.
- A transfer is complete once the member has attended an initial appointment at the receiving health home and the medical record has been delivered to the receiving health home.
    - The referring health home is responsible for ensuring the member has transportation to the transfer appointment, delivering all medications (if applicable) and delivering the medical record. Additionally, if the member has an HCDM or receives special assistance, the referring team is responsible for ensuring the HCDM or designated representative is in attendance.
    - If the member fails to keep the scheduled appointment with the newly assigned clinical team, it is the responsibility of the referring health home's clinical team to engage in outreach efforts to determine the reason for the missed appointment and assist in rescheduling the missed appointment with the receiving health home. The referring health home is responsible for ensuring the

member has transportation to the initial appointment at the new health home. The referring health home retains all responsibility for the member's care as outlined in the ISP until the completion of the transfer process.

- If the member is currently on court-ordered treatment, MC ACC-RBHA's Court Liaison Administrator needs to be notified via email once the transfer is complete. The referring health home will send all emails to **currans2@MercyCareAZ.org**.
- For any concerns regarding the transfer guidelines, you can contact MC ACC-RBHA for appropriate interventions or questions at **smimemberservicesrequest@MercyCareAZ.org.**

Transfer Process

- The clinical director/site administrator of the referring health home will ensure that documentation is prepared and delivered to the receiving health home within 7 days after the Release of Information is signed. All transfer activities will be documented in the medical record.
- The person or HCDM and OHR (if applicable) will be notified of the transfer referral by the referring health home with the intention that the receiving health home assign the person to a clinical team within the required timeframes. This will be documented in the medical record.
- The referring health home shall prepare a transfer packet to include the following medical record information:
    - Transfer of care cover sheet
    - Part E
    - Part D
    - AUD
    - ARCP
    - Medical sheet
    - Last three doctor notes
    - Last three progress notes
    - Face sheet
    - COT/Special Assistance or HCDM paperwork
    - A progress note indicating a conversation with the member or member's HCDM with the transfer request
    - Last psychiatric evaluation
    - Labs from the past year
    - EKG from the past year, if applicable
    - Medication lists for the past year and current medication list to include medical and physical health medications
    - Progress notes for the past year (last 3 progress notes)

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

    - Schedule time to discuss concerns and/or special treatment needs as identified by the transfer packet documentation or arranges a prescriber-to-prescriber call if needed.
- If the member chooses to transfer to an integrated health home, the ART will need to assist the member in changing their PCP assignment.

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

3.06 – Provider Deliverables

There are provider deliverables required for MC ACC-RBHA. If you have any questions regarding the deliverables, contact your Network Relations Specialist/Consultant at 602-586-1880 or 866-602-1979.

Compliance

Providers who are compliant with Deliverable standards require no further action until the next submission.

Providers who are "Out of Compliance" with Deliverable standards will be contacted by the Network Relations Specialist/Consultant to re-educate the provider on compliance requirements related to Deliverables standards. The Network Relations Specialist/Consultant will continue to monitor provider compliance each month.

Corrective Action Plan

MC ACC-RBHA will require a Corrective Action Plan (CAP) from all Providers identified as "Out of Compliance" with Deliverable's standards. CAP's will be due from the Providers within 15 business days of notice for non-compliance. The Network Management representative will send a follow up letter to the providers reminding them of the CAP due date and content.

If compliance is not evident after additional interventions, the case will be escalated to the MC ACC-RBHA Chief Operating Officer (COO) with recommendations for further actions, which may include referral restrictions, sanctions, or possible termination from the network for breach of contract.

Submission of Provider Deliverables to MC ACC-RBHA

Provider Use of SFTP

MC ACC-RBHA has chosen to use Secure File Transfer Protocol (SFTP) for files exchanged with providers because it is secure and can be set up for automatic routing. A provider can choose between two ways to use SFTP for file transfer:

- The provider's IT group can establish an SFTP environment on the provider's server; or
- A provider can apply for a username and password to sign on to a MC ACC-RBHA SFTP environment and upload/download the file there. A routing tag used for internal routing is set up for each provider; the routing tag is never seen by the provider, as it is strictly used for routing within MC ACC-RBHA data systems. A provider can complete the **SFTP Connectivity Enrollment Form** available under **Forms** on the MC website and submit it through their Network Relations Specialist/Consultant to initiate their SFTP set up.

File Naming Conventions

Certain conventions must be followed so that we can take advantage of receipt logging and available SFTP automation. The names of files to be transferred are chosen so that they follow this pattern:

Recipient_ReportName_YYYYMMDD_Sender

The four parts of the name are separated by an underscore (_). For example, the October access-to-care report that is sent to the Children's System of Care team at MC ACC-RBHA from the People of Color Network has this name:

CSOC_Accesstocare_201410_POCN

In this case, the date portion (YYYYMMDD) was designed to use just a year and month, so that the file name reflects the month being reported. Admin Review information for General Mental Health (GMH) members being sent to Lifewell Behavioral Wellness from the MC ACC-RBHA Quality Management Provider Monitoring team might have this name:

LBW_Admin Review-GMH_20141023_QMPM

There is a "master list" of provider abbreviations to ensure consistency; the file name and other conventions are shared with providers by the program areas. Certain basic information about each deliverable and a link to the associated template will appear in the MC ACC-RBHA Provider Manual.

Incoming Files

Files will be routed to the appropriate program area's network drive/folder and to a SharePoint location for automatic logging of receipt of the file. The software "sweeps" the arrival area every minute, reviewing the names of files to identify any that are to be automatically routed. The name of the arriving file will be prefixed with the provider's routing tag when it is delivered. For example, the access-to-care report from People of Color Network described above would arrive as:

RBHAProvPeoColorScha79_ CSOC_Accesstocare_201410_POCN

The routing tag ends after the first underscore. The SFTP software is configured to use the member (CSOC) and report name (Accesstocare) to route the file to the program area's network drive/folder; that information along with the date portion (201410) and sender (POCN) are used at the SharePoint to log that specific deliverable as received.

Outgoing Files

To send a file to a provider, a program area will label the file with the appropriate name and affix the intended member's routing tag to the front of the file name. For example, the Admin Review file destined for Lifewell described above would be constructed as:

RBHAProvLifeWellScha123_ LBW_Admin Review-GMH_20141023_QMPM

The file can then be placed (copied or cut-and-pasted) into the established outgoing SFTP folder. SFTP software will delete the file from this folder and move the file to where the provider can sign on and retrieve it (or move it to the provider's system, depending on how they have set up the SFTP). The routing tag is removed when the file leaves the MC ACC-RBHA SFTP area. Note that if the file is placed in the outgoing SFTP folder without the routing tag, it will be moved to a MC ACC-RBHA server and deleted – it will **not** be routed to the provider. If an archive folder is configured for the program area, a copy of the file will be placed in the archive when it is sent to the provider; a date-timestamp reflecting when the file is sent will be added to the file name.

3.07 – Business Continuity and Disaster Preparedness

MC ACC-RBHA provides health care benefits to its Members. To provide benefits, the Contracted Facilities, Providers and Vendors must be able to recover from any disruption in services as quickly as possible. This recovery can be accomplished by the development of Business Continuity and Incident Management Plans that contain strategies for recovery. The Business Continuity and Incident Management Plans are part of the Federal Government's Continuity of Operations Programs (COOP) requirements.

Responsibilities

The Facility, Provider or Vendor shall develop and maintain a Business Continuity and Incident Management Plan which assures MC ACC-RBHA that the provision of covered services will occur as stated in 42 C.F.R. 438.207 and 42 C.F.R. 438.208. A summary of the Business Continuity and Incident Management Plan should be submitted with the **Business Continuity and Incident Management Plan Checklist** available under Forms on the MC website, to the designated Compliance Officer, within 15 days from the start of each contract year. The comprehensive

summary shall be no longer than five pages and shall address all Business Continuity and Incident Management Plan requirements outlined below. Facilities, Providers or Vendors shall prepare adequate Business Continuity and Incident Management Plans that are reviewed and tested at least annually and update them as needed.

Business Continuity and Incident Management Plan

- The Business Continuity and Incident Management Plan (Plan) shall be reviewed and updated at least annually by the Facility, Provider or Vendor.
- The Facility, Provider or Vendor shall ensure that its staff is trained and familiar with the Plan.
- The Plan should be specific to the Contractor's operations in Arizona and reference local resources. Generic Plans which do not reference operations in Arizona and their relationship to MC ACC-RBHA are not appropriate.
- The Plan should contain, at a minimum, planning, and training for:
    - Complete loss of use of the main site (e.g., major fire or flood).
    - Complete loss of systems and applications (e.g., data center disaster).
    - Loss of a critical Third-Party Supplier (e.g., internet and telephones).
    - Wide-spread Severe Staffing Shortage (e.g., pandemic).
    - How the Facility, Provider or Vendor will communicate with MC ACC-RBHA during a business disruption. *(Plan should include Reuben Lopez, 480-364-3838 as the specific contact at MC ACC-RBHA).* The Plan shall contain a listing of key customer priorities and key factors that could cause disruption and timelines for when a Facility, Provider or Vendor will be able to resume critical customer services when a disruption occurs. The Facility, Provider or Vendor shall also include any additional priorities as identified to be critical key priorities or factors.
    - How MC ACC-RBHA will contact the Facility, Provider or Vendor in the event of a business disruption outside of normal business hours. *(The name and phone numbers for two contacts).*
    - Provisions for periodic testing, at least annually. Results of the tests are documented.
- The Plan should identify the Facility, Provider or Vendor's greatest priorities and provide recovery guidelines and procedures to respond to an event impacting the critical functions at a basic level until normal functions have been restored.
- The Plan should address how, during a business disruption, the Facility, Provider or Vendor will provision for facilities, hospitals or other locations in the event members are being displaced.
- The Plan should provide the procedures to follow during a disruption when transporting members and other critical resources to alternate operating locations.

- The Plan should include realistic timelines for the resumption of basic services for the Facility, Provider or Vendor's greatest priorities.
- The Plan should include primary and alternate Business Continuity Planning Coordinators and includes primary and alternate methods of contact for each.
- The Plan should include actions performed by the Facility, Provider or Vendor that benefit the general public before a disruption occurs (e.g., educational outreach, protecting vulnerable populations, having appropriate interventions).
- The Plan should include plans and procedures can be performed by the Facility, Provider or Vendor to benefit the general public during a disruption (e.g., limiting adverse public health effects, coordinating efforts with government departments and agencies, reducing public health risks, and other activities designed to mitigate health adverse effects and/or deaths).
- The Plan should include procedures for providing counselling to their employees and volunteers during and after the most severe disruptions.

Resources

The Federal Emergency Management Agency (FEMA) has a website which contains additional information on Business Continuity and Incident Management Planning, including checklists for reviewing a Plan. MC ACC-RBHA encourages the Facility, Provider or Vendor to use relevant parts of these checklists in the evaluation and testing of its own Business Continuity and Incident Management Plans. The Facility, Provider or Vendor can also reference the Arizona Governor's Office of Homeland Security and Emergency Preparedness and the Ready websites for supplementary information. Links to these websites are provided:

Federal Emergency Management Agency**:** **http://www.fema.gov/**
FEMA Continuity of Operations Program: **http://www.fema.gov/continuity-operations**
Arizona Division of Emergency Management: **https://dema.az.gov/emergency-management**
Arizona Department of Emergency & Military Affairs: **http://www.azdema.gov/**
Arizona Department of Homeland Security: **http://www.azdohs.gov/**
Arizona Emergency Information Network: **https://ein.az.gov/**
Ready: **http://www.ready.gov/**

3.08 – Behavioral Health Satisfaction Survey

The Behavioral Health Satisfaction Survey requests independent feedback from Title XIX/XXI adult members/HCDMs and families of youth receiving services. The surveys measure consumers' perceptions of behavioral health services in relation to the following domains:

- Access to timeliness of behavioral health care
- Perceived outcome of behavioral health care
- Communication with clinicians
- Patient rights

- Member services and assistance
- Overall rating of behavioral health provider

The information collected from the surveys is used to improve the care and services that members receive from behavioral health providers. Results from the survey provide comprehensive data to make systemic program improvements.

ACC-RBHA Chapter 4 – Covered and Non-Covered Services

4.00 – Covered and Non-Covered Services

Behavioral Health Covered Services

MC ACC-RBHA will cover behavioral health services consistent with the table below. The AHCCCS Medical Policy Manual, Policy 310-B – Title XIX/XXI Behavioral Health Service Benefit contains a complete list of covered services.

Available Behavioral Health Services*

SERVICES		TITLE XIX/XXI CHILDREN AND ADULTS	NON-TITLE XIX/XXI MEMBERS DETERMINED TO HAVE SMI
TREATMENT SERVICES			
Behavioral Health Counseling and Therapy	Individual	Available	Available******
	Group	Available	Available******
	Family	Available	Available******
Behavioral Health Screening, Mental Health Assessment and Specialized Testing	Behavioral Health Screening	Available	Available******
	Mental Health Assessment	Available	Available
	Specialized Testing	Available	Not Available
Other Professional	Traditional Healing	Not Available with Title XIX/XXI funding**	Not Available**
	Auricular Acupuncture	Not Available with Title XIX/XXI funding**	Not Available**
REHABILITATION SERVICES			
Skills Training and Development	Individual	Available	Available
	Group	Available	Available
	Extended	Available	Available
Cognitive Rehabilitation		Available	Available
Behavioral Health Prevention/Promotion Education		Available	Available

Psycho Educational Services and Ongoing Support to Maintain Employment	Psycho Educational Services	Available	Available
	Ongoing Support to Maintain Employment	Available	Available
MEDICAL SERVICES			
Chiropractic Services		Available	Available
Medication Services***		Available	Available
Lab, Radiology and Medical Imaging		Available	Available
Medical Management		Available	Available
Electro-Convulsive Therapy		Available	Available******
SUPPORT SERVICES			
Care Management		Available	Available (See **Care Manager Assignment Criteria in Attachment A)**
Personal Care		Available	Available
Home Care Training (Family)		Available	Available
Self Help/Peer Services		Available	Available
Therapeutic Foster Care (TFC)		Available	Available******
Respite Care****		Available	Available
Supported Housing		Provided based on available grant funds**	Provided based on available grant funds*
Sign Language or Oral Interpretive Service		Provided at no charge to the member	Provided at no charge to the member
Transportation	Emergency	Available	Limited to crisis service-related transportation
	Non-Emergency	Available	Available

CRISIS INTERVENTION SERVICES		
Crisis Intervention – Mobile	Available	Available
Crisis Intervention - Telephone	Available	Available
Crisis Intervention - Stabilization	Available	Available
INPATIENT SERVICES		
Hospital	Available	Available but limited*****
Behavioral Health Inpatient Facility	Available	Available but limited*****
RESIDENTIAL SERVICES		
Behavioral Health Residential Facility	Available	Available but limited****
Room and Board	Not Available with TXIX/XXI funding**	Available******
BEHAVIORAL HEALTH DAY PROGRAMS		
Supervised Day	Available	Available
Therapeutic Day	Available	Available******
Medical Day	Available	Available******

*Services may be available through federal block grants

**Services not available with TXIX/XXI funding or state funds but may be provided if grant funding or other funds are available.

***See the AHCCCS Drug List for further information on covered medications.

****No more than 600 hours of respite care per contract year (October 1st through September 30th) per member.

*****Coverage is limited to 23-hour crisis observation/stabilization services, including detoxification services. Up to 72 hours of additional crisis stabilization may be covered, based upon the availability of funding

******Pending availability of funding

Physical Health Care Services

The table below lists physical health care services available for Title XIX/XXI eligible members determined to have a Serious Mental Illness (SMI), who are receiving both behavioral health and physical health care services from MC ACC-RBHA (see the AHCCCS Covered Services, Acute Care, listed in the **AHCCCS Medical Policy Manual**, for further information on covered physical health care services and dental services).

Available Physical Health Care Services

SERVICES	TITLE XIX		TITLE XXI
	<21	≥21	≤19
Audiology	X	X	X
Breast Reconstruction after Mastectomy	X	X	X
Chiropractic Services	X		X
Cochlear Implants	X		X
Emergency Dental Services	X	X	X
Preventive & Therapeutic Dental Services	X		X
Limited Medical and Surgical Services by a Dentist (for Members Aged 21 and older)		X	
Dialysis	X	X	X
Emergency Services – Medical	X	X	X
Emergency Eye Exam	X	X	X
Vision Exam/Prescriptive Lenses (includes replacement for members under age 21)	X		X
Lens Post Cataract Surgery	X	X	X
Treatment for Medical Condition of the Eye	X	X	X
Health Risk Assessment & Screening Tests (for Members aged 21 and older)		X	
Preventive Examinations in the Absence of any Known Disease or Symptom	X		X
HIV/AIDS Antiretroviral Therapy	X	X	X
Home Health Services	X	X	X
Hospice	X	X	X
Hospital Inpatient Medical	X	X	X
Hospital Observation	X	X	X

Hospital Outpatient Medical	X	X	X
Hysterectomy (medically necessary)	X	X	X
Immunizations	X	X	X
Laboratory	X	X	X
Maternity Services	X	X	X
Family Planning	X	X	X
Early and Periodic Screening, Diagnosis and Treatment (Medical Services) and Well Exams*	X		X
Other Early and Periodic Screening, Diagnosis and Treatment Services Covered by Title XIX	X		X
Medical Foods	X	X	X
Durable Medical Equipment	X	X	X
Medical Supplies	X	X	X
Prosthetic	X	X	X
Orthotic Devices	X	X	X
Nursing Facilities (up to 90 days)	X	X	X
Non-Physician First Surgical Assistant	X	X	X
Physician Services	X	X	X
Foot and Ankle Services	X	X	X
Prescription Drugs	X	X	X
Primary Care Provider Services	X	X	X
Private Duty Nursing	X	X	X
Radiology and Medical Imaging	X	X	X
Occupational Therapy – Inpatient	X	X	X

Occupational Therapy – Outpatient (limitations apply)	X	X	X
Physical Therapy – Inpatient	X	X	X
Physical Therapy – Outpatient (limitations apply)	X	X	X
Speech Therapy – Inpatient	X	X	X
Speech Therapy – Outpatient (limitations apply)	X		X
Respiratory Therapy	X	X	X
Total Outpatient Parenteral Nutrition	X	X	X
Non-Experimental Transplants Approved for Title XIX Reimbursement*			
Transplant Related Immunosuppressant Drugs	X	X	X
Transportation – Emergency	X	X	X
Transportation – Non-emergency	X	X	X
Triage	X	X	X
Well Exams		X	

*****See the AHCCCS Medical Policy Manual, Policy 310, 310-DD, *Covered Transplants and Related Immunosuppressant Medications*.
*MC ACC-RBHA does not limit the number of well visits for members under 21 years of age.

For additional information on available covered services and provider responsibilities for EPSDT Services, Family Planning, Maternity Care, and Women's Preventive Services, refer to **MC Provider Manual Chapter 100 – General Terms, Chapter 4 – Provider Responsibilities, Chapter 5 – Early and Periodic Screening, Diagnostic and Treatment (EPSDT), Chapter 7 – Family Planning, and Chapter 8 – Maternity Care Services**.

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.

MC ACC-RBHA has specific covered and non-covered medical 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.

Covered Services

For a complete listing of covered medical services for MC ACC-RBHA, please refer to MC ACC-RBHA's **Member Handbook** available on the MC website.

Providers may arrange medically necessary non-emergent transportation for MC ACC-RBHA members by calling Member Services at 800-564-5465.

Member Handbook

MC ACC-RBHA is responsible for the **Member Handbook** which is available on the MC website. Providers can request member handbooks by completing the **Mercy Care Member Handbook Order Form,** available under **Forms** which is available on the MC website, in its entirety and submit to your Network Management representative. Handbooks are packaged 40 handbooks to one box. There is a minimum order of one box.

The MC ACC-RBHA Member Handbook applies to SMI, and DCS CHP members. Please direct MC ACC-RBHA members who request a copy of the handbook to our website for the most expeditious service.

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

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

- MC ACC-RBHA Member Services at 602-586-1841/800-564-5465 (Integrated SMI and DCS CHP).

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

Documentation of receipt of the member handbook must be filed in the member's record.

- Member Handbooks will be available and easily accessible at all provider sites and is

available on the MC ACC-RBHA website (Member Handbook). Upon request, copies must be made available to known consumer and family advocacy organizations and other human service organizations. The Member Handbook is available in both English and Spanish.

- Members receiving healthcare services have the right to request and obtain a Member Handbook at least annually. MC ACC-RBHA notifies members of their right to request and obtain a Member Handbook at least annually by publishing this information using notices or newsletters accessible on MC ACC-RBHA's website.
- AHCCCS may require MC ACC-RBHA to revise the Member Handbook and distribute it to all current members if there is a significant program change. AHCCCS determines if a change qualifies as significant.

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

Non-Covered Services

The following services are considered non-covered services:

- Services from a provider who is NOT contracted with MC ACC-RBHA (unless prior approved by the Health Plan);
- Cosmetic services or items;
- Personal care items such as combs, razors, soap etc.;
- Any service that needs prior authorization that was not prior authorized;
- Services or items given free of charge, or for which charges are not usually made;
- Services of special duty nurses, unless medically necessary and prior authorized;
- Physical therapy that is not medically necessary;
- Routine circumcisions;
- Services that are determined to be experimental by the health plan medical director;
- Pregnancy terminations and termination counseling, unless medically necessary, pregnancy is the result of rape or incest, or if physical illness related to the pregnancy endangers the health of the mother;
- Health services if you are in prison or in a facility for the treatment of tuberculosis;
- Experimental organ transplants, unless approved by AHCCCS;
- Sex change operations;
- Reversal of voluntary sterilization;
- Medications and supplies without a prescription;
- Treatment to straighten teeth, unless medically necessary and approved by MC ACC-RBHA;
- Prescriptions not on our list of covered medications, unless approved by MC ACC-RBHA; and
- Physical exams for qualifying for employment or sports activities.

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

- Hearing aids, including bone-anchored hearing aids;
- Cochlear implants;
- Insulin pumps;
- Microprocessor controlled lower limbs and microprocessor-controlled joints for lower limbs;
- Percussive vests;
- Routine eye examinations for prescriptive lenses or glasses;
- Outpatient Hospice – Effective 10/1/09 hospice for Acute Care adult members (21 years or older) is not covered.
- Routine dental services, unless related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw;
- Chiropractic services (except for Medicare QMB members); and
- Outpatient speech therapy (except for Medicare QMB members).

Medicare Part D Prescription Drug Coverage

Members eligible for Medicare Part D must access the Medicare Part D prescription drug coverage by enrolling with a Medicare Prescription Drug Plan (PDP) or Medicare Advantage Prescription Drug plan (MA-PD).

ACC-BHA Chapter 5 – Network Requirements

5.00 – Provider Network Development and Management

To ensure that MC ACC-RBHA has established a process to develop, maintain and monitor their network of contracted providers sufficient in size, scope, and types of providers to deliver all covered services according to the AHCCCS standards and requirements.

Network Development

MC ACC-RBHA will develop and maintain a network of providers that:

- Is sufficient in size, scope, and types of providers to deliver all covered behavioral health services and satisfy all the service delivery requirements; and
- Can deliver culturally and linguistically appropriate services, in-home and community-based services for the American Indian members and other culturally diverse populations. These cultural and linguistic needs must take into consideration the prevalent language(s), including sign language, spoken by populations in the geographic service area.

MC ACC-RBHA must design, establish, and maintain a network that covers, at a minimum

- Covered services that are accessible to all current and anticipated Title XIX/XXI and non-Title XIX/XXI members, as applicable, in terms of timeliness, amount, duration and scope;
- Current and anticipated utilization of services and the number of network providers not accepting new referrals;
- The geographic location of providers and their proximity to members, considering distance, travel time, the means of available transportation and access for members with a disability;
- The identification of current network gaps and the methodology used to identify them, and the immediate short-term interventions identified when a gap occurs, including provisional credentialing;
- Interventions to fill network gaps and barriers to those interventions; outcome measures/evaluation of interventions;
- Member Satisfaction Survey data, complaint, grievance, and appeal data;
- Issues, concerns, and requests brought forth by other state agency personnel;
- Ongoing activities for network development based on identified gaps and future needs projection;
- Specialized health competencies to deliver services to children, youth, and adults with developmental or cognitive disabilities, sexual offenders, sexual abuse trauma victims, individuals with substance use disorders, individuals in need of dialectical behavior therapy; and infants and toddlers under the age of five (5) years; and

- A network of providers that delivers (24) twenty-four-hour substance use disorder/psychiatric crisis stabilization services.

Network Management

MC ACC-RBHA must:

- Monitor network compliance with all policies and rules of AHCCCS and the Contractor, including:
  - AHCCCS Minimum Network Standards in association with the AHCCCS Contractor Operations Manual Policy 436;
  - Process to evaluate its Provider Services Staffing levels based on the needs of the provider community;
  - A process to track and trend provider inquiries that include timely acknowledgement and resolution including systemic actions as appropriate;
  - Recruit, select, credential, re-credential, and contract with providers in a manner that incorporates quality management utilization, office audits, medical record reviews, and provider profiling;
  - Provide training for providers and maintain records of such training;
  - Network compliance with all policies and procedures related to the grievance/appeal processes and ensuring the member's care is not compromised during the grievance/appeal processes;
  - The adequacy, accessibility, and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English; and
  - On-going monitoring of out-of-state providers to ensure compliance with AHCCCS standards of care and to identify gaps in the system of care.
- Tracking and responding to provider inquiries:
  - MC ACC-RBHA tracks and trends provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate;
  - MC ACC-RBHA ensures that provider calls are acknowledged within three (3) business days of receipt, are resolved and the result communicated to the provider within thirty (30) business days of receipt (includes referrals from AHCCCS);
  - MC ACC-RBHA ensures adequate staffing to handle provider inquiries/complaints/requests for information and ensure that staff members are trained, at a minimum, in the following:
    - Provider inquiry processing and tracking (including resolution timeframes);
    - MC ACC-RBHA procedures for initiating provider contracts or AHCCCS provider registration;
    - Claim submission methods and resources;

- Claim dispute and appeal procedures;
- Identifying and referring quality of care issues; and
- Fraud, waste, and program abuse reporting requirements.

MC ACC-RBHA must monitor the number of members assigned to each Primary Care Provider (PCP) and the PCP's total capacity to assess the providers' ability to meet AHCCCS appointment standards.

Reporting

MC ACC-RBHA will provide all required deliverables with the frequency and due dates specified as stated in their respective Contract/IGA; inclusive of incident report for out-of-state placements.

5.01 – Material Changes

MC ACC-RBHA must ensure the timely and accurate reporting of material changes to the network, affecting behavioral health members to AHCCCS. MC ACC-RBHA also ensures that all subcontracted providers adhere to the requirements of this chapter.

MC ACC-RBHA develops and maintains a Network with sufficiency in size, scope, and types of providers to deliver all covered behavioral health services and satisfy all the service delivery requirements. MC ACC-RBHA will:

- Communicate with the network providers regarding contractual and/or program changes and requirements;
- Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;
- Process provisional credentials.

MC ACC-RBHA Responsibilities

During the material transition process, MC ACC-RBHA is responsible for:

- Communicating with providers regarding contract requirements and program changes;
- Ensuring the provision of medically necessary covered services should the network become temporarily insufficient within the contracted service area;
- Monitoring the adequacy, accessibility, and availability of the provider network to meet the needs of the members, including the provision of care to members with limited proficiency in English; and
- Expedited and temporary credentialing process.

Material Network Change – AHCCCS Notifications

For all MC ACC-RBHA Provider Changes:

Notify MC ACC-RBHA of any material change in the size, scope or configuration of the Contractor's provider network that differs from the most recent network inventory.

Submit the notification of a material change in the provider network, including draft letter to notify affected members, ninety (90) days prior to the expected implementation of the change.

MC ACC-RBHA will notify AHCCCS in writing within one (1) day of knowledge of any unexpected network material change, see form for specific requirements.

The MC ACC-RBHA Member Notification Letter is required to be sent out to all members affected by the change at least 30 days prior to any material change. This letter must be submitted to and approved by the AHCCCS Policy Office before it is printed, posted, or disseminated to members.

MC ACC-RBHA is responsible for the content of any Member Notification Letter sent to members by their subcontracted providers and cannot delegate this responsibility to notify MC ACC-RBHA members of any material network change described in this chapter to subcontracted providers.

5.02 – Out of State Treatment for Behavioral Health System

General Requirements

When MC ACC-RBHA considers an out-of-state treatment for a child or young adult (18 – 21 years old), 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/HCDM (not including those not under HCDM between 18 and under 21 years of age) agrees with the out-of-state treatment;
- The out-of-state treatment facility is registered as an AHCCCS provider; and is willing to accept AHCCCS rates or enter into a Single Case Agreement (SCA) with MC ACC-RBHA;
- 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, MC ACC-RBHA 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;
- 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) in coordination with the family/HCDM will coordinate with the AHCCCS Health Plan to make
- arrangements and document all contacts and arrangements;
- MC ACC-RBHA Health Plan Coordinator will send notification of the pending out-of-state transition with the admission date and facility to the appropriate Health Plan AHCCCS Behavioral Health Coordinator.
- Cultural considerations have been explored and incorporated into the ISP; and
- If a member has been placed out-of-state secondary to an emergency or unforeseen event, MC ACC-RBHA 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/HCDM is involved throughout the duration of the treatment. This may include family counseling in member or by teleconference or video- conference;
- The CFT or ART must ensure that essential and necessary health care services are provided in coordination with the member's medical health plan; Home passes are allowed as clinically appropriate and in accordance with the **AHCCCS Medical Policy Manual – Policy 310-B – Title XIX/XXI Behavioral Health Service Benefit.** For youth in Department of Child Safety (DCS) custody, home passes must be determined only in close collaboration with DCS.

Initial Notification to AHCCCS Office of Management

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

Process for Initial Notification to MC ACC-RBHA

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

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

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

- The BHH Clinical Leadership will coordinate with applicable key stakeholders (i.e., DCS and JPO) and verify they agree to an out-of-state placement. If there is disagreement, which cannot be resolved, the BHH Clinical Leadership may contact MC ACC-RBHA for assistance in resolution.
- The MC ACC-RBHA Care Management Department will review the form and forward by secure email to the AHCCCS Office of Medical Management at MedicalManagement@azahcccs.gov for review and approval prior to placing the child or young adult.

- When the out-of-state treatment is approved AHCCCS, MC ACC-RBHA will notify the BHH Clinical Leadership and direct them to complete the out of state placement process.
- MC ACC-RBHA will identify out-of-state AHCCCS registered providers and send referrals to the provider and care management team.
- Once the accepting facility is identified, MC ACC-RBHA 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 BHH's Clinical Leadership will complete the **AHCCCS Exhibit 450-1, Out of State Placements Form** and submit to the MC ACC-RBHA 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 MC ACC-RBHA to AHCCCS. The update will include a review of progress, CFT participation, evaluation of the discharge plan and availability of services based on the member's needs.

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

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

5.03 – Use of Telemedicine

MC ACC-RBHA and subcontracted providers shall use teleconferencing to extend the availability of clinical, educational, and administrative services. All clinical services provided through the interactive video teleconferencing will conform to established policies for confidentiality and maintenance of records.

MC ACC-RBHA will ensure that all prescribing of controlled substance through telemedicine will conform to all federal and state regulations.

Interactive video functions are approved for the following purposes:

- Direct clinical services;
- Case consultations;
- Collateral services;
- Training and education;
- Administrative activities of participating agencies;

- Management activities including Quality Management, Grievance and Appeal, Finance, Advocacy, Utilization and Risk Management, Clinical Consultation, and MIS; and
- Other uses as approved by MC ACC-RBHA.

MC ACC-RBHA shall establish policies and procedures for scheduling and prioritization of use of interactive video conferencing.

Reimbursement for telemedicine services should follow customary charges for the delivery of the appropriate procedure code(s).

Informed Consent

Before a health care provider delivers health care via Telemedicine, verbal or written informed consent from the behavioral health member or their health care decision maker must be obtained.

Informed consent can 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 HCDM can understand and comprehend. A listing of specific elements that must be provided is under our General and Informed Consent section.

Exceptions to this consent requirement include:

- If the telemedicine interaction does not take place in the physical presence of the patient; and
- In an emergency in which the patient or the patient's health care decision maker is unable to give informed consent; or (3) 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.

If a recording of the interactive video service is to be made, a separate consent to record shall be obtained. Items to be included in the consent are:

- Identifying information;
- A statement of understanding that a recording of information and images from the interactive video service will be made;
- A description of the uses for the recording;
- A statement of the member's right to rescind the use of the recording;
- A date upon which permission to use of the recording will be void unless otherwise renewed by signature of the member receiving the recorded service; and

- For members receiving services related to alcohol and other drugs or HIV status, written, time-limited informed consent must be obtained that specifies that no material, including videotape, may be re-disclosed.

If a telemedicine session is recorded, the recording must be maintained as a component on the member's medical record, in accordance with 45 C.F.R. Part 164.524. MC ACC-RBHA has established a process that allows members to attain telemedicine information in their medical records.

Licensure

Before a health care provider delivers behavioral health care services through telemedicine, the treating healthcare provider must be licensed in the state in which the patient resides (see **A.R.S. §36-3601-3603**).

Confidentiality

At the time services are being delivered through interactive video equipment, no member, other than those agreed to by the member receiving services will observe or monitor the service either electronically or from "off camera".

To ensure confidentiality of telemedicine sessions, providers must do the following when providing services via telemedicine:

- The videoconferencing room door must always remain closed;
- If the room is used for other purposes, a sign must be posted on the door, stating that a clinical session is in progress; and
- Implement any additional safeguards to ensure confidentiality.

Documentation

Medical records of telemedicine interventions must be maintained according to usual practice.

Electronically recorded information of direct, consultative, or collateral clinical interviews will be maintained as part of the member's clinical record. All policies and procedures applied to storage and security of clinical information will apply.

All required signatures must be documented in the medical record and must be made available during auditing activities performed by AHCCCS.

ACC RBHA Chapter 6 – Pharmacy Management

6.00 - 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 Care 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.

6.01 - 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

6.02 - 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.

6.03 - 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 6.11 – Request for Non-PDL Drugs** below 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.

6.04 - 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.

6.05 - 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.

6.06 - 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.

6.07 - 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

6.08 - 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

6.09 - 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 at 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.**

6.10 - 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 HCDM for each psychotropic medication prescribed. When obtaining informed consent, the BHP must communicate in a manner that the member and/or HCDM can understand and comprehend. It is preferred that

the prescribing clinician provide information forming the basis of an informed consent decision. In specific situations in which this is not possible or practicable, information may be provided by another credentialed behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience.

The comprehensive clinical record must include documentation of the essential elements for obtaining informed consent. Essential elements for obtaining informed consent for medication are contained within the **Informed Consent for Psychotropic Medication Treatment**. The use of this form is recommended as a tool to document informed consent for psychotropic medications. If Informed Consent for Psychotropic Medication Treatment is not used to document informed consent, the essential elements for obtaining informed consent must be documented in the member's individual comprehensive clinical record in an alternative fashion.

Psychotropic Medication Monitoring

Psychotropic medications are known to affect health parameters. Depending on the specific psychotropic medication(s) prescribed, these parameters must be monitored according to current national guidelines, considering individualized factors. At a minimum, these must include:

- **Heart Rate and Blood Pressure:** On initiation of any medication, follow up at week 12, and at least annually thereafter or more frequently as clinically indicated.
- **Weight/Body Mass Index (BMI):** On initiation of any medication, follow up at week 4, 8, 12, each visit and at least annually thereafter.
- **Abnormal Involuntary Movements (AIMS):** On initiation of any antipsychotic medication, follow up at week 12, and at least every six months thereafter or more frequently as clinically indicated.
- **Fasting glucose:** On initiation of any medication affecting this parameter, follow up at week 12, and at least annually thereafter or more frequently as clinically indicated.
- **Lipids:** On initiation of any medication affecting this parameter, at week 12, and at least annually thereafter or more frequently as clinically indicated.
- **Complete Blood Count (CBC):** On initiation of any medication affecting this parameter and at least annually thereafter or more frequently as clinically indicated.
- **Liver function:** On initiation of any medication affecting this parameter and at least annually thereafter or more frequently as clinically indicated.
- **Lithium level:** Within one week of initiation of lithium or significant change in dose, follow up at 6 months, and at least annually thereafter or more frequently as clinically indicated.
- **Thyroid functions:** On initiation of lithium, at 6 months, at any significant change in dose, and at least annually thereafter, or more frequently as clinically indicated.
- **EKGs**: On initiation of any medication affecting the QT interval, then as clinically indicated.

- **Renal function:** On initiation of lithium, follow up at 3 months, 6 months, at any significant change in dose, and at least annually thereafter or more frequently as clinically indicated.
- **Valproic acid level:** Within one week of initiation of valproic acid or divalproex or significant change in dose and at least annually thereafter or more frequently as clinically indicated.
- **Carbamazepine level:** Within one week of initiation of carbamazepine or significant change in dose and at least annually thereafter or more frequently as clinically indicated.
- **Review of all Medications**, including medications prescribed by the PCP and medical specialists, OTC medications, and supplements at least annually or more frequently as clinically necessary.
- **Children** are more vulnerable than adults about developing several antipsychotic induced side effects. These included higher rates of sedation, extrapyramidal side effects (except for akathisia), withdrawal dyskinesia, prolactin elevation, weight gain and at least some metabolic abnormalities. (Journal of Clinical Psychiatry 72:5 May 2011)

Polypharmacy

Commonly used psychotropic medication combinations include the following: medication combinations used to treat multiple disorders in the same patient, medication combinations that offer unique treatment advantages for a single disorder, and medication combinations to address side effects of an effective agent **(Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents J. AM. ACAD. CHILD ADOLESC. PSYCHIATRY, 48:9, SEPTEMBER 2009)**.

MC Care 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 Care has established system requirements for monitoring the following:

- Adverse drug reactions;
- Adverse drug event; and
- Medication errors.

The above referenced 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.

6.11 - 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

6.12 – 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.

6.13 – Other Pharmacy Management

Complementary and Alternative Medicine (CAM)

Complementary and alternative medicine (CAM) is not AHCCCS reimbursable.

When a BHP uses Complementary and Alternative Medicine (CAM), (see the **Arizona Medical Board's Guidelines for Physicians Who Incorporate or Use Complementary or Alternative Medicine in Their Practice**) informed consent must be obtained from the member or HCDM, when applicable, for each CAM prescribed. When obtaining informed consent, behavioral health medical practitioners must communicate in a manner that the member and/or HCDM

can understand and comprehend. The comprehensive clinical record must include documentation of the essential elements for obtaining informed consent. Essential elements for obtaining informed consent for medication are contained within the Informed Consent for Psychotropic Medication Treatment.

The use of **Informed Consent for Psychotropic Medication Treatment** is recommended as a tool to document informed consent for CAM. 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.

Pharmacy Education Meetings

The MC ACC-RBHA pharmacy department will be conducting pharmacist to Behavioral Health Provider (BHP) pharmacy education meetings throughout the year. These meetings will allow time to review new psychotropic education, BHP's report card, and to address any other issues or concerns including but not limited to outlier and high-risk members. The pharmacy claim data will be utilized to rank, trend, and compare all BHPs over time and to other peers. Prescriber report cards are provided and will include pharmacy related data such as but not limited to total member count, average cost per prescription, number of prescriptions filled per quarter, total costs for all prescriptions filled, average number of prescriptions per participant, number of adult and child/adolescent inter-class poly-pharmacy claims, and top twenty medications filled for the specified BHP.

ACC-RBHA Chapter 7 – Peer and Family Support Services and Partnership Requirements with Peer-Run and Family-Run Organizations

7.00 – 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 on further developing or enhancing their curricula, written feedback will be provided within 2 weeks, and a follow up meeting will be scheduled to review recommendations and discuss any enhancements. Prospective and current PSETPs interested in recommendations and input from the OIFA Team may also request additional review and oversight through contact with **oifateam@mercycareaz.org**.

Provider agencies rendering peer support services to any AHCCCS member including fee for service members shall maintain documentation evidencing that all actively employed peer/recovery support specialists have met the required qualifications and credentialing. All providers of peer/recovery support services are required to complete and submit quarterly reports to the OIFA Team, utilizing AMPM Policy 963: approved AHCCCS portal.

Peer Support Employment Training Programs (PSETPs) are approved through AHCCCS/OIFA. PSETPs shall include core elements addressed in AMPM Policy 963: Section H. Additional resources for development of curriculum can be found by contacting **oifateam@mercycareaz.org.** PSETPs are required to send all credentialed individuals who completed and passed their training program to AHCCCS/OIFA via email at **oifa@azahcccs.gov** utilizing AMPM Policy 963: Attachment C and must retain copies of Attachment C that may be made available to MC OIFA upon request. Individuals credentialed in another state shall submit their credential to AHCCCS/OIFA 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 meeting the above criteria may be credentialed as a parent/family support specialist by completing training and passing a competency exam through an AHCCCS/OIFA approved Credentialed Parent/Family Support Training Program. Individuals are credentialed by the agency operating the Credentialing Parent/Family Support Training Program. A list of training programs can be accessed by reaching out to **oifateam@mercycareaz.org**.

Provider agencies rendering credentialed family support services to any AHCCCS member including fee for service members shall maintain documentation evidencing that all actively employed credentialed parent/family support specialists that have met the required qualifications and credentialing. All providers are required to complete and submit biannual reports to the OIFA Team utilizing AMPM Policy 964: approved AHCCCS portal.

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 on further developing or enhancing their curricula, written feedback will be provided within 2 weeks, and a follow-up meeting will be scheduled to review recommendations and discuss any enhancements. Prospective and current CPFSPs interested in recommendations and input from the OIFA Team may also request additional review and oversight through contact with **oifateam@mercycareaz.org**. Additional resources for development of curriculum can be found by contacting **oifateam@mercycareaz.org**.

CPFSPs are required to send all credentialed individuals completing their training program to AHCCCS/OIFA. Individuals credentialed in another state shall submit their credential to AHCCCS/OIFA through their employing provider.

Individuals employed as a credentialed parent and/or family support specialist shall have a minimum of 8 hours of continuing education relevant to parent and/or family support with at least one hour covering ethics and boundaries related to the practice of family support.

Agencies employing credentialed parent and/or family support specialists shall provide supervision by individuals qualified as behavioral health technicians or behavioral health

professionals. Supervision shall require that supervisors of credentialed parents and/or family supports be established to be conducive to a sound support structure for family supports, including establishing a process for reviewing, monitoring, and training the family support on a regularly occurring basis as deemed appropriate by the provider. Supervision shall be documented and inclusive of both clinical and administrative supervision. Supervisors of parent and/or family support specialists shall have adequate access to continuing education relevant to the provision of family support services and best practices in providing supervision to credentialed parent/family support providers.

7.01 – 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 MC 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 strengths-based assessment and service planning approach. The model incorporates the concept of a "team", established for each member receiving behavioral health services.

For children, this team is the Child and Family Team (CFT) and for adults, this team is the Adult Recovery Team (ART). At a minimum, the functions of the Child and Family Team and Adult Recovery Team include initial and ongoing engagement of the member, family and others who are significant in meeting the behavioral health needs of the member, including their active participation in the decision-making process and involvement in treatment.

The team process emphasizes a family friendly, culturally sensitive, and clinically sound model that focuses on identification of the member and family strengths. The process includes engagement and input from those members being served, as well as their family and significant others, and focuses on identifying the member's and team member's preferences.

MC requires the following from subcontractors and providers:

- The ability to welcome and engage family members in the member's service planning and service delivery as full partners in the planning, delivery, and evaluation of services and supports;
- Demonstration of the ability to include family members viewpoint in the service planning and service delivery processes;
- Encourage and engage family members to participate, be active and respected as part of the member's team;
- During the assessment process, establish that the service assessment and service planning process is viewed as a partnership and is a team approach;
- During the Individual Service Plan (ISP) development, the assessor will identify the unique strengths, needs and preferences of the member, family/caregiver and identified team members. The needs (and associated services) identified in the ISP will be tailored to the unique strengths, values and beliefs of each individual member and their family, and will be updated as members progress toward recovery and their goals evolve;
    - All Individual Service Planning (ISP) and development with children is completed collaboratively with the child's parent and/or primary caregiver;
    - Development and prioritization of ISP goals are not focused solely on the child, but include the parent, caregiver, and the needs of the family as a whole;

- All ISP should consider the inclusion of community and natural supports;
- Providers are required to adhere to **AHCCCS Clinical Guidance Tool Family and Youth Involvement in the Children's Behavioral Health System**.
- Provide support to family members to assist in eliminating barriers preventing them from actively participating on the member's team, and;
- Establish a mechanism that will provide family support be accessible to families to help engage the family and to help the individual best utilize their natural support network;
- Establish partnerships with peer-run and family-run organizations to co-facilitate trainings on peer and family-professional partnerships, and;
- Partner with peer and family-run organizations in the delivery of training on peer-to-peer and family-to-family roles for Peer and Parent/Family Support Provider roles employed in the system.

MC requires providers to demonstrate documentary evidence to show participation of at least one peer, youth or family during the interview process when hiring for all direct services staff positions. MC requires affiliated providers to have at least one peer/recovery support specialist assigned on each adult recovery team.

ACC RBHA Chapter 8 – Dental and Vision Services

8.00 – Dental Overview

Liberty Dental Plan

Effective January 1, 2026, Liberty Dental Plan will administer dental benefits for MC ACC-RBHA.

Liberty Dental Plan has administrative oversight for the following responsibilities:

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

MC ACC-RBHA 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 at the following claims address:

Liberty Dental Plan
Attention: Claims
P.O. Box 401086
Las Vegas, NV 89140

For electronic claims submissions, Liberty Dental Plan works directly with the following Clearinghouses:

DentalXchange (800-576-6412)
Vyne Dental (463-218-6519)

You can contact your software vendor to make certain that they have Liberty Dental Plan listed as the payer and claim mailing address on your electronic claim. Your software vendor will be able to provide you with any information you may need to ensure that submitted claims are forwarded to Liberty Dental Plan. Liberty Dental Plan's Payer ID is CX083.

If you have additional questions regarding your claims for Liberty Dental Plan, you may contact them directly at 888-352-7924. They will be happy to assist you.

You may also utilize their Interactive Voice Response (IVR) system 24 hours a day, 7 days a week that provides up-to-date information regarding member eligibility, claim status, and much more. Benefits associated with this program and more detailed information regarding Liberty Dental Plan can be found in their Provider Reference Guide on-line at **https://www.libertydentalplan.com/Resources/Documents/AZ-Provider-Reference-Guide.pdf.**

Billing for Medical Services

- Physicians performing general anesthesia will bill on the CMS 1500 form with the appropriate CPT/HCPCS codes.
- Ambulatory Surgical Centers will bill on the CMS 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
Claims Department
P.O. Box 982975
El Paso, TX 79998-2975

8.01 – Dental Covered Services

Dental Screening/Dental Treatment for members under 21

More information regarding Dental Screening/Dental Treatment for members under 21 is available under the **MC Provider Manual Chapter 100 – General Terms, Chapter 5 – Early and Periodic Screening, Diagnostic and Treatment (EPSDT)**.

The following dental services/dental treatments are covered for members under age 21:

- Oral health screenings
- Cleanings
- Fluoride treatments
- Dental sealant
- Oral hygiene education
- X-rays
- Fillings
- Extractions
- Other therapeutic and medically necessary procedures
- Routine dental services

Two (2) routine preventive dental visits are covered per year. Visits to the dentist must take place within six months and one day after the previous visit. The first dental visit should take place by one year of age. 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** at **https://www.libertydentalplan.com/Resources/Documents/AZ-Provider-Reference-Guide.pdf**. MC ACC-RBHA 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 links to the AHCCCS Medical Policy Manual:

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

Effective April 1, 2023, American Indian/Alaskan Native MC members over the age of 21 years with an SMI designation have an Enhanced Tribal Dental Benefit which covers preventive oral health care procedures in addition to the Emergency Dental Benefit. American Indian/Alaskan Native MC Care members over 21 with an SMI designation do not need to do anything to receive this benefit and may continue to see the same dentist. American Indian/Alaskan Native members who qualify for this benefit who have questions or need help may contact MC Member Service at 602-263-3000 or 1-800-624-3879 (TTY 711).

Informed Consent for Dental Treatment

Informed consent is a process by which the provider advises the recipient/recipient's representative of the diagnosis, proposed treatment and 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 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 limit. If the member agrees to pursue the receipt of services:

- The provider must supply the member a document describing the service and the anticipated cost of the service.
- Prior to service delivery, the member must sign and date a document indicating that he/she understands that he/she will be responsible for the cost of the service to the extent that it exceeded the $1,000 limit.

8.02 – Vision Services

Vision Overview

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

Coverage for Eligible Members 18, 19 & 20 Years of Age

- 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 care is covered.
- 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.

Nationwide Referral Instructions

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

Coverage for Eligible Members 21 Years and Over

- Emergency eye care, which meets the definition of an emergency medical condition is covered.
- Medically necessary vision examination and optometry services are covered unless it is for prescriptive lenses. Eye examinations for prescriptive lenses are not covered.
- Treatment of medical conditions of the eye after cataract surgery.
- Prescriptive lenses are only covered if they are the sole visual prosthetic device used by the member after a cataract extraction. (AMPM Policy 310-JJ - Orthotics and Prosthetics).
- Cataract removal is covered if certain criteria is met. For more information on the criteria needed, please review the AHCCCS AMPM Chapter 300 - Exhibit 300-1 - AHCCCS Covered Benefits with Special Circumstances.

8.03 – Dental and Vision Community Resources for Adults

AHCCCS benefits do not include routine dental and vision services for adults. However, there are community resources available to help members obtain routine dental and vision care. For more information, call MC ACC-RBHA's Member Services at 800-564-5465.

ACC RBHA Chapter 9 – Care Coordination

9.00 – Integrated Care Management

Care Management

MC ACC-RBHA's Care Management program has been designed to improve member health outcomes. The program provides needed care in the most appropriate setting and in a culturally competent and accessible format. Additional information can be found on our website under Care Management/Disease Management. Referrals for care management can be completed by calling the Care Management Referral Line at 602-798-2627 or e-mailing the Care Management Department at **MMICCareManagementReferrals@aetna.com.**

Responsibilities

MC ACC-RBHA's Chief Medical Officer (CMO) is responsible for directing and overseeing MC ACC-RBHA's care management program with the assistance of the Medical Management Administrator and the Director of Care Management. This oversight includes ensuring the incorporation of treatment practice guidelines into the care management practice and program.

MC ACC-RBHA has established a policy for a Care Management program that covers the following objectives:

- Identify the top tier of high risk/high-cost members with Serious Mental Illness (SMI) in a fully integrated health care program (estimated at twenty percent [20%]);
- Effectively transition members from one level of care to another;
- Streamline, monitor and adjust member's care plans based on progress and outcomes;
- Reduce hospital admissions and unnecessary emergency department and crisis service use; and
- Provide members with the proper tools to self-manage care to safely live, work, and integrate into the community:
    - Inform members of health care conditions that require follow up; and
    - Educate members on the benefits of complying with prescribed treatment regimens.

General Requirements

For all members determined to have a SMI diagnosis who are receiving physical health care services through MC ACC-RBHA, MC ACC-RBHA must:

- Establish and maintain a Care Management Program (CMP).
- Allow the member to select (or MC ACC-RBHA) a PCP or BH clinician who is formally designated as having primary responsibility for coordination of the member's overall health care.

- Educate and communicate with PCPs who treat depression, anxiety, and ADHD. Identify members with special health care needs and:
    - Ensure an assessment by a qualified health care professional for ongoing needs is completed.
    - Ensure ongoing communication among providers.
    - Ensure that a mechanism for direct access to specialists exists, as appropriate.
    - For members in the Integrated plan who are discharging from the Arizona State Hospital (AzSH), MC ACC-RBHA must provide all insulin dependent diabetic members with the same brand and model glucose monitoring device as used in the hospital upon discharge from AzSH;
- On an ongoing basis, utilize tools and strategies to develop a case registry for all SMI members which at a minimum, will include:
    - Diagnostic classification methods that assign primary and secondary chronic co-morbid conditions;
    - Predictive models that rely on administrative data to identify those members at high risk for over-utilization of behavioral health and physical health services, adverse events, and higher costs;
    - Incorporation of health risk assessments into predictive modeling to tier members into categories of need to design appropriate levels of clinical intervention, especially for those members with the most potential for improved health-related outcomes and more cost-effective treatment; and
    - Criteria for identifying the top tier of high cost, high risk members for enrollment into the Care Management Program.
- Assign and monitor Care Management caseloads consistent with a member's acuity and complexity of need for Care Management.
- Allocate Care Management resources to members consistent with acuity and evidence-based outcome expectations.
- Provide technical assistance to Care Managers including case review, continuous education, training, and supervision.
- Communicate Care Management activities with all the MC ACC-RBHA organizational units with emphasis on regular channels of communication with the MC ACC-RBHA's Medical Management, Quality Management and Adult Systems of Care departments.
- Assist in facilitating communication to exchange information between PCP and Behavioral Health provider, including monitoring to ensure coordination and remediation if the communication does not occur.
- Have Care Managers who, at a minimum, will be required to complete a comprehensive case analysis review of each member enrolled in MC ACC-RBHA's Care Management Program at the Supportive and Intensive levels of care on a quarterly basis. The case analysis review shall include, at a minimum:
    - A medical record chart review;

- Consultation with the member's treatment team;
- Review of administrative data such as claims/encounters; and
- Demographic and customer service data.

Eligibility

MC ACC-RBHA's care management program is available to enrolled members who qualify for the care management program, are Title XIX and have been determined to have a status of seriously mentally ill (SMI). The assessed needs of the member determine the level and type of care management. Typical members are those who:

- Are at high risk of poor health outcomes and high utilization;
- Have an acute or chronic diagnosis or condition; and
- Have inappropriately managed their health care and require more complex or frequent healthcare and services.

Member Identification for Care Management

MC ACC-RBHA utilizes data from multiple sources to identity members who may benefit from care management to meet their individualized needs. These tools allow for members to be stratified into a case registry and their specific risks identified, including chronic co-morbid conditions and specific gaps in care. Members may be identified through population-based tools (i.e., predictive modeling) and individual-based tools (i.e., Health Risk Assessment [HRA]).

Daily, HRAs are incorporated into the care management business application, in addition to predictive modeling data, to further identify members that may need care management. This data also assists in identifying the appropriate care management level, particularly for those members with the greatest potential for improved health outcomes and increased cost-effective treatment.

In addition, members are identified for care management through various referral sources from within MC ACC-RBHA and through external sources, also known as Surveillance Referrals. These referral sources include, but are not limited to, the following:

- Member self-referral
- Family and/or caregiver
- Interdisciplinary Team (IDT)
- Utilization Management (UM) referral
- Quality Management (QM) referral
- Various other MC ACC-RBHA departments
- Discharge planner referral
- Provider referral
- Provider submissions of the American College of Obstetricians and Gynecologists (ACOG) comprehensive assessment tool

- Provider submission of an Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Clinical Sample Template
- AHCCCS – Arizona Health Care Cost Containment System

To make a referral on behalf of a member to the Care Management program, contact 800-564-5465, Option 2 for Provider Calls, then select Option 1 to speak with a MC ACC-RBHA Member Service Representative (MSR). Upon receipt of referral, MC ACC-RBHA's Care Management department will assess the member's eligibility against the criteria and provide written notification of placement decision within 30 days of referral.

Care Planning

The care manager and members of the treatment team each participate in the development of the care plan which is designed to prioritize goals that consider the member's and caregiver's strengths, needs, goals, and preferences. All providers participating in the member's care will receive a copy of this plan and are asked to update it, as necessary.

The care plan will support and help to inform the member's Individual Recovery Plan/Individual Service Plan but will not be a substitute for that plan. The treatment team assigned to the ACC-RBHA Health Home or Integrated Health Home (IHH) should work with the member to incorporate items from the care plan into the member's Individual Recovery Plan/Individual Service Plan which supports the overall wellness of the member.

As part of the care planning process, the care manager documents a schedule for follow up with the treatment team and convenes care plan reviews at intervals consistent with the identified member care needs and to ensure progress and safety. Care plan reviews are pre-scheduled and designed to evaluate progress toward care plan goals and meeting member needs. The care plan can be revised or adjusted at any point based on member progress and outcomes. The care plan identifies the next point of review and is saved in the member's electronic record in the care management business application system.

Case Rounds

A member's unique care needs can also be addressed through formal interdisciplinary case rounds. In case rounds, both treatment and non-treatment staff may present cases to their peers and treatment leaders to seek guidance and recommendations on how to best address the member's physical, behavioral, and social care needs. Case rounds typically focus on members who are at high risk, have complex co-morbid conditions and/or have difficulty sustaining an effective working relationship with treatment and/or non-treatment staff. Case rounds may also include representatives from the member's treatment team. Case rounds are done at minimum bi-weekly, twice a month.

9.01 - Chronic Condition Management

Chronic condition management is part of the Care Management program. It is intended to enhance the health outcomes of members. Chronic condition management targets members who have illnesses that have been slow to respond to coordinated management strategies in the areas of diabetes, respiratory (COPD, asthma), and cardiac (CHF). Also included in chronic condition management are High Risk Obstetrical members and members who are diagnosed with HIV/AIDS. The primary goal of disease management is to positively affect the outcome of care for these members through education and support and to prevent exacerbation of the condition, which may lead to unnecessary hospitalization.

The objectives of chronic condition management programs are to:

- Identify members who would benefit from the specific chronic condition management program.
- Educate members on their disease, symptoms, and effective tools for self-management.
- Monitor members to encourage/educate about self-care, identify complications, assist in coordinating treatments and medications, and encourage continuity and comprehensive care.
- Provide evidence-based, nationally recognized expert resources for both the member and the provider.
- Monitor effectiveness of interventions.

The following conditions are specifically included in MC ACC-RBHA's Chronic Condition Management programs and have associated **Clinical Guidelines** that are reviewed annually by the Medical Management/Utilization Management Committee.

Asthma

The Asthma Disease Management program offers coordination of care for identified members with primary care physicians, specialists, community agencies, the member's caregivers, and/or family. Member education and intervention is targeted to empower and enable compliance with the physician's treatment plan.

Providers play an important role in helping members manage this chronic disease by promoting program goals and strategies, including:

- Preventing chronic symptoms.
- Maintaining "normal" pulmonary function.
- Maintaining normal activity levels.
- Maintaining appropriate medication ratios.
- Preventing recurrent exacerbation and minimizing the need for emergency treatment or hospitalizations.

- Providing optimal pharmacotherapy without adverse effects.
- Providing education to help members and their families better understand the disease and its prevention/treatment.

Chronic Obstructive Pulmonary Disease (COPD)

The COPD Disease Management program is designed to decrease the morbidity and mortality of members with COPD. The goal of the program is to collaborate with providers to improve the quality of care provided to members with COPD, decrease complication rates and utilization costs, and improve the member's health. The objectives of the COPD Disease Management program are to:

- Identify and stratify members.
- Provide outreach and disease management interventions.
- Provide education through program information and community resources.
- Provide provider education through the COPD guidelines, newsletters, and provider profiling.

Congestive Heart Failure (CHF)

The CHF Disease Management program is designed to develop a partnership between MC ACC-RBHA, the PCP and the member to improve self-management of the disease. The program involves identification of members with CHF and subsequent targeted education and interventions. The CHF Chronic Condition Management program educates members with CHF on their disease, providing information on cardiac symptoms, blood pressure management, weight management, nutritional requirements, and benefits of smoking cessation.

Diabetes

The Diabetes Chronic Condition Management program is designed to develop a partnership between MC ACC-RBHA, the PCP and the member to improve self-management of the disease. The program involves identification of members with diabetes and subsequent targeted education and interventions. In addition, the program offers providers assistance in increasing member compliance with diabetes care and self-management regimens. Providers play an important role in helping members manage this chronic condition. MC ACC-RBHA appreciates providers' efforts in promoting the following program goals and strategies:

- Referrals for formal diabetes education through available community programs;
- Referrals for annual diabetic retinal eye exams by eye care professionals as defined in MC ACC-RBHA's Diabetes Management Clinical Guidelines;
- Laboratory exams that include:
    - Glycohemoglobins at least twice annually
    - Micro albumin
    - Fasting lipid profile annually; and
- Management of co-morbid conditions like blood pressure, CHF, and blood cholesterol.

HIV/AIDS

Early identification and intervention of members with HIV allows the care manager to assist in developing basic services and information to support the member during the disease process. The care manager links the member to community resources that offer various services, including housing, food, counseling, dental services, and support groups. The member's cultural needs are continually considered throughout the care coordination process.

The MC ACC-RBHA care manager works closely with the PCP, the MC ACC-RBHA corporate director of pharmacy, and a MC ACC-RBHA medical director to assist in the coordination of the multiple services necessary to manage the member's care. PCPs wishing to provide care to members with HIV/AIDS must provide documentation of training and experience and be approved by the MC ACC-RBHA credentialing process. These PCPs must agree to comply with specific treatment protocols and AHCCCS requirements. PCPs may elect to refer the member to an AHCCCS approved HIV specialist for the member's HIV treatment.

High Risk Obstetrical

Members that have been identified as high-risk obstetrical patients, either for medical or social reasons, are assigned to an OB care manager to try to ensure a good newborn/mother outcome. The care manager may refer the expectant mother to a variety of community resources, including WIC, food banks, childbirth classes, smoking cessation, teen pregnancy care management, shelters, and counseling to address substance abuse issues. A care manager monitors the pregnant woman throughout the pregnancy and provides support and assistance to help reduce risks to the mother and baby.

Care managers also work very closely with the PCP to make sure that the member is following through with all prenatal appointments and the prescribed medical regimen. Members with complex medical needs are also assigned a care manager so that all the member's medical and perinatal care issues are addressed appropriately.

ACC RBHA Chapter 10 – Coordination of Care

10.00 – Inter-TRBHA Coordination of Care

General Provisions

Computation of Time – In computing any period prescribed or allowed by this chapter, the period begins the day after the act, event, or decision occurs and includes all calendar days and the final day of the period. If the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or a legal holiday. If the period is not designated as calendar days and is less than 11 days, then intermediate Saturdays, Sundays, and legal holidays must not be included in the computation.

Jurisdictional Responsibilities

For adults (members 18 years and older), the TRBHA jurisdiction is determined by the member's current place of residence, except members who are unable to live independently must not be transferred to another TRBHA. This is applicable regardless of where the adult HCDM lives.

Responsibility for service provision, other than crisis services, remains with the home TRBHA when the enrolled member is visiting or otherwise temporarily residing in a different TRBHA area but:

- Maintains a place of residence in his or her previous location with an intent to return and
- The anticipated duration of the temporary stay is less than three months.

For children (ages 0-17 years), TRBHA responsibility is determined by the current place of residence of the child's parent(s) or HCDM unless the AHCCCS-eligible child is in the custody of DCS, remains with the same court of jurisdiction and moves to another county due to the location of an out-of-home placement (e.g., foster home, kinship, or group home).

Inter-TRBHA transfers must be completed within 30 days of referral by the home TRBHA. The home TRBHA must ensure that activities related to arranging for services or transferring a case does not delay a member's discharge from an inpatient or residential setting.

Out-of-Area Service Provision

Crisis Services

Crisis services must be provided without regard to the member's enrollment status. When a member presents for crisis services the TRBHA will:

- Provide needed crisis services;
- Ascertain the member's enrollment status with all TRBHAs and determine whether the member's residence is temporary or permanent.

- If the member is enrolled with another TRBHA, notify the home TRBHA within 24 hours of the member's presentation. The home TRBHA or their contracted providers is fiscally responsible for crisis services and must:
  - Decide with the TRBHA at which the member presents to provide needed services, funded by the home TRBHA;
  - Arrange transportation to return the member to the home TRBHA area; or
  - Determine if the member intends to live in the new TRBHA and if so, initiate a transfer. Members who are unable to live independently but clearly express an intent/desire to permanently relocate to another service area can be transferred. However, the home TRBHA must decide on housing and consider this a temporary placement for three months. After three months, if the member continues to clearly express an intent/desire to remain in this new service area, the inter-TRBHA transfer can proceed.
- If the member is not enrolled with any TRBHA, lives in GSA 6 and has presented for services, behavioral health providers must notify the MC ACC-RBHA to initiate an enrollment. Providers should notify MC ACC-RBHA at 800-564-5465.
- If the member is not enrolled with any TRBHA, lives outside of GSA 6 and is presenting for crisis services, MC ACC-RBHA must enroll the member, provide needed crisis services, and initiate the inter-TRBHA transfer.
- If TRBHA or provider receives a referral regarding a hospitalized member whose residence is located outside the TRBHA, or provider must immediately coordinate the referral with the member's designated TRBHA.

Non-Emergency Services

If the member is not enrolled with a TRBHA, lives outside of the service area, and requires services other than a crisis or urgent response to a hospital, the TRBHA must notify the designated TRBHA associated with the member's residence within 24 hours of the member's presentation. The designated TRBHA must proceed with the member's enrollment if determined eligible for services. The designated TRBHA is fiscally responsible for the provision of all medically necessary covered services including transportation services for eligible members.

Courtesy Dosing of Methadone

A member receiving methadone administration services who is not a member of take-home medication may receive up to two courtesy doses of methadone from a TRBHA while the member is traveling out of the home TRBHA's area. All incidents of provision of courtesy dosing must be reported to the home TRBHA. The home TRBHA must reimburse the TRBHA providing the courtesy doses upon receipt of properly submitted bills or encounters.

Referral for Service Provision

If a home TRBHA initiates a referral to another TRBHA or a service provider in another TRBHA's area for the purposes of obtaining behavioral health services, the home TRBHA must:

- Maintain enrollment and financial responsibility for the member during the period of out-of-area behavioral health services,
- Establish contracts with out-of-area service providers and authorize payment for services,
- Maintain the responsibilities of the behavioral health provider, and
- Provide or arrange for all needed services when the member returns to the home TRBHA's area.

Children in the Custody of DCS

If an AHCCCS-eligible child is in the custody of DCS, remains with the same court of jurisdiction and moves to another county due to the location of an out-of-home placement, the child may continue any current treatment in the previous county and/or seek new or additional treatment in the out-of-home placement's county.

Inter-TRBHA

A transfer will occur when:

- An adult member voluntarily elects to change their place of residence to an independent living setting from one TRBHA's area to another.
- Members who are unable to live independently but clearly express an intent/desire to permanently relocate to another service area can be transferred. However, the home TRBHA must decide on housing and consider this to be a temporary placement for 3 months. After 3 months, if the member continues to clearly express an intent/desire to remain in this new service area, the inter-RBHA transfer can proceed.
- The parent(s) or HCDM(s) of a child change their place of residence to another TRBHA's area; or
- The court of jurisdiction of a dependent child change to another TRBHA's area.
    - A transfer will not occur when an AHCCCS-eligible child is in the custody of DCS, remains with the same court of jurisdiction and moves to another county due to the location of an out-of-home placement (e.g., foster home, kinship, or group home).

Inter-TRBHA transfers are not to be initiated when a member is under pre-petition screening or court ordered evaluation).

Timeframes for initiating an Inter-TRBHA transfer

The home TRBHA shall initiate a referral for an Inter-TRBHA transfer:

- 30 days prior to the date on which the member will move to the new area; or

- If the planned move is in less than 30 days, immediately upon learning of the member's intent to move.

Inter-RBHA Process

The referral is initiated when the home TRBHA provides a completed **Inter-TRBHA Transfer Request Form**. In addition, the following information must be provided to the receiving TRBHA as quickly as possible:

- The member's comprehensive clinical record,
- Consents for release of information;
- For Title XIX eligible members between the ages of 21 and 64, the number of days the member has received services in an IMD in the contract year (July 1 – June 30);
- The number of hours of respite care the member has received in the contract year (July 1 – June 30); and
- The receiving TRBHA must not delay the timely processing of an Inter-TRBHA transfer because of missing or incomplete information.

Upon receipt of the transfer packet, the receiving TRBHA must:

- Notify the home TRBHA within seven calendar days of receipt of the referral for Inter-TRBHA transfer;
- Proceed with deciding for the transfer; and
- Notify the home TRBHA if the information contained in the referral is incomplete.

Within 14 days of receipt of the referral for an Inter-TRBHA transfer, the receiving TRBHA or its subcontracted providers must:

- Schedule a meeting to establish a transition plan for the member. The meeting must include:
    - The member or the member's HCDM or parent, if applicable;
    - Representatives from the home TRBHA;
    - Representatives from the Arizona State Hospital (AzSH), when applicable;
    - The behavioral health provider and representatives of the CFT/adult clinical team;
    - Other involved agencies; and
    - Any other relevant participant at the member's request or with the consent of the HCDM.
- Establish a transition plan that includes at least the following:
    - The member's projected moving date and place of residence;
    - Treatment and support services needed by the member and the timeframe within which the services are needed;
    - A determination of the need to request a change of venue for court ordered treatment and who is responsible for making the request to the court, if

applicable;
- Information to be provided to the member regarding how to access services immediately upon relocation;
- The enrollment date, time, and place at the receiving TRBHA and the formal date of transfer, if different from the enrollment date;
- The date and location of the member's first service appointment in the receiving TRBHA's GSA;
- The individual responsible for coordinating any needed change of health plan enrollment, primary care provider assignment, and medication coverage;
- The member's behavioral health provider in the receiving TRBHA's GSA, including information on how to contact the behavioral health provider;
- Identification of the member at the receiving TRBHA who is responsible for coordination of the transfer, if other than the member's behavioral health provider;
- Identification of any special authorization required for any recommended service (e.g., non-formulary medications) and the individual who is responsible for obtaining needed authorizations; and
- If the member is taking medications prescribed for a behavioral health issue, the location and date of the member's first appointment with a practitioner who can prescribe medications. There must not be a gap in the availability of prescribed medications to the member.

On the official transfer date, the home TRBHA must enter a closure and disenrollment into CIS. The receiving TRBHA must enter an intake and enrollment into CIS at the time of transfer. If the member scheduled for transfer is not located or does not show up for his/her appointment on the date arranged by the TRBHAs to transfer the member, the TRBHAs must collaborate to ensure appropriate re- engagement activities occur and proceed with the inter-TRBHA transfer, if appropriate. Each TRBHA must designate a contact member responsible for the resolution of problems related to enrollment and disenrollment

When a member presents for crisis services, providers must first deliver needed behavioral health services and then determine eligibility and TRBHA enrollment status. Members enrolled after a crisis event may not need or want ongoing behavioral health services through the TRBHA. Providers must conduct re- engagement efforts, however, members who no longer want or need ongoing behavioral health services must be dis-enrolled (i.e., closed in the CIS) and an inter-TRBHA transfer must not be initiated. Members who will receive ongoing behavioral health services will need to be referred to the appropriate TRBHA and an inter-TRBHA transfer initiated if the member presented for crisis services in a GSA other than where the member resides.

Timeframes specified above cover circumstances when behavioral health members inform their provider or TRBHA prior to moving to another service area. When behavioral health members inform their provider or TRBHA less than 30 days prior to their move or do not inform their provider or TRBHA of their move, the designated TRBHA must not wait for all the documentation from the previous TRBHA before scheduling services for the behavioral health member.

Complaint Resolution

A member determined to have a Serious Mental Illness that is the subject of a request for out-of-area service provision or Inter-TRBHA transfer may file an appeal.

Any party involved with a request for out-of-area service provision or Inter-TRBHA transfer may initiate the complaint resolution procedure. Parties include the home TRBHA, receiving TRBHA, member being transferred, or the member's HCDM or parent, if applicable; the Arizona State Hospital (AzSH), if applicable, and any other involved agencies.

The following issues may be addressed in the complaint resolution process:

- Any timeframe or procedure contained in this policy;
- Any dispute concerning the level of care needed by the member; and
- Any other issue that delays the member's discharge from an inpatient or residential setting or completion of an Inter-TRBHA transfer.

Procedure for Non-Emergency Disputes

First Level

- A written request for the complaint resolution process shall be addressed to:
    - The member's behavioral health provider at the home TRBHA, or other individual identified by the TRBHA, if the issue concerns out-of-area service provision; or
    - The identified behavioral health provider at the receiving TRBHA, or other individual identified by the TRBHA, if the issue concerns an Inter-TRBHA transfer.
- The behavioral health provider must work with involved parties to resolve the issue within five days of receipt of the request for complaint resolution.
- If the problem is not resolved, the behavioral health provider must, on the fifth day after the receipt of the request, forward the request for complaint resolution to the second level.

Second Level

- Issues concerning out-of-area service provision must be forwarded to the Chief Executive Officer, or designee, of the home TRBHA.

- Issues concerning Inter-TRBHA transfers must be forwarded to the Chief Executive Officer, or designee, of the receiving TRBHA.
- The Chief Executive Officer must work with the Chief Executive Officer of the other involved TRBHA to resolve the issue within five days of receipt of the complaint resolution issue.
- If the problem is unresolved, the Chief Executive Officer must, on the fifth day after the receipt of the request, forward the request to the Deputy Director of AHCCCS.

Third Level

- The Deputy Director of AHCCCS, or designee, will convene a group of financial and/or clinical personnel as appropriate to the complaint resolution issue to address and resolve the issue.
- The Deputy Director will issue a final decision within five days of receipt of the request.

Procedure for Emergency Disputes

An emergency dispute includes any issue in which the member is at risk of decompensation, loss of residence, or being in violation of a court order. The home TRBHA must ensure that medically necessary behavioral health services continue pending the resolution of an emergency dispute between TRBHAs.

First Level

- Issues concerning out-of-area service provision must be forwarded to the Chief Executive Officer, or designee, of the home TRBHA.
- Issues concerning Inter-TRBHA transfers must be forwarded to the Chief Executive Officer, or designee, of the receiving TRBHA.
- The Chief Executive Officer must work with the Chief Executive Officer of the other involved TRBHA to resolve the issue within two days of receipt of the complaint resolution issue.
- If the problem is unresolved, the Chief Executive Officer must, on the second day after the receipt of the request, forward the request to the Deputy Director of AHCCCS.

Second Level

- The Deputy Director of AHCCCS, or designee, will convene a group of financial and/or clinical personnel as appropriate to the complaint resolution issue, to address and resolve the issue.
- The Deputy Director will issue a final decision within two days of receipt of the request.

10.01 – Coordination of Care with AHCCCS Health Plans, PCPs, and Medicare Providers

Coordinating Care with AHCCCS Health Plans

The following procedures will assist behavioral health providers in coordinating care with AHCCCS Health Plans:

- If the identity of the member's primary care provider (PCP) is unknown, subcontracted providers must contact the Complete Care Health Plan or the Behavioral Health Coordinator of the member's designated health plan to determine the name of the member's assigned PCP.
- If the member is determined to have a serious mental illness, providers should contact MC ACC-RBHA Member Services to determine the name and contact information for the member's PCP. TRBHA enrolled members who have never contacted their PCP prior to entry into the behavioral health system should be encouraged to seek a baseline medical evaluation. TRBHA enrolled members should also be prompted to visit their PCP for routine medical examinations annually or more frequently if necessary.
- MC ACC-RBHA subcontracted providers should request medical information from the member's assigned PCP. Examples include current diagnosis, medications, pertinent laboratory results, last PCP visit, Early Periodic Screening, Diagnosis and Treatment (EPSDT) screening results and last hospitalization. If the PCP does not respond to the request, the subcontracted provider should contact the health plan's Behavioral Health Coordinator for assistance.
- MC ACC-RBHA subcontracted providers must address and attempt to resolve coordination of care issues with AHCCCS Health Plans and PCPs at the lowest possible level. If problems persist, contact the MC ACC-RBHA Complete Care Health Plan and Provider Coordinator via Customer Services at 800-564-5465.

MC ACC-RBHA and Complete Care Health Plan and Provider Coordinator

MC ACC-RBHA has designated a Complete Care Health Plan and Provider Coordinator who gathers, reviews, and communicates clinical information requested by PCPs, Complete Care Behavioral Health Coordinators and other treating professionals or involved stakeholders.

MC ACC-RBHA maintains a designated and published phone number for the Complete Care Health Plan and Provider Coordinator or a clearly recognized prompt on an existing phone number that facilitates prompt access to the Complete Care Health Plan and Provider Coordinator and that is staffed during business hours. The phone number is (800) 564-5465.

MC ACC-RBHA provides Complete Care Health Plan and Provider Coordinators with training, which includes, at a minimum, the following elements:

- Provider inquiry processing and tracking (including resolution timeframes);
- MC ACC-RBHA procedures for initiating provider contracts or AHCCCS provider registration;
- Claim submission methods and resources;
- Claim dispute and appeal procedures; and

- Identifying and referring quality of care issues.

Sharing Information with PCPs, AHCCCS Complete Care Health Plans, Other Treating Professionals, and Involved Stakeholders

To support quality medical management and prevent duplication of services, behavioral health providers are required to disclose relevant behavioral health information pertaining to Title XIX and Title XXI eligible members to the assigned PCP, AHCCCS Complete Care Health Plans, other treating professionals, and other involved stakeholders within the following required timeframes:

- **Urgent** – requests for intervention, information, or response within 24 hours.
- **Routine** – Requests for intervention, information, or response within 10 days.

Coordination of Care for Members with a Serious Mental Illness

Members with a Serious Mental Illness receive their behavioral health and medical care through an integrated service delivery system. Members have the choice to receive services in the setting that meets their needs and preferences, including:

- A co-located setting.
- An integrated Patient-Centered Medical Home.

MC ACC-RBHA's subcontracted providers are responsible for actively participating on the member's clinical team, working with the member to develop the member's Individual Service Plan, and sharing information on the member's progress, and the services and medications the member is receiving.

Coordination of Care for Members

For all Title XIX/XXI enrolled members who are not determined to have a Serious Mental Illness, subcontracted providers are required to:

- Notify the assigned PCP of the results of PCP initiated behavioral health referrals;
- Provide a final disposition to the health plan Behavioral Health Coordinator in response to PCP initiated behavioral health referrals;
- Coordinate the placement of members in out-of-state treatment settings;
- Provide a copy to the PCP of any executed advance directive, or documentation of refusal to sign an advance directive, for inclusion in the behavioral health member's medical record; and
- Notify, consult with, or disclose other events requiring medical consultation with the member's PCP.

Upon request by the PCP or member, information for any enrolled member must be provided to the PCP.

When contacting or sending any of the above referenced information to the member's PCP, subcontracted providers must provide the PCP with an agency contact name and telephone number in the event the PCP needs further information.

MC ACC-RBHA subcontracted providers should use **Communication Document** for coordinating care with the AHCCCS Health Plan PCP or Behavioral Health Coordinator. The form includes the required elements for coordination purposes and must be completed in full for coordination of care to be considered to occur. For complex problems, direct provider-to-provider contact is recommended to support written communications.

Communication Document will not have to be used if there is a properly documented progress note. To be considered properly documented the progress note must:

- Include a header that states "Coordination of Care";
- Be legible; and
- Include all the required elements contained in the **Communication Document**.

Responsibility for Fee-for-Service Members

It is the responsibility of MC ACC-RBHA to provide fee-for-service behavioral health services to Title XIX/XXI eligible members **not** enrolled with an AHCCCS Health Plan.

MC ACC-RBHA is responsible for providing all inpatient emergency behavioral health services for fee-for-service members with psychiatric or substance abuse diagnoses.

MC ACC-RBHA is responsible for behavioral health services to Native American Title XIX and Title XXI eligible members referred by an Indian Health Services (IHS) or tribal facility for emergency services rendered at non-IHS facilities.

Responsibility for Members enrolled in AHCCCS Health Plan

MC ACC-RBHA is responsible for behavioral health services during Prior Period Coverage. This is limited to the behavioral health services only and after the individual has been medically cleared. The Health Plan Contractor is still obligated to provide all necessary medical services. The following rules apply for other areas of coverage:

Pre-petition Screenings and Court Ordered Evaluations

Payment for pre-petition screenings and court ordered evaluation is the responsibility of the county. In Maricopa County, these services are provided through the MC ACC-RBHA provider network.

Emergency Behavioral Health Services

When a Title XIX or Title XXI eligible member presents in an emergency room setting, the member's AHCCCS Health Plan is responsible for all emergency medical services including triage, physician assessment, and diagnostic tests.

MC ACC-RBHA, or when applicable, its designated behavioral health provider, is responsible for psychiatric and/or psychological evaluations in emergency room settings provided to all Title XIX and Title XXI members enrolled with MC ACC-RBHA.

MC ACC-RBHA is responsible for providing all non-inpatient emergency behavioral health services to Title XIX and Title XXI eligible members. Examples of non-inpatient emergency services include assessment, psychiatric evaluation, mobile crisis, peer support, and counseling.

MC ACC-RBHA is responsible for providing all inpatient emergency behavioral health services to members with psychiatric or substance abuse diagnoses for all Title XIX and Title XXI eligible members.

MC ACC-RBHA is responsible for Emergency transportation of a Title XIX or Title XXI eligible member to the emergency room (ER) when the member has been directed by MC ACC-RBHA or a subcontracted provider to present to this setting to resolve a behavioral health crisis. MC ACC-RBHA or the subcontracted provider directing the member to present to the ER must notify the emergency transportation provider of MC ACC-RBHA's fiscal responsibility for the service.

Emergency transportation of a Title XIX or Title XXI eligible member required to manage an acute medical condition, which includes transportation to the same or higher level of care for immediate medically necessary treatment, is the responsibility of the member's AHCCCS Health Plan.

The Provider is responsible for coordination of care including care coordination for Medication Assisted Treatment (MAT) with primary behavioral health or integrated care provider, AHCCCS Health Plans, Primary Care Providers and Medicare Providers within 24 hours and in accordance with both AHCCCS and MC Care's Provider Manual.

Non-emergency Behavioral Health Services

For Title XIX and Title XXI eligible members, MC ACC-RBHA is responsible for the provision of all non-emergency behavioral health services.

If a Title XIX or Title XXI eligible member is assessed as needing inpatient psychiatric services by MC ACC-RBHA or a subcontracted provider prior to admission to an inpatient psychiatric setting, MC ACC-RBHA is responsible for authorizing and paying for the full inpatient stay.

When a medical team or health plan requests a behavioral health or psychiatric evaluation prior to the implementation of a surgery, medical procedure, or medical therapy to determine if there are any behavioral health contraindications, MC ACC-RBHA is responsible for the provision of this service. Surgeries, procedures, or therapies can include gastric bypass, interferon therapy, or other procedures for which behavioral health support for a patient is indicated.

Non-Emergency Transportation

Transportation of a Title XIX or Title XXI eligible member to an initial behavioral health intake appointment is the responsibility of MC ACC-RBHA.

Please refer to **MC Provider Manual Chapter 100 – General Terms, Chapter 9 – Emergency and Non-Emergency Transportation, Section 9.04 – Medically Necessary Non-Emergency Transportation for Physical and Behavioral Health Services** for additional information and requirements for non-emergency transportation.

Medical Treatment for Members in Behavioral Health Treatment Facilities

When a Title XIX or Title XXI eligible member is in a residential treatment center and requires medical treatment, the AHCCCS Health Plan is responsible for the provision of covered medical services for members designated as GMH/SU or children. For members determined to have a Serious Mental Illness, MC ACC-RBHA is responsible for the provision of, and payment for their medical care. Subcontracted providers are responsible for arranging for those services and coordinating with the member's PCP to obtain prior authorization, as needed.

If a non-SMI, Title XIX or Title XXI eligible member is in an inpatient psychiatric facility and requires medical treatment, those services are included in the per diem rate for the treatment facility. If the member requires inpatient medical services that are not available at the inpatient psychiatric facility, the member must be discharged from the psychiatric facility and admitted to a medical facility. The AHCCCS Health Plan is responsible for medically necessary services received at the medical facility, even if the member is enrolled with MC ACC-RBHA. For members determined to have a Serious Mental Illness, MC ACC-RBHA retains responsibility for all medically necessary medical and behavioral health services provided while the member is in a facility.

PCPs Prescribing Psychotropic Medications

Within their scope of practice and comfort level, an AHCCCS Health Plan PCP may elect to treat select behavioral health disorders. The select behavioral health disorders that AHCCCS Health Plan PCPs can treat are:

- Attention-Deficit/Hyperactivity Disorder;

- Uncomplicated depressive disorders; and
- Anxiety disorders.

The "Agreed Conditions"

Certain requirements and guiding principles regarding medications for psychiatric disorders have been established for members under the care of both a health plan PCP and MC ACC-RBHA subcontracted provider simultaneously. The following conditions apply:

- Title XIX and Title XXI enrolled members must not receive medications for psychiatric disorders from the health plan PCP and behavioral health provider simultaneously. If a member is identified to be simultaneously receiving medications from the health plan PCP and MC ACC-RBHA subcontracted behavioral health provider, the behavioral health provider must immediately contact the PCP to coordinate care and agree on who will continue to medically manage the member's behavioral health condition.
- Medications prescribed by providers within the behavioral health system must be filled by MC ACC-RBHA contracted pharmacies under the pharmacy benefit. This is particularly important when the pharmacy filling the prescription is part of the contracted pharmacy network for both MC ACC-RBHA and the member's AHCCCS Health Plan. MC ACC-RBHA and contracted providers must take active steps to ensure that prescriptions written by providers by MC ACC-RBHA providers are not charged to the member's AHCCCS Health Plan.

General Requirements

When it is necessary for a MC ACC-RBHA member to be referred to another provider for medically necessary services that are beyond the scope of the member's primary care physician (PCP), the PCP only needs to call Member Services and refer the member to the appropriate MC ACC-RBHA provider. MC ACC-RBHA's website includes a provider search function for your convenience.

Transitions of Members with ADHD, Depression, and/or Anxiety to Care of Primary Care Physician

Members who have a diagnosis of Attention Deficit/Hyperactivity Disorder (ADHD), depression and/or anxiety and who are stable on their medications may transition back to the care of their PCP for the management of these diagnoses, if the member, their HCDM or parent and the PCP agree to this treatment transition. MC ACC-RBHA requires its subcontracted providers to facilitate this process and to ensure that the following steps are taken:

- The subcontracted provider must contact the member's PCP to discuss the member's current medication regime and to confirm that the PCP is willing and able to provide treatment for the member's ADHD, depression, and/or anxiety.
- If the PCP agrees to transition treatment for the member's diagnosis of ADHD, depression and/or anxiety, the subcontracted provider must provide the PCP with a

transition packet that includes (at a minimum):
    - A written statement indicating that the member is stable on a medication regime;
    - A medication sheet or list of medications currently prescribed by the MC ACC-RBHA Behavioral Health Medical Practitioner (BHMP);
    - A psychiatric evaluation;
    - Any relevant psychiatric progress notes that may assist in the ongoing treatment of the member;
    - A discharge summary outlining the member's care and any adverse responses the member has had to treatment or medication; and
    - A copy of the packet must be sent to the member's AHCCCS Health Plan Behavioral Health Coordinator as well as to the member's PCP.
- The subcontracted provider and MC ACC-RBHA must ensure that the member's transition to the PCP is seamless, and that the member does not go without medications during this transition period.

General Psychiatric Consultations

Behavioral health practitioners must be available to AHCCCS Health Plan PCPs to answer diagnostic and treatment questions of a general nature.

General psychiatric consultations are not member specific and are usually conducted over the telephone between the PCP and the behavioral health practitioner.

One-Time Face-to-Face Psychiatric Evaluations

Behavioral health providers must be available to conduct a face-to-face evaluation with a Title XIX/XXI eligible member upon his/her PCP's request.

A one-time face-to-face evaluation is used to answer PCPs specific questions and provide clarification and evaluation regarding a member's diagnosis, recommendations for treatment, need for behavioral health care, and/or ongoing behavioral health care or medication management provided by the PCP.

The PCP must have seen the member prior to requesting a one-time face-to-face psychiatric evaluation with the behavioral health provider.

AHCCCS Health Plan PCPs must be provided current information about how to access psychiatric consultation services. A PCP requesting a general psychiatric consultation should call MC ACC-RBHA Member Services directly at 800-564-5465. To request a one-time face-to-face psychiatric consultation, the PCP should complete the **Communication Document** (please

specify the type of service requested) and fax it to 844-424-3975. The Member Services staff will arrange for psychiatric consultations to be provided within 24 hours of request.

MC ACC-RBHA is obligated to offer general consultations and one-time face- to-face psychiatric evaluations and must provide direct and timely access to behavioral health medical practitioners (physicians, nurse practitioners, and physician assistants) or other behavioral health practitioners if requested by the PCP.

Coordination of Care with Medicare Providers

Effective October 1, 2015, in accordance with AHCCCS directives; Complete Care members with Medicare Prime plans or Medicare Advantage as their primary payer will be realigned for **General Mental Health/Substance Abuse** (GMH/SU) benefits from their current AHCCCS Complete Care - Regional Behavioral Health Agreement (ACC-RBHA) to their Complete Care plans. Prior to October 1, 2015, this coverage is facilitated by the MC ACC-RBHA in Maricopa County.

MC ACC-RBHA dual eligible members will continue to receive their care through MC ACC-RBHA.

Medicare Advantage Plans

Medicare health plans, also known as Medicare Advantage (MA) plans, are managed care entities that have a Medicare contract with the Centers for Medicare and Medicaid Services (CMS) to provide services to Medicare beneficiaries. MA plans provide the full array of Medicare benefits, including Medicare Part A, hospital insurance; Medicare Part B provides medical insurance; and Medicare Part D provides prescription drug coverage.

Many of the AHCCCS Contracted Health Plans are MA plans. These plans provide Medicare Part A, Part B and Part D benefits in addition to Medicaid services for dual eligible members and are referred to as MA-PD SNPs (Medicare Advantage-Prescription Drug/Special Needs Plans).

Inpatient Psychiatric Services

Medicare has a lifetime benefit maximum for inpatient psychiatric services. When the benefit is exhausted AHCCCS becomes the primary payer. MC ACC-RBHA implements cost sharing responsibilities and billing for inpatient psychiatric services.

MC ACC-RBHA will coordinate inpatient care and discharge planning care with the inpatient team for Medicare members receiving inpatient services with Medicare providers.

Outpatient Behavioral Health Services

Medicare provides some outpatient behavioral health services that are also AHCCCS covered behavioral health services. MC ACC-RBHA implements cost sharing responsibilities and billing for outpatient behavioral health services.

MC ACC-RBHA will coordinate outpatient care with Medicare providers for Medicare members receiving covered behavioral health services.

Medication Assisted Treatment (MAT)

MC ACC-RBHA providers are responsible to provide "whole-patient" services to members, including behavioral services and MAT services. If a member is receiving behavioral health services from a provider but is also in need of MAT services from another provider; providers are responsible for coordinating care to best serve the member. Providers are expected to adhere to HIPPA standards.

Prescription Medication Services

Medicare eligible behavioral health members must enroll in a Medicare Part D Prescription Drug Plan (PDP) or a Medicare Advantage Prescription Drug Plan (MA-PD) to receive the Part D benefit. PDPs only provide the Part D benefit, and any Medicare registered provider may prescribe medications to behavioral health members enrolled in PDPs. Some MA-PDs may contract with MC ACC-RBHA or subcontracted providers to provide the Part D benefit to Medicare eligible behavioral health members.

10.02 – Coordination of Behavioral Health Care with Other Governmental Entities

MC conducts comprehensive care coordination across the continuum of health care and non-clinical health care-related needs and services.

MC works collaboratively to coordinate care with other government agencies, including outlining expectations of partnerships through collaborative protocols and/or MOUs which are posted in the **Availity** portal. The protocols/MOUs are developed with stakeholders and establish processes and roles to ensure effective collaboration with identified governmental agencies. MC maintains collaborative relationships with other government agencies that deliver services to member and their families, ensuring access to services, and coordinating care with consistent quality.

Department of Child Safety (DCS)

When a child receiving behavioral health, services is also in the custody of DCS, the subcontracted provider must work towards effective coordination of services with the DCS Specialist. Providers are expected to:

- Coordinate the development of the behavioral health service plan with the child welfare case plan to avoid redundancies and/or inconsistencies.

- Ensure an urgent response to DCS initiated referrals for children who have been removed from their homes.
- Provide the DCS Specialist and the juvenile court with preliminary findings and recommendations on behavioral health risk factors, symptoms, and service needs for hearing.
- Work collaboratively on child placement decisions if placement and funding are being sought for behavioral health treatment.
- Invite the DCS Specialist, DCS providers and resource parents to participate in the behavioral health assessment and service planning process as members of the Child and Family Team (CFT).
- Strive to be consistent with the service goals established by other agencies serving the child or family. Behavioral health service plans must be directed by the CFT toward the behavioral health needs of the child, and the team should seek the active participation of other involved agencies in the planning process.
- Attend team meetings such as Team Decision Making (TDM) and Family Group Decisions (as appropriate) for providing input about the child and family's health needs. Where it is possible, TDM and CFT meetings should be combined.
- Coordinate, communicate and expedite necessary services to stabilize in-home and out-of- home placements provided by DCS.
- Provide behavioral health services during the reunification process and/or other permanency plan options facilitated by DCS. Parent-child visitation arrangements and supervision are the responsibility of DCS. Therapeutic visitation is not a covered behavioral health service.
- Ensure responsive coordination activities and service delivery that supports DCS planning and facilitates adherence to DCS established timeframes (see **AHCCCS Medical Policy Manual 585 – The Unique Behavioral Health Services Needs of Children, Youth, and Families Involved with DCS** and the MC ACC and Department of Child Safety Collaborative Protocol (ACC DCS Protocol) which is posted in the **Availity** portal.

ADES/ADHS ARIZONA Families F.I.R.S.T. (Families in Recovery Succeeding Together) Program
Providers must ensure coordination for parents/families referred through the Arizona Families F.I.R.S.T (AFF) program (see **Overview of the Arizona Families F.I.R.S.T. Program Model & Referral Process**). MC follows a Collaborative Protocol with the Department of Child Safety Arizona Families F.I.R.S.T. Program (AFF Collaborative Protocol) for care coordination which is posted in the **Availity** portal.

The AFF program provides expedited access to substance abuse treatment for parents and caregivers referred by DCS and the ADES/FAA Jobs Program. AHCCCS participates in statewide implementation of the program with ADES (see **A.R.S. 8-881**). MC ACC-RBHA and providers must:

- Accept referrals for Title XIX and Title XXI eligible and enrolled members and families referred through AFF;
- Accept referrals for Non-Title XIX and Non-Title XXI members and families referred through AFF and provide services, if eligible;
- Ensure that services made available to members who are Non-Title XIX and Non-Title XXI eligible are provided by maximizing available federal funds before expending state funding as required in the **Governor's Executive Order 2008 -01**;
- Collaborate with DCS, the ADES/FAA JOBS Program and Substance Abuse Treatment providers to minimize duplication of assessments and achieve positive outcomes for families; and
- Develop procedures for collaboration in the referral process to ensure effective service delivery through the MC ACC-RBHA system of care. Appropriate authorizations to release information must be obtained prior to releasing information.

The goal of the AFF Program is to promote permanency for children, stability for families, protect the health and safety of abused and/or neglected children and promote economic security for families. Substance abuse treatment for families involved with DCS must be family centered, provide for enough support services, and must be provided in a timely manner.

Arizona Department of Education (ADE), Schools, or Other Local Educational Authorities

AHCCCS has delegated the functions and responsibilities as a State Placing Agency to MC ACC-RBHA for members in Maricopa County. MC ACC-RBHA and providers work in collaboration with the ADE to place children with behavioral health service providers.

Providers serving children can gain valuable insight into an important and substantial element of a child's life by soliciting input from school staff and teachers. Subcontracted providers can collaborate with schools and help a child achieve success in school by:

- Working in collaboration with the school and sharing information to the extent permitted by law and authorized by the child's parent or HCDM;
- For children receiving special education services, actively consider information and recommendations contained in the Individual Education Plan (IEP) during the ongoing assessment and service planning process;
- For children receiving special education services, participate with the school in developing the child's IEP and share the behavior treatment plan interventions, if applicable;
- Inviting teachers and other school staff to participate in the CFT if agreed to by the child and HCDM;
- Having a clear understanding of the IEP requirements as described in the **Disabilities Education Act (IDEA) of 2004**;
- Ensuring that students with disabilities who qualify for accommodations under of the

Section 504 of the Rehabilitation Act of 1973 are provided adjustments in the academic requirements and expectations to accommodate their needs and enable them to participate in the general education program; and
- Ensuring that transitional planning occurs prior to and after discharge of an enrolled child from any out-of-home placement.

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 student will receive services.
- The acceptance of the **AHCCCS School-based Universal Referral Form** to refer Arizona students for services.
- Providers will track all referrals from schools and their outcomes including situations where referred students are transferred to other agencies due to capacity issues. Providers will share this information with MC upon request.
- There is communication back to the school districts in situations where referred students are transferred to other agencies due to capacity issues.
- For children who receive special education services, including those in the custody of DCS, include information and recommendations contained in the 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 children from any out-of-hone 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 will share information with their MC ACC-RBHA enrolled members on the resources available on school campuses and any provider programming offered including those programs offered during school breaks.

Courts and Corrections

MC ACC-RBHA and behavioral health providers are expected to collaborate and coordinate care for behavioral health members involved with:

- The Arizona Department of Corrections, Rehabilitation, and Reentry (ADCRR) & Community Corrections (Parole)
- Arizona Department of Juvenile Corrections (ADJC)
- County Jails & Medical Services Providers
- The Arizona Superior Court & County Probation Departments
- Municipal Mental Health Courts, such as problem solving or specialty city courts

When a member receiving behavioral health services is also involved with a court or correctional agency, providers work towards effective coordination of services by:

- Working in collaboration with the appropriate staff involved with the member;
- Inviting probation or member's parole officer to participate in the development of the ISP and all subsequent planning meetings as members of the member's clinical team with member's approval;
- Actively considering information and recommendations contained in probation or parole case plans when developing the ISP; and
- Ensuring that the provider evaluates and participates in transition planning prior to the release 3. eligible members and arranges and coordinates care upon the member's release, including:
    - Adults who remain in the juvenile justice system under extended jurisdiction up to age 19 pursuant to Arizona Revised Statutes 8-202 (2021) – Jurisdiction of Juvenile Court; and
    - Youth who are remanded to the adult criminal justice system.

MC ACC-RBHA and the Arizona Department of Corrections, Rehabilitation, and Reentry (ADCRR) have an established mutually agreed upon protocol to ensure effective and efficient delivery of behavioral health services. The MOU/**Collaborative Protocol between Mercy ACC-RBHA and Arizona Department of Corrections, Rehabilitation, and Reentry (ADCRR)**, available in **Availity** portal, defines the respective roles and responsibilities of each party.

MC ACC-RBHA and the Arizona Department of Juvenile Corrections (ADJC) have an established mutually agreed upon protocol to ensure effective and efficient delivery of behavioral health services. The Collaborative Protocol between MC ACC-RBHA and Arizona Department of Juvenile Corrections defines the respective roles and responsibilities of each party.

MC ACC-RBHA and the Maricopa, Gila, and Pinal County Adult and Juvenile Probation Departments have established mutually agreed upon **Collaborative Protocols**, available in the Availity portal, to ensure effective and efficient delivery of behavioral health services; these

agreements encompass the County Jails, Medical Service Providers and Maricopa, Gila, and Pinal County Probation. The Collaborative Protocols define the respective roles and responsibilities of each party and are available in the **Availity** portal.

Administrative Orders have been filed for each of the jurisdictions in which specialty courts are supported by MC Liaisons.

Arizona County Jails

In Maricopa County, Gila, and Pinal County, when a member receiving behavioral health services has been determined to have, or is perceived to have, a Serious Mental Illness and is detained in a County Jail, the subcontracted provider must assist the member by:

- Working in collaboration with the appropriate staff involved with the member;
- Ensuring that screening and assessment services, medications and other behavioral health needs are provided to jailed members;
- Ensuring that the member has a viable discharge plan, that there is continuity of care if the member is discharged or incarcerated in another correctional institution, and that pertinent information is shared with all staff involved with the member's care or incarceration with member approval;
- Determining whether the member is eligible for the Jail Diversion Program; and
- Ensuring that both an appointment with a Behavioral Health Medical Professional and a Primary Care Provider occur within the first 7 days after release if member is incarcerated for 20 days or longer.

Behavioral health providers must ensure that appropriate coordination also occurs for behavioral health members with jail personnel at other county jails throughout the state. For further information regarding MC ACC-RBHA enrolled members who are incarcerated, please contact the Justice Services Department through customer service at 800-564-5465, e-mail **AdultCourtLiaisons@MercyCareAZ.org** for matters involving adults, or **JuvenileCourtLiaisons@MercyCareAZ.org** for matters regarding youth, or visit **www.MercyCareAZ.org**.

Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA)

MC ACC-RBHA and the Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA) have a mutually developed collaborative protocol to ensure effective and efficient provision of comprehensive rehabilitative and employment support services for individuals with SMI to achieve increased independence or gainful employment. The Statewide Collaborative Protocol between MC ACC-RBHA and ADES/RSA defines the respective roles and responsibilities of each party. The **Statewide Collaborative Protocol with Arizona Rehabilitation Services Administration (RSA)** is available in the **Availity** portal.

Prevocational and Employment related services available through MC ACC-RBHA are distinct from vocational services available through RSA/VR **Vocational Rehabilitation | Arizona Department of Economic Security**. Please refer to the AHCCCS Covered Behavioral Health Services Guide on the **AHCCCS Medical Coding Resources webpage** for additional details including billing limitations related to prevocational and employment support services.

Arizona Department of Health Services/Office of Assisted Living Licensing

When a member receiving behavioral health services is residing in an assisted living facility, providers must coordinate with the Office of Assisted Living Licensing to ensure that the facility is licensed and that there are no existing violations or legal orders. Providers must also determine and ensure that the member living in an assisted living facility is at the appropriate level of care. The provider can coordinate with the Office of Assisted Living Licensing to determine the level of care that a particular assisted living facility is licensed to provide.

For further information regarding MC ACC-RBHA enrolled members who are seeking Assisted Living services, please call customer service at 1-800-564-5465, or visit **www.MercyCareAZ.org.**

Providers, members, and community stakeholders should contact the MC ACC-RBHA Housing Department through customer service at 1-800-564-5465 to report unsafe conditions.

Veterans Administration Health Care System

MC ACC-RBHA and the Veterans Administration Health Care System have a mutually developed collaborative protocol available to ensure effective communication and coordination of services. The Collaborative Protocol between MC ACC-RBHA and the Veterans Administration Health Care System defines the respective roles and responsibilities of each party. The **Collaborative Protocol with Veterans Administration Health Care Services** is available in the **Availity** portal.

Tribal Agencies and Entities

MC honors the unique choice tribal members are entitled to in where to receive health care. MC honors the tribal sovereignty of each of the 22 tribal nations in Arizona.

MC Tribal Relations consults with Indian Health Service, Tribal 638, and Urban Tribal providers including TRBHAs for timely care coordination, transfers of care, resolution of service barriers and to share pertinent updates. Care coordination may include MC department subject matter experts, HCDM and provider staff, as needed. Care coordination may also be facilitated for tribal members enrolled in a fee for service option.

Collaborative agreements and collaborative protocols are jointly drafted between MC and tribal nations for service provision within tribal lands in respect to tribal sovereignty.

When invited, MC participates in community outreach/engagement opportunities such as tribal community health fairs or other tribal community events. MC Tribal Relations also identifies sponsorship opportunities that promote tribal member health care or that improve tribal HRSN.

MC Tribal Relations may provide training related to the Tribal Health Care Delivery System which includes the unique recognition process of a tribal court order for involuntary treatment, the meaning and importance of tribal sovereignty, fee for service options available to tribal members and the contemporary impacts of historical trauma affecting indigenous population health.

10.03 – Care Coordination for Management of Hospitalized Members Related to Integrated Health Program Service Requirements

The provider:

- Is responsible for coordination of care with AHCCCS Health Plans, primary care providers, and Medicare providers.
- Must have ACT and specialty ACT teams available 24/7 to provide crisis and/or coordination of services to assist in the assessment of members who are seeking or in need of ED or inpatient services or are being discharged from ED or inpatient facilities.
- Is responsible for ensuring that the primary care provider (PCP) and other specialty providers are involved in the treatment planning process to ensure medical interventions and physical health concerns are identified in the Individual Service Plan (ISP).
- Must maintain complete, accurate, and timely documentation of all delivered services. The provider should share electronic medical records and participate in health information exchange (HIE) to ensure information is shared between all providers delivering care to members.
- Shall coordinate care with the primary care provider/Integrated Health provider, as well as other providers involved in any treatment related to the member's care.
- Will document coordination and participation in ongoing communication with ACC-RBHA Health Home/provider, adult recovery team (ART)/children and family team (CFT), where applicable, and with MC ACC-RBHA.
- Will document coordination and participation in discharge planning efforts with ACC-RBHA Health Home/provider, ART/CFT (where applicable) and with MC ACC-RBHA.

Coordination of Care for Members with a Serious Mental Illness

Members with a Serious Mental Illness receive their behavioral health and medical care through an integrated service delivery system. Members have the choice to receive services in the setting that meets their needs and preferences, including:

- Separate behavioral health and physical health providers
- An integrated health home

MC ACC-RBHA's subcontracted providers are responsible for actively participating on the member's clinical team, working with the member to develop the member's integrated Individual Service Plan, and sharing information on the member's progress, and the services and medications the member is receiving.

10.04 – Transition from Child to Adult Services

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

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

Elements Addressed as Part of Young Adult's Transition Plan

Not all young adults transfer to the adult Serious Mental Illness (SMI) or General Mental Health/Substance Abuse (GMH/SU) system, but for young adults who do, providers must ensure a smooth transition. To accomplish a smooth transition, providers must develop a clear and explicit process and procedure that will ensure and support the delivery of children's and adult services during the transition period. Providers must ensure that adult system staff attend and are a part of the Child and Family Team (CFT) during the four to six months prior to the child turning 18 to provide information and be part of the service planning, development and coordination effort that needs to take place so the individualized needs of that young adult can be met on the day they turn 18 years of age. Providers must also ensure that any coordination efforts that remain after a young adult turns 18 are appropriately handled by the children's provider. This may include attendance at intakes, level of care admissions, and/or support to the young adult in successfully connecting to the adult provider.

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

- Identifying the young adult's behavioral health needs into adulthood;
- Identifying personal strengths that will assist the young adult when he/she transitions to the adult system;
- Identifying staff who will coordinate services after the young adult reaches age 18, including any changes in the behavioral health provider, clinical team, HCDM, or family involvement;
- Identifying and collaborating with other involved state agencies and stakeholders to jointly establish a behavioral health service plan and prevent duplication of services.
- Establishing how the transition will be implemented;

- Planning for where the young adult will reside upon turning 18 and how he/she will support him/herself. If an SMI eligibility determination is made, consider initiating a referral for housing, if needed;
- Identifying the need for referrals to and assistance with applications for Supplemental Security Income (SSI), Rehabilitation Services Administration (RSA), SMI eligibility determination, Title XIX and Title XXI eligibility, housing, HCDM, training programs, etc. In addition, the team and/or behavioral health provider should assist in gathering necessary information to expedite these applications/determinations when the time comes to apply, including obtaining medical and school records to substantiate these needs. The team and/or behavioral health provider begin to develop a timeline and task list for when appointments are needed;
- Identifying the need for transportation to appointments and other necessary activities;
- Identifying special needs that the young adult may have and/or whether the young adult will require special assistance services;
- Identifying whether the young adult has appropriate life skills, social skills and employment or education plans;
- Taking necessary action if the young adult is not eligible for Title XIX or Title XXI benefits and/or Social Security Disability Income (SSDI) and is not determined to meet criteria for SMI services. Identifying supports needed to be in place for a successful transition;
- Following guidelines established in **AHCCCS Clinical Guidance Tool Practice Protocol, Transition to Adulthood**; and
- Meeting the provisions of the JK Settlement Agreement and the Arizona Vision and 12 Principles.

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

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

Child Transition to Adult Services – Year Prior

When a young adult receiving behavioral health, services reach the age of 17, behavioral health providers must determine whether the young adult is potentially eligible for services as an adult

with a Serious Mental Illness. If so, behavioral health providers must refer the young adult for an SMI eligibility determination if applicable.

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

- Submit the SMI Packet Evaluation if applicable;
- Assist the young adult and/or family or HCDM in applying for potential benefits (e.g., SSI, food stamps, etc.);
- Assist the young adult and/or family in determining whether an application for Title XIX or Title XXI benefits is to be submitted; if the young adult and/or family is already eligible, determine if eligibility will continue for the young adult once he/she turns 18; if young adult's current eligibility will not continue, assist the family in completing the re-application process;
- Assist the young adult and/or family to schedule their first well visit with a primary care provider to occur on or after their 18th birthday (An EPSDT visit is synonymous with a well visit);
- Address any new authorization requirements for sharing protected health information due to the young adult turning 18 to ensure that the clinical team can continue to share information;
- Ensure that the young adult's behavioral health category assignment is changed. Once the young adult's behavioral health category assignment has been changed, ongoing behavioral health service appointments must be provided according to the timeframes for routine appointments; and
- Upon turning 18 years of age, if the member is not eligible for services as a member determined to have a Serious Mental Illness or the member has been determined ineligible for Title XIX or Title XXI services, behavioral health providers can continue to provide behavioral health services.

ACC RBHA Chapter 11 – Concurrent Review

11.00 - Concurrent Review

Continued authorization request determinations are based on written medical care criteria that assess the need for the continued stay. The extension of a stay will be assigned a new review date each time a review occurs. Any review that does not appear to meet medical necessity criteria will be sent to medical director review for final determination. Complete Care Medical and Behavioral Inpatient, Complete Care Long Term Inpatient or Rehabilitation, Behavioral Health Inpatient, Behavioral Heath Residential or TFC Facilities are notified of determinations and next review dates. For all other requests for prior authorized services, contact MC ACC-RBHA Utilization Management Department at 800-564-5465 or submit a faxed request to 800-217-9345 prior to the expiration of the covered authorization. For notification of Inpatient Behavioral Health Admission, please fax to 855-825-3165. For notification of Physical Health admissions, please fax to 866-300-3926.

Federal regulations from the Centers for Medicare and Medicaid Services (CMS) limit federal funding for services to persons in Institute of Mental Disease (IMD) who are aged 21-64. Federal Rule **42 C.F.R. 438.6(e)** prohibits the use of federal Medicaid funding to Managed Care Organizations whose members are in IMDs for more than 15 days during a calendar month.

Federal regulations for IMDs include the following:

- Is limited to adults aged 21-64;
- Eliminates existing federal authority allowing the Arizona Health Care Cost Containment System (AHCCCS) to utilize IMDs with no limits (the "in lieu of" option);
- Limits coverage for IMD stays to 15 days during a calendar month;
- Defines an IMD as a facility established and maintained primarily for the care and treatment of people with mental diseases;
- Is intended to improve access to short-term inpatient psychiatric and substance-use disorder treatment for Medicaid managed care members.

MC ACC-RBHA is committed to coordinating with facilities for members who have reached the 10th day of inpatient hospitalization in an IMD facility during a calendar month. The following grid outlines the requirements for care coordination for IMD facilities:

IMD Admission Day	Action to be Completed
At admission	MC ACC-RBHA will notify upon admission the estimated number of inpatient IMD days that a member has utilized in the current calendar month. *

With 24 hours of Admission	IMD facility shall develop a discharge plan and communicate this specific plan to the MC ACC-RBHA Utilization Management (UM) consultant.
10th Day	A peer-to-peer discussion regarding discharge coordination will occur.
13th Day	Determination is made if the member will be discharged by day 15. If medically necessary care is required beyond 15 days, and a safe transfer can be made, a transfer will be facilitated to a non-IMD treatment setting.
14th Day	The MC ACC-RBHA UM Consultant will contact the facility to ensure the member is being discharged or that an appropriate transfer has been arranged.
15th Day	Member will be discharged or transferred, and the facility must provide same day discharge information to MC Plan / MC ACC-RBHA to confirm the discharge of the member.

***IMD days are calculated based on calendar days, not business days.**

Acute Medical and Behavioral Health Facilities

Initial institutional stays are based on the adopted criteria, the member's specific conditions, and the projected discharge date. Reviews will occur on a schedule dictated by the member's diagnosis or condition. Emergency initial concurrent reviews are completed within one business day of MC ACC-RBHA's receipt of notification of admission. Subsequent reviews will be determined based on the member's specific condition not to exceed 7 days. Providers are notified of the next review date. Providers receive notification of next review date and are responsible for requesting further stay and providing clinical information on the scheduled review date.

Acute Long-Term Inpatient or Rehabilitation Facilities

Ongoing reviews of members in acute long-term inpatient or rehabilitation units of facilities are conducted on a schedule dictated by the member's diagnosis and condition not to exceed 7 days. Providers receive notification of next review date and are responsible for requesting further stay and providing clinical information on scheduled review date.

Skilled Nursing Facilities (SNF)

MC ACC-RBHA will provide medically necessary nursing facility services for integrated members receiving physical healthcare services, including when the member has ALTCS pending. Ongoing reviews of members in skilled nursing facility units are conducted on a schedule dictated by the

member diagnosis and condition not to exceed 7 days. Providers are notified of next review date and are responsible for requesting further stay and providing clinical information on scheduled review date.

MC ACC-RBHA will be responsible for nursing facility reimbursement only during the time the member is enrolled with the contractor and if the member becomes ALTCS-eligible and is enrolled with an ALTCS contractor before the end of the maximum ninety (90) days per contract year of nursing facility coverage. The ninety (90) day per AHCCCS contract year limitation is monitored and will be applied for nursing facility services. AHCCCS is notified electronically when a member has been residing in a nursing facility for forty-five (45) days.

Child and Adolescent TFC

The initial authorization is valid up to 90 days. Providers are notified of next review date and are responsible for requesting further stay and providing clinical information on the scheduled review date.

Concurrent reviews are conducted within 90 days of admission of a prior authorized service. Subsequent reviews are scheduled based on the member's progress according to continued stay criteria not to exceed 90 days.

Behavioral Health Residential Facilities (BHRF)

The BHRF level of care requires prior authorization, including all modified services. The initial authorization for behavioral health residential facilities 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.

ACC-RBHA Chapter 12 – Quality Management

12.00 – Quality Management

MC ACC-RBHA works in partnership with providers to continuously improve the care given to our members. The MC ACC-RBHA Quality Management (QM) Program is comprised of the following areas:

- The Quality of Care Department monitors the quality of care provided by the provider network, as well as the review and resolution of issues related to the quality of health care services provided to members.
- Provider Monitoring is responsible for monitoring provider services and service sites per AMPM 910 Attachment A requirements.
- The Credentialing Department is responsible for provider credentialing/recredentialing activities.
- The Performance Improvement Department monitors and improves HEDIS and other clinical performance measure rates, maternity, family planning, and EPSDT quality indicators.

Quality Management Department Responsibilities

The Quality Management Department is responsible for development of Clinical Practice Guidelines and policies related to quality management. Whenever possible, MC ACC-RBHA adopts AHCCCS requirements and practice guidelines from national organizations known for their expertise around concern. Please refer to the Clinical Guidelines located on the MC ACC-RBHA Provider website.

Quality Management and Performance Improvement Plan

Under the leadership of the Chief Medical Officer, MC ACC-RBHA's Quality Management department has developed a written Annual QM Plan that addresses MC ACC-RBHA's proposed methodology to meet or exceed AHCCCS minimum performance standards for contractual performance measures, as well as statewide performance improvement projects (PIPs). The QM Plan describes the components of the program and how the activities improve the quality of care and service delivery for enrolled members.

Measurement Tools

MC ACC-RBHA must measure performance using measurement tools specified by CMS and AHCCCS and report its performance to CMS/AHCCCS. MC ACC-RBHA is required to make available to CMS/AHCCCS information from these measures to provide members with a means to assess the value they receive for their health care dollar and to hold health plans responsible for their performance. As a contracting medical provider, you may be required to assist in medical record data collection.

Procedures for HEDIS/Clinical Performance Measure Improvement

All contracted providers are expected to meet MPS as established by AHCCCS and/or MC ACC-RBHA. It is equally as important that rates improve year over year. Providers must implement and maintain strategies to monitor and continuously improve their rates.

MC ACC-RBHA's Performance Improvement Department is available to providers for technical assistance. Examples of the types of technical assistance available include:

- Strategies/best practices for improving rates
- Clarification on rate calculations
- Clarification on billing/documentation related to performance measures
- Assistance in improving maternity quality indicators:
    - Reduction of elective inductions of labor and Caesarean sections;
    - Reduction of low birth weight/very low birth weight;
    - Increasing utilization of family planning benefits after delivery; and
    - Reduction of pre-term deliveries.
- Assistance in improving EPSDT quality indicators (Title XIX integrated members ages 18-20):
    - Use of EPSDT Forms;
    - Required screenings;
    - Increasing utilization of biannual preventive dental visits; and
    - Increasing utilization of annual EPSDT visits.

Chronic Care Improvement Plan

MC ACC-RBHA is required to have a Chronic Care Improvement Program (CCIP). This program must identify members with multiple or sufficiently severe chronic conditions who meet criteria for participation in the program and must have a mechanism for monitoring member participation in the program. As a contracted medical provider, you may be required to assist in medical record data collection or verification to confirm eligibility or participation in the CCIP**.**

Provider-Preventable Conditions

If a Health Care Acquired Condition (HCAC) or Other Provider Preventable Condition (OPPC) is identified, MC Care will conduct a quality of care investigation and report the occurrence and results of the investigation to the AHCCCS Clinical Quality Management Unit. MC ACC-RBHA must also submit a list of HCAC cases that were opened and investigated as part of the quarterly report deliverable to AHCCCS 45 days following the end of the quarter.

12.01 – Provider Monitoring

Please see Mercy Care Provider Manual, Chapter 100 General Terms, Section 12.03 – Provider Monitoring for audit information and compliance standards.

12.02 – Performance Improvement Projects

MC ACC-RBHA is committed to establishing high quality healthcare services. One method for achieving this is through adherence to the standards and guidelines set by CMS. MC ACC-RBHA adheres to CMS standards and guidelines and, in turn, promotes improvement in the quality of healthcare provided to members through the development and implementation of Performance Improvement Projects (PIPs). Performance Improvement Projects consist of utilizing a comprehensive protocol endorsed by CMS, as described in the AHCCCS Medical Policy Manual (AMPM), Chapter 900 and 42 CFR 438.240. The protocol standards and guidelines help to ensure that Medicaid managed care organizations meet these quality assurance requirements when conducting Medicaid External Quality Review Activities.

Performance Improvement Projects (PIPs)

A PIP is a systematic process created to:

- Identify, plan, and implement system interventions to improve the quality of care and services provided to members;
- Evaluate and monitor the effectiveness of system interventions and data on an ongoing basis; and
- Result in significant performance improvement sustained over time using measures and interventions.

PIPs are designed to:

- Demonstrate achievement and sustainment of improvement for significant aspects of clinical care and non-clinical services;
- A clinical study topic would be one for which outcome indicators measure a change in behavioral health status or functional status; and,
- A non-clinical or administrative study topic would be one for which indicators measure changes in member satisfaction or processes of care.

Correct significant systemic issues come to the attention of MC ACC-RBHA in part through:

- Data from MC ACC-RBHA functional areas (e.g.: network, medical director's office);
- Statewide contractor performance data and contract monitoring activities;
- Tracking and trending of complaints, grievance and appeal data and quality of care concerns;
- Provider credentialing and profiling as well as other oversight activities, such as chart reviews;
- Quality Management/Utilization Management data analysis and reporting; and
- Member and/or provider satisfaction surveys and feedback.

MC ACC-RBHA contracted healthcare providers play an integral role in the implementation of the MC ACC-RBHA PIPs. Healthcare providers shall participate with any or all aspects of the PIP implementation process.

There are ten (10) steps to be undertaken when conducting PIPs:

1. Select the study topic(s). In general, a clinical or non-clinical issue selected for study should affect a significant number of members and have a potentially significant impact on health, functional status, or satisfaction.
2. Define the study question(s). It is important to clearly state, in writing, the question(s) the study is designed to answer. Stating the question(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.
3. Select the study indicator(s). A study indicator is a quantitative or qualitative characteristic reflecting a discrete event (e.g., a member has stopped taking medication and has experienced a crisis which resulted in hospitalization), or a status (e.g., a member has/has not experienced a crisis that resulted in hospitalization) that is to be measured. Each project should have one or more quality indicators for use in tracking performance and improvement over time.
4. Use a representative and generalizable study population. Once a topic has been selected, measurement and improvement efforts must be system wide. A decision needs to be made as to whether to review data for the entire population or use a sample of the population.
5. Use sound sampling techniques (if sampling is used). If a sample is to be used to select members of the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. When conducting a study designed to estimate the rates at which certain events occur, the sample size has a large impact on the level of statistical confidence in the study estimates.
6. Reliably collect data. Procedures used to collect data for a given PIP must ensure that the data collected on the PIP indicators are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. Potential sources of data include administrative data (e.g., enrollment, claims, and encounters), medical records, tracking logs, results of any provider interviews and results of any member interviews and surveys. Data can be collected from either automated data systems or by a manual review of records.
7. Implement intervention and improvement strategies. Real, sustained improvements in care result from a continuous cycle of measuring and analyzing performance and developing and implementing system-wide improvements in care. Actual improvements in care depend on thorough analysis and implementation of appropriate solutions.
8. Analyze data and interpret study results. Data analysis begins with examining the performance of the selected clinical or non-clinical indicators. The analysis of the study data should include an interpretation of the extent to which the PIP was successful and

what follow-up activities are planned as a result.

9. Plan for "real" improvement. When a change in performance is found, it is important to know whether the change represents "real" change or random chance. This can be assessed in several ways but is most confidently done by calculating the degree to which an intervention is statistically significant.
10. Achieve sustained improvement. Real change results from changes in the fundamental processes of health care delivery. Such changes should result in sustained improvements. In contrast, a one-time improvement can result from unplanned accidental occurrences or random chance. If real change has occurred, the project should be able to achieve sustained improvement.

MC ACC-RBHA targets specific areas for quality improvement and may request that contracted providers participate in initiatives for one or more of the performance improvement projects identified in this chapter. When applicable, contracted providers are expected to collaborate with MC ACC-RBHA, other providers, stakeholders, and community members to implement recommended improvement strategies that are developed because of an identified performance improvement project.

12.03 – Peer Review

Peer Review

MC ACC-RBHA has established and maintains a Peer Review Committee. The Peer Review Committee serves as the primary entity responsible for ensuring MC ACC-RBHA and subcontracted providers adhere to a clinically appropriate peer review process. The AHCCCS Bureau of Quality and Integration may submit a matter for peer review to the Chair of the Peer Review Committee, or designee.

Matters appropriate for peer review may include, but are not limited to:

- Questionable clinical decisions;
- Lack of care and/or substandard care;
- Inappropriate interpersonal interactions or unethical behavior;
- Physical or sexual abuse by provider staff;
- Allegations of criminal or felonious actions related to practice;
- Issues that immediately impact the member and that are life threatening or dangerous;
- Unanticipated death of a member;
- Issues that have the potential for adverse outcome; or
- Allegations from any source that bring into question the standard of practice.

Peer Review Committee membership will include:

- The Chief Medical Officer (Chair);
- The Deputy Chief Medical Officer;

- The QM Administrator;
- Quality of Care Reviewers;
- QM Medical Directors
- At least one provider of the same or similar specialty under review and representation of healthcare professionals from local communities in which MC ACC-RBHA has enrolled members; and
- MC ACC-RBHA's CMO may invite provider with a special scope of practice when necessary.

Non-voting Members:

- Licensed Practitioners, internal and external, when necessary

The Peer Review Committee will convene at least quarterly but, in emergent cases, an ad hoc meeting will be called by the Chair or designee.

The Peer Review Committee will examine selected peer review outcomes from MC ACC-RBHA's, and information made available through the quality management process to monitor MC ACC-RBHA's peer review process. As a result of the review, the Peer Review Committee will make recommendations to MC ACC-RBHA's Chief Medical Officer that may include, but are not limited to:

- Peer contact;
- Education;
- Rehabilitative service referral;
- Credentialing review;
- Corrective Action Plans; and/or
- Other corrective actions as deemed necessary.

The Peer Review Committee and Quality Management Committee must review its monitoring process and corresponding guidance documents annually.

The Peer Review Committee may also make recommendations for MC ACC-RBHA Chief Medical Officers to refer cases to AHCCCS, Department of Child Safety (DCS) or Adult Protective Services (APS), Arizona Medical Board, and/or other professional regulatory review boards as applicable, for further investigation or action and notification to regulatory agencies.

MC ACC-RBHA must implement recommendations made by the Peer Review Committee. Some Peer Review recommendations may be appealable agency actions under Arizona law. A MC ACC-RBHA subcontracted provider may appeal such a decision through the administrative process described in **A.R.S. §41-1092, et seq**.

All aspects of the peer review process must be kept confidential and must not be discussed outside of committee except for the purposes of implementing recommendations made by the Peer Review Committee. Confidentiality must be extended to, but is not limited to, all the following:

- Peer review reports;
- Meeting minutes;
- Documents;
- Discussions;
- Recommendations; and
- Participants.

All participants in the Peer Review Committee must sign a confidentiality and conflict of interest statement at the initiation of each peer review committee meeting.

Procedures for MC ACC-RBHA Peer Review

Evidence of a quality deficiency in the care or service provided, or the omission of care or service, by a healthcare professional or provider is subject to peer review. The evidence may include, but is not limited to, information received in a report from a state regulatory board or agency, Medicare/Medicaid sanctions, the National Practitioner Data Bank (NPDB), a member complaint, provider complaint, observations by individuals working for or on behalf of MC ACC-RBHA, or other federal, state, or local government agencies.

The MC ACC-RBHA Peer Review Committee is chaired by the Chief Medical Officer (CMO), and the membership includes Administrators and Managers of other departments within MC ACC-RBHA and representation of healthcare professionals from local communities in which MC ACC-RBHA has enrolled members (including physical health care Primary Care Physicians (PCPs and or Specialist). MC ACC-RBHA's CMO may invite providers with a special scope of practice when necessary. A PCP must be part of the Peer Review Committee when a physical health care case is being reviewed. A Behavioral Health Medical Professional (BHMP) must be part of the Peer Review Committee when a behavioral health case is being reviewed.

The CMO is responsible for implementing the quality and utilization management programs, which include peer review. As the chair-member of the Peer Review Committee, the CMO directs and actively participates in, or oversees, all aspects of the confidential peer review process. Each member of the Peer Review Committee signs a statement at all Peer Review Committee meetings acknowledging agreement with MC ACC-RBHA's confidentiality and conflict of interest standards.

The Quality Management (QM) department is responsible for the initial referral evaluation of quality and utilization concerns, generation of healthcare professional or provider notification

letters, referral review, and presentation of quality and utilization concerns to the CMO. The CMO recommends cases that need to go to Peer Review.

The QM Department schedules Peer Review Committee meetings and coordinates peer review support operations by processing, researching, and documenting referrals. The QM Department also assists with peer review follow-up activities in accordance with MC ACC-RBHA policies and procedures, or as directed by the CMO.

The Peer Review Committee is responsible for making recommendations to the CMO. Together they must determine appropriate action which may include, but not limited to peer contact, education, credentials, limits on new member enrollment, sanctions, or other corrective actions. The CMO is responsible for implementing the actions.

Peer Review Committee Recommendations

Based upon the presented information, the Peer Review Committee may:

- Request additional information.
- Assign or adjust the severity level.
- Request an outside peer review consultation and report prior to rendering a decision, if such a consultation was not already ordered by the CMO or MC ACC-RBHA medical director.
- Require the CMO to develop an action plan, which may include, but is not limited to the following:
    - ***Peer contact:*** The Committee may recommend that the MC ACC-RBHA medical director or CMO personally contact the healthcare professional or provider to discuss the committee's action.
    - ***Education:*** The Committee may recommend that information or educational material be sent to the healthcare professional or provider or that the healthcare professional or provider seek additional training. Confirmation of the completed training will be required to be sent to MC ACC-RBHA.
    - ***Committee appearance:*** The Committee may recommend that the healthcare professional or provider attend a committee meeting to discuss the issue with committee members
    - ***Credentials action:*** The Committee may recommend that MC ACC-RBHA reduce, restrict, suspend, terminate, or not renew the healthcare professional's MC ACC-RBHA credentials necessary to treat members as a participating provider.
- The healthcare professional may be required to develop a Corrective Action Plan (CAP) to:
    - Ensure the specific member issue has been adequately resolved.
    - Reduce/eliminate the likelihood of the issue reoccurring.
    - Determine, implement, and document appropriate interventions.

    - Be reviewed at the following Quality Management Committee
- The QM department monitors the success of the CAP/interventions.
- The Peer Review Committee may require new interventions/approaches when necessary.

12.04 – Behavioral Health Satisfaction Survey

This chapter outlines the process for MC ACC-RBHA and behavioral health providers that deliver covered behavioral health services to Title XIX or Title XXI eligible members receiving services in the public behavioral health system.

The surveys request independent feedback from Title XIX/XXI adult members/HCDM and families of youth receiving services through Arizona's publicly funded behavioral health system. The surveys measure consumers' perceptions of behavioral health services in relation to the following domains:

- Access to timeliness of behavioral health care
- Perceived outcome of behavioral health care
- Communication with clinicians
- Patient rights
- Member services and assistance
- Overall rating of behavioral health provider

The information collected from the surveys is used to improve the public behavioral health system. Results from the survey provide comprehensive data to make systemic program improvements.

ACC-RBHA Chapter 13 – Service Authorizations

13.00 – Securing Services and Prior Authorization

Purpose of Utilization Review Process

MC ACC-RBHA Utilization Management activities are designed to ensure a comprehensive, systematic, and ongoing process to monitor the appropriate use of health care resources in the amount and duration necessary to achieve the best possible health outcomes. MC ACC-RBHA analyzes and monitors provider and member outcomes to guide improvement activities to enhance clinical and program efficiency and quality.

The goals of utilization review are to evaluate the medical necessity criteria of the admission and/or the service provided. Ensuring the appropriateness of all medically necessary and covered services for pre-services, concurrent, and post-services delivered to members and monitoring, reviewing, and detecting under- or over-utilization of services.

MC ACC-RBHA adopts tools, such as service planning guidelines, to retrospectively review the utilization of services. The goals of utilization review include:

- Detecting under- or over-utilization of services;
- Defining expected service utilization patterns;
- Identifying providers and/or clinicians who could benefit from technical assistance;
- Facilitating the examination of clinicians and clinical teams that are effectively allocating services.

13.01 - Securing Services Does Not Require Authorization

The clinical team, or PCP in coordination with the clinical team, is responsible for identifying and securing the service needs of each behavioral health or integrated member through the assessment and service planning processes. Rather than identifying pre-determined services, the clinical team should focus on identifying the underlying needs of the behavioral health member, including the type, intensity, and frequency of support and treatment needed.

As part of the service planning process, it is the clinical team's responsibility to identify available resources and the most appropriate provider(s) for services utilizing MC ACC-RBHA's network of Participating Healthcare Providers (PHP). This is done in conjunction with the clinical team, the behavioral health member, family, and natural supports. If the service is available through a contracted provider, the member can access the service directly. If the requested service is only available through a non-contracted provider, the clinical team is responsible for coordinating with MC ACC-RBHA to obtain the requested service as outlined below.

Although Adult TFC is not a prior authorized service, MC ACC-RBHA requires the submission of the **Adult HCTC Application,** available under **Forms** on the MC website, in order to access this service.

Prior authorization for the following physical health services is not required:

- Emergency services
- Non-par facility services for the following obstetrical services:
  - OB observation
  - Vaginal delivery if stay is no longer than forty-eight hours
  - Cesarean delivery if stay is no longer than ninety-six hours
- Medical observation

13.02 - Accessing Services with Non-Contracted Providers

If MC ACC-RBHA's network does not have a Participating Healthcare Provider (PHP) to perform the requested and medically necessary service, the member may be referred to out of network providers. Out of network requests are prior authorized and a member may be referred if:

- The services required are not available within the MC ACC-RBHA network.
- MC ACC-RBHA prior authorizes the services.

To prior authorize the service, a provider must be AHCCCS registered to receive reimbursement.

If out of network services are not prior authorized, the referring and servicing providers may be responsible for the cost of the service. The member may not be billed if the provider fails to follow MC ACC-RBHA's policies. Both referring and receiving providers must comply with MC ACC-RBHA's policies, documents, and requirements that govern referrals (paper or electronic), including prior authorization. Failure to comply may result in delay in care of the member, a delay or denial of reimbursement, or costs associated with the referral being changed to the referring provider. If a team has made all attempts to find an in-network provider for a medically necessary service and is unable to secure the service within the required timeframes, the team may request a Letter of Agreement to MC ACC-RBHA for these services with an AHCCCS registered provider.

MC ACC-RBHA requires the following information to process the prior authorization:

- Requested services (including covered service codes and units)
- Provider demographic information (name, license, address, phone number, AHCCCS ID)
- Copy of the service plan indicating needed services have been documented
- Reason for referral to a non-contracted provider (e.g., specialty not available in

network)
- Reason this service is the only medically viable alternative for the member
- Time frames for processing requests
    - **Expedited Service Authorization Request:** A request for services in which either the requesting provider indicates or the MCP determines that following the standard timeframes for issuing an authorization decision could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. In these circumstances, the authorization decision must be expedited and must be made within 72 hours from the date of receipt of the service request. If the due date for an expedited authorization decision falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona, the expedited decision must be made on the day preceding the weekend or holiday.
    - **Expedited Authorization Request Downgraded to a Standard Request:** When MCP receives an expedited request for a service authorization and the requested service is not of an expedited medical nature, the MCP will downgrade the expedited authorization request to a standard request.
    - **Standard Service Authorization Request:** A request from the member, the representative, or a provider for a service for the member. The authorization decision must be made within 14 calendar days from the date of receipt of the service request.

The process for securing services through a non-contracted provider is as follows for Behavioral and Physical Health requests:

- Securing Non-Contracted Behavioral Health Adult & Children's Services:
    - MC ACC-RBHA contracts directly with providers for all levels of care.
    - It is the outpatient team's responsibility to secure all clinically necessary services in support of the treatment plan, including those from non- contracted providers. In the event the outpatient team is unable to secure services through an MC ACC-RBHA contracted provider, follow the process below. Prior authorization must be requested, completed, and executed before claims can be submitted or paid.
        - Non-contracted providers need to be AHCCCS-registered.
- Securing Non-Contracted Physical Health Services
    - MC ACC-Care contracts directly with providers for all levels of care
    - Physical health providers can prior authorization when a service through MC ACC-RBHA In-Network provider is not available
    - Use the Physical Health **Prior Authorization Standard Request Form**, available under **Forms** on the MC website.

- If a request to secure covered services through a non-contracted provider is denied, a notice of adverse benefit determination must be provided.
- If a request to secure covered services through a non-contracted provider is denied, a notice of the -action must be provided.
- If MC ACC-RBHA is unable to secure services with a non-contracted provider, MC ACC-RBHA will contact the requestor of the service to identify alternate providers until appropriate services have been obtained.

For a provider to expedite payment of a Single Case Agreement or Letter of Agreement, be sure to include a copy of the SCA/ LOA with the claim.

13.03- Accessing Services that Require Prior Authorization

Emergency Situations

Prior authorization is never applied in an emergency. A retrospective review may be conducted after the member's immediate behavioral health needs have been met. If upon review of the circumstances, the behavioral or physical health service (integrated members) did not meet admission authorization criteria, payment for the service may be denied. The test for appropriateness of the request for emergency services must be whether a prudent layperson, similarly situated, would have requested such services.

Behavioral Health emergency inpatient admissions require the provider to notify MC ACC-RBHA of all admissions via fax at 855-825-3165.

Services Requiring Prior Authorization:

- Non-emergency admission to and continued stay in an inpatient medical facility; psychiatric or detoxification acute inpatient facility;
- Non-emergency admission to and continued stay for eating disorder facilities
- Admission to and continued stay in a behavioral health inpatient facility (BHIF Level I);
- Admission to and continued stay in a behavioral health residential facility (BHRF);
- Admission to and continued stay in treatment for child and adolescent TFC services;
- Non-emergency services outside the geographic service area of MC ACC-RBHA;
- Non-emergency services outside the MC ACC-RBHA contracted Provider Network;
- Specific pharmacy practices;
- Non-emergency out of network services
- Physical Health services such as pain management
- In order to determine if a Physical Health service is required a provider may utilize the **ProPat** link in **Availity**.

Physical Health Providers under Integrated Care

MC ACC-RBHA requires prior authorization for selected acute outpatient services, hospice, skilled nursing services, rehabilitation services, planned outpatient procedures, and/or planned hospital procedures. Questions related to specific outpatient services that require prior authorization can be directed to Member Services at 800-564-5465.

Prior authorization guidelines are reviewed and updated regularly. To request an authorization, find out what requires authorization, or to check on the status of an authorization, please visit **Availity**. You may also fax our Prior Authorization Department at 800-217-9345.

MC ACC-RBHA has prior authorization staff to authorize health care 24 hours per day, seven days per week. This staff includes Arizona-licensed nurses and physicians.

MC ACC-RBHA employs licensed clinicians to review and make prior authorization decisions. Any decision to reduce or deny a request for services based on medical necessity criteria review must be made by a MC ACC-RBHA medical director or physician designee.

A denial of a request for a requested service or equipment, admission to or continued stay in an inpatient facility, BHIF, BHRF or Child/Adolescent TFC can only be made by a MC ACC-RBHA medical director or physician designee.

Following a decision to deny the attending facility physician or requesting provider can ask for a peer-to-peer review.

Notice must be provided in accordance with Notice and Appeal Requirements for behavioral health inpatient.

13.04 - How to Request a Prior Authorization

The following documentation is required to obtain prior authorization:

- For a non-emergent admission to an acute inpatient, psychiatric acute hospital or sub-acute facility, detoxification or for an eating disorder, a **Certification of Need (CON)**, available under **Forms** on the MC website, must be completed.
- Please refer to our **Authorization Criteria Adult SMI Behavioral Health Residential Facility,** available under **Forms** on the MC website. In addition, please refer to **AMPM Policy 320-V – Behavioral Health Residential Facilities** for detailed information regarding this. MC ACC-RBHA follows all AHCCCS criteria that applies in this policy.
- 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.

- Child/Adolescent Behavioral Health Inpatient Facility (BHIF) non-emergent request, the Clinical Team must submit a **Prior Authorization Request for Children and Adolescents**

BHIF, BHRF & TFC, available under **Forms** on the MC website, via fax to 855-825-3165 regardless of TPL coverage. **Authorization cannot be provided without all the requested documentation.**

- A Certification of Need (CON) must be completed after approval by the requesting provider prior to admission.
- Approval for child/adolescent behavioral health inpatient facility (BHIF) is valid for up to forty-five days. If not admitted before the expiration of the 45 days the clinical team must submit the **Child and Adolescent 45 Day Clinical Review for Continued Prior Authorization of Residential Facility** form, available under **Forms** on the MC website.

- For Adult or Child /Adolescent Behavioral Health Residential Facility (BHRF) or Child TFC non-emergent request, the Clinical Team must complete the appropriate form:
  - **Prior Authorization: BHRF and ABHTH**, available under **Forms** on the MC website and submit via fax to 855-825-3165). Approval is valid for 45 days.
  - **Prior Authorization Request for Children and Adolescents BHIF, BHRF & TFC**, available under **Forms** on the MC website, **application,** and fax to MC ACC-RBHA at 855-825-3165 followed by telephonic notification to MC ACC-RBHA Utilization Management via MC ACC-RBHA's Member Services Department at 800-564-5465**. Authorization cannot be provided without all the required documentation.**
    - Approval for child/adolescent behavioral health residential facilities is valid for up to forty-five days and a **Child and Adolescent 45 Day Clinical Review for Continued Prior Authorization of Residential**
    - **Facility**, available under **Forms** on the MC website, must be submitted if additional days are needed.
    - Approval for child/adolescent TFC is valid for up to sixty days and a **Child and Adolescent 60 Day Clinical Review for Continued Prior Authorization of TFC**, available under **Forms** on the MC website, must be faxed to MC ACC-RBHA at 855-825-3165.
    - **Authorization Criteria for Behavioral Health Residential Facility, Children/Adolescent** is available under **Forms** on the MC website.
- Non-emergency inpatient eating disorder requires prior authorization according to MCG guidelines. Complete the **Prior Authorization: Inpatient Eating Disorder**, available under **Forms** on the MC website, form, and fax to 844-424-3976 or for urgent request call 800-564-5465 to review with the MC ACC-RBHA Utilization Management Department.
- MC ACC-RBHA requires prior authorization for selected Durable Medical Equipment (DME). Questions related to specific DME that require prior authorization can be directed to Member Services at 800-564-5465. Additionally, individuals who are discharged from

the Arizona State Hospital (AzSH) must be provided with the same brand and model of glucometer and supplies the individual was trained on while in the hospital.

13.05 - Third Party Liability (TPL)

MC ACC-RBHA matches TPL for copays and deductible if the provider is an AHCCCS registered provider. For the following services we require notification or a prior authorization request to ensure coordination of care and proactive discharge planning.

Emergency Inpatient Behavioral Health Admissions with TPL

Providers are required to notify MC ACC-RBHA at the time of admission for all TPL. MC ACC-RBHA reviews for members with TPL coverage in an acute hospital to match the TPL authorization and to confirm that proactive discharge planning is in place. Providers are required to notify MC ACC-RBHA at the time that the TPL has denied and to appeal all decisions if they believe the member needs further inpatient treatment. MC ACC-RBHA will review for continued stay determinations based on clinical information provided and medical care criteria that assess the need for the continued stay. If approved, MC ACC-RBHA will assign the next review date based on the member's specific condition not to exceed 7 days. Providers receive notification of next review date and are responsible for requesting further stay and providing clinical information on the scheduled review date.

Child/Adolescent Behavioral Health Inpatient Facility Prior Authorization Request with TPL

When a clinical team has identified a request for behavioral health inpatient facilities for a member that has a TPL, they will submit a BHIF prior authorization request at the same time and assist the parent or HCDM with contacting the TPL to request prior authorization. MC ACC-RBHA will match the primary insurance authorization and review to ensure that coordination of care and proactive discharge planning is in place. Providers are required to notify MC ACC-RBHA at the time that the TPL has denied and to appeal all decisions if they believe the member needs further inpatient treatment. MC ACC-RBHA will review for continued stay determinations based on clinical information provided and medical care criteria that assess the need for the continued stay. If approved MC ACC-RBHA will assign the next review date based on based on the member's specific condition not to exceed 30 days. Providers receive notification of next review date and are responsible for requesting further stay and providing clinical information on the scheduled review date.

13.06 - Requirements for Certification of Need (CON) and Recertification of Need (RON)

A CON is a certification made by a physician that inpatient or behavioral health inpatient facility services are or were needed at the time of the member's admission. A CON is not an authorization tool designed to approve or deny an inpatient service but rather it is a federally required attestation by a physician that inpatient services are or were needed at the time of the member's admission. The decision to authorize a service that requires prior authorization is determined through the application of admission and continued stay authorization criteria.

In the event of an emergency, the CON must be completed:

- For members aged 21 or older, within 72 hours of admission; and
- For members under the age of 21, within 14 days of admission.

A Recertification of Need (RON) is a re-certification made by a physician, nurse practitioner, or physician assistant that inpatient services are still needed for a member. A RON must be completed at least every 60 days for a member who is receiving services in an inpatient facility. An exception to the 60-day timeframe exists for inpatient services provided to members under the age of 21. The treatment plan (individual plan of care) for members under the age of 21 in an inpatient facility must be completed and reviewed every 30 days. The completion and review of the treatment plan in this circumstance meets the requirement for the re-certification of need.

The following documentation is needed to satisfy the requirements of a CON and RON and is maintained in the members' medical record:

- Proper treatment of the member's behavioral health condition requires services on an inpatient basis under the direction of a physician.
- The service can reasonably be expected to improve the member's condition or prevent further regression so that the service will no longer be needed;
- Outpatient resources available in the community do not meet the treatment needs of the member; and
- CONs, a dated signature by a physician; and
- RONs, a dated signature by a physician, nurse practitioner, or physician assistant.

Additional CON requirements include:

- If a member becomes eligible for Title XIX or Title XXI services while receiving inpatient services, the CON must be completed and kept in the member's record.
- For members under the age of 21 receiving inpatient psychiatric services: Federal rules set forth additional requirements for completing CONs when member under the age of 21 are admitted to or are receiving services in an inpatient facility. These requirements include the following:
    - For an individual who is Title XIX/XXI eligible when admitted, the CON must be completed by the clinical team that is independent of the facility and must include a physician who has knowledge of the member's situation and who is competent in the diagnosis and treatment of mental illness, preferably child psychiatry;
    - For emergency admissions, the CON must be completed by the team responsible for the treatment plan within 14 days of admission. This team is defined in 42 CFR §441.156 as "an interdisciplinary team of physicians and other personnel who are employed by, or provide services to patients in the facility"; and

    - For members who are admitted and then become Title XIX or Title XXI eligible while at the facility, the team responsible for the treatment plan must complete the CON. The CON must cover any period for which claims for payment are made.
- Compliance with federal requirements related to the Certification of Need (CON) and Recertification of Need (RON) for MC ACC-RBHA authorized services including hospitals and behavioral health inpatient facilities is mandatory. The facilities will be required to complete a CON for each admission and keep the CON in the member's record.
- Physical Health Inpatient providers are required to document the above information in the medical chart.

13.07 – Discharge Planning

MC ACC-RBHA has developed and implemented a discharge planning process to address the post-discharge clinical and social needs of the member upon discharge. Discharge planning should take into consideration a member's unique needs and supports and involve key stakeholders such as other agencies involved with the member such as HCDNM, the Office of Human Rights (OHR), the Department of Children Services (DCS) or acute health plan care managers. As a best practice, proactively planning for discharge allows for member continuity of care by utilizing needs assessment at admission and staging discharge plans as the member progresses to being discharge ready. Proactive discharge planning provides for best practice in care needs evaluation between the member, the facility, and MC ACC-RBHA with the goal of preventing readmission within thirty (30) days of hospital health discharge. The process is initiated by the provider utilizing a qualified healthcare professional as soon as possible before, upon, or immediately after admission and updated periodically during the inpatient admission to ensure accurate determination of continuing care needs. The discharge plan must be appropriately documented in the member's medical record and must be completed before discharge occurs. MC ACC-RBHA must ensure that its subcontracted providers have a process that includes:

- Proactive discharge assessment by qualified healthcare professionals identifying and assessing the specific post-discharge bio-psychosocial and medical needs of the eligible member prior to discharge. This process shall include the involvement and participation of the eligible member and representative(s), as applicable. The member and representative(s), as applicable, must be provided with the written discharge plan with instructions and recommendations identifying resources, referrals, and possible interventions to meet the member's assessed and anticipated needs after discharge.
- The coordination and management of the care that the eligible member receives following discharge from an acute setting. This may include:
    - Providing appropriate post discharge community referrals and resources.
    - Scheduling follow up appointments with the member's primary care provider and/or other outpatient healthcare providers within seven days or sooner of discharge.

Coordination of care involving effective communication of the eligible member's treatment plan and medical history across the various outpatient providers to ensure that the member receives medically necessary services that are both timely and safe after discharge. This includes:

- Access to nursing services and therapies.
- Coordination with the member's outpatient clinical team to explore interventions to address the member's needs, such as care management, disease management, placement options, and community support services.
- Access to prescribed discharge medications.
- Coordination of care with the acute care plan, when applicable.
- Post-discharge follow-up contact to assess the progress of the discharge plan according to the member's assessed clinical (physical health care) and social needs.

A discharge plan must be documented in the member's medical record.

13.08 - Medical Necessity Criteria

To support prior and continued authorization decisions, MC ACC-RBHA uses nationally recognized evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system. Criteria is reviewed annually and approved by the Medical Management/Utilization Management Committee.

If MCG Guidelines indicate "current role remains uncertain" for the requested service, the next criteria in the hierarchy or other nationally accepted guidelines, should be consulted and applied.

For prior or continued authorization of outpatient or inpatient behavioral and physical health services, MC ACC-RBHA applies:

- Criteria require by AHCCCS and by the applicable state or federal regulatory agency.
- Applicable AHCCCS Medical Policy Manual (AMPM) or MCG Guidelines as the primary decision support for most medical diagnoses and conditions.
- American Society of Addiction Medicine (ASAM)
- Other nationally accepted guidelines

For services in a Behavioral Health Inpatient Facility for members under the age of 21, the following criteria will be used by MC ACC-RBHA and behavioral health providers:

- Prior to denials for a Behavioral Health Inpatient Facility, MC ACC-RBHA Medical Directors or designees will talk with the treating psychiatrist/ psychiatric nurse practitioner most familiar with the member in order to gather any additional information that could be helpful in making the determination. If a psychiatrist or psychiatric nurse practitioner has not yet been involved, an evaluation should be

arranged for MC ACC-RBHA's Medical Director or designee to obtain the professional opinion of a behavioral health clinician.

- In addition, if a denial is issued for admission to a Behavioral Health Inpatient Facility, MC ACC-RBHA will provide a clearly outlined alternative plan at the time of the denial. This may require development of a Child and Family Team (CFT), if one has not already been established, or consultation with the CFT. It is expected that the alternative treatment plan will adequately address the behavioral health treatment needs of the child and will provide specific information detailing what services will be provided, where these services will be provided, when these services will be available, and what specific behaviors will be addressed by these services. It is also expected that the alternative treatment plan will include what crisis situations can be anticipated and how the crisis will be addressed. Please refer to:
- Admission to Behavioral Health Hospital Facility or Behavioral Health Inpatient Facility Authorization Criteria; and
- Continued Behavioral Health Hospital Facility or Behavioral Health Inpatient Facility Authorization Criteria.

To obtain additional information on how to access or obtain practice guidelines and coverage criteria for authorization decisions, please contact MC ACC-RBHA Member Services at 800-564-5465.

Alternative Placement not Available upon Discharge

If a member receiving inpatient services no longer requires services on an inpatient basis under the direction of a physician, but services suitable to meet the member's behavioral health needs are not available or the member cannot return to the member's residence because of a risk of harm to self or others, services may continue to be authorized as long as there is an ongoing, active attempt to secure a suitable discharge placement or residence in collaboration with the community or other state agencies as applicable. All such instances shall be logged and provided to MC ACC-RBHA upon request.

13.09 - Coverage and Payment of Emergency Services

The following conditions apply with respect to coverage and payment of emergency behavioral health services for members who are Title XIX or Title XXI eligible:

- Emergency behavioral health services must be covered, and reimbursement made to providers who furnish the services regardless of whether the provider has a contract with MC ACC-RBHA;
    - The provider is registered with AHCCCS for this service.
- Payment must not be denied when:
    - MC ACC-RBHA or behavioral health provider instructs a member to seek emergency behavioral health services;
    - A member has had an emergency behavioral health condition, including cases in

which the absence of medical attention would have resulted in:
    - Placing the health of the member (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
    - Serious impairment to bodily functions; or
    - Serious dysfunction of any bodily organ or part.
- Emergency behavioral health conditions must not be limited to a list of diagnoses or symptoms;
- MC ACC-RBHA may not refuse to cover emergency behavioral health services based on the failure of a provider to notify MC ACC-RBHA of a member's screening and treatment within 3 days of presentation for emergency services.
- A member who has an emergency behavioral health condition must not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member; and
- The attending emergency physician, or the provider treating the member, is responsible for determining when the member is sufficiently stabilized for transferor discharge, and such determination is binding MC ACC-RBHA.

The following conditions apply with respect to coverage and payment of post-stabilization care services for a member who has received emergency medical or psychiatric hospitalization who is Title XIX or Title XXI eligible. MC ACC-RBHA is responsible for post-stabilization services and ensuring adherence to the following requirements, even in situations when the function has been delegated to a subcontracted provider.

Post-stabilization care services must be covered without authorization and reimbursement made to providers that furnish the services regardless of whether the provider has a contract with MC ACC-RBHA for the following situations:

- Post-stabilization care services that were pre-authorized by MC ACC-RBHA;
- Post-stabilization care services that were not pre-authorized by MC ACC-RBHA or because MC ACC-RBHA did not respond to the treating provider's request for pre-approval within one hour after being requested to approve such care or could not be contacted for pre-approval; or
- MC ACC-RBHA and the treating physician cannot reach agreement concerning the member's care and a MC ACC-RBHA physician is not available for consultation. In this situation, MC ACC-RBHA must give the treating physician the opportunity to consult with a contracted physician and the treating physician may continue with care of the member until a contracted physician is reached or one of the following criteria is met:
    - MC ACC-RBHA physician with privileges at the treating hospital assumes responsibility for the member's care;
    - MC ACC-RBHA physician assumes responsibility for the member's care through transfer;

- MC ACC-RBHA and the treating physician reach an agreement concerning the member's care; or
- The member is discharged.

13.10 - Newborn Notification Process

Providers must fax a newborn notification to MC ACC-RBHA's dedicated fax number at 844-525-2223. MC ACC-RBHA will report newborn information to AHCCCS and in turn will fax back the newborn AHCCCS ID number to the provider.

Well Newborn:

- No authorization is required for vaginal delivery (2 days).
- No authorization is required for cesarean section delivery (4 days).

Sick Newborn:

- Providers will need to contact the Newborn's health plan for authorization.

13.11 - Technology

MC ACC-RBHA will ensure review and adoption of new technologies and/or adoption of new uses to existing technologies utilizing evidence-based research and guidelines. Adoption of evidence-based research and guidelines include a meta-analysis of related peer reviewed literature.

Providers may initiate a request for coverage of new approved technologies including the usage of new applications for established technologies by submitting the proposal in writing to the MC ACC-RBHA Medical Director for review. The proposal must include (at a minimum):

- Medical necessity criteria;
- Documentation supporting medical necessity;
- A cost analysis for the new technology; and
- Peer reviewed literature indicating the efficacy of the new technology or the modification in usage of the existing technology.

MC ACC-RBHA shall participate in the review of new approved technologies, including the usage of new applications for established technologies through the MC ACC-RBHA Pharmacy and Therapeutics Committee and the Medical Management Committee.

MC ACC-RBHA shall review requests and inform the requestor and member of the decision to provide the technology in a timely manner. When the request is accompanied with a service authorization request, the decision for coverage must be completed in a timely manner - within 3 business days for an expedited request, 14 days for a standard request, with an extension of up to 14 additional days if the extension is in the best interest of the member. Discussion reflecting consideration of a new approved technology, including the usage of a new application for

established technology and MC ACC-RBHA's determination of coverage shall be documented in the Pharmacy and Therapeutics Committee meeting minutes and the Medical Management Committee meeting minutes.

MC ACC-RBHA will notify AHCCCS of its decision to cover a new approved technology, including the usage of new applications for established technology within 30 days of reaching that determination.

Consideration for systemic implementation of the coverage of the technology will be prioritized for consideration by AHCCCS based on trends and the meta-analysis of peer reviewed literature.

13.12 – Pre-Admission Screening and Resident Review (PASRR)

The PASRR screening consists of a two-stage identification and evaluation process and is conducted to assure appropriate placement and treatment for those identified with Serious Mental Illness (SMI) and/or Mental Retardation (MR).

- PASRR Level I screenings are used to determine whether the member has any diagnosis or other presenting evidence that suggests the potential presence of SMI and/or MR.
- PASRR Level II evaluations are used to confirm whether the member indeed has SMI and/or MR. If the member is determined to have SMI and/or MR, this stage of the evaluation process determines whether the member requires the level of services in a Nursing Facility (NF) and/or specialized services (inpatient/hospital psychiatric treatment).

Medicaid certified NFs must provide PASRR Level I Screening, or verify that screening has been conducted, to identify SMI and/or ID prior to initial admission of members to a nursing facility bed that is Medicaid certified or dually certified for Medicaid/Medicare.

PASRR LEVEL 1

Screening

See **Arizona Pre-Admission Screening and Resident Review (PASRR) Level I Screening Document**.

PASRR Level I screenings can be conducted by the following professionals:

- Hospital discharge planners;
- Nurses;
- Social workers; or
- Other NF staff that have been trained to conduct the Level I PASRR screening and make Level II PASRR referrals.

ALTCS PASRR assessors or care managers may conduct Level I PASRR screenings, but it is the ultimate responsibility of the facility where the member is located to ensure that the Level I and

Level II PASRR is completed prior to the member being admitted into the receiving NF.

A PASRR Level I Screening is not required for readmission of members who were hospitalized and are returning to the NF, or for inter-facility transfers from another NF if there has not been a significant change in their mental condition. The PASRR Level I Screening form and PASRR Level II evaluation must accompany the readmitted or transferred member.

A PASRR Level I Screening is required if a member is being admitted to a NF for a convalescent period, or respite care, not to exceed 30 days. If later it is determined that the admission will last longer than 30 days, a new PASRR Level I Screening is required. The PASRR Level II evaluation must be done within 40 calendar days of the admission date.

Review

Upon completion of a PASRR Level I Screening, documents are forwarded to the PASRR Coordinator within the AHCCCS Bureau of Quality Management Operations. If necessary, referrals for a PASRR Level II evaluation to determine if a member has a SMI diagnosis.(These are forwarded to the AHCCCS Office of the Medical Director.)

When a PASRR Level I Screening is received by MC ACC-RBHA, the PASRR Coordinator reviews it and, if needed, consults with the MC ACC-RBHA Medical Director or designee (must be a Board-eligible or Board-certified psychiatrist and have an unrestricted, active license to practice medicine in Arizona) to determine if a PASRR Level II evaluation is necessary. If it is determined that a PASRR Level II evaluation should be conducted, the PASRR coordinator must:

- Forward copies of the PASRR Level I Screening and any other documentation to AHCCCS; and
- Send a letter to the member/legal representative that contains notification of the requirement to undergo a Level II PASRR evaluation.

PASRR LEVEL II

Evaluations

MC ACC-RBHA must develop an administrative process for conducting PASRR Level II evaluations and must ensure that:

- If a member is awaiting discharge from a hospital, the evaluation should be completed within 3 working days and all PASRR Level II evaluations must be completed within 5 working days of receipt of the PASRR Level I Screening; and
- The criteria used to make the decision about appropriate placement are not affected by the availability of placement alternatives.

Criteria

The PASRR Level II evaluation includes the following criteria:

- The evaluation report must include the components of the **Level II PASRR Psychiatric Evaluation**;
- The evaluation must be performed by a physician who is a Board-eligible or Board-certified psychiatrist and has an unrestricted, active license to practice medicine in Arizona;
- The evaluation can only be performed by a psychiatrist who is independent of and not directly responsible for any aspect of the care or treatment of the member being evaluated;
- The evaluation and notices must be adapted to the cultural background, language, ethnic origin, and means of communication used by the individual being evaluated;
- The evaluation must involve the individual being evaluated, the individual's legal representative, if one has been designated under state law, and the individual's family, if available and if the individual or the legal representative agrees to family participation;
- Evaluators may use relevant evaluative data, obtained prior to initiation of preadmission screening or resident reviews, if the data are considered valid and accurate and reflect the current functional status of the individual. However, in the case of individualized evaluations, to supplement and verify the currency and accuracy of existing data, the State's PASRR program may need to gather additional information necessary to assess proper placement and treatment.
- The evaluation report must include the **Pre-Admission Screening and Resident Review (PASRR) Invoice**. (AMPM Exhibit 1220-3).

Review

The MC ACC-RBHA Medical Director or designee reviews all evaluations and makes final Level II placement determinations prior to the proposed/current placement.

MC ACC-RBHA must provide copies of the completed PASRR Level II evaluation to the referring agency, Arizona Health Care Cost Containment System, Division of Health Care Management (AHCCCS/DHCM) PASRR Coordinator, facility, primary care provider, and person/legal representative.

Cease Process and Documentation

If at any time in the PASRR process it is determined that the person does not have a SMI or has a principal/primary diagnosis identified as an exemption in the Level I Screening, the evaluator must cease the PASRR process of screening and evaluation and document such activity.

SMI Determination

MC ACC-RBHA reviews each person determined to have a SMI on an annual basis, or when a significant change in the resident's physical or mental condition has been noted to ensure the continued appropriateness of nursing home level of care and the provision of appropriate behavioral health services.

Reporting

MC ACC-RBHA shall report monthly to AHCCCS concerning the number and disposition of residents:

- Not requiring nursing facility services but requiring specialized services for SMI.
- Residents not requiring nursing facility services or specialized services for SMI.
- Any appeals activities and dispositions of appeal cases.

Discharge

Per **42 C.F.R. 483.118(b) (1 and 2)**, MC ACC-RBHA will work with the facility to arrange for the safe and orderly discharge of the resident. The facility, in accordance with **42 C.F.R. 483.12(a)** will prepare and orient the resident for discharge.

Per **42 C.F.R. 483.118 (c) (i-iv),** MC ACC-RBHA will work with the facility to provide an alternative disposition plan for any resident who requires specialized services and who have continuously resided in a nursing facility for at least 30 months prior to the determination as defined in **42 C.F.R. 483.120**. MC ACC-RBHA, in consultation with the resident's family or legal representative and caregivers, offer the resident the choice of remaining in the facility or of receiving services in an alternative appropriate setting.

Recommendations

The **Level II PASRR Psychiatric Evaluation** includes the recommendations of services for lesser intensity by the evaluating Psychiatrist as per **42 C.F.R.483.120, 128(h) (i) (4 and 5)**.

The MC ACC-RBHA Medical Director or designee (must be a Board-eligible or Board-certified psychiatrist and have an unrestricted, active license to practice medicine in Arizona) will determine if the person requires nursing facility level of care and if specialized services are needed based on individualized evaluations or advance group determinations in accordance with **42 C.F.R. § 483.130-134.** Individual evaluations or advance group determinations may be made for the following circumstances:

- The person has been diagnosed with a terminal illness; or
- Severe physical illness results in a level of impairment so severe that the person could not benefit from specialized services. The person will be reassessed when notified by the nursing facility of an improvement in their condition; and
- Other conditions as listed in **42 C.F.R. § 483.130-134**.

Appeal and Notice Process Specific to PASRR Evaluations

MC ACC-RBHA shall send a written notice no later than three (3) working days following a PASRR determination in the context of either a preadmission screening or resident review that adversely affects a Title XIX/XXI eligible person.

MC ACC-RBHA must provide AHCCCS with any requested information, and to make available witnesses necessary to assist with the defense of the decision on appeal, if a person appeals the determination of the PASRR evaluation.

Retention

MC ACC-RBHA must retain case records for all Level II evaluations for a period of 6 years in accordance with **A.R.S. §12-2297**.

MC ACC-RBHA must permit authorized AHCCCS personnel reasonable access to files containing the reports received and developed.

Training

Training will be provided to psychiatrists and any other medical professionals that conduct Level II evaluations as needed.

13.13 - Retrospective Review Added Address Change

MC ACC-RBHA provides retrospective reviews for the following situations and will be reviewed within 30 days of receipt of medical record:

- Notification of stay after care has been provided due to provider's inability to ascertain member's insurer while services were being rendered.
- When a person becomes Title XIX/XXI eligible after discharge from an Inpatient (Acute or Sub- Acute) facility.

Providers may submit medical records for retrospective review to MC ACC-RBHA utilizing the following processes:

- STFP: MC ACC-RBHA SFTP (Secure File Transfer Protocol) which enables registered providers to submit medical records through a secured electronic portal. Providers must register by submitting an **SFTP Connectivity Enrollment Form** to your Network Management Specialist/Consultant, or by mailing to:

  Mercy Care ACC-RBHA
  Network Management Department
  4750 S. 44th Place, Ste 150
  Phoenix, AZ 85040

- Claims that have been denied for no authorization are considered a Claims Appeals

and must be sent to the following address:

Mercy Care ACC-RBHA
Claims Disputes
4750 S. 44th Place, Ste 150
Phoenix, AZ 85040

- Grievance & Appeals must be sent to the following address:

Mercy Care ACC-RBHA
Grievance & Appeals
4750 S. 44th Place, Ste 150
Phoenix, AZ 85040

Retrospective reviews are conducted by qualified staff: nurses; nurse practitioners; physicians; physician assistants; and behavioral health professionals. The reviewer monitors the appropriateness of care that was provided, the progress a recipient made, and the progress toward the recipient's discharge planning using standardized criteria.

13.14 – Provider-Preventable Conditions

A member's health status may be compromised by hospital conditions and/or medical personnel in ways that are sometimes diagnosed as a "complication." If it is determined that the complication resulted from a Health Care-Acquired Condition (HCAC) or Other Provider-Preventable Condition (OPP), any additional hospital days or other additional charges resulting from the HCAC or OPPC will not be reimbursed.

If it is determined that the HCAC or OPPC was a result of mistake or error by a hospital or medical professional, MC ACC-RBHA must conduct a quality of care investigation and report the occurrence and results of the investigation to the AHCCCS Clinical Quality Management Unit.

13.15 – Inter-Rater Reliability

Inter-rater reliability testing is completed by all MC ACC-RBHA staff making medical necessity criteria determinations (including medical directors, nurses, physicians, behavioral health professionals, nurse practitioners, and/ or physician assistants). Medical necessity criteria determinations include, but are not limited to conducting prior authorization, concurrent review, and retrospective review.

ACC-RBHA Chapter 14 – Contract Compliance

14.00 – Confidentiality

Information and records obtained while providing or paying for covered health services to a member is confidential and is only disclosed according to the provisions of this policy and procedure and applicable federal and state law. In the event of an unauthorized use/disclosure of unsecured PHI, the covered entity responsible for the breach must notify all affected members. Medical records must be maintained in accordance with written protocols pertaining to their care, custody, and control as mandated by Arizona Revised Statutes Title 36, Chapter 32, Article 1 §32-3211.

Overview of Confidentiality

MC ACC-RBHA employees and subcontracted behavioral health providers must keep medical and behavioral health records, and all information contained in those records confidential and cannot disclose such information unless permitted or required by federal or state law. The law regulates two major categories of confidential information:

- Information obtained when providing healthcare services not related to alcohol or drug abuse referral, diagnosis, and treatment; and
- Information obtained in the referral, diagnosis and treatment of alcohol or drug abuse.

Protected Health Information Not Related to Alcohol and Drug Treatment

Information obtained when providing healthcare services not related to alcohol and drug abuse treatment is governed by state law and the HIPAA Privacy Rule, **45 C.F.R., Part 164**, **Subparts A and E, Part 160 Subparts A and B** ("the HIPAA Rule"). The HIPAA Rule permits a covered entity (health plan, healthcare provider, and healthcare clearinghouse) to use or disclose protected health information with or without patient authorization in a variety of circumstances, some of which are required and others that are permissive. Many of the categories of disclosures contain specific words and phrases that are defined in the HIPAA Rule. Careful attention must be paid to the definitions of words and phrases to determine whether disclosure is allowed. In addition, the HIPAA Rule may contain exceptions or special rules that apply to a particular disclosure. State law may affect a disclosure. For example, the HIPAA Rule may preempt a state law, or a state law may preempt the HIPAA Rule. In addition, a covered entity must, with certain exceptions, make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the disclosure.

In January 2013, The Department of Health, and Human Services (Federal Registrar, volume 78, no. 17) substantially expanded the HIPAA Privacy and Security Rule and affects how MC ACC-RBHA and health care providers are required to use and disclose protected health information. In addition, MC ACC-RBHA and health care providers are now required to notify each individual

whose unsecured PHI has been impermissibly used or disclosed in accordance with the HITECH Acts Security Breach Notification requirement.

Before disclosing protected health information, it is good practice to consult the specific citation to the HIPAA Rule, state law and consult with legal counsel before disclosing an individual's protected health information. See **Disclosure of Information Not Related to Alcohol or Substance Abuse Treatment** for more detail regarding the disclosure of behavioral health information not related to alcohol or drug referral, diagnosis, or treatment.

Drug and Alcohol Abuse Information

Information regarding treatment for alcohol or drug abuse is afforded special confidentiality by Federal statute and regulation. This includes any information concerning a member's diagnosis or treatment from a federally assisted alcohol or drug abuse program or referral to a federally assisted alcohol or drug abuse program.

General Procedures for All Disclosures

Unless otherwise exempted by state or federal law, all information obtained about a member related to the provision of healthcare services to the member is confidential whether the information is in oral, written, or electronic format.

All records generated as a part of the MC ACC-RBHA grievance and appeal processes are legal records, not medical records, although they may contain copies of portions of a member's medical record. To the extent these legal records contain personal medical information, MC ACC-RBHA will redact or de-identify the information to the extent allowed or required by law.

List of Members Accessing Records

Providers are required to maintain a list of every member or organization that inspects a currently or previously enrolled member's records other than the member's clinical team, the uses to be made of that information and the staff member authorizing access. The access list must be placed in the enrolled member's record and must be made available to the enrolled member, their HCDM or other designated representative. Providers must retain consent and authorization medical records as prescribed in **A.R.S. §12-2297**.

Disclosure to Clinical Teams

Disclosure of information to members of a clinical team may or may not require an authorization depending upon the type of information to be disclosed and the status of the receiving party. Information concerning diagnosis, treatment or referral for drug or alcohol treatment may only be disclosed to members of a clinical team with patient authorization as prescribed in this chapter. Information not related to drug and alcohol treatment may be disclosed without patient authorization to members of a clinical team for purposes of

treatment, payment, or healthcare operations, as permitted by and in compliance with **§164.506** of the HIPAA Rule. Unless otherwise prescribed in federal regulations or statute, it is not necessary to obtain a signed release to share behavioral health related information with the member's parent/HCDM, primary care provider (PCP), the member's Health Plan Behavioral Health Coordinator acting on behalf of the PCP or authorized state social service agencies. Disclosure to members of a clinical team for purposes other than treatment, payment, or healthcare operations, as permitted by and in compliance with **§164.506** of the HIPAA Rule requires the authorization of the member or the member's HCDM, or parent as prescribed in this chapter.

Disclosure to Members in Court Proceedings

Disclosure of information to members involved in court proceedings including attorneys, probation, or parole officers, HCDM's ad litem and court appointed special advocates may or may not require an authorization depending upon the type of information to be disclosed and whether the court has entered orders permitting the disclosure.

Disclosure of Information Not Related to Alcohol and Drug Treatment

Overview of Types of Disclosure

The HIPAA Rule and state law allow a covered entity to disclose protected health information under a variety of conditions. This is a general overview and does not include an entire description of legal requirements for each disclosure. The latter part of this chapter contains a more detailed description of circumstances that are likely to involve the use or disclosure of behavioral health information.

Below is a general description of all required or permissible disclosures:

- To the individual and the individual's health care decision maker;
- To health, mental health and social service providers for treatment, payment, or health care operations;
- Incidental to a use or disclosure otherwise permitted or required by **45 C.F.R. Part 164, Subpart E**;
- To a member or entity with a valid authorization;
- Provided the individual is informed in advance and can agree or prohibit the disclosure:
- For use in facility directories;
- To members involved in the individual's care and for notification purposes;
- When required by law;
- For public health activities;
- About victims of child abuse, neglect, or domestic violence;
- For health oversight activities;
- For judicial and administrative proceedings;
- For law enforcement purposes;

- About deceased members;
- For cadaveric organ, eye, or tissue donation purposes;
- For research purposes;
- To avert a serious threat to health or safety or to prevent harm threatened by patients;
- To a human rights committee;
- For purposes related to the Sexually Violent Members program;
- With communicable disease information;
- To personal representatives including agents under a healthcare directive;
- For evaluation or treatment;
- To business associates;
- To the Secretary of Health and Human Services or designee to investigate or determine compliance with the HIPAA Rule;
- For specialized government functions;
- For worker's compensation;
- Under a data use agreement for limited data;
- For fundraising;
- For underwriting and related purposes;
- To the Arizona Center for Disability Law in its capacity as the State Protection and Advocacy Agency;
- To a third-party payer to obtain reimbursement;
- To a private entity that accredits a healthcare provider;
- To the legal representative of a healthcare entity in possession of the record for the purpose of securing legal advice;
- To a member or entity as otherwise required by state or federal law;
- To a member or entity permitted by the federal regulations on alcohol and drug abuse treatment (**42 C.F.R. Part 2**);
- To a member or entity to conduct utilization review, peer review, and quality assurance pursuant to **Section 36-441**, **36-445**, **36-2402** or **36-2917**;
- To a member maintaining health statistics for public health purposes as authorized by law; and
- To a grand jury as directed by subpoena.

Disclosure of Behavioral Health Information

Below is a description of the circumstances in which behavioral health information is likely to be required or permitted to be disclosed:

- Disclosure to an individual or the individual's health care decision maker;
- A covered entity is required to disclose information in a designated record set to an individual when requested unless contraindicated. Contraindicated means that access is reasonably likely to endanger the life or physical safety of the patient or another

member (**A.R.S. §36-507(3)**; **45 C.F.R. §164.524**); A covered entity should read and carefully apply the provisions in **45 C.F.R. §164.524** before disclosing protected health information in a designated record set to an individual.

- An individual has a right of access to his or her designated record set, except for psychotherapy notes and information compiled for pending litigation (**45 C.F.R. §164.524(a)(1)** and Section 13405(e) of the HITECH Act). Under certain conditions a covered entity may deny an individual access to the medical record without providing the individual with an opportunity for review (**45 C.F.R. §164.524(a) (2)**). Under other conditions, a covered entity may deny an individual access to the medical record and must provide the individual with an opportunity for review (**45 C.F.R. §164.524(a) (3)**). A covered entity must follow certain requirements for a review when access to the medical record is denied (**45 C.F.R. §164.524(a) (4)**).
- An individual must be permitted to request access or inspect or obtain a copy of his or her medical record (**45 C.F.R. §164.524(b) (1)**). A covered entity is required to act upon an individual's request in a timely manner (**45 C.F.R. §164.524(b) (2)**).
- An individual may inspect and be provided with one free copy per year of his or her own medical record unless access has been denied.
- A covered entity must follow certain requirements for providing access, the form of access and the time and manner of access (**45 C.F.R. §164.524(c)**).
- A covered entity is required to make other information available in the record when access is denied, must follow other requirements when making a denial of access, must inform an individual of where medical records are maintained and must follow certain procedures when an individual requests a review when access is denied (**45 C.F.R. § 164.524(d)**).
- A covered entity is required to maintain documentation related to an individual's access to the medical record (**45 C.F.R. § 164.524(e)**).

Disclosure with Individual's or Individual's Authorization or Individual's Health Care Decision Maker

The HIPAA Rule allows information to be disclosed with an individual's written authorization.

For all uses and disclosures that are not permitted by the HIPAA Rule, patient authorization is required (**45 C.F.R. §164.502(a) (1) (iv**)); and **164.508**). An authorization must contain all the elements in **45 C.F.R. §164.508**.

A copy of the authorization must be provided to the individual. The authorization must be written in plain language and must contain the following elements:

- A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion;

- The name or other specific identification of the member(s), or class of members, authorized to make the requested use or disclosure;
- The name or other specific identification of the member(s), or class of members, to whom the covered entity may make the requested use or disclosure;
- A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose;
- An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. The statement "end of the research study," "none", or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research repository; and
- Signature of the individual and date. If the authorization is signed by a personal representative of the individual, a description of the representative's authority to act for the individual must also be provided.

In addition to the core elements, the authorization must contain statements adequate to place the individual on notice of all the following:

- The individual's right to revoke the authorization in writing, and either:
    - The exceptions to the right to revoke and a description of how the individual may revoke the authorization; or
    - A reference to the covered entity's notice of privacy practices if the notice of privacy practices tells the individual how to revoke the authorization.
- The ability or inability to condition treatment, payment, enrollment, or eligibility for benefits on the authorization, by stating either:
    - The covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs the authorization when the prohibition on conditioning of authorizations in **45 C.F.R. § 164.508 (b)(4)** applies; or
    - The consequences to the individual of a refusal to sign the authorization when, in accordance with **45 C.F.R. § 164.508 (b) (4)**, the covered entity can condition treatment, enrollment in the health plan or eligibility for benefits on failure to obtain such authorization.
- The potential for information disclosed pursuant to the authorization to be subject to re-disclosure by the member.

Disclosure to Health, Mental Health, and Social Service Providers

Disclosure is permitted without patient authorization to health, mental health and social service providers involved in caring for or providing services to the member for treatment, payment or

healthcare operations as defined in the HIPAA Rule. These disclosures are typically made to primary care physicians, psychiatrists, psychologists, social workers (including the Arizona Department of Economic Security (DES), or other behavioral health professionals. Particular attention must be paid to **45 C.F.R. §164.506(c)** and the definitions of treatment, payment, and healthcare operations to determine the scope of disclosure. For example, a covered entity is allowed to disclose protected health information for its own treatment, payment, or healthcare operations (**45 C.F.R. § 164.506(c) (1)**). A covered entity may disclose for treatment activities of a healthcare provider including providers not covered under the HIPAA Rule (**45 C.F.R. § 164.506(c) (2)**).

A covered entity may disclose to both covered and non-covered healthcare providers for payment activities (**45 C.F.R. § 164.506(c) (3)**). A covered entity may disclose to another covered entity for the healthcare operations activities of the receiving entity if each entity has or had a direct treatment relationship with the individual and the disclosure is for certain specified purposes in the definition of healthcare operations (**45 C.F.R. § 164.506(c)(4)**).

If the disclosure is not for treatment, payment, or healthcare operations or required by law, patient authorization is required.

The HIPAA Rule does not modify a covered entity's obligation under **A.R.S. §13-3620** to report child abuse and neglect to the Department of Child Safety (DCS) or disclose a child's medical records to DCS for investigation of child abuse cases.

Similarly, a covered entity may have an obligation to report adult abuse and neglect to DES Adult Protective Services (APS). See **A.R.S. §46-454**. The HIPAA Rule imposes other requirements in addition to those contained in **A.R.S. §46-454**, primarily that the individual be notified of the making of the report or a determination by the reporting member that it is not in the individual's best interest to be notified (**45 C.F.R. §164.512(c)**).

Disclosure to Other Members

A covered entity may disclose protected health information without authorization to other members including family members actively participating in the patient's care, treatment, or supervision. Prior to releasing information, an agency or non-agency treating professional or that member's designee must have a verbal discussion with the member to determine whether the member objects to the disclosure. If the member objects, the information cannot be disclosed. If the member does not object, or the member lacks capacity to object, the treating professional must perform an evaluation to determine whether disclosure is in that member's best interests. A decision to disclose or withhold information is subject to review pursuant to **A.R.S. §36-517.01**.

An agency or non-agency treating professional may only release information relating to the member's diagnosis, prognosis, need for hospitalization, anticipated length of stay, discharge plan, medication, medication side effects, and short-term and long-term treatment goals (**A.R.S. § 36-509(7)**).

The HIPAA Rule imposes additional requirements when disclosing protected health information to other members including family members. A covered entity may disclose to a family member or other relative the protected health information directly relevant to the member's involvement with the individual's care or payment related to the individual's health care. If the individual is present for a use or disclosure and has the capacity to make health care decisions, the covered entity may use or disclose the protected health information if it obtains the individual's agreement, provides the individual with the opportunity to object to the disclosure and the individual does not express an objection. If the individual is not present, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the individual's incapacity or an emergency circumstance, the covered entity may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the individual and, if so, disclose only the protected health information that is directly relevant to the member's involvement with the individual's health care (**45 C.F.R. §164.510(b)**).

Disclosure to Agent under Healthcare Directive

A covered entity may treat an agent appointed under a healthcare directive as a personal representative of the individual (**45 C.F.R. §164.502(g)**). Examples of agents appointed to act on an individual's behalf include an agent under a health care power of attorney (**A.R.S. §36-3221 *et seq.)***; surrogate decision makers (**A.R.S. §36-323**); and an agent under a mental health care power of attorney (**A.R.S. §36-3281**).

Disclosure to a Personal Representative

Unemancipated Minors: A covered entity may disclose protected health information to a personal representative, including the personal representative of an unemancipated minor, unless one or more of the exceptions described in **45 C.F.R. §164.502(g)(3)(i)** or **164.502(g)(5)** applies. See **45 C.F.R. §164.502(g) (1)**.

- The general rule is that if state law, including case law, requires or permits a parent, HCDM or other member acting *in loco parentis* to obtain protected health information, then a covered entity may disclose the protected health information (See **45 C.F.R. §164.502(g)(3)(ii)(A)**).
- Similarly, if state law, including case law, prohibits a parent, HCDM or other member acting *in loco parentis* from obtaining protected health information, then a covered entity may not disclose the protected health information (**45 C.F.R. §164.502(g)(3)(ii)(B)**).

- When state law, including case law, is silent on whether protected health information can be disclosed to a parent, HCDM or other member acting *in loco parentis,* a covered entity may provide or deny access under **45 C.F.R. §164.524** to a parent, HCDM or other member acting *in loco parentis* if the action is consistent with State or other applicable law, provided that such decision must be made by a licensed healthcare professional, in the exercise of professional judgment (**45 C.F.R. § 164.502(g)(3)(ii)(C)**).

Adults and Emancipated Minors: If under applicable law, a member has authority to act on behalf of an individual who is an adult or an emancipated minor in making decisions related to health care, a covered entity must treat such members as a personal representative with respect to protected health information relevant to such personal representation (**45 C.F.R. §164.502(g) (2)**). Simply stated, if there is a state law that permits the personal representative to obtain the adult or emancipated minor's protected health information, the covered entity may disclose it. A covered entity may withhold protected health information if one or more of the exceptions in **45 C.F.R. §164.502(g) (5)** applies.

Deceased Members: If under applicable law, an executor, administrator, or other member has authority to act on behalf of a deceased individual or of the individual's estate, a covered entity must treat such members as a personal representative with respect to protected health information relevant to the personal representation (**45 C.F.R. §164.502(g)(4)**). A covered entity may withhold protected health information if one or more of the exceptions in **45 C.F.R. §164.502(g) (5)** applies. **A.R.S. §§ 12-2294 (D)** provides certain members with authority to act on behalf of a deceased member.

Disclosure for Court Ordered Evaluation or Treatment

An agency in which a member is receiving court ordered evaluation or treatment is required to immediately notify the member's HCDM or agent or, if none, a member of the member's family that the member is being treated in the agency (**A.R.S. §36-504(B)**). The agency shall disclose any further information only after the treating professional or that member's designee interviews the member undergoing treatment or evaluation to determine whether the member objects to the disclosure and whether the disclosure is in the member's best interests. A decision to disclose or withhold information is subject to review pursuant to section **A.R.S. §36-517.01**.

If the individual or the individual's HCDM makes the request for review, the reviewing official must apply the standard in **45 C.F.R. §164.524(a) (3)**. If a family member makes the request for review, the reviewing official must apply the "best interest" standard in **A.R.S. §36-517.01**.

The reviewer's decision may be appealed to the superior court (**A.R.S. §36-517.01(B)**). The agency or non-agency treating professional must not disclose any treatment information during the period an appeal may be filed or is pending.

Disclosure for Health Oversight Activities

A covered entity may disclose protected health information without patient authorization to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions or other activities necessary for appropriate oversight of entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards (**45 C.F.R. §164.512(d)**).

Disclosure for Judicial and Administrative Proceedings Including Court Ordered Disclosures

A covered entity may disclose protected health information without patient authorization during any judicial or administrative proceeding in response to an order of a court or administrative tribunal, provided that the covered entity discloses only the protected health information expressly authorized by the order (**45 C.F.R. §164.512(e)**). In addition, a covered entity may disclose information in response to a subpoena, discovery request or other lawful process without a court order if the covered entity receives satisfactory assurances that the requesting party has made reasonable efforts to provide notice to the individual or has made reasonable efforts to secure a qualified protective order; see **45 C.F.R. §164.512(e) (1) (iii), (iv) and (v)** for what constitutes satisfactory assurances.

Disclosure to Members Doing Research

A covered entity may disclose protected health information to members doing research without patient authorization provided it meets the de-identification standards of **45 C.F.R. §164.514(b)**. If the covered entity wants to disclose protected health information that is not de-identified, patient authorization is required or an Institutional Review Board or a privacy board in accordance with the provisions of **45 C.F.R. §164.512(i) (1) (i)** can waive it.

Disclosure to Prevent Harm Threatened by Patients

Mental health providers have a duty to protect others against the harmful conduct of a patient (**A.R.S. §36-517.02**). When a patient poses a serious danger of violence to another member, the provider has a duty to exercise reasonable care to protect the foreseeable victim of the danger (***Little v. All Phoenix South Community Mental Health Center, Inc.,* 186 Ariz. 97, 919 P.2d 1368 (1996**)). A covered entity may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information without patient authorization if the covered entity, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a member or the public and is to a member or members reasonably able to prevent or lessen the threat, including the target of the threat, or

is necessary for law enforcement authorities to identify or apprehend an individual (**See 45 C.F.R. §164.512(j)(1)(ii); 164.512(f)(2) and (3)** for rules that apply for disclosures made to law enforcement; see **45 C.F.R. §164.512(j)(4)** for what constitutes a good faith belief).

Disclosures to Human Rights Committees

Protected health information may be disclosed to a human rights committee without patient authorization provided personally identifiable information is redacted or de-identified from the record (**A.R.S. §36-509(10)**) and **41-3804**). In redacting personally identifiable information, a covered entity must comply with the HIPAA Rule de-identification standards in **45 C.F.R. § 164.514(b)** and not state law. If a human rights committee wants non-redacted identifiable health information for official purposes, it must first demonstrate to MC ACC-RBHA that the information is necessary to perform a function that is related to the oversight of the behavioral health system, and in that case, a covered entity may disclose protected health information to the human rights committee in its capacity as a health oversight agency (**45 C.F.R. §164.512(d) (1)**).

Disclosure to the Arizona Department of Corrections

Protected health information may be disclosed without patient authorization to the state department of corrections in cases where prisoners confined to the state prison are patients in the state hospital on authorized transfers either by voluntary admission or by order of the court (**A.R.S. §36-509(5)**). The HIPAA Rule limits disclosure to correctional institutions to certain categories of information that are contained in **45 C.F.R. §164.512(k) (5)**.

Disclosure to Governmental Agency or Law Enforcement to Secure Return of Patient

Protected health information may be disclosed to governmental or law enforcement agencies, if necessary, to secure the return of a patient who is on unauthorized absence from any agency where the patient was undergoing court ordered evaluation or treatment. According to **A.R.S. §36-509 (6) (A)**, a covered entity may disclose limited information without patient authorization to law enforcement to secure the return of a missing member (**45 C.F.R. §164.512(f) (2) (i)**). In addition, a covered entity is permitted limited disclosure to governmental agencies to prevent or lessen a serious and imminent threat to the health or safety of a member or the public (**45 C.F.R. §164.512(j)**).

Disclosure to Sexually Violent Members (SVP) Program

Protected health information may be disclosed to a governmental agency or a competent professional, as defined in **A.R.S. §36-3701**, to comply with the SVP Program (**A.R.S., Title 36, Chapter 37; A.R.S. §36-509(9)**).

A "competent professional" is a member, who may be a psychologist or psychiatrist, is approved by the Superior Court and is familiar with the state's sexually violent member's

statutes and sexual offender treatment programs. A competent professional is either statutorily required or may be ordered by the court to perform an examination of a member involved in the sexually violent members program and must be given reasonable access to the member to conduct the examination and must share access to all relevant medical and psychological records, test data, test results and reports (**A.R.S. §36-3701(2)**).

In most cases, the disclosure of protected health information to a competent professional or made in connection with the sexually violent members program is required by law or ordered by the court. In either case, disclosure under the HIPAA Rule without patient authorization is permitted. See **45 C.F.R. §164.512(a)** (disclosure permitted when required by law) and **45 C.F.R. §164.512(e)** (disclosure permitted when ordered by the court). If the disclosure is not required by law/ordered by the court or is to a governmental agency other than the sexually violent members program, the covered entity may have the authority to disclose if the protected health information is for treatment, payment, or health care operations. See **45 C.F.R. §164.506(c)** to determine rules for disclosure for treatment, payment, or healthcare operations.

Disclosure of Communicable Disease Information

A.R.S. §36-661 et seq. includes several provisions that address the disclosure of communicable disease information. The general rule is that a member who obtains communicable disease related information while providing a health service or pursuant to a release of communicable disease related information must not disclose or be compelled to disclose that information (**A.R.S.§ 36-664(A)**). Certain exceptions for disclosure are permitted to:

- The individual or the individual's health care decision maker;
- AHCCCS or a local health department for the purpose of notifying a Good Samaritan;
- An agent or employee of a health facility or a healthcare provider;
- A health facility or a healthcare provider;
- A federal, state, or local health officer;
- Government agencies authorized by law to receive communicable disease information;
- Members authorized pursuant to a court order;
- The DES for adoption purposes;
- The Industrial Commission;
- The Arizona Department of Health Services to conduct inspections;
- Insurance entities; and
- A private entity that accredits a healthcare facility or a healthcare provider.

A.R.S. §36-664 also addresses issues with respect to the following:

- Disclosures to the Department of Health Services or local health departments are also permissible under certain circumstances:

  - Authorizations;
  - Re-disclosures;
  - Disclosures for supervision, monitoring, and accreditation;
  - Listing information in death reports;
  - Reports to the Department; and
  - Applicability to insurance entities.
- An authorization for the release of communicable disease related information the protected member must sign information or, if the protected member lacks capacity to consent, the member's health care decision maker (**A.R.S. §36-664(F)**). If an authorization for the release of communicable disease information is not signed, the information cannot be disclosed. An authorization must be dated and must specify to whom disclosure is authorized, the purpose for disclosure and the period during which the authorization is effective. A general authorization for the release of medical or other information, including communicable disease related information, is not an authorization for the release of HIV-related information unless the authorization specifically indicates its purpose as authorization for the release of HIV-related information and complies with the requirements of **A.R.S. §36-664(F)**.
- The HIPAA Rule does not preempt state law with respect to disclosures of communicable disease information; however, it may impose additional requirements depending upon the type, nature, and scope of disclosure. It is advisable to consult with the HIPAA Compliance Officer and/or legal counsel prior to disclosure of communicable disease information.
- For example, if a disclosure of communicable disease information is made pursuant to an authorization, the disclosure must be accompanied by a statement in writing which warns that the information is from confidential records which are protected by state law that prohibits further disclosure of the information without the specific written consent of the member to whom it pertains or as otherwise permitted by law. **A.R.S. §36-664(H)** affords greater privacy protection than **45 C.F.R. §164.508(c) (2) (ii)**, which requires the authorization to contain a statement to place the individual on notice of the potential for re-disclosure by the member and thus is no longer protected. Therefore, any authorization for protected health information that includes communicable disease information must contain the statement that re-disclosure of that information is prohibited.

Disclosure to Business Associates

The HIPAA Rule allows a covered entity to disclose protected health information to a business associate if the covered entity obtains satisfactory assurances that the business associate will safeguard the information in accordance with **45 C.F.R. §164.502(e)** and the HITECH Act.

See the definition of "business associate" in **45 C.F.R. § 160.103**. Also see **45 C.F.R. §164.504(e)** and **Section 13404** of the HITECH Act for requirements related to the documentation of satisfactory assurances through a written contract or other written agreement or arrangement.

Disclosure to the Arizona Center for Disability Law, Acting in its Capacity as the State Protection and Advocacy Agency Pursuant to 42 U.S.C. § 10805

Disclosure is allowed when:

- An enrolled member is mentally or physically unable to consent to a release of confidential information, and the member has no HCDM or other legal representative authorized to provide consent; and
- A complaint has been received by the Center, or the Center asserts that the Center has probable cause to believe that the enrolled member has been abused or neglected.

Disclosure to Third Party Payers

Disclosure is permitted to a third-party payer to obtain reimbursement for health care, mental health care or behavioral health care provided to a patient (**A.R.S. §36-509(13)**).

Disclosure to Accreditation Organization

Disclosure is permissible to a private entity that accredits a healthcare provider and with whom the healthcare provider has an agreement that requires the agency to protect the confidentiality of patient information (**A.R.S. §36-509(14)**).

Disclosure of Alcohol and Drug Information

MC ACC-RBHA and subcontracted providers that provide drug and alcohol screening, diagnosis or treatment services that are federally assisted alcohol and drug programs must ensure compliance with all provisions contained in the Federal statutes and regulations referenced in this chapter.

MC ACC-RBHA and subcontracted providers must notify members seeking and/or receiving alcohol or drug abuse services of the existence of the federal confidentiality law and regulations and provide each member with a written summary of the confidentiality provisions. The notice and summary must be provided at admission or as soon as deemed clinically appropriate by the member responsible for clinical oversight of the member.

MC ACC-RBHA and subcontracted providers may require enrolled members to carry identification cards while the member is on the premises of an agency. A subcontracted provider may not require enrolled members to carry cards or any other form of identification when off the subcontractor's premises that will identify the member as a member of drug or alcohol services.

MC ACC-RBHA and subcontracted providers may not acknowledge that a currently or previously enrolled member is receiving or has received alcohol or drug abuse services without the enrolled member's authorization.

MC ACC-RBHA and subcontracted providers must respond to any request for a disclosure of the records of a currently or previously enrolled member that is not permissible under this policy or federal regulations in a way that will not reveal that an identified individual has been or is being diagnosed or treated for alcohol or drug abuse.

Release of information concerning diagnosis, treatment or referral from an alcohol or drug abuse program must be made only as follows:

- The currently or previously enrolled member or their HCDM authorizes the release of information. In this case, authorization must be documented on an authorization form which has not expired or been revoked by the patient. The proper authorization form must be in writing and must contain each of the following specified items:
    - MC ACC-RBHA or subcontracted provider must advise the member or HCDM of the special protection given to such information by federal law.
    - Authorization must be documented on an authorization form that has not expired or been revoked by the patient. The proper authorization for must be in writing and must contain each of the following specified items:
        - The name or general designation of the program making the disclosure;
        - The name of the individual or organization that will receive the disclosure;
        - The name of the member who is the subject of the disclosure;
        - The purpose or need for the disclosure;
        - How much and what kind of information will be disclosed;
        - A statement that the member may revoke the authorization at any time, except to the extent that the program has already acted in reliance on it;
        - The date, event, or condition upon which the authorization expires, if not revoked before;
        - The signature of the member or HCDM; and
        - The date on which the authorization is signed.

Re-Disclosure

Any disclosure, whether written or oral made with the member's authorization as provided above must be accompanied by the following written statement: "This information has been disclosed to you from records protected by federal confidentiality rules (**42 C.F.R. part 2**). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the member to whom it pertains or as otherwise permitted by **42 C.F.R. Part 2**. A general authorization for the release of medical or

other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

If the member is a minor, authorization must be given by both the minor and his or her parent or HCDM.

If the member is deceased, authorization may be given by:

- A court appointed executor, administrator, or another personal representative; or
- If no such appointments have been made, by the member's spouse; or
- If there is no spouse, by any responsible member of the member's family.

Circumstances Where No Authorization Required

Authorization is not required under the following circumstances:

- **Medical Emergencies:** Information may be disclosed to medical personnel who need the information to treat a condition which poses an immediate threat to the health of any individual, not necessarily the currently or previously enrolled member, and which requires immediate medical intervention. The disclosure must be documented in the member's medical record and must include the name of the medical member to whom disclosure is made and his or her affiliation with any healthcare facility, name of the member making the disclosure, date and time of the disclosure and the nature of the emergency. After emergency treatment is provided, written confirmation of the emergency must be secured from the requesting entity.
- **Research Activities:** Information may be disclosed for the purpose of conducting scientific research according to the provisions of **42 C.F.R. §2.5.**
- **Audit and Evaluation Activities:** Information may be disclosed for the purposes of audit and evaluation activities according to the provisions of **42 C.F.R. §2.53**.
- **Qualified Service Organizations:** Information may be provided to a qualified service organization when needed by the qualified service organization to provide services to a currently or previously enrolled member.
- **Internal Agency Communications:** The staff of an agency providing alcohol and drug abuse services may disclose information regarding an enrolled member to other staff within the agency, or to the part of the organization having direct administrative control over the agency, when needed to perform duties related to the provision of alcohol or drug abuse diagnosis, treatment, or referral for treatment to a member. For example, an organization that provides several types of services might have an administrative office that has direct administrative control over each unit or agency that provides direct services.
- Information concerning an enrolled member that does not include any information about the enrolled member's receipt of alcohol or drug abuse diagnosis, treatment or referral for treatment is not restricted under this chapter. For example, information

concerning an enrolled member's receipt of medication for a psychiatric condition, unrelated to the member's substance abuse, could be released as provided in ***Disclosure of Information Not Related to Alcohol and Drug Treatment*** of this chapter.

- **Court-ordered disclosures:** A state or federal court may issue an order that authorizes an agency to make a disclosure of identifying information that would otherwise be prohibited. A subpoena, search warrant or arrest warrant is not sufficient standing alone, to require or permit an agency to make a disclosure.
- **Crimes Committed by a Member on an Agency's Premises or Against Program Personnel:** Agencies may disclose information to a law enforcement agency when a member who is receiving treatment in a substance abuse program has committed or threatened to commit a crime on agency premises or against agency personnel. In such instances, the agency must limit the information disclosed to the circumstances of the incident. It may only disclose the member's name, address, last known whereabouts, and status as a member receiving services at the agency.
- **Child Abuse and Neglect Reporting:** Federal law does not prohibit compliance with the child abuse reporting requirements contained in **A.R.S. §13-3620**.

A general medical release form or any authorization form that does not contain all the elements listed in ***Disclosure of Alcohol and Drug Information*** above is not acceptable.

Security Breach Notification

MC ACC-RBHA and their subcontracted providers, in the event of an impermissible use/disclosure of unsecured PHI, must provide notification to all members affected by the breach in accordance with **Section 13402** of the HITECH Act.

Telemedicine

To ensure confidentiality of telemedicine sessions, providers must do the following when providing services via telemedicine:

- The videoconferencing room door must always remain closed;
- If the room is used for other purposes, a sign must be posted on the door, stating that a clinical session is in progress.

Telemedicine should be restricted to dedicated utilities with built in controls to ensure that a third party is unable to intrude on the session or watch the service as it is being provided.

14.01 – Verification of U.S. Citizenship or Lawful Presence for Public Behavioral Health Benefits

Eligibility for Behavioral Health Services Verification

The following individuals are eligible for public behavioral health services:

- Members determined to be eligible for AHCCCS.

- Members not eligible for AHCCCS but determined to have a Serious Mental Illness (SMI) AND can provide documentation of citizenship/lawful presence.

Eligibility for Behavioral Health Services without Verification

Members not eligible for AHCCCS and NOT determined as SMI but who qualify to receive behavioral health services funded through the Substance Use Block Grant (SUBG) or the Projects for Assistance in Transition from Homelessness (PATH) Program are eligible to receive services. However, members receiving services funded by SUBG or PATH must still be screened for AHCCCS eligibility.

Members presenting for and receiving crisis services are not required to provide documentation of eligibility with AHCCCS nor are they required to verify U.S. citizenship/lawful presence prior to or to receive crisis services.

Completing AHCCCS Eligibility Determination Screening

If a member is currently enrolled with AHCCCS and has been assigned to MC ACC-RBHA, verification of citizenship/lawful presence has already been completed.

For an illustration on how the verification process works, see Flowchart for the **Citizenship/Lawful Presence Verification Process Through Health-e-Arizona PLUS.**

For a list of those members who are exempt from citizenship verification, see **Members Who Are Exempt from Verification of Citizenship during the Prescreening and Application Process**.

Providers must complete an eligibility determination screening for all members who are not identified as being currently enrolled with AHCCCS using the subscriber version of the **Health-e-Arizona PLUS**. An eligibility screening will be conducted:

- Upon initial request for behavioral health services;
- At least annually thereafter, if still receiving behavioral health services; and
- When significant changes occur in the member's financial status.

Completing Eligibility Screening using Health-e-Arizona PLUS Application for Benefits

The behavioral health provider meets with the member and completes the **Health-e-Arizona PLUS Application for Benefits**. Once the online application screening has been completed, the Health-e-Arizona PLUS online application tool will indicate:

- If the member is potentially AHCCCS eligible the behavioral health provider must obtain from the applicant:
    - Documentation of identification and U.S. Citizenship needed if the member claims to be a U.S. citizen (see **Documents Accepted by AHCCCS To Verify Citizenship and Identity**); or

    - Documentation needed of identification and lawful presence in the U.S. if the applicant states that he/she is not a U.S. citizen (see **Non-Citizen/Lawful Presence Verification Documents**).
    - The required U.S. citizenship/lawful presence documents are considered "permanent documents." Permanent documents include proof of age, Social Security Number, U.S. citizenship, or immigration status. These are eligibility factors that typically do not change and only need to be verified once.
- When providers use the online member verification system and enter a member's social security number, the member's photo, if available from the Arizona Department of Motor Vehicles (MVD), will be displayed on the AHCCCS eligibility verification screen along with other AHCCCS coverage information. The added photo image assists providers to quickly validate the identity of a member.

If the Health-e-Arizona PLUS online screening tool indicates that the member may not be eligible for AHCCCS, the member may:

- Choose to continue with the AHCCCS eligibility application, in which case the provider must assist the member in completing the application process and obtain the required identification and citizenship/lawful presence documents as indicated above or those required for Non-Title XIX Eligible individuals as outlined in **Requirement to Verify Citizenship for Non-AHCCCS Eligible Individuals (Department of Economic Security)**; or
- Decide to not continue with the online application process, the provider will need to determine if the member is eligible for behavioral health services. The provider must continue to work with the member to obtain the required citizenship/lawful presence documents whenever possible for future eligibility status need.

Required Identification or Citizenship/Lawful Presence Documents

To the extent that it is practicable, contracted providers are expected to assist applicants in obtaining required documentation of identification and citizenship/lawful presence within the timeframes indicated by Health-e-Arizona PLUS (30 days from date of application submission unless otherwise stated).

Members who are unable to provide required documentation of citizenship or lawful presence are not eligible for publicly funded behavioral health services unless they meet the criteria outline in **COMPLETING AHCCCS ELIGIBILITY DETERMINATION SCREENING**. If the member obtains the required documentation later, he/she may reapply for AHCCCS eligibility using Health-e-Arizona PLUS (and submit all required documentation with the reapplication, with no waiting period).

Pending the outcome of the AHCCCS eligibility determination, a member may be provided services.

Document Requirements

Documentation of screening a member through Health-e-Arizona PLUS must be included in the behavioral health medical record, including the application summary and final determination of eligibility status notification printed from the Health-e-Arizona PLUS website.

If a member has refused to participate in the screening process, the documented refusal to participate in the screening and/or application process must be maintained.

14.02 – Reporting Discovered Violations of Immigration Status

Identification of Violations

MC ACC-RBHA employees and providers must refrain from conduct or actions that could be considered discriminatory behavior. It is unlawful and discriminatory to deny a member healthcare services, exclude members from participation in those services, or otherwise discriminate against any member based on grounds of race, color, or national origin.

MC ACC-RBHA employees and providers must not use any information obtained about a member's citizenship or lawful presence for any purpose other than to provide a member with healthcare contracted services.

Factors that must **NOT** be considered when identifying a potential violation:

- The member's primary language is a language other than English;
- The member was not born in the United States;
- The member does not have a Social Security number;
- The member has a "foreign sounding" name;
- The member cannot provide documentation of citizenship or lawful presence;
- The member is identified by others as a non-citizen; and
- The member has been denied AHCCCS eligibility for lack of proof of citizenship or lawful presence.

If a member applying for healthcare services, while completing the application process or while conducting business with MC ACC-RBHA or its healthcare providers, **voluntarily reveals** that he or she is not lawfully present in the United States, then and only then, may the MC ACC-RBHA employee or healthcare provider consider it to be a reportable violation.

MC ACC-RBHA employees and providers must not require documentation of citizenship or lawful presence from members who are not personally applying for services, but who are acting on behalf of or assisting the applicant (for example, a parent applying on behalf of a child).

It is **not** the responsibility of MC ACC-RBHA to verify validity of the submitted documents. Documents must be copied for files and submitted, as requested, to the appropriate agency, as instructed through Health-e-Arizona PLUS.

The criteria for screening and applying for AHCCCS eligibility are not changed by these reporting requirements. Further, the documentation requirements for verifying or establishing citizenship or lawful presence are not changed by this process.

MC ACC-RBHA employees and healthcare providers must follow the expectations outlined in this policy when identifying and reporting violations. Reporting fraud to the AHCCCS Office of Inspector General is available on the AHCCCS **Report Suspected Fraud or Abuse of the Program** web page. The MC ACC-RBHA employee or provider who identifies a violation must submit an online report to AHCCCS as outlined above.

Documentation Expectations

The MC ACC-RBHA employee/provider must document in the member's medical record (if the provider) or in the Corporate Compliance Office (if MC ACC-RBHA) the following:

- Reason for making a report, including how the information was obtained and whether it was an oral or written declaration;
- The date the report was submitted to AHCCCS; and
- Any actions taken because of the report.

ACC-RBHA Chapter 15 – Demographic and Other Member Data

15.00 - Enrollment, Disenrollment and Other Data Submission

The collection and reporting of accurate, complete, and timely enrollment, demographic, clinical, and disenrollment data is of vital importance to the successful operation of the AHCCCS behavioral health service delivery system. It is necessary for behavioral health providers to submit specific data on each member who is actively receiving services from the behavioral health system. As such, it is important for behavioral health provider staff (e.g., intake workers, clinicians, data entry staff) to have a thorough understanding of why it is necessary to collect the data, how it can be used and how to accurately label the data. This policy has relevance for those providers that conduct assessments, ongoing service planning, and annual updates.

This data in turn is used by AHCCCS to:

- Monitor and report on outcomes of individuals in active care (e.g., changes in diagnosis), employment/educational status, place of residence, substance use, number of arrests);
- Comply with federal and state funding and/or grant requirements;
- Assist with financial-related activities such as budget development and rate setting;
- Support quality management and utilization management activities; and
- Respond to requests for information.

Enrollment and Disenrollment Transaction Requirements

General Requirements

- Arizona Health Care Cost Containment System (AHCCCS) enrolled individuals are considered enrolled with the MC ACC-RBHA at the onset of their eligibility. They are provided an AHCCCS identification card listing their assigned health plan. This assignment is sent daily from AHCCCS to MC ACC-RBHA.
- For a Non-Title XIX/XXI eligible member to be enrolled, providers must submit an enrollment transaction to MC ACC-RBHA.
- For a Non-Title XIX/XXI eligible member who receives a covered behavioral health service, he/she must be enrolled effective the date of first contact by a behavioral health provider.
- All members who are served through the AHCCCS behavioral health system must have an active episode of care, even if the member only receives a single service (e.g., crisis intervention, one-time face-to-face consultation).
- An episode of care is the start and end of services for a behavioral health need as documented by transmission of a demographic record. For both AHCCCS enrolled and Non-Title XIX/XXI eligible individuals, the individuals must have an open episode of care starting at the first date of service and ending with the last date of service. For members that are designated as SMI, both TXIX and Non-Title XIX, please see **Chapter 2 –**

Network Provider Service Delivery Requirements, Section 2.12 – SMI Patient Navigator of this manual.

Collection of Enrollment Information

Providers must actively secure any needed information to complete the enrollment for a Non-Title XIX/XXI eligible individual. An enrollment transaction will not be accepted by MC ACC-RBHA if required data elements are missing.

For AHCCCS enrolled individuals, the eligibility and enrollment information are provided to MC ACC-RBHA by AHCCCS daily and is available to providers on **Availity**.

Timeframes for Submitting Enrollment and Disenrollment Data for Non-Title XIX/XXI Eligible Individuals

The following data submittal timeframes apply to the enrollment/disenrollment transactions:

- The enrollment transaction must be submitted to MC ACC-RBHA within 14 days of the first contact with a behavioral health member;
- Dis-enrollments are managed and processed by MC ACC-RBHA.

Required Events for Submittal of an Enrollment Transaction for Non-Title XIX/XXI Eligible Individual

In addition to submitting an enrollment transaction when beginning services, a transaction must also be submitted when any of the following have changed:

- Name;
- Address;
- Date of birth;
- Gender;
- Marital status; or
- Third party insurance information.

Other considerations for both Non-Title XIX/XXI eligible and AHCCCS enrolled individuals.
For an AHCCCS enrolled individual, AHCCCS will notify MC ACC-RBHA of changes to the above information. That information will be provided from AHCCCS to MC ACC-RBHA on a daily file.

When a member in an episode of care permanently re-locates from one TRBHA's geographic area to another TRBHA's geographic area, an inter-TRBHA transfer must occur (see **Chapter 10 – Coordination of Care, Section 10.00 – Inter-TRBHA Coordination of Care** in this manual). The steps that are necessary to facilitate an inter-TRBHA transfer include the following data submission requirements:

- The home TRBHA must submit a disenrollment transaction effective on the date of transfer and end the episode of care; and

- The receiving TRBHA must submit an enrollment transaction on the date of accepting the member for services and start an episode of care.
- AHCCCS will notify MC ACC-RBHA when a MC ACC-RBHA enrolled member is determined eligible for the Arizona Long Term Care System (ALTCS) Elderly and Physically Disabled (EPD) Program. This information will be passed to MC ACC-RBHA on a daily file.

Technical Assistance with Problems Associated with Electronic Data Submission

At times, technical problems or other issues may occur in the electronic transmission of the data from the behavioral health provider to the receiving T/ ACC-RBHA. If a provider requires assistance with technical related problems or issues, please contact MC ACC-RBHA customer service at 800-564-5465.

Demographic and Clinical Data

Collection of Demographic and Clinical Data Timeframes

Demographic and clinical data will be collected starting at the first date of service. For both AHCCCS enrolled and Non-Title XIX/XXI eligible individuals, a demographic record must be collected within 45 days of the first service and submitted to AHCCCS within 55 days. Additional clinical data may be collected at subsequent assessment and service planning meetings with the member (e.g., education, vocation) as well as during periodic and annual updates. Demographic and clinical data recorded in the member's behavioral health medical record must match the demographic file on record with AHCCCS.

Specific Data Elements

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

Use of Demographic and Clinical Data

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

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

Technical Assistance with Demographic and Clinical Data Submission

At times, technical problems or other issues may occur in the electronic transmission of the clinical and demographic data from the behavioral health provider to the AHCCCS. Any questions about the portal or the data fields in the portal should be submitted to DHCM/DAR

Information Management/Data Analytics Unit (IMDAU) Manager, Angela Aguayo at Angela.Aguayo@azahcccs.gov and should also include Lori Petre (Lori.Petre@azahcccs.gov), Data Analysis and Research Manager for DHCHM/DAR. If there are any technical issues with the portal contact Customer Support at either ISDCustomerSupport@azahcccs.gov or 602-417-4451.

RBHA Chapter 16 – Reporting Requirements

16.00 – Medical Institution Reporting of Medicare Part D

Medicare eligible members, including members who are dually eligible for Medicare (Title XVIII) and Medicaid (Title XIX/XXI) receive Medicare Part D prescription drug benefits through Medicare Prescription Drug Plans (PDPs) or Medicare Advantage Prescription Drug Plans (MA-PDs). Medicare Part D coverage includes co-payment requirements of all members. However, Medicare Part D co-payments are waived when a dual eligible member enters a Medicaid funded medical institution for at least a full calendar month. Medical institutions must notify the AHCCCS when a dual eligible member is expected to be in the medical institution for at least a full calendar month to ensure co-payments for Part D is waived. The waiver of co-payments applies for the remainder of the calendar year, regardless of whether the member continues to reside in a medical institution. Given the limited resources of many dual eligible members and to prevent the unnecessary burden of additional co-pay costs, it is imperative that these individuals are identified as soon as possible.

To ensure that dual eligible member's Medicare Part D co-payments are waived when it is expected that dual eligible members will be in a medical institution funded by Medicaid for at least a full calendar month, AHCCCS must be notified immediately upon admittance.

Reporting must be done using the **AHCCCS Notification to Waive Medicare Part D Co-Payments for Members in a Medicaid Funded Medical Institution**. Providers must not wait until the member has been discharged from the medical institution to submit the form. Reporting must be done on behalf of the following:

- Members who have Medicare Part "B" only;
- Members who have used their Medicare Part "A" lifetime inpatient benefit; and
- Members who are in continuous placement in a single medical institution or any combination of continuous placements that are identified below.

Medical Institutions

Medical institutions include the following providers:

- Acute Hospital (PT 02)
- Psychiatric Hospital – IMD (PT 71)
- Residential Treatment Center – IMD (PT B1, B3)
- Residential Treatment Center – Non IMD (PT 78, B2)
- Nursing Homes – (PT 22)

16.01 – Reporting of Seclusion and Restraint

Definitions

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

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

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

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

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

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

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

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

Reporting to MC ACC-RBHA

Licensed behavioral health facilities and programs, including out-of-state facilities, authorized to use seclusion and restraint must report each occurrence of seclusion and restraint and

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

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

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

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

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

ACC-RBHA Chapter 17 – Grievance System and Member Rights - Reserved

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

ACC-RBHA Chapter 18 – Provider Requirements for Specific Programs and Services

18.00 – Provider Requirements for Specific Programs and Services

Specialized Provider Requirements are contractual documents for specialty 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 specialized providers must comply with all requirements outlined in their specific Provider Requirements**.** These documents can be found in **Availity**.

ACC-RBHA Chapter 19 – Non-Title XIX/XXI Services

19.00 - Non-Title XIX/XXI Overview

Please refer to **Section 2.15 – Services with Special Circumstances**, in this Chapter, as that section outlines eligibility, and spend prohibition program requirements for Federal Block grants and discretionary grants.

Each Year, MC ACC-RBHA formulates a spending plan to secure funds for the entire year for Non-Title XIX/XXI. This spending plan dictates the allocation of funds to providers, specifying amounts for each funding category.

The spending plan prioritizes eligible populations and sets limitations on service delivery to guarantee each funds' availability and service continuity throughout the year.

It is important to note that the spending plan is subject to modification during the course of the year.

Funding is predetermined and restricted, allocated through County and Legislative funds. The availability of services is contingent upon the extent of funding.

- Members must satisfy eligibility criteria to access services.
- Some services for certain populations may be restricted due to funding constraints.
- The range of available services may differ among RBHA's because of limitations in funding.
- It is important to note that services are not considered an entitlement.
- Services are limited by the availability of funds, except for medication management for members with an SMI designation.

Ensuring access to a comprehensive care system for children, adults, and underserved populations is essential. This system guarantees consistent reporting on access to care, service quality, and outcomes.

Funding may come from:

- State Appropriated General Funds, County Funds
- State Non-Appropriated Funds
- Block or Formula grants
- Discretionary grants, or other grant-based funding

State-only or Non-Medicaid covered services are services that are not covered through Title XIX/XXI funding. However, services are covered through Non-Title XIX/XXI funding for Title XIX/XXI eligible and Non-Title XIX/XXI eligible members.

These services include:

- Auricular Acupuncture
- Childcare
- Mental Health Services (formerly known as traditional healing)
- Room and board
- Supportive Housing
- Children's Behavioral Health Services*

*Children's Behavioral Health Services delivered as a result of a referral from an educational institution, in compliance with A.R.S. § 36-3436.01.

Some of the Non-Medicaid covered services are limited to certain priority population members, as shown in **AHCCCS Medical Policy Manual (AMPM) Exhibit 300-2B**. Services through Non-Title XIX/XXI funding are limited to availability of funds.

19.01 - Provider Responsibilities for Non-Title XIX/XXI Services

Providers must:

- Implement a formal community education and marketing plan to inform community members about the available services.
- Keep the RBHA updated on the status of all programs, including new additions and terminations.
- Upon request from the RBHA, furnish program descriptions and community education and marketing plans.

NOTE: These program descriptions and marketing plans are subject to audit to ensure adherence to funding, policy, and provider manual requirements.

Providers must gain knowledge of available services for applicable members. Additional services dependent on member's status include:

- Residential treatment
- Counseling
- Case management
- SMI assessments for eligibility determination (regardless of eligibility status)

Crisis services

- Community-based supportive services, encompassing:
    - Respite care
    - Peer and family support
    - Employment services

    - Medication management
    - Limited transportation
- MC shall ensure that its subcontractors educate and encourage Non-Title XIX/XXI SMI individuals to enroll in a *qualified health plan* through the federal health insurance exchange and offer assistance for those choosing to enroll during open enrollment periods and qualified life events.
- The following applies:
    - Individuals enrolled in a *qualified health plan* continue to be eligible for NT XIX/XXI covered services that are not covered under the qualified health plan.
    - May **not** be used to cover premiums, deductibles, or copays.
    - MC shall ensure the receipt of a denial-of-service coverage prior to utilization of Non-Title XIX/XXI funding for services otherwise covered under a qualified health plan.

For members with a serious mental illness (SMI) designation:

- Permanent supportive housing (PSH) services are available to all Title XIX/XXI and Non-title XIX/XXI.

19.02 - Funding Restrictions, Eligibility, and Priority Populations

Priority populations for the Non-Title XIX/XXI funding include populations that have been identified by the Substance Abuse and Mental Health Services Administration (SAMHSA):

- Individuals with SMI determinations
- Individuals who have experienced a first episode of psychosis (FEP) within the past two years
- Children with serious emotional disturbance (SED) identification
- Individuals with Substance Use Disorders (SUD)
- SUD priority includes pregnant women and women with dependent children (PW/WDC), people who inject drugs (PWID), and those with an Opioid Use Disorder (OUD)
- All other individuals with a substance abuse disorder, regardless of gender or route of use are also considered priority population (as funding is available)
- Recognize eligibility and screening requirements

19.03 – Eligibility Requirements

Providers must support individuals in applying for Arizona Public Programs **before** accessing behavioral health services not covered by Title XIX/XXI. This assistance is particularly crucial during the intake process for behavioral health services, covering:

- Title XIX/XXI eligibility
- Medicare enrollment
- Medicare Savings programs
- Affordable Care Act Advantage Plans

- Nutrition and Cash assistance
- Medicare Prescription Drug Program (Medicare Part D), inclusive of the "Extra Help with Medicare Prescription Drug Plans Costs" low-income subsidy

Effective coordination among all involved parties is essential for ensuring seamless access to public services and programs.

Eligibility Screening and Documentation Requirements

All recipients must undergo a Title XIX/XXI eligibility screening, and the results must be documented in the comprehensive clinical record after the initial screening, annual screening, and screenings prompted by significant changes in financial status must be documented.

The eligibility screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Low Subsidy Program involves a three-step process:

- Verify the member's Title XIX or Title XXI eligibility.
- For members not eligible for Title XIX or Title XXI, screen for potential Title XIX or other eligibility.
- Assist members with applications for Title XIX or other eligibility, as indicated by the screening tool.

To access Title XIX/XXI or other eligibility information, contracted providers can utilize alternative verification processes 24/7.

Behavioral health providers are required to screen all Non-Title XIX/XXI members using the Health-e Arizona PLUS online application. While a screening is not mandatory during the delivery of emergency services, it must be initiated within five days if the member seeks or is referred for ongoing behavioral health services.

To initiate a screening for Title XIX or other eligibility, MC ACC-RBHA or the provider engages with the member and completes AHCCCS eligibility screening using the Health-e Arizona PLUS online application for all Non-Title XIX members.

If the screening tool indicates that the member does not meet the criteria for Title XIX or any other AHCCCS eligibility, behavioral health services may be provided to the member in adherence to **MC Provider Manual Chapter 100 – General Terms, Chapter 4 – Provider Responsibilities, Section 4.33 - Copayments**. In the event that the member is deemed ineligible for Title XIX or Title XXI benefits, behavioral health services may still be extended in accordance with **MC Provider Manual Chapter 100 – General Terms, Chapter 4 – Provider Responsibilities, Section 4.33 - Copayments**. It is imperative to exhaust all alternative funding sources before resorting to these funds.

All services rendered must be thoroughly documented in the member's medical records, adhering to AHCCCS and RBHA documentation and coding requirements. Providers should ensure the availability of funds before referring members for services and are obligated to verify fund eligibility before billing for services.

Persons who decline involvement in the AHCCCS screening and application procedure are not qualified for state-funded behavioral health services, as outlined in **§36-3408** and **AMPM Policy 650**.

The subsequent circumstances do not amount to an individual's rejection of participation. An individual's incapacity to acquire the necessary documentation for eligibility assessment and/or an individual's inability to participate due to their mental illness, without the presence of a HCDM, as outlined in **§36-3408 – Eligibility for Behavioral health service system** and **AMPM Policy 650 – Behavioral health provider requirements for assisting individuals with eligibility verification and screening/application for public health benefits**.

19.04 – Restrictions for Non-Title XIX/XXI Funding

Non-Title XIX/XXI funding shall not be utilized for the following:

- Cash payments to members currently receiving or intending to receive health services.
- The purchase or improvement of land, construction, or permanent improvement of any building or facility, except for minor remodeling, which requires written approval from AHCCCS.
- Acquisition of major medical equipment.
- Flex funds purchases.
- Sponsorship for events and conferences.
- Childcare services with the exception of SUBG.

Service delivery requirements include:

- Services must align with medical necessity criteria
- Outpatient services are deemed medically necessary irrespective of members:
    - Diagnosis, as long as there are documented behaviors and/or symptoms that stand to gain from behavioral health services, and a
    - Valid ICD-10-CM diagnostic code is employed
- For individuals with an SMI designation, all services are expected to adhere to Evidence-Based Practices (EBP) with demonstrated fidelity.
- Additionally, services should actively recognize and tackle HRSN 5 domains:
    - Housing
    - Food
    - Transportation

- Utilities
- Safety

Clinical Approach to Care

All offerings must adopt a trauma-informed assessment and intervention methodology that recognizes, honors, and incorporates the cultural values, beliefs, and practices of patients and their families. Additionally, these services should account for the HRSN. Furthermore, they should actively promote recovery and resilience

Providers must aim to treat the family as a cohesive unit whenever feasible and clinically suitable. Acknowledging the significant role of families in the recovery and resilience process, it is mandatory for providers to admit both parents and their children into treatment services when deemed appropriate.

Coordination of Care

Providers must promptly accept all individuals seeking Mental Health (MH) or Substance Use Disorder (SUD) services and conduct eligibility screenings for Title XIX/XXI funding, Affordable Care Act Advantage Plan funding, SUBG or MHBG funding, or funding through state or county allocations.

- If found eligible for Title XIX/XXI funding, providers are obligated to assist individuals in enrolling in an **ACC Health Plan** of their choice.
- For American Indian Members, the option to choose a Complete Care Plan (CCC), The American Indian Health Program (AIHP), or a TRBHA (when available) is available. Additionally, adults with Serious Mental Illness (SMI) should be enrolled in the T/RBHA in their respective area.
- Providers are mandated to collaborate with various parties to ensure seamless access to services and maintain continuity of care.

Providers are mandated to collaborate with the RBHA to promptly enroll applicants in Non-Title XIX/XXI services funded through Federal Grants, State or County funds upon a service request. Simultaneously, providers must continue assisting the member in applying for Title XIX/XXI services.

Efficient coordination among all involved parties is required by providers to ensure seamless access to services and maintain continuity of care throughout the enrollment process.

While awaiting a determination of Title XIX/XXI eligibility, members may receive services through Non-Title XIX/XXI funding. However, upon the determination of Title XIX eligibility, services covered by Title XIX but initially billed to Non-Title XIX/XXI. Funding must be reversed and charged to Title XIX funding for the retro-covered dates of eligibility. This does not apply to Title XXI members, as there is no Prior Period Coverage for these members.

If a Title XIX/XXI funded member loses Medicaid eligibility while receiving behavioral health services, the provider should attempt to prevent an interruption in services.

The provider should work with the health plan and ACC-RBHA/TRBHA care coordinators to determine whether the member is eligible to continue services through available Non-Title XIX/XXI funding. If the provider does not receive Non-Title XIX/XXI funding, the provider and member should work together to determine whether the member can receive services from a provider that does receive Non-Title XIX/XXI funding. If so, the provider should facilitate a transfer.

Effective coordination among all parties is a requirement for providers to ensure access to services, maintain continuity of care, and prevent any disruptions in services during the transition.

Providers lacking Non-Title XIX/XXI funds must actively engage with members and collaborate with the RBHA to identify an alternative provider for the member's service. This includes efficiently coordinating the transfer of care.

Providers are mandated to coordinate effectively among all parties to ensure:

- Seamless access to services,
- Maintain continuity of care, and
- Prevent any interruption in services during the transition.

RBHA-contracted providers who receive funding other than Title XIX/XXI must accept all referrals for Children's Behavioral Health services from families and school personnel, irrespective of the funding origin.

It is mandatory for providers to enroll eligible children in Title XIX/XXI services and explore all other relevant funding sources before resorting to Non-Title XIX/XXI State Legislative funding.

To minimize disruption to a child's education and classroom instruction, services should ideally be offered outside of regular classroom school hours whenever feasible.

Providers must identify any obstacles to care for all individuals seeking services and collaborate with the care coordination teams of all relevant health plans and payers.

In cases where the provider is unable to address the issues promptly to guarantee the health and safety of the member, they are obligated to reach out to the **AHCCCS/DHCM Clinical Resolutions Unit (CRU)**.

PLAN SPECIFIC TERMS

Providers are obligated to inform the RBHA Care Coordination Teams when members are unable to access services due to funding constraints.

Additionally, providers must follow up with these members to offer alternative services until the originally referred services can be provided.

Additional reference materials from AHCCCS and MC will assist you in understanding Title XIX-XXI. Please review the following links for additional information:

- **Non-Title XIX SMI**
- **Non-Title XIX-XXI FAQ**
- **Non-Title Enrollment Reference Guide**
- **Crisis State-Only Membership Services On-line Reference Guide**