



Mercy Care RBHA



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Mercy Care Provider Manual

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RBHA Chapter 1 – Mercy Care RBHA Overview

1.00 – About Mercy Care RBHA

Mercy Care RBHA (herein Mercy RBHA), as part of MC, is a not-for-profit partnership sponsored by Dignity Health and Ascension Care Management. Mercy RBHA is committed to promoting and facilitating quality health care services with special concern for the values upheld in Catholic social teaching, and preference for the poor and persons with special needs. Aetna Medicaid Administrators, LLC administers Mercy RBHA for Dignity Health and Ascension Care Management.

Mercy RBHA is a managed care organization that provides health care services to people in Arizona's Medicaid program that integrates member's behavioral health and physical health needs. Mercy RBHA provides services to the Arizona Medicaid populations that include:

- **Serious Mental Illness:** Persons who, as a result 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.
- **Comprehensive Medical and Dental Program (CMDP):** CMDP is a health plan established to provide medical and dental care, inpatient, outpatient, and other services for individuals in foster care through agreements between the Arizona Department of Economic Security (ADES), the Arizona Health Care Cost Containment System (AHCCCS - the State's Medicaid Authority) and ADHS.
- **Crisis:** Behavioral health members receiving emergency/crisis services through our Crisis Response Network.
- **Grants:** Behavioral health members may be covered under grants such as:
 - **Substance Abuse Block Grant (SABG)** 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 SABG 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. SABG 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](#).

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- **Governor's Office - Substance Use Disorder Services (GO-SUDS)** are dollars allocated to Mercy Care by the state of Arizona. These funds are allocated to substance abuse treatment providers specifically for uninsured or under-insured individuals with an Opioid Use Disorder (OUD). These dollars are the payer of last resort.
- **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 designation, Title XIX/XXI, and Non-Title XIX/XXI children with an SED designation, 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 Targeted Response Grant (STR) & State Opioid Response Grant (SOR)** are federal dollars intended for Increasing infrastructure and access to Opioid Use Disorder (OUD) treatment. 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 Mercy RBHA, a locally owned and operated non-profit health plan, as the Regional Behavioral Health Authority (RBHA) for Maricopa County.

Under contract with Mercy RBHA, providers are expected to follow the contents of this provider manual, Mercy RBHA Policies and Procedures as well as fulfill the scope of the contract terms. Mercy 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 Mercy RBHA, its departments and their functions, please visit www.MercyCareAZ.org.

Mercy Care RBHA is dedicated to providing its members 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 assure those needs are met.

The Arizona Health Care Cost Containment System (herein AHCCCS) has developed expectations for Mercy RBHA's Provider Manual, which includes content specific to our geographic service areas (GSA) and communities. The Mercy RBHA Provider Manual describes

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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
- Mercy RBHA itself.

The Mercy 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 Abuse Block Grant (SABG); Mental Health Block Grant (MHBG); or Governor' 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. Mercy 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 Mercy 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 at <https://www.azahcccs.gov/> 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.

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

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

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

- The Substance Abuse Block Grant (SABG) supports a variety of substance abuse services in both specialized addiction treatment and more generalized behavioral health settings, and for priority populations outlined within the [320-T2 – Non-Title XIX/XXI Services and Funding \(Excluding Block Grants and Discretionary Grants\)](#).
- 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 an SMI designation, Title XIX/XXI and Non-Title XIX/XXI for children with an SEC designation, and Title XIX/XXI and Non-Title XIX/XXI individuals in need of First Episode Psychosis (FEP) services.

Mercy RBHA administers other federal, state and locally funded behavioral health services. Individuals can get more information about AHCCCS programs by visiting their website at <https://www.azahcccs.gov/>.

[1.02 – Overview of Mercy RBHA](#)

Mercy 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

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- 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 is the community standard; and
- Interested healthcare members and families are provided training and supervision to be retained as providers of peer support services.

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

Mercy 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.

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Mercy 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 1: 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 of 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, care manager, medical assistant, team member to lead care coordinating, team member to lead wellness activities, housing coordinator, 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.

Model 2: Virtual Health Home

A virtual health home is designed for those members who choose to stay with their primary care practice or behavioral health clinic which are not integrated. This model provides health coaches at selected primary care practices, who work as part of team within the PCP practice and closely coordinate care with a Behavioral Health Representative at a partnered behavioral health clinic. These health coaches take a whole-member oriented approach and work with the member, the primary care physician and the behavioral health provider to coordinate care, medications and promote wellness.

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

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- 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.

Additionally, the Data Collection Instrument (DCI) is required for all T19 members enrolled in an Integrated Health Home (IHH) or Virtual Health Home (VHH). The DCI is to be completed within 30 days of a member's enrollment in an IHH or VHH, and annually thereafter. For those enrolled in the VHH model, the physical health partner would complete the DCI. 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/VHH's targeted thresholds for the DCI is identified as 85% per IHH/VHH (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. Mercy RBHA incorporates any changes made by AHCCCS into their provider manual as soon as it's 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 Mercy 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 Mercy RBHA's website at www.MercyCareAZ.org, and via email to all contracted providers.

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- 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 www.MercyCareAZ.org.

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RBHA Chapter 2 – Network Provider Service Delivery Requirements**2.00 – SMI Eligibility Determination*****General Requirements***

This chapter applies to:

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

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

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

- Requests an SMI determination;
- A guardian/legal representative who is authorized to consent to inpatient treatment makes a request on behalf of the member;
- An Arizona Superior Court issues an order instructing that a member is to undergo a SMI evaluation/determination; or
- Has both a qualifying SMI diagnosis and functional impairment because of the qualifying diagnosis.

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

Computation of time is as follows:

- Evaluation date with a qualified clinician = day zero (0), regardless of 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 Mercy RBHA or designee. Providers that contract with Mercy 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

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

Completion Process of Initial SMI Eligibility Determination

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

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

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

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

- Request the additional information in order to make a determination of whether the member is SMI and obtain an authorization for the release of information, if applicable
- Initiate an assessment including completion of the [AHCCCS Medical Policy Manual 320-P Serious Mental Illness Determination](#).

Criteria for SMI Eligibility Determination

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

Functional Criteria for SMI Determination

To meet the functional criteria for SMI, a member must have, as a result 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 the majority of basic needs of hygiene, grooming, nutrition, medical and dental care. Unwilling to seek prenatal care or

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- 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

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- 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 in order 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 T/RBHA and their subcontracted providers must ensure the young adult receives an eligibility determination as outlined in the [AHCCCS Medical Policy Manual 320-P Serious Mental Illness Determination.](#)

If the youth is determined eligible, or likely to be determined eligible for services as a member with a Serious Mental Illness, the adult behavioral health services care manager is then contacted to join the CFT and participate in the transition planning process. **After obtaining permission from the parent/guardian, it is the responsibility of the children's behavioral health service provider to contact and invite the adult behavioral health services care manager to upcoming planning meetings.** Additionally, the children's provider must track and report the following information to Mercy RBHA, CFT transition date (date the adult and children's provider attended a CFT) and adult intake date. When more than one T/RBHA 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.

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

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

Completion Process of Final SMI Eligibility Determination

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

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

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

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

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

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Issues Preventing Timely Completion of SMI Eligibility Determination

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

- There is substantial difficulty in scheduling a meeting at which all necessary participants can attend
- The member fails to keep an appointment for assessment, evaluation or any other necessary meeting
- The member is capable of, but temporarily refuses to cooperate in the preparation of the completion of an assessment or evaluation
- The member or the member's guardian and/or designated representative requests an extension of time
- Additional documentation has been requested, but has not yet been received
- There is insufficient functional or diagnostic information^{1F1} to determine SMI eligibility within the required time periods.

Crisis Response Network

Crisis Response Network must:

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

Situations in which Extension is due to Insufficient Information

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

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

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

If the evaluation or information cannot be obtained within the required time period because of the need for a period of observation or abstinence from substance use in order to establish a qualifying mental health diagnosis, the member shall be notified that the determination may, with the agreement of the member, be extended for up to 90 (calendar) days.

Notification of SMI Eligibility Determination

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

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

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

Re-enrollment or Transfer

If the member's status is SMI at disenrollment, or upon transfer from another T/RBHA, the member's status shall continue as SMI upon re-enrollment, opening of a new episode of care, or transfer.

Review of SMI Eligibility Determination

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

If, as a result of such review, the member is determined to no longer meet the diagnosis and functional requirements for SMI status, Mercy RBHA must ensure that:

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- Services are continued depending on Title XIX/XXI eligibility, or other Mercy 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 T/RBHA 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 Mercy RBHA for approval. Mercy RBHA is responsible for monitoring and validating the forms. Mercy RBHA must keep copies of the validated Serious Mental Illness Determination Verification form in the member's record.

SMI Decertification

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

1. SMI Clinical Decertification

- A member who has a SMI designation or a member working with an individual from the member's clinical team may request a SMI Clinical Decertification. A SMI Clinical Decertification 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.

2. SMI Administrative Decertification

- A member who has a SMI designation may request a SMI Administrative Decertification if the member has not received behavioral health services for a period of two or more years.
 - Upon receipt of a request for Administrative Decertification, Mercy RBHA shall direct the member to contact AHCCCS DHCM Customer Service.
 - AHCCCS will evaluate the member's request and review data sources to determine the last date the member received a behavioral health service.

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AHCCCS will inform the member of changes that may result with the removal of the member's SMI designation. Based upon review, the following will occur:

- In the event the member has not received a behavioral health service within the previous two years, the member will be provided with AMPM Exhibit 320-P-3. This form must be completed by the member and returned to AHCCCS.
- In the event the review finds that the member has received behavioral health services within the prior two-year period, the member will be notified that they may seek decertification of their SMI status through the Clinical Decertification process.

SMI Clinic Transfer Protocol

- Once CRN determines the SMI decertification, CRN sends an email to the SMI clinic indicating the specific member status of decertification.
- As soon as the SMI clinic receives notification that a member has completed and been approved for SMI decertification, the SMI clinic will immediately begin working with the member in order to determine where the member wants to transfer their services.
- The SMI clinic must complete appropriate coordination between a GMH/SA 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 SMI clinic to the GMH/SA provider(s) or alternative BHMP/ PCP must be completed in less than thirty (30) days from the time the SMI clinic 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 SMI clinic but is T19, the SMI clinic that the member was paneled to under the Navigator level of care is responsible for completing the transfer of the member.
- If a member does not want to transfer to a GMH/SA provider or BHMP/PCP or refuses to sign a release of information for a receiving provider, the SMI clinic will complete appropriate outreach and engagement which requires two outreach attempts.
- The SMI clinic will offer the member the opportunity to obtain their medical records (see **MC Chapter 4.0 – Provider Requirements, Section 4.17 – 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 SMI clinic 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

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the provider (see [MC Chapter 4.0 – Provider Requirements, Section 4.17 – Member’s Medical Records](#)).

Paneling of Members with SMI

If member preference is unavailable, the member is paneled to an ABHC based on geographic proximity. Paneling to an ABHC is aligned to member eligibility. Members are not paneled to an ABHC during gaps in enrollment or while eligible in a plan other than Integrated or Non-Title XIX SMI.

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 a RBHA, may opt out of receiving physical health services from the 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 Mercy Maricopa.
- Recent Determination – There is a 14-day transitional period for a change in health plan for Medicaid members determined with SMI.

In addition to being paneled to an ABHC, members receiving services through Assertive Community Treatment (ACT) teams must be paneled to an ACT Team.

SMI clinics and ACT teams are required to manage their panels through the Member Paneling tool available in Provider Intake on the Mercy Care Secure Web Portal. Panel changes submitted through the Member Paneling tool are processed nightly and loaded directly into the Mercy Care provider information systems. Specific instructions on utilization of the **Provider Intake Member Paneling Tool** are available under the [Reference Material and Guides](#) of our website.

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

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

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

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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, go to: <https://azweb.statemedicaid.us/Account> 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 Mercy 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

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- 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. Mercy 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 Mercy 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, Mercy 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

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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 Chapter 4 – Provider Requirements, Section 4.17 – Member’s Medical Records](#)).

Mercy 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 Chapter 4 – Provider Requirements, Section 4.30 - 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 Chapter 4 – Provider Requirements, Section 4.30 - 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 Chapter 4 – Provider Requirements, Section 4.30 - 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 Mercy 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

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- 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 Mercy 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 **RBHA Chapter 12 – Service Authorizations, Section 12.05 – Third Party Liability (TPL)** regarding how to coordinate benefits for members with other insurance including Medicare. If a behavioral health/integrated care member is unsure of Medicare eligibility, Mercy 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, Mercy 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, Mercy 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 www.medicare.gov. 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 Mercy RBHA or provider determines that a member may be eligible for the LIS (see Social Security Administration (SSA) website at www.ssa.gov for income and resource limits), Mercy 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 at: <http://www.socialsecurity.gov/i1020>;
- By calling 800-772-1213;

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- In member at an SSA local office; or
- By mailing a paper application to the SSA.

Mercy 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 offer assistance 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, Mercy 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 that 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 Mercy 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 the eligibility determination;
- A member is incapable of participating because of their mental illness and does not have a legal guardian; 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

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who have been receiving behavioral health services and subsequently decline to participate in the screening/referral process, Mercy RBHA must provide written notification of the intended termination using **Notice of Decision and Right to Appeal**. (See **RBHA Chapter 16 – Grievance System and Member Rights, Section 16.03 – 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

Mercy 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 Mercy 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 Mercy 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 Mercy 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.

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- Refrain from directing members solely to Mercy Care's Member Services.

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

- Warm transfer the member to Mercy 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 T/RBHA 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](#)

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Policy Manual, Policy 310-B – Title XIX/XXI Behavioral Health Service Benefit.

- **WHEN:** Appointment for initial assessment with a BHP or *behavioral health technicians* (as defined in 9 A.A.C. 10) must meet the Mercy RBHA's credentialing requirements to provide assessment and evaluation services within 7 business days of referral or request for behavioral health services.
- **WHO:** All Mercy RBHA members.
- **WHAT:** Includes any medically necessary covered behavioral health service including medication management and/or additional services.
- **WHEN:** Routine care appointments:
 - i. Initial assessment within seven calendar days of referral or request for service,
 - ii. 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, and
 - iii. 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 Abuse Block Grant (SABG) 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;

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- 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 Mercy Care 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 Mercy Care 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 guardian;
- 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 Assigned Behavioral Health Clinic (ABHC) 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

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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 on our [Forms](#) web page that is in the Provider Manual Attachments section of our website.

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 T/RBHA, 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, temporary hotel assistance, bed bugs treatment, biohazard cleaning, and moving assistance.
- **WHO:** All Title XIX/XXI eligible members, all Non-Title XIX/XXI members enrolled with a T/RBHA, 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 T/RBHA, all members determined to have a Serious Mental Illness and any member in an emergency or crisis.

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Referrals for Hospitalized Members

Behavioral health providers must quickly respond to referrals pertaining to eligible members not yet enrolled in the T/RBHA 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
- Mercy Care 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

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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 Mercy 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, Mercy 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 Mercy RBHA contracted provider.
- Confirm that the Mercy RBHA contracted provider can deliver the needed covered service;
- Confirm the Mercy RBHA contracted provider can meet the timeliness of the needed service; and
- Coordinate the referral.
- If no Mercy RBHA contracted provider can meet the timeliness of the needed service, behavioral health members must be referred to a provider outside of Mercy 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 Mercy 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 Mercy 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 relative to outpatient treatment appointment and residential bed availability by calling Mercy RBHA at 800-564-5465;
- Confirm that non-contracted provider can meet the timeliness of the needed service;
- Call Mercy RBHA at 800-564-5465 to request a prior authorization; and
- Coordinate the referral.

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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, Mercy 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 Chapter 4 – Provider Requirements, 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 legal guardian;
- Whether or not the member, parent or legal guardian is aware of the referral;
- Transportation and other special needs for assistance due to impaired mobility, visual/hearing impairments or developmental or cognitive impairment;

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- 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 why the medication is being prescribed; and
- Names and telephone numbers of individuals the member, parent or guardian 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 Chapter 4 – Provider Requirements, Section 4.02 Appointment Availability Standards**.

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

In situations in which the member seeking services or his/her family member, legal guardian or significant other contacts Mercy RBHA or provider directly about accessing behavioral health services, Mercy 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, Mercy RBHA and providers must conduct an eligibility determination for SMI in accordance with **MCCC 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

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engagement activities consistent with **RBHA Chapter 2 – Network Provider Service Delivery Requirements, Section 2.03 - Outreach, Engagement, Reengagement and Closure.**

Mercy 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, Mercy 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 why. 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:

- Mercy RBHA Member Services Department will gather the following basic information from the guardian:
 - 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 guardian has a provider preference. If the guardian does not have a provider preference, the youth will be

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referred to an Assigned Behavioral Health Clinic (ABHC) based on geographic access, specialty services and an algorithm.

- The Member Service Representative will advise parent/guardian of ABHCs in area that meets the child's needs and the guardian will select the ABHC.
- The Member Service Representative will warm transfer the call to the identified ABHC. Prior to the warm transfer of the guardian, the Member Service Representative will advise the ABHC of service type requested, parent/guardian name, member name, address, date of birth, and AHCCCS ID number. The ABHC will gather any additional information from the caller and schedule an intake appointment within 7 days.

DCS Integrated Rapid Response Referrals

Expectations:

- A child is removed from their home and placed in DCS Custody.
- DCS, law enforcement, or other individuals including the out-of-home placement or adoptive parent make a DCS Integrated Rapid Response Referral. DCS provides appropriate documentation (generally a Temporary Custody Notice and/or Notice to Provider to Solari - Crisis Response Network (Solari - CRN)) within 24 hours of the child's removal.
- Solari – CRN verifies the Integrated Rapid Response Referral is complete and dispatches the referral to an Integrated Rapid Response provider based on the location of the DCS out of home caregiver.
- DCS, law enforcement, or other individuals including the out-of-home placement or adoptive parent make a DCS Integrated Rapid Response Referral. DCS provides appropriate documentation (generally a Temporary Custody Notice and/or Notice to Provider to Crisis Response Network (CRN)) within 24 hours of the child's removal.
- The caregiver will be contacted by an Integrated Rapid Response Team Clinician and the team will be dispatched within the first 72 hours of a child being referred to Integrated Rapid Response. If the child has immediate behavioral health needs, the assessment/crisis team will be dispatched within 2 hours of being notified.
- The Integrated Rapid Response provider will follow the Integrated Rapid Response outreach and closure protocol when scheduling an appointment with the out-of-home caregiver:
 - Complete 3 documented attempts to outreach Caregiver
 - Phone calls at different times of the day
 - Email (copy DCS)
 - Attempt to visit residence when possible
 - Letter
- Completed and documented attempts to contact DCSS and supervisor
 - Separate phone calls to DCSS and Supervisor
 - 1 email to both including efforts made to complete IRRA and dates/times of attempts
- Escalation after attempts

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- Send final request to PM, DCSS, DCS Supervisor AND DCS CHP
DCSBHUnit@azDCS.gov, Mercy Care DCS@mercycaresaz.org. Subject line: IRRRA final outreach – (include PI#)
- If no response, send closure letter to the dedicated DCS CHP mailbox
DCSBHUnit@azDCS.gov, DCS PM, DCSS, DCS Supervisor and copy
DCS@mercycaresaz.org. Subject line: IRRRA closure - (include PI#)
- A referral will be made to an Integrated Rapid Response Provider to complete the behavioral health assessment and developmental screening and Physical Health Screening.
- **Out of County of Jurisdiction Dispatches**
 - IRR providers must contact the selected ABHC in the Court of Jurisdiction and DCS within 24 hours of receiving the IRR dispatch. The contact will include the assigned staff completing the IRR Assessment and their contact information
 - If no ABHC in the Court of Jurisdiction is selected by DCS on the IRR referral, Solari-CRN will suggest a randomly selected ABHC in the Court of Jurisdiction when dispatching the referral;
- The Integrated Rapid Response Provider will coordinate the selection of a PCP with the out-of-home caregiver, including scheduling an initial wellness visit with the PCP within 30 days of the removal date, if possible;
- If during the Physical Health Screening, any acute concerns are indicated or noticed, the member/caregiver should be referred to the ER/Urgent Care for evaluation.
- During the Physical Health Screening, if the member's condition is not acute, but has healthcare needs that must be met prior to the initial PCP appointment, then contact the PCP/ordering provider to resolve the needs. If the PCP/Provider is not known or is unable to meet the need in the required time, support the caregiver to connect with the Mercy Care 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 Mercy Care Integrated Care Management.
- If an Integrated Rapid Response referral is not submitted or the Integrated Rapid Response Team is not dispatched within this timeframe, DCS, law enforcement, or individuals including the out-of-home placement or adoptive parent may contact the Mercy Care Designated DCS Point of Contact at dcsc@MercyCareAZ.org.
- A developmental screening and assessment will be completed. The developmental checklist and warning signs will be provided to caregivers.
- Integrated Rapid Response Team will assess to determine if high needs care management (HNCM) services are recommended.
- The Integrated Rapid Response Team will make a referral, based on the youth's acuity (or the need for HNCM) and guardian's preference for an intake appointment with a ABHC to complete the comprehensive assessment. If the guardian does not have a provider preference and does not need HNCM, the youth will be referred by the

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Integrated Rapid Response Team to a ABHC based geographic access, specialty services, and an algorithm.

- The referral will be emailed to the identified ABHC by the DCS Rapid Response Team. The identified provider information will be provided to the guardian.
- The ABHC will contact the DCS Specialist and/or DCS out-of-home placement to set-up an intake to begin services. If unable to contact the DCS out-of-home placement, the ABHC will contact the DCS Specialist to set up an intake to begin services.
- The ABHC will notify DCS Rapid Response Team within 7 days of the referral of the status of the referral and/or the completed intake date.
- The ABHC will follow the ABHC 7-day Intake outreach and closure protocol when scheduling an initial intake after the Integrated Rapid Response assessment:
 - Complete 3 documented attempts to outreach Caregiver
 - Phone calls at different times of the day
 - Email (copy DCS)
 - Attempt to visit residence when possible
 - Letter
 - Completed and documented attempts to contact DCSS and supervisor
 - Separate phone calls to DCSS and Supervisor
 - 1 email to both including efforts made to complete IRRA and dates/times of attempts
 - Escalation after attempts
 - Staff with ABHC leadership
 - ABHC leadership outreaches DCS PM, DCSS, DCS supervisor
 - If no resolution, send closure letter to the dedicated DCS CHP System of Care mailbox CHPSystemofCare@AZDCS.GOV, DCS PM, DCSS, DCS Supervisor and copy DCS@mercycaresaz.org. Subject line: ABHC 7-day Intake closure - (include PI#)

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 must identify the Mercy RBHA contracted provider(s) who are able to provide the needed Direct Support or Specialty service (see **Direct Support and Specialty Provider Directory** for a list of DSP and Specialty Providers). Please note that referrals for Meet Me Where I Am (MMWIA) and Multi-Systemic Therapy (MST) services can only be made by a High Needs Care Manager (HNCM).
- The CFT Facilitator and/or HNCM will complete the **Request for Direct Support or Specialty Provider Services** form, available on our [Forms](#) web page, and will send the form with the following documents to the identified provider agencies:

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- CFT service plan/CFT Notes;
- Strengths Needs and Cultural Discovery (if CALOCUS 4, 5, or 6);
- Current assessment or most recent annual update;
- Crisis/Support Plan;
- CALOCUS;
- Current Psychiatric Notes and Evaluation (if applicable); and
- MMWIA Prioritization Form for MMWIA 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:
 - If the referral is accepted the guardian will be notified; and
 - The Direct Support or Specialty Provider will assess to determine next steps and for treatment needs.
- 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 Mercy RBHA Member Services at 800-564-5465 of a youth that is currently inpatient without an open episode of care with an ABHC.
- If the youth will not be discharged within 24 hours, Mercy RBHA will refer to a High Needs Care Management (HNCM) provider utilizing an identified algorithm.
- The referral is documented and forwarded to the Mercy 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.

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- 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 **RBHA Chapter 2 – Network Provider Service Delivery Requirements, 2.00 Eligibility Screening for AHCCCS Health Insurance, Medicare Part D**). 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 **RBHA Chapter 13 – Contract Compliance, Section 13.01 – Verification of U.S. Citizenship or Lawful Presence for Public Behavioral Health Benefits**).

- 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:

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- The collection of contact information, insurance information, the reason why 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 Mercy 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 Mercy 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 on our [Forms](#) web page and refer the member to the appropriate Mercy RBHA Participating Health Provider (PHP). Mercy 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 providers.

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- Member may self-refer to certain specialists for specific services, such as an OB/GYN 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 Mercy RBHA on the date of service (s) and eligible to receive the service.
- If Mercy 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 Mercy RBHA network.
 - Mercy 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 Mercy RBHA's policies. Both referring and receiving providers must comply with Mercy 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 Mercy 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 Mercy 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 Mercy RBHA.
- Obtain prior authorization for services that require prior authorization or are performed by a non-PHP.
- Complete a **Specialist Referral Form** available on our [Forms](#) web page 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

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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 Mercy 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 Mercy RBHA on the date of service, Mercy 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 Mercy 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 Mercy RBHA on the date of service.

Maternity Referrals

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

- A pregnant Mercy RBHA member may self-refer to any Mercy RBHA contracted Maternity Care Practitioner.
- The PCP may refer pregnant members to a Mercy 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.
- Schedule a minimum of one postpartum visit at approximately six weeks postpartum.
- When necessary, refer members to other practitioners in accordance with the Mercy RBHA referral policies and procedures.
- Schedule return visits for members with uncomplicated pregnancies consistent with the American College of Obstetrics and Gynecology 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.
 - Schedule first-time appointments within the required time frames.
 - Members in first trimester – within seven calendar days.

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- Members in third trimester – within three calendar days.
- High-risk Members – within three calendar days of identification or immediately when an emergency condition exists.

Ancillary Referrals

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

Member Self-Referrals

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

- Family Planning Services
- 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 for Members 18 years of age and older.

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

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. Mercy 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 Mercy 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

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- 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 Mercy 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
- Development and coordination of outreach programs to Native American tribes in Arizona to provide services for tribal members

Engagement

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

- The member and/or member's legal guardian
- The member's family/significant others, if applicable and amenable to the member
- Other agencies/providers as applicable
- For members with a Serious Mental Illness who are receiving Special Assistance, the member (guardian, family member, advocate or other) designated to provide Special Assistance

Behavioral health providers must provide services in a culturally competent manner in accordance with Mercy 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 that in which members from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices in the context of negotiating treatment options
- Provide care by communicating to members in their preferred language and ensuring that they understand all clinical and administrative information.
- 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)

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- Establish an empathic service relationship in which the member experiences the hope of recovery and is considered to have the potential to achieve recovery while developing hopeful and realistic expectations
- Demonstrate the ability to welcome the member, and/or the member's legal guardian, the member's family members, others involved in the member's treatment and other service providers as collaborators in the treatment planning and implementation process
- Demonstrate the desire and ability to include the member's and/or legal guardian's viewpoint and to regularly validate the daily courage needed to recover from persistent and relapsing disorders
- Assist in establishing and maintaining the member's motivation for recovery
- Provide information on available services and assist the member and/or the member's legal guardian, the member's family, and the entire clinical team in identifying services that help meet the member's goals
- Provide the member with choice when selecting a provider and the services they participate in
- At Risk Crisis Plans will address managing any change in a client's health, medical status, or behavior that is not immediately and obviously life-threatening (such as a heart attack, a seizure or immediate danger to self or others), but is nevertheless seriously concerning and may also include any significant and concerning change in a client's health, medical status, or behavior

Reengagement

For SMI Members, the reengagement policy is as follows:

SMI Behavioral Health Clinics 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 Clinic 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 performing

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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 SMI Behavioral Health Clinic should develop their own detailed policies outlining the consistency and methods of outreach and should include but is not limited to:

- Communicating in the member's preferred language.
- Contacting the member or the member's legal guardian by telephone, at times when the member may reasonably be expected to be available (e.g., after work or school) within 24 hours.
- Whenever possible, contacting the member or the member's legal guardian face-to-face, if telephone contact is insufficient to locate the member or determine acuity and risk.
- Sending a letter to the current or most recent address requesting contact once the outreach process has begun, informing the member of the outreach process, except when a letter is contraindicated due to safety concerns (e.g., domestic violence) or confidentiality issues. The SMI Behavioral Health Clinic 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 SMI Behavioral Health Clinic 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 Mercy Care).
- 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.

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- 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.
- For all members receiving Adult General Mental Health Substance Use, the provider must attempt a telephonic contact, within 24 hours. If they are unable to reach the member/guardian, telephonic contact should be made again within 72 hours.

For Children Members, the reengagement policy is as follows:

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

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

- a. Communicating in the member's preferred language;
- b. Contacting the member/guardian/designated representative by telephone at times when the member may reasonably be expected to be available (e.g., after work or school);
- 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/guardian/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.

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

For children in the custody of DCS, if attempts to contact the DCS Specialist or the DCS Supervisor is unsuccessful, contact the Mercy RBHA Child Welfare Single Point of Contact at DCS@MercyCareAZ.org to assist with reengagement. For CMDP Youth who have been in services under one year and all re-engagement attempts have been unsuccessful, please contact the Mercy 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 assigned behavioral health clinical team or the

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

- Whenever possible, contacting the member, member's assigned behavioral health clinical team or the member's legal guardian face-to-face, if telephone contact is insufficient to locate the member or determine acuity and risk
- Sending a letter to the current or most recent address requesting contact once three (3) separate outreach attempts at personal contact are unsuccessful, except when a letter is contraindicated due to safety concerns (e.g., domestic violence) or confidentiality issues. The SMI Behavioral Health Service Provider will note safety or confidentiality concerns in the progress notes section of the clinical record and include a copy of the letter sent in the comprehensive clinical record
- For members determined to have a Serious Mental Illness who are receiving Special Assistance for his/her involvement in member's reengagement efforts

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

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

No Show Policy

For all members receiving Serious Mental Illness, 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.

For all members receiving Adult General Mental Health Substance Use and Children's Services, the provider must attempt a telephonic contact, within 24 hours. If they are unable to reach the

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member/guardian, an attempt to make telephonic or face to face contact should be made again within 72 hours and should follow the steps outline under the reengagement section.

For children in the custody of DCS or adopted children, 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 Mercy RBHA Child Welfare Single Point of Contact at DCS@MercyCareAZ.org to assist with re-engagement. For CMDP Youth who have been in services under one year and all re-engagement attempts have been unsuccessful, please contact the Mercy RBHA Child Welfare Single Point of Contact at DCS@MercyCareAZ.org.

Follow-Up After Significant and/or Critical Events

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

- Discharged from inpatient services in accordance with the discharge plan and clinical team should be present at discharge and complete clinically appropriate home visits and discharge follow-up (please see below for specific timeframe requirements);
- Involved in a behavioral health crisis within timeframes based upon the member's clinical needs, with minimum contact within 24 hours (please see below regarding specific BHMP required timeframes for appointments);
- Refusing prescribed psychotropic medications within timeframes based upon the member's clinical needs and individual history; and
- Released from local and county jails and detention facilities within 72 hours.
- For children removed from their parent or guardian by the Department of Child Safety (DCS), within 72 hours of notification from DCS.

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

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

- The BHMP appointment must be scheduled within 72 business hours following discharge.
- 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

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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 evaluate the member within 24 business hours and see the BHMP within 72 business hours. For ACT adult members, it is expected that the clinical team evaluate the member within 24 actual hours and see the BHMP within 72 actual hours.

Outreach to Service Members, Veterans, and Families

Mercy Care will partner with community organizations which provide care and support for service members, veterans and families. Utilizing a collaborative approach, Mercy Care will identify members who may benefit from outreach regarding available programs and services and shall develop and implement outreach activities which inform members and families of the benefits available and how to access those services. Mercy Care will train staff on the available community resources and appropriate actions to take to ensure members are afforded the ability to be connected to these resources. Providers may access additional online training to better understand the needs of veterans, service members, and their families through PsychArmor Institute. Please use this [link](#) to create an account. When you login, there will be a list of pre-populated/suggested courses on your profile, but you may also access the full list of courses by clicking on the “courses” tab at the top of your screen.

2.05 – Emergency Services

Mercy RBHA covers behavioral health emergency services for Mercy RBHA members. If a member is experiencing a behavioral health crisis, please contact the Crisis Response Network at 800-631-1314.

During a member’s behavioral health emergency, the Crisis Response Network clinician may dispatch a behavioral health mobile crisis team to the site of the member to de-escalate the

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situation and evaluate the member for behavioral health services. All medically necessary services are covered by Mercy RBHA. T

2.06 – Crisis Intervention Services

Crisis intervention services are provided to a member for stabilizing or preventing a sudden, unanticipated, or potentially dangerous behavioral health condition, episode or behavior. 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 or in the community. 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.

General Requirements

To meet the needs of individuals in communities throughout Arizona, Mercy 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: 602-222-9444; toll free 800-631-1314; or TTY/TTD toll free 800-327-9254.
 - Answer calls within three (3) telephone rings (equivalent to 18 seconds), with a call abandonment rate of less than three (3%) percent.
 - Offer interpretation or language translation services to members who do not speak or understand English and for the deaf and hard of hearing.
- Mobile Crisis Intervention Services
 - Mobile crisis intervention services available 24 hours per day, seven days a week;
 - Mobile crisis teams will respond within one (1) hour to a psychiatric crisis in the community.
 - If a two-member team responds, one member may be a Behavioral Health Technician, including a peer or family member, provided he/she has supervision and training as currently required for all mobile team members.
- 23-hour crisis observation/stabilization services, including detoxification services.
- Up to 72 hours of additional crisis stabilization as funding is available for mental health and substance use related services.
- Work collaboratively with local emergency departments and first responders.

Psychiatric and Substance Use Emergencies for Child and Adolescent

St. Luke's Behavioral Health Center (child and adolescent services only)
1800 E. Van Buren St.

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Phoenix, AZ 85006
Phone: 602-251-8535

Psychiatric Emergencies for Adults

Community Bridges- Community Psychiatric Emergency Center
358 E. Javelina Ave.
Mesa, AZ 85210
Phone: 877-931-9142

Connections AZ Urgent Psychiatric Care Center (UPC)
1201 S. 7th Ave., #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

Substance Use Emergencies for Adults

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

Up to 72 hours of additional crisis stabilization as funding is available for mental health and substance use related services at an inpatient psychiatric acute or sub-acute facility.

Management of Crisis Services

While Mercy RBHA must provide a standard set of crisis services to ensure the availability of these services throughout the state, Mercy RBHA will also be able to meet the specific needs of communities located within their service area. Mercy RBHA will utilize the following in managing crisis services:

- Allocate and manage funding to maintain the availability of required crisis services for

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the entire fiscal year;

- Work collaboratively with local hospital-based emergency departments to determine whether a Mercy RBHA-funded crisis provider should be deployed to such locations for crisis intervention services;
- Work collaboratively with local inpatient hospitals to determine whether and for how many hours such locations are used for crisis observation/stabilization services; and
- When Non-Title XIX/XXI eligible individuals are receiving crisis services and require medication, Mercy RBHA will use the generic medication formulary identified in the Non-Title XIX SMI benefit.

Whenever possible, Crisis Services are to be delivered within the community at the least restrictive level of care available.

General Mental Health/Substance Use (GMH/SU) Member Contact in Sub-Acute and Inpatient Facilities

Upon finding out that a client has been admitted to an inpatient level of care:

- Behavioral health providers must attempt to speak with the sub-acute or inpatient provider daily.
- Behavioral health providers must actively participate in the client's discharge planning and should make plans for follow up activities once the client is discharged (actual discharge planning should begin to occur at the time of admission).

Behavioral health providers must also document activities in the clinical record and conduct follow-up activities to maintain engagement within the following timeframes:

- Community Based Mercy RBHA Contracted Behavioral Health Providers must have telephonic or face to face contact with member within 24 hours of crisis episode or discharge.
- Member to see prescriber within 7 days of discharge.

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

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assessment of the member, the intensity of the behavioral targets, and complexity and range of treatment goals.

Please refer to our Claims Processing Manual available on our [Claims](#) web page 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 performs 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:

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- 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 in order to assist in the generalization and maintenance of treatment targets. This shall include the Child and Family Team (CFT) or Adult Recovery Team (ART) for members enrolled with Mercy Care 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).

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2.08 – Assessment and Service Planning

Mercy 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.

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For additional information regarding the Child and Family Team practice refer to [AHCCCS Practice Protocol Child and Family Team Practice](#).

The 9 Guiding Principles are as follows:

- Respect
- People choose their services
- Focus on the whole person and natural supports
- Independence
- Integration, collaboration, participation in community
- Partnership between individuals, staff, family members and natural supports
- People define their own successes
- Services are strength-based, flexible and responsible
- 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.

Mercy 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 American Society of Addiction Medicine (ASAM) 3rd edition must be incorporated for members identified with substance use disorders. Providers must collect and submit all required demographic information in accordance with the criteria outlined in the [AHCCCS DUGless User Guide \(DUG\)](#) and **RBHA Chapter 14.0 -Enrollment, Disenrollment and Other Data Submission**.

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 4 – Provider Responsibilities, Section 4.37 – 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 30 days of the BHT signature.

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Minimum elements of the behavioral health assessment

Mercy 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 Chapter 4 – Provider Responsibilities – Section**

4.17 – Member’s Medical Records.

- Presenting issues/concerns;
- History of present illness, including review of major psychiatric symptoms (i.e., mood, depression, anxiety, psychosis, suicidal ideation, homicidal ideation, and other behavioral health symptoms) and frequency/duration of symptoms;
- Psychiatric history, including history of previous psychiatric hospitalization(s) and psychotropic medication trial(s);
- Medical history;
- Current medications, including over the counter (OTC) medications;
- Allergies and other adverse reactions;
- Developmental history for children/youth under the age of 18 and with other populations if clinically relevant;
- Trauma history for children/youth under the age of 18 and with other populations if clinically relevant;
- Family history;*
- Educational history/status;*
- Employment history/status;
- Housing status/living environment;
- Social history;*
- Legal history, including custody/guardianship status, pending litigation, Court Ordered Evaluation/Court Ordered Treatment (COE/COT) history, criminal justice history, and any history of sex offender adjudication;
- Substance abuse history including type of substance, duration, frequency, route of administration, longest period of sobriety, and previous treatment history;
- Standardized substance use screen for children age 11 to 18 and referral for comprehensive assessment when screened positive;
- Substance use screen for adults age 18 and older using the American Society of Addiction Medicine (ASAM) 3rd Edition – Revised of Patient Placement Criteria (ASAM Criteria);
- Labs/ Diagnostics, if applicable;
- Mental Status Examination;
- Risk Assessment: the potential risk of harm to self or others based on self-reports, clinical symptoms, personality factors, past history, substance abuse, criminogenic factors, etc.;
- Brief summary/Bio-Psycho-Social formulation;
- Axial Diagnoses I-V; and

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- Date, begin, and end time of the assessment and printed name, signature, and professional credential of the provider completing the behavioral health assessment. If a privileged BHT completes the assessment, the assessment must also include a printed name, signature, professional credential, date and time of the privileged BHP who reviewed the assessment information.*
 - 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 AGE 0 TO 5: Birth to Five Assessment to be completed within 90 days of intake, with a minimum of 2 documented observations to occur within a 45 – 60-day period and the first observation to occur within 21 days of intake. Recommendations for treatment to be reviewed with the Guardian/Primary Caregiver and Stakeholders within a Child and Family Team meeting. Developmental screening for children age 0-5 with a referral for further evaluation by the child's Primary Care Provider (PCP), the Arizona Early Intervention Program (AzEIP) for children age 0-3, or the public-school system for children age 3-5 when developmental concerns are identified.
 - ONLY REQUIRED FOR CHILDREN AGE 6 TO 18: Child and Adolescent Level of Care Utilization System (CALOCUS) Score and Date.
 - ONLY REQUIRED FOR CHILDREN AGE 6 TO 18 WITH CALOCUS SCORE OF 4 OR HIGHER: Strength, Needs and Culture Discovery Document.
 - ONLY IF INDICATED: Seriously Mentally Ill Determination (for members who request SMI determination or have an SMI qualifying diagnosis) in accordance with Chapter 2.5 – Serious Mental Illness Determination.
 - ONLY REQUIRED FOR MEMBERS DETERMINED SMI: Special Assistance assessment in accordance with Chapter 2.13 – Special Assistance for Members Determined to have a Serious Mental Illness.

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 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

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medications and counseling/behavioral therapies to provide a “whole patient” approach to the treatment of substance use disorders. Mercy 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. Mercy 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 – Chapter 17 – Billing Encounters and Claims, Section 17.08 – MC as Secondary Insurer**).

FOOD INSECURITIES

In addition to the AHCCCS minimum requirements for the comprehensive assessment, Mercy 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 social determinants of health 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 times 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. This is why 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;

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- Outreaching friends/family members for assistance has proven to be unsuccessful;
- Unable to locate food access through community programs/resources;
- Difficulty with budget planning, etc.

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

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

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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 90 days after the initial appointment.

The behavioral health member, his/her guardian (if applicable), advocates (if assigned) must be included in the development of the service plan. In addition, family members, designated representatives, 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 Chapter 4 – Provider Responsibilities, Section 4.17 – 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/guardian and the date it was signed;
- Documentation of whether or not the member/guardian is in agreement 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 Chapter 2.13 – Special Assistance for Members Determined to have a Serious Mental Illness); and
- The Service Plan Rights Acknowledgement Template dated and signed by the member or guardian, the member who filled out the service plan and a BHP if a BHT fills out the service plan.

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

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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 Chapter 4 – Provider Responsibilities, Section 4.37 – Credentialing/Recredentialing**. In the event that a BHT completes the service plan, a BHP must review and sign the service plan within 30 days of the BHT signature.

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, designated representatives, and guardians should be given the option of attending this meeting in person to review the team's recommendations. If the member/designated representative declines to attend in person, the case manager or designated staff should contact the member/designated representative 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 also utilize the assistance of the clinic peer support specialist in engagement and to assist in resolution.

The behavioral health member and/or their parent/guardian must be provided with a copy of their plan. Questions regarding service plans or member rights should be directed to Mercy 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 as long as 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

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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. In the event that 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 on our [Forms](#) web page and submit it to Mercy RBHA Medical Management at ComplexCase@MercyCareAZ.org for review. For additional guidance see Provider Manual, **Chapter 20 – Grievance Systems and Member Rights**, 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, Mercy 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 of the Non-Title XIX/XXI covered services included in the service plan, the member and/or legal or designated representative **must** be given a **Notice of Decision and Right to Appeal (For Individuals with a Serious Mental Illness)** by the behavioral health representative on the team.

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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

BHPs must complete an annual assessment update with input from the member and family, if applicable, that records a historical description of the significant events in the member's life and how the member/family responded to the services/treatment provided during the past year. Following this updated assessment, the service plan should then be updated as necessary. While the assessment and service plan must be updated at least annually, the assessment and service plan may require more frequent updates to meet the needs and goals of the member and his/her family.

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

Transfer Assessments

If a behavioral health assessment that complies with the assessment requirements is received from a behavioral health provider other than the intake agency or the intake agency 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: (1) the patient's assessment information is reviewed and updated, by a BHP, if additional information that affects the patient's assessment is identified, by utilizing a collateral note. (2) The review and update of the patient's assessment information needs to be documented in the patient's medical record within 48 hours after review.

Please Note: The following instances would not require a BHP review within 48 hours following assessment retrieval: (1) the provider is contracted with another behavioral health provider with whom a formal agreement has been made to provide services; (2) an intake agency receives a referral from another behavioral health provider, following intake (due to additional services being required outside of the array of services offered by the behavioral health provider performing the intake; i.e. HNCCM).

2.09 – Clinical Guidelines

Mercy RBHA has outlined our clinical guidelines on our [Clinical Guidelines](#) web page.

Behavioral health clinical guidelines can also be found on the AHCCCS website under [Clinical Guidance Tools](#).

There are minimum expectations for SMI clinical teams to include the following individuals:

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Supportive/Connective Level of Care

- 1 Psychiatrist (BHMP)
- 1 Registered Nurse
- 1 Rehabilitation Specialist
- 1 Peer Support Specialist (per clinic)
- 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
- 1 Benefits Specialist

ACT Level of Care

- 1 Psychiatrist (BHMP)
- 2 Registered Nurses
- 1 ACT Specialist
- 2 Substance Abuse Specialists
- 1 Independent Living Specialist
- 1 Peer Support Specialist
- 1 Housing Specialist
- 1 Rehabilitation Specialist
- 1 Employment Specialist
- 1 Program Assistant
- 1 Clinical Coordinator (Team Leader)

In addition to already instated state 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.

2.10 – Serious Mental Illness Decertification

SMI DECERTIFICATION

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

2. SMI Clinical Decertification

- A member who has a SMI designation or a member working with an individual from the member's clinical team may request a SMI Clinical Decertification. A SMI Clinical Decertification is a determination that a member who has a SMI designation no longer meets SMI criteria. If, because of a review, the member is determined to no longer meet the diagnostic and/or functional requirements for SMI status:

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- 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.
- Mercy 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 Decertification

- A member who has a SMI designation may request a SMI Administrative Decertification if the member has not received behavioral health services for a period of two or more years.
 - Upon receipt of a request for Administrative Decertification, Mercy RBHA shall direct the member to contact AHCCCS DHCM Customer Service.
 - AHCCCS will evaluate the member's request and review data sources to determine the last date the member received a behavioral health service. AHCCCS will inform the member of changes that may result with the removal of the member's SMI designation. Based upon review, the following will occur:
 - In the event the member has not received a behavioral health service within the previous two years, the member will be provided with AMPM Exhibit 320-P-3. This form must be completed by the member and returned to AHCCCS.
 - In the event the review finds that the member has received behavioral health services within the prior two-year period, the member will be notified that they may seek decertification of their SMI status through the Clinical Decertification process.

SMI CLINIC TRANSFER PROTOCOL

- Once CRN determines the SMI decertification, CRN sends an email to the SMI clinic indicating the specific member status of decertification.
- As soon as the SMI clinic receives notification that a member has completed and been approved for SMI decertification, the SMI clinic will immediately begin working with the member to determine where the member wants to transfer their services.
- The SMI clinic must complete appropriate coordination between a GMH/SA provider(s) or BHMP/PCP of the member's choice to eliminate any gaps in care for the member.
- The transferring of services from the SMI clinic to the GMH/SA provider(s) or alternative BHMP/ PCP must be completed in less than thirty (30) days from the time the SMI clinic is notified the member is determined to no longer meet SMI criteria.
- All coordination must be appropriately documented in the member's medical record.

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- 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 SMI clinic but is T19, the SMI clinic that the member was paneled to under the Navigator level of care is responsible for completing the transfer of the member.
- If a member does not want to transfer to a GMH/SA provider or BHMP/PCP or refuses to sign a release of information for a receiving provider, the SMI clinic will complete appropriate outreach and engagement which requires two outreach attempts.
- The SMI clinic 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 SMI clinic 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.

MERCY RBHA TRANSFER PROTOCOL

Mercy 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, Mercy 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. Mercy 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 Mercy RBHA and Non-Title XIX SMI eligibility plans are paneled to an Assigned Behavioral Health Clinic (ABHC). Mercy RBHA panels newly enrolled members to an ABHC based on member preference. If member preference is unavailable, the member is paneled to an ABHC based on geographic proximity. Paneling to an ABHC is aligned to member eligibility. Members are not paneled to an ABHC during gaps in enrollment or while eligible in a plan other than Integrated or Non-Title XIX SMI.

There are numerous scenarios where a member 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 a RBHA, may opt out of receiving physical health services from the RBHA and be transferred to an Acute Care Contractor for his/her physical health services if one or more of the

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applicable opt out criteria are satisfied. Members who meet the opt-out criteria will continue to receive behavioral health services through Mercy RBHA.

- Recent Determination – There is a 14-day transitional period for a change in health plan for Medicaid members determined with SMI.

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

SMI clinics and ACT teams are required to manage their panels through the Member Paneling tool available in Provider Intake on the Mercy Care Secure Web Portal. Panel changes submitted through the Member Paneling tool are processed nightly and loaded directly into the Mercy RBHA provider information systems. Specific instructions on utilization of the **Provider Intake Member Paneling Tool** are available under the [Reference Material and Guides](#) section of our website.

IHH Health Homes, SMI clinics 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 legal guardian's signature on a general consent form, before receiving behavioral health services.

For members under the age of 18, the parent, legal guardian, or a lawfully authorized custodial agency must give general consent to treatment, demonstrated by the parent, legal guardian, or a lawfully authorized custodial agency representative's signature on a general consent form prior to the delivery of behavioral health services.

Any member aged 18 years and older or the member's legal guardian, or in the case of members under the age of 18, the parent, legal guardian or a lawfully authorized custodial agency, after being fully informed of the consequences, benefits and risks of treatment, has the right not to consent to receive behavioral health services.

Any member aged 18 years and older or the member's legal guardian, or in the case of members under the age of 18, the parent, legal guardian or a lawfully authorized custodial agency has the right to refuse medications unless specifically required by a court order or in an emergency.

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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 (available under our [Forms](#) web page)
- 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](#))
- Consent for Electroconvulsive Therapy (ECT) (available under our [Forms](#) web page)

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's, or if under the age of 18, the member's parent, legal guardian or lawfully authorized custodial agency representative's written agreement to participate in and to receive non-specified (general) behavioral health services. See **Consent to Treatment Form**.

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, guardian or custodian shall give informed consent for treatment by signing and dating an acknowledgment that he or she has received the information and gives informed consent to the proposed treatment.

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- When informed consent is given by a third party, the identity of the third party and the legal capability to provide consent on behalf of the member, must be established. If the informed consent is for psychotropic medication or telemedicine and the member, or if applicable, the member's guardian refuses to sign an acknowledgment and gives verbal informed consent, the medical practitioner shall document in the member's record that the information was given, the 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, legal guardian 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 legal guardian, it must be documented in written fashion. Informed consent is required in the following circumstances:

- Prior to the initiation of any psychotropic medication or initiation of Complementary and Alternative Treatment (CAM). The use of [AMPM 310-V – Prescription Medications – Pharmacy Services, Attachment A – Informed Consent for Psychotropic Medication Treatment](#) is recommended as a tool to review and document informed consent for psychotropic medications, and
- Prior to the delivery of behavioral health services through telemedicine.

Electro-Convulsive Therapy (ECT), Research Activities, Voluntary Evaluation and Procedures/ Services with Known Substantial Risks or Side Effects

Written informed consent must be obtained from the member, parent or legal guardian, unless treatments and procedures are under court order, in the following circumstances:

- Before the provision of ECT;
- Prior to the involvement of the member in research activities;
- Prior to the provision of a voluntary evaluation for a member. The use of the Application for Voluntary Evaluation (English/Spanish), available on our [Forms](#) web page, is required for members determined to have a Serious Mental Illness and is recommended as a tool

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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.

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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, legal guardian or an appropriate court prior to the member's admission to any medical detoxification, inpatient facility or residential program operated by a behavioral health provider.

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 to or save the life of a minor child.

Non-emergency Situations

In cases where the parent is unavailable to provide general or informed consent and the child is being supervised by a caregiver who is not the child's legal guardian (e.g., grandparent) and does not have power of attorney, general and informed consent must be obtained from one of the following:

- Lawfully authorized legal guardian;
- Foster 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.

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If someone other than the child's parent intends to provide general and, when applicable, informed consent to treatment, the following documentation must be obtained and filed in the child's comprehensive clinical record:

Individual/Entity	Documentation
Legal guardian	Copy of court order assigning custody
Relatives	Copy of power of attorney document
Another 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

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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 Home Care Training to Home Care Client (HCTC).

Any minor who has entered into 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 legal guardian 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 Mercy 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 legal guardian; and

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- Provide notice that a copy of the actual survey, analysis or evaluation questions to be asked of the student is available for inspection upon request by the parent or legal guardian.

Completion of 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 Direct Care SMI Clinics service structure to ensure that all members designated as SMI or Title XIX have a behavioral 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 Direct Care SMI Clinic.

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 Mercy 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 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

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- 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 RBHA Chapter 2, Section 2.03 – Outreach, Engagement, Reengagement and Closure).
- 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 RBHA and inter-RBHA transfer/move was completed with coordinated efforts from the treatment team.

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- 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 Mercy 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 when another member may be, because of a mental disorder:

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

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

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

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

Based on the court-ordered evaluation, the evaluating agency may petition for court-ordered treatment on behalf of the member. A hearing, with the member and his/her legal representative and the physician(s) treating the member, will be conducted to determine whether the member will be released and/or whether the agency will petition the court for

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court-ordered treatment. For the court to order ongoing treatment, the person must be determined, because of the evaluation, to be DTS, DTO, PAD, or GD. Court-Ordered Treatment (COT) may include a combination of inpatient and outpatient treatment. Inpatient treatment days are limited contingent on the member's designation as DTS, DTO, PAD, or GD. Members identified as:

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

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

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

County agencies and Mercy 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 as a result of civil action, an individual may be ordered by a court for evaluation and/or treatment upon:

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

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Licensing Requirements

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

Pre-Petition Screening

PINAL COUNTY

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

GILA COUNTY

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

MARICOPA COUNTY

There is an intergovernmental agreement between Maricopa County and AHCCCS for the management, provision of, and payment for Pre-Petition Screening and Court Ordered Evaluation. AHCCCS in turn contracts with Mercy RBHA for these pre-petition screening and court ordered evaluation functions. Mercy 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 screening agency must follow these procedures:

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

Filing of Non-Emergent Petitions

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

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Non-emergent Process

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

- For all other residents of Maricopa County (not enrolled with a Mercy 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 Mercy RBHA Clinic, an applicant contacts the Mercy RBHA Customer Service Line at 800-564-5465 or the Crisis Response Network Crisis Line 800-631-1314 and requests a PAD or GD petition application be completed on an identified member in the community. An applicant can also go in person to UPC, RRC, or CPEC 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 Mercy RBHA Clinic enrolled behavioral health members.
- For Mercy 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 Mercy 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

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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 MIHS Desert Vista Campus Legal Office, 570 West Brown Road, Mesa, AZ 85201, and 480-344-2000. This involves all Persistently or Acutely Disabled (PAD) and Gravely Disabled (GD) petitions. Danger to Self (DTS) and Danger to Others (DTO) petitions that do not require immediate intervention can also be filed on a non-emergent basis. Please use the following forms for filing the non-emergent petition: Petition for Court Ordered Evaluation and Application for Involuntary Evaluation.
- Eight copies and the original Petition for Court-Ordered Evaluation, Application for Involuntary Evaluation, Pre-Petition Screening Report and the Police Mental Health Detention Information Sheet, must be submitted by the behavioral health member's Care Manager or the pre-petition team to the Legal Department at Maricopa Integrated Health System (MIHS) Desert Vista Campus for review by the County Attorney, preparation of the Detention Order, and filing with the Superior Court. These documents must be filed within 24 hours of completion, excluding weekends and holidays.
- Once the petition is filed with the court, the Legal Department at MIHS Desert Vista Campus Delivers the Detention Order to the Police Department to have the behavioral health member brought to the UPC, RRC or CPEC for evaluation. NOTE: The Petition for Court Ordered Evaluation and Police Mental Health Detention Information Sheet) expire 14 days from the date the judge signs off on the order for COE.

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

Emergent process

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

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

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Emergency Admission for Evaluation being accepted by the UPC, RRC or CPEC admitting officer, then the Mercy RBHA Medical Director must be notified.

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

Court-Ordered Evaluation

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

Mercy 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,

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

Mercy RBHA encourages the utilization of outpatient evaluation on a voluntary or involuntary basis. Mercy 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 to the Legal Department at Maricopa Integrated Health System(MIHS) Desert Vista Campus for review by the County Attorney, preparation of the service order, and filing with the Superior Court.
- Once the petition is filed with the court, the Legal Department at MIHS Desert Vista delivers the service order to the police department to have the member served legal notice of the date/time/location of the outpatient evaluation. One of the eight copies of the petition documents shall be stored by the member's 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 MIHS 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 SMI Clinic, the Mercy 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 MIHS 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.

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- If the two evaluating psychiatrists completing the Outpatient Court Ordered Evaluation determine the member needs COT, then the two physician's Affidavit and social work report will be delivered to the MIHS Legal Department within 1 business day of the evaluation. The Mercy 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 Mercy 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 MIHS Legal Department. An outpatient evaluation will then be scheduled at Desert Vista Hospital and the Case Manager or PAD Team will be responsible for notifying the member of the date and time of the evaluation, provide transportation to and from the evaluation, and provide any documentation requested by the physician's conducting the evaluation.
- The voluntary outpatient or inpatient assessment must include evaluation by two psychiatrists and the involvement of either two social workers, or one social worker and one psychologist, who shall complete the outpatient treatment plan. The voluntary psychiatric evaluation shall include determination regarding the existence of a mental disorder, and whether, because of a mental disorder, the individual meets one or more of the standards. The psychiatric evaluation must also include treatment recommendations. The psychiatrists completing the outpatient psychiatric evaluations will submit a written affidavit to the MIHS Legal Department regarding their findings.
- If the psychiatrists do not believe that the member needs COT, then the MIHS Legal Department will forward the physicians' affidavits to the Care Manager or PAD Team with an explanation that the member has been determined not to need COT.

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- If the psychiatrists completing the voluntary inpatient evaluation or voluntary outpatient evaluation determine the member needs COT, then the two physician's Affidavit and a social work report will be delivered to the MIHS Legal Department within 1 business day of the evaluation. The Mercy 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 Mercy RBHA for court-ordered evaluations Mercy RBHA contracts with Maricopa Integrated Health Systems 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 member nominated as guardian or conservator; and
- A copy of all petitions must be mailed to the superintendent of the Arizona State Hospital.

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

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

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

Members placed on COT after finding of Not Competent/Not Restorable in a Criminal Matter (Rule 11 COT)

Members placed on COT after having been found not competent and not restorable (Rule 11) require special treatment and tracking by the Outpatient Agency. ARS §36-544 requires the Outpatient Agency to file a notice with the court and prosecuting attorney within five (5) days of a members unauthorized absence from treatment and request the court toll (suspend) the treatment order for the period the patient is absent. “Unauthorized absence” means:

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

Additionally, the statute 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.

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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

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.

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

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

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

When a member referred for court-ordered treatment is Title XIX/XXI eligible and/or determined or suspected to have a Serious Mental Illness, Mercy 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 guardian;
- The medical director of the receiving behavioral health provider accepts the transfer; and
- The consent of the court for the transfer is obtained as necessary.
- In order to coordinate a transfer of a member under court-ordered treatment to ALTCS or another RBHA, the behavioral health member's clinical team will coordinate with the Mercy RBHA Court Advocacy Department at MercyCareNetworkManagement@mercycaresaz.org.
- To coordinate a transfer of a member under COT from one SMI Clinic to another, the behavioral health member's current psychiatrist will discuss the transfer with the

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receiving psychiatrists. If both SMI Clinics agree that the transfer is appropriate, the receiving psychiatrist will then provide a Letter of Intent to Treat to the SMI Clinic Court Coordinator of the sending SMI Clinic. The SMI Clinic Court Coordinator will then prepare a motion to transfer treatment provider, review with SMI Clinic attorney, and file with the court. The member's care will not be transitioned to the receiving SMI Clinic until the new treatment provider is reflected on the COT.

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

Mercy 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**, Mercy 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 Mercy 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

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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, Mercy 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.

Mercy 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, Mercy 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 Mercy RBHA. This clinical communication and coordination with the Mercy 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

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patient. The Court shall order the least restrictive treatment alternative available.” Mercy 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 Indians have regarding their health care, including behavioral health services, payment of behavioral health services for AHCCCS eligible American Indians may be covered through a T/RBHA, RBHA or IHS/638 provider (see [Behavioral Health Services Payment Responsibilities](#) on the [AHCCCS Tribal Court Procedures for Involuntary Commitment](#) web page for a diagram of these different payment structures).

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 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.

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- Before moving into Permanent Supportive Housing, tenants are asked about their housing preferences and are offered the same range of choices as are available to others at their income level in the same housing market.
- Housing is affordable, with tenants paying no more than 30 percent of their income toward rent and utilities, with the balance available for discretionary spending.
- Housing is integrated. Tenants can interact with neighbors who do not have psychiatric disabilities.
- Tenants have choices in the supportive services that they receive. They are asked about their choices and can choose from a range of services, and different tenants receive different types of services based on their needs and preferences.
- As needs change over time, tenants can receive more intensive or less intensive supportive services without losing their homes.
- Supportive services promote recovery and are designed to help tenants choose, get, and keep housing.
- The provision of housing and the provision of supportive services are distinct.

For SMI members living outside of the Central GSA, housing subsidies can be accessed through the AHCCCS Housing Program (AHP) administrator.

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.^{3F³}
- 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 [Mercy RBHA Chapter 17 – Grievances, Appeals and Claim Disputes, Section 17.03 – Notice and Appeal Requirements \(SMI and Non-SMI/Non-Title XIX/XXI\)](#).
- Housing related grievances and requests for investigation for members determined to have SMI must be addressed in accordance with [MC Chapter 17 – Grievances, Appeals](#)

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and Claim Disputes, Section 17.02 – Conduct of Investigations Concerning Members with Serious Mental Illness.***Other MC Housing Requirements***

MC submits Housing Deliverables and periodic reports on housing programs to AHCCCS, as outlined in the AHCCCS/MC contract.

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.

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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 Abuse Block Grant (SABG)

Mercy Care receives funding for behavioral health services through the Federal Substance Abuse Block Grant (SABG). SABG 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 SABG Block Grant funding. [Current contracted SABG providers can be found here](#) or by calling Mercy Care 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 Abuse Block Grant (SABG) Priority Populations

The following populations are prioritized and covered under the Substance Abuse Block Grant (SABG) 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).

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Eligibility

All members receiving SABG-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.

SABG 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 SABG 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 SABG. 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 SABG 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-Mercy Care AHCCCS Complete Care (ACC) Plan
 - Providers must apply for segmentation every 30 days

Response Times

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

- **WHEN:** Intakes must be provided within 48 hours from the referral/initial request for services.

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- **WHAT:** Any needed covered behavioral health service, including admission to a residential program if clinically indicated. If a residential program is temporarily unavailable, an attempt shall be made to place the member within another provider agency facility, including those in other geographic service areas. If capacity still does not exist, the member shall be placed on an actively managed wait list and interim services must be provided until the individual is admitted. Interim services 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 their children.
- **WHEN:** Behavioral health services provided within a timeframe indicated by clinical need but no later than 14 days following the initial request for services/referral. All subsequent behavioral health services must be provided within timeframes according to the needs of the member.
- **WHAT:** Includes any needed covered behavioral health services. Admit to a clinically appropriate substance use treatment program (can be residential or outpatient based on the member’s clinical needs); if unavailable, interim services must be offered to the member. Interim services are described in the section “Interim Services for Pregnant Women/Injection Drug Users.”
- **WHO:** Other Priority Populations

Choice of Substance Use Providers

Members receiving substance use treatment services under the SABG 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 SABG must notify members of this right using the [AHCCCS Medical Policy Manual, Policy 320-T1 Block Grants and Discretionary Grants, Attachment A](#). Members must document that the member has received notice in the member’s comprehensive clinical record. If a member objects to the religious character of a behavioral health provider, the provider must refer the member to an alternative provider within 7 days, or earlier when clinically indicated, after the date of the objection. Upon making such a referral, providers must notify Mercy Care of the referral and ensure that the member makes contact with the alternative provider. Upon making a referral, the provider will notify Mercy Care’s General Mental Health/Substance Use Administrator by calling **800-564-5465**.

Available Services

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

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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

Mercy Care 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 Mercy 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.

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

The purpose of interim services is to reduce the adverse health effects of substance use, promote the health of the individual and reduce the risk of transmission of disease. For residential providers the provision of interim services must be documented in the client's chart as well as reported to Mercy Care through the online waitlist. Title XIX/XXI eligible members who also meet a priority population type may not be placed on a wait list. The minimum required interim services include education and/or referrals that cover:

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

SABG Reporting Requirements

Providers must promptly submit information for Priority Population Members (Pregnant Women, Women with Dependent Children and Intravenous Drug Users) who are waiting for

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placement in a Residential Treatment Center, to the AHCCCS SABG Online Waitlist System, or, pending technological barriers in a different format upon written approval by Mercy Care and AHCCCS.

- Title XIX/XXI members may not be added to the wait list.
- Priority Population Members must be added to the wait list if Mercy Care or its providers are not able to place the member in a Residential Treatment Center within the timeframes prescribed in [AHCCCS Medical Policy Manual 320-T1, Exhibit I](#).
 - For pregnant females the requirement is within 48 hours,
 - Women with dependent children the requirement is within 5 calendar days
 - All other substance users the requirement is within 14 calendar days.
- Non-Title XIX/XXI members may be added to the waitlist if there are no available services.

Restrictions use of Substance Abuse Block Grant (SABG)

SABG 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 in excess of 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.

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Additional information & Resources

- [Mercy Care Crisis/State-only Membership Services Online](#)
- [Mercy Care Member Eligibility Presentation](#)
- [AHCCCS Frequently Asked Questions for SABG & MHBG](#)
- [AMPM 320-T1](#)
- [AMPM Exhibit 300-2B](#)
- [AMPM 650](#)

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

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

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

- Increase outreach and identification of under and uninsured individuals with OUD
- Increase navigation to OUD treatment
- Increase utilization of OUD treatment services

Eligibility

The SUDS funding is passed on to sub-recipient providers to provide services **for underinsured and uninsured** Arizonans *with* opioid use disorder. *AHCCCS requires that SUDS-funded providers use the allocation as a payor of last resort and SABG funds have been exhausted.*

Not all network contracted providers receive GO-SUDS Funding. Current contracted GO-SUDS providers can be found by calling Mercy Care 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.

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

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 an SMI designation, Title XIX/XXI, and Non-Title XIX/XXI children with an SED designation, and Title XIX/XXI and Non-Title XIX/XXI individuals in need of FEP services.

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Not all network contracted providers receive MHBG Funding. Current contracted MHBG providers can be found by calling Mercy Care 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 with SMI, SED or 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
- Members shall indicate active mental health symptoms within the previous 12-months to be eligible for MHBG services.

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;

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- 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 in excess of 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)

Mercy 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 guardian, Mercy RBHA or behavioral health provider must still submit a notification to the OHR. Mercy 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).

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A member who is subject to a general guardianship has been found to be incapacitated under **A.R.S. §14-5304** and therefore automatically satisfies the criteria for Special Assistance. Similarly, if Mercy RBHA or its subcontracted provider recommends a member with a SMI for a general guardianship or a guardianship 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 Mercy RBHA and its subcontracted provider to review the individual's need more closely for Special Assistance:

- Residence in a 24-hour setting;
- Limited guardianship; or
- Mercy RBHA or its subcontracted provider is recommending and/or pursuing the establishment of a limited guardianship; 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 Mercy RBHA or subcontracted provider;
- The member's clinical team;
- Mercy 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

Mercy 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.

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Documentation

Mercy 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 Office of Human Rights (OHR) by completing **Notification of Members in Need of Special Assistance**, available in our [Forms](#) web page, in accordance with the procedures outlined below.

Before submitting the **Notification of Members in Need of Special Assistance**, available in our [Forms Library](#) web page, Mercy RBHA's subcontracted providers shall check if the member is already identified as in need of Special Assistance. A notation of Special Assistance designation and a completed **Notification of Members in Need of Special Assistance**, available in our [Forms](#) web page, should already exist in the clinical record. However, if it is unclear, subcontracted providers must review Mercy RBHA data or contact Mercy RBHA to inquire about status. Mercy 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, Mercy RBHA's subcontracted providers must notify the Office of Human Rights (OHR) using **Notification of Members in Need of Special Assistance (Part A)**, available in our [Forms](#) web page, 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 form must be submitted immediately, with a notation indicating the urgency. Mercy 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 a guardianship 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 submission of the **Notification of Member in Need of Special Assistance**, available in our [Forms](#) web page, the form should be submitted within the required timeframes, followed by submittal of the guardianship documentation.

The Office of Human Rights (OHR) administration (Office Chief or Lead Advocate) reviews the notification form 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 form to obtain clarification. The OHR responds to the Mercy RBHA subcontracted provider by completing **Notification of Members in Need of Special Assistance, Part B**, available in our [Forms](#) web page, within five working days of receipt of notification and any necessary clarifying information from Mercy 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.

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The notification process is complete only when OHR returns the form, with Part B completed, to the Mercy RBHA subcontracted providers. The Mercy 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 of Members in Need of Special Assistance**, available in our [Forms](#) web page. 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, Mercy 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 MERCY 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 original **Notification of Members in Need of Special Assistance**, available in our [Forms](#) web page, (with Parts A & B completed when first identified), 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 Mercy 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 time period to appeal must have expired);
- The member dies;
- The member’s episode of care is ended with Mercy RBHA (Non-Title XIX member with a SMI will also be dis-enrolled) and the member is not transferred to another T/RBHA.
- Submission of a Part C is not needed when a member transfers to another T/RBHA, as the Special Assistance designation follows the member.

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The Mercy RBHA subcontracted providers must first perform all required re-engagement efforts, which includes contacting the member providing Special Assistance, per **RBHA Chapter 2 – Network Provider Service Delivery Requirements, Section 2.03 – Outreach, Engagement, Reengagement and Closure**, proper notice and appeal rights must be provided and the time to appeal must have expired.

Upon receipt of the **Notification of Members in Need of Special Assistance, Part C**, available in our [Forms](#) web page, the OHR administration reviews the content to confirm accuracy and completeness and send it back to the agency that submitted it, copying Mercy RBHA or its subcontracted provider.

Requirements of Mercy RBHA and Providers

The Mercy RBHA subcontracted providers must maintain open communication with the member/agency (guardian, 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/guardian 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 Mercy 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.

Mercy RBHA's subcontracted providers shall provide relevant details and a copy of the original **Notification of Members in Need of Special Assistance**, available in our [Forms](#) web page, (both Parts A and B) 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 T/RBHA, care management provider site or care manager.

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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 Mercy 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

Mercy 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 Mercy 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, Mercy RBHA OGA must review whether the member is already identified as in need of Special Assistance.

If so, the Mercy 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. Mercy 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. Mercy RBHA OGA shall also forward a copy of any subsequent notice of hearing.

Documentation and Reporting Requirements

Mercy RBHA's subcontracted providers must maintain a copy of the completed **Notification of Member in Need of Special Assistance**, available in our **Forms Library** web page, (Parts A, B and updated B, if any) 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, Mercy RBHA and subcontracted providers must maintain a copy of the Notification of Member in Need of Special Assistance in the comprehensive clinical record.

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

Mercy 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). Mercy RBHA must also establish a process with such providers to obtain quarterly updates on individuals currently identified as Special Assistance to support the Mercy 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. Mercy 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.
- Mercy 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).
- MERCY 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

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contact the Mercy RBHA AzSH Liaison to discuss the recommendation for admission to AzSH. Mercy RBHA will initiate the Mercy RBHA AzSH Review Process. Mercy RBHA must agree with the other referral source that a referral for admission to AzSH is necessary and appropriate. If the candidate is not T/RBHA enrolled, Mercy 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 **MCCC Chapter 3 – Behavioral Health, Section 3.06 – Behavioral Health Appointment Standards** to AzSH.

The enrollment date is effective the first date of contact by Mercy RBHA. Mercy RBHA will also complete a Title XIX application once T/RBHA enrollment is completed. For all non-T/RBHA enrolled Tribal behavioral health members, upon admission to AzSH, the hospital will enroll the member, if eligible in the AHCCCS Indian Health Program.

- For TRBHA (Tribal RBHA only) enrolled behavioral health members, Mercy RBHA must also agree with the referring agency that admission to AzSH is necessary and appropriate, and Mercy RBHA must prior authorize the member's admission (see **RBHA Chapter 12 – Service Authorizations, Section 12.00 - Securing Services and Prior Authorization**).
- Mercy 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 **RBHA Chapter 2 – Network Provider Service Delivery Requirements, Section 2.12 - Special Assistance for Members Determined to have a Serious Mental Illness (SMI)** 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 in our [Forms](#) web page, should be included in the application for admission. Mercy 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.
- Mercy 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 Mercy 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.

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- 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 Mercy RBHA list for AzSH. If the behavioral health member's admission is pending, the referral agency must provide AzSH 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.

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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 Mercy 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.

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- Treatment goals and recommended assessment/treatment interventions must be carefully developed and coordinated with the outpatient providers (including Mercy RBHA, ALTCS Health Plan, other provider(s), the behavioral health member's legal guardian, 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 Mercy RBHA to be addressed. Mercy RBHA AzSH Liaison will monitor the participation of the outpatient team and assist when necessary. AZSH liaison will refer all SMI TXIX members to Mercy 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.

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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 Mercy RBHA continued stay reviews.

All Mercy 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. Mercy 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, Mercy 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 **RBHA Chapter 12 – Service Authorizations, Section 1SMIO – Securing Services and Prior Authorization.**

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 Mercy 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 Mercy RBHA.
- Monthly comprehensive status reports need to be completed and submitted to Mercy RBHA, the PSRB and AHCCCS.

Through the active coordination by the Adult Clinical Team and with Mercy 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.

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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 Mercy 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, Mercy RBHA must immediately take steps necessary to transition the behavioral health member into community-based treatment as soon as possible. Mercy RBHA has up to thirty (30) days to transition the behavioral health member out of AzSH. Mercy 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 Mercy 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 Mercy 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 Mercy 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.

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- 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 Mercy RBHA.
- Monthly comprehensive status reports need to be completed and submitted to Mercy RBHA, the PSRB and AHCCCS.

Through the active coordination by the Adult Clinical Team and with Mercy 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 Mercy 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 Mercy 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 age 18 up to the age of twenty-one (21) years whose condition is identified as an eligible CRS diagnosis. The **Collaborative Protocol for Coordination of Care with United HealthCare's Children's Rehabilitative Services (CRS) Programs**, available in our [Forms](#) web page, is available on our website for further review.

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.

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Mercy 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 Mercy 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 Mercy RBHA level of care criterion to each case.

The AzSH Utilization Manager will request to appeal Mercy 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

Mercy 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 Mercy RBHA.

AzSH agrees to cooperate with Mercy 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.

Mercy 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 Mercy RBHA within five (5) months after the date of service.

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Payment by Mercy 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 Mercy RBHA within thirty/ninety (30/90) days of the Mercy RBHA receiving the initial claim submission.

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

Availability of Funds

Payments made by Mercy 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 Mercy RBHA from AHCCCS authorized for expenditure in the manner and for the purposes provided in this chapter.

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

Indemnification

Mercy 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 Mercy RBHA, Mercy RBHA employees, agents, directors, trustees, and/or representatives.

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

Mercy RBHA External Medical Record Review

Mercy 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).

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RBHA Chapter 3 – Additional Mercy Care RBHA Provider Responsibilities**3.00 – Provider Selection**

Within the Mercy 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;
- Adults with a general mental health and/or substance abuse condition (GMH/SA);
- 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 Mercy 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 Mercy 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

Mercy 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.

Mercy 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. Mercy 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, similar to downloading applications on a smartphone.

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Providers are granted access to the HIE by being a member of the Mercy 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 in compliance with HIPAA rules and regulations and any agreement set forth by Mercy RBHA.

Mercy RBHA complies with all requirements of federal and state confidentiality statutes, 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.

Mercy 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 on our [Forms](#) web page 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

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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 Health Home staff must ensure that the member is able to schedule an appointment while the member is at the clinic after completing the previous BHMP, RN, or PCP appointment.

Contact Guidelines for Children in the Custody of DCS

- The Children's Assigned Behavioral Health Clinic (ABHC) 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 **one (1) year** from the date of behavioral health enrollment unless services are declined by the guardian 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 ABHC 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 is a caseload ratio of between 1:8 and 1:25, with 1:15 being the desired target.

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

Established Clinical Targets and Maximum Ceilings for ACT, Supportive and Connective	
Assertive Community Treatment (ACT) Specialists	12 members
Supportive Case Managers	30 members with a maximum of 40
Connective Case Managers	70 members with a maximum of 100

Maximum Ceilings	
Supportive	Connective
40	0
38	5
36	10
34	15

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Maximum Ceilings	
Supportive	Connective
32	20
30	25
28	30
26	35
24	40
22	45
20	50
18	55
16	60
14	65
12	70
10	75
8	80
6	85
4	90
2	95
0	100

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

3.05 – Intra-RBHA Clinic Transfers

Transfer Guidelines

- The direct care clinic (DCC) and/or agency shall implement a transfer for members needing specialized services which are unable to be provided by the current clinic, team and/or agency, or when the member or guardian 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 guardian must agree with the transfer.
- In cases where the member or guardian 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 guardian to discuss and attempt to resolve.
- Agencies will respect the member's or guardian's choice and voiced request to transfer services to another agency.
- If transferring from an integrated clinic, discussion and documentation should occur for choice of PCP with the member. The integrated clinic shall assist member in choosing

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the PCP from Mercy RBHA website. The integrated clinic will outreach to the new identified PCP to include discussion about member care, transfer of medical records, and ensuring the PCP is aware of BH clinic information. An appointment with the outside PCP will be made in partnership with the member. The integrated clinic will ensure the member has a supply of medical medications that will last until the PCP appointment.

- If transferring to an integrated clinic, the member must agree to the PCP located at the integrated clinic. The member must sign the consent form agreeing with receiving services from the PCP as well as the BHMP at the integrated clinic. The BH clinical team will ensure the member has a supply of medical medications until the transfer appointment at the integrated clinic.
- 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 clinic/care management team. The referring agency clinic 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 clinic 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**.

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- Transfers between ACT teams are expected to be completed in less than twenty-one (21) days from the time the receiving clinic receives the transfer request. If the transfer is not complete in the 21-day timeline, smimemberservicesrequest@MercyCareAZ.org should be contacted.
- If the referring agency concludes that the requested transfer should not take place as a result 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 Mercy 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 Mercy 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 clinic. If there is any question regarding "clinical instability" from the receiving clinic, the SMI member services mailbox should be utilized.
 - It is expected that these members be managed within their current network and that alternate clinics 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 clinic selection from the agency clinic 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 clinic's temporary lack of capacity, once the clinic 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 clinic based on the member's preference.
- A transfer is complete once the member has attended an initial appointment at the receiving clinic and the medical record has been delivered to the receiving clinic.
 - The referring clinic 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 a guardian or receives special assistance, the referring team is responsible for ensuring the guardian 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 clinic'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 clinic. The

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referring clinic is responsible for ensuring the member has transportation to the initial appointment at the new clinic. The referring clinic 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, Mercy RBHA's Court Liaison Administrator, needs to be notified via email once the transfer is complete. The referring clinic will send all emails to currans2@MercyCareAZ.org.
- For any concerns regarding the transfer guidelines, you can contact Mercy RBHA for appropriate interventions or questions at smimemberservicesrequest@MercyCareAZ.org.

Transfer Process

- The clinical director/site administrator of the referring clinic will ensure that documentation is prepared and delivered to the receiving clinic within 7 days after the Release of Information is signed. All transfer activities will be documented in the medical record.
- The member or guardian and OHR (if applicable) will be notified of the transfer referral by the referring clinic with the intention that the receiving clinic assign the member to a clinical team within the required timeframes. This will be documented in the medical record.
- The referring clinic shall prepare a transfer packet to include the following medical record information:
 - Transfer of care cover sheet
 - Part E
 - Part D
 - AUD
 - ARCP
 - Medical sheet
 - Last three doctor notes
 - Last three progress notes
 - Face sheet
 - COT/Special Assistance or guardianship paperwork
 - A progress note indicating a conversation with the member or member's guardian 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)

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

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

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

3.06 – Provider Financial Reporting

The **Mercy RBHA Provider Financial Reporting Guide** and **Mercy RBHA Provider Financial Reporting Guide Attachments** are available on our [Forms](#) web page under the **Mercy Care RBHA Provider Manual Attachments** tab. The documents were developed to ensure that all Mercy RBHA subcontracted providers and vendors develop and understand the financial requirements and responsibilities inherent in their contract with Mercy RBHA. The primary objectives of this reporting guide are to establish consistency and uniformity in financial reporting and to provide guidelines to assist providers in meeting contractual reporting requirements.

The Guide includes:

- General Accounting Requirements
- Requirements for Reporting
- Unaudited Annual and Quarterly Reports
- Audited Financial Reporting
- Provider Delivery Schedule
- Fee Schedule and Funding Requests

3.07 – Provider Deliverables

There are provider deliverables required under AHCCCS and Mercy RBHA. Mercy RBHA produced the **Provider Deliverables**, available under our [Forms](#) web page, which has a list of deliverables that includes a description of the deliverables, how they should be submitted, who they should be submitted to and how often they should be submitted. If you have any questions regarding the deliverables, contact your Network Relations Specialist/Consultant at 602-586-1880 or 866-602-1979.

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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

Mercy 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 Mercy 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 Mercy RBHA

Provider Use of SFTP

Mercy 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 Mercy 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 Mercy RBHA data systems. A provider can complete the **SFTP Connectivity Enrollment Form** available under our [Forms](#) web page, (in the Forms section of the Provider Manual) 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

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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 Mercy 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 Mercy 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 Mercy RBHA Provider Manual.

Incoming Files

Files will be routed to the appropriate program area's network drive/folder and also 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 also 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

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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 Mercy 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 Mercy 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.

3.08 – Business Continuity and Disaster Preparedness

Mercy RBHA provides health care benefits to its Members. In order 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 contains 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 Mercy 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 our [Forms](#) web page, 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 updating 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 Mercy RBHA are not appropriate.
- The Plan should contain, at a minimum, planning and training for:

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- 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 Mercy RBHA during a business disruption. *(Plan should include Woodrow Terrell, (602) 402-8190 as the specific contact at Mercy 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 Mercy 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.

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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. Mercy 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/>

3.09 – Behavioral Health Satisfaction Survey

The Behavioral Health Satisfaction Survey requests independent feedback from Title XIX/XXI adult members/guardians 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.

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RBHA Chapter 4 – Covered and Non-Covered Services

4.00 – Covered and Non-Covered Services

Behavioral Health Covered Services

Mercy 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

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Psycho Educational Services and Ongoing Support to Maintain Employment	Psycho Educational Services	Available	Available
	Ongoing Support to Maintain Employment	Available	Available
MEDICAL SERVICES			
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
Home Care Training to Home Care Client (HCTC)		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

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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 Mercy 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).

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Available Physical Health Care Services

SERVICES	TITLE XIX		TITLE XXI
	<	≥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
Preventative & Therapeutic Dental Services	X		X
Limited Medical and Surgical Services by a Dentist (for Members Age 21 and older)		X	
Dialysis	X	X	X
Emergency Services – Medical	X	X	X
Emergency Eye Exam	X	X	X
Vision Exam/Prescriptive Lenses	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 age 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

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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)	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

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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, Chapter 300, Policy 310, 310-DD, *Covered Transplants and Related Immunosuppressant Medications*.

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.

Mercy 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 Mercy RBHA, please refer to Mercy RBHA's **Member Handbook**, available under our [Member Handbook](#) web page.

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

Member Handbook

Mercy RBHA is responsible for the **Member Handbook** (available on our [Member Handbook](#) web page). Providers can request member handbooks by completing the **Mercy Care RBHA Member Handbook Order Form**, available in our [Forms](#) web page, 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 Mercy RBHA Member Handbook applies to SMI, and CMDP members. Please direct Mercy RBHA members who request a copy of the handbook to our website for the most expeditious service.

GMHSU members will no longer receive the Mercy RBHA handbook, as the benefits for those members may be different. It is also important to note these members may be enrolled in one of seven health plans, so it is imperative providers ensure the corresponding handbook is offered to each member.

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

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

- Mercy RBHA Member Services at 602-586-1841/800-564-5465 (Integrated SMI and CMDP).

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

- Provide the Member Handbook to each member/guardian/designated representative or household within 12 Business Days of receipt of notification of the enrollment date to members receiving physical health care services.
- Provide the Member Handbook to each member/guardian/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 Mercy RBHA website ([Member Handbook](#)). Upon request, copies must be made available to known consumer and family advocacy organizations and other

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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. Mercy 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 Mercy RBHA's website.
- AHCCCS may require Mercy RBHA to revise the Member Handbook and distribute it to all current enrollees if there is a significant program change. AHCCCS determines if a change qualifies as significant.

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

Non-Covered Services

The following services are considered non-covered services:

- Services from a provider who is NOT contracted with Mercy 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;
- Abortions and abortion counseling, unless medically necessary, pregnancy is the result of rape or incest, or if physical illness related to the pregnancy endangers the health of the mother;
- Health services if you are in prison or in a facility for the treatment of tuberculosis;
- Experimental organ transplants, unless approved by AHCCCS;
- Sex change operations;
- Reversal of voluntary sterilization;
- Medications and supplies without a prescription;
- Treatment to straighten teeth, unless medically necessary and approved by Mercy RBHA;
- Prescriptions not on our list of covered medications, unless approved by Mercy 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;

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- 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).

SMI Support Services

Dependent on available funding, limited eviction prevention services, as listed below, are available to assist members in securing housing and remaining housed. Members may request services through their assigned behavioral health clinic. The member's clinical team will determine whether a member is eligible and whether any requested service is appropriate on a case by case basis. All services are subject to availability of funding.

Hotel Assistance

- Provides enrolled SMI members temporary assistance to address a member's immediate homeless status.
 - This service is available for seven (7) days with a maximum of \$70.00 per night.
 - This service is available only one (1) time, per fiscal year, per member,
 - This service is dependent on the availability of funding and eligibility as determined by the member's clinical team on a case by case basis.

Startup Boxes

- Provides enrolled SMI members moving into their first independent place of residence (apartment) with one start up box containing necessary household essentials.
 - This service is dependent on availability of funding and eligibility as determined by the member's clinical team on a case by case basis.

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Move in Assistance

- Provides enrolled SMI members with assistance with move in costs (including required deposits).
- This service is available to members for a total lifetime benefit of \$1,525.00.
- This service is dependent on availability of funding and eligibility as determined by the member's clinical team on a case by case basis.

Moving Assistance

- Provides enrolled SMI members with assistance with moving their belongings from one location to another (including storage units).
- This service is dependent on availability of funding and eligibility as determined by the member's clinical team on a case by case basis.

GMH/SU and SMI Support Services

Rental & Utility Assistance

- Provides enrolled GMSHA and SMI member's assistance for eviction prevention and utility shut off prevention.
 - Eviction is determined by formal notice to the member (member's name must be on the lease or rental agreement).
 - Utility shut off prevention is determined by formal notice to the member (member's name must be on the utility agreement).
- Provides a maximum lifetime amount of \$1,500.00 per member.
- This service is dependent on availability of funding and eligibility as determined by the member's clinical team on a case by case basis.

Move in Assistance

- Provides enrolled GMSHA and SMI members with move in assistance (not packing) to a new place of residence. This is for assistance related to moving into housing in the community.
 - Provides a maximum lifetime amount of \$1,500.00 per member.
 - This service is dependent on availability of funding and eligibility as determined by the member's clinical team on a case by case basis.

Providers are responsible for specific deliverable requirements related to the use and tracking of these funds.

- The direct care clinic will submit all receipts to SMIMemberServicesRequest@MercyCareAZ.org within five (5) business days.
- It is the responsibility of the direct care clinic to ensure Mercy RBHA receives the receipt within the five (5) business days. If the provider fails to meet these standards or

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demonstrates a pattern of non-compliance, the provider will be subject to Corrective Action, Notice to Cure and/or Sanctions.

RBHA Chapter 5 – Network Requirements**5.00 – Provider Network Development and Management**

To ensure that Mercy 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

Mercy 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.

Mercy 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,

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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

Mercy 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 Chapter 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:
 - Mercy RBHA tracks and trends provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate;
 - Mercy 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);
 - Mercy 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);
 - Mercy RBHA procedures for initiating provider contracts or AHCCCS provider registration;
 - Claim submission methods and resources;

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- Claim dispute and appeal procedures;

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

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

Reporting

Mercy 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

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

Mercy 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. Mercy 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.

Mercy RBHA Responsibilities

During the material transition process, Mercy 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 Mercy RBHA Provider Changes:

Notify Mercy 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.

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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.

A **Notification of Changes to the Network**, available on our [Forms](#) web page, is required. The completed form must be submitted electronically to Mercy RBHA Network Management to your assigned Network Relations Specialist/Consultant using email MaterialChanges@MercyCareAZ.org.

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

The Mercy 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.

Mercy RBHA may require subcontracted providers to submit a **Network Material Change Transaction Grid Template**, available on our [Forms](#) web page, (template to be copied into an excel spreadsheet by provider) used to provide a plan for transitioning members affected by the change, deficiency or condition to their current provider and to assure the restoration of the network to full capacity. If required, Mercy RBHA will provide the Transition Grid and specific monthly reporting requirements. The Transition Grid will be submitted for a period to be determined by Mercy RBHA.

Mercy 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 Mercy RBHA members of any material network change described in this chapter to subcontracted providers.

5.02 – Peer/Recovery Support Training, Certification and Supervision Requirements

Peer/Recovery Support Specialist and Trainer Qualifications

Members with lived experience of recovery from mental health and/or substance abuse disorders serve an important role as behavioral health providers; and Mercy RBHA expects consistency and quality in peer-delivered behavioral health services and support for peer-delivered behavioral health services statewide.

- Individuals training or seeking credentialing and employment as Peer/Recovery Support Specialists must:
 - Self-identify as a “peer”, and
 - Meet the requirements to function as a behavioral health paraprofessional, behavioral health technician, or behavioral health professional.

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- Individuals meeting the above criteria may be credentialed as a Peer/Recovery Support Specialist by completing training and passing a competency test through an AHCCCS/OIFA approved Peer Support Employment Training Program. AHCCCS/OIFA oversees the approval of all credentialing materials including curriculum and testing tools. Credentialing through an AHCCCS/OIFA approved Peer Support Employment Training Program is applicable statewide.
- Agencies may employ individuals prior to the completion of credentialing through a Peer Support Employment Training Program. However, other required trainings must be completed prior to delivering behavioral health services. See Peer/Recovery Support Specialist Employment Training Program Approval Process. An individual must be credentialed as a Peer/Recovery Support Specialist under the supervision of a qualified individual prior to billing Peer Support Services.
- Mercy RBHA's Office of Individual and Family Affairs provides continuing education opportunities relevant to peer/recovery support services through the online learning management system, Relias. In addition to online education OIFA will periodically offer live training sessions.

Peer/Recovery Support Specialist Employment Training Approval Process

A Peer/Recovery Support Employment Training Program must submit its program curriculum, competency exam, and exam-scoring methodology (including an explanation of accommodations or alternative formats of program materials available to individuals who have special needs) to the AHCCCS Office of Individual and Family Affairs (OIFA). AHCCCS/OIFA will issue feedback or approval of the curriculum, competency exam, and exam-scoring methodology in accordance with ***Peer/Recovery Support Employment Training Curriculum Standards***.

Approval of curriculum is binding for no longer than three years after AHCCCS approval. Three years after initial approval and thereafter, the program must resubmit their curriculum for review and re-approval to AHCCCS/OIFA. If a program makes substantial changes (meaning change to content, classroom time, etc.) to their curriculum or if there is an addition to required elements (see ***Peer Support/Recovery Employment Training Curriculum Standards***) during this three-year period, the program must submit the updated curriculum to AHCCCS/OIFA for review and approval.

AHCCCS/OIFA will base approval of the curriculum, competency exam and exam scoring methodology only on the elements included in this chapter. If a Peer/Recovery Support Employment Training Program requires regional or culturally specific training exclusive to a GSA or tribal community, the specific training cannot prevent employment or transfer of Peer/Recovery Support Specialist certification based on the additional elements or standards.

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Competency Exam

Individuals seeking certification and employment as a Peer/Recovery Support Specialist must complete and pass a competency exam with a minimum score of 80% upon completion of required training. Each Peer/Recovery Support Employment Training Program has the authority to develop a unique competency exam. However, all exams must include at least one question related to each of the curriculum core elements listed in *Peer/Recovery Support Employment Training Curriculum Standards*. Individuals certified in another state may obtain certification after passing a competency exam. If an individual does not pass the competency exam, the Peer/Recovery Support Employment Training Program may require that the individual repeat or complete additional training prior to taking the competency exam again.

Peer/Recovery Support Employment Training Curriculum Standards

A Peer/Recovery Support Employment Training Program curriculum must include, at a minimum, the following core elements:

- **Concepts of Hope and Recovery:**
 - Instilling the belief that recovery is real and possible;
 - The history of the recovery movement and the varied ways that behavioral health issues have been viewed and treated over time and in the present;
 - Knowing and sharing one's story of a recovery journey; how one's story can assist others in many ways;
 - Mind- Body-Spirit connection and holistic approach to recovery; and
 - Overview of the Individual Service Plan (ISP) and its purpose.
- **Advocacy and Systems Perspective:**
 - Overview of state and national behavioral health system infrastructure and the history of Arizona's behavioral health system;
 - Stigma and effective stigma reduction strategies: countering self-stigma; role modeling recovery; and valuing the lived experience;
 - Introduction to organizational change - how to utilize member-first language and energize one's agency around recovery, hope, and the value of peer support;
 - Creating a sense of community; the role of culture in recovery;
 - Forms of advocacy and effective strategies – consumer rights and navigating behavioral health system; and
 - Introduction to the Americans with Disabilities Act (ADA).
- **Psychiatric Rehabilitation Skills:**
 - Strengths based approach; identifying one's own strengths and helping others identify theirs; building resilience;
 - Distinguishing between sympathy and empathy; emotional intelligence;
 - Understanding learned helplessness; what it is, how it is taught and how to assist others in overcoming its effects;

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- Introduction to motivational interviewing; communication skills and active listening;
- Healing relationships – building trust and creating mutual responsibility;
- Combating negative self-talk: noticing patterns and replacing negative statements about one's self; using mindfulness to gain self-confidence and relieve stress;
- Group facilitation skills; and
- Introduction to Culturally & Linguistically Appropriate Services (CLAS) Standards; creating a safe and supportive environment.
- **Professional Responsibilities of the Peer Support Employee and Self-Care in the Workplace:**
 - Qualified peers must receive training on the following elements prior to delivering any covered healthcare services:
 - Professional boundaries and ethics - the varied roles of the helping professional;
 - Collaborative supervision and the unique features of the Peer/Recovery Support Specialist;
 - Confidentiality laws and information sharing – understanding the Health Insurance Portability and Accountability Act (HIPAA);
 - Responsibilities of a mandatory reporter; what to report and when;
 - Understanding common signs and experiences of mental illness, substance abuse, addiction and trauma;
 - Orientation to commonly used medications and potential side effects;
 - Guidance on proper service documentation, billing and using recovery language throughout documentation;
 - Self-care skills and coping practices for helping professionals; the importance of ongoing supports for overcoming stress in the workplace; resources to promote personal resilience; and understanding burnout and using self-awareness to prevent compassion fatigue, vicarious trauma and secondary traumatic stress.

Some curriculum elements include concepts included in required training. Peer/Recovery Support employment training programs must not duplicate training required of peers for employment with a licensed agency or Community Service Agency (CSA). Training elements in this chapter must be specific to the Peer/Recovery Support Specialist's role in the public healthcare system and instructional for peer-delivered services.

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Supervision of Certified Peer/Recovery Support Specialists

Agencies employing Peer/Recovery Support Specialists must provide supervision by individuals qualified as Behavioral Health Technicians or Behavioral Health Professionals. Supervision must be appropriate to the services being delivered and the Peer/Recovery Support Specialist's qualifications as a Behavioral Health Technician, Behavioral Health Professional or Behavioral Health Paraprofessional. Supervision must be documented and inclusive of both clinical and administrative supervision.

Individuals providing supervision must receive training and guidance to ensure current knowledge of best practices in providing supervision to Peer/Recovery Support Specialists.

Mercy RBHA, Office of Individual and Family Affairs (OIFA) oversees and can make available to providers policies and procedures regarding resources available to agencies for establishing supervision requirements and any expectations for agencies regarding Mercy RBHA monitoring/oversight activities for this requirement.

Process for Submitting Evidence of Certification

Agencies employing Peer/Recovery Support Specialists who are providing peer support services are responsible for keeping records of required qualifications and certification. Mercy RBHA, Office of Individual and Family Affairs (OIFA) ensure that Peer/Recovery Support Specialists meet qualifications and have certification, as described in this chapter, through quarterly provider deliverable reporting.

5.03 - Parent/Family Support Provider Training, Credentialing and Supervision Requirements

The Arizona Health Care Cost Containment System/Office of Individual and Family Affairs (AHCCCS/OIFA) has established training requirements and credentialing standards for Credentialed Parent/Family Support roles providing Parent/Family Support Services, as described in the Covered Behavioral Health Services Guide. Mercy RBHA recognizes the importance of the Credentialed Parent/Family Support role as a viable component in the delivery of integrated services and expects statewide support for these roles. Mercy RBHA expects consistency and quality in parent/family delivered support of integrated services in both the Children's and Adult Systems statewide.

Credentialed Parent/Family Support Provider and Trainer Qualifications

Individuals credentialed in another state must submit their credential to AHCCCS/ OIFA. The individual must demonstrate their state's credentialing standards meet those of AHCCCS prior to recognition of their credential.

- Individuals seeking employment as a Credentialed Parent/Family Support Provider or Trainer in the children's system must:

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- Be a parent or primary caregiver with lived experience who has raised or is currently raising a child with emotional, behavioral, mental health or substance use needs; and
- Meet the requirements to function as a behavioral health professional, behavioral health technician, or behavioral health paraprofessional.
- Individuals seeking employment as a Credentialed Parent/Family Support Provider or Trainer in the adult system must:
 - Have lived experience as a primary natural support for an adult with emotional, behavioral, mental health or substance abuse needs, and
 - Meet the requirements to function as a Behavioral Health Professional (BHP), Behavioral Health Technician (BHT), or Behavioral Health Paraprofessional (BHPP).

Credentialed Parent/Family Support Provider Training Program Approval Process

A Credentialed Parent/Family Support Provider Training Program must submit its program curriculum, competency exam, and exam-scoring methodology (including an explanation of accommodations or alternative formats of program materials available to individuals who have special needs) to AHCCCS/OIFA. AHCCCS/OIFA will issue feedback or approval of the curriculum, competency exam, and exam-scoring methodology.

Approval of curriculum is binding for no longer than three years. Three years after initial approval and thereafter, the program must resubmit their curriculum for review and re-approval. If a program makes substantial changes (meaning change to content, classroom time, etc.) to its curriculum or if there is an addition to required elements during this three-year period, the program must submit the updated content to AHCCCS/OIFA for review and approval no less than 60 days before the changed or updated curriculum is to be utilized.

AHCCCS/OIFA will base approval of the curriculum, competency exam, and exam-scoring methodology only on the elements included in this policy. If a Credentialed Parent/Family Support Provider Training Program requires regional or culturally specific training exclusive to a GSA or specific population, the specific training cannot prevent employment or transfer of parent/family support credentials based on the additional elements or standards.

Competency Exam

Individuals seeking employment as a Credentialed Parent/Family Support Provider must complete and pass a competency exam with a minimum score of 80% upon completion of required training. Each Credentialed Parent/Family Support Provider Training Program has the authority to develop a unique competency exam. However, all exams must include questions related to each of the curriculum core elements listed. Agencies employing Credentialed Parent/Family Support Providers who are providing parent/family support services are required to ensure that its employees are competently trained to work with its population.

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Individuals certified or credentialed in another state must submit their credential to AHCCCS/OIFA. The individual must demonstrate their state's credentialing standards meet those of AHCCCS prior to recognition of their credential.

Individuals certified or credentialed in another state may obtain credentialing with AHCCCS after passing a competency exam. If an individual does not pass the competency exam, the Credentialed Parent/Family Support Provider Training Program shall require that the individual complete additional training prior to taking the competency exam again.

Credentialed Parent/Family Support Provider Employment Training Curriculum Standards

A Credentialed Parent/Family Support Provider Employment Training Program curriculum must include the following core elements for members working with both children and adults:

- **Communication Techniques:**
 - Member first, strengths-based language; using respectful communication; demonstrating care and commitment;
 - Active listening skills: The ability to demonstrate empathy, provide empathetic responses and differentiate between sympathy and empathy; listening non-judgmentally; and
 - Using self-disclosure effectively; sharing one's story when appropriate.
- **System Knowledge:**
 - Overview and history of the Arizona Behavioral Health (BH) System: Jason K., Arizona Vision and 12 Principles and the Child and Family Team (CFT) process; Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems; Adult Recovery Team (ART); and Arnold v. Sarn; Introduction to the Americans with Disabilities Act (ADA); funding sources for behavioral health systems;
 - Overview and history of the family and peer movements; the role of advocacy in systems transformation;
 - Rights of the caregiver/enrolled member; and
 - Transition Aged Youth: Role changes when bridging the Adult System of Care (ASOC) and Children's System of Care (CSOC) at transition for an enrolled member, family and team.
- **Building Collaborative Partnerships and Relationships:**
 - Engagement; identifies and utilizes strengths;
 - Utilize and model conflict resolution skills, and problem-solving skills;
 - Understanding individual and family culture, biases, stigma, and system's cultures; and
 - The ability to identify, build and connect individuals and families, including families of choice to natural, community and informal supports.

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- **Empowerment:**
 - Empower family members and other supports to identify their needs, and promote self-reliance;
 - Identify and understand stages of change; and
 - Be able to identify unmet needs.
- **Wellness:**
 - Understanding the stages of grief and loss;
 - Understanding self-care and stress management;
 - Understanding compassion fatigue, burnout, and trauma;
 - Resiliency and recovery; and
 - Healthy personal and professional boundaries.

Some curriculum elements may include concepts that are part of the required training, as described in AHCCCS Medical Policy Manual (AMPM) Policy 1060 and the Behavioral Health Practice Tool on Unique Needs of Children, Youth and Families Involved with DCS. Credentialed Parent/Family Support Provider training programs must not duplicate training required of individuals for employment with a licensed agency or Community Service Agency (CSA). Training elements in this section are specific to the Credentialed Parent/Family Support role in the public behavioral health system and instructional for parent/family support interactions.

Mercy RBHA, Office of Individual and Family Affairs (OIFA) can make available policies and procedures as well as additional resources for development of curriculum.

Supervision of Credentialed Parent/Family Support Providers

Agencies employing Credentialed Parent/Family Support Providers must provide supervision by individuals qualified as Behavioral Health Technicians or Behavioral Health Professionals. Supervision must be appropriate to the services being delivered and the qualifications of the Credentialed Parent/ Family Support Provider as a BHT, BHP or BHPP. Supervision must be documented and inclusive of both clinical and administrative supervision.

Individuals providing supervision must receive training and guidance to ensure current knowledge of best practices in providing supervision to Credentialed Parent/Family Support Providers.

Mercy RBHA, Office of Individual and Family Affairs can make available to the providers policies and procedures regarding resources available to agencies for establishing supervision requirements and any expectations for provider's regarding Mercy RBHA monitoring/oversight activities for this requirement.

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Process of Credentialing

Agencies employing Credentialed Parent/Family Support Providers who are providing parent/family support services are responsible for keeping records of required qualifications and credentialing. Mercy RBHA, Office of Individual and Family Affairs (OIFA) ensure that Parent/Family Support Providers meet qualifications and have certification, as described in this chapter, through quarterly provider deliverable reporting.

5.04 – Out of State Treatment for Behavioral Health***General Requirements***

When Mercy 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/guardian (not including those not under guardianship between 18 and under 21 years of age) is in agreement 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 Mercy 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.
- In the event that a member has been placed out-of-state secondary to an emergency situation, unforeseen event, or by a third-party liability insurance, Mercy 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 is in agreement 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 has been developed that addresses the needs and strengths of the member;
- All applicable prior authorization requirements have been met;

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- 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 Assigned Behavioral Health Clinic (ABHC) in coordination with the family/legal guardian will coordinate with the AHCCCS Health Plan to make
- arrangements and document all contacts and arrangements;
- Mercy 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
- In the event that a member has been placed out-of-state secondary to an emergency situation or unforeseen event, Mercy 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/guardian is involved throughout the duration of the treatment. This may include family counseling in member or by teleconference or video-conference;

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- 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

Mercy RBHA is required to obtain approval from the AHCCCS Office of Medical Management prior to an out-of-state treatment and upon discovering that a Mercy RBHA enrollee is in an out-of-state treatment using [AHCCCS Exhibit 450-1, Out-of-State Placement Form](#). Prior authorization must be obtained before making a referral for out-of-state treatment; in accordance with Mercy RBHA criteria. Mercy 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 Mercy RBHA

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

For children/adolescent and adults under the age of 21, the ABHC 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 ABHC Clinical Leadership will coordinate with applicable key stakeholders (i.e., DCS and JPO) and verify they agree an out of state placement. If there is disagreement, which cannot be resolved, the ABHC Clinical Leadership may contact Mercy RBHA for assistance in resolution.
- When the ABHC Clinical Leadership and key stakeholders agree on the treatment, the ABHC Clinical Leadership will complete the [AHCCCS Exhibit 450-1, Out of State Placements Form](#) and submit to the Mercy RBHA Utilization Management Department via secure e-mail to ChildrensDischargePlanning@MercyCareAZ.org within 2 business days for identifying the need for out-of-state treatment.
- The Mercy 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, Mercy RBHA will notify the ABHC Clinical Leadership and direct them to complete the out of state placement process.

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- Mercy 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, Mercy 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 ABHC Clinical Leadership will complete the [AHCCCS Exhibit 450-1, Out of State Placements Form](#) and submit to the Mercy 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 Mercy 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.

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

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

5.05 – Family and Youth Involvement in the Children's Behavioral Health System

Effective Family Participation in Service Planning and Delivery

Through the Child and Family Team (CFT) process, parents/caregivers and youth are treated as full partners in the planning, delivery and evaluation of services and supports.

Parents/caregivers and youth are equal partners in the local, regional, tribal and state representing the family perspective as participants in systems transformation. Mercy RBHA subcontracted providers must:

- Ensure that families have access to information on the CFT process and have the opportunity to fully participate in all aspects of service planning and delivery.
- Approach services and view the enrolled child in the context of the family rather than isolated in the context of treatment.
- Recognize that families are the primary decision-makers in service planning and delivery.
- Provide culturally and linguistically relevant services that appropriately respond to a family's unique needs.
- Assess the family's need for family support partner and make family support available to the CFT when requested.

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- Provide information to families on how they can contact staff at all levels of the service system inclusive of the provider agency, Mercy RBHA, and AHCCCS at intake and throughout the CFT process.
- Work with Mercy RBHA to develop training in family engagement and participation, roles and partnerships for provider staff, parents/caregivers, youth and young adults (see the AHCCCS protocol [Family and Youth Involvement in the Children's Behavioral Health System](#) for more information on these roles).

Responsibilities of Mercy RBHA and Providers

Family members, youth and young adults must be involved in all levels of the behavioral health system, whether it is serving on boards, committees and advisory councils or as employees with meaningful roles within the system. To ensure that family members, youth and young adults are provided with training and information to develop the skills needed, Mercy RBHA and its subcontracted providers must:

- Support parents/caregivers, youth and young adults in roles that have influence and authority;
- Establish recruitment, hiring and retention practices for family, youth and young adults within the agency that reflect the cultures and languages of the communities served;
- Provide training for families, youth and young adults in cultural competency;
- Assign resources to promote family, youth and young adult involvement including committing money, space, time, personnel and supplies;
- Demonstrate a commitment to shared decision making;
- Ensure that service planning and delivery is driven by family members, youth and young adults;
- Support requests for services from family members, youth and young adults that respond to their unique needs, including providing information/educational materials to explore various service options;
- Obtain consent which allows families, youth and young adults to opt out of some services and choose other appropriate services;
- Provide contact information and allow contact with all levels of personnel within the agency for families, youth and young adults; and
- Make a Family Support Partner (FSP) available to the family when requested by the CFT.

Responsibilities of Mercy RBHA

- Support family, youth and young adults in roles that have influence and promote shared responsibility and active participation;
- Assign resources to promote family, youth and young adult involvement including committing money, space, time, personnel and supplies;

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- Involve parents/caregivers, youth and young adults as partners at all levels of planning and decision making, including delivery of services, program management and funding; and
- Develop and make available to providers, policies and procedures specific to these requirements.

Organizational Commitment to Employment to Family Members

Mercy RBHA subcontracted providers must demonstrate commitment to employment of parents/caregivers, and young adults by:

- Providing positions for parents/caregivers and young adults that value the first member experience;
 - Providing compensation that values first-member experience commensurate with professional training;
 - Establishing and maintaining a work environment that values the contribution of parents/caregivers, youth and young adults;
 - Providing supervision and guidance to support and promote professional growth and development of parent/caregivers and young adults in these roles;
 - Providing the flexibility needed to accommodate parents/family members and young adults employed in the system, without compromising expectations to fulfill assigned tasks/roles;
 - Promoting tolerance of the family, youth and young adult roles in the workplace;
 - Committing to protect the integrity of these roles; and
- Developing and making available to providers policies and procedures specific to these requirements.

Adherence Measurements

Adherence to this chapter will be measured through the use of one or more of the following:

- Surveys, including the Annual Network Family Survey and Youth Satisfaction Survey;
- Analysis of the behavioral health system, including the Annual Network Inventory and Analysis of Family Roles and System of Care Practice Reviews; and
- Other sources as required by the AHCCCS contracts or Mercy RBHA IGAs.

5.06 – Use of Telemedicine

Mercy 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.

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

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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 Mercy RBHA.

Mercy 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 legal guardian 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 situation 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:

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- 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. Mercy 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 remain closed at all times;
- 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.

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

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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.

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
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040

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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/Mercy DD/MCLTC: 602-263-3000 or toll-free 800-624-3879
 - Mercy RBHA: 602-586-1841 or toll-free 800-564-5465
- For injectable medications dispensed by the physician and billed through the member's medical insurance, please call 602-263-3000 or toll-free 800-624-3879 to initiate prior authorization for the requested specialty medication.
- For medication quantities which exceed recommended doses.
- For specialty drugs which require certain established clinical guidelines be met before consideration for prior authorization.
- For certain medications on the PDL that are noted as requiring prior authorization or step therapy.

In instances where a prescription is written for drugs not on the PDL, the pharmacy may contact the prescriber to either request a PDL alternative or to advise the prescriber that prior authorization is required for non-PDL drugs. Please see [Chapter 13 – Pharmacy Management, Section 13.13 – Request for Non-PDL Drugs](#) 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.

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- 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 at 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 Stimote Nasal Spray which must be filled at CVS Specialty Pharmacy.
- Insulin; Insulin syringes

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- 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
- Non-indicated uses of FDA approved medications without prior approval by MC
- Lifestyle medications (such as medications for sexual dysfunction)
- 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 are covered for MC members, through Aetna Medicaid Administrators LLC.

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

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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 why 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;

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Annual reassessments must ensure that the provider prescribing psychotropic medication notes in the client's record:

- The reason for the use of the medication and the effectiveness of the medication;
- The appropriateness of the current dosage;
- All medication (including medications prescribed by the PCP and medical specialists, OTC medications, and supplements) being taken and the appropriateness of the combination of the medications; and
- Any side effects such as weight gain and/or abnormal/involuntary movements if treated with an anti-psychotic medication.

Informed Consent

Informed consent must be obtained from the member and/or legal guardian for each psychotropic medication prescribed. When obtaining informed consent, the BHP must communicate in a manner that the member and/or legal guardian can understand and comprehend. It is preferred that the prescribing clinician provide information forming the basis of an informed consent decision. In specific situations in which this is not possible or practicable, information may be provided by another credentialed behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience.

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

Psychotropic Medication Monitoring

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

- **Heart Rate and Blood Pressure:** On initiation of any medication, follow up at week 12, and at least annually thereafter or more frequently as clinically indicated.
- **Weight/Body Mass Index (BMI):** On initiation of any medication, follow up at week 4, 8, 12, each visit and at least annually thereafter.
- **Abnormal Involuntary Movements (AIMS):** On initiation of any antipsychotic medication, follow up at week 12, and at least every six months thereafter or more frequently as clinically indicated.

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- **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](#)).

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Mercy Care recognizes two types of polypharmacy: intra-class polypharmacy and inter-class polypharmacy. Below are Mercy Care'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

Mercy 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 Mercy Care.

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.

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.

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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.

The Non-Formulary Guideline 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
- All 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 guardian,

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when applicable, for each CAM prescribed. When obtaining informed consent, behavioral health medical practitioners must communicate in a manner that the member and/or legal guardian 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 Mercy 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.

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RBHA Chapter 7 – Partnership Requirements with Families and Family-Run Organizations**7.00 – Peer and Family Support Services**

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.

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 services are available to all MC Title 19 and Non-Title 19 members and their families within the health home setting as well as at community-based supportive service organizations. 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 is in agreement.

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Trainers of peer/recovery support specialists, and individuals seeking training and/or employment as a peer and/or recovery support specialist shall:

- a) **Self-identify as a peer**
- b) **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. Credentialing is required statewide to deliver peer support services. A list of training programs can be accessed by reaching out to oifateam@mercycaresaz.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@mercycaresaz.org. Should the OIFA Team have feedback to further develop or enhance their curricula, written feedback will be provided within 2 weeks and a follow up meeting will be scheduled to review recommendations and discuss any enhancements. Prospective and current PSETPs interested in recommendations and input from the OIFA Team may also request additional review and oversight through contact with oifateam@mercycaresaz.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 quarterly reports utilizing AMPM Policy 963: Attachments A, B, C and E.

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 in AMPM Policy 963: Attachment D, as well as by contacting oifateam@mercycaresaz.org for questions or assistance. PSETPs are required to send all credentialed individuals who completed and passed 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 peer and/or recovery support specialist (PRSS) shall have adequate access to continuing education relevant to peer support. PRSS shall obtain a minimum of two hours of Continuing Education and Ongoing Learning relevant to Peer Support, per year. Agencies employing peer and/or recovery support specialists shall provide supervision by

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individuals qualified as behavioral health technicians or behavioral health professionals. 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 parent/family support specialists and individuals seeking training and/or employment as a parent/family support specialist shall:

- a. Self-identify as an individual who has lived experience as a primary natural support for an adult with emotional, behavioral health or substance abuse needs OR as a parent or primary caregiver with lived experience who has raised or is currently raising a child with emotional, behavioral health and/or substance use disorders
- b. Qualify as a behavioral health paraprofessional, behavioral health technician, or behavioral health professional.

Individuals meeting the above criteria may be credentialed as a parent/family support specialist by completing training and passing a competency exam through an AHCCCS/OIFA approved Credentialed Parent/Family Support Training Program. Individuals are credentialed by the agency operating the Credentialing Parent/Family Support Training Program. A list of training programs can be accessed by reaching out to oifateam@mercycares.org.

Provider agencies rendering family support services to any AHCCCS member including fee for service members shall maintain documentation of all actively employed parent/family support specialists that have met the required qualifications and credentialing. All providers are required to complete quarterly reports utilizing AMPM Policy 964: Attachments A, B, C and D.

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

Additional resources for development of curriculum can be found by contacting oifateam@mercycares.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 parent and/or family support specialist shall have adequate access to continuing education relevant to parent and/or family support. Agencies employing parent and/or family support specialists shall provide supervision by individuals qualified as behavioral health technicians or behavioral health professionals. 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

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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.

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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 Mercy Care Office of Individual and Family Affairs by the fifteenth of the following month.

When applicable, the Mercy Care 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 a 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;

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- 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 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

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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;

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- 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.

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RBHA Chapter 8 – Dental and Vision Services**8.00 – Dental Services*****Dental Screening/Dental Treatment for children under 21***

More information regarding Dental Screening/Dental Treatment for children ages 18 – 21st birthday is available under the **Chapter 100 – Mercy Care Provider Manual - Chapter 5 – Early and Periodic Screening, Diagnostic and Treatment (EPSDT), under Section 5.13 – Dental Screening and Referrals.**

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

- oral health screenings
- cleanings
- fluoride treatments
- 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 children under age 21 are in accordance with AHCCCS' [Exhibit 431, Attachment A - AHCCCS Dental Periodicity Table](#).

Mercy Care 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. A dental emergency is an acute disorder of oral health resulting in severe pain and/or infection as a result of pathology or trauma.

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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
- Members age 21 and older that qualify for an emergent root canal may have a crown placed to complete the care. Otherwise, permanent crowns are not a covered benefit.

*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.

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- 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:

- [Exhibit 310 D1 - Dental Services for Members 21 Years of Age and Older](#)

8.01 – Vision Services

Vision Overview

Mercy RBHA covers eye and optometric services provided by qualified eye/optometry professionals within certain limits based on member age and eligibility:

- Emergency eye care, which meets the definition of an emergency medical condition, is covered for all members.
- For members who are 21 years of age or older, treatment of medical conditions of the eye, excluding eye examinations for prescriptive lenses and the provision of prescriptive lenses, are covered.
- Vision examinations and the provision of prescriptive lenses are covered for members under the EPSDT program and for adults when medically necessary following cataract removal.
- Cataract removal is covered for all eligible members under certain conditions. For more information, visit the AHCCCS website under Medical Policy for AHCCCS Covered Services.

Coverage for Eligible Members 18, 19 & 20 Years of Age

- Medically necessary emergency eye care, vision examinations, prescriptive lenses and treatments for conditions of the eye.
- PCPs are required to provide initial vision screening in their office as part of the EPSDT program.
- Members 18-20 years of age with vision screening of 20/60 or greater should be referred to the contracted vision provider for further examination and possible

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provision of glasses.

- Replacement of lost or broken glasses is a covered benefit.
- Contact lenses are not a covered benefit.

Nationwide Referral Instructions

Nationwide is Mercy 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 Mercy RBHA's website. The member may call Nationwide directly to schedule an appointment.

Coverage for Eligible Members 21 Years and Over

- Emergency care for eye conditions when the eye condition meets the definition of an emergency medical condition; for cataract removal and/or medically necessary vision examinations; and for prescriptive lenses if required following cataract removal.
- Routine eye exams and glasses are not a covered service for adults.
- Adults 21 years of age and older should be referred to Nationwide for the diagnosis and treatment of eye diseases as well.

8.02 – 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 Mercy RBHA's Member Services at 800-564-5465.

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RBHA Chapter 9 – Care Coordination**9.00 – Integrated Care Management*****Care Management***

Mercy 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

Mercy RBHA's Chief Medical Officer (CMO) is responsible for directing and overseeing Mercy 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.

Mercy 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 in order to safely live, work, and integrate into the community:
 - Inform members of particular 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 Mercy RBHA, Mercy RBHA must:

- Establish and maintain a Care Management Program (CMP).
- Allow the member to select (or Mercy RBHA) a PCP or BH clinician who is formally designated as having primary responsibility for coordination of the member's overall health care.

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- 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), Mercy 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 in order 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 of the Mercy RBHA organizational units with emphasis on regular channels of communication with the Mercy 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 Mercy 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;

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- Consultation with the member's treatment team;
- Review of administrative data such as claims/encounters; and
- Demographic and customer service data.

Eligibility

Mercy 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

Mercy RBHA utilizes data from multiple sources to identify 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]).

On a daily basis, 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 Mercy 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 Mercy RBHA departments
- Discharge planner referral
- Provider referral
- Provider submissions of the American College of Obstetricians and Gynecologists (ACOG) comprehensive assessment tool

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- Provider submission of an Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Tracking Form
- 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 Mercy RBHA Member Service Representative (MSR). Upon receipt of referral, Mercy RBHA's Care Management department will assess the member's eligibility against the aforementioned 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 member at the Assigned Behavior Health Clinic (ABHC) 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.

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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 Mercy 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.

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- 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 Mercy 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 Mercy 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. Mercy 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 Mercy 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.

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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 Mercy RBHA care manager works closely with the PCP, the Mercy RBHA corporate director of pharmacy, and a Mercy 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 Mercy 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 of the member's medical and perinatal care issues are addressed appropriately.

PLAN SPECIFIC TERMS**RBHA Chapter 10 – Coordination of Care****10.00 – Inter-T/RBHA 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 T/RBHA 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 T/RBHA. This is applicable regardless of where the adult guardian lives.

Responsibility for service provision, other than crisis services, remains with the home T/RBHA when the enrolled member is visiting or otherwise temporarily residing in a different T/RBHA 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), T/RBHA responsibility is determined by the current place of residence of the child's parent(s) or legal guardian 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-T/RBHA transfers must be completed within 30 days of referral by the home T/RBHA. The home T/RBHA 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 T/RBHA will:

- Provide needed crisis services;
- Ascertain the member's enrollment status with all T/RBHAs and determine whether the member's residence is temporary or permanent.

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- If the member is enrolled with another T/RBHA, notify the home T/RBHA within 24 hours of the member's presentation. The home T/RBHA or their contracted providers is fiscally responsible for crisis services and must:
 - Decide with the T/RBHA at which the member presents to provide needed services, funded by the home T/RBHA;
 - Arrange transportation to return the member to the home T/RBHA area; or
 - Determine if the member intends to live in the new T/RBHA 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 T/RBHA must decide for 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-T/RBHA transfer can proceed.
- If the member is not enrolled with any T/RBHA, lives in GSA 6 and has presented for services, behavioral health providers must notify the Mercy RBHA to initiate an enrollment. Providers should notify Mercy RBHA at 800-564-5465.
- If the member is not enrolled with any T/RBHA, lives outside of GSA 6 and is presenting for crisis services, Mercy RBHA must enroll the member, provide needed crisis services and initiate the inter-T/RBHA transfer.
- If T/RBHA or provider receives a referral regarding a hospitalized member whose residence is located outside the T/RBHA or provider must immediately coordinate the referral with the member's designated T/RBHA.

Non-Emergency Services

If the member is not enrolled with a T/RBHA, lives outside of the service area, and requires services other than a crisis or urgent response to a hospital, the T/RBHA must notify the designated T/RBHA associated with the member's residence within 24 hours of the member's presentation. The designated T/RBHA must proceed with the member's enrollment if determined eligible for services. The designated T/RBHA 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 T/RBHA while the member is traveling out of the home T/RBHA's area. All incidents of provision of courtesy dosing must be reported to the home T/RBHA. The home T/RBHA must reimburse the T/RBHA providing the courtesy doses upon receipt of properly submitted bills or encounters.

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Referral for Service Provision

If a home T/RBHA initiates a referral to another T/RBHA or a service provider in another T/RBHA's area for the purposes of obtaining behavioral health services, the home T/RBHA 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 T/RBHA'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-T/RBHA

A transfer will occur when:

- An adult member voluntarily elects to change their place of residence to an independent living setting from one T/RBHA'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 T/RBHA must decide for 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 legal guardian(s) of a child change their place of residence to another T/RBHA's area; or
- The court of jurisdiction of a dependent child changes to another T/RBHA'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-T/RBHA transfers are not to be initiated when a member is under pre-petition screening or court ordered evaluation).

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Timeframes for initiating an Inter-T/RBHA transfer

The home T/RBHA shall initiate a referral for an Inter-T/RBHA 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 T/RBHA provides a completed **Inter-T/RBHA Transfer Request Form**. In addition, the following information must be provided to the receiving T/RBHA 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 T/RBHA must not delay the timely processing of an Inter-T/RBHA transfer because of missing or incomplete information.

Upon receipt of the transfer packet, the receiving T/RBHA must:

- Notify the home T/RBHA within seven calendar days of receipt of the referral for Inter-T/RBHA transfer;
- Proceed with deciding for the transfer; and
- Notify the home T/RBHA if the information contained in the referral is incomplete.

Within 14 days of receipt of the referral for an Inter-T/RBHA transfer, the receiving T/RBHA 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 guardian or parent, if applicable;
 - Representatives from the home T/RBHA;
 - 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 member's guardian.

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- 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 T/RBHA 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 T/RBHA'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 T/RBHA's GSA, including information on how to contact the behavioral health provider;
 - Identification of the member at the receiving T/RBHA 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 T/RBHA must enter a closure and disenrollment into CIS. The receiving T/RBHA 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 T/RBHAs to transfer the member, the T/RBHAs must collaborate to ensure appropriate re- engagement activities occur and proceed with the inter-T/RBHA transfer, if appropriate. Each T/RBHA 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 T/RBHA enrollment status. Members enrolled after a crisis event may not need or want ongoing behavioral health services through the T/RBHA. Providers must conduct re- engagement efforts however, members who no longer

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want or need ongoing behavioral health services must be dis-enrolled (i.e., closed in the CIS) and an inter-T/RBHA transfer must not be initiated. Members who will receive ongoing behavioral health services will need to be referred to the appropriate T/RBHA and an inter-T/RBHA 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 T/RBHA prior to moving to another service area. When behavioral health members inform their provider or T/RBHA less than 30 days prior to their move or do not inform their provider or T/RBHA of their move, the designated T/RBHA must not wait for all the documentation from the previous T/RBHA 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-T/RBHA transfer may file an appeal.

Any party involved with a request for out-of-area service provision or Inter-T/RBHA transfer may initiate the complaint resolution procedure. Parties include the home T/RBHA, receiving T/RBHA, member being transferred, or the member's guardian 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-T/RBHA 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 T/RBHA, or other individual identified by the T/RBHA, if the issue concerns out-of-area service provision; or
 - The identified behavioral health provider at the receiving T/RBHA, or other individual identified by the T/RBHA, if the issue concerns an Inter-T/RBHA 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.

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- 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 T/RBHA.
- Issues concerning Inter-T/RBHA transfers must be forwarded to the Chief Executive Officer, or designee, of the receiving T/RBHA.
- The Chief Executive Officer must work with the Chief Executive Officer of the other involved T/RBHA 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 T/RBHA must ensure that medically necessary behavioral health services continue pending the resolution of an emergency dispute between T/RBHAs.

First Level

- Issues concerning out-of-area service provision must be forwarded to the Chief Executive Officer, or designee, of the home T/RBHA.
- Issues concerning Inter-T/RBHA transfers must be forwarded to the Chief Executive Officer, or designee, of the receiving T/RBHA.
- The Chief Executive Officer must work with the Chief Executive Officer of the other involved T/RBHA 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.

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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. See the **AHCCCS Contracted Health Plans Behavioral Health Coordinators**, available on our [Forms](#) web page, for contact information for the Behavioral Health Coordinators for each AHCCCS Health Plan.
- If the member is determined to have a serious mental illness, providers should contact Mercy RBHA Member Services to determine the name and contact information for the member's PCP. T/RBHA 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. T/RBHA enrolled members should also be prompted to visit their PCP for routine medical examinations annually or more frequently if necessary.
- Mercy 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.
- Mercy 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 Mercy RBHA Complete Care Health Plan and Provider Coordinator via Customer Services at 800-564-5465.

Mercy RBHA and Complete Care Health Plan and Provider Coordinator

Mercy 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.

Mercy 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

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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.

Mercy 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);
- Mercy 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.
- A virtual health home in which the member receives services from different providers that share information through the Mercy RBHA health information exchange.

Mercy 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;

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- 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.

Mercy 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 Mercy RBHA to provide fee-for-service behavioral health services to Title XIX/XXI eligible members **not** enrolled with an AHCCCS Health Plan.

Mercy RBHA is responsible for providing all inpatient emergency behavioral health services for fee-for-service members with psychiatric or substance abuse diagnoses.

Mercy 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.

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Responsibility for Members enrolled in AHCCCS Health Plan

Mercy 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 Mercy 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.

Mercy 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 Mercy RBHA.

Mercy 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.

Mercy 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.

Mercy 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 Mercy RBHA or a subcontracted provider to present to this setting to resolve a behavioral health crisis. Mercy RBHA or the subcontracted provider directing the member to present to the ER must notify the emergency transportation provider of Mercy 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.

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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 Mercy Care's Provider Manual.

Non-emergency Behavioral Health Services

For Title XIX and Title XXI eligible members, Mercy 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 Mercy RBHA or a subcontracted provider prior to admission to an inpatient psychiatric setting, Mercy 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, Mercy 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 Mercy RBHA.

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, Mercy 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 Mercy RBHA. For members determined to have a Serious Mental Illness, Mercy RBHA retains responsibility for all medically necessary medical and behavioral health services provided while the member is in a facility.

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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 Mercy 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 Mercy 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 Mercy 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 Mercy RBHA and the member’s AHCCCS Health Plan. Mercy RBHA and contracted providers must take active steps to ensure that prescriptions written by providers by Mercy RBHA providers are not charged to the member’s AHCCCS Health Plan.

General Requirements

When it is necessary for a Mercy 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 Mercy RBHA provider. Mercy 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 guardian or parent and the PCP agree to this treatment transition. Mercy RBHA requires its subcontracted providers to facilitate this process and to ensure that the following steps are taken:

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- 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 Mercy 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 Mercy 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.

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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 Mercy 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.

Mercy 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 Regional Behavioral Health Authority (RBHA) to their Complete Care plans. Prior to October 1, 2015, this coverage is facilitated by the Mercy RBHA in Maricopa County.

Mercy RBHA dual eligible members will continue to receive their care through Mercy 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 (see **AHCCCS Contracted Health Plans Behavioral Health Coordinators**, available under our [Forms](#) web page). 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. Mercy RBHA implements cost sharing responsibilities and billing for inpatient psychiatric services.

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Mercy 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. Mercy RBHA implements cost sharing responsibilities and billing for outpatient behavioral health services.

Mercy RBHA will coordinate outpatient care with Medicare providers for Medicare members receiving covered behavioral health services.

Medication Assisted Treatment (MAT)

Mercy 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 Mercy 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

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.

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- 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 Clinical Guidance Tool Practice Protocol, The Unique Behavioral Health Service Needs of Children, Youth, and Families Involved with DCS](#)).

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](#)).

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**). Mercy 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

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- Develop procedures for collaboration in the referral process to ensure effective service delivery through the Mercy 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 Mercy RBHA for members in Maricopa County. Mercy 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 legal guardian;
- 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 legal guardian;
- 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.

Courts and Corrections

Mercy RBHA and behavioral health providers are expected to collaborate and coordinate care for behavioral health members involved with:

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- The Arizona Department of Corrections (ADC) & Community Corrections (Parole)
- Arizona Department of Juvenile Corrections (ADJC)
- Maricopa County Jail & Correctional Health Services
- The Arizona Superior Court & Maricopa County Probation
- Municipal Mental Health Courts, such as the City of Glendale and Mesa 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 of eligible members and arranges and coordinates care upon the member's release.

Mercy RBHA and the Arizona Department of Corrections (ADC) have an established mutually agreed upon protocol to ensure effective and efficient delivery of behavioral health services. The **Collaborative Protocol between MERCY RBHA and Arizona Department of Corrections (ADC)**, available on our [Forms](#) web page, defines the respective roles and responsibilities of each party.

Mercy 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 Mercy RBHA and Arizona Department of Juvenile Corrections defines the respective roles and responsibilities of each party.

Mercy RBHA and the Maricopa County Adult Probation have an established mutually agreed upon protocol, **Collaborative Protocol with Adult Probation**, available on our [Forms](#) web page, to ensure effective and efficient delivery of behavioral health services; this agreement encompasses Maricopa County Jail, Correctional Health Services and Maricopa County Probation. The Collaborative Protocol between Mercy RBHA and Maricopa County Adult Probation defines the respective roles and responsibilities of each party.

Additional data sharing agreements have been developed with the City of Glendale Municipal Court, City of Tempe Municipal Court and the City of Mesa Municipal Court.

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The **Collaborative Protocol with Maricopa County Juvenile Probation Department** is available on our [Forms](#) web page as well.

Arizona County Jails

In Maricopa County 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 Maricopa County or Pinal 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 upon request;
- 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 30 days or longer.

For all other members receiving behavioral health services in Maricopa County and all other Arizona counties, behavioral health providers must ensure that appropriate coordination also occurs for behavioral health members with jail personnel at other county jails.

For further information regarding Mercy RBHA enrolled members who are incarcerated, please contact the Court Liaison Department through customer service at 800-564-5465 or visit www.MercyCareAZ.org.

Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA)

Mercy 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 Mercy 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 on our [Forms](#) web page.

Prevocational and Employment related services available through Mercy RBHA are distinct from vocational services available through RSA. Please refer to the [AHCCCS Medical Policy Manual \(AMPM\) Chapter 300 Exhibit C310-B – TITLE XIX/XXI Behavioral Health Service Benefit](#) for additional details.

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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 Mercy 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 Mercy RBHA Housing Department through customer service at 1-800-564-5465 to report unsafe conditions.

Veterans Administration Health Care System

Mercy 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 Mercy 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 our [Forms](#) web page.

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.

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- Will document coordination and participation in ongoing communication with SMI Clinic/provider, adult recovery team (ART)/children and family team (CFT), where applicable, and with Mercy RBHA.
- Will document coordination and participation in discharge planning efforts with SMI Clinic/provider, ART/CFT (where applicable) and with Mercy 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
- A virtual health home

Mercy 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 in 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 in order 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

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handled by the children's provider. This may include attendance at intakes, level of care admissions, and/or support to the young adult in successfully connecting to the adult provider.

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

- Identifying the young adult's behavioral health needs into adulthood;
- Identifying personal strengths that will assist the young adult when he/she transitions to the adult system;
- Identifying staff who will coordinate services after the young adult reaches age 18, including any changes in the behavioral health provider, clinical team, guardian or family involvement;
- Identifying and collaborating with other involved state agencies and stakeholders to jointly establish a behavioral health service plan and prevent duplication of services.
- 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, guardianship, training programs, etc. In addition, the team and/or behavioral health provider should assist in gathering necessary information to expedite these applications/determinations when the time comes to apply, including obtaining medical and school records to substantiate these needs. The team and/or behavioral health provider begin to develop a timeline and task list for when appointments are needed;
- Identifying the need for transportation to appointments and other necessary activities;
- Identifying special needs that the young adult may have and/or whether the young adult will require special assistance services;
- Identifying whether the young adult has appropriate life skills, social skills and employment or education plans;
- Taking necessary action if the young adult is not eligible for Title XIX or Title XXI benefits and/or Social Security Disability Income (SSDI) and is not determined to meet criteria for SMI services. Identifying supports needed to be in place for a successful transition;
- Following guidelines established in [AHCCCS Clinical Guidance Tool Practice Protocol, Transition to Adulthood](#); 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

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services is the choice of the young member when he/she reached 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 reaches 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.

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;
- Assist the young adult and/or family or guardian in applying for potential benefits (e.g., SSI, food stamps, etc.);
- Assist the young adult and/or family in determining whether an application for Title XIX or Title XXI benefits is to be submitted; if the young adult and/or family is already 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.

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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 Health Residential or HCTC Facilities are notified of determinations and next review dates. For all other requests for prior authorized services, contact Mercy 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.

Mercy 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

At admission

Action to be Completed

Mercy RBHA will notify upon admission the estimated number of inpatient IMD days that a member has utilized in the current calendar month.*

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<i>With 24 hours of Admission</i>	IMD facility shall develop a discharge plan and communicate this specific plan to the Mercy RBHA Utilization Management (UM) consultant.
<i>10th Day</i>	A peer-to-peer discussion regarding discharge coordination will occur.
<i>13th Day</i>	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.
<i>14th Day</i>	The Mercy RBHA UM Consultant will contact the facility to ensure the member is being discharged or that an appropriate transfer has been arranged.
<i>15th Day</i>	Member will be discharged or transferred and the facility must provide same day discharge information to Mercy Care Plan / Mercy 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 Mercy 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)

Mercy 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

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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.

Mercy 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 for 30 days. Providers are notified of next review date and are responsible for requesting further stay and providing clinical information on the scheduled review date.

Behavioral Health Residential Facilities (BHRF)

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 Mercy RBHA Utilization Management two weeks prior to the last day of the expiration of the current authorization.

Child and Adolescent HCTC

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.

Adult Behavioral Health Residential Facilities

For the SMI population, the initial authorization for adult 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 Mercy RBHA Utilization Management at 800- 564-5465, 2 weeks prior to the last day of the expiration of the current authorization. BHRF level of care for GMH/SU population does not require prior authorization except for Eating Disorder Treatment.

PLAN SPECIFIC TERMS**RBHA Chapter 12 – Quality Management****12.00 – Quality Management**

Mercy RBHA works in partnership with providers to continuously improve the care given to our enrollees. The Mercy 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 enrollees.
- Provider Monitoring is responsible for quality improvement activities and clinical studies using data collected from providers and encounters.
- 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, Mercy RBHA adopts AHCCCS requirements and practice guidelines from national organizations known for their expertise in the area of concern. Please refer to the [Clinical Guidelines](#) located on the Mercy RBHA Provider website.

Quality Management and Performance Improvement Plan

Under the leadership of the Chief Medical Officer, Mercy RBHA's Quality Management department has developed a written Annual QM Plan that addresses MERCY 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

Mercy RBHA must measure performance using measurement tools specified by CMS and AHCCCS and report its performance to CMS/AHCCCS. Mercy RBHA is required to make available to CMS/AHCCCS information from these measures to provide enrollees 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.

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Procedures for HEDIS/Clinical Performance Measure Improvement

All contracted providers are expected to meet MPS as established by AHCCCS and/or Mercy 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.

Mercy 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

Mercy RBHA is required to have a Chronic Care Improvement Program (CCIP). This program must identify enrollees with multiple or sufficiently severe chronic conditions who meet criteria for participation in the program and must have a mechanism for monitoring enrollee 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.

Quality of Care Concerns

Documentation Related to Quality of Care Concerns

Quality of Care (QOC) concerns may be referred by state agencies, internal AHCCCS sources or internal Mercy RBHA departments (e.g., Grievance and Appeals, Utilization Management, Children's System of Care, Adult System of Care, Medical Management, etc.), and external sources (e.g., behavioral health members; providers; other stakeholders; Incident, Accident, and Death reports). A QOC can be referred for any participating or non-participating provider and out of state placements. Upon receipt of a QOC concern, AHCCCS follows the procedures below. As participants in the QOC process, Mercy RBHA follows these same procedures:

- Document each issue raised, when and from whom it was received and the projected time frame for resolution.

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- Determine promptly whether the issue is to be resolved through one or more of the following Mercy RBHA areas:
 - Quality of Care;
 - Customer Service/Complaint Resolution;
 - Grievance and appeals process; and/or
 - Fraud, waste, and program abuse.
- Acknowledge receipt of the issue and explain to the member or provider the process that will be followed to resolve his or her issue through written correspondence. If the issue is being addressed as other than a QOC investigation, explain to the member or provider the process that will be followed to resolve their issue using written correspondence. QOC related concerns will remain in the quality management arena due to state and federal regulations: **42 U.S.C. 1320c-9, 42 U.S.C. 11101 et seq., A.R.S. §36-2401, A.R.S. §36-2402, A.R.S. §36-2403, A.R.S. §36-2404, A.R.S. §36-2917.**
- Assist the member or provider as needed to complete forms or take other necessary actions to obtain resolution of the issue.
- Ensure confidentiality of all member information.
- Inform the member or provider of all applicable mechanisms for resolving the issue.
- Document all processes (include detailed steps used during the investigation and resolution stages) implemented to ensure complete resolution of each issue, including but not limited to:
 - Corrective action plan(s) or action(s) taken to resolve the concern;
 - Documentation that education/training was completed. This may include, but is not limited to, in-service attendance sheets and training objectives;
 - New policies and/or procedures; and
 - Follow-up with the member that includes, but is not limited to:
 - Assistance as needed to ensure that the immediate health care needs are met; and
 - Closure/resolution letter that provides sufficient detail to ensure all covered, medically necessary care needs are met and a contact name/telephone number to call for assistance or to express any unresolved concerns.

Process of Evaluation and Resolution of Quality of Care Concerns

The quality of care concern process at Mercy RBHA includes documentation of identification, research, evaluation, intervention, resolution, and trending of member and provider issues. Resolution must include both member and system interventions when appropriate. The quality of care process must be a stand-alone process and shall not be combined with other agency meetings or processes. This process is also outlined in the AHCCCS Desktop Protocol – Quality of Care and Peer Review.

- Mercy RBHA completes the following actions in the QOC process:

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- Identification of the quality of care issues;
 - Initial assessment of the severity of the quality of care issue;
 - Prioritization of action(s) needed to resolve immediate care needs when appropriate;
 - Review of trend reports to determine possible trends related to the provider(s) involved in the allegation(s) including type(s) of allegation(s), severity and substantiation, etc.;
 - Research, including, but not limited to a review of the log of events, documentation of conversations, and medical records review, mortality review, etc.; and
 - Quantitative and qualitative analysis of the research, which may include root cause analysis.
- For substantiated QOC allegations it is expected that some form of action is taken, for example:
 - Developing an action plan to reduce/eliminate the likelihood of the issue reoccurring;
 - Determining, implementing, and documenting appropriate interventions;
 - Monitoring and documenting the success of the interventions;
 - Incorporating interventions into the organization's Quality Management (QM) program if appropriate; or
 - Implementing new interventions/approaches, when necessary.
 - Each issue/allegation must be resolved; member and system resolutions may occur independently from one another. The following determinations should be used for each allegation in a QOC concern:
 - **Substantiated** – the alleged complaint (allegation) or reported incident was verified or proven to have happened based on evidence and had a direct effect on the quality of the member's behavioral health care. Substantiated allegations require a level of intervention such as a performance improvement plan, or a corrective action plan of steps to be taken to improve the quality of care or service delivery and/or to ensure the situation will not likely happen again.
 - **Unable to Substantiate** – there was not enough evidence at the time of the investigation to show whether a QOC allegation did occur or did not occur. The evidence was not sufficient to prove or disprove the allegation. No intervention or corrective action is needed or implemented.
 - **Unsubstantiated** – there was enough credible evidence (preponderance of evidence) at the time of the investigation to show that a QOC allegation did occur. The allegation is based on evidence, verified or proven, to have not occurred. No intervention or corrective action is needed or implemented.

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- Mercy RBHA uses the following process to determine the level of severity of the quality of care issue:
 - **Level 0** – (Track and Trend Only) - No quality issue finding.
 - **Level 1** – Quality issue exists with minimal potential for significant adverse effects to the patient/recipient.
 - **Level 2** – Quality issue exists with significant potential for adverse effect to the patient/recipient.
 - **Level 3** - Quality issue exists with significant adverse effects on the patient/recipient, is dangerous or life-threatening.
 - **Level 4** - Quality issue exists with the most severe adverse effects on the patient/recipient; no longer impacts the patient/recipient with the potential to cause harm to others.
- Mercy RBHA reports issues to the appropriate regulatory agency including Adult Protective Services, AHCCCS, Department of Child Safety, Attorney General's Office, or law enforcement agency for further research/review or action. Initial reporting may be made verbally but must be followed by a written report within one business day.
- Cases are referred to the Peer Review Committee when appropriate. Any case ending in a severity level of 3 or higher is automatically referred to the Peer Review Committee. Referral to the Peer Review Committee shall not be a substitute for implementing interventions.
- If an adverse action is taken with a provider due to a quality of care concern, Mercy RBHA will report the adverse action to the AHCCCS Clinical Quality Management Unit (CQM) as well as to the National Practitioner Data Bank. Mercy RBHA, as an active participant in the process, must notify AHCCCS of any adverse action taken against a provider.
- Upon receiving notification that a health care professional's organizational provider or other provider's affiliation with their network is suspended or terminated as a result of a quality of care issue, Mercy RBHA will provide written notification to the appropriate regulatory/licensing board and AHCCCS. Mercy RBHA, as active participants in the process, are required to notify Mercy RBHA of the same.
- When the review of a quality of care concern is complete, Mercy RBHA will submit a closing letter to AHCCCS Clinical Quality Management (CQM). These letters will include the following:
 - A description of the issues/allegations, including new issues/allegations identified during the investigation/review process;
 - A substantiation determination and severity level for each allegation;
 - An overall substantiation determination and level of severity for the case;
 - Written response from or summary of the documents received from referrals made to outside agencies such as accrediting bodies, or medical examiner.

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Tracking/Trending of Quality of Care Issues

Mercy RBHA uses data pulled from QOC database to monitor the effectiveness of QOC-related activities to include complaints and allegations received from members and providers, as well as from outside referral sources. Mercy RBHA also tracks and trends QOC data and reports trends and potential systemic problems to AHCCCS.

The data from the QOC database will be analyzed and evaluated to determine any trends related to the quality of care or service in Mercy RBHA's service delivery system or provider network and aggregated for the state. When problematic trends are identified through this process, Mercy RBHA will incorporate the findings in determining systemic interventions for quality improvement. Mercy RBHA incorporates trended data into systemic interventions.

- As evaluated trended data is available, Mercy RBHA will prepare and present analysis of the QOC tracking and trending information for review and consideration of action by the Quality Management Committee and Chief Medical Officer, as Chair-member of the Quality Management Committee.
- Quality tracking and trending information from all closed quality of care issues within the reporting quarter will be submitted to AHCCCS/Division of Health Care Management/Clinical Quality Management (AHCCCS/ DHCM/CQM) utilizing the Quarterly Quality Management Report. The report will be submitted within 45 days after the end of each quarter and will include the following reporting elements:
 - Types and numbers/percentages of substantiated quality of care issues;
 - Interventions implemented to resolve and prevent similar incidences; and
 - Resolution status of "substantiated", "unsubstantiated" and "unable to substantiate" QOC issues.

If a significant negative trend is found, Mercy RBHA may choose to consider it for a performance improvement activity to improve the issue resolution process itself, and/or to make improvements that address other system issues raised during the resolution process.

Mercy RBHA will submit to AHCCCS CQM all pertinent information regarding an incident of abuse, neglect, exploitation and unexpected death as soon as aware of the incident. Pertinent information must not be limited to autopsy results only but must include a broad review of all issues and possible areas of concern. Delays in the receipt of autopsy results shall not result in a delay in the investigation of a quality of care concern by Mercy RBHA. Delayed autopsy results will be used to confirm the resolution of the QOC concern. Mercy RBHA will also revise closing letters to AHCCCS if the cause and manner of death changes the findings of a QOC investigation.

Mercy RBHA must ensure that member health records are available and accessible to authorized staff of their organization and to appropriate State and Federal authorities, or their

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delegates, involved in assessing quality of care or investigating member or provider quality of care concerns, complaints, allegations of abuse, neglect, exploitation grievances and Health Care Acquired Conditions (HCAC). Member record availability and accessibility must be in compliance with Federal and State confidentiality laws, including, but not limited to, Health Insurance Portability and Accountability Act (HIPAA) and **42 C.F.R. 431.300 et seq.**

Provider-Preventable Conditions

If a Health Care Acquired Condition (HCAC) or Other Provider Preventable Condition (OPPC) is identified, Mercy Care will conduct a quality of care investigation and report the occurrence and results of the investigation to the AHCCCS Clinical Quality Management Unit. Mercy 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 – Performance Improvement Projects

Mercy 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. Mercy 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 through the use of 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.

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Correct significant systemic issues come to the attention of Mercy RBHA in part through:

- Data from Mercy 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.

Mercy RBHA contracted healthcare providers play an integral role in the implementation of the Mercy 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

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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 on 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.

Mercy 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 Mercy RBHA, other providers, stakeholders, and community members to implement recommended improvement strategies that are developed as a result of an identified performance improvement project.

12.02 – Peer Review

Peer Review

Mercy RBHA has established and maintains a Peer Review Committee. The Peer Review Committee serves as the primary entity responsible for ensuring Mercy 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.

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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 Mercy RBHA has enrolled members; and
- Mercy 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 Mercy RBHA's and information made available through the quality management process to monitor Mercy RBHA's peer review process. As a result of the review, the Peer Review Committee will make recommendations to Mercy 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.

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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 Mercy 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.

Mercy RBHA must implement recommendations made by the Peer Review Committee. Some Peer Review recommendations may be appealable agency actions under Arizona law. A Mercy 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 of 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 Mercy 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 Mercy RBHA, or other federal, state, or local government agencies.

The Mercy RBHA Peer Review Committee is chaired by the Chief Medical Officer (CMO) and the membership includes Administrators and Managers of other departments within Mercy RBHA and representation of healthcare professionals from local communities in which Mercy RBHA has enrolled members (including physical health care Primary Care Physicians (PCPs and or Specialist). Mercy 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

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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 Mercy 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 Mercy 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 Mercy 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 Mercy 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

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- training will be required to be sent to Mercy 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 Mercy RBHA reduce, restrict, suspend, terminate, or not renew the healthcare professional's Mercy 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.

12.03 – Behavioral Health Satisfaction Survey

This chapter outlines the process for Mercy 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/guardians 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.

PLAN SPECIFIC TERMS**RBHA Chapter 13 – Service Authorizations****13.00 – Securing Services and Prior Authorization*****Purpose of Utilization Review Process***

Mercy 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. Mercy 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.

Mercy 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 Mercy 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 Mercy RBHA to obtain the requested service as outlined below.

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Although Adult HCTC is not a prior authorized service, Mercy RBHA requires the submission of the **Adult HCTC Application**, available on our [Forms](#) web page, 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 Mercy 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 Mercy RBHA network.
- Mercy RBHA prior authorizes the services.

In order to prior authorize the service, a provider must be AHCCCS registered in order 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 Mercy RBHA's policies. Both referring and receiving providers must comply with Mercy RBHA's 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. 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 Mercy RBHA for these services with an AHCCCS registered provider.

Mercy RBHA requires the following information in order 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

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- 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:
 - Mercy 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 a Mercy 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
 - Mercy Care contracts directly with providers for all levels of care
 - Physical health providers can prior authorization when a service through Mercy RBHA In-Network provider is not available

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- Use the Physical Health **Prior Authorization Standard Request Form**, available on our [Forms](#) web page.
- In the event that a request to secure covered services through a non-contracted provider is denied, a notice of adverse benefit determination must be provided.
- In the event that a request to secure covered services through a non-contracted provider is denied, a notice of the -action must be provided.
- If Mercy RBHA is unable to secure services with a non-contracted provider, Mercy RBHA will contact the requestor of the service to identify alternate providers until appropriate services have been obtained.

In order 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 situation. 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 Mercy 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) (This is not required for GMH/SA with the exception of residential services for Eating Disorder Treatment.);
- Admission to and continued stay in treatment for child and adolescent home care training to home care client (HCTC) services;
- Non-emergency services outside the geographic service area of Mercy RBHA;

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- Non-emergency services outside the Mercy 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 our Mercy Care Secure Web Portal.

Physical Health Providers under Integrated Care

Mercy 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 [Mercy RBHA's Secure Web Portal](#). You may also fax our Prior Authorization Department at 800-217-9345.

Mercy 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.

Mercy 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 Mercy 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 HCTC can only be made by a Mercy RBHA medical director or physician designee, after an offer of verbal or written collaboration with the request provider or clinician. If the offer is declined, a decision can be made based on the available information.

Following a decision to deny but prior to the Notice being sent to the member, the attending facility physician or requesting provider can ask for a peer to peer review.

Notice must be provided in accordance Notice and Appeal Requirements for behavioral health inpatient. When a request does not appear to meet medical necessity criteria and is being considered for denial, a discussion with a facility attending physician, requesting provider or their designee is offered. Notification will be given prior to a final denial decision and still allows for a determination to be made within appropriate time frames.

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13.04 - How to Request a Prior Authorization

The following documentation is required in order 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 **SAMPLE Certification of Need (CON)**, available on our Forms Library web page, must be completed. Please refer to our **Authorization Criteria Adult SMI Behavioral Health Residential Facility**, available on our **Forms Library** web page. In addition, please refer to **[AMPM Policy 320-V – Behavioral Health Residential Facilities](#)** for detailed information regarding this. Mercy RBHA follows all AHCCCS criteria that applies in this policy.
- Child/Adolescent Behavioral Health Inpatient Facility (BHIF) non-emergent request, the Clinical Team must submit a **Therapeutic Residential Service Request for Children and Adolescents**, available on our **[Forms](#)** web page, 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 on our **[Forms](#)** web page.
- For Adult or Child /Adolescent Behavioral Health Residential Facility (BHRF) or Child TFC non-emergent request, the Clinical Team must complete the appropriate form:
 - **Adult BHRF request - (Referral for Behavioral Health Residential Facility Services for Adults)** application, available on our **[Forms](#)** web page, and submit via fax to 855-825-3165). Approval is valid for 45 days.
 - **Child/Adolescent BHRF or TFC – Therapeutic Residential Service Request for Children and Adolescents**, available on our **[Forms](#)** web page, application and fax to Mercy RBHA at 855-825-3165 followed by telephonic notification to Mercy RBHA Utilization Management via Mercy RBHA's Member Services Department at 800-564-5465. **Authorization cannot be provided without all the required documentation.**

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- 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 on our [Forms](#) web page, 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 on our [Forms](#) web page, must be faxed to Mercy RBHA at 855-825-3165.
- **Authorization Criteria for Behavioral Health Residential Facility, Children/Adolescent** and **Authorization Criteria For Therapeutic Foster Care (TFC) Children/Adolescent**, available on our [Forms](#) web page.
- Non-emergency inpatient eating disorder requires prior authorization according to MCG guidelines. Complete the **Inpatient Eating Disorder Request for Prior Authorization**, available on our [Forms](#) web page, form and fax to 844-424-3976 or for urgent request call 800-564-5465 to review with the Mercy RBHA Utilization Management Department.
- Electroconvulsive therapy (ECT) requires prior authorization according to MCG criteria. Complete the **ECT Prior Authorization Form**, available on our [Forms](#) web page, and fax to 844-424-3976; or for urgent requests call 800-564-5465 to review with Mercy RBHA's Utilization Management Department.
- Behavioral Health psychological and psychosexual testing approval is made in accordance with MCG guidelines. Neuropsychological testing approval will be according to the guidelines in [AHCCCS Medical Policy Manual](#), Neuropsychological Testing. To request psychological, psychosexual and neuropsychological testing prior authorization, complete the **Psychological and Neuropsychological Testing Prior Authorization** form, available on our [Forms](#) web page. Fax the request form to Mercy RBHA's Utilization Management Department at 844-424-3976.
- Mercy 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)

Mercy 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.

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Emergency Inpatient Behavioral Health admissions with TPL

Providers are required to notify MERCY RBHA at the time of admission for all TPL. Mercy 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 Mercy RBHA at the time that the TPL has denied and to appeal all decisions if they believe the member needs further inpatient treatment. Mercy 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, Mercy RBHA will assign a 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 guardian with contacting the TPL to request prior authorization. Mercy 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 Mercy RBHA at the time that the TPL has denied and to appeal all decisions if they believe the member needs further inpatient treatment. Mercy 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 Mercy RBHA will assign a 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 age 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

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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 of time for which claims for payment are made.
- Compliance with federal requirements related to the Certification of Need (CON) and Recertification of Need (RON) for Mercy RBHA authorized services including hospitals and behavioral health inpatient facilities is mandatory. The facilities will be required to

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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

Mercy 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 guardians, 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 Mercy 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. Mercy 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:

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- 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, Mercy 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, Mercy 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 Mercy RBHA and behavioral health providers:

- Prior to denials for a Behavioral Health Inpatient Facility, Mercy 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

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- evaluation should be arranged in order for Mercy 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, Mercy 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 Mercy 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 Mercy 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 Mercy RBHA;
 - The provider is registered with AHCCCS for this service.
- Payment must not be denied when:
 - Mercy RBHA or behavioral health provider instructs a member to seek emergency behavioral health services;

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- 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;
- Mercy RBHA may not refuse to cover emergency behavioral health services based on the failure of a provider to notify Mercy 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 actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and such determination is binding Mercy RBHA.

The following conditions apply with respect to coverage and payment of post-stabilization care services for a member who was received emergency medical or psychiatric hospitalization who is Title XIX or Title XXI eligible. Mercy 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 Mercy RBHA for the following situations:

- Post-stabilization care services that were pre-authorized by Mercy RBHA;
- Post-stabilization care services that were not pre-authorized by Mercy RBHA or because Mercy 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
- Mercy RBHA and the treating physician cannot reach agreement concerning the member's care and a Mercy RBHA physician is not available for consultation. In this situation, Mercy RBHA must give the treating physician the opportunity to consult with a contracted physician and the treating

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physician may continue with care of the member until a contracted physician is reached or one of the following criteria is met:

- Mercy RBHA physician with privileges at the treating hospital assumes responsibility for the member's care;
- Mercy RBHA physician assumes responsibility for the member's care through transfer;
- Mercy 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 Mercy RBHA's dedicated fax number at 844-525-2223. Mercy 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

Mercy 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 Mercy 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.

Mercy RBHA shall participate in the review of new approved technologies, including the usage of new applications for established technologies through the Mercy RBHA Pharmacy and Therapeutics Committee and the Medical Management Committee.

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Mercy 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 Mercy RBHA's determination of coverage shall be documented in the Pharmacy and Therapeutics Committee meeting minutes and the Medical Management Committee meeting minutes.

Mercy 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, in order 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.

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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 PAS 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 (See [Covered Behavioral Health Services Guide, Reference Table B4 – ICD-10 Diagnosis Codes Effective 6/15/2016](#)) (These are forwarded to the AHCCCS Office of the Medical Director.)

When a PASRR Level I Screening is received by Mercy RBHA, the PASRR Coordinator reviews it and, if needed, consults with the Mercy 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:

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- 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

Mercy 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

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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 Mercy RBHA Medical Director or designee reviews all evaluations and makes final Level II placement determinations prior to the proposed/current placement.

Mercy 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

Mercy 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 in order to ensure the continued appropriateness of nursing home level of care and the provision of appropriate behavioral health services.

Reporting

Mercy 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)**, MERCY 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.

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Per **42 C.F.R. 483.118 (c) (i-iv)**, Mercy 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**. Mercy 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 Mercy 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

Mercy 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.

Mercy RBHA must provide AHCCCS with any requested information, and to make available witnesses necessary to assist with the defense of the decision on appeal, in the event that a person appeals the determination of the PASRR evaluation.

Retention

Mercy RBHA must retain case records for all Level II evaluations for a period of 6 years in accordance with **A.R.S. §12-2297**.

Mercy RBHA must permit authorized AHCCCS personnel reasonable access to files containing the reports received and developed.

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Training

Training will be provided to psychiatrists and any other medical professionals that conduct Level II evaluations as needed.

13.13 - Retrospective Review

Mercy 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 Mercy RBHA utilizing the following processes:

- SFTP: Mercy Care 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 RBHA
Utilization Management Department
4500 E. Cotton Center Blvd.
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 RBHA
Claims Disputes
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040
- Grievance & Appeals must be sent to the following address:
Mercy Care RBHA
Grievance & Appeals
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040

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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, Mercy 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 Mercy 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.

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RBHA Chapter 14 – Contract Compliance**14.00 – Confidentiality**

Information and records obtained in the course of 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

Mercy 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 in order 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 Mercy RBHA and health care providers are required to use and disclose protected health information. In addition, Mercy RBHA and health care providers are now required to notify each individual

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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 Mercy 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, Mercy 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 guardian 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

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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 in order to share behavioral health related information with the member's parent/legal guardian, 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 legal guardian 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, guardians' 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 has the opportunity to 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;

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- 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

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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 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 of 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;

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- 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 of 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

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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**.

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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, guardian 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, guardian 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)**).

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- When state law, including case law, is silent on whether protected health information can be disclosed to a parent, guardian 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, guardian 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 guardian 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 guardian 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**.

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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 in the course of 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

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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 Mercy 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**, in order 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

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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 in order 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 a number of provisions that address the disclosure of communicable disease information. The general rule is that a member who obtains communicable disease related information in the course of 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:

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- 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 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 time 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.

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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 legal guardian 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

Mercy 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.

Mercy 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.

Mercy 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.

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Mercy 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.

Mercy 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 guardian 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:
 - Mercy RBHA or subcontracted provider must advise the member or guardian 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 form 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 guardian; 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

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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 legal guardian.

If the member is deceased, authorization may be given by:

- A court appointed executor, administrator or other 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

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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 of the elements listed in [*Disclosure of Alcohol and Drug Information*](#) above is not acceptable.

[*Security Breach Notification*](#)

Mercy RBHA and their subcontracted providers, in the event of an impermissible use/disclosure of unsecured PHI, must provide notification to any and 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 remain closed at all times;
- 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.

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- 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 Abuse Block Grant (SABG) or the Projects for Assistance in Transition from Homelessness (PATH) Program are eligible to receive services. However, members receiving services funded by SABG 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 in order to receive crisis services.

Completing AHCCCS Eligibility Determination Screening

If a member is currently enrolled with AHCCCS and has been assigned to Mercy 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

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- 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 at a later date, 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.

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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

Mercy 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.

Mercy 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, in the course of completing the application process or while conducting business with Mercy 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 Mercy RBHA employee or healthcare provider consider it to be a reportable violation.

Mercy 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).

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It is **not** the responsibility of Mercy 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.

Mercy 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 Mercy RBHA employee or provider who identifies a violation must submit an online report to AHCCCS as outlined above.

Documentation Expectations

The Mercy RBHA employee/provider must document in the member's medical record (if the provider) or in the Corporate Compliance Office (if Mercy 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 as a result of the report.

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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 particular 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 Mercy 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 Mercy RBHA.
- For a Non-Title XIX/XXI eligible member to be enrolled, providers must submit an enrollment transaction to Mercy 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 **RBHA**

PLAN SPECIFIC TERMS**Chapter 2 – Network Provider Service Delivery Requirements, Section 2.07 – SMI Patient Navigator.*****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 Mercy RBHA if required data elements are missing.

For AHCCCS enrolled individuals, the eligibility and enrollment information are provided to Mercy RBHA by AHCCCS daily and is available to providers on the Mercy Care Secure Web Portal.

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 Mercy RBHA within 14 days of the first contact with a behavioral health member;
- Dis-enrollments are managed and processed by Mercy 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 Mercy RBHA of changes to the above information. That information will be provided from AHCCCS to Mercy RBHA on a daily file.

When a member in an episode of care permanently re-locates from one T/RBHA's geographic area to another T/RBHA's geographic area, an inter-T/RBHA transfer must occur (see **RBHA Chapter 8 – Coordination of Care, Section 8.00 – Inter-T/RBHA Coordination of Care**). The steps that are necessary to facilitate an inter-T/RBHA transfer include the following data submission requirements:

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- The home T/RBHA must submit a disenrollment transaction effective on the date of transfer and end the episode of care; and
- The receiving T/RBHA must submit an enrollment transaction on the date of accepting the member for services and start an episode of care.
- AHCCCS will notify Mercy RBHA when a Mercy 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 Mercy 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/RBHA. If a provider requires assistance for technical related problems or issues, please contact Mercy 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.

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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.

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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)

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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, in order 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 through the use of 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 Mercy 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 subsequent to the occurrence of seclusion or restraint to Mercy RBHA's Quality Management Department within five (5) calendar days of the occurrence. The individual reports must be submitted on the **Policy 962, Attachment A, Seclusion and Restraint Individual Reporting Form**. This form is available on Mercy RBHA's website.

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

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

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

PLAN SPECIFIC TERMS**RBHA Chapter 17 – Grievance System and Member Rights****17.00 – Title XIX/XXI Notice and Appeal Requirements*****General Requirements***

“Day” is defined as any calendar day unless otherwise specified.

Computation of Time

Computation of time for appeals begins the day after the act, event or decision and includes the final day of the period. For purposes of computing all timeframes, except for the standard service authorization time frames and extensions thereof, if the final day of the period is a weekend day (Saturday or Sunday) or legal holiday, the period is extended until the end of the next day that is not a weekend day or a legal holiday.

For a standard service authorization with or without an extension, if the final day of the period is a weekend day or legal holiday the period is shortened to the last working day immediately preceding the weekend day or legal holiday.

Computation of time in calendar days includes all calendar days. Computation of time in workdays includes all working days, i.e., non-weekend.

Language and Format Requirements

Mercy RBHA is responsible for sending notice to Title XIX/XXI eligible members must ensure that:

- Notice and written documents related to the appeals process must be available in each prevalent, non-English language spoken within Mercy RBHA’s Geographic Service Area;
- As applicable, Mercy RBHA must provide free oral interpretation services to explain information contained in the notice or as part of the appeal process for all non-English languages;
- Notice and written documents related to the appeals process must be available in alternative formats, such as Braille, large font or enhanced audio and take into consideration the special communication needs of the member; and
- Notice and written documents must be written using an easily understood language and format.

Delivery of Notices

All notices identified herein, including those provided during the appeal process, shall be mailed to the required party at their last known residence or place of business. If it may be unsafe to contact the member at his or her home address, or the member has indicated that he or she does not want to receive mail at home, the alternate methods identified by the individual for communicating notices shall be used.

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Prohibition of Punitive Action

Mercy RBHA or Providers must not take punitive action against a Title XIX/XXI eligible member who decides to exercise their right to appeal. Mercy RBHA does not take punitive action against member or member's legal guardian who requests an expedited resolution to an appeal or who supports a Title XIX/XXI eligible member's appeal.

Notice of Adverse Benefit Determination (NOA)

For Title XIX/XXI covered services, notice must be provided following:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service that is not TXIX/XXI covered; and
- The denial of the Title XIX/XXI member's request to obtain services outside the network.

Complex Case Request

Mercy RBHA is responsible for sending all Notices of Adverse Benefit Determination (NOA) to Title XIX/XXI eligible members. Providers who determine an action are required to complete a **Complex Case Review Form**, available on our [Forms Library](#) web page, and forward their request to Mercy RBHA Medical Management at ComplexCase@MercyCareAZ.org for review. Providers must include the following information in their email request:

- Member name, date of birth, AHCCCS ID number, services request, type of request, whether the request is immediate or routine
- Brief description of the reason for the notice with any applicable dates
- The name of the requestor, their title, email address, fax and phone number

ACT services

ACT teams are required to submit Complex Case Review forms for all Title XIX/XXI eligible members who have been screened for ACT services (per ACT referral screening protocols) and member has been preliminarily determined to not meet ACT criteria by the ACT screening team. ACT teams shall complete a Complex Case Review form within 7 calendar days from the day the ACT screening team rendered a preliminary decision that the member who was referred does not meet criteria for ACT services.

Non-Prior Authorized Level of Care

Providers are expected to work with the member regarding clinical and service needs. Providers will review needs of the member and determine if the member/guardian is in agreement

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regarding services. If a member/guardian is not in agreement, the provider will complete the following actions:

- Utilize staffing to address member needs
- Include the right support system
- Update the ISP to support member outcomes
- If unable to come to agreement, the provider will complete the **Complex Case Review Form**, available on our [Forms](#) web page, and submit it to Mercy RBHA at email: ComplexCase@MercyCareAZ.org.
- Mercy RBHA will respond and coordinate next steps on complex cases that can't be resolved at the provider level. If the provider is unable to support the member in the current setting and needs subject matter expert support from the plan level.
- Mercy RBHA will respond and coordinate next steps in accordance with timeframes below:
 - Within one business day on immediate resolution requests
 - Within 5 business days on routine resolution requests

The provider does not complete an NOA for member closures. The provider needs to follow the guidelines in Provider Manual **RBHA Chapter 2 – Network Provider Service Requirements, Section 2.03, Outreach, Engagement, Re-engagement and Closure** for the following areas:

- Engagement
- Reengagement
- No Show Policy
- Follow-Up After Significant and/or Critical Events
- Ending an Episode of Care for Person in Behavioral Health System
- Further Treatment Declined
- Lack of Contact

Authorized Level of Care

When a provider has determined they are not clinically able to support the member in current setting, they will:

- Outreach the assigned Mercy RBHA Utilization Review staff, and
- Mercy RBHA UM staff reviews the case with the medical director (MDR) to determine if the member still meets medical necessity.
 - If the member still meets medical necessity, the UM team will coordinate a transfer to another provider at the same level of care.
 - If the member no longer meets medical necessity, the MDR completes a denial and Mercy RBHA issues the NOA in accordance with applicable policies.

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AHCCCS sends notices to Title XIX/XXI eligible members enrolled with a Tribal RBHA (TRBHA) following:

- The denial or limited authorization of a requested service, including the type or level of service (see **RBHA Chapter 12 – Service Authorizations, Section 12.00 - Securing Services and Prior Authorization**); and
- The reduction, suspension or termination of a previously authorized service. AHCCCS sends notices to Title XIX/XXI eligible members who have been adversely affected by a PASRR determination in the context of either a preadmission screening or a resident review.

Communication of Notice to Title XIX/XXI Eligible Members

The use of **Notice of Adverse Benefit Determination**, available on our **Forms Library** web page, is required when providing notice regarding an action concerning a Title XIX/XXI member which will include the following:

- The requested service;
- The reason/purpose of that request in layperson terms;
- The action taken or intended to be taken (denial, limited authorization, reduction, suspension or termination) with respect to the service request;
- The effective date of the action;
- The reason for the action, including member specific facts;
- The legal basis for the action;
- Where members can find copies of the legal basis;
- The right to and process for appealing the decision; and
- Legal resources for members for help with appeals, as prescribed by AHCCCS

Delivery of Notices

The **Notice of Adverse Benefit Determination**, available on our **Forms Library** web page, must be mailed to the Title XIX/XXI eligible member and, when applicable, their legal representative or designated representative (e.g., Department of Economic Security/Division of Children, Youth and Families/Department of Child Safety (DCS) Specialist and/or advocate for SMI members requiring special assistance). For Title XIX/XXI eligible members under the age of 18, the **Notice of Adverse Benefit Determination**, available on our **Forms Library** web page, must be mailed to their legal or custodial parent or a government agency with legal custody of the Title XIX/XXI eligible member.

All notices must be mailed to all parties at their last known residence or place of business. If it may be unsafe to contact a member at his or her home address, or the member does not want to receive mail at home, alternate methods identified by the member for communicating notice must be used.

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*Notice of Adverse Benefit Determination Timeframes**Notice of Adverse Benefit Determination for Service Authorization Requests*

For service authorization requests, the following timeframes for sending **Notice of Adverse Benefit Determination**, available on our **Forms Library** web page, are in effect (See **RBHA Chapter 12.0 – Service Authorizations, Section 12.00 – Securing Services and Prior Authorization** for required timeframes for decisions regarding prior authorization requests):

- For an authorization decision related to a service requested by or on behalf of a Title XIX/XXI eligible member, Mercy RBHA must send a **Notice of Adverse Benefit Determination**, available on our **Forms Library** web page, within 14 days following the receipt of the member's request;
- For an authorization request in which Mercy RBHA indicates or determines, that the 14 calendar day timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, the responsible entity must make an expedited authorization decision and send the **Notice of Adverse Benefit Determination**, available on our **Forms Library** web page, as expeditiously as the member's health condition requires;
- If the Title XIX/XXI eligible member requests an extension of either timeframe above, the Mercy RBHA must extend the timeframe up to an additional 14 days;
- If Mercy RBHA needs additional information and the extension is in the best interest of the member, Mercy RBHA shall extend the 14-calendar day or the three working day timeframe up to an additional 14 days. If Mercy RBHA extends the timeframe, Mercy RBHA must:
 - Give the Title XIX/XXI eligible member written notice of the reason for the decision to extend the timeframe using [Notice of Extension of Timeframe for Service Authorization Decision Regarding Title XIX/XXI Services](#), and inform the member of the right to file a complaint if the member disagrees with the decision; and
 - Issue and carry out the determination as expeditiously as the member's condition requires and no later than the date the extension expires.
 - For service authorization decisions not reached within the maximum timeframes outlined above, the authorization shall be considered denied on the date that the timeframe expires.
 - Mercy RBHA shall provide the requesting provider written notification of a decision to deny a service authorization.

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Notice of Adverse Benefit Determination for Service Termination, Suspension or Reduction

For service terminations, suspensions or reductions, the following timeframes are in effect:

- Mercy RBHA must send the **Notice of Adverse Benefit Determination** at least 10 days before the date of the action with the following exceptions. Mercy RBHA may send the **Notice of Adverse Benefit Determination** no later than the date of the action if:
 - Mercy RBHA has factual information confirming the death of a Title XIX/XXI member;
 - Mercy RBHA receives a clear written statement signed by the Title XIX/XXI member or their legal representative that the member no longer wants services or gives information to Mercy RBHA that requires termination or reduction of services and indicates that the member understands that this will be the result of supplying that information;
 - The Title XIX/XXI member is an inmate of a public institution that does not receive federal financial participation and the member becomes ineligible for TXIX/XXI;
 - The Title XIX/XXI member's whereabouts are unknown and the post office returns mail to Mercy RBHA indicating no forwarding address;
 - The Title XIX/XXI eligible member's whereabouts are unknown and the post office returns mail, directed to the Title XIX/XXI eligible member, to Mercy RBHA or the provider, indicating no forwarding address;
 - Mercy RBHA establishes the fact that the Title XIX/XXI member has been accepted for Medicaid by another state. Mercy RBHA may shorten the period of advance notice to five days before the date of action if Mercy RBHA has verified facts indicating probable fraud; or
 - Mercy RBHA may shorten the period of advance notice to five (5) working days before the date of action if there are verified facts indicating probable fraud by the Title XIX/XXI eligible member.

Notice of Adverse Benefit Determination for Denial of Claim for Payment

Mercy RBHA is designated to authorize services and shall send a **Notice of Adverse Benefit Determination** to the Title XIX/XXI eligible member if they deny a claim for payment to the provider for a service that is not Title XIX/XXI covered.

Title XIX/XXI Appeal and State Fair Hearing Process

A Title XIX/XXI eligible member may appeal the following actions with respect to Title XIX/XXI covered services:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service that is not TXIX/XXI covered;

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- The failure to provide TXIX/XXI services in a timely manner;
- The failure to act within the timeframes required for standard and expedited resolution of appeals and standard disposition of grievances; and
- The denial of a TXIX/XXI enrollee's request to obtain services outside the Mercy RBHA's provider network.

A Title XIX/XXI eligible member adversely affected by PASRR determination in the context of either a preadmission screening or a resident review may file an appeal under this policy.

Responsibility

Mercy RBHA is responsible for processing appeals and does not delegate this function to a provider. AHCCCS processes appeals related to actions initiated by a Tribal RBHA or one of their subcontracted providers. Any responsibilities attributed to Mercy RBHA are the responsibility of AHCCCS if the action relates to a Tribal RBHA or one of their subcontracted providers or relates to an appeal concerning a PASRR determination. Information gathered during the appeal process is considered confidential and the member's rights to privacy are protected throughout the process.

The following information is provided to familiarize providers with the Title XIX/XXI appeal process.

Filing an Appeal or Request a State Fair Hearing

The following members or authorized representative(s) may file an appeal or request a State Fair Hearing regarding an action:

- A Title XIX/XXI eligible member;
- A legal or authorized representative, (e.g., Department of Child Safety (DCS) Specialist and/or advocate for SMI members requiring special assistance), including a provider, acting on behalf of the member, with the member's or legal representative's written consent.
- A Title XIX/XXI eligible member adversely affected by a PASRR determination in the context of either a preadmission screening or a resident review.

Standard and Burden of Proof

The standard of proof on all issues on appeal shall be the preponderance, or the greater weight, of the evidence. The burden of proof for all issues on appeal is on the complainant (individual or agency) appealing.

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Denial of Request for Appeal

In the event Mercy RBHA refuses to accept a late appeal or determines that the decision being appealed does not constitute an action subject to these appeal requirements, Mercy RBHA must inform the appellant in writing by sending a Notice of Appeal Resolution.

Timeframe for Filing Standard Appeal

A Title XIX/XXI eligible member has up to 60 days after the date of the **Notice of Adverse Benefit Determination** to file a standard appeal. The appeal may be filed orally or in writing.

Timeframes for MERCY RBHA to Resolve a Standard Appeal

Mercy RBHA resolves standard appeals and mails written Notice of Appeal Resolution no later than 30 days from the date of receipt of the appeal unless an extension is in effect.

Extension of Timeframe for Standard Appeal Resolution

If a Title XIX/XXI eligible member requests an extension of the 30-day timeframe, Mercy RBHA will extend the timeframe up to an additional 14 days. If Mercy RBHA needs additional information and the extension is in the best interest of the member, Mercy RBHA may extend the 30-day timeframe up to an additional 14 days.

Expedited Appeal

Mercy RBHA conducts an expedited appeal if:

- Mercy RBHA receives a request for an appeal from a Title XIX/XXI eligible member and determines that taking the time for a standard appeal resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function;
- Mercy RBHA receives a request for an expedited appeal from a Title XIX/XXI eligible member supported with documentation from the provider that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain or regain maximum function; or
- Mercy RBHA receives a request for an expedited appeal directly from a provider, with the Title XIX/XXI eligible member's written consent, and the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain or regain maximum function.

Denial of Expedited Appeal

If Mercy RBHA denies a request for expedited resolution of an appeal from a Title XIX/XXI eligible member, Mercy RBHA will resolve the appeal within the standard resolution timeframe and make reasonable efforts to give the member prompt oral notice of the denial. Within two calendar days, Mercy RBHA follows up with written notice of the denial.

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Timeframes for MERCY RBHA to Resolve an Expedited Appeal

Mercy RBHA must resolve expedited appeals and mail a written Notice of Appeal Resolution within 72 hours after the day Mercy RBHA receives the appeal unless an extension is in effect.

Extension of Expedited Appeal Resolution Timeframe

If a Title XIX/XXI eligible member requests an extension of the 72-hour timeframe, Mercy RBHA will extend the timeframe up to an additional 14 days. If Mercy RBHA needs additional information and the extension is in the best interest of the member, Mercy RBHA extends the three working day timeframe up to an additional 14 days.

Filing Appeals

All appeals must be submitted in writing, along with substantiating documentation to:

Mercy Care RBHA
Attn: Grievance and Appeals
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040
Fax: 602-351-2300

A member can also file an appeal orally by contacting:

Mercy Care RBHA
Grievance and Appeals
Phone: 602-586-1719
866-386-5794

Requesting a State Fair Hearing

A Title XIX/XXI eligible member, legal or authorized representative may request a State Fair Hearing following Mercy RBHA's resolution of an appeal. The request must be in writing and submitted to:

Mercy Care RBHA
Attn: Grievance and Appeals
4500 E. Cotton Center Blvd
Phoenix, AZ 85040
Phone: 602-586-1719
866-386-5794
Fax: 602-351-2300

The request must be received by Mercy RBHA no later than 120 days after the date that the member received the Notice of the Appeal Resolution.

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Assistance to Title XIX/XXI Eligible Members in Filing an Appeal and/or Requesting a State Fair Hearing

Mercy RBHA provides reasonable assistance to Title XIX/XXI eligible members in completing forms and other procedural steps. Reasonable assistance includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD (teletypewriter/telecommunications device for the deaf and text telephone) and interpreter capability. Reasonable assistance may be offered by a provider or referred to Mercy RBHA by contacting the Grievance and Appeals department at 602-453-6098 or 866-386-5794.

AHCCCS Timeframe for Resolution of a State Fair Hearing

AHCCCS will send a Notice of State Fair Hearing according to **ARS §41-1092.05** if a timely request for a State Fair Hearing is received.

For appeals resolved pursuant to the standard resolution timeframes, AHCCCS will send an AHCCCS Director's decision to the Title XIX/XXI member no later than 30 days after the date of the Administrative Law Judge's recommended decision and within 90 days after the date that the appeal was filed with Mercy RBHA, not including the number of days the Title XIX/XXI eligible member took to file for a State Fair Hearing, and days for continuances granted at the Title XIX/XXI eligible member's request.

For appeals resolved pursuant to the expedited resolution timeframes, within three working days after the date AHCCCS receives the case file and information from Mercy RBHA concerning an expedited appeal resolution, AHCCCS will send the Title XIX/XXI eligible member the AHCCCS Director's decision which results from the State Fair Hearing and the Administrative Law Judge's Recommended Decision. AHCCCS will make reasonable efforts to provide oral notice of the AHCCCS Director's decision.

Continuation of Services during Appeal or State Fair Hearing Process

For the purposes of this chapter, if the following criteria are met, services shall be continued based on the authorization that was in place prior to the denial, termination, reduction or suspension of services that has been appealed. A Title XIX/XXI eligible member's services can continue during the appeal and State Fair Hearing process, unless continuation of services would jeopardize the health or safety of the member or another member, if:

- The member files the appeal timely*;
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment or the appeal involves a denial if the provider asserts the denial represents a necessary continuation of a previously authorized service;
- The services were ordered by an authorized provider; and
- The member requests continuation of services.

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*Timely filing means filing on or before the later of the following:

- Within 10 days after the date that Mercy RBHA or the subcontracted provider mails or delivers the **Notice of Adverse Benefit Determination**; or
- The effective date of the action as indicated in the **Notice of Adverse Benefit Determination**.

If a member wishes services to continue during appeal, they must request the continuation of services when the appeal is initially filed **and** at the time of requesting a State Fair Hearing.

Discontinuation of Services during Appeal or State Fair Hearing Process

Mercy RBHA is required to continue services until one of the following occurs:

- The Title XIX/XXI eligible member withdraws the appeal;
- The Title XIX/XXI eligible member makes no request for continued benefits within 10 days of the delivery of the Notice of Appeal Resolution or
- The AHCCCS Administration issues a State Fair Hearing decision adverse to the Title XIX/XXI eligible member.

Upheld Appeal

If the AHCCCS Director's decision upholds Mercy RBHA's action, Mercy RBHA may recover the cost of the services furnished to a Title XIX/XXI eligible member while the appeal is pending if the services were furnished solely because of the requirements above.

Overtured Appeal

If Mercy RBHA or AHCCCS Director reverses a decision to deny, limit, or delay authorization of services, and the member received the disputed services while an appeal was pending, Mercy RBHA will process a claim for payment from the provider in a manner consistent with the Mercy RBHA or Director's Decision and applicable statutes, rules, policies, and contract terms. (See **ARS §36-2904**).

Mercy RBHA is required to provide the disputed services that were not provided during the appeal or State fair hearing process no later than 72 hours from the date it overturns the appeal (if appeal is overturned) (438.424(a)).

The provider will have 90 days from the date of the reversed decision to submit a clean claim to Mercy RBHA for payment. For all claims submitted because of a reversed decision, Mercy RBHA is prohibited from denying claims as untimely if they are submitted within the 90-day timeframe.

Mercy RBHA is also prohibited from denying claims submitted by providers because of a reversed decision because the member chose not to request continuation of services during the

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appeals/hearing process. A member's failure to request continuation of services during the appeals/hearing process is not a valid basis to deny the claim.

17.01 – Complaint Resolution

General Requirements

Mercy RBHA develops and provides training to staff responsible for taking complaints. The training plan is submitted to AHCCCS and updated annually on an ad hoc basis as modified. The training must include information regarding the complaint (member grievance) process; appeals, SMI grievances and requests for investigations; and customer service requirements.

Individuals responsible for taking complaints must provide assistance as indicated by the following:

- An action that is subject to appeal through the Title XIX/XXI Member Appeal process shall be treated as an appeal pursuant to **RBHA Chapter 17 – Grievance System and Member Rights, Section 16.00 - Title XIX/XXI Notice and Appeal Requirements** to establish the earliest possible filing date for the appeal.
- For members determined to have SMI who are appealing a decision regarding SMI eligibility, or Non-TXIX/XXI members appealing the need for a covered service, see **RBHA Chapter 17 – Grievance System and Member Rights, Section 16.03 - Notice and Appeal Requirements (SMI and Non-Title XIX/XXI)**.
- For allegations of rights violations concerning members determined to have SMI see **RBHA Chapter 17 – Grievance System and Member Rights, Section 16.02 - Conduct of Investigations Concerning Members with Serious Mental Illness**.

In the event a complainant is dissatisfied with the resolution to a complaint, the issue(s) in dispute may still be referred to applicable appeal and grievance processes.

Mercy RBHA shall not route or otherwise encourage the direct filing of complaints with AAHCCCS unless the member is AHCCCS or Arizona Long Term Care Services (ALTCs) eligible and enrolled and the complaint is specific or directly relates to the acute care health plan/provider.

There are no time limits placed on filing a complaint.

Mercy RBHA Requirements for Handling Complaints

Responsibilities for resolving complaints pursuant to requirements of this policy shall not be delegated by Mercy RBHA to provider agencies.

Regardless of who within the organization receives a complaint or whether it is filed orally or in writing, Mercy RBHA shall have a centralized complaint resolution process and designated individuals to whom all complaints shall be referred.

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Complaints may be made to Mercy RBHA orally or in writing by members or those seeking covered services, their families or legal guardian(s), authorized representatives, other agencies, or the public.

- For oral complaints: Call Mercy RBHA at 602-586-1841
- To submit a written complaint: Mail the complaint to:
Mercy Care RBHA
Attn: Complaints
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040

All complaints will be acknowledged. Complaints filed orally shall be considered acknowledged at the time of filing. Written complaints must be acknowledged to the complainant within 5 working days of receipt by Mercy RBHA but acted upon in accordance with the urgency of the concern. If verbal acknowledgment is not achieved, a written acknowledgement letter must be sent within the 5-day timeframe. The letter will include a contact name and a phone number.

When information is received, either orally or in writing, that the individual has Limited English Proficiency (LEP) or any other communication need; Mercy RBHA must follow requirements outlined in **MC Chapter 4 – Provider Requirements, Section 4.25 Cultural Competency, Health Literacy and Linguistic Services**, regarding oral interpretation services, translation of written materials, and services for the deaf and hard of hearing:

- For all individuals with LEP, the provider must make available oral interpretation services.
- For individuals needing translation in the prevalent non-English language within the region, Mercy RBHA shall provide a written translation in accordance with the requirements of **MC Chapter 4 – Provider Requirements, Section 4.25 – Cultural Competency, Health Literacy and Linguistic Services**.
- For individuals who need translation in a language that is not considered a prevalent non-English language within the region or who require alternative formats (such as TTY/TTD), Mercy RBHA shall provide oral interpretation of written materials or make alternative communication formats available as indicated.
- Mercy RBHA must follow up on each complaint as expeditiously as the member's condition requires.

Mercy RBHA must address the identified issues as expeditiously as the member's condition requires. Complaints involving or asserting an immediate need such as a crisis service or assessment, access to medication, or health and safety concerns require immediate follow up.

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Mercy RBHA is required to dispose of each complaint and provide oral or written notice to affected parties as quickly as possible and in conformance with confidentiality requirements. If a member requests a written explanation of the complaint resolution, the complaint resolution response must be mailed within 10 days.

Most complaints should be resolved within 10 business days of receipt, but in no case longer than 90 days.

Mercy RBHA is responsible for investigating the complaint and issuing a resolution decision and shall ensure that:

- Individuals who make decisions regarding complaints are not involved in any previous level of review or decision-making; and
- Individuals making decisions about complaints that involve the denial of an expedited resolution of an appeal, or that involve clinical issues must be health care professionals with the appropriate clinical expertise in treating the member's condition.

If the complainant is dissatisfied with Mercy RBHA's resolution of their complaint, Mercy RBHA will advise the complainant that they may contact AHCCCS for additional review. AHCCCS will review the complaint and Mercy RBHA's efforts to resolve the complaint and intervene as indicated by the review.

In the event Mercy RBHA receives a complaint referred from AHCCCS, Mercy RBHA will provide AHCCCS with a written summary that describes the steps taken to resolve the complaint, including the findings, plan for resolution, and any plan for correction, within the timeframe specified by AHCCCS. Mercy RBHA will acknowledge receipt of AHCCCS referred complaints expeditiously and according to the urgency and response timeframe identified by AHCCCS.

Mercy RBHA shall ensure that any specific corrective action or other action directed by AHCCCS is implemented.

Mercy RBHA shall:

- Maintain individual complaint records that include adequate, dated documentation, including but not limited to:
 - Copies of communication generated during the resolution process;
 - Documentation of actions taken to ensure that immediate health care needs are met;
 - Documentation of all steps taken to resolve the concern, including the date the complaint was acknowledged and the date the complainant was notified of the resolution;
 - Documentation of the plans for resolution;

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- Documentation of plans for correction;
- Evidence that the resolution and any plans for correction have been implemented; and
- Evidence that identified issues are referred for additional follow up as indicated, including referrals to Quality Management, Network Management, Grievance and Appeals, Fraud and Abuse, and/or regulatory agencies.
- For complaints taking greater than 10 business days to resolve from the date of filing, the reason for the delay.
- Maintain a log of all complaints received utilizing a set of fields which documents the following information:
 - The enrollee's first and last name;
 - The date the complaint was made;
 - Title XIX/XXI eligibility status;
 - The source of the complaint;
 - A description of the complaint;
 - Any identified communication need (e.g., need for translator);
 - The outcome reached;
 - The length of time for outcome as indicated in Section G.1.h. of this policy;
 - Covered service category;
 - Treatment setting; and
 - Behavioral health category.
- Routinely review the data collected through the complaint process as part of the Mercy RBHA's quality improvement strategy and network sufficiency review.

17.02 – Conduct of Investigations Concerning Members with Serious Mental Illness***General Requirements***

Members requesting or receiving services shall be notified of their right to file grievances or request investigations according to the requirements set forth in **RBHA Chapter 16 – Grievance System and Member Rights, Section 16.03 - Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)**. Mercy RBHA and the AzSH, shall respond to grievances and requests for investigations in accordance with this policy and the requirements and timelines contained in **9 A.A.C. 21, Article 4**.

Computation of Time – In computing any period prescribed or allowed by this policy, 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.

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Mercy RBHA or the AzSH shall use the unique Docket Number each appeal filed. The file and all correspondence generated shall reference the Docket Number.

Agency Responsible for Resolving Grievances and Requests for Investigation

Grievances involving an alleged rights violation, or a request for investigation involving an allegation that a condition requiring investigation exists, which occurred in an agency operated by Mercy RBHA, one of its subcontracted providers or the AzSH, and which does not involve a client death or an allegation of physical or sexual abuse, shall be filed with and investigated by Mercy RBHA or the AzSH.

Grievances or requests for investigation involving physical or sexual abuse or death that occurred in the AzSH, an agency which is operated by Mercy RBHA or one of its subcontracted providers or because of an action of a member employed by Mercy RBHA or one of its subcontracted providers shall be addressed and investigated by AHCCCS.

Grievances involving a rights violation, or a request for investigation involving an allegation that a condition requiring investigation exists and which occurred in an agency that is not AzSH, Mercy RBHA or one of their subcontracted providers, shall be addressed to the appropriate regulatory division or agency.

The AHCCCS Deputy Director, or designee, the Mercy RBHA Chief Executive Officer (CEO), or the Chief Executive Officer of the AzSH, before whom a grievance or request for investigation is pending, shall immediately take whatever action may be reasonable to protect the health, safety and security of any client, complainant or witness.

Grievance/Request for Investigation Process Timeliness and Method for Filing Grievances

Grievances or a request for investigation must be submitted to AzSH or Mercy RBHA, orally or in writing, no later than 12 months from the date the alleged violation or condition requiring investigation occurred. This timeframe may be extended for good cause as determined by the AHCCCS Deputy Director, or designee, Mercy RBHA Director, or CEO of AzSH, before whom the grievance or request for investigation is pending.

All grievances or requests for investigation must be submitted orally or in writing to:

Mercy Care RBHA
Attn: Grievances and Appeals
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040
Fax Number: 602-351-2300
Phone: 602-586-1719 or 866-386-5794

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Within five days of receipt of a grievance or request for investigation, AzSH or Mercy RBHA must inform the member filing the grievance or request for investigation, in writing, that the grievance or request has been received.

Any employee or contracted staff of AzSH, Mercy RBHA or its subcontracted provider, shall, upon request, assist a member receiving services, or their legal guardian, in making an oral or written grievance or request for investigation or direct the member to an available supervisory or managerial staff who shall assist the member to file a grievance or request for investigation.

All oral grievances and requests for investigation must be accurately reduced to writing by AzSH, Mercy RBHA or its subcontracted provider that receives the grievance or request, on the **Appeal or SMI Grievance Form**, available on our [Forms](#) web page.

Preliminary Disposition

Summary Disposition – AzSH, Mercy RBHA Director or designee, may summarily dispose of a grievance or request for investigation, which shall not include any notice or right for further review or hearing, when:

- The alleged violation occurred more than one year prior to the date of request; or
- The grievance request is primarily directed to the level or type of mental health treatment provided and can be fairly and efficiently addressed through the service planning or appeal process as described in **9 A.A.C. 21, Articles 3 and 4**.

Disposition without Investigation

Within seven days of receiving a grievance or request for investigation, AzSH, Mercy RBHA Director or designee, may resolve the matter without conducting a full investigation when:

- The matter involves no material dispute as to the facts alleged in the grievance or request for investigation;
- The allegation is frivolous, meaning that it:
 - Involves conduct that is not within the scope of Title 9, Chapter 21;
 - Is impossible on its face; or
 - Is substantially like conduct alleged in two previous grievances or requests for investigation within the past year and which have been determined to be unsubstantiated.
- Is resolved fairly and efficiently within seven days without a formal investigation.

Within seven days of the grievance or request for investigation, AzSH, Mercy RBHA's Director or designee, shall prepare a written dated decision which shall explain the essential facts as to why the matter may be appropriately resolved without investigation, and the resolution. The written decision shall contain a notice of appeal rights, and information to request assistance

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from the AHCCCS Office of Human Rights (OHR) and the State Protection and Advocacy System. Copies of the decision shall be sent to the member filing the grievance or request for investigation and to the AHCCCS OHR for members who need special assistance.

Conducting Investigation of Grievances

AzSH, and Mercy RBHA shall conduct the investigation pursuant to **A.A.C. R9-21-406**.

If an extension of any time frame related to the grievance process in **A.A.C. R9-21, Article 4** is needed; it must be requested and approved in compliance with **A.A.C. R9-21-410(B)**.

Specifically:

- Mercy RBHA investigator or any other official responsible for responding to grievances must address their extension request to Mercy RBHA Director or designee.
- The Mercy RBHA investigator or any other Mercy RBHA official responsible for responding to grievances must address their extension request to the AHCCCS Deputy Director or designee; and
- A Mercy RBHA request for an extension to complete an investigation for grievances remanded pursuant to **A.A.C. R9-21-407(B)(2)** or any other period established by AHCCCS decisions relating to a grievance shall be addressed to the AHCCCS Deputy Director or designee.

Grievance Investigations – Allegations of Rights Violations or Physical Abuse

The investigator shall:

- Interview the member who filed the grievance and the member receiving services who is identified as the subject of the violation or abuse (if different) prior to interviewing the member alleged to be the perpetrator of the rights violation, or physical or sexual abuse.
- If the member who is the subject of the investigation needs special assistance, the investigator shall contact the member's advocate; or if no advocate is assigned, the member shall contact AHCCCS OHR, and request that an advocate be present to assist the member during the interview and any other part of the investigation process.
- Request assistance from the AHCCCS OHR if the member identified as the subject needs assistance to participate in the interview and any other part of the investigation process.
- Prepare a written report that contains at a minimum:
 - A summary for each individual interviewed of information provided by the individual during the interview conducted;
 - A summary of relevant information found in documents reviewed;
 - A summary of any other activities conducted as a part of the investigation;
 - A description of any issues identified during the investigation that, while not related to the allegation or condition under investigation, constitutes a rights violation or condition requiring investigation;

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- A conclusion, based on the facts obtained in the investigation, that the alleged violation or abuse is either substantiated or not substantiated based on a preponderance of the evidence. The conclusion must describe those findings and/or factors that led to this determination; and
- Recommended actions or a recommendation for required corrective action, if indicated.

Decisions

Within 5 days of receipt of the investigator's report, AHCCCS' Deputy Director or designee, Mercy RBHA Director, or the CEO of AzSH shall review the investigation case record, and the report, and issue a written, dated decision which shall either:

- Accept the report and state a summary of findings and conclusions and any action or corrective action required of AzSH, Mercy RBHA Director, and send copies of the decision, subject to confidentiality requirements provided for in **RBHA Chapter 13 – Contract Compliance, Section 13.00 Confidentiality** to the investigator, AzSH, Mercy RBHA Director, the member who filed the grievance, the member receiving services identified as the subject of the violation or abuse (if different), and the AHCCCS Office of Human Rights for members deemed in need of Special Assistance. The decision sent to the grievant and the member who is the subject of the grievance (if different) shall include a notice of the right to request an administrative appeal of the decision within 30 days from the date of receipt of the decision. The decision must be sent to the grievant by certified mail or by hand- delivery.
- Reject the report for insufficiency of facts and return the matter for further investigation. The investigator must complete the further investigation and deliver a revised report to AHCCCS' Deputy Director or designee, Mercy RBHA Director, or the Chief Executive Officer of the AzSH within 10 days.

Actions

AHCCCS' Deputy Director or designee, Mercy RBHA Director, or the CEO of the AzSH may identify actions to be taken, as indicated above, which may include:

- Identifying training or supervision for or disciplinary action against an individual found to be responsible for a rights violation or condition requiring investigation identified during investigation of a grievance or request for investigation;
- Developing or modifying a mental health agency's practices or protocols;
- Notifying the regulatory entity that licensed or certified an individual according to **A.R.S. Title 32, Chapter 33** of the findings from the investigation; or
- Imposing sanctions, which may include monetary penalties, according to the terms of a contract, if applicable.

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Disagreement with Decision

A grievant or the client who is the subject of the grievance, who disagrees with the final decision of Mercy RBHA or AzSH, may file a request for an administrative appeal within 30 days from the date of their receipt of the Mercy RBHA or AzSH decision. The request for administrative appeal must specify the basis for the disagreement. Failure to specify the basis for the disagreement may result in a summary determination in favor of the Mercy RBHA or AzSH decision.

Administrative Appeal

In the event an administrative appeal is filed, Mercy RBHA or AzSH, shall forward the full investigation case record, which includes all elements in **A.A.C. R9-21-409(D)(1)**, to AHCCCS' Deputy Director or designee through the AHCCCS OGA. The failure of Mercy RBHA or AzSH to forward a full investigation case record that supports the Mercy RBHA or AzSH decision may result in a summary determination in favor of the member filing the administrative appeal. Mercy RBHA or AzSH shall prepare and send with the investigation case record, a memo in which Mercy RBHA states:

- Any objections AzSH or Mercy RBHA has to the timeliness of the administrative appeal;
- AzSH's or Mercy RBHA's response to any information provided in the administrative appeal that was not addressed in the investigation report; and
- AzSH or Mercy RBHA understands the basis for the administrative appeal.

Within 15 days of the filing of the administrative appeal, AHCCCS' Deputy Director or designee, will review the appeal and the investigation case record and may discuss the matter with any of the members involved or convene an informal conference, and prepare a written, dated decision which shall either:

- Accept the investigator's report with respect to the facts as found, and affirm, modify or reject the decision of the agency director with a statement of reasons. The decision, along with a notice of the right to request an administrative hearing within 30 days from the date of receipt of the decision, shall be sent to the appealing party, with copies of the decision provided to the AzSH or Mercy RBHA Director, as indicated; the OHR; and the applicable human rights committee; or
- Reject the investigator's report for insufficiency of facts and remand the matter with instructions to Mercy RBHA or AzSH for further investigation and decision. Mercy RBHA or AzSH shall conduct further investigation and complete a revised report and decision to AHCCCS' Deputy Director or designee within 10 days. Upon receipt of the report and decision, AHCCCS shall render a final decision consistent with the procedures described above; or;
- Reject Mercy RBHA's decision and remand the matter with instructions to Mercy RBHA or AzSH to conduct an investigation, or to conduct further investigation, issue an initial or revised, decision, and include a notice of the right of the grievant or client who is the

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subject of the grievance to request an administrative appeal to AHCCCS of the decision within 30 days from the date of receipt of the decision, consistent with the requirements in **A.A.C. R9-21-406, et. seq.**

A grievant or member who is the subject of the grievance who is dissatisfied with the decision of AHCCCS' Deputy Director, or designee may request an administrative hearing before an administrative law judge within 30 days of the date of the decision.

Upon receipt of a request for a hearing, the hearing shall be scheduled and conducted according to the requirements in **A.R.S. §41-1092 et seq.**

After the expiration of the time frames for administrative appeal and administrative hearing as described above, or after the exhaustion of all appeals regarding outcome of the investigation, Mercy RBHA or AzSH Director, or the Deputy Director, or designee of AHCCCS, shall take any corrective action required and add to the record a written, dated report of the action taken. A copy of the report shall be sent to the AHCCCS OHR for members in need of Special Assistance.

Unless an investigation request is made pursuant to **A.A.C. R9-21-403(A)** or **R9-21-403(B)**, investigations into the deaths of members receiving services shall be conducted as described in **MC Chapter 14 – Quality Management, Section 14.10 - Incident, Accident, Death Reporting.**

Grievance Investigation Records and Tracking System

AHCCCS, AzSH, and Mercy RBHA will maintain records in the following manner:

- All documentation received and mailed related to the grievance and investigation process will be date stamped on the day received;
- AHCCCS, AzSH, and Mercy RBHA will maintain a grievance investigation case record for each case. The record shall include:
 - The docket number assigned;
 - The original grievance/investigation request letter and the **Appeal or SMI Grievance Form**;
 - Copies of all information generated or obtained during the investigation;
 - The investigator's report which will include a description of the grievance issue, documentation of the investigative process, names of all members interviewed, written documentation of the interviews, summary of all documents reviewed, the investigator's findings, conclusions and recommendations; and
 - A copy of the acknowledgment letter, final decision letter and any information/documentation generated by an appeal of the grievance decision;
- AHCCCS, AzSH, and Mercy RBHA will maintain all grievance and investigation files in a secure designated area and retain for at least 5 years;

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Other Matters Related to Grievance Process

Pursuant to the applicable statutes, AzSH and Mercy RBHA shall maintain confidentiality and privacy of grievance matters and records at all times.

Notice shall be given to a public official, law enforcement officer, or other member, as required by law, that an incident involving death, abuse, neglect, or threat to a member receiving services has occurred, or that a dangerous condition or event exists.

AzSH or Mercy RBHA shall notify the Deputy Director or designee of AHCCCS when:

- A member receiving services files a complaint with law enforcement alleging criminal conduct against an employee;
- An employee or contracted staff files a complaint with law enforcement alleging criminal conduct against a member receiving services;
- An employee, contracted staff, or member receiving services is charged or convicted of a crime related to a rights violation, physical or sexual abuse, or death of a member receiving services.

17.03 – Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)***General Requirements for Notice and Appeals***

Behavioral health providers must be aware of general requirements guiding notice and appeal rights for the populations covered in this chapter. Behavioral health providers may have direct responsibility for designated functions (i.e., sending notice) as determined by Mercy RBHA and/or may be asked to provide assistance to members who are exercising their right to appeal.

Time Computed

In computing any time prescribed or allowed in this chapter, the period begins the day after the act, event or decision occurs. If the period is 11 days or more, the period must be calculated using calendar days, which means that weekends and legal holidays are counted. If, however, the period is less than 11 days, the period is calculated using working days, in which case, weekends and legal holidays must not be included in the computation. In either case, 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.

Language, Format and Comprehensive Clinical Record Requirements

Notice and related forms must be available in each prevalent, non-English language spoken in Mercy RBHA's geographic service area (GSA). As designated by Mercy RBHA, behavioral health providers must provide free oral interpretation services to all members who speak non-English languages for purposes of explaining the appeal process and/or information contained in the notice. Mercy RBHA is responsible for providing oral interpretation services at no cost to the member receiving such services.

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Notice and other written documents pertaining to the appeal process must be available in alternative formats, such as Braille, large font or enhanced audio and must take into consideration any special communication needs of the member applying for or receiving behavioral health services. Mercy RBHA is responsible for ensuring the availability of these alternative formats.

The provision of notice must be documented by placing a copy of the notice in the member's comprehensive clinical record.

Delivery of notices and appeal decisions

All notices and appeal decisions must be personally delivered or mailed by certified mail to the required party, at their last known residence or place of business. If it may be unsafe to contact the member at his or her home, or the member has indicated that he or she does not want to receive mail at home, the alternate methods identified by the member for communicating notices must be used.

Notice Requirements for Members with Serious Mental Illness

For actions (see definition) related to Title XIX/XXI covered services, see **RBHA Chapter 16 – Grievance System and Member Rights, Section 16.00 - Title XIX/XXI Notice and Appeal Requirements**.

The following provisions apply to notice requirements for members determined to have a SMI and for members for which an SMI eligibility determination is being considered.

Members who are evaluated for an SMI eligibility determination must receive **the Appeal or SMI Grievance Form**, available on our [Forms](#) web page, at the time of determination.

The Notice of Decision and Right to Appeal (for Individuals with a Serious Mental Illness) must be provided to members determined to have a Serious Mental Illness or to members applying for SMI services when:

- Initial eligibility for SMI services is determined. The notice must be sent within 3 days of the eligibility determination;
- A decision is made regarding fees or waivers;
- The assessment report, service plan or individual treatment and discharge plan is developed, provided or reviewed;

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- A decision is made to modify the service plan, or to reduce, suspend or terminate any service that is a covered service funded through Non-Title XIX funds 6F2. In this case, notice must be provided at least 30 days prior to the effective date unless the member consents to the change in writing or a qualified clinician determines that the action is necessary to avoid a serious or immediate threat to the health or safety of the member receiving services or others;
- A decision is made that the member is no longer eligible for SMI services; and
- A Pre-Admission Screening and Resident Review (PASRR) determination in the context of either a preadmission screening or an annual resident review, which adversely affects the member.

Additional Notices

The following additional notices must be provided to members determined to have a Serious Mental Illness or members applying for SMI services:

- The **Notice of Legal Rights for Members with Serious Mental Illness**, available on our [Forms](#) web page, must be given at the time of admission to a behavioral health provider agency for evaluation or treatment. The member receiving this notice must acknowledge in writing the receipt of the notice and the behavioral health provider must retain the acknowledgement in the member's comprehensive clinical record. All behavioral health providers must post **Notice of Legal Rights for Members with Serious Mental Illness**, available on our [Forms](#) web page, in both English and Spanish, so that it is readily visible to behavioral health members and visitors;
- The **Notice of Discrimination Prohibited**, available on our [Forms](#) web page, posted in English and Spanish so that it is readily visible to members visiting the agency, and a copy provided at the time of discharge from the behavioral health provider agency.

Provider Notice Responsibility

Following a decision requiring notice to a behavioral health member, Mercy RBHA will ensure the communication of a notice to the member.

Notice Requirements for Non-Title XIX/XXI/Non-SMI Population

Notice is not required to members who are not eligible for Title XIX/XXI or SMI services under this policy.

Appeal Requirements

Appeals that are related to Mercy RBHA or one of their contracted behavioral health providers' decisions must be filed with Mercy RBHA.

² Actions or decisions that deny, suspend, reduce, or terminate a member's or member's services or benefits to avoid exceeding the state funding legislatively appropriated for those services or benefits do not require Notice.

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Title XIX/XXI eligible members applying for or who have been determined to have a SMI and who are appealing an action affecting Title XIX/XXI covered services may elect to use either the Title XIX/XXI appeal process (see **RBHA Chapter 16 – Grievance System and Member Rights, Section 16.0 - Title XIX/XXI Notice and Appeal Requirements**) or the appeal process for members determined to have a SMI described in **RBHA Chapter 16 – Grievance System and Member Rights, Section 16.3 - Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)**.

Types of Appeal

There are two appeal processes applicable to this section:

- Appeals of members applying for an eligibility determination or who have been determined to have a SMI; and
- Appeals for other covered service-related issues.

Filing Members and Entities

The following members and entities may file an appeal:

- An adult applying for or receiving behavioral health services, their legal guardian, guardian ad litem, designated representative or attorney if Special Assistance, or the member meeting Special Assistance needs;
- A legal guardian or parent who is the legal custodian of a member under the age of 18 years;
- A court appointed guardian ad litem or an attorney of a member under the age of 18 years;
- A state or governmental agency that provides behavioral health services through an Interagency Service Agreement/Intergovernmental Agreement (ISA/IGA) with AHCCCS, but which does not have legal custody or control of the member, to the extent specified in the ISA/IGA between the agency and AHCCCS; and
- A provider, acting on the behavioral health member's behalf and with the written authorization of the member.

Timeframes for Appeals

Appeals must be filed orally or in writing with Mercy RBHA when required, within 60 days from the date of the decision being appealed. Late appeals must be accepted upon showing good cause.

Where to Appeal

- Mercy RBHA
 - Oral Appeal: Call (800) 564-5465
 - Fax Appeal: Fax to (602) 351-2300

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- Written appeal:
 - Mercy Care RBHA
 - Attn: Appeals
 - 4500 E. Cotton Center Blvd.
 - Phoenix, AZ 85040

Appeal Process of Members with Serious Mental Illness

An appeal may be filed concerning one or more of the following:

- Decisions regarding the member's SMI eligibility determination;
- Sufficiency or appropriateness of the assessment;
- Long-term view, service goals, objectives or timelines stated in the Individual Service Plan (ISP) or Inpatient Treatment and Discharge Plan (ITDP);
- Recommended services identified in the assessment report, SP or ITDP;
- Actual services to be provided, as described in the ISP, plan for interim services or ITDP;
- Access to or prompt provision of services;
- Findings of the clinical team about the member's competency, capacity to make decisions, need for guardianship or other protective services or need for Special Assistance;
- Denial of a request for a review of, the outcome of, a modification to or failure to modify, or termination of an SP, ITDP or portion of an ISP or ITDP;
- Application of the procedures and timeframes for developing the ISP or ITDP;
- Implementation of the ISP or ITDP;
- Decision to provide service planning, including the provision of assessment or care management services to a member who is refusing such services, or a decision not to provide such services to the member;
- Decisions regarding a member's fee assessment or the denial of a request for a waiver of fees;
- Denial of payment of a claim;
- Failure of Mercy RBHA to act within the timeframes regarding an appeal; or
- A PASRR determination, in the context of either a preadmission screening or an annual resident review, which adversely affects the member.

Standard Appeal Process

Within 5 working days of receipt of an appeal, Mercy RBHA must inform the appellant in writing that the appeal has been received and of the procedures that will be followed during the appeal.

In the event Mercy RBHA refuses to accept a late appeal or determines that the issue may not be appealed, Mercy RBHA must inform the appellant in writing that they may, within 10 days of

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their receipt of Mercy RBHA's decision, request an Administrative Review of the decision with the AHCCCS OGA.

If a timely request for Administrative Review is filed with AHCCCS regarding Mercy RBHA's decision, AHCCCS shall issue a final decision of within 15 days of the request (for members requiring Special Assistance, see **RBHA Chapter 2 – Network Provider Service Delivery Requirements, Section 2.11 – Special Assistance for Members Determined to have a Serious Mental Illness**).

Informal Conference with Mercy RBHA

Within 7 days of receipt of an appeal, Mercy RBHA shall hold an informal conference with the member, guardian, any designated representative, care manager or other representative of the service provider, if appropriate.

Mercy RBHA must schedule the conference at a convenient time and place and inform all participants in writing, two days prior to the conference, of the time, date and location, the ability to participate in the conference by telephone or teleconference, and the appellant's right to be represented by a designated representative of the appellant's choice.

The informal conference shall be chaired by a representative of Mercy RBHA with authority to resolve the issues under appeal, who shall seek to mediate and resolve the issues in dispute.

Mercy RBHA representative shall record a statement of the nature of the appeal, the issues involved, any resolution(s) achieved, the date by which the resolution(s) will be implemented and identify any unresolved issues for further appeal.

If the issues in dispute are resolved to the satisfaction of the member or guardian, if applicable, Mercy RBHA shall issue a dated written notice to all parties, which shall include a statement of the nature of the appeal, the issues involved, the resolution achieved and the date by which the resolution will be implemented.

If the issues in dispute are not resolved to the satisfaction of the member or guardian and the issues in dispute do not relate to the member's eligibility for behavioral health services, the member or guardian shall be informed that the matter will be forwarded for further appeal to AHCCCS for informal conference, and of the procedure for requesting a waiver of the AHCCCS informal conference.

If the issues in dispute are not resolved to the satisfaction of the member or guardian and the issues in dispute relate to the member's eligibility for SMI services or the member or guardian has requested a waiver of the AHCCCS informal conference in writing, Mercy RBHA shall:

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- Provide written notice to the member or guardian of the process to request an administrative hearing.
- Determine at the informal conference whether the member or guardian is requesting Mercy RBHA to request an administrative hearing on behalf of the member or guardian and, if so, file the request with AHCCCS within 3 days of the informal conference.
- For a member who needs special assistance, send a copy of the appeal, results of information conference and notice of administrative hearing to the Office of Human Rights (OHR).
- In the event the member appealing fails to attend the informal conference and fails to notify Mercy RBHA of their inability to attend prior to the scheduled conference, Mercy RBHA shall reschedule the conference. If the member appealing fails to attend the rescheduled conference and fails to notify Mercy RBHA of their inability to attend prior to the rescheduled conference, Mercy RBHA will close the appeal docket and send written notice of the closure to the member appealing.
 - In the event the appellant requests the appeal be re-opened due to not receiving the informal conference notification and/or due to good cause, Mercy RBHA can re-open the appeal and proceed with the informal conference.
- For all appeals unresolved after an informal conference with Mercy RBHA, Mercy RBHA must forward the appeal case record to the AHCCCS OGA within three days from the conclusion of the informal conference.

AHCCCS Informal Conference

Unless the member or guardian waives an informal conference or the issue on appeal relates to eligibility for SMI services, AHCCCS shall hold a second informal conference within 15 days of the notification from Mercy RBHA that the appeal was unresolved.

- At least 5 days prior to the date of the second informal conference, AHCCCS shall notify the participants in writing of the date, time and location of the conference.
- The informal conference shall be chaired by a representative of AHCCCS with authority to resolve the issues under appeal who shall seek to mediate and resolve the issues in dispute.
- The AHCCCS representative shall record a statement of the nature of the appeal, the issues involved, any resolution(s) achieved, the date by which the resolution(s) will be implemented and identify any unresolved issues for further appeal.
- If the issues in dispute are resolved to the satisfaction of the member or guardian, AHCCCS shall issue a dated written notice to all parties, which shall include a statement of the nature of the appeal, the issues involved, the resolution achieved and the date by which the resolution will be implemented.
 - For a member in need of Special Assistance, AHCCCS shall send a copy of the informal conference report to the OHR.

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- If the issues in dispute are not resolved to the satisfaction of the member or guardian, AHCCCS shall:
 - Provide written notice to the member or guardian of the process to request an administrative hearing.
 - Determine at the informal conference whether the member or guardian is requesting AHCCCS to request an administrative hearing on behalf of the member or guardian and, if so, file the request within 3 days of the informal conference.
 - For a member who needs Special Assistance, send a copy of the notice to the OHR.
 - In the event the member appealing fails to attend the informal conference and fails to notify AHCCCS of their inability to attend prior to the scheduled conference, AHCCCS may issue a written notice, within 3 working days of the scheduled conference, which contains a description of the decision on the issue under appeal and which advises the appellant of their right to request an Administrative Hearing.
 - In the event the appellant requests the appeal be re-opened due to not receiving the informal conference notification and/or due to good cause, AHCCCS can re-open the appeal and proceed with the informal conference.

Requests for Administrative Hearing

A written request for hearing filed with AHCCCS must contain the following information:

- Case name (name of the applicant or member receiving services, name of the appellant and the docket number);
- The decision being appealed;
- The date of the decision being appealed; and
- The reason for the appeal.

In the event a request for administrative hearing is filed with Mercy RBHA, Mercy RBHA shall ensure that the written request for hearing, appeal case record and all supporting documentation is received by the AHCCCS OGA within 3 days from such date.

Administrative hearings shall be conducted and decided pursuant to **A.R.S. §41-1092 et seq.**

Expedited appeals

A member, or a provider on the member's behalf, may request an expedited appeal for the denial or termination of crisis or emergency services, the denial of admission to or the termination of a continuation of inpatient services, if inpatient services are a covered benefit, or for good cause.

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Within 1 day of receipt of a request for an expedited appeal, Mercy RBHA must inform the appellant in writing that the appeal has been received and of the time, date and location of the informal conference; or

Issue a written decision stating that the appeal does not meet criteria as an expedited appeal and that the appellant may request an Administrative Review from AHCCCS of this decision within 3 days of the decision. The appeal shall then proceed according to the standard process described in this chapter.

Expedited Informal Conference

Within 2 days of receipt of a written request for an expedited appeal, Mercy RBHA shall hold an informal conference to mediate and resolve the issues in dispute.

AHCCCS Expedited Informal Conference

Within two days of notification from Mercy RBHA, AHCCCS shall hold an informal conference to mediate and resolve the issue in dispute, unless the appellant waives the conference at this level, in which case the appeal shall be forwarded within one day to the AHCCCS Director to schedule an administrative hearing.

Within one day of the informal conference with AHCCCS, if the conference failed to resolve the appeal, the appeal shall be forwarded to the AHCCCS Director to schedule an administrative hearing.

Requests for Administrative Hearing

A written request for hearing filed with AHCCCS must contain the following information:

- Case name (name of the applicant or member receiving services, name of the appellant and the docket number);
- The decision being appealed;
- The date of the decision being appealed; and
- The reason for the appeal.

In the event a request for administrative hearing is filed with Mercy RBHA, Mercy RBHA shall ensure that the written request for hearing, appeal case record and all supporting documentation is received by the AHCCCS OGA within 3 days.

Administrative hearings shall be conducted and decided pursuant to **A.R.S. §41-1092 et seq.**

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Continuation of Services during Appeal Process

For members determined to have a SMI, the member's behavioral health services will continue while an appeal of a modification to or termination of a covered behavioral health service is pending unless:

- A qualified clinician determines the modification or termination is necessary to avoid a serious or immediate threat to the health or safety of the member or another individual; or
- The member or, if applicable, the member's guardian, agrees in writing to the modification or termination.

Appeals for Non-Title XIX/XXI/Non-SMI Population

Based on available funding, a member who is Non-Title XIX/XXI and Non-SMI may file an appeal of a decision that is related to a determination of need for a covered service (e.g., modification to previously authorized services for a non-Title XIX/XXI eligible member). In these circumstances, there is no continuation of services available during the appeal process.

Mercy RBHA in processing the appeal must:

- Inform the appellant in writing within 5 working days of receipt that the appeal has been received and of the procedures that will be followed during the appeal;
- Provide the appellant a reasonable opportunity to present evidence and allegations of fact or law in member and in writing; and
- Provide a written decision no later than 30 days from the day the appeal is received. The decision shall include a summary of the issues involved, the outcome of the appeal, and the basis of the decision. For appeals not resolved wholly in favor of the appellant, Mercy RBHA shall advise the appellant in writing of their right to request an administrative hearing with AHCCCS no later than 30 days from the date of Mercy RBHA's decision, and how to do so.

Requests for Administrative Hearing

A written request for hearing filed with AHCCCS must contain the following information:

- Case name (name of the applicant or member receiving services, name of the appellant and the docket number);
- The decision being appealed;
- The date of the decision being appealed; and
- The reason for the appeal.

In the event a request for administrative hearing is filed with Mercy RBHA, Mercy RBHA shall ensure that the written request for hearing, appeal case record and all supporting documentation is received by AHCCCS OGA within 3 days.

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Behavioral Health Provider Responsibilities

While providers are not directly responsible for the resolution of appeals, they are required to actively participate in the process as follows:

- Provide information deemed to be necessary by Mercy RBHA, AHCCCS or the Office of Administrative Hearings (e.g., documents and other evidence); and
- Cooperate and participate as necessary throughout the appeal process.

Behavioral health providers must be available to assist a member in the filing of an appeal. For members determined to have a SMI, the Office of Human Rights may be available to assist the member in filing as well as resolving the appeal.

Behavioral health providers must not retaliate against any member who files an appeal or interfere with a member's right to file an appeal. Additionally, no punitive action may be taken against a behavioral health provider who supports a member's appeal.

17.04 – Provider Claim Disputes

The provider claim disputes process affords providers the opportunity to challenge a decision by Mercy RBHA that impacts the provider for issues involving:

- A payment of a claim;
- The denial of a claim;
- The recoupment of payment of a claim; and
- The imposition of sanctions.

Providers will initially submit a claim dispute to Mercy RBHA when:

- Challenging a decision of Mercy RBHA; or
- Disputing a claim payment issue for services provided to members enrolled with Mercy RBHA.

Once Mercy RBHA makes a decision regarding a provider claim dispute, the provider may request another review of the decision, referred to as an administrative hearing.

Many times, disagreements between a provider and Mercy RBHA can be resolved through an informal process. Providers are encouraged to try and solve issues at the informal level before initiating the formal provider claim dispute process. However, providers should be aware that the formal process contains very specific timeframes within which to file for a review and/or hearing and resolving issues through an informal process does not suspend or postpone these timeframes.

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The intent of this chapter is to describe the options available to providers to resolve issues and other events related to a decision of Mercy RBHA. The chapter is organized to delineate the process for filing a claim dispute:

- For providers disputing a decision of Mercy RBHA; and
- The process for requesting an administrative hearing in the event a provider does not agree with the claim dispute decision of Mercy RBHA.

Prior to Filing an Initial Claim Dispute

All providers are encouraged to seek informal resolution of a concern by first contacting the appropriate entity responsible for the decision. For concerns regarding claims, it is important for providers to understand why the claim was denied before initiating a claim dispute. Denied claims may be the result of filing errors or missing supporting documentation, such as an explanation of benefits (EOB) or an invoice. Resubmitting claims with the requested information or corrections can result in resolution of the issue and full payment of the claim. To get assistance with the informal resolution of a decision, please contact:

Mercy Care RBHA
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040
Phone: 800-564-5465

General Requirements

Computation of Time - A written claim dispute is considered filed when it is received by Mercy RBHA established by a date stamp or other record of receipt. Providers must use the following methodology in computing any period described in this chapter:

- Computation of time for calendar day begins the day after the act, event or decision 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 an issue is unable to be resolved informally, providers may dispute the decision by filing a written claim dispute. For all provider claim disputes related to decisions of Mercy RBHA, the provider must file the claim dispute with Mercy RBHA at:

Mercy Care RBHA
Attn: Appeals Department
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040

You may also submit your claim dispute through email at mercyappeals@aetna.com or fax. Not only do we now have the ability to receive disputes by fax, but we can also respond

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back to our providers via fax, allowing you to receive faster decisions. If you choose to send via fax, please fax your disputes to 602-351-2300.

All claim disputes must be submitted to the Mercy RBHA Appeals Department. Please include all supporting documentation with the initial claim dispute submission. The claim dispute must specifically state the factual and legal basis for the dispute requested, along with copies of any supporting documentation, such as remittance advice(s), medical records, or claims. Failure to specifically state the factual and legal basis may result in denial of the claim dispute.

Mercy RBHA must utilize a unique Docket Number for each claim dispute filed. The Docket Number is established as follows:

- The Mercy RBHA letter code (see **T/RBHA Codes for Docket Numbers** form, available on our [Forms](#) web page);
- The date of receipt of the claim dispute using the MMDDYY format;
- The letter code "P" which designates the case as a claim dispute;
- A four-digit sequential number, which begins on January 1 of each year as 0001.

All documentation received during the claim dispute resolution process must be date stamped upon receipt.

All claim dispute case records must be filed in secured locations and retained for five years after the most recent decision has been rendered.

All decisions shall be personally delivered or mailed by certified mail to the party at their last known residence or place of business.

Claim Dispute Log

The Office of Grievance and Appeals database shall maintain the log of all claim disputes initiated under this policy. Mercy RBHA is responsible for entering all information related to the claim dispute resolution process necessary for the accurate and timely maintenance of the log.

The log shall contain:

- A unique Docket Number;
- A substantive but concise description of the claim dispute including whether the claim dispute is related to the provision of Title XIX or Title XXI covered services;
- The date the claim dispute was received;
- The nature, date, and outcome of all subsequent decisions, appeals, or other relevant events; and
- A substantive but concise description of the final decision, the action taken to implement the decision and the date the action was taken.

PLAN SPECIFIC TERMS

Notification of Right to File Claim Dispute

Mercy RBHA must provide an affected provider a remittance advice that includes provider's right to file a claim dispute and how to do so, upon the payment, denial or recoupment of payment of a claim. Mercy RBHA must notify an affected provider of the right to file a claim dispute and how to do so when a decision is made to impose a sanction.

Initiate Claim Dispute

It is important for providers to ensure the claim dispute is submitted in writing and contains all required information and is filed within the required timeframes. Failure to do so will result in the denial of the claim dispute.

The notice of claim dispute must specify the statement of the factual and legal basis for the claim dispute and the relief requested. Claim disputes may be denied if the filing party has failed to provide a comprehensive factual or legal basis for the dispute.

Claim Disputes may be submitted in writing or through fax. Please note submission information under *Computation of Time*.

Timeframes for Initiating Claim Dispute

The claim dispute must be filed within the following established timeframes:

- Within 60 days of the date of notice advising that a sanction will be imposed, or
- For challenges to the payment, denial or recoupment of a claim, the later of the following:
 - 12 months of the date of delivery of the service;
 - 12 months after the date of eligibility posting; or
 - Within 60 days after the payment or denial of a timely claim submission, or the recoupment of payment, whichever is later.

Claim Disputes of Mercy RBHA Decisions

Within 5 days of receipt of a claim dispute, Mercy RBHA shall send written acknowledgment that the claim dispute has been received, will be reviewed and that a decision will be issued within 30 days of receipt of the claim dispute, absent extension of the timeline.

If Mercy RBHA determines that it was not responsible for the claim dispute, they must immediately forward the claim dispute to the responsible RBHA or to AHCCCS with an explanation of why the claim dispute is being forwarded.

- A copy of the transmittal shall be sent by Mercy RBHA to the party filing the claim dispute.

PLAN SPECIFIC TERMS

- The receiving RBHA must ensure that a decision is rendered within 30 days of Mercy RBHA's receipt of the notice of claim dispute unless an extension has been granted pursuant to 3.g. of this policy.

Mercy RBHA Notice of Decision

Mercy RBHA shall issue a written, dated decision which must be mailed by certified mail to all parties no later than 30 days after the provider files a claim dispute with Mercy RBHA, unless the provider and Mercy RBHA have agreed to a longer period. The Decision must include and describe in detail, the following:

- The nature of the claim dispute;
- The issues involved;
- Mercy RBHA's decision and the reasons supporting decision, including references to applicable statute, rule, applicable contractual provisions, policy and procedures;
- The provider's right to request a hearing by filing a written request for hearing to AHCCCS no later than 30 days after the date the provider receives Mercy RBHA's decision;
- The provider's right to request an informal settlement conference prior to hearing; and
- If the claim dispute is overturned, the requirement that Mercy RBHA must reprocess and pay the claim(s), with interest, when applicable, in a manner consistent with the decision within 15 business days of the date of the decision.

Extension of Time

To request an extension of the 30-day timeframe, the provider must submit to Mercy RBHA prior to the expiration of the original time limit, a written request including the reasons for the extension and a proposed new timeframe that does not unreasonably postpone final resolution of the matter. A representative of Mercy RBHA may also request an extension. In either case, the provider and Mercy RBHA must agree to the extension in writing. Documentation of the agreement to the extension of time must be maintained in the claim dispute case record.

Requests for Administrative Hearing

If the party filing a claim dispute is dissatisfied with the Mercy RBHA Notice of Decision or if a Notice of Decision is not received within 30 days after the claim dispute is filed, absent an extension of time; a request for an administrative hearing may be filed, in writing, with a request to the AHCCCS Office of Grievance and Appeals.

Timeframes for Requesting an Administrative Hearing

The provider's request for a hearing must be filed in writing and received by AHCCCS no later than 30 calendar days of the date of receipt of the Mercy RBHA Notice of Decision, absent of an extension of time. A written request for hearing is considered filed when received by the AHCCCS Office of Grievance and Appeals established by a date stamp or other record of receipt.

PLAN SPECIFIC TERMS

Requirements for a Request for Administrative Hearing

The request for an administrative hearing to AHCCCS must include:

- Provider name, AHCCCS identification Number, address, phone number and the docket number;
- Member's name and AHCCCS identification number;
- The date of receipt of the claim dispute;
- The issue to be determined at the administrative hearing; and
- A summary of Mercy RBHA actions undertaken to resolve the claim dispute and basis of the determination.

Scheduling of an Administrative Hearing

Pursuant to **A.R.S. §41-1092.03**, upon receipt of a request for hearing, the AHCCCS Office of Grievance and Appeals must request that AHCCCS schedule an administrative hearing pursuant to **A.R.S. §41-1092.05**.

If the AHCCCS or Mercy RBHA decision regarding a claim dispute is reversed through the claim dispute or hearing process, AHCCCS or Mercy RBHA shall reprocess and pay the claim(s) with interest, when applicable, in a manner consistent with the decision within 15 business days of the date of the decision unless a different timeframe is specified.

Administrative Process

The Administrative Hearing Process shall be conducted according to **A.R.S. Title 41, Chapter 6, Article 10**.

Appeal of AHCCCS Director's decisions:

- For Title XIX and Title XXI covered services, an appellant aggrieved by the Director's decision may appeal the decision to AHCCC by filing a written notice of appeal within 30 calendar days of receipt of the decision to:
AHCCCS
Office of Administrative Legal Services
701 E. Jefferson St., MD-620
Phoenix, AZ 85034

Detecting Fraud and Program Abuse

Mercy RBHA tracks, trends and analyzes claim disputes for purposes of detecting fraud and program abuse. Mercy RBHA reports all suspected fraud, waste and/or program abuse involving any Title XIX/XXI funds to the AHCCCS Office of the Inspector General (OIG) within ten (10) business days of discovery.

PLAN SPECIFIC TERMS

RBHA Chapter 18 – Provider Requirements for Specific Programs and Services**18.0 – 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.

Provider Requirements for Specific Programs and Services for Mercy RBHA include the following:

- [Adult Substance Use Residential \(BHRF-SUD\)](#)
- [Assertive Community Treatment \(ACT\)](#)
- [Assertive Community Treatment \(ACT\) with PCP Partnership](#)
- [Behavioral Health Homes \(BHH\) for Members with Serious Mental Illness \(SMI\)](#)
- [Child Adolescent Specialty Provider](#)
- [Children's Assigned Behavioral Health Clinic](#)
- [Children's Residential Facilities Behavioral Health](#)
- [Child Therapeutic Foster Care](#)
- [Crisis Call Center](#)
- [Crisis Facility with 23 Hour Observation and Level 1 Sub-Acute](#)
- [Crisis Facility with 23 Hour Observation and Stabilization Child and Adolescent](#)
- [Employment Rehabilitation Service Provider](#)
- [First Episode Psychosis](#)
- [Flex Care Services – SMI Adult](#)
- [Forensic Assertive Community Team \(FACT\) with Primary Care Physician Partnership](#)
- [Hospital Rapid Response](#)
- [Integrated Health Home for Members with Serious Mental Illness](#)
- [Medical Assertive Community Treatment](#)
- [Medication Assisted Treatment \(MAT\) Services](#)
- [Mercy Care Initiatives NT-19 SMI Transitions \(MINT\) Program](#)
- [Mobile Crisis Services](#)
- [Peer and Family Operated Organization](#)
- [Peer Warm Line](#)
- [Permanent Supportive Housing Services Provider](#)
- [Supported Employment](#)
- [Temporary Housing Assistance](#)
- [Virtual Health Home](#)