mercy care

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

Visit: **www.MercyCareAZ.org**

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

Content highlighted in yellow represents change since the last Provider Manual iteration.

MC Chapter 1 – Mercy Care Complete Care/Mercy Care DD/Department of Child Safety Comprehensive Health Plan Overview

1.00 – MCCC/Mercy DD/DCS CHP Overview

Mercy Care Complete Care (herein MCCC), Mercy Care DD (herein Mercy DD) and Department of Child Safety Comprehensive Health Plan (herein DCS CHP), as part of Mercy Care, is a not-for-profit partnership sponsored by Dignity Health and Ascension Care Management. MCCC, Mercy DD and DCS CHP (herein referred to as Mercy Care [MC]) are 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 Care family planning for Dignity Health and Ascension Care Management.

MC is managed care organizations that provides health care services to people in Arizona's Medicaid program. MC has held a pre-paid capitated contract with the AHCCCS Administration since 1985. MC provides services to the Arizona Medicaid populations including:

- **AHCCCS Complete Care**: Members select the managed care plan to administer their benefits. MCCC is contracted in Maricopa, Pinal, and Gila Counties to provide covered services to enrolled members and integrates both their behavioral health and physical health needs.
- **Children's Rehabilitative Services (CRS):** Arizona's Children's Rehabilitative Services (CRS) program provides medical and behavioral health care, treatment, and related support services to Arizona Health Care Cost Containment System (AHCCCS) members who meet the eligibility criteria and completed the application to be enrolled in the CRS program and have been determined eligible.
- **Division of Developmental Disabilities Long Term Care program:** Members are enrolled through the Arizona Department of Economic Security/Division of Developmental Disabilities (DDD). DDD is a Medicaid program administered by AHCCCS through the Department of Economic Security (DES). MCCC and Mercy DD are contracted with DDD to provide acute care services. DDD members are in the following counties:
    - Apache
    - Cochise
    - Coconino
    - Gila
    - Graham
    - Greenlee
    - La Paz
    - Maricopa
    - Mojave
    - Navajo
    - Pima
    - Pinal
    - Santa Cruz
    - Yavapai
    - Yuma

- **Department of Child Safety Comprehensive Health Plan (DCS CHP):** The Department of Child Safety Comprehensive Health Plan (DCS CHP) is a statewide program administered by the Arizona Department of Child Safety (DCS). DCS CHP is the health plan for Arizona's children and youth placed in out-of-home care and leverages the relative strengths and expertise of the Department of Child Safety (DCS) and MC Members are enrolled with DCS CHP by their custodial agency (the agency that placed them in out-of-home care). DCS is contracted directly with AHCCCS to provide covered services for Medicaid eligible children in foster care and accordingly holds ultimate decision-making authority and accountability for the services and population covered.

  Custodial agencies are:
  - Arizona Department of Child Safety (DCS)
  - Arizona Department of Juvenile Corrections (ADJC)
  - Administrative Office of the Court/Juvenile Probation Office (AOC/JPO)
- **General Mental Health and Substance Use (GMH/SU):** General Mental Health and Substance Use (GMH/SU) services are provided to adult members age 18 and older who have been determined to have an illness in this category. These individuals do not have a serious mental illness. General mental health disorders may include, but are not limited to, anxiety or depression. Substance use services are also provided for members using one or more substances or have a dependency on a substance that causes harm to themselves or others. Additionally, services are also available for members dealing with both a general mental health concerns and a substance use at the same time known as co-occurring disorders.
- **KidsCare:** AHCCCS offers health insurance through KidsCare for eligible children (under age 19) who are not eligible for other AHCCCS health insurance. For those who qualify, there are monthly premiums. Please review the KidsCare webpage on the AHCCCS website for additional information.

MC Chapter 2 – Covered and Non-Covered Services

2.00 – Coverage Criteria

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

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

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

2.01 - Covered Services

Covered Services for all members include:

- Hospital care;
- Doctor office visits, including specialist visits;
- Health risk assessments and screenings for members age 21 years of age and over;
- Laboratory, radiology and medical imaging;
- Durable medical equipment and supplies'
- Medications on MC's list of covered medicines. Members with Medicare will receive their medications through Medicare Part D;
- Emergency care;
- Care to stabilize you after an emergency;
- Home health services (such as nursing and home health aide);
- Nursing home, when used instead of hospitalization, up to 90 days a year;
- Inpatient rehabilitation services, including occupational, speech and physical therapy;
- Respiratory therapy;
- Outpatient Rehabilitation services, including occupational, speech, physical and respiratory therapy (limitations apply) for patients older than age 21
- Routine immunizations;
- AHCCCS-approved organ and tissue transplants and related prescriptions (limitations apply);
- Dialysis;
- Foot and ankle services;
- Maternity care (prenatal, labor and delivery, postpartum);
- Family planning services;
- Behavioral health services;
- Medically necessary and emergency transportation. Providers may arrange medically necessary non-emergent transportation for MC members by calling Member Services at 602-263-3000 or 800-624-3879;
- Medical foods;

- Emergency eye exam and lens post cataract surgery;
- Urgent care;
- Hospice;
- Wellness exams and preventative screenings; and
- Incontinence briefs to avoid or prevent skin breakdown, with limitations.

Additional covered services for children (under age 21):

- Identification, evaluation, and rehabilitation of hearing loss;
- Medically necessary personal care. This may include help with bathing, toileting, dressing, walking and other activities that the member is unable to do for medical reasons;
- Routine preventive dental services, including oral health screenings, cleanings, fluoride treatments, dental sealant, oral hygiene education, X-rays, fillings, extractions and other therapeutic and medically necessary procedures;
- Vision services, including exams and prescriptive lenses (a limited selection of lenses and frames are covered);
- Outpatient speech, occupational and physical therapy;
- Chiropractic services;
- Conscious sedation;
- Adaptive aids (DD members only);
- Medically necessary practitioner visits to member's home (DD members only);
- Incontinence briefs, with limitations; and
- Acute services for DDD Members enrolled in CR.

Additional services for Qualified Medicare Beneficiaries (QMB):

- Chiropractic services;
- Outpatient occupational therapy; and
- Any services covered by Medicare but not by AHCCCS.

Limited and Excluded Services

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

BENEFIT/SERVICE	SERVICE DESCRIPTION	SERVICE EXCLUSIONS OR LIMITATIONS
Percussive vests	This vest is placed on a person's chest and shakes to loosen mucous.	AHCCCS will not pay for percussive vests. Supplies, equipment maintenance (care of the vest) and repair of the vest will be paid for.
Bone-anchored hearing aid	A hearing aid that is put on a person's bone near the ear by surgery. This is to carry sound.	AHCCCS will not pay for Bone-Anchored Hearing AID (BAHA). Supplies, equipment maintenance (care if the hearing aid) and repair of any parts will be paid for.
Cochlear implant	A small device that is put in a person's ear by surgery to help you hear better.	AHCCCS will not pay for cochlear implants. Supplies, equipment maintenance (care of the implant) and repair of any parts will be paid for.
Lower limb microprocessor controlled joint/ prosthetic	A device that replaces a missing part of the body and uses a computer to help with the moving of the joint.	AHCCCS will not pay for a lower limb (leg, knee, or foot) prosthetic that includes a microprocessor (computer chip) that controls the joint.
Emergency dental service	Emergency treatment for pain, infection, swelling and/or injury	Emergency dental services are covered for members under the age of 21. Covered emergency dental services for members 21 years of age and older are limited to problem focused exam, required X-rays, jaw fractures, biopsies, and medically necessary anesthesia.
Transplants	A transplant is when an organ or blood cells are moved from one person to another.	Approval is based on the medical need and if the transplant is on the "covered" list. Only transplants listed by AHCCCS as covered will be paid for.
Occupational and Physical Therapy	Exercises taught or provided by a physical therapist to make you stronger or help improve movement	Outpatient Occupational Therapy services are covered for members under the age of 21, when medically necessary. Outpatient Occupational Therapy services are covered for members, 21 years of age and older as follows: • 15 OT visits per benefit year for restoring a skill or level of function and maintaining that skill or level of function once restored, and

	• 15 OT visits per benefit year for acquiring a new skill or a new level of function and maintaining that skill or level of function once acquired. Outpatient physical therapy visits are limited to 15 habilitate / 15 rehabilitative for a total of 30 visits for the continued care for one diagnosis per contract year (10/1– 9/30). For dual eligible members, the health plan is responsible for paying the Medicare cost of share limited to 15 habilitate/15 rehabilitative for a total of 30 visits for the continued care for one diagnosis per contract year (10/1-09/30).

Orthotic Devices

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

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

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

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

Repairs or Adjustments of Purchased Equipment:

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

Member Handbook

MC is responsible for the **Member Handbook**, available on our **Member Handbook** web page by line of business.

The MC Member Handbook applies to ACCC members, including GMHSU, non-CMDP, CRS, DDD (physical health only) and DCS CHP members.

GMH/SU members will no longer receive the 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. MC also notifies members annually that they can request a printed copy of the Member Handbook by contacting MC Member Services.

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

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

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

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

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

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

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

2.02 – Non-Covered Services

Non-covered services include:

- Services from a provider who is NOT contracted with MC (unless prior approved by the Health Plan)
- Cosmetic services or items;
- Personal care items such as combs, razors, soap etc.;
- Any service that needs prior authorization that was not prior authorized;

- Services or items given free of charge, or for which charges are not usually made;
- Services of special duty nurses, unless medically necessary and prior authorized;
- Physical therapy that is not medically necessary;
- Routine circumcisions;
- Services that are determined to be experimental by the health plan medical director;
- 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 MC;
- Prescriptions not on our list of covered medications, unless approved by MC;
- Physical exams for qualifying for employment or sports activities;

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

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

MC Chapter 3 – Behavioral Health

3.00 - Behavioral Health Overview

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

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

3.01 - Behavioral Health Provider Types

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

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

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

3.02 - Alternative Living Arrangements

MC also includes the following alternative living arrangements:

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

3.03 - Emergency Services

Behavioral health crisis services are available to Mercy Care members and can be accessed through the crisis lines in the regions as listed below. Crisis mobile teams may also be dispatched through the crisis lines.

- Maricopa County served by Mercy Care:
  1-800-631-1314 or **602-222-9444**
- Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz, and Yuma Counties served by Arizona Complete Health - Complete Care Plan:
  1-866-495-6735
- Apache, Coconino, Gila, Mohave, Navajo, and Yavapai Counties served by Health Choice Arizona:
  1-877-756-4090
- Gila River and Ak-Chin Indian Communities:
  1-800-259-3449
- Salt River Pima Maricopa Indian Community:
  1-855-331-6432

Since DCS CHP is a state-wide plan administered by Mercy Care, please contact the phone number under the county the member resides in.

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 1:20, with 1:15 being the desired target. Justification must be provided for caseload ratios below 8 and for those over 15 youth. A caseload ratio between 16 to 20 must be the result of one or more of the following exceptions:

- Children/adolescents who have been served by the high needs case management model and no longer need the level of care; and
- Siblings of children in HNCM being managed by the same entity increases coordination of care for these children and their families/caretakers.

3.05 – Behavioral Analysis Services

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

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

Behavior Analysis Services are prescribed or recommended in specific dosages, frequency, intensity, and duration by a qualified Behavioral Health Professional as the result of an assessment of the member, the intensity of the behavioral targets, and complexity and range of treatment goals.

Please refer to 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:

- 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 MC and may include the Health Care Decision Maker, Primary Care Provider (PCP), school, medical specialists, behavioral health prescribers, Department of Child Safety (DCS) and/or other state-funded programs, and others as applicable.

- Result in progress reports at minimum, every six months. Progress reports shall include, but are not limited to the following components:
    - Member Identification;
    - Background Information (family dynamics, school placement, cultural considerations, prenatal and/or developmental history, medical history, sensory, dietary and adaptive needs, sleep patterns, and medications);
    - Assessment Findings (i.e., social, motor, and self-help skills, maladaptive behaviors, and primary caregiver concerns);
    - Outcomes (measurable objectives progress towards goals, clinical recommendations, treatment dosage, family role and family outcomes, and nature of family participation); and
    - Care Coordination (transition statement and individualized discharge criteria).
- Be consistent with applicable professional standards and guidelines relating to the practice of behavior analysis as well as Arizona Medicaid laws and regulations and Arizona state Behavior Analyst licensure laws and regulations (A.R.S. §32-2091).

3.06 - Behavioral Health Consults

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

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

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

3.07 - Behavioral Health Screening

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

3.08 - Behavioral Health Appointment Standards

MC routinely monitors providers for compliance with appointment standards. The minimum standard requirements are:

- Urgent - Within 24 hours of referral.
- Routine - within 30 days of referral.

3.09 - Behavioral Health Provider Coordination of Care Responsibilities

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

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

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

3.10 – DDD Coordination of Care

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

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

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

The Health Insurance Portability and Accountability Act (HIPAA) governs how Covered Entities (CEs) protect and secure Protected Health Information (PHI). HIPAA also provides regulations that describe the circumstances in which CEs are permitted to use and disclose PHI for certain activities without first obtaining an individual's authorization. These circumstances include treatment and health care operations

related to members services and should be the minimum amount necessary to achieve the disclosure purpose. Please note, this memorandum does not include disclosure of Part 2, HIV, or communicable disease related data and information as these have added privacy protections under federal or state law.

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

- Cognitive/intellectual disability (C/ID)
- Autism spectrum disorder
- Cerebral palsy
- Epilepsy

The referring party should attempt to obtain and gather the following information prior to calling the DDD's Customer Service Line office at 844-770-9500. The application may be submitted by email at **DDDapply@azdes.gov**, dropped off in person at any DDD office, or mailed in. Diagnostic information should include the following:

- **Cognitive/Intellectual Disability:** Documentation indicating that the member was identified with a qualifying cognitive disability prior to the age of 18, as determined by a licensed psychologist, certified school psychologist and/or psychometrist working under the supervision of a licensed psychologist or certified school psychologist.
- **Cerebral Palsy:** Signed documentation of a diagnosis from a licensed physician.
- **Epilepsy:** Signed documentation of a diagnosis from a licensed physician.
- **Autism Spectrum Disorder:** A psychiatrist, licensed psychologist, child neurologist, or developmental pediatrician and pediatricians with specialized training in Autism.

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

3.11 - DD Members with an SMI Designation, Provider Requirements

Clinic Transfers

Transfer Guidelines (only applicable to Central GSA)

Transfer Guidelines below are for DD SMI (only applicable to Central GSA); Northern and Southern GSA transfer guidelines are determined by clinical need of the member.

Integrated Health/Behavioral Health home/clinic 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 for members with the dual designation of SMI and DD. In accordance with the 9 Guiding Principles of member empowerment and self-determination, personal preference is given the utmost consideration and the member or guardian must agree with the transfer.

- In cases where the member or guardian/designated representative would like to transfer.
- If the request for transfer is due to lack of services or dissatisfaction, clinical leadership at the transferring agency will meet with the member or guardian to discuss and attempt to resolve.

- Outpatient Transfers between and to ACT teams (ex: supportive to ACT, ACT to ACT and ACT to FACT) are expected to be completed in less than twenty-one (21) days from the time the receiving ACT team receives the transfer request. The ACT team should screen members within two weeks of the receiving the outpatient referral to ensure they meet ACT criteria. If the member meets ACT Criteria and the transfer is not complete in the 21-day timeline, **smimemberservicesrequest@mercycareaz.org** should be contacted. For Inpatient Level 1 referrals, Newly Determined SMI ACT referrals, referral waitlist and transfer protocols, please refer to the **ACT Operational Manual**.
- Transfers between ACT teams are expected to be completed in less than twenty-one (21) days from the time the receiving clinic receives the transfer request. If the transfer is not complete in the 21-day timeline, **smimemberservicesrequest@mercycareaz.org** should be contacted.

Transfer Process

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

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

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

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

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

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

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

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

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

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

Reengagement

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

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.

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

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

- Discharged from inpatient services in accordance with the discharge plan and within 7 days or no later than 30 days;
- Involved in a behavioral health crisis within timeframes based upon the member's clinical needs, but no later than 7 days;
- Refusing prescribed psychotropic medications within timeframes based upon the member's clinical needs and individual history; and
- Released from local and county jails and detention facilities within 72 hours.

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

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

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

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

The expectation for non-ACT adult DD SMI members being discharged from 23.9 observation/crisis is for the clinical team to evaluate the member within 24 business hours and see the BHMP within 72 business hours. For ACT adult DD SMI members, it is expected that the clinical team evaluate the member within 24 actual hours and see the BHMP within 72 actual hours.

Case Management (only applicable to Central GSA)

Contact Guidelines are listed below for DD SMI (only applicable to Central GSA); Northern and Southern GSA contact guidelines are determined by clinical need of the member.

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-to-face services dependent on the member's individual need.	

Caseload Ratios for DD SMI Members (only applicable to Central GSA)

Caseload ratio guidelines below for DD SMI (only applicable to Central GSA); Northern and Southern GSA caseload ratio guidelines are determined by clinical need of the member.

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

Maximum Ceilings	
Supportive	**Connective**
40	0

Maximum Ceilings	
Supportive	Connective
38	5
36	10
34	15
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

3.12 - PCP Coordination of Care

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

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

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

3.13 – General and Informed Consent

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

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

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

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

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

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

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

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

General Requirements

- Any member aged 18 years and older, in need of behavioral health services must give voluntary general consent to treatment, demonstrated by the member's or legal guardian's signature on a general consent form, before receiving behavioral health services.
- For members under the age of 18, the parent, legal guardian, or a lawfully authorized custodial agency (including foster care givers A.R.S. 8.514.05(C)) must give general consent to treatment, demonstrated by the parent, legal guardian, or a lawfully authorized custodial agency representative's signature on a general consent form prior to the delivery of behavioral health services.
- Any member aged 18 years and older or the member's legal guardian, or in the case of members under the age of 18, the parent, legal guardian or a lawfully authorized custodial agency, after being fully informed of the consequences, benefits and risks of treatment, has the right not to consent to receive behavioral health services.
- Any member aged 18 years and older or the member's legal guardian, or in the case of members under the age of 18, the parent, legal guardian or a lawfully authorized custodial agency has the right to refuse medications unless specifically required by a court order or in an emergency.
- Providers treating members in an emergency are not required to obtain general consent prior to the provision of emergency services. Providers treating members pursuant to court order must obtain consent, as applicable, in accordance with A.R.S. Title 36, Chapter 5.
- All evidence of informed consent and general consent to treatment must be documented in the comprehensive clinical record per the **AHCCCS AMPM Policy 940**.
- MC must develop and make available to providers policies and procedures that include any additional information or forms.
- A foster parent, group home staff, foster home staff, relative, or other person or agency in whose care a child is currently placed may give consent for:
  - Evaluation and treatment for emergency conditions that are not life threatening, and
  - Routine medical and dental treatment and procedures, including Early Periodic Screening Diagnosis and Treatment (EPSDT) services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (A.R.S. §8-514.05(C)).
- To ensure timely delivery of services, consent for intake and routine behavioral health services may be obtained from either the foster caregiver or the Department of Child Safety Specialist (DCSS) whomever is available to do so immediately upon request (A.R.S. § 8-514.05(C)).
- Foster or kinship caregivers can consent to evaluation and treatment for routine medical and dental treatment and procedures, including behavioral health services. Examples of behavioral health services in which foster, or kinship can consent to include:
  - Assessment and service planning,
  - Counseling and therapy,
  - Rehabilitation services,
  - Medical Services,
  - Psychiatric evaluation,
  - Psychotropic medication,
  - Laboratory services,
  - Support Services,
  - Case Management,
  - Personal Care Services,

- Family Support,
- Peer Support,
- Respite,
- Sign Language or Oral Interpretive Services,
- Transportation,
- Crisis Intervention Services,
- Behavioral Health Day Programs.

- A foster parent, group home staff, foster home staff, relative, or other person or agency in whose care a child is currently placed shall not consent to:
  - General Anesthesia,
  - Surgery,
  - Testing for the presence of the human immunodeficiency virus,
  - Blood transfusions,
  - Abortions.
- Foster or kinship caregivers may not consent to terminate behavioral health treatment. The termination of behavioral health treatment requires Department of Child Safety (DCS) consultation and agreement.
- If the foster or kinship caregiver disagrees on the behavioral health treatment being recommended through the Child and Family Team (CFT), the CFT including the foster or kinship caregiver and DCS case worker should reconvene and discuss the recommended treatment plan. Only DCS can refuse consent to medically recommended behavioral health treatment.

General Consent

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

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

Informed Consent

- In all cases where informed consent is required by this policy, informed consent must include at a minimum:
  - The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions,
  - Information about the member's diagnosis and the proposed treatment, including the intended outcome, nature and all available procedures involved in the proposed treatment,
  - The risks, including any side effects, of the proposed treatment, as well as the risks of not proceeding,
  - The alternatives to the proposed treatment, particularly alternatives offering less risk or other adverse effects,
  - That any consent given may be withheld or withdrawn in writing or orally at any time. When this occurs, the provider must document the member's choice in the medical record;
  - The potential consequences of revoking the informed consent to treatment, and

- A description of any clinical indications that might require suspension or termination of the proposed treatment. Documenting Informed Consent:
  - Members, or if applicable the member's parent, guardian, or custodian, shall give informed consent for treatment by signing and dating an acknowledgment that he or she has received the information and gives informed consent for the proposed treatment.
  - When informed consent is given by a third party, the identity of the third party and the legal capability to provide consent on behalf of the member, must be established. If the informed consent is for psychotropic medication or telemedicine and the member, or if applicable, the member's guardian refuses to sign an acknowledgment and gives verbal informed consent, the medical practitioner shall document in the member's record that the information was given, the member refused to sign an acknowledgment and that the member gives informed consent to use psychotropic medication or telemedicine.
- When providing information that forms the basis of an informed consent decision for the circumstances identified above, the information must be:
  - Presented in a manner that is understandable and culturally appropriate to the member, parent, legal guardian, or an appropriate court; and
  - Presented by a credentialed behavioral health medical practitioner or a registered nurse with at least one year of behavioral health experience. It is preferred that the prescribing clinician provide information forming the basis of an informed consent decision. In specific situations in which it is not possible or practicable, information may be provided by another credentialed behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience.
- Psychotropic Medications, Complementary and Alternative Treatment and Telemedicine:
  - Unless treatments and procedures are court ordered, providers must obtain written informed consent, and if written consent is not obtainable, providers must obtain oral informed consent. If oral informed consent is obtained instead of written consent from the member, parent, or legal guardian, it must be documented in written fashion. Informed consent is required in the following circumstances:
    - Prior to the initiation of any psychotropic medication or initiation of Complementary and Alternative Treatment (CAM). The use of **AMPM 310-V – Prescription Medications – Pharmacy Services, Attachment A – Informed Consent for Psychotropic Medication Treatment** is recommended as a tool to review and document informed consent for psychotropic medications, and
    - Prior to the delivery of behavioral health services through telemedicine.
  - Electro-Convulsive Therapy (ECT), research activities, voluntary evaluation and procedures or services with known substantial risks or side effects.
  - Written informed consent must be obtained from the member, parent, or legal guardian, unless treatments and procedures are under court order, in the following circumstances:
    - Before the provision of (ECT),
    - Prior to the involvement of the member in research activities,
    - Prior to the provision of a voluntary evaluation for a member. The use of AMPM Exhibit 320-Q-1, Application for Voluntary Evaluation is required for members determined to have a

Serious Mental Illness and is recommended as a tool to review and document informed consent for voluntary evaluation of all other populations, and
    - Prior to the delivery of any other procedure or service with known substantial risks or side effects.
- Written informed consent must be obtained from the member, legal guardian, or an appropriate court prior to the member's admission to any medical detoxification, inpatient facility or residential program operated by a behavioral health provider.
- If informed consent is revoked, treatment must be promptly discontinued, except in cases in which abrupt discontinuation of treatment may pose an imminent risk to the member. In such cases, treatment may be phased out to avoid any harmful effects.
- Informed Consent for Telemedicine:
    - Before a health care provider delivers health care via telemedicine, verbal or written informed consent from the member or their health care decision maker must be obtained. Refer to the AHCCCS AMPM Policy 320-I for additional detail.
    - Informed consent may be provided by the behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience. When providing informed consent, it must be communicated in a manner that the member and/or legal guardian can understand and comprehend.
    - Exceptions to this consent requirement include:
        - If the telemedicine interaction does not take place in the physical presence of the member;
        - In an emergency in which the member or the member's health care decision maker is unable to give informed consent; or
        - To the transmission of diagnostic images to a health care provider serving as a consultant or the reporting of diagnostic test results by that consultant.

Special Requirements for Children

- In accordance with A.R.S. §36-2272, except as otherwise provided by law or a court order, no person, corporation, association, organization or state-supported institution, or any individual employed by any of these entities, may procure, solicit to perform, arrange for the performance of or perform mental health screening in a nonclinical setting or mental health treatment on a minor without first obtaining consent of a parent or a legal custodian of the minor child. If the parental consent is given through telemedicine, the health professional must verify the parent's identity at the site where the consent is given. This section does not apply when an emergency exists that requires a person to perform mental health screening or provide mental health treatment to prevent serious injury to or save the life of a minor child.
- Non-Emergency Situations
    - In cases where the parent is unavailable to provide general or informed consent and the child is being supervised by a caregiver who is not the child's legal guardian (e.g., grandparent) and does not have power of attorney, general and informed consent must be obtained from one of the following:
        - Lawfully authorized legal guardian,

- Foster parent, group home staff or another person with whom the DCS has placed the child, or
- Government agency authorized by the court.

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

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

NOTE: If behavioral health providers doubt whether the individual bringing the child in for services is a person/agency representative in whose care DCS has placed the child, the provider may ask to review verification, such as documentation given to the individual by DCS indicating that the individual is an authorized DCS placement. If the individual does not have this documentation, then the provider may also contact the child's DCS case worker to verify the individual's identity.

- For any child who has been removed from the home by DCS, the foster parent, group home staff, foster home staff, relative or other person or agency in whose care the child is currently placed may give consent for the following behavioral health services:
  - Evaluation and treatment for emergency conditions that are not life threatening, and
  - Routine medical and dental treatment and procedures, including early periodic screening, diagnosis and treatment services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (including behavioral health services and psychotropic medications).

- Any minor who has entered into a lawful contract of marriage, whether that marriage has been dissolved subsequently, any emancipated youth or any homeless minor may provide general and, when applicable, informed consent to treatment without parental consent (A.R.S. §44-132).

- Emergency Situations
  - In emergencies involving a child in need of immediate hospitalization or medical attention, general and, when applicable, informed consent to treatment is not required.
  - Any child, 12 years of age or older, who is determined upon diagnosis of a licensed physician, to be under the influence of a dangerous drug or narcotic, not including alcohol, may be considered an emergency and can receive behavioral health care as needed for the treatment of the condition without general and, when applicable, informed consent to treatment.

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

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

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

3.14 - Family Involvement

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

social support to the member. Information can be shared with other parties with written permission from the member or the member's guardian.

3.15 - Members with Diabetes and the Arizona State Hospital

- Members with diabetes who are admitted to the Arizona State Hospital (herein AzSH) for behavioral health services will receive training to use a glucometer and testing supplies during their stay at AzSH.
- Upon discharge from AzSH, PCPs must ensure these members are issued the same brand and model of glucometer and supplies that they were trained to use during their AzSH admission.
- MC's behavioral health coordinator will notify the PCP of the member's discharge from AzSH and provide information on the brand and model of equipment and supplies that should be continued to be prescribed.
- The MC behavioral health coordinator will work with AzSH to ensure the member has enough testing supplies to last until an office visit can be scheduled with the provider.
- In the event the member's mental status renders them incapable or unwilling to manage their medical condition and that condition requires skilled medical care, the MC behavioral health coordinator will work with AzSH and the PCP to obtain an appropriate placement for additional outpatient services.
- For re-authorization for continued behavioral health services, contact the member's provider-based case manager, and fax the Behavioral Health Treatment Plan and progress notes requesting continued authorization. Be sure to include the services to be delivered, frequency of services to be delivered and duration of services provided.
- ALWAYS verify member eligibility prior to the provision of services.

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

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

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

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

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

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

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

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

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

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

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

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

In addition to court ordered treatment 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”.

Licensing Requirements

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

Pre-Petition Screening

PINAL COUNTY

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

GILA COUNTY

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

MARICOPA COUNTY

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

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

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

Filing of Non-Emergent Petitions

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

- The Clinical Team or Pre-Petition Team will staff the application for involuntary evaluation (Application for Involuntary Evaluation and Pre-Petition Screening Report) with a psychiatrist. The psychiatrist need never have met the person to decide 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 provider-base case manager or the pre-petition team to the Legal Department at Maricopa Integrated Health System (MIHS) Desert Vista Campus for review by the County Attorney, preparation of the Detention Order, and filing with the Superior Court. These documents must be filed within 24 hours of completion, excluding weekends and holidays.
- Once the petition is filed with the court, the Legal Department at MIHS Desert Vista Campus Delivers the Detention Order to the Police Department to have the behavioral health member brought to the UPC, RRC or CPEC for evaluation. NOTE: The **Petition for Court Ordered Evaluation** and **Police Mental Health Detention Information Sheet**) expire 14 days from the date the judge signs off on the order for COE.
- One of the eight copies of petition documents shall be stored by the behavioral health member's provider-based case manager or the pre-petition team in a secure place (such as a locked file cabinet) to ensure the behavioral health member's confidentiality. A petition for involuntary evaluation may not be stored in the medical record if the behavioral health member has not been court ordered to receive treatment.

Emergent Filing

In cases where it is determined that there is reasonable cause to believe that the member is in such a condition that without immediate hospitalization, he/she is likely to harm himself/herself or others, an application for emergency admission can be filed. Only applications indicating Danger to Self and/or Danger to Others can be filed on an emergent basis and shall be filed at the Urgent Psychiatric Care (UPC),

1201 S 7th Ave; 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. MC contracts with the UPC, RCC, and CPEC to assist the applicant in preparing the **Application for Emergency Admission for Evaluation** when an emergent evaluation is requested and can also assist when an Application for Court Ordered Evaluation on a non-emergent basis is needed due to the person not meeting criteria for an emergency admission.

Emergent process

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

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

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

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

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

Court Ordered Outpatient Evaluation

- After the pre-petition screening, if the member is refusing a voluntary evaluation and the psychiatrist determines the member is safe to go through an Outpatient Court Ordered Evaluation, then the provider-based case manager or pre-petition team will deliver the original Application for Involuntary Evaluation, **Pre-Petition Screening Report**, and **Petition for Court Ordered Evaluation** to the Legal Department at Maricopa Integrated Health System(MIHS) Desert Vista Campus for review by the County Attorney, preparation of the service order, and filing with the Superior Court.
- Once the petition is filed with the court, the Legal Department at MIHS Desert Vista delivers the service order to the police department to have the member served legal notice of the date/time/location of the outpatient evaluation. One of the eight copies of the petition documents shall be stored by the member's provider-based case manager or PAD team in a secure place (such as a locked file cabinet) to ensure the behavioral health member's confidentiality. A petition for involuntary evaluation may not be stored in the medical record if the behavioral health member has

not been court ordered to receive treatment.

- The MIHS Legal Department will arrange for an outpatient Court Ordered Evaluation and notify the provider-based case manager or Pre-Petition Team of the date and time of the evaluation.
- If the Outpatient COE is scheduled to take place at Desert Vista, the provider-based case manager will arrange for transportation for the member to and from the Outpatient COE and will provide any documents requested by the psychiatrists conducting the evaluation. If the member is not enrolled at an SMI Clinic, the MC Court Liaison will assist the member in arranging transportation.
- If the two evaluating psychiatrists do not believe that the member needs COT, then the MIHS Legal Department will forward the physicians' affidavits to the provider-based case manager or Pre-Petition Team with an explanation that the member has been determined not to need COT.
- If the two evaluating psychiatrists completing the Outpatient Court Ordered Evaluation determine the member needs COT, then the two physician's **Affidavit and social** work report will be delivered to the MIHS Legal Department within 1 business day of the evaluation. The MC Court Liaison will then file a Petition for Court Ordered Treatment with the Maricopa County Superior Court within 2 business days.

Voluntary Evaluation

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

Voluntary Inpatient or Outpatient Evaluation

- If the individual agrees to a voluntary evaluation, complete the **Application for Voluntary Evaluation** and review with a psychiatrist.
- If the psychiatrist determines that a voluntary evaluation is appropriate, then a decision as to whether the evaluation is to take place on an inpatient or outpatient basis will be made by the psychiatrist.
- If the psychiatrist determines an inpatient voluntary evaluation is necessary, the provider-based case manager or PAD Team is to arrange for a voluntary admission to UPC, RRC, or CPEC, for the evaluation to take place, assist the member in signing in and deliver the original notarized **Application for Voluntary Evaluation** to the UPC, RRC, or CPEC Coordinator.
- If the psychiatrist determines an outpatient voluntary evaluation is acceptable, then the provider-based case manager or PAD Team will deliver the original, notarized **Application for Voluntary Evaluation** to the MIHS Legal Department. An outpatient evaluation will then be scheduled at Desert Vista Hospital and the provider-based case manager or PAD Team will be responsible for notifying the member of the date and time of the evaluation, provide transportation to and from the evaluation, and provide any documentation requested by the physician's conducting the evaluation.
- The voluntary outpatient or inpatient assessment must include evaluation by two psychiatrists and the involvement of either two social workers, or one social worker and one psychologist, who shall complete the outpatient treatment plan. The voluntary psychiatric evaluation shall include determination regarding the existence of a mental disorder, and whether, because of a mental disorder, the individual meets one or more of the standards. The psychiatric evaluation must also include treatment recommendations. The psychiatrists completing the outpatient psychiatric evaluations will submit a written affidavit to the MIHS Legal Department regarding their findings.
- If the psychiatrists do not believe that the member needs COT, then the MIHS Legal Department will forward the physicians' affidavits to the provider-based case manager or PAD Team with an explanation that the member has been determined not to need COT.
- If the psychiatrists completing the voluntary inpatient evaluation or voluntary outpatient evaluation determine the member needs COT, then the two physician's **Affidavit** and a social work report will be delivered to the MIHS Legal Department within 1 business day of the evaluation. The Mercy 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.

MC contracts with Maricopa Integrated Health Systems for inpatient Court Ordered Evaluations and Outpatient Court Ordered Evaluations when the county does not contract with MC for 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.

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

For ACC members on COT, the Outpatient Agency appointed by the court to supervise and administer COT is responsible 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 statue requires the Outpatient Agency to:

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

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

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

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

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

Judicial Review and COT Renewal Timelines/Forms

Judicial Review

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

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

Application for COT Renewal

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

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

**Please note that both psych reports must be completed by 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, MC will:

- Conduct an evaluation to determine if the member has a Serious Mental Illness in accordance with **MC Chapter 3 – Behavioral Health, Section 3.14 – SMI Eligibility Determination**, and conduct a behavioral health assessment to identify the member's service needs in conjunction with the member's clinical team, as described in **MC Chapter 10 – Behavioral Health Assessments and Treatment/Service Planning.**
- Provide necessary court ordered treatment and other covered behavioral health services in

accordance with the member

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

Transfer from one behavioral health provider to another

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

- The member does not have a court appointed guardian;
- The medical director of the receiving behavioral health provider accepts the transfer; and
- The consent of the court for the transfer is obtained as necessary.
- In order to coordinate a transfer of a member under court ordered treatment to ALTCS or another RBHA, the behavioral health member's clinical team will coordinate with the MC Court Advocacy Department at **MercyCareNetworkManagement@mercycareaz.org**.
- To coordinate a transfer of a member under COT from one SMI Clinic to another, the behavioral health member's current psychiatrist will discuss the transfer with the 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

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

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

Domestic Violence Offender Treatment

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

Court ordered substance use evaluation and treatment

Substance use evaluation and/or treatment (i.e., DUI services) ordered by a court under **A.R.S. §36-2027** is the financial responsibility of the county, city, town, or charter city whose court issued the order for

evaluation and/or treatment. Accordingly, if MC receives a claim for such services, the claim will be denied with instructions to the provider to bill the responsible county, city, or town.

Court Ordered Treatment for American Indian Tribal Members in Arizona

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

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

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

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

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

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

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

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

Due to the options American 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).

3.17 - Behavioral Health Treatment Plans and Daily Documentation

Behavioral Health Treatment Plan

A Behavioral Health Treatment Plan must be developed and reviewed/updated annually on each MC member, and as needed should a change in the member's condition require a modification to the treatment plan. The treatment plan should include strengths, measurable goals and presenting behavioral issues. For the behavioral issues, list recommended behavioral interventions to be utilized. Amended/renewed plans should indicate goals achieved or barriers interfering with success and recommendations to address this.

Daily Documentation

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

3.18 – SMI Eligibility Determination

General Requirements

This chapter applies to:

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

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

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. MC 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 MC or designee. Providers that contract with MC must submit the SMI evaluation to the designees as soon as practicable, but no later than 11:59 p.m. on the next business day following the evaluation. **MC or designee will have at least two (2) business days to complete the SMI determination.**

Completion Process of Initial SMI Eligibility Determination

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

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

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

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

- Request the additional information to decide 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 Eligibility 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 most basic needs of hygiene, grooming, nutrition, medical and dental care. Unwilling to seek prenatal care or necessary medical/dental care for serious medical or dental conditions. Refuses treatment for life threatening illnesses because of behavioral health disorder.
- **A risk of serious harm to self or others** – Seriously disruptive to family and/or community. Pervasively or imminently dangerous to self or others' bodily safety. Regularly engages in assaultive behavior. Has been arrested, incarcerated, hospitalized or at risk of confinement because of dangerous behavior. Persistently neglectful or abusive towards others in the member's care. Severe disruption of daily life due to frequent thoughts of death, suicide, or self-harm, often with behavioral intent and/or plan. Affective disruption causes significant damage to the member's education, livelihood, career, or personal relationships.
- **Dysfunction in role performance** – Frequently disruptive or in trouble at work or at school. Frequently terminated from work or suspended/expelled from school. Major disruption of role functioning. Requires structured or supervised work or school setting. Performance significantly below expectation for cognitive/developmental level. Unable to work, attend school, or meet other developmentally appropriate responsibilities; or
- **Risk of Deterioration** – A qualifying diagnosis with probable chronic, relapsing and remitting course. Co-morbidities (like mental retardation, substance dependence, personality disorders, etc.). Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors (life-threatening or debilitating medical illnesses, victimization, etc.). Other (past psychiatric history; gains in functioning have not solidified or are a result of current compliance only; court-committed; care is complicated and requires multiple providers; etc.).

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

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

Member with Co-occurring Substance use

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

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

If the youth is determined eligible, or likely to be determined eligible for services as a member with a Serious Mental Illness, the adult behavioral health services provider-based case manager is then contacted to join the CFT and participate in the transition planning process. **After obtaining permission from the**

parent/guardian, **it is the responsibility of the children's behavioral health service provider to contact and invite the adult behavioral health services provider-based case manager to upcoming planning meetings.** Additionally, the children's provider must track and report the following information to MC, CFT transition date (date the adult and children's provider attended a CFT) and adult intake date. When more than one 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.

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

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

Completion Process of Final SMI Eligibility Determination

The licensed psychiatrist, psychologist, or nurse practitioner designated by 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 enough information to determine SMI eligibility, the member shall be provided written notice of the SMI eligibility determination within three (3) business days of the initial meeting with the qualified assessor.

Issues Preventing Timely Completion of SMI Eligibility Determination

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

- There is substantial difficulty in scheduling a meeting at which all necessary participants can attend
- The member fails to keep an appointment for assessment, evaluation, or any other necessary meeting
- The member is capable of, but temporarily refuses to cooperate in the preparation of the completion of an assessment or evaluation
- The member or the member's guardian and/or designated representative requests an extension of time
- Additional documentation has been requested, but has not yet been received
- There is insufficient functional or diagnostic information1F1 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 enough information, but no later than the end date of the extension

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

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

[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).

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 MC or behavioral health provider:

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

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

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

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

Verification of SMI Eligibility Determinations

When a 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 MC and providers to "verify" a member's current SMI eligibility.

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

SMI Decertification

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

1. ***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:
     - The Determining Entity shall ensure that written notice of the determination and the right to appeal is provided to the affected member with an effective date of 30 days after the date the written notice is issued.
     - MC 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, MC 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/SU provider(s) or BHMP/PCP of the member's choice to eliminate any gaps in care for the member.
- The transferring of services from the SMI clinic to the GMH/SU 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/SU 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 – 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 the provider.

MC Transfer Protocol

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

Paneling of Members with GMH/SU

All members enrolled in MC and Non-Title XIX SMI eligibility plans are paneled to an Assigned Behavioral Health Clinic (ABHC) once behavioral health services are initiated within identified paneling organizations. Members will be re-paneled, as appropriate, to paneling organizations that are the primary catalyst of behavior health services. Members entering behavioral health services via emergency and/or crisis services will be paneled according to member preference and geographical location. If member preference is

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

Paneling of Members with SMI

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

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. MC 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 MC Availity Web Portal. Panel changes submitted through the Member Paneling tool are processed nightly and loaded directly into the Mercy Maricopa 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.

3.19 – Reporting of Seclusion and Restraint

Definitions

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

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

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

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

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

- Holding a client for no longer than 5 minutes;
- Without undue force, 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 MC

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 MCLTC's Quality Management Department within five (5) calendar days of the occurrence. The individual reports must be submitted on the **Policy 962, Attachment A, Seclusion and Restraint Individual Reporting Form.** This form is available on MC's website.

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

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

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

3.20 – Out of State Treatment for Behavioral Health

General Requirements

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

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

Conditions before Referral for Out-of-State Placement

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

- All less restrictive, clinically appropriate treatment interventions have either been provided or considered by the CFT or ART and found not to meet the member's needs;
- The CFT or ART has been involved in the service planning process and agrees with the out-of-state treatment;
- The CFT or ART has determined how they will remain active and involved in service planning once the out-of-state treatment has occurred;
- The CFT or ART develops a proposed Individual Service Plan that includes a discharge plan has been developed that addresses the needs and strengths of the member;
- All applicable prior authorization requirements have been met;
- The Arizona Department of Education has been consulted to ensure that the educational program in the out-of-state placement meets the **Arizona Department of Education Academic Standards** and the specific educational needs of the member;
- Coordination has occurred with other state agencies involved with the member, including notification to the DDD Medical Director when the individual is enrolled DD eligible;
- The member's AHCCCS Health Plan Behavioral Health Coordinator or health care provider has been contacted and a plan for the provision of any necessary non-emergency medical care has been established and is included in the comprehensive clinical record. The Behavioral Health Home in coordination with the family/legal guardian will coordinate with the AHCCCS Health Plan to decide and document all contacts and arrangements;
- MC Health Plan Coordinator will send notification of the pending out-of-state transition with the

admission date and facility to the appropriate Health Plan AHCCCS Behavioral Health Coordinator.

- Cultural considerations have been explored and incorporated into the ISP; and
- If a member has been placed out-of-state secondary to an emergency situation or unforeseen event, MC must address all above conditions as soon as notification of the out-of-state placement is received.

The Individual Service Plan (ISP)

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

- Discharge planning is initiated at the time of request for prior authorization or notification of admission (if placed prior by TPL or another state agency), including:
    - The measurable treatment goals being addressed by the out-of-state placement and the criteria necessary for discharge back to in-state services;
    - The planned or proposed in-state residence where the member will be returning;
    - The recommended services and supports required once the member returns from the out-of-state placement;
    - What needs to be changed or arranged to accept the member for subsequent in-state treatment that will meet the member's needs;
    - How effective strategies implemented in the out-of-state treatment will be transferred to the member's subsequent in-state treatment;
    - The actions necessary to integrate the member into family and community life upon discharge; and
    - The CFT or ART actively reviews the member's progress with clinical staffing occurring at least every 30 days. Clinical staffing must include the staff of the out-of-state facility.
- The member's family/guardian is involved throughout the duration of the treatment. This may include family counseling in member or by teleconference or video- conference;
- The CFT or ART must ensure that essential and necessary health care services are provided in coordination with the member's medical health plan; Home passes are allowed as clinically appropriate and in accordance with the **AHCCCS Covered Behavioral Health Services Guide**. 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

MC is required to obtain approval from the AHCCCS Office of Medical Management prior to an out-of-state treatment and upon discovering that a MC 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 MC criteria. MC requires their providers assist with supplying the information required on the form and with providing copies of supporting clinical documentation.

Process for Initial Notification to MC

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

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

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

- The Behavioral Health Home Clinical Leadership will coordinate with applicable key stakeholders (i.e. DCS, JPO, and DDD) and verify they agree for an out of state placement. If there is disagreement, which cannot be resolved, the Behavioral Health Home Clinical Leadership may contact MC for assistance in resolution.
- When the Behavioral Health Home Clinical Leadership and key stakeholders agree on the treatment, the Behavioral Health Home Clinical Leadership will complete the **AHCCCS Exhibit 450-1, Out of State Placements Form** and submit to the MC 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 MC Care Management Department will review the form and forward by secure email to the AHCCCS Office of Medical Management at **MedicalManagement@azahcccs.gov** for review and approval prior to placing the child or young adult.
- When the out-of-state treatment is approved AHCCCS, MC will notify the Behavioral Health Home Clinical Leadership and direct them to complete the out of state placement process.
- MC will identify out-of-state AHCCCS registered providers and send referrals to the provider and case management team.
- Once the accepting facility is identified, MC will facilitate a Single Case Agreement (SCA) and coordination transportation.

Periodic Updates to AHCCCS Office of Medical Management

In addition to providing initial notification, updates are required to be submitted every 30 days to AHCCCS regarding the member's progress in meeting the identified criteria for discharge from the out-of-state treatment. The Behavioral Health Home Clinical Leadership will complete the **AHCCCS Exhibit 450-1, Out of State Placements Form** and submit to the MC UM Department via secure e-mail to **ChildrensDischargePlanning@MercyCareAZ.org** no later than 5 business days before the 30 day update is due to AHCCCS. The 30-day update timelines will be based upon the date of admission to the out-of-state treatment as reported by MC to AHCCCS. The update will include a review of progress, CFT participation, evaluation of the discharge plan and availability of services based on the member's needs.

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

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

3.21 – Behavioral Health Assessment and Service Planning Overview

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

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

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

- Ongoing engagement of the member, family and other formal and informal supports who are significant in meeting the behavioral health needs of the member, including their active participation in the decision-making process and involvement in treatment;
- An assessment process is conducted to elicit information on the strengths, needs and goals of the individual member and his/her family, identify the need for further or specialty evaluations, and support the development and updating of a service plan which effectively meets the member's/family's needs and results in improved health outcomes;
- Continuous evaluation of the effectiveness of treatment through the CFT and ART process, the ongoing assessment of the member, and input from the member and his/her team resulting in modification to the service plan, if necessary;
- Provision of all covered services as identified on the service plan, including assistance in accessing community resources, as appropriate and, for children, services which are provided in accordance with the Arizona Vision and 12 Principles, and for adults, services which are provided in accordance with the 9 Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems;
- Ongoing collaboration, including the communication of appropriate clinical information, important to achieving positive outcomes (e.g., primary care providers, school, child welfare, juvenile or adult probation, other involved service providers);
- Oversight to ensure continuity of care by taking the necessary steps (e.g., clinical oversight, development of facility discharge plans, or after-care plans, transfer of relevant documents) to assist members who are transitioning to a different treatment program, (e.g., inpatient to outpatient setting), changing behavioral health providers and/or transferring to another service delivery system (e.g., out-of-area, out-of-state or to an Arizona Long Term Care System (ALTCS) Contractor); and
- Development and implementation of transition plans prior to discontinuation or modification of behavioral health services.

For additional information regarding the Child and Family Team practice refer to **AHCCCS Practice Protocol Child and Family Team Practice**.

3.22 - Assessments

All individuals being served in the public behavioral health system must have a behavioral health assessment upon an initial request for services. For individuals who continue to receive behavioral health services, updates to the assessment must occur at least annually.

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

MC does not mandate that a specific assessment tool or format be utilized. However, assessment of substance use disorders and related levels of service provision using the current version of the American Society of Addiction Medicine (ASAM) must be incorporated for members identified with substance use disorders.

The initial and annual assessment must be completed by a behavioral health professional (BHP) or behavioral technician (BHT) under the clinical oversight of a BHP, who is trained on the minimum elements of a behavioral health. If an assessment is conducted and documented by a BHT, a BHP must review and sign the assessment information that was documented by the BHT within 30 days of the BHT signature.

3.23 - Minimum Elements of the Behavioral Health Assessment

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

- 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 use 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 American Society of Addiction Medicine (ASAM) Criteria (current required version);
- 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, history, substance use, criminogenic factors, etc.;
- Summary/Bio-Psycho-Social formulation;
- Axial Diagnoses I-V; and
- 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, Division of Developmental Disabilities).
    - **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 Service Intensity Instrument (CASII) Score and Date.
    - **ONLY REQUIRED FOR CHILDREN AGE 6 TO 18 WITH CASII SCORE OF 4 OR HIGHER:** Strength, Needs and Culture Discovery Document.
    - **ONLY IF INDICATED:** Seriously Mentally Ill Determination (for members who request SMI determination or have an SMI qualifying diagnosis.

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

*Additionally, confirm that sexual abuse/behavior information was documented as part of the member's Family, Educational, and Social History.

prescribing privileges. If the assessor is unsure regarding a member's need for psychotropic medications, then the assessor must review the initial assessment and treatment recommendations with his/her clinical supervisor or a licensed medical practitioner with prescribing privileges.

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

3.24 - 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 MC Medical Management at **ComplexCase@MercyCareAZ.org** for review. For additional guidance see Provider Manual, Title XIX/XXI Notice and Appeal Requirements, subsection Complex Case Requests. Medical Management staff will evaluate the request to determine if it requires a notice. If a notice is required, MC will issue the NOA in accordance with ACOM 414, Notice of Adverse Benefit Determination and Notices of Extension for Service Authorizations.

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

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

3.25 - 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).

3.26 - Transfer Assessment

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. HNCM).

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

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

For DDD members who have been determined to have SMI and who can live independently, MC has several programs to support independent living, including rental subsidies, supportive housing programs and project-based housing that combines housing services with other covered behavioral health services.

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

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

- Housing is integrated. Tenants can interact with neighbors who do not have psychiatric disabilities.
- Tenants have choices in the supportive services that they receive. They are asked about their choices and can choose from a range of services, and different tenants receive different types of services based on their needs and preferences.
- As needs change over time, tenants can receive more intensive or less intensive supportive services without losing their homes.
- Supportive services promote recovery and are designed to help tenants choose, get, and keep housing.
- The provision of housing and the provision of supportive services are distinct.

For SMI members living outside of the Central GSA, MC will assist the Support Coordinator with accessing similar housing resources in the Northern and Southern GSAs.

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 uses supportive housing allocations for individuals with a SMI and according to any restrictions pertaining to the funding source. For example, an allocation may require it be used for Title XIX/XXI members, while another allocation may require it be used for Non-Title XIX members.
- Housing must be safe, stable, and consistent with the member's recovery goals and be the least restrictive environment necessary to support the member. Shelters, hotels, and similar temporary living arrangements do not meet this expectation.
- 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.3F[3]
- MC may charge up to, but not greater than, 30% of a tenant's income towards rent. If a rent payment is increased in state funded housing programs, MC's subcontracted providers must provide the tenant with a 30-day notice at the time of the tenant's annual recertification.
- 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 may provide move-in assistance and eviction prevention services to those members in permanent housing. When move-in assistance is provided, MC prioritizes assistance with deposits and payment for utilities over other methods of assistance, such as move-in kits or furnishings, consisting of pots and pans, dishes, sheets, etc. MC encourages its subcontracted providers to seek donations for necessary move-in/home furnishing items whenever possible. MC does not use supportive housing allocations or other funding received from AHCCCS (including block grant funds) to purchase furniture.
- For appeals related to supportive housing services, MC and its subcontracted providers must follow the requirements in **MC Chapter 7 – Grievances, Appeals and Claim Disputes, Section 7.04 – 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 7 – Grievances, Appeals and Claim Disputes, Section 7.03 – Conduct of Investigations Concerning Members with Serious Mental Illness.**

For SMI members living outside of the Central GSA, MC will assist the Support Coordinator with accessing similar housing resources in the Northern and Southern GSAs.

Other MC Housing Requirements

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

MC Housing Programs and Requirements for Central GSA

MC's housing programs include specialized housing units to meet the needs of members determined to have SMI who are difficult to place in the community partly due to crime free/drug free ordinances and specific behavioral health related service needs. Current specialized housing includes housing that is specifically designed to provide and accommodate the following services or conditions for members determined to have SMI:

- Housing for females with co-occurring disorders who are homeless;
- Apartment complexes for members determined to have SMI with criminal backgrounds released from jail with a major biological disorder;
- Housing for members determined to have SMI who are hearing impaired or deaf;
- Housing for members determined to have SMI who have sexualized behaviors and need on-site support;
- Gender based house model living for older females determined to have SMI;
- Apartment complex housing and services to 18-25-year-old adults transitioning from the children's system of care to the adult system of care;
- Specialized homes for polydipsia; and
- Housing suited to meet medical needs of members determined to have SMI with diabetes and other chronic diseases.

Federal Programs and Assistance

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

- Significantly increases resources to prevent homelessness.
- New incentives will place more emphasis on rapid re-housing, especially for homeless families.
- The existing emphasis on creating permanent supportive housing for people experiencing chronic homelessness will continue, and families have been added to the definition of chronically homeless.

- Rural communities will have the option of applying under a different set of guidelines that may offer more flexibility and more assistance with capacity building.

HUD published the HEARTH Continuum of Care (CoC) Program interim rule on July 31, 2012 and it became effective August 31, 2012. Changes made include codifying the Continuum of Care process, expanding the definition of homelessness, and focusing selection criteria more on performance. The purpose of the CoC Homeless Assistance Program is to reduce the incidence of homelessness in CoC communities, by assisting homeless individuals and families in quickly transitioning to self-sufficiency and permanent housing, as authorized under Title IV of the McKinney–Vento Homeless Assistance Act.

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

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

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

Federal HUD Housing Choice Voucher Program

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

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

MC has a network of employment and rehabilitation service providers to meet the rehabilitation needs of members. MC employment and rehabilitation providers are competent in providing employment services, see **AHCCCS Contractor Operations Manual Policy 447 - Employment** effective 9/4/2019. Employment and rehabilitation services include the provision of educating, coaching, training, and demonstrating skills, to remediate/prevent existing/anticipated functional deficits. Please refer to the **AHCCCS Medical Policy Manual (AMPM) Chapter 300 Exhibit C310-B - Title XIX/XXI Behavioral Health Service Benefit** for additional details.

Rehabilitation Services include:

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

Prevocational and Employment related services available through MC are distinct vocational services available through RSA/VR program. The Vocational Rehabilitation program provides a variety of services to persons with disabilities, with the ultimate goal to prepare for, enter into, or retain employment. Additional VR program details can be found on the **ADHS Vocational Rehabilitation web page**.

Members enrolled in DDD services please note: MC will coordinate with the assigned DD Support Coordinator to avoid duplication of employment supports.

The Division similarly offers Long Term Services and Supports (LTSS) employment supports. To avoid the duplication of efforts, the member's DDD Support Coordinator and Planning Team shall determine the service provider that best meets the member's needs for employment support. The determination and coverage responsibility will be documented in the member's Planning Document.

Member enrolled in DDD & SMI services please note: MC works collaboratively with Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA) in the Central GSA. MC and the Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA) have mutually developed collaborative protocols to ensure effective and efficient provision of comprehensive rehabilitative and employment support services for individuals determined eligible for SMI services to achieve increased independence or gainful employment. The Collaborative Protocol with ADES/RSA defines the respective roles and responsibilities of each party. The Collaborative Protocol with RSA District apply statewide and are available on our **Forms** web page.

Prevocational and Employment related services available through MC 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.

Members enrolled in DDD services please note: Members' Support Coordinators are responsible for making any Vocational Rehabilitation referrals. MC will coordinate with the DDD Support Coordinator to support the member connect to RSA.

3.29 - Collection of Demographic and Clinical Data Timeframes

Demographic and clinical data will be collected starting at the first date of service. A demographic record must be collected within 45 days of the first service and submitted to AHCCCS within 55 days. Additional

clinical data may be collected at subsequent assessment and service planning meetings with the member (e.g., education, vocation) as well as during periodic and annual updates. Demographic and clinical data recorded in the member's behavioral health medical record must match the demographic file on record with AHCCCS.

Specific Data Elements

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

Use of Demographic and Clinical Data

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

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

Technical Assistance with Demographic and Clinical Data Submission

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

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

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

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

4.01 – Funding

Special Populations

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

Substance Abuse Block Grant (SABG) Populations

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

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

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

- **WHEN:** Behavioral health services provided within a timeframe indicated by clinical need, but no later than 48 hours from the referral/initial request for services.
- **WHAT:** Any needed covered behavioral health service, including admission to a residential program if clinically indicated. If a residential program is temporarily unavailable, an attempt shall be made to place the member within another provider agency facility, including those in other geographic service areas. If capacity still does not exist, the member shall be placed on an actively managed wait list and interim services must be provided until the individual is admitted. Interim services include counseling/education about HIV and Tuberculosis (include the risks of transmission), the risks of needle sharing and referral for HIV and TB treatment services if necessary, counseling on the effects of alcohol/drug use on the fetus and referral for prenatal care.

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

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

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

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

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

Eligibility

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

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

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

4.02 – Referral and Intake Process

Behavioral Health Referral and Intake Process

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

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

Responding to Referrals

Follow-Up

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

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

Documenting and Tracking Referrals

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

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

Intake

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

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

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

- The collection of contact information, insurance information, the reason 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-.
- The review and dissemination of MC's Notice of Privacy Practices (NPP) and the AHCCCS HIPAA Notice of Privacy Practices (NPP) located at; and
- The review of the member's rights and responsibilities as a member of behavioral health services, including an explanation of the appeal process.

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

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

Integrated Care Specific Referral and Intake Guidelines

It may be necessary for a MC member to be referred to another provider for medically necessary services that are beyond the scope of the member's PCP. For those services, providers only need to complete the **Specialist Referral Form** available on our **Forms Library** web page and refer the member to the appropriate

MC Participating Health Provider (PHP). MC's website includes a provider search function for your convenience.

There are two types of referrals:

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

Referrals must meet the following conditions:

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

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

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

Referring Provider's Responsibilities

- Confirm that the required service is covered under the member's benefit plan prior to referring the member.
- Confirm that the receiving provider is contracted with MC.
- Obtain prior authorization for services that require prior authorization or are performed by a non-PHP.
- Complete a Specialist Referral Form available on our **Forms Library** 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 member's medical record). The provider rendering services based on the referral is responsible to:

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

Period of Referral

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

Maternity Referrals

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

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

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

- Coordinate the members maternity care needs until completion of the postpartum visits.
- Schedule a minimum of one postpartum visit at approximately six weeks postpartum.
- When necessary, refer members to other practitioners in accordance with the MC referral policies and procedures.
- Schedule return visits for members with uncomplicated pregnancies consistent with the 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.
    - 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 MC contracted ancillary providers.

Member Self-Referrals

MC 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.

4.03 – Outreach, Engagement, Reengagement and Closure

Outreach

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

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

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

Engagement

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

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

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

- Provide a courteous, welcoming environment that provides members with the opportunity to explore, identify and achieve their personal goals
- Engage members in an empathic, hopeful, and welcoming manner during all contacts
- Provide culturally relevant care that addresses and respects language, customs, and values and is responsive to the member's unique family, culture, traditions, strengths, age, and gender
- Provide an environment 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 (see **MC Chapter 4 – Provider Requirements, Section 4.25 – Cultural Competency, Health Literacy and Linguistic Services**)
- Be aware of and seek to gain an understanding of members with varying disabilities and characteristics
- Display sensitivity to, and respect for, various cultural influences and backgrounds (e.g., ethnic, racial, gender, sexual orientation, socio-economic class, and veteran status)
- Establish an empathic service relationship in which the member experiences the hope of recovery and is considered to have the potential to achieve recovery while developing hopeful and realistic expectations
- Demonstrate the ability to welcome the member, and/or the member's legal guardian, the member's family members, others involved in the member's treatment and other service providers as collaborators in the treatment planning and implementation process
- Demonstrate the desire and ability to include the member's and/or legal guardian's viewpoint and to regularly validate the daily courage needed to recover from persistent and relapsing disorders
- Assist in establishing and maintaining the member's motivation for recovery
- Provide information on available services and assist the member and/or the member's legal guardian, the member's family, and the entire clinical team in identifying services that help meet the member's goals
- Provide the member with choice when selecting a provider and the services they participate in
- At Risk Crisis Plans will address managing any change in a client's health, medical status, or behavior that is not immediately and obviously life-threatening (such as a heart attack, a seizure or immediate danger to self or others), but is nevertheless seriously concerning and may also include any significant and concerning change in a client's health, medical status, or behavior

Reengagement

For GMH/SU members, the reengagement policy is as follows:

Behavioral health providers must attempt to re-engage members in an episode of care that have withdrawn from participation in the treatment process prior to the successful completion of treatment, refused services or failed to appear for a scheduled service. All attempts to reengage members who have withdrawn from treatment, refused services, or failed to appear for a scheduled service must be

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

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

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

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

MC behavioral health providers are expected to:

- Involve the member, their parent/guardian, their families, or significant others in transition or aftercare planning;
- For extenuating circumstances involving crisis calls, follow up within 24 hours and if the member is unreachable, initiate a welfare check that could include utilizing law enforcement services, family members and significant others as designated by the member;
- Commence discharge planning at the time of intake;
- Within 24 hours of notification of admission and after the initial concurrent review, the clinical team contacts the inpatient social worker to schedule discharge planning staffing;
- Within 72 hours of notification of admission and after the initial concurrent review has occurred, the clinical team coordinates with a MC Care Coordinator to provide an initial discharge plan;
- Involve the member, parent/guardian, and/or family members in the selection of aftercare providers and appointment times, and make sure that aftercare appointments meet established access standards;
- Formalize discharge planning in writing with a discharge summary and follow up actions clearly indicated with scheduled aftercare appointments;

- Ensure members have enough medications or a prescription to last until the follow-up BHP appointment. This includes coordination with the inpatient treating physician and may include prior authorization requests to the MC;
- Within 72 hours of discharge, a BHMP completes a face-to-face comprehensive evaluation of the member and addresses any medication and/or treatment issues;
- Implement a multi-disciplinary team approach which includes the following:
    - A home visit within 5 days of discharge to identify environmental issues that may need interventions to prevent hospital readmission.
    - Weekly face-to-face contact after discharge for at least four consecutive weeks intended to identify causes, which led to the hospitalization and assess the member's ability to engage in their own wellness and transition successfully to community care. *
    - A Clinical Team Nurse will schedule an appointment within 10 days of discharge to ensure behavioral health members understand medications, dosages, side effects and any medication changes post discharge. **
    - 30-day post discharge face to face to formally review the discharge transition to determine if the member is at risk for readmission; assess the level of care needed; and develop a written action plan to maintain independence in the community.

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

    ** The children's provider may not employ a RN, if that is the case, it is enough if there is evidence in the BHMP note ensuring the member/guardian understands medications, dosages, side effects and any medication changes post discharge.

For Children members, the reengagement policy is as follows:

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

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

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. 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,
d. 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.

2. 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. All attempts to re-engage these members shall be clearly documented in the comprehensive clinical record.

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

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

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

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

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

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

Ending an Episode of Care for Member in Behavioral Health System

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

For children in the custody of DCS who have been enrolled with a Behavioral Health Home for less than 12 months, the Behavioral Health Home must elevate closure reasons of 'Treatment Completed', 'Lack of Contact', or 'Declined Further Services' to the MC Child Welfare Single Point of Contact at **DCS@MercyCareAZ.org** prior to ending the Episode of Care.

Clinical Factors

Treatment Completed:

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

Further Treatment Declined:

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

- All applicable and required reengagement activities described in *Reengagement* have been conducted and clearly documented in the member's comprehensive clinical record; and
- The member does not meet clinical standards for initiating the pre-petition screening or petition or petition for treatment process.

- Upon receiving a request from a DCS Specialist or representative for a child in the custody of DCS to discontinue services and/or dis-enroll a foster child, the behavioral health provider will conduct a Child Family Team (CFT) meeting to determine if this is clinically sound. If the child has been enrolled with the Behavioral Health Home for less than 12 months, the Behavioral Health Home must elevate the request to decline further treatment to MC Child Welfare Single Point of Contact at **DCS@MercyCareAZ.org**.

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

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

Administrative Factors:
Eligibility/Entitlement Information Changes Including:

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

Behavioral health providers may dis-enroll Non-Title XIX/XXI eligible members for non-payment of assessed co-payments per **MC Chapter 4 – Provider Requirements, Section 4.309 - Copayments** under the following conditions:

- The member is not eligible as a member determined to have a Serious Mental Illness (SMI); and
- Attempts at reasonable options to resolve the situation, (e.g., informal discussions) do not result in resolution. All efforts to resolve the issue must be documented in the member's comprehensive clinical record, in accordance with **MC Chapter 4 – Provider Requirements, Section 4.30 – Copayments**.

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

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

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

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

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

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

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

Notifications must include the following member information:
- AHCCCS ID;
- Name;
- Date of Birth;
- Incarceration date; and
- Name of public institution where incarcerated.

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

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

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

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

One-Time Consultations:
For members who are in the system for a one-time consultation, the member's episode of care may be ended if the behavioral health provider and the member or the member's legal guardian mutually agrees that ongoing behavioral health services are not needed. The Non-Title XIX individual would also be dis-enrolled.

Serving Members Previously Enrolled in Behavioral Health System

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

For members not receiving services for less than one year:

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

For members not receiving services for one year or longer:

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

4.04 – Serious Mental Illness Determination

General Requirements

This section applies to:

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

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

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. MC 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 MC or designee. Providers that contract with MC must submit the SMI evaluation to the designees as soon as practicable, but no later than 11:59 p.m. on the next business day following the evaluation. MC or designee will have at least two (2) business days to complete the SMI determination.

Completion Process of Initial SMI Eligibility Determination

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

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

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

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

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

Criteria for SMI Eligibility Determination

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

Functional Criteria for SMI Determination

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

- **Inability to live in an independent or family setting without supervision** – Neglect or disruption of ability to attend to basic needs. Needs assistance in caring for self. Unable to care for self in safe or sanitary manner. Housing, food, and clothing must be provided or arranged for by others. Unable to attend to most basic needs of hygiene, grooming, nutrition, medical and dental care. Unwilling to seek prenatal care or necessary medical/dental care for serious medical or dental conditions. Refuses treatment for life threatening illnesses because of behavioral health disorder.
- **A risk of serious harm to self or others** – Seriously disruptive to family and/or community. Pervasively or imminently dangerous to self or others' bodily safety. Regularly engages in assaultive behavior. Has been arrested, incarcerated, hospitalized or at risk of confinement because of dangerous behavior. Persistently neglectful or abusive towards others in the member's care. Severe disruption of daily life due to frequent thoughts of death, suicide, or self-harm, often with behavioral intent and/or plan. Affective disruption causes significant damage to the member's education, livelihood, career, or personal relationships.
- **Dysfunction in role performance** – Frequently disruptive or in trouble at work or at school. Frequently terminated from work or suspended/expelled from school. Major disruption of role functioning. Requires structured or supervised work or school setting. Performance significantly below expectation for cognitive/developmental level. Unable to work, attend school, or meet other developmentally appropriate responsibilities; or
- **Risk of Deterioration** – A qualifying diagnosis with probable chronic, relapsing and remitting course. Co-morbidities (like mental retardation, substance dependence, personality disorders, etc.). Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors (life-

threatening or debilitating medical illnesses, victimization, etc.). Other (past psychiatric history; gains in functioning have not solidified or are a result of current compliance only; court-committed; care is complicated and requires multiple providers; etc.).

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

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

Member with Co-Occurring Substance Use

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

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

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

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

SMI Eligibility Determination for Children Transitioning into the Adult System

When the adolescent reaches the **age of 17.5** and the Child and Family Team (CFT) believes that the youth may meet eligibility criteria as an adult with a Serious Mental Illness (SMI), the 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 provider-based case manager is then contacted to join the CFT and participate in the transition planning process. **After obtaining permission from the parent/guardian, it is the responsibility of the children's behavioral health service provider to contact and invite the adult behavioral health services provider-based case manager to upcoming planning meetings.** Additionally, the children's provider must track and report the following information to MC, CFT transition date (date the adult and children's provider attended a CFT) and adult intake date. When more than one 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.

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

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

Completion Process of Final SMI Eligibility Determination

The licensed psychiatrist, psychologist, or nurse practitioner designated by 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; and
- A review of current and historical information, if any, obtained orally or in writing by the assessor from collateral sources, and/or present or previous treating clinicians.

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

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

eligibility requirements must be based upon a face-to-face functional evaluation conducted by a designated psychiatrist, psychologist, or nurse practitioner. The psychiatrist, psychologist, or nurse practitioner shall document the specific reason(s) for the disagreement in the member's comprehensive clinical record.

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

Issues Preventing Timely Completion of SMI Eligibility Determination

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

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

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; and
- Not use the delay as a waiting period before determining SMI status or as a reason for determining that the member does not meet the criteria for SMI eligibility (because the determination was not made within the time standards).

Situations in which Extension is due to Insufficient Information:

- 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; and
- SMI eligibility must be determined within three days of obtaining enough information, but no later than the end date of the extension.

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

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

Notification of SMI Eligibility Determination

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

If the eligibility determination results in a denial of SMI status, 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; and
- The statement that Title XIX/XXI eligible members will continue to receive needed Title XIX/XXI covered services.

Re-Enrollment or Transfer

If the member's status is SMI at disenrollment, or upon transfer from another 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 MC or behavioral health provider:

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

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

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

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

Verification of SMI Eligibility Determinations

When a 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 MC and providers to "verify" a member's current SMI eligibility.

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

4.05 - Special Populations

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

Substance Abuse Block Grant (SABG)

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

Coverage and Prioritization

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

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

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

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. Members must document that the member has received notice in the member's comprehensive clinical record.

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

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

Available Services

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

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

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

- Childcare
- Case management
- Transportation

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

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

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

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

The purpose of interim services is to reduce the adverse health effects of substance use, promote the health of the individual, and reduce the risk of transmission of disease. Provision of interim services must be documented in the client's chart as well as reported to MC through the online waitlist. Interim services are available for Non-Title XIX/XXI priority populations who are maintained on an actively managed wait list. Title XIX/XXI eligible members who also meet a priority population type may not be placed on a wait list (see **MC Chapter 3 – Behavioral Health, Section 3.06 – Behavioral Health Appointment Standards**. The minimum required interim services include education that covers:

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

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 placement in a Residential Treatment Center, to the MC SABG Waitlist System, or in a different format upon written approval by MC.

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

Other SABG Requirements

MC is required to designate:

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

HIV Early Intervention Services

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

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

Eligibility for HIV Early Intervention Services

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

Requirements for Providers Offering HIV Early Intervention Services

HIV early intervention service providers who accept funding under the Substance Abuse Block Grant (SABG) must provide HIV testing services.

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

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

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

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

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

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

Reporting Requirements for HIV Early Intervention Services

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

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

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

Monitoring Requirements for HIV Early Intervention Services

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

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

Minimum Performance Expectations

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

Delivery Considerations Services to Substance Abuse Block Grant (SABG) Populations

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

Restrictions use of Substance Abuse Block Grant (SABG)

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

- To provide inpatient hospital services, except for detox services;
- To make cash payments to intended members of health services;
- To purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
- To satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds (Maintenance of Effort);

- To provide financial assistance to any entity other than a public or nonprofit private entity;
- To provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug use and the risk that the public will become infected with the etiologic agent for AIDS;
- To pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of **Executive Level I of the Executive Salary Schedule** for the award year; and
- To purchase treatment services in penal or correctional institutions of the State of Arizona.

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

Mental Health Block Grant (MHBG)

The MHBG provides funds to establish or expand an organized community-based system of care for providing Non-Title XIX mental health services to children with serious emotional disturbances (SED) and adults with serious mental illness (SMI). These funds are used to:

- Carry out the State plan contained in the application;
- Evaluate programs and services, and;
- Conduct planning, administration, and educational activities related to the provision of services.

Coverage and Prioritization

The MHBG provides Non-Title XIX/XXI behavioral health services to adults with SMI and children with SED.

The MHBG must be used:

- To ensure access to a comprehensive system of care, including employment, housing, case management, rehabilitation, dental, and health services, as well as mental health services and supports;
- To promote participation by consumer/survivors and their families in planning and implementing services and programs, as well as in evaluating State mental health systems;
- To ensure access for underserved populations, including people who are homeless, residents of rural areas, and older adults;
- To promote recovery and community integration for adults with SMI and children with SED;
- To provide for a system of integrated services to include:
    - Social services;
    - Educational services;
    - Juvenile justice services;
    - Substance use services;
    - Health and behavioral health services; and
    - To provide for training of providers of emergency health services regarding behavioral health.

Restrictions on Use of MHBG Funds

The State shall not expend MHBG funds on the following activities:

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

Room and Board services funded by the MHBG are limited to children with SED.

4.06 – Crisis Intervention Services

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, MC will ensure that the following crisis services are available:

- Telephone Crisis Intervention Services:
    - Telephone crisis intervention and NurseLine services, including a toll-free number, available 24 hours per day, seven days a week: 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.
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 MC must provide a standard set of crisis services to ensure the availability of these services throughout the state, MC will also be able to meet the specific needs of communities located within their service area. MC will utilize the following in managing crisis services:

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

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

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

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

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

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

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

4.07 – Training Requirements

MC leadership's expectation is that all contracted General Mental Health/Substance Use providers are knowledgeable about the Substance Abuse Block Grant (SABG). This includes providers having SABG posters and materials available in waiting areas, and to be able to speak to uninsured and underinsured individuals who may need treatment or providing a referral for treatment.

MC Chapter 5 – Pharmacy Management

5.00 - Pharmacy Management Overview

Prescription drugs may be prescribed by any authorized provider, such as a PCP, attending physician, dentist, etc. Prescriptions should be written to allow generic substitution whenever possible and signatures on prescriptions must be legible for the prescription to be dispensed. The **Preferred Drug List (PDL)** on our **Pharmacy** webpage, also referred to as a Formulary, identifies the medications selected by AHCCCS and the Pharmacy and Therapeutics Committee (P&T Committee) that are clinically appropriate to meet the therapeutic needs of our members in a cost effective manner.

5.01 - Updating the Preferred Drug Lists (PDLs)

MC's PDLs are developed, monitored, and updated by AHCCCS and the P&T Committee. The P&T Committee continuously reviews the PDLs and medications are added or removed based on objective, clinical and scientific data. Considerations include efficacy, side effect profile, and cost and benefit comparisons to alternative agents, if available.

Key considerations:

- Therapeutic advantages outweigh cost considerations in all decisions to change PDLs. Market share shifts, price increases, generic availability and varied dosage regimens may affect the actual cost of therapy.
- Products are not added to the list if there are less expensive, similar products on the formulary.
- When a drug is added to the PDL, other medications may be deleted.
- Participating physicians may request additions or deletions for consideration by the P&T Committee. Requests should include:
    - Basic product information, indications for use, its therapeutic advantage over medications currently on the PDL.
    - Which drug(s), if any, the recommended medication would replace in the current PDL.
    - Any published supporting literature from peer reviewed medical journals.

All PDL requested additions should be sent to:

Aetna Medicaid Administrators LLC
Mercy Care Corporate Director of Pharmacy
4500 E. Cotton Center Blvd.
Phoenix, AZ 85040

5.02 - Notification of PDL Updates

MC will not remove a medication from the PDL without first notifying providers and affected members. MC will provide at least 30 days' notice of such changes. MC is not required to send a hard copy of the PDL each time it is updated, unless requested. A memo may be used to notify providers of updates and changes and may refer providers to view the updated PDL on the MC website. MC may also notify providers of changes to the PDL via direct letter. MC will notify members of updates to the PDL via direct mail and by notifying the prescribing provider, if applicable.

5.03 - Prior Authorization Required

Prior authorization is required:

- If the drug is not included on the PDL.
- If the prescription requires compounding.
- For injectable medications dispensed by the physician and billed through the member's medical insurance, please call to initiate prior authorization for the requested specialty medication:
    - **Mercy Care: 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.
- A request for additional information is sent to the prescriber by fax within 24 hours of the submitted request when the prior authorization request for a medication lacks enough information to render a decision. A final decision will be rendered within seven business days from the initial date of the request.
- If an authorization is denied, MC notifies members and practitioners and/or providers regarding how to initiate an expedited appeal at the time they are notified of the denial.
- MC *will fill a*t *least* a 4-day supply of a covered outpatient prescription drug in an emergent situation.

5.04 - Over the Counter (OTC) Medications

A limited number of OTC medications are covered for MC members. OTC medications require a written prescription from the physician that must include the quantity to be dispensed and dosing instructions. Members may present the prescription at any MC contracted pharmacy. OTCs are limited to the package

size closest to a 30-day supply when filled at a retail pharmacy and up to a 90-day supply when filled at CVS mail order pharmacy. Please refer to the **Provider Drug List** for more information.

5.05 - Generic vs. Brand

Generic medications represent a considerable cost savings to the health care industry and Medicaid program. As a result, generic substitution with A-rated products is mandatory unless the brand has been specifically authorized or as otherwise noted. In all other cases, brand names are listed for reference only.

5.06 - Diabetic Supplies

Diabetic supplies are limited to a 30-day supply (to the nearest package size) with a prescription when filled at a retail pharmacy and up to a 90-day supply when filled at CVS mail order pharmacy.

5.07 - Injectable Drugs

The following types of injectable drugs are covered when dispensed by a licensed pharmacist or administered by a participating provider in an outpatient setting and may require prior authorization:

- Immunizations when administered by a pharmacy in a retail pharmacy
- Chemotherapy for the treatment of cancer
- Medication to support chemotherapy for the treatment of cancer
- Glucagon emergency kit
- Hemophilia medications including Ceprotin and Stimate Nasal Spray which must be filled at CVS Specialty Pharmacy.
- Insulin; Insulin syringes
- Immunosuppressant drugs for the post-operative management of covered transplant services
- Rhogam

5.08 - Exclusions

The following items, by way of example, are not reimbursable by MC:

- DESI drugs (those considered less than effective by the FDA)
- Non-FDA approved agents
- Rogaine
- Any medication limited by federal law to investigational use only
- Medications used for cosmetic purposes
- Non-indicated uses of FDA approved medications without prior approval by MC
- Lifestyle medications (such as medications for sexual dysfunction)
- Medications used for fertility

5.09 - Family Planning Medications and Supplies

Aetna Medicaid Administrators LLC administers the family planning benefit for MC that includes:

- Over-the-counter items related to family planning (condoms, foams, etc.) are covered and do not require prior authorization. However, the member must present a written prescription, to the pharmacy including the quantity to be dispensed. A supply for up to 30-days is covered.
- Injectable medications, administered in the provider's office, such as Depo-Provera will be reimbursed at the MC Fee Schedule, unless otherwise stated in the provider's contract.

- Oral contraceptives are covered for MC members, through Aetna Medicaid Administrators LLC.

5.10 - Behavioral Health Medications

PCP Medication Management Services: In addition to treating physical health conditions, MC will allow PCPs to treat behavioral health conditions within their scope of practice. PCPs who treat members with behavioral health conditions may provide medication management services including prescriptions, laboratory, and other diagnostic tests necessary for diagnosis, and treatment. For PCPs prescribing medications to treat SUDs, the PCP must refer the member to a behavioral health provider for the psychological and/or behavioral therapy component of the MAT model and coordinate care with the behavioral health provider.

***Transfer of Care*:** For members transitioning from a BHMP to a PCP or from a PCP to a BHMP: PCPs and BHMPs shall coordinate the care and ensure that the member has a sufficient supply of medication(s) to last through the date of the member's first appointment with the PCP or BHMP.

Psychotropic Medication: Prescribing and Monitoring

Psychotropic medication will be prescribed by a psychiatrist who is a licensed physician, or a licensed nurse practitioner, licensed physician assistant, or physician trained or experienced in the use of psychotropic medication; that has seen the client and is familiar with the client's medical history or, in an emergency, is at least familiar with the client's medical history.

When a client on psychotropic medication receives a yearly physical examination, the results of the examination will be reviewed by the physician prescribing the medication. The physician will note any adverse effects of the continued use of the prescribed psychotropic medication in the client's record.

Whenever a prescription for medication is written or changed, a notation of the medication, dosage, frequency or administration, and the reason 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;

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

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

Informed Consent

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

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

Psychotropic Medication Monitoring

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

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

- **Abnormal Involuntary Movements (AIMS):** On initiation of any antipsychotic medication, follow up at week 12, and at least every six months thereafter or more frequently as clinically indicated.
- **Fasting glucose:** On initiation of any medication affecting this parameter, follow up at week 12, and at least annually thereafter or more frequently as clinically indicated.
- **Lipids:** On initiation of any medication affecting this parameter, at week 12, and at least annually thereafter or more frequently as clinically indicated.
- **Complete Blood Count (CBC):** On initiation of any medication affecting this parameter and at least annually thereafter or more frequently as clinically indicated.
- **Liver function:** On initiation of any medication affecting this parameter and at least annually thereafter or more frequently as clinically indicated.
- **Lithium level:** Within one week of initiation of lithium or significant change in dose, follow up at 6 months, and at least annually thereafter or more frequently as clinically indicated.
- **Thyroid functions:** On initiation of lithium, at 6 months, at any significant change in dose, and at least annually thereafter, or more frequently as clinically indicated.
- **EKGs**: On initiation of any medication affecting the QT interval, then as clinically indicated.
- **Renal function:** On initiation of lithium, follow up at 3 months, 6 months, at any significant change in dose, and at least annually thereafter or more frequently as clinically indicated.
- **Valproic acid level:** Within one week of initiation of valproic acid or divalproex or significant change in dose and at least annually thereafter or more frequently as clinically indicated.
- **Carbamazepine level:** Within one week of initiation of carbamazepine or significant change in dose and at least annually thereafter or more frequently as clinically indicated.
- **Review of all Medications**, including medications prescribed by the PCP and medical specialists, OTC medications, and supplements at least annually or more frequently as clinically necessary.
- **Children** are more vulnerable than adults about developing several antipsychotic induced side effects. These included higher rates of sedation, extrapyramidal side effects (except for akathisia), withdrawal dyskinesia, prolactin elevation, weight gain and at least some metabolic abnormalities. (Journal of Clinical Psychiatry 72:5 May 2011)

Polypharmacy

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

MC recognizes two types of polypharmacy: intra-class polypharmacy and inter-class polypharmacy. Below are MC's expectations regarding prescribing multiple psychotropic medications to a member being treated for a behavioral health condition:

- **Intra-class Polypharmacy:** Defined as more than two medications prescribed at the same time within the same class, other than for cross-tapering purposes. The member's medical record must contain documentation specifically describing the rationale and justification for the combined use.

- **Inter-class Polypharmacy:** Defined as more than three medications prescribed at the same time from different classes of medications for the overall treatment of behavioral health disorders. The medical record must contain documentation specifically describing the rationale and justification for the combined use.
- **Polypharmacy in Children aged Birth to Five:** Defined as use of more than one psychotropic medication at a time (see **Practice Guidelines for Children: Birth to Five Years of Age**).

Reporting Requirements

MC has established system requirements for monitoring the following:

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

The above referenced events are identified, reported, tracked, reviewed, and analyzed by MC.

An incident report must be completed for any medication error, adverse drug event and/or adverse drug reaction that results in harm and/or emergency medical intervention.

5.11 - Request for Non-PDL Drugs

A participating or nonparticipating practitioner/provider acting on behalf of a member is to obtain prior authorization from MC before prescribing or obtaining medications that are not listed in the Formulary/PDL or the member's prescription drug benefit. MC will require the practitioner/ provider to submit the MC Pharmacy Prior Authorization request form and all the necessary supporting medical documentation (e.g., pertinent medical records, completed Federal Drug Administration [FDA] Med Watch form).

The prescribing provider is responsible for submitting authorization requests for non-formulary drugs to the Pharmacy Prior Authorization unit by phone, fax, or electronic PA (ePA), and is responsible for providing medical information necessary to review the request.

Pharmacy Prior Authorization will accept drug-specific information necessary for the authorization review from the prescribing practitioner. MC will inform the member and provider of authorization approvals or denials by written notice.

Any new drugs that are approved by the FDA will be considered through AHCCCS and the P&T Committee review process for addition to MC formulary, and would be made available as a non-formulary drug, requiring PA, upon their availability in the marketplace

To support routine Non-Formulary pharmacy authorization decisions, MC uses guidelines, based on FDA-approved indications, evidence-based clinical literature, recognized off-label use supported by peer-reviewed clinical studies, and member's benefit design, which are applied based on individual members. 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

5.12 – Discarded Physician-Administered Medications

Discarded federally and state reimbursable physician-administered medications shall not be billed to MC. A.A.C. R9-22-209(C) provides that pharmaceutical services are covered only if they are prescribed. The unused portion of a physician administered drug is not covered because it's not medically necessary or prescribed.

A.R.S. §36-2918(A)(1) prohibits a person from making a claim for an item or service that the person knows or has reason to know was not provided as claimed.

A.R.S. §36-2918(A)(3)(b) prohibits a person from submitting a claim for items and services that substantially exceed the needs of the patient.

MC Chapter 6 – Partnership Requirements with Families and Family-Run Organizations

6.00 – 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 agrees.

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@mercycareaz.org.**

Provider agencies rendering peer support services to any AHCCCS member including fee for service members shall maintain documentation evidencing that all actively employed peer/recovery support specialists have met the required qualifications and credentialing. All providers of peer/recovery support services are required to complete 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@mercycareaz.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 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@mercycareaz.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@mercycareaz.org**. CPFSPs are required to send all credentialed individuals completing their training program to AHCCCS/OIFA. Individuals credentialed in another state shall submit their credential to AHCCCS/OIFA through their employing provider.

Individuals employed as a 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 of family support services and best practices in providing supervision to credentialed parent/family support providers.

6.01 – Incorporating Peer and Family Voice and Choice in Integrated Care Service Delivery

Advisory Councils

All behavioral health providers must establish and maintain an Advisory Council made up of individuals receiving services at that provider clinic, direct service staff, clinic leadership, and relevant community members/neighbors.

The purpose of the Advisory Council is to provide a formal structure and process for individuals receiving services and their family members or loved ones to participate in organizational decision making and to have regular dialogue with clinic leaders. The Council provides an opportunity for individuals and their family members, direct clinic staff and vested community members to participate and be involved in improving the delivery of services, improving the environment in which services are provided, and enhancing customer service.

Leadership for the council will consists of a chair, co-chair and an advisory council facilitator/note taker. The chair and co-chair positions will be held by either individual receiving service and/or family members/loved ones. The advisory council facilitators and note taker duties will be administered by clinic staff.

Advisory Councils will meet monthly for a minimum of one hour. Advisory council leadership is to ensure at least 2 members and 1 family member be present and in attendance during the council meeting. The meeting's agenda must allot time for the members/family members or loved ones to voice their concerns

and ideas regarding the clinic. Guest speakers can also be present to discuss resources and relevant system education for members and their families.

Monthly meeting minutes need to be taken and posted in the clinic lobby for public consumption and comment. Meeting minutes, sign-in sheets and agendas will be retained and distributed to the MC Office of Individual and Family Affairs (OIFA) representative by the first business day of the following month.

Advisory Councils will be entrusted with the responsibility of reviewing member feedback and making recommendations for continuous improvement to the provider leadership. Provider leadership is expected to attend Advisory Council meetings.

When applicable, the MC OIFA will assist the council to implement actions, solutions or requests developed at the meetings. OIFA will be available to the Advisory Councils for assistance, as well as participation in the 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;

- 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 incorporates the concept of a "team", established for each member receiving behavioral health services.

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

The team process emphasizes a family friendly, culturally sensitive, and clinically sound model that focuses on identification of the member and family strengths. The process includes engagement and input from

those members being served, as well as their family and significant others, and focuses on identifying the member's and team member's preferences.

MC requires the following from subcontractors and providers:

- The ability to welcome and engage family members in the member's service planning and service delivery as full partners in the planning, delivery and evaluation of services and supports;
- Demonstration of the ability to include family members viewpoint in the service planning and service delivery processes;
- Encourage and engage family members to participate, be active and respected as part of the member's team;
- During the assessment process, establish that the service assessment and service planning process is viewed as a partnership and is a team approach;
- During the Individual Service Plan (ISP) development, the assessor will identify the unique strengths, needs and preferences of the member, family/caregiver and identified team members. The needs (and associated services) identified in the ISP will be tailored to the unique strengths, values and beliefs of each individual member and their family, and will be updated as members progress toward recovery and their goals evolve;
    - All Individual Service Planning (ISP) and development with children is completed collaboratively with the child's parent and/or primary caregiver;
    - Development and prioritization of ISP goals are not focused solely on the child, but include the parent, caregiver, and the needs of the family as a whole;
- All ISP should consider the inclusion of community and natural supports;
- Providers are required to adhere to **AHCCCS Clinical Guidance Tool Family and Youth Involvement in the Children's Behavioral Health System**.
- Provide support to family members to assist in eliminating barriers preventing them from actively participating on the member's team, and;
- Establish a mechanism that will provide family support be accessible to families to help engage the family and to help the individual best utilize their natural support network;
- Establish partnerships with peer-run and family-run organizations to co-facilitate trainings on peer and family-professional partnerships, and;
- Partner with peer and family-run organizations in the delivery of training on peer-to-peer and family-to-family roles for Peer and Parent/Family Support Provider roles employed in the system.

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

MC Chapter 7 – Dental and Vision Services

7.00 - Dental Overview

DentaQuest

Effective January 1, 2015, DentaQuest will administer dental benefits for MC. DentaQuest has administrative oversight for the following responsibilities:

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

MC will administer the following for our members:

- Grievances
- Customer Service Calls from Members

Claims with dates of service on or after January 1, 2015 need to be sent to DentaQuest at the following claims address:

DentaQuest of Arizona, LLC – Attention: Claims
P.O. Box 2906
Milwaukee, WI 53201-2906

For electronic claims submissions, DentaQuest works directly with the following Clearinghouses:

Change Healthcare (888-255-7293)
Tesla (800-724-7420)
EDI Health Group (800- 576-6412)
Secure EDI (877-466-9656)
Mercury Data Exchange (866-633-1090)

You can contact your software vendor to make certain that they have DentaQuest listed as the payer and claim mailing address on your electronic claim. Your software vendor will be able to provide you with any information you may need to ensure that submitted claims are forwarded to DentaQuest. DentaQuest's Payer ID is CX014.

If you have additional questions regarding your claims for DentaQuest, you may contact them directly at 844-234-9831. They will be happy to assist you.

You may also utilize their Interactive Voice Response (IVR) system 24 hours a day, 7 days a week that provides up-to-date information regarding member eligibility, claim status, and much more. Benefits associated with this program and more detailed information regarding DentaQuest can be found in their Office Reference Manual on-line at **www.dentaquestgov.com**.

7.01 – Dental Covered Services

Dental Screening/Dental Treatment for children under 21

More information regarding Dental Screening/Dental Treatment for children under 21 is available under the **MC Chapter 100 – MC 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
- dental sealant
- oral hygiene education
- x-rays
- fillings
- extractions
- other therapeutic and medically necessary procedures
- routine dental services

Two (2) routine preventive dental visits are covered per year. Visits to the dentist must take place within six months and one day after the previous visit. The first dental visit should take place by one year of age. Members under 21 years of age do not need a referral for dental care.

Benefits covered for children under age 21 are in accordance with AHCCCS' **Exhibit 431, Attachment A - AHCCCS Dental Periodicity Table**. Benefits are also outlined in the DentaQuest Office Manual available at **www.dentaquestgov.com**.

MC assigns all members under 21 years of age to a dental home. A dental home is where the member and a dentist work together to best meet dental health needs. Having a dental home builds trust between the member and the dentist. It is a place where the member can get regular, ongoing care, not just a place to go when there is a dental problem. A "dental home" may be an office or facility where all dental services are provided in one place. Members can choose or change their assigned dental provider.

Emergency Dental Services for Members 21 Years of Age and Older

Members 21 years of age or older have a $1,000 annual emergency dental benefit per health plan year. The annual benefit plan year runs from October 1 - September 30. Medically necessary emergency dental care and extractions are covered for persons age 21 years and older who meet the criteria for a

dental emergency. A dental emergency is an acute disorder of oral health resulting in severe pain and/or infection because of pathology or trauma.

Emergency dental services* include:

- Emergency oral diagnostic examination (limited oral examination - problem focused);
- Radiographs and laboratory services limited to the symptomatic teeth;
- Composite resin due to recent tooth fracture for anterior teeth;
- Prefabricated crowns, to eliminate pain due to recent tooth fracture only;
- Recementation of clinically sound inlays, onlays, crowns, and fixed bridges;
- Pulp cap, direct or indirect plus filling;
- Root canals and vital pulpotomies when indicated for the treatment of acute infection or to eliminate pain;
- Apicoectomy performed as a separate procedure, for treatment of acute infection or to eliminate pain, with favorable prognosis;
- Immediate and palliative procedures, including extractions if medically necessary, for relief of pain associated with an oral or maxillofacial condition;
- Tooth reimplantation of accidentally avulsed or displaced anterior tooth, with favorable prognosis;
- Temporary restoration which provides palliative/sedative care (limited to the tooth receiving emergency treatment);
- Initial treatment for acute infection, including, but not limited to, periapical and periodontal infections and abscesses by appropriate methods;
- Preoperative procedures and anesthesia appropriate for optimal patient management; and
- Cast crowns limited to the restoration of root canal treated teeth only.

*Emergency dental services do not require prior authorization.

Dental services that are **not** covered:

- Diagnosis and treatment of TMJ - except to reduce trauma
- Maxillofacial dental services that are not needed to reduce trauma
- Routine restorative procedures and routine root canal therapy
- Bridgework to replace missing teeth
- Dentures

Covered dental services not subject to the $1,000 emergency dental limit include:

- Extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck, or head.
- Members who require medically necessary dental services before getting a covered organ or issue transplant**:
    - Treatment for oral infections
    - Treatment of oral disease, including dental cleanings, treatment of periodontal disease, medically necessary extractions and simple restorations.

**These services are covered only after a transplant evaluation determines that the member is a candidate for organ or tissue transplantation.

Anesthesia related to the emergency dental services also falls under the annual $1,000 benefit.

Emergency dental codes are covered only if they meet the criteria of emergent treatment per AHCCCS policy. For additional detail regarding this benefit, we are including the following links to the AHCCCS Medical Policy Manual:

- **Exhibit 310 D1 - Dental Services for Members 21 Years of Age and Older**
- **Exhibit 310 D2 - Arizona Long Term Care System Adult Dental Services**

7.02 – Vision Services

Vision Overview

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

- 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 and for adults when medically necessary following cataract removal.
- Cataract removal is covered for all eligible members under certain conditions. For more information, please review the **AHCCCS Medical Policy Manual, Chapter 300**.

Coverage for Children (Under Age 21)

- 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 under age 21 with vision screening of 20/60 or greater should be referred to the contracted vision provider for further examination and possible 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 MC's contracted vendor for all vision services, including diabetic retinopathy exams. Members requiring vision services should be referred by the PCP's office to a Nationwide provider listed on MC's website. The member may call Nationwide directly to schedule an appointment.

Coverage for Adults (21 years and older)

- 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.

Dental and Vision Community Resources for Adults

AHCCCS benefits do not include routine dental and vision services for adults. However, there are community resources available to help members obtain routine dental and vision care. For more information, call MC's Member Services at 6

MC Chapter 8 – Grievances, Appeals and Claims Disputes

8.00 - Grievances

MC's Grievance System includes a process for member grievances, member appeals, provider claim disputes and access to the State Fair Hearing system.

A Grievance is described as any written or verbal expression of dissatisfaction over anything that does not involve appealing a decision, such as a denial or discontinuance of services or benefits. Grievances may be filed by a member or provider authorized in writing to act on the member's behalf. A grievance may be submitted orally or in writing to any MC staff person. Grievances include, but are not limited to, issues regarding:

- Quality of care or services
- Accessibility or availability of services
- Interpersonal relationships (e.g. rudeness of a provider or employee, cultural barriers, or insensitivity)
- Claims or billing
- Failure to respect a member's rights

To file a grievance, members and/or a provider filing on behalf of a member, should contact Mercy Care Grievance System Department by phone at 602-586-1719, Toll -Free at 866-386-5794, or in writing at:

Mercy Care
Grievance System Department
4755 S. 44th Place
Phoenix, AZ 85040

MC will respond and resolve member grievances at the time of the initial call, if possible, or within 90 days if further investigation is needed.

If the grievance involves a quality of care concern, it will be forwarded to MC's Quality Management Department for further review. The concern will be investigated, and the member will receive a closure letter after the investigation is completed.

8.01 - Provider Claim Disputes

A claim dispute is a dispute involving the payment of a claim, denial of a claim, imposition of a sanction or reinsurance. A provider may file a claim dispute based on:

- Claim Denial
- Recoupment
- Dissatisfaction with Claims Payment

Before a provider initiates a claims dispute, the following needs to occur:

- The claim dispute process should only be used after other attempts to resolve the matter have failed.

- The provider should contact MC Claims and/or Network Management to seek additional information prior to initiating a claim dispute.
- The provider must follow all applicable laws, policies and contractual requirements when filing.
- According to the Arizona Revised Statute, Arizona Administrative Code and AHCCCS guidelines, all claim disputes related to a claim for system covered services must be filed in writing and received by the administration or the prepaid capitated provider or program contractor:
    - Within 12 months after the date of service.
    - Within 12 months after the date that eligibility is posted.
    - Or within 60 days after the date of the denial of a timely claim submission, whichever is later.

You may submit your claim dispute in writing through the mail or send electronically to us through fax. We have the ability to receive disputes by fax, but we can also respond 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.

Written claim disputes must be submitted to the MC 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.

MC will acknowledge a claim dispute request within five (5) business days after receipt. If a provider does not receive an acknowledgement letter within five (5) business days, the provider must contact the Appeals Department. Once received, the claim dispute will be reviewed, and a decision will be rendered within 30 days after receipt. MC may request an extension of up to 45 days, if necessary. If you are submitting via mail, the claim dispute, including all supporting documentation, should be sent to:

Mercy Care
Grievance System Department
4755 S. 44th Place
Phoenix, AZ 85040

If a provider disagrees with the MC Notice of Decision, the provider may request a State Fair Hearing. The request for State Fair Hearing must be filed in writing no later than 30 days after receipt of the Notice of Decision. Please clearly state "State Fair Hearing Request" on your correspondence. All State Fair Hearing Requests must be sent in writing to the follow address:

Mercy Care
Grievance System Department
Attention: Hearing Coordinator
4755 S. 44th Place
Phoenix, AZ 85040

8.02 - Appeals

An appeal is a request for review of an action by a member or their authorized representative, such as a provider. An appeal can be filed for various reasons including the denial or limited authorization of a requested service, the type or level of service, or for the reduction, suspension, or termination of a previously authorized service. An authorized representative acting on behalf of the member, with the member's written consent, may file an appeal or request a State Fair Hearing on behalf of a member.

Standard Appeals - An appeal must be filed either orally or in writing with MC within 60 days after the date of the Notice of Adverse Benefit Determination. A provider may assist a member in filing an appeal. MC does not restrict or prohibit a provider from advocating on behalf of a member.

Standard Appeal Resolution - MC will resolve the appeal and mail the written Notice of Appeal Resolution to the member within 30 days after the day MC receives the appeal.

Expedited Appeals - If a provider believes that the time for a standard resolution appeal could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, the provider can submit a request for an Expedited Appeal, with the member's written consent, along with supporting documentation to MC. MC will acknowledge an expedited appeal within one working day of receipt.

Expedited Appeal Resolution - MC will resolve the appeal and mail a written Notice of Appeal Resolution to the member as expeditiously as the member's health condition warrants, but not later than 72 hours after MC receives the Expedited Appeal. MC will also make reasonable efforts to provide prompt oral notification to the member. This timeframe may be extended if MC needs additional information and the extension is in the best interest of the member. If the request for an Expedited Appeal is denied, MC will decide the appeal within the standard timeframe (30 days from the day MC receives the Expedited Appeal).

Each appeal should be filed separately. To file an appeal, please submit in writing, along with all substantiating documentation to**:**

Mercy Care
Grievance System Department
4755 S. 44th Place
Phoenix, AZ 85040
602-351-2300 (FAX)

A member may also file an appeal orally by contacting:

Mercy Care
Grievance System Department
Phone: 602-586-1719
Toll Free: 866-386-5794

An authorized representative, including a provider, acting on behalf of the member, with the member's written consent, may request a State Fair Hearing on behalf of the member. The request for State Fair Hearing must be in writing, submitted to and received by MC, no later than 120 days after the date the member receives the Notice of Appeal Resolution.

All State Fair Hearing Requests must be sent in writing to the follow address:

Mercy Care
Grievance System Department
Attention: Hearing Coordinator
4755 S. 44th Place
Phoenix, AZ 85040
602-351-2300 (fax)

8.03 – 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 MC **Chapter 8 – Grievance, Appeals and Claims Disputes, Section 8.04 - Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)**. MC 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.

MC or the AzSH shall use the unique Docket Number for 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 MC, 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 MC 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 MC or one of its subcontracted providers or because of an action of a member employed by MC 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, MC or one of their subcontracted providers, shall be addressed to the appropriate regulatory division or agency.

The AHCCCS Deputy Director, or designee, the MC 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 MC, 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, MC 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 Complete Care
Attn: Grievances System Department
4755 S. 44th Place
Phoenix, AZ 85040
Fax Number: 602-351-2300
Phone: 602-586-1719 or 866-386-5794

Within five days of receipt of a grievance or request for investigation, AzSH or MC 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, MC 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, MC 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, MC 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, MC 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, MC'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 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 MC 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:

- MC investigator or any other official responsible for responding to grievances must address their extension request to MC Director or designee.
- The MC investigator or any other MC official responsible for responding to grievances must address their extension request to the AHCCCS Deputy Director or designee; and
- A MC 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;
    - 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.
- Grievances or requests for investigation involving physical or sexual Abuse or death shall be filed with and investigated by AHCCCS

Decisions

Within 5 days of receipt of the investigator's report, AHCCCS' Deputy Director or designee, MC 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, MC Director, and send copies of the decision, subject to confidentiality requirements to the investigator, AzSH, MC 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, MC Director, or the Chief Executive Officer of the AzSH within 10 days.

Actions

AHCCCS' Deputy Director or designee, MC 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.

Disagreement with Decision

A grievant or the client who is the subject of the grievance, who disagrees with the final decision of MC or AzSH, may file a request for an administrative appeal within 30 days from the date of their receipt of the MC 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 MC or AzSH decision.

Administrative Appeal

In the event an administrative appeal is filed, MC 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 AHCCCS. The failure of MC or AzSH to forward a full investigation case record that supports the MC or AzSH decision may result in a summary determination in favor of the member filing the administrative appeal. MC or AzSH shall prepare and send with the investigation case record, a memo in which MC states:

- Any objections AzSH or MC has to the timeliness of the administrative appeal;
- AzSH's or MC's response to any information provided in the administrative appeal that was not addressed in the investigation report; and
- AzSH or MC 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 MC 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 MC or AzSH for further investigation and decision. MC 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 MC's decision and remand the matter with instructions to MC 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 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, MC 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.

Grievance Investigation Records and Tracking System

AHCCCS, AzSH, and MC 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 MC 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 MC will maintain all grievance and investigation files in a secure designated area and retain for at least 5 years.

Other Matters Related to Grievance Process

Pursuant to the applicable statutes, AzSH and MC 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 MC 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; or
- 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.

8.04 – Notice and Appeal Requirements (SMI and Non-SMI)

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 MC and/or may be asked to aid 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 MC's geographic service area (GSA). As designated by MC, 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. MC is responsible for providing oral interpretation services at no cost to the member receiving such services.

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 MC 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

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), available on our Forms web page, 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;
- 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, MC will ensure the communication of a notice to the member.

Appeal Requirements

Appeals that are related to MC or one of their contracted behavioral health providers' decisions must be filed with MC.

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 MC 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

- MC
  - Oral Appeal: Call 602-586-1719 or toll-free 866-386-5794
  - Fax Appeal: Fax to (602) 351-2300
  - Written appeal:

    Mercy Care Complete Care
    Attn: Grievance System Department
    4755 S. 44th Place
    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 MC 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, MC 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 MC refuses to accept a late appeal or determines that the issue may not be appealed, MC must inform the appellant in writing that they may, within 10 days of their receipt of MC's decision, request an Administrative Review of the decision with AHCCCS.

If a timely request for Administrative Review is filed with AHCCCS regarding MC's decision, AHCCCS shall issue a final decision of within 15 days of the request (for members requiring Special Assistance.

Informal Conference with MC

Within 7 days of receipt of an appeal, MC shall hold an informal conference with the member, guardian, any designated representative, care manager or other representative of the service provider, if appropriate.

MC 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 MC with authority to resolve the issues under appeal, who shall seek to mediate and resolve the issues in dispute.

MC 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, MC 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, MC 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 MC 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 MC of their inability to attend prior to the scheduled conference, MC shall reschedule the conference. If the member appealing fails to attend the rescheduled conference and fails to notify MC of their inability to attend prior to the rescheduled conference, MC 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, MC can re-open the appeal and proceed with the informal conference.
- For all appeals unresolved after an informal conference with MC, MC must forward the appeal case record to AHCCCS 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 MC 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.
- 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 MC, MC shall ensure that the written request for hearing, appeal case record and all supporting documentation is received by AHCCCS 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.

Within 1 day of receipt of a request for an expedited appeal, MC 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, MC shall hold an informal conference to mediate and resolve the issues in dispute.

AHCCCS Expedited Informal Conference

Within two days of notification from MC, 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 MC, MC shall ensure that the written request for hearing, appeal case record and all supporting documentation is received by AHCCCS within 3 days.

Administrative hearings shall be conducted and decided pursuant to A.R.S. §41-1092 et seq.

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.

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 MC, 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.

8.05 – 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 Human Rights must ensure that the person(s) 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, borderlineintellectual functioning, or diminished intellectual capacity);
- Language barrier (an inability to communicate, other than the need for aninterpreter/translator); or
- Medical condition (including, but not limited to traumatic brain injury, dementia, or severe psychiatric symptoms).

A member who is subject to a general 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 ageneral 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 SpecialAssistance:

- Developmental disability involving cognitive ability,
- Residence in a 24-hour setting,
- Limited guardianship or Mercy RBHA or its subcontracted provider is recommending and/or pursuing the estblmnt of a limited guardianship; or
- Existence of a serious medical condition that affects his/her intellectual and/or cognitivefunctioning (such as dementia, traumatic brain injury (TBI), etc.)

The following criteria shall not be considered when deciding as to whether or not a member is in need of Special Assistance.
The member:

- Needs things explained in more basic terms,
- Is able but not willing to participate in treatment, service planning, ITDP, the appeal, grievance or investigation processes,
- Can speak and advocate for themselves but present with interpersonal issues that make working with the member challenging,
- Needs more regular and effective engagement from the treatment team, or

- Makes decisions that the clinical team may not agree with
  Has a special need, (e.g. unable to read or write, needs an interpreter).

Person 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 case manager as specified in A.A.C. R9-21-101 The member's clinical team as specified in the A.A.C R9-21-101;
- 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 aSMI need Special Assistance on an ongoing basis. Minimally this screening must occur at the following stages:

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

Documentation

Mercy RBHA's subcontracted providers shall document in the member's medical record (e.g. on the assessment, service plan, ITDP, face sheet) each time a member is assessed for the need of Special Assistance, indicating the factors reviewed and the conclusion. If the conclusion is that the member needs Special Assistance, notification shall be provided to AHCCCS/DCAIR, OHR by completing the notification form, Part A, in the AHCCCS QM Portal, at QMportal.azahcccs.gov, in accordance with the procedures below.

Mercy RBHA and subcontracted providers shall submit a notification to AHCCCS/DCAIR, OHR by completing the Part A section of the notification within five (5) business days of identifying a member who needs Special Assistance and shall include:

- If the member requires immediate support (e.g. ITDP, active SMI appeal or grievance); the notification shall be submitted immediately,
- Notation if the member was or was not informed of the notification. If the member was not informed of the notification then it shall be documented with, an explanation of why not, and
- A copy of the court ordered guardianship and contact information of the appointed guardian if the member is under full and permanent legal guardianship.
- If guardianship documentation is not available at the time the member is identified as in need of Special Assistance, the notification is required to be submitted within the required timeframes, followed by submittal of the required documentation. The notification shall remain in pending status until the documentation is received. Contractors, Tribal ALTCS and TRBHAs shall ensure the documentation is submitted timely.

Mercy RBHA shall review the completed Part A section of the notification, and:

- Verify the accuracy of all demographic information,
- Verify criteria and/or documentation submitted,
- Request additional or missing information from the provider if needed, and
- Move the notification forward in the process by submitting to AHCCCS/DCAIR, OHR

AHCCCS/DCAIR, OHR will review the notification to ensure it contains all required information and respond within five (5) business days of receipt. After review, AHCCCS/DCAIR, OHR will:

- Contact Mercy RBHA submitting the form for clarification, if needed,
- Designate which agency/individual will provide Special Assistance by completing Part B of the notification, and
- Change the status of the notification to active.

Mercy RBHA and subcontracted providers requesting an updated Part B, to change the individual/agency assigned to meet Special Assistance needs, shall submit a notification to AHCCCS/DCAIR OHR by updating the guardian/advocate information section on Part A of the notification and including any new documentation required (e.g. guardianship documentation).

Requests to update the Part B shall be submitted when any of the following changes occur:

- The individual or entity currently identified as providing Special Assistance is no longer actively involved or is unable to continue to meet the member's needs,
- There is a change in guardianship status, or b.
- The member requests a change in the individual/agency meeting Special Assistance needs.

Members No Longer in Need of Special Assistance

The Mercy RBHA or subcontracted provider must notify the OHR within ten (10) days of an event or determination when a member receiving Special Assistance no longer meets criteria by completing a Part C Notification Form within the Portal noting:

- The reasons why Special Assistance is no longer required;
- The effective date;
- The name and title of the staff individual completing the form; and
- The date the form is completed.

Mercy RBHA or subcontracted providers shall complete the Part C when any of the following apply:

The original basis for the member meeting Special Assistance criteria is no longer applicable and the member does not otherwise meet criteria. This includes when a member is determined that the SMI designation is no longer appropriate and the designation has been removed. A Part C due to change is SMI designation shall not be completed until after the period to appeal has expired;

- The member passes away;
- The member enters a Department of Corrections (DOC) facility;
- The member moves out of state and no longer receives behavioral health services in Arizona;
- The member elects not to receive services from Mercy RBHA and the member is not transferred to another Contractor, Tribal ALTCS, or TRBHA.

The Mercy RBHA subcontracted providers must first perform all required reengagement efforts, which includes contacting the individual providing Special Assistance, as specified in AHCCCS AMPM Policy 1040 prior to submission of the Part C.

Submission of a Part C is not needed when a member transfers to another Contractor, Tribal ALTCS, or TRBHA, as the Special Assistance designation follows the member and shall be included in medical record during the transfer.

Upon receipt of Part C, AHCCCS/DCAIR, OHR will review the content to confirm accuracy and:

- Send additional follow up questions to the Contractor if needed, or
- Change the status of the notification to closed.

Requirements of Mercy RBHA and Providers

Mercy RBHA and subcontracted providers, and AHCCCS Behavioral Health Grievance and Appeals (BHGA) shall maintain open communication with the individuals (family, guardian, friend, designated representative, AHCCCS/DCAIR, OHR advocate, etc.) assigned to meet the member's Special Assistance needs. Minimally, this involves providing timely notification to the individual providing Special Assistance to ensure involvement in the following:

- Service plan development, updates and review including any instance when the member makes a decision regarding service options and/or denial/modification/ termination of services (service options include not only a specific service, but also potential changes to provider, site, physician and case manager assignment), as specified in AMPM Policy 320-O,
- ITDP planning including any time a member is admitted to a psychiatric inpatient facility and involvement throughout the stay and discharge,
- The appeal process including circumstances that may warrant the filing of an appeal, so all Notices of Adverse Benefit Determination (NOA) or Notices of Decision (NOD) issued to the member/guardian/designated representative shall also be copied to the individual designated to meet Special Assistance needs, and
- Investigation or grievance, including when an investigation/grievance is filed, and circumstances when initiating a request for an investigation/grievance may be warranted.

In the event that the procedures outlined in the section above are delayed, in order to ensure the participation of the individual or entity providing Special Assistance to the Member, Mercy RBHA, subcontracted providers, and BHGA shall:

- Document the reason for the delay in the medical record, or the investigation, grievance, or appeal file, and
- Contact the OHR Advocate of the day line at (602)364-4548 or 1-800-421-2124, to ensure there is a representative available to assist and support the member, and

- If an emergency service is needed, ensure that the Member receives the needed services in the interim and provide prompt notification to the assigned agency/individual providing Special Assistance.

Mercy RBHA and subcontracted providers shall provide timely relevant details and a copy of the notification to the receiving entity and when applicable, the case manager, when a Member who needs Special Assistance is:

- Admitted to an inpatient facility,
- Admitted to a BHRF setting, or
- Transferred to a different Contractor, Tribal ALTCS, TRBHA, Case Management Provider site, or case manager.

Mercy RBHA and subcontracted providers shall ensure that Special Assistance Member demographic information is updated within five (5) business days of a change in any of the following sections of the Part A:

- Member residence information; residence type, address, city, state, zip, and phone number,
- Provider information; Assigned Provider Agency, Treatment team names, phone numbers and email addresses, or
- Clinical information: Diagnosis and Clinical Basis for Special Assistance (e.g. Guardianship is assigned to a member who previously met criteria due to a Cognitive Barrier).
- Guardian/Advocate Information; relationship to member, name, address, and phone number.

Mercy RBHA and subcontracted providers shall periodically review whether the member's needs are being met by the individual or agency designated to meet the member's Special Assistance needs. If a concern arises, it should first be addressed with the individual or agency providing Special Assistance. If the issue is not promptly resolved, further action shall be taken to address the issue, which may include contacting Mercy RBHA or AHCCCS/DCAIR, OHR for assistance.

Confidentiality

Mercy RBHA and subcontracted providers shall grant AHCCCS/DCAIR, OHR access to medical records of members in need of Special Assistance in accordance with federal and state confidentiality laws as specified in AMPM Policy 940.

AHCCCS will provide a list to the IOCs, monthly, that contains the names of members in need of Special Assistance. The IOCs shall safeguard the provided list and keep confidential any Protected Health Information (PHI). The IOCs shall inform AHCCCS/DCAIR, OHR annually in writing of how confidentiality of the Special Assistance lists is maintained. If IOCs request additional information that contains PHI that is not included in the monthly list, the request shall be in accordance with the requirements as specified in AMPM Policy 960.

Office of Grievance and Appeals Reporting Requirements

Upon receipt of a request for investigation, an SMI grievance or appeal, Mercy RBHA and the BHGA shall review whether the member is already identified as in need of Special Assistance. Further details regarding investigations are as specified in ACOM Policy 444 and ACOM Policy 446.

If the member is identified as in need of Special Assistance, Mercy RBHA or BHGA shall ensure that:

- A copy of the request for investigation or SMI grievance or appeal is sent to AHCCCS/DCAIR, OHR within five (5) business days of receipt of the request. Mercy RBHA or BHGA shall also forward a copy of the final grievance/investigation decision to AHCCCS/DCAIR, OHR within five (5) business days of issuing the decision,
- A copy of the SMI grievance or appeal for a member who is identified as in need of Special Assistance is sent to AHCCCS/DCAIR, OHR upon occurrence,
- The results of the Informal Conference (IC) regarding SMI appeals are sent to AHCCCS/DCAIR, OHR. Mercy RBHA or BHGA shall also forward a copy of any subsequent notice of hearing, and

All of the above required documents are emailed to AHCCCS/DCAIR, OHR at **OHRts@AZAHCCCS.gov**.

Documentation and Reporting Requirements

Mercy RBHA and subcontracted providers shall clearly document in the member's medical record and in the case management/client tracking system if a member is identified as in need of Special Assistance, the individual/agency assigned currently to provide Special Assistance, the relationship, and contact information including phone number and mailing address.

CHAPTER 200 – MERCY CARE (MC) PROVIDER MANUAL
MERCY CARE COMPLETE CARE (MCCC), MERCY CARE DD (MERCY DD) AND DEPARTMENT OF CHILD SAFETY COMPREHENSIVE HEALTH PLAN (DCS CHP) – PLAN SPECIFIC TERMS

To support Mercy RBHA and the 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 SpecialAssistance 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.

MC Chapter 9 – Scopes of Work

9.00 – Scopes of Work

Scopes of Work are contractual documents for specialized providers and lines of business that outlines 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 Scope of Work.

Scopes of Work for MC include the following:

- **Adult Intensive Outpatient Program (IOP) – GMH/SU – Mercy Care**
- **Medically Assisted Treatment-Services – Mercy Care**
- **Adult Outpatient Services – GMH/SU – Mercy Care**
- **Employment Rehabilitation – Exhibit B – Mercy Care**
- **Permanent Supportive Housing – Housing Provider – Exhibit B – Mercy Care**
- **Human Service Campus (HSC) Service Coordination (Phoenix R.I.S.E.) – Exhibit B – Mercy Care**

All Scopes of Work are available in our Web Portals – **MC Availity Web Portal** and **MC RBHA Availity Web Portal**. You must sign on to the portal in order to access. A document titled **Scopes of Work** provides further detail under the **Provider Documents** section.