SECTION I: Introduction

WELCOME

Welcome to Care1st Health Plan Arizona, Inc. (Care1st). As a provider you play a very important role in the delivery of health care services to our members.

The Care1st Provider Manual is intended to be used as a guideline for the provision of covered services to Care1st members. This manual contains policies, procedures, and general reference information, including minimum standards of care which are required of Care1st Providers.

As a Care1st Provider, we hope this information will help you better understand how Care1st operates. This Manual is applicable to the Care1st Acute Arizona Health Care Cost Containment System (AHCCCS) Complete Care line of business. Should you or your staff have any questions about any information contained in this Manual or anything else about Care1st, please feel free to contact our Network Management at any time. See Section II for phone numbers for Network Management and for other departments that you may need to contact.

Care1st works closely with our contracted Primary Care Physicians (PCPs), Specialists, and other Providers to ensure that our members receive medically necessary and appropriate covered services. We are a managed care delivery system in which the PCPs serve as a "gatekeeper" for member care. PCPs are responsible for coordinating and overseeing the delivery of services to members on their patient panel. We look forward to working with you and your staff to provide quality health care services to Care1st members.

MISSION STATEMENT

Care1st Health Plan Arizona will be the most provider-oriented managed care organization that will strive to continuously improve the quality of services rendered to its members.

INTRODUCTION TO CARE1ST

Care1st is committed to working closely with our providers in order to deliver the highest quality services in a provider-friendly environment. Care1st has a locally-based Senior Medical Director (Sr MD) and senior management team. All health plan functions are conducted locally in Care1st's Tempe office. All day-to-day operational decisions are made at the local health plan.

SECTION I: Introduction

CARE1ST'S DEPARTMENTAL ORGANIZATION

NETWORK MANAGEMENT

The Network Management Department is made up of provider services, contracting and data maintenance and is responsible for the contracting, maintenance and education of the provider network. Network Management serves as the liaison between providers and the health plan.

The Network Management Representative is the provider's primary point of contact within Care1st. The Network Management Representative will answer any questions you may have or direct you to the appropriate department within the organization. The Network Management Representative is assigned to your office by geographic location and provider type.

CUSTOMER SERVICE

Customer Service has primary responsibility for assigning members to PCPs and changing PCP assignments. The Customer Service Department is the members' primary point of contact with Care1st. Customer Service provides members with informational materials and educates members on use of the health plan. The majority of concerns, complaints, and grievances from members are logged through the Customer Service Department.

MEDICAL MANAGEMENT/QUALITY IMPROVEMENT

The Medical Management and Quality Improvement Departments include the functions of Medical Management, Quality Improvement, EPSDT (Early and Periodic Screening Diagnosis and Treatment), Behavioral Health and Maternal and Child Health. Detailed descriptions of these functions are found later in this manual. The Care1st Sr MD has oversight responsibility for all actions and decisions made within the Medical Management and Quality Improvement Departments. Medical Management includes prior authorization, concurrent review, case and disease management and medical claims review.

Care1st has a Credentialing/Peer Review Committee, and Pharmacy and Therapeutics Committee, which report to the Clinical and Service Quality Improvement/Medical Management Committee.

CLAIMS

The Claims Department reviews and adjudicates submitted claims and reports all encounters to AHCCCS. In addition, Claims Customer Service has a "help line" to address any questions or concerns that providers may have about their submitted or paid claims.

CLAIM DISPUTES AND APPEALS

The Claim Disputes and Appeals Team is responsible for the timely adjudication of provider claim disputes and member appeals, as well as representation of Care1st at administrative hearings.

COMPLIANCE

The Compliance Department oversees the Care1st Compliance Program which includes Health Insurance Portability and Accountability Act (HIPAA), Privacy, Fraud and Abuse and the Cultural Competency Program.

PHARMACY

The Pharmacy Department is responsible for overseeing the consistent administration of the pharmacy benefit for Care1st members by ensuring appropriate and cost-effective pharmacy services.

FINANCE

Finance oversees the accounting and financial activities of the organization which includes processing payments for the provider network.

SECTION II: Quick Reference Contact List

DEPARTMENTAL CONTACTS

Care1st
602.778.1800 or 1.866.560.4042

Department	Phone	ACC Fax	RBHA Fax
Customer Service	Options 5, 3	602.778.1814	602.778.1814
Claims Customer Service - Medical	Options 5, 4	602.778.8346	602.778.8346
Claim Disputes and Appeals	Options 5, 9	602.778.8371	833.619.0415
Claim Liaison	866.560.4042	602.778.8346	602.778.8346
Compliance	866.560.4042	602.778.1814	602.778.1814
DentaQuest	800.440.3408	N/A	N/A
Envolve Dental	844.876.2028	N/A	N/A
Care Management	866.560.4042	602.224.4372	833.618.1980
Disease Management	866.560.4042	602.224.4372	833.618.1980
Hospital/SNF Admission Notification	Options 5, 6	602.778.8386	602.778.8386
Inpatient Behavioral Health Admission Notifications	Options 5, 6	602.778.1838	833.592.1301
NIA (Complex Imaging, MRA, MRI, PET and CT)	800.327.0641 Options 5, 6, 3	N/A	N/A
Prior Authorization – Behavioral Health	Options 5, 6, 2	602.778.1838	833.592.1301

SECTION II: Quick Reference Contact List

Prior Authorization-Pharmacy	Options 5, 5	602.778.8387	602.778.8387
Prior Authorization – Biopharmacy (Inoffice Injectables)	N/A	833.417.0447	833.417.0447
Prior Authorization-Medical **Status Inquiry** **Urgent Telephonic Requests or Revisions To Existing Prior Authorizations or Questions on Denied Authorizations**	Options 5, 6 Options 5, 6	602.778.1838	833.618.1979
Turning Point (Orthopedic Procedures)	480.865.2486	N/A	N/A
Network Management	Options 5, 7	602.778.1875	602.778.1875

SECTION II: Quick Reference Contact List

WEBSITE www.care1staz.com

Our website is an additional resource for our provider network. It contains up to date information including but not limited to the following:

- Blast Fax Communications
- Community Resources
- Forms
- Mailings
- Formulary
- Provider Listings
- Prior Authorization Guidelines
- Provider Manual
- Provider Search (by Type/Specialty/Location)

Network providers may also complete a one-time registration process in order to obtain a log on and temporary password for secure access to the Care1st website that will provide additional functionality to:

- Check Claims Status
- Verify Eligibility
- View Remittance Advices

To complete the registration process:

1. Choose "Provider Logon" under the Provider menu
2. Complete the Request Access On-Line Form
3. You will receive your logon and password via email

CARE1ST CONTRACTED VENDORS

Please reference our Prior Authorization Guidelines to determine authorization requirements.

DME & MEDICAL SUPPLIES (colostomy/ostomy, catheters, supplies, etc.)

Preferred Homecare — Phone: 480.446.9010
Fax: 480.446.7695

ENTERAL

Option 1 Nutrition Solutions — Phone: 480.883.1188
Fax: 480.883.1193

HOME HEALTH (Skilled Nursing and Home Therapy)

Professional Cares — Phone: 602.395.5114

Fax: 480.666.0248

INFUSION

Coram — Phone: 480.240.3200
Fax: 480.505.0455

GLUCOSE MONITORS

Care1st members use monitors by OneTouch like OneTouch Verio® meter or OneTouch Ultra®. A meter can be obtained by contacting OneTouch at 800.789.7022 or www.OneTouch.orderpoints.com and input order code 738WEL001. Once a physician script is written, members obtain the meter, test strips and lancets at a contracted pharmacy.

Continuous Glucose Monitors (CGM)

Continuous Glucose Monitors (Dex-com or Freestyle Libre) are reviewed by our Medical PA team to determine medical necessity. Please fax all requests to 602.778.1838 for medical necessity review. CGM devices are supplied on the pharmacy benefit but reviewed by our Medical PA team.

LABORATORY SERVICES

Sonora Quest — Phone: 602.685.5000

Sonora Quest is our exclusive laboratory vendor. All outpatient laboratory services are sent to Sonora Quest for processing.

Sonora Quest patient service locations are available at www.sonoraquest.com by clicking on the patient service center locator tab. Web-based patient service center appointment scheduling is also available and offers members the ability to schedule an appointment for a convenient day and time, resulting in reduced wait time upon arrival at a patient service center. The web based scheduling system is available 24-hr a day. Walk-in appointments are still available during scheduled hours of operation as well, although appointments are encouraged.

OPTOMETRY/VISION

Nationwide Vision — Phone: 480.354.7976

PEAK FLOW METERS

It is vital that a PCP driven asthma action plan be developed for each member as they use the peak flow meter in order to ensure that asthma is managed as effectively as possible. When a peak flow meter is indicated, the physician/practice contacts the contracted DME provider who dispenses the peak flow meter to the member.

WOUND VAC

SECTION II: Quick Reference Contact List

Sisu Healthcare Solutions Phone: 480.999.4488
Fax: 480.999.6163

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

Administration	Phone: 602.417.7200
Member Eligibility Verification	Phone: 602.417.7000
Provider Registration	Phone: 602.417.7670, Option 5
Fraud and Abuse Hotline	Phone: 602.417.4193/888.487.6686

HEARING IMPAIRED

Care1st has agreements with Valley Center of the Deaf (VCD) (Maricopa County) and Community Outreach Program for the Deaf (Pima County) to provide American Sign Language interpreters at no cost to members or providers. Services are available and arranged through Member Services. Valley Center of the Deaf recommends setting up services seven business days in advance of the appointment and Community Outreach Program for the Deaf recommends setting up services 10 business days in advance of appointment.

In addition, if the provider's office needs to contact a member by telephone, they may do so via Arizona Relay Service. Providers may dial 711 for TTY users or go to the website at (www.azrelay.org) to see other alternatives for members that do not use TTY. This is a state program and there is no charge associated with this service.

TRANSLATION SERVICES

Care1st is dedicated to working with its contracted providers to effectively deliver quality health care services to its culturally and linguistically diverse membership. Moreover, Care1st members have a right to interpretation services. To assist in meeting this challenge, Care1st offers over-the-phone language interpretation services to all contracted providers. Provided by CyraCom International, this language interpretation service offers qualified medical interpreters with knowledge of health care terminology and procedures. Available 24 hours a day, 7 days a week, this service helps providers and their staff access interpretation services, so that you can provide care to even the most diverse communities. All Care1st contracted providers have access to CyraCom's interpretation services. Each practice is assigned a PIN that is required to access CyraCom's interpretation services. All fees for services will be billed directly to Care1st so that you can focus on ensuring effective communication with your Care1st non-English speaking patients. Please call 800.481.3293 to access this service. CyraCom's customer service is also available to provide assistance at 800.481.3289.

SECTION III: Provider Roles and Responsibilities

GENERAL AND INFORMED CONSENT TO TREATMENT

General Requirements
As per AHCCCS AMPM 320-Q General and Informed Consent, each member has the right to participate in decisions regarding his or her physical and/or behavioral health care, including the right to refuse treatment. It is important for members seeking physical or behavioral health services to be made aware of the service options and alternatives available to them as well as specific risks and benefits associated with these services in order to be able to agree to these services.

There are two primary types of consent for physical and behavioral health services:

General Consent and Informed Consent.

1. Unless otherwise provided by law, General Consent shall be obtained before any services and/or treatment are provided. Verification of member's enrollment does not require consent.

2. 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 shall obtain consent, as specified in A.R.S. Title 36, Chapter 5.

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

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

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.

SECTION III: Provider Roles and Responsibilities

Universal requirements for informed consent
A higher level of consent may be required for provision of specific behavioral or physical health services or for services provided to vulnerable members. This is not an exhaustive list of those instances but a guide of some situations in which informed consent may be necessary.

1. Providers of behavioral health services shall gain Informed Consent in a variety of specific circumstances for members with an SMI designation. These requirements can be found in A.A.C. R9-21-206.01.
2. At times, involuntary treatment, including medications, 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.
3. At a minimum, the following treatments and services require Informed Consent:
    a. Surgical or other procedures requiring anesthesia services,
    b. Sterilization as specified in all requirements in 42 CFR 441, Subpart F and AMPM Policy 420,
    c. Procedures or services with known substantial risks or side effects (psychotropic medications, electroconvulsive therapy). Informed consent is required for each psychotropic medication prescribed. Essential elements for obtaining informed consent for medication are contained within AMPM 310-V, Prescription Medications – Pharmacy Services: Attachment A – Informed Consent – Assent For Psychotropic Medication Treatment. The use of AMPM Exhibit 320-Q-A, 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
    d. As required by Arizona or Federal law.
4. Telehealth– In addition to the requirements set forth in section of Universal Requirements for Informed Consent of this Policy, before a provider delivers health care via telehealth, verbal or written Informed Consent from the member, or when applicable, the member's Health Care Decision Maker, shall be obtained as specified in AMPM Policy 320-I, A.R.S. §36-3602, and A.A.C. R9-21-206.01. Exceptions to this Consent requirement include:
    a. If the telehealth interaction does not take place in the physical presence of the member,

b. In an emergency situation in which the member, or when applicable, the member's Health Care Decision Maker is unable to give Informed Consent, or
c. Transmission of diagnostic images to a health care provider serving as a consultant or the reporting of diagnostic test results by that consultant.

General consent for adults

Adults are considered individuals ages 18 years and older or emancipated minors as specified in A.R.S. §12-2451 et seq.

1. The following specifications apply to both general and informed consent. Unless otherwise provided by law:
    a. Any member in need of physical or behavioral health services shall give voluntary General Consent to treatment and/or services, as demonstrated by the member, or when applicable, the member's Health Care Decision Maker's signature on a General Consent form, before receiving treatment and/or services,
    b. Any member, or when applicable, the member's Health Care Decision Maker after being fully informed of the consequences, benefits and risks of treatment, has the right to not consent to receive physical or behavioral health services,
    c. Any member or, when applicable, the member's Health Care Decision Maker has the right to refuse medications unless specifically required by a court order or in an emergency situation, and
    d. A member, or when applicable, the member's Health Care Decision Maker, may revoke Informed Consent or General Consent at any time orally or by submitting a written statement withdrawing the consent.

General and informed consent for children

Unless otherwise provided by law:

1. To the extent legally authorized to do so, the member's Health Care Decision Maker, shall give General Consent to treatment, demonstrated by the authorized Health Care Decision Maker's signature on a General Consent form prior to the delivery of physical or behavioral health services, or refuse treatment.
    a. Under A.R.S. §8-514.05, in situations where the Department of Child Safety (DCS) and/or Foster Caregiver are temporarily operating as the Health Care Decision Maker of a child member, consent may only be granted for some services.
    b. In cases where the member's Health Care Decision Maker is unavailable to provide General or Informed Consent and the child is being supervised by a caregiver who is not the child's Health Care Decision Maker (e.g. grandparent), a Health Care Power of Attorney (or a document with similar provisions) is necessary to provide General and Informed Consent.

SECTION III: Provider Roles and Responsibilities

Emergency Situations

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

Emancipated Minor

1. In the event the child is an emancipated minor, evidence of an emancipation shall be required, except in emergency situations under A.R.S. §12-2453, and
2. Any minor who has entered into a lawful contract of marriage, whether or not 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).

Foster Children

1. For any child who has been removed from the home by DCS, the Foster Caregiver may give General Consent for the following:
    a. Routine physical, behavioral health, and dental treatment and procedures, including but not limited to, 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) (A.R.S. §8-514.05(C-D), and
        i. Evaluation and treatment for emergency conditions that are not life threatening.
2. A Foster Caregiver (except for a DCS case manager) shall not consent to:
    a. General Anesthesia,
    b. Surgery,
    c. Testing for the presence of the Human Immunodeficiency Virus (HIV),
    d. Termination of behavioral health treatment,
    e. Blood transfusions, or
    f. Abortions.

Documentation

1. All evidence of informed consent and general consent to treatment must be documented in the comprehensive clinical record as per AMPM Policy 940 Medical Records and Communication of Clinical Information.

2. If the member, or when applicable, the member's Health Care Decision Maker, refuses to sign a written acknowledgment and gives verbal Informed Consent or General Consent instead, the provider shall document in the member's medical record that the information was given, the member or the member's Health Care Decision Maker refused to sign an acknowledgment, and that the member, or when applicable, the member's Health Care Decision Maker, gives consent.
3. Informed Consent shall be correctly documented in the member's medical record and the form shall include relevant information about the service provided, the providers name and certification to provide the service and the signature of the member of their Health Care Decision Maker, when applicable, and for the requirements of documenting consent for mobile dental services, refer to A.R.S. §32-1299.25.
4. For the requirements of documenting consent for mobile dental services, refer to A.R.S. §32-1299.25.

Revocation of Informed Consent

If informed consent is revoked, treatment must be promptly discontinued, except in cases in which abrupt discontinuation of treatment may pose an imminent risk to the member. In such cases, treatment may be phased out to avoid any harmful effects.

Special Requirements For Children

In accordance with A.R.S. § 36-2272, except as otherwise provided by law or a court order, no 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 the written or oral consent of a parent or a legal custodian of the minor child. If the parental consent is given through telemedicine, the health professional must verify the parent's identity at the site where the consent is given. This does not apply when an emergency exists that requires a 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 other person with whom the Department of Economic Security/Department of Child Safety (DES/DCS)
- Government agency authorized by the court.

SECTION III: Provider Roles and Responsibilities

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

Individual/Entity	Documentation
Legal Guardian	Copy of court order assigning custody
Relatives	Copy of power of attorney document
Other member/agency	Copy of court order assigning custody
DCS out-of-home placements (for children removed from the home by DCS), such as: Foster home, group home, kinship, other member/agency in whose care DCS has placed the child.	Copy of Notice to Provider-Educational and Medical (DCS Form FC-069)

- For any child who has been removed from the home by DCS, the foster parent, group home staff, foster home staff, relative or other member 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 or not that marriage has been dissolved subsequently emancipated youth or any homeless minor may provide general and, when applicable, informed consent to treatment without parental consent (A.R.S. § 44-132).

Consent for behavioral health survey or evaluation for school-based prevention programs

1. Written consent shall be obtained from a child's Health Care Decision Maker for any behavioral health survey, analysis, or evaluation conducted in reference to a school-based prevention program administered by AHCCCS. A.R.S. §15-104 requires written consent from a child's Health Care Decision Maker for any behavioral health survey.

2. Attachment B shall be used to gain the Health Care Decision Maker's 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 shall satisfy all of the following requirements:
a. Contain language that clearly explains the nature of the screening program and when and where the screening will take place,

b. Be signed by the child's Health Care Decision Maker, 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 Health Care Decision Maker.
3. Completion of Attachment B applies solely to consent for a survey, analysis, or evaluation only, and does not constitute consent for participation in the program itself.
4. Analysis, or evaluation conducted in reference to a school based prevention program.

PCP GATEKEEPER ROLE

The Primary Care Physician (PCP) serves as the gatekeeper for the health care services of his/her assigned members. Care1st contracts with PCPs for the specialties of Internal Medicine, Family Practice, General Practice, Pediatrics and sometimes OB/GYNs. The PCP is responsible for coordinating, supervising, and delivering care rendered to assigned members. PCPs are responsible for providing AHCCCS covered services that are included in their contracts and are within the scope of the physician's practice. If a referral to a specialist or ancillary medical service is necessary, the PCP is to follow the established process for obtaining such services (described in Section IX). Only contracted providers should be used for referrals, except in extenuating circumstances, given prior approval by Care1st.

Additional responsibilities include:

- Coordinating care except for children's dental services when provided without a PCP referral.
- Ensuring behavioral health information is included in the member's medical record.
- Utilizing the AHCCCS approved EPSDT tracking forms or approved electronic versions.
- Providing clinical information regarding member's health and medications to the treating provider (including behavioral health providers) within 10 business days of a request from the provider.
- Enrolling as a Vaccines for Children (VFC) provider if serving children.

Care1st has no policies which prevent the PCP from advising or advocating on behalf of the member.

SECTION III: Provider Roles and Responsibilities

PCP ASSIGNMENT AND PANEL RESTRICTIONS

Members are assigned to a provider based on geographic location, provider availability, the member's age, and any special medical needs of the member. All members can request to change their PCP at any time.

A PCP may limit the size of their panel by making a request to voluntarily close their panel. When a provider closes his/her panel, the provider is no longer open for the auto-assignment default process or member choice selection. Exceptions may be made for immediate family of members already on the PCP's panel or other reasons requested by the PCP. PCPs may also request a maximum number of members to be assigned at the time of contracting.

Conversely, Care1st may elect to close or limit a provider's panel if the provider has difficulty meeting appointment or wait time standards, or if there are concerns regarding quality, utilization, or related issues. The provider's panel may be re-opened upon Care1st's approval of a corrective action plan.

MEMBERS WITH SPECIAL HEALTH CARE NEEDS

Members with SHCN are those members who have serious and chronic physical, developmental, and/or behavioral conditions requiring medically necessary services of a type or amount beyond that required by members generally, that lasts or is expected to last one year or longer and may require ongoing care not generally provided by a PCP The following populations that meet this definition but are not limited to:

1. Members with qualifying Children's Rehabilitative Services (CRS) conditions.
2. Members diagnosed with HIV/AIDS.
3. Members diagnosed with opioid use disorder, separately tracking pregnant members and members with co-occurring pain and opioid use disorder.
4. Members who are being considered for or are actively engaged in a transplant process and for up to one-year post transplant.
5. Members enrolled in the Arizona Long Term Care System (ALTCS):
    a. Members enrolled in the ALTCS program serving individuals who are elderly and/or have a physical disability, and
    b. Members enrolled in the ALTCS program serving individuals who have a developmental and/or intellectual disability.
6. Members who are engaged in care or services through the Arizona Early Intervention Program (AzEIP).
7. Members who are enrolled in Comprehensive Health Plan (CHP).
8. Members who transition out of CHP up to one year post transition.
9. Members with an SMI designation.

10. Any child that has a Child and Adolescent Level of Care Utilization System (CALOCUS) level of 4+.
11. Members who have a Seriously Emotionally Disturbed (SED) diagnosis flag in the system.
12. Substance exposed newborns and infants diagnosed with neonatal abstinence syndrome (NAS).
13. Members diagnosed with Severe Combined Immunodeficiency (SCID).
14. Members with a diagnosis of autism or at risk for autism.

For members with special health care needs determined to need a specialized course of treatment or regular care monitoring, Care1st allows members to directly access a specialist (for example through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.

SPECIALIST RESPONSIBILITY

Specialists are qualified and licensed to provide AHCCCS covered services within the scope of their specialty. Contracted Specialists will accept referrals from PCPs and provide medically necessary services covered by AHCCCS and Care1st within the scope of their specialty. For members requiring additional specialty services, refer to the procedure outlined in Section IX. Specialists are expected to provide appropriate visit documentation to the PCP.

Care1st has no policies which prevent providers from advising or advocating on behalf of the member.

COVERING PHYSICIANS

If for any reason a physician is unable to provide Covered Health Care Services to a member, the provider may secure the services of a Covering Physician. The Covering Physician must be a qualified Care1st provider before delivering Covered Health Care Services to the member.

SERVICE DELIVERY RESPONSIBILITIES

Providers are responsible for member coverage 24 hours a day, 7 days a week. This may be accomplished through an answering service that contacts the physician or on-call physician. The provider may also use an answering machine that directs the patient to the on-call physician. An answering machine on which the member is expected to leave a message is not acceptable. It is unacceptable to use a hospital emergency department as a means of providing 24 hour coverage.

SECTION III: Provider Roles and Responsibilities

Excluded Participation in Federal Health Care Programs

Important reminder, as a registered provider with the AHCCCS Administration you are obligated under 42 C.F.R. §1001.1901(b), to screen all employees, contractors, and/or subcontractors to determine whether any of them have been excluded from participation in Federal health care programs. You can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE, and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp

CARE COORDINATION

PCPs are responsible for coordinating medical care for members who may be receiving services from other state and community agencies which may include:

- Arizona Long Term Care System (ALTCS)
- Department of Developmental Disabilities (DDD)
- Regional Behavioral Health Authority (RBHA) and/or Behavioral Health Home Providers

APPOINTMENT AND WAIT TIME STANDARDS

AHCCCS has established appointment availability and office wait time standards to which the provider is expected to adhere. These standards are monitored on an ongoing basis to ensure compliance. Appointment availability standards are measured for both "Established" and "New" patients for Primary Care, Specialist and Dental providers.

An "Established" Patient is defined as a member that has received professional services from the physician or any other physician of the same specialty who belongs to the same group or practice, within the past three years from the date of appointment.

A "New" Patient is defined as a member that has not received any professional services from the physician or any other physician of the same specialty who belongs to the same group or practice, within the past three years from the date of appointment.

SECTION III: Provider Roles and Responsibilities

APPOINTMENT AVAILABILITY STANDARDS

PCP	SPECIALTY / DENTAL SPECIALTY	DENTAL	MATERNITY
***Urgent** As expeditiously as the member's health condition requires, but no later than 2 business days of request **Routine** Within 21 calendar days of request	***Urgent** As expeditiously as the member's health condition requires, but no later than 2 business days of referral **Routine** Within 45 calendar days of referral	***Urgent** As expeditiously as the member's health condition requires, but no later than 3 business days of referral **Routine** Within 45 calendar days of referral	**First Trimester** Within 14 calendar days of request **Second Trimester** Within 7 calendar days of request **Third Trimester** Within 3 business days of request **High Risk Pregnancies** As expeditiously as the member's health condition requires, but no later than 3 business days of identification of high risk by health plan or maternity care provider, or immediately if an emergency exists

BEHAVIORAL HEALTH

1. *Provider Appointments*

a. ***Urgent Need**

i. As expeditiously as the member's health condition requires, but no later than 24 hours from identification of need

b. **Routine Care**

i. Initial assessment within 7 calendar days of referral or request for service

ii. The first behavioral health service following the initial assessment within the timeframe indicated by the behavioral health condition, but:

a. For members age 18 years or older, no later than 23 calendar days after the initial assessment

b. For members under the age of 18 years old, no later than 21 days after the initial assessment and

iii. All subsequent services within the timeframe indicated by the behavioral health condition, but no later than 45 calendar days from the identification of need

2. *Referrals for Psychotropic Medications*

a. Assess the urgency of the need immediately

b. If clinically indicated, provide an appointment with a Behavioral Health Medical Professional (BHMP) within the timeframe that ensures the member

i. does not run out of needed medications; or

ii. does not decline in his/her behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need.

*Urgent is defined as an acute, but not necessarily life or limb threatening disorder, which, if not attended to, could endanger the patient's health.

WAIT TIME STANDARDS

A member should wait no more than 45 minutes for a scheduled appointment with a PCP or specialist, except when the provider is unavailable due to an emergency.

NON-EMERGENCY TRANSPORTATION STANDARDS

Transportation providers must schedule the transportation so that the member arrives on time for the appointment, but no sooner than one hour before the appointment; does not have to wait more than one hour after calling for transportation after the conclusion of the appointment to be picked up; nor have to wait for more than one hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of the treatment.

PROVIDER NETWORK CHANGES

All provider changes must be submitted in writing to your Care1st Network Management Representative (NMR) in advance. The provider changes affected by this policy include terminations, office relocations, leaves of absence, or extended vacation.

PCP TERMINATIONS/MEMBER REASSIGNMENT

a. If the terminating PCP practices under a group vendor contract, the members may remain with the group if Care1st determines that to be the appropriate course of action.

b. If the terminating PCP practices under a solo vendor contract, the members will be reassigned to another contracted PCP.

PROVIDER LEAVE OF ABSENCE OR VACATION

PCPs must provide adequate coverage when on leave of absence or on vacation. PCPs must submit a coverage plan to their Care1st Network Management Representative for any absences longer than four (4) weeks. Absences over ninety (90) days may require transfer of members to another PCP.

NURSING FACILITY AND ALTERNATIVE RESIDENTIAL SETTING TERMINATIONS

To the extent applicable, Care1st follows the procedures set forth in ACOM Policy 421 Contract Termination: Nursing Facilities and Alternative Residential Settings to provide for the needs of the members residing in the facility at the time of contract termination.

AHCCCS PROVIDER ENROLLMENT PORTAL (APEP)

As of August 31, 2020, all new providers, as well as existing providers who need to update their accounts, will use the APEP. This online system, available 24/7, streamlines the provider enrollment process and eliminates the need for paper-based applications.
Providers must register for a Single-Sign-On (SSO) to access APEP by visiting, https://www.azahcccs.gov/PlansProviders/APEP/Access.html.

SECTION III: Provider Roles and Responsibilities

REMOVAL OF MEMBER FROM PANEL

There are infrequent occasions when a provider believes that he/she cannot continue to care for a particular member. Providers should make every effort to work with the member to resolve any issues. Providers with difficult or non-compliant members are encouraged to call the Customer Service Department for assistance with these members. As a last resort, providers may request that the member be removed from his/her panel. To request a member be removed from a panel, follow the procedure outlined in Section V, Eligibility and Enrollment.

PROVIDER INQUIRIES, COMPLAINTS/GRIEVANCES AND REQUESTS FOR INFORMATION

Providers are instructed to contact Network Management regarding an inquiry, complaint/grievance and requests for information. Acknowledgement of provider inquiries, complaints/grievances and requests for information occurs within three business days of receipt.

The Network Management Representative (NMR) works with internal departments, the provider and other applicable parties to facilitate the resolution of inquiries, complaints/grievance and requests for information. Every effort is made to resolve the provider's concern within five working days. Resolution and communication of resolution does not exceed 30 business days unless a different time frame is agreed upon by the NMR and the provider.

PROVIDER SELECTION AND NON-DISCRIMINATION

Care1st must comply with all provider selection requirements established by the state [42 CFR 457.1208, 42 CFR 457.1233(a), 42 CFR 438.12(a)(2), 42 CFR 438.214(e)].

PROVIDER DIRECTORY

The Care1st Provider Directory is updated on a regular basis. All providers are encouraged to review their information in the directory and are responsible for submitting any changes to their assigned NMR. The Provider Directory is available on our website - www.care1staz.com, or you may contact Network Management for a printed version.

PROVIDER LOCATIONS WITH ACCOMMODATIONS

New providers complete the AzAHP Practitioner Data Form to initiate the credentialing and contracting process. The data form contains questions related to populations the provider is able to service/accommodate. This information is then loaded to the provider record in the Care1st claims payment system and used to populate the "Accommodates Accessibility needs for Members with Disabilities" data element of our Provider Search Tool.

SECTION III: Provider Roles and Responsibilities

ELIGIBILITY VERIFICATION

Providers are responsible for verifying member eligibility prior to rendering medical services. To verify eligibility providers can visit our website www.care1staz.com or contact Customer Service.

Specialists should always verify member eligibility on the day of the appointment. PCPs must verify both eligibility and member assignment on the date of service. Care1st will not reimburse providers for services rendered to members who are not eligible on the date of service. Providers should not rely solely on member identification cards to verify eligibility.

CANCELLED AND MISSED APPOINTMENTS

Providers are expected to develop a system for documenting and following up on cancelled or missed appointments. This is especially critical for children receiving EPSDT services and pregnant members. Please use our *No Show Appointment Log* to notify our EPSDT Team when a Care1st member "no shows" to a scheduled visit. Member outreach and education will occur immediately. The *No Show Appointment Log* is available on our website in the Forms section of our Provider drop down menu. You may also contact Network Management for a copy to be faxed/mailed to your office.

AHCCCS COST SHARING & COPAYMENTS

As a result of changes in Federal and State laws and regulations, including provisions of the Deficit Reduction Act of 2005, AHCCCS expanded member copayment requirements effective *October 1, 2010*. The expanded copayment requirements, which are described in AHCCCS Final Rule A.A.C. R9-22-711, include mandatory copayments for certain populations, higher optional (non-mandatory) copayment amounts for certain populations, and clarification of the services and populations which are exempt from both mandatory and optional copayments.

MANDATORY (REQUIRED) COPAYMENTS

AHCCCS members who have *mandatory* copayments for certain services are:

- Transitional Medical Assistance (TMA) members (Copay Level 50)

TMA Copays (Copay Level 50)

Pharmacy	$2.30
Office Visits	$4.00

Outpatient Professional Therapies	$3.00
Surgeries (In Office; Outpatient non-emergent; ASCs	$3.00

Mandatory copayments **permit** providers to **deny** services to members who do not pay the copayment. However, certain services (such as emergency services) are exempt from mandatory copayments, and specific members (such as individuals under the age of 19) are also exempt from copayments. Please be aware that payments to providers are reduced by the amount of a member's copayment obligation *regardless of whether or not the provider successfully collects the mandatory copayment.*

These copayments do not apply to:

- People under age 19
- People determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services
- An individual designated eligible for Children's Rehabilitative Services (CRS) pursuant to Title 9, Chapter 22, Article 13
- ACC, CMDP, and RBHA members who are residing in nursing facilities or residential facilities such as an Assisted Living Home and only when member's medical condition would otherwise require hospitalization. The exemption from copayments for these members is limited to 90 days in a contract year
- People who are enrolled in the Arizona Long Term Care System (ALTCS)
- People who are Qualified Medicare Beneficiaries
- People who receive hospice care
- American Indian members who are active or previous users of the Indian Health Service, tribal health programs operated under P.L. 93-638, or urban Indian health programs
- People in the Breast & Cervical Cancer Treatment Program (BCCTP)
- People receiving child welfare services under Title IV-B on the basis of being a child in foster care or receiving adoption or foster care assistance under Title IV-E regardless of age
- People who are pregnant and throughout the postpartum period following the pregnancy
- Individuals in the Adult Group (for a limited time*)

* NOTE: For a limited time, persons who are eligible in the Adult Group will not have any copays. Members in the Adult Group include persons who were transitioned from the AHCCCS Care program as well as individuals who are between the ages of 19-64, and who are not entitled to Medicare, and who are not pregnant, and who have income at or below 133% of the Federal Poverty Level (FPL) and who are not AHCCCS eligible under any other category. Copays for persons in the Adult Group with income over 106% FPL are planned for the future. Members will be told about any changes in copays before they happen.

Services that do not require a co-pay include:

- Hospitalizations and services received while in a hospital
- Emergency services
- Services received in the emergency department
- Family Planning services and supplies
- Pregnancy related health care and health care for any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for pregnant women
- Preventative services, such as well visits, pap smears, colonoscopies, mammograms and immunizations
- Provider preventable services

OPTIONAL (NON-MANDATORY) COPAYMENTS

Optional (also known as non-mandatory) copayments apply to AHCCCS members who are not required to make the mandatory copayments as noted above. When a member has an optional copayment, providers are **prohibited** from denying the service when the member is unable to pay the copayment. As in mandatory copayment situations, there are certain services (such as emergency services) and certain populations (such as individuals under age 19) which are exempt from the optional copayment.

5% LIMIT ON ALL COPAYS

The amount of total copays cannot be more than 5% of the family's total income (before taxes and deductions) during a calendar quarter (January-March, April-June, July-September, and October-December). The 5% limit applies to both optional and required copays.

HOW TO DETERMINE IF A MEMBER HAS A MANDATORY COPAYMENT

Providers can identify whether a member has a mandatory copayment by using a member's specific copay level available through various AHCCCS eligibility verification systems ***other than IVR***. EVS, the web, and HIPAA transactions 270 and 271 will identify a member's copay level, but IVR will not. A member's copay level in the AHCCCS verification system corresponds to specific copayment amounts for specific services.

AHCCCS Online, https://azweb.statemedicaid.us/Account/Login.aspx, has the most current eligibility and copayment information for all AHCCCS members. If you are not registered to use this system, register by choosing the "Register" link under "New Account". The Co-Payment tab at the top of the page of the member's eligibility verification screen indicates the member copay level and provides a link to the AHCCCS

Copay Grid, which provides you the detail on the mandatory copay levels and applicable services.

COPAYMENT TRACKING

AHCCCS Administration tracks each member's specific copayment levels by service type, and this information will also identify those members who have reached the 5% copayment limit. AHCCCS further identifies whether the member is subject to a mandatory or a nominal copayment and when copayments cannot be charged, i.e. the service or member is exempt from copayments.

Ongoing updates from AHCCCS regarding copayment requirements can be found at: https://azahcccs.gov/PlansProviders/RatesAndBilling/copayments.html

Please refer to Section V, Eligibility and Enrollment and Section XI, Billing, Claims and Encounters of this Provider Manual for additional information.

Physicians are responsible for providing all covered services described in Section VI as medically necessary and appropriate. PCPs are responsible for ensuring that their members receive EPSDT services and immunizations according to the periodicity schedule with which they have been provided.

ASIIS

The State of Arizona (ARS 36-135 and AAC R9-6-706 and R9-6-707) requires that immunizations administered to children covered by AHCCCS be reported to the Arizona State Health Department ASIIS system. ASIIS - which stands for the Arizona State Immunization Information System - requires that all immunizations are reported at least monthly, and it is recommended that high volume immunization providers report more frequently. Your office can report to ASIIS electronically or by paper, and ASIIS can also accept data exports from a patient management/billing system. Training by ADHS is provided free of charge. While the law does not require reporting of adult immunizations, ASIIS recommends doing so.

Contact Information:

- ASIIS website https://asiis.azdhs.gov/
- Training - contact ASIIS Hotline at 877.491.5741
- For Technical Support call 602.364.3899 or 877.491.5741
- For free ASIIS web-based application call 602.364.3899 or 877.491.5741
- For paper forms call 602.364.3899 or 1.877.491.5741
- For assistance with other methods of electronic data transfer call 602.364.3619

SECTION III: Provider Roles and Responsibilities

REFERRALS AND PRIOR AUTHORIZATION

PCPs and Behavioral Health Providers are responsible for initiating and coordinating referrals for their assigned members when medically appropriate. Providers are responsible for receiving prior authorization, as required. Refer to the Prior Authorization Guidelines available on our website and the Prior Authorization process outlined in Section IX, Medical Operations.

Specialty providers, including Behavioral Health providers, may be identified using the **Provider Search** function under the **Our Network** link on the Care1st Provider website. Select "Specialist" as the Provider Type and "Behavioral Health" as the Specialty. Once the specialist has been identified, follow the "Referral/Prior Authorization Process from PCP to Specialist" steps found in Section IX: Medical Operations, page 4.
Behavioral Health Hospitals and Outpatient Centers will be found under the **Ancillary Provider Search**, also under the **Our Network** link. Provider Manual Section VII: Behavioral Health Services provides details for the Behavioral Health Referral process.

You may also contact the Care1st Behavioral Health Department for assistance:

- Behavioral Health Coordinator 602.778.1800 x 1826
- Behavioral Health Coordinator 602.778.1800 x 4145
- Behavioral Health Director 602.778.1800 x1834

SUBMITTING CLAIMS AND ENCOUNTERS

All services, including capitated services, provided to Care1st members must be documented and submitted to the health plan on the appropriate claim form. AHCCCS conducts routine data validation studies to ensure that providers are submitting accurate information. Providers must adhere to claim submission and encounter reporting requirements pursuant to their contracts. Refer to Section XI, Billing, Claims and Encounters for additional information.

INAPPROPRIATE USE OF THE EMERGENCY ROOM

PCPs are expected to discourage the inappropriate use of the emergency room by members. Members should be instructed to call 911 any time they believe they have a life-threatening emergency. In non-emergent situations, PCPs should not refer members to the Emergency Department as a means of resolving appointment availability issues.

A more detailed description of covered emergency services is found in Section VI, Covered Services.

SECTION III: Provider Roles and Responsibilities

MEDICAL RECORDS

Please refer to Section X for Medical Record requirements. Providers are required to keep a medical record on each patient that is consistent with accepted medical standards. Records should include the patient's advance directives and notations of any recommendations or discussions regarding patient education, family planning, or preventive services. Providers are required to establish a medical record for each assigned child under age 21 for the purpose of documenting EPSDT services, regardless of whether the child has been seen by the provider.

Members are guaranteed the right to request and receive one copy of their medical record at no cost to them. The member also has the right to request that the medical record be amended or corrected [45 CFR Part 160, 164, 42 CFR 457.1220, 42 CFR 438.100(a)(1), 42 CFR 438.100(b)(2)(vi)].

Providers are required to create a medical record when information is received about a member. If the PCP has not yet seen the member, such information may be kept temporarily in an appropriately labeled file, in lieu of establishing a medical record, but must be associated with the member's medical record as soon as one is established.

When a member changes PCPs, his or her medical records or copies of medical records must be forwarded to the new PCP within 10 business days from receipt of the request or more quickly if necessary.

RECORD RETENTION

Providers must retain medical records in accordance with all federal and state regulations. This includes, but not is limited to compliance with A.R.S. §12-2297 which provides, in part, that a health care provider shall retain patient medical records according to the following:

1. If the patient is an adult, the provider shall retain the patient medical records for at least six years after the last date the adult patient received medical or health care services from that provider.
2. If the patient is under 18 years of age, the provider shall retain the patient medical records either for at least three years after the child's eighteenth birthday or for at least six years after the last date the child received medical or health care services from that provider, whichever date occurs later.

In addition, the provider shall comply with the record retention periods specified in HIPAA laws and regulations, including, but not limited to, 45 CFR 164.530(j)(2).

In accordance with Arizona Administrative Code R9-22-512 (E) all providers shall furnish records requested by the Administration or a contractor to the Administration or

the contractor at no charge. If the provider uses a vendor to store medical records, it is the provider's responsibility to work with the vendor and facilitate receipt of the requested records at no charge to Care1st.

END OF LIFE CARE/ ADVANCE CARE PLANNING

End of Life care is member-centric care that includes Advance Care Planning, and the delivery of appropriate health care services and practical supports. The goals of End of Life care focuses on providing treatment, comfort, and quality of life for the duration of the member's life.

Advance Care Planning is a billable face-to-face discussion between a qualified health care professional and the member/guardian/designated representative. A qualified health care professional is a Medical Doctor (MD), Doctor of Osteopath (DO), Physician Assistant (PA), or Nurse Practitioner (NP). This face-to-face discussion should consist of the following:

- Educate the member/guardian/designated representative about the member's illness and the health care options that are available to the member to enable them to make educated decisions
- Identify the member's healthcare, social, psychological and spiritual needs
- Develop a written member centered plan of care that identifies the member's choices for care and treatment, as well as life goals
- Share the member's wishes with family, friends, and his or her physicians
- Complete Advance Directives. An advance directive is a document (such as living wills and health care/medical powers of attorney) by which a person makes provisions for health care decisions in the event that, in the future, he/she becomes unable to make those decisions
- Refer to community resources based on member's needs
- Assist the member/guardian/designated representative in identifying practical supports to meet the member's needs

Advance Care Planning is a covered, reimbursable service when provided by a qualified health care professional. The provider may bill for providing Advance Care Planning separately during a well or sick visit.

Providers and their staff will complete annual training in the concepts of EOL care, Advance Care Planning and Advance Directives as offered by Care1st.

NON-DISCRIMINATION POLICY

Care1st members have the right to receive courteous, considerate care regardless of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, physical or mental handicap, or source of payment. Providers must be compliant with the

Americans with Disabilities Act (ADA) requirements and Title VI which prohibits discrimination on the basis of disability.

CULTURALLY COMPETENT CARE

Members have the right to have services provided in a culturally competent manner with consideration for members with limited knowledge of English, limited reading skills, vision, hearing, and those with diverse cultural and ethnic backgrounds. Services shall be offered that are sensitive to the differences in race, ethnic background, linguistic group age, gender, lifestyle, education, literacy level, disability, religion, social group or geographic location. Cultural competency in health refers to being aware of cultural differences among diverse racial, ethnic, and other minority groups, respecting those differences and taking steps to apply that knowledge to professional practice. Better communication with patients, families and groups from diverse cultures, improves health outcomes and patient satisfaction. Refer to our website for additional resources: https://www.care1staz.com/az/providers/compliance.asp, then click on "Cultural Competency"

LANGUAGE SERVICES

Care1st believes that effective health communication is as important to health care as clinical skill. Health care providers must recognize and address the unique cultural, language, and health literacy of diverse members and communities to improve individual and community health.. Moreover, Care1st members have a right to interpretation services. To assist in meeting this challenge, Care1st offers over-the-phone language interpretation services to all contracted providers. Provided by CyraCom International, this language interpretation service offers qualified medical interpreters with knowledge of health care terminology and procedures. Available 24 hours a day, 7 days a week, this service helps providers and their staff access interpretation services, so that you can provide care to even the most diverse communities. All Care1st contracted providers have access to CyraCom's interpretation services. Each practice is assigned a PIN that is required to access CyraCom's interpretation services. All fees for services will be billed directly to Care1st so that you can focus on ensuring effective communication with your Care1st non-English speaking patients. Please call 800.481.3293 to access this service. CyraCom's customer service is also available to provide assistance at 800.481.3289.

AMERICAN SIGN LANGUAGE INTERPRETATION

Care1st contracts with Valley Center of the Deaf to provide American Sign Language Interpreters at no cost to members or providers. Services are available and arranged through Member Service. Valley Center of the Deaf recommends setting up services seven business days in advance of the appointment and Community Outreach Program for the Deaf recommends setting up services 10 business days in advance of appointment.

SECTION III: Provider Roles and Responsibilities

CLAS Standards

1 Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

2 Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3 Recruit, promote and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

4 Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

5 Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6 Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7 Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8 Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

9 Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

10 Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

11 Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12 Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

13 Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14 Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts of interest.

15 Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Institute for
Health Professions Education

Georgia G. Hall, Ph.D., MPH

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TABLE OF CONTENTS

SECTION ONE

INTRODUCTION

This guide is intended to help Providers and their staff meet the challenge of caring for an increasingly diverse patient population, whose culture - which includes language, lifestyle, values, beliefs and attitudes may, differ from those of the dominant society.

Since these and other elements of culture influence the experience of illness, access to care, and the process of getting well, Providers and their staff are compelled to learn about them and incorporate that knowledge into the patient care plan.

Cultural competence can be defined as a combination of knowledge, clinical skills and behaviors that lead to positive outcomes of patient care with ethnically and culturally diverse populations.

Central to cultural competency is the provision of services, education and information in appropriate languages and at appropriate comprehension and literacy levels.

Benefits of a culturally competent approach to care:

- Devise more appropriate plans of care
- Improve quality of patient care and outcomes
- Reduce patient non-compliance
- Improve patient satisfaction
- Provide enhanced individual and family care
- Gain sensitivity to patient needs
- Work more effectively with diverse patient populations
- Adhere to federal and state requirements

SECTION TWO

HEALTH BELIEFS, ATTITUDES, AND BEHAVIORS: IMPLICATIONS FOR CLINICAL CARE

Culturally competent healthcare

An understanding of value systems and their influence on health is essential to providing culturally competent healthcare. Every culture has a value system that dictates behavior directly or indirectly by setting and encouraging specific norms. Health beliefs and practices, in particular, reflect that value system.

Providing care for patients from diverse backgrounds requires understanding one's own values as well as the values of other groups. There is a natural tendency for people to be culture bound, that is, to assume that their values, customs, attitudes and behaviors are always appropriate and right.

The following list, comparing dominant Anglo–American values with those of more traditional cultures demonstrates their differing views.

Anglo-American	**More traditional cultures**
Personal control over environment	Fate
Change	Tradition
Time dominates	Human interaction dominates
Human equality	Hierarchy/rank/status
Individualism/privacy	Group welfare
Self-help	Birthright inheritance
Competition	Cooperation
Future Orientation	Past orientation
Action/goal/work Orientation/informality	"Being" orientation
Directness/openness/honesty	Formality
Practicality/efficiency	Idealism/Spiritualism

Source:
Cross-Cultural Counseling: A guide for Nutrition and Health Counselors, U.S. Department of Agriculture/US Department of Health and Human Services, Nutrition Education Committee for Maternal and Child Nutrition Publications, 1986.

General beliefs

- Beliefs about the cause, prevention, and treatment of illness vary among cultures. These beliefs dictate the practices used to maintain health. Health practices can be classified as folk, spiritual or psychic healing practices, and conventional medical practices. Patients may follow a specific process in seeking health care. Cultural healers may be used in addition to conventional medical care.

Understanding your values and beliefs

- Cross-cultural healthcare requires Providers and their staff to care for patients without making judgments about the superiority of one set of values over the other.

- Providers are not only influenced by the cultural values they were raised with, but also by the culture of medicine which has its own language and values. The complexity of the health care system today is time oriented, hierarchical and founded on disease management and the preservation of life at any cost. Realizing these values as part of the current medical culture will be useful when dealing with patients with different values.

Knowing your patient

- The difference between a Provider who is culturally competent and one who is culturally aware is in the service that person provides. A culturally competent Provider is aware of the cultural differences and even more aware of the individual and his or her personal needs.

Appreciate the heterogeneity that exists within cultural groups

- As studies about cultural and ethnic groups demonstrate, there are distinctive characteristics that contribute to their uniqueness. Knowledge about these unique characteristics is important to the development of culturally relevant programs.

- Since significant variability may exist between and among individuals from the same cultural and ethnic group, over-generalization is a danger. Such variability can be due to: age, level of education, family, rural/urban residence, religiosity, level of adherence to traditional customs, and for immigrant patients, degree of assimilation and acculturation.

The role of economics

- The culture of poverty is as important as a person's ethnicity, social status and cultural background. Economic status may influence the patient's ability to acquire medical supplies or other resources (such as running water, electricity, adequate space, healthful or specific diet, etc.) needed for continuity of care and wellness. Decisions that are made about lower income patients' care must be sensitive to the differing degrees of access to resources.

The role of religious beliefs

- Religious beliefs can often influence a patient's decision about medical treatment. Because of their religious faiths, patients may request diagnosis but not treatment. If a particular treatment is absolutely necessary, Providers may find it helpful to consult with the patient's spiritual leader. Patients who seek mainstream medical care may also seek treatment from healers in their culture. Rather than discouraging this, especially if the alternative treatment is not harmful, Providers and their staff may want to incorporate traditional healing into the general treatment plan.

The role of the family

- Traditional cultures place a greater emphasis on the role of the family. Decision-making about health issues may be a family affair. It can be helpful for Providers and their staff to take this into account as medical decision-making takes place.

  Questions to consider:

  1. How many family members can accompany the patient into the room?

  2. Should friends be allowed in the room?

  3. Who can or should be told about the patient's condition?

SECTION THREE

STRATEGIES AND APPROACHES IN ASSESSING PATIENT'S BELIEFS ABOUT HEALTH AND ILLNESS

Cultural assessment

Cultural assessment of the patient is an important step in identifying the patient's views and beliefs related to health and illness. Beliefs about the cause, prevention, and treatment of illness vary among cultures. Such beliefs dictate the practices used to maintain health. Studies have classified Health Practices into several categories: **folk practices**, **spiritual** or **psychic healing practices,** and **conventional medical practices**.

In addition to the general data collected from a patient, the following checklist may be helpful in gaining culturally specific information.

- Where were you born?
- If you were born outside the USA, how long have you lived in this country?
- Who are the people you depend upon the most for help? (Family members, friends, community services, church etc.)
- Are there people who are dependent on you for care? Who are they? What kind of care do you provide?
- What languages do you speak?
- Can you read and write in those languages?
- What is the first thing you do when you feel ill?
- Do you ever see a native healer or other type of practitioner when you don't feel well?
- What does that person do for you?
- Do you ever take any herbs or medicines that are commonly used in your native country or cultural group?
- What are they, and what do you take them for?
- What foods do you generally eat? How many times a day do you eat?
- How do you spend your day?
- How did you get here today?
- Do you generally have to arrange for transportation when you have appointments?

Cultural assessment (continued)

To help Providers and their staff conduct cultural assessments, the questionnaire below will help determine a patient's beliefs about his or her problem:

Tools To Elicit Health Beliefs

1. What do you call your problem? What name does it have?
2. What do you think caused your problem?
3. Why do you think it started when it did?
4. What does your sickness do to you? How does it work?
5. How severe is it? Will it have a short or long course?
6. What do you fear most about your disorder?
7. What are the chief problems that your sickness has caused for you?
8. What kind of treatment do you think you should receive? What are the most important results you hope to receive from treatment?

Further Questions to Consider

- Do individuals in this culture feel comfortable answering questions?
- When the Provider asks questions, does the patient, or family, perceive this as a lack of knowledge?
- Who should be told about the illness?
- Does the family need a consensus or can one person make decisions.
- Does the patient feel uncomfortable due to the gender of the Provider?
- Does more medicine mean more illness to the patient?
- Does no medication mean healthy?
- Does the patient prefer to feel the symptoms, or mask them?
- Does the patient prefer ONE solution or choices of treatment?
- Does the patient want to hear about risks?

(Source: Kleinman, Arthur A. Patients and Healers in the Context of Culture. The Regents of the University of California. 1981.

SECTION FOUR

EFFECTIVE PATIENT COMMUNICATION AND EDUCATION STRATEGIES

Communication

Intercultural communication is a key clinical issue in medicine and can determine quality of care. The language barrier is a particularly serious problem for Providers and patients alike. Since effective communication between patients and Providers is necessary for positive outcomes, the use of translators is essential.

Even with English speaking populations, it can be a challenge for the patient to try to understand the medical jargon that is commonplace among professionals in the healthcare setting. For example, words like "diet" have different meanings to professionals than they have in the general public.

Other Factors Influencing Communication:

Conversational style:	It may be blunt, loud and to the point – or quiet and indirect.
Personal space:	People react to others based on their cultural conceptions of personal space. For example, standing "too close" may be seen as rude in one culture and appropriate in another.
Eye contact:	In some cultures, such as Native American and Asian, avoiding direct eye contact may be a sign of respect and represents a way of honoring a person's privacy.
Touch:	A warm handshake may be regarded positively in some cultures, and in others, such as some Native American groups, it is viewed as disrespectful. Greeting with an embrace or a kiss on the cheek is common among some cultures.
Response to pain:	People in pain do not always express the degree of their suffering. Cultural differences exist in patient's response to pain. In an effort to "be a good patient" some individuals may suffer unnecessarily.

Time orientation: Time is of the essence in today's medical practice. Some cultural groups are less oriented to "being on time" than others.

Other Factors Influencing Communication (Continued):

What's in a name: Some patients do not mind being called by their first name; others resent it. Clarify the patient's preference early on in the patient-Provider relationship.

Nonverbal communication: Messages are communicated by facial expressions and body movements that are specific to each culture. Be aware of variations in non-verbal communication to avoid misunderstandings.

When English is a second language: According to the US Census Bureau, 14% of Americans speak a language other than English in their home and 6.7 million people have limited or no English skills. As these numbers continue to grow, the need for multilingual care becomes more significant.

Patients with limited English proficiency may have more difficulty expressing thoughts and concerns in English and may require more time and patience. It is best to use simple vocabulary and speak slowly and clearly. Do not assume that because the patient can speak English that he can read and write in English as well. Remember, just because somebody speaks with a "perfect" American accent, doesn't mean that they will have complete and full mastery of the English language.

Translators: Often, volunteers from the community or relatives are brought by the patient to help with translation. Since patients may be reluctant to confide personal problems with non-professionals and may leave out important facts, this practice should be discouraged. Realize that it may be difficult for patients to discuss personal issues in front of a third non-professional party. The use of employees as translators (secretaries, house keeping etc.) may not be a better solution.

Translators should understand and speak a language well enough to manage medical terminology. The ideal translator is a professional. If a professional translator is not available, over the phone translation services can be used.

Enhancing cross-cultural communication

Communicate effectively:	Allow more time for cross-cultural communication, use translators who are not family members and ask questions about cultural beliefs.
Understand differences:	Realize that family integration is more important than individual rights in many cultures. Involve spiritual or religious advisors when appropriate. Be aware of your own cultural beliefs and biases. Be sensitive to your authority as a medical professional.
Identify areas of potential conflict:	Determine who is the appropriate person to make decisions and clarify and discuss important ethical disagreements with them.
Compromise:	Show respect for beliefs that are different from your own. Be willing to compromise about treatment goals or modalities whenever possible. Remember that taking care of patients from other cultures can be time-consuming and challenging. In almost all instances, however, the extra time and effort expended will result in more satisfied patients, families and professionals.

SECTION FIVE

CULTURAL RESOURCES AND INTERPRETATION/TRANSLATION SERVICES

ALL AHCCCS contracted Health Plans and Program Contractors provide a variety of cultural competency resources, including interpretation/translation services and cultural awareness training. Under the AHCCCS program, these organizations are required to provide interpretation/translation services to Providers and Members free of charge.

If you need interpretation/translation services for patient care or wish to receive more information about available cultural competency resources, please contact the patient's AHCCCS Health Plan or Program Contractor to make the necessary arrangements.

AHCCCS and its participating Health Plans and Program Contractors encourage you to use professional interpretation/translation services. Use of non-professional interpretation/translation services such as by bilingual staff and/or a patient's family member may jeopardize patient outcomes.

INTERNET RESOURCES

There are many cultural competency resources available on the Internet. The following listing is intended for informational purposes only.

General Reference sites:

- National Center for Cultural Competence: http://nccc.georgetown.edu/foundations/need.html
- Ethnomed: http://ethnomed.org/culture/
- http://bearspace.baylor.edu/Charles_Kemp/www/hispanic_health.htm Great site for information on Hispanic and other cultures (i.e. Bosnian refugees).
- Society of Teachers of Family Medicine: Multicultural Health Care and Education General curriculum information and listings of print, experiential exercises, games, simulations and video resources (not online). STFM homepage http://www.stfm.org/

General Reference sites (continued):

- AMSA (American Medical Student Association): http://www.amsa.org/AMSA/Homepage/About/Committees/REACH/CSSP.aspx
- Cross Cultural Health Care Program (CCHCP) Site offers schedules/location/fees of cultural competency training, interpreter training, research projects, community collaboration, and other services. Online registration for training sessions, interpreter and translation services. http://www.xculture.org/
- Communicating with your doctor - things you can do to help build an effective partnership http://www.ucsfhealth.org/education/communicating_with_your_doctor/
- CCCH develops cultural competency programs, organization assessment tools, and education and training resources. http://www.crosshealth.com/
- The Office of Minority Health (OMH) was created in 1986 and is one of the most significant outcomes of the 1985 *Secretary's Task Force Report on Black and Minority Health*. The Office is dedicated to improving the health status of racial and ethnic minorities, eliminating health disparities, and achieving health equity in the United States. OMH was reauthorized by the Patient Protection and Affordable Care Act of 2010 http://minorityhealth.hhs.gov/
- U.S Department of Health and Human Services - Health Resources and Service Administration: clinical resources http://www.hrsa.gov/publichealth/index.html
- The Health Center Program– What is a health center http://bphc.hrsa.gov/about/
- Department of Health and Human Services / Health Resources and Services Administration / Bureau of Primary Health Care (4350 East-West Highway, Bethesda, MD 20814)
- Interface International: Provides publications and training tools (c/o Suzanne Salimbene, Ph.D. / 3821 East State Street, Suite 197, Rockford, IL 61108 / Phone: (815) 965-7535 / e-mail: IF4YOU@aol.com)
- Simulation Training System (218 Twelfth Street, Del Mar, CA 92014-0901) / Resources for Cross-cultural Health Care: http://www.diversityrx.org/
- National Urban League (Phone: 212-310-9000) or http://www.nul.org/
- African Community Health and Social League http://www.progway.org/ACHSS.html
- Association of Asian Pacific Community Health Organizations http://www.aapcho.org
- National Coalition of Hispanic Health and Human Services Organizations http://www.hispanichealth.org/
- Center for American Indian and Alaskan Native Health Phone: http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/Pages/CAIANH.aspx
- www.culturalorientation.net
- The Provider's Guide to Quality and Culture http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English

SECTION IV: Member Rights & Responsibilities

Care1st is committed to treating members with respect and dignity. Member rights and responsibilities are shared with staff, providers and members each year. Care1st informs members of their rights and responsibilities in the Member Handbook.

MEMBER RIGHTS

Care1st member has the following rights.

Respect and Dignity:

1. Be treated with respect and with due consideration for his or her dignity and privacy.
2. Receive polite and courteous care. Members must be treated fairly and with respect no matter their race, ethnicity, national origin, gender, age, behavioral health condition (intellectual) or physical disability, sexual preference, genetic information, ability to pay or ability to speak English.
3. Get services in a language that member understands at no cost to the member. Member has the right to get an interpreter if member has limited English or if member is hearing impaired.
4. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
5. Exercise his or her right and that the exercise of those rights shall not adversely affect service delivery to member [42 CFR 438.100(c)].

Receive Information:

1. Request information on the structure and operation of Care1st or its subcontractors.
2. Request information on whether or not Care1st has Physician Incentive Plans (PIP) that affect the use of referral services, the right to know the types of compensation arrangements Care1st uses, the right to know whether stop-loss insurance is required and the right to a summary of member survey results, in accordance with PIP regulation.
3. Receive information about formulating Advance Directives.
4. Be given information about Care1st providers, including their qualifications and the languages other than English that they speak.
5. Get a summary of Care1st's member survey results.
6. Be told in writing of any changes to Customer Services.
7. Be told in writing when Care1st reduces, suspends, terminates, or denies any service requested by a provider, and be told what to do if member does not agree with Care1st's decision.
8. Be told what treatment options or other types of care and services are available to member, and the benefits and disadvantages of each choice. And, that these are

given to member in a manner right to his or her condition and ability to understand.

Confidentiality and Privacy:

1. Have his or her medical records and any information about health care be private and confidential.

Treatment:

1. Use any hospital or other setting for emergency care.
2. Choose PCP from Care1st's list of PCPs. Member also has the right to change PCPs if he or she wish to do so.
3. Participate in decisions regarding their health care, refuse any medical treatments, and to be told what will happen if they do not get treatment.
4. Know and understand his or her medical problems and healthcare conditions so that member can make informed decisions about his or her healthcare. Ask and be told the cost member would pay if he or she chose to pay for a service that Care1st does not cover.
5. Get a second opinion at no cost from another Care1st health care professional or from someone outside the network if the Care1st network is not sufficient.
6. Decide who member wants to be present for their treatments and exams.
7. Have available upon request the criteria that decisions are based on.

Medical Record:

1. Request and received a copy of his or her medical records and to request that they be amended or corrected, as specified in 45 CFR part 164 and applicable State law.
2. Ask for a copy of their medical records annually as determined by federal and state law at no cost to them. *
3. Have their medical records and any information about their health care kept private and confidential.
4. Receive a reply within 30 days to their request for a copy of their records. **
5. Inspect their medical records at no cost to them.
6. Ask that their medical records be updated or corrected.
7. Have their medical records transferred from their previous provider to their new provider within 10 days of their request.

* Their right to access medical records may be denied if the information is psychotherapy notes, compiled for, or in a reasonable anticipation of a civil, criminal or administrative action, protected health information subject to the Federal Clinical Laboratory Improvement Amendments of 1988 or exempt pursuant to 42 CFR 493.3(a)(2).

** The response may be the copy of the record or a written denial that includes the basis for the denial and information about how to seek review of the denial in accordance with 45 CFR Part 164 (AMPM 410-B9e).

Reporting Member Concerns:

1. Tell Care1st about any problems, complaints or grievances member has with his or her health care services, providers, or Care1st.
2. File a complaint with Care1st regarding the adequacy of a Notice of Adverse Determination letter they received.
3. Contact AHCCCS Medical Management if Care1st does not resolve their concern of adequacy with the Notice of Adverse Determination letter they received.
4. File a complaint with Care1st regarding the adequacy of a Notice of Adverse Determination letter you received. Member has the right to Contact AHCCCS Medical Management at MedicalManagement@azahcccs.gov if Care1st does not resolve his or her concern of adequacy with the Notice of Adverse Determination letter member received. (Maricopa County – 602-417-7000; Outside Maricopa County –1-800-962-6690)

MEMBER RESPONSIBILITIES

Care1st members have the following responsibilities.

AHCCCS Eligibility:

1. Keep member's AHCCCS eligibility up to date. Keep all AHCCCS eligibility appointments, and tell the eligibility worker when anything that could affect member's eligibility changes in the household.
2. Keep member's ID card safe. Do not throw it away. Member may not loan, sell or give the ID card to another person. Letting someone else use member's ID card is fraud. If member loans or gives the card to someone else, member could lose the AHCCCS eligibility. Member could also have legal action taken against him or her.

Information About Health Insurance Coverage:

1. Carry the Care1st ID card at all times and identify as a Care1st member BEFORE member get any services.
2. Tell Care1st Customer Services, member's PCP, and other Care1st providers about any other insurance member has.

Respect and Dignity:

1. Respect member's doctors, their staff, and the other people who provide services.

SECTION IV: Member Rights & Responsibilities

Know the Providers:

1. Know the name of member's PCP. Keep PCP's name, address and telephone number where member can easily find it.

Appointments with PCP and Other Providers

1. Make appointments with member's PCP during office hours instead of using Urgent Care or the Emergency Room for things that are not urgent or emergencies.
2. Keep all scheduled appointments and be on time. Call the doctor's office ahead of time if member needs to cancel an appointment or if member is going to be late.

Treatment:

1. Tell member's PCP or other Care1st providers if member does not understand his or her condition or the treatment plan.
2. Give member's PCP or other Care1st providers complete information about member's health and all ongoing care member receives. Tell providers about past problems or illnesses member has had, if member has been in the hospital or emergency rooms, and all drugs and medicines that member is taking.
3. Tell member's PCP or other Care1st providers about any changes in member's health or medical condition.
4. Follow member doctor's instructions carefully and completely. Ensure that member understands the instructions before you leave the provider's office.
5. Take an active part in managing member's healthcare and take care of problems before they become serious. Ask questions about his or her care.
6. Take all medications as prescribed and take part in programs that help member be well.
7. Bring member's children's shot records to all of their PCP visits.

Co-Payment:

1. Pay member co-payment when it is required.

Transportation:

1. Schedule transportation at least three days in advance. Notify transportation if member needs to change or cancel the appointment.

Reporting Member Concerns or Question:

1. Call or write to Customer Services when member has questions, problems, or grievances (complaints).
2. Tell Care1st or AHCCCS if member suspects fraud or abuse by a provider or another member.

SECTION IV: Member Rights & Responsibilities

GRIEVANCES

Members may call or write to Customer Service if they have a grievance or problem regarding their health care services, or if they think they have not been treated appropriately. Customer Service may request the provider's assistance to resolve the issue. Providers may be contacted to clarify the situation and/or to provide education regarding AHCCCS and Care1st policies and procedures. Customer Service works to resolve grievances within 10 business days of receipt, absent extraordinary circumstances, but no longer than 90 days from receipt.

GRIEVANCES AND INVESTIGATIONS CONCERNING PERSONS WITH SERIOUS MENTAL ILLNESS (SMI)

The Health Plan providers are required to understand the legal rights of persons with SMI provided for in Arizona Administrative Code Title 9, Chapter 21 (9 A.A.C. 21 (PDF), Article 2. The Health Plan and its providers are required to initiate an SMI Grievance Investigation upon receipt of a non-frivolous allegation that (1) a mental health provider has violated a member's legal rights; or (2) a condition requiring investigation exists (an incident or condition that appears to be dangerous, illegal, or inhumane, including a client death).

Filing Requirements:

A request for an SMI Grievance Investigation involving an alleged rights violation or condition requiring investigation that does not involve a client death or an allegation of physical or sexual abuse shall be filed with and investigated by The Health Plan. Requests for an SMI Grievance Investigation must be submitted to The Health Plan, orally or in writing, no later than 12 months from the date the alleged violation or condition requiring investigation. This timeframe may be extended for good cause.

Any person may request an SMI Grievance Investigation by completing the **Appeal or Serious Mental Illness Grievance Form** (AHCCCS ACOM Chapter 400, Section 446, Attachment A) and delivering it to The Health Plan at the following address:

Care1st Health Plan Arizona
Attn: Grievance and Appeal Department
1850 W. Rio Salado Parkway Suite 211
Tempe, AZ 85281
833-619-0415

A request for an SMI Grievance Investigation involving client death, physical abuse, or sexual abuse is filed with and investigated by the AHCCCS Administration pursuant to AHCCCS ACOM 446 – Grievances and Investigations Concerning Persons with Serious Mental Illness.

The Health Plan and its providers are required to report Quality of Care Concerns and Incidents, Accidents, and Deaths to The Health Plan Quality Management. (**See Section 10 – Quality Management Requirements**). The provider's obligation to request an SMI Grievance Investigation as described above is separate from the provider's reporting requirements described in **Section 10 – Quality Management Requirements**.

Please note the following exclusions:

- This process does not apply to allegations asserting a violation relating to the right to receive services, supports and/or treatment that are State-funded and are no longer funded by the State due to limitations on legislative appropriation;
- This process does not apply to service planning disagreements more appropriately managed as appeals as described in Sections 8.4 and 8.5 and A.A.C. R9-21-405 (PDF)
- This process is only available for allegations involving behavioral health services. Grievances involving physical health services or services for persons who are not in the SMI Program are managed according to Section 8.1.

Notice of Decision and Right to Appeal:

The Health Plan follows the investigation process described in Arizona Administrative Code Title 9, Chapter 21 (9 A.A.C. 21), Article 4, and in AHCCCS ACOM 446 (Grievance and Investigations Concerning Persons with Serious Mental Illness). When the investigation is concluded, The Health Plan issues a decision letter to the grievant (and the member and other authorization representatives) outlining the investigation, findings of fact, conclusions of law, and in the case of substantiated allegations, the corrective measure(s) being imposed to correct the identified deficiency or deficiencies.

If the member or authorized representative is not satisfied with the outcome of The Health Plan's Investigation, the grievant has access to an administrative review and/or an administrative hearing as described in AHCCCS ACOM 446 (Grievance and Investigations Concerning Persons with Serious Mental Illness). To request an administrative review or administrative hearing, the appellant must send their written request to The Health Plan at the following address:

Care1st Health Plan Arizona
Attn: Grievance and Appeal Department
1850 W. Rio Salado Parkway Suite 211
Tempe, AZ 85281
833-619-0415

Upon receipt of a request for an administrative review or administrative hearing, The Health Plan transmits the request and the file, if any, to AHCCCS Office of Administrative Legal Services pursuant to AHCCCS ACOM 445 (Submission of Request for Hearing).

ADVANCE DIRECTIVES

The Patient Self-Determination Act, passed by Congress in 1991, requires that health care providers educate patients on issues related to Advance Directives, which may include a living will or a health care power of attorney. The Act requires all Medicare and Medicaid providers to furnish timely information so patients have the opportunity to express their wishes regarding the refusal of medical care. Care1st as well as AHCCCS must comply with this Act, and request your cooperation in helping us become compliant. Documentation is required in the medical record as to whether or not an adult member has completed an Advanced Directive. Below are suggestions to assist in bringing your medical records into compliance with this standard:

1. Add a line to your initial patient assessment record stating
    a. Advance Directive discussed - Yes or No
    b. Do you have a Living Will or Power of Attorney - Yes or No

2. For paper charts, stamp the front of the member's chart or provide a "sticker" on the chart with the above statements(s). Please be sure to address the above questions with the member.

For more information on health care directives, the following organizations offer assistance and resources:

Arizona Medical Association	www.azmed.org
Arizona Hospital & Healthcare Association	www.azhha.org
Arizona Aging and Adult Administration	www.azdes.gov/aaa
American Academy of Family Physicians	www.aafp.org
American Association of Retired Persons	www.aarp.org
American Hospital Association	www.putitinwriting.org

SECTION V: Eligibility and Enrollment

ELIGIBILITY DETERMINATION AND ENROLLMENT

Eligibility for AHCCCS is determined by different agencies depending on the program to which the member is applying. These agencies/entities include AHCCCS and the Social Security Administration. Care1st does not play any role in determining eligibility.

All members are given the opportunity to select a health plan serving their geographic area. If they do not select a plan, they are automatically assigned one by AHCCCS. Individuals applying for KidsCare must select a health plan at the time of application. Members are assigned to health plans, and become enrolled on a health plan's roster, every day of the month.

CHANGE OF CONTRACTOR

Members who are outside of their initial enrollment choice or their Annual Enrollment Choice (AEC) period may request a plan change from Care1st if certain conditions are met. Care1st follows the criteria set forth in ACOM Policy 401 Change of Contractor: Acute Care Contractors to determine if the member meets the required criteria for a plan change. Members may submit plan change requests to the Contractor or AHCCCS. Care1st may not request disenrollment because of an adverse change in the member's health status, nor because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

TRANSITION OF MEMBERS

Care1st adheres to the AMPM and the ACOM standards (ACOM Policies 401 and 402 and AMPM Chapter 500) for member transitions between Plans or Geographical Service Areas (GSAs), Children's Rehabilitative Services (CRS), the Comprehensive Medical and Dental Program (CMDP), Department of Economic Security (DES), Regional Behavioral Health Authority (RBHA), or to the Arizona Long Term Care System (ALTCS) plan, and upon termination or expiration of a plan's contract with AHCCCS.

The relinquishing plan is responsible for timely notification to the receiving plan regarding pertinent information related to any special needs of transitioning members. The new plan, when receiving a transitioning member with special needs, is responsible to coordinate care with the relinquishing plan in order that services are not interrupted, and for providing the new member with plan and service information, emergency numbers and instructions on how to obtain services. Transition activities also include transmitting appropriate medical records and case management files of the transitioning member.

SECTION V: Eligibility and Enrollment

KIDSCARE

KidsCare is a program for children with family incomes above the AHCCCS eligibility limits, but who do not have private insurance. It is administered by AHCCCS, and is financed by a combination of state and federal funds, like AHCCCS.

KidsCare services are similar to those provided to AHCCCS members. All policies and procedures described in this manual apply to KidsCare as well as AHCCCS members.

RATE CODES

Each member falls within a rate code or eligibility category. Rate codes are important to PCPs because capitation rates are determined by rate code. In addition, there is some slight variation in coverage and co-payment requirements based on rate code.

Major rate code categories are as follows:

- **NEAD –** Newly Eligible Adults
- **ACMA (formerly known as AHCCCS CARE)** - Eligible individuals and childless adults whose income is less than or equal to 100% of the FPL
- **QMB** - **Q**ualified **M**edicare **B**eneficiary
- **SOBRA** - **S**ixth **O**mnibus **B**udget **R**econciliation **A**ct (pregnant women and young children above the federal poverty level)
- **SSI** - **S**ocial **S**ecurity **I**ncome (for Blind, Aged and Disabled)
- **TANF** - **T**emporary **A**ssistance to **N**eedy **F**amilies (Previously know as "AFDC")
- **KIDSCARE** - KidsCare (Children's Health Insurance Program)
- **BCCTP** - **B**reast and **C**ervical **C**ancer **T**reatment **P**rogram

MEMBER IDENTIFICATION CARDS

Care1st issues identification cards for AHCCCS members. **Members may not be refused service because they do not have their ID card.** The identification card does not guarantee that the member is still eligible for services. To verify eligibility providers can visit our website www.care1staz.com or contact Customer Service as outlined below.

SECTION V: Eligibility and Enrollment

PCP ASSIGNMENT

Members will be assigned a PCP based on geographic location, provider availability, the member's age, and any special medical needs of the member. Directions on how to view and/or obtain a listing of contracted PCPs is included in the Member Packet so members may change their PCP.

Providers may request a PCP assignment member roster from Care1st. Care1st will provide the roster within 10 business days of receipt of the request. To request a PCP assignment member roster, please contact Network Management at 1-866-560-4042 (5, 7).

PCP ASSIGNMENT CHANGES

MEMBER INITIATED

Members may request a PCP change at any time and for any reason by contacting the Customer Service Department. Each eligible member in a family may select a different PCP.

Most change requests received by the Customer Service Department will be effective the following day. Members who request frequent PCP changes will be contacted by the Customer Service Department to determine why they are unable to establish an ongoing relationship with a PCP.

PROVIDER INITIATED

There are infrequent occasions when a provider believes that he/she cannot continue to care for a particular member. Providers should make every effort to work with the member to resolve any issues. Providers with difficult or non-compliant members are encouraged to call the Customer Service Department for assistance with these members. As a last resort, providers may request that the member be removed from his/her panel. Providers must notify the member (with a copy to the Customer Service Department) in writing that they can no longer provide services to the member and must:

- Be sent on the provider's letterhead and include the member's name, AHCCCS ID, date of birth, the specific reason for the change request, and the signature of the Provider,
- Request that the member choose a new PCP,
- Indicate that the provider will continue to provide emergency care for 30-day period following their written request, or, until that member is reassigned to another PCP

Upon receipt of a change request, the Customer Service Department will contact and reassign the member considering member choice as well as geographic, linguistic,

medical needs, and other member variables. The transferring provider must be available for care thirty (30) days after the member is notified and is also responsible for forwarding the member record to the new provider within ten (10) business days from receipt request for transfer of the medical records.

The following are not acceptable grounds for a provider to seek the transfer of a member:

- Member's Medical Condition
- Amount, variety, or cost of covered services required by a member
- Demographic and Cultural characteristics

Care1st does not condone discrimination against its members for any reason and will investigate any allegations or indications of such.

ELIGIBILITY VERIFICATION

Although members do not frequently lose eligibility mid-month, it does occur. Members may also request a PCP change during the month. To ensure payment, **all providers must verify eligibility at the time of service.** Eligibility and PCP assignment can be verified using one of the verification methods defined below.

WEBSITE - www.care1staz.com

Our website offers member eligibility, claims status and online remittance advice viewing and printing. A one-time registration process is required in order to obtain a log on and password. To complete the registration process:

1. Choose "Login" under the Provider menu
2. Complete the Registration On-Line Form
3. You will receive your logon and temporary password via e-mail

CUSTOMER SERVICE

To speak with a representative from our Customer Service Department dial 602.778.1800 or 1.866.560.4042 (options 5, 3)

NEWBORN NOTIFICATION

Hospital providers are required to notify AHCCCS of all newborns in a timely manner to be eligible for reimbursement from Care1st.

AHCCCS COST SHARING & COPAYMENTS

MANDATORY (REQUIRED) COPAYMENTS

AHCCCS members who have *mandatory* copayments for certain services are:

- Transitional Medical Assistance (TMA) members (Copay Level 50)

TMA Copayments (Copay Level 50)

Pharmacy	$2.30
Office Visits	$4.00
Outpatient Professional Therapies	$3.00
Surgeries (In Office; Outpatient non-emergent; ASCs	$3.00

Mandatory copayments **permit** providers to **deny** services to members who do not pay the copayment. However, certain services (such as emergency services) are exempt from mandatory copayments, and specific members (such as individuals under the age of 19) are also exempt from copayments. Please be aware that payments to providers are reduced by the amount of a member's copayment obligation *regardless of whether or not the provider successfully collects the mandatory copayment.*

These copayments do not apply to:

- People under age 19
- People determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services
- An individual designated eligible for Children's Rehabilitative Services (CRS) pursuant to Title 9, Chapter 22, Article 13
- ACC, CMDP, and RBHA members who are residing in nursing facilities or residential facilities such as an Assisted Living Home and only when member's medical condition would otherwise require hospitalization. The exemption from copayments for these members is limited to 90 days in a contract year
- People who are enrolled in the Arizona Long Term Care System (ALTCS)
- People who are Qualified Medicare Beneficiaries
- People who receive hospice care
- American Indian members who are active or previous users of the Indian Health Service, tribal health programs operated under P.L. 93-638, or urban Indian health programs
- People in the Breast & Cervical Cancer Treatment Program (BCCTP)
- People receiving child welfare services under Title IV-B on the basis of being a child in foster care or receiving adoption or foster care assistance under Title IV-E regardless of age
- People who are pregnant and throughout the postpartum period following the pregnancy
- Individuals in the Adult Group (for a limited time*)

* NOTE: For a limited time persons who are eligible in the Adult Group will not have any copays. Members in the Adult Group include persons who were transitioned from the AHCCCS Care program as well as individuals who are between the ages of 19-64, and who are not entitled to Medicare, and who are not pregnant, and who have income at or below 133% of the Federal Poverty Level (FPL) and who are not AHCCCS eligible under any other category. Copays for persons in the Adult Group with income over 106% FPL are planned for the future. Members will be told about any changes in copays before they happen.

Services that will not require a copayment include:

- Hospitalizations and services received while in a hospital
- Emergency services
- Services received in the emergency department
- Family Planning services and supplies
- Pregnancy related health care and health care for any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for pregnant women
- Preventative services, such as well visits, pap smears, colonoscopies, mammograms and immunizations
- Provider preventable services

OPTIONAL (NON-MANDATORY) COPAYMENTS

Optional (also known as non-mandatory) copayments apply to AHCCCS members who are not required to make the mandatory copayments as noted above. When a member has an optional copayment, providers are **prohibited** from denying the service when the member is unable to pay the copayment. As in mandatory copayment situations, there are certain services (such as emergency services) and certain populations (such as individuals under age 19) which are exempt from the optional copayment.

5% LIMIT ON ALL COPAYS

The amount of total copays cannot be more than 5% of the family's total income (before taxes and deductions) during a calendar quarter (January-March, April-June, July-September, and October-December). The 5% limit applies to both optional and required copays.

HOW TO DETERMINE IF A MEMBER HAS A MANDATORY COPAYMENT

Providers can identify whether a member has a mandatory copayment by using a member's specific copay level available through various AHCCCS eligibility verification

systems ***other than IVR***. EVS, the web, and HIPAA transactions 270 and 271 will identify a member's copay level, but IVR will not. A member's copay level in the AHCCCS verification system corresponds to specific copayment amounts for specific services.

AHCCCS Online, https://azweb.statemedicaid.us/Account/Login.aspx, has the most current eligibility and copayment information for all AHCCCS members. If you are not registered to use this system, register by choosing the "Register" link under "New Account". The Co-Payment tab at the top of the page of the member's eligibility verification screen indicates the member copay level and provides a link to the AHCCCS Copay Grid, which provides you the detail on the mandatory copay levels and applicable services.

COPAYMENT TRACKING

AHCCCS Administration tracks each member's specific copayment levels by service type, and this information will also identify those members who have reached the 5% copayment limit. AHCCCS will further identify whether the member is subject to a mandatory or a nominal copayment and when copayments cannot be charged, i.e. the service or member is exempt from copayments.

Ongoing updates from AHCCCS regarding copayment requirements can be found at: https://azahcccs.gov/PlansProviders/RatesAndBilling/copayments.html

SECTION VI: Covered Services

COVERED SERVICES

Services covered by AHCCCS for Care1st members are determined by the AHCCCS Administration. Covered services must be medically necessary. For services that require prior authorization, please reference the Prior Authorization Guidelines.

Below is a reference list of AHCCCS-covered services. Some of these services are limited in scope or duration or available to certain populations only. The list is followed by a more detailed description of selected services that have restrictions or require additional explanation.

1. Doctor visits
2. Visits with a nurse practitioner or physician's assistant
3. Emergency care
4. Emergency transportation
5. Health check-ups including screening and assessments
6. Nutritional evaluations
7. Outpatient hospital care
8. Rehabilitation services in accordance with AHCCCS rules
9. Hospice care for all ages
10. Radiology, medical imaging, lab work and other tests
11. Chiropractic care (for members under age 21 and "QMB" members)
12. Podiatry Care
13. Maternity care
14. Family Planning
15. Well child care (EPSDT care) including immunizations
16. Behavioral health services (see Section VII)
17. Most medically necessary supplies and equipment
18. Prescriptions
19. Home health services
20. Nursing home care (if used instead of hospitalization) up to 90 days per contract year (i.e. October 1st through September 30th)
21. AHCCCS approved organ and tissue transplants and related drugs
22. Dialysis
23. Preventive dental care and treatments for members under age 21
24. Medical and surgical services related to dental (oral) care and certain pre-transplant services and prophylactic extraction of teeth for members over age 21
25. Vision care including eyeglasses for members under age 21

26. Vision care for members age 21 and over following cataract surgery and for emergency eye conditions
27. Hearing evaluations and treatment (hearing aids) for members under age 21
28. Hearing evaluations for members age 21 and over
29. Medically necessary foot care
30. Medically necessary transportation
31. Outpatient Physical Therapy (limited to 15 visits for the purpose of rehabilitation to restore a level of function and 15 visits for the purpose of keeping or getting to a level of function per contract year (10/1-9/30) for adult members 21 years and older)
32. Medically necessary orthotics

CHIROPRACTIC SERVICES

Covered services are available for members under age 21 and "QMB" (Qualified Medicare Beneficiaries). Coverage is limited to manual manipulation of the spine to correct subluxation.

CHILDREN'S REHABILITATIVE SERVICES (CRS)

CRS serves individuals under 21 years of age who has a CRS-covered condition that requires active treatment as established under A.A.C. R9-22-1303.

Anyone can fill out a CRS application form, including, a family member, provider, or health plan representative. To apply for the CRS program, a CRS application needs to be completed and mailed or faxed to the AHCCCS CRS Enrollment Unit, with medical documentation that supports that the applicant has a CRS qualifying condition.

Please submit the application with supporting documentation applicable to the diagnosis to:

AHCCCS/Children's Rehabilitative Services
Attn: CRS Enrollment Unit
801 East Jefferson MD3500
Phoenix, AZ 85034
Or
Fax to 602-252-5286

The AHCCCS CRS Enrollment Unit may also assist an applicant with completing the form. You can contact them at: 602-417-4545 or 1-855-333-7828.

SECTION VI: Covered Services

As a provider if you submit an application on the member's behalf you need to contact the Health Plan through our Care Coordination team by calling 602-778-1800 or 1-866-560-4042 TTY 711 (select option 4 then option 9). Care1st is responsible to notify the member or his/her parent/guardian that an application for CRS designation has been submitted on the member's behalf.

Website for the CRS application:
https://azahcccs.gov/Members/GetCovered/Categories/CRS.html

The definition of active treatment is a current need for treatment or anticipated treatment or evaluation for continuing treatment of the CRS qualifying condition(s) will be needed within the next 18 months from the last date of service for the treatment.

List of qualifying medical conditions is on the AHCCCS website at:
https://www.azahcccs.gov/Members/Downloads/CRS/QualifyingMedicalConditions.pdf

DENTAL

For ACC Members:	**For RBHA Members:**
DentaQuest is administering the dental benefits for Care1st. DentaQuest manages the dental benefits provided to Care1st members on behalf of Care1st. DentaQuest provides the following functions for Care1st and can be reached at 800.440.3408: • Prior Authorization • Claims Adjudication and payment (see section XI for claims information) • Provider Credentialing • Provider Customer Service	Envolve Dental is administering the dental benefits for Care1st. Envolve Dental manages the dental benefits provided to Care1st members on behalf of Care1st. Envolve Dental provides the following functions for Care1st and can be reached at 844.876.2028: • Prior Authorization • Claims Adjudication and payment (see section XI for claims information) • Provider Credentialing • Provider Customer Service

AHCCCS COVERED DENTAL SERVICES

Dental services are covered for all EPSDT members age 20 and younger. This includes medically necessary dental services such as dental screenings, preventive services, therapeutic dental services, medically necessary dentures, and pre-transplantation dental services.

All EPSDT age members, ages 20 years and younger are assigned to a Dental Home.

SECTION VI: Covered Services

What is a Dental Home?
A Dental Home is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way, as defined by the American Academy of Pediatric Dentistry.

Member Assignment
Members are assigned to a dental home based on their age and their residence.

A member may change their assigned dental home by calling:

For ACC Members:	For RBHA Members:
DentaQuest at 800.440.3408	Care1st member services

Periodicity Schedule
Recommendations regarding the routine preventive care of AHCCCS members may be found via the AHCCCS Dental Periodicity Schedule (AMPM Policy 431 Attachment A). The schedule is available on our website www.care1staz.com Click on *Care1st > Providers > Practice and Preventive Health Guidelines* and scroll down to the Periodicity Link.

Care1st encourages our EPSDT aged members to schedule checkups with their dentist every 6 months beginning by age one (1).

Beginning October 1, 2017, AHCCCS covers the following dental services for members 21 years and older:

- Emergency dental services up to $1000 per member per contract year (October 1 – September 30). A dental emergency is defined as "an acute disorder of oral health resulting in severe pain and/or infection as a result of pathology or trauma".
- Medical and surgical services related to dental (oral) care for members 21 years and older. Covered dental services must be related to the treatment of a medical condition such as acute pain (excluding TMJ), infection, or fracture of the jaw. Covered dental services include examining the mouth, x-rays, care of fractures of the jaw or mouth, giving anesthesia and pain medications and/or antibiotics.
- Certain pre-transplant services and prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head is also covered only after a transplant evaluation determines that the member is an appropriate candidate for organ or tissue transplantation.

SECTION VI: Covered Services

DENTAL GUIDELINES

For ACC Members:	For RBHA Members:
DentaQuest manages the dental benefits provided to Care1st members on behalf of Care1st. For detailed information, please reference the DentaQuest Office Reference Manual (ORM) on the DentaQuest website at www.dentaquest.com . If you do not have internet access, you may contact DentaQuest directly at 800.440.3408 and request a hard copy of the ORM.	Envolve Dental manages the dental benefits provided to Care1st members on behalf of Care1st. For detailed information, please reference the Envolve Provider Manual on the Envolve Dental website at www.envolvedental.com. If you do not have internet access, you may contact Envolve Dental directly at 844-876-2028 to review.

DENTAL CONSENT

Informed consent is a process by which the dental provider advises the member, member's parent or legal guardian of the diagnosis, proposed treatment and alternate treatment methods with associated risks and benefits of each, as well as the associated risks and benefits of not receiving treatment.

Informed consents for oral health treatment include:

1. A written consent for examination and/or any preventative treatment measure, which does not include an irreversible procedure, as mentioned below. This consent is completed at the time of initial examination and is updated at each subsequent six month follow-up appointment.

2. A separate written consent for any irreversible, invasive procedure, including but not limited to dental fillings, pulpotomy, etc. In addition, a written treatment plan must be reviewed and signed by both parties, as described below, with the member's parent or legal guardian receiving a copy of the complete treatment plan.

All providers must complete the appropriate informed consents and treatment plans for AHCCCS members as listed above, in order to provide quality and consistent care, in a manner that protects and is easily understood by the member and/or the member's parent or legal guardian. Consents and treatment plans must be in writing and signed/dated by both the provider and the member, or the member's parent or legal guardian, if the member is under 18 years of age or is 18 years of age or older and

considered an incapacitated adult (as defined in A.R.S. § 14-5101). Completed consents and treatment plans must be maintained in the members' chart and are subject to auditing.

EMERGENCY SERVICES

DEFINITION

"Emergency Medical Condition" means a medical condition manifesting itself by the sudden onset of symptoms of acute severity, which may include severe pain such that a reasonable person would expect that the absence of immediate medical attention could result in (1) placing the member's health in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

EMERGENCY CARE

Care1st members are entitled to access emergency care without prior authorization. However, Care1st requires that when an enrollee is stabilized but requires additional medically-necessary health care services, that providers notify Care1st prior to, or at least during the time of rendering these services. Care1st wishes to assess the appropriateness of care and assure that care is rendered in the proper venue.

LIFE THREATENING OR DISABLING EMERGENCY

Delivery of care for potentially life threatening or disabling emergencies should never be delayed for the purposes of determining eligibility or obtaining prior authorization. These functions should be done either concurrently with the provision of care or as soon after as possible.

BUSINESS HOURS

In an emergency situation, if a member is transported to an emergency department (ED), the ED physician will contact the member's PCP as soon as possible (post stabilization) in order to give him/her the opportunity to direct or participate in the management of care.

MEDICAL SCREENING EXAM

Hospital EDs under Federal and State Laws are mandated to perform a medical screening exam (MSE) on all patients presenting to the ED. Emergency services include additional screening examination and evaluation needed to determine if a psychiatric emergency medical condition exists. Care1st will cover emergency services necessary to screen and stabilize members without prior authorization in cases where a prudent layperson acting reasonably would have believed that an emergency medical condition existed.

AFTER BUSINESS HOURS

After regular Care1st business hours member eligibility is obtained and notification is provided by calling the telephone number on the member ID card, which is the regular

Customer Service telephone number. During these hours the number connects to a 24-hour information service, which is available to members as well as to providers. Nurse triage services are available in the event that a member calls for advice relating to a clinical condition that they are experiencing during, before or after business hours. In these cases the member will be given advice or directed to go to the nearest urgent care facility, ED, or to call 911 depending on the circumstances and the nurse triage protocols.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

DESCRIPTION

EPSDT is a state-administered, federal program which provides comprehensive health care (as defined in Arizona Administrative Code R9-22-213) through primary prevention, early intervention, diagnosis and medically necessary treatment of physical and behavioral health problems for enrolled AHCCCS members under 21 years of age. EPSDT also provides for all medically necessary services to treat, correct, diminish, or ameliorate physical and behavioral conditions and illnesses, identified in an EPSDT screening. General limitations and exclusions, other than the requirement for medical necessity, do not apply to EPSDT services.

AMOUNT, DURATION AND SCOPE

EPSDT screening services are provided in compliance with the periodicity requirements of Title 42 of the Code of Federal Regulations (42 CFR) Section 441.58. Care1st is required to ensure members receive required health screenings in compliance with the AHCCCS EPSDT periodicity schedule. AHCCCS' EPSDT periodicity schedule is intended to meet reasonable and prevailing standards of medical and dental practice and specifies screening services at each stage of the child's life. The service intervals represent minimum requirements, and any services determined by a primary care provider to be medically necessary should be provided, regardless of the interval.

SCREENING REQUIREMENT

Comprehensive periodic screenings must be conducted according to the time frames identified in the AHCCCS EPSDT Periodicity Schedule, and inter-periodic screenings as appropriate for each member. The AHCCCS EPSDT Periodicity Schedule is based on recommendations by the Arizona Medical Association and is closely aligned with guidelines of the American Academy of Pediatrics. EPSDT visit must include the following:

1. A comprehensive health and developmental history (including physical, nutritional, and behavioral health assessments). For additional information, see Developmental Screening Tools below.

2. Nutritional Screening and Assessment by a PCP

3. Applicable Behavioral Health Screenings and Services provided by a PCP

4. Developmental Screening according to age

5. A comprehensive unclothed physical examination

6.. Appropriate immunizations according to age and health history

7.. Laboratory tests (including blood lead screening assessment and testing, see handbook for requirements, anemia testing and, diagnostic testing for sickle cell trait if a child has not been previously tested with sickle cell preparation or a hemoglobin solubility test)

8.. Health education, counseling, and chronic disease self-management

9. Appropriate oral health screening, intended to identify gross tooth decay or oral lesions, conducted by a physician, physician's assistant, or nurse practitioner

10. Appropriate vision, hearing, and speech testing and diagnosis, as well as treatments for defects in vision and hearing, including provision of eyeglasses and hearing aids. Appropriate therapies including speech therapy are also covered under EPSDT, and

11. Tuberculin skin testing as appropriate to age and risk. Children at increased risk of tuberculosis (TB) include those who have contact with persons:

    a. Confirmed or suspected as having TB

    b. In jail or prison during the last five years

    c. Living in a household with an HIV-infected individual or the child is infected with HIV, and

    d. Traveling/immigrating from or having significant contact with individuals indigenous to endemic countries.

EPSDT SERVICE STANDARDS

EPSDT services must be provided according to community standards of practice and the AHCCCS EPSDT Periodicity Schedule. The EPSDT and Dental periodicity schedules can be found at:
https://www.azahcccs.gov/shared/MedicalPolicyManual/,
Policy 430 Attachment A and Policy 431 Attachment A.

SECTION VI: Covered Services

AHCCCS EPSDT Clinical Sample Templates (i.e. tracking forms) are used to document services provided in compliance with AHCCCS standards. A copy of the clinical sample template is submitted to Care1st to the attention of the EPSDT Team. Age-specific EPSDT clinical sample templates may be ordered by submitting a completed EPSDT Order Form (available on our website under Forms of the Provider drop down menu). Clinical Sample Templates may also be downloaded at: https://www.azahcccs.gov/shared/MedicalPolicyManual/, Policy 430 Attachment E

Offices implementing electronic medical records please note: Documentation of the EPSDT visit MUST adhere to and contain all of the components found on the EPSDT clinical sample template. A copy of the electronic medical record is be submitted to Care1st as a replacement for the current EPSDT Clinical Sample Template that is submitted.

EPSDT providers must adhere to the following specific standards and requirements:

1. **Immunizations –** All appropriate immunizations must be provided to bring and maintain each EPSDT member's immunization status up to date. EPSDT covers all child and adolescent immunizations according to the Advisory Committee on Immunization Practices (ACIP) Recommended Schedule. Refer to the CDC website: https://www.cdc.gov/vaccines/schedules/ for current immunization schedules. Providers must participate in the Arizona Department of Health Service (ADHS) Vaccines For Children (VFC) program to ensure the delivery of immunization services, if seeing members under the age of 19. Providers must re-enroll in the VFC Program yearly. Additionally, all immunizations given must be reported to the Arizona State Immunization Information System (ASIIS). VFC can be reached at 602.364.3642. ASIIS can be reached at 877.491.5741.

2. **Eye examinations and prescriptive lenses** - EPSDT covers eye examinations as appropriate to age according to the AHCCCS EPSDT Periodicity Schedule and as medically necessary. Prescriptive lenses are provided to correct or ameliorate defects, physical illness and conditions discovered by EPSDT screenings, subject to medical necessity.

Blood Lead Screening - EPSDT covers blood lead screening for all members at 12 months and 24 months of age and for those members between the ages of 24 and 72 months who have not been previously tested or who missed with the 12 or 24 month test. Lead levels may be measured at other times other than those specified if thought to be medically indicated by the provider, by responses to a lead poisoning verbal risk assessment, or in response to parental concerns. Additional Screening for children under 6 years of age is based on the child's risk as determined by either the member's residential zip code or presence of other known factors. Appropriate follow up shall align with CDC recommendations for actions based on blood lead levels and ADHS recommendations.

3. **Organ and tissue transplantation services** - EPSDT covers medically necessary non-experimental organ and tissue transplants approved for Title XIX reimbursement in accordance with respective transplant policies as noted in Policy 310-DD of the AHCCCS Medical Policy Manual.

4. **Nutritional Assessment and Nutritional Therapy** - Nutritional Assessments are conducted to assist members whose health status may improve with nutrition intervention. AHCCCS covers the assessment of nutritional status provided by the member's primary care provider (PCP) as a part of the EPSDT screenings specified in the Periodicity Schedule and on an inter-periodic basis as determined necessary by the member's PCP. AHCCCS also covers nutritional assessment provided by a registered dietitian when ordered by the member's PCP. AHCCCS covers Nutritional Therapy for EPSDT members on an Enteral Nutrition, TPN Therapy, or oral basis when determined medically necessary to provide either complete daily dietary requirements or to supplement a member's daily nutritional and caloric intake.

   Commercial Oral Supplemental Nutritional Feeding: Provides nourishment and increases caloric intake as a supplement to the member's intake of other age appropriate foods, or as the sole source of nutrition for the member. Nourishment is taken orally and is generally provided through commercial nutritional supplements available without prescription.

   a. PA is required for commercial oral nutritional supplements unless the member is also currently receiving nutrition through enteral nutrition or TPN Therapy. PA is not required for the first 30 days if the member requires commercial oral nutritional supplements on a temporary basis due to an emergent condition.

   b. Medical necessity for commercial oral nutritional supplements must be determined on an individual basis by the member's PCP or specialty provider, using at least the criteria specified in AMPM Policy 430. The PCP or specialty provider must use the AHCCCS approved form, "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements" to obtain PA from Care1st. The "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements" form may be found at https://www.azahcccs.gov/shared/MedicalPolicyManual/, Policy 430, Attachment B.

   c. The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must document that the PCP or specialty provider has provided nutritional counseling as a part of the health risk assessment and Screening services provided to the member. The documentation must specify alternatives that were tried in an effort to boost caloric intake and/or change food consistencies before considering commercially

available nutritional supplements for oral feedings, or to supplement feedings.

The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must indicate which criteria were met when assessing the medical necessity of providing commercial oral nutritional supplements. At least two of the following criteria must be met:

1. The member is at or below the 10th percentile for weight-for-length or BMI on the appropriate growth chart for their age and gender, for 3 months or more (For members under age two, confirmation that the World Health Organization's (WHO) growth charts were used per CDC and AAP guidance).;
2. The member has reached a plateau in growth and/or nutritional status for more than six months or more than three months if member is less than one year of age;
3. The member has already demonstrated a medically significant decline in weight within the three-month period prior to the assessment and,
4. The member is able to consume/eat no more than 25% of his/her nutritional requirements from age-appropriate food sources

Additionally, both of the following requirements must be met:

1. The member has been evaluated and treated for medical conditions that may cause problems with growth (such as feeding problems, behavioral conditions or psychosocial problems, endocrine or gastrointestinal problems), and
2. The member has had a trail of higher caloric foods, blenderized foods, or commonly available products that may be used as dietary supplements for a period no less than 30 days in duration.

6. **Oral Health Services -** As part of the physical examination, the physician, physician's assistant or nurse practitioner should perform an oral health screening. A screening is intended to identify gross dental or oral lesions (including tooth decay), and the application of fluoride varnish, but is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan. Depending on the results of the oral health screening, referral to a dentist should be made according to the following timeframes:

Category	Recommendation	Criteria
Urgent	Within 24 hours	Pain, infection, swelling and/or soft tissue ulceration of approximately two weeks duration or longer.

Early	Within three weeks	Decay without pain, spontaneous bleeding of the gums and/or suspicious white or red tissue areas.
Routine	Next regular checkup	None of the above problems identified.

An oral health screening should be part of an EPSDT screening conducted by a PCP; however, it does not substitute for examination through direct referral to a dentist. PCPs are expected to refer EPSDT members for appropriate services based on needs identified through the screening process and for routine dental care based on the periodicity schedule. Evidence of this referral should be documented on the EPSDT form. In addition to PCP referrals, EPSDT members are allowed self-referral to a dentist who is included in the provider network.

Application of fluoride varnish by a PCP during an EPSDT visit is reimbursed separately when:

1. The child is six months of age with at least one tooth erupted
2. Application of the varnish is performed by a physician, physician's assistant or nurse practitioner who has completed the appropriate training (*see **Training** section below for details on how to become certified*);
3. The varnish is billed separately from the EPSDT visit using CDT code 99188.
4. Recurrent applications may occur and be billed every six months up to two years of age

Training

To meet AHCCCS requirements for the enhanced reimbursement of services outlined above, a qualified medical professional must:

1. Complete training/certification for these services, and
2. Submit the proof of training/certification to CAQH. By submitting the proof of training/certification to CAQH, this information is accessible to all AHCCCS health plans with whom you contract.

AHCCCS recommended training for fluoride varnish application is located at http://www.smilesforlifeoralhealth.org. Refer to Training Module 6 that covers caries-risk assessment, fluoride varnish, and counseling.

DEVELOPMENTAL SCREENING TOOLS

AHCCCS approved developmental screening tools should be utilized for developmental screenings by all participating PCPs who care for EPSDT age members. PCPs must be trained in the use and scoring of the developmental screening tools, as indicated by the American Academy of Pediatrics. The developmental screening should be completed for

EPSDT members during the 9 month, 18 month and 30 month EPSDT visits. Autism Spectrum Disorder (ASD) Specific Developmental Screening should be completed at the 18 month and 24 month EPSDT visits. A copy of the screening tool must be kept in the medical record.

Additional reimbursement may be received when:

1. Accepted tools are described in the CMS Core Measure Developmental Screening in the First Three Years of Life. Examples of accepted tools include:
    a. Parents' Evaluation of Developmental Status (PEDS)
    b. Ages & Stages Questionnaire (ASQ)
2. PCP is trained in the use and scoring of the developmental screening tools, as indicated by the American Academy of Pediatrics (*see **Training** section below for details on how to become certified*);
3. The screening is billed separately from the EPSDT visit using CPT code 96110 with an EP modifier.

Training
To meet AHCCCS requirements for the enhanced reimbursement of services outlined above, a qualified medical professional must:

1. Complete training/certification for these services, and
2. Submit the proof of training/certification to CAQH. By submitting the proof of training/certification to CAQH, this information is accessible to all AHCCCS health plans with whom you contract.

A list of available training resources may be found in the Arizona Department of health Services website:
www.azdhs.gov/clinicians/training-opportunities/developmental/index.php

FAMILY PLANNING SERVICES

Family planning services and supplies are covered for members regardless of gender when provided by appropriate Family Planning Providers to members who voluntarily choose to delay or prevent pregnancy. Each year, physicians and other practitioners should discuss and document in the medical record that each member of reproductive age has been notified verbally or in writing of the availability of family planning services. Family planning services and supplies include covered medical, surgical, pharmacological and laboratory benefits specified below. Covered services also include the provision of accurate information and counseling to allow members to make informed decisions about the specific family planning methods available.

Family planning services and supplies for members eligible to receive full health care coverage and members eligible to receive family planning extension services may receive the following medical, surgical, pharmacological, and laboratory services:

1. Contraceptive counseling, medication, and/or supplies, including, but not limited to: oral and injectable contraceptives, long-acting reversible contraceptives (LARCs/IPLARCs), intrauterine devices, diaphragms, condoms, foams and suppositories. Prior to insertion of subcutaneous implantable contraceptives, the family planning provider must provide proper counseling to the eligible member to minimize the likelihood of a request for early removal. Counseling information is to include the statement to the member indicating if the device is removed within two years of insertion, the member may not be an appropriate candidate for reinsertion for at least one year after removal.

2. Associated medical and laboratory examinations including ultrasound studies related to family planning

3. Treatment of complications resulting from contraceptive use, including emergency treatment

4. Natural family planning education or referral to qualified health professionals,

5. Postcoital emergency oral contraception within 72 hours after unprotected sexual intercourse. Note: Mifepristone also know as Mifeprex or RU 486 is not postcoital emergency oral contraception, and

6. Sterilization services are covered for members regardless of gender when the requirements specified in Policy for sterilization services are met (including hysteroscopic tubal sterilizations).

The following are not covered for the purpose of family planning or family planning extension services:

1. Infertility services including diagnostic testing, treatment services or reversal of surgically induced infertility
2. Pregnancy termination counseling, or
3. Pregnancy terminations including the use of Mifepristone (Mifeprex or RU 486) and hysterectomies

Screening and treatment for Sexually Transmitted Infections (STI) are covered for all members regardless of gender.

HOME HEALTH

Home health care is a covered service when members require part-time or intermittent care but do not require hospital care under the daily direction of a physician. Twenty-four (24) hour care is not a covered service.

SECTION VI: Covered Services

HEARING

Hearing evaluation and treatment (hearing aids) are covered for members under age 21. Hearing evaluations are covered for member age 21 and older.

LABORATORY

Sonora Quest is contracted for all outpatient laboratory work for all lines of business, lab draws in the office must be sent to Sonora Quest for processing. Service locations are available at www.sonoraquest.com by clicking the patient service center locator tab. Web-based patient service center appointment scheduling is also available and offers members the ability to schedule an appointment for a convenient day and time, resulting in reduced wait time upon arrival at a patient service center. The web based scheduling system is available 24-hr a day. Walk-in appointments are still available during scheduled hours of operation as well, although appointments are encouraged.

MATERNITY CARE

SERVICES INCLUDED IN THE TOTAL OB PACKAGE

- OB Physical Exams
- Initial and subsequent history
- Weight and blood pressure
- Breast stimulation studies
- Genetic counseling (*excludes testing)
- Artificial rupture of membrane
- Follow up visits
- Fetal scalp monitoring
- Induction of labor
- Delivery (includes multiple births)
- 5+ prenatal visits & 1 post partum (pap smear included)
- Family planning services and supplies
- Laboratory services and handling fees by TOB provider Maternity counseling
- Nutritional Evaluation
- Inpatient & Observation services
- Wet preps and wet mounts
- External cephalic versions
- Risk Screening per ACOG Standards
- All Prenatal Visits
- WIC Referrals for Medically Eligible Members
- Prostaglandin Gel Insertion

SERVICES EXCLUDED FROM THE TOTAL OB PACKAGE & REIMBURSED SEPARATELY - Prior authorization may be required

• Amniocentesis • Amnioinfusion (requires prior authorization) • Colposcopy (CPT codes 56820-56821, 57420-57421, 57452, 57454-57456 and 57460-57461) • OB Ultrasound (3 or more 2D ultrasounds require prior authorization) • Non-Maternity related visits	• Post Delivery D&C (59160) • Post-partum Tubal Ligation (requires prior authorization) • RhoGAM Injection • Surgical Assist • Non-stress test • Lab Services not billed by TOB provider

HIGH RISK PRENATAL HOME CARE INFUSION

Please contact our Case Management Team at 602.778.1800 x8301 for assistance with high risk members.

MATERNITY CARE APPOINTMENT SCHEDULING

• First trimester	• Within 14 calendar days of request
• Second trimester	• Within 7 calendar days of request
• Third trimester	• Within 3 business days of request
• High risk pregnancies	• Within 3 business days of identification of high risk by the health plan or maternity care provider, or immediately if an emergency exists

Return appointments are scheduled per the ACOG standards indicated below:

- Monthly through 28 weeks
- Bi-weekly between 29 and 36 weeks
- Weekly after the 36th week

Post-partum services are to be provided per ACOG standards.

WELL WOMAN CARE

A well woman exam includes (as appropriate for age): pap smear, Chlamydia screening and referral for a mammogram. Bill with the appropriate preventive care codes. Women may self-refer to any contracted OB/GYN or be directly referred by their PCP.

OPTOMETRY/VISION

Covered services are available for members under age 21. Members may self refer to *Nationwide Vision*. Covered services per contract year (i.e. October 1st through September 30th) include:

• 1 exam
• 1 pair of prescription lenses or additional frames and glasses if medically necessary
• 1 repair of prescription lenses

ORTHOTICS AND PROSTHETICS

Orthotic and Prosthetic services are covered when medically indicated, costs less than other treatments that are as helpful for the condition and prescribed by a contracted provider for members under the age of 21.

Orthotic devices will be covered for adults, i.e. members over the age of 21, when the following apply:

a. The use of the orthotic is medically necessary as the preferred treatment option consistent with Medicare Guidelines.
b. The orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition.
c. The orthotic is ordered by a Physician or Primary Care Practitioner.

Medical equipment may be rented or purchased only if other sources, which provide the items at no cost, are not available. When prior authorization for an adult member is requested, plans are being required to obtain a completed Certificate of Medical Necessity to document medical necessity and that the criteria defined above is met.

Prosthetic services, except for microprocessor controlled lower limbs and microprocessor controlled joints for lower limbs, for adult member 21 years and older are a covered benefit.

PHARMACY

FORMULARY

The Care1st Preferred Drug List and Behavioral Health Drug List are available on our website at www.care1staz.com. The Formularies are updated quarterly and as needed following the AHCCCS P&T committee meeting. Updated Drug Lists can be viewed on our website at www.care1staz.com and formulary update notifications are sent to all in network providers via Blast Fax at least 30 days prior to changes. Providers may also contact Network Management for a copy. Please ensure that your office is prescribing medications listed on the current formularies. Before submitting a Prior Authorization Request for a non-formulary medication, consider all formulary alternatives. Prior authorization requests and supporting documentation must be submitted to Care1st for review for all medications that are not on the Care1st formulary or are listed on the formulary but required prior authorization.

Care1st utilizes the AHCCCS Drug List as mandated by AHCCCS AMPM Policy 310-V. Our website contains a link to the AHCCCS Drug List on the AHCCCS website.

1. AHCCCS developed the AHCCCS Drug List of the medications that are available to all members when medically necessary.
2. AHCCCS' goal is to use the AHCCCS Drug List to assist providers when selecting clinically appropriate medications for AHCCCS members.
3. The AHCCCS Drug List is not an all-inclusive list of medications.
4. The AHCCCS Drug List specifies medications available without prior authorization as well as medications that have specific quantity limits, or require step therapy and/or prior authorization prior to dispensing to AHCCCS members.
5. Health plans are required to cover all medically necessary, clinically appropriate, cost effective medications that are federally and state reimbursable.
6. Care1st's formularies are more expansive – they include the medications listed on the AHCCCS Drug List and additional drugs necessary to meet the needs of our specific patient population. The drugs fall into the following categories:
   - Preferred
   - Non Preferred
   - Step Therapy
   - Non Formulary
   - Excluded
   - Prior Authorization

The Prescription Benefit Manager manages all prescription drug transactions and pharmacy networks for all lines of business.

SPECIALTY MEDICATIONS AND LIMITED SPECIALTY NETWORK:

Care1st has a Limited Specialty Network primarily for chronic conditions that require Specialty Medications dispensed through the pharmacy benefit. The Limited Specialty Network was developed with 3 key areas of focus:

- Specialty Pharmacy Certification
- Documented and proactive adherence management to minimize gaps and identify barriers to care AND
- Drug therapy management programs to promote cost effective drug management

The current pharmacies included in our Limited Specialty Network include:

AcariaHealth	Multiple Locations Nationwide	1-800-511-5144
CVS Caremark Specialty Pharmacy	Multiple Locations Nationwide	1800-237-2767 OR 1-866-387-2573

Prior Authorization Process

- Complete the Pharmacy Prior Authorization Request available at the Care1st website (www.care1staz.com) and fax it to us at 602.778.8387 OR

- Submit an Electronic Prior Authorization (ePA): through COVER MY MEDS. The landing page is located at https://www.covermymeds.com/main/prior-authorization-forms/

Prior Authorization Process for Medical Benefit Drugs

Please review the Prior Authorization Guidelines for J and Q codes that require prior authorization. In addition, all unclassified drugs (i.e. J3490, J9999) require prior authorization. Requests for provider-administered drugs through the Medical benefit may be submitted:

- Via our Secure Provider Portal
- Via fax using the appropriate Prior Authorization request form

Contact the Pharmacy Prior Authorization department at 866-560-4042 (Options 5, 5) if you have any questions.

PODIATRY

The following medically necessary podiatric services are covered for members:

- Casting for the purpose of construction or accommodating orthotics
- Orthopedic shoes that are an integral part of a brace
- Foot care for patients with severe systemic disease which prohibits care by a nonprofessional person
- Bunions with underlying neuroma

Non-covered services include:

- Treatment of fungal (mycotic) infections without underlying systemic disease
- Painful bunions without laceration

RADIOLOGY

Radiology services required in the course of diagnosis, prevention, treatment and assessment are covered services.

REHABILITATION

OCCUPATIONAL THERAPY

Occupational therapy services are medically prescribed treatments to improve or restore functions which have been impaired by illness or injury, or which have been permanently lost or reduced by illness or injury. Occupational therapy is intended to improve the member's ability to perform those tasks required for independent functioning.

Amount, Duration and Scope: Care1st covers medically necessary inpatient and outpatient occupational therapy services for all members. Outpatient occupational therapy visits are limited to 15 rehabilitation visits and 15 habilitation visits for a total of 30 OT visits per contract year (October 1 – September 30) for adult members 21 years and older. Append modifier GO to the billing code for OT services.

Inpatient occupational therapy consists of evaluation and therapy. Therapy services may include:

a. Cognitive training
b. Exercise modalities
c. Hand dexterity
d. Hydrotherapy
e. Joint protection
f. Manual exercise
g. Measuring, fabrication or training in use of prosthesis, arthrosis, assistive device, or splint
h. Perceptual motor testing and training
i. Reality orientation
j. Restoration of activities of daily living
k. Sensory re-education, and
l. Work simplification and/or energy conservation

PHYSICAL THERAPY

Physical therapy is a covered service when provided by, or under the supervision of, a registered physical therapist to restore, maintain or improve muscle tone, joint mobility or physical function.

Amount, Duration and Scope: Care1st covers medically necessary physical therapy services for all members. Physical therapy is covered on an inpatient and outpatient basis. Outpatient physical therapy visits are limited to 15 visits for the purpose of rehabilitation to restore a level of function and 15 visits for the purpose of keeping or getting to a level of function per contract year (10/1-9/30) for adult members 21 years and older.

SPEECH THERAPY

Speech therapy is the medically prescribed provision of diagnostic and treatment services provided by, or under, the direct supervision of a qualified speech pathologist.

Amount, Duration and Scope: Care1st covers medically necessary speech therapy services provided to all members who are receiving inpatient care at a hospital (or a nursing facility) when services are ordered by the member's PCP. Speech therapy provided on an outpatient basis is covered only for members under the age of 21 receiving EPSDT services, KidsCare and ALTCS members.

Inpatient speech therapy consists of evaluation and therapy. Therapy services may include:

a. Articulation training

b. Auditory training
c. Cognitive training
d. Esophageal speech training
e. Fluency training
f. Language treatment
g. Lip reading
h. Non-oral language training
i. Oral-motor development, and
j. Swallowing training

TRANSPORTATION

Medically necessary transportation to and from contracted providers is a covered service for members who are not able to arrange or pay for transportation. Members are responsible for contacting Customer Service to arrange transportation 3 days prior to a routine appointment.

TELEHEALTH

Care1st covers medically necessary, non-experimental, and cost effective Telehealth services provided by AHCCCS register providers. Telehealth is healthcare services delivered via asynchronous (store and forward), remote patient monitoring, Teledentistry, or telemedicine (interactive audio and video).

There are no geographic restrictions for Telehealth, as these services can be provided within rural or urban regions. Care1st promotes the use of Telehealth to support an adequate provider network.

ASYNCHRONOUS (Store and forward)

Asynchronous is defined as transmission of recorded health history (e.g. pre-recorded videos, digital data, or digital images, such as x-rays and photos) through a secure electronic communications system between a practitioner, usually a specialist, and a member or other practitioner, in order to evaluate the case or to render consultative and/or therapeutic services outside of a synchronous (real-time) interaction.

Asynchronous care allows practitioners to assess, evaluate, consult, or treat conditions using secure digital transmission services, data storage services and software solutions.

Asynchronous does not require real-time interaction with the member. Reimbursement for this type of consultation is limited to:

- Allergy/Immunology
- Cardiology;

- Dermatology;
- Infectious diseases;
- Neurology;
- Ophthalmology;
- Pathology;
- Radiology;
- Behavioral Health

SYNCHRONOUS TELEMEDICINE AND REMOTE PATIENT MONITORING

The practice of synchronous (real-time) health care delivery, diagnosis, consultations, and treatment and the transfer of medical data through interactive audio and video communications that occur in the physical presence of the patient.

Synchronous (real-time) Telemedicine and Remove Patient Monitoring:

- Shall not replace provider choice for healthcare delivery modality
- Shall not replace member choice for healthcare delivery modality
- Shall not be AHCCCS-covered services that are medically necessary and cost effective

TELEDENTISTRY

Teledentistry is defined as the acquisition and transmission of all necessary subjective and objective diagnostic data through interactive audio, video or data communications by AHCCCS registered dental provider to a dentist at a distant site for triage, dental treatment planning, and referral.

Care1st covers Teledentistry for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) aged members when provided by an AHCCCS registered dental provider. Refer to AMPM Policy 431 for more information on Oral Health Care for EPSDT aged members including covered dental services.

Teledentistry includes the provision of preventative and other approved therapeutic services by the AHCCCS registered Affiliated Practice Dental Hygienist, who provides dental hygiene services under an affiliated practice relationship with a dentist. Refer to AMPM Policy 431 for information on Affiliated Practice Dental Hygienist.

Teledentistry does not replace the dental examination by the dentist, limited periodic and comprehensive examinations cannot be billed through the use of Teledentistry alone.

CONDITIONS, LIMITATIONS, EXCLUSIONS, AND OTHER INFORMATION

1. All Telehealth reimbursable services shall be provided by an AHCCCS registered provider.
2. Non-emergency transportation (NEMT) is a covered benefit for member transport to and from the Originating Site where applicable.
    a. An Originating Site is defined as a Location of the AHCCCS member at the time the service is being furnished via telehealth or where the asynchronous service originates.
3. Informed consent standards for Telehealth services should adhere to all applicable statutes and policies governing Telehealth, including A.R.S. §36-3602.
4. Confidentiality standards for Telehealth services should adhere to all applicable statutes and policies governing Telehealth.
5. There are no Place of Service (POS) restrictions for Distant Site.
    a. A Distant Site is defined as the site at which the provider is located at the time of the service is provided via telehealth.
6. The POS on the service claim is the Originating Site.

Refer to the AHCCCS coding webpage for coding requirements for Telehealth services, including applicable modifiers and Place of Service (POS)

TELEHEALTH COVID 19 TEMPORARY WAIVERS

Telehealth codes have been temporarily expanded to include telephonic codes. Please refer to the AHCCCS Frequently Asked Questions for expanded updated COVID 19 Telehealth and Delivery guidance.

NON-COVERED SERVICES

In response to significant fiscal challenges facing the State and continuing growth in the Medicaid population, AHCCCS implemented several changes to the adult benefit package. The changes to the benefit package impact ***all*** adults 21 years of age and older, unless otherwise specified.

Complete information regarding benefit changes can be found on the AHCCCS website: https://www.azahcccs.gov/Resources/Legislation/sessions/BenefitChanges.html

AHCCCS EXCLUDED BENEFITS TABLE FOR ADULTS 21 YEARS AND OLDER

Bone-Anchored Hearing Aids	AHCCCS will eliminate coverage of Bone-Anchored Hearing AID (BAHA). Supplies, equipment maintenance and repair of component parts will remain a covered benefit. Documentation that establishes the need to replace a component not operating effectively must be provided at the time prior authorization is sought.	L8690, L8692
Cochlear Implants	AHCCCS will eliminate coverage of cochlear implants. Supplies, equipment maintenance and repair of component parts will remain a covered benefit. Documentation that establishes the need to replace a component not operating effectively must be provided at the time prior authorization is sought.	L8614
Prosthetics	AHCCCS is limiting this benefit change to apply only to the elimination of microprocessor controlled lower limbs and microprocessor controlled joints for lower limbs.	L5856, L5857, L5858 and L5973

SECTION VII: Behavioral Health Services

OVERVIEW

Care1st will cover behavioral health services consistent with the information below. AHCCCS Covered Behavioral Health Services Guide has a complete list of covered services.

AVAILABLE BEHAVIORAL HEALTH SERVICES*

- Behavioral Health Counseling & Therapy (Individual, Group, Intensive Outpatient Programming, and Family*)
- Behavioral Health Screening, Mental Health Assessment and Specialized Testing
- Rehabilitation Services
  - Skills Training and Development
  - Cognitive Rehabilitation
  - Behavioral Health Prevention/Promotion Education
  - Psycho Educational Services and Ongoing Support to Maintain Employment
- Other Professional (Traditional Healing, Auricular Acupuncture**)
- Medical Services***
  - Medication Services
  - Lab, Radiology and Medical Imaging
  - Medication Management
  - Electro-Convulsive Therapy
- Support Services
  - Case Management
  - Behavior Coaching
  - Personal Care
  - Home Care Training (Family)
  - Self Help/Peer Services
  - Home Care Training to Home Care Client (HCTC)
  - Respite Care****
  - Supportive Housing *****
  - Sign Language or Oral Interpretive Services
  - Transportation
- Crisis Intervention Services
- Inpatient Services (Hospital & Behavioral Health Inpatient Facility)
- Residential Services
- Behavioral Health Day Programs (Supervised, Therapeutic, Medical)

*Intensive Outpatient Programming (IOP) consists of programming that occurs for 3 days a week with each session being a minimum of 3 hours in length. Service codes utilized include H0015 (Substance Use) and S9480 (Mental Health). IOP requires prior authorization.

** Services not available with TXIX/XXI funding, but may be provided based upon available grant funding and approved use of general funds.

***See the Care1st Drug List for further information on covered medications.

****No more than 600 hours of respite care per contract year. The 12 months will run from Oct 1 through September 30 of the next year.

*****Services may be available through federal block grants

SECTION VII: Behavioral Health Services

SYSTEM VALUES AND GUIDING PRINCIPLES

All healthcare services must be delivered in accordance with AHCCCS system values and adhere to the following vision and principles:

Children's System of Care

1. Arizona's Vision:
    - In collaboration with the child and family and others, Arizona will provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Services will be tailored to the child and family and provided in the most appropriate setting, in a timely fashion and in accordance with best practices, while respecting the child's family's cultural heritage.

2. Arizona's Twelve Principles:
    - Collaboration with the Child and Family- Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes. Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.
    - Functional outcomes – Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.
    - Collaboration with others – When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented. Client centered teams plan and deliver services. Each child's team includes the child and parents and any foster parents, any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including, as appropriate, the child's teacher, the child's Department of Child Safety representative and/or Division of Developmental Disabilities caseworker, and the child's probation officer. The team (a) develops a common assessment of the child's and family's strengths and needs, (b) develops an individualized service plan, (c) monitors implementation of the plan and (d) makes adjustments in the plan if it is not succeeding.
        - Accessible services – Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need. Plans identify transportation the parents and child need to access behavioral health services, and how transportation assistance will be provided. Behavioral health services are adapted or created when they are needed but not available.
        - Best practices – Competent individuals who are adequately trained and supervised provide behavioral health services. They are delivered in accordance with guidelines adopted by ADHS that incorporate evidence-based "best practice." Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children who

are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, and the need for stability and the need to promote permanency in class member's lives, especially class members in foster care. Behavioral Health Services are continuously evaluated and modified if ineffective in achieving desired outcomes.

- Most appropriate setting – Children are provided behavioral health services in their home and community to the extent possible. Behavioral health services are provided in the most integrated setting appropriate to the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's need.
- Timeliness – Children identified as needing behavioral health services are assessed and served promptly.
- Services tailored to the child and family – The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.
- Stability – Behavioral health service plans strive to minimize multiple placements. Service plans identify whether a member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk. Behavioral health service plans anticipate crises that might develop and include specific strategies and services that will be employed if a crisis develops. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and criminal justice system. Behavioral health service plans anticipate and appropriately plan for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services.
- Respect for the child and family's unique cultural heritage – Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.
- Independence – Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self-management. Behavioral health service plans identify parents' and children's need for training and support to participate as partners in the assessment process, and in the planning, delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with understanding written materials, will be made available.
- Connection to natural supports – The behavioral health system identifies and appropriately utilizes natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

SECTION VII: Behavioral Health Services

Adult System of Care

1. Provision of Person Centered Care – Services are provided that meets the member where they are without judgment, with great patience, and compassion.
2. Individualized Treatment and Choice - Persons in Mental health and/or Substance recovery choose services and are included in program decisions that are based on their individual and unique treatment needs.
3. Program Development Efforts - A person in recovery has choice and a voice. Their self-determination in driving services, program decisions and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the "informed consumer" and the broadest possible palette from which choice is made. Persons in recovery should be involved at every level of the system, from administration to service delivery.
4. Focus on Individual as a Whole Person - Every member is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual's social community.
5. Empower Individuals Taking Steps Towards Independence and Increased Autonomy - Members find independence through exploration, experimentation, evaluation, contemplation and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.
6. Integration, Collaboration, and Participation with the Community of One's Choice - Every member is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscores one's role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism is valued.
7. Partnership Between Individuals, Staff, and Family Members/Natural Supports for Shared Decision Making with a Foundation of Trust - Treatment decisions are made through a collaborative partnership with the member who is the driving force in their treatment. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expands understanding and empathy, and leads to the creation of optimum protocols and outcomes.
8. Strengths–Based, Flexible, Responsive Services Reflective of an Individual's Cultural Preferences - All members can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and mores. A person in recovery is the source of his/her own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life and in daily functioning.
9. Hope Is the Foundation for The Journey Towards Recovery - A person in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience and creates the environment for uncommon and unexpected positive outcomes to be made real. A person in recovery is held as boundless in potential and possibility.

SECTION VII: Behavioral Health Services

PHARMACY MANAGEMENT

Psychotropic Medication: Prescribing And Monitoring
Policies and procedures on the appropriate use of psychotropic medications have been developed based on AHCCCS guidance and minimum requirements. As stated in the Arizona Administrative Code R9-21-207 (C), our policies and procedures provide guidance on the appropriate use of psychotropic medications by:

- Promoting the safety of persons taking psychotropic medications;
- Reducing or preventing the occurrence of adverse side effects;
- Promoting positive clinical outcomes for behavioral health recipients who are taking psychotropic medications.
- Monitoring the use of psychotropic medications to foster safe and effective use; and
- By clarifying that medications will not be used for the convenience of the staff, in a punitive manner or as a substitute for other services and shall be given in the least amount medically necessary with particular emphasis placed on minimizing side effects which would otherwise interfere with aspects of treatment.

Visit our website at www.care1staz.com for additional information on the Minimum Laboratory Monitoring Requirements for Psychotropic Medications. Providers can also call Providers Services at 866-560-4042 to obtain a hard copy document.

Psychotropic medication will be prescribed by a licensed psychiatrist, psychiatric nurse practitioner, licensed physician assistant, or other physician trained or experienced in the use of psychotropic medication. The prescribing clinician must have seen the member and is familiar with the member's medical history or, in an emergency, is at least familiar with the member's medical history.

When a member 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 member'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 member'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 person's comprehensive clinical record and must be scheduled in a timely manner.

SECTION VII: Behavioral Health Services

Behavioral health medical professionals (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 person'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
- All current medications prescribed by the PCP and medical specialists and current over the counter (OTC) medications, including supplements currently being taken for the appropriateness of the combination of the medications;
- For sexually active females of childbearing age, a review of reproductive status (pregnancy)
- For post-partum females, a review of breastfeeding status
- Psychotropic medication monitoring parameters (heart rate, blood pressure, weight, BMI, labs, including serum levels, as indicated)
- A review of the recipient's profile in the Arizona State Board of Pharmacy Controlled Substance Prescription Monitoring Program (CSPMP) database when initiating a controlled substance (i.e. amphetamines, opiates, benzodiazepines, etc.) that will be used on a regular basis or for short term. Evaluate addition of such agents when the member is known to be receiving opioid pain medications or another controlled substance from a secondary prescriber.

Annual Assessments
Reassessments must ensure that the provider prescribing psychotropic medication notes in the member's record:

- The reason for the use of each medication and the effectiveness of that medication
- The appropriateness of the current dosages
- An updated medication list that includes all prescribed medications, dose and frequency prescribed by the PCP and medical specialists, OTC medications, and supplements being taken
- Any side effects such as weight gain and/or abnormal involuntary movements if treated with an anti-psychotic medication;
- Rationale for the use of two medications from the same pharmacological class
- Rationale for the use of more than three different psychotropic medications in adults, and
- Rationale for the use of more than one psychotropic medication in the child and adolescent population.

SECTION VII: Behavioral Health Services

Informed Consent
Informed consent must be obtained from the member and/or legal guardian for each psychotropic medication prescribed. When obtaining informed consent, the BHMP 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. Documentation must be completed on AMPM Policy 310-V, Attachment A, Informed Consent/Assent for Psychotropic Medication Treatment.

The comprehensive clinical record must include documentation of the essential elements for obtaining informed consent. 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.

For more information regarding informed consent, please see section on General and Informed Consent to Treatment and AHCCCS AMPM Policy 320-Q General and Informed Consent.

Prior Authorization Criteria for Behavioral Health Drugs
The Care1st Preferred Drug List and Behavioral Health Drug List available on our public website lists preferred drugs that have been reviewed and selected by the AHCCCS Pharmacy and Therapeutics (P&T) committee. Care1st Prior Authorization (PA) requirements are also based on AHCCCS recommendations. Care1st uses a combination of AHCCCS PA criteria and Health Plan PA criteria to review requests for medications that are not on the Care1st drug lists or are listed on the preferred drug lists but require PA. The AHCCCS Pharmacy and Therapeutics (P&T) committee and Health Plan P&T committee are responsible for developing, managing and updating the Pharmacy Prior authorization criteria. Care1st PA criteria is based on clinical appropriateness, scientific evidence, and standards of practice that include, but are not limited, to all of the following:

- Food and Drug Administration (FDA) approved indications and limits,
- Published practice guidelines and treatment protocols,
- Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes,
- Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmaco-economic studies, and
- Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-date)

All Antipsychotics and lithium prescriptions have to be prescribed by a licensed psychiatrist, psychiatric nurse practitioner, licensed physician assistant, or other physician trained in the use of psychotropic medications. Care1st maintains a list for Behavioral Health (BH) providers and claims will not adjudicate unless the provider is listed on the Care1st BH roster file. Providers prescribing antipsychotic drugs and Lithium still have to comply with PA requirements. Please

review the Care1st Preferred Drug List and Behavioral Health Drug List for additional information on medications and PA requirements. If you are a BH provider and needs to be added to the Care1st BH roster file contact your Provider Network Representative for assistance.

Quantity Limits

- Opioid prescriptions: For adults, limited to not more than a 5-day supply for initial fill. For minors, except in case of cancer, other chronic disease (see 310-V) or traumatic injury, all fills are limited to a 5-day supply or less days. See AHCCCS Policy 310-V for a list of diagnoses that are exempt from these opioid quantity limits for adults and minors. All opioids prescriptions are subject to a MME of < 90 MME (morphine milligram equivalents).

Arizona Opioid Epidemic Act

Care1st providers will adhere to the provisions and directives of the Arizona Opioid Epidemic Act. Provisions in the Arizona Opioid Epidemic Act include the following (which are effective as of April 26, 2018, unless otherwise specified):

- A five-day limit on the first fill of an opioid prescription (with some exceptions, including for infants being weaned off opioids at the time of hospital discharge).
- A dosage limit of less than 90 MME (morphine milligram equivalent) for new opioid prescriptions, with some exceptions.
- Regulatory oversight by the Arizona Department of Health Services on pain management clinics to ensure that opioid prescriptions are provided only when necessary and to prevent patients from receiving multiple prescriptions. This provision also includes enforcement mechanisms.
- A "Good Samaritan" law to encourage people to call 9-1-1 in an overdose situation.
- Three hours of education on the risks associated with opioids for all professions that prescribe them.
- A requirement that opioid prescriptions must be issued electronically.
- Medication Assisted Treatment
- Care1st will attempt to expand MAT access to 24 hours/seven days per week. Care1st's contracting efforts will include the 24/7 Opioid Treatment Providers in all its GSAs.
- Care1st will provisionally credential Mid-Level Practitioners, as outlined in AMPM 950, providing Medication Assisted Treatment at Opioid Treatment Programs approved by exemption as laid out in AMPM Policy 660 after its effective date of 10/1/18
- Care1st will comply with the decisions made by the AHCCCS Pharmacy and Therapeutics Committee regarding preferred agents for MAT available without prior authorization. Non-preferred agents are available with prior authorization.
- Care1st will educate providers on the use of Naloxone, promote its accessibility, and encourage co-prescribing in individuals taking 90MED or more daily.

- Expand Peer support services for individuals with Opioid Use Disorders (OUDs) for navigating individuals to Medication Assisted Treatment (MAT), and increasing participation and retention in MAT treatment and recovery supports.
- Care1st's contracting strategy includes Peer and Family Support Organizations in all its GSAs
- Care1st actively promotes collaboration between Emergency Department and Inpatient providers and Peer Support service providers to increase access to peer supports for our individuals with OUD.
- PCPs who treat individuals with OUD may provide Medication Assisted Treatment where appropriate within their scope of practice. PCPs prescribing medications to treat Opioid Use Disorder (OUD) must refer the individual to a behavioral health provider for the psychological and/or behavioral therapy component of the Medication Assisted Treatment (MAT) model and coordinate care with the behavioral health provider.
- The Individual Handbook will contain educational information on how to access behavioral health services.
- Care1st shall ensure through its' education and monitoring efforts with PCPs that regular screening takes place for substance use disorders and that individuals screening positive are appropriately referred for behavioral health services.

Guest Dosing

Care 1st ensures that guest dosing is consistent with Substance Abuse and Mental Health Services Administration's (SAMHSA's) guidance regarding medication safety and recovery support. An individual may be administered sufficient daily dosing from an Opioid Treatment Program (OTP) center other than their Home OTP Center when they are unable to travel to the Home OTP Center or when traveling outside of the home OTP center's area, for business, pleasure, or emergency. The member may receive guest dosing from another OTP center (Guest OTP Center) within their GSA, or outside their GSA. Guest dosing may also be approved outside the State of Arizona when the member's health would be endangered if travel were required back to the state of residence

A member may qualify for guest dosing when:

- The member is receiving administration of Medication Assisted Treatment (MAT) services from a SAMHSA-Certified Opioid Treatment Program (OTP)
- The member needs to travel outside their Home OTP Center area
- The member is not eligible for take home medication
- The Home OTP center (Sending OTP Center) and Guest OTP Center have agreed to transition the member to the Guest OTP center for a scheduled period of time.

When referring a member for services, the sending OTP center shall:
1) Forward information to the Receiving OTP Center prior to the member's arrival, Information shall include at a minimum:

a) A valid release of information signed by the patient,
b) Current medications,
c) Date and amount of last dose administered or dispensed,
d) Physician order for guest dosing, including first and last dates of guest dosing,
e) Description of clinical stability including recent alcohol or illicit drug abuse,
f) Any other pertinent information,
2) Provide a copy of the information to the member in a sealed, signed envelope for the member to present to the Receiving OTP Center,
3) Submit notification to the Contractor of enrollment of the guest dosing arrangement, and
4) Accept the member upon return from the Receiving OTP Center unless other arrangements have been made.

Upon receipt of the referral, the Guest OTP Center shall:
1) Respond to the Sending OTP Center in a timely fashion, verifying receipt of information and acceptance of the member for guest medication as quickly as possible,
2) Provide the same dosage that the patient is receiving at the member's Sending OTP Center, and change only after consultation with Sending OTP Center,
3) Bill the member's Contractor of enrollment for reimbursement utilizing the appropriate coding and modifier,
4) Provide address of Guest OTP Center and dispensing hours,
5) Determine appropriateness for dosing prior to administering a dose to the member. The Guest OTP Center has the right to deny medication to a patient if they present inebriated or under the influence, acting in a bizarre manner, threatening violence, loitering, or inappropriately interacting with patients,
6) Communicate any concerns about a guest-dosing the member to the Sending OTP Center including termination of guest-dosing if indicated, and
7) Communicate last dose date and amount back to the Sending OTP Center.

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, taking into account-individualized factors. At a minimum, these must include:
On initiation of any medication and at each BHMP evaluation and monitoring visit:

- Heart Rate
- Blood Pressure
- Weight

On initiation of any medication and at least every six months thereafter, or more frequently as clinically indicated:

- Body Mass Index (BMI)

On initiation of any medication affecting this parameter and at least annually thereafter or more frequently as clinically indicated:

- Fasting glucose
- Lipids
- Complete Blood Count (CBC)
- Liver function
- Lithium level, including with any significant change in dose
- Thyroid function, including within one month of initiation of lithium or a thyroid medication
- Renal function, including within one month of initiation of lithium
- Valproic acid or divalproex level, including with any significant change in dose
- Carbamazepine level, including with any significant change in dose

Abnormal Involuntary Movements (AIMS), including for members on any antipsychotic medication

Children are more vulnerable than adults with regard to developing a number of 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)

Type of Medication	Monitoring Action
Controlled Substances	Prescribers should check the Arizona Pharmacy Board's Controlled Substance Prescription Monitoring Program (CSPMP) when prescribing a controlled substance (i.e. amphetamines, opiates, benzodiazepines, etc.). Medical decision-making regarding the results should be documented in the medical record. Health Plans may consider members for single pharmacy and/ or provider locks. Send requests for consideration to Care1st Pharmacy Department at 602-778-8387. The Health Plan also does monthly monitoring for poly-pharmacy and poly-prescribers. Please see AMPM 310-FF for the specifics of this program. • Opioid prescriptions: For adults, limited to a 5 day supply or less for initial fill. For minors, except in case of cancer, other chronic disease (See AMPM 310-V for a list of exempt diagnoses) or traumatic injury, all fills are limited to 5 days or less. See AHCCCS Policy 310-V for a list of diagnoses that are exempt from these opioid quantity limits for adults and minors.
Opiate dependence medications	It is not necessary that a behavioral health medical practitioner must always perform a psychiatric assessment on a member who is being referred to an Opiate Maintenance program prior

	to that referral, as the Opiate Maintenance Program medical practitioner is the treating physician who will make the determination as to the appropriateness of opiate maintenance medications. Methadone and other opiate dependence medications, such as buprenorphine, are provided as per federal and licensure standards. When opiate dependence medications are discontinued, they are tapered in a safe manner in order to minimize the risks of relapse and physiologic jeopardy.
Transition of medications when person loses medication benefit	Providers ensure that members who need to be dis-enrolled or who lose their Care1st medication benefit while receiving psychotropic medications, including methadone, are monitored by an appropriate medical professional who gradually and safely decreases the medication, or continues to prescribe the medication until an alternate provider has assumed responsibility for the member.
Medications during transitions between ACC, RBHAs, agencies or prescribers	It is the responsibility of the member's current prescriber, including the PCP, to ensure that persons transitioning have adequate supplies of medications to last until the appointment with the next prescriber. It is the responsibility of the provider assuming the person's care to ensure that the person is scheduled with an appointment within clinically appropriate time frames such that the person does not run out of medications, does not experience a decline in functioning and in no case longer than 30 days from identification of need.

CRISIS INTERVENTION SERVICES

Crisis intervention services are provided to a member for the purpose of stabilizing or preventing any sudden, unanticipated, or potentially dangerous behavioral health condition, episode or behavior. Crisis intervention services are delivered 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 (i.e. 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 stabilizations, and/or therapeutic and supportive services to prevent, reduce, or eliminate a crisis situation.

In the event crisis intervention services are needed this is provided through the local county crisis line:

- Maricopa
  1-800-631-1314 or 1-800-327-9254 (TTY)

- Pima and Pinal
  1-866-495-6735 or 1-877-613-2076 (TTY)
- Apache, Coconino, Gila, Mohave, Navajo and Yavapai
  1-877-756-4090 or 1-800-327-9254 (TTY)
- Gila River and Ak-chin Indian Community
  1-800-259-3449
- Salt River Pima Maricopa Indian Community
  1-855-331-6432

REFERRAL PROCESS

A referral may be made directly by the member, Health Care Decision Maker, a Contractor, Primary Care Provider (PCP) or other provider within their scope of practice, hospital, treat and refer provider, jail, court, probation or parole officer, tribal government, Indian Health Services, school or other governmental or community agency; and for members in the legal custody of the Department of Child Safety (DCS) and/or in out-of-home placement as specified in A.R.S. §8-512.01 and ACOM Policy 449.

Accepting Referrals
Providers are required to accept referrals for behavioral health services 24 hours a day, 7 days a week. The processing of referrals will not be delayed to missing or incomplete information. An acknowledgement of receipt of a referral will be provided to the referring entity within 72 hour from the date it was received.

Sufficient information is collected through the referral to:

- Assess the urgency of the member's needs,
- Track and document the disposition of referral to ensure subsequent initiation of services. BH provider will comply with timeliness standards as specified in ACOM Policy 417,
- Ensure members who have difficulty communicating due to a disability, or who require language services, are afforded appropriate accommodations to assist them in fully expressing their needs.

Information or documents collected in the referral process are kept confidential and protected in accordance with applicable federal and state statutes, regulations, and policies.

Providers offer a range of appointment availability and flexible scheduling options based upon the needs of the member.

Member's and referrals sources may contact Care1st Customer Service line at 602.778.1800 or 1.866.560.4042 for additional assistance.

SECTION VII: Behavioral Health Services

Referrals for Members Admitted to a Hospital
Referrals involving members admitted to a hospital for psychiatric reasons are to be responded to as outlined below:

1. For referrals involving an individual not currently receiving behavioral health services, the Behavioral Health Provider will attempt to conduct a face-to-face intake evaluation with the member within 24 hours of referral, but will ensure the evaluation occurs prior to discharge from the hospital.
2. For members already receiving behavioral health services, the Behavioral Health Provider will ensure coordination, transition, and discharge planning activities are completed in a timely manner as outlined in AMPM Policy 1020.

PCP Referral to Behavioral Health Services
A PCP is able to refer a member to behavioral health services in a variety of ways. These include:

1. Referring to an Outpatient Clinic Provider (PT 77) for specific services (i.e. peer support, counseling, etc.) as an intake/assessment and treatment plan must be completed indicating the service(s) to be provided are medically necessary.
2. Contacting the provider service line at 602.778.1800 or 1.866.560.4042.
3. Referring to the provider directory: www.care1staz.com>Providers>Our Network
4. Contacting the Member Services Monday-Friday 8 a.m.-5 p.m. at 602.778.1800
5. Submitting a referral to Care Management by using the Care1st Care Management Referral Form, which can be found at https://care1staz.com/az/providers/frequentlyusedforms.asp
6. Establishing a collaborative relationship with neighboring contracted behavioral health providers

PCP/Member Self-Referral to Behavioral Health Specialty Providers
A PCP/member may refer directly to a specialty provider for behavioral health services. Examples of specialty providers include, but are not limited to, the following: Community Service Agencies (CSAs), Peer Run and Family Run Organizations, Meet Me Where I Am (MMWIA) Providers, or Employment Network Providers (i.e. Wedco. Beacon Group, Focus Employment Services).

An intake/assessment and treatment plan must be completed indicating the service(s) to be provided are medically necessary. Specialty providers may engage in assessment and service/treatment planning activities to support timely access to medically necessary behavioral health services. Specialty providers will provide documentation to the Behavioral Health provider for inclusion in the member's comprehensive Behavioral Health clinical record.

Referral to A Provider For A Second Opinion
Title XIX/XXI health care members are entitled to a second opinion. Upon a Title XIX/XI eligible healthcare member's request or at the request of the treating physician, Care1st must provide for

a second opinion from a healthcare professional within the network, or arrange for the healthcare member to obtain one outside the network when an in-network provider is not available, at no cost to the member.

Eligibility Verification and Screening

Behavioral health providers are required to assist members with applying of Arizona Public Programs (Title XIX/XXI, Medicare Savings Programs, Nutrition Assistance, and Cash Assistance), and Medicare Prescription Drug Program (Medicare Part D), including the Medicare Part D "Extra Help with Medicare Prescription Drug Plan Costs" low income subsidy program, as well as verification of U.S. citizenship/lawful presence prior to receive Non-Title XIX/XXI covered behavioral health services, at the time of intake for behavioral health services.

Eligibility status is essential for identification of the types of behavioral health services an individual may be able to access.

For individuals who are not currently Title XIX/XXI eligible, a financial and eligibility screening and application will be completed to determine eligibility. Verification of an individual's identification and citizenship/lawful presence in the United States is completed through the AHCCCS Health-e-Arizona Plus (HEAPlus) application process. Behavioral health Providers are required to assist individuals in completing this screening and verification process.

An individual who is not eligible for Title XIX/XXI covered services may still be eligible for Non-Title XIX/XXI services including services through the Substance Abuse Block Grant (SABG), the Mental Health Block Grant (MHBG), or the Projects for Assistance in Transition from Homelessness (PATH) Program. See AMPM Policy 320-T regarding non-discretionary federal grants and the delivery of behavioral health services. An individual may also be covered under another health insurance plan, including Medicare.

If the individual is in need of emergency services, the individual may begin to receive services immediately provided that within five days from the date of service a financial screening is initiated.

Individuals presenting for and receiving crisis services are not required to provide documentation of Title XIX/XXI eligibility nor are they required to verify U.S. citizenship/lawful presence prior to or in order to receive crisis services.

Title XIX/XXI Eligibility Verification and Screening/Application Process

Verification of an individual's current Title XIX/XXI eligibility status. The following verification processes are available 24 hours a day, 7 days a week:

a) AHCCCS web-based verification (Customer Support 602-417-4451)
b) Interactive Voice Response (IVR) system
c) Medifax

d) If an individual's Title XIX/XXI eligibility status cannot be determined using one of the above methods, the provider will:
    a. Call Care1st for assistance during normal business hours or
    b. Call the AHCCCS Verification Unit, which is open Monday through Friday, from 8:00-5:00 p.m.

Interpret eligibility information.

a) A provider can access the AHCCCS Codes and Values (CV) 13 Reference System when using the eligibility verification methods described above. This includes a key code index that may be used to interpret AHCCCS' eligibility key codes and/or AHCCCS rate codes,
b) For information on the eligibility key codes and AHCCCS rate codes refer to the AHCCCS Reference Subsystem Codes and Values on the AHCCCS website, and
c) If Title XIX/XXI eligibility status and provider responsibility is confirmed, the provider shall provide any needed covered behavioral health services in accordance with AMPM.

For individuals that are not identified as Title XIX/XXI eligible, providers are to assist individuals with the AHCCCS screening/application process for Title XIX/XXI or other Public Program eligibility through HEAPlus at the following times:

a) Upon initial request for behavioral health services
b) At least annually, if still receiving behavioral health services, and
c) When significant changes occur in the individual's financial status.

To conduct the AHCCCS screening/application for Title XIX/XXI or other Public Program eligibility through HEAPlus, behavioral health providers will meet with the individual and complete the AHCCCS HEAPlus online application. Once completed, HEAPlus will indicate if the individual is potentially Title XXI/XXI eligible.

a) To the extent that it is practicable, the provider is expected to assist applicants in obtaining the required documentation of identification and U.S. citizenship/lawful presence within the timeframes indicated by HEAPlus,
b) For information regarding what documents are required in order to verify proof of U.S. citizenship/lawful presence refer to Arizona's Eligibility Policy Manual for medical, Nutrition, and Case Assistance Manual Chapter 500, Policy 507 and Policy 524
c) Documentation of Title XIX/XXI and other Public Program eligibility screening/application will be included in the individual's medical record including the Application Summary and final Determination of eligibility status notification printed from HEAPlus,
d) Pending the outcome of the Title XIX/XXI or other Public Program screening/application, if the individual is determined ineligible for Title XIX/XXI or other Public Program benefits,
e) Upon the final processing of a Title XIX/XXI and other Public Program screening/application, if the individual is determined ineligible for Title XIX/XXI or other Public Program benefits, regardless of verification of US Citizenship/Lawful

Presence, the individual is eligible for covered Non-Title XIX/XXI services in accordance with AMPM 320-T.

f) An individual found not to be eligible for Title XIX/XXI or other Public Program benefits may submit the application for review by AHCCCS and/or DES. Additional information requested and verified by AHCCCS and/or DES may result in the individual subsequently receiving Title XIX/SSI or other Public Program.

PCP SCREENING

1. PCPs are to use validated screening instruments to screen adults and children related behavioral health needs, social determinants of health and trauma.
2. Providers have access to the screening tools above and other tools via links on the Care1st website: https://www.care1staz.com/az/providers/preventivehealth.asp.
3. The medical record will reflect screening results and timely referral to a behavioral health provider if needed. A PCP must provide three culturally and linguistically appropriate behavioral health provider referrals.
4. If the PCP practice uses an integrated services healthcare delivery model, with onsite behavioral health professionals, an in-house referral and intake and assessment session is expected to occur within 7 days for routine situations, and immediately for urgent situations. Based upon the behavioral health assessment, the behavioral health professional will determine if an individual's behavioral health needs can be addressed within the integrated care provider, or if the individual requires more extensive or specialized services beyond the scope of the integrated care provider practice (e.g. longer term psychotherapy, neuropsychological testing).
5. If the PCP does not have onsite behavioral health professionals, or if the integrated behavioral health provider's assessment determines that the member requires specialized service beyond the scope of the services provided at the integrated care practice, then the PCP is expected to provide at least three culturally and linguistically appropriate behavioral health provider referrals, connect the member with the member's chosen behavioral health provider, and track the member's subsequent appointment with that provider.
6. For PCPs prescribing medications to treat Substance Use Disorders (SUDs), the PCP must refer the member to a behavioral health provider for the psychological and/or behavioral therapy component of the Medication Assisted Treatment (MAT) model and coordinate care with the behavioral health provider.

OUTREACH, ENGAGEMENT, REENGAGEMENT AND CLOSURE

The behavioral health system provides outreach activities to inform the public of the benefits and availability of behavioral health services and how to access them. Care1st disseminates 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 include, but are not limited to:

- Participation in local health fairs or health promotion activities;
- Involvement with local schools;
- Involvement with Outreach Activities for military veterans, such as Arizona Veterans Stand Down Coalition events,
- Development of Outreach program and activities for first responders (i.e. policy, fire, EMT),
- Development of Outreach programs to members experiencing homelessness;
- 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/county Arizona Department of Child Safety (DCS) offices and programs;
- Regular interaction with agencies that have contact with pregnant women/teenagers who have a substance use disorder;
- 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 Care1st geographic service areas, including members who reside in jails, homeless shelters, county detention facilities or other settings;
- Provision of information to behavioral health advocacy organizations, and
- Development and coordination of outreach programs to Native American tribes in Arizona to provide services for tribal members.

Engagement

Behavioral Health Providers actively engage the following in the treatment planning process by including the following:

- The member/Health Care Decision Maker (HCDM), Designated Representative (DR),
- The member's family / significant others, if applicable and amenable to the member;
- Other agencies/providers as applicable; and,
- The member/HCDM, and DR as applicable, advocate, or other individual designated to provide Special Assistance for members with a Serious Mental Illness who are receiving Special Assistance as specified in AMPM Policy 320-R.

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Providers engage incarcerated members with high incidence or prevalence of behavioral health issues, or who are underserved as specified in AMPM Policy 1022.

Re-Engagement
Re-engagement efforts will be made for 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 re-engage 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 re-engage the member by:

- Communicating in the member's preferred language;
- Contacting the member/HCDM, DR as applicable 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/HCDM, DR as applicable face-to-face, if telephone contact is insufficient to locate the member or determine acuity and risk; and
- Sending a letter to the current or most recent address requesting contact, if all attempts at personal contact are unsuccessful, except when a letter is contraindicated due to safety concerns (e.g., domestic violence) or confidentiality issues. The provider will note safety or confidentiality concerns in the progress notes section of the clinical record and include a copy of the letter sent in the comprehensive clinical record.

If the above activities are unsuccessful the providers will make further attempts to re-engage the following populations:

a. Members determined to have an SMI
b. Members on court ordered treatment,
c. Members known to have been recently released from incarceration,
d. Children, pregnant women, and/or teenagers with a substance abuse disorder, and
e. Any member determined to be at risk of relapse, increased symptomology, or deterioration,
f. Individuals with a potential for harm to self or others

Further attempts include at a minimum: contacting the member/HCDM, DR 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 must be clearly documented in the comprehensive clinical record.

If face-to-face contact with the member is successful and 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.

Follow-Up After Significant and/or Critical Events
Providers are to document in the clinical record any follow-up activities that are conducted to maintain engagement within the following timeframes:

- Discharged from inpatient services in accordance with the discharge plan and within 7 days of the members' release to ensure member stabilization, medication adherence, and to avoid re-hospitalization;
- Involved in a behavioral health crisis within timeframes based upon the person's clinical needs, but no later than 7 days;
- Refusing to adhere to prescribed psychotropic medication schedule, based upon the member's clinical needs and history, and
- When the member changes location or when a change in the member's level of care occurs

Ending an Episode of Care for Member's in Behavioral Health System

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

Clinical Factors
Treatment Completed:
A member's episode of care must end upon completion of treatment. A Non-Title XIX person would also be dis-enrolled at treatment completion. Prior to ending the episode of care or dis-enrolling a person 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 person would also be dis-enrolled from services.

Prior to ending the episode of care or dis-enrolling a member for declining further treatment, the behavioral health provider must ensure the following:

- All applicable and required re-engagement activities 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 for treatment process

Lack of Contact:

- A member's episode of care may be ended if Care1st or behavioral health provider is unable to locate or make contact with the person after ensuring that all applicable and required re-engagement activities 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 persons for non-payment of assessed co-payments, under the following conditions:

- The person is not eligible as a person determined to have a Serious Mental Illness (SMI)
- 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 person's comprehensive clinical record

Out-of-State Relocations:

- A member's episode of care must be ended for a person who relocates out-of-state after appropriate transition of care. A Non-Title XIX individual would also be disenrolled. 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 ACC or T/RBHA and requires ongoing behavioral health services must be closed from one ACC or T/RBHA and transferred to the new ACC or T/RBHA. Services must be transitioned.

Arizona Department of Corrections Confinements:

- A member age 18 or older must be disenrolled 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

- Children who become incarcerated should not automatically have their Episode of Care closed.

Inmates of public institutions:

- Members who become incarcerated should not automatically have their Episode of Care closed.

Deceased Persons:

- A member's episode of care must be ended following acknowledgement that the person is deceased, effective on the date of the death. The Non-Title XIX member would be disenrolled from the system.

Crisis Episodes:

- The behavioral health provider conducts all applicable and required re-engagement 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 member would be dis-enrolled from the system.
- For members who are enrolled as a result 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 re-engagement 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 member would be dis- enrolled from the system.

One-Time Consultations: For members who are in the system for the purpose of 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.

DUGless Data Reporting

For demographic elements with no identified alternative data source or Social Determinate identifier, AHCCCS has created an online portal (DUGless) to be accessed directly by providers for the collection of the remaining data elements for members.

Providers are required to submit demographic data directly to AHCCCS. Information on specific data elements is available at https://www.azahcccs.gov/PlansProviders/Demographics/. Data and information assist in monitoring and tracking of the following:

1. Access and utilization of services,
2. Community and stakeholder information
3. Compliance of Federal, State, and grant requirements,
4. Health disparities and inequities,
5. Member summaries and outcomes,
6. Quality and Medical Management activities, and
7. Social Determinants of Health

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 AHCCCS. Any questions

about the portal or the data fields in the portal should be submitted to DHCM/DAR Information Management/Data Analytics Unit Manager and Data Analysis and Research Manager. In addition, support can be obtained at ISDCustomerSupport@azahcccs.gov or 602-417-4451.

Serving Member's Previously Enrolled in the 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 person has been out of the behavioral health system.

For members not receiving services for less than 6 months:

- If the member has not received a behavioral health assessment in the past 6 months, 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 six months 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 six months) with the member, and if needed, coordinate the development of a revised service plan with the person's clinical team.
- If the member presents at a different ACC, T/RBHA or provider, obtain new general and informed consent to treatment.
- If the member presents at a different ACC, T/RBHA or provider, obtain new authorizations to disclose confidential information.
- Submit new demographic and enrollment data

For members not receiving services for 6 months or longer:

- Conduct a new intake, behavioral health assessment and service plan
- Obtain new general and informed consent to treatment
- Obtain new authorizations to disclose confidential information
- Submit new demographic and enrollment data

ASSESSMENT, SERVICE AND/OR TREATMENT PLANNING

Overview
Behavioral Health Assessments, Service, and/or Treatment Planning are conducted in compliance with Adult Behavioral Health Service Delivery System-Nine Guiding Principles, and the Arizona Vision and Twelve Principles for Children's Behavioral Health Service Delivery as specified in AMPM Policy 100, AMPM Chapter 200, AMPM 320-O, and A.A.C. Title 9, Chapters 10 and 21, as applicable.

1. General Requirements
   A. Assessments, Service, and Treatment Plans are conducted by an individual within their scope of practice (e.g. Behavioral Health Professionals (BHPs), Behavioral Health Technicians (BHTs) and under the appropriate oversight or supervision, as applicable

B. Incorporate the concept of a "team" established for each member receiving behavioral health service,
    a. The team is based on member/Health Care Decision Maker (HCDM) choice,
    b. The team does not require a minimum number of participants and can consist of whoever is identified by the member/HCDM,
C. Utilize Service Plan Rights Acknowledgement Template to indicate agreement or disagreement with the service plan and awareness of the right to appeal if not in agreement with the service plan.

2. The health home provider serves as the primary responsible entity for coordination of all primary, physical and/or behavioral health services and supports to deliver and/or arrange whole person care.
3. Behavioral health providers outside of the Health Home may complete assessment, service, and treatment planning to support timely access to medically necessary behavioral health services, as allowed under licensure (A.A.C. R9 et. Seq.) and specified in ACOM Policy 417.
    a) Should a behavioral health provider outside the Health Home complete any type of Behavioral Health Assessment, the behavioral health provider will communicate with the Health Home regarding assessment findings within 30 days of the first date of service. In situations when a specific assessment is duplicated, the results of such assessments will be discussed collaboratively to address clinical implications for treatment needs. Differences will be addressed within the CFT participation from both the Health Home and Behavioral Health Provider outside of the Health Home.
    b) Behavioral health providers will supply completed Assessment, Service, and Treatment Plan documentation to the health home for inclusion in the member's medical record.
4. The Assessment, Service, and Treatment Plan are included in the medical record in accordance with AMPM Policy 940,
5. Behavioral Health Assessments, service, and Treatment Plans are updated at minimum once annually or more often as needed based on clinical necessity and/or upon significant life events including but not limited to:

    i. Moving,
    ii. Death of a friend or family member,
    iii. Change in family structure (e.g. divorce, incarceration),
    iv. Hospitalization,
    v. Major illness of individual or family member,
    vi. Incarceration, and
    vii. Any event which may cause a disruption of normal life activities.
6. The Health home is responsible for maintaining the Treatment and Service Plan updates to meet the changing behavioral health needs for members.

SECTION VII: Behavioral Health Services

Behavioral Health Assessments

1. Comprehensive Assessments
    a. Individuals receiving behavioral health services receive a comprehensive behavioral health assessment. The assessment conducted is in compliant with the Rules set forth in A.A.C. Title 9, Chapters 10 and 21, and/or ACOM Policy 417, as applicable
    b. The health home is responsible for maintaining the comprehensive behavioral health assessment within the medical record, and for ensuring periodic assessment updates are completed to meet the changing behavioral health needs for individuals who continue to receive behavioral health services.
        i. An assessment will include an evaluation of the member's:
            1. Presenting concerns,
            2. Information on the strengths and needs of the member and his/her/their family,
            3. Behavioral health treatment
            4. Medical conditions and treatment
            5. Sexual behavior and, if applicable, sexual abuse
            6. Substance abuse, if applicable,
            7. Living environment
            8. Educational and vocational training
            9. Employment
            10. Interpersonal, social, and cultural skills
            11. Development history
            12. Criminal justice history,
            13. Public (e.g. unemployment, food stamps, etc.) and private resources (e.g. faith-based, natural supports, etc.)
            14. Legal status (e.g. presence or absence of a legal guardian) and apparent capacity (e.g. ability to make decisions or complete daily living activities)
            15. Need for special assistance, and
            16. Language and communication capabilities
        ii. Additional components of the assessment include:
            1. Risk assessment of the member
            2. Mental status examination of the member
            3. A summary of impressions, and observations,
            4. Recommendations for next steps
            5. Diagnostic impressions of the qualified clinician
            6. Identification of the need for further or specialty evaluations, and
            7. Other information determined to be relevant.
    c. In situations when a specific assessment is duplicated (e.g. developmental assessment, CALOCUS), the results of such assessments are discussed collaboratively with any other provider that may have completed an assessment, to address clinical indications for treatment needs. Differences are addressed

within the "team" with participation from both the health home and behavioral health provider outside of the health home.

2. Additional Assessments
    a. Children ages 0 through five: Developmental screening shall be conducted for children age 0-5 with a referral for further evaluation when developmental concerns are identified. Information on standardized assessments is available within AMPM Behavioral Health Practice Tool (BHPT) 210
    b. Children Age 6 through 17 – an age appropriate assessment will be completed by the Health Home during the initial assessment and updated at every six months,
    c. Children Age 6 through 17 – Strengths, Needs and Culture Discovery Document will be completed as deemed appropriate by the Health Home
    d. Children Age 11 through 17 - Standardized tool is used to evaluate for potential substance use
        i. In the event of positive results, the information is shared with the providers involved in the child's care and may be shared only if the member has authorized sharing of protected health information.
    e. Individuals ages 18 and up: A standardized tool, ASAM will be used to evaluate for potential substance use.
        i. In the event of positive results, the information is shared with the providers involved with the member's care and may be shared only if the member has authorized sharing of protected health information.

Service and/or Treatment Planning

Service planning encompasses a description of all covered health services that are deemed as medically necessary and based on member voice and choice. The service plan has a uniform, single plan that is developed and administered by the health home, FFS provider or the ALTCS Case Manager, and includes all treatment plans and additional relevant documents from other service providers or entities involved in the members' care (i.e., education, probation, etc.).

Treatment planning may occur within or outside of the health home based on the member's identified need. A member may have multiple treatment plans based on various clinical needs.

1. The service and/or treatment plan is based on a current assessment and/or specific treatment need (e.g., out of home services, specialized behavioral health treatment for substance use).

2. The service or treatment plan identifies the services and supports to be provided, according to the covered, medically necessary services specified in AMPM Policy 310-B.

3. Providers make available and offer the option of having a Family Support Specialist and/or Peer Recovery specialist to provide covered services when appropriate, as well as for the purpose of navigating members to treatment or increasing participation and retention in treatment and recovery support services.

4. The behavioral health provider documents whether or not the member, or when applicable, their HCDM, and/or Designated Representative (DR) agrees or disagrees with the service or

treatment plan and has indicated such agreement or disagreement by either a written or electronic signature on the service or treatment plan.

5. The health home coordinates with any entity involved in the member's care including, but not limited to Care1st, PCP(s), TRBHAs, case managers, DCS, probation as applicable, regarding Behavioral Health Assessments, Service, and Treatment Planning as specified in AMPM Policy 541.

Crisis and Safety Planning

General Purpose of a Crisis and Safety Plan

A Crisis and Safety Plan provides a written method for potential crisis support or intervention which identifies needs and preferences that are most helpful in the event of a crisis. The Crisis and Safety Plan will be developed in accordance with the Vision and Guiding Principles of the Children's System of Care and the Nine Guiding Principles of the Adult System of Care as specified in AMPM Policy 100. Crisis and Safety plans will be trauma informed, with a focus on safety and harm reduction.

The development of a Crisis and Safety Plan will be completed in alignment with the member's Service and Treatment Plan, and any existing Behavior plan if applicable. It will be considered, when clinically indicated. Clinical indicators may include, but are not limited to needs identified in members Treatment, Service, or Behavior plan in addition to any one or a combination of the following:

a) Justice Invovlement
b) Previous psychiatric hospitalizations
c) Out of home placements
    a. Home and Community Based Service (HCBS) settings (e.g. assisted living facility)
    b. Nursing facilities
    c. Group Home settings,
d) Special Health Care Needs,
e) Court Ordered Treatment,
f) History of DTS/DTO
g) Individuals with an SMI designation,
h) Individuals identified as High Risk/High Needs, and
i) Children ages 6-17 with a CALOCUS Level of 4, 5, or 6.

Crisis and Safety Plans are updated annually, or more frequently if a member meets one or a combination of the above criteria, or if there is a significant change in the member's needs. A copy of the Crisis and Safety Plan will be distributed to the team members that assisted with development of the Crisis and Safety Plan.

A Crisis and Safety Plan does not replace or supplant a Mental Health Power of Attorney or behavior plan, but rather serves as a compliment to these existing documents.

SECTION VII: Behavioral Health Services

Essential Elements
A Crisis and Safety Plan establishes goals to prevent or ameliorate the effects of a crisis and will specifically address:

a) Techniques for establishing safety, as identified by the member and/or healthcare decision maker, as well as members of the CFT or ART,
b) Identification of realistic interventions that are most helpful to the individual and his/her family members or support system,
c) Reduction of symptoms
d) Guiding the support system toward ways to be most helpful
e) Any physical limitations, comorbid conditions, or unique needs of the member (e.g. involvement with DCS or Special Assistance)
f) Necessary resources to reduce the change for a crisis or minimize the effects of an active crisis for the member. This may include, but is not limited to:
    i. Clinical (support staff/professionals), medication, family, friends, parent, guardian, environment
    ii. Notification to and/or coordinate with others, and
    iii. Assistance with and/or management of concerns outside of crisis (e.g. animal care, children, family members, room-mates, housing, financials, medical needs, school, work).

Psychotropic Medications
For members for or identified as needing ongoing psychotropic medications for a behavioral health condition, the assessor must establish an appointment with a licensed medical practitioner with prescribing privileges. If the assessor is unsure regarding a member's need for psychotropic medications, then the assessor must review the initial assessment and treatment recommendations with her/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. Care1st 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. Care1st 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.

Serving Member's Previously Enrolled in the 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 person has been out of the behavioral health system.

For members not receiving services for less than 6 months:

- If the member has not received a behavioral health assessment in the past 6 months, 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 six months 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 six months) with the member, and if needed, coordinate the development of a revised service plan with the person's clinical team.
- If the member presents at a different ACC, T/RBHA or provider, obtain new general and informed consent to treatment.

Required for Children Ages 6 through 17

Care1st requires its contracted providers to have policies and procedures in place to ensure that staff (i.e. case managers, clinicians, etc.) implement and administer the Child and Adolescent Level of Care Utilization System (CALOCUS) for all children receiving services between the ages of 6 through 17. All individuals administering the CALOCUS will complete initial training, which will be recorded in Relias, and will pass initial and ongoing fidelity monitoring.

The CALOCUS will be administered within the first 45 days of intake, at least every six months, and as significant changes occur in the life of the child. This may include but not limited to discharge from inpatient, behavioral health short-term residential treatment, or therapeutic foster care.

In addition to the CALOCUS (or other assessment) level of acuity and high-need determination for children ages six through 17 may be assessed through clinical evaluation as well as CALOCUS score. This evaluation and high need identification will also trigger an updated CALOCUS, as well as review of the current treatment/service plan.

CALOCUS assessments can be completed by any individual who has been trained to implement this assessment, and is practicing within their scope. Due to the potential for duplication of the CALOCUS assessment, treating behavioral health providers shall collaborate to ensure that differences in CALOCUS levels are addressed at the clinical level and through the CFT.

The following AHCCCS Behavioral Health Practice Tools shall be utilized:

1. Youth Involvement in the Children's Behavioral Health System,
2. Child and Family Team,
3. Children's Out of Home Services,
4. Family and Youth Involvement in the Children's Behavioral Health System,
5. Psychiatric Best Practice for Children Birth to Five Years of Age,
6. Support and Rehabilitation Services for Children, Adolescents, and Young Adults,
7. Transition to Adulthood, and
8. Working with the Birth to Five Population.

Required for Children Age 6 to 17 with CALOCUS Score of 4 or Higher

- Strength, Needs and Culture Discovery Document
- Referral to a High Needs Case Manager (HNCM)

High Needs Case Management (HNCM)

Children that are considered high needs are to be referred to a high needs case manager. The following options are offered when assigning an agency to provide high needs case management:

a. Option 1: The member's originally assigned provider offers high needs case management. In these situations, the family may be offered to receive high needs case management and other needed services through a single provider agency. In these circumstances, the provider serves as the designated health home for that child.
b. Option 2: The originally assigned provider does not offer high needs case management necessitating an external referral to another provider agency to access high needs case management services. In this situation the family has two additional options:
    i. Responsibility for all services can be transferred to the high needs case management provider agency and this provider will become the member's designated health home. This option is ideal as it streamlines the coordination of care and medical record documentation under one entity; OR
    ii. The child and family can choose to remain with the originally assigned provider (i.e. maintain established relationship, better alignment with family preferences or needs) and only receive high needs case management from the high needs case management provider agency. In these circumstances, the originally assigned provider shall function as the member's designated health home. Providers are responsible for ensuring timely and efficient care coordination between all involved provider agencies. This may include referral expectations and allowable exceptions based on family preference.

Behavioral Health Providers are to ensure that caseload ratios are within the indicated parameters and will notify the RBHA and/or Care1st when barriers exist to meeting the establishment requirements. Caseloads are submitted to the RBHA and/or Care1st (for those agencies not contracted with the RBHAs) on a monthly basis. The RBHAs then share this information with Care1st and the other AHCCCS Complete Care Contractors. Collectively these are monitored for compliance. When an issue of noncompliance has occurred the RBHA and Care1st partner together to develop and address the need for a corrective action plan.

HNCM caseload requirements are as follows:

- For a full FTE (1.0), have a caseload ratio of high needs children not less than 1:8 and not more than 1:25, with 1:15 being the desired target. The caseload cap is 25 to allow for continuity of care for children who have been receiving high needs case management, but are not ready to begin transition from that level of care and for high needs case management siblings, and

- Provide case management and other support and rehabilitation services to their assigned members.

Transition Age Youth

Providers are expected to follow the AHCCCS Behavioral Health Guidance Tool: Transition to Adulthood Practice Tool. The transition from child to adult services will include at minimum the following:

1. A coordination plan between child providers and the anticipated adult providers.
2. A process that begins no later than when the child reaches the age of 16.
3. A transition plan for the member that focuses on assisting the member with gaining the necessary skills and knowledge to become a self-sufficient adult and facilitates a seamless transition from child services to adult services.
4. Based on clinical presentation, an SMI eligibility determination is completed when the adolescent reaches the age of seventeen, but no later than age 17 and 6 months.
5. Any additional stakeholder, behavioral and physical healthcare entity involved with the child will be included in the transition process, as applicable (e.g. DDD, juvenile justice, CMDP, education system).
6. A coordination plan to meet the unique needs for Members with Special Health Care Needs, including members with CRS designation.

In addition, providers delivering care to Transition Age Youth will provide and/or refer members to child providers who utilize the Transition to Independence (TIP) model of care into their service delivery.

Providers are encouraged to utilize identified First Episode Psychosis (FEP) centers, which have implemented evidence-based practices and track outcomes for children with specialized healthcare needs such as Transition Aged Youth: FEP Programs. Providers will coordinate with FEP Centers through Child & Family Team or Adult Recovery Team process.

When appropriate for members, who are uninsured or underinsured and have been determined to have an FEP, behavioral health providers will refer and assist in coordinating care to MHBG providers. The MHBG is allocated from the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide mental health treatment services to adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED). Each Regional Behavioral Health Authority receives funding as a pass through grant to ensure access to covered behavioral health services.

Funding targets the following populations:

- Adults (18 and older) with a serious mental illness (SMI)
- Children (17 and under) with a serious emotional disturbance (SED)
- Individuals experiencing a Frist Episode of Psychosis (FEP)

SECTION VII: Behavioral Health Services

Providers will have an established process for ensuring that staff that provide service delivery to adolescents, young adults and their families have been trained and understand how to implement the practice elements outlined in Care1st Policy 550: Transition Age Youth as well as AHCCCS: Transition to Adulthood Practice Tool. Verification of training completion must be documented in Relias.

Case Management Services for Members determined to be SMI
Behavioral Health Providers are to ensure that caseload ratios and contact requirements are within the indicated parameters as outlined in AMPM Policy 570 and Attachment A Case Management Caseload Ratios and Review Cycle and will notify the RBHA and/or Care1st when barriers exist to meeting the established requirements. Caseloads are submitted to the RBHA and/or Care1st through a quarterly case management inventory deliverable. These deliverables are monitored for compliance and when an issue of noncompliance has occurred the RBHA and contracted provider will work together to develop and address the need for a corrective action plan.

Caseload requirements are as follows:

- SMI Assertive Caseload is 12:1
- SMI Supportive Caseload is 30:1
- SMI Connective Caseload is 70:1

ASSERTIVE COMMUNITY TREATMENT SERVICES

Service Requirements

Providers delivering ACT Team services may be required to establish ACT teams that comply with the requirements outlined in the SAMHSA Assertive Community Treatment (ACT) Evidence-Based Practices Kit, https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345, in communities approved by the Health Plan. Compliance expectations will be based on geographic service needs and available resources.

Fidelity Standards

Providers delivering ACT Team services shall participate in SAMSHA EBP fidelity audits coordinated with the Health Plan on an annual basis at minimum.

Reporting Requirements

Providers shall submit all documents, reports and data in the format prescribed by the Health Plan and within the time frames specified. Provider is required to submit any additional documents and/or ad hoc reports as requested by the Health Plan.

Other Requirements

ACT Team providers must participate in all trainings and meetings required or requested by AHCCCS and/or The Health Plan. ACT Team providers must coordinate for continuity of care between provider, member's Behavioral Health Home, community stakeholders, and other Specialty Providers (both physical and behavioral health) involved with the member.

COORDINATION OF CARE WITH OTHER GOVERNMENTAL AGENCIES

Arizona Department of Child Safety (DCS)

When a child receiving behavioral health services is also receiving services from DCS, the provider must work towards effective coordination of services with the DCS Specialist. Providers are expected to:

- Coordinate the development of the Service Plan with the DCS case plan to avoid redundancies and/or inconsistencies.
- Provide the DCS with preliminary findings and recommendations on behavioral health risk factors, symptoms and service needs for court hearings.
- Perform an assessment and identify behavioral health needs of the child, the child's parents and family and provide necessary behavioral health services, including support services to temporary caretakers.
- As appropriate, engage the child's parents, family, caregivers, and DCS Specialist in the behavioral health assessment and service planning process as members of the Child and Family Team (CFT).
- Attend team meetings such as Team Decision Meetings (TDM) for the purpose of providing input about the child and family's behavioral health needs. When it is possible, TDM and CFT meetings should be combined.
- Coordinate necessary services to stabilize in-home and out-of-home placements provided by DCS.
- Coordinate provision of behavioral health services in support of family reunification and/or other permanency plans identified in DCS.
- Coordinate activities and service delivery that supports the child and family Plans and facilitates adherence to established timeframes.
- Coordinate actives that include coordination with the adult service providers rendering services to adult family members.

DCS Arizona Families F.I.R.S.T (Families in Recovery Succeeding Together-AFF) Program

Providers are to coordinate with parents/families referred through the Arizona Families F.I.R.S.T (AFF) program and participate in the family's CFT to coordinate services for the family and temporary caretakers.

SECTION VII: Behavioral Health Services

The AFF Program provides expedited access to substance use treatment for parents/families/caregivers referred by DCS and the ADES/Family Assistance Administration (FAA) Jobs Program. AHCCCS participates in statewide implementation of the program with DCS. Providers are too coordinate the following:

Accept referrals for Title XIX and Title XXI eligible and enrolled members and families referred through AFF:

a. Accept referrals for Title XIX/XXI eligible and enrolled members and families referred through the AFF program, Non-Title XIX/XXI members and families referred through the AFF Program, if eligible
b. Ensure that services made available to members who are Non-Title XIX/XXI eligible are provided by maximizing available federal funds before expending state funding as required in the Governor's Execution Order 2008-01
c. Collaborate with DCS, the ADES/FAA Jobs Program and substance use disorder treatment providers to minimize duplication of assessments
d. Develop procedures for collaboration in the referral process to ensure effective service delivery through the behavioral health system. Appropriate authorizations to release information will be obtained prior to releasing information

Arizona Department of Education (ADE), Schools, Or Other Local Educational Authorities
AHCCCS has delegated the functions and responsibilities as a State Placing Agency to Care1st for members in the Northern and Central GSA under A.R.S. §15-1181 for children receiving special education services pursuant to A.R.S. §15-761 et seq. This includes the authority to place a student at a Behavioral Health Inpatient Facility, which provides care, safety, and treatment.

Providers are to collaborate with schools and help a child achieve success in schools as follows:

a. Work with the school and share information to the extent permitted by law and authorized by the member or Health Care Decision Maker (HCDM) as specified in AMPM Policy 940.
b. For children receiving special education services, actively consider information and recommendations contained in the Individualized Education Program (IEP) during the ongoing assessment and service planning;
c. For children receiving special education services, include information and recommendations contained in the Individualized Education Program (IEP) during the assessment and service planning process (refer to AMPM Policy 320-O). Behavioral health providers participate with the school in developing the child's IEP and share the behavior treatment plan interventions, if applicable;
d. Invite teachers and other school staff to participate in the CFT if agreed to by the child and Health Care Decision Maker;
e. Support accommodation for students with disabilities who qualify under Section 504 of the Rehabilitation Act of 1973, and
f. Ensure that transitional planning occurs prior to and after discharge of an enrolled child from any out-of-state placement.

SECTION VII: Behavioral Health Services

Behavioral health providers collaborate with schools to provide appropriate behavioral health services in school settings, identified as Place of Service (POS) 03 and submit reports as specified by Care1st.

Care1st is not responsible for services provided by Local Educational Authorities (LEAs), as specified in AMPM Policy 710, for members receiving special education services.

Department of Economic Security
Arizona Early Intervention Program (AzEIP)
Providers will coordinate member care with AzEIP as follows:

a. Ensure that children birth to three years of age are referred to AzEIP in a timely manner when information obtained in the child's behavioral health assessment reflects developmental concerns,
b. Ensure that children found to require behavioral health services as part of the AzEIP evaluation process receive appropriate and timely service delivery, and
c. Ensure that, if an AzEIP team has been formed for the child, the behavioral health provider coordinates team functions to avoid duplicative processes between systems.

Courts and Corrections
Behavioral health providers collaborate and coordinate care for members with behavioral health needs and for members involved with:

1. Arizona Department of Corrections (ADOC)
2. Arizona Department of Juvenile Corrections (ADJC)
3. Administrative Offices of the Court (AOC), or
4. County Jails System

Behavioral health providers will coordinate member care as follows:

1. Work in collaboration with the appropriate staff involved with the member. Invite probation or parole representatives to participate in the development of the Service Plan and all subsequent planning meetings for the CFT and ART with the member's/Health Care Decision Maker's approval
2. Actively consider information and recommendations contained in probation or parole case plans when developing the Service Plan
3. Ensure that the behavioral health provider evaluates and participates in transition planning prior to the release of eligible members and arranges and coordinates enrolled member care upon the member's release.

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

SECTION VII: Behavioral Health Services

The purpose of RSA is to work with individuals with disabilities to achieve increased independence or gainful employment through the provision of comprehensive rehabilitative and employment support services.

Providers must coordinate member care by:

1. Working in collaboration with the vocational rehabilitation (VR) counselors or employment specialists in the development and monitoring of the member's employment goals;
2. Ensuring that all related vocational activities are documented in the comprehensive clinical record;
3. Inviting RSA staff to be involved in planning for employment programming to ensure that there is coordination and consistency with the delivery of vocational services; and
4. Participating and cooperating with RSA in the development and implementation of a Regional Vocational Service Plan inclusive of RSA services available to adolescents.

PROVIDER AND STATEWIDE HOUSING ADMINISTRATOR RESPONSIBILITIES

Health Plan Provider Agencies shall designate a primary clinical or housing point of contact for the AHP Administrator to reach when applications for housing have been approved and a member receives an available unit/voucher. Please provide that POC via email to Kristi.Denk@care1staz.com and OIFA@care1staz.com

AHCCCS Housing Program (AHP) is administered by Arizona Behavioral Health Corporation (ABC) and HOM Inc. All applications and waitlist questions are to be directed to ABC. The Housing Application and ABC process can be found at the ABC Housing web site https://azabc.org/ahp/. 602-712-9200 Only Provider Agencies and Clinics shall contact ABC Housing.

HOM Inc. 602 265-4640 Phoenix 520 534-2941 Pima & BOS
Contact for Members/Clients and Health Home or Housing Staff about a housing concern for people already housed or approved for a housing voucher. https://www.hominc.com/ https://www.hominc.com/ahp-faqs/

When a member identifies a need for housing services and supports Provider Agencies are required to add to the Individual Service Plan (ISP) and fill out the AHP housing application forms. The AHP forms are fillable and will require signatures from all parties. These forms are emailed via secure email to the AHP Administrator for processing. The member will be added to the statewide housing list. When the AHP Administrator has a housing option available the member will be notified via email along with the Provider clinical teams, case managers and the health plan. This

is in effort to coordinate care as much as possible with AHCCCS Providers and the AHP Administrator.

AHCCCS is responsible for the overall oversight, fund distribution, operation, and ensuring that AHP funds are utilized for their intended purposes and in compliance with all federal, state, and local laws and regulations. To achieve these goals, AHCCCS utilizes a statewide Housing Administrator to manage and operate the AHCCCS Housing Program.

Provider Responsibilities

The Provider Agency is responsible for assisting and supporting members to secure and maintain housing as part of overall physical and behavioral health service provision. This includes coordination with the AHP Administrator for AHP programs if eligible, as well as other community-based housing and programs (e.g., Housing Choice Vouchers, Department of Housing and Urban Development (HUD) COC programs).

The designated provider agency will provide housing support services to members. The service provider can be the member's assigned health home/designated provider, or the services can be offered by referral to a qualified third party as noted in the member's individual service plan. If offered by a third party provider, the health home/assigned provider will ensure coordination of services as part of the member's integrated care plan

To adequately support members housing needs, the Provider Agencies shall: Ensure identification, assessment, screening, and documentation of individuals that have housing needs including homelessness, housing instability, or adequate and appropriate setting at discharge from residential, crisis or inpatient facility. It may also include administration of any AHCCCS approved standardized assessment tools that include housing evaluation, coordinate with the AHP Administrator and contracted providers to identify and refer members identified with a high need for housing services.

The Provider Agency shall assist members to identify, apply and qualify for housing options they may be eligible for including AHP subsidies and supports as well as other mainstream affordable and PSH programs (e.g., HUD Housing Choice Vouchers, HUD McKinney Vento COC grants), to ensure a range of housing settings and programs are available to individuals consistent with the individual's recovery goals, individual's service plan, choice and offer the least restrictive environment necessary to support the member. Shelters, hotels, and similar temporary living arrangements do not meet this expectation.

The Provider Agency is required to coordinate with an individual's treatment team or care coordinator, to participate and support AHP Administrator and other mainstream housing processes including assistance in securing eligibility documentation, attending housing briefings

to ensure tenant understand housing rights, duties and processes, assist in housing search and lease up process help with move in and ongoing requirements (e.g., lease renewal).

Whenever possible, not actively refer or place individuals in a homeless shelter, licensed Supervisory Care Homes, unlicensed board and care homes, or other similar facilities upon discharge from an institutional setting. For individuals enrolled in AHP housing, Provider Agencies shall provide coordination between the housing provider, AHP Administrator, and clinical teams to ensure members receive appropriate wraparound supportive services to ensure housing stability and progress towards case plan goals. This may include delivery of services within the individual's housing placement as appropriate. Ensure coordination of services and housing for all eligible members including those from other systems of care (e.g., Fee for Services) as appropriate to ensure members have access to housing programs and services,

The Provider Agency Shall demonstrate that the provider agency staff and provider housing program staff have received training, demonstrated competency, and utilized evidence-based practices to coordinate housing based supportive services to assist individuals in attaining and maintaining permanent housing placement and retention.

The Provider Agencies shall demonstrate they can capably conduct and utilize any AHCCCS-required current or emerging standardized assessment tool for assessing and documenting housing needs such as the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) or other AHCCCS approved acuity tool.

The Provider Agency shall participate in the local HUD COC Homeless Management Information System (HMIS), a software application designed to record and store client-level information on the characteristics and service needs of homeless persons. The HMIS is used to coordinate care, manage program operations, and better serve clients. Examples and suggested HMIS coordination requirements are included in the plan contracts, Collaborate with State, County and local government agencies to support homeless and housing initiatives to resolve issues, develop new housing capacity, and address barriers to housing that affect members.

RBHA will monitor housing providers for compliance with the SAMHSA Fidelity Monitoring tool as required. Provision of required housing specific data will require coordination with AHCCCS Housing Administrator.

Develop and make available to the Providers, policies, and procedures regarding specific housing coordination and related requirements and ensure all services including housing supports are provided in a culturally competent manner and do not intentionally or unintentionally discriminate, and work with providers and community to identify new projects for possible SMI HTF application to AHCCCS to expand housing capacity for individuals determined SMI.

It is the responsibility of the Provider Agency to be aware of AHP eligibility requirements and ensure that all members referred for AHP housing are eligible. Provider shall verify eligibility

upon issuance of housing support or renewal of the housing support. Have an established and publish processes verifying eligibility upon issuance of housing support or renewal of the housing support.

SMI ELIGIBILITY DETERMINATION

General Requirements

As per AMPM 320-P Serious Mental Illness Eligibility Determination, this section applies to:

- Members who are referred for, request or have been determined to need an eligibility determination for SMI;
- Members determined to be SMI for whom a review of the determination is indicated; and
- Care1st, subcontracted providers and the AHCCCS Determining Entity (Solari Crisis and Human Services).

All members must be evaluated for SMI eligibility by a qualified assessor (as defined in A.A.C. R9-21-101(B)), and have an SMI determination made by the Solari Crisis and Human Services, if:

- The member requests an SMI determination; or
- A guardian/legal representative who is authorized to consent to inpatient treatment pursuant to A.R.S. 14-5312.01 for the member makes a request on their behalf; or
- An Arizona Superior Court issues an order instructing the person to undergo an SMI evaluation.

The SMI eligibility determination record must include all of the documentation that was considered during the review of the determination as well as any current and/or historical treatment records used in consideration of the determination. All documentation used in consideration of the determination must be maintained in hardcopy or electronic format.

Computation of time is as follows:

- Day Zero: Initial assessment date with a qualified clinician regardless of time of the assessment
- Day One: The next business day after the initial assessment is completed. The initial assessment and all other required documents must be provided to Solari Crisis and Human Services as soon as practicable, but no later than 11:59PM on Day One. The qualified clinician will notify Care1st Care Management that an SMI eligibility application has been submitted.
- Day Three: The third business day after the initial assessment is completed. Solari Crisis and Human Services will complete the final determination no later than Day Three.
- **Determination Due Date:** Three business days after Day Zero, excluding weekends and holidays, and is the date that the determination decision will be rendered. This date is amended if an extension is approved in accordance with Care1st policy.

Process for Completion of the Initial SMI Evaluation

Upon receipt of a referral, request, or identification of the need for an SMI determination, Care1st, Care1st providers, designated Department of Corrections (DOC) or Arizona Department of Juvenile Corrections (ADJC) staff person will schedule an appointment for an initial meeting with the person and a qualified clinician (as per AMPM Policy 950 Credentialing and Re-Credentialing Process). This is to occur no later than 7 days after receiving the request or referral.

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

- Make a clinical assessment whether the member is competent enough to participate in an evaluation;
- Obtain written consent from the person or, if applicable, the member's guardian to conduct an evaluation;
- Provide to the member and, if applicable, the member's guardian, the information required in A.A.C. R9-21-301(D)(2), a client rights brochure, and the appeal notice required by A.A.C. R9-21-401(B); and
- Obtain a release of information for any documentation that would assist in the determination
- Conduct an assessment if one has not been completed within the last six months
- Complete the SMI Determination Form as per AMPM Exhibit 320-P-1 Serious Mental Illness Determination which must be signed and dated by a licensed clinician

Upon completion of the initial evaluation, submit all information to the Determining Entity within one business day.

- Notify Care1st care management of the submission.

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

- Request the additional information in order to make a determination of whether the member is SMI and obtain an authorization for the release of information, if applicable
- Refer the member for a psychiatric evaluation for further diagnostic and functional clarification.

Criteria for SMI Eligibility Determination

The determination of SMI requires both a qualifying SMI diagnosis and functional impairment, or risk of deterioration, as a result of the qualifying diagnosis (see Exhibit 320-P-2, Serious Mental Illness Qualifying Diagnosis).

To meet the functional criteria for SMI status, a member must have, as a result of a qualifying SMI diagnosis, dysfunction in at least one of the following four domains, 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.
- 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 person'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 person'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 for SMI Eligibility
    - 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 are not sufficient 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 abuse, for purposes of SMI determination, presumption of functional impairment is as follows:

- For psychotic diagnoses (bipolar I disorder with psychotic features, delusional disorder, major depression, recurrent, severe, with psychotic features, schizophrenia, schizoaffective disorder and psychotic disorder NOS) functional impairment is presumed to be due to the qualifying psychiatric diagnosis;
- For other major mental disorders (bipolar disorders, major depression and obsessive compulsive disorder), functional impairment is presumed to be due to the psychiatric diagnosis, unless:
    - The severity, frequency, duration or characteristics of symptoms contributing to the functional impairment cannot be attributed to the qualifying mental health diagnosis; or

  - The assessor can demonstrate, based on a historical or prospective period of treatment, that the functional impairment is present only when the person is abusing substances or experiencing symptoms of withdrawal from substances.
- For all other mental disorders not covered above, functional impairment is presumed to be due to the co-occurring substance use unless:
  - The symptoms contributing to the functional impairment cannot be attributed to the substance abuse disorder; or
  - The assessor can demonstrate, based on a historical or prospective period of treatment, that the functional impairment is present only when the individual is actively using substances or experiencing symptoms of withdrawal from substances.

- A diagnosis of substance-induced psychosis can only be made if both of the following conditions are present:
  - There is no psychosis present before a period of substance use that is of sufficient type, duration, and intensity to cause psychotic symptoms, and
  - The psychosis remits complete (not partially) after a period of abstinence of 30 Days or less

Continuation of new onset psychotic symptoms after a 30-Day period of abstinence requires a presumptive diagnosis of a persistent psychotic disorder.

For persistent psychosis of undetermined onset, the absence of clear remission of psychosis during a period of abstinence of 30 Days or less should be considered presumptive evidence of a persistent psychotic disorder for SMI eligibility purposes.

For individuals who are not able to attain or maintain a period of abstinence from substance use, who continue to use substances and/or do not experience consecutive Days of abstinence, this is not a disqualifier to initiate the SMI Eligibility and Determination process. Some individuals will not meet the 30 Day period of abstinence. This does not preclude them from the SMI Eligibility assessment and Determination process.

A Complete SMI Determination Packet Includes:

- Solari Crisis and Human Services Consent for Assessment Form
- SMI Determination Form
- Comprehensive assessment that must be dated within 6 months of the submission- Solari Crisis and Human Services has an example form that may be used
- Psychiatric evaluation or psychiatric evaluation and management visit that addresses the current and recurrent functional impairments, risk of deterioration and qualifying diagnoses of the individual
- Recent hospital records or treatment records demonstrating individual's level of functioning and evidence of deterioration

- Waiver of the Three Day Determination Form- applicants are encouraged to waive their right to a 3 day determination so that Solari Crisis and Human Services can pursue historical treatment records and have additional time to review the requests
- Demographic Form (optional) to assist Solari Crisis and Human Services with contacting the individual and other involved parties during the determination process
- Releases of Information Form for Solari Crisis and Human Services to communicate with emergency contact, family members or prior inpatient and outpatient providers

Submission of the SMI Determination Request

- All requests are submitted through the Solari Crisis and Human Services SMI Provider Submission Portal or by fax (844-611-4752)
- Clinical contact should be the clinician most familiar with the individual's clinical history and who can address the effect of substance use on clinical presentation, if applicable. In most cases this would be the behavioral health medical provider. This contact is used to obtain additional information and if there is a potential denial, to discuss appeal or reconsideration.
- Packets must be complete, dated and signed
- Additional documents can be submitted as updates to the original submission

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 (ADHS) 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.

Completion Process of Final SMI Eligibility Determination

The licensed psychiatrist, psychologist, or nurse practitioner designated by Solari Crisis and Human Services 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 Solair Crisis and Human Services qualified assessor (see AMPM Policy 950 Credentialing and Re-Credentialing Processes); 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 person's comprehensive clinical record.
- Disagreement regarding functional impairment: Determination that the member does not meet eligibility requirements must be documented by the psychiatrist, psychologist, or nurse practitioner in the member's comprehensive clinical record to include the specific reasons for the disagreement and will include a clinical review with the qualified clinician.

If there is sufficient information to determine SMI eligibility, the person 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.

NOTE: Insufficient diagnostic information is 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.

Solari Crisis and Human Services must:

- Document the reasons for the delay in the member's eligibility determination record when there is an administrative or other emergency that will delay the determination of SMI status; 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).

Notification of SMI Eligibility Determination

1. If the member is determined SMI, the SMI status must be reported to the member or their legal guardian by CRN in writing, including notice of the member's right to appeal the decision (as outlined in ACOM Policy 444).

2. If the eligibility determination results in a denial of a SMI status, Solari Crisis and Human Services will provide written notice of the decision and include:

a. The reason for denial of SMI eligibility (as outlined in AMPM Exhibit 320-P-1),
b. The right to appeal (as outlined in ACOM Policy 414 and ACOM Policy 444), and
c. 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 in the AHCCCS Technical Interface Guidelines.

Re-Enrollment or Transfer

If the member's status is SMI at disenrollment or transition to another ACC, TRBHA or Tribal ALTCS, the member's status will continue as SMI. A member will retain their SMI status unless a determination is made by Solari Crisis and Human Services that the member no longer meets criteria.

Review of SMI Eligibility

Care1st care manager, or contracted behavioral health providers may seek a review of a member's SMI eligibility from Solari Crisis and Human Services :

a. As part of an instituted, periodic review of all members determined to have a SMI,
b. When there has been a clinical assessment that supports that the member no longer meets the functional and/or diagnostic criteria, or
c. As requested by a member who has been determined to meet SMI eligibility criteria, or their legally authorized representative.

A review of the determination may not be requested by Care1st or their contracted behavioral health providers within six months from the date a member has been determined SMI eligible.

SMI Decertification

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

1. A member who has a SMI designation or an individual from the member's clinical team may request a SMI Clinical Decertification from the AHCCCS designee, which conducts SMI determinations. A SMI Clinical Decertification is a determination that a member who has a SMI designation no longer meets SMI criteria. If, as a result of a

review, the member is determined to no longer meet the diagnostic and/or functional requirements for SMI status:

a. Solari Crisis and Human Services will 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,
b. Care1st requires that services are continued in the event an appeal is timely filed, and that services are appropriately transitioned as part of the discharge planning process.

PARTNERSHIPS WITH FAMILIES AND FAMILY-RUN ORGANIZATIONS IN THE CHILDREN'S BEHAVIORAL HEALTH SYSTEM

Effective Family Participation in Service Planning and Delivery
Through the Child and Family Team (CFT) process, parents/caregivers and youth are treated as full partners in the planning, delivery and evaluation of services and supports. Parents/caregivers and youth are equal partners in the local, regional, tribal and state representing the family perspective as participants in systems transformation. Care1st subcontracted providers must:

- Ensure that families have access to information on the CFT process and have the opportunity to fully participate in all aspects of service planning and delivery.
- Approach services and view the enrolled child in the context of the family rather than isolated in the context of treatment.
- Recognize that families are the primary decision-makers in service planning and delivery.
- Provide culturally and linguistically relevant services that appropriately respond to a family's unique needs.
- Assess the family's need for a family support partner and make family support available to the CFT when requested.
- Provide information to families on how they can contact staff at all levels of the service system
- Work with Care1st to develop training in family engagement and participation, roles and partnerships for provider staff, parents/caregivers, youth and young adults.

Responsibilities of Care1st and Providers
Family members, youth and young adults must be involved in all levels of the behavioral health system, whether it is serving on boards, committees and advisory councils or as employees with meaningful roles within the system. To ensure that family members, youth and young adults are provided with training and information to develop the skills needed, Care1st and its subcontracted providers must:

- Support parents/caregivers, youth and young adults in roles that have influence and authority.

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

Responsibilities of Care1st

- Support family, youth and young adults in roles that have influence and promote shared responsibility and active participation.
- Assign resources to promote family, youth and young adult involvement including committing money, space, time, personnel and supplies;
- Involve parents/caregivers, youth and young adults as partners at all levels of planning and decision making, including delivery of services, program management and funding; and
- Develop and make available to providers, policies and procedures specific to these requirements.

Organizational Commitment to Employment ~~to~~ of Family Members

Care1st subcontracted providers must demonstrate commitment to employment of parents/caregivers, and young adults by:

- Providing positions for parents/caregivers and young adults that value the first person experience.
- Providing compensation that values first-person experience commensurate with professional training.
- Establishing and maintaining a work environment that values the contribution of parents/caregivers, youth and young adults.
- Providing supervision and guidance to support and promote professional growth and development of parent/caregivers and young adults in these roles.

- Providing the flexibility needed to accommodate parents/family members and young adults employed in the system, without compromising expectations to fulfill assigned tasks/roles.
- Promoting tolerance of the family, youth and young adult roles in the workplace.
- Committing to protect the integrity of these roles.
- Developing and making available to providers, policies and procedures specific to these requirements

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

- Analysis of the behavioral health system, including the Annual Network Inventory and Analysis of Family Roles and System of Care Practice Reviews.
- Other sources as required by the AHCCCS/ACC contracts

MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES; INCLUDING, FEDERAL GRANT AND STATE APPROPRIATIONS REQUREMENTS

AHCCCS receives Federal grants and State appropriations to provide services to Non-Title XIX/XXI eligible populations in addition to Federal Medicaid (Title XIX) and the State Children's Health Insurance Program (Title XXI) funding. The federal grants are awarded by a Federal agency, typically by the Substance Abuse and Mental Health Services Administration (SAMHSA), and made available to the State. The Arizona State legislature annually issues appropriations targeting specific needs in the State. The grants and State appropriations may vary significantly from year to year. AHCCCS disburses the grant and State appropriations funding throughout Arizona for the delivery of covered services in accordance with the requirements of the fund source.

The Substance Abuse Block Grant (SABG), the Mental Health Block Grant (MHBG) are annual formula grants authorized by the United States Congress. The Substance Abuse and Mental Health Services Administration (SAMHSA) facilitates these grant awards to states in support of a national system of mental health and substance use disorder prevention and treatment services.

Federal grant funds can be used to provide behavioral health and substance use services to the Non-Title XIX/XXI parent/guardian/custodian of a Title XIX/XXI, Non-Title XIX/XXI, or Title XIX/XXI child/children who is/are at risk of being removed from their home by the Department of Child Safety (DCS) and is/are eligible under the Block Grant SED or SUD eligibility criteria. The grant-funded provider is required to ensure the Non-Title XIX/XXI parents, guardians, or custodians of a child who is at risk of being removed from the family receive the services and supports needed to preserve the family unit and enable the child with SED or SUD to remain in the home. These services should include, but are not limited to, life skills training such as parenting classes, skill building, and anger management. The provider shall

adhere to eligibility requirements as specified in Sections of this Provider Manual for eligibility criteria for the MHBG/SABG Grants.

Federal Grant and State Appropriation funding shall not be used to supplant other funding sources; if funds from the Indian Health Services and/or Tribal owned/or operated facilities are available, the IHS/638 funds shall be treated as the payor of last resort.

All the requirements of the SABG and MHBG provisions outlined in The Health Plan Provider Manual apply to SABG and MHBG funded-providers. Many of the service provisions in this section are Best Practices for the delivery of SUD and MHD services and apply to all providers delivering SUD and MHD services to Title XIX/XXI and Non-Title XIX/XXI members, including those providers who do not receive Block Grant or State Appropriation funds.

Non-Title XIX/XXI Contracted Provider Requirements (Federal Block Grant and State Appropriation Funds)

Providers receiving Federal Block Grant funds and/or State Appropriation funds are required to use funds for authorized purposes as directed by The Health Plan, account for funds in a manner that permits separate reporting by fund source and track and report expenditures, including unexpended funds. Unexpended or inappropriately used funds are subject to recoupment.

Providers receiving grant and/or State Appropriation funding are required to ensure all members receiving Federal Grant and/or State Appropriation funded services are screened for Title XIX/XXI eligibility at intake and annually, documenting the eligibility screening in the medical record. Providers shall enroll the individual in Non-Title XIX/XXI funded services immediately, while continuing to assist the individual with the processes to determine Title XIX/XXI eligibility. If the individual is deemed eligible for Title XIX/XXI funding, the Member can choose a Contractor and American Indian Members may choose either a Contractor, or AIHP, or a TRBHA if one is available in their area, and receive covered services through that Contractor or AIHP or a TRBHA.

The provider shall work with the Care Coordination teams of all involved Contractors or payers to ensure each Member's continuity of care. Members designated as SMI are enrolled with a RBHA. American Indian Members designated as SMI have the choice to enroll with a TRBHA for their behavioral health assignment if one is available in their area. If a Title XIX/XXI Member loses Title XIX/XXI eligibility while receiving behavioral health services, the provider shall attempt to prevent an interruption in services. The provider shall work with the care coordinators of the Contractor or RBHA in the GSA where the Member is receiving services, or Contractor enrolled or AIHP enrolled Members, or the assigned TRBHA, to determine whether the Member is eligible to continue services through available Non-Title XIX/XXI funding. If the provider does not receive Non-Title XIX/XXI funding, the provider and Member shall work, together to determine where the Member can receive services from a provider that does receive Non-Title XIX/XXI funding. The provider shall then facilitate a transfer of the Member to the identified provider and work with the Care Coordination teams of all involved Contractors or payors.

SECTION VII: Behavioral Health Services

Providers will be paid for treating Members while payment details between entities are determined. If a Title XIX/XXI Member, whether Contractor or AIHP enrolled, requires Non-Title XIX/XXI services, the provider shall work with the RBHA in the GSA where the Member is receiving services, or the assigned TRBHA, to coordinate the Non-Title XIX/XXI services. Behavioral health providers are required to assist individuals with applying for Arizona Public Programs (Title XIX/XXI, Medicare Savings Programs, Nutrition Assistance, and Cash Assistance), and Medicare Prescription Drug Program (Medicare Part D), including the Medicare Part D "Extra Help with Medicare Prescription Drug Plan Costs" low income subsidy program prior to receiving Non-Title XIX/XXI covered behavioral health services, at the time of intake for behavioral health services.

An individual who is found not eligible for Title XIX/XXI covered services may still be eligible for Non-Title XIX/XXI services. An individual may also be covered under another health insurance plan, including Medicare. Individuals who refuse to participate in the AHCCCS screening/application process are ineligible for state funded behavioral health services. Refer to A.R.S. §36-3408 and AMPM Policy 650. The following conditions do not constitute an individual's refusal to participate:

- An individual's inability to obtain documentation required for the eligibility determination[MRL1] , and/or;
- An individual is incapable of participating as a result of their mental illness and does not have a legal guardian. Pursuant to the U.S. Attorney General's Order No. 2049–96 (61 Federal Register 45985, August 30, 1996), individuals presenting for and receiving crisis, mental health or SUD treatment services are not required to verify U.S. citizenship/ lawful presence prior to or in order to receive crisis services.

Members can be served through Non-Title XIX funding while awaiting a determination of Title XIX/XXI eligibility. However, upon Title XIX eligibility determination the covered services billed to Non-Title XIX, that are Title XIX covered, will be reversed by the Contractor and charged to Title XIX funding for the retro covered dates of Title XIX eligibility. This does not apply to Title XXI Members, as there is no Prior Period Coverage for these Members.

If there are any barriers to care, the provider shall work with the Care Coordination teams of all involved health plans or payers. If the provider is unable to resolve the issues in a timely manner to ensure the health and safety of the Member, the provider shall contact AHCCCS/DHCM, Clinical Resolutions Unit (CRU). If the provider believes that there are systemic problems, rather than an isolated concern, the provider shall notify AHCCCS/DHCM, CRU of the potential barrier v. AHCCCS will conduct research and work with the Contractors and responsible entities to address or remove the potential barriers.

Providers receiving Non-Title XIX/XXI funds (Federal Block Grant and/or State Appropriation Funds) are required to meet the following additional service delivery and reporting requirements:

- Develop and maintain internal policies and procedures related to the type of funds received. The policies and procedures must meet grant and funding guidelines and be approved by The Health Plan. The policies and procedures are subject to audits by the Health Plan at least annually;

- Ensure grant and state appropriation funds are expended in conformance with grant and/or state appropriation rules;
- Employ and document strategies and monitoring of targeted interventions to improve health outcomes including, but not limited to Social Determinants of Health (SDOH) and National Outcome Measures (NOMS);
- Employ and document the use of and expansion of Evidence Based Practices and Programs (EBPPs) and demonstrate ongoing fidelity;
- Deliver evidence-based services to special populations requiring substance use interventions and supports; including, homeless individuals, individuals with sight limitations, who are deaf or hard of hearing, persons with criminal justice involvement and persons with co-occurring mental health disorders;
- Provide specialized, evidence-based treatment and recovery support services for all populations as contracted;
- Providers of treatment services that include clinical care to those with a SUD shall also be designed to have the capacity and staff expertise to utilize FDA approved medications for the treatment of SUD/OUD and/or have collaborative relationships with other providers for service provision;
- Specific requirements regarding preferential access to services and the timeliness of responding to a Member's identified needs;
- Report program descriptions, service utilization, outreach activities, total enrolled members and similar data upon request to the Health Plan to effectively identify programs available in the community, measure capacity, unmet needs and respond to requests from AHCCCS;
- Treat the family as a unit, admitting women and their children into treatment as appropriate;
- Arrange and coordinate primary medical care for women who are receiving SUD services, including prenatal care;
- Arrange for gender-specific SUD treatment and other therapeutic interventions for women that address issues of relationships, sexual abuse, physical abuse, parenting and childcare while women are receiving services;
- Arrange for childcare while women receive SUD services to facilitate access to care;
- Make available and document continuing education in the delivery of grant or State appropriation funded services or activities (or both, as the case may be) to employees of the facility who provide the services or activities;
- Submit specific data elements and record limited information in the AHCCCS DUGless Portal Guide (Reference: AHCCCS DUGless Portal Gide for requirements).
- Providers are required to comply with AHCCCS demographic requirements, submitting demographic data to AHCCCS through the AHCCCS DUGLess portal. The AHCCCS Demographic & Outcomes Data Set User Guide and describes the minimum required data elements that comprise the demographic data set, in part.

Mental Health Room and Board Funded Through Grants and State Appropriation Funds

Mental Health Room and Board is not a Medicaid reimbursable service. Specialized populations may be eligible to receive Federal grant or State appropriation funding to cover the cost of Mental Health Room and Board. Room and Board includes the provision of lodging and meals to an individual residing in a residential facility or supported independent living setting which may include but is not limited to:

- Housing costs;
- Services such as food and food preparation;
- Personal laundry; and
- Housekeeping.

For providers who own the properties, room and board comprises real estate costs (debt service, maintenance, utilities, and taxes) and food and food preparation, personal laundry, and housekeeping. Room and Board may also be used to report bed hold/home pass days in Behavioral Health Residential facilities.

Room and Board services do not require prior-authorization for payment. Contracted providers are required to verify member eligibility and maintain accurate accounting of expenses and utilization. For room and board services (H0046 SE), the following billing limitations apply:

- All other fund sources (e.g. Arizona Department of Child Safety (DCS) funds for foster care children, SSI) shall be exhausted prior to billing this service; and
- Room and Board services funded by the SABG are limited to children/adolescents with a Substance Use Disorder (SUD), and adult priority population Members (pregnant females, females with dependent child(ren), and people who use drugs by injection with a Substance Use Disorder) to the extent in which funding is available. Room and Board services may be available for a Member's dependent child(ren) as a support service for the Member when they are receiving medically necessary residential treatment services for a SUD. The Room and Board would apply to a Member with dependent children, when the child(ren) reside with the Member at the Behavioral Health Residential Facility. The use of this service is limited to: Members receiving residential services for SUD treatment where the family is being treated as a whole, but the child is not an enrolled Member receiving billable services from the provider.
- Room and Board Services funded by the MHBG are limited to youth with SED qualifying diagnoses.
- Room and Board Services funded through State Appropriation Funds are limited to members meeting eligibility requirements for State Appropriation Funds and requires prior approval by The Health Plan.

Federal Block Grant Specific Requirements

Providers receiving MHBG and/or SABG funds are required to obtain and maintain an Inventory of Behavioral Health Services (I-BHS) number through SAMHSA. Grant funded providers may not discriminate against members receiving services on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in a religious practice. If a member objects to the religious nature or religious practice of a provider organization, the provider must give the member the right to a referral to another provider of substance use disorder treatment that provides a service of at least equal value and facilitate the receipt of services from the other provider within seven (7) days of the request or earlier based on the member's condition (see AMPM Policy 320-T1, Attachment A.)

SECTION VII: Behavioral Health Services

Providers receiving Federal Block Grant funds are required to meet all the applicable requirements outlined in the AHCCCS Policy Manual, AMPM 320 T1-Block Grants and Discretionary Grants and 2 CFR Part 200 ; including demonstrating full knowledge and adherence to the following:

- Member eligibility criteria to receive services through these funding sources;
- Prioritization of funding;
- Federal grant requirements and notifications;
- Prohibited use of the funds;
- Separate reporting, single audit requirements, subaward information; and
- Available services through each funding source.

Providers may not use grant funds, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual or organization that provides or permits marijuana use for the purpose of treating substance use or mental disorders. For example, refer to 45 CFR 75.300(a) which requires Health and Human Services HHS to ensure that federal funding is expended in full accordance with U.S. statutory requirements; and 21 U.S.C. 812(c) (10) and 841 which prohibits the possession, manufacture, sale, purchase, or distribution of marijuana. This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the Drug Enforcement Administration (DEA) and under the Food and Drug Administration (FDA) approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

Grant funded providers are required to ensure expenditures are in accordance with 2 CFR Part 200, Grants and Agreements, and ensure compliance with approved indirect cost agreements and/or use of a de minimis rate (Reference: 2 CFR 200.414). The policies and procedures must be comprehensive regarding SABG, MHBG, and other federal grants that include, but are not limited to, a listing of prohibited expenditures, references to the SABG and MHBG FAQs, AMPM 320-T1, Exhibit 300-2b, monitoring and separately reporting of funds by SABG, MHBG and other federal grant funding categories. Provider grant recipients are required to utilize the AHCCCS Federal Grant FAQs document to educate staff about the grants (Reference document: AHCCCS FAQs- Substance Abuse Block Grant (SABG) and Mental Health Block Grant (MHBG).

SUBSTANCE ABUSE BLOCK GRANT (SABG) SPECIFIC REQUIREMENTS – CFDA #93.959

SABG Services and Prioritization

The SABG and SABG Coronavirus Response and Relief Supplemental Appropriations Act (CRRSAA) funds support primary prevention services, early intervention services, and treatment services for persons with substance use disorders. SABG treatment services shall be designed to support the long-term treatment and substance-free recovery needs of eligible Members. The funds are used to plan, implement, and evaluate activities to prevent and treat substance use disorders. Grant funds are also used to provide referral

and early intervention services for HIV, tuberculosis disease, hepatitis C and other communicable diseases in high-risk substance users.

The SABG CRRSAA program is designed to provide funds to States, Territories, and one Indian Tribe for the purpose of planning, implementing, and evaluating activities to prevent and treat substance use disorder (SUD). States may use this supplemental COVID-19 Relief funding to:

- Promote effective planning, monitoring, and oversight of efforts to deliver SUD prevention, intervention, treatment, and recovery services; and
- Promote support for providers; and
- Maximize efficiency by leveraging the current infrastructure and capacity; and
- Address local SUD related needs during the COVID-19 pandemic.

The Goals of the SABG include, but are not limited to the following:

- To ensure access to a comprehensive system of care, including employment, housing services, case management, rehabilitation, dental services, and health services, as well as SUD services and supports;
- To promote and increase access to evidence-based practices for treatment to effectively provide information and alternatives to youth and other at-risk populations to prevent the onset of substance use or misuse;
- To ensure specialized, gender-specific, treatment as specified by AHCCCS and recovery support services for females who are pregnant or have dependent children and their families in outpatient/residential treatment settings;
- To ensure access for underserved populations, including youth, residents of rural areas, veterans, Pregnant Women, Women with Dependent Children , People Who Inject Drugs (PWID) and older adults, e. to promote recovery and reduce risks of communicable diseases; and
- To increase accountability through uniform reporting on access, quality, and outcomes of services.

Substance use treatment services shall be available to all eligible Members with a SUD based upon medical necessity and the availability of funds; including youth and adults with Opioid Use Disorders. SABG funds are used to ensure access to treatment and long-term supportive services for the following populations (in order of priority):

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

Families involved with DCS who are in need of substance use disorder treatment and are not Title XXI/XXI eligible, can receive services paid for with SABG funds as long as funds are available.

SECTION VII: Behavioral Health Services

All Members receiving SABG-funded services are required to have a Title XIX/XXI eligibility screening and application completed and documented in the medical record at the time of intake and annually thereafter. Members shall be required to indicate active substance use within the previous 12-months to be eligible for SABG treatment services. This includes individuals who were incarcerated and reported using while incarcerated. The 12-month standard may be waived for individuals on medically necessary methadone maintenance upon assessment for continued necessity, and/or incarcerated for longer than 12 months that indicate opioid use in the 12 months prior to incarceration.

Choice of SABG Substance Use Disorder Providers (Charitable Choice)
Members receiving SUD treatment services under the SABG have the right to receive services from a provider to whose religious character they do not object. Behavioral health providers providing SUD treatment services under the SABG shall notify Members at the time of intake of this right as required in AHCCCS AMPM Policy 320-T1 Attachment A. Providers shall document that the Member has received notice in the Member's medical record. If a Member objects to the religious character of a behavioral health provider, the provider shall refer the Member to an alternate provider within seven days, or earlier when clinically indicated, after the date of the objection. Upon making such a referral, providers shall notify the RBHAs, of the referral and ensure that the Member makes contact with the alternative provider.

Substance Use Disorder Services and Provider Program Requirements
Substance Use Disorder treatment services must be designed to support the long-term recovery needs of eligible persons and meet the applicable requirements set forth in the Health Plan Provider Manual. Specific requirements apply regarding preferential access to services and the timeliness of responding to a person's identified needs (see Section on Appointment Standards and Timeliness of Service).
Substance Use Disorder treatment programs must include the following minimum core components: outreach, screening, referral, early intervention, case management, relapse prevention, childcare services and continuity of addiction treatment. These are critical components for treatment programs targeting substance-using individuals. In addition, medical providers must be included in the treatment planning process from the initial contact for services to verify continuity and coordination of care. The overall goal in a continuum of comprehensive addiction treatment is improved life functioning and wellbeing, as measured by: an increase in medical wellness and improved psychosocial, spiritual, social and family relationships.

- Additional non-Medicaid reimbursable services available to Title XIX/XXI and Non-Title XIX/XXI members through SABG funding include:

Auricular acupuncture to the pinna, lobe or auditory meatus to treat alcoholism, substance use disorders or chemical dependency by a certified acupuncturist practitioner pursuant to A.R.S. 32-3922

- Mental Health Services (Traditional Healing Services) for mental health or substance use provided by qualified traditional healers. These services include the use of routine or advanced techniques aimed to relieve the emotional distress evident by disruption to the person's functional ability.
- Childcare Services (also referred to as child sitting services): Childcare supportive services are covered when providing medically necessary Medicated Assisted Treatment or outpatient (non-residential) SUD treatment or other supportive services for SUD to Members with dependent children, when the family is being treated as a whole. The following limitations apply:

  - The amount of Childcare services and duration shall not exceed the duration of MAT or Outpatient (non-residential) treatment or support services for SUD being provided to the Member whose child(ren) is present with the Member at the time of receiving services;
  - Childcare services shall ensure the safety and well-being of the child while the Member is receiving services that prevent the child(ren) from being under the direct care or supervision of Member;
  - The child is not an enrolled Member receiving billable services from the provider; and
  - Other means of support for childcare for the children are not readily available or appropriate.
- Supported housing services provided by behavioral health professionals, behavioral health technicians, or behavioral health paraprofessionals, to assist individuals or families to obtain and maintain housing in an independent community setting including the individual's own home or apartments and homes owned or leased by a provider;
- Mental Health Services, Room and Board;
- Other Non-Title XIX/XXI Behavioral Health Services: For Non-Title XIX/XXI eligible populations, most behavioral health services that are covered through Title XIX/XXI funding are also covered through Non-Title XIX/XXI funding including but not limited to: services provided in a residential setting, counseling, case management, and supportive services, but Non-Title XIX/XXI funded services may be restricted to certain Members as described in The Health Plan Provider Manual and as specified in AMPM Exhibit 300-2B, and are not an entitlement.

Services provided through Non-Title XIX/XXI funding are limited by the availability of funds.

Additional SABG Contracted Provider Requirements
The following SABG contracted provider requirements are applicable to all SABG contracted SUD treatment providers:

- Ensure preference is given to pregnant women who are seeking SUD treatment;
- Notify the Health Plan Behavioral Health department immediately when the provider has reached capacity and can no longer accept more pregnant women into the program;
- Arrange interim services within 48 hours of a pregnant woman not being able to be accepted into the program;
- Clearly indicate on program materials that pregnant women are the first priority for referral into the program;
- SABG funded providers are required to maintain service utilization, attendance and capacity records and report the information utilizing the AHCCCS SABG Capacity Management Report template (AMPM 320-T1, Attachment J) as required by AHCCCS;
- Provide HIV Activity Reports, training materials and Ad hoc reports as requested;
- Participate in the annual AHCCCS Independent Case Review process; providing treatment and documentation in compliance with the AHCCCS Substance Abuse Block Grant (SABG) Case File Review Tool
  - SABG treatment providers are required to train and educate provider staff and audit staff performance related to the most recent Case File Review Tool standards; correcting

deficiencies to promote ongoing performance improvement. (Reference: AHCCCS Substance Abuse Prevention Case File Review Findings).

- SABG treatment providers are required to respond timely to record requests to facilitate the annual audit.

Waitlist and Interim Services for Pregnant and Parenting Women/Teenagers and People Who Use Drugs By Injection (Non-Title XIX/XXI only)

BHRF providers serving members with substance use disorders and receiving SABG funding are required to promptly submit information for Priority Population Members (i.e. Pregnant Women/Teenagers, Women/Teenagers with Dependent Children, and People Who Use Drugs by Injection who are waiting for placement in a Behavioral Health Residential Facility (BHRF), to the AHCCCS online Residential Waitlist System. Title XIX/XXI Members may not be added to the Residential Waitlist. Priority Population Members who are not pregnant, parenting women/teenagers, or People Who Use Drugs by Injection shall be added to the Residential Waitlist if the provider is not able to place the Member in a BHRF within the Response Timeframes for Designated Behavioral Health Services as outlined herein. For women/teenagers who are pregnant, the requirement is within 48 hours, for women with dependent children the requirement is within 5 calendar days and for individuals who use drugs by injection the requirement is within 14 calendar day.

The purpose of interim services is to reduce the adverse health effects of substance use disorders, promote the health of the individual, and reduce the risk of transmission of disease. Interim services must be made available for Non-Title XIX/XXI priority populations who are maintained on an actively managed wait list. Provision of interim services must be documented in the Member's chart as well as reported to the State through the State SABG Waitlist System. The minimum required interim services include education that covers the following:

- 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.

Provider Program Requirements Related to Gender-Specific Services and SABG Priority Populations and Parents with Children

SABG funded providers are required to disseminate information about Priority Population eligibility by posting and advertising at community provider locations and through strategic methods; including, but not limited to street outreach programs, posters placed in targeted community areas and other locations where pregnant women, women with dependent children, persons who inject drugs, and uninsured or underinsured people with SUD who do not meet eligibility for Title XIX/XXI are likely to attend, in accordance with the specifications in 45 CFR 96.131(a)(1-4). SABG providers shall publicize admission preferences by frequently disseminating information about treatment availability to community-based organizations, healthcare providers, and social services agencies.

Providers shall publicize the availability of gender-based substance use disorder treatment services for pregnant women or women who have dependent children. Publication must include, at minimum, the posting of fliers at each SABG service delivery site notifying pregnant women or women with dependent children of the availability and right to receive substance use disorder treatment services at no cost.

SUD treatment providers serving parents with dependent children shall:

- Deliver the following services as needed: referral for primary medical care for women and primary pediatric care for children; gender-specific substance use treatment; therapeutic interventions for children; and case management and medically-necessary transportation to access medical and pediatric care.
- Eliminate barriers to access treatment through incorporation of childcare, case management and medically-necessary transportation to medical and pediatric care and treatment services.
- Prioritize services available for substance use disorder treatment services for pregnant women pursuant to A.R.S. § 36-141.

Specific goals of women-focused treatment include reducing fetal exposure to alcohol/drugs, verifying a healthy birth outcome as an immediate priority, and addressing issues relevant to women; such as, domestic abuse and violence, demands of child-rearing, vocational and employment skills.

- SUD treatment providers are required to ensure that case management, childcare and transportation do not pose barriers to access to obtaining substance use disorder treatment. Contracted providers with approved funding may bill "Childcare T1009 - for Dependent Children" to provide childcare support services for a member who meets the criteria for SABG funding as defined in the Health Plan Provider Manual and the AMPM 320-T1.

SABG contracted treatment providers must comply with Program Requirements for Pregnant Women and Women with Dependent Children in accordance with this Provider Manual as follows:

- Engage, retain, and treat pregnant women and women with dependent children who request and are in need of substance use disorder treatment.
- Deliver outreach, specialized evidence-based treatment, and recovery support services for pregnant women, women with dependent children or women attempting to regain custody of children.
- Deliver services to the family as a unit and for residential treatment programs, admit both women and their children into treatment.
- Deliver medically necessary covered services to each pregnant individual who requests and is in need of substance use disorder treatment within forty-eight (48) hours of the request.
- Deliver medically necessary covered services for women with dependent children within five (5) days.

SABG Funded Childcare Supportive Services (Amount, Duration, and Scope of SABG Funded Childcare Support Services)

- The amount of services and duration is dependent upon the BHRF or Outpatient (non-residential) treatment or recovery support services for SUD being provided to the member and whose child is present with the member at the time of the treatment. Childcare supportive services are covered when providing medical necessary BHRF or outpatient (non-residential) treatment or other supportive services for SUD to Members with dependent children, when the family is being treated as a whole, the following limitations apply:
    - The amount of Childcare services and duration shall not exceed the duration of BHRF or Outpatient (non-residential) treatment or support services for SUD being provided to the Member whose child(ren) is present with the Member at the time of receiving services;
    - Childcare services shall ensure the safety and well-being of the child while the Member is receiving services, which prevent the child(ren) from being under the direct care or supervision of Member;
    - The child is not an enrolled Member receiving billable services from the provider, and;
    - Other means of support for childcare for the children are not readily available or appropriate.
- The scope of the Childcare Recovery Support Services should be what is necessary to ensure the safety and well-being of the child while the member is in treatment services, which prevent the child(ren) from being under the direct care or supervision of the member.
- The service is to be billed in 15 minute increments not to exceed the amount of time the enrolled member received services.

The use of SABG Funded Childcare Support Services is limited to:

- Enrolled members receiving BHRF or Outpatient (non-residential) treatment or recovery support services for SUD treatment where the family is being treated as a whole, but the child is not an enrolled member receiving billable services from the provider.
- Where other means of supports for childcare for the child are not readily available or appropriate.
- Only Provider Types that provide BHRF or Outpatient (non-residential) SUD treatment or recovery support services are eligible for this service.

Each Provider providing SUD treatment services to parents with Dependent Children shall have policies and procedures that address: informed consent, case management, transportation, facilities, staffing, supervision, monitoring, documentation, service description, safety measures, ages accepted, and schooling/service accessibility to the children. The content of the policies and procedures must be included in the informed consent documentation that must be reviewed and signed by the member acknowledging the potential benefits and risks associated with receiving the Childcare Recovery Support Service as a part of the member's treatment.

Program Requirements for Persons Involved with Injection Drug Use

Providers must engage in evidence-based best practice outreach activities to encourage individuals in need of services to undergo treatment and deliver medically necessary covered services to persons involved with injection drug use who request and are in need of substance use disorder treatment. SABG contracted providers must ensure that each individual who requests, and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment not later than 14 days after making the request for

admission to such a program; or 120 days after the date of such request, if no such program has the capacity to admit the individual on the date of such request and if interim services, including referral for prenatal care, are made available to the individual not later than 48 hours after such request. MAT providers must notify the Health Plan when an intravenous drug use program has reached ninety percent (90%) of its capacity. Providers are prohibited from using SABG funds to supply individuals with hypodermic needles or syringes to use illegal drugs.

Human Immunodeficiency Virus (HIV) , Tuberculosis (TB), Hepatitis C and Other Communicable Diseases (Referral, Screening and Early Intervention Services)

SUD treatment providers must refer persons with substance use disorders for HIV, tuberculosis, hepatitis C and other communicable disease screening. In addition, providers must deliver services to persons with HIV in accordance to requirements in this Provider Manual.

Because individuals with substance use disorders are considered at high risk for contracting HIV-related illness, the SABG requires the use of HIV intervention services to reduce the risk of transmission of this disease. SABG funded HIV Early Intervention services are available exclusively to Members receiving substance use disorder treatment. SABG funded HIV services may not be provided to incarcerated populations per 45 CFR 96.135.2.

SUD treatment providers are required to establish linkages with a comprehensive community resource network of related health and social services organizations to ensure a wide-based knowledge of the availability of these services and must provide locations and specified times for Members to access HIV Early Intervention services. Providers shall inform Members of the opportunity to receive HIV education, screenings and early intervention services and facilitate Members' access to the services. Substance use treatment providers must make their facilities available for HIV Early Intervention providers contracted with the Health Plan and verify Members have access to HIV Early intervention services. Providers may contact the Health Plan customer service for assistance in locating and obtaining access to HIV Early Intervention Services.

Requirements for Providers Offering HIV Early Intervention Services
HIV early intervention service providers who accept funding under the SABG must provide HIV testing services. 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 Centers for Medicare and Medicaid (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. For a complete list of waived Rapid HIV tests please see (http://www.fda.gov/cdrh/clia/cliawaived.html). 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 verify any HIV testing will be performed accurately. (See Centers for Disease Control Quality Assurance Guidelines).

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 ADHS Office of HIV Prevention.

HIV early intervention providers are required to collect and report early intervention activities to the Health Plan utilizing the AHCCCS SABG HIV Activity Report (AMPM Policy 320-T, Attachment E). In addition, HIV early intervention providers are required to regularly provide education and training to members and staff at SUD treatment facilities; collecting and reporting education and training site visits utilizing the AHCCCS SABG HIV site visit Report (AMPM Policy 320-T, Attachment F).

Contracted HIV early intervention providers are required to administer a minimum of one test per $600 in HIV funding.

HIV Education and Pre/Post-Test Counseling
The HIV Prevention Counseling training provided through Arizona Department of Health Services must be completed by all the Health Plan 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. HIV education and pre/post-test counseling. The Health Plan HIV Coordinators and provider staff delivering HIV Early Intervention Services for the SABG also must attend an HIV Early Intervention Services Webinar issued by the State on an annual basis, or as indicated by the State. The Webinar will be recorded and made available by the State. 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 are required to actively participate in regional community planning groups to verify 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 shall be retained and recorded by the provider. This same number will be used for reporting in the Luther data base as required by the CDC. 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
HIV early intervention services providers are required to submit monthly progress reports to the Health Plan. The Health Plan will conduct bi-annual site visits to providers offering HIV Early Intervention Services. The State HIV Coordinator, the Health Plan HIV Coordinator, provider staff, and supervisors relevant to HIV services must be in attendance during site visits. As part of the site visit, provider must make available a budget review and a description/justification for use of the SABG funding.

SECTION VII: Behavioral Health Services

Oxford House Program Requirements
Providers contracted to provide Oxford House services are required to employ evidence based practices and abide by all approved program description requirements and applicable grant requirements as outlined in The Health Plan Provide Manual and by AHCCCS. Providers are required to maintain processes to demonstrate continuing fidelity to the model. Oxford House providers are required to collect, analyze and report service utilization, outcomes, financial and program data as requested by The Health Plan and AHCCCS; including completing the Oxford House Model Report (AMPM 320-T1, Attachment H) and the Oxford House Financial Report (AMPM 320-T1, Attachment F-1).

SABG Program and Financial Management Policies
SABG contracted providers must establish program and financial management policies and procedures for services funded by the SABG to meet all requirements in the provider agreement, the Provider Manual and the requirements of the Children's Health Act of 2000, P.L. 106-310 Part B of Title XIX of the Public Health Service Act (42 USC 300 et seq.) and 45 CFR Part 96 as amended. The policies and procedures should include, but are not limited to, a listing of prohibited expenditures, references to the SABG FAQs, monitoring and reporting of funds by priority populations and funding category.

All providers who receive SABG funding are required to submit their SABG Policy and Procedure to the Health Plan annually, each November. As applicable, Procedures should include reporting and monitoring requirements to track encountering of SABG funds and to verify that treatment services are delivered at a level commensurate with funding under the SABG. Providers must submit SABG related program reports. These reports must be submitted in a format prescribed by the Health Plan.

The Health Plan must submit an annual plan regarding outreach activities and coordination efforts with local substance use disorder coalitions. Providers receiving SABG funds are required to provide the Health Plan with requested information to complete the report.

Grant funding is the payor of last resort for Title XIX/XXI behavioral health covered services which have been exhausted (e.g. respite), Non-Title XIX/XXI covered services, and for Non-Title XIX/XXI eligible Members for any services. Grant funding shall not be used to supplant other funding sources, if funds from the Indian Health Services and/or Tribal owned/or operated facilities are available, the IHS/638 funds shall be treated as the payor of last resort. Copayments, or any other fee, are prohibited for the provision of services funded by SABG Block Grants.

Restrictions on the Use of SABG Grant Funds
Providers may not expend SABG funds on the following activities:

- Inpatient hospital services,
- Acute Care or physical health care services including payment of copays, unless otherwise specified for Priority Populations,
- Make cash payments to intended recipients of health services,
- Purchase or improvement of land, purchase, construct, or permanently improve any building or facility except for minor remodeling with written approval from AHCCCS,
- Purchase of major medical equipment,

- To satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds,
- Provide financial assistance (grants) to any entity other than a public or nonprofit private entity,
- Provide individuals with hypodermic needles or syringes for illegal drug use, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug use and the risk that the public will become infected with the etiologic agent for Acquired Immune Deficiency Syndrome (AIDS),
- Pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of Level I of the Executive Salary Schedule for the award year, see https://grants.nih.gov/grants/policy/salcap_summary.htm,
- Purchase of treatment services in penal or correctional institutions in the State of Arizona,
- Flex funds purchases, or
- Sponsorship for events and conferences.

ADDITIONAL MENTAL HEALTH BLOCK GRANT (MHBG) CONTRACTED PROVIDER REQUIREMENTS – CFDA #93.958

The MHBG and MHBG Coronavirus Response and Relief Supplemental Appropriations Act (CRRSAA) provides funds to establish or expand an organized community-based system of care for providing Non-Title XIX/XXI mental health services to children with serious emotional disturbances (SED), youth and young adults experiencing First Episode Psychosis (FEP) and adults with a Serious Mental Illness (SMI). MHBG funding may be used to provide Non-Title XIX/XXI services for Title XIX/XXI members meeting the above criteria. The MHBG Block Grant funds are used to: (1) carry out the State plan contained in the federal grant application; (2) evaluate programs and services; and (3) conduct planning, administration, and educational activities related to the provision of services. The goals of the MHBG include, but are not limited to the following:

- Ensuring access to a comprehensive system of care, including employment, housing services, case management, rehabilitation, dental services, and health services, as well as mental health services and supports;
- Promoting participation by consumer/survivors and their families in planning and implementing services and programs, as well as in evaluating State mental health systems;
- Ensuring access for underserved populations, including people who are homeless, residents of rural areas, and older adults;
- Promoting recovery and community integration for adults with SMI and children with SED; and
- Increasing accountability through uniform reporting on access, quality, and outcomes of services.

MHBG CRRSAA is designed to provide comprehensive community mental health services to adults with serious mental illness (SMI) or children with serious emotional disturbance (SED). States may use this supplemental COVID-19 Relief funding to prevent, prepare for, and respond to SMI and SED needs and gaps due to the on-going COVID-19 pandemic. The COVID-19 pandemic has significantly impacted people with mental illness. Public health recommendations, such as social distancing, are necessary to reduce the spread of COVID-19. However, these public health recommendations can at the same time

negatively impact those with SMI/SED. The COVID-19 pandemic can increase stress, anxiety, feelings of isolation and loneliness, the use of alcohol or illicit substances, and other symptoms of underlying mental illness.

The MHBG Block Grant requires AHCCCS to maintain a statewide planning council with representation by Members, family members, State employees and providers.

Populations Covered and Prioritization
To be eligible for services under MHBG, Members shall be determined to have an SMI, an SED, or ESMI/FEP. Screenings/assessments may be covered for Non-Title XIX/XXI eligible Members when they are conducted to determine SMI or SED eligibility, for block grant funding regardless of the assessment's determination. Providers are required to verify and document that members indicate active mental health symptoms in the previous 12-months to be eligible for MHBG federal block services.

Other funding sources, such as the State General Fund appropriations for SMI shall be utilized before block grant funding to ensure block grants are the payor of last resort. Refer to AMPM 320-O for additional information on behavioral health assessments and treatment/service planning.

In serving children with SED, youth and young adults experiencing FEP, and adults with SMI, MHBG funds may be used for the following:

- 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 Member/survivors and their families in planning and implementing services and programs, as well as in evaluating State mental health systems;
- To verify 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 a SMI youth and young adults experiencing FEP, and children with SED;
- To provide for a system of integrated services to include:
    - Social services;
    - Educational services;
    - Juvenile justice services;
    - Substance use disorder services; and
    - Health and services.
- To provide for training of providers of emergency health services regarding behavioral health.

MHBG Specific Provider Requirements
- MHBG funded providers are required to ensure members receiving services under the MHBG are given access to comprehensive system of care services offered through the Health Plan provider network or community; including, employment, housing services, case management, rehabilitation, dental, health services as well as mental health services;

- MHBG funded providers must account for funds separately; and ensure staff resources are appropriately allocated and employed according to grant requirements; including:
    - Ensuring MHBG funded positions or interventions are not used to fulfill the requirement of other contracts; including Title XIX/XXI contract requirements;
    - Ensuring MHBG funded positions do not simultaneously bill for services, unless specified in the Health Plan award letter.

First Episode Psychosis (FEP) Programs

Providers delivering FEP programs funded through MHBG and Title XIX/XXI funding are required to develop an annual Program Description and Operating Plan and obtain approval of the Plan from the Health Plan and AHCCCS. Once approved the provider must implement the Plan as written and document adherence and performance of the Plan; including, conducting outreach as outlined in the Plan and serving the required number of members outlined in the Plan. The provider must collect, analyze and timely report all data required in the Plan. All FEP programs must be based on Evidence Based Practices approved by AHCCCS. FEP providers must develop, implement and demonstrate a process to verify ongoing fidelity to the model. FEP providers are required to develop and execute an Annual Community Education and Marketing Plan to educate families, high schools, and institutions of higher learning, first responders and communities about the early signs and symptoms of FEP. The provider is required to document and report educational and marketing efforts; including dates, venues, attendees or recipients training and education. In addition, the FEP provider is required to collect, analyze and report data required in the First Episode Psychosis Program Status Report (See AMPM 320-T1, Attachments C and C-1).

The following are diagnoses that qualify under ESMI/FEP. These are not intended to include conditions that are attributable to the physiologic effects of an SUD, are attributable to an intellectual/developmental disorder, or are attributable to another medical condition:

- Delusional Disorder;
- Brief Psychotic Disorder;
- Schizophreniform Disorder;
- Schizophrenia;
- Schizoaffective Disorder;
- Other specified Schizophrenia Spectrum and Other Psychotic Disorder;
- Unspecified Schizophrenia Spectrum and Other Psychotic Disorder;
- Bipolar and Related Disorders, with psychotic features; and
- Depressive Disorders, with psychotic features.

Members do not have to be or designated as SMI or SED to be eligible for FEP services. Individuals who are accessing FEP MHBG services can be GMH at the beginning, or throughout their FEP episode of care.

Adolescents in Detention

Most adjudicated youth from secure detention do not have community follow-up or supervision, therefore, risk factors remain unaddressed. Youth in juvenile justice systems often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and

insufficient use of community-based services. MHBG services to adolescents in detention is contingent upon funding availability, and Health Plan and AHCCCS approval.

MHBG funded providers may deliver services to Adolescents with SED in detention in accordance to the following requirements:

- Services may only be provided in juvenile detention facilities meeting the description provided by the OJJDP;
- Juvenile detention facilities are used only for temporary and safe custody, are not punitive, and are not correctional or penal institutions.

Services shall be provided:

- Only to voluntary members with SED;
- By qualified BHPs/BHTs/BHPPs;
- Based upon assessed need for SED services;
- Utilizing EBPPs;
- Following an individualized service plan;
- For a therapeutically indicated amount of duration and frequency; and
- With a transition plan completed prior to transfer to a community based provider.

Non-Encounterable MHBG Activities or Positions
Contracted MHBG SED services for outreach activities or positions that are non-encounterable can be an allowable expense, but they shall be tracked, activities monitored, and outcomes collected on how the outreach is getting access to care for those Members with SED.

The use of MHBG SED funds in schools is allowable as long as the following requirements are met:

- Funded positions or interventions cannot be used to fulfill the requirement for the same populations as the funds for Behavioral Health Services for School-Aged Children listed in the Title XIX/XXI Contract;
- Funded positions cannot bill for services provided;
- Funded positions or interventions need to focus on identifying those with SED and getting those who do not qualify for Title XIX/XXI engaged in services through the MHBG; and
- This funding shall be utilized for intervention, not Prevention, meaning that Members who are displaying behaviors that could be signs of SED can be assisted, but MHBG funding shall not be used for general Prevention efforts to children who are not showing any risks of having SED.

Provider Management of MHBG Funds
Providers must comply with all terms, conditions, and requirements of the MHBG including the Children's Health Act of 2000, P.L. 106-310 Part B of Title XIX of the Public Health Service Act (42 U.S.C. 300 et seq.) and 45 CFR Part 96 as amended. Providers must retain documentation of compliance with Federal

requirements, and produce upon the Health Plan request, financial, performance, and program data that is subject to audit. These services will be available based upon medical necessity and the availability of funds. Providers must report MHBG and SABG funds and services separately and report or produce information related to block grant expenditures to the Health Plan upon request. Providers must manage the MHBG funds during each fiscal year to make funds available for obligation and expenditure until the end of the fiscal year for which the funds were paid.

Providers must have internal MHBG policies and procedures that should include, but are not limited to, a listing of prohibited expenditures, references to the MHBG FAQs, monitoring and reporting of funds by priority populations and funding category. All providers who receive MHBG funding are required to submit their MHBG Policy and Procedure to the Health Plan annually, each November. Copayments, or any other fee, are prohibited for the provision of services funded by MHBG Block Grants.

Restrictions on the Use of MHBG Block Grant Funds
Providers must ensure that MHBG Block Grant funds are not expended on the following activities:

- Inpatient hospital services,
- Acute Care or physical health care services including payment of copays, unless otherwise specified for priority populations,
- Cash payments to intended recipients of health services,
- Purchase or improvement of land, purchase, construct, or permanently improve any building or other facility, except for minor remodeling with written approval from AHCCCS
- Purchase major medical equipment,
- To satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds,
- Provide financial assistance (grants) to any entity other than a public or nonprofit private entity,
- Provide individuals with hypodermic needles or syringes so for illegal drug use, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug use and the risk that the public will become infected with the etiologic agent for Acquired Immune Deficiency Syndrome (AIDS),
- Pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of Level I of the Executive Salary Schedule for the award year (see National Institutes of Health (NIH) Grants & Funding Salary Cap Summary),
- Purchase treatment services in penal or correctional institutions of the State of Arizona,
- Flex fund purchases,
- Sponsorship for events and conferences,
- Childcare Services.

For Non-TXIX/XXI eligible persons court ordered for DV treatment, the individual can be billed for the DV services (ACOM Policy 423).

State Opioid Response Grant (SOR) - CFDA #93.788

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The SOR program aims to address the opioid crisis by increasing access to medication assisted treatment using the three FDA-approved medications including: methadone, buprenorphine products, including single-entity buprenorphine products, buprenorphine/naloxone tablets, films, buccal preparations, long-acting injectable buprenorphine products, buprenorphine implants, and injectable extended-release naltrexone for the treatment of Opioid Use Disorder (OUD). The overarching goal of the SOR project is to increase access to MAT treatment, coordinated and integrated care, opioid use disorder (OUD)/stimulant use disorder recovery support services and prevention activities to reduce the prevalence of OUDs, stimulant use disorder and opioid-related overdose deaths. The grant provides for the provision of prevention, treatment and recovery activities for OUD (including illicit use of prescription opioids, heroin, and fentanyl and fentanyl analogs). This program also supports evidence-based prevention, treatment, and recovery support services to address stimulant misuse and use disorders, including for cocaine and methamphetamine.

Eligible populations are individuals with OUD, stimulant use disorder, and populations at risk for developing either and related behavioral health consequences.

SOR Grant funded providers are required to:

- Implement evidence-based treatments, practices, and interventions for OUD and make available FDA-approved MAT to those diagnosed with OUD
- Implement and maintain a robust peer support program and support sustained recovery
- Coordinate with the Health Plan and correctional facilities to sustain and identify early MAT eligible individuals re-entering the community
- Coordinate care with hospitals and emergency departments to facilitate warm handoffs and entry into treatment
- Provide street-based outreach
- Provide or coordinate access to supportive housing services
- Implement FDA-approved MAT for OUD. Medical withdrawal (detoxification) is not the standard of care for OUD, is associated with a very high relapse rate, and significantly increases an individual's risk for opioid overdose and death if opioid use is resumed. Therefore, medical withdrawal (detoxification) when done in isolation is not an evidence-based practice for OUD. If medical withdrawal (detoxification) is performed, it shall be accompanied by injectable extended-release naltrexone to protect such individuals from opioid overdose in relapse and improve treatment outcomes
- Employ effective prevention and recovery support services to ensure that individuals are receiving a comprehensive array of services across the spectrum of prevention, treatment, and recovery
- Implement evidence-based prevention, treatment, and recovery support services to address stimulant misuse and use disorders
- Collect and report outreach activities and treatment data as requested by the Health Plan and/or AHCCCS
- Develop and maintain internal policies and procedures for federal grant tracking, including the SOR grant, which should include, but are not limited to, a listing of prohibited expenditures, monitoring and reporting of funds. All providers who receive SOR funding are required to submit their SOR Policy and Procedure to the Health Plan annually, each November.

Restrictions on the Use of SOR Grant Funds

- Pay the salary of an individual at a rate in excess of Executive Level II. The Executive Level II salary can be found in SAMHSA's standard terms and conditions for all awards at https://www.samhsa.gov/grants/grants-management/notice-award-noa/standard-terms-conditions. This amount reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization.
- Pay for any lease beyond the project period.
- Pay for the purchase or construction of any building or structure to house any part of the program.
- Provide residential or outpatient treatment services when the facility has not yet been acquired, sited, approved, and met all requirements for human habitation and service provision. (Expansion or enhancement of existing residential services is permissible.)
- Provide detoxification services unless it is part of the transition to MAT with extended-release naltrexone
- Make direct payments to individuals to enter treatment or continue to participate in prevention or treatment services. Note: A recipient or treatment or prevention provider may provide up to $20 non-cash incentive to individuals to participate in required data collection follow-up. This amount may be paid for participation in each required follow up interview.
- Meals are generally unallowable unless they are an integral part of a conference grant or specifically stated as an allowable expense in the FOA. Grant funds may be used for light snacks, not to exceed $3.00 per person.
- Support non-evidence-based treatment.

Non-Title XIX/XXI Services and Funding (Excluding Block Grant and Discretionary Grants)

AHCCCS receives specific appropriations of the general fund for Non-Title XIX/XXI behavioral health services from the Arizona State Legislature. The goals of the funding are:

To ensure access to a comprehensive system of care for children and adults; including

- Employment;
- Housing services;
- Case management;
- Rehabilitation;
- Mental health and substance abuse services and support.

Non-Title XIX/XXI eligible populations include:

- Non-Title XIX/XXI Persons with SMI;
- Non-Title XIX/XXI individuals in the GMH behavioral health category;
- Non-Title XIX/XXI individuals in the SUD behavioral health category.

SECTION VII: Behavioral Health Services

AHCCCS covers Non-Title XIX/XXI behavioral health services (mental health and/or substance use) within certain limits for Title XIX/XXI and Non-Title XIX/XXI Members when medically necessary. Payment for behavioral health services covered under Non-Title XIX/XXI Funds (excluding federal grants) are limited to providers contracted to deliver the services and subject to availability of funds and the approval of The Health Plan.

- Auricular Acupuncture Services is the application b of auricular acupuncture needles to the pinna, lobe, or auditory meatus to treat mental health, alcoholism, substance use or chemical dependency by a certified acupuncturist practitioner as specified in A.R.S. §32-3922. 2;
- Mental Health Services (Traditional Healing Services) Treatment services for mental health or substance use problems provided by traditional healers;
- Supported Housing services provided by behavioral health professionals, behavioral health technicians, or behavioral health paraprofessionals, to assist individuals or families to obtain and maintain housing in an independent community setting including the individual's own home or apartments and homes owned or leased by a subcontracted provider;
- Mental Health Services, Room and Board;
- Other Non-Title XIX/XXI Behavioral Health Services For Title XIX/XXI Eligible Populations;
- Crisis Services; and
- Assessments for Non-Title XIX/XXI Members when they are conducted to determine SMI eligibility. Non-Title XIX/XXI SMI General Funds may be used for the assessment, regardless of whether the individual is found to have a SMI and includes individuals who are assessed at 17.5 years old and older.

Restrictions on the Use of Non-Title XIX/XXI State Appropriation Funds

Non-Title XIX/XXI Funding may not be utilized for the following:

- Cash payments to members receiving or intending to receive health services;
- Purchase or improvement of land, purchase, construct, or permanently improve any building or facility except for minor remodeling with written approval from AHCCCS;
- Purchase of major medical equipment;
- Flex funds purchases of non-medically necessary services and supports that are not reimbursable or covered under Title XIX/XXI or Non-Title XIX/XXI;
- Sponsorship for events and conferences; or
- Childcare Services.

American Rescue Plan Act (ARPA) Supplemental Block Grant

The American Rescue Plan Act of 2021 (ARPA) provides additional funds to support states through Block Grants to address the effects of the COVID-19 pandemic for Americans with substance use disorders. The COVID-19 pandemic has created health and social inequities in America, including the critical importance of supporting people with substance use disorders. Additionally, societal stress and distress over this newly emerging disaster created the need for nimble and evolving policy and planning in addressing mental and substance use disorder services.

ARPA Substance Abuse Block Grant (SABG)

The substance use disorder (SUD) prevention, intervention, treatment, and recovery support services continuum includes various evidence-based services and supports for individuals, families, and communities. Integral to the SABG are its efforts to support health equity through its priority focus on the provision of SUD prevention, treatment, and recovery support services to identified underserved populations.

These populations include, but are not limited to:

- Pregnant women and women with dependent children,
- Persons who inject drugs,
- Persons using opioids and/or stimulant drugs associated with drug overdoses,
- Persons at risk for HIV, TB, and Hepatitis,
- Persons experiencing homelessness,
- Persons involved in the justice system,
- Persons involved in the child welfare system,
- Black, Indigenous, and People of Color (BIPOC),
- LGBTQ individuals,
- Rural populations,
- Other underserved groups.

ARPA Mental Health Block Grant (MHBG)

Funds must be used for:

- Adults designated to have a serious mental illness (SMI),
- Children determined to have a serious emotional disturbance (SED), and first-episode psychosis (FEP) or early SMI programs.

Funding is focused on supporting behavioral health crisis continuum. An effective statewide crisis system which affords equal access to crisis support that meets needs anytime, anyplace, and for anyone. This includes those living in remote areas and underserved communities as well as youth, older adults, persons of diverse backgrounds, and other marginalized populations; the crisis service continuum will need to be able to equally and adeptly serve everyone.

Refer to Sections for SABG and MHBG for additional block grant requirements.

NON-TITLE XIX/XXI INDIVIDUALS WITH SUDS

The State receives some funding for services through the Federal Substance Abuse Block Grant (SABG). SABG funds are used to provide substance abuse services for Non-Title XIX/XXI eligible persons. As a

condition of receiving this funding, certain populations are identified as priorities for the timely receipt of designated services. Any providers contracted with The Health Plan for SABG funds must follow the requirements found in this Section. For all other providers that do not currently receive these funds, the following expectations do not apply. Please refer to section regarding MHBG and State Funding Services for more information.

SABG Block Grant Populations

The following populations are prioritized and covered under the SABG Block Grant:

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

Response Times for Designated Behavioral Health Services under the SABG Block Grant:

WHEN	WHAT	WHO
Behavioral health services provided within a timeframe indicated by clinical need, but no later than 48 hours from the referral/initial request for services.	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 person within another provider agency facility, including those in other geographic service areas. If capacity still does not exist, the person 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	Pregnant individuals/teenagers referred for substance abuse treatment (includes pregnant injection drug users and pregnant substance abusers) and substance-using females with dependent children, including those attempting to regain custody of their child(ren).

	alcohol/drug use on the fetus and referral for prenatal care.	
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 services must be provided within timeframes according to the needs of the person.	Includes any needed covered behavioral health services; Admit to a clinically appropriate substance abuse treatment program (can be residential or outpatient based on the person's clinical needs); if unavailable, interim services must be offered to the person. Interim services shall minimally include education/interventions with regard to HIV and tuberculosis and the risks of needle sharing and must be offered within 48 hours of the request for treatment.	All other injection drug users
Behavioral health services provided within a timeframe indicated by clinical need but no later than 23 days following the initial assessment. All subsequent behavioral health services must be provided within timeframes according to the needs of the person.	Includes any needed covered behavioral health services.	All other persons in need of substance abuse treatment

SECTION VII: Behavioral Health Services

WORKFORCE DEVELOPMENT AND TRAINING REQUIREMENTS

Workforce Development (WFD) All Lines of Business

This following information applies to care providers contracted with Care1st for the Arizona Health Care Cost Containment System (AHCCCS) to include AHCCCS Complete Care (ACC). It discusses the requirements, expectations, and recommendations in developing the workforce. The initiatives align with Workforce Development Policy ACOM 407.

Care1st Workforce Development Operation (WFDO) implements, monitors, and regulates Provider WFD activities and requirements. In addition, Care1st evaluates the impact of the WFD requirements and activities to support Providers in developing a qualified, knowledgeable, and competent workforce.

In collaboration with AHCCCS, ACC, and AWFDA's, ensures that all course content is culturally appropriate, has a trauma informed approach and is developed using adult-learning principles and guidelines. Additionally, it is aligned with company guidelines and WFD industry standards, the Substance Abuse and Mental Health Services Administration (SAMHSA) core competencies for WFD, federal and state requirements and the requirements of several agencies, entities, and legal agreements.

Workforce Groups

Arizona Association of Health Plans (AzAHP) unites the companies that provide health care services to the almost two million people that are members of the (AHCCCS). AzAHP supplies assistance and resources to enhance the long-term care workforce through our ALTCS AzAHP Workforce Development Alliance, and they offer valuable training programs through the ACC/RHBA AzAHP Workforce Development Alliance.

Arizona Healthcare Workforce Development Coalition (AHWFDC) is organized by the WFD Department at AHCCCS and includes members from the eight MCOs. This group represents ACC, ALTCS, DCS CHP,
DES/DDD and RBHA lines of business. Together we ensure that initiatives across the state of Arizona align with all lines of business.

AzAHP Workforce Development Alliance (AWFDA) A name given to the WFD Administrators from each Contractor that jointly plan and conduct WFD activities for a particular line of business.

- The **ACC/RBHA AWFDA** includes the WFD Administrators from ACC, RBHA, and CMDP Contractors. In addition to conducting joint WFD planning, the ACC/RBHA/CMDP AWFDA collectively manages the contract between the AzAHP and the Learning Management System (LMS) vendor.

Definitions

Competency is defined as worker's demonstrated ability to perform the basic requirements of a job intentionally, successfully, and efficiently, multiple times, at or near the required standard of performance.

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Competency Development is a systematic approach for ensuring that workers are adequately prepared to perform the basic requirements of their jobs. Competency based WFD.

Workforce Capability is the interpersonal, cultural, clinical/medical, and technical competence of the collective workforce or individual worker.

Workforce Capacity is the number of qualified, capable, and culturally representative personnel required to sufficiently deliver services to members.

Workforce Connectivity is the workplace's linkage to sources of potential workers, information required by workers to perform their jobs, and technologies for connecting to workers and/or connecting workers to information

Workforce Development is an approach to improve outcomes by enhancing the knowledge, skills, and competencies of the workforce in order to create, sustain, and retain a viable workforce. It aids in changes to culture, changes to attitudes, and changes to people's potential to influence outcomes.

Training/Compliance Requirements

1. **Prevention of Abuse and Neglect**
    a. The Provider workforce shall have access to and be compliant with all workforce training and/or competency requirements specified in federal and state law, AHCCCS policies, guidance documents, manuals, contracts, plans such as network development, quality improvement, corrective action, etc., and/or special initiatives.
    b. Providers shall have processes for documenting training, verifying the qualifications, skills, and knowledge of personnel; and retaining required training and competency transcripts and records.
2. **Residential Care (24-Hour Care Facilities) Annual Requirements**
    a. Crisis prevention/de-escalation training for all member-facing staff prior to serving members.
    b. For facilities where restraints are approved, a nationally approved restraint training for all member-facing staff. This curriculum should include non-verbal, verbal and physical de-escalation techniques.
3. **Division of Licensing Services (DLS) Required Training**
    a. DLS agencies must be aware of all training requirements to be completed and documented based on all additional licensing or accrediting licensing agencies. This includes the Bureau of Medical Facilities Licensing (BMFL) / Bureau of Residential Facilities Licensing (BRFL), Joint Commission, grant requirements and other entities, as applicable.
4. **Community Service Agencies Community service agencies (CSAs)**
    a. CSAs must submit documentation as part of the first and annual CSA application. The documentation must show that all direct service staff and volunteers have

completed CSA training before providing services to members. For a list of all required CSA-specific training, see the AMPM Policy 961-C – Community Service Agencies.

Network Workforce Data Collection

It is the responsibility of the Contractor to produce a Network Workforce Development Plan for each line of business to include ACC. A portion of this data will be supported by the Provider Workforce Development Plan (as applicable to LOB), the ACOM 407 Attachment A Survey, and any additional means that are identified.

ACOM 407, Attachment A Survey

Care1st requires that all contracted provider types listed below complete the ACOM 407 Attachment A Survey annually to fulfill the requirements from ACOM 407. To meet this requirement, all Health Plans and lines of business have collaborated extensively to create a single provider survey that will be disseminated from one source (AZAHP vs. seven separate surveys being disseminated and duplicated). The survey will remain open for one month for providers to complete.

Provider types include: Nursing Homes, Home Health Agencies, Personal Care Attendant, Group Homes (DD), Adult Day Health, Assisted Living Homes, Homemaker, Attendant Care, Assisted Living Center, Supervisory Care Homes, Respite, Day Programs, Developmental Homes, Employment Programs, Habilitation Provider, In-home Nursing Services, Occupational Therapist, Physical Therapist, Speech/Hearing Therapist, ACC Core Codes, Integrated Clinics, Community Service Agency, Rural Substance Abuse Transitional Agency, Crisis Services Provider, Behavioral Health Residential Facility, Level I Residential Treatment Center – Secure (IMD), Level I Residential Treatment Center – Secure, Level I Residential Treatment Center – Nonsecure (non-IMD), Level I Residential Treatment Center – Nonsecure (IMD), Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Behavioral Health Outpatient Clinic, and additional BH providers to be considered.

Survey Link: https://form.jotform.com/210889281159162

ADHOC Initiatives

Care1st will promote optional WFD initiatives with ACC Providers that support the growth of business practices, improve member outcomes, and increase the competency of the workforce.

Workforce Development Technical Assistance Needs

The Care1st Workforce Development Administrator is available to provide technical assistance for various workforce development related needs. Technical Assistance needs could include:

- WFDP Guidance
- Recruitment Assistance
- Competency Review
- Workforce Development Goal Review
- Career Path Development
- Training Needs
- Metrics Review
- Relias
- Technology Assistance
- Network Capacity Review
- Cultural Competency
- Diversity/Equity/Inclusion Support
- Community Resources
- Other

For additional information on the Provider Workforce Development Plan (P-WFDP) requirement, training plans and the provider forums, or to discuss technical assistance needs, please reach out to our WFDO.

Behavioral Health (BH) ACC Providers:

Training/Compliance Requirements

Relias Learning Management System (LMS)

The ACC/RBHA AWFDA Providers, under the provider types listed at the link below, ensure that all staff who work in programs that support, oversee, or are paid by the Health Plan contract have access to Relias and are enrolled in the AzAHP Training Plans listed in this addendum. This includes, but is not limited to, full time/part time/on-call, direct care, clinical, medical, administrative, leadership, executive and support staff.

Provider types:

https://azahp.org/azahp/azahp-wfda/resources-2/

Exceptions:

- Any staff member(s) hired for temporary services working less than 90 days is required to complete applicable training at the discretion of the Provider.
- Any staff member(s) hired as an intern is required to complete applicable training at the discretion of the Provider.
- Any Independent Contractor (IC) is required to complete applicable training at the discretion of the Provider.
- Behavioral Health Hospitals
- Federally Qualified Healthcare providers (FQHCs), may request exemption from their contracted Health Plan(s). Exemptions may be granted on a case-by-case basis and will take into account the following: Portion of AHCCCS Members

enrolled in the network and served by that provider, geographic area serviced, and number of other service providers in the surrounding area.
- Housing Providers
- Individually Contracted Practitioners
- Prevention Providers
- Transportation Providers

Agencies must manage and maintain their Relias Learning portal. This includes activating and deactivating users as well as enrollment and disenrollment of courses/events.

To request access to Relias, please contact your Care1st Workforce Development Administrator for further assistance. The request should include the following information:
- Provider Agency Name
- Contract Start Date
- Address
- Key WFD Contact
  - Name
  - Phone Number
  - Email Address
- Contract Type (ACC/RBHA)
- Provider Type (GMH/SU, Children's, Integrated Health Home, etc.)
- Number of Users (# employees at the agency who need Relias access)
- List of Health Plans provider is contracted with (if known)

BH provider agencies with 20 or more users will be required to purchase access to Relias Learning for a one-time fee of $1500 for full-site privileges. A full-site is defined as a site in which the agency may have full control of course customizations and competency development.

Provider agencies with 19 or fewer users will be added to AzAHP Relias Small Provider Portal at no cost with limited-site privileges. A limited-site is defined as one in which the courses and competencies are set-up according to the standard of the plan with no customization or course development provided. Contact workforce@azahp.org to do so.

Provider agencies that expand to 20 or more users will be required to purchase full site privileges to Relias Learning immediately upon expansion.

*Fee is subject to change if a Provider requires additional work beyond a standard sub-portal implementation.

AzAHP Core Training Plans

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AzAHP–Core Training Plan (90 Days)
The Training Plan below is set to auto-enroll all NEW Relias users in your system who have been assigned one (or more) of the 7 Health Plans under the "Plan" field in their user profile. If the employee hired has a previous account under another agency, please ensure that you have their transcripts transferred (there is a job aid available at www.azahp.org).

1. Welcome to Relias (Due within 7 days of hire date)
2. *AHCCCS –Health Plan Fraud (0.75hrs)
3. *AHCCCS –NEO –Rehabilitation Employment (0.5hrs)
4. *AzAHP –AHCCCS 101 (2.0hrs)
5. *AzAHP –Client Rights, Grievances and Appeals (1.25hrs)
6. *AzAHP –Cultural Competency in Health Care (1.0hrs)
7. *AzAHP –Quality of Care Concern (1.0hr)
8. Corporate Compliance: The Basics (0.5hrs)
9. Customer Service (0.5hrs)
10. Ethical Decision Making: The Basics (0.5hrs)
11. Integrating Primary Care with Behavioral Healthcare (1.25hrs)
12. Introduction to HIPAA (0.5hrs)

AzAHP –Core Training Plan (Annual)
The Training Plan below is set to auto-enroll all Relias users in your system who have been assigned one (or more) of the 7 Health Plans under the "Plan" field in their user profile.

1. Personalized Learning: Understanding the HIPAA Regulations Due: January 31st
2. Ethical Decisions Making: The Basics (0.5hrs) Due: March 31st
3. Abuse and Neglect: What to Look For and How to Respond (1.5hrs) Due: April 30th
4. Corporate Compliance: The Basics (0.5hrs) Due: May 31st
5. *AzAHP –Cultural Competency in Health Care (1.0hrs) Due: June 30th
6. *AHCCCS –Health Plan Fraud (0.75hrs) Due: October 31st
7. *AzAHP –Quality of Care Concern (1.0hr) Due: December 31st

Quarterly Reports
The ACC/RBHA AWFDA will run Quarterly Learner/Course Status Reports on the two AzAHP Training Plans: *AzAHP – Core Training Plan (90 Days) & *AzAHP – Core Training Plan (Annual). The goal for Providers is to hold a 90% (or higher) completion rate for this group of courses, within the specified reporting period. Reporting time frames for this initiative are listed below:

- **01/01-03/31 – ACC/RBHA AWFDA will run this report on 4/30**
- **04/01-06/30 – ACC/RBHA AWFDA will run this report on 7/31**
- **07/01- 09/30 – ACC/RBHA AWFDA will run this report on 10/31**
- **10/01-12/31 – ACC/RBHA AWFDA will run this report on 1/31**

If either of those dates falls on a weekend or holiday, the ACC/RBHA AWFDA reserves the right to run the report on the following business day.

Provider agencies falling at 75% or below on the above completion reports will be required to have at least 1 Relias Administrator/Supervisor from their agency complete the course titled: **AzAHP – Navigating & Managing Your Relias Portal*

Provider agencies falling below 90% on the above completion reports may be subject to corrective action and/or sanctions (including suspension, fines or termination of contract) by their contracting Health Plan(s).

General Mental Health (GMSH)/Substance Use (SU)

Staff members completing assessments of substance use disorders and subsequent levels of care must complete the American Society of Addiction Medicine (ASAM) criteria-specific training. This training is required before staff may use the assessment tool with members. They must also complete any approved substance use/abuse course every year. The assessment should align with the most recent ASAM criteria.

Network Workforce Data Collection

Provider Workforce Development Plan (P-WFDP)

The ACC/RBHA AWFDA Providers, under the provider types listed at the link below, complete the annual Provider Workforce Development Plan (P-WFDP).

Provider types:

https://azahp.org/azahp/azahp-wfda/resources-2/

The P-WFDP Template is provided for this deliverable by the ACC/RHBA AWFDA to providers. Due dates for these plans will be determined by the ACC/RHBA AWFDA and communicated to Providers.

Failure to submit your completed annual P-WFDP deliverable by the annual due date may result in corrective action and/or sanctions (including suspension, fines, or termination of contract).

Exceptions to the above include: Behavioral health hospitals, Individual practitioners, prevention and transportation agencies. Federally Qualified Health Centers (FQHCs) may request exemption from their contracted Health Plan(s). Exemptions may be granted on a case-by-case basis and will take into account the following: Portion of AHCCCS members enrolled in the network and served by that provider, geographic area serviced and number of other service providers in the surrounding area.

Miscellaneous

ACC/RBHA AWFDA Provider Forums

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The ACC/RHBA AWFDA consists of representatives from the AzAHP, Relias, and the Workforce Development Administrators from all seven ACC Health Plans. On the second Thursday of each month, the ACC/RBHA AWFDA hosts a virtual provider forum to update the Behavioral Health Network on Workforce Development related issues, training, and Relias. We encourage providers to attend the forums for up to date information on WFD related topics.

PEER/RECOVERY SUPPORT SPECIALIST TRAINING, CREDENTIALING, AND SUPERVISION REQUIREMENTS

Peer/Recovery Support Specialist and Trainer Qualifications
Trainers of Peer and Recovery Support Specialists, and individuals seeking to be credentialed and employed as Peer and Recovery Support Specialists shall:

- Meet the requirements to qualify as a behavioral health paraprofessional, behavioral health technician, or behavioral health professional, and
- Self-identify as an individual who:
    - Is or has been a recipient of behavioral health treatment for mental health disorders, substance use disorders, and/or other traumas associated with significant life disruption, and
    - Has an experience of recovery to share.

Individuals meeting the above criteria may be credentialed as a Peer/Recovery Support Specialist by completing training and passing a competency test with a minimum score of 80% through an AHCCCS/OIFA approved Peer Support Employment Training Program. AHCCCS/OIFA will oversee the approval of all credentialing materials including curriculum and testing tools. Individuals are credentialed by the agency in which he/she completed the Peer Support Employment Training Program; however, credentialing through an AHCCCS/OIFA approved Peer Support Employment Training Program is applicable statewide, regardless of which program a person has gone through for credentialing.

Some agencies may wish to employ individuals prior to the completion of credentialing through a Peer Support Employment Training Program however, an individual must be credentialed as a Peer Support Specialist/Recovery Support Specialist under the supervision of a qualified individual prior to billing Peer Support Services.

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

If a program makes substantial changes (meaning change to content, classroom time, etc.) to their curriculum or if there is an addition to required elements the program must submit the updated content to AHCCCS/OIFA for review and approval. AHCCCS/OFIA will base approval of the curriculum, competency exam and exam scoring methodology only on the elements included in this updated content. If a Peer Support Employment Training Program requires regional or culturally specific training exclusive to a GSA or tribal community, the specific training cannot prevent employment or transfer of Peer Support Specialist/Recovery Support Specialist approval based on additional elements or standards.

Competency Exam

Individuals seeking credentialing and employment as a Peer/Recovery Support Specialist must pass a competency exam with a minimum score of 80% upon completion of required training. Each Peer Support Employment Training Program has the authority to develop a unique competency exam. However, all exams must include at least one question related to each of the curriculum core elements listed in Subsection H of Peer Support Employment Training Curriculum Standards. If an individual does not pass the competency exam, the Peer Support Employment Training Program may require that the peer repeat or complete additional training prior to taking the competency exam again. For individuals certified in another state, credentials must be sent to AHCCCS/DCAIR OIFA, via email at oifa@azahcccs.gov. The individual must demonstrate their state's credentialing standards meet those of CMS's requirements prior to recognition of their credential.

Peer Support Employment Training Curriculum Standards

A Peer Support Employment Training Program curriculum must include the following core elements:

a. Concepts of Hope and Recovery
   i. Instilling the belief that recovery is real and possible,
   ii. The history of the recovery movement and the varied ways that behavioral health issues have been viewed and treated over time and in the present,
   iii. Knowing and sharing one's story of a recovery journey and how one's story can assist others in many ways,
   iv. Mind-Body-Spirit connection and holistic approach to recovery, and
   v. Overview of the Individual Service Plan (ISP) and its purpose.

b. Advocacy and Systems Perspective
   i. Overview of state and national behavioral health system infrastructure and the history of Arizona's behavioral health system,
   ii. Stigma and effective stigma reduction strategies: countering self-stigma; role modeling recovery and valuing the lived experience,

iii. Introduction to organizational change - how to utilize person-first language and energize one's agency around recovery, hope, and the value of peer support,
iv. Creating a sense of community; creating a safe and supportive environment.
v. Forms of advocacy and effective strategies – consumer rights and navigating the behavioral health system, and
vi. Introduction to the Americans with Disabilities Act (ADA).

c. Psychiatric Rehabilitation Skills and Service Delivery

i. Strengths based approach; identifying one's own strengths and helping others identify theirs; building resilience,
ii. Distinguishing between sympathy and empathy, emotional intelligence,
iii. Understanding learned helplessness; what it is, how it is taught and how to assist others in overcoming its effects,
iv. Introduction to motivational interviewing; communication skills and active listening,
v. Healing relationships – building trust and creating mutual responsibility,
vi. Combating negative self-talk: noticing patterns and replacing negative statements about one's self; using mindfulness to gain self-confidence and relieve stress,
vii. Group facilitation skills, and
viii. Introduction to Culturally & Linguistically Appropriate Services (CLAS) Standards. The role of culture in recovery.

d. Professional Responsibilities of the Peer Support Employee and Self Care in the Workplace

i. Professional boundaries and ethics - the varied roles of the helping professional, collaborative supervision and the unique role of the Peer/Recovery Support Specialist,
ii. Confidentiality laws and information sharing – understanding the Health Insurance Portability and Accountability Act (HIPAA),
iii. Responsibilities of a mandatory reporter; what to report and when,
iv. Understanding common signs and experiences of mental illness, substance abuse, addiction and trauma, orientation to commonly used medications and potential side effects,
v. Guidance on proper service documentation, billing and using recovery language throughout documentation,
vi. Self-care skills and coping practices for helping professionals, the importance of ongoing supports for overcoming stress in the workplace, resources to promote personal resilience; and,

understanding burnout and using self-awareness to prevent compassion fatigue, vicarious trauma and secondary traumatic stress.

a. Qualified peers must receive training on all of the elements listed above prior to delivering any covered healthcare services.

Peer support employment training programs must not duplicate training required of peers for employment with a licensed agency or Community Service Agency (CSA). Training elements in this section must be specific to the peer role in the public healthcare system and instructional for peer interactions.

Continuing Education and Ongoing Learning
It is required that individuals employed as Peer/Recovery Support Specialists complete a minimum of 2 hours of Continuing Education and Ongoing Learning each calendar year. Access to training relative to Peer/Recovery Support can be obtained by contacting Care1st's Individual and Family Affairs Department via email at oifa@care1staz.com, and the health plan has designated our Manager of Individual and Family Affairs Debra Jorgensen as SME regarding Peer Support Employment Training. The Manager of Individual and Family Affairs is authorized to request a review of any contracted providers' curriculum they are using to credential their Peer/Recovery Supports. It is expected that all requested material will be provided within 14 calendar days of the request.

Supervision of Peer/Recovery Support Specialists
Supervision is intended to provide support to Peer/Recovery Support Specialists in meeting the needs of members receiving Peer/Recovery Support. Supervision provides an opportunity for growth within the agency and encouragement of recovery efforts.

Agencies employing Peer/Recovery Support Specialists must have a qualified individual (behavioral health professional (BHP) or behavioral health technician (BHT)) level staff member designated to provide Peer/Recovery Support Specialist supervision. Supervision must be appropriate to the services being delivered, documented, and inclusive of both clinical and administrative supervision.

Individuals providing supervision must receive training and guidance to ensure current knowledge of Evidence Based Practices in providing supervision to Peer/Recover Support Specialists.

Process for Submitting Evidence of Credentialing
Agencies employing Peer/Recovery Support Specialists who are providing peer support services are responsible for keeping up to date records of required qualifications and credentialing for these individuals. Care1st will ensure through audits that Peer/Recovery Support Specialists meet qualifications and have credentialing, as described in this section.

PARENT/FAMILY SUPPORT PROVIDER TRAINING, CREDENTIALING, AND SUPERVISION REQUIREMENTS

Peer/Recovery Support Specialist and Trainer Qualifications

1. Children's System
   a. Individuals seeking certification and employment as a Parent/Family Support Provider or Trainer in the children's system must:
      i. Be a parent or primary caregiver with lived experience who has raised or is currently raising a child with emotional, behavioral, mental health or substance use disorder needs; and
      ii. Meet the requirements to function as a behavioral health professional, behavioral health technician, or behavioral health paraprofessional.
2. Adult System
   a. Individuals seeking certification and employment as a Parent/Family Support Provider or Trainer in the adult system must:
      i. Have lived experience as a primary natural support for an adult with emotional, behavioral, mental health or substance use disorder needs; and
      ii. Meet the requirements to function as a behavioral health professional, behavioral health technician, or behavioral health paraprofessional.

Individuals meeting the above criteria may be certified as a Parent/Family Support Specialist by completing training and passing a competency test through an AHCCCS/OIFA approved Parent/Family Support Training Program. AHCCCS/OIFA will oversee the approval of all certification materials including curriculum and testing tools. Certification through AHCCCS/OIFA approved Parent/Family Support Employment Training Program is applicable statewide.

Credentialed Parent/Family Support Provider Training Program Approval Process

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

Approval of curriculum is binding for no longer than three years. Three years after initial approval and thereafter, the program must resubmit their curriculum for review and re-approval.

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

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

Competency Exam

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

Individuals certified or credentialed in another state must submit their credential to AHCCCS/OIFA. The individual must demonstrate their state's credentialing standards meet those of AHCCCS prior to recognition of their credential. If that individual's credential/certification doesn't meet Arizona's standard the individual may obtain certification after passing a competency exam. If an individual does not pass the competency exam, the Parent/Family Support Provider Training Program shall require that the individual complete additional training prior to taking the competency exam again.

Credentialed Parent/Family Support Provider Employment Training Curriculum Standards

a. Communication Techniques:
   i. Person first, strengths-based language; using respectful communication; demonstrating care and commitment;
   ii. Active listening skills: The ability to demonstrate empathy, provide empathetic responses and differentiate between sympathy and empathy; listening non-judgmentally;
   iii. Using self-disclosure effectively; sharing one's story when appropriate.

b. System Knowledge:

i. Overview and history of the Arizona Behavioral Health System: Jason K., Arizona Vision and 12 Principles and the Child and Family Team (CFT) process; Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, Adult Recovery Team (ART), and Arnold v. Sarn; Introduction to the Americans with Disabilities Act (ADA); funding sources for behavioral health systems,
ii. Overview and history of the family and peer movements; the role of advocacy in systems transformation,
iii. Rights of the caregiver/enrolled member
iv. Transition Aged Youth: Role changes when bridging the Adult System of Care (ASOC) and Children's System of Care (CSOC) at transition for an enrolled member, family and Team.

c. Building Collaborative Partnerships and Relationships:
i. Engagement; Identifies and utilizes strengths;
ii. Utilize and model conflict resolution skills, and problem solving skills,
iii. Understanding individual and family culture; biases; perceptions; system's cultures;
iv. The ability to identify, build and connect individuals and families, including families of choice to natural, community and informal supports;

d. Empowerment:
i. Empower family members and other supports to identify their needs, and promote self-reliance,
ii. Identify and understand stages of change and
iii. Be able to identify unmet needs.

e. Wellness:
i. Understanding the stages of grief and loss; and
ii. Understanding self-care and stress management;
iii. Understanding compassion fatigue, burnout, and trauma;
iv. Resiliency and recovery;
v. Healthy personal and professional boundaries.

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

Supervision of Credentialed Parent/Family Support Provider

Agencies employing Parent/Family Support Providers must provide supervision by individuals qualified as Behavioral Health Technicians or Behavioral Health Professionals. Supervision must be appropriate to the services being delivered and the

qualifications of the Parent/Family Support Provider as a Behavioral Health Technician, Behavioral Health Professional, or Behavioral Health Paraprofessional. Supervision must be documented and inclusive of both clinical and administrative supervision.

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

Process for Submitting Evidence of Credentialing
Agencies employing Credentialed Parent/Family Support Providers who are providing family support services are responsible for keeping up to date records of required qualifications and credentialing for these individuals. Care1st will ensure through audits that Credentialed Parent/Family Support Providers meet qualifications and have credentialing, as described in this section.

TELEPHONIC CONSULTATION SERVICES

A Care1st psychiatrist may provide a telephonic psychiatric consultation for PCPs who have diagnostic or treatment concerns or questions of a general nature. The PCP initiates this type of consult by calling Member Services Line and requesting a general psychiatric consultation.

FACE-TO-FACE CONSULTATION SERVICES

A PCP can arrange for a member to have a face-to-face consultation with a Care1st psychiatrist if clinically indicated. The expectation is that the PCP will continue to manage the member's psychotropic medications following the consultation if deemed appropriate. The member must have been seen by the PCP prior to requesting this type of consultation. The PCP may use the Behavioral Health Services Referral Form and check the "One Time Consultation" box for assistance in referring the member for consultation.

COORDINATION OF CARE

In addition to treating physical health conditions, PCPs are able to treat behavioral health conditions within their scope of practice. For purposes of medication management, it is not required that the PCP be the member's assigned PCP. 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. A member who is receiving medication management services from the PCP can also receive non-medication management services (i.e. counseling) through the behavioral health system, assuming there is close coordination of care and regular communication between the PCP and the behavioral health provider.

SECTION VII: Behavioral Health Services

Close coordination of care and regular communication between the PCP and the behavioral health provider is essential. AHCCCS requires PCPs to respond to a behavioral health provider's requests for information within 10 business days of receiving the request. The response should include all pertinent clinical information regarding diagnoses, medication, laboratory results, last PCP visit and any recent hospitalizations.

Conversely, relevant behavioral health information from a behavioral health provider should be forwarded to a member's PCP at the initiation of treatment, periodically during ongoing treatment, in response to sentinel events such as a suicide attempt or a psychiatric hospital admission, and upon discharge from behavioral health services. PCPs must document or initial signifying review of a member's behavioral health information when received from a behavioral health provider. PCPs are responsible for establishing a detailed and comprehensive medical record. Medical records will be maintained in a manner, which conforms to professional standards, complies with records retention requirements, and permits effective medical review and audit processes, and which facilitates an adequate system for follow up treatment. The maintenance of medical records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information and which comply with AMPM Policy 940 and AMPM Policy 550. Providers are to maintain and share a member health record in accordance with professional standards [42 CFR 457.1230(c), 42 CFR 438.208(b)(5)].

When a PCP receives behavioral health information, a medical record will be established even if the PCP has not yet seen the assigned member. In lieu of actually establishing a medical record, such information may be kept temporarily in an appropriately labeled file but must be associated with the member's medical record as soon as one is established.

TRANSFER OF CARE

Transition from PCP to Behavior Health Provider

A transfer of care referral should be initiated from the PCP to a behavioral health provider for evaluation and continued medication management services when the member has not responded to treatment within six months, has experienced an acute increase in the severity of symptoms, or has presented with additional behavioral health symptoms that are outside of the scope of practice of the PCP. Transfer of care to behavioral health should also occur following a sentinel event, such as a suicide attempt or psychiatric hospitalization, when there are co-morbid emotional, physical, sexual or substance abuse issues or at the member's request.

PCPs should use the Behavioral Health Services Referral Form, check the "Ongoing Behavioral Health Services" box, and fax to Care1st when transferring a member's care to a behavioral health provider. The referral form includes a "Reason for Referral" section where the PCP describes the reason for transfer, including all diagnostic information. Current psychotropic medications should be listed under "Additional Information" and the PCP should designate whether the member has an adequate supply of these medications

for the next 30 days. If not, the timeframes for dispensing and refilling medications during the transition period should be noted.

The PCP must ensure that a member has access to sufficient medication, by prescription or refill, until their first appointment with the behavioral health provider who will be continuing medication management services. PCPs may use the Pharmacy Prior Authorization Form located on our website under the Forms section of the Provider menu to request interim or "bridge" medication for the member until their first behavioral health medication appointment.

When a member attends the behavioral health intake appointment, the behavioral health provider may request medical records if clinically indicated. The behavioral health provider will fill out a request for medical records, have the member sign a release of information and fax or mail the request to the PCP. Upon receipt of a request for medical records or for additional medical information, the PCP must respond within 10 business days to ensure all pertinent information is received by the behavioral health provider prior to the member's first scheduled appointment with the behavioral health provider. This response should include all pertinent information regarding the reason for transfer, current diagnoses and medications, laboratory results, medication history, last date psychotropic medication was prescribed, last PCP visit and any recent hospitalizations.

Confidential medical records that are mailed to the behavioral health provider should be marked confidential and sealed appropriately. When medical records are faxed to the behavioral health provider, they are received on a confidential fax line and delivered directly to the assigned clinician and/or prescriber. Every precaution should be taken by the PCPs office staff to ensure the confidentiality of a member's medical record.

Note: A release of information from the member is required for any communication regarding substance abuse or HIV treatment.

Continuity of care is vital when transferring a member's behavioral health care from the PCP to a behavioral health provider, so PCPs are encouraged to call Care1st's Care Management Team to assist in the transition process. The Care Management Team will contact the member (or the member's parent or legal guardian) to verify that a behavioral health intake and medication appointment has been scheduled with the behavioral health provider. The care manager will discuss any member concerns regarding the transfer of care, confirm that sufficient medication is available, and if not, assist the member in obtaining a prescription for the required medication. After the intake and medication appointment has been scheduled, a follow up call will be made to the member and the behavioral health provider within 30 days to confirm that behavioral health services are in place. The member's behavioral health disposition will then be reported to their PCP by phone and/or fax.

Transfer from Behavioral Health Provider to a PCP

When a member is transitioning from a Behavioral Health Medical Professional (BHMP) to a PCP for a behavioral health medication management will continue on the medication(s) prescribed by the BHMP until the member can transition to their PCP. The BHMP/Behavioral Health Provider will coordinate the care and ensure that the member has a sufficient supply of behavioral health medications to last through the date of the member's first appointment with their PCP. Members receiving behavioral health medications from their PCP may simultaneously receive counseling and other medically necessary services.

OUT OF STATE PLACEMENT

It may be necessary to consider an out-of-state placement for a child or young adult to meet the member's unique circumstances or clinical needs.

The following circumstances must exist in order to consider an out-of-state placement for a member:

1. The CFT or ART will explore all applicable and available in-state services and placement options and,
    a. Determine that the services do not adequately meet the specific needs of the member, or
    b. In-state facilities decline to accept the member.
2. The member's family/guardian is in agreement with the out-of-state placement (for minors and members between 18 and under 21 years of age under guardianship),
3. The out-of-state placement is registered as an AHCCCS provider,
4. Prior to placement, ensure the member has access to non-emergent medical needs by an AHCCCS registered provider,
5. The out-of-state placement meets the Arizona Department of Education Academic Standards, and
6. A plan for the provision of non-emergency medical care must be established.

Prior authorization and approval from AHCCCS is required for all out-of-state placements.

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 member, or the safety of other members, 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 member to submit an application for pre-petition screening when another member may be, as a result 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. Information about the tribal court process and the procedures under state law for recognizing and enforcing a tribal court order can be found in this section under Court-Ordered Treatment for American Indian Tribal Members in Arizona.

Pre-petition screening includes an examination of the member's mental status and/or other relevant circumstances by a designated screening agency. Upon review of the application, examination of the member and review of other pertinent information, a licensing screening agency's medical director or designee will determine if the member meets criteria for DTS, DTO, PAD, or GD as a result 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 person or others, an emergency admission for evaluation may be necessary. The screening agency, upon receipt of the application shall act as prescribed within 48 hours of the filing of the application excluding weekends and holidays as described in A.R.S. §36-520.
Based on the court-ordered evaluation, the evaluating agency may petition the 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 member must be determined, as a result of the evaluation, to be DTS, DTO, PAD, or GD. Court-ordered treatment 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 may be identified by the court to supervise the member's outpatient treatment. In some cases, the mental health agency may be the AHCCCS Complete Care (ACC) contractor; however, before the court can order a mental health agency to supervise the member's outpatient treatment, the agency medical director must agree and accept responsibility by submitting a written plan to the court.

At every stage of the pre-petition screening, court-ordered evaluation, and court-ordered treatment process, a member will be provided an opportunity to change his/her status to

voluntary. Under voluntary status, the member is no longer considered to be at risk for DTS/DTO and agrees in writing to receive a voluntary evaluation.

County agencies and Care1st contracted agencies responsible for pre-petition screening and court-ordered evaluations may use the following forms prescribed in 9 A.A.C. 21, Article 5:

- Application for Involuntary Evaluation
- Application for Voluntary Evaluation (English/Spanish)
- Application for Emergency Admission for Evaluation
- Petition for Court-Ordered Evaluation
- Petition for Court-Ordered Treatment
- Affidavit, Addendum No. 1 and Addendum No. 2

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 as a court-ordered evaluation or court ordered treatment agency must adhere to ADHS licensing requirements.

County Contracts
Pre-petition Screening
Arizona Counties are responsible for managing, providing, and paying for pre-petition screening and court-ordered evaluations and are required to coordinate provision of behavioral health services with Care1st for Care1st members.

Some counties contract with RBHAs to process pre-petition screenings and petitions for court-ordered evaluations. (See Arizona Revised Statutes A.R.S. §§ 36-545.04, 36-545.06 and 36-545.07). For additional information regarding behavioral health services refer to 9 A.A.C. 22, 2, &12. Refer to ACOM policy 437 for clarification regarding financial responsibility for the provision of medically necessary behavioral health services rendered after completion of a Court Ordered Evaluation.

The Northern Arizona Geographic Service Area is comprised of Apache, Navajo, Coconino, Yavapai, and Mohave Counties. Care1st is not contracted with the county governments in this GSA to provide pre-petition screenings and court-ordered evaluation services. Care1st has been informed either by the counties or by their subcontractors that

the counties have made the following arrangements for pre-petition screening and court ordered evaluation services:

- Apache County has made arrangements with Little Colorado Behavioral Health Services, Inc. to accept pre-petition screenings and to assist with the court ordered evaluation process
- Navajo County has contracted with ChangePoint Integrated Health, Inc. to provide pre-petition screenings and court-ordered evaluations
- Coconino County has an intergovernmental agreement with AHCCCS for these services. In-turn, AHCCCS contracts with Health Choice Integrated Care to provide pre-petition screening and court ordered evaluation services. HCIC has contracted with The Guidance Center, Inc. to be the lead provider for pre-petition screenings and court-ordered evaluations. Encompass Health Services may provide pre-petition screenings in the northern part of Coconino County
- Yavapai County has contracted with Polara Heal to provide pre-petition screenings and court-ordered evaluations
- Mohave County has contracted with Mohave Mental Health Centers, Inc. to provide pre-petition screening

The Central Arizona Geographic Service area is comprised of Maricopa, Gila, and Pinal county. Care1st has been informed either by the counties or by their subcontractors that the counties have made the following arrangements for pre-petition screening and court ordered evaluation services:

- Maricopa County has an intergovernmental agreement with AHCCCS for these services. In-turn, AHCCCS contracts with Mercy Maricopa to provide pre-petition screening and court ordered evaluation services.
- Pinal County has made arrangements with Horizon Health & Wellness to provide pre-petition screenings and court-ordered evaluations.
- 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

Based upon the county of location of the person to be screened and or evaluated behavioral health providers should contact the entities listed above to refer for pre-petition screening or court-ordered evaluation.

Pre-Petition Screening

Any behavioral health provider that receives an application for court-ordered evaluation (see AMPM Policy 320-U, Exhibit 320-U-1) must immediately refer the applicant for pre-petition screening and petitioning for court-ordered evaluation to the Contractor designated pre-petition screening agency or county facility.

Pre-Petitioning Screening Processes:

The pre-petition screening agency must follow these procedures:

- Provide pre-petition screening within 48 hours excluding weekends and holidays.
- Prepare a report of opinions and conclusions.
- If pre-petition screening was not possible, the screening agency must report reasons why the screening was not possible, including opinions and conclusions of staff individuals who attempted to ensure Medical Director or designee review of the report in the event the report indicates that there is no reasonable cause to support the allegations for court-ordered Evaluation by the applicant.
- Prepare a petition for court-ordered evaluation and file the petition if the screening agency determines that the person, due to a mental disorder, including a primary diagnosis of dementia and other cognitive disorders, is DTS, OTO, PAD, or GD. AMPM Policy 320-U, Exhibit 320-U-3, documents pertinent information for court-ordered evaluation.
- Ensure completion of AMPM Policy 320-U, Exhibit 320-U-2, and take all reasonable steps to procure hospitalization on an emergency basis, if it determines that there is reasonable cause to believe that the person, without immediate hospitalization, is likely to harm themselves or others.
- Contact the county attorney prior to filing a petition if it alleges that a person is DTO.

Emergent/Crisis Petition Filing Process for Contractors Contracted as Evaluating Agencies

When it is determined that there is reasonable cause to believe that the person being screened is in a condition that without immediate hospitalization is likely to harm themselves or others, an emergent application can be filed. The petition must be filed at the appropriate agency as determined by the Evaluating Agency.

- Only applications indicating DTS and/or DTO can be filed on an emergent basis.
- The applicant must have personally seen or witnessed the behavior of the person that is a danger to self or others and not base the application on second hand information.
- The applicant must complete the Application for Involuntary Evaluation Exhibit 320-U-1 as per AMPM Policy 320-U.
- The applicant and all witnesses identified in the application as direct observers of the dangerous behavior, may be called to testify in court if the application results in a petition for COE Within 48 hours of receipt of AMPM Policy 320-U, Exhibit 320-U-2 and all corroborating documentation necessary to successfully complete a determination, the admitting physician will determine if enough evidence exists for an emergency admission for evaluation. If there is enough evidence to support the emergency admission for evaluation, the facility is not currently operating at

or above its allowable member capacity, and the person does not require medical transportation to the appropriate facility.

- If the person requires a medical facility, or if placement cannot be arranged within 48 hours after the approval of AMPM Policy 320-U, Exhibit 320-U-2, the Medical Director of the Contractor will be consulted arrange for a review of the case.
- An AMPM Policy 320-U, Exhibit 320-U-2, may be discussed by telephone with the facility admitting physician, the referring physician and a police officer to facilitate transportation of the person to be evaluated.
- A person proposed for emergency admission for evaluation may be apprehended and transported to the facility under the authority of law enforcement using the written AMPM Policy 320-U, Exhibit 320-U-2.
- A 23-hour emergency admission for evaluation begins at the time the person is detained involuntarily by the admitting physician who determines there is reasonable cause to believe that the person, as a result of a mental disorder, is a DTS or DTO and that during the time necessary to complete prescreening procedures the person 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:
    a. The person's ability to consent to voluntary treatment will be assessed.
    b. The person shall be offered and receive treatment to which he/she may consent. Otherwise, the only treatment administered involuntarily will be for the safety of the person or others, i.e. seclusion/restraint or pharmacological restraint in accordance with A.R.S § 36-513.
    c. The psychiatrist will complete the Evaluation within 24 hours of determination that the person no longer requires involuntary evaluation.

Court-Ordered Evaluation

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. The procedures for court-ordered evaluations are outlined below:

Care1st and its subcontracted behavioral health provider must follow these procedures:

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

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

Voluntary Evaluation

Any Care1st contracted behavioral health provider that receives an application for voluntary evaluation must immediately refer the member to the facility responsible for voluntary evaluations in the region/area where the member is located. The evaluation agency must obtain the member's informed consent prior to the evaluation (see AMPM Policy 320-U, Exhibit 320-U-7) 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 person will voluntarily receive an evaluation; and if a behavioral health provider conducts a voluntary evaluation service as described in this section, the comprehensive clinical record must include:

- A copy of the application for voluntary evaluation, AMPM Policy 320-U, Exhibit 320-U-7 A completed informed consent form (see AMPM Policy 320-Q) and
- A written statement of the member's present medical condition.

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 AMPM Policy 320-U, Exhibit 320-U-4)
- Any behavioral health provider filing a petition for court-ordered treatment must do so in consultation with the person'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 AMPM Policy 320-U, Exhibit 320-U-5);
- 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 person was found before evaluation, and to any person nominated as guardian or conservator; and
- A copy of all petitions must be mailed to the superintendent of the Arizona State Hospital.

Persons Who Are Title XIX/XXI Eligible And/or Determined To Have SMI

When a person referred for court-ordered treatment is Title XIX/XXI eligible and/or determined or suspected to have a Serious Mental Illness, the behavioral health provider will:

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

AGENCY TRANSFERS FOR MEMBERS ON COURT ORDERED TREATMENT

This Section pertains to court ordered treatment under A.R.S. § 36, Chapter 5 and the Arizona Administrative Code R9-21-507.

Note: The following are general guidelines-each County has the right to request additional or different documentation. When the specific County process is known, it shall be included in this guide.

A person ordered by the court to undergo treatment and who is without a guardian may be transferred from one provider to another provider, as long as the medical director of the provider initiating the transfer has established that:

- The member's Court Ordered Treatment is not expiring within 90 days of the transfer,
- There is no reason to believe that the person will suffer more serious physical harm or serious illness as a result of the transfer;
- The person is being transitioned to a level and kind of treatment that is more appropriate to the person's treatment needs; and
- The medical director of the receiving provider has accepted the person for transition.

The medical director of the provider requesting the transition must have been the provider that the court committed the person to for treatment or have obtained the court's consent to transition the person to another provider as necessary.

The medical director of the provider requesting the transition must provide notification to the receiving provider allowing sufficient time (but no less than 3 days) for the transition to be coordinated between the providers. Notification of the request to transition must include:

- A summary of the person's needs;

- A statement that, in the medical director's judgment, the receiving provider can adequately meet the person's treatment needs;
- A modification to the individual service plan, if applicable;
- Documentation of the court's consent, if applicable;
- A written compilation of the person's treatment needs and suggestions for future treatment by the medical director of the transitioning provider to the medical director of the receiving provider. The medical director of the receiving provider must accept this compilation before the transition can occur; and

This is best accomplished by sending an email to the provider the member has requested to be transferred to and requesting a "Letter of Intent to Treat".
The receiving Provider's Title 36 liaison should be cc'd on any emails when a member on court ordered treatment is going to be transferred.

The Letter of Intent can be a letter from the Medical Director of the receiving Behavioral Health Clinic that includes:

- Name and DOB of the individual on COT
- COT start and end date
- The standard under which the person is court ordered (DTO; /DTS; PAD; GD)
- Printed name and signature of the receiving Provider's Medical Director
- Effective transfer date (date of intake)
- The letter can read simply: *"This letter is to verify that Dr. X and Provider Y has agreed to provide court ordered treatment to member Z"*
- The Behavioral Health Clinic must keep a copy of the letter in the clinical record.

The Medical Director of the receiving Provider notifies Court in writing that there has been a change in oversight of the individuals COT. It is recommended that an official document from the court be requested that reflects the current treatment Provider/Medical Director as the responsible party overseeing the court ordered treatment

MEMBERS CURRENTLY BEING SERVED BY A CLINIC WHO CANNOT PROVIIDE OUTPATIENT SERVICES FOR COURT ORDERED TREATMENT
This refers to those clinics who do not have a psychiatrist on staff to provide monitoring of the outpatient treatment plan. If a member is currently receiving services at such a clinic and due to distance cannot transfer to another clinic that can provide this service, the current clinic should outreach to the Care1st Court Coordinator.

Court-Ordered Treatment for Persons Charged With Or Convicted Of A Crime
Care1st or its 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, Care1st will cover DV services with Title XIX/XXI funds when the person 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 persons' court ordered for DV treatment, the individual can be billed for the DV services.

Court ordered substance abuse evaluation and treatment
Substance abuse evaluation and/or treatment (i.e., DUI services) ordered by a court under A.R.S. § 36-2027 is the financial responsibility of the county, city, town or charter city whose court issued the order for evaluation and/or treatment. Accordingly, if ADHS/AHCCCS or Care1st receives a claim for such services, the claim will be denied and the provider is 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 person 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, Care1st 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. AMPM Policy 320-U, Exhibit 320-U-6, A.R.S. § 12-136 Domestication or Recognition of Tribal Court Order is a flow chart demonstrating the communication between tribal and state entities. Care1st and its providers must comply with state recognized tribal court orders for Title XIX/XXI and Non-Title XIX SMI persons. When tribal providers are also involved in the care and treatment of court ordered tribal members, Care1st 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 in an effort to communicate and ensure clinical coordination with the Care1st staff. This clinical communication and coordination with Care1st is necessary to assure continuity of care and to avoid delays in admission to an appropriate facility for treatment upon state/county court recognition of the tribal court order. The Arizona State Hospital should be the last placement alternative considered and used in this process.

A.R.S. § 36-540 (B) states, "The Court shall consider all available and appropriate alternatives for the treatment and care of the patient. The Court shall order the least restrictive treatment alternative available." Care1st 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, ACC, or IHS/638 provider. See on the AHCCCS website under Tribal Court Procedures for Involuntary Commitment-Tribal Court Procedures for Involuntary Commitment for a diagram of payment structures.

Tolling a Court Ordered Treatment

Per Statute 36.544; a member's Court Ordered Treatment is tolled during the unauthorized absence of the patient and resumes running only on the patient's voluntary or involuntary return to the treatment agency.

As defined by the Statute, an unauthorized absence is the following:

- if a member is no longer living in a placement or residence specified by the treatment plan without authorization OR
- leaving or failing to return to the county or state without authorization
- Absent from an inpatient treatment facility without authorization

The Statute indicates within five (5) days after notification of a patient's unauthorized absence, the Behavioral Health Provider shall file a motion with the Court to request a Toll of the Court Ordered Treatment. Behavioral Health Provider Title 36 Liaisons will be responsible for Filing Toll requests with the Courts, monitoring the number of days of the Toll and ensuring Status Reports for re-engagement efforts are filed every 60 days up to 180-Tolled Days. Tolled Orders will be reported to the Care1st Court Coordinators.

Should the member not be re-engaged voluntarily or involuntarily, the Behavioral Health Provider has the option to ask the Court to terminate the Court Ordered Treatment after 180 days on Toll. Tolling a Court Order will move forward the expiration date of the current Order based upon the number of days the member was absent.

Judicial Reviews A.R.S. § 36-546
Every 60 days the provider must inform the individual of his/her right to Judicial Review and must document this in the clinical record, however, the individual can request this at anytime Judicial Reviews are to be calendared and offered every 60 days from the date of the original court order. The provider on a monthly basis submits the date the judicial review was offered as well as supporting documentation demonstrating evidence this was offered (i.e. progress note, prescriber notes or established judicial review form). This process ensures monitoring of timely requests.

If an individual is hospitalized pursuant to an amendment the provider must offer the individual a Judicial Review within seventy-two (72) hours of admission. This Judicial Review does not change the count of the 60 days set from the date of the court order. It is considered an exception per statute and is permitted before the 60 days.
Court requires the psychiatric report to contain sufficient clinical information to render a decision regarding whether the individual needs continued court-ordered treatment or not. This psychiatric report can be in the form of a progress note. At a minimum the Judicial Review must include information regarding individual's insight regarding his/her mental illness and information regarding adherence to court-ordered treatment plan. If the individual does not attend the Judicial Review appointment, the prescriber must complete a chart review to provide this information. If an individual is hospitalized pursuant to an amended outpatient treatment plan and requests a Judicial Review, merely stating the individual is hospitalized is not enough factual information for Court to render a decision. The prescriber should attempt to contact the inpatient BHMP to gather information for the Judicial Review. Failure to provide sufficient evidence of need for continued treatment could result in Court requesting a hearing on the matter.

If an individual no longer needs COT or it is inappropriate for the individual to be on a COT, the Medical Director can request through Judicial Review for the court to terminate the COT. The court may or may not approve this request.
A hearing can be set by the Judge/Commissioner on his/her own or if requested by the defense attorney.

Annual Review A.R.S. § 36-543
Within 90 -45 days of the expiration of the court order, the provider must conduct an annual review of an individual who was court-ordered to treatment as Gravely Disabled or Persistently or Acutely Disabled (GD & PAD) to determine if continuation of COT is appropriate and assess the needs of the individual for guardianship or conservatorship or both. The annual review includes a review of the mental health treatment and clinical records contained in the individual's treatment file.
If the Medical Director believes that continuation of the court-ordered treatment is appropriate, the Medical Director appoints one or more psychiatrists (depending on the County) to carry out a psychiatric examination of the individual. Each psychiatrist participating in the psychiatric examination must submit a report to the Medical Director that includes the following:

1) The psychiatrist's opinions as to whether the individual continues to have a grave disability or persistent or acute disability as a result of a mental disorder and is in need of continued COT
2) A statement as to whether suitable alternatives to COT are available
3) A statement as to whether voluntary treatment would be appropriate
4) Review of the individual's need for a guardian or conservator or both
5) Whether the individual has a guardian with mental health powers that would not require continued COT
6) The result of any physical examination that is relevant to the psychiatric condition of the individual.

To ensure this review has taken place the provider submits on the month that the annual review is due progress notes indicating the BHMP met with the individual 45-90 days prior to expiration of the court order. Additionally, the individual's clinical team shall hold a service planning meeting, not less than 45 days prior to the expiration of the court-ordered treatment to determine if the court order should continue.

If the Medical Director believes after reviewing the annual review that continued COT is appropriate, the Medical Director files with Court, no later than forty-five days before the expiration of the court order for treatment, an application for continued court-ordered treatment and the psychiatric examination conducted as part of the annual review. If the individual is under guardianship, the Medical Director must mail a copy of the application to the individual's guardian.

The annual exam must have current contact information for the individual. This includes full address, zip code, and telephone number. If the individual's location and/or other contact. If any information changes, provider staff is required to contact the individual's attorney with this new information.

A hearing is conducted if requested by the individual's attorney on behalf of the request of the individual or otherwise ordered by Court.

For individuals determined DTS and/or DTO the provider must initiate the pre-petition screening process pursuant to Arizona Administrative Code.

TERMINATION/RELEASE FROM COURT ORDERED TREATMENT A.R.S. § 36-541.01

Upon written request of the individual's Behavioral Health Medical Provider, a Court may order an individual to be released from court-ordered treatment prior to the expiration of the court-ordered period.

Specifically, the Title 36 Statute states "A patient who is ordered to undergo treatment pursuant to this article may be released from treatment before the expiration of the period ordered by the court if, in the opinion of the medical director of the mental health treatment agency, the patient no longer is, as a result of a mental disorder, a danger to others or a danger to self or no longer has a persistent or acute disability or a grave disability. A person who is ordered to undergo treatment as a danger to others may not be released or discharged from treatment before the expiration of the period for treatment ordered by the court unless the medical director first gives notice of intention to do so as provided by this section."

TERMINATION FROM REPORTING A MEMBER WHO IS ON COURT ORDERED TREATMENT

There are certain circumstances when a Behavioral Health Home may no longer be required to report to The Health Plan a member who is on Court Ordered Treatment. These conditions would be as follows: 1) a member has been sentenced to the Department of Corrections, 2) a member has died, 3) the member has lost AHCCCS benefits and is NOT Severely Mentally Ill (SMI) and does not meet SMI criteria, 5) the member's Court Order has been Tolled for 180 days and the Court approves the Behavioral Health Home's request to terminate the Court Order, 6) the Order is dismissed during a Judicial Review hearing, and 7) the member has agreed to become voluntary.

SUPPENSION OF OUTPATIENT TREATMENT PLAN

In some Counties there are certain circumstances where a petition to request a suspension of the agency supervision of the outpatient treatment may be submitted to the Court. This is done on a case by case basis. Any agency wishing to use this petition must contact the Care1st Court Coordinator prior to requesting this petition.

REPORTING

SECTION VII: Behavioral Health Services

Per AHCCCS, monthly reporting is required for all persons on court ordered treatment. All providers must identify and track treatment engagement of Court Ordered Treatment (COT) individuals.

- Provider can complete/submit updates at any time during the reporting month, but all updates (updates include monthly excel workbook deliverable and required documentation) must be completed and submitted no later than the 2nd business day of the next month.
- Provider must submit initial or continuing COTs as soon as they are received from the Court.

COT TRACKING

The Behavioral Health Medical Director shall review the condition of a patient on conditional outpatient treatment via chart review at least once every thirty days and enter the findings in writing in the patient's file. In conducting the review, the medical director shall consider all reports and information received and may require the patient to report for further evaluation. If a COT member missed an appointment, the provider will follow up within 24 hours.

RESIDENTIAL FACILITIES SERVING JUVENILES

Contracted residential facilities that serve juveniles are required to comply with all relevant provisions in A.R.S. §36-1201.

FISCAL RESPONSIBILITY

Benefit Coordination for Behavioral Health Services and Physical Health Services is outlined in Policy 432 of the AHCCCS Contractor Operations Manual (ACOM). The policy is located at the following website:
http://www.azahcccs.gov/shared/ACOM/Chapter400.aspx > select policy 432.

SECTION VIII: Claim Disputes and Appeals

PROVIDER CLAIM DISPUTES & APPEALS

Care1st encourages providers to check claim status on our website www.care1staz.com or contact Claims Customer Service for assistance with questions or issues regarding claim payment, partial payment, or non-payment. As a reminder, initial claim submissions must be received within six months from the date of service. A claim may be disputed by filing a claim dispute.

A Claim Dispute is:

1. a formal legal challenge of a health plan's disposition of a claim
2. a time sensitive process that is without exception

A Claim Dispute is not:

1. an alternate claim submission or resubmission process
2. a billing and or write-off requirement
3. a means for a contracted provider to seek an exception of claims rules

AHCCCS guidelines require that all claim disputes (i.e. complete or partial denial of a claim) be submitted in writing within 12 months from the date of service; within 12 months after the date of eligibility posting; the date of discharge (for an inpatient claim); or within 60 days of the last adverse action, whichever is greater. A provider should never wait longer than the required timeframes to file a dispute: however, **providers are encouraged to exhaust all available means of resolving an issue before filing a dispute**.

All requests for dispute should include:

1. A completed claim dispute form OR a letter detailing the factual and legal basis for the dispute. (Please submit one Claim Dispute Form or a letter for each disputed claim. The Claim Dispute Form is available on our website in the "Forms" section of the Provider menu or by contacting Network Management).

2. A copy of the original claim and remittance advice

3. Supporting documentation for reconsideration. For provider disputes with a clinical component (such as denied inpatient days, or services denied for no prior authorization), additional documentation should include a narrative describing the situation, an operative report and medical records as applicable.

4. ***Mail*** the completed form(s) and documentation to:

   Care1st Provider Claim Disputes
   1850 W Rio Salado Parkway, Suite 211
   Tempe, AZ 85281

Note: Disputes that fail to detail the facts of the case, the legal argument or are submitted with incomplete information will be denied without medical review. Care1st will not attempt to solicit supporting documentation.

SECTION VIII: Claim Disputes and Appeals

PROCEDURE

- Care1st acknowledges claim dispute requests within five business days of receipt. If you do not receive an acknowledgement letter you should contact the Claim Disputes & Appeals Team to inquire about the status of the matter immediately.
- Disputes are reviewed and a decision issued within 30 calendar days of receipt. Care1st may request an extension of up to 14 calendar days, if a need for additional information is established.
- Care1st issues ALL decisions, whether approved or denied, in writing.

If a provider disagrees with the resolution of a matter, a request for State Fair Hearing may be filed in writing, and within 30 days from the date of receipt of the Care1st decision letter. The process for requesting a hearing will be provided in the decision letter. When a request for State Fair Hearing is received, the plan will copy the case file and forward it to the AHCCCS Office of Administrative Legal Services (OALS) who will either schedule an administrative hearing or render an "*informal decision*". The provider will be notified by the AHCCCS Office of Administrative Legal Services of hearing dates, times and locations. AHCCCS administrative hearings are conducted by an Administrative Law Judge at the Office of Administrative Hearings. At the conclusion of the hearing, the Administrative Law Judge will issue a recommended decision to the AHCCCS Administration, AHCCCS Administration issues a final determination.

MEMBER APPEALS

A provider may appeal on behalf of a member with the member's written consent or may direct the member to the Customer Service Department for appeal submission.

Members may appeal telephonically, in person, or in writing within 120 days of the adverse action. Expedited Member Appeals are resolved within 72 hours while standard appeals are resolved in 30 days. An extension of up to 14 days may be taken for either expedited or standard appeals, if required to fully investigate the matter.

All Member Appeals are mailed to:

Care1st
Member Appeals
1850 W Rio Salado Parkway, Suite 211
Tempe, AZ 85281

Note: All claim disputes and appeals are tracked for trends, however no action is ever taken against a provider who files a claim dispute, supports an enrollee's appeal or advocates on behalf of the member.

SECTION IX: Medical Operations

OVERVIEW

The Care1st Medical Management (MM) program ensures that members get the right care from the appropriate service provider at the right place and at the right time. The framework of Care1st's MM Program drives the processes used to identify utilization patterns such as recidivism, adverse outcomes, and under/over utilization which may indicate quality of care issues. The program is further designed to identify and manage care for high risk members to ensure that appropriate care is delivered by accessing the most efficient resources. Finally, the MM program identifies opportunities to promote preventive health measures to decrease acute and chronic health care conditions. Care1st does not provide financial incentives for MM decision makers to encourage decisions that result in underutilization. Care1st does not reward practitioners, or other individuals involved in utilization review, for denying a service.

PRIOR AUTHORIZATION AND REFERRAL PROCESS

Prior authorization (PA) is a process by which Care1st determines in advance whether a service that requires prior approval will be covered, based on the initial information received. Services that require PA include though are not limited to all non-emergent services rendered by a non-participating care provider, vendor or facility and out-of-state services. Also any service considered experimental, investigational, or new technology procedures with by-report or new CPT codes require PA. PA may be pended until the receipt of required clinical documentation to substantiate compliance with criteria used by Care1st. For a complete list of services requiring authorization, refer to the online Care1st Arizona website: https://www.care1staz.com/az/providers/priorauthreferencegrid.asp.
Criteria used by Care1st to make decisions are available upon request.

The MM Department uses clinically sound, nationally developed and accepted criteria for making medical necessity decisions. Clinical criteria utilized in decision making include, but is not limited to:

- AHCCCS Guidelines
- InterQual Guidelines
- Official Disability Guidelines (ODG)
- American College of Obstetrics and Gynecology
- The American Academy of Pediatrics
- CMS Guidelines
- Centene/Care1st Guidelines
- Hayes, Inc.

SECTION IX: Medical Operations

PA is not a guarantee of payment. Reimbursement is dependent upon the accuracy of the information received with the original PA request, whether or not the service is substantiated through concurrent and/or medical review, eligibility, and whether the claim meets claims submission requirements.

AUTHORIZATION FORMS

PAs for medical services are requested on the *Medical/Behavioral Health Prior Authorization Form*. To obtain a Total OB authorization, submit a completed Pregnancy Risk Assessment Form and *ACOG Records*. Medications not listed on the Care1st Preferred Drug List (PDL) and Behavioral Health Preferred Drug List (BH PDL) are considered non-formulary drugs. Providers must submit prior authorization requests for all non-formulary medications and medications listed on the formulary with a PA requirement. Care1st will cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable. Prior Authorization forms are available on the Care1st website www.care1staz.com under the *Forms* section of the Provider menu. The Prior Authorization Guidelines and Formularies are also available on our website under the provider link. Providers without internet access may contact Network Management for a copy to be mailed or faxed to your office.

Authorization requests for dental services must be submitted directly to:

For ACC Members:	**For RBHA Members:**
DentaQuest of Arizona, LLC – Authorizations PO Box 2906 Milwaukee, WI 53201-2906 Fax: 262.241.7150 The DentaQuest Office Reference Manual identifies dental prior authorization and claim submission requirements are available on the DentaQuest website or by contacting DentaQuest at 800.440.3408.	Requests for dental services that require authorization are submitted directly to Envolve Dental via mail, electronic clearinghouse, or Envolve Dental's provider web portal at www.envolvedental.com. Dental prior authorization requests sent by mail should be sent to: Envolve Dental PO Box 20132 Tampa, FL 33622-0132 The Envolve Dental Provider Manual identifies dental prior authorization and claim submission requirements and is available on the Envolve Dental website or by contacting Envolve Dental at (844-876-2028)

SECTION IX: Medical Operations

PRIOR AUTHORIZATION NUMBER SUBMISSION ON CLAIM

A PA number is issued by the PA Department for approved treatment authorization requests. The PA number must be included on the claim in order for claims adjudication and payment to occur.

1. UB-04 – place PA number in field 63
2. CMS 1500 – place PA number in field 23
3. ADA (J430D) – place PA number in field 2

A denial will occur if the PA number is not included for services requiring PA.

PRIOR AUTHORIZATION TIPS

- Please refer to the Prior Authorization Guidelines for procedures that require PA in addition to the visit. Prior authorization is required for some services when Care1st is the secondary payer.
- Please direct members to contracted providers including when Care1st is the secondary payer. All services requested for a non-contracted provider require prior authorization.
- For Specialties that require authorization for the initial consultation and/or follow-up visits, all visits and in-office procedures performed must fall within the authorization date range approved.
- Your PA request will be processed more expeditiously if you fax the completed Medical Health Prior Authorization Form with all supporting documentation and medical records. Allow sufficient time to process your request (especially on Friday afternoons following hospital discharges).
- Please contact Care1st for the status of your PA request before sending a duplicate request.
- Provide the past year's medical records and/or any supporting documents to justify request. Failure to submit supporting documents may delay processing.
- Provide laboratory results such as cultures and sensitivities, cholesterol panels, or any other pertinent lab results to expedite the medical necessity reviews for both medical and pharmacy requests.
- Prior authorization requests for medications are reviewed and completed within 24 hours of receipt. If needed, a 4- day supply of a non-excluded medication following a hospital or ED discharge can be obtained by calling the Care1st Pharmacy Department at 1-866-560-4042 (Options 5,5).

MEDICAL AND SERVICE AUTHORIZATION TIME FRAMES

Inpatient and outpatient referral requests for Care1st members that are received from primary care and specialty care physicians will be processed according to status within the following designated time frames:

Urgent - Processed and returned no later than 72 hours from date received by the PA Department as long as all necessary supporting medical documentation is included for review. Please remember not to use urgent for requests for member or provider convenience.

NOTE: Care1st reserves the right to review and downgrade urgent requests to routine status if determined not to be urgent. Urgent referrals are not for provider convenience and should only be used for urgently needed treatments. The requesting provider's office will be contacted by phone and fax if the team has determined a request should be downgraded to routine and allow the provider to submit additional documentation that would show the need for an urgent referral.

Routine- Processed and returned with authorization number within 14 calendar days from the date received by the PA Department. Providers will be notified of the determination via facsimile within one working day of making the decision.

Pended- Requests will be pended upon receipt for up to 28 calendar days if appropriate supporting documentation is not included with the request. Failure to submit supporting documentation will delay the processing of your request.

Note: If the information submitted is not adequate, it will be pended in order to afford the opportunity for the MM staff to obtain additional medical information.

For routine requests that are pended for more information, the PA Department will make two attempts to obtain any outstanding medical information that is required to make a determination based on medical necessity. This will increase the amount of time it takes to process the request and may take up to 28 days to complete the process. If two documented attempts to obtain additional information from the requesting provider have been unsuccessful, the applicable Medical Director will make a determination to approve, modify, or deny the authorization based on the medical information submitted by the provider.

Denial of authorization requests based on medical necessity occurs only after a Care1st Medical Director has reviewed the request and determines that the service does not meet criteria. You will receive notification that you can request a Peer to Peer discussion with a medical director if you have questions or concerns on the denial decision.

REFERRAL/PRIOR AUTHORIZATION PROCESS FROM PCP TO SPECIALIST

1. Select a contracted specialist.
2. Refer to the PA Guidelines to determine if an authorization is required.
3. If PA is NOT required, the PCP may contact the contracted specialist and schedule an appointment.

4. If PA is required, complete the Medical Health Prior Authorization Form, which must contain all supporting documentation including ICD-10 and/or CPT codes, and office fax number of the requesting provider. Supporting documentation should include physician progress notes, lab results, diagnostic test results and reports, consultant notes, or any other medical documentation from the medical record that is pertinent to the service being requested that will assist in making the decision.
5. Fax the completed Medical Health Prior Authorization Form and supporting documentation to the PA Department.
6. The PA Department will return the Medical Health Prior Authorization Form, with the authorization number, by fax.
7. After the approved Medical Health Prior Authorization Form has been received, contact the specialist and schedule the member's appointment. After the appointment has been made, send copy of approved Medical Health Prior Authorization Form to the authorized specialist.
8. Notify the member of the time, date, and location of the scheduled appointment.

SPECIALIST RESPONSIBILITIES

1. Schedule appointments for members in accordance with appointment availability standards when an appointment is requested by a contracted PCP.
2. If a member fails to appear for a scheduled visit the specialty care provider may reschedule the appointment within ninety (90) days without obtaining another PA number, as long as the member remains eligible with Care1st.
3. Use the PA number for billing purposes.
    - The PA number is valid for a consultation and two follow-up visits unless otherwise noted on the Medical Health Prior Authorization Form.
    - The PA number for a consultation is valid for ninety (90) days.
    - Authorizations for follow up visits are valid for ninety (90) days when given with a consultation, as long as the member retains eligibility with Care1st.
4. Verify member eligibility prior to all appointments (see note below).
5. Provide scheduled services.
6. Provide a copy of the consultation notes to the member's PCP.
7. If the Specialist plans to perform a surgery or a special procedure that requires PA, a Medical Health Prior Authorization Form must be completed and faxed to the PA Department.
    - The specialist must attach a legible consult note or clearly written documents to support the request along with appropriate ICD-10 and CPT codes.
    - Upon receipt of the Medical Health Prior Authorization Form, the PA Department will review and approve the procedure as necessary. An authorization number will be issued and noted on the Medical Health

Prior Authorization Form then faxed back to the specialist. Authorization numbers for procedures remain valid for ninety (90) days. After that time, the request must be re-submitted to Care1st.

8. Ensure medical care is appropriate and consistent with each member's individualized health care needs.

NOTE: Claims will not be reimbursed if authorization is not obtained prior to date of service or if the member is not eligible with Care1st on the date of service. To verify member eligibility, providers should contact the Customer Service Department or use our secure Provider Portal on our website. It is the responsibility of the providers to verify eligibility prior to rendering services.

REFERRAL PROCESS FROM SPECIALIST TO ANOTHER SPECIALIST

When a specialist needs to refer a member to another specialist, it is not necessary for the member to be referred back to the PCP. The referring specialist should follow the guidelines as outlined above.

REFERRALS TO DENTAL PROVIDERS

For ACC Members:	**For RBHA Members:**
1. Prior authorizations, claim submissions and claim inquiries are submitted to DentaQuest. For additional information see Section VI Covered Services.	1. Prior authorizations, claim submissions and claim inquiries are submitted to Envolve Dental. For additional information see Section VI Covered Services.
2. Members may schedule their own appointment with any contracted general dentist.	2. Members may schedule their own appointment with any contracted general dentist.
3. The DentaQuest Office Reference Manual (ORM) provides detailed information regarding prior authorization and claim submission requirements. The DentaQuest ORM is available on the DentaQuest web site www.dentaquest.com or by contacting DentaQuest at 800.440.3408. All dental offices must verify member eligibility prior to rendering services.	3. The Envolve Dental Provider Manual provides detailed information regarding prior authorization and claim submission requirements. The Envolve Dental Provider Manual is available on the Envolve Dental website at envolvedental.com or by contacting Envolve Dental at 800.440.3408. All dental offices must verify member eligibility prior to rendering services.
4. After dental services are provided, the dentist is responsible for sending a printed report to the PCP to be included in the member's medical record.	4. After dental services are provided, the dentist is responsible for sending a printed report to the PCP to be included in the member's medical record.

SECTION IX: Medical Operations

ELECTIVE INPATIENT CARE

For Care1st members who require elective inpatient care (acute hospital), the admitting physician should:

- Complete the Medical Health Prior Authorization Form, which must contain all supporting documentation including ICD-10 codes, CPT codes, and office fax number of the requesting provider.
- Fax the Medical Health Prior Authorization Form to the PA Department.
- For urgent requests, the PCP may call the PA Department. NOTE: Medical information will be required over the phone to justify medical necessity for approval of the service being requested.
- The PA Department will return the Medical Health Prior Authorization Form with the authorization number via fax.
- After the approved Medical Health Prior Authorization Form has been received, contact the hospital and schedule the member's hospitalization and send approved Medical Health Prior Authorization Form to the authorized facility.

Providers who provide services on a fee-for-service basis for inpatients must use the applicable hospital's PA number on the claim.

EMERGENCY DEPARTMENT CARE

Care1st does not require PA for a member to receive emergency services. Members may seek care at any emergency department in the event of an emergency.

REFERRALS TO ANCILLARY PROVIDERS

Providers should follow the instructions outlined above under "Referral Process from PCP to Specialist", considering the following:

DURABLE MEDICAL EQUIPMENT

Covered durable medical equipment (DME) must be medically necessary and prescribed by a PCP or specialist. DME can be obtained by directly contacting the Care1st contracted DME Provider.

Please include the following information when faxing your request:

1. Member information
    - Name
    - AHCCCS identification number
    - Phone number
    - Address

- Diagnoses
- Weight

2. Amount, type and size of equipment desired including HCPC code
3. Completed and signed Certificate of Medical Necessity (for oxygen and motorized wheelchair).
4. Recent room air oxygen content (RA O2) must be 88% or less, if the request is for oxygen

The following limitations apply:

- Reasonable repairs or adjustments of purchased medical equipment are covered when necessary to make the equipment serviceable and when the cost of repair is less than the cost of rental or purchase of another unit. The equipment must be considered medically necessary by Care1st.

- The rental of such equipment shall terminate no later than the end of the month in which the member no longer needs the medical equipment as certified by the authorized provider or when the member is no longer eligible or enrolled with Care1st (except during transitions of care as specified by the Care1st Medical Director).

- If the duration of medically necessary rental equipment exceeds the cost of purchase, the Care1st Medical Director shall make the determination of rental or purchase of said equipment.

HOME HEALTH CARE AND HOME INFUSION

- Home Health Care and Home Infusion is obtained by directly contacting a Care1st contracted provider.
- If a Care1st member requires long term Home Health Care or Home Infusion a referral to the Care Management Division is made by the PA Department.

OUTPATIENT RADIOLOGY SERVICES

- Refer to the Care1st PA Guidelines for imaging services which require prior authorizations.
- Select a Care1st contracted provider from the Radiology Grid.
- Contact the contracted provider to schedule an appointment.
- It is the responsibility of the imaging service provider to verify member eligibility prior to rendering services.

OUTPATIENT LABORATORY SERVICES

- Complete laboratory requisition and direct member to a Care1st contracted laboratory site.

- If specimen is collected in office, contact the contracted laboratory for pick-up.
- PCPs and Specialists may perform in-office labs based on the Clinical Laboratory Improvement Amendments (CLIA) test complexity categorization provisions utilized by AHCCCS. In order for a lab to be payable, AHCCCS must allow the lab to be performed in POS 11. Practices with CLIA certifications must ensure that each CLIA certification is on file at AHCCCS for each provider and that each provider has an agency code of 200 noted on the AHCCCS PR020 Licenses/Certifications screen. All other laboratory services must be performed by Sonora Quest.

ORTHOTICS AND PROSTHETICS

When referring a Care1st member for orthotic/prosthetic services, the provider's office must submit a Medical Health Prior Authorization Form along with supporting documentation and appropriate HCPC code(s). Once approved, the orthotic/prosthetic provider will contact the member for fitting and delivery.

REHABILITATION SERVICES (OCCUPATIONAL/PHYSICAL/SPEECH THERAPY)

- For all AHCCCS members under 21, select a contracted provider for referral and fax a completed Medical Health Prior Authorization Form to the PA Department for review and approval.
- Speech Therapy for members 21 years and older is not an AHCCCS covered benefit.
- Outpatient physical therapy (PT) and occupational therapy (OT) visits for members 21 years and older are limited to 15 visits for the purpose of rehabilitation to restore a level of function and 15 visits for the purpose of keeping or getting to a level of function, for a total of 30 PT visits and 30 OT visits per contract year (10/1-9/30).

NUTRITIONAL SUPPLEMENTS FOR ELIGIBLE EPSDT MEMBERS

Members receiving oral nutritional supplements are tracked through the PA process or through ongoing reports received from the nutritional vendor. PCPs are required to complete the "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements" Form. The "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements" form may be found at http://www.azahcccs.gov/shared/downloads/MedicalPolicyManual/Chap400.pdf, pp. 90-91.

- Medical necessity for commercial oral nutritional supplements must be determined on an individual basis by the member's PCP or specialist. Providers requesting oral nutritional supplements should submit the

completed medical necessity form to the nutritional vendor or to PA for review and approval.

- The PCP or specialist must document that nutritional counseling has been provided to the member. The documentation must include alternatives that have been tried.
- The completed medical necessity form must indicate the criteria that are met. At least two criteria must be met. The criteria includes:
  - The member is at or below the 10th percentile on the appropriate growth chart for their age and gender for three months or more.
  - The member has reached a plateau in growth and/or nutritional status for more than six months (prepubescent).
  - The member has already demonstrated a medically significant decline in weight within the past three months (prior to the assessment).
  - The member is able to consume/eat no more than 25% of his/her nutritional requirements from age-appropriate food sources.

CARE COORDINATION

PCPs in their care coordination role serve as the referral agent for specialty and referral treatments and services provided to Care1st members assigned to them, and attempt to ensure coordinated quality care that is efficient and cost effective. Coordination responsibilities include, but are not limited to:

1. Referring members to providers, vendors or hospitals within the Care1st network, as appropriate, and if necessary, referring members to out-of-network specialty providers;
2. Coordinating with Care 1st's Prior Authorization Department with regard to prior authorization procedures for members;
3. Conducting follow-up (including maintaining records of services provided) for referral services that are rendered to their assigned members by other providers, specialty providers and/or hospitals;
4. Coordinating the medical behavioral health care of the Care1st members assigned to them, including at a minimum:
   - Oversight of drug regimens to prevent negative interactive effects;
   - Follow-up for all emergency services and coordination of inpatient care;
   - Coordination of services provided on a referral basis; and
   - Assurance that care rendered by specialty providers is appropriate and consistent with each member's health care needs.

CARE MANAGEMENT

The Care1st Care Management (CM) program is a collaboration between Care Managers, members and providers, which assesses, plans, implements, coordinates,

monitors and evaluates options and services to meet the members' health care needs. The Care Management Program is developed to specifically address the needs of the members with complex medical or social conditions, high utilization, high costs, special needs, or high-risk conditions. The focus is on assisting members to use medical, social, or community resources effectively to maximize their quality of life.

Care Management will identify, support and engage our most vulnerable members at any point in the health care continuum and help them achieve improved health status. The goal is to decrease fragmentation of healthcare service delivery, to facilitate appropriate utilization of available resources, and to optimize member outcomes through education, care coordination and advocacy services for the medically compromised populations served. The program integrates medical, behavioral, and socioeconomic assistance to members by facilitating assessment of risk and health needs, coordination of care/benefits, service delivery, community resources, and education. Care Management will provide for continuity of care, transition of care, and coordination of care or services for all members' needs in an integrated and member-centric fashion.
Our objectives include:

- Increasing member engagement with the PCP and PCP-referred specialists
- Increasing member understanding and use of plan benefits
- Increasing member awareness of community resources available to help improve their quality of life
- Increasing members understanding of diseases/conditions
- Decreasing unnecessary emergency room utilization
- Decreasing unnecessary hospital visits and admissions
- Encouraging members to self-manage their conditions effectively and develop and sustain behaviors that may improve the member's quality of life; and
- Optimizing member's health outcomes.

Care Management is available to all members. Potential candidates for CM include, but are not limited to the following:

- Members with complex, chronic or co-morbid conditions such COPD,CHF, CAD, Diabetes, Asthma, HIV/AIDS, depression
- Members discharged home from acute inpatient or SNF with multiple services and coordination need
- Members requiring care coordination
- High utilizes of services such as pharmacy or emergency departments (either by cost or volume)
- Special populations (e.g., aged, blind, disabled, HIV-positive, substance abusers, pregnant women, special needs children, members with behavioral health needs, serious mental illness (SMI)

SECTION IX: Medical Operations

Identification of members in need of care management can come from a variety of different referral sources. Member identification occurs through, but not limited to:

- Data mining through claims, utilization management, hospital census/discharge reports, lab, and pharmacy data
- Predictive modeling information allowing care management to identify members at high risk for increased utilization of the healthcare system due to poorly controlled medical conditions.
- Health Assessment Survey (HAS) outcomes
- Direct Referrals to the Program include but not limited to:
    - Internal staff/department referrals such as Member Services, Medical Directors, Prior Authorization, Concurrent Review, CRS Coordinator, Quality, Pharmacy, and Behavioral Health
    - Practitioner referrals
    - 24/7 Nurse Line
    - Crisis Line
    - Member or caregiver self-referral.
    - External agency working with the member including AHCCCS, or CMS

The Care Management Department will determine whether a member is appropriate for care management services by gathering and critically assessing relevant, comprehensive data, and potential positive healthcare effectiveness.

Care management process

- Screening and identification of members with high risk health problems or situations that could respond to care management
- Assessing members needs and determining barriers to care
- Developing an individualized care plan with inputs from the member and the PCP/Specialist(s)
- Identifying and implementing effective interventions, including exploration of alternative resources
- Working collaboratively with members' practitioners and providers as well as with other disciplines inside and outside the plan
- Coordinating care for defined conditions/diseases to attain optimal clinical and quality of life outcomes
- Providing education, support, and monitoring for the member, member's family, and others involved in care
- Working to ease barriers for members with special needs or cultural or language requirements
- Assisting members through Transitions of Care including but not limited to hospital to home.

Evaluating continuously the care plan to update and/or revise to accurately reflect the current member's needs.

To refer a patient to the care management program, please contact our Team at 1-866-560-4042

DISEASE MANAGEMENT

Care1st provides Disease Management programs to assist practitioners in managing members diagnosed with targeted chronic illnesses. Conditions included in disease management initiatives are those that frequently result in exacerbations and hospitalizations (high-risk) that require high usage of certain resources, and that have been shown to respond to coordinated management strategies.

Disease management activities include interventions such as:

- Assessment of member's risk and needs
- Education about disease, medications and self management
- Adherence monitoring
- Assistance with finding or coordinating resources and/or exploring alternative resources
- Working to ease barriers for members with special needs or cultural or language requirements

Potential candidates for Disease Management are identified thought:

- Administrative data such as medical and pharmacy claims
- Laboratory data
- HEDIS data
- Self reported data through health risk assessments
- Provider referrals
- Member and family self referrals
- Internal referrals from Care1st staff members

Disease management programs are structured around nationally recognized evidence-based guidelines. The guidelines are posted on the Care1st website: https://www.care1staz.com/az/providers/diseasemanagement.asp

A paper copy of the guidelines is available to providers upon request.

To refer a patient to the disease management program, please contact our Team at 1-866-560-4042

PHARMACY MANAGEMENT

FORMULARY

The Care1st formularies, including updates, are made available as PDF documents

on our website www.care1staz.com. Updated Drug Lists can be viewed on our website www.care1staz.com based on P&T implementation dates. Currently, AHCCCS P&T updates are effective April 1, July 1, and October 1. The Pharmacy department will send out formulary updates to all contracted providers 30 days prior to implementation via Blast Fax. Providers may also contact Network Management for a copy. Please ensure that your office is prescribing medications listed on the current formularies. Before submitting a Prior Authorization Request for a non-formulary drug or medication that requires PA, consider all formulary alternatives. The Care1st Preferred Drug List and Behavioral Health Preferred Drug List can be found on the Care1st website at www.care1staz.com. Submit Drug Prior authorization requests and supporting documentation to Care1st for review:

- Electronically via Cover My Meds
  - http://www.covermymeds.com/main/prior-authorization-forms/
- Via fax using the appropriate Prior Authorization form
- By calling our pharmacy department at 866-560-4042 (option 5, 5)

Care1st utilizes the AHCCCS Drug List as mandated by Policy 310-V. Our website contains a link to the AHCCCS Drug List on the AHCCCS website.

1. AHCCCS developed the AHCCCS Drug List of the medications that are available to all members when medically necessary.
2. AHCCCS' goal is to use the AHCCCS Drug List to assist providers when selecting clinically appropriate medications for AHCCCS members.
3. The AHCCCS Drug List is not an all-inclusive list of medications.
4. The AHCCCS Drug List specifies medications available without prior authorization as well as medications that have specific quantity limits, or require step therapy and/or prior authorization prior to dispensing to AHCCCS members.
5. Health plans are required to cover all medically necessary, clinically appropriate, cost effective medications that are federally and state reimbursable.

Care1st's formulary is more extensive than the AHCCCS PDL – it includes the medications listed on the AHCCCS Drug List and additional drugs necessary to meet the needs of our specific patient population. Our Prescription Benefit Manager manages all prescription drug transactions and pharmacy networks for all lines of business.

DRUG UTILIZATION MANAGEMENT TOOLS

For certain drugs, there are additional requirements for coverage. These requirements ensure appropriate drug therapy is utilized by the most cost effective means. A team of physicians and pharmacists develop the specific requirements. Examples of these utilization management tools include:

Prior Authorization (PA) is the process by which certain drugs are reviewed against specific prior authorization criteria that is developed by either AHCCCS

P&T or Care1st P&T prior to allowing the prescription to be filled. PA'd drugs on the pharmacy benefit will not adjudicate prior to obtaining PA approval. For drugs on the medical benefit, if prior approval is not received, then the drug may not be approved for payment.

Quantity Limits (QL) are designed to identify the excessive use of drugs which may be dangerous in large quantities and to highlight the potential need for a different type of treatment. Quantity limits define the amount of the drug that is covered per prescription or for a defined period of time (for example, per month).

Step Therapy is the practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary. The aims are to control costs and minimize risks. Also called step protocol.

Step-therapy allows coverage only after specific preferred medications are tried first. When applied to a pharmacy plan, step-therapy requires one or more prerequisite, clinically equivalent drugs (in many cases less expensive) to be tried before certain "step-therapy" drugs will be covered.

Antipsychotics and Lithium: All antipsychotics and lithium medications must be prescribed by an in-network behavior health specialist per AHCCCS AMPM Policy 310-V. Please contact the Care1st Network Management Department at 866-560-4042 (Options 5, 7) to be added to the antipsychotic-lithium prescriber network.

All requests for non-formulary drugs will be reviewed for medical necessity and for prior use of formulary alternatives.

PRESCRIPTION DRUG COVERAGE LIMITATIONS

1. A new prescription or refill prescription in excess of a 30-day supply or a 90-unit dose is not covered unless:

    a. The member will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed 90 days or 90-unit dose, whichever is greater; or

    b. The medication is prescribed for contraception and the prescription is limited to no more than a 90-day supply.

    c. Care1st does not currently provide prescriptions for more than 30-day supply except in the instances outlined above.

2. Prescription drugs for covered transplantation services will be provided in accordance with AHCCCS transplantation policies.

3. AHCCCS covers the following for AHCCCS members who are eligible to receive Medicare:

    a. Over-the-counter medications that are not covered as part of the Medicare Part D prescription drug program and meet the requirements in section D of this policy.
    b. Medications for persons determined to have a SMI, regardless of Title XIX/XXI eligibility, when their third-party insurer (Medicare or private insurance) denies coverage for a medication that is a covered behavioral health medication on the Preferred Drug List.
    c. Medicare Part D copays for persons determined to have a SMI, when the medication is used to treat a behavioral health diagnosis.
    d. Short-term medication coverage for non-Title XIX/XXI SMI and dual eligible SMI members who have opted out of Medicare part D when:
        a. The member is unable to obtain required documentation to support an eligibility determination, or
        b. Due to their mental status, the member is unable or refuses to participate in a Medicare Plan D, AND they do not have a legal guardian.
    e. For dual eligible SMI members, Care1st provides secondary coverage of their Medicare-covered prescription medications for the remainder of a calendar year after they have been in a medical institution funded by Medicaid for a full calendar month.

PHARMACY BENEFIT EXCLUSIONS

1. Medication prescribed for the treatment of a sexual or erectile dysfunction, unless prescribed to treat a condition other than a sexual or erectile dysfunction and the Food and Drug Administration has approved the medication for the specific condition.

2. Medications that are personally dispensed by a physician, dentist or other provider except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.

3. Drugs classified as Drug Efficacy Study Implementation (DESI) drugs by the Food and Drug Administration

4. Outpatient medications for members under the Federal Emergency Services Program, except for dialysis related medications for Extended Services individuals

5. Medical Marijuana. Refer to Policy 320-M, *Medical Marijuana*

6. Drugs eligible for coverage under Medicare Part D for Care1st members eligible for Medicare whether or not the member obtains Medicare Part D coverage.

7. Experimental medications are excluded from coverage.

8. Medications furnished solely for cosmetic purposes.

VACCINES AND EMERGENCY MEDICATIONS ADMINISTERED BY PHARMACISTS TO PERSONS AGE 19 YEARS AND OLDER

Care1st covers vaccines and emergency medication without a prescription order when administered by a pharmacist who is currently licensed and certified by the Arizona State Board of Pharmacy consistent with the limitations of this Policy and state law ARS §32-1974.

1. For purposes of this section "Emergency Medication" means emergency epinephrine and diphenhydramine. "Vaccines" are limited to AHCCCS covered vaccines as noted in the AMPM Policy 310-M

2. The pharmacy providing the vaccine must be an AHCCCS registered provider (see note below regarding Indian Health Services (IHS)/638 outpatient facilities).

3. Vaccine administration by pharmacists is limited to the Care1st network pharmacies.

4. Influenza Vaccinations are available in pharmacies for all AHCCCS members ages 3 years of age and older during the flu season.

5. COVID-19 vaccinations are covered through the member's medical and pharmacy benefit depending on the setting vaccine is being administered.

PHARMACY PRIOR AUTHORIZATION

If a drug requires prior authorization, the request should be completed by the prescribing physician/physician's representative. The required information must be provided in order for the request to be considered. Only pertinent clinical documentation should accompany the request.

Pharmacy Benefit requests for pharmacy-dispensed drugs may be:

- Faxed to Care1st at 602-778-8387 or

- Phoned in at 866-560-4042 (Options 5, 5) or

- Submitted via Electronic Prior Authorization (ePA) through Cover My Meds http://www.covermymeds.com/main/prior-authorization-forms/

The turn-around time (TAT) for review of Drug Prior Authorization requests is as follow:

24 hours – All Drug Prior authorization requests are processed and returned no later than 24 hours from date received by the Pharmacy PA Department as long as all necessary supporting medical documentation is included for review.

7 business days- Missing information requests will be pended upon receipt for up to 7 business days if appropriate supporting documentation is not included with the request. Failure to submit supporting documentation will delay the processing of your request.

Determinations for coverage will be faxed to the requesting provider, and denials are mailed to the patient (member)/guardian. Step therapy requests are handled the same as prior authorization requests. All pertinent information regarding previous drug therapy should be included.

Requests for uses outside the accepted indications (off-label use) will require documented clinical support (e.g., published clinical trials, nationally accepted practice guidelines) concluding that the treatment is safe and effective for the requested diagnosis, patient age, and dosage regiment requested.

LIMITED SPECIALTY NETWORK:

Care1st Medicaid has a Limited Specialty Network primarily for chronic conditions that require Specialty Medications dispensed through the pharmacy benefit. The Limited Specialty Network was developed with 3 key areas of focus:

- Specialty Pharmacy Certification
- Documented and proactive adherence management to minimize gaps and identify barriers to care AND
- Drug therapy management programs to promote cost effective drug management

The current pharmacies included in our Limited Specialty Network include:

AcariaHealth	Multiple Locations Nationwide	1-800-511-5144
CVS Caremark Specialty Pharmacy	Multiple Locations Nationwide	1800-237-2767 OR 1-866-387-2573

Contact Pharmacy Prior Authorization at 866-560-4042 (Options 5, 5) if you have any questions.

CONCURRENT REVIEW

Care1st provides for continual reassessment of all acute inpatient care. Concurrent review includes both admission certification and continued stay review. Concurrent review is performed by nurses who work closely with the medical director in reviewing documentation for each case. Other levels of care such as partial day hospitalization or skilled nursing care may also require concurrent review at Care1st's discretion. Review may be performed on-site or may be done via telephone or fax. The authorization is given for the admission day and from then on, contingent upon the inpatient care satisfying criteria for that level of care. This would include the professional services delivered to the inpatient on that day. Any exceptions to this (i.e. procedures, diagnostic studies, or professional services provided on an otherwise medically necessary inpatient day which do not appear to satisfy criteria) will require documented evidence to substantiate payment. Care1st uses the Milliman Care Guidelines® to ensure consistency in hospital-based utilization practices. A copy of individual guidelines pertaining to a specific case is available for review upon request. Providers are notified when there are denials given for a specific day.

RETROSPECTIVE REVIEW

Care1st reserves the right to perform retrospective review of care provided to its member for any reason. Additionally, care is subject to retrospective review when claims are received for services not authorized. There may also be times, during the process of concurrent review (especially telephonic) that the Concurrent Review Nurse is not satisfied with the concurrent information received based on the Milliman Care Guidelines®. When this occurs the case will be pended for a full medical record review by the Chief Medical Officer.

PRACTICE GUIDELINES

Care1st utilizes practice guidelines, criteria, quality screens and other standards for certain areas of medical management, disease management, and preventive health. Our guidelines follow nationally accepted standards and are reviewed and approved by our Medical Management Committee, which is comprised of both clinical staff and network physicians. Updates occur annually or more frequently if needed. If you have questions on our guidelines or would like a hard copy of our guidelines mailed to your office you may contact Network Management.

SECTION X: Quality Improvement

OVERVIEW

The Quality Improvement (QI) Program is designed to objectively, systematically, and expeditiously monitor and evaluate the quality, appropriateness and outcome of care and services, and the structures and processes by which they are delivered to Plan members, and to continuously pursue opportunities for improvement and problem resolution.

SCOPE

The scope of the QI Program is comprehensive and includes activities that have a direct and indirect influence on the quality and outcome of clinical care and services delivered to all Care1st Plan members. The scope of the QI Program encompasses both quality of care and quality of service. Responsibility for monitoring the scope of care rests with the QI Department.

This QI Program covers all programs and products. All QI standards and procedures are applicable to all Care1st members.

Care1st targets special and vulnerable populations for focused quality studies, which may include childhood immunizations, dental services, behavioral health, utilization, customer satisfaction, EPSDT screening and follow-up.

Quality Improvement activities may include but are not limited to:

- Access to and availability of care
- Quality and coordination between physical and behavioral health services
- Provider satisfaction
- Credentialing/Recredentialing
- Clinical practice guidelines
- Under/over utilization
- Adverse outcomes/sentinel events
- Medical record keeping practices
- Facility/Office site review results
- Member satisfaction, complaints and grievances
- Timeliness of handling claims
- High risk and high volume services
- HEDIS results
- Performance Measures
- Performance Improvement Projects
- Patient Safety Measures

SECTION X: Quality Improvement

Care1st adopts and maintains clinical guidelines, criteria, quality screens and other standards against which quality of care, access, and service can be measured. Practice guidelines are available on our website (www.care1staz.com) under the Providers drop down menu. For requests for training, obtaining additional information or if you do not have internet access and would like a copy mailed to your office, please contact Network Management.

Compliance with standards is measured using a variety of techniques, including but not limited to:

- Quality of service concerns
- HEDIS
- Quality of care concerns
- Performance Indicators
- Medical record audits
- Facility/Office site review results
- Outcome measures
- Focused review studies
- Member satisfaction surveys
- Peer Review
- Access to care audits
- Disease management outcomes
- EPSDT compliance rates

CONFIDENTIALITY AND CONFLICT OF INTEREST

All information related to the QI process is considered confidential. All QI data and information, inclusive of but not limited to, minutes, reports, letters, correspondence, and reviews, are housed in a designated and secured area within the QI Department. All aspects of quality review are deemed confidential. All persons involved with review activities will adhere to the confidentiality guidelines applicable to the appropriate committee.

All persons attending the Quality Oversight Committee (QOC) or its related committee meetings will sign a Confidentiality Statement. All Care1st personnel are required to sign a Confidentiality Agreement upon employment.

No persons shall be involved in the review process of QI issues in which they were directly involved. If potential for conflict of interest is identified, another qualified reviewer will be designated.

Furthermore, information provided to physicians within the network may be proprietary and/or confidential. When this occurs it is expected that physicians will hold this information in confidence and treat the handling of such information with care.

SECTION X: Quality Improvement

DISCLOSURE OF MEMBER HEALTH INFORMATION

To ensure the confidential release of member information, the following apply:

- Providers should submit all necessary documentation when submitting a request for a referral.
- Providers may release a member's medical information to other health care providers, Care1st or AHCCCS as long as it is necessary for treatment of the member's condition, or administration of the program.
- Member's records are to be transferred to a new PCP within ten business days when one is selected.
- Release of medical information to out of network providers generally requires authorization from the member or guardian.
- Medical records must be released in accordance with Federal or State laws, court orders, or subpoenas.

CREDENTIALING AND RECREDENTIALING

Care1st credentials all providers within its network to ensure they are adequately trained, appropriately licensed and able to provide quality health care to Care1st enrollees. Care1st re-credentials all providers within its network at least every three years in order to ensure their continued adherence to Care1st quality standards.

Care1st partners with the Arizona Association of Health Plans (AzAHP) in a delegated agreement with a Credentialing Verification Organization (CVO) to ensure all primary source verification of the credentialing process is completed. All providers are required to utilize the Council for Affordable Quality Healthcare (CAQH) application.

The Care1st credentialing program does not discriminate against a health care professional, solely on the basis of the license or certification or a health care professional who serves high risk populations or who specializes in the treatment of costly conditions.

The Credentialing/Peer Review Committee (CPRC) is delegated the responsibility of monitoring credentialing and re-credentialing activities for providers and practitioners. The Credentialing Committee meets at least ten times annually, but may meet more frequently as needed.

SECTION X: Quality Improvement

Scope of responsibilities include but are not limited to:

1. Review, recommend, approve or deny initial credentialing and re-credentialing of contracted network.
2. Ensure appropriate reporting to regulatory/national data banks.
3. Ensure the provision of a fair hearing process.
4. Oversight of delegated credentialing.
5. Peer review for adverse outcomes.
6. When a practitioner's contracting/recredentialing status is denied or restricted based upon a quality concern, the practitioner is provided appeal rights and procedures upon notice of the denial or restriction.

PEER REVIEW

Peer Review is conducted in any situation where, based on the findings of a Quality of Care review, peers are needed to assess the appropriateness or necessity of a particular course of treatment, to review or monitor a pattern of care provided by a specific provider or to review aspects of care, behavior or practice, as may be deemed inappropriate. The Peer Review Committee scope includes cases where there is evidence of deficient quality or the omission of the care or service provided by a participating, or non-participating, physical, or behavioral health care professional whether delivered in or out of state. The Chief Medical Officer or designee is responsible for authorizing the referral of cases for peer review based on the findings of a quality of care investigation.

All peer review consultants (including members of the Credentialing/Peer Review or ad-hoc Peer Review Committees) are duly licensed professionals in active practice. At least one consultant will be a provider with the same or similar specialty training as the provider whose care is being reviewed, except in those cases where there is no applicable board certification for the specialty. At a minimum he Peer Review committee shall consist of the local CMO or designee as Chair, contracted medical providers and a contracted BH provider from the community that serves AHCCCS members.

If the Peer Review Committee makes a recommendation to the Board of Directors to deny, limit, suspend or terminate privileges based on a medical disciplinary cause or reason, the affected provider shall be entitled to a formal hearing pursuant to the Fair Hearing Procedure.

FAIR HEARING

A provider is entitled to an appeal and/or hearing if the Peer Review Committee makes a recommendation to:

- Suspend
- Terminate or
- Non-renew a physician's contract.

The provider will be notified of the committee's recommendation and has 30 days following the date of notice, to request a hearing. The request must be submitted in writing to the Chief Medical Officer or designee.

The Chief. Medical Officer or designee will schedule a hearing as soon as practicable. The Chief Medical Officer or designee will appoint at least 3 providers and an alternate who have the requisite expertise to ensure a fair hearing. At least 1 provider will be of the same specialty as the practitioner requesting the hearing. No provider will be in direct economic competition with the affected provider and will not stand to gain direct financial benefit from the outcome.

Both parties are entitled to legal representation. Expert testimony and presentation of supporting documents are allowed.

The committee will complete its investigation within 30 days unless both parties agree to a longer period of time to obtain information.

The committee will issue a final decision which may consist of one of the following:

- Continue the immediate action effect
- Impose other sanctions structured to prevent harm to member or to correct identified issues
- Remove the immediate action.

A provider may appeal an action only after the committee renders a final decision. Any action taken as a result of the recommendation of the committee becomes a part of the provider's Credentialing file. Care1st reports to the appropriate authorities such as licensing or disciplinary bodies, AHCCCS or to other appropriate authorities, any provider who are terminated for quality of care issues.

DUTY TO WARN

All providers, regardless of their specialty or area of practice, have a duty to protect others against a member's potential danger to self and/or dangers to others. When a provider determines, or under applicable professional standards, reasonably should have determined, that a member poses a serious danger to self or others, the provider has a duty to exercise care to protect others against imminent danger of a member harming him/herself or others. The foreseeable victim need not be specifically

identified by the member, but may be someone who would be the most likely victim of the member's dangerous conduct.

The provider's responsibility to take reasonable precautions to prevent harm threatened by a member may include any of the following:

a) Communicating, when possible, the threat to all identifiable victims.

b) Notifying law enforcement in the area where the member or any potential victim resides.

c) Taking reasonable steps to initiate proceedings for voluntary or involuntary hospitalization in accordance with AHCCCS AMPM 320-U.

d) Taking any other precautions that a reasonable and prudent provider would take under the circumstances.

No cause of action or legal liability may be imposed against a behavioral health provider for breaching a duty to prevent harm to a person caused by a member unless both of the following occur:

a) The member has communicated to the behavioral health provider an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim(s), and the member has the apparent intent and ability to carry out such threat

b) The behavioral health provider fails to take reasonable precautions.

INCIDENTS, ACCIDENT, AND DEATH REPORTING

An Incident, Accident, and Death (IAD) report must be submitted to Care1st in writing or via the AHCCCS QM Portal by the individual or organizational provider within two business days of the event. If the incident is a Sentinel IAD then it must be submitted within one business day of the occurrence or awareness of the occurrence.

An IAD is reportable if it includes: allegations of abuse/neglect/exploitation of a member, death of a member, delays in access care, healthcare acquired or provider preventable conditions, serious injury, injury from seclusion/restraint, medication error at a licensed facility, missing person from licensed BH facility, member suicide attempt, suspected or alleged criminal activity and any other incident that casus harm or has potential to cause harm to a member.

Sentinel IAD's include death associated with a missing person, suicide or attempted suicide or self-harm resulting in serious injury while in a healthcare setting, death or serious injury associated with medication error or fall in a healthcare setting, stage 3, 4 or unstageable pressure ulcers acquired after admit to healthcare setting, death or serious injury associated with use of seclusion and/or restraints, sexual abuse/assault during provision of services, death or serious injury resulting from assault during the provision of services and homicide committed or allegedly committed by member.

Care1st Quality Improvement Department will review the IAD report within 24 hours of receipt to make a determination of whether the incident includes a quality of care concern (QOC). Care1st must assure that the report is fully and accurately completed. If the report is returned to the provider for corrections, the provider must return the corrected version of the report to the Quality Improvement Department within 24 hours of receipt.

MEDICAL RECORD GUIDELINES

PCPs must maintain a legible medical record for each enrolled member who has been seen for medical appointments or procedures, and/or for whom a provider receives medical/behavioral health records from other providers who have seen the enrolled member. If the PCP has not yet seen the member such information may be kept temporarily in an appropriately labeled file, in lieu of establishing a medical record, but must be associated with the member's medical record as soon as one is established. The record must be kept up-to-date, be well organized and comprehensive with sufficient detail to promote effective patient care and quality review. The PCP must maintain a comprehensive record whether a hard copy chart or electronic medical record (EMR) is used, that incorporates at least the following components:

Physical health medical record requirements

1. Member identification information on each page of the medical record. (i.e., name or AHCCCS identification number)

2. Identifying demographics including the member's name, current and previous address, telephone number, email address, AHCCCS identification number, gender, birth sex, age, date of birth, marital status, race, ethnicity, preferred language, next of kin, and if applicable, guardian or health care decision maker

3. Initial history for the member that includes family medical history, social history and preventive laboratory screenings. The initial history for members under age 21 should also include prenatal care and birth history

4. Past medical history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations (to include discharge summaries), surgeries and emergent/urgent care received

5. Immunization records (required for children; recommended for adult members if available)

6. Dental history if available, and current dental needs and/or services

7. Current problem list

8. Current medications

9. Documentation, initialed by the member's PCP to signify review of:

    a. Diagnostic information including:
        i. Lab tests and screenings
        ii. Radiology reports
        iii. Physical examination notes, and/or other pertinent data

    b. Documentation of coordination of care activities including but not limited to:
        i. Reports form referrals, consultations and specialists
        ii. Emergency//urgent care reports
        iii. Hospital discharge summaries
        iv. Transfer of care to other providers, and
        v. Behavioral health referrals and services provided, if applicable

10. Documentation as to whether or not an adult member has been provided information regarding advance directives, and whether an advance directive has been executed

11. Documentation related to requests for release of information and subsequent release

12. Documentation of a Health Care Power of Attorney or documentation of an authorized Health Care Decision Maker, if applicable

13. Documentation that reflects diagnostic, treatment and disposition information related to a specific member was transmitted to the PCP and other providers as appropriate to promote continuity of care and quality management of the member's health care

14. Documentation to reflect review of the Controlled Substances Prescription Monitoring Program (CSPMP) database prior to prescribing a controlled substance or another medication that is known to adversely interact with controlled substances.

15. Documentation of appropriate completed consents (general and/or informed) and treatment plans which are signed and dated by both the provider and the member, or the member's parent or legal guardian, if the member is under 18 years of age or is 18 years of age or older and considered an incapacitated adult (as defined in A.R.S. § 14-5101).

    a. General consent refers to documentation of an agreement from the member or the member's representative to receive physical health services to address the member's medical condition or behavioral health services to address the member's behavioral health issues

    b. Informed consent refers to documentation that the member was advised of a proposed treatment, surgical procedure, psychotropic drug, or diagnostic procedure; alternatives to the treatment, surgical procedure, psychotropic drug, or diagnostic procedure; and associated risks and possible complications; and documented authorization for the proposed treatment, surgical procedure, psychotropic drug, or diagnostic procedure from the member or the member's representative

16. Obstetric providers must also complete a risk assessment tool for obstetric patients (i.e. Mutual Insurance Company of Arizona Obstetric Risk Assessment Tool [MICA] or American College of Obstetrics and Gynecology [ACOG]). Lab screenings for members requiring obstetric care must also conform to ACOG guidelines.

17. Documentation that each member of reproductive age is notified verbally or in writing of the availability of family planning.

18. Evidence that PCPs are utilizing and retaining AHCCCS approved developmental screening tools.

19. Documentation on the current age appropriate EPSDT tracking form or the equivalent elements noted in the EMR.

20. For medical records relating to provision of behavioral health services, documentation shall include, but is not limited to: Behavioral Health history; applicable assessments; service plans and/or treatment plans; crisis and/or safety plan; medication information if related to behavioral health

diagnosis; medication informed consents, if applicable; progress notes; general and/or informed consent.

21. Unique device identifier(s) for implantable devices are documented, if applicable.

22. When a member changes PCPs, his or her medical records or copies of medical records must be forwarded to the new PCP within 10 business days from receipt of the request for transfer of the medical records.

Behavioral Health Medical Record Requirements

The following elements shall be included in all behavioral health medical records:

1. Initial behavioral health assessment that includes:

    a. An initial comprehensive assessment and annual update or follow-up for significant life events.

    b. Assessment must be signed by the BHT and cosigned by the BHP within 72 hours of completion.

    c. The assessment must include presenting concerns, current physical and BH conditions, mental status exam, clinical observations, diagnostic impression, summary and recommendations.

    d. The assessment must include diagnostic information, family history, trauma history, assessment for sexualized behaviors, substance use/or exposure, ASAM if needed, needs related to living environment, needs related to healthcare, needs related to socialization, needs related to education and/or vocational training, needs related to employment, needs related to well-being, developmental history, needs related to public and private resources, presence or absence of health care decision maker, presence of a court order, history of a criminal justice involvement and assessment of a court order, history of criminal justice involvement and assessment of need for assistance with communication.

2. Service plan documentation that includes:

    a. A service plan that was completed and dated/signed by a BHP and reviewed with the member and/or health care decision maker.

    b. The Services plan should address the needs identified within the

assessment related to living environment, health care, socialization, education/vocation, employment and well-being.

c. The service plan goals are based on member/family/healthcare decision maker vision, goals that are positive and utilize the member's identified strengths.

3. The following general clinical chart requirements include:

a. Evidence that peer support or family support has been offered, services were implemented form the treatment plan within 45 days, person-centered language is used and member/family are linked to additional services as needed.

b. If the member is a child and has a CALOCUS score of 4, 5, 6, a high needs case manager is assigned.

c. There is evidence in the chart that there is one person who coordinates planning and delivery of services, collaboration is occurring, crisis or safety concerns are assessed and addressed, engagement or re-engagement for a BH crisis no later than next business day, evidence that transition age youth activities begin no later than 16 years of age, evidence that an initial SMI is present if necessary, members with SMI designation have been assessed for special assistance, services are continually evaluated with member/decision maker.

4. Cultural Competence documentation includes the following:

a. Documentation demonstrates the provision of culturally informed services, provider assessed the need for qualified interpretation services and the need for qualified translator services to communicate in the preferred language of the member/family.

AHCCCS is not required to obtain written approval from a member before requesting the member's medical record from the PCP or any other organization or agency. Care1st may obtain a copy of a member's medical records without written approval of the member if the reason for such request is directly related to the administration of the AHCCCS program. AHCCCS shall be afforded access to all members' medical records whether electronic or paper within 20 business days of receipt of request or more quickly if necessary.

Information related to fraud and abuse may be released, however, HIV-related information shall not be disclosed except as provided in A.R.S. §36-664, and

substance abuse information shall only be disclosed consistent with Federal and State law, including but not limited to 42 CFR 2.1 et seq.

MEDICAL RECORD RETENTION

All providers shall maintain records relating to covered services and expenditures including reports to AHCCCS and documentation used in the preparation of reports to AHCCCS. Providers shall comply with all specifications for record keeping established by AHCCCS. All books and records shall be maintained to the extent and in such detail as required by AHCCCS rules and policies. Records shall include but not be limited to financial statements, records relating to the quality of care, medical records, prescription files and other records specified by AHCCCS.

Providers agree to make available, at all reasonable times during the term of this contract, any of its records for inspection, audit or reproduction by any authorized representative of AHCCCS, State or Federal government. In accordance with Arizona Administrative Code R9-22-512 (E) all providers shall furnish records requested by the Administration or a contractor to the Administration or the contractor at no charge. If the provider uses a vendor to store medical records, it is the provider's responsibility to work with the vendor and facilitate receipt of the requested records at no charge to Care1st or the Care1st delegate.

Providers shall preserve and make available, at no cost, all records for a period of five years from the date of final payment under this contract unless a longer period of time is required by law.

Providers shall comply with the record retention periods specified in HIPAA laws and regulations, including, but not limited to, 45 CFR 164.530(j)(2).

Providers shall comply with the record keeping requirements delineated in 42 CFR 438.3(u) and retain such records for a period of no less than 10 years.

For retention of patient medical records, the provider shall ensure compliance with A.R.S. §12-2297 which provides, in part, that a health care provider shall retain patient medical records according to the following:

1. If the patient is an adult, the provider shall retain the patient medical records for at least six years after the last date the adult patient received medical or health care services from that provider.
2. If the patient is under 18 years of age, the provider shall retain the patient medical records either for at least three years after the child's eighteenth birthday or for at least six years after the last date the child received

medical or health care services from that provider, whichever date occurs later.

In addition, the provider shall comply with the record retention periods specified in HIPAA laws and regulations, including, but not limited to, 45 CFR 164.530(j)(2).

If the provider's contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available, at no cost, for a period of five years from the date of any such termination. Records which relate to grievances, disputes, litigation or the settlement of claims arising out of the performance of this contract, or costs and expenses of this contract to which exception has been taken by AHCCCS, shall be retained by the provider for a period of five years after the date of final disposition or resolution thereof.

Seclusion and Restraint

Seclusion and restraint are high-risk interventions that must be used to address emergency safety situations only when less restrictive interventions have been determined to be ineffective, in order to protect Members, staff members or others from harm. All persons have the right to be free from seclusion and restraint, in any form, imposed as a means of coercion, discipline, convenience or retaliation by staff. Seclusion or restraint may only be imposed to ensure the immediate physical safety of the person, a staff member or others and must involve the least restrictive intervention, and be discontinued at the earliest possible time (42 CFR §482.13).

This section includes seclusion and restraint reporting requirements for contracted behavioral health inpatient facilities (42 CFR §482.13) (A.A.C. R9-21) and behavioral health inpatient facilities serving persons under the age of 21 (42 CFR §483 Subpart E).

Seclusion and Restraint Reporting to Care1st

Contracted behavioral health inpatient facilities shall follow local, state and federal regulations and requirements related to seclusion and restraint.

Contracted behavioral health inpatient facilities authorized to use seclusion and restraint shall report the following to Care1st:

- Each occurrence of seclusion and restraint within five (5) calendar days of the occurrence, via email SM_AZ_qmnurse@care1staz.com. Failure to submit seclusion and restraint reports timely may result in corrective action for late submission of a contract deliverable.
    - Any incident that resulted in an injury or complication requiring medical attention must be reported within 24 hours of occurrence.

- Reports of seclusion and restraint are to be submitted using the form **962 Attachment A.** This form can be obtained by emailing SM_AZ_qmnurse@care1staz.com. The form **962 Attachment A, Seclusion and Restraint Reporting Form** must be completed in its entirety and include the required information detailed on AMPM 962.
- In the event that a use of seclusion or restraint requires face-to-face monitoring, a report detailing face-to-face monitoring must be completed and attached to the reporting form. The face-to-face monitoring form must include the requirements as per 42 CFR 482.13, 42 CFR § 483 Subpart 12, and R9-21-204.
- Care1st may also request copies of provider agency Policies and Procedures pertaining to the use of seclusion and restraint, evidence of staff trainings, and any corrective actions taken to reduce the frequency of usage.
- Each behavioral health inpatient facility or Mental Health Agency shall report the total number of incidents of the use of S&R involving AHCCCS members in the prior month to Care1st by the fifth calendar day of the month. If there were no incidents of Seclusion or restraint during the reporting period, the report should so indicate.

SECTION XI: Billing, Claims And Encounters

CLAIM SUBMISSION

ELECTRONIC DATA INTERCHANGE (EDI)

Care1st encourages you to submit your medical claims electronically.

Advantages include:

- decreased submission costs
- faster processing and reimbursement
- allows for documentation of timely filing

EDI is for primary and secondary claims only with the exception of claims when a member's primary insurance is WellCare Liberty (formerly ONECare) and their secondary insurance is Care1st, as our system automatically coordinates processing for these claims. If submitting secondary claims via paper include a red and white copy of the appropriate claim form (UB04 or CMS1500) sorted in the first position, with the primary insurance explanation of benefits attached.

Medical/Behavioral Health (CMS 1500& UB 04) Claims

Care1st works with CHANGE Healthcare 800.215.4730 for acceptance of EDI CMS 1500 & UB 04 claims.

Our CHANGE Healthcare Payer ID:

For ACC Members	For RBHA Members
57116	68069

Claims may be submitted electronically directly to CHANGE Healthcare or from your clearinghouse to CHANGE Healthcare. If you experience problems with your EDI submission, first contact your software vendor to validate the claim submissions and upon verification of successful submission, contact CHANGE Healthcare directly at 800.215.4730.

Note: Faxed claims are not accepted

Dental (J430D) Claims

For ACC Members:	For RBHA Members:
Dental claims should be submitted directly to DentaQuest and information regarding paper and electronic claims as well as electronic funds transfers can be found in the Office Reference Manual on the DentaQuest website www.dentaquest.com.	Dental claims should be submitted directly to Envolve Dental and information regarding paper and electronic claims as well as electronic funds transfers can be found on the Envolve Dental website https://www.envolvedental.com

SECTION XI: Billing, Claims And Encounters

ELECTRONIC FUNDS TRANSFER (EFT)

EFT allows payments to be electronically deposited directly into a designated bank account without the need to wait for the mail and then make a trip to the bank to deposit your check!

Medical/Behavioral Health Claims

For ACC Members	For RBHA Members
The EFT form is available on our website under the Forms section of the Provider menu. If you do not have internet access, contact Network Management and we will provide you with the form.	Register with PaySpan Health to receive payment via EFT. You can sign up via their website at www.PaySpanHealth.com or contact PaySpan Health provider support at 1.877.331.7154.

HIPAA 5010 TRANSACTIONS

Care1st is compliant with the AHCCCS implementation of all 5010 transactions. Trading partners are required to begin sending electronic transactions in the 5010 format. We encourage you to reach out to your respective clearinghouse to obtain specific instructions to ensure you understand how the changes with 5010 may impact your submissions and receipt of data. Some of the major changes with the 5010 claims submission process are listed below:

- Service and billing address: The service and billing address must be the physical address associated with the NPI and can no longer be a post office box or lock box. The pay to address may still contain a post office box or lock box.

- State and Postal Codes: State and zip codes are required when the address is in the US or Canada only. Postal codes must be a 9-digit code for billing and service location addresses.

  Rendering tax identification number: The rendering provider tax identification number requirement has been removed. The only primary identification number allowed is the NPI. Secondary identification numbers are only for atypical providers (such as non-emergent transportation) and we recommend you use the G2 qualifier. The billing tax ID is still required.

- Number of diagnosis codes on a claim: For electronic submissions, it is a requirement that diagnoses are reported with a maximum of 12 diagnosis codes per claim under the 5010 format and paper CMS 1500 submissions contain a maximum of 12 diagnosis codes per claim.

SECTION XI: Billing, Claims And Encounters

CLAIM ADDRESSES

Medical Claims:

Direct CMS 1500 and UB-04 claim forms (initial submissions and resubmissions) and medical records to:

For ACC Members	For RBHA Members
Attention Claims Department P.O. Box 31224 Tampa, FL 33631-3224	Attention Claims Department PO Box 8070 Farmington, MO 63640-8070

When submitting medical records via paper include a red and white copy of the appropriate claim form (UB04 or CMS1500) sorted in the first position, with the requested records/information attached. As an alternative records may also be submitted in one of the formats below depending on provider type

- Records for facility based services may be uploaded to our secure FTP server – Requests for accessibility to this server can be submitted to DL_AZ_EDI@care1staz.com. Please include a copy of a Red and White UB in the first position with the original claim number.
- Records for clinic based services may mailed to:

For ACC Members	For RBHA Members
Attention Claims Department P.O. Box 31224 Tampa, FL 33631-3224	Attention Claims Department PO Box 8070 Farmington, MO 63640-8070

Please include a red and white CMS1500 in the first position with the original claim number.

CLAIMS CUSTOMER SERVICE

Medical Claims (CMS 1500 and UB-04 Claim Types):

Claim status can be checked 24 hours a day, seven days a week online at www.care1staz.com.

Our Claims Customer Service Team is also available to assist you during the business hours listed below:

Monday – Friday 8:00 AM - 12:00 PM & 1:00 PM - 4:30 PM
Ph. 602.778.1800/866.560.4042 (Options in order 5, 4).

SECTION XI: Billing, Claims And Encounters

CLAIM LIAISON

Our *Claim Liaison* is an excellent resource and is available to assist your office via phone at 602.778.1800 x1877, through email at AZClaimsLiaisons@Care1stAZ.com, or in person with questions regarding claim submission and processing.

REQUIRED ID NUMBERS

AHCCCS ID

A six-digit AHCCCS provider ID number is required in order to bill services to Care1st. This number may be obtained by contacting the AHCCCS Provider Registration unit at 602.417.7670, Option 5. In the event that a provider's AHCCCS ID number changes, the provider is responsible for notifying Care1st of this change.

FEDERAL TAX ID

The Provider must also report the Federal Tax Identification Number (TIN) under which they will be paid. The Federal TIN (Employer Identification Number, EIN) must also be billed on the CMS 1500 form in Field 25.

NATIONAL PROVIDER IDENTIFICATION (NPI)

Care1st requires all providers to submit the rendering/servicing provider's NPI on every claim. Care1st requires that when applicable, the prescribing, referring, attending and operating provider NPI(s) also be present on claim submissions. Claims without the required NPI(s) will be denied.

Please work with your billing team to ensure that NPI(s) are submitted appropriately with each claim submission and call us if you have any questions or need assistance.

- To apply for an Individual NPI and/or Organizational NPI online, go to www.nppes.cms.hhs.gov or contact National Provider Identifier Enumerator Call Center 800.465.3203 to request a paper application.

- If you have not yet notified Care1st of your NPI(s), please fax a copy of your NPI(s) confirmation to Network Management at 602.778.1875.

- Providers must also communicate their NPI(s) to AHCCCS Provider Registration. A copy of the NPI Number Notification, along with the provider's name, AHCCCS ID Number and signature of the provider or authorized signor may be mailed or fax to the following:

  AHCCCS – Provider Registration
  PO Box 25520
  Mail Drop 8100
  Phoenix, AZ 85002
  Fax Number: 602.256.1474

SECTION XI: Billing, Claims And Encounters

BILLING FOR SERVICES RENDERED

CLAIM FORMS

The Centers for Medicare and Medicaid Services (CMS) now requires providers to submit all claims on the newest version of each claim form.

- Practitioners – CMS 1500 (version 02/12)
- Facilities – UB-04
- Dental – J430D

Claims must be submitted on the revised CMS1500 Claim Form (version 02/12). Claims submitted on the old claim form will be denied.

Services can be billed on one of three forms: the CMS 1500 claim form for professional services, the UB-04 for inpatient and outpatient facility services, dialysis, nursing home and hospice services or the J430D for dental services. All providers must submit claim forms as documentation of services rendered, even if the provider has a capitated agreement with the health plan for the service.

TIMELY FILING GUIDELINES

When Care1st is primary, the initial claim submission must be received within six months from the date of service.

Secondary claim submissions must include a copy of the primary payer's remittance advice and be received within 60 days of the date of the primary payer's remittance advice or six months from the date of service, whichever is greater.

- Acceptable proof of timely filing documentation must establish that Care1st or its agent has received a claim or claim related correspondence
    - Acceptable examples of proof of timely filing include:
        - Signed courier routing form documenting the specific documents contained
        - Certified mail receipt that can be specifically tied to a claim or related correspondence
        - Successful fax transmittal confirmation sheet documenting the specific documents faxed
        - Acceptable confirmation report from Emdeon (our sole electronic clearinghouse) documenting successful transmittal
    - Unacceptable examples of proof of timely filing include:
        - Provider billing history
        - Any form or receipt that cannot be specifically tied to a claim or related correspondence
        - Acceptance confirmation report from any electronic clearinghouse other than Emdeon

SECTION XI: Billing, Claims And Encounters

DUPLICATE CLAIMS

Care1st receives a large number of duplicate claim submissions as a result of claims being frequently resubmitted within 30 days from the date of initial submission.

To avoid duplicate claims, we recommend validating claims status after 14 days following submission and allowing 60 days prior to resubmission of a claim. The 60 days allows us to meet our goal of paying claims within 30 days from the date of receipt and also allows enough time for billing staff to post payments. Resubmission of claims prior to 60 days causes slower payment turnaround times.

Verify claim status prior to resubmitting a claim. Your claim status can be verified 24-hours a day, seven days a week on our website. Minimizing duplicate submissions reduces your administrative costs.

SCANNING TIPS

All paper claims are input into our system using a process called data lifting and must be submitted in a red and white format.

1. With the exception of a signature in box 31, handwriting is not acceptable on paper claims. All claims containing handwriting will be returned
2. Printing claims on a laser printer will create the best possible character quality
3. If a dot matrix printer must be used, please change the ribbon regularly
4. Courier 12 pitch non proportional font is best for clean scanning
5. Use black ink for all claim submissions
6. Always attempt to ensure that clean character formation occurs when printing paper claims *(i.e. one side of the letter/number is not lighter/darker than the other side of the letter/number)*
7. Ensure that the claim form is lined up properly within the printer prior to printing
8. If a stamp is required, refrain from red ink as this may be removed during the scanning process
9. Make every effort to not place additional stamps on the claim such as received dates, sent dates, medical records attached, resubmission, etc. *(characters on the claim from outside of the lined boxes have a tendency to "throw off" the registration of the characters within a box)*
10. Use an original claim form as opposed to a copied claim form as much as possible
11. Use a standard claim form as opposed to a form of your own creation *(individually created forms have a tendency to not line up correctly, prohibiting the claim from scanning cleanly)*

SECTION XI: Billing, Claims And Encounters

REQUIRED CLAIM FIELDS

The "required" fields to be completed on a **CMS 1500** Claim Form* are as follows:

Field	Description
1a	Insurer's I.D. Number
2	Patient's Name (last, First, Middle Initial)
3	Patient's Birth Date/Sex
5	Patient's Address
9	Other Insurer's Name
9a	Other Insurer's Policy or Group Number
9b	Other Insurer's Date of Birth/Sex
9c	Employer's Name or School Name
9d	Insurance Plan Name or Program Name
10	Patient Condition Related to: a,b,c
12	Patient's or Authorized Person's Signature
13	Insurer's or Authorized Person's Signature
14	Date of Current Illness; Injury; Pregnancy
17	Name of Referring Physician or Other Source
17a	Other ID Number
17b	NPI Number (only required if box 17 is populated)
21	Diagnosis or Nature of Illness or Injury 1,2,3,4
22	Resubmission code/ original claim number
23	Prior Authorization Number
24a	Date(s) of Service
24b	Place of Service
24d	Procedures, Service or Supplies
24f	Charges (usual and customary amount(s))
24g	Units
24j	Rendering Provider's NPI
25	Federal Tax ID Number or Social Security Number
28	Total Charge
31	Signature of Physician or Supplier and Provider Identification Number
32	Name and Address of Location Where Services were rendered – when the address in box 33 is not the address where services where rendered, box 32 must be populated with the service location. **Note:** For transportation claims, the complete pick up and drop off address is required. If the Pick-Up location is an area where there is no street address, enter a description of where the service was rendered (e.g. 'crossroad of State Road 34 and 45' or 'exit near mile marker 265 on Interstate 80')
33	Provider's Facility Name, Supplier's Billing Name (as registered with the IRS), Address, Zip code, and Phone Number
33a	Provider's Organizational NPI

Operative reports, consult notes, consent forms and/or any other documentation required in order to determine reimbursement status of a claim must also be attached.

SECTION XI: Billing, Claims And Encounters

The "required" fields to be completed on a **UB-04** Claim Form are as follows:

Field	Description
1	Provider Name, Address, and Phone Number
3b	Medical Record Number
4	Bill Type
5	Federal Tax Number
6	Statement Covers Period
9	Patient Name
9	Patient Address
10	Patient Date of Birth
11	Patient Sex
12	Admission Date
13	Admission Hour (Inpatient only)
14	Type of Admission
15	Source of Admission (Inpatient only)
16	Discharge Hour (Inpatient only)
17	Patient Status (Inpatient and observation only)
19-28	Condition Codes
42	Revenue Code
43	Revenue Code Description
44	HCPCS/ Rates
45	Service Date – Required for outpatient billings with more than 1 DOS in box 6
46	Service Units
47	Total Charges by Revenue Code
50	Payer
51	Health Plan ID Number
52	Release of Information
56	Rendering Provider's NPI (field required)
58	Insurer's Name
59	Patient's Relationship to Insured
60	Patient I.D. Number
61	Group Name
62	Insurance Group Number
63	Treatment Authorization Codes
64	Original claim number (document control number)
65	Employer Name
66	Other Diagnosis Codes
69	Admitting Diagnosis Codes
74	Principal Procedure Code and Dates
74 a-e	Other Procedure Codes
76	Attending Physician Name (required for bill types 11x, 12x, 21x and 22x) and NPI Number (required if name field is populated)
77	Operating Physician Name and NPI Number (NPI Number only required if name field is populated)
78-79	Other Physician Names and NPI Numbers (NPI Number only required if name field is populated)

SECTION XI: Billing, Claims And Encounters

OTHER INSURANCE

Care1st is always the payor of last resort and is secondary to Medicare and all other third party carriers. When the patient has other insurance, the primary insurance carrier must be billed first. When a patient notifies the provider of other insurance, Care1st must be notified. Care1st coordinates benefits, applying lesser of methodology as applicable, following AHCCCS Policy (ACOM 201 – Cost Sharing for Members Covered by Medicare and Medicaid and ACOM 432 – Benefit coordination and Fiscal Responsibility for Behavioral Health Services and Physical Health Services). Please refer to our Prior Authorization Guidelines for prior authorization requirements. Prior authorization is required for some services when Care1st is the secondary payer.

BALANCE DUE CLAIMS

When submitting a claim for balance due, the provider must include a complete copy of the claim along with the other insurance carrier's Explanation of Benefits (EOB) or Remittance Advice (RA), include the remark code/remittance comments section of the RA. Care1st must receive any balance due claim within 60 days of the receipt of the primary carrier's EOB or RA or 180 days from the date of service, whichever is greater.

AHCCCS is the payor of last resort. If a member is enrolled with a Medicare Risk HMO, the member should be directed to their Medicare Risk HMO. However, if the Medicare Risk HMO does not authorize a Medicaid covered service, Care1st shall review the requested service for medical necessity and potentially elect to authorize it.

As the payor of last resort, Care1st has liability of benefits after all other third party payer benefits have been paid. Care1st will have no cost sharing obligation if Medicare or the other insurance payment exceeds the Care1st allowed amount for the service.

If the services billed are not a benefit from Medicare or the other insurance plan, Care1st may reimburse the procedure if the services are medically necessary. If Medicare or the other insurance disallows a service for not being medical necessary or did not adhere to the primary insurance criteria Care1st will not be financially responsible.

When a member is WellCare Liberty (formerly ONECare) primary and Care1st secondary our system will automatically coordinate processing for these services and submission of the primary remittance advice along with another claim will not be necessary. This is only when the member is both Care1st and Liberty. Please contact our Claims Customer Service Team if you have not received a remittance advice for both lines of business within 90 days.

SECTION XI: Billing, Claims And Encounters

COST SHARING MATRIX

Covered Services	Care1st Responsibility	In Network	Out Of Network	Prior Auth Required
Medicare only covered services*	Cost Sharing responsibility for QMB Duals only	N/A	N/A	NO
AHCCCS only-not covered by Medicare	Reimbursement for all medically necessary services	YES	NO	YES/NO
AHCCCS and Medicare covered Services (except for emergent/pharmacy svcs)	Cost sharing responsibility only	YES	NO	NO
Emergency Services	Cost sharing responsibility only	YES	YES	NO
Pharmacy and Other Physician Ordered Services	Cost sharing responsibility until member reaches HMO Cap, then full reimbursement	YES	NO	YES/NO

*Care1st is not responsible for cost sharing for Medicare Only Services for Non-QMBs (Qualified Medicare Beneficiary, entitled to AHCCCS and Medicare Part A and B services).

MEMBER BILLING

In accordance with Arizona Administrative Code, providers are prohibited from billing AHCCCS members for covered services.

Arizona Administrative Code R9-22-702 states in part, "an AHCCCS registered provider shall not do either of the following, unless services are not covered or without first receiving verification from the Administration [AHCCCS] that the person was not an eligible person on the date of service:

1. Charge, submit a claim to, or demand or collect payment from a person claiming to be AHCCCS eligible; or
2. Refer or report a person claiming to be an eligible person to a collection agency or credit reporting agency"

Care1st members may not be billed, or reported to a collection agency for any AHCCCS **covered service**.

A member may only be billed when the member knowingly receives non-covered services, if the provider notifies the member in advance of the charges and the member signs a statement agreeing to pay for the AHCCCS non-covered services.

Provider cannot collect copayments, coinsurance or deductibles from members with other insurance regardless of the type of carrier. Providers must bill Care1st as the secondary plan and Care1st will coordinate benefits.

SECTION XI: Billing, Claims And Encounters

CLAIMS RESUBMISSION POLICY

Resubmissions/reconsiderations must be received within the following time frames:

- 12 months from date of service
- 60 days of the date of recoupment or 90 days from the date of the reversed dispute decision, if greater than 12 months from the date of service
- 60 days from the date on the primary payer's remittance advice, if greater that 12 months from the date of service
- Original claim number listed in field 22 on HCFA1500 and field 64 on UB04
- Resubmissions received with incorrect or missing the required information listed above will be rejected or denied

Note: Care1st will re-adjudicate claims re-submitted by providers if an initial claim was filed within the original prescribed submission deadline of six months from the date of service.

RESUBMISSIONS/CORRECTED CLAIMS

When submitting a corrected/voided claim please utilize the format below:

- Resubmissions on CMS1500 forms must include indicator 7 and the original claim number in field 22 (EDI Loop 2300)
- Voided claims on CMS1500 forms must include indicator 8 and the original claim number in field 22 (EDI Loop 2300)
- For UB04 forms bill type XX7 (replacement) or XX8 (void) with the original claim number in field 64 (Loop 2300)

If you feel that you have identified a billing issue that may result in a resubmission project exceeding 50 claims, please work directly with your Network Management Representative to coordinate the project.

DUPLICATE OR ERRONEOUS PAYMENTS

Providers will refund promptly to Care1st any payment incorrectly collected from Care1st for services for which another carrier or entity has or should have primary responsibility. In the event of any overpayment, erroneous payment, duplicate payments or other payment of an amount in excess of which the provider is entitled, Care1st may, in addition to any other remedy, recover the same by offsetting the amount overpaid against current and future reimbursements due to the Provider.

EXPLANATION OF REMITTANCE ADVICE

The Remittance Advice (RA) is an explanation of the payment arrangements that is sent out with the claims payment to the provider. The report identifies key payment information. If you have any questions regarding a RA, please contact Claims Customer Service or Network Management.

SECTION XI: Billing, Claims And Encounters

REMITTANCE ADVICE COLUMNS AND DESCRIPTIONS

The following are the report columns and descriptions included in the RA:

HEADER

Company	The line of business (Care1st), logo and address
Vendor/	
Remit Date	Check payment Date
Vendor No.	A unique internal number identifying the pay to vendor
Check No.	The check number assigned .
Payment	The total amount being paid by the check
TIN	Tax identification number

CLAIM PAYMENT DETAIL

Claim Number	The Care1st internal document number assigned to the claim
Member	Member Name
State ID	AHCCCS ID
Patient ID	Patient ID submitted on the claim
Claim Provider	The Care1st internal unique provider ID number and rendering provider name
DRG	The DRG assigned for payment (when applicable)
Date Approved	Date adjudicated for payment/ denial in the Care1st claims system
POS	Place of Service submitted on the claim
Health Plan ID	N/A for Care1st
Payment To	Payment to Vendor or Member & amount
Invoice Number	The claim invoice number taken from the CONSTANT file and entered on the Enter/Update General Claims screen.
Dates of Service	Dates of service submitted on the claim
Procedure	The revenue code, HCPCS, or CPT code submitted on the claim
Procedure Description	A brief description of the service submitted
Qty	The total quantity/ units submitted for the service
Req. Amt	The billed amount for the procedure
Elig. Amt	The eligible amount for the procedure
COB. Amt	The amount paid by the primary carrier via coordination of benefits
Discount	The amount withheld for discounts (i.e. quick payment discount, contractual discount, etc.)
Copay	The member copayment amount
Coins	The member coinsurance amount
Ded Amt	The member deductible amount
Pay Amt	The payment amount for the service submitted
Adj Code	Reason code that defines claim payment

CLAIM AND REMIT TOTALS

Req. Amt	The total billed amount for the claim/ remit
Elig. Amt	The total eligible amount for the claim/remit
COB. Amt	The total amount paid by the primary carrier via coordination of benefits for the claim/ remit
Discount	The total amount withheld for discounts (i.e. quick payment discount, contractual discount, etc.) for the claim/ remit
Copay	The total member copayment amount for the claim/ remit
Coins	The total member coinsurance amount for the claim/ remit
Ded Amt	The total member deductible amount for the claim/ remit
Pay Amt	The total payment amount for the service submitted for the claim/ remit
Req. Amt	The billed amount for the procedure
Elig. Amt	The eligible amount for the procedure

SECTION XI: Billing, Claims And Encounters

REMITTANCE ADVICES AVAILABLE ON WEBSITE

Medical

For your convenience, remittance advices are available for reviewing and printing on our website for up to 6 months from the date of payment, minimizing delay between receipt of dollars and the ability to post payment. Contact Network Management to obtain a login or confirm your login status. To obtain copies of a remittance advice older than 6 months, please contact claims customer service at 602.778.1800/866.560.4042 (Options in order 5, 4).

Dental

For ACC Members:	For RBHA Members:
For information regarding dental remittances advices reference the Office Reference Manual (ORM) on the DentaQuest website at www.dentaquest.com.	For information regarding dental remittances advices reference the Envolve Dental Website for Provider resources: https://www.envolvedental.com/providers/provider-resources.html . Additional information is available at https://www.envolvedental.com/.

BENEFIT COORDINATION AND FISCAL RESPONSIBILITY FOR BEHAVIORAL HEALTH SERVICES AND PHYSICIAL HEALTH SERVICES EFFECTIVE 10/01/18

Effective 10/01/18 ACOM policy 432 was revised to reflect the AHCCCS Complete Care (ACC) model. This revision addresses the integration of behavioral health services into the AHCCCS complete care plans for purposes of benefit coordination, and delineation of financial responsibility for AHCCCS covered physical and behavioral health services.

For fully integrated members covered under an AHCCCS Complete Care (ACC) plan, the enrolled entity is responsible for both physical and behavioral health services for non-SMI (Serious Mental Illness) members. Payment for AHCCCS covered behavioral health services is indicated in **Attachment A, matrix of financial responsibility, responsibility by party.**

Please review the updated policy 432 and attachment A, matrix of financial responsibility, responsibility by party for changes effective 10/1/18 on the AHCCCS website.

http://www.azahcccs.gov/ > Plans/Providers > Guides-Manuals-Policies > AHCCCS Contractor Operational Manual (ACOM) > Chapter 400 Operations > 432 Benefit

SECTION XI: Billing, Claims And Encounters

Coordination and Fiscal Responsibility for Behavioral Health Services and Physical Health Services

Direct path to Chapter 400:
https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/432.pdf

PRIOR PERIOD COVERAGE

- Prior Period Coverage (PPC) extends from the beginning date of an AHCCCS recipient's eligibility to the date prior to the recipient's date of enrollment with Care1st. Care1st reimburses providers for covered services rendered to eligible members in accordance with AHCCCS guidelines.
- Verify PPC by looking for rates codes with 3 numbers and a letter.
- Providers have six (6) months from the day member eligibility is entered to submit PPC claims.
- There are no prior authorization requirements during the PPC time frame.
- The Plan is responsible for reimbursing providers only for medically necessary services rendered during the PPC period. If the plan denies an inpatient hospital stay for lack of medical necessity the entire stay will not be paid for either the PPC or prospective time period.
- Prior authorization requirements do apply in accordance with the provider's contract once prospective enrollment begins.

IMPORTANT NOTES

- When box 31 on the CMS 1500 form has "Signature on File," this is acceptable as long as the processor can determine the servicing provider. When only the group name appears in Box 33 and the processor is unable to determine the servicing provider, the claim will be denied. Box 33 should always indicate the facility name as provided to the IRS, AHCCCS, and Care1st.
- If the same service is performed on the same day and by the same provider, the claim must be submitted with the applicable modifier and supporting documentation attached.
- If a claim is received with dates of service that fall after the received date the entire claim will be denied.
- Diagnosis codes that require a 4th - 7th digit will be denied if not submitted with appropriate code. Care1st never changes or alters a diagnosis code.

- If applicable, the prior authorization number must be indicated on all claims (CMS 1500 field 23, EDI loop 2300 REF/G1, UB04 field 63 EDI loop 2300 REF/G1) to avoid denials.

MODIFIERS

Valid and approved AHCCCS modifiers should be used when submitting claims to Care1st. Claims that are submitted with an inappropriate or missing modifier will be denied. The following are a few commonly used modifiers and tips on appropriate usage:

***MODIFIER 25* (Separate identifiable E&M service)**

When an EPSDT visit (99381-99385 or 99391-99395) is performed in conjunction with a sick visit (99201-99245) for members less than 21 years of age, modifier 25 is required on the sick visit CPT code in order to be reimbursed for both the EPSDT visit and the sick visit. If both visits are performed in conjunction with VFC immunizations, the modifier 25 is required on both the E&M and EPSDT codes. Modifier EP is required on the EPSDT visit code. The sick visit is reimbursed at 50% of the applicable fee schedule. Please remember that both visits must be billed on the same claim form. See the SL modifier section below for an example of how to bill a sick visit, EPSDT visit and VFC vaccine administration.

EP MODIFIER

Modifier EP is billed in conjunction with 96110 for reimbursement of developmental testing utilizing any of the three AHCCCS approved Developmental Tool: PEDS Tool, MCHAT or ASQ. Providers must first complete the training for the tool that is utilized to be eligible for reimbursement for this service.

The EP modifier is also required on preventative EPSDT services (CPT codes 99381-99385, 99391-99395) and to designate all services related to the EPSDT well child visit, including routine vision and hearing screenings. For more information, see our blast fax communication from August 28, 2014 on our website and the AHCCCS Medical Policy Manual (AMPM) Chapter 400 Policy 430-29 Section H. See the SL modifier section below for an example of how to bill a sick visit, EPSDT visit and VFC vaccine administration.

***SL MODIFIER* (State supplied vaccine)**

Vaccines administered to members under the age of 19 are ordered through the Vaccines for Children (VFC) program. For a complete listing of eligible VFC codes, refer to www.azdhs.gov/phs/immun/act_aipo.htm. To be eligible for reimbursement, bill vaccines supplied through the VFC Program as outlined in the claim example below.

CLAIM EXAMPLE: Billing sick visit, EPSDT visit and vaccine code(s) for single date of service:

Patient (under the age of 19) makes appointment because of an earache. Office determines it is time for EPSDT evaluation and vaccine. Office bills:

- Both the sick and well diagnosis codes
- Sick visit is billed with appropriate E&M (99201-99245) with modifier 25
- EPSDT visit is billed with appropriate E&M (99381-99385 or 99391-99395) with modifier 25 and modifier EP
- Vision screening is performed as part of the EPSDT visit (92015) with modifier EP
- VFC vaccine code is billed with the applicable NDC and the SL modifier
- Vaccine administration code is billed with the SL modifier

***MODIFIER 50* (bilateral procedure)**
Modifier 50 is required for all bilateral procedures. Please refer to the current coding guidelines for a listing of appropriate bilateral procedures.

Bilateral procedures are billed on one line with 1 unit and the 50 modifier:

EXAMPLE:
Line 1: 69436, with "50" modifier, full dollar amount, 1 unit
Total payment: 150% of fee schedule

***MODIFIER 59* (distinct procedural service)**
Modifier 59 is required to identify a truly distinct and separate service and should not be used if the procedure is performed on the same site. When an already established modifier is appropriate, it should be used instead of modifier 59 (example modifier 91 for repeat clinical procedures). Care1st applies NCCI (National Correct Coding Initiative) bundling edits to claims. Claims submitted with modifier 59 are subject to medical review and office notes/operative reports are required with the claim submission for consideration. Effective 01/01/15 four new HCPCS modifiers to define subsets of the modifier 59, used to define a "Distinct Procedural Service", are available for use:

- XE: Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter
- XS: Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
- XP: Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner
- XU: Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

Records are required for modifier 59, XE, XS, XP & XU when billed with the following codes: 36600, 43210-43239, 45380-45398, 45900-45999, 46600-46615, 49560-49568, 51600-51720, 51725-51798, 52000-52318, 58100-58120, 62310-64640 or 69100-69999. Records are also required for these modifiers for 96372 billed with pain management procedures or 94640 billed with 94060.

MODIFIER 76 **(repeat procedure by same physician)**
Modifier 76 is required to identify repeat procedures preformed by the same physician. When multiple procedures are performed by the same provider, all services should be submitted on one claim on a single line when possible.

Example (No records required when all services billed on line or only a single repeat code has modifier 76)

- Line 1 – 73020/26 for units

Claims submitted with modifier 76 billed on the same code on multiples lines, or the same code with modifier 76 on multiple claims are subject to medical review and records are required with the claim submission in order to be considered.

Example (Records required for review)

- Line 1 – 73020/26 for 1 unit
- Line 2 – 73020/26/76 for 1 unit
- Line 3 – 73020/76 for 1 unit

MODIFIER 77 (repeat procedure by a different physician)
Modifier 77 is required to identify repeat procedures performed by different physicians. Claims submitted with modifier 77 do not require medical records when the modifier is billed on single procedure code on the claim.

MODIFIERS GP & GO (Therapy code modifiers)
Modifier GP is required to identify physical therapy services and is appended to the appropriate case rate, or therapy code. Modifier GO is required to identify occupational therapy services and is appended to the appropriate case rate, or therapy code. Please refer to your billing guidelines for coding requirements.

All therapy service codes must be billed on a single line for each date of service to ensure accurate payment (date spans are not accepted).

MODIFIER 91 (repeat clinical diagnostic laboratory test)
Modifier 91 is required to identify repeat procedures performed by the same physician. When multiple procedures are performed by the same provider, both services are submitted on the same claim. Claims submitted with modifier 91 are subject to medical review and records are required with the claim submission in order to be considered

***MODIFIER* SG (Ambulatory Surgical Center facility service)**
Modifier SG is required on surgical procedures to identify the facility billing and is not used for professional services.

***MODIFIERS QK, QX & QY* (Anesthesia with CRNA oversight)**
When anesthesia services are provided by a CRNA with oversight from a physician, the appropriate modifier is required (QK, QX, or QY).

Services are reimbursed to each provider (CRNA and supervising physician) at 50%.

ADDITIONAL MODIFIER CRITERIA

- When a complete laboratory service is performed (both professional and technical component), the service should be billed on a single service line with no modifier.

- Modifiers are required for all DME, Prosthetics and Orthotics and Ambulance services.

- When both the technical and professional component are performed by the same provider of service, the service code(s) should be billed on a single service line without a modifier, and not billed on two separate lines with the TC and 26 modifiers.

OPERATIVE REPORT

An operative report is required for the following surgical procedures:

- Multiple procedures with a total allowed amount greater than $5000.00
- Any surgical procedure billed with modifier(s):
  - 62, 66, 76, 77, 78, XE or XP – All Claims
  - 59, XS, XU – Claims with codes billed in the ranges under modifier 59 section
- Any unlisted procedures
- Any surgical procedure billed for a higher level of care than originally prior authorized

REFUNDS

When submitting a refund, please include a copy of the remittance advice, a letter or memo explaining why you believe there is an overpayment, a check in the amount of the refund, and a copy of the primary payer's remittance advice (if applicable) and a corrected claim (if applicable).

If multiple claims are impacted, submit a copy of the applicable portion of the remittance advice for each claim and note the claim in question on the copy. When

a refund is the result of a corrected claim, please submit the corrected claim with the refund check.

Refunds are mailed to Care1st, Attention: Finance, 1850 W Rio Salado Parkway, Suite 211, Tempe, AZ 85281.

ANESTHESIA

Notes are required for all timed procedures and are subject to medical review. The specific anesthesia start and end time must be submitted on the CMS-1500 form. The total number of minutes is required in the unit field (25G).

The following are not reimbursable:

00938	99116
94656	99135
99100	99140

- Consultations of other evaluation and management code on the same day as an anesthesia administration are not payable. Consultations provided the day before anesthesia services are payable separately when prior authorization is obtained.

- Daily pain management following surgery is not a covered expense.

Certified Registered Nurse Anesthetists (CRNA) are reimbursed at 100% of the AHCCCS fee schedule.

When services are provided by a CRNA and oversight is provided by a supervision physician, the applicable modifier must be submitted on each claim. The QX modifier is billed with the CRNA service when medical direction is provided by a physician. The QY modifier is billed by the supervising physician to indicate medical direction was provided to the CRNA. The QK modifier is billed by the supervising physician to indicate that medical direction was provided to multiple concurrent anesthesia procedures.

As a reminder, the anesthesia record is required anytime the anesthesia starts and stops during a procedure.

ASSISTANT SURGEONS

Assistant surgeon bills are submitted with a modifier -80 or -81. These charges are reimbursed at 20% of the reimbursement rate of the assistant surgeon. Assistant surgeon charges submitted for a physician assistant, nurse practitioner, or clinical nurse specialist should be submitted with modifier AS.

SECTION XI: Billing, Claims And Encounters

DIALYSIS

- For facility billings, the type of bill must be 72x and the appropriate modifiers must be billed for the specific dialysis services.
- Admission date/hour and discharge hour should be left blank on dialysis services to avoid claims rejections.
- Physicians do not require their own authorization. They may use facility authorization.

GENERAL MENTAL HEALTH/SUBSTANCE ABUSE BILLING GUIDELINES

Integrated Clinics and Behavioral Health Outpatient Clinics

Services received at an Integrated Clinic or Behavioral Health Outpatient Clinic are billed under the clinic location as indicated below.

- Rendering Provider = service location, not a practitioner. The site specific NPI is used and is placed in the following location:
  - Paper claim-Box 24J
  - EDI claim-Loop 2310B bill (Note: If Loop 2010AA: NM109 also contains the site location NPI, Loop 2310B can be left blank)
  - Effective 06/01/2022 the rendering providers name and NPI for services billed under the clinic location (Outpatient Behavioral Health and Integrated Clinics must be included on claims in the field(s) below.

Behavioral Health Paper Claims	***Behavioral Health EDI Claims***
Box 19	Loop 2300 NTE segment

- Signature field is left blank for clinic facility billing. The signature field is located as follows:
  - Paper claim-Box 31
  - EDI CLAIM-LOOP 2300: CLM06

AHCCCS Registered Practitioner

Services rendered by an AHCCCS registered practitioner, i.e. Licensed Marriage/Family Therapist (LMFT), Licensed Professional Counselor (LPC), Licensed Independent Substance Abuse Counselor(LISAC), Physician (MD), Physician Assistant (PA), Nurse Practitioner (NP), Social Worker (LCSW) or a Psychologist, are billed under the rendering practitioner.

- Rendering provider = the practitioner. The practitioner's NPI is placed in the following location:
  - Paper claim-Box 24J
  - EDI claim-Loop 2310B

- Signature field is populated with the rendering practitioner's name. The signature field is located as follows:
  - Paper claim-Box 31
  - EDI claim-Loop 2300: CLM06

DURABLE MEDICAL EQUIPMENT

- Canes, crutches, standard walkers, standard wheelchairs and supplies do not require an authorization when provided by a contracted provider.

- Valid modifiers must be submitted with DME services to indicate NU (new) or RR (rental rate). Claims submitted without one of these modifiers will be denied.

EMERGENCY TRANSPORTATION PROVIDERS

Claims for emergent transportation, including transport transfer services to a higher level of care (such as member transfer from Skilled Nursing Facility to Hospital), must indicate Emergency in Box 24C. Emergent services do not require prior authorization; however non-emergent services must be authorized accordingly. Inter-facility transports require authorization.

The appropriate modifier for ambulance services must also be billed.
Fractional mileage is now accepted by AHCCCS and should be billed on transport claims when applicable. The full pick up address (or location if an address is not available) and drop off address are required in box 32 for ambulance services. If the pick-up location is an area where there is no street address, enter a description of where the service was rendered (e.g. 'crossroad of State Road 34 and 45' or 'exit near mile marker 265 on Interstate 80'). Claims that do not contain this information will be denied.

For electronic claims, the pick-up location must be billed in loop 2310E and the drop off location must be billed in loop 2310F. No trip ticket is required if these fields are populated correctly.
For paper claims, a trip ticket is required on each claim. Pick-up and drop-off requirements are as follows:

1. Pickup and/or drop off location = facility, i.e. hospital, SNF
   - Street address, city, state, zip required in box 32
2. Pick up and/or drop off location ≠ facility
   - Street address, city, state, zip required in box 32
3. Pick up location = area where there is NO street address
   - Description of where service was rendered (e.g. 'crossroad of State Road 34 and 45' or 'exit near mile marker 265 on Interstate 80') required in box 32

Claims that do not contain the minimum requirements are denied.

Supplies provided during emergency transportation are to be billed by the ambulance service and not the supply company. Billable code range for supplies = A0010- A0999. Supplies are billed with 1 unit.

Ambulance wait time is not a covered benefit.

FAMILY PLANNING SERVICES

Authorization is NOT required for family planning services, but the diagnosis must indicate family planning.

Services not covered by AHCCCS for family planning include:

1. Services for the diagnosis or treatment of infertility
2. Abortion counseling
3. Abortions, unless one of the following conditions is met:

    a. The pregnant member suffers from a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the member in danger of death unless the pregnancy is terminated.

    b. When the pregnancy is a result of rape or incest.

    c. The pregnancy termination is medically necessary according to the medical judgment of a licensed physician who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or mental health problem for the pregnant member by:
        i. Creating a serious physical or mental health problem for the pregnant member
        ii. Seriously impairing a bodily function of the pregnant member
        iii. Causing dysfunction of a bodily organ or part of the pregnant member, or
        iv. Preventing the pregnant member from obtaining treatment for a health problem

Care1st requires a completed Federal Consent Form for all voluntary sterilization procedures, including claims submitted for sterilization services provided during the recipient's retro-eligibility period, prior period coverage (PPC). Federal consent is required for tubal ligations.

Federal consent requirements for voluntary sterilization require:

- Thirty days, but not more than 180 days, must have passed between the date of informed consent and the date of sterilization, except in the case of a premature delivery or emergency abdominal surgery.
- The recipient may be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since the recipient gave informed consent for the sterilization.
- In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.
- The person securing the informed consent and the physician performing the sterilization procedure must sign and date the consent form.
- The surgeon involved with the sterilization procedure must submit a copy of the signed Federal Consent Form.
- The recipient must be at last 21 years of age at the time the consent is signed.

FQHC/RHC PPS RATE

AHCCCS health plans reimburse FQHC/RHC claims at the PPS rate in accordance with AHCCCS billing requirements.

There are specific requirements for reimbursement, which are posted to the AHCCCS website in Chapter 10 FQHC/RHC Addendum of the AHCCCS Fee-for-Service Provider Manual. Please reference this Chapter for important claim submission details.

Reminders:

1. The billed amount for the T1015 must be greater than or equal to the PPS rate or lesser of is applied
2. The rendering provider on the claim is the FQHC not the practitioner. The site specific NPI and/or the FQHC entity name is placed in the following fields of the claim:

Medical Paper Claims	***Dental Paper Claims***	***Medical & Dental EDI Claims***
Box 24J and 32	Box 54 and 56	Loop 2310B and 2310C

3. The participating/performing practitioner information is listed the following fields of the claim:

Medical Paper Claims	***Dental Paper Claims***	***Medical & Dental EDI Claims***
Box 19	Box 35	Loop 2300 NTE segment

4. Services provided in some places of service outside the FQHC/RHC, i.e. services rendered in an inpatient hospital setting, should be billed under the servicing practitioner vs. the FQHC/RHC

5. When submitting a paper claim, populate box 31 on medical and box 53 on dental claims with 'Signature on file'. (For 837 submissions this field, loop 2300, clm, 06 should be left blank).
6. At a minimum, there should at least be 2 codes billed. The T1015 and the actual service(s) rendered. All services performed at the visit should be billed on the same claim.
7. For maternity claims:
    - All prenatal and post-partum visits should be billed by the FQHC/RHC site and will be paid the PPS rate
    - The delivery is billed under the practitioner that performed the delivery
8. Coordination with other primary insurance is applied to the whole claim to determine secondary payment
9. For members that have WellCare Liberty (formerly ONECare) and Care1st coverage, the secondary claim must be submitted to Care1st on paper with a copy of the Liberty remittance advice.

HOME HEALTH

- Nursing supplies are not considered routine. All supplies require prior authorization to be reimbursed.

- Any nursing visits not included in the per diem (more than one per month) or visits longer than two hours must be authorized by the case manager for reimbursement.

HOSPICE SERVICES

- Services must be billed on a UB-04 claim form using bill types 81x, 82x, the third digit must be 1 through 4 or 6 through 8.

- All UB-04 hospice/end of life claims require itemization, unless Medicare is primary.

- Care1st reimbursement rates for the four levels of service are all-inclusive rates that include durable medical equipment, medication and other health care services (physician) related to the recipient's terminal illness.

IMMUNIZATIONS/INJECTABLES

VACCINE FOR CHILDREN (VFC) PROGRAM

PCPs rendering services to children under the age of 19 and covered by AHCCCS must participate in the VFC program and coordinate with the Arizona Department of Health Service Vaccines for Children (VFC) program in the delivery of immunization services. Through the VFC program, the federal government purchases and makes available to the states, free of charge, vaccines for children

under the age of 19 who are Title XIX eligible, Native American, or Alaskan Native, not insured, or whose insurance does not cover immunizations.

Immunizations must be provided according to the Advisory Committee on Immunization Practices Recommended Schedule which is found at www.cdc.gov/vaccines or on our website www.care1staz.com (See Practice & Preventive Health Guidelines under the Provider menu). For more information regarding the VFC program or to enroll as a VFC provider please call the Vaccine Center at 602.364.3642. The VFC program updates its covered vaccines as needed. For a complete listing of eligible VFC codes, refer to http://www.azdhs.gov/phs/immun/act_aipo.htm#vfc.

When E&M services and VFC services are performed on the same day, billing for these services are submitted on the same claim. One administration fee is reimbursed for each immunization, including combination vaccines. To receive reimbursement for the administration of a VFC vaccine, bill the vaccine CPT code (including the NDC) with an SL modifier and the applicable vaccine administration code with an SL modifier. Administration fees should be billed on a single line, with the appropriate number of units.

OTHER INJECTABLES

Unclassified drug codes (i.e. J3490) require description & dosage and should only be used if there is no other appropriate code. A description of the specific drug is required along with the applicable NDC.

DRUG BILLING/NATIONAL DRUG CODE (NDC)

Drugs administered in outpatient clinical settings in accordance with Federal Deficit Reduction Act of 2005 require the NDC. All paper and electronic UB-04 and CMS 1500 claims must include the appropriate National Drug Code (NDC) number on claims for payments for drugs administered in an outpatient setting.

NDC is billed with an N4 qualifier when submitted electronically and must be billed in the following format: With 11 digits for the NDC, the unit of measure (F2, GR, ML, or UN) and the quantity (examples: N411111111111 F210 for electronic submission or 11111111111 F210 for paper submission)

Claim lines billed without the NDC code are denied.

J3490 is used for unclassified drugs – the unit of measure and dosage quantity should be billed following the NDC billing guidelines. The line level quantity billed should always reflect 1 (one).

SECTION XI: Billing, Claims And Encounters

LABORATORY

PCPs and Specialists may bill in office labs based on the Clinical Laboratory Improvement Amendments (CLIA) test complexity categorization provisions utilized by AHCCCS. In order for a lab to be payable, the lab must be allowed by AHCCCS to be performed in POS 11. Practices with CLIA certifications must ensure that each CLIA certification is on file at AHCCCS for each provider and that each provider has an agency code of 200 noted on the AHCCCS PR020 Licenses/Certifications screen. All other laboratory services, including drug screening, must be referred to Sonora Quest.

Sonora Quest patient service locations are available at www.sonoraquest.com by clicking on the patient service center locator tab. Web-based patient service center appointment scheduling is also available and offers members the ability to schedule an appointment for a convenient day and time, resulting in reduced wait time upon arrival at a patient service center. The web based scheduling system is available 24 hours per day. Walk-in appointments are still available during scheduled hours of operation as well, although appointments are encouraged.

MATERNITY SERVICES

When submitting prenatal care and delivery claims, the following guidelines and coding procedures will apply:

Prior Authorization for total OB packages must be requested within 30 days of pregnancy confirmation. If the member leaves the practice prior to delivery Care1st does not need to be contacted to update the authorization to fee for service. The new practice will need to submit a notification to Care1st

Care1st reimburses obstetrical care as a total OB (TOB) package. To qualify for a TOB package, a minimum of 5 ante partum visits must be rendered in addition to the delivery. To confirm this requirement was satisfied, the appropriate delivery CPT procedure code is billed in addition to the ante partum visits. Ante partum and post partum visits may be billed in one of two ways with the appropriate E&M CPT code (99211-99215) on individual service lines with 1 in the 'units' field for each date of service.

- Prenatal visits are billed as fee for service and reimbursed as they occur at the lesser of the provider's contract rate, or billed charges. When the delivery claim is received a reconciliation will be performed on all prenatal visits paid.
    - For claims that meet the total OB criteria all prenatal visits will be adjusted at the time the total OB package is paid and confirmation of recoupment of these claims will appear on same remittance as the total OB payment
    - If the member does not qualify for the total OB package, the delivery claim will be paid at the appropriate delivery only rate and fee for service prenatal visits will not be recouped.

- Pre-natal visits may also be reported with the final total OB claim as a 0.00 or 0.01 charge line if the member qualifies for the total OB package. Please see the example below if billing in this format.

AHCCCS requires health plans to collect all dates of service for obstetrical care. This change does not impact policies related to global billing, however it requires that all dates of service must be reported on the claim [AMPM Policy 410 Section D(3)(f)]. Consequently, each ante partum date of service must be billed individually, or with the final claim at the time of delivery. .

Total OB Example: **for prenatal visits billed as a 0.00 or 0.01 line charge with the total OB package :**

OB physician performs 6 ante partum visits between January 1 and April 30 and delivery occurs May 5.

- Line 1: Appropriate total OB care delivery CPT code
- *Line 2: 1st Ante partum visit billed with the date of service and E&M CPT code
- *Line 3: 2nd Ante partum visit billed with the date of service and E&M CPT code
- *Line 4: 3rd Ante partum visit billed with the date of service and E&M CPT code
- *Line 5: 4th Ante partum visit billed with the date of service and E&M CPT code
- *Line 6: 5th Ante partum visit billed with the date of service and E&M CPT code
- *Line 7: 6th Ante partum visit billed with the date of service and E&M CPT code
- *Line 8: Post partum visit billed with the date of service and E&M CPT code. *Claims for the total OB package can be billed prior to the post partum visit being rendered. Please be sure to submit the post partum visit once it is completed.*

*****Each visit must be billed on a separate line with the specific date of service and a unit of 1.

All services included in the TOB package are billed with the delivery. Reimbursement is made on the total OB care delivery CPT code.

To report services related to maternity care, use the appropriate CPT-4 office visit codes and the appropriate ICD-10-CM pregnancy diagnosis codes.

Pregnant women up to 21 years and younger are required to have an EPSDT visit. This visit should be billed with the appropriate date of service and $0.00 amount at

the time the total OB package is billed. This service should be billed on a separate line from the prenatal visits.

CPT PROCEDURE CODES, VAGINAL DELIVERY

59400 Package Routine obstetric care including antepartum care (a minimum of five visits), vaginal delivery (with or without episiotomy and/or forceps) and postpartum care. Total OB package should be billed after delivery.

59409 Vaginal delivery only (with or without episiotomy), forceps or breech delivery. Use when there are fewer than five prenatal visits and total OB authorization was obtained.

59410 Vaginal delivery only (with or without episiotomy), forceps or breech delivery including postpartum care. Use when there are fewer than five prenatal visits and total OB authorization was obtained.

59610 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery.

CPT PROCEDURE CODES, CESAREAN DELIVERY

59510 Package Routine obstetric care including antepartum care (a minimum of five visits), cesarean delivery, and postpartum care. Total OB care should be billed after delivery.

59514 Cesarean delivery only with no postpartum or antepartum care. Use when there are fewer than five prenatal visits and total OB authorization was obtained.

59515 Cesarean delivery only including postpartum care. Use when there are fewer than five prenatal visits and total OB authorization was obtained.

59525 Subtotal or total hysterectomy after cesarean delivery.

59618 Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery.

*Multiple births should be paid using the total OB code for the first birth and the delivery only code with a 51 modifier for subsequent births.

LABOR AND DELIVERY

Providers should use ASA code:

00857 Continuous epidural analgesia for labor and cesarean section

00955 Continuous epidural analgesia for labor and vaginal delivery

00850 Base (7) + time for cesarean section-8 total time units max

00946 Base (5) + time for vaginal delivery-8 total time units max

01960 Anesthesia for vaginal delivery only-8 total time units max

01961 Cesarean delivery only-8 total time units max

01967 Neuraxial labor analgesia/anesthesia for planned vaginal delivery-8 total time units max

01968 Cesarean delivery following neuraxial labor analgesia/anesthesia-8 total time units max

01969 Cesarean hysterectomy following-8 total time units max

OB anesthesia does not require documentation. We pay the base units plus a maximum of 8 time units for labor and delivery anesthesia. Providers should not bill 01996 with anesthesia for delivery.

ADDITIONAL OB INFORMATION

- If a provider different from the provider with the total OB authorization performs the delivery only, the provider with the total OB authorization shall be reimbursed for all prenatal visits on a fee-for-service basis. The prenatal visits should be submitted indicating each individual date of service and separate charges for each visit. Should provider change facility affiliation, Care1st must be notified regarding disposition of members. The authorization may follow the physician but final billings must be initiated by each facility and each facility must indicate the dates of service and charges that apply. The physician's facility that provides the delivery will be eligible for total OB reimbursement if the authorization is on file and the minimum numbers of visits have taken place.
- A total OB authorization includes all prenatal visits and postpartum care (including Prior Period Coverage dates). When a patient transfers care to another provider, a new OB auth must be obtained.
- Any additional surgical procedures performed during the delivery admission must also be reported along with appropriate diagnosis. If a postpartum

tubal ligation is performed, the signed consent form must be submitted with the claim.

- Providers must bill each prenatal visits on a separate service line with 1 unit each on the CMS 1500 claim form.
- No prior authorization is required for assistant surgeon services on cesareans. Assistant surgeon services are not covered for vaginal deliveries, only for cesareans.
- OB claims need a minimum of five visits in order to qualify and be paid for a total OB package rate. If no prenatal visits are billed with total OB package codes 59400, 59510, 59610, or 59618 the claim will be denied.
- If a claim indicates pregnancy terminated, patient transferred care, or patient moved out of state, the provider(s), total OB authorization will still cover all charges incurred up to that point to be paid fee-for-service. The reason for discontinuation of care should be indicated on the CMS 1500 form.
- The operative report, prior authorization and the Federal consent form are required for sterilization services. Consent form must be signed 30 days prior to sterilization. Total Hysterectomies do not require an authorization if performed on an emergency basis and they never require a federal consent form.
- 2D OB ultrasounds (3 or more) require prior authorization

MID-LEVEL PROFESSIONALS (NP'S & PA'S)

NPs and PAs are reimbursed at the Care1st Midlevel Fee Schedule.

DEVELOPMENTAL SCREENING TOOLS

AHCCCS approved developmental screening tools should be utilized for developmental screenings by all participating PCPs who care for EPSDT age members. PCPs must be trained in the use and scoring of the developmental screening tools, as indicated by the American Academy of Pediatrics. The developmental screening should be completed for EPSDT members during the 9 month, 18 month and 24 month EPSDT visits. A copy of the screening tool must be kept in the medical record.

Additional reimbursement may be received when:

1. One of the AHCCCS approved screening tools (listed below) is completed during a 9, 18 or 24 month EPSDT visit:
    a. Parents' Evaluation of Developmental Status (PEDS)
    b. Modified Checklist for Autism in Toddlers (M-CHAT-R/F)
    c. Ages & Stages Questionnaire (ASQ)

2. PCP is trained in the use and scoring of the developmental screening tools, as indicated by the American Academy of Pediatrics;
3. The screening is billed separately from the EPSDT visit using CPT code 96110 with an EP modifier.

RADIOLOGY

Providers must bill with either a 26 (professional) or TC (technical) modifier for correct reimbursement. When billed with no modifier, provider is indicating they provided both the technical and professional services. All services performed for a specific service date or date span must be billed on a single claim.

SKILLED NURSING FACILITY (SNF)

- The type of bill for facility billings must be 21x
- Revenue codes for room & board for SNFs is 190-194 and 199
- Medicare Part B Only does not cover respiratory therapy; it does cover occupational, physical and speech therapies.
- Medicare Part B Only providers are required to itemize their charges, items covered by Medicare Part B need to be identified.

* SNF providers cannot bill with overlapping months.

SURGERY PROVIDERS

- An operative report is required for the following surgical procedures:
    1. Multiple procedures with a total allowed amount greater than $5000.00
    2. Any surgical procedure billed with modifier(s) 62, 66, 76, 77, or 78
    3. Surgical procedures billed with modifier 59 when billed with the following codes: 36600, 43210-43239, 45380-45398, 45900-45999, 46600-46615, 49560-49568, 51600-51720, 51725-51798, 52000-52318, 58100-58120, 62310-64640 or 69100-69999
    4. Any unlisted procedures
    5. Any surgical procedure billed for a higher level of care than originally prior authorized
- Multiple procedures are paid at 100% of the applicable fee schedule for the primary procedure, and 50% of the applicable fee schedule for the next five procedures. When an operative report is required and not submitted, the claim will be denied for the operative report. Office

procedures require office note's if an OP report is not available. In order to eliminate any delay in payment, submit an OP Report with a surgery claim.

- Planned surgeries require their own prior authorizations. Surgical trays (A4550) are not reimbursable.

MEDICAL CLAIMS REVIEW

The Medical Management (MM) Department has assigned the medical claims analysis responsibility to the medical claims analysts who are responsible for reviewing and analyzing all claims deemed appropriate for retrospective review. The MM Department uses the following guidelines, criteria, and coding indexes to review a claim:

- International Classification of Diseases-Tenth Edition (ICD-10)
- Current Procedural Terminology (CPT)
- CMS Common Procedure Coding System (HCPCS)
- Medicare Guidelines
- Milliman Care Guidelines®
- National Correct Coding Guide: Correct Coding Initiatives (CCI)
- UB Editor
- McKesson Claim Check

The following types of claims are reviewed by MM on a regular basis. Please note that this is not an all-inclusive list and is subject to change at any time.

- All Level-V Emergency Medicine Physician charges
- Inpatient claims that are set to pay at the inpatient outlier rate, or exceeding a payment threshold of $50,000.00
- Multiple and Bilateral Surgeries over $500.00
- Select surgical procedures utilizing modifier 59 (See modifier section of this document.
- Inpatient PPC claims
- Observation over 24-hours
- Critical care
- Prolonged services
- Anesthesia unusual services
- Unlisted/ By report procedures

As needed, the results of the MM analysis are forwarded to the Sr MD for review and decision. All identified claims that do not meet the criteria may be subject to

denial or reduction of reimbursement and are reviewed by the Sr MD or designee. All cases of potential fraud or abuse are referred to AHCCCS in accordance with Care1st's Fraud and Abuse policy.

The outcomes and aggregate adjustments are compiled, tabulated and presented monthly to the MM Committee by the Sr MD.

If appropriate, members will be referred to MM for monitoring and assistance with continuity of the member's care.

ENCOUNTER DATA

Care1st is required to submit a record (encounter data) of provider claims for all valid Medicaid covered services to AHCCCS. The required encounter data include paid claims, zero paid claims and select denied claims. AHCCCS uses the encounter data for many things, some of which are to:

- Evaluate health care quality
- Evaluate plan performance
- Develop provider payment rates which plans may use

ENCOUNTER DATA VALIDATION

As part of an annual federal requirement, AHCCCS may request medical records from practitioners and hospitals or claim copies for services provided to AHCCCS members during a previous AHCCCS contract year (October 1st through September 30th). This process is referred to as a Data Validation Study. The study audits the integrity of claims submitted to AHCCCS health plans and ultimately to AHCCCS Administration. Quality indicators are affected by the accuracy of the claims submitted and reimbursement to your practice can be negatively impacted by inaccurate claims submission.

Following the tips below will help ensure each Data Validation study is successful:

1. Medical record copies must be legible. Please check the ink in your printers or review the quality of the photocopies before records are packaged and mailed.
2. Physician signatures must be legible on all documentation per Medicare requirements. If the signature is not legible, the printed name should be included under the signature and must be legible.
3. All medical record documentation must have the date of services and the patient's name on every page.

4. Documentation for office visits/consults must support the level of service billed.
5. Documentation must support the number of units billed.
6. Documentation for time-based services (i.e. anesthesia) must include the time element.
7. Diagnoses must be reported to the highest level of specificity.
8. Ambulance mileage must be documented on the medical record.

Care1st appreciates and values your assistance and partnership during the annual data validation study.

SECTION XII: Fraud, Waste and Abuse

FRAUD AND ABUSE

Arizona Revised Statute ARS 36-2918.01 requires providers to immediately report suspected fraud and abuse. Members or providers who intentionally deceive or misrepresent in order to obtain a financial gain or benefit they are not entitled to must be reported to Care1st or directly to AHCCCS.

It is imperative that our providers continue to partner with us to ensure that the reported millions of dollars lost to Medicaid fraud and abuse does not originate with Arizona providers. Members and providers who act fraudulently hurt honest providers and exhaust limited resources available to serve those in need.

Examples of member fraud might include use of someone else's member ID card or failure to report other insurance. An example of provider fraud might include billing for services not provided, billing for a level of service not provided, or miscoding a claim to obtain reimbursement exceeding what a provider is entitled to receive.

To report any suspected provider or member fraud or abuse, the following options are available:

- Call the Care1st Fraud Hotline 866-685-8664
- Call the Care1st anonymous Compliance Hotline 866-364-1350
- Call the Care1st Compliance Officer at 602-778-1800 x8302
- Email fraud and abuse directly to AzCHFWA@azcompletehealth.com
- You may mail Care1st at:

Care1st Health Plan
Attention: Compliance Department
1850 W Rio Salado Parkway, Suite 211
Tempe, AZ 85281

- You may report direct to AHCCCS by completing the fraud and abuse referral available at https://azahcccs.gov/Fraud/ReportFraud/ and may be submitted online or mailed to:

Arizona Health Care Cost Containment System (AHCCCS)
Inspector General
Office of Inspector General (OIG)
801 E. Jefferson St., Mail Drop 4500
Phoenix, AZ, 85034

- Call the AHCCCS Provider Fraud Hotline:
  - In Maricopa County: 602-417-4045
  - Outside of Maricopa County: 888-ITS-NOT-OK or 888-487-6686
- AHCCCS Member Fraud Hotline:
  - In Maricopa County: 602-417-4193
  - Outside of Maricopa County: 888-ITS-NOT-OK or 888-487-6686

The Health Plan providers are required to immediately report, but no later than 10 days, all suspected FWA involving any Title XIX/XXI and NTXIX/XXI funds, AHCCCS providers, or AHCCCS Members to the AHCCCS Office of Inspector General (OIG). Notification shall also be made to the Health Plan. Please remember to have as much information about the matter being reported as possible. You may remain anonymous if you choose to.

The Health Plan's providers are responsible for ensuring that mechanisms are in place for the identification, prevention, detection and reporting of fraud, waste and abuse. All employees of providers must be familiar with the types of FWA that could occur during their normal daily activities. AHCCCS has published e-learning training seminars on their website entitled "Fraud Awareness for Providers". The training discusses provider and member fraud.

The e-learning can be found at: https://azahcccs.gov/Fraud/Providers/

ANTI-FRAUD PLAN

Most of the initial legislation and enforcement of health care fraud and abuse has been in the Medicare/Medicaid and Hospital (Stark) areas. However, health care fraud and abuse in managed care is beginning to receive attention and inquiry.

The federal Deficit Reduction Act of 2005 requires any entity, including any Medicaid managed care organizations such as Care1st to establish written policies for its employees, subcontractors and agents that give detailed information about federal and state false claims laws and whistleblower protections, and the organization's (Care1st's) policies and procedures for detecting and preventing fraud, waste and abuse.

Care1st's Anti-Fraud Plan addresses these requirements of federal and state laws and is a useful tool on the subject of fraud, waste and abuse. The Anti-Fraud Plan is available at the following location: https://www.care1staz.com/az/providers/compliance.asp.

SECTION XII: Fraud, Waste and Abuse

DEFICIT REDUCTION ACT

Care1st providers are required to train their staff on the following aspects of the Federal False Claims Act provisions:

- The False Claims Act, Including Examples of False Claims and Remedies
- Federal Whistleblower Protections
- AHCCCS - Prohibited Acts and Remedies

FEDERAL FALSE CLAIMS ACT

The Federal False Claims Act (FCA) is a federal statute that covers fraud involving any federally funded contract or program including Medicaid and Medicare.

The FCA establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

The term "knowingly" means that a person, with respect to information:

- had actual knowledge of falsity of information in the claim, or
- acted in "deliberate ignorance" of whether or not the information was true, or
- acted in "reckless disregard" of the truth or falsity of the information in a claim.

It is not necessary that the person had a specific intent to defraud the government.

The False Claims Act prohibits seven types of conduct:

1. **False Claim:** Filing false or fraudulent claims. A Claim includes any request or demand for money that is submitted to the U.S. government or its contractors (like Care1st). So a provider or hospital claim, or a vendor billing, submitted to Care1st involving Medicaid or Medicare programs counts as a claim.
2. **False Statement:** Making or using false statements or records.
3. **Conspiracy:** Conspiring with others to submit false claims that are actually paid by the government.
4. **Delivery of Less Property:** Delivering less property than the amount stated on the receipt or certificate.
5. **Delivery of Improper Receipt:** Delivering a receipt for property without knowing whether the information on the receipt is true.
6. **Unauthorized Seller:** Knowingly buying or receiving property from a government employee or official who is not authorized to sell it.
7. **Reverse false claims:** A reverse false claim involves using a false statement to conceal, avoid or decrease the amount of an obligation.

EXAMPLES OF A FALSE CLAIM

- Billing for procedures not performed
- Violation of another law, for example a claim was submitted appropriately but the service was the result of an illegal relationship between a physician and the hospital (physician received kick-backs for referrals)
- Falsifying information in the medical record or in a claim
- Improper bundling or coding of charges, and
- Misrepresentation by a member or provider to seek benefits provided by Care1st or other Medicaid or Medicare contractor/health plan.

REMEDIES

- Violation of the False Claims Act is punishable by a civil penalty of not less than $5,500 and not more than $11,000, plus 3 times the amount of damages that the Government sustains because of the violation
- A federal false claims action may be brought by the U.S Attorney General
- An individual also may bring what is called a qui tam action for violation of the False Claims Act. This means the individual files a civil action on behalf of the government
- An individual who files a qui tam action receives an award only if, and after, the Government recovers money from the defendant as a result of the lawsuit. Generally, the court may award the individual between 15 and 30 percent of the total recovery from the defendant, whether through a favorable judgment or settlement. The amount of the award depends, in part, upon the Government's participation in the suit and the extent to which the individual substantially contributed to the prosecution of the action
- A statute of limitations provides the amount of time that may pass before an action may no longer be brought for violation of the law. Under the False Claims Act, the statute of limitations is six years after the date of violation or three years after the date when material facts are known or should have been known by the government, but no later than ten years after the date on which the violation was committed

FEDERAL WHISTLEBLOWER PROTECTIONS

Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under the False Claims Act, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under the False Claims Act, shall be entitled to all relief necessary to make the employee whole. Such relief shall include reinstatement with the same seniority status such employee would

have had but for the discrimination, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An employee may bring an action in the appropriate district court of the United States for such relief. (31 USC 3730(h))

AHCCCS- Prohibited Acts

Prohibits the presentation to AHCCCS or a Program Contractor, such as Care1st, the following:

- A claim for a medical or other item or service that the person knows or has reason to know was not provided as claimed;
- A claim for a medical or other item or service that the person knows or has reason to know is false or fraudulent;
- A claim for payment that the person knows or has reason to know may not be made by the system because:
    a. The person was terminated or suspended from participation in the program on the date for which the claim is being made.
    b. The item or service claimed is substantially in excess of the needs of the individual or of a quality that fails to meet professionally recognized standards of health care.
    c. The patient was not a member on the date for which the claim is being made.
- A claim for a physician's service or an item or service incidental to a physician's service, by a person who knows or has reason to know that the individual who furnished or supervised the furnishing of the service:
    a. Was not licensed as a physician.
    b. Obtained the license through a misrepresentation of material fact.
    c. Represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board if the individual was not certified.
- A request for payment that the person knows or has reason to know is in violation of an agreement between the person and the State of Arizona or AHCCCS.

REMEDIES

A person who violates one of the provisions above is subject, in addition to any other penalties that may be prescribed by federal or state law, to a civil penalty not to exceed two thousand dollars for each item or service claimed and is subject to an assessment of not to exceed twice the amount claimed for each item or service.