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.

CREDENTIALING DEPARTMENT

The Credentialing Department ensures that Care1st Health Plan Arizona develops and maintains a network of professional practitioners and providers who are qualified to meet the health care needs of covered members in an efficient, compliant, safe and effective manner.

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.

SECTION I: Introduction

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
1.866.560.4042

Department	Phone	Fax
Customer Service	Options 5, 3	833.618.1980
Claims Customer Service - Medical	Options 5, 4	833.619.0416
Claim Disputes and Appeals	Options 5, 9	833.619.0415
Compliance	866.560.4042	N/A
Envolve Dental	844.876.2028	N/A
Fraud, Waste & Abuse	866.685.8664 24/7 Hotline	N/A
Care Management	866.560.4042	833.618.1980
Disease Management	866.560.4042	833.618.1980
Inpatient Behavioral Health Admission Notifications	FAX notice of admission	833.592.1301
Inpatient Physical Health Admission Notifications	FAX notice of admission	833.618.2174
Inpatient SNF Notifications	FAX notice of admission	833.618.2174
Newborn Notification	FAX notice of admission	833.618.1027

SECTION II: Quick Reference Contact List

New Century Health (Oncology/Supportive Drugs)	888.999.7713	877.624.8602
NIA (Complex Imaging, MRA, MRI, PET and CT)	800.327.0641 Options 5, 6, 3	800.784.6864
Prior Authorization – Inpatient Behavioral Health	We encourage you to submit requests via our secure Provider Portal	833.592.1301
Prior Authorization – Outpatient Behavioral Health	We encourage you to submit requests via our secure Provider Portal	833.592.1301
Prior Authorization – Biopharmacy (In office Injectables)	We encourage you to submit requests via our secure Provider Portal	833.417.0447
Prior Auth – Dental	Options 5, 6, 1, 2 (Envolve Dental)	We encourage you to submit requests via Envolve Dental Portal.
Prior Auth-Elective Inpatient & All Outpatient	Options 5, 6, 2	833.618.2174 We encourage you to submit requests via our secure Provider Portal.
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	833.618.1979

SECTION II: Quick Reference Contact List

Prior Auth-Pharmacy	We encourage you to submit requests via Cover My Meds	602-778-8387
Turning Point (Orthopedic Procedures)	480.865.2486	N/A
Network Management	Options 5, 7	833.618.1507

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

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.

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.

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.

PCP ASSIGNMENTAND 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.

SOCIAL DETERMINANTS OF HEALTH

AHCCCS and the Health Plan collect and track member outcomes related to Social Determinants of Health. The use of specific International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) diagnostic codes representing Social Determinants of Health are a valuable source of information that relates to member health related social needs.

The Social Determinants of Health codes identify the conditions in which people are born, grow, live, work, and age. They are often responsible, in part, for health inequities. They include factors like:

- Education
- Employment
- Physical environment
- Socioeconomic status
- Social support networks

As appropriate and within the scope of practice, providers are required to routinely screen for, and document, the presence of social determinants. Regardless of the screening tool selected, the provider must screen for the following social risk factors of health at a minimum:

- Homeless/Housing
- Transportation Assistance
- Employment Instability
- Justice/Legal Involvement
- Social Isolation/Social Support

Any identified social determinant diagnosis codes should be provided on all claims for AHCCCS members to comply with state and federal coding requirements.

SECTION III: Provider Roles and Responsibilities

The Health Plan encourages provider usage of the AHCCCS-Approved Closed-Loop Referral System (CLRS) to properly refer members to Community Based Organizations (CBOs) providing services addressing social determinant of health needs.

The following ICD-10-CM diagnosis codes are defined as Social Determinants of Health codes under ICD-10-CM. Note that they may be added or updated quarterly. These codes are not to be used as primary ICD-10 diagnosis codes. Social Determinant of Health codes should instead be listed as secondary, tertiary, etc., ICD-10 codes.

PCP Treatment and Referrals (Behavioral Health)

Treatment of Behavioral Health Disorders

Within their scope of practice, PCPs may provide behavioral health services for select behavioral health disorders such as anxiety, mild depression, postpartum depression, attention deficit hyperactivity disorder (ADHD) and substance use disorder (SUD). PCPs who treat members with behavioral health disorders may provide medication management services including prescriptions, laboratory, and other diagnostic tests as necessary for diagnosis and treatment. For the purposes of medication management, it is not required that the PCP be the member's assigned PCP. Prior Authorization (PA) may be required for the antipsychotic class of medications. PCPs prescribing medications to treat SUD 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; peer support services are available as part of the MAT model.

PCPs must use step therapy as indicated for ADHD, anxiety disorder, mild depression, postpartum depression, and opioid use disorder (OUD). Step therapy is required for medication not on the Arizona Health Care Cost Containment System (AHCCCS) preferred drug list or behavioral health preferred drug list. This includes the requirement that if the PCP receives documentation from The Health Plan or T/RBHA behavioral health providers regarding completion of step therapy, the PCP continues prescribing the same brand and dosage of current medication unless a change in medical condition is clearly evident.

Psychotropic medications are listed in The Health Plan Preferred Drug List, available on the provider website at www.care1staz.com. For additional information regarding pharmacy benefits, contact the Health Plan Pharmacy Department.

PCPs are responsible for initiating, supervising, and coordinating referrals for behavioral health services as necessary and maintaining continuity of member care.

Referrals

SECTION III: Provider Roles and Responsibilities

PCPs are required to comply with the Health Plan, AHCCCS and RBHA or T/RBHA guidelines for referring their assigned members for behavioral health services. Referrals are based on, but not limited to:

- Member request (members may also self-refer to a behavioral health provider);
- Sentinel event, such as a member-defined crisis episode;
- Psychiatric hospitalization;
- Identification of behavioral health diagnosis or condition outside the scope of the PCP.

PCPs must transfer the member to a behavioral health provider contracting with the Health Plan (for dual-eligible members), the Regional Behavioral Health Authority (RBHA) or Tribal/Regional Behavioral Health Authority (T/RBHA) if symptoms become severe or if the member needs additional behavioral health services. PCPs must ensure members are not simultaneously receiving behavioral health medication from both the behavioral health provider and PCP. When the member is identified to be simultaneously receiving medications from the PCP and behavioral health provider, the PCP must immediately contact the behavioral health provider to coordinate care and agree on who will continue to medically manage the person's behavioral health condition.

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.

PCP SCREENING REQUIREMENTS

1. PCPs are to use validated screening instruments to screen adults and children related behavioral health needs (general mental health and substance use), social determinants of health, and trauma.
2. Providers have access to the screening tools above and other tools via links on the Care1st website: www.care1staz.com
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. Care1st maintains a list of TIC-certified therapists. For additional information contact the Behavioral Health department and/or Member Services.

MEMBERS WITH SPECIAL HEALTH CARE NEEDS

Members with Special Health Care Needs (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 who are pregnant (especially pregnant women who are high risk or in their third trimester).
2. Members in the process of having major organ or tissue transplantation services.
3. Members who are on high-cost specialty drug or biologic.
4. Members who are being considered for or actively engaged in a transplant process for up to one-year post transplant.
5. Members with a chronic illness, which has placed the member in a high-risk category and/or resulted in emergency department utilization, hospitalization, or placement in nursing care, or other facilities.
6. Members with significant medical or behavioral health conditions (e.g., diabetes, asthma, hypertension, depression, or serious mental illness) that require ongoing specialist care and appointments.
7. Chemotherapy and/or radiation therapy.
8. Dialysis.
9. Members hospitalized at the time of transition.

10. Members with ongoing needs such as:
    a. Medical equipment including ventilators and other respiratory equipment
    b. Home care services, such as attendant care or home health
    c. Medically necessary transportation on a scheduled and/or ongoing basis
    d. Prescription medications (including those that have been stabilized through a step therapy process), and/or
    e. Pain management services.
11. Members who frequently contact AHCCCS, State and local officials, the Governor's office and/or media
12. Members with qualifying Children's Rehabilitative Services (CRS) conditions.
13. Members diagnosed with Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (HIV/AIDS).
14. Members enrolled in the ALTCS program serving individuals who are elderly and/or have a physical disability, and
15. Members enrolled in the ALTCS program serving individuals who have a developmental and/or intellectual disability.
16. Members who are engaged in care or services through the Arizona Early Intervention Program (AzEIP).
17. Members with a Serious Mental Illness (SMI) designation.
18. Any child that has a Child and Adolescent Level of Care Utilization System (CALOCUS) level of 4+.
19. Members who have a Seriously Emotionally Disturbed (SED) diagnosis flag in the system or who qualified for the SED designation through the SED eligibility determination process in the AHCCCS system.
20. Substance exposed newborns and infants diagnosed with neonatal abstinence syndrome (NAS).
21. Members diagnosed with Severe Combined Immunodeficiency (SCID).
22. Members with a diagnosis of autism or at risk for autism.
23. Members diagnosed with Opioid Use Disorder (OUD) separately tracking pregnant women and members with co-occuring pain and opioid use disorder
24. Members enrolled in the Division of Child Safey (DCS) Comprehensive Health Program (CHP).
25. Members who transition out of the CHP up to one-year post transition.
26. Members identified as High Need/High-Cost member.
27. Members on conditional release from Arizona State Hospital (ASH).
28. Other services not indicated in the State Plan for eligible members but covered by Title XIX/XXI for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) eligible members, including members whose conditions require ongoing monitoring or screening.
29. Members who at the time of their transition have received Prior Authorization (PA) or approval for:
    a. Scheduled elective surgery
    b. Procedures and/or therapies to be provided on dates after their transition including post-surgical follow-up visits.

c. Sterilization and have a signed sterilization consent form, but are waiting for the expiration of the 30-day period,
d. Behavioral health services
e. Appointments with a specialist located out of the contractor service area and
f. Nursing facility admissions.

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.

Excluded Participation in Federal Health Care Programs

SECTION III: Provider Roles and Responsibilities

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.

APPOINTMENT AVAILABILITY STANDARDS

SECTION III: Provider Roles and Responsibilities

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 as expeditiously as the member's health condition requires 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, as expeditiously as the member's health condition requires 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.

3. *For persons in legal custody of the Arizona Department of Child Safety and Adopted Children:*

a. Rapid response - When a child enters out-of-home placement within the timeframe indicated by the behavioral health condition, but no later than 72 hours after notification by the Arizona Department of Child Safety (DCS) that a child has been or will be removed from their home,
b. Initial assessment - Within seven calendar days after the initial referral or request for behavioral health services,
c. Initial appointment - Within timeframes indicated by clinical need, but no later than 21 calendar days after the initial assessment, and
d. Subsequent Behavioral Health Services - Within the timeframes according to the needs of the person, but no longer than 21 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 Provider Relations & Contracting Specialist 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 Provider Relations & Contract Specialist 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

SECTION III: Provider Roles and Responsibilities

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.

RIGHT TO REVIEW AND CORRECT INFORMATION

All practitioners participating within the Care1st Health Plan Arizona, Inc network have the right to review information obtained by the Care1st Health Plan Arizona to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and state licensing agencies. This does not allow a practitioner to review peer review-protected information such as references, personal recommendations, or other information that is peer review protected.

Should a practitioner believe any of the information used in the credentialing/re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by the practitioner, the practitioner has the right to correct any erroneous information submitted by another party. To request release of such information, a practitioner must submit a written request to Care1st Credentialing Department. Upon receipt of this information, the practitioner has 14 days to provide a written explanation detailing the error or the difference in information to the Care1st Health Plan. . The Care1st Health Plan Credentialing Committee will then include the information as part of the credentialing/re-credentialing process.

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.

SECTION III: Provider Roles and Responsibilities

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 Find a Provider Search Tool.

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 http://www.azdhs.gov/preparedness/epidemiology-disease-control/immunization/asiis/index.php 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

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 **Find a Doctor** function on the Care1st Provider website. Select "Behavioral Health" as the Category and "Professionals" as the Provider Type. 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 **"Behavioral Health" Category and "Facilities" as the Provider Type**, also under the **Find a Doctor** link. Provider Manual Section VII: Behavioral Health Services provides details for the Behavioral Health Referral process.

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.

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.

QUALITY IMPROVEMENT

Network Practitioners and Providers are contractually required to cooperate with all Quality Improvement (QI) activities to improve the quality of care and services and member experience. This includes the collection and evaluation of performance data and participation in Care1st's QI programs. Practitioner and Provider contracts, or a contract addendum, also require that Practitioners and Providers allow Care1st the use of their performance data for quality improvement activities.

As part of this program, providers and practitioners are required to cooperate with Quality Improvement (QI) activities and allow Care1st to use their performance data.

SECTION III: Provider Roles and Responsibilities

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, gender diversity, sexual preference, physical or mental ability, or source of payment. Providers must be compliant with the Americans with Disabilities Act (ADA) requirements and Title VI which prohibits discrimination based on disability.

CULTURALLY COMPETENT AND RESPONSIVE CARE

Members have the right to have services provided in a culturally responsive and competent manner with consideration for members with limited English Proficiency (LEP), limited reading skills, vision, hearing, audio-processing limitations, and those with cultural diversities. Services shall be offered that are culturally sensitive to the differences in race, ethnic background, linguistic, group age, gender diversity, lifestyle, education, literacy, 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 and health care practice. Better communication with members, families and groups from diverse cultures improves health outcomes and member satisfaction. Refer to our website for additional resources: https://www.care1staz.com/providers/resources/cultural-competency.html.

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, families and communities to improve individual, family and community health. Moreover, Care1st members have a right to interpretation-translation services, auxiliary aids, augmentative and alternative communication devices. 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, at no cost, this service helps providers and their staff access interpretation services, so that you can provide care. All Care1st contracted providers have access to CyraCom's interpretation services. Each practice is assigned a PIN 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 members. Please call 800.481.3293 (TTY:711) to access this service. CyraCom's customer service is also available to provide assistance at 800.481.3289 (TTY:711).

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 Services. Valley Center of the Deaf recommends setting up services seven to ten 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.

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 complaints and conflicts of interest.

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

Institute for
Health Professions Education

Georgia G. Hall, Ph.D., MPH

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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:	*S*how 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 members have the following rights.

Respect and Dignity:

1. Be treated with respect and with due consideration for their 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 diversity, 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 their 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 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 a member does not agree with Care1st's decision.
8. Receive information on treatment options and alternatives, presented in a manner appropriate to the member's condition, cultural preferences, language preference, health literacy, and ability to understand.

9. Receive information related to coordination of care concerning schools and state agencies that may occur, as appropriate and within the limits of applicable regulations.

Confidentiality and Privacy:

1. Have their 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. Members also have the right to change PCPs if they wish to do so.
3. Participate in treatment decisions regarding their health care, including the right to refuse treatments.
4. Know and understand their medical problems and healthcare conditions so that members can make informed decisions about their healthcare. Ask and be told the cost members would pay if they 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 receive a copy of their 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 (about 4 and a half weeks) 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 (about 1 and a half weeks) 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 (CLIA exempt) pursuant to 42 CFR 493.3(a)(2).
** The response may be a 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 164.524(d)(2) and 164.524(B).

Reporting Member Concerns:

1. Tell Care1st about any problems, complaints or grievances a member has with their 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 their concern of adequacy with the Notice of Adverse Determination letter member received. (Maricopa County – 602-417-7000; Outside Maricopa County – 1-800-962-6690) (TTY:711).

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 a member's eligibility changes in the household.
2. Keep member's ID card safe. Do not throw it away. Members may not loan, sell or give the ID card to another person. Letting someone else use their member ID card is fraud. If a member loans or gives the card to someone else, a 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 gets 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.

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 a member needs to cancel an appointment or if a 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 the member understands the instructions before they 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 the 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 a member needs to change or cancel the appointment.

Reporting Member Concerns or Question:

1. Call or write to Customer Services when a member has questions, problems, or grievances (complaints).
2. Tell Care1st or AHCCCS if a 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. Additionally, PCP assignments may be influenced by providers who demonstrate quality, cost-effective care or by providers participating in value-based purchasing initiatives.

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). The PCP assignment member roster will include, at a minimum, the following:

- Assigned members' name,
- Assigned members' date of birth,
- Assigned members' AHCCCS ID,
- AHCCCS ID of the assigned PCP, and
- Effective date of member assignment to PCP.

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)

SECTION V: Eligibility and Enrollment

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.

SECTION V: Eligibility and Enrollment

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 SERVICES

The Health Plan has a comprehensive dental network for members. To serve the needs of its members, the health plan partners with Envolve Dental who administers the health plan's dental benefits. Dental Providers must submit claims and prior authorizations to Envolve Dental, or by phone at 844-876-2028.

The Health Plan offers dental services for:

- Oral Health Care for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) aged members
- EPSDT and Oral Health services through the RBHA are covered only for members 18 to 21 years of age. All other members receive Oral Health and EPSDT services up to 21 years of age.
- Preventive dental services for EPSDT Members under the age of 21 years
- Therapeutic Dental Services for members under 21
- Emergency Dental Coverage for members under 21
- PCP Fluoride Varnish Application for children up to 5 years of age

Eligible EPSDT Members up to the age of 21 years old have comprehensive dental service benefits which include preventive, therapeutic and emergency dental services. All members age out of the Oral Health & EPSDT program and services at age 21.

If a member does not qualify under their dental eligibility and a medical condition is present, medical necessity is determined by the health plan. Medical documentation is required and must be submitted directly to the health plan for review and prior authorization determination.

Dental Providers should include parent/guardian or caregivers in all consultations and counseling of members regarding preventive oral health care and the clinical findings.

The Health Plan adheres to the Dental Uniform Prior Authorization List and the Uniforms Warranty List as outlined in AHCCCS AMPM Policy 431.

Oral Health Care for Early and Periodic Screening, Diagnosis and Treatment aged members

As part of the physical examination, the physician, physician's assistant, or nurse practitioner must perform an oral health screening. A screening is intended to identify gross dental or oral lesions 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 must be made as outlined in the Contract:

- URGENT - As expeditiously as the member's health condition requires but no later than three business days from the request
- ROUTINE - Within 45 days of request·

PCPs must refer EPSDT members for appropriate services based on needs identified through the screening process and for routine dental care based on the AHCCCS EPSDT Periodicity Schedule (AMPM Chapter 430). Evidence of this referral must be documented on the AHCCCS Clinical Visit Sample Template and in the member's medical record.

EPSDT Members may select a dentist within the health plans contracted network and receive preventive dental services without a referral.

PCP Application of Fluoride Varnish

Physicians who have completed the AHCCCS required training may be reimbursed for fluoride varnish applications completed at the EPSDT Well Child Visit for members as often as every three months up to 5 years of age, after the eruption of the first tooth.

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. Upon completion of the required training, providers should upload a copy of their certificate to the Council for Affordable Quality Healthcare (CAQH) site. Providers should also submit a copy of their certification to the Health Planvia fax at (855) 872-1858 or email to HEDIS_Operations@azcompletehealth.com. This certificate is used in the credentialing process to verify completion of training necessary for reimbursement. An oral health screening must be part of an EPSDT screening conducted by a PCP; however, it does not

substitute for examination through direct referral to a dentist. PCPs must refer EPSDT members for appropriate services based on needs identified through the screening process and for routine dental care based on the AHCCCS Dental Periodicity Schedule (AMPM Chapter 431, Attachment A). Evidence of this referral must be documented on the AHCCCS Clinical Visit Sample Template and in the member's medical record.

Preventive Dental Services

Preventive dental services provided as specified in the AHCCCS Dental Periodicity Schedule AHCCCS AMPM 431, Attachment A, https://www.azahcccs.gov/shared/MedicalPolicyManual/, including but not limited to:

- Diagnostic services include comprehensive and periodic examinations. The Health Plan allows two oral examinations and two oral prophylaxes per member per year for all members up to 21 years of age. For members up to five (5) years of age, fluoride varnish may be applied four times a year (i.e., one every three months). Additional examinations or treatments shall be deemed medically necessary;
- Radiology services screening for diagnosis of dental abnormalities and/or pathology, including panoramic or full-mouth x-rays, supplemental bitewing x-rays, and occlusal or periapical films, as medically necessary and following the recommendations by the American Academy of Pediatric Dentistry (AAPD); and
- Panorex films are covered as recommended by AAPD, up to three times maximum per provider for members between ages three (3) to twenty (20). Additional panorex films needed above this limit must be deemed medically necessary through the health plan prior authorization process. Preventive services, including:

Preventive services, including:

- Oral prophylaxis performed by a dentist or dental hygienist which includes self-care oral hygiene instructions to member, if able, or to the parent/ legal guardian;
- Application of topical fluoride varnish. The use of a prophylaxis paste containing fluoride or fluoride mouth rinses do not meet the AHCCCS standard for fluoride treatment;
- Dental sealants for first and second molars are covered every three years up to age 15, with a two- time maximum benefit. Additional applications must be deemed medically necessary and require prior authorization through The Health Plan;
- Space maintainers when posterior primary teeth are lost and when deemed medically necessary through The Health Plan prior authorization process.

Therapeutic Dental Services

All therapeutic dental services will be covered when they are considered medically necessary and cost effective but may be subject to PA by the health plan.

These services include, but are not limited to:

- Periodontal procedures, scaling/root planing, curettage, gingivectomy, and osseous surgery;
- Crowns:
    - When appropriate, stainless-steel crowns may be used for both primary and permanent posterior teeth; composite, prefabricated stainless steel crowns with a resin window or crowns with esthetic coatings should be used for anterior primary teeth; or
    - Precious or cast semi-precious crowns may be used on functional permanent endodontically treated teeth, except third molars, for members who are 18 to 21 years of age.
- Endodontic services including pulp therapy for permanent and primary teeth, except third molars (unless a third molar is functioning in place of a missing molar);
- Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations unless the member is 18 to 21 years of age and has had endodontic treatment;
- Restorations of anterior teeth for children under the age of five, when medically necessary. Children, five years and over with primary anterior tooth decay should be considered for extraction, if presenting with pain or severely broken-down tooth structure, or be considered for observation until the point of exfoliation as determined by the dental provider;
- Removable dental prosthetics, including complete dentures and removable partial dentures; and
- Orthodontic services and orthognathic surgery are covered only when these services are necessary to treat a handicapping malocclusion. Services must be medically necessary and determined to be the primary treatment of choice or an essential part of an overall treatment plan developed by both the PCP and the dentist in consultation with each other. Orthodontic services are not covered when the primary purpose is cosmetic.

Examples of conditions that may require orthodontic treatment include the following:

1. Congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services;
2. Trauma requiring surgical treatment in addition to orthodontic services; or
3. Skeletal discrepancy involving maxillary and/or mandibular structures.

Emergency Dental Coverage for Members under 21 Years of Age

EPSDT covers the following dental services:

Emergency dental services including:

1. Treatment for pain, infection, swelling and/or injury;
2. Extraction of symptomatic (including pain), infected and non-restorable primary and permanent teeth, as well as retained primary teeth (extractions are limited to teeth which are symptomatic); and
3. General anesthesia, conscious sedation or anxiolysis (minimal sedation, members respond normally to verbal commands) when local anesthesia is contraindicated or when management of the member requires it. (See AHCCCS AMPM Policy 430, Section E, Item No. 8 regarding conscious sedation.)

Dental Services Not Covered For EPSDT Age Members

Orthodontic services are not covered when the primary purpose is cosmetic. Extraction of asymptomatic teeth are generally not covered services; this includes third molars. Services or items furnished solely for cosmetic purposes are not covered.

Emergency Dental Coverage For Members 21 Years of Age and Older

Medically necessary emergency dental care and extractions are covered for persons age 21 years and older who meet the criteria for a dental emergency. A dental emergency is an acute disorder of oral health resulting in severe pain and/or infection as a result of pathology or trauma.

AHCCCS covers the following dental services provided by a licensed dentist for members who are 21 years of age or older:

1. Emergency dental services up to $1000 per member per contract year (October 1st to September 30th) as a result of A.R.S. §36-2907. The emergency dental services are described in subsection A;
2. Medical and surgical services furnished by a dentist only to the extent such services may be performed under state law either by a physician or by a dentist when such services would be considered a physician service if furnished by a physician (A.A.C. R9-22-207);
3. These services must be related to the treatment of a medical condition such as acute pain (excluding Temporomandibular Joint Dysfunction [TMJ] pain), infection, or fracture of the jaw. Covered services include a limited problem focused

examination of the oral cavity, required radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate anesthesia and the prescription of pain medication and antibiotics. Diagnosis and treatment of TMJ is not covered except for reduction of trauma. Services described in this paragraph are not subject to the $1000 adult emergency dental limit.

The following services and procedures are covered as emergency dental services:

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

Follow up procedures necessary to stabilize teeth as a result of the emergency service are covered and subject to the $1000 limit.

Limitations

Adult Emergency Dental Services Limitations for Persons age 21 Years and Older.

Maxillofacial dental services provided by a dentist are not covered except to the extent prescribed for the reduction of trauma, including reconstruction of regions of the maxilla and mandible.

Diagnosis and treatment of temporomandibular joint dysfunction (TMD or TMJ) is not covered except for the reduction of trauma.

Routine restorative procedures and routine root canal therapy are not emergency dental services and are not covered.

Treatment for the prevention of pulpal death and imminent tooth loss is limited to non-cast fillings, crowns constructed from pre-formed stainless steel, pulp caps, and pulpotomies only for the tooth causing pain or in the presences of active infection.

Fixed bridgework to replace missing teeth is not covered.

Dentures are not covered.

Exceptions for Transplants and Members with Cancer

I. Transplant Cases

- For members who require medically necessary dental services as a pre-requisite to AHCCCS covered organ or tissue transplantation, covered dental services are limited to the elimination of oral infections and the treatment of oral disease. Covered dental services are limited to the following:
- Dental cleaning (Prophylaxis);
- Treatment of periodontal disease;
- Medically necessary extractions;
- Simple restorations. A simple restoration means silver amalgam and/or composite resin fillings, stainless steel crowns or preformed crowns.

The health plan covers these services only after a transplant evaluation determines that the member is an appropriate candidate for organ or tissue transplantation. These services are not subject to the $1000 adult emergency dental limit.

II. Members with Cancer

Covered dental services are limited to the following:

- Prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head is also covered. These services are not subject to the $1000 adult emergency dental limit.

III. Members on Ventilators

- Cleanings for members who are in an inpatient hospital setting and are placed on a ventilator or are physically unable to perform oral hygiene are covered for dental

cleanings performed by a hygienist working under the supervision of a physician. These services are not subject to the $1,000 adult emergency dental limit. If services are billed under the physician, then medical codes will be submitted and are not subject to the $1000 adult emergency dental limit.

Charging of Members

Emergency dental services of $1000 per contract year are covered for AHCCCS member's age 21 years and older. Billing of AHCCCS members for emergency dental services in excess of the $1000 annual limit is permitted only when the provider meets the requirements of A.A.C R9-22-702 and A.A.C. R9-28-701.10.

In order to bill the member for emergency dental services exceeding the $1000 limit, the provider must first inform the member in a way s/he understands, that the requested dental service exceeds the $1000 limit and is not covered by AHCCCS. Before providing the dental services that will be billed to the member, the provider must furnish the member with a document to be signed in advance of the service, stating that the member understands that the dental service will not be fully paid by AHCCCS and that the member agrees to pay for the amount exceeding the $1000 emergency dental services limit, as well as services not covered by AHCCCS.

The member must sign the document before receiving the service in order for the provider to bill the member. It is expected that the document contains information describing the type of service to be provided and the charge for the service.

Informed Consent

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

1. Informed consent for oral health treatment:
    1. A written consent for examination and/or any 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, and
    2. A separate written consent for any irreversible, invasive procedure, including but not limited to dental fillings, pulpotomies, etc. In addition, a written treatment plan shall be reviewed and signed by both parties, as described below, with the member/ guardian/designated representative receiving a copy of the complete treatment plan.
2. All providers shall 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 the member, member's guardian, and/or designated representative. This requirement extends to all Contractor mobile unit providers. Consents and treatment plans shall be in writing, signed and dated by both the provider and the patient or patient's representative, if the patient is a) under 18 years of age or b) is 18 years of age or older and considered an incapacitated adult (as specified in A.R.S. §14-5101). Completed consents and treatment plans shall be maintained in the members' chart and are subject to audit.

Facility and Anesthesia Charges

Adult members requiring general anesthesia in an ambulatory service center or outpatient hospital the general anesthesia are subject to the $1000 emergency dental limit.

Dentist performing general anesthesia on adult emergency members must bill dental codes that count towards the $1000 adult emergency benefit.

Physicians performing general anesthesia on adult emergency members for a dental procedure must bill medical codes and it will count towards the $1000 emergency dental limit.

Dental Referrals

Dental services may be initiated by a Primary Care Provider (PCP) through referral to a participating dental provider, the member or member's legal guardian. No referral is required for an eligible member to make a dental appointment or receive dental care from one of the contracted health plan dental providers. Prior authorizations may be required for therapeutic services.

The AHCCCS EPSDT Periodicity Schedule gives providers necessary information regarding timeframes in which age-related required screenings and services must be provided. Depending on the results of the oral health screening, a referral to a dentist must be made.

PCP Providers must:

- Encourage Members who call for a dental referral to obtain any routine or follow up care and document all referrals in the Member's medical record.
- Identify appropriate dental services based on needs
- Document evidence of referrals on the AHCCCS Clinical Visit Sample Template or in the member's electronic medical records;
- Refer members for a dental assessment if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/or treatment

by a dental professional according to the AHCCCS EPSDT Dental Periodicity Schedule (AMPM Chapter 431, Attachment A)..
- Encourage eligible Members to see a dentist regularly;
- Obtain appropriate prior authorization before rendering non-emergency dental services.

Although the AHCCCS Dental Periodicity Schedule (AMPM Chapter 431, Attachment A) identifies when routine referrals begin, PCP's may refer EPSDT members for a dental assessment at an earlier age if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/or treatment by a dental professional. In addition to PCP referrals, EPSDT members are allowed self-referral to dentists who are in the health plan provider network.

Dental Home Assignment for EPSDT age Members under the age of 21

The American Academy of Pediatric Dentistry (AAPD) defines the dental home as the ongoing relationship between dentist and the member, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. The dental home must include:

1. Comprehensive oral health care, including acute care and preventive services in accordance with the Arizona Health Care Cost Containment System (AHCCCS) Dental Periodicity Schedule;
2. Comprehensive assessment for oral diseases and conditions;
3. Individualized preventive dental health program based upon a caries-risk assessment and a periodontal disease risk assessment;
4. Anticipatory guidance about growth and development issues (such as teething, digit or pacifier habits);
5. Plan for acute dental trauma;
6. Information about proper care of the child's teeth and gingivae. This would include the prevention, diagnosis, and treatment of disease of the supporting and surrounding tissues and the maintenance of health, function and esthetics of those structures and tissues;
7. Dietary counseling; and
8. Referrals to dental specialists when care cannot directly be provided within the dental home.

Members must be assigned to a dental home by age one and seen by a dentist for routine preventive care according to the AHCCCS Dental Periodicity Schedule (AHCCCS AMPM Chapter 400, Exhibit 431- Members must also be referred for additional oral health care concerns requiring additional evaluation and/or treatment.

A member may change their assigned dental home by calling Care1st Member Services at 1-866-560-4042.

Provider Request for Dental Home Re-assignment of an EPSDT Age Member

Dental home providers can request that a covered member be removed from their panel by issuing the person a written notice and allowing up to 60 days for assignment to a new dental home provider.

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

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a comprehensive child health program of prevention, treatment, correction, and improvement (amelioration) of physical and behavioral/mental health conditions for AHCCCS members up to 21 years of age. The purpose of EPSDT is to ensure the availability and accessibility of health care resources, as well as to assist Medicaid members in effectively utilizing these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health conditions for AHCCCS members up to 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary, mandatory, and optional services listed in Federal Law 42 USC 1396d (a) to correct or ameliorate defects and physical and behavioral/mental illnesses and conditions identified in an EPSDT screening, whether or not the services are covered under the AHCCCS State Plan. Members receiving EPSDT and Oral Health services through the RBHA are only covered for members 18 up to 21 years of age. All members age out of Oral Health & EPSDT services at age 21. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

A well child visit is synonymous with an EPSDT visit. EPSDT services include all screenings and services described below, as well as the referenced AHCCCS EPSDT Periodicity Schedule, (AMPM Chapter 430, Attachment A [Insert link: https://www.azahcccs.gov/shared/MedicalPolicyManual/]) and the AHCCCS Dental Periodicity Schedule, (AMPM Chapter 431, Attachment A [Insert link: https://www.azahcccs.gov/shared/MedicalPolicyManual/]).

SECTION VI: Covered Services

EPSDT Coverage

EPSDT coverage includes the following:

1. Immunizations;
2. Blood Lead Screening;
3. Covered Services (refer to AHCCCS AMPM, Chapter 310 [Insert link: https://www.azahcccs.gov/shared/MedicalPolicyManual/] for detailed coverage);
4. Metabolic Medical Foods;
5. Nutritional Therapy;
6. Oral Health Services;
7. Cochlear and Osseointegarted Implantation;
8. Conscious Sedation;
9. Behavioral Health Services;
10. Religious Non-Medical health care Institution Services;
11. Care Management Services;
12. Chiropractic Services;
13. Personal care;
14. Incontinence Briefs;
15. Medically Necessary therapies.

In addition, federal and State law govern the provision of EPSDT services for Members under the age of 21 years. The provider is responsible for providing these services to pregnant Members under the age of 21 unless the Member has selected an Obstetrics (OB) provider to serve as both the OB and Primary Care Provider. In that instance, the OB provider must provide EPSDT services to the pregnant Member.

EPSDT includes, but is not limited to, coverage of: inpatient and outpatient hospital services, laboratory and x-ray services, physician services, naturopathic services; nurse practitioner services, medications, dental services, therapy services, behavioral health services, medical equipment; medical appliances; and medical supplies, orthotics, prosthetic devices, eyeglasses, transportation, and family planning services. EPSDT also including a comprehensive history, developmental and behavioral health screenings, comprehensive unclothed physical examination, appropriate vision testing, hearing testing, laboratory tests, dental screenings and immunizations. However, EPSDT services do not include services that are experimental, that are solely for cosmetic purposes, or that are not cost effective when compared to other interventions or treatments.

PCP EPSDT Regulatory Requirements

SECTION VI: Covered Services

PCPs are required to comply with EPSDT regulatory requirements, including the following:

1. Provide EPSDT services in accordance with Section 42 USC 1396d (a) and (r), 1396a (a) (43), 42 C.F.R. 441.50 et seq. and AHCCCS rules and policies;
2. Providers must complete a Developmental screening (using an AHCCCS-approved developmental screening tool) for members ages 9, 18 and 30 months;
3. Providers must complete the Autism Spectrum Disorder (ASD) Specific Developmental Screening at the 18 month and 24 month visits;
4. Document immunizations within 30 days of administration of an immunization into the Arizona State Immunization Information System (ASIIS);
5. Enroll every year in the Vaccines for Children (VFC) program;
6. Providers must use and complete all applicable elements of the AHCCCS EPSDT Clinical Sample Templates as required by the AHCCCS AMPM, Chapter 430, Section A [insert link: https://www.azahcccs.gov/shared/MedicalPolicyManual/], (or an electronic equivalent that includes all components from the hard-copy form);
    - AHCCCS EPSDT Clinical Sample Template located within the AHCCCS AMPM Chapter 430, Attachment E.
7. Provide and document EPSDT screening services in accordance with the AHCCCS EPSDT and Dental Periodicity Schedules AHCCCS EPSDT Periodicity Schedule (AHCCCS AMPM, Chapter 430, Attachment A [insert link: https://www.azahcccs.gov/shared/MedicalPolicyManual/]) and the Dental Periodicity Schedule (AHCCCS AMPM Chapter 431, Attachment A [insert link: https://www.azahcccs.gov/shared/MedicalPolicyManual/],),
8. Refer members for follow up, diagnosis and treatment, ensuring that treatment is initiated within 60 days of screening services;
9. If appropriate, document in the medical record the member's or legal guardian's decision not to utilize EPSDT services or receive immunizations;
10. Document a health database assessment on each EPSDT participant. The database must be interpreted by a physician or licensed health professional who is under the supervision of a physician, and provide health counseling/education at initial and follow up visits;
11. Ensure all infants receive both the first and second newborn screening tests;
12. Ensure all infants with confirmed hearing loss receive services prior to turning six months of age;
13. Implement protocols for care and coordination of members who received Tuberculosis (TB) testing to ensure timely reading of the TB skin test and treatment, if medically necessary;
14. Send copies of the completed EPSDT Clinical Sample Templates to the health plan's Quality Management Department by secure fax at (844)266-5339;
15. Providers must verify that Members receive EPSDT services in compliance with the AHCCCS EPSDT Periodicity Schedule (AHCCCS AMPM, Chapter 430,

Attachment A) and the Dental Periodicity Schedule (AHCCCS AMPM Chapter 431, Attachment A), https://www.azahcccs.gov/shared/MedicalPolicyManual/;

16. Schedule the next appointment at the time of the current office visit for children ages 24 months and younger;
17. Claims for EPSDT services must be submitted on a CMS (formerly HCFA) 1500 form. Providers must bill for preventative EPSDT services using the preventative service, office or other outpatient services and preventive medicine CPT codes (99381 – 99385, 99391 – 99395) with an EP modifier;
18. Refer members to Children's Rehabilitative Services (CRS) when they have conditions covered by the CRS program;
19. Initiate and coordinate referrals to ALTCS, Audiology, DDD, Dental, Occupational Therapy, Physical Therapy, Speech, Developmental, behavioral health, Women, Infants and Children (WIC), the Arizona Early Intervention Program (AzEIP) and Head Start as necessary.

Hospital or birthing center shall screen all newborns using a physiological hearing screening method prior to initial hospital discharge, including outpatient re-screening for babies who were missed or are referred from the initial screening. Outpatient re-screening shall be scheduled at the time of the initial discharge and completed between two and six weeks of age. Additionally, when there is an indication that a newborn or infant may have a hearing loss or congenital disorder, the family shall be referred to the PCP for appropriate assessment, care coordination and referral(s).

An EPSDT Well-Child Basic Elements

A Well-Child exam includes the following elements:

1. Comprehensive health and developmental history, including growth and development screening 42 CFR 441.56(b)(1) which includes physical, nutritional, and behavioral health assessments;
2. Developmental screening. Providers are required to complete a developmental screening (using an AHCCCS-approved developmental screening tool) for members during visits at ages 9, 18 and 30 months. However, any time there is a potential developmental concern, it is appropriate for providers to screen the member. Developmental survey items are part of each EPSDT visit so that if concerns are noted, a screening can be done;
3. Autism Spectrum Disorder (ASD) Specific Developmental Screening at the 18 month and 24 month visits;
4. A comprehensive unclothed physical examination;
5. Provide appropriate immunizations according to age and health history;
6. Laboratory tests appropriate to age and risk for blood lead, tuberculosis skin testing, anemia testing and sickle cell trait;

7. Health education, counseling, chronic disease self-management, counseling about child development, healthy lifestyles and accident and disease prevention;
8. An oral health screening must be part of an EPSDT screening conducted by a Primary Care Provider; however, it does not replace the need for examination through direct referral to a Dentist;
9. Fluoride varnish application as often as every three months between the ages of 6 months and 2 years of age, after the eruption of the first tooth (by providers who have completed training);
10. Provide appropriate vision and hearing/speech testing;
11. Nutritional Screening by a PCP;
12. Nutritional Assessment by a PCP;
13. Obesity screening using the body mass index (BMI) percentile for children (or weight-for-length percentile for members less than two years of age);
14. Behavioral health screening, referrals, and services;
15. Tuberculin skin testing as appropriate to age and risk. Children at increased risk of Tuberculosis (TB) include those who have contact with persons;
    - Confirmed or suspected as having TB,
    - In jail or prison during the last five years,
    - Living in a household with an HIV-infected person or the child is infected with HIV, and
    - Traveling/emigrating from, or having significant contact with persons indigenous to, endemic countries.
16. Provide Anticipatory Guidance;
17. Vision exam appropriate to age, according to the AHCCCS EPSDT Periodicity Schedule; and
18. Documentation of the member's AHCCCS Identification number on the AHCCCS EPSDT Clinical Sample Templates or electronic medical record.

Vision Coverage for EPSDT Aged Members

The Health Plan covers eye and optometric services provided by qualified eye/optometry professionals within certain limits based on Member age and eligibility. All vision services related to medical issues should be verified with the Health Plan. Emergency eye care, which meets the definition of an emergency medical condition, is covered for all Members. For Members who are 21 years of age or older, treatment of medical conditions of the eye, excluding eye examinations for prescriptive lenses and the provision of prescriptive lenses, are covered through the Health Plan. Vision examinations and the provision of prescriptive lenses are covered for Members under the EPSDT program and for adults when medically necessary following cataract removal. Cataract removal is a covered medical service for all eligible Members with certain conditions. For more information, visit the AHCCCS website under Medical Policy for AHCCCS Covered Services.

Appropriate vision screenings are covered during an EPSDT visit. EPSDT benefits cover eye examinations as appropriate to age according to the AHCCCS EPSDT Periodicity

Schedule (AHCCCS AMPM, Chapter 430, Attachment A) and as medically necessary using standardized visual tools. Payment for vision and hearing exams, (including, but not limited to CPT codes 92015, 92081, 92285, 92551, 92552, 92553, 92567, 92568, 92285, 92286, 92587, 92588, 95930, and 99173) or any other procedure that may be interpreted as fulfilling the vision requirements provided in a PCP's office during an EPSDT visit, are considered part of the EPSDT visit and are not a separately billable service.

Ocular photoscreening with interpretation and report, bilateral (CPT code 99177) is covered for children aged three to five as part of the EPSDT visit due to challenges with a child's ability to cooperate with traditional vision screening techniques. Ocular photoscreening is limited to a lifetime coverage limit of one. This procedure, although completed during the EPSDT visit, is a separately billable service through the Health Plan. Automated visual screening, described by CPT code 99177, is for vision screening only, and not recommended for or covered by AHCCCS when used to determine visual acuity for purposes of prescribing glasses or other corrective devices. All vision services related to medical issues should be verified with the Health Plan. Coverage for EPSDT members includes:

- Medically necessary emergency eye care, vision examinations, prescriptive lenses, frames for eyeglasses and treatments for conditions of the eye;
- PCPs are required to provide initial vision screening in their office as part of the EPSDT program. Vision exams provided in a PCP's office during an EPSDT visit are not a separately billable service;
- Replacement of lost or broken glasses, or due to a change in prescription is a covered benefit.

Vision CPT codes with the EP modifier must be listed on the claim form in addition to the preventive medicine CPT codes for visit screening assessment. With the exception of CPT code 99177, no additional reimbursement is allowed for these codes.

Medical condition-related and preventive vision services including hardware should be billed through the Health Plan. Providers can verify all non-emergency services with the appropriate entity in advance of care, as needed.

Sick Visit Performed in Addition to an EPSDT Visit

Billing of a "sick visit" at the same time as an EPSDT if a separately billable service if:

https://www.azahcccs.gov/PlansProviders/Downloads/MedicalCodingResources/AMPM430EPSDT_PolicyCodingResource.pdf

1. An abnormality is encountered, or a preexisting problem is addressed in the process of performing an EPSDT service and the problem or abnormality is significant

enough to require additional work to perform the key components of a problem-oriented E/M service.
2. The "sick visit" is documented on a separate note.
3. History, Exam, and Medical Decision-Making components of the separate "sick visit" already performed during the course of an EPSDT visit are not to be considered when determining the level of the additional service (CPT Code 99201-99215). An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service, and which does not require additional work and the performance of the key components of a problem-oriented E/M service is included in the EPSDT visit and should not be reported.
4. The current status (not history) of the abnormality or preexisting condition is the basis of determining medical necessity.

Modifier 25 must be added to the Office/Outpatient code to indicate that a significant, separately identifiable evaluation and management service was provided by the same physician on the same day as the preventive medicine service.

Developmental Screening Tools

Primary care providers (PCPs) must be trained in the use and scoring of developmental screening tools. Training resources may be found at Arizona Department of Health Services website at www.azdhs.gov/

The following developmental screening tools are available for members at their 9, 18 and 30 month EPSDT visit:

- Ages and Stages Questionnaires™ Third Edition (ASQ) is a tool used to identify developmental delays in the first five years of a child's life. The sooner a delay or disability is identified, the sooner a child can be connected with services and support that make a real difference. The tool is available online at www.agesandstages.com.
- The Modified Checklist for Autism in Toddlers Revised (M-CHAT-R) used only as a screening tool by a PCP, for members ages 18 and 24 months, to screen for autism when medically indicated. The tool is available online at www.m-chat.org.
- The Parents' Evaluation of Developmental Status (PEDS) used for developmental screening of EPSDT members from birth to 8 years of age. The tool is available online at www.pedstest.com or https://www.pedstestonline.com/.

An additional payment for use of screening tools is covered when the following criteria are met:

- The member's EPSDT visit is at 9, 18, or 30 months;
- Prior to providing the service, the provider must complete the required training for the developmental screening tool being utilized and submit a copy of the training certificate to the Council for Affordable Quality Healthcare (CAQH). Providers must also submit to the Health Plan via fax to (855) 872-1858 or email to HEDIS_Operations@azcompletehealth.com.
- The code is appropriately billed using CPT-4 code 96110 and the "EP" modifier. Providers must retain copies of the completed tools in the member's medical record and submit it to the health plan with the completed AHCCCS EPSDT Clinical Sample Templates.
    - Only for the 9, 18, or 30 month screening may the "EP" modifier be added to the CPT-4 code 96110.

PCP Application of Fluoride Varnish

Physicians who have completed the AHCCCS required training may be reimbursed for fluoride varnish applications completed at the EPSDT visit.

Application of fluoride varnish may be billed separately from the EPSDT visit using CPT Code 99188. Fluoride varnish can be applied as often as every three months between the ages of 6 months and 5 years of age, after the eruption of the first tooth.

Blood Lead Screening

EPSDT requires 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 either the 12-month or 24-month test.

- Lead levels may be measured at 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 six year of age is based on the child's risk as determined by either the member's residential zip code or presence of other known risk-factors.
- The ADHS Parent Questionnaire may be utilized to help determine if a lead test should be performed outside of the required testing ages.
- Providers must report blood lead levels equal to or greater than 3.5 micrograms of lead per deciliter of whole blood or as determined by CDC recommendations to ADHS (A.A.C. R9-4-302).
- In-office capillary blood draws utilizing validated CLIA waived testing equipment will be covered for in-network point of care EPSDT visits.

Missed/No-Show EPSDT Appointments

Providers are expected to follow up with members who miss or no-show their EPSDT appointments and notify the health plan when a member has missed or cancelled three or more visits. Providers may utilize the health plan's Missed/No-Show Log. Providers are encouraged to use the recall system in order to reduce the number of missed or cancelled appointments.

Arizona Early Intervention

AHCCCS and AzEIP jointly developed procedures for the coordination of services under Early Periodic Screening, Diagnostic and Treatment (EPSDT) and AzEIP to ensure the coordination and provision of EPSDT and AzEIP services.

PCP-Initiated Services

When concerns about a child's development are initially identified by the child's primary care physician (PCP), the PCP requests an evaluation and, if medically necessary, approval of services from the health plan.

Evaluation/Services: The Health Plan may pend approval for services until the evaluation has been completed by the provider and may deny services if the PCP determines there is no medical need for services based on the results of the evaluation.

- Requests for services from PCPs, licensed providers or the AzEIP service coordinator based on the Individual Family Service Plan (IFSP) must be reviewed for medical necessity prior to authorization and reimbursement.
- If services are approved, The Health Plan authorizes the services with The Health Plan
- participating provider, whenever possible, and notifies the PCP (requesting provider if other than the PCP) that (a) the services are approved, and (b) identifies the provider that has been authorized, the frequency, duration, and the service begin and end dates.
- The Health Plan follows the Code of Federal Regulation 42 438.210 for completion of prior authorization requests.

The Health Plan provides a decision as expeditiously as the member's health condition requires, but not later than 48 hours following the receipt of a standard authorization request, with a possible extension of up to 48 hours if the member or provider requests an extension or if The Health Plan justifies a need for additional information and the delay is in the member's best interest.

Referral to AzEIP: After completing the evaluation, the provider who conducted the evaluation submits an evaluation report to the PCP (requesting provider if other than the PCP) and the Health Plan's Prior Authorization Department for authorization of medically necessary services.

If the evaluation indicates that the child scored two standard deviations below the mean, which generally translates to AzEIP's eligibility criteria of 50 percent developmental delay, the child continues to receive all medically necessary EPSDT covered services through the health plan. The health plan's EPSDT Coordinator refers the child to AzEIP for non-medically necessary services that are not covered by Medicaid, but are covered under IDEA Part C. If the evaluation report indicates that the child does not have a 50 percent developmental delay, the EPSDT Specialist continues to coordinate medically necessary care and services for the child.

The Health Plan and AzEIP continue to coordinate services for Medicaid children who are eligible for and enrolled in both AzEIP and Medicaid. The EPSDT Coordinator assists the parent or caregiver in scheduling the EPSDT covered services, as necessary or as requested. The EPSDT services are provided by the health plan's participating provider (or AzEIP service provider reimbursed by the health plan) until the services are determined by the PCP and provider to no longer be medically necessary.

AzEIP-Initiated Service Requests

When concerns about a Medicaid enrolled child's development are initially identified by AzEIP:

- If an EPSDT-eligible child is referred to AzEIP, AzEIP screens and, if needed, conducts an evaluation to determine the child's eligibility for AzEIP. AzEIP obtains parental consent to request and release records to and from the health plan and the child's PCP;
- The PCP reviews all AzEIP documentation and determines which services are medically necessary based on review of the documentation;
- The PCP takes no longer than 10 business days from the date the EPSDT Specialist faxes the documentation to the PCP to determine which services are medically necessary and returns the signed AzEIP AHCCCS Member Service Request form (AHCCCS AMPM Chapter 430, Attachment D [insert link: https://www.azahcccs.gov/shared/MedicalPolicyManual/]) to the EPSDT Coordinator.

The PCP will determine the requested services are medically necessary:

1. Within two business days, the EPSDT Coordinator sends the completed AzEIP AHCCCS Member Service Request form located at (AHCCCS AMPM, Chapter 430, Attachment D [insert link: https://www.azahcccs.gov/shared/MedicalPolicyManual/]) to the AzEIP service coordinator and PCP advising them that: (a) the services are approved, and (b) identifying the provider that has been authorized, the frequency, duration, and the service begin and end dates;
2. The Health Plan authorizes services with a participating provider whenever possible;
3. AzEIP providers may only be reimbursed (a) if they are AHCCCS registered and (b) for the categories of services for which they are registered and that were provided. Billing must be completed in accordance with AHCCCS guidelines;
4. When services are determined by the PCP and service provider to be no longer medically necessary, the AzEIP service coordinator implements the process for amending the IFSP, which may include (a) non medically necessary services covered by AzEIP, and (b) changes made to IFSP outcomes and IFSP services, including payer, setting, etc;
5. The AzEIP service coordinator, family and other IFSP team members review the IFSP at least every six months or sooner if requested by any team member. If services are changed (deleted or added) during an annual IFSP or IFSP review, the AzEIP service coordinator notifies the EPSDT Coordinator and PCP within two business days of the IFSP review. If a service is added, the AzEIP service coordinator's notification to the EPSDT coordinator initiates the process for determining medical necessity and authorizing the service as outlined above.

If the requested services do not show a 50% developmental delay:

- If the evaluation report received by a PCP, licensed provider or AzEIP, indicates that the child does not have a 50% developmental delay, medically needed services and therapies will be provided as needed.
- The health plan EPSDT Coordinator will coordinate medically necessary care and services for the child, including anticipatory guidance for the member's parent/HCDM or Physician.
- The EPSDT services are provided by the health plan until the services are determined to no longer be medically necessary.

Body Mass Index or Weight-for-Length

Primary care providers (PCPs) should calculate each child's body mass index (BMI) starting at age 2 until the member is age 21 (or weight-for-length percentile for members

less than two years of age). BMI is used to assess underweight, overweight and those at risk for overweight. BMI for children is sex and age specific. PCPs are required to calculate the child's BMI percentile utilizing the Centers for Disease Control and Prevention website [Insert link: https://www.cdc.gov/growthcharts/] for Body Mass Index (BMI) and growth chart resources or for children under age two, refer to the Centers of Disease Control and Prevention website for weight-for-length chart.

The following established percentile cutoff points are used to identify underweight and overweight in children:

PERCENTILE	WEIGHT
≥ 95th percentile	Obese
85th to < 95th percentile	Overweight
5th to < 85th percentile	Healthy Weight
< 5th percentile	Underweight

Primary care providers (PCPs) should calculate the growth of children under 2 years of age by using the World Health Organization (WHO) growth standards to monitor growth for infants and children ages 0 to 2 years of age in the U.S., as the Centers for Disease Control and Prevention recommends the use of the WHO standards for children under age 2 to avoid incorrectly labeling a child as failure to thrive despite following the optimal growth

pattern for children in this age group. Refer to the Centers for Disease Control and Prevention website for WHO growth chart resources.

Medical Food

The Health Plan covers medical foods when medically necessary for members diagnosed with one of the following inherited metabolic conditions:

1. phenylketonuria
2. homocystinuria
3. maple syrup urine disease
4. galactosemia (requires soy formula)
5. beta keto-thiolase deficiency
6. citrullinemia
7. glutaric acidemia type I
8. 3 methylcrotonyl CoA carboxylase deficiency
9. isovaleric acidemia
10. methylmalonic acidemia
11. propionic acidemia
12. arginosuccinic acidemia
13. tyrosinemia type I
14. HMG CoA lyase deficiency
15. Very long chain acyl-CoA Dehydrogenase deficiency (VLCAD)
16. Long Chain acyl-CoA Dehydrogenase deficiency (LCHAD)
17. cobalamin A, B, C deficiencies

Medical foods are metabolic formula or modified low- protein foods produced or manufactured specifically for persons with a qualifying metabolic disorder and are not generally used by persons in the absence of a qualifying metabolic disorder. Soy formula is covered for members receiving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and KidsCare members diagnosed with galactosemia and only until they are able to eat solid lactose-free foods.

Upon completion of the member's initial consultation with a genetics physician and metabolic nutritionist, and the determination that metabolic formula and/or low-protein foods are necessary to meet the member's nutritional needs, providers forward the request for metabolic nutrition to the Health Plan's Prior Authorization unit for review and processing. All approvals and payments for medical foods are the responsibility of The Health Plan.

Nutritional Assessment and Nutritional Therapy

Nutritional assessments are part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for the health plan's members under age 21, whose health status may improve with nutrition intervention. Nutritional therapy is covered for EPSDT-eligible health plan members for the below enteral, Total Parenteral Nutritional (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.

- Enteral nutritional therapy–Provides liquid nourishment directly to the digestive tract of a member who cannot ingest an appropriate amount of calories to maintain an acceptable nutritional status. Enteral nutrition is commonly provided by jejunostomy tube (J-tube), gastrostomy tube (G-tube) or nasogastric (N/G) tube Parenteral nutritional therapy - Provides nourishment through the venous system to members with severe pathology of the alimentary tract, which does not allow absorption of sufficient nutrients to maintain weight and strength.
- Commercial oral supplemental nutritional feedings - 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

The Health Plan covers the following for members with a medical condition described in the section above:

- Special Supplemental Program for Women, Infants and Children (WIC)-eligible infant formulas, including specialty infant formulas;
- Medical foods;
- Parenteral feedings; and
- Enteral feedings.

Refer to the Medical Foods section for the health plan's members with a congenital metabolic disorder, such as phenylketonuria, homocystinuria, maple syrup urine disease, or galasctosemia.

Nutritional Assessment and Nutritional Therapy – Members Ages 21 and Older

Nutritional assessments and nutritional therapy are provided for members whose health status may improve with nutrition intervention. Arizona Health Care Cost Containment System (AHCCCS) covers nutritional therapy on an enteral, parenteral, and oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member's daily nutritional and caloric intake.

Nutritional assessments and nutritional therapy are covered benefits for members ages 21 and older when all of the following apply:

- The member is currently underweight with a BMI of less than 18.5 presenting serious health consequences for the member, or the member has demonstrated a medically significant decline in weight within the past three months (prior to the assessment).
- The member is able to consume no more than 25 percent of their nutritional requirements from typical food sources.
- The member has been evaluated and treated for medical conditions that may cause problems with weight gain (such as feeding problems, behavioral conditions, or psychosocial problems, or endocrine or gastrointestinal problems).
- The member has had a trial 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. After this trial, there is clinical documentation and other supporting evidence indicating that higher caloric foods would be detrimental to the member's overall health.

Referrals for Nutritional Assessment

Nutritional assessments are conducted to assist members whose health status may improve with nutritional intervention. The health plan covers the assessment of nutritional status, as determined necessary and as a part of health risk assessment and screening services provided by the member's primary care provider (PCP).

Nutritional assessment services provided by a registered dietitian are covered when ordered by the member's PCP.

To initiate a referral for a nutritional assessment, complete the health plan's referral form and fax it to the health plan's Prior Authorization Department.

The assessment of a member's nutritional status is covered as part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program specified in the Arizona Health Care Cost Containment System (AHCCCS) EPSDT Periodicity Schedule (AMPM Chapter 430, Attachment A), and on an inter-periodic basis as determined necessary by the member's primary care physician (PCP). This includes members who are under or overweight. A PCP may perform the nutritional assessment or may refer the member to a registered dietician.

Providers are required to provide education, support and training, if the member, parent or guardian elects to prepare the member's food, regarding proper sanitation and temperatures to avoid contamination of foods that are blended or specially prepared for the member, and

provide encouragement and assistance to the parent/guardian/HCDM,DR in weaning the member from the necessity for supplemental nutritional feedings.

Prior Authorization for Nutritional Therapy

Prior authorization is always required for nutritional therapy. Providers must submit all clinically relevant information for medical necessity review and prior authorization requests. To obtain prior authorization for enteral or parenteral nutritional therapy, providers must complete and submit a Request for Prior Authorization form to the health plan‘s Prior Authorization Department.

Prior authorization is required for commercial oral supplemental nutritional feedings, including specialty infant formulas, unless the member is also currently receiving nutrition through enteral or parenteral feedings. Prior authorization 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. An example of a nutritional supplement is an amino acid-based formula used by a member for eosinophilic gastrointestinal disorder.

The primary care physician (PCP) or attending physician must determine medical necessity on an individual basis for commercial oral nutritional supplements.

For prior authorization on commercial oral supplemental nutritional feedings, the member’s PCP or attending physician must complete and submit the Arizona Health Care Cost Containment System (AHCCCS)-approved Certificate of Medical Necessity for Commercial Oral Nutritional Supplements form to the health plan’s Prior Authorization Department.

The PCP or attending physician must have documentation that nutritional counseling was provided as part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program and specify alternatives that were tried in an effort to boost caloric intake and change food consistencies before considering commercially available nutritional supplements for oral feedings, or to supplement feedings.

The PCP or attending physician must complete the Certificate of Medical Necessity for Commercial Oral Nutritional Supplements form and indicate on the form which criteria were met when assessing medical necessity of providing commercial oral nutritional supplements.

Behavioral Health Screening and Services provided by a PCP

Behavioral health services are covered for members eligible for EPSDT. PCP’s may provide behavioral health services within their scope of practice. Refer to (AHCCCS

AMPM, Chapter 510), https://www.azahcccs.gov/shared/MedicalPolicyManual/ [Insert Link: https://www.azahcccs.gov/shared/MedicalPolicyManual/] .

American Indian/Alaska Native members may receive behavioral health services through an Indian Health Service or tribally operated 638 facility, regardless of health plan enrollment or behavioral health assignment,

Screenings including:

i. Postpartum consisting of a standard norm-criterion referenced screening tool to be performed for screening the birthing parent for signs and symptoms of postpartum depression during the one-, two-, four- and six-month EPSDT visits. Positive screening results require referral to appropriate case managers and services at the respective maternal health plan, and

ii. Adolescent Suicide consisting of a standardized, norm-referenced screening tool specific for suicide and depression shall be performed at annual EPSDT visits beginning at age 10 years of age. Positive screening results require appropriate and timely referral for further evaluation and service provision.

A Developmental Surveillance must be performed by the PCP at each EPSDT visit.

FAMILY PLANNING SERVICES

The Health Plan covers family planning services in accordance with the AHCCCS AMPM Policy 420 (Family Planning) https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/400/420.pdf for all Members, regardless of gender, who choose to delay or prevent pregnancy.

1. Covered family planning services and supplies for members include the following medical, surgical, pharmacological, and laboratory services as well as contraceptive devices (including Intrauterine Devices (IUDs) and subdermal implantable contraceptives):
    a. Contraceptive counseling, and/or medication and supplies, including, but not limited to oral and injectable contraceptives, LARC (Long-Acting Reversible Contraceptive)(including placement of Immediate Postpartum Long-Acting Reversible Contraceptives [IPLARC]), , diaphragms, condoms, foams and suppositories,
    b. Associated medical and laboratory examinations and radiological procedures, including ultrasound studies related to family planning,
    c. Treatment of complications resulting from contraceptive use, including emergency treatment,
    d. Natural family planning education or referral to qualified health professionals,

e. Post-coital emergency oral contraception within 72 hours after unprotected sexual intercourse (mifepristone, also known as Mifeprex or RU-486, is not a post-coital emergency oral contraception).
f. Sterilization:
    1. Clarification related to hysteroscopic tubal sterilization:
        1. Hysteroscopic tubal sterilization is not immediately effective upon insertion of the sterilization device. It is expected that the procedure will be an effective sterilization procedure three months following insertion. Therefore, during the first three months the member must continue using another form of birth control to prevent pregnancy, and
        2. At the end of the three months, it is expected that a hysterosalpingogram will be performed confirming that the member is sterile. After the confirmatory test, the member is considered sterile.

2. Coverage for the following family planning services are as follows:
    a. Pregnancy screening is a covered service,
    b. Pharmaceuticals are covered when associated with medical conditions related to family planning or other medical conditions,
    c. Screening and treatment for Sexually Transmitted Infections (STI) are covered services for members, regardless of gender,
    d. Sterilization services are covered regardless of member's gender when the requirements specified in AHCCCS Policy for sterilization services are met (including hysteroscopic tubal sterilizations, if available), and

    Pregnancy termination is covered only as specified in AMPM Policy 410.
3. Limitations - The following are not covered for the purpose of family planning services and supplies:
    a. Infertility services including diagnostic testing, treatment services and reversal of surgically induced infertility,
    b. Pregnancy termination counseling,
    c. Pregnancy terminations except as specified in AMPM Policy 410, and
    d. Hysterectomies for the purpose of sterilization. Refer to AMPM Policy 310-L for hysterectomy coverage requirements.

Requirements for Providing Family Planning Services and Supplies

Providers are required to collaborate with the Health Plan to implement effective family planning services which includes:

1. Notifying Members of reproductive age of the specific covered family planning services and supplies available and how to request them. Notification must be in accordance with ARS § 36.2904(L). The information provided to Members should include, but is not limited to:
    a. A complete description of covered family planning services and supplies available, including counseling regarding availability and benefits of LARC and IPLARC;

   b. Information advising how to request/obtain these services;
   c. Information that assistance with scheduling is available; and
   d. A statement that there is no copayment or other charge for family planning services and supplies.
   e. A statement that medically necessary transportation services are available.
2. Provide family planning services that are:
   a. Provided in a manner free from coercion or behavioral/mental pressure;
   b. Available and easily accessible to Members;
   c. Provided in a manner which assures continuity and confidentiality;
   d. Provided by, or under the direction of, a qualified physician or practitioner; and
   e. Documented in the medical record. In addition, documentation must be recorded that each Member of reproductive age (12-55 years) was notified verbally or in writing of the availability of family planning services and supplies.
3. Provide translation/interpretation of information related to family planning in accordance with the requirements of the cultural competency policy.
4. Have a process for ensuring prior to insertion of intrauterine and subdermal implantable contraceptives, the family planning provider has provided proper counseling to the eligible Member to minimize the likelihood of a request for early removal.
5. Establish procedures for referral of those Members who may lose AHCCCS eligibility to low-cost/no-cost agencies for family planning services.

In addition, providers are responsible for the following:

- Informing pregnant members by the end of the second trimester of family planning services and supplies and how to request them, including information on LARC/IPLARC.
- Making appropriate referrals to health professionals who provide family planning services.
- Keeping complete medical records regarding referrals.
- Verifying and documenting a member's willingness to receive family planning services.
- Providing medically necessary management of Members with family planning complications.
- Notify Members of reproductive age either directly or to the appropriate Health Care Decision Maker (HCDM), whichever is most appropriate, of the specific covered family planning services and supplies available to them, and a plan to deliver those services to members who request them.
  - Members of any age whose sexual behavior exposes them to possible conception or Sexually Transmitted Infections (STIs) should have access to the most effective methods of contraception.
  - Every effort should be made to include partners in such services.

- Providing counseling and education to Members of all genders that is age appropriate and includes information on prevention of unplanned pregnancies. Counseling should include the following:
    - The member's short- and long-term goals;
    - Spacing of births to promote better outcomes for future pregnancies; and
    - Preconception counseling to assist Members in deciding on the advisability and timing of pregnancy, to assess risks and to reinforce habits that promote a healthy pregnancy.
    - Sexually transmitted infections, to include methods of prevention, abstinence, and changes in sexual behavior and lifestyle that promote the development of good health habits.

Contraceptives should be recommended and prescribed for sexually active Members. Providers are required to discuss the availability of family planning services annually. Information should include all of the family planning services and supplies covered through AHCCCS as well as instructions to members regarding how to access these services and supplies. If a member's sexual activity presents a risk or potential risk, the provider should initiate an in-depth discussion on the variety of contraceptives available and their use and effectiveness in preventing sexually transmitted infections (including HIV/AIDS). Such discussions must be documented in the Member's medical record.

Sterilization

The Health Plan requires all participating providers to comply with the informed consent forms and procedures for sterilization as specified in the AHCCCS Specifications Manual (42 CFR Part 441, Sub-part B). The following criteria must be met for the sterilization of a member to occur:

- The Member is at least 21 years of age at the time the consent is signed.
    - For Members under the age of 21, the provider must be able to demonstrate medical necessity for the procedure with supporting documentation including Prior Authorization. The medical necessity prior authorization and supporting documentation must be submitted to The Health Plan.
- Mental competency is determined; member has not been declared mentally incompetent.
- Voluntary consent was obtained without coercion; and
- Thirty (30) days, but not more than 180 days, 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.
- Members may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since they 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.

Any Member requesting sterilization must sign an AHCCCS AMPM, Chapter 400, Exhibit 420 Attachment A, (AHCCCS Consent to Sterilization Form Attachment A), with a witness present when the consent is obtained. Suitable arrangements must be made to ensure that the information in the consent form is effectively communicated to Members with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds, as well as Members with visual and/or auditory limitations. Prior to signing the consent form, a member shall have been given a copy of the consent form and offered factual information that includes all of the following:

1. Consent form requirements (specified in 42 CFR 441.250 et seq.),
2. Answers to questions asked regarding the specific procedure to be performed;
3. Notification that withdrawal of consent can occur at any time prior to surgery without affecting future care and/or loss of federally funded program benefits;
4. A description of available alternative methods;
5. Advice that the sterilization procedure is considered to be irreversible,
6. A thorough explanation of the specific sterilization procedure to be performed,
7. A description of available alternative methods
8. A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used;
9. A full description of the advantages or disadvantages that may be expected as a result of the sterilization; and
10. Notification that sterilization cannot be performed for at least 30 days post consent.
11. Sterilization consents may NOT be obtained when a member:
12. Is in labor or childbirth;
13. Is seeking to obtain, or is obtaining, a pregnancy termination; or
14. Is under the influence of alcohol or other substances that affect the Member's state of awareness.

The Health Plan submits a Monthly Sterilization Report to AHCCCS which documents the number of sterilizations performed for all Members under the age of 21 years of age during the month. If no sterilizations were performed for Members under the age of 21 years of age during the month, the monthly report must still be submitted to attest to that information.

Hysteroscopic tubal sterilization is not immediately effective upon insertion of the sterilization device. It is expected that the procedure will be an effective sterilization procedure three months following insertion. Therefore, during the first three months the member must continue using another form of birth control to prevent pregnancy. At the end of the three months, it is expected that a hysterosalpingogram will be performed confirming that the Member is sterile. After the confirmatory test, the member is considered sterile.

Medically Necessary Pregnancy Termination for Title XIX/XXI Adults With SMI

Prior authorization is required for pregnancy termination except in emergency situations where the life of the mother is threatened. In these situations, authorization may be sought post procedure. Prior authorization must be obtained before the services are rendered or the services will not be eligible for reimbursement. Pregnancy termination services are covered when one of the following occurs:

- 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.
  The pregnancy is a result of incest.
- The pregnancy is a result of rape; or
- 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:
  - Creating a serious physical or mental health problem for the pregnant Member;
  - Seriously impairing a bodily function of the pregnant Member;
  - Causing dysfunction of a bodily organ or part of the pregnant Member;
  - Exacerbating a health problem of the pregnant Member; or
  - Preventing the pregnant Member from obtaining treatment for a health problem.

For medical necessary pregnancy terminations, providers must submit AHCCCS AMPM Chapter 410 Attachment D (AHCCCS Verification of Diagnosis by Contractor for a Pregnancy Termination Request) to the Health Plan Medical Director including a written explanation describing why the procedure is medically necessary, a copy of the Member's medical record and written informed consent from the Member. The provider is required to obtain the written informed consent and retain it in the Member's medical record for all pregnancy terminations. For pregnant Members younger than 18 years of age, or those 18 or older and considered incapacitated, providers must secure a dated signature of the pregnant Member's parent/Health care Decision Maker (HCDM) indicating approval of the pregnancy termination procedure is required.

In addition, if the pregnancy termination is requested as a result of incest or rape, providers must include identification of the proper authority to which the incident was reported. This must include the name of the agency to which it was reported, the report number (if available), and the date that the report was filed. This documentation requirement shall be

waived if the treating provider certifies that, in his/her/their professional opinion, the member was unable, for physical or psychological reasons, to comply with the requirement.

Follow Food and Drug Administration (FDA) medication guidance for the use of medications to end a pregnancy. Current standards of care per ACOG shall be utilized when the duration of pregnancy is unknown or if ectopic pregnancy is suspected.

Pregnancy termination by surgery is recommended in cases when medications are used and fail to induce termination of the pregnancy. When medications are administered, the following documentation is also required:

- Name of medication(s) used,
- Duration of pregnancy in days,
- The date medication was given,
- The date any additional medications were given (unless a complete abortion was already confirmed), and
- Documentation that pregnancy termination occurred.

Prior Authorization Requirements for Sterilization and Pregnancy Termination

Prior authorization is required for sterilization of Members under the age of 21 or pregnancy termination. Prior authorization must be obtained before the services are rendered or the services will not be eligible for reimbursement. The Health Plan monitors all claims and encounters with a primary diagnosis of pregnancy termination.

To obtain authorization for sterilization, complete the applicable forms:

- For sterilization: AHCCCS AMPM, Chapter 400, Exhibit 420 (Consent for Sterilization Form) and AHCCCS AMPM, Chapter 800, Exhibit 820-1 (Hysterectomy Consent and Acknowledgement Form)

To obtain authorization for pregnancy termination, except in cases of medical emergencies, the provider shall obtain a Prior Authorization from the Health Plan Medical Director. A completed AHCCCS AMPM Section 410 Attachment C (Certificate of Necessity for Pregnancy Termination) and the AHCCCS AMPM Section 410 Attachment D (Verification of Diagnosis by Contractor for Pregnancy Termination Request) forms shall be submitted with the request for Prior Authorization, along with the lab, radiology, consultation or other testing results that support the justification/necessity for pregnancy termination. The Health Plan Medical Director or designee will review the Prior Authorization request and supporting documentation and expeditiously authorize the procedure if the documentation meets the criteria for justification of pregnancy termination.

In cases of medical emergency, the provider must submit all documentation of medical necessity to the Health Plan within two working days of the date on which the pregnancy termination procedure was performed.

For pregnancy termination: A completed AHCCCS AMPM Section 410 Attachment C (Certificate of Necessity for Pregnancy Termination) is required.

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.

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

Maternity care services include, but are not limited to, pregnancy identification through the submission of **Provider Manual Form Notification of Pregnancy** form (can be obtained by calling the Customer Services at 1-866-560-4042), prenatal services, treatment of pregnancy related conditions, labor and delivery services, postpartum depression screening, and postpartum care. In addition, related services such as outreach and family planning services are provided (AHCCCS AMPM Policy 420 – Maternity Care Services), whenever appropriate, based on the member's current eligibility and enrollment.

Maternity Care Provider Standards

SECTION VI: Covered Services

Providers must provide quality maternity care services with the goal of achieving optimal birth outcomes. Upon identification of Member pregnancy, all Maternity Care Providers are required to submit the **Provider Manual Form Notification of Pregnancy Form (NOP)** (can be obtained by calling the Customer Service at 866-560-4042). For members who are identified as being medically or socially at-risk/high-risk should be referred to the Health Plan to coordinate care with the Member's physical/behavioral health providers throughout the pregnancy, delivery, and postpartum treatment. This includes identified difficulties with navigating the health care system, evidenced by missed visits, transportation difficulties, or other perceived barriers. Particular attention should be given to the screening, assessment, and treatment of perinatal mood disorders, to include post-partum depression, and substance use disorders.

Members who transition to a new Health Plan or become enrolled during their third trimester must be allowed to complete maternity care with their current AHCCCS-registered provider, regardless of contractual status, to ensure continuity of care.

The Health Plan confirms that members who are receiving physical health care services and who are pregnant have a designated maternity care provider for the duration of the Member's pregnancy and postpartum care.

AHCCCS AMPM Policy 410 (Maternity Care Services) provides detailed descriptions of maternity care requirements and expectations. Members have a choice to be assigned a Primary Care Provider that provides obstetrical care consistent with the freedom of choice requirements for selecting health care professionals so as not to compromise the Member's continuity of care.

For anticipated low-risk deliveries, Members may elect to receive labor and delivery services in their home from their maternity provider and may also elect to receive prenatal care, labor and delivery, and postpartum care by licensed midwives.

According to the American College of Obstetricians and Gynecologists (ACOG) guidelines, all cesarean section deliveries must be medically necessary and include medical documentation to attest to medical necessity. Inductions and cesarean section deliveries prior to 39 weeks must be medically necessary. Any inductions performed prior to 39 weeks or cesarean sections performed at any time that are found to not be medically necessary based on nationally established criteria are not eligible for payment.

General Obstetrical Standards of Care

All providers must follow standard guidelines such as those established by the American College of Obstetrics and Gynecology (ACOG) standards of care, which include, but are not limited to the following:

- Use of a standardized prenatal medical record and risk assessment tool, such as the ACOG Form, documenting all aspects of maternity care.
- Completion of history including medical and personal health (including infections and exposures), menstrual cycles, past pregnancies and outcomes, and family and genetic history.
- Clinical expected date of confinement.
- Performance of physical exam (including determination and documentation of pelvic adequacy).
- Performance of laboratory tests at recommended time intervals.
- Comprehensive risk assessment incorporating psychosocial, nutritional, medical, and educational factors.

Routine prenatal visits with blood pressure, weight, fundal height (tape measurement), fetal heart tones, urine dipstick for protein and glucose, ongoing risk assessment with any change in pregnancy risk recorded and an appropriate management plan. Providers are required to screen all pregnant members through the Controlled Substances Prescription Monitoring Program (CSPMP) once a trimester, and for those members receiving opioids, appropriate intervention and counseling must be provided, including referral of members for behavioral health services as indicated for Substance Use Disorder (SUD) assessment and treatment.

Providers need to identify perinatal mood and anxiety disorders during and after pregnancy for referral of members to the appropriate health care providers. Perinatal and Postpartum depression screenings, using any norm-criterion referenced screening tool, should be conducted at least once during the pregnancy and then repeated at the postpartum visit with appropriate counseling and referral made if a positive screening is obtained.

Maternity care providers need to be aware of and encouraged to use the Arizona Perinatal Psychiatry Access Line (A-PAL) when questions surrounding mental health or substance use treatment, including medication management, arise,

Providers must educate Members about healthy behaviors during the perinatal period, including the importance proper nutrition, dangers of lead exposure to people who are pregnant and their developing babies, tobacco cessation, avoidance of alcohol and other harmful substances, including illegal drugs, screening for sexually transmitted infections, the physiology of pregnancy, the process of labor and delivery, breast feeding, other infant care information, prescription opioid use, interconception health and spacing, family planning options, including IPLARC options; warning signs of complications of pregnancy and postpartum, including when to contact the provider and postpartum follow-up.

Providers need to refer members to support resources such as WIC, as well as other community-based resources to support healthy pregnancy outcomes, including information about, and referrals to, home visiting programs for pregnant individuals and their children,

ADHS Breastfeeding Hotline, and other infant care resources., In the event where a member loses eligibility, the member shall be notified where they may obtain low-cost or no-cost maternity services.

Providers are also required to educate Members about the risks associated with elective deliveries prior to 39 weeks and/or Cesarean-sections (C-Sections) unless medically necessary; signs and symptoms of preterm labor; effects of smoking, diabetes, hypertension on pregnancy and/or fetus/infant; prenatal and postpartum visits. Providers are required to inform members of voluntary prenatal HIV/AIDS testing and the availability of medical counseling and treatment, as well as the benefits of treatment for birthing parent and baby, if the test is positive. In the event where a member loses eligibility, the member must be notified where they may obtain low-cost or no-cost maternity services. In preparation for delivery, it is important for providers to discuss pain management/pain treatment plan options with the member and offer Immediate Postpartum Long-Acting Reversible Contraception (IPLARC). For members with barriers to care, providers can contact the Health Plan Care Management Team to assist the member with a plan of safe care prior to discharge including behavioral health services, alternative infant care, and alternative nutritional supplementation plans if the member is breastfeeding.

Health Plan Care Management Staff are available to assist providers with managing pregnant members with substance use disorders. The Care1st Maternal Child Health Care Management Team can be reached by calling Customer Service at 1-866-560-4042 (TTY/TDD: 711).The staff includes nurses with OB clinical expertise and social workers. They are available to assist providers with coordination of care and collaboration between the OBGYN and other providers. This can be done through the provision of education, providing support and resources to the member including behavioral health services, and alternative nutritional supplementation plans if the member is breastfeeding. Because many do not view prescription medications as a “substance,” it is important to engage in a face-to-face discussion about all types of substance use with a pregnant member and with all members of reproductive age even when the member does not report or denies use. **An individualized plan of care should be developed using American College of Obstetrics and Gynecologists (ACOG) guidelines for each member identified with a history of Substance Use Disorder (SUD), including medication adjustment needs, evidenced-based breastfeeding recommendation and precautions, and Narcan prescription.** It is also important that screening be done for additional health issued related to SUD, including Hepatitis C, as well as inquiring about any barriers to care. All pregnant members must be screened for STI’s, including syphilis at the first prenatal visit, third trimester, and time of delivery. In preparation for delivery, it is important for providers to discuss pain management/pain treatment plan options with the member and offering Immediate Postpartum Long-Acting Reversible Contraception (IPLARC). For members with barriers to care, providers can contact the Health Plan Care Management staff to assist the member with a plan of safe care prior to discharge including behavioral health services, alternative infant care, and alternative nutritional supplementation plans if the member is breastfeeding.

HIGH RISK PRENATAL HOME CARE INFUSION

Please contact our Case Management Team at 1-866-560-4042 for assistance with high risk members.

High Risk Maternity and Perinatal Care Management

The Health Plan Integrated Care Managers, together with providers, identify pregnant members who are at risk for adverse pregnancy outcomes. The Health Plan assists providers in managing the care of at-risk pregnant Members due to medical conditions, social determinants, severe mental illness, or non-compliant behaviors. The Health Plan evaluates At Risk Members for ongoing follow up during their pregnancy. The Care1st Maternal Child Health Care Management Team can be reached by calling Customer Service at 1-866-560-4042 (TTY/TDD: 711).

The Health Plan's Maternal Child Health Team provides comprehensive care management services to high-risk pregnant Members, for the purpose of improving maternal and fetal birth outcomes. The perinatal care management team consists of a social worker, care management associates, and professional registered nurses skilled in working with the unique needs of high-risk pregnant members. The Maternal Child Health Team take a collaborative approach in working with outpatient behavioral health providers, PCPs and OB/GYNs to engage high risk pregnant Members throughout their pregnancy and postpartum period. Members who present with high-risk perinatal conditions should be referred to the Health Plan care management team. These conditions include:

- A history of preterm labor before 37 weeks of gestation;
- Bleeding and blood clotting disorders;
- Chronic medical conditions;
- Polyhydramnios or oligohydramnios;
- Placenta previa, abruption or accreta;
- Cervical changes;
- Multiple gestation;
- Teenage mothers;
- Hyperemesis;
- Poor weight gain;
- Advanced maternal age;
- Substance abuse;
- Prescribed psychotropic drugs;
- Domestic violence; and
- Non-adherence with Obstetrics appointments.

Reporting High Risk and Non-Adherent Behaviors in Pregnant Members

Behavioral Health providers, obstetrical physicians and practitioners must refer all "at risk" pregnant Members to The Health Plan. The following types of situations must be reported to The Health Plan for Members that:

- Are diabetic and display consistent complacency regarding dietary control and/or use of insulin.
- Fail to follow prescribed bed rest.
- Fail to take tocolytics as prescribed or do not follow home uterine monitoring schedules.
- Admit to or demonstrate continued alcohol and/or other substance abuse disorder.
- Show a lack of resources that could influence well-being (e.g. food, shelter, and clothing).
- Frequently visit the emergency department/urgent care setting with complaints of acute pain and request prescriptions for controlled analgesics and/or mood altering drugs.
- Fail to appear for two or more prenatal visits without rescheduling and fail to keep rescheduled appointment. Providers are expected to make two attempts to bring the member in for care prior to contacting The Health Plan.

MATERNITY CARE APPOINTMENT SCHEDULING

• First trimester • Second trimester • Third trimester • High risk pregnancies	• Within fourteen (14) calendar days of request • Within seven (7) calendar days of request • Within three (3) business days of request • as expeditiously as the member's health condition requires and no later than three (3) business days of identification of high risk by the contractor or maternity care provider, or immediately if an emergency exists.

Outreach, Education and Community Resources for Pregnant Members

The Health Plan is committed to maternity care outreach. Maternity care outreach is an effort to identify currently enrolled pregnant individuals and to enter them into prenatal care as soon as possible, but no later than within the first trimester or 42 days after enrollment. Behavioral provider Care Coordinators, PCPs, OB/GYNs and other treating providers are expected to ask about pregnancy status when Members call for appointments,

to report positive pregnancy tests to The Health Plan through submission of **Provider Manual Form Notification of Pregnancy form (NOP),** (can be obtained by calling the Customer Service at 1-866-560-4042 (TTY/TDD: 711)) and to provide general education and information about prenatal care, when appropriate, during Member office visits.

The Health Plan is involved in many community efforts to increase the awareness of the need for prenatal care. PCPs are strongly encouraged to actively participate in these outreach and education activities, including the Women, Infants and Children (WIC) Nutritional Program. Please encourage Members to enroll in this program in order to support healthy pregnancy outcomes. Various other services are available in the community to help pregnant individuals and their families. Please call The Health Plan for information about how to help your patients use these services.

Questions regarding the availability of community resources may also be directed to the Arizona Health Care Cost Containment System (AHCCCS) Hot Line at 800-833-4642.

Loss of AHCCCS Coverage During Pregnancy

Members may lose AHCCCS eligibility during pregnancy. Although Members are responsible for maintaining their own eligibility, providers are encouraged to notify The Health Plan if they are aware that a pregnant Member is about to lose or has lost eligibility. The Health Plan Member Services can assist in coordinating or resolving eligibility and enrollment issues so that pregnancy care may continue without a lapse in coverage. Please call Member Services at 888-560-4042 to report eligibility changes for pregnant Members.

Newborns

AHCCCS covers no less than 48 hours of inpatient hospital care after a routine vaginal delivery and no less than 96 hours of inpatient care after a cesarean delivery.

The newborn may be covered under the Health Plan. Prior to the birth of the baby, the mother will be asked to select a PCP for the newborn. The newborn is assigned to the pre-selected PCP after delivery. The mother may elect to change the assigned PCP at any time.

Special Policies

Covered related services with special policy and procedural guidelines include, but are not limited to:

- Circumcision (for males) is only covered when it is determined to be medically necessary. The procedure requires prior authorization by the Health Plan Medical Director or designee for enrolled members;
- Extended stays for newborns related to status of birthing parent's stay:
    - Members will receive up to 48 hours of inpatient hospital care after a routine vaginal delivery and up to 96 hours of inpatient care after a cesarean

delivery. The attending health care provider, in consultation with an agreement by the member, may discharge the member or newborn prior to the minimum length of stay. A newborn may be granted an extended stay in the hospital of birth when the member's continued stay in the hospital is beyond the minimum 48- or 96-hour stay, whichever is applicable. In addition, if the member's stay is to extend beyond 48/96 hours, an extended stay for the newborn shall be granted if the member's condition allows for member-infant interaction and the child is not a ward of the State or is not to be adopted.

- Home uterine monitoring technology:
  - AHCCCS covers medically necessary home uterine monitoring technology for members with premature labor contractions before 35 weeks gestation, as an alternative to hospitalization.
  - If the member has one or more of the following conditions, home uterine monitoring may be considered:
    - Multiple gestation, particularly triplets or quadruplets,
    - Previous obstetrical history of one or more births before 35 weeks gestation, or
    - Hospitalization for premature labor before 35 weeks gestation with a documented change in the cervix, controlled by Tocolysis and ready to be discharged for bed rest at home.

These guidelines refer to home uterine activity monitoring technology and do not refer to daily provider contact by telephone or home visit.

- Labor and delivery services provided in freestanding birthing centers
  - Services rendered in a freestanding birthing center must be provided by a physician by a Certified Nurses midwife (CNM) who has hospital admitting privileges for labor and delivery services, or a Licensed Midwife [AP1] (LM) who is following licensing and practice requirements as specified in A.A.C. R9-16-111-113;
  - Only members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated may be scheduled to deliver at a freestanding birthing center. Risk status shall be determined by the attending physician or CNM using standardized assessment tools for high-risk pregnancies. The age of the member shall also be a consideration in the risk status evaluation, members younger than 18 years of age are generally considered high risk.
- Labor and delivery services provided in a home setting:
  - For members who meet specified medical criteria, labor and delivery services provided in the home by the member's maternity provider, physicians, CNMs, or LMs would be covered.
  - Only members with an anticipated uncomplicated prenatal course and a low-risk labor and delivery should deliver in member's home.

- Risk status shall initially be determined at the time of the first visit, and each trimester thereafter, by the member's maternity care provider, using current standardized assessments for high-risk pregnancies.
- A risk assessment shall be conducted when a new presenting complication or concern arises to ensure appropriate care and referral to a qualified provider, if necessary.
- Physicians and practitioners who render home labor and delivery services must have admitting privileges at an acute care hospital in close proximity to the site where the services are provided in the event of complications during labor and/or delivery.
- For anticipated home labor and delivery, LMs shall have a plan of action, including the name and address of an AHCCCS registered physician who can be contacted immediately and an acute care hospital in close proximity to the planned location of labor and delivery for referral in the event that complications should arise. This plan of action shall be submitted to the Health Plan Medical Director or designee for enrolled members.
- Upon delivery of the newborn, the physician, CNM or LM is responsible for conducting newborn examination procedures, including a mandatory Bloodspot Newborn Screening Panel and referral of the infant to an appropriate health care provider for a mandatory hearing screening, as well as a second mandatory Bloodspot Newborn Screening Panel and a second newborn hearing screening (if infant's first hearing screening indicates further assessment is needed). Refer the infant and/or member to an appropriate health care provider for follow-up care of any assessed problematic conditions.
- In addition, the maternity care provider shall notify the birthing parent's Health Plan, of the birth no later than one day from the date of birth, in order to enroll the newborn with AHCCCS.

Neonate Transfers Between Acute Care Facilities

Acutely ill neonates may be transferred from one acute care center to another, given certain conditions. The chart that follows provides the levels of care, conditions appropriate for transfer, and criteria for transfer.

Refer to the below table for neonatal care:

Level of Care		Transfer Criteria
From	To	
Primary	Secondary	1. The nursing and medical staff of the sending hospital cannot provide: • The level of care needed to manage the infant beyond stabilization to transport • The required diagnostic evaluation and consultation services needed 2. Transportation orders specify the type of transport, the training level of the transport crew and the level of life support
	Tertiary	Same as above
Secondary	Tertiary	Same as above
	Primary	Same as above
Tertiary	Tertiary (rare)	1. The sending and receiving neonatalogists (and surgeons, if involved) have spoken and agreed that the transfer is safe. 2. The infant is expected to remain stable, considering the period of time required for the distance to be traveled. 3. Transport orders specify the type of transport and training level of the transport crew.
	Secondary	Same as above
	Primary	Same as above

WELL WOMAN CARE/ANNUAL PREVENTIVE CARE

An annual preventive care visit is intended for the identification of risk factors for disease, identification of existing medical/mental health problems, and promotion of healthy lifestyle habits essential to reducing or preventing risk factors for various disease processes. An annual well-person preventative care visit is a covered benefit for members to obtain the recommended preventive services, including preconception counseling. Providers are responsible for having a process to inform members about preventative health services annually and within 30 days of enrollment for newly enrolled members.

The information must include:

- The benefits of preventive care,
- A complete description of services available,
- Assistance in obtaining information on how to obtain medically necessary transportation,
- A statement that there is no copayment or other charges for the preventive care.

The information must also be provided in a second language, in addition to English, in accordance with the requirements of the AHCCCS Division of Health Care Management (DHCM) "Cultural Competency" policy.

As such, the annual preventative care visit is inclusive of a minimum of the following:

1. A physical exam (well exam) that assesses overall health;
2. Clinical breast exam (if/as necessary);
3. Pelvic exam (if/as necessary, according to current recommendations and best standards of practice);
4. Review and administration of immunizations, screenings and testing as appropriate for age and risk factors. NOTE: Genetic screening and testing is not covered;
5. Screening and counseling focused on maintaining a healthy lifestyle and minimizing health risks. Screening and counseling addresses at a minimum the following:
    a. Proper nutrition;
    b. Physical activity;
    c. Elevated BMI indicative of obesity;
    d. Tobacco/substance use, abuse, and/or dependency;
    e. Depression screening;
    f. Interpersonal and domestic violence screening that includes counseling involving elicitation of information from members of all ages about current/past violence and abuse, in a culturally sensitive and supportive manner to address current health concerns about safety and other current or future health problems;
    g. Sexually transmitted infections;
    h. Human Immunodeficiency Virus (HIV);
    i. Family planning counseling and supplies;
    j. Preconception counseling that includes discussion regarding a healthy lifestyle before and between pregnancies that includes: (**NOTE: Preconception counseling does not include genetic testing.)**
        i. Reproductive history and sexual practices
        ii. Healthy weight, including diet and nutrition, as well as the use of nutritional supplements and folic acid intake
        iii. Physical activity or exercise
        iv. Oral health care
        v. Chronic disease management
        vi. Emotional wellness
        vii. Tobacco and substance use (caffeine, alcohol, marijuana, and other drugs), including prescription drug use
        viii. Recommended intervals between pregnancies
6. Initiation of necessary referrals when the need for further evaluation, diagnosis, and/or treatment is identified.

Immunizations:

- The Health Plan will cover the Human Papilloma Virus (HPV) vaccine for members.
- Providers must coordinate with the Arizona Department of Health Services (ADHS) Vaccines for Children (VFC) Program in the delivery of immunization services if providing vaccinations to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) aged members less than 19 years of age.
- Immunizations must be provided according to the Advisory Committee on Immunization Practices Recommended Schedule.
- Refer to the CDC website where this information is included.

Providers must enroll and re-enroll annually with the VFC program, in accordance with AHCCCS contract requirements in providing immunizations for EPSDT aged members less than 19 years of age and must document each EPSDT age member's immunizations in the Arizona State Immunization Information System (ASIIS) registry. The VFC program must be used for members under 19 years of age. Providers not enrolled in the VFC program will not be assigned members aged 19 years and under.

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

Preferred Drug List The Care1st Preferred Drug List (PDL) and Behavioral Health Drug List are available on our website at www.care1staz.com. The Drug Lists 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 Drug List(s). 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 Drug Lists or are listed on the Drug Lists 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 website and the AHCCCS Drug List. .

The Care1st Preferred Drug Lists:

1. Are determined by the AHCCCS Pharmacy and Therapeutics Committee and provides a list of safe, cost-effective and efficacious medications that are available to members.
2. AHCCCS' goal is to use the Drug List to assist providers when selecting clinically appropriate medications for members.
3. The Care1st Drug List is not an all-inclusive list of medications.
4. The Care1st 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 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 Drug Lists 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 Care1st.

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

AcariaHealth is the Care1st Preferred Specialty Pharmacy:

AcariaHealth	Multiple Locations Nationwide	1-800-511-5144

Prior Authorization Process

- Submit an Electronic Prior Authorization (ePA) request: through COVER MY MEDS. The landing page is located at
- https://www.covermymeds.com/main/prior-authorization-forms/ OR
- Complete the Pharmacy Prior Authorization Request Form available on the Care1st website (www.care1staz.com) and fax it to us at 602.778.8387

Prior Authorization Process for Medical Benefit Drugs

Please review the Prior Authorization Guidelines for J and Q codes that require prior authorization using the online Pre-Auth Check Tool located on our website (www.care1staz.com). 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 Outpatient Prior Authorization request form and faxing requests to the Biopharmacy/Medpharmacy department

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*

- Treatment Services
  - Behavioral Health Counseling & Therapy (Individual, Group, Intensive Outpatient Programming, and Family*)
  - Behavioral Health Screening, Mental Health Assessment and Specialized Testing
  - Psychophysiological therapy and biofeedback
- Rehabilitation Services
  - Skills Training and Development
  - Cognitive Rehabilitation
  - Health Promotion
  - 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 Outpatient and Behavioral Health Day Programs Behavioral Health Residential Facility Services
- Behavior Analysis
- Crisis Intervention Services
- Inpatient Services (Hospital, Behavioral Inpatient Facilities, Observation/Stabilization Services, Partial Hospitalization Programs)

SECTION VII: Behavioral Health Services

*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

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.
-
- Competent individuals who are adequately trained and supervised provide behavioral health services. Behavioral health services utilize treatment modalities and programs that are evidenced based and supported by Substance Abuse and Mental Health Services Administration (SAMSHA) or other nationally recognized organizations. 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 member's lives, especially 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.

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.

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 Centene Pharmacy Services 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)

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All Antipsychotics 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 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.

The Health Plan Preferred Drug List (PDL)
Providers are required to abide by the Health Plan's Preferred Drug List (PDL) as applicable, when prescribing medications for members in accordance with this Provider Manual. Providers are also required to adhere to the requirements of the AHCCCS Psychotropic Medication informed consent requirements in accordance with this Provider Manual.

Quantity Limits

- Opioid prescriptions: For adult opioid naïve members, short-acting opioids are 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 opioid prescriptions are subject to an MME of < 90 MME (morphine milligram equivalents). Prior authorization is required for chronic opioid use.

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 :

- 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.

Registration with Controlled Substance Prescription Monitoring Program

All medical practitioners are required to register and utilize the Arizona Controlled Substance Prescription Monitoring Program (CSPMP, PMP). Practitioners must obtain a patient utilization report for the preceding 12 months from the controlled substances PMP

central database tracking system before prescribing opioid analgesics or benzodiazepines in schedules II-IV. Practitioners are not required to obtain a report if the patient is:

- Receiving hospice care or being treated for cancer or cancer-related illness;
- If the practitioner will administer the controlled substance;
- If the patient is receiving the controlled substance during the course of inpatient or residential treatment in a hospital, nursing care facility or mental health facility;
- If the medical practitioner, under specific legislation, prescribed controlled substances for no more than five days after oral surgery, and
- As outlined in AHCCCS AMPM Chapter 300, Policy 310-FF

https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/

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 1-866-560-4042 (option 5, then 5). 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 adult opioid naïve members, Short-acting opioids are limited to a 5-day supply or less for initial fill. For minors, except in case of cancer, other chronic disease 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

The referral process serves as the principal pathway by which persons are able to gain prompt access to publicly supported services. The intake process serves to collect basic member information in order to enroll members in the AHCCCS system, screen for Title XIX/XXI AHCCCS eligibility and determine the need for any copayments. It is critical that both the referral process and intake process are culturally sensitive, efficient, engaging, and welcoming to the member and/or family member seeking services, and leads to the provision of timely and appropriate services based on the urgency of the situation.

A "referral" is any oral, written, faxed or electronic request for services made by the Member, the Member's legal guardian or Health Care Decision Maker (HCDM), family member, an AHCCCS Acute Contractor, PCP, Hospital, Treat and Refer Provider, Jail, Court, Probation or Parole Officer, Tribal Entity, his/638 Tribally Operated Facility, School, or other state or community agency.

Providers must not arbitrarily or prematurely reject or disqualify a member from services/referrals without prior authorization by the Health Plan. Providers must resolve referral disputes promptly, relative to the urgency of the situation. The Health Plan will promptly intervene and resolve any dispute between a provider and a referring source when those parties cannot informally resolve disputes regarding the need for emergency, urgent, or routine appointments.

The Health Plan providers are responsible for managing referrals and wait lists for Non-Title XIX/XXI persons in accordance with the SABG Block Grant for identified priority populations when services are temporarily unavailable. See AMPM Policy 650 Behavioral Health Provider Requirements for Assisting Individuals with Eligibility Verification and Screening/Application for Public Health Benefits.

If The Health Plan network is unable to provide medically necessary services to Title XIX/XXI persons, The Health Plan will verify timely and adequate coverage of needed services through an out-of-network provider until a network provider is contracted.

OBJECTIVES
To facilitate a member's access to services in a timely manner, providers will maintain an effective process for the referral and intake for services that includes:

Communicating to potential referral sources the process for making referrals (e.g., centralized intake, identification of providers accepting referrals);

Collecting enough basic information about the person to determine the urgency of the situation and subsequently scheduling the initial assessment within the required timeframes and with an appropriate provider.

Adopting a welcoming, trauma-informed, and engaging manner with the member and/or member's legal guardian/family member;

Ensuring that intake interviews are culturally appropriate and delivered by providers who are respectful and responsive to the Member's cultural needs.

Keeping information or documents gathered in the referral process confidential and protected in accordance with applicable federal and State statutes, regulations and policies;

Informing, as appropriate, the referral source about the final disposition of the referral; and

Conducting intake interviews that ensure the accurate collection of all the required information necessary and ensure Members who have difficulty communicating because of a disability or who require language assistance are afforded appropriate accommodations to assist them in fully expressing their needs.

WHERE TO SEND REFERRALS

The Health Plan maintains a provider directory on its website that is available to AHCCCS Health Plans and Department of Economic Security District Program Administrators (DES). A printed copy can be made available upon request. The directory indicates which providers are accepting referrals and conducting initial assessments and intakes. It is important for providers to promptly notify The Health Plan of any changes that would impact the accuracy of the provider directory (e.g., change in telephone or fax number, no longer accepting referrals).

Individuals may access services by directly contacting a Behavioral Health Home. Contracted Behavioral Health Homes are identified on The Health Plan website (www.care1staz.com) and in The Health Plan Member Handbook. Members may also call The Health Plan Customer Service at 1-866-560-4042, 24 hours a day/7 day a week, and receive a referral to a contracted Health Home. During normal business hours, The Health Plan will transfer callers to an intake provider. After-hour referrals are provided to Health Home providers who are expected to follow up on the referral. The Crisis Call Center staff tracks referrals to verify the caller is appropriately connected with a Health Home. In addition, the Crisis Call Center has access to emergent and urgent psychiatric appointments at intake provider sites and can schedule these appointments on the Member's behalf.

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Providers are required to notify The Health Plan of any changes that would alter or change the information provided through the directory. A 30-day notice is required for changes in telephone number, fax number, email address, service changes, staff changes, service capacity changes or ability to accept new referrals.

CHOICE OF PROVIDERS

The Health Plan offers Members a choice in selecting providers, and providers are required to provide each Member a choice in selecting a provider of services, provider agency, and direct care staff. Providers are required to allow Members to exercise their right to services from an alternative In-Network provider and offer each Member access to the most convenient In-Network service location for the service requested by the Member. In addition, providers must make available all Covered Services to all Title XIX/XXI eligible American Indians, whether they live on or off reservation. Eligible American Indian Members may choose to receive services through a RBHA/MCO/Health Plan, Tribal and Regional Behavioral Health Authorities, or through an IHS or 638 tribal providers.

REFERRALS TO A PROVIDER FOR A SECOND OPINION

Title XIX/XXI Members are entitled to a second opinion and providers are required to provide proof that each Member is informed of the right to a second opinion.

Upon a Title XIX/XXI eligible Member's request or at the request of the provider's treating physician, the provider must—at no cost to the Member—make available a second opinion from a qualified health care professional either within the network or arrange for the Member to obtain a second opinion from a qualified health care professional outside the network (42 CFR 438.206(b)(3)). For purposes of this section, a "qualified health care professional" is (a) an AHCCCS registered provider of covered health services (b) who is a physician, a physician assistant, a nurse practitioner, a psychologist, or an independent master's level therapist.

A behavioral health provider can arrange for a second opinion in-network or can contact the Health Plan Customer Service at 1-866-560-4042, 8:00 a.m. – 5:00 p.m. Monday – Friday, for assistance. Out-of-Network requests should be submitted to The Health Plan Utilization Management department for review and processing. A provider must maintain a record identifying both (1) the date of service for the second opinion and (2) the name of the provider who provided the second opinion. There must be documentation in the clinical chart of the following:

- 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.

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REFERRALS INITIATED BY DEPARTMENT OF ECONOMIC SECURITY/DEPARTMENT OF CHILD SAFETY (DES/DCS) PENDING THE REMOVAL OF A CHILD

Upon notification from DES/ Department of Child Safety (DCS) that a child has been or is at risk of being taken into the custody of DES/Department of Child Safety (DCS), providers are expected to respond in an urgent manner.

ACCEPTING REFERRALS

Providers must establish written procedures for accepting and acting upon referrals, including emergency referrals. Providers must accept referrals for services as identified in the provider's contract with the Health Plan unless The Health Plan grants a written waiver or suspension of this requirement. Providers must not arbitrarily or prematurely reject or eject a member from services/referrals without prior authorization of the Health Plan. Providers must accept referrals, regardless of diagnosis, level of functioning, age, Member's status in family, or level of service needs. (See 42 CFR 438.210 (a)(3)(iii))

The process for making referrals, including self-referrals, is clearly communicated to members and providers. The process shall ensure the engagement of the member/HCDM or the Designated Representative (DR) to maximize family voice and choice of service providers. Providers must accept and respond to emergency referrals of Title XIX/XXI eligible Members and Non-Title XIX/XXI Members with SMI twenty-four (24) hours a day, seven (7) days a week. An acknowledgement of receipt of a referral shall be provided to the referring entity within 72 hours from the date it was received.

Emergency referrals do not require prior authorization. Emergency referrals include those initiated for Title XIX/XXI eligible and Non-Title XIX/XXI with SMI Members admitted to a hospital or treated in the emergency room. Providers must respond within twenty-four (24) hours upon receipt of an emergency referral.

The following information shall be collected from referral sources:

- Date and time of referral;
- Information about the referral source including name, telephone number, fax number, affiliated agency, and relationship to the person being referred;
- Name of person being referred, address, telephone number, gender, age, date of birth and, when applicable, name and telephone number of parent or legal guardian;
- Whether or not the person, parent, or legal guardian is aware of the referral;
- Transportation and other special needs for assistance due to impaired mobility, blindness/low vision or being deaf or hard of hearing, or developmental or cognitive impairment;
- Accommodations due to cultural uniqueness and/or the need for interpreter services;

- Information regarding payment source (i.e., AHCCCS, private insurance, Medicare or self-pay) including the name of the AHCCCS health plan or insurance company;
- Name, telephone number, and fax number of AHCCCS primary care provider (PCP) or other PCP as applicable;
- Reason for referral including identification of any potential risk factors such as recent hospitalization, evidence of suicidal or homicidal thoughts, pregnancy, and current supply of prescribed psychotropic medications;
- Medications prescribed by the Member's PCP or other medical professional including the reason why the medication is being prescribed; and
- The names and telephone numbers of individuals the Member, parent, or guardian may wish to invite to the initial appointment with the referred Member.
- Sufficient information is collected through the referral to:
- Assess the urgency of the member's needs,
- Track and document the disposition of referrals to ensure subsequent initiation of services. The Contractor shall comply with timeliness standards 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 appointments and flexible scheduling options based upon the needs of the member.

Providers should act on a referral regardless of how much information they obtained. While the information listed above will facilitate evaluating the urgency and type of practitioner the Member may need to see, timely triage and processing of referrals must not be delayed because of missing or incomplete information.

When psychotropic medications are a part of a member's treatment or have been identified as a need by the referral source, providers must respond in accordance with Appointment Standards and Timeliness of Service guidelines.

When individuals seek services, or their family member, legal guardian, or significant other contacts a provider directly about accessing services, provider shall ensure that the protocol used to obtain the necessary information about the person seeking services is engaging and welcoming.

When an SMI eligibility determination is being requested as part of the referral or by the person directly, providers must conduct an eligibility determination for SMI. The SMI assessment and pending determination will not delay behavioral health service delivery to the Member.

SECTION VII: Behavioral Health Services

RESPONDING TO REFERRALS

Follow-Up: When a request for services is initiated but the Member does not appear for the initial appointment, the provider must attempt to contact the Member and implement engagement activities. The provider must also attempt to notify the entity that made the referral.

Final Dispositions: Within 30 days of receiving the initial assessment, or if the person declines services, within 30 days of the initial request for services, the provider must notify the following referral sources of the final disposition:

- AHCCCS health plans;
- AHCCCS PCPs;
- Arizona Department of Economic Security;
- Arizona Department of Child Safety;
- Arizona Department of Economic Security/Division of Developmental Disabilities;
- Arizona Department of Corrections;
- Arizona Department of Juvenile Corrections;
- County Adult and Juvenile Detention Centers;
- Administrative Offices of the Court;
- Arizona Department of Economic Security/Rehabilitation Services Administration; and
- Arizona Department of Education and affiliated school districts.

The final disposition must include:

1. The date the Member was seen for the initial assessment; and
2. The name and contact information of the provider who will assume primary responsibility for the Member's behavioral health care, or
3. If no services will be provided, the reason why.

When required, authorization to release information will be obtained prior to communicating the final disposition to the referral sources referenced above.

DOCUMENTING AND TRACKING REFERRALS

The Health Plan provider shall document and track all referrals for services including, at a minimum, the following information:

- Person's name and, if available, AHCCCS identification number;
- Name and affiliation of referral source;
- Date of birth;
- Type of referral (immediate, urgent, routine)
- Date and time the referral was received;

- If applicable, date and location of first available appointment and, if different, date and location of actual scheduled appointment; and
- Final disposition of the referral.

ELIGIBILITY SCREENING AND SUPPORTING DOCUMENTATION

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:

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

If an individual's Title XIX/XXI eligibility status cannot be determined using one of the above methods, the provider will:

- Call Care1st for assistance during normal business hours or
- Call the AHCCCS Verification Unit, which is open Monday through Friday, from 8:00-5:00 p.m.

Interpret eligibility information.

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,

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 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:

- Upon initial request for behavioral health services
- At least annually, if still receiving behavioral health services, and
- 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.

- 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,
- 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
- 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,
- 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,

- 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.
- 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.

INTAKE INTERVIEWS

Providers must conduct intake interviews in an efficient and effective manner that is both "person friendly," trauma-informed, and verifies the accurate collection of all required information necessary for enrollment into the system or for collection of information for AHCCCS eligible individuals who are already enrolled. The intake process must:

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

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

- The collection of contact information, insurance information, the reason why the person is seeking services and information on any accommodations the person may require to effectively participate in treatment services (i.e., need for oral interpretation or sign language assistance, consent forms in large font, etc.).
- The collection of required member information and completion of client member information sheet, including the Member's primary/preferred language;
- The completion of any applicable authorizations for the release of information to other parties;
- Advising the member that The Health Plan Member Handbook is available to them;
- The review and completion of a general consent to treatment;
- The collection of financial information, including the identification of third-party payers and information necessary to screen and apply for AHCCCS health insurance, when necessary;
- Advising Non-Title XIX/XXI persons determined to have a SMI that they may be assessed a copayment;

- The review and dissemination of The Health Plan Notice of Privacy Practices and the AHCCCS HIPAA Notice of Privacy Practices in compliance with 45 CFR 164.520 (c)(1)(B) (PDF); and
- The review of the person's rights and responsibilities as a member of services, including an explanation of the appeal process.

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

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

SPECIALTY BEHAVIORAL HEALTH AGENCY REFERRALS

All Health Plan contracted providers are responsible for ensuring timely and appropriate service delivery as requested by the member and/or as determined necessary to meet the member's needs. Specialty Behavioral Health Agencies (i.e., ABA, Support and Rehabilitation Services, Employment, etc.) are responsible for determining medical necessity for specialty services and regularly reporting progress to Behavioral Health Homes and PCPs as appropriate.

REFERRALS FOR SCREENING AND/OR DIAGNOSIS OF AUTISTM SPECTRUM DISORDERS

The Health Plan covers medically necessary behavioral health services for all AHCCCS-eligible children and adults, including the diagnosis and treatment for individuals who may have an Autism Spectrum Disorder (ASD). Care1st maintains a Center of Excellence (COE) for Autism Spectrum Disorder. For additional information refer to The Plan website (www.care1staz.com) and/or contact member services for information.

AHCCCS-eligible families who are engaged in services within the Health Plan, and who believe an adult or child may have ASD, should schedule an appointment with their psychiatrist, primary care or behavioral health provider.

Children and adults not currently engaged with a behavioral health provider in the Health Plan can contact their primary care provider, who can then refer the child and family to a specialized ASD diagnosing provider and/or a member can contact Care1st or contact a local behavioral health provider to schedule an appointment. Members are able to self-refer directly for services. Providers and/or members can find a list of diagnosing providers on The Plan website (www.care1staz.com) and/or can also contact member services for information.

In addition, if there is a diagnosis of Autism, per AMPM 310B families may choose to seek Applied Behavior Analysis (ABA) services. Behavior Analysts utilize contextual factors,

motivating operations, antecedent stimuli, positive reinforcement, and other consequences to help people develop new behaviors, increase, or decrease existing behaviors, and emit behaviors under specific environmental conditions. Refer to AMPM Policy 320-S for more information. Providers and/or members can find a listing of providers who deliver ABA on The Plan website (www.care1staz.com) and/or can also contact member services for information.

Members who need any assistance with establishing and/or connecting with services, or require any support, may receive this help through the Care1st Care Management Program. Please refer to Care Management section in the provider manual for additional information on how to refer.

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

PCPs are required to comply with The Health Plan, AHCCCS and RBHA or T/RBHA guidelines for referring their assigned members for behavioral health services. Referrals are based on, but not limited to:

- member request (members may also self-refer to a behavioral health provider);
- sentinel event, such as a member-defined crisis episode;
- psychiatric hospitalization;
- identification of behavioral health diagnosis outside the scope of the PCP or substance abuse disorder issues.

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: https://www.care1staz.com/find-a-doctor.html

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://www.care1staz.com/providers/resources/care-management.html
6. Establishing a collaborative relationship with neighboring contracted behavioral health providers

PCPs must transfer the member to a behavioral health provider contracting with The Health Plan (for dual- eligible members) or the Regional Behavioral Health Authority (RBHA) or Tribal/Regional Behavioral Health Authority (T/RBHA) if symptoms become severe or if the member needs additional behavioral health services. PCPs must ensure members are not simultaneously receiving behavioral health medication from both the behavioral health provider and PCP. When the member is identified to be simultaneously receiving medications from the PCP and behavioral health provider, the PCP must immediately contact the behavioral health provider to coordinate care and agree on who will continue to medically manage the person's behavioral health condition.

PCPs must use step therapy as needed for ADHD, anxiety disorder, mild depression, postpartum depression, and opioid use disorder (OUD). Step therapy is required for medication not on the Arizona Health Care Cost Containment System (AHCCCS) preferred drug list or behavioral health preferred drug list. This includes the requirement that if the PCP receives documentation from The Health Plan, or T/RBHA behavioral health providers regarding completion of step therapy, the PCP continues prescribing the same brand and dosage of current medication unless a change in medical condition is clearly evident.

Psychotropic medications are listed in The Health Plan Preferred Drug List, available on the provider website at www.care1staz.com. For additional information regarding pharmacy benefits, contact the Health Plan Pharmacy Department.

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, Support and Rehabilitation Services for children, youth, and young adults, or Employment Network Providers. Care1st maintains a list of TIC-certified therapists. For additional information contact the Behavioral Health department and/or Member 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 primary Behavioral Health provider for inclusion in the member's comprehensive Behavioral Health clinical record.

1.

SECTION VII: Behavioral Health Services

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
Providers must provide services in a culturally competent manner in accordance with The Health Plan Cultural Competency Plan.

Providers are required to:

- Provide a courteous, welcoming environment that provides persons with the opportunity to explore, identify, and achieve their personal goals;

- Engage persons in an empathic, hopeful, and welcoming manner during all contacts;
- Provide culturally relevant care that addresses and respects language, customs, and values and is responsive to the person's unique family, culture, traditions, strengths, and age, to meet the needs of members with diverse cultural and ethnic backgrounds, including those with limited English Proficiency, disabilities, and regardless of gender, sexual orientation, or gender identity;
- Provide an environment in which consumers from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices in the context of negotiating treatment options;
- Provide care by communicating to Members in their preferred language and verifying that they understand all clinical and administrative information;
- Be aware of and seek to gain an understanding of persons with varying disabilities and characteristics;
- Display sensitivity to, and respect for, various cultural influences and backgrounds (e.g., ethnic, racial, gender identity, sexual orientation, and socio-economic class);
- Establish an empathic service relationship in which the person experiences the hope of recovery and is considered to have the potential to achieve recovery while developing hopeful and realistic expectations;
- Demonstrate the ability to welcome the person, and/or the person's legal guardian, the person's family members, others involved in the person's treatment and other service providers as collaborators in the treatment planning and implementation process;
- Demonstrate the desire and ability to include the person's and/or legal guardian's viewpoint and to regularly validate the daily courage needed to recover from persistent and relapsing disorders;
- Assist in establishing and maintaining the person's motivation for recovery; and
- Provide information on available services and assist the person and/or the person's legal guardian, the person's family, and the entire clinical team in identifying services that help meet the person's goals.
- For members with an SMI who are receiving Special Assistance, the person designated to provide Special Assistance per AHCCCS AMPM Policy 320-R.
- The Contractor shall ensure providers engage incarcerated members with high incidence or prevalence of behavioral health issues, or who are underserved as specified in AMPM Policy 1022.

See AMPM Policies:
1040, found at:
https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/1000/1040.pdf

310-B found at:
https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/310B.pdf

1022 found at:
https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/1000/1022.pdf

320-R found at:
https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320R.pdf

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.
- For persons determined to have a Serious Mental Illness who are receiving Special Assistance (see AHCCCS AMPM section 320-R)

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

a. Members with an SMI or SED designation
b. Members on court ordered treatment,
c. Members with a history of justice involvement
d. Children, pregnant women, and/or teenagers with a substance use 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
g. Members experiencing, or at risk of experiencing homelessness.

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.

Re-Engagement for Members on Court Ordered Treatment

"For members who are on Court Ordered Treatment, it is the expectation that providers will re-engage within 24 hours of a missed appointment and continue frequent re-engagement efforts until such a time as the member is re-engaged and adherent with treatment, the court order is amended/revoked with the person placed in a psychiatric facility, or it has been confirmed that the member is now living in a different Regional Behavioral Health Authority/Managed Care Organization/Health Plan area or that the member has permanently moved out of state".

- If a member misses a Behavioral Health Medical Provider (BHMP) appointment, whether it is because the member canceled, no-showed, or the provider canceled the appointment, Re-engagement attempts should immediately be started to reschedule the missed BHMP appointment. The appointment should be rescheduled so that the requirement of a monthly appointment is met.
- BHMP emergency appointment slots should be utilized to accommodate this appointment.
- Missed appointments and non-adherence to the treatment plan should prompt the treatment team to re-evaluate the treatment plan to ensure that it is meeting the member's needs and goals. A member's input into the plan, with attention to achieving their goals as much as possible, will help with engagement. Any barriers to attending appointments should be assertively and creatively addressed, for example a member's difficulties with communication, transportation, competing commitments, childcare, managing schedules, etc. The treatment plan should be as flexible and personalized as possible to facilitate each member's adherence.
- If maximal effort to re-engage a member into outpatient treatment fails, the treatment team should file a revocation so that the member may be assessed in a crisis setting. This is especially important if the member has missed an injection as a result of missing their outpatient appointment. Whether or not the member is hospitalized as a result of the revocation, revocations are another opportunity to re-engage the member and amend the treatment plan with the member's input.
- If a provider does not reschedule the missed appointment within two business days, the provider should not revoke the member for this reason alone. Instead, the provider must make arrangements to reschedule the member as soon as possible.

Providers should not revoke a member due to a provider administrative or coordination issue.

Follow-Up After Missed Appointments
Providers are required to contact all persons who miss scheduled appointments without rescheduling. Providers must contact the person following a missed appointment or as soon as possible but no later than two workdays after the missed appointment. Documentation of all attempts to reach the person shall be documented in the person's medical record. At least three attempts shall be made to reschedule a missed appointment and shall include contacts made by certified mail and telephone. Face-to-face outreach shall be required for all persons receiving medication services, all individuals identified to be at risk, or to persons who have reported danger to self/danger to others thoughts in the last year. All outreach attempts shall be completed within thirty days of a missed appointment.

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

Additionally, for persons released from jail or hospital settings, outpatient providers must help establish priority prescribing clinician appointments based on the needs of the member but no later than 7 days of the person's release to ensure client stabilization, medication adherence, and to avoid re-hospitalization.

Ending Treatment for Members in Behavioral Health System
Providers may not end a member's treatment because of an adverse change in the member's health status or because of the member's utilization of medical services, diminished capacity, or uncooperative or disruptive behavior. Providers must not arbitrarily or prematurely reject or eject a member from services without prior authorization of The Health Plan. However, under certain circumstances, it may be appropriate or necessary to close a person's chart for administrative reasons, or after re-engagement efforts described above have been expended.

Children Held at County Detention Facilities
Providers must check the AHCCCS Pre-paid Medical Management Information System (PMMIS) to determine eligibility for treatment services prior to the delivery of each behavioral health service to a child who is held in a county detention facility.

Contact the Health Plan for assistance when a child loses their Title XIX/XXI eligibility while in detention. Children who lose their eligibility or have their eligibility suspended while temporarily in detention may be eligible for Mental Health Block Grant (MHBG) funded services, depending on availability of funds and prior approval of AHCCCS. Funding availability may vary from year to year based on the availability of applicable Non-Title XIX/XXI funds. Funding for services for Adolescents in detention must be approved by AHCCCS based on an approved Health Plan comprehensive work plan (Reference AMPM 320 T1 for additional information and requirements)

Even when funding is not available, Behavioral Health Homes are required to maintain contact with children in detention and during the 30-day period prior to release to facilitate appropriate release planning.

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

In order for AHCCCS to monitor any change in a member's legal status, and to determine eligibility, The Health Plan providers are required to notify The Health Plan and AHCCCS via e-mail, and if they become aware that an AHCCCS eligible member is incarcerated. AHCCCS has established an email address for this purpose. Notifications shall be sent via email to the following email address: MCDUJustice@azahcccs.gov. Notifications must include the following Member information:

- AHCCCS ID;
- Name;
- Date of Birth;
- Incarceration date; and
- Where incarcerated.

Behavioral Health Homes are required to maintain contact with persons in detention and during the 30-day period prior to release to facilitate appropriate release planning. These coordination of care services are funded through state funds and block grant funds.

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/AODA Information Management/Data Analytics Unit Manager and AODA Analytics Administrator for DHCM/AODA . In addition, technical support for the portal can be obtained at ISDCustomerSupport@azahcccs.gov or 602-417-4451.

Serving Members 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

All persons being served in the public behavioral health system must have a behavioral health assessment upon an initial request for services. For persons who continue to receive services, updates to the assessment must occur at least annually. Behavioral health assessments must be utilized to collect necessary information that will inform providers of how to plan for effective care and treatment of the individual.

AHCCCS does not mandate that a specific assessment tool or format be used but requires certain minimum elements. Providers must collect and submit all required member information in accordance with the criteria outlined in the AHCCCS Demographic and Outcome Data Set User Guide (DUG).

The initial and annual assessment must be completed by a behavioral health professional (BHP) or behavioral health technician (BHT) under the clinical oversight of a BHP, trained on the minimum elements of a behavioral health assessment and who meets the necessary training requirements.

Assessment Requirements

AHCCCS has established the following minimum elements that must be included in a comprehensive behavioral health assessment and documented in the comprehensive clinical record, in accordance with AHCCCS AMPM Section 320-O, Behavioral Health Assessment and Treatment Service Planning Providers are required to have policies in place to monitor accuracy and completion of the behavioral health assessment.

For persons referred for or identified as needing ongoing psychotropic medications for a behavioral health condition, the assessor must establish an appointment with a licensed medical practitioner with prescribing privileges, in accordance with Appointment Standards and Timeliness of Service. If the assessor is unsure regarding a person's need for psychotropic medications, then the assessor must review the initial assessment and treatment recommendations with their clinical supervisor or a licensed medical practitioner with prescribing privilege.

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.
D. The outpatient provider of behavioral health services is responsible for maintaining all behavioral health assessments within the medical record, and for ensuring periodic assessment updates are completed to meet the changing behavioral health needs for members who continue to receive behavioral health services.
E. If an assessment was completed by another provider or prior to outpatient treatment, the provider must review, update and document member's assessment information per A.A.C. R9-10-1011
F. All providers shall maintain an immediately accessible copy of the member's assessment (see AMPM Policy 940)

2. The Assessment, Service, and Treatment Plan are included in the medical record in accordance with AMPM Policy 940,
3. 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. Change in level of care
    vii. Incarceration, and
    viii. Any event which may cause a disruption of normal life activities, based on a member's identified perspective, and need.

Behavioral Health Assessments

Assessments

1. Individuals receiving behavioral health services receive a comprehensive behavioral health assessment. The assessment conducted is in compliance with the Rules set forth in A.A.C. Title 9, Chapters 10 and 21, and/or ACOM Policy 417, as applicable.

2. The outpatient provider of behavioral health 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.
    a. The behavioral health provider documents in the member's medical record that the assessment has been shared with the member's PCP.
        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.
    b. 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.
3. Additional Assessments

a. Children birth 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 Policy 461. The Early Childhood Service Intensity Instrument (ECSII) is not required, but may be utilized, as an additional option for identifying developmental concerns for children birth through five. This information shall be shared with the providers involved in the child's treatment and care, Tribal ALTCS case manager or the TRBHA.
b. Children Ages six through 17 – an age-appropriate assessment will be completed by the outpatient provider during the initial assessment and updated at least every six months. This information shall be shared with the providers involved in the child's treatment and care, Tribal ALTCS case manager or the TRBHA.
c. Children Ages six through 17 – Strengths, Needs and Culture Discovery Document will be completed and shared with the providers involved in the child's treatment and care, Tribal ALTCS case manager or the TRBHA.
d. Children Ages 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.

BEHAVIORAL HEALTH SERVICES FOR CHILDREN IN DCS CARE, KINSHIP PLACEMENT OR ADOPTED

The Health Plan and our contracted children's behavioral health providers, ensure the provision of timely behavioral health services to children enrolled with the Health Plan who may be residing with an out-of-home caregiver, may be adopted or may be placed in an out-of-home dependency with the Department of Child Safety (DCS). The Health Plan and our contracted children's providers coordinate care between the out-of-home caregiver or adoptive parent(s), all providers and DCS as appropriate.

1. Request for Behavioral Health Out-of-Home Treatment:
    a. After a request is made to place a child in a behavioral health out-of-home treatment setting, the Health Plan issues a determination as to that request no later than 72 hours or as expeditiously as the member's health condition warrants due to the member displaying dangerous or threatening behaviors directed towards themselves or others. These settings include behavioral

health residential facilities, therapeutic foster homes and behavioral health in-patient facilities. In the event the Health Plan determines there is insufficient information to make a determination, the behavioral health provider is required to assist the health plan to obtain required information within the 72-hour timeframe. In the event the request for behavioral out-of-home treatment is denied, the contracted behavioral health provider and the health plan ensures medically necessary alternative services are offered to the member and caregivers.

b. If the member is hospitalized due to threatening behaviors prior to a determination on the request for behavioral health out-of-home treatment, the Health Plan coordinates with the hospital and out-patient behavioral health provider to ensure an appropriate and safe discharge plan. The discharge plan includes recommended follow-up services including CFT recommendations in accordance with AMPM 1020.

c. The Health Plan issues a Notice of Adverse Benefit Determination (NOA) as specified in ACOM Policy 414 for any adverse action related to the request for behavioral health out-of-home treatment.

2. Behavioral Health Appointment Standard:
   a. Upon notification from an out-of-home caregiver or Adoptive Parent(s) that a recommended behavioral health service has not provided to a member (as specified in ACOM Policy 417), the Health Plan and contracted providers are aware of the requirement to also report the failure to receive the approved behavioral health services to the AHCCCS Clinical Resolution Unit at 602-364-¬4558 or 1-800-867-5808, or by email at DCS@azahcccs.gov.
      i. The Health Plan and contracted providers notifies the member's Health Care Decision Maker (HCDM) that the member may receive services directly from any AHCCCS registered provider, regardless of whether the provider is contracted with the Health Plan,
      ii. Obtain the name and contact information of the identified non-contracted provider of service, if applicable to verify their AHCCCS registration, and
      iii. Obtain information needed to determine medical necessity of requested services not received.
3. Education:
   a. The Health Plan and contracted children's out-patient behavioral health providers are responsible for providing education to providers, members, families, and other parties involved with the member's care, on an ongoing basis. This includes but is not limited to, the following areas:
      i. Rights and responsibilities as delineated in A.R.S. § 8-512.01.
      ii. Trauma-informed care.
      iii. Navigating the behavioral health system.
      iv. Coordination of Care with all providers.
      v. Covered services.

vi. Referral process including Arizona Families First (Family in Recovery Succeeding Together, AFF).
vii. The role of the health plan.
viii. The role of DCS, as applicable.
ix. Additional trainings identified by the Member Advisory Council or obtained via stakeholder input.

Social Determinants of Health and Specific Behavioral Health Home Housing Screening and Service Requirements

AHCCCS and the Health Plan collect and track member outcomes related to Social Determinants of Health. The use of specific International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) diagnostic codes representing Social Determinants of Health are a valuable source of information related to member health.

The Social Determinants of Health codes identify conditions in which people are born, grow, live, work, and age. They are often responsible, in part, to health inequities. They include factors such as

- Education
- Employment
- Physical environment
- Socioeconomic status, and
- Social support networks.

As appropriate and within a scope of practice, providers should be routinely screening for, and documenting, the presence of social determinants. Any identified social determinant diagnosis codes should be provided on all claims for AHCCCS members in order to comply with state and federal coding requirements.

Behavioral Health Homes are required to coordinate with the AHCCCS Housing Administrator to secure a Housing Management Information System (HMIS) license in order to ensure that members are entered into the Care1st Health Plan Coordinated Entry. The Health Plan requires that providers complete a homeless assessment using the Vulnerability Index Service Prioritization Decision Assistance Tool (VI SPDAT) for all members experiencing homelessness, at risk of homelessness, or request assistance with housing.

The Behavioral Health Home must then enter the VI SPDAT assessment for each member into the Continuum of Care (CoC) Care1st Health Plan Coordinated Entry through the Homeless Management Information System (HMIS) database referring the member to the Health Plan Coordinated Entry Housing list. Members meeting the HUD definition of homelessness will also be entered into the CoC Coordinated Entry List. This step will open

housing opportunities beyond the Health Plan housing programs for members experiencing homelessness, assist providers in maintaining contact with those members, and ensure heightened coordination and collaboration with the full network of homeless and housing services available in local communities.

Behavioral Health Homes serving adults are required to identify and screen members; including members with SMI that satisfy Section 8 criteria and refer prospective tenant to the appropriate contracted Public Housing Authority. Providers are required to participate with the individual's treatment team in order to identify available housing units and to place the individual in an affordable appropriate living environment upon discharge from an institutional setting.

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 primary behavioral health agency 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.

Appeals or Service Plan Disagreements

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

Despite a behavioral health provider's best effort, it may not be possible to achieve consensus when developing the service plan. In cases that the person and/or legal or designated representative disagree with some or all of the Title XIX/XXI covered services included in the service plan, the person and/or legal or designated representative must be given the opportunity to obtain a second opinion from an in-network provider or, if necessary, an out-of-network provider at no cost.

In cases that a person determined to have a SMI and/or legal or designated representative disagree with some or all of the Non-Title XIX/XXI covered services included in the service plan, the person and/or legal or designated representative must be given a copy of the Appeal or Serious Mental Illness Grievance Form located in the AHCCCS ACOM Chapter 400, Section 446, Attachment A by the behavioral health representative on the team.

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

Updates to the Assessment and Service Plan

Providers must complete an annual assessment update with input from the Member and family, if applicable, that records a historical description of the significant events in the person's life and how the person/family responded to the services/treatment provided during the past year. Following this updated assessment, the service plan should then be updated as necessary. While the assessment and service plan must be updated at least annually, the assessment and service plan may require more frequent updates to meet the needs and goals of the Member and their family. Providers must have a policy in place to monitor timely updates of both assessments and services plans.

Safety Planning

General Purpose of a Crisis and Safety Plan

A 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. A 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 the Safety Plan will be completed in alignment with the member's Service and Treatment Plan, and any existing Behavior plan if applicable. Safety Plans

will be considered when any of the following clinical indicators are identified in a member's treatment, service or behavioral plan:

a) Justice Involvement
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 or present concern of DTS/DTO
g) Members with an SMI designation,
h) Members identified as High Risk/High Needs, and/or
i) Children ages 6-17 with a CALOCUS Level of 4, 5, or 6.

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 Safety Plan will be distributed to the team members that assisted with development of the Safety Plan.

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

Essential Elements

A 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) Realistic interventions that are most helpful to the individual and his/her family members or support system,
c) Guiding the support system toward ways to be most helpful to members and their families.
d) Multisystem Involvement Adherence to COT if applicable. 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, DR, environmental
    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, roommates, housing, financials, medical needs, schoolwork).

SECTION VII: Behavioral Health Services

Psychotropic Medications
For members 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)

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). Providers should coordinate medical and physical care, to include applying for medical and behavioral health care coverage, including how to select a health plan and a physician.
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. Children turning 18 years of age may also choose to remain with their current Behavioral Health Provider, transfer to another provider as desired or clinically indicated, or close out the behavioral health system entirely.

Providers are required to screen for the conditions of Social Determinants of Health with an approved AHCCCS SDOH screening tool before linking the Young Adult to community based organizations to address the needs.

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)

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. Courses are available online, which include Transition to Independence Process and AHCCCS Policy 280: Transition to Adulthood. 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.

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)
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.

SECTION VII: Behavioral Health Services

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.

REQUIREMENTS OF ORGANIZATIONS PROVIDING EMPLOYMENT SERVICES

All contracted behavioral health providers and integrated health care providers are required to deliver or assist members in obtaining employment and rehabilitation services. Provider Organizations delivering and billing employment and rehabilitation related activities shall employ at least one fully dedicated Employment Specialist. Provider Organizations delivering and billing for employment and rehabilitation services are required to employ an adequate number of fully dedicated Employment Specialists to meet the needs of the

members served in each clinic. It may be permissible for the employment/rehabilitation staff to cover more than one clinical team or split time with other duties, based on staffing, availability, regional locations and enrollment numbers, with prior approval from the Health Plan Employment Administrator and AHCCCS.

Provider Organizations delivering employment and rehabilitation services are required to:

- Monitor employment service utilization including job placement data and ensure accurate and reliable employment status within the Supplemental Member Data Provider Portal.
- Implement Supported Employment and meet SAMHSA Supported Employment fidelity.
- Fulfill the requirements listed in all employment Technical Assistance Documents and provide annual training to all clinical staff on the Technical Assistance Documents.
- Provide benefits planning utilizing Disability Benefits 101 (www.db101.org).
- Adhere to the guidelines within the Interagency Service Agreement (ISA) between AHCCCS and ADES/RSA.
- Provider Organizations serving adults determined Seriously Mentally Ill (SMI) are responsible for ensuring at least a 7% of members with SMI determinations are engaged with RSA/VR services versus the providers' overall enrollment of members with SMI determinations.
- Make all reasonable efforts to become mutually contracted with ADES/RSA.
- Adhere to ACOM Policy 447: (www.azahcccs.gov/shared/Dowloads/ACOM/PolicyFiles/400/447.pdf)

Employment Specialists must:

- Connect members to sustainable employment resources in the community including RSA/VR, AZ@Work, Linkages of Arizona, etc.
- Provide individualized supports to assist members in obtaining and maintaining competitive employment.
- Fulfill responsibilities listed in the ISA/Collaborative Protocol with ADES/RSA and refer all adults interested in employment services to the RSA/VR Program.
- Participate in Health Plan sponsored meetings/events and ad hoc coordination meetings with AHCCCS and ADES/RSA.

SMI AND SED ELIGIBILITY DETERMINATIONS

In order to ensure that persons with a serious mental illness(SMI) or serious emotional disturbance (SED) are promptly identified and enrolled for services, AHCCCS has developed a standardized process for the referral, evaluation, and determination for SMI

and SED eligibility. The requirements associated with the referral for a SMI or SED evaluation and eligibility determination are set forth in AHCCCS 320P Eligibility Determinations for Individuals with Serious Emotional Disturbance and Serious Mental Illness. Additionally, the SMI and SED Determination Forms are found at https://community.solari-inc.org/eligibility-and-care-services/provider-forms/.

CRITERIA FOR SMI AND SED ELIGIBILITY

1. All individuals from birth to 18 years old shall be evaluated for SED eligibility by a qualified clinician and have an SED eligibility determination made by the determining entity if the individual or their Health Care Decision Maker (HCDM) makes such a request.
2. Individuals 17.5 or older will be evaluated for SMI eligibility by a qualified clinician as defined in A.A.C. R9-21-101(B) , and have an SMI eligibility determination made by the determining entity if:
3. The individual makes such a request,
4. A HCDM makes a request on behalf of the individual,
5. An Arizona Superior Court issues an order for the individual to undergo and SMI evaluation/determination.
    a. Clinically indicated by the presence of a qualifying diagnosis, or
    b. There is reason to believe that the assessment may indicate the presence of a qualifying diagnosis and functional limitation(s).
6. The SMI assessment and evaluation process may begin for an individual at 17.5 years of age, while the SMI eligibility category will not become effective until age 18 years of age.
7. The SED or SMI eligibility record shall contain all of the documentation that was considered during the review including, but not limited to, current and/or historical treatment records. The record may be maintained in either hardcopy or electronic format.
8. The Health Plan, Tribal ALTCS, and TRBHA case manager shall develop and make available to providers any requirements or guidance on SED and SMI eligibility evaluation record location and/or maintenance.
9. Computation of time is as follows:
    a. Day Zero: The day the initial assessment is completed by a qualified clinician, regardless of time of the assessment,
    b. Day One: The next business day after the initial assessment is completed. The individual or organization completing the initial assessment must provide it to the determining entity as soon as practicable, but no later than 11:59 pm on day one.
    c. Day Three: The third business day after the initial assessment is completed. The determining entity will have at least two business days to complete the final SMI eligibility determination, but the final SMI eligibility determination will be completed no later than day three, and

d. Determination Due Date: Day Three (three business days after Day Zero, excluding weekends and holidays) is the date that the determination decision shall be rendered. This date may be amended if an extension is approved in accordance with this policy.

10. Tribal ALTCS or TRBHA program may delegate to the determining entity all the responsibilities specified in this Policy and/or as contained in their Intergovernmental Agreement (IGA) as it relates to eligibility determinations.

Process for Completion of the Initial SED or SMI Assessment:

1. Upon receipt of a referral, a request, or identification of the need for SED or SMI Eligibility Determination, the receiving party (Health Plan care coordinators, the individual's contracted Behavioral Health provider, Tribal ALTCS, TRBHA case manager, the FFS provider for members enrolled in AIHP, or designated Arizona Department of Corrections (ADC) or Arizona Department of Juvenile Corrections (ADJC) staff) will schedule an assessment with the individual and a qualified clinician if one has not been completed within the last six months. This will occur as expeditiously as the member's health condition requires, but no later than seven business days after receiving the request or referral.
2. For urgent eligibility determination referrals for individuals admitted to a hospital for psychiatric reasons, the determining entity can accept an assessment completed by the hospital, so long as it meets the criteria needed to render a decision.
3. During the assessment meeting with the individual, the clinician shall:
    a. Make a clinical judgment as to whether the individual is competent enough to participate in an evaluation,
    b. Obtain written consent to conduct the assessment from the individual or, if applicable, the individual's HCDM, unless the individual has been ordered to undergo evaluation as part of Court Ordered Treatment (COT) proceedings,
    c. Provide to the individual and, if applicable, the individual's HCDM, 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),
    d. Obtain authorization for the release of information, if applicable, (as specified in AMPM Policy 940) for any documentation that would assist in the determination of the individual's eligibility for SED or SMI designation,
    e. Conduct an assessment that is an accurate representation of the member's current level of functioning if one has not been completed within the last six months,
    f. Complete the SED or SMI eligibility determination packet on the SMI Provider Submission Portal, and
    g. Upon completion, submit all information to the Determining Entity within one business day.

Criteria for SED Eligibility:

1. The final determination of SED requires both a qualifying SED diagnosis and functional impairment because of the qualifying diagnosis. Refer to Prepaid Medical Management Information System (PMMIS) screen RF260 and the Medical Coding Page on the AHCCCS website for a list of qualifying diagnoses.
2. To meet the functional criteria for SED, an individual shall have, because of a qualifying SED diagnosis, dysfunction in at least one of the following four domains, as specified below, for most of the past six months, or for most of the past three months with an expected continued duration of at least three months:

a. Seriously disruptive to family and/or community. Pervasively or imminently dangerous to self or others' bodily safety. Regularly engages in assaultive behavior. Has been arrested, incarcerated, hospitalized or is at risk of confinement because of dangerous behavior. Persistently neglectful or abusive towards others. Severe disruption of daily life due to frequent thoughts of death, suicide, or self-harm, often with behavioral intent and/or plan. Affective disruption causes significant damage to the individual's education or personal relationships,

b. Dysfunction in role performance. Frequently disruptive or in trouble at home or at school. Frequently suspended/expelled from school. Major disruption of role functioning. Requires structured or supervised school setting. Performance significantly below expectation for cognitive/developmental level. Unable to attend school or meet other developmentally appropriate responsibilities,

c. Child and Adolescent Level of Care Utilization System (CALOCUS) recommended level of care 4, 5, or 6, or

d. Risk of deterioration:

   i. A qualifying diagnosis with probable chronic, relapsing, and remitting course,

   ii. Co-morbidities (e.g., developmental/intellectual disability, Substance Use Disorder (SUD), personality disorders),

   iii. Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors (e.g., life-threatening or debilitating medical illnesses, victimization), or

   iv. Other (e.g., past psychiatric history, gains in functioning have not solidified or are a result of current compliance only, court-committed, care is complicated and requires multiple providers).

3. An inability to obtain existing records or information, or lack of a face-to-face psychiatric or psychological evaluation shall not be sufficient in and of themselves for denial of SED eligibility.

Criteria for SMI Eligibility:

1. The final determination of SMI requires both a qualifying SMI diagnosis and functional impairment because of the qualifying diagnosis. Refer to PMMIS screen RF260 and the Medical Coding Page on the AHCCCS website for a list of qualifying diagnoses.

2. To meet the functional criteria for SMI status, an individual shall have, because of a qualifying SMI diagnosis, dysfunction in at least one of the following four domains, as specified below, for most of the past 12 months, or for most of the past six months with an expected continued duration of at least six months:

a. Inability to live in an independent or family setting without supervision – neglect or disruption of ability to attend to basic needs, including but not limited to, hygiene, grooming, nutrition, medical care and/or dental care. Needs assistance in caring for self. Unable to care for self in a safe or sanitary manner. Housing, food, and clothing is or shall be provided or arranged for by others. Unable to attend to the majority of basic needs of hygiene, grooming, nutrition, medical and dental care. Unwilling to seek prenatal care or necessary medical/dental care for serious medical or dental conditions. Refuses treatment for life threatening illnesses because of behavioral health disorder, a risk of serious harm to self or others,

b. Seriously disruptive to family and/or community. Pervasively or imminently dangerous to self or others' bodily safety. Regularly engages in assaultive behavior. Has been arrested, incarcerated, hospitalized or is at risk of confinement because of dangerous behavior. Persistently neglectful or abusive towards others. Severe disruption of daily life due to frequent thoughts of death, suicide, or self-harm, often with behavioral intent and/or plan. Affective disruption causes significant damage to the individual's education, livelihood, career, or personal relationships,

c. 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

d. Risk of deterioration.
    i. A qualifying diagnosis with probable chronic, relapsing, and remitting course,
    ii. Co-morbidities (e.g., developmental/intellectual disability, Substance Use Disorder (SUD), personality disorders),
    iii. Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors (e.g., life-threatening or debilitating medical illnesses, victimization), or
    iv. Other (e.g., past psychiatric history, gains in functioning have not solidified or are a result of current compliance only, court-committed, care is complicated and requires multiple providers).

3. The following reasons shall not be sufficient in and of themselves for denial of SMI eligibility:
    i. An inability to obtain existing records or information, or
    ii. Lack of a face-to-face psychiatric or psychological evaluation.

Individuals With Co-Occurring Substance Use:

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

preclude them from the SED or SMI eligibility assessment and determination process.

Process for Completion of Final SED or SMI Eligibility Determination:

1. The Health Plan shall develop and make available to its providers, policies and procedures that describe the providers' requirements for submitting the evaluation packet and providing additional clinical information for the determining entity to make the final SED or SMI eligibility determination.
2. In the event the determining entity requires additional information to make a final SED or SMI eligibility determination, the evaluating agency shall respond to the determining entity within three business days of request of the information.
3. The licensed psychiatrist, psychologist, or nurse practitioner designated by the determining entity shall make a final determination as to whether the individual meets the eligibility requirements for SED or SMI status based on:
    a. A face-to-face assessment or reviewing a face-to-face assessment by a qualified clinician, and
    b. 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.
4. The following shall 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 (BHP) or Behavioral Health Technician (BHT) that cannot be resolved by oral or written communication:
    a. Disagreement regarding diagnosis: determination that the individual does not meet eligibility requirements for SED or SMI status shall 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 individual's comprehensive clinical record, and
    b. Disagreement regarding functional impairment: determination that the individual does not meet eligibility requirements shall be documented by the psychiatrist, psychologist, or nurse practitioner in the individual's comprehensive clinical record to include the specific reasons for the disagreement and will include a clinical review with the qualified clinician.
5. If there is sufficient information to determine SED or SMI eligibility, the determining entity shall provide the individual with notice, in writing, of the SED or SMI eligibility determination (Notice of Decision) within three business days of the initial meeting with the qualified clinician as specified within this Policy.
6. The determining entity shall provide notification of the eligibility determination result to AHCCCS via the AHCCCS Behavioral Health Web Portal and to the provider who completed the Assessment/Evaluation through an agreed upon medium. For AIHP members, the determining entity shall also provide notification to AHCCCS/DFSM at casemanagers@azahcccs.gov or to the appropriate TRBHA,

when applicable. For Tribal ALTCS members, the determining entity shall also provide notification to the individual's Tribal ALTCS case manager. For DDD THP members, the determining entity shall also provide notification to AHCCCS/DFSM at thp-altcs@azahcccs.gov.

7. Once an SED or SMI eligibility determination decision is made and submitted to AHCCCS, AHCCCS will update the member's behavioral health category to SED or SMI respectively and will provide the eligibility determination documentation to the MCO of enrollment or AIHP, as applicable, via the AHCCCS Secured File Transfer Protocol (SFTP) server.

Issues Preventing Timely Completion of Eligibility Determination – Extending Completion of Eligibility Determination Time Period:

1. The time to initiate or complete the SED or SMI eligibility determination may be extended no more than 20 days if the individual agrees to the extension, and:
    a. There is substantial difficulty in scheduling a meeting at which all necessary participants can attend,
    b. The individual fails to keep an appointment for assessment, evaluation or any other necessary meeting,
    c. The individual is capable of, but temporarily refuses to cooperate in the preparation of the completion of an assessment or evaluation,
    d. The individual or the individual's HCDM requests an extension of time,
    e. Additional documentation has been requested but has not yet been received, or
    f. There is insufficient functional or diagnostic information to determine SED or SMI eligibility within the required time periods.
2. Insufficient diagnostic information shall be understood to mean that the information available to the reviewer is suggestive of two or more equally likely working diagnoses, only one of which qualifies as SED or SMI, and an additional piece of existing historical information or a face-to-face psychiatric evaluation is likely to support one diagnosis more than the other(s).
3. The determining entity shall:
    a. Document the reasons for the delay in the individual's eligibility determination record when there is an administrative or other emergency that will delay the determination of an SED or SMI status, and
    b. Not use the delay as a waiting period before determining SED or SMI status or as a reason for determining that the individual does not meet the criteria for SMI eligibility (because the determination was not made within the time standards).
4. In situations in which the extension is due to insufficient information:
    a. The determining entity shall request and obtain the additional documentation needed (e.g., current and/or past medical records) and/or perform or obtain any necessary psychiatric or psychological evaluations,

   b. The designated reviewing psychiatrist, psychologist, or nurse practitioner shall communicate with the individual's current treating clinician, or appropriate clinical team member, if any, prior to the determination of SED or SMI, if there is insufficient information to determine the individual's level of functioning, and
   c. Eligibility shall be determined within three days of obtaining sufficient information, but no later than the end date of the extension.
5. If the evaluation or information cannot be obtained within the required time period because of the need for a period of observation or abstinence from substance use in order to establish a qualifying mental health diagnosis, the individual is notified by the Determining Entity that the determination may, with the agreement of the individual, be extended for up to 60 calendar days for an Extended Evaluation Period (EEP). This is a 60-day period of abstinence or reduced use from drug and/or alcohol use in order to help the reviewing psychologist make an informed decision regarding SED or SMI eligibility.

This extension may be considered a technical re-application to ensure compliance with the intent of A.A.C. R9-21-303. However, the individual does not need to actually reapply. Alternatively, the determination process may be suspended, and a new application initiated upon receipt of necessary information.

If the individual refuses to grant an extension, SED or SMI eligibility must be determined based on the available information. If SED or SMI eligibility is denied, the individual will be notified of their appeal rights and the option to reapply in accordance with this Policy.

Notification of SED or SMI Determination

1. If the individual is determined to qualify for an SED or SMI designation, this shall be reported to the individual or their HCDM by the determining entity in writing, including notice of the individual's right to appeal the decision, on the form approved by AHCCCS.
2. If the eligibility determination results in a determination that an individual does not qualify for SED or SMI designation, the determining entity shall provide written notice of the decision and include:
   a. The reason for denial of SED or SMI eligibility
   b. The right to appeal, and
   c. The statement that Title XIX/XXI eligible individuals will continue to receive needed Title XIX/XXI covered services. In such cases, the individual's behavioral health category assignment shall be assigned based on criteria in the AHCCCS technical interface guidelines.

Reenrollment or Transfer

1. If the individual's status is SED or SMI at disenrollment, while incarcerated, or when transitioning to another health plan, AIHP, Tribal ALTCS, TRBHA, or DDD THP, the individual's status shall continue as SED or SMI.
2. An individual will retain their SED or SMI status unless a determination is made by the determining entity that the individual's enrollment remains active and the individual no longer meets criteria.
3. The Health Plan or behavioral health provider shall ensure that the SMI determination process is initiated for adolescents as specified in AMPM Policy 467 and AMPM Policy 520.

Removal of SED or SMI Designation

1. The Health Plan shall make available to their providers the policies and procedures for reviewing an SED or SMI designation.
2. A review of the eligibility determination may not be requested within the first six months from the date an individual has been designated as SED or SMI eligible.
3. The Health Plan, Tribal ALTCS case manager, TRBHA, or behavioral health providers may request a review of an individual's SED or SMI designation from the determining entity:
    a. As part of an instituted, periodic review of all individuals designated to have an SED or SMI,
    b. When there has been a clinical assessment that supports that the individual no longer meets the functional and/or diagnostic criteria, or
    c. As requested by an individual who has been determined to meet SED or SMI eligibility criteria, or their HCDM.
4. Based upon review of the individual's request and clinical data provided, removal of SED or SMI behavioral health category will occur if:
    a. The individual is an enrolled member and has not received any behavioral health service within the previous six months, or
    b. The individual is determined to no longer meet the diagnostic and/or functional requirements for SED or SMI designation.
5. In the event of the Removal of Designation, the determining entity shall:
    a. Inform the individual of changes that may result with the removal of the individual's SED or SMI designation,
    b. Provide written notice of the determination and the right to appeal to the affected individual with an effective date of 30 calendar days after the date the written notice is issued, and
    c. The Health Plan or behavioral health provider shall ensure that services are continued in the event an appeal is timely filed, and that services are appropriately transitioned.

SECTION VII: Behavioral Health Services

CRISIS INTERVENTION SERVICES

Crisis intervention services are provided to a person for the purpose of stabilizing or preventing a sudden, unanticipated, or potentially dangerous behavioral health condition, episode, or behavior. Crisis intervention services are provided in a variety of settings, such as hospital emergency departments, face-to-face at a person's home, over the telephone, or in the community. These intensive and time limited services may include screening, (e.g., triage and arranging for the provision of additional crisis services) assessing, evaluating, or counseling to stabilize the situation, medication stabilization and monitoring, observation and/or follow-up to verify stabilization, and/or other therapeutic and supportive services to prevent, reduce or eliminate a crisis situation.

At the time behavioral health crisis intervention services are provided, a person's enrollment or eligibility status may not be known. However, crisis intervention services must be provided, regardless of enrollment or eligibility status.

Any person presenting with a behavioral health crisis in the community, regardless of Medicaid eligibility or enrollment status, is eligible for crisis services. Collaboration agreements between Health Plans and local law enforcement/first responders address continuity of services during a crisis, jail diversion and safety, and strengthening relationships between first responders and providers.

Overview of Crisis Intervention Services

To meet the needs of individuals in communities throughout Arizona, The Health Plan provides the following crisis services:

- Telephone crisis intervention services provided by The Health Plan contracted Crisis Call Center available 24 hours per day, seven days a week:
    - Arizona residents can access crisis services by calling the statewide crisis line at 844-534-4673 (HOPE).

- Mobile crisis intervention services, commonly known as Crisis Mobile Teams (CMTs), are available 24 hours a day, seven days a week.
    - If one person CMT responds, this person shall be a Behavioral Health Professional or a Behavioral Health Technician.
    - If a two-person CMT responds, one person may be a Behavioral Health Paraprofessional, including a peer or family member, provided they have supervision and training as currently required for all mobile team members.
    - Peers should comprise 25% of each CMT provider's CMT staff.
- Crisis stabilization/observation services, including detoxification services;
    - The Health Plan provides crisis stabilization and detoxification services through Behavioral Health Inpatient Facilities, Behavioral Health Hospital Facilities, and Substance Abuse Transitional Facilities.
    - Arizona residents can access crisis services by calling the statewide crisis line at 844-534-4673 (HOPE).

- Up to 24 hours of additional crisis stabilization as funding is available for mental health and substance abuse disorder related services.

Management of Crisis Services
The Health Plan maintains availability of crisis services in each county served. The Health Plan utilizes the following in managing crisis services:

- The Health Plan allocates and manages funding to maintain the availability of required crisis services for the entire fiscal year;
- The Health Plan works collaboratively with local hospital-based emergency departments to determine whether a The Health Plan-funded crisis provider should be deployed to such locations for crisis intervention services;
- The Health Plan works collaboratively with local Behavioral Health Inpatient Facilities to determine whether, and for how many hours, such locations are used for crisis observation/stabilization services; and
- When Non-Title XIX/XXI eligible individuals are receiving crisis services and require medication, The Health Plan uses the generic medication formulary identified in the Non-Title XIX/XXI Crisis benefit (see Pharmaceutical Requirements).

The Health Plan seeks to ensure Members receive crisis services on a timely basis and, when appropriate, in their homes and communities. CMTs are available to help Members obtain appropriate crisis services. The Health Plan discourages providers from sending Members to emergency rooms for non-medical reasons.

24-HR URGENT ENGAGEMENT (UE) PROGRAM REQUIREMENTS
Urgent Engagement is the process of engaging people into care who have experienced a crisis and have been admitted to an inpatient facility. It is intended to engage persons into care, rather than fulfilling an administrative function. The process includes ensuring effective coordination of care, engagement, discharge planning, a Serious Mental Illness (SMI) screening when appropriate (reference SMI Eligibility Determination), screening for eligibility, referral as appropriate, and prevention of future crises. Once the Behavioral Health Home completes the UE process, the Behavioral Health Home is the entity that is responsible for coordination of necessary service and discharge planning. Health Homes are required to begin each UE within 24 hours of activation by The Health Plan's Urgent Engagement Team and respond in person or by phone to the requesting Behavioral Health Inpatient Facility.

Behavioral Health Home Urgent Engagement Responsibility
Behavioral Health Homes must accept referrals and requests for Urgent Engagements 24 hours a day and seven days a week. Providers are required to record, report and track completion of Urgent Engagements.

For persons who are not yet enrolled in Medicaid, Block Grant programs or the Marketplace, Behavioral Health Homes are required to continue to pursue coverage for the person.

24-hour Urgent Engagements at a Behavioral Health Inpatient Facility (BHIF)
Every Care1st enrolled or State Only individual who resides in The Health Plan covered service area and meets the requirements (listed below) are eligible for an Urgent Engagement.

- Member is hospitalized at a Behavioral Health Inpatient Facility
- Member is not in active care with a Behavioral Health Home
  The selected Behavioral Health Home has 24-hours to arrive at the facility and complete the Urgent Engagement assessment. In the event the individual is sleeping or otherwise unable to participate in the Urgent Engagement process, the Behavioral Health Home shall reschedule the Urgent Engagement assessment within 24-hours and inform The Health Plan of the status.

Behavioral Health Homes activated by the Urgent Engagement process are required to enroll members and non-eligible members refusing services during the COE (Court Ordered Evaluation) process. Once the member is Court Ordered, the Behavioral Health Home is required to proceed with engagement and service delivery; including, an SMI screening.

The Health Home shall transmit the Urgent Engagement Disposition form to AzCHDISPO@azcompletehealth.com within 24-hours of completing assessment.

24-hour Urgent Engagements at a Physical Health Inpatient Facility
Every Care1st enrolled or State Only individual who resides in The Health Plan covered service area and meets the requirements (listed below) are eligible for an Urgent Engagement.

- Member is hospitalized at a Physical Health Inpatient Facility
- Member is not in active care with a Behavioral Health Home

Behavioral Health Homes are required to arrive at the facility or call and complete the urgent engagement assessment within 24 hours of the request. The Behavioral Health Home shall complete the Urgent Engagement assessment within 24-hours and transmit the Urgent Engagement Disposition form to AzCHDISPO@azcompletehealth.com within 24-hours of completing the assessment. In the event the individual is sleeping or otherwise unable to participate in the urgent engagement process, the Behavioral Health Home shall reschedule the urgent engagement assessment within 24-hours and inform The Health Plan of the status.

SECTION VII: Behavioral Health Services

24-hour SMI Evaluation at a Behavioral Health Facility (BHIF)
Every Care1st enrolled or State Only individual who resides in the Health Plan covered service area and meets the requirements (listed below) are eligible for an Urgent Engagement.

- Member is hospitalized at a Behavioral Health Inpatient Facility for psychiatric reasons.
- Member is not in active care with a Behavioral Health Home
- Member presents with a need for an SMI evaluation, is eligible to be assessed for an SMI diagnosis.

The Behavioral Health Home shall complete the Urgent Engagement assessment within 24-hours and transmit the Urgent Engagement Disposition form to AzCHDISPO@azcompletehealth.com within 24-hours of completing assessment.

The Behavioral Health Home shall submit the SMI evaluation packet within seven days of the Urgent Engagement assessment to the designated SMI Evaluation provider, Solari.

SMI Evaluation at the Arizona State Hospital (ASH)
The purpose of the SMI evaluation services, for persons from The Health Plan geographic area admitted to ASH, are for discharge planning. The Behavioral Health Home has seven calendar days to complete the assessment and submit the Urgent Engagement Disposition form to AzCHDISPO@azcompletehealth.com within 24-hours.

The Behavioral Health Home shall submit the SMI evaluation packet within seven days of the Urgent Engagement assessment to the designated SMI Evaluation provider, Solari.

Capacity to Travel
Behavioral Health Homes must maintain capacity to travel to locations within Arizona to complete Urgent Engagements. Where travel distance is a barrier, telephonic response is acceptable but not preferred.

Computer and Wireless Specifications

Behavioral Health Homes must verify Urgent Engagement staff have access to a laptop, mobile printer, and wireless web connectivity to allow access to electronic medical information in the field. The computer and wireless specifications meet or exceed The Health Plan requirements.

SECTION VII: Behavioral Health Services

CRISIS LINE PROVIDER PROGRAM REQUIREMENTS

General Requirements for Crisis Line providers

Referrals
Crisis Line providers must comply with the requirements outlined in Provider Manual Section, Substance Use Disorder Treatment Requirements.

After Hours
Crisis Line providers must maintain an administrator–on-call to address any after-hours, weekend or holiday concerns or issues.

Services
Services must be individualized to meet the needs of Members and families. Crisis Line providers must incorporate the Member's perspective on treatment progress. This is to verify that the Member's perspectives are honored, they are effectively engaged in treatment planning, and in the process of care. Crisis Line providers must provide monitoring, feedback, and follow up after the crisis based on the changing needs of the individual. The family must be treated as a unit and included in the treatment process, when determined to be clinically appropriate. Crisis Line providers must obtain and document child, family, and Member input in treatment decisions.

Substance Use Disorders (SUD) Services
Crisis Line providers providing SUD services must develop services that are designed to reduce the intensity, severity and duration of substance use and the number of relapse events, including a focus on life factors that support long-term recovery as appropriate.

Coordination of Care
Crisis Line providers must contact the Behavioral Health Home following a member's utilization of crisis services. Crisis Line providers must verify coordination and continuity within and between service providers and natural supports to resolve initial crisis and to reduce further crisis episodes over time.

Community-Based Alternatives
Crisis Line providers must promote community-based alternatives instead of treatments that remove Members from their family and community. In situations where a more restrictive level of care is temporarily necessary, Crisis Line providers must work with Members to transition back into community-based care settings as rapidly as is clinically feasible and must partner with community provider agencies to develop and offer services that are alternatives to more restrictive facility-based care.

Staff Requirements and Training
All Clinical Supervisors must meet the appropriate Arizona Board of Behavioral Health Examiners requirements to conduct clinical supervision. Crisis Line providers must

demonstrate completion of all Arizona Department Health Services Division of Licensing training requirements are met for all direct care staff. All staff Members must complete an annual training in Cultural Competency and annual Fraud & Abuse Training, and providers must maintain documentation verifying completion of the training. In addition, providers must verify that all staff and family of Members who provide Peer Support or Family Support have adequate training to support them in successfully fulfilling the requirements of their position.

Crisis Line providers must notify The Health Plan of any staff changes or incidents impacting credentialing involving Behavioral Health Professionals or Behavioral Health Medical Professionals within forty-eight (48) business hours of any additions, terminations, or changes.

Quality Improvement
Crisis Line providers must participate in clinical quality improvement activities that are designed to improve outcomes for Arizona Members.

Electronic Health Record (EHR)
Crisis Line providers are highly encouraged to have in place a fully operational EHR; including, electronic signature, and remote access, as required to meet Federal Medicaid and Medicare requirements. In addition, Crisis Line providers must allow State and Health Plan staff access to the EHR for the purpose of conducting audits.

Service Requirements

Crisis Line providers must maintain a twenty-four (24) hours per day, seven (7) days per week crisis response system that has a single toll-free crisis telephone number and additional specialty toll-free numbers or local crisis telephone number. The Crisis Line must:

- Be widely publicized within the covered service area and included prominently on The Health Plan website, the Member Handbook, Member newsletters, and as a listing in the resource directory of local telephone books;
- Be staffed with a sufficient number of staff to manage a telephone crisis response line to comply with the requirements of the Agreement;
- Be answered within three (3) telephone rings, or within 15 seconds on average, with an average call abandonment rate of less than 3% for the month.
- Include triage, referral and dispatch of service providers and patch capabilities to and from 911 and other crisis providers as applicable;
- Offer interpretation or language translation services to persons who do not speak or understand English and for the deaf and hard of hearing; and

Staff Requirements
Crisis Line providers must follow the requirements below:

- Establish and maintain the appropriate ADHS Division of Licensing license to provide required services.
- Maintain appropriate Arizona licensed medical staff, Arizona licensed Behavioral Health Professionals, ADHS Division of Licensing facility licenses, qualified Behavioral Health Technicians and Paraprofessionals, and Peer Support staff to adequately address and triage Member calls and verify the safe and effective resolution of calls.
- Maintain bilingual (Spanish/English) capability on all shifts and employee interpreter services to facilitate crisis telephone counseling for all callers.
- Provide consistent clinical supervision to verify services are in compliance with the Arizona Principles and all ADHS Division of Licensing, and State supervision requirements are met.
- Employ adequate staff to implement the Crisis AfterCare Recovery program.

Telephone Call Response Requirements
Crisis Line providers must verify that all calls for Crisis Mobile Teams are answered within three telephone rings, or within fifteen (15) seconds, as measured by the monthly Average Speed of Answer. All crisis calls must be live answered.

Crisis Line providers must report monthly, quarterly, and annually, all phone access statistics to include total number of calls received, number and percent abandoned, average speed of answer, and number of calls outside standards. Crisis Line providers must report daily a phone access report that identifies number of calls outside standards, amount of time to answer call for each call outside standards, and number of abandoned calls associated with call outside standards.

Crisis Counseling, Triage, Tracking, Mobile Team Dispatch and Resolution
Crisis Line providers must meet the following requirements:

- Provide crisis counseling, triage and telephonic follow-up 24/7/365. All crisis calls must be live answered. Crisis callers must not receive a prompt, voice mail message, or be placed in a phone queue.
- Provide crisis counseling and triage services to all persons calling The Health Plan Crisis Line, regardless of the caller's eligibility for Medicaid services.
- Review Crisis Plans identified in The Health Plan data system to assist with crisis resolution and suggest appropriate interventions.
- Dispatch mobile team services delivered by provider agencies and must track mobile team intervention resolution in compliance with protocols established or approved by The Health Plan. Crisis Line providers must report on a weekly and monthly basis these dispatches in a format approved by The Health Plan. Daily reports may be required as needed.
- Assess the safety of a crisis scene prior to mobile team dispatch and track mobile teams to monitor the safety of the mobile team staff.

- Follow-up with Members, crisis mobile team staff, Integrated Care Managers, and system partners to verify appropriate follow-up and coordination of care.
- Assess Member dangerousness to self and others and provide appropriate notification to The Health Plan, Behavioral Health Home Health Care Coordinator, and obtain information on Member's consistent use of medications to minimize dangerousness and promote safety to the Member and community.
- Follow community standards of care and best practice guidelines to warn and protect Members, family members and the community due to threats of violence.
- Document all interactions and triage assessments to facilitate effective crisis resolution and validate interventions.
- Conduct a follow-up call within seventy-two (72) hours to make sure the caller has received the necessary services ensuring at least three attempts to connect by phone for follow up are made. Verify Members are successfully engaged in treatment before closing out the crisis episode and follow-up to verify system partner and Member satisfaction with the care plan.
- Support the Crisis Mobile Teams and arrange for transports, ambulance, etc.
- Provide reports that track and summarize the requests for, daily call statistics report, CMT timeliness report, urgent response report, acute health plan inquiry log, crisis indicator data report, client activity report, and 24 Hour Mobile Urgent Intake requests the disposition of such assessments in a format established or approved by The Health Plan.
- Make reasonable attempts to verify that the dispositions are completed.
- Document and report any delay reasons to The Health Plan in real time for all Urgent Response requests.

Member Outreach, Engagement

Safety Net

Crisis Line providers must serve as a "safety net" to The Health Plan Members by re-engaging Members into treatment, as identified by The Health Plan and per data provided by The Health Plan.

Documentation and Monitoring

Crisis Line providers must document and monitor consistent use of crisis services for persons identified as High Need by The Health Plan, provider agencies or by family report. All High Need situations involving danger to self or others must be staffed immediately with an independent licensed supervisor and the supervision must be documented in the record.

Grievances and Service Gaps

Crisis Line providers must notify The Health Plan through The Health Plan data systems of any service delivery problems, grievances, service gaps and concerns raised by Members, family members, and system partners.

SECTION VII: Behavioral Health Services

Encounters
Crisis Line providers must encounter and document all services in compliance with the AHCCCS Covered Behavioral Health Service Guide.

Quality Improvement
Crisis Line providers must conduct outreach calls to facilitate quality improvement initiatives, as determined by The Health Plan, such as but not limited to the timely completion of Service Plans, use of medications, Health Care Coordinator selection and Member satisfaction, consistent use of treatment services, and frequency of treatment team meetings. Crisis Line providers must participate in satisfaction surveys sponsored by the State and The Health Plan as requested and must conduct satisfaction surveys from reports generated by The Health Plan.

Coordination of Care
Crisis Line providers must facilitate effective coordination of care with provider agency staff to promote effective recovery for Members. Crisis Line providers must track resolution until Member reports being successfully engaged in care and consistently engages in treatment.

Member Assistance and Providing Information
Crisis Line providers must assist Members in getting their prescriptions filled, obtaining services, resolving access to care problems, and obtaining medically necessary transportation services. Crisis Line providers must also refer Members for outpatient services and warm transfer callers to agencies or service providers whenever possible upon completion of the call. Follow up calls shall be made to verify referred caller made and kept appointment. Crisis Line providers must explain to callers the process to access services, authorization process for Behavioral Health Inpatient and Hospital services and provide names and locations of intake agencies accessible to the caller.

Members must be informed about The Health Plan website, Member rights and grievance and appeal procedures as appropriate. Crisis Line providers must assist Members in addressing third party liability and "payer of last resort" issues related to accessing services including pharmacy services.

Crisis Line providers must assist Members in managing their own care, in better understanding their rights, in identifying and accessing resources, and in more effectively directing their care.

Member Eligibility
Crisis Line providers must research Member eligibility for services on behalf of providers and Members and make available eligibility information to callers to assist access to care. Crisis Line providers must make available to Members, family members, and provider agencies treatment information about Evidenced Based Practices and shall assist callers in becoming better informed about services and recovery.

Peer Outreach and Coordination
Crisis Line providers must successfully coordinate services with PFROs; including, Peer Crisis AfterCare Programs, Peer Warm Lines, Peer Community Reentry Programs, and Peer Hospital Discharge Programs.

Crisis
Crisis Line providers must participate in all trainings and crisis coordination meetings required or requested by the State and/or The Health Plan. Crisis Line providers must successfully implement a Crisis AfterCare Recovery Team, employing program staff during peak hours Monday through Friday. The Crisis After-Care Recovery Team must conduct outreach, service coordination and crisis stabilization services to Members following mobile crisis team visits, crisis telephone calls, hospitalization, and The Health Plan coordination of care requests. In addition, Crisis Line providers must document coordination efforts in The Health Plan software systems.

Online Scheduling System
Crisis Line providers must participate in and use the selected 24/7 online scheduling system to schedule emergent follow-up appointments and urgent intake assessments with an outpatient provider following a crisis episode.

CRISIS MOBILE TEAM PROVIDER PROGRAM REQUIREMENTS
Crisis Mobile Team providers must provide CMT services in the assigned geographic areas and in accordance to State and The Health Plan requirements.

Supervision by Independently Licensed Behavioral Health Professional
Crisis Mobile Team providers must verify that the Crisis Mobile Team Program is clinically supervised by a The Health Plan Credentialed Independently Licensed Behavioral Health Professional. Crisis Mobile Team providers must verify all Risk Assessments and crisis notes are reviewed and signed off by a The Health Plan Credentialed Independently Licensed Behavioral Health Professional within 24 business hours.

Crisis Mobile Team Provider
Crisis Mobile Team providers must coordinate all services through The Health Plan Crisis Mobile Team provider and follow crisis protocols established by The Health Plan and community stakeholders. Crisis Mobile Team providers must work collaboratively with The Health Plan Crisis Line Provider to receive mobile team dispatches, coordinate all services, and facilitate crisis resolution planning. Crisis Mobile Team providers must report all staffing changes to The Health Plan Network Development Department through the specified deliverable. Crisis Mobile Team providers are required to carry, and use as required, GPS enabled phones provided by crisis line provider. Crisis Mobile Team Agencies are required to have a super-user available within their agency for technical support. GPS phones will enable one number electronic dispatching from the crisis line

provider. GPS phones must be kept with crisis mobile team staff on shift at all times. Crisis Mobile Team staff must be trained in appropriate use of the GPS phones. Crisis Mobile Team providers are required to cover the cost of damaged or lost GPS phones as requested by The Health Plan crisis phone provider. If you are assigned a GPS enabled cellular device, it is a condition precedent that you read and sign your specific User Agreement prior to receiving any such cellular device or devices.

Coordination Calls and Coordination with Outpatient Providers
Crisis Mobile Team providers must participate in crisis coordination calls and meetings to facilitate effective working relationships. Crisis Mobile Team providers must verify CMT services are closely linked to the provider's outpatient provider and that coordination of care is occurring with outpatient providers for members who have been in a crisis. If the crisis occurs during business hour, the expectations is that the coordination occurs in real time.

Staffing and Training
Crisis Mobile Team providers must employ adequate staff to consistently meet the requirements for crisis mobile teams. Crisis mobile teams must have the capacity to serve specialty needs of population served including youth and children, Tribal members, and developmentally disabled. Crisis Mobile Team providers must ensure adequate coverage to maintain full crisis team capacity as a result of staff illnesses and vacations. All direct care crisis staff must be Critical Incident Stress Management (CISM) trained. Crisis Mobile Team providers must participate in training events sponsored by The Health Plan and the State to enhance the performance of the crisis system.

Mobile Crisis Vehicles
Crisis Mobile Teams must be able travel to the place where the individual is experiencing the crisis. Crisis Mobile Team providers must provide and maintain mobile crisis vehicles to facilitate transports and field interventions.

Title 36 Screenings
Crisis Mobile Team providers must ensure Title 36 screenings are conducted by staff other than mobile team staff unless The Health Plan holds a contract with the applicable County, in which case the mobile crisis team should follow the requirements specified in that contract. See Pre-Petition Screening.

Telephone and Internet Connectivity
Crisis Mobile Team providers shall be provided GPS enabled cell phones for all crisis staff on duty and must verify effective connectivity. Crisis Mobile Team providers must provide internet and telephone connectivity through cell phone technology to verify staff have the capacity to communicate spontaneously by phone and the internet while in the field. Crisis Mobile Team providers must verify each mobile team has the capability to wirelessly connect and access the electronic medical information in the field as well as email. In

addition, Provider must verify the computer and wireless specifications meet or exceed The Health Plan requirements.

Safety
Crisis Mobile Team providers must verify the safety of Members under the care of the Crisis Mobile Team at all times, and verify at-risk Members are monitored and supervised by professional staff in person as long as the person remains a Danger to Self/Danger to Others (DTS/DTO).

14.7.9 Follow Up Care
Crisis Mobile Team providers must record referrals, dispositions, and overall response time. Crisis Mobile Team providers must verify all Members are effectively engaged in follow up care before terminating crisis services.

Services
Crisis Mobile Team assessment and intervention services in the community are available to any person in the county regardless of insurance or enrollment status. Upon dispatch, Crisis Mobile Team response time expectations are as follows: No Crisis Mobile Team response should be greater than 90 minutes; or if the Crisis Mobile Team is presently located in the same town/city as the law enforcement call, the response time will be no greater than 30 minutes; or if the Crisis Mobile Team is not presently located in the same town/city as the law enforcement call, the response time is no greater than 90 minutes

Crisis Mobile Teams must have the ability to assess and provide immediate crisis intervention and make reasonable efforts to stabilize acute psychiatric or behavioral symptoms, evaluate treatment needs, and develop individualized plans to meet the individual's needs. Crisis Mobile Team providers must deliver crisis response, crisis assessment and crisis stabilization services that facilitate resolution, not merely triage and transfer. Crisis Mobile Team providers must initiate and maintain collaboration with fire, law enforcement, emergency medical services, hospital emergency departments, AHCCCS Complete Care Health plans and other providers of public health and safety services to inform them of how to use the crisis response system, to coordinate services and to assess and improve the crisis services.

Tracking
Crisis Mobile Teams must maintain adequate licenses to allow each team to utilize and update The Health Plan Risk Management/High Needs Tracking System to effectively coordinate care for Members in crisis.

CRISIS TRANSPORTATION PROVIDER PROGRAM REQUIREMENTS
Crisis Transportation providers must provide medically necessary transportation services in the assigned geographic areas and in accordance to State and the Health Plan requirements. Crisis Transportation providers must establish and maintain appropriate licenses to provide transportation services identified in the Scope of Work.

Coordination
Crisis Transportation providers must coordinate all services through the Health Plan Crisis Line Provider and follow crisis protocols established by the Health Plan. Crisis Transportation providers must participate in crisis coordination calls and meetings to facilitate effective working relationships as requested.

Staff Requirements
Staffing must consistently meet AHCCCS, the State, ADHS Division of Licensing, and The Health Plan requirements. Crisis Transportation providers must verify staff capacity to meet availability requirements as identified in provider's contract with The Health Plan. Crisis Transportation providers must maintain appropriately trained, supervised, and ADHS Division of Licensing and AHCCCS qualified transportation professionals to conduct transports.

Crisis Transportation providers must provide consistent supervision to verify services are in compliance with the Arizona Principles, and verify all ADHS Division of Licensing regulations and State supervision requirements are met. In addition, all staff transporting Members must maintain DES Fingerprint Clearance cards and maintain copies in Personnel files.

Training
Crisis Transportation providers must participate in training events sponsored by The Health Plan and the State as requested, and verify staff complete all required trainings and document trainings.

Vehicles and Cell Phones
Crisis Transportation providers must provide and maintain safe, clean and updated vehicles to facilitate transportation. Crisis Transportation providers must provide cell phones for all transportation staff on duty to verify effective connectivity and safety.

Billing and Paperwork
Crisis Transportation providers must bill all medically necessary transportation services utilizing transportation service codes, through the Health Plan's contracted broker/vendor. Crisis Transportation providers must maintain appropriate paperwork in accordance with State and AHCCCS regulations. Crisis Transportation providers must encounter and document all services in compliance with the AHCCCS Covered Behavioral Health Service Guide.

CRISIS STABILIZATION UNITS/23-HR OBSERVATION UNITS

Purpose of Program
To provide facility-based crisis services for the purpose of stabilizing or preventing a sudden, unanticipated, or potentially dangerous behavioral health condition, episode, or

behavior. These intensive and time limited services are designed to prevent, reduce, or eliminate a crisis situation and are provided 24 hours a day, 7 days a week.

Services To Be Provided

Health, Risk and Acuity Assessments for Triage
All individuals entering the facility (based on Arizona Division of Licensing approval to accept members) shall have a basic health, risk and acuity screening completed by a qualified behavioral health staff member as defined by ACC R9-10-114. Triage assessments shall be completed within fifteen (15) minutes of an individual's entrance into the facility. Any individual demonstrating an elevated health risk shall be seen by appropriate staff to meet the member's needs.

Comprehensive Screening and Assessment
Comprehensive screenings and assessments shall be completed on all individuals presenting at the facility to determine the individual's behavioral health needs and immediate medical needs. Assessments are required to be completed by a qualified behavioral health professional as defined by ARS Title 32 and ACC R9-10-101. Screening and assessment services may result in a referral to community services, enrollment in The Health Plan system of care, admittance to crisis stabilization services, or admittance to inpatient services. At minimum, a psychiatric and psychosocial evaluation, diagnosis and treatment for the immediate behavioral crisis shall be provided. Breathalyzer analysis of Blood Alcohol Level and/or specimen collections for suspected drug use may be provided as clinically appropriate.

Crisis Intervention Services
Crisis intervention services (stabilization) is an immediate and unscheduled behavioral health service provided in response to an individual's behavioral health issue, to prevent imminent harm, to stabilize, or resolve an acute behavioral health issue. Crisis stabilization services are able to be provided for a maximum of 23 hours and designed to restore an individual's level of functioning so that the individual might be returned to the community with coordinated follow up services. Services provided include assessment, counseling, intake and enrollment, medical services, nursing services, medication and medication monitoring, and the development of a treatment plan. Discharge planning and coordination of care shall begin immediately upon admission and shall be developed through coordination with the Behavioral Health Home.

Provider Title 36 Emergency Petition
If licensed to provide court ordered evaluation and treatment, the provider shall verify that services and examinations necessary to fulfill the requirements of ARS §36-524 through ARS §36-528 for emergency applications for admission for involuntary evaluation are provided in the least restrictive setting available and possible with the opportunity for the individual to participate in evaluation and treatment on a voluntary basis. Prior to seeking an individual's admission to a Behavioral Health Inpatient Facility for Court Ordered

Evaluation (COE) Provider shall make all reasonable attempts to engage the individual in voluntary treatment and discontinue the use of the involuntary evaluation process.

Provider shall verify that staff members are available to provide testimony at Title 36 hearings upon the request of County courts.

Reporting Requirements
Provider shall submit all documents, reports and data in accordance with the Deliverable Schedule noted in the Deliverable Requirements. All deliverables shall be submitted 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.

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.

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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.

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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.

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.)

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.

SECTION VII: Behavioral Health Services

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.

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.

SECTION VII: Behavioral Health Services

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.

SECTION VII: Behavioral Health Services

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.

Oxford House Program Requirements

SECTION VII: Behavioral Health Services

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.

SECTION VII: Behavioral Health 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

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.

SECTION VII: Behavioral Health Services

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.

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.

SECTION VII: Behavioral Health Services

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	Any needed covered behavioral health service, including admission to a	Pregnant individuals/teenagers referred for substance abuse treatment (includes pregnant

later than 48 hours from the referral/initial request for services.	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 alcohol/drug use on the fetus and referral for prenatal care.	injection drug users and pregnant substance abusers) and substance-using females with dependent children, including those attempting to regain custody of their child(ren).
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

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, RBHA 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

AZ Workforce Development Alliance – ACC, ACC-RBHA (AWFDA-ACC, ACC-RBHA) is comprised of all the AHCCCS Complete Care (ACC) & Regional Behavioral Health Authority (RBHA) Plans in the state of Arizona. This includes, Arizona Complete Health, Banner University Health Plans, Care 1st, Health Choice Arizona, (Blue Cross-BlueShield, Mercy Care, Molina Complete Care, and United Healthcare Community Plan. Together they act as a single point of contact for reference and direction for the shared provider network. This Alliance is dedicated to working with Relias, the Arizona Health Care Cost Containment System (AHCCCS), health care Providers, Members, and Communities as a whole, to drive long lasting and effective changes in workforce

development and Member outcomes. To achieve this vision, they are working collaboratively as seven separately established Health Plans to assist the Provider network in the transition from a prescriptive and compliance-based system, to a more autonomous, integrated, and competency-based system. Their mission is to evaluate, monitor, and support the development of the capability, capacity, connectivity, culture and commitment of our provider workforce.

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) includes members from AHCCCS, Arizona Complete Health, Banner University Family Care, BCBSAZ Health Choice, Care 1st, Department of Child Safety Comprehensive Health Plan (DCS CHP), Department of Economic Security/Division of Developmental Disabilities (DES/DDD), Mercy Care, Molina Complete Care and UnitedHealthcare Community Plan. This group represents ACC, ACCRBHA, ALTCS, DCS CHP, and DES/DDD lines of business. Together we ensure that initiatives across the state of Arizona align with all lines of business.

AzAHP Workforce Development Alliance (AWFDA) is comprised of all the AHCCCS Complete Care (ACC) & Regional Behavioral Health Authority (RBHA) Plans in the state of Arizona. This includes, Arizona Complete Health, Banner University Health Plans, BCBSAZ Health Choice, Care 1st, Department of Child Safety Comprehensive Health Plan, Mercy Care, Molina Complete Care, and United Healthcare Community Plan. Together they act as a single point of contact for reference and direction for the shared provider network. This Alliance is dedicated to working with Relias, the Arizona Health Care Cost Containment System (AHCCCS), health care Providers, Members, and communities as a whole; to drive long lasting and effective changes in workforce development and Member outcomes. To achieve this vision, they are working collaboratively as eight separately established Health Plans to assist the Provider network in the transition from a prescriptive and compliance-based system, to a more autonomous, integrated, and competency-based system. Their mission is to evaluate, monitor, and support the development of the capability, capacity, connectivity, culture and commitment of the provider workforce.

Definitions

Provider Workforce Development (WFD) is an approach to improving healthcare outcomes of our members by enhancing the training, skills and competency of the Provider workforce. It is an integrative effort between all departments (e.g., leadership, marketing,

finance, quality, clinical, human resources, facilities, etc.) to set goals and initiatives to improve the Provider workforce and provide better member services and care.

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.

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. Abuse & Neglect Prevention

1. Care1st will ensure that providers have access to and are in compliance with all training programs and practices required by the Report of the Abuse & Neglect Prevention Task Force (enacted by Governor Douglas A. Ducey November 1, 2019), as follows:

• Resources and training programs to assist professionals and family caregivers prevent and manage stress and burnout;
• Training for all personnel in the prevention and detection of all forms of abuse and neglect; and
• Routine exercises and drills to test the reactions of staff to simulated conditions where abuse and neglect could potentially occur are incorporated into the providers ongoing workforce/staff training and development plan.

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.
5. **Child and Adolescent Level of Care Utilization System (CALOCUS)**
   a. Employees completing the CALOCUS assessments are required to have training in CALOCUS prior to using the assessment tool with members when assessing for the determination of which children may require high needs case management. Ongoing competency assessments are also required to evaluate a staff member's knowledge and skills.
   b. Any other trained provider (PCP, specialty provider, etc.) working with children and adolescents is also able to conduct the CALOCUS assessment and trained providers can coordinate with the health home to share the assessment results for care coordination purposes.
   c. To ensure the proper identification of children and adolescents with complex needs and appropriate levels of care, AHCCCS has contracted with Deerfield Behavioral Health (Deerfield) to license the Child and Adolescent Level of Care Utilization System (CALOCUS) and Level of Care Utilization System (LOCUS) software, as well as access to online training for those who have familiarity with instruments that measure level of serve acuity. The agreement includes the licensing of both CALOCUS/LOCUS online, though AHCCCES is currently only requiring the use of the CALOCUS. This also includes licensing of the integrated Electronic Health Record (EHR) products, with the intent that providers include the assessment in their data feeds into the Health Information Exchange (HIE).
      a. Providers can implement CALOCUS/LOCUS in one of two was:
         1. Through the web-based version at locus.azahcccs.gov
         2. Through an EHR integration
      b. Regardless of the option chosen, providers must reach out to Deerfield and sign their end user license agreement. There is no cost associated

with this agreement. Key contact at Deerfield is Matthew Monago at mmonago@journeyhealth.org. Be sure to identify that your organization is an AHCCCS provider when outreaching.

d. Individuals who have previously taken the CASII training will also need to complete the CALOCUS training. This will ensure consistent alignment with AHCCCS contractual requirements for CALOCUS training, establish a baseline level of CALOCUS understanding for those that administer the tool, and enhance efforts to maintain fidelity to CALOCUS administration.
    a. For children's providers serving children in the Department of Child Safety Comprehensive Health Plan, Care1st asks to prioritize the completion of the CALOCUS for youth that are either living in a DCS funded Qualified Residential Treatment Program (QRTP) or are being considered to go into a QRTP.
    b. If there are questions regarding CALOCUS training requirements related to the AHCCCS contract, provider agencies can reach out to the Contract Compliance Officer at the Health Plan.
e. Monitoring process
    a. Care1st will monitor the CALOCUS certification process. Relias reports are run to monitor those who have completed it, as well as those who have not completed the requirement in the 30-day timeframe. Reports are compared to the Deerfield completion reports, ensuring fidelity to this AHCCCS requirement. In addition to the 30-day timeframe, provider staff must meet the 2.5-hour minimum time commitment when attending the training through Deerfield.
f. Provider Agency Requirements
    a. All child and adolescent provider agencies who meet the requirements for the CALOCUS training must do the following:
        1. Enroll employees who are required to take the Deerfield CALOCUS training in the "AzAHP-CALOCUS Training Requirement (30 Days)" training plan in Relias.
        2. Once the employee has been enrolled and completes the CALOCUS training through Deerfield, the provider agency's supervisor/administrator must mark them complete in the Relias CALOCUS Training Requirement module.
        3. Once all steps have been completed, the employee will have met the requirements for CALOCUS certification.

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 /RBHA. 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 BH provider types listed on the AzAHP website complete the AZ Healthcare Workforce Goals and Metrics Assessment annually to fulfill the requirements from ACOM 407 & ACOM 407 Attachment A. 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. multiple assessments being disseminated and duplicated). Refer to the website (AZAHP.ORG) for the most up-to-date information, including a list of required Provider Types and a link to the assessment.

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/RBHA Providers:

Training/Compliance Requirements
Relias Learning Management System (LMS)

All AHCCCS Complete Care (ACC)/ Regional Behavioral Health Authority (RBHA) Behavioral Health (BH) Providers must have access to Relias Learning. This is the Learning Management System used by the ACC-RBHA Health Plans and their contracted BH providers through the Arizona Association of Health Plans (AzAHP). Agencies must designate a Relias Administrator (or Supervisor if utilizing the Small Provider Portal) to manage and maintain their Relias Learning portal. This includes activating and deactivating users, enrollment and disenrollment of courses/events, and general reporting and/or oversite of the users in the Relias, to ensure compliance with training requirements.

Per AHCCCS' ACOM 407 and the HP Provider Manuals, it is a contractual requirement that all ACC, ACC-RBHA BH contracted agencies with designated Provider types (listed below) track their staff's course completions of the mandated statewide training requirements through the Statewide Learning Management System, identified as Relias.
• 39 Habilitation Provider
• 77 Behavioral Health Outpatient Clinic
• IC Integrated Clinic
• A3 Community Service Agency
• A6 Rural Substance Abuse Transitional Agency
• B7 Crisis Services Provider
• B8 Behavioral Health Residential Facility
• B1 Level I Residential Treatment Center-Secure (IMD)
• 78 Level I Residential Treatment Center Secure (non IMD)
• B2 Level I Residential Treatment Center-Non-Secure (non-IMD)
• B3 Level I Residential Treatment Center-Non-Secure (IMD)
• C2 Federally Qualified Health Center (FQHC)
29 Community/Rural Health Center (RHC)

SECTION VII: Behavioral Health Services

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
- CEO and/or Key WFD Contact(s):
  - Name
  - Phone Number
  - Email Address
- Contract Type (ACC/RBHA)
- Provider Type / codes (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.

SECTION VII: Behavioral Health Services

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.

Required Training

AzAHP Core Training Plans

AzAHP–Core Training Plan (90 Days)

Care1st requires that Behavioral Health Providers under the ACC, ACC-RBHA lines of business, 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. (This includes, but is not limited to, full time/part time/on-call, direct care, clinical, medical, administrative, leadership, executive and support staff). 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. *AHCCCS – Health Plan Fraud
2. *AHCCCS – NEO – Rehabilitation Employment
3. *AzAHP - Cultural Competency in Health Care
4. *AzAHP – AHCCCS 101
5. *AzAHP – Quality of Care Concern
6. *AzAHP – Client Rights, Grievances and Appeals
7. Basics of Corporate Compliance
8. HIPAA: Basics
9. Integration of Primary and Behavioral Healthcare

AzAHP –Core Training Plan (Annual)

1. *AHCCCS - Health Plan Fraud
2. *AZAHP - Cultural Competency in Health Care
3. *AZAHP - Quality of Care Concern
4. Basics of Corporate Compliance
5. HIPAA: Basics
6. Preventing, Identifying, and Responding to Abuse and Neglect

SECTION VII: Behavioral Health Services

The above Training Plan 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.

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)

Provider - Workforce Development Plan (P-WFDP) Care1st, Mercy Care, Arizona Complete Health, Banner University Family Care, Health Choice Arizona, Molina Complete Care and United Healthcare Community Plan, requires that all Behavioral Health AHCCCS Complete Care (ACC) and Regional Behavioral Health Authority (RBHA) contracted provider agencies, complete an annual Provider - Workforce Development Plan (P-WFDP). Required Provider types can be found at AZAHP.ORG. The purpose of the P-WFDP is to encourage Provider organizations to work together and ensure members receive services from a workforce that is qualified, competent, and sufficiently staffed. The

SECTION VII: Behavioral Health Services

P-WFDP shall include a description of organizational goals, objectives, tasks, and timelines to develop the workforce. The overall approach and philosophy to Workforce Development is to ensure a comprehensive, systematic, and measurable structure that incorporates best practices at all levels of service delivery and utilizes Adult/Children's Guiding Principles, Adult Learning Theories/Methods, Trauma-informed Care, Equitable Services and Culturally Competent practices. All training initiatives, action steps, and monitoring procedures outlined in the P-WFDP are to include targeted efforts for all employees (e.g., direct care Providers, supervisors, administrators, and support staff) who are paid by, partially paid by, or support an agency's Health Plan contract(s).

Provider types:
https://azahp.org/azahp/azahp-wfda/resources-2/

The P-WFDP template is provided for this deliverable by the AWFDA-ACC, ACC-RBHA to providers. P-WFDP's will be submitted between 2/1 – 2/28, annually. Early and late submissions will not be accepted unless an extension was received and granted by the deadline, determined by the AWFDA-ACC, ACC-RBHA (12/31).
• Extension Requests: must be submitted to the workforce@azahp.org email before the date specified by the AWFDA-ACC, ACC-RBHA for each year. Non-submittals are subject to contracted health plan policies as it pertains to the P-WFDP deliverable.
• Exemption Requests: Federally Qualified Healthcare Providers (FQHCs), may request an exemption from their contracted Health Plan(s). Exemptions may be granted on a case-by-case basis and will consider the following: Portion of AHCCCS Members enrolled in the network and served by that Provider, the geographic area serviced, and the number of other service Providers in the surrounding area. Exemption requests must be submitted on/before December 31st and will be reviewed by the Alliance.

Failure, by the contracted Provider agency, to submit the 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), from your contracted Health Plan(s).

Miscellaneous
ACC/RBHA AWFDA Provider Forums

The AZ Workforce Development Alliance (AWFDA-ACC, ACC-RBHA) hosts monthly webinars to provide information, resources and updates for Behavioral Health ACC-RBHA contracted providers. These virtual meetings occur on the second Thursday of each month and registration information for these events will be sent out via email, to all individuals on the Workforce Development email distribution list. It is the Provider agency's responsibility to attend these sessions or review the recorded webinars when they are made available. These recordings can be found by visiting the AWFDA Website.

REQUIRED TRAINING SPECIFIC TO CHILD AND FAMILY TEAM (CFT) INITAITIVES

The statewide Child and Family Team (CFT) Facilitator Course initiative and the two associated Train-the-Trainer (TtT) courses are for Providers who serve children and adolescents in the Children's System of Care (CSOC) **and** have employees who facilitate CFT's.

Initiative 1: CFT Facilitator Course

- The CFT Facilitator Course is 2 days in length, is intended for in-person delivery, and meets all AHCCCS and Health Plan training requirements for individuals who will be leading/facilitating CFT sessions.
- It is expected that provider agencies be prepared to train this course in-house, which enables providing complimentary agency-specific processes, procedures, and protocols, thus creating a robust learner-centric experience for attendees and future CFT facilitators.
- Once an agency has an employee who has become a CFT Champion, by successfully completing the TtT session (noted below), the requirement is for the CFT Champion to train the 2-day CFT Facilitator course to newly hired employees at the provider agency. Employees who already meet the existing CFT Facilitator training requirement need not attend the new course; however, each provider agency may make their own determination otherwise.
- All provider agencies shall utilize the AHCCCS approved training curriculum (ACOM 580, Section F # 2), which is made available to the CFT Champion upon completion of their CFT Facilitator TtT session.

Initiative 2: CFT Facilitator Train the Trainer (TtT)

- The CFT Facilitator TtT session is approximately 6 hours in length and is delivered via virtual instructor-led training. TtT sessions are offered throughout the year. These sessions are intended for employees who will be delivering the 2-day CFT Facilitator course in-house in their own agency. These identified employees will be known as "CFT Champions."
- CFT Champions who participate in the TtT session must be seasoned employees who possess skills equivalent to lead training sessions and must have completed CFT training requirements already in place and must be competent in CFT facilitation. It is left to the discretion of each provider agency to verify trainer competency. Presumption will be that participants have been internally vetted as competent by their provider agency prior to enrollment.

Initiative 3: CFT Supervisor Training

- The CFT Supervisor Training is approximately 5 hours in length, is intended for in-person delivery, and is for leaders who supervise employees who facilitate

CFT's. The CFT Supervisor Training is required for all new and existing leaders. Once the agency has a CFT Champion who successfully completes the CFT Supervisor TtT session (as noted below), this training will provide guidance to leaders related to coaching CFT Facilitators on CFT Practice and the identified competency measurements (ACOM 580, Section G # 1).

Initiative 4: CFT Supervisor Train the Trainer (TtT)

- The CFT Supervisor TtT session is approximately 2.5 hours in length and will be delivered via virtual instructor-led training. CFT Supervisor TtT sessions will be offered throughout the year. These sessions are intended for employees who will be training the CFT Supervisor Training Course in-house within their own agency. These identified staff will be the **same** CFT Champions that took the CFT Facilitator TtT.

AzAHP – CFT Champion Certification Process

- An ****AZAHP- CFT Champion Certification*** training plan has been created in Relias for the identified CFT Champions meeting the above noted requirements.
  - Agency leadership will need to **enroll** the identified CFT Champion(s) in the training plan.
  - Within the training plan there are three module requirements:
  - *AzAHP- CFT Overview (a self-paced course expected to be completed before attending the TtT session),
  - *AZAHP- CFT Facilitator TtT, and
  - *AZAHP- CFT Supervisor TtT.
- If the identified CFT Champion has taken CFT Overview in the last two years, they will not have to take it again and will be given credit automatically in Relias.

Initiative 5: Triannual CFT Collaborative Sessions

- In addition to CFT Champions attending TtT Facilitator Courses, delivering the 2-day CFT Facilitator Training, and CFT Supervisor Training; CFT Champions are required to attend triannual CFT Collaborative Sessions. During these sessions CFT Champions will meet with Health Plan Trainers and leaders to discuss as a group, best practices, challenges, and opportunities for growth and development regarding CFT administration and implementation.

Training and Supervision Expectations

- Provider agencies who have employees that are designated to facilitate/lead CFT's shall be trained in the elements of the CFT Practice Guide, complete an in-person, AHCCCS approved CFT facilitator curricula, and demonstrate competency via the Arizona Child and Family Team Supervision Tool.
- The CFT Supervision Tool must be completed within 90 days, and facilitators must maintain or enhance proficiency within six months as attested to by a supervisor, and annually thereafter (AMPM 580 (F), Attachment C & D).

Monitoring Process

- **CFT Champion Certification**
  - All agencies who are required to have CFT Champions will be tracked in Relias.
  - Workforce Development will maintain a list of all CFT Champions and their provider agencies.

Arizona Child and Family Team Supervisions Tool (AMPM 580 (F), Attachment C & D). The supervision tool requirements will be tracked in Relias via the CFT Competency Evaluation Tool for all employees who facilitate/lead CFT's.

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 can 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.

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.

For providers subcontracted with The Health Plan, the provider notifies The Health Plan of the intent to make a referral for out-of-state placement.

Prior to placing the child or young adult the Behavioral Health Home provider must notify Care1st Behavioral Health Utilization department of the intent to place a member in out-of-state placement. The Health Plan will review the documentation and forward it to the Division of Healthcare Management (DHCM) office with AHCCCS for approval of the out-of-state placement request. The Health Plan will notify the Division of Healthcare Management through the AHCCCS QM portal prior to or upon notification of a member being placed in an Out-of-Home placement. Prior authorization is required for this level of care.

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.

Periodic Updates to AHCCCS

In addition to providing initial notification, the provider is required to submit updates to the Health Plan for review. The updates will be forwarded to the AHCCCS regarding the person's progress in meeting the identified criteria for discharge from the out-of-state placement every 30 days.

Once completed, the Behavioral Health Home must submit updates the Behavioral Health Utilization department every 30 days the person continues to remain in out-of-state placement. The 30 day update timelines will be based upon the date of approval by AHCCCS of the out-

of-state placement. The Health Plan will review the form and forward the information to the DCHM office within AHCCCS.

Required Reporting of an Out-of-State Provider
All out-of-state providers are required to meet the reporting requirements of all incidences of injury/accidents, abuse, neglect, exploitation, healthcare acquired conditions, and/or injuries from seclusion/restraint implementations.

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."

SECTION VII: Behavioral Health Services

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 only contracted with Coconino and Navajo county governments in these GSAs to provide pre-petition screenings and court-ordered evaluation services. The following arrangements for pre-petition screening and court ordered evaluation services exist:

- 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 Care1st who in-turn contracts with ChangePoint Integrated Health, Inc. to provide pre-petition screenings and court-ordered evaluations.
- Coconino County has contract with Care1st. In-turn, Care1st contracts with The Guidance Center to provide pre-petition screening and court ordered evaluation services.
- Yavapai County has contracted with Polara Health to provide pre-petition screenings and court-ordered evaluations.
- Mohave County has contracted with Southwest Behavioral Health to provide pre-petition screening.

Pre-Petition Screening
Unless otherwise indicated in an intergovernmental agreement (IGA), 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 the member's contractor or the FFS program that is responsible for the provision of

behavioral health services. Some counties contract with Regional Behavioral Health Authority/Managed Care Organization/Health Plans to process pre-petition screenings and petitions for court-ordered evaluations.

All applicants calling The Health Plan for court-ordered evaluations are referred to the Crisis Call Center at 866-495-6735 to assist callers in identifying the correct pre-petition screening agency and answering any questions they may have about the process.

When a county does not contract with The Health Plan for pre-petition screening services, the Crisis Call Center will answer any questions the caller may have about the process and warm-transfer the caller to the appropriate county-contracted prepetition screening agency.

When a county contracts with The Health Plan for pre-petition screening and petitioning for court-ordered evaluation, the Crisis Call Center will dispatch a designated pre-petition screening agency.

During the pre-petition screening, the designated agency shall offer assistance to the applicant, if needed, requested by the member, member's representative, or identified as a need by the member's clinical team, in the preparation of the application for involuntary COE. Any behavioral health provider that receives an application for COE shall immediately refer the application for pre-petition screening and petitioning for COE to the Contractor designated pre-petition screening agency or county facility. The pre-petition screening agency must conduct the following procedures:

- Provide pre-petition screening within forty-eight hours of the request excluding weekends and holidays;
- Prepare a report of the clinical assessment, professional 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 members who attempted to conduct the pre-petition screening;
- Request the screening agency's medical director or designee review the report if it indicates that there is no reasonable cause to believe the allegations of the applicant for the court-ordered evaluation;
- Prepare a petition for court-ordered evaluation and file the petition if the screening agency's Medical Director determines that the person, due to a mental disorder, including a primary diagnosis of dementia and other cognitive disorders, is a Danger to Self (DTS), Danger to Others (DTO), Persistently or Acutely Disabled (PAD), or Gravely Disabled (GD). Refer to the Petition for Court-Ordered Evaluation form for pertinent information for court-ordered evaluation;
- If the screening agency determines that there is reasonable cause to believe that the person, without immediate hospitalization, is likely to harm themselves or others, the screening agency will verify completion of the Application for Emergency

Admission for Evaluation form, and take all reasonable steps to procure hospitalization on an emergency basis; and

- Contact the county attorney prior to filing a petition if it alleges that a person is a Danger to Others.

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.

1. Applications indicating DTS, DTO, PAD, and GD can be filed on an emergent basis.
2. The applicant shall have knowledge of the behavior(s) displayed by the individual that is a danger to self or others consistent with requirements as specified in A.R.S. § 36-524.
3. The applicant shall complete application for Emergency Admission for Evaluation, as specified in A.R.S. § 36.524.
4. The applicant and all witnesses identified in the application as direct observers of the dangerous behavior(s) may be called to testify in court if the application results in a petition for COE.
5. Immediately upon receipt of an application for Emergency Admission for Evaluation, as specified in A.R.S. § 36-524, 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 appropriate facility is not currently operating at or above its allowable member capacity, and the individual does not require medical care, then, facility staff will immediately coordinate with local law enforcement or other transportation service contracted by the county for the detention of the individual and transportation to the appropriate facility.
6. If the individual requires a medical facility, or if appropriate placement cannot be arranged within the 48-hour timeframe identified above relating to the application for Emergency Admission for Evaluation, as specified in A.R.S. § 36-524, the Medical Director of the Contractor, or for FFS members, the FFS Provider's Medical Director, shall be consulted to arrange for a review of the case.
7. The application for Emergency Admission for Evaluation, as specified in A.R.S. § 36-524 may be discussed by telephone with the facility admitting physician, the referring physician, and a peace officer to facilitate transportation of the individual to be evaluated.
8. An individual proposed for emergency admission for evaluation may be apprehended and transported to the facility under the authority of law enforcement or other transportation entity contracted by the county using the application for

Emergency Admission for Evaluation, as specified in A.R.S. § 36-524, A.R.S § 36-524(D) and A.R.S § 36-525(A), which outlines criteria for a peace officer or other county contracted transportation provider to apprehend and transport an individual based upon either a telephonic or written application for emergency admission.

9. An emergency admission for evaluation begins at the time the individual is detained involuntarily by the admitting physician who determines if there is reasonable cause to believe that the individual, as a result of a mental disorder, is DTS, DTO, PAD, or GD, and that during the time necessary to complete pre-screening procedures the individual is likely, without immediate hospitalization, to suffer harm or cause harm to others.
10. During the emergency admission period of up to 23 hours the following occurs:
    a. The individual's ability to consent to voluntary treatment is assessed,
    b. The individual shall be offered and receive treatment to which they may consent; otherwise, the only treatment administered involuntarily will be for the safety of the individual or others, i.e., seclusion/restraint or pharmacological restraint as specified in A.R.S. § 36-513, and
    c. When applicable, the psychiatrist will complete the Voluntary Evaluation within 24 hours of determining that the individual no longer requires an involuntary evaluation.

Court-Ordered Evaluation

If, after review of the petition for evaluation, the individual is reasonably believed to be DTS, DTO, PAD, or GD as a result of a mental disorder, the court can issue an order directing the individual to submit to an evaluation at a designated time and place. The order shall specify whether the evaluation will take place on an inpatient or an outpatient basis. The court may also order that, if the individual does not or cannot submit, the individual be taken into custody by a peace officer or other county contracted transportation provider and delivered to an evaluation agency. For further requirements surrounding COEs on an inpatient basis, refer to A.R.S. § 36-529.

If the pre-petition screening indicates that the individual may be DTS, DTO, PAD, or GD, the screening agency will file a petition for COE. When, through an IGA with a county, the Contractor is contracted to provide COE, they shall adhere to the following requirements when conducting COEs:

- An individual who is reasonably believed to be DTS, DTO, PAD, or GD as a result of a mental disorder shall have a petition for COE prepared, signed and filed by the Medical Director of the agency or designee,
- An individual admitted to an evaluation agency shall receive an evaluation as soon as possible, and receive care and treatment as required by their condition for the full period they are hospitalized,
- A clinical record shall be kept for each individual which details all medical and psychiatric evaluations and all care and treatment received by the individual,

- An individual being evaluated on an inpatient basis shall be released within 72 hours (not including weekends and court holidays) if further evaluation is not appropriate, unless the individual makes application for further care and treatment on a voluntary basis, or unless an application for COT has been filed, and
- On a daily basis at minimum, an evaluation shall be conducted throughout the COE process for the purposes of determining if an individual desires to be switched to a voluntary status or qualifies for discharge.

Voluntary Evaluation
Any Health Plan provider that receives an application for voluntary evaluation must immediately refer the person to the facility responsible for voluntary evaluations. Providers are to contact the Crisis Call Center at 1-866-495-6735 for assistance.

The Health Plan providers must follow these procedures:

- The evaluation agency must obtain the individual's informed consent prior to the evaluation (see AHCCCS Section 320-U-7, Application for Voluntary Evaluation) and provide evaluation at a scheduled time and place within five days of the notice that the person will voluntarily receive an evaluation; and
- 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.

If a 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, use AHCCCS AMPM Section 320-U-7 Application for Voluntary Evaluation;
- A completed informed consent form; and
- A written statement of the person'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.

Background
Per Arizona Revised Statutes 36-545.06-County Services: "Each County shall provide directly, or by contract the services of a screening Provider and an evaluation Provider."

Each County must have a process in place for:

- Involuntary mental health treatment requests and evaluations
- Court proceedings to satisfy the statutory requirements under Title 36 for individuals under court-ordered evaluation and court-ordered treatment.

Every County in Arizona manages this responsibility differently based on their interpretation of the state statutes and the resources in that County. The Court Ordered Treatment/Court Ordered Evaluation (COT/COE) Coordinator and Liaison are required to work with the County Attorney's Office to ensure proper execution of its procedures.

The Health Plan is responsible for treatment of an eligible person* once placed under a Title 36 civil commitment or court-ordered treatment (COT). Per Arizona Administrative Code (R9-21-504) the RBHA/MCO/Health Plan "shall provide, either directly or by contract all treatment required by A.R.S. Title 36, Chapter 5, Article 5."

* Populations eligible for RBHA/MCO/Health Plan services per The Health Plan Provider Manual Section 2.1.1-2:

- Title XIX/XXI enrolled individuals;
- Persons determined to have a Serious Mental Illness;
- Special populations, including individuals receiving services through the Substance Abuse Block Grant (SABG)

Overview
Each Behavioral Health Home per the Health Plan contract scope of service is required to designate a staff person to serve as COT/COE Coordinator and Liaison for Title 36 and Court-Ordered services. Each provider should also have a designated back-up staff person to answer inquiries if the designated Coordinator/Liaison is out of the office.

SECTION VII: Behavioral Health Services

A Provider coordinates the provision of clinically appropriate covered services to individuals requiring court ordered treatment and serves as the Supervising Provider for court-ordered outpatient treatment plans.

In all cases, the Provider Medical Director** or physician designee has primary responsibility for oversight of an individual's court-ordered treatment and is responsible for reviewing and signing all documents filed with Court, including the initial court-ordered treatment plan.

** Per ARS 36-501 (24) Definitions - Medical Director of a mental health treatment Provider" means a psychiatrist, or other licensed physician experienced in psychiatric matters, who is designated in writing by the governing body of the Provider as the person in charge of the medical services of the Provider for the purposes of this chapter and includes the chief medical officer of the state hospital."

Individuals on court ordered treatment (COT) are one of the most at-risk populations served. These Individuals will need to receive services with a Behavioral Health Provider who can submit the Outpatient treatment Plan to the Courts.

- Individuals on COT must be seen at least monthly by the Medical Director or designee (must be a Prescriber)
- Outreach and engagement with these individuals should be assertive and follow the re-engagement processes within The Health Plan Provider Manual (Section 3.4). The goal is to avoid re-hospitalization and improve the quality of life for the individual.
- A solid crisis plan must be developed that includes what works and does not work for this individual, support that can help, and types of outreach that should be attempted if the individual has an increase in symptoms or disengages from treatment.
- The Health Plan has developed crisis protocols for every County served that include detailed descriptions about the way the crisis system works in each respective County. There are extensive sections on involuntary treatment that should be referenced for details on how each County facilitates the COT process.
- Providers must closely monitor COT expiration dates. Pursuant to A.R.S 36-540 (D), a court order cannot exceed 365 days, but some counties may order fewer days. Providers must ensure they understand the County's interpretation of the COT expiration date. Providers must monitor expiration dates to schedule annual reviews to determine if the individual's COT should continue for another year. Additionally, it gives Providers enough time to file a Petition for Continued Treatment with Court for individuals who were found Persistently or Acutely Disable or Gravely Disabled.
- The Health Plan will monitor and audit COT requirements and will issue Corrective Action Letters and/or Sanctions for failure to follow the requirements.

SECTION VII: Behavioral Health Services

Requirements
Each Provider is responsible for maintaining a current list of individuals who are receiving court-ordered treatment.

Urgent Engagement, SMI Evaluations and AHCCCS Screening for Member in COE/COT Process
The Health Plan enrolled and State Only (N19/NSMI) individuals who are identified as not engaged with a behavioral health provider must be referred for urgent engagement and "for persons who are not yet enrolled in Medicaid, Block Grant programs, or the Marketplace, Behavioral Health Homes are required to continue to pursue coverage for the person".

For individuals going through Court Ordered Evaluation to be Court Ordered for Treatment, all avenues are explored to determine eligibility for services offered by The Health Plan. Therefore, when an agency in any county is activated for an Urgent Engagement for an individual who is NT19 and GMH and being evaluated for Court Ordered Treatment, an SMI evaluation/assessment should be completed. In general, the SMI determination should be expedited by checking the 3-day turnaround time frame. The Behavioral Health Home should also conduct financial screenings and assist the individual in applying for Title 19 benefits.

Should the member refuse services during the Court Ordered Evaluation process; the Behavioral Health Home activated due to an urgent engagement shall retain the member until the member is Court Ordered for Treatment and then proceed to engage the member so that eligibility with AHCCCS and an SMI determination can be completed. Please contact the Title 36 Coordinator at The Health Plan for additional Technical Assistance.
Behavioral Health Homes are required to enroll and engage Title XIX members who refuse services during the COE process upon the member being Court Ordered.

Provider Participation in Hearings
The assigned Health Home must ensure a representative with knowledge of the member attend all COT hearings, including the original hearing for court-ordered treatment, judicial reviews, and Petitions for Continued Treatment of Gravely Disabled (GD) or Persistently or Acutely Disabled (PAD). It is expected that the representative will follow courtroom rules of decorum. The representative should be prepared to provide information/clarification to Court regarding facts relevant to the hearing and the proposed outpatient treatment plan. The representative must be present to receive orders set forth by the Judge/Commissioner and specific orders regarding the submitted outpatient treatment plan.

Treatment Plan Development and Filing
Prior to the date of the hearing, the Health Home Agency representative is responsible for coordinating an Adult Recovery Team (ART) meeting for enrolled individual to develop discharge plans and ensure that those plans are included in the individual's Individual

Service Plan (ISP). The ISP must be discussed/reviewed with the Agency Medical Director or physician designee. The individual's inpatient team must be involved in and agree to discharge decisions.

The COT outpatient treatment plan must be signed by the Agency Medical Director or physician designee and appropriate staff that reviewed the plan with the individual and the outpatient team. The individual is not required to sign the COT outpatient treatment plan and individual signature is optional. If the individual does not sign the plan, the individual signature line is to be left blank. Information regarding why the individual did not sign the plan is not to be written on the plan.

The COT outpatient treatment plan should have the individual's correct address/zip code and phone number and the type of residence (home, family, friend, BHRF, jail, etc.). If the individual is to reside with family, friends, etc., Provider staff must confirm this arrangement with family, friends, etc.

If a COT outpatient treatment plan has not been completed, the Agency representative is to inform Court why the plan has not been completed and the projected date of completion.

Overview

The provider can amend/revoke an individual's court order and place the individual in an inpatient setting if the individual is not following the terms of the court order. It is important to note that only the Medical Director or physician designee can request an amendment/revocation of the outpatient treatment plan. Note: Medical Directors are required to be available after hours if needed in order to facilitate the revocation/amendment of a court order.

- It is important the provider track the numbers of days a member has spent in an inpatient setting, because there are a limited amount of inpatient days the court may order pursuant to A.R.S. 36-540:
- DTS up to 90 days
- DTO & PAD up to 180 days
- GD up to 365 days
- If there are no more inpatient days available, the Medical Director must determine if the individual requires continued court-ordered treatment. If the individual is DTO/DTS the provider can follow the process for an Emergency Application for Evaluation for Admission. If the individual is PAD/GD, the provider can initiate the Annual Review process or follow the Pre-Petition Screening process.
- Amended outpatient treatment orders do not increase the total period of commitment originally ordered by Court.

Emergent Amendment/Revocation A.R.S. 36-540 (E)(5)
If the individual is presenting with DTO/DTS behaviors and requires immediate hospitalization, the provider can verbally amend the outpatient treatment plan without an order from Court. The Medical Director or physician designee must contact an inpatient psychiatrist, discuss and agree that the individual requires immediate inpatient treatment. The Medical Director or physician designee may authorize a peace officer to transport the individual to the inpatient treatment facility.

The Medical Director of the outpatient treatment facility must file a motion for an amended court order requesting inpatient treatment no later than the next working day following the individual being taken to the inpatient facility. If this paperwork is not filed in this timeframe, the individual may be detained and treated for no more than 48 hours, excluding weekends and holidays.

When an individual is hospitalized pursuant to an amended order, the provider must inform the individual of the right to judicial review and the right to consult with counsel pursuant to A.R.S. 36-546.

Non-Emergent Amendment/Revocation A.R.S. 36-540 (E)(4)
If the provider determines that the individual is not complying with the terms of the order or that the outpatient treatment plan is no longer appropriate, the Medical Director or physician designee can petition the court to amend/revoke the outpatient treatment plan to inpatient treatment. Court, without a hearing and based on the court record, the patient's medical record, the affidavits, and recommendations of the Medical Director (must be notarized) , and the advice of staff and physicians or the psychiatric and mental health nurse practitioner familiar with the treatment of the patient, may enter an order amending its original order.

If the individual refuses to comply with an amended order for inpatient treatment, the court may authorize and direct a peace officer, on the request of the Medical Director, to take the individual into protective custody and transport the individual for inpatient treatment.

When an individual is hospitalized pursuant to an amended order, the provider must inform the individual of the right to judicial review and the right to consult with counsel pursuant to A.R.S. 36-546.

Quash a Court's Order for Law Enforcement to Transport for a Non-emergent Amendment
If Court has entered an order for law enforcement to transport the individual to an inpatient treatment facility and the provider believes this level of care is no longer required, the Provider can motion the court to quash the order to transport by law enforcement. This ensures the individual is not unnecessarily transported to an inpatient facility.

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:

1. If a member is no longer living in a placement or residence specified by the treatment plan without authorization;
2. Leaving or failing to return to the county or state without authorization;
3. Absent from an inpatient treatment facility without authorization.

The Statute indicates within five (5) days after a patient's unauthorized absence, the Behavioral Health Homes shall file a motion with the Court to request a Toll of the Court Ordered Treatment.

Behavioral Health Home 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 Health Plan Title 36 Coordinators.

Should the member not be re-engaged voluntarily or involuntarily, the Behavioral Health Home 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
Providers must inform the individual of the right to Judicial Review every 60 days and must document this in the clinical record. Judicial Reviews are to be calendared and offered every 60 days from the date of the original court order. The days from the court order are as follows: 60, 120, 180, 240,300, and 360. It is the responsibility of the Provider to track the Judicial Review dates and ensure a Judicial Review is offered to an individual under Court-Ordered Treatment (COT) every 60 days. If an individual is hospitalized pursuant to an amendment to the outpatient treatment plan the Provider must inform the individual of the right to judicial review and the right to consult with counsel pursuant to A.R.S. 36-546. 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 60 days.

A Judicial Review must also be offered to the member should the member be absent for 60 or more days, returns and is re-engaged in treatment. The due dates of the offers may need to be adjusted upon return.

If the individual requests Judicial Review, the Health Care Coordinator completes the Judicial Review-right to Speak to Legal Counsel Form. The form includes the following information:

1. The individual being treated and the treating Provider.
2. The individual to whom the request for release was made.
3. The individual making the request for release, indicating whether the individual is the individual being treated or someone acting on the individual's behalf.

The individual reports the current address and signs the form. The Health Care Coordinator must schedule an appointment for the individual to be evaluated by a Behavioral Health Medical Professional (BHMP) of the Provider. The completed PM form and psychiatric report must be completed and submitted to the County Attorney within 72 hours of the request and by the filing deadline.

The Behavioral Health Medical Provider appointment should be scheduled no later than 48 hours from request, so the Judicial Review form is received by the County Attorney or law firm the next day, to meet the 72-hour timeframe.

If the individual declines a Judicial Review, the Health Care Coordinator completes the same form - Judicial Review-right to Speak to Legal Counsel, and the individual signs this form. The individual provides a current address and location. The Provider maintains this form in the clinical record. If the individual is unavailable at the time the Judicial Review is due, the Health Care Coordinator completes the same form- Judicial Review-right to speak to Legal Counsel. The Health Care Coordinator must provide reasons why the individual was not available for the Judicial Review and include outreach and re-engagement attempts made. The Provider maintains this form in the clinical record. It should match the progress notes regarding outreach.

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 the individual's insight regarding mental illness and information regarding adherence to court-ordered treatment plan. If the individual does not attend the Judicial Review appointment, all attempts should be made to reschedule the appointment. If the member does not attend, the health care coordinator should then confirm with the member that they have changed their mind and are no longer requesting a judicial review hearing. If an individual is hospitalized pursuant to an amended outpatient treatment plan and requests a Judicial Review, merely stating the individual is involuntarily hospitalized is not enough factual information for Court to render a decision. The BHMP should attempt to contact the inpatient Behavioral Health Medical Provider 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. A hearing can be set by the Judge/Commissioner or if requested by the defense attorney.

Status Reports
At the original hearing for court order, the Judge/Commissioner may direct the provider to submit status reports to Court. The Judge/Commissioner will set the dates when the reports are to be submitted.

Annual Review A.R.S. 36-543
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, as determined by the County. 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.

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. The following information must be indicated and written in the BHMP progress notes of the service planning meeting for the annual review that you submit:

- That this appointment is for the face-to-face annual review appointment;
- That the recommendation is either to roll/continue the members COT or to allow the COT to expire;
- That the recommendation was discussed with the member.

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 information changes, provider staff must contact the individual's attorney with this new information.

Annual Review of Incarcerated Members or Missed Annual Review of Appointments
For the Annual Review requirement, please ensure that the Psychiatrist/Behavioral Health Medical Provider does the following within the allotted time frame (45-90 days) of the Annual Review dates:

1. For Incarcerated members:
    a. A note is required in the chart that consists of the following information:
        i. This is an annual review;
        ii. Circumstances as to why the member was not present;
        iii. Indicate the date the member was booked to jail and that the member is still incarcerated;
        iv. If the medical director is willing, indicate whether their recommendation is to roll the order or to allow it to expire. If the recommendation is to roll based on the member's clinical record and a Petition for Continued Treatment with the Court is unable to be filed, indicate that due to lack of coordination from the jail, this is not possible;
        v. Indicate the date when you attempted to reach out to the jail psychiatrist to discuss member's annual review;
        vi. File in the Member's medical Record;
    b. A copy of this note is required to be sent to the Title 36 Coordinator indicating this is an annual review for an incarcerated member.
    c. For members who have missed scheduled annual review appointments within the required time frame, prior to the 45th day of the COT expiring, a chart review may be necessary.
    d. A note is required in the chart that consists of the following information:
        i. This is a chart review for the required annual review;
        ii. Dates of previous annual review appointments scheduled and missed.
        iii. Circumstances as to why the member was not present,

iv. Date a revocation was filed with the Court when appropriate.
v. Indicate whether their recommendation is to roll the order or to allow it to expire. If recommendation would be to roll, indicate that due to lack of contact with the member, this is not possible;
vi. Indicate that re-engagement protocols have been attempted to locate the member (A request for progress notes to review re-engagement attempts may be asked for);
vii. File in the Member's medical record;
viii. Send a copy to the Title 36 Coordinator indicating this is an annual review for a missing member.

If your agency uses a psychiatric annual review examination form, please use that document and include the above information.

NOTE: You should still enter these reviews as the annual review for the member

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.

For individuals whose Court Order is currently being tolled, the annual review will not be required until the member is re-engaged into services.

Progress notes for the annual review can be emailed as soon as the annual review has been completed, but no later than the 2nd business day of the following month the annual review must have been completed.

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.

Suspension of Outpatient Treatment Plan
In some Counties there are certain circumstances where a motion 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. This suspension relieves the Behavioral Health Home of the responsibility of services specifically for the court ordered treatment.

Termination of a Court Order that has been Tolled
Per Revised ARS Title 36 Statute 36-544, if a member's Court Order has been tolled for 180 days, the Behavioral Health Home may petition the court to terminate the member's Court Ordered Treatment. The Court may or may not approve of the request.

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.

Transportation from the sending provider to the receiving provider is the responsibility of the sending behavioral health provider.

ARIZONA STATE HOSPITAL (ASH) Arizona State Hospital (ASH) is a Level I facility currently licensed under applicable State and local law, is accredited by the Joint Commission and certified by the Centers for Medicare and Medicaid Services (CMS). ASH is a long-term inpatient psychiatric hospital that provides the most restrictive setting for care in the state. Coordination between ASH and the Health Plan must occur in a manner that ensures persons being admitted meet medical necessity criteria. Pursuant to A.R.S. § 36-201 through 36-217, ASH provides inpatient care and treatment to patients with mental disorders, personality disorders or emotional conditions. The level of care provided at ASH must be the most appropriate and least restrictive treatment option for the person (A.R.S. § 36-501(21)). The provision of appropriate, medically necessary covered behavioral health services must be consistent with treatment goals outlined on the admission application and individual needs identified in the course of treatment of individuals admitted to ASH.

The goal of all hospitalizations of persons at ASH is to provide comprehensive evaluation, treatment, and rehabilitation services to assist each behavioral health recipient in their own recovery, and to achieve successful placement into a less restrictive community-based treatment option.

1. Admissions

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

- The Member must not require acute medical care beyond the scope of medical care available at ASH.
- The referral source must make reasonably good-faith efforts to address the individual's target symptoms and behaviors in an inpatient setting(s).
- The referral source must complete Utilization Review of the potential admission referral and it recommend admission to the ASH as necessary and appropriate, and as the least restrictive option available for the person based on clinical status.
- When a community provider agency or other referral source believes that a civilly committed or voluntarily admitted adult is a candidate to be transferred from another inpatient facility for treatment at ASH, the agency will contact the Health Plan ASH Liaison to discuss the recommendation for admission to ASH. The Health Plan must be in agreement with the referral source that a referral for admission to ASH is necessary and appropriate. If the candidate is not Health Plan enrolled, the Member will be referred for SMI determination and the enrollment

process prior to application or at the latest within twenty-four (24) hours of admission pursuant to **Section III Provider Roles and Responsibilities — Appointment and Wait Time Standards** to ASH. The enrollment date is effective the first date of contact by the Health Plan contracted Behavioral Health Home. The Health Plan Behavioral Health Home is required to also complete a Title XIX/XXI application once enrollment is completed. For all non- T/RBHA enrolled Tribal behavioral health recipients, upon admission to ASH, the hospital will enroll the person, if eligible in the AHCCCS Indian Health Program.

- For T/RBHA (Tribal RBHA only) enrolled Members, AHCCCS must also be in agreement with the referring agency that admission to ASH is necessary and appropriate, and AHCCCS must prior authorize the person's admission (see **Section IX Medical Operations – Prior Authorization and Referral Process).**
- The Health Plan ASH Liaison will provide the agency with the ASH Application packet and list of requested documents. Upon completion of the ASH application packet, the Health Plan ASH Liaison will forward the completed packet of information regarding the referral to the ASH Admissions Office, and if determined to be SMI and previously assessed as requiring Special Assistance, then the existing Special Assistance form should be included in the package. If the form has not been completed, please refer to **Section VII Behavioral Health Services - Special Assistance for Members Determined to have a Serious Mental Illness** for further instructions.
- The ASH Admissions Office confirms receipt of the complete packet and notifies the referral source of missing or inadequate documentation within two business days of receipt. ASH cannot accept any person for admission without copies of the necessary legal documents.
- For TXIX enrolled persons, the Health Plan needs to generate a Letter of Authorization (LOA) or issue a denial. Once the member is accepted, the Certification of Need (CON) and Letter of Authorization (LOA) are provided to ASH just prior to admit with other documents as outlined in the ASH Admission Workflow; an ASH document. See **AHCCCS Prior Authorization Forms: Certification of Need at** https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/priorauthorizationforms.html**.**
- The Health Plan is responsible for notifying ASH's Admissions Office of any previous court ordered treatment days utilized by the Member. Members referred for admission must have a minimum of forty-five (45) inpatient court-ordered treatment days remaining to qualify for admission. The Member's AHCCCS eligibility will be submitted by the Health Plan the Health Plan to the ASH Admissions Office with the admission application and verified during the admission review by the ASH Admissions Office. The ASH Admissions Office will notify (AHCCCS) Member Services of the behavioral health recipient's admission to A~~z~~SH and any change in health plan selection, or if any other information is needed.

- The ASH Chief Medical Officer or Acting Designee will review the information within 14 calendar days after receipt of the completed packet and determine whether the information supports admission and whether ASH can meet the Member's treatment and care needs.
- If the ASH Chief Medical Officer or Acting Designee determines that the Member does not meet criteria for admission, the Chief Medical Officer or Acting Designee will provide a denial letter.
- If the admission is approved, the Admissions Office will send the acceptance statement from the Chief Medical Officer or Acting Designee to the referral source.
- A Court Order for transfer is not required by ASH when the proposed Member is already under a Court Order for treatment with forty-five (45) remaining inpatient days. However, in those jurisdictions in which the court requires a court order for transfer be issued, the referring agency will obtain a court order for transfer to ASH.
- If a Court Order for transfer is not required, the ASH Admissions Office will set a date and time for admission. It is the responsibility of the referring agency to make the appropriate arrangements for transportation to ASH.
- When ASH is unable to admit the accepted behavioral health recipient immediately, ASH shall establish a pending list for admission. If the behavioral health recipient's admission is pending for more than 15 days, the referral agency must provide ASH a clinical update in writing, including if any alternative placements have been explored while pending, and if the need for placement at ASH is still necessary.

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.

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.

REPORTING

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.
- It is highly recommended that each Provider designate a backup designee for the COT/COE Coordinator and Liaison to manage report submission and any questions from the Health Plan T-36 Coordinator if the Provider's COT/COE Coordinator and Liaison is not available.
- There can be multiple updates per member per month depending on the number of events occurring in the reporting month.

PERSONS WHO ARE TITLE XIX/XXI ELIGIBLE OR NON-TITLE XIX/XXI AND/OR DETERMINED TO HAVE A SERIOUS MENTAL ILLNESS (SMI)

When a person referred for court-ordered treatment is Title XIX/XXI or non-Title XIX/XXI eligible and/or determined or suspected to have SMI, the provider must:

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

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.

SECTION VII: Behavioral Health Services

Court ordered DUI Services

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.

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.

ARIZONA STATE HOSPITAL

ASH is a Level I facility currently licensed under applicable State and local law, is accredited by The Joint Commission and certified by the Centers for Medicare and Medicaid Services (CMS). ASH is a long-term inpatient psychiatric hospital that provides the most restrictive setting for care in the state. Coordination between ASH and The Health Plan must occur in a manner that ensures persons being admitted meet medical necessity criteria. Pursuant to A.R.S. § 36-201 through 36-217, ASH provides inpatient care and treatment to patients with mental disorders, personality disorders or emotional conditions. The level of care provided at ASH must be the most appropriate and least restrictive treatment option for the person (A.R.S. § 36-501(21)). The provision of appropriate, medically necessary covered behavioral health services must be consistent with treatment

goals outlined on the admission application and individual needs identified in the course of treatment of individuals admitted to ASH.

The goal of all hospitalizations of persons at ASH is to provide comprehensive evaluation, treatment, and rehabilitation services to assist each behavioral health recipient in their own recovery, and to achieve successful placement into a less restrictive community-based treatment option.

Admissions

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

i. The Member must not require acute medical care beyond the scope of medical care available at ASH.
ii. The referral source must make reasonable good-faith efforts to address the individual's target symptoms and behaviors in an inpatient setting(s).
iii. The referral source must complete Utilization Review of the potential admission referral and it recommend admission to the ASH as necessary and appropriate, and as the least restrictive option available for the person based on clinical status.
iv. When a community provider agency or other referral source believes that a civilly committed or voluntarily admitted adult is a candidate to be transferred from another inpatient facility for treatment at ASH, the agency will contact The Health Plan to discuss the recommendation for admission to ASH. The Health Plan must be in agreement with the referral source that a referral for admission to ASH is necessary and appropriate. If the candidate is not Health Plan enrolled, the Member will be referred for SMI determination and the enrollment process prior to application or at the latest within twenty-four (24) hours of admission pursuant to Appointment Standards and Timeliness of Service to ASH. The enrollment date is effective the first date of contact by a The Health Plan contracted Behavioral Health Home. The Health Plan Behavioral Health Home is required to also complete a Title XIX/XXI application once enrollment is completed. For all non-T/RBHA enrolled Tribal behavioral health recipients, upon admission to ASH, the hospital will enroll the person, if eligible in the AHCCCS Indian Health Program.
v. For T/RBHA (Tribal RBHA only) enrolled Members, AHCCCS must also be in agreement with the referring agency that admission to ASH is necessary and appropriate, and AHCCCS must prior authorize the person's admission.

vi. The Health Plan and/or other referral sources must contact the ASH Admissions Office and forward a completed packet of information regarding the referral to the Admissions Office, and if determined to be SMI and previously assessed as requiring Special Assistance, then the existing Special Assistance form should be included in the package. If the form has not been completed.

vii. The Admissions Office confirms receipt of the complete packet and notifies the referral source of missing or inadequate documentation within two business days of receipt. ASH cannot accept any person for admission without copies of the necessary legal documents.

viii. For TXIX enrolled persons, The Health Plan needs to generate a Letter of Authorization (LOA) or issue a denial. Once the member is accepted, the Certification of Need (CON) and Letter of Authorization (LOA) are provided to ASH just prior to admit with other documents as outlined in the ASH Admission Workflow; an ASH document. See AHCCCS Prior Authorization Forms: Certification of Need.

ix. The Health Plan is responsible for notifying ASH's Admissions Office of any previous court ordered treatment days utilized by the Member. Members referred for admission must have a minimum of forty-five (45) inpatient court-ordered treatment days remaining to qualify for admission. The Member's AHCCCS eligibility will be submitted by The Health Plan the Health Plan to the ASH Admissions Office with the admission application and verified during the admission review by the ASH Admissions Office. The ASH Admissions Office will notify (AHCCCS) Member Services of the behavioral health recipient's admission to ASH and any change in health plan selection, or if any other information is needed.

x. The Chief Medical Officer or Acting Designee will review the information within 14 calendar days after receipt of the completed packet and determine whether the information supports admission and whether ASH can meet the Member's treatment and care needs.

xi. If the ASH Chief Medical Officer or Acting Designee determines that the Member does not meet criteria for admission, the Chief Medical Officer or Acting Designee will provide a denial letter.

xii. If the admission is approved, the Admissions Office will send the acceptance statement from the Chief Medical Officer or Acting Designee to the referral source.

xiii. A Court Order for transfer is not required by ASH when the proposed Member is already under a Court Order for treatment with forty-five (45) remaining inpatient days. However, in those jurisdictions in which the court requires a court order for transfer be issued, the referring agency will obtain a court order for transfer to ASH.

xiv. If a Court Order for transfer is not required, the ASH Admissions Office will set a date and time for admission. It is the responsibility of the referring agency to make the appropriate arrangements for transportation to ASH.

xv. When ASH is unable to admit the accepted behavioral health recipient immediately, ASH shall establish a pending list for admission. If the behavioral health recipient's admission is pending for more than 15 days, the referral agency must provide ASH a clinical update in writing, including if any alternative placements have been explored while pending, and if the need for placement at ASH is still necessary.

Adult Members Under Civil Commitment

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

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

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

The Member must not suffer more serious harm from proposed care and treatment at ASH. (AAC R9-21-507(B)(1) (PDF)).

Hospitalization at ASH must be the most appropriate level of care to meet the person's treatment needs, and the person must be accepted by the Chief Medical Officer for transfer and admission (AAC R9-21-507(B)(2) (PDF)).

Treatment and Community Placement Planning

ASH will begin treatment and community placement planning immediately upon admission, utilizing the Adult Clinical Team model. All treatment is patient-centered and is provided in accordance with AHCCCS-established five principles of person-centered treatment for adult Members determined to have SMI.

Members shall remain assigned to their original clinic/outpatient treatment team throughout their admission, unless the Member initiates a request to transfer to a new clinic site or treatment team.

i. Consideration of comprehensive information regarding previous treatment approaches, outcomes and recommendations/input from The Health Plan and other outpatient community treatment providers is vital.
ii. Representative(s) from the outpatient treatment team are expected to participate in treatment planning throughout the admission in order to facilitate enhanced coordination of care and successful discharge planning.
iii. Treatment goals and recommended assessment/treatment interventions must be carefully developed and coordinated with the outpatient providers (including The Health Plan, ALTCS Health Plan, other providers/other state agencies as appropriate), the Member's legal guardian, family members, significant others as authorized by the Member and advocate/designated representative whenever possible.
iv. The first Inpatient Treatment and Discharge Plan (ITDP) meeting, which is held within 10 days of the Member´s admission, should address specifically what symptoms or skill deficits are preventing the Member from participating in treatment in the community and the specific goals/objectives of treatment at ASH. This information should be used to establish the treatment plan.
v. The first ITDP meeting should also address the discharge plan for reintegration into the community. The Member's specific needs for treatment and placement in the community, including potential barriers to community placement and successful return to the community, should be identified and discussed.
vi. All required medical services for enrolled members residing at ASH that are not provided by ASH will be provided by Valleywise Health Medical Center. The Health Plan will provide payment to MIHS for all medically necessary services provided to enrolled T19/21 persons with a Serious Mental Illness (SMI) as described in the AHCCCS ACOM – Policy 432- Benefit Coordination and Fiscal Responsibility for Behavioral Health Services and Physical Health Services, Section III–B, titled Specific Circumstances Regarding Payment for Behavioral Health Services.

ASH will provide all treatment plans to the responsible agency. The responsible agency should indicate review of an agreement/disagreement with the treatment plan on the document. Any disagreements should be discussed as soon as possible and resolved as outlined in AAC 9R-21 (PDF).

Treatment plans are reviewed and revised collaboratively with the Adult Clinical Team at least monthly.

Any noted difficulties in collaboration with the outpatient provider treatment teams will be brought to the attention of The Health Plan to be addressed. The Health Plan Hospital Liaison will monitor the participation of the outpatient team and assist when necessary.

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

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

Recertification of Need (RON)
The ASH Utilization Manager is responsible for the recertification process, when recertification is required, for all Title XIX/XXI eligible persons and is the contact for ASH for all The Health Plan continued stay reviews.

The ASH Utilization Manager will work directly with the Member's attending physician to complete the Recertification of Need (RON). For members 65 and over, the RONs cover up to a 60 day span, for members under 21 the RONs cover a 30 day span and are submitted accordingly. The RON will be sent to The Health Plan within five (5) days of expiration of the current CON/ RON. If required by The Health Plan, the ASH Utilization Manager will send to The Health Plan Utilization Review staff additional information/documentation needed for review to determine continued stay. The Health Plan pays the first 30 days following admission to the ASH for T19 members; following this period, a 1-day authorization is created for all members regardless of age, and then denies.

All Health Plan decisions regarding to the approval or denial for continued stay will be rendered prior to the expiration date of the previous authorization and upon receipt of the RON for those Members. The Health Plan authorization decisions are based on review of chart documentation supporting the stay and application of the AHCCCS Level Continued Stay criteria. If continued stay is approved, The Health Plan sends a Letter of Approval (LOA) to the ASH Utilization Management Department with the completed RON and updated standard nomenclature diagnosis codes (if applicable). Denials will be issued upon completion of the denial process.

Transition to Community Placement Setting

The Member is considered to be ready for community placement and is placed on the Discharge Pending List when the following criteria are met:

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

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

When the Member has not been placed in a community placement setting within 30 days, a quality of care concern will be initiated by the Health Plan or AHCCCS, if an agreement has not been made between ASH and the outpatient treatment team that the discharge will take place after 30 days.

For T19/21 persons with a Serious Mental Illness and insulin-dependent diabetes, Health Plan will provide at discharge the same brand and model glucose monitoring device as used competently at ASH. Care must be coordinated with the ASH prior to discharge to ensure that all supplies are authorized and available to the member upon discharge.

ASH Conditional Release Requirements

The Health Plan has processes in place to provide high touch care management and/or other behavioral health and related services to members on Conditional Release from the Arizona State Hospital (ASH) that are consistent with the Conditional Release Plan (CRP) per AHCCCS AMPM Policy 320Z https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320Z.pdf: Members on Conditional Release. This includes but is not limited to assignment to a

contractor care manager, which may be the assigned Health Plan ASH liaison or another team care manager working in conjunction with the Health Plan ASH liaison. Care management functions may not delegate these functions to a subcontracted provider.

The Health Plan Care Manager or ASH Liaison acts as the single point of contact and is responsible to provide, at a minimum, the following:

- Collaboration with the outpatient treatment team, ASH, and the Superior Court;
- Discharge planning coordination with ASH;
- Participation in developing and implementing Conditional Release Plans;
- Participation in the modification of an existing Individual Service Plan (ISP) or the modification of an existing ISP that complies with the Conditional Release Plan (CRP);
- Member outreach and engagement to help evaluate compliance with CRP;
- Attendance in outpatient staffing at least once per month;
- Coordination of care with member's treatment team, TRBHA, and physical and behavioral health providers to implement the ISP and CRP;
- Routine delivery of comprehensive status reporting to AHCCCS, ASH and Superior Court as specified in A.R.S. § 133991 and A.R.S. §13-3994 – 4000;
- In the event that a member violates any term of their CRP, psychiatric decompensation, or use of alcohol, illegal substances or prescription medications not prescribed to the member, the Health Plan will confirm immediate notification to the Superior Court and ASH was completed by the outpatient provider and provide a copy to AHCCCS;
- The Health Plan agrees and understands that is will follow all obligations, including those stated above, applicable to it as set forth in A.R.S. § 133991 and A.R.S. §13-3994 - 4000.

The Health Plan provides training and technical assistance to outpatient providers serving members on Conditional Release and assures providers demonstrate understanding of A.R.S. § 133991 and A.R.S. §13-3994 – 4000 duties of outpatient providers. The Health plan ensures the monthly Conditional Release Deliverable is received from the outpatient provider team monthly by the 2nd day of the month for the previous months' date and submitted to AHCCCS as required by AMPM 320Z. The Conditional Release Report can be found at https://www.azahcccs.gov/Resources/Downloads/ConditionalReleaseMonthlyMonitoringReport.pdf. The Health Plan will coordinate with the outpatient provider for additional documentation at the request of AHCCCS Medical Management.

In the event that a member's mental status renders them incapable or unwilling to manage their medical condition and the member has a skilled medical need, the Health Plan must arrange ongoing medically necessary nursing services in a timely manner.

SPECIAL ASSISTANCE FOR MEMBERS DETERMINED TO HAVE A SERIOUS MENTAL ILLNESS

Behavioral Health Homes and contracted BH Inpatient Facilities must identify and report to the AHCCCS Office of Human Rights (OHR) on members determined to have a Serious Mental Illness (SMI) who meet the criteria for Special Assistance. If the person's Special Assistance needs appear to be met by an involved family member, friend, designated representative or guardian providers must still submit a notification to the OHR. Behavioral Health Homes, contracted BH Inpatient Facilities and the Behavioral Health Office of Grievances and Appeals (BHOGA) must ensure that the person designated to provide Special Assistance is involved at key stages.

Behavioral Health Homes and contracted BH Inpatient Facilities are expected to follow the policies and procedures outlined in AMPM Policy 320-R, all other applicable AHCCCS policies and state policies outlined in Arizona Revised Statutes and Arizona Administrative Code.

General Requirements

Criteria to deem a member to be in need of Special Assistance:

A member determined to have a Serious Mental Illness (SMI) is in need of Special Assistance if the member is unable to do any of the following:

i. Communicate preferences for services;
ii. Participate effectively in Individual Service Planning (ISP) or Inpatient Treatment Discharge Planning (ITDP);
iii. Participate effectively in the appeal, grievance or investigation processes.

The member's limitations described above must also be due to any of the following:

iv. Cognitive ability/intellectual capacity (i.e. cognitive impairment, borderline intellectual functioning, or diminished intellectual capacity);
v. Language barrier (an inability to communicate, other than a need for an interpreter/translator); and/or
vi. Medical condition (including, but not limited to traumatic brain injury, dementia, or severe psychiatric symptoms).

A member who is subject to general guardianship has been found to be incapacitated under A.R.S. § 14-5304, and therefore automatically satisfies the criteria for Special Assistance.

For a member determined to have a SMI, the existence of any of the following circumstances may warrant the Behavioral Health Home to more closely review whether the member is in need of Special Assistance:

i. Developmental disability involving cognitive ability;
ii. Residence in a 24 hour setting;
iii. Limited guardianship, or The Health Plan or the Behavioral Health Home is recommending the establishment of a limited guardianship; or
iv. Existence of a serious medical condition, that affects intellectual and/or cognitive functioning (such as, dementia or traumatic brain injury).

Persons Qualified to Make a Special Assistance Determination

Specific staff and agencies are qualified to screen for Special Assistance and determine whether a member qualifies for Special Assistance (See AHCCCS AMPM Policy 320-R for specific requirements).

Screening for Special Assistance

Behavioral Health Homes and contracted Behavioral Health (BH) Inpatient Facilities perform screenings to assess whether members determined to have a SMI are in need of Special Assistance, in accordance with the criteria set out in AHCCCS AMPM Policy 320-R.

Documentation

Special Assistance documentation and record keeping policies and procedures are referenced in AMPM Policy 320 Special Assistance for Members Determined to Have a Serious Mental Illness.

If a member is currently identified as a member in need of Special Assistance, a notation of "Special Assistance" and a completed AHCCCS AMPM 320-R, Attachment A, Notification of Member in Need of Special Assistance should already exist in the clinical record. However, if it is unclear, Behavioral Health Homes and contracted Behavioral Health Inpatient Facilities can contact The Health Plan Independent Oversight Committee Liaison to inquire about current status. The Behavioral Health Plan maintains a database on members in need of Special Assistance and shares data with Health Homes and contracted Behavioral Health Inpatient Facilities on a regular basis.

Notification Requirements to the Office of Human Rights

Behavioral Health Homes and contracted Behavioral Health Inpatient Facilities are expected to follow the policies and procedures for notifying the Office of Human Rights as outlined in AMPM Policy 320-R.

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Behavioral Health Homes and contracted Behavioral Health inpatient Facilities must use the current electronic Special Assistance Notification Form found on the AHCCCS QM Portal.

Members No Longer in Need of Special Assistance
Behavioral Health Homes and contracted Behavioral Health Inpatient Facilities are expected to follow the policies and procedures for notifying the Office of Human Rights when a member no longer meets Special Assistance criteria, as outlined in AHCCCS AMPM Policy 320-R.

Requirement to Help Ensure the Provision of Special Assistance
Behavioral Health Homes and contracted BH Inpatient Facilities collaborate with and involve the member (guardian, family member, friend, Office of Human Rights advocate, etc.) meeting Special Assistance needs in all relevant Behavioral Health planning and processes. Behavioral Health Homes and contracted Behavioral Health Inpatient Facilities are expected to follow the policies and procedures within AHCCCS AMPM Policy 320-R.

Behavioral Health Home Reporting Requirements
Behavioral Health Homes and contracted BH Inpatient Facilities are expected to follow all reporting requirements listed within the AHCCCS AMPM Policy 320-R.

Confidentiality Requirements

Behavioral Health Homes shall grant access to clinical records of members in need of Special Assistance to the Office of Human Rights in accordance with federal and state confidentiality laws (AHCCCS AMPM Policy 550).

Independent Oversight Committees receive confidential information related to Special Assistance members and are expected to safeguard the information in accordance with the requirements set out in AHCCCS ACOM, Policy 447.

Other Procedures
Behavioral Health Homes and contracted Behavioral Health Inpatient Facilities must follow the training requirements related to Special Assistance, as outlined in AHCCCS AMPM, Policy 320-R and AHCCCS AMPM Policy 1060.

Behavioral Health Homes and contracted Behavioral Health Inpatient Facilities must assign one staff member to act as the Special Assistance Single Point of Contact. The Single Point of Contact must be proficient in all Special Assistance policies and procedures as outlined in AHCCCS AMPM, Policy 320-R and all other applicable Special Assistance policy.

The Single Point of Contact verifies AHCCCS Office of Human Rights requests for further information and/or ensures timely submission of documents. The Single Point of Contact is responsible to review all information provided on AHCCCS AMPM 320-R Attachment A, Notification of Member in Need of Special Assistance, prior to submission to AHCCCS Office of Human Rights to ensure member meets criteria.

Behavioral Health Home Single Point of Contact staff are required to attend the Special Assistance Single Point of Contact Monthly Conference Call. Behavioral Health Homes should notify The Health Plan Special Assistance Department (OIFA) to inform of any changes in Single Point of Contact staff.

Transfer of a Special Assistance Member
Notice of a request to transfer, for all Special Assistance members, must be shared with The Health Plan prior to initiating the transfer through the Provider Portal and submitting the transfer packet. All changes and updates to a Special Assistance member's services, including transfers, requires collaboration with the person assigned to meet Special Assistance needs.

ADDITONAL BEHAVIORAL HEALTH HOME REQUIREMENTS

The Health Plan requires contracted Behavioral Health Home providers to meet additional service delivery requirements as outlined below, in addition to all behavioral health requirements outlined in The Health Plan Provider Manual. These include recovery support, access to care, outreach and engagement, enrollment, staffing, and system partner coordination of care. Members can select a Behavioral Health Home to receive their services. Members with chronic behavioral health care conditions are encouraged to receive their coordination of care services through a contracted Behavioral Health Home. The following contracted Behavioral Health Homes are required to meet the requirements identified in this section in addition to all behavioral health requirements identified in the Health Plan Provider Manual.

Screening and Serving Members with Complex Needs
All children must be screened for High Needs at the time of the initial comprehensive assessment and annually thereafter, per the AHCCCS AMPM 320-O, a high needs assessment (using the AHCCCS identified tool when available), for children ages 6-17.

Providers must place a copy of the children's High Needs screening tool in the Member's Electronic Health Record. A progress note is required following each screening, describing the actions taken as a result of the screening.

Providers must develop and implement service plans for Members with High/Complex Needs that include strategies to address a crisis and deliver all appropriate services to help

the Member remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and the criminal justice system.

Declination of Intensive Services

Providers are required to follow evidenced based practices and must ensure Members with High Needs receive appropriate services and take action to address risk management concerns when Members decline against medical advice to receive services. Permitted actions include: 1) notifying Members, guardians and families in writing of the risks associated with declining to accept more intensive treatment, 2) seek a court order for treatment when the adult Member/guardian declines more intensive treatment and the Member is a risk to themselves or others, or 3) with sufficient notice to the Member, decline to continue to provide treatment services which are ineffective in meeting the Member's needs.

High Needs Case Management (HNCM)

Behavioral Health Homes providing services to children are responsible for ensuring that the ratio of HNCM to Children with High Needs does not exceed 1:25. A ratio of 1:15 is preferred.

Behavioral Health Homes providing services to adults are expected to employ an adequate number of Health Care Coordinators to maintain low member to staff ratios and meet the needs of Adult High Needs members.

Appropriate case management intensity is paramount in assisting members in meeting their recovery goals and is based on member need and acuity of symptoms. AMPM Policy 570, Attachment A has identified four levels of case management intensity with different levels of required case manager to member contact:

i. Assertive Community Treatment (ACT) Case Management with a ratio of 12:1
ii. Individuals with Serious Mental Illness (SMI) designation. One component of a comprehensive model of treatment based upon fidelity criteria developed by the Substance Abuse and Mental Health Services Administration. ACT case management focuses upon individuals with severe and persistent mental illness that seriously impairs their functioning in community living, in conjunction with a multidisciplinary team approach to coordinating care across multiple systems (e.g., social services, housing services, health care).
iii. High Needs Case Management for Children with a ratio of 25:1.
iv. Focuses upon providing case management and other support and rehabilitation services to children with complex needs and multiple systems involvements for whom less intensive case management would likely impair their functioning. Children with high service intensity

needs who require to be offered the assignment of a high needs case manager are identified as:

v. Children 0 through five years of age with two or more of the following:
vi. Other agency involvement; specifically: AzEIP, DCS, and/or DDD, and/or;
vii. Out of home placement for behavioral health treatment (within past six months), and/or;
viii. Psychotropic medication utilization (two or more medications), and/or;
ix. Evidence of severe psycho-social stressors (e.g., family member serious illness, disability, death, job loss, eviction), and
x. Children six through 17 years of age: CALOCUS level of 4, 5, or 6.
xi. Supportive Case Management for Children and Adults with a ratio of 30:1
xii. Individuals with an SMI designation, General Mental Health/ Substance Use (GMH/SU), or children. Supportive Case Management: Focuses upon individuals for whom less intensive case management would likely impair their functioning. Supportive case management provides assistance, support, guidance and monitoring in order to achieve maximum benefit from services. Caseloads may include individuals with an SMI designation as well as individuals with a general mental health condition or substance use disorder as clinically indicated.
xiii. Connective Case Management for Children and Adults with a ratio of 70:1
xiv. Individuals with an SMI designation, GMH/SU, or children. Focuses on individuals who have largely achieved recovery and who are maintaining their level of functioning. Connective case management involves careful monitoring of the individual's care and linkage to service. Caseloads may include both individuals with an SMI designation as well as individuals with a general mental health condition or substance use disorder as clinically indicated.

The providers are responsible for ensuring the integrity of the role of the HNCM by empowering the HNCM o facilitate the delivery of behavioral health services; enhance treatment goals and treatment effectiveness; and coordinate services for Members with High Needs.

Requirements for Behavioral Health Homes in Meeting the Needs of Members with High/Complex Needs

Behavioral Health Homes are expected to:

i. Provide 24/7/365 services as clinically appropriate when planned in advance.

ii. Maintain low HNCM to member ratios. The AHCCCS AMPM 570 requires Behavioral Health Homes that serve children with High Needs to ensure that the ratio of HNCM's to Children with High Needs does not exceed 1:25. A ratio of 1:15 is preferred.
iii. Provide support and rehabilitation services that improve member outcomes and reduces the number of members in Out-of-Home placements, reduces Emergency Department visits, and reduces Inpatient stays by providing appropriate support in the member's community and home.
iv. Maintain an adequate number of Direct Support Staff to meet the needs of adult High Needs members.

Transition to Adulthood

Children turning 18 years of age may choose to remain with their current Behavioral Health Home, transfer to another Behavioral Health Home as desired or clinically indicated, or close out of the behavioral health system entirely.

Behavioral Health Home Access to Care Requirements

Screening

Providers must perform various screening and assessment services:

a. Providers must apply for AHCCCS coverage on behalf of Members through Health-e Arizona and assist Members in renewing their AHCCCS enrollment by completing applications on their behalf through Health-e Arizona and not refer persons to DES offices.
b. Offer in-person screenings and assessments for Medicaid, SMI, SABG and MHBG eligibility at no cost to Members or persons requesting the screening/assessment.
c. Provide intake, assessment and coordination services in the community, hospitals, nursing homes, state agency offices, detention, jail and prison facilities, specialty provider offices and Member's homes.
d. Providers must screen all children age 8 to 18, and adults for substance use disorders utilizing a standardized screening tool, at minimum:
    i. At intake;
    ii. Bi-annually for children and annually for adults; and
    iii. Within 7 days of reported or suspected problematic use.

If a screening yields positive results, members must receive a more comprehensive assessment to include substance use history, current use, and trauma.

a. Ensure that all Comprehensive Assessments, Individualized Service Plans, and Assessment Updates are signed by a The Health Plan -Credentialed, Licensed Behavioral Health Professional or Behavioral Health Medical Professional within 72 hours after the member received the assessment.

The Health Plan promotes a network of Trauma Informed Care (TIC)-certified therapists. The Health Plan will analyze the network sufficiency of TIC-certified therapists. Behavioral Health Homes must provide trauma screenings for youth and families. Behavioral Health Providers must ensure the provision of Trauma Informed Care Services, including routine trauma screenings and ensuring sufficient capacity of TIC certified therapists.

Referrals

a. Establish written criteria and procedures for accepting and acting upon referrals, including emergency referrals. The written criteria must include the definition of a referral for health services as described by the State.
b. When a Member requests to access Covered Services, there shall be no wrong door. The Health Plan and Provider are required to respond when a Member requests Covered Services and follow through to ensure the Member receives appropriate services. Provider is required to assist any Member with obtaining Covered Services for which the Member is eligible, from the Participating Health Care Providers best suited to deliver effective services to Member.
c. Behavioral Health Home providers must accept all referrals for intakes and services for populations identified provider's contract with The Health Plan, unless The Health Plan grants a written waiver or suspension of this requirement.
d. Accept all referrals regardless of diagnosis, level of functioning, age, Member's status in family or level of service needs.
e. Providers serving non-Title XIX/XXI must accept and respond to emergency referrals twenty-four (24) hours a day, seven (7) days a week.
f. Make appropriate referrals to and schedule appointments with In-Network Specialty Providers to meet Members' treatment needs and effectively coordinate care.
g. Have a process to verify all Network options have been explored and exhausted before completing a request for out-of-Network services. Provider must notify The Health Plan of all Out-of-Network requests.
h. Provider understands that all community residents, including visitors are eligible to receive crisis services and provider must

assist anyone experiencing a crisis in obtaining crisis services through a The Health Plan contracted crisis provider by calling the Crisis Call Center.

Outpatient Services

Providers must offer outpatient services identified in the provider's agreement with The Health Plan, including intakes, comprehensive assessments, service planning, coordination of care and outpatient services to all populations specified in the provider's agreement with The Health Plan.

Case management services shall be provided by individuals who are qualified BHPs or BHTs/BHPPs supervised by BHPs. Case Management is a provider level supportive service provided to improve treatment outcomes (Reference AHCCCS AMPM 310-B.) Examples of case management activities to meet member's Service Plan goals include:

a. Assistance in maintaining, monitoring and modifying behavioral health services
b. Assistance in finding necessary resources other than behavioral health services
c. Coordination of care with the member's healthcare providers, Family, community resources, and other involved supports including educational, social, judicial, community and other State agencies
d. Coordination of care activities related to continuity of care between levels of care (e.g. inpatient to outpatient care) and across multiple services (e.g. personal assistant, nursing services, and Family counseling)
e. Assisting members in applying for Social Security benefits when using the SSI/SSDI Outreach, Access, and Recovery (SOAR) approach; including,
f. Face-to-face meetings with member
g. Phone contact with member, and
h. Face-to-face and phone contact with records and data sources (e.g. jail staff, hospitals, treatment providers, schools, Disability Determination Services, Social Security Administration, physicians).
i. SOAR services shall only be provided by staff who have been certified in SOAR through SAMHSA SOAR Technical Assistance Center.
j. When using the SOAR approach, billable activities do not include:
1. Completion of SOAR paperwork without member present
2. Copying or faxing paperwork
3. Assisting members with applying for benefits without using the SOAR approach, and
4. Email.
k. For provider case management utilized when assisting members in applying for Social Security benefits (using the SOAR approach) the modifier HK is required.
l. Billing T1016 with an HK modifier indicates the specific usage of the SOAR approach and it cannot be used for any other service.
m. Outreach and follow-up of crisis contacts and missed appointments, and

n. Participation in staffing, case conferences, or other meetings with or without the member or their Family participating.
o. For provider case management used to facilitate a Child and Family Team (CFT), the modifier U1 is required.

Case Management limitations include:

a. Billing for case management is limited to providers who are directly involved with providing services to the member
b. Provider Case Management is not a reimbursable service for ALTCS E/PD, including Tribal ALTCS. Case Management is provided through the ALTCS E/PD Contractors or Tribal ALTCS Program
c. Provider Case management services provided by licensed inpatient, residential (BHRF) or day program providers are included in the rate for these settings and cannot be billed separately. However, providers other than the inpatient, residential (BHRF) facility, or day program can bill case management services provided to the member
d. A single practitioner may not bill case management simultaneously with any other service
e. For assessments, the provider may bill all time spent in direct or indirect contact (e.g. indirect contact may include email or phone communication specific to a member's services) with the member and other involved parties involved in implementing the member's Treatment/Service Plan
f. More than one provider agency may bill for case management at the same time, as long as it is clinically necessary and documented within the member's Treatment/Service Plan
g. More than one individual within the same agency may bill for case management at the same time, as long as it is clinically necessary and documented within the member's Treatment/Service Plan, and
h. When a provider is picking up and dropping off medications for more than one member, the provider shall divide the time spent and bill the appropriate case management code for each involved member.

Answering Service

Providers must maintain an answering service and telephone prompts appropriate to direct Members to verify access to services 24/7. Include language on telephone prompts, voicemail, answering services and advertisements that identifies the provider as Member of The Health Plan's Network of Providers and informs Members what to do in case of an emergency.

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 60 days of the notice of 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.

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.

SECTION IX: Medical Operations

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.

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)

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.
- 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 can be obtained by calling the Care1st Pharmacy Department at 1-866-560-4042 (Options 5,5).
- Up to a 14- day supply of a non-excluded formulary medication can be obtained following a hospital or ED discharge by calling the Pharmacy Department.
- Prior Authorization is not required when Care1st is the secondary payer.

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.

ADMINISTRATIVE DAYS

The Health Plan will consider administrative days for an acute hospitalized member who no longer meets medical necessity criteria and is ready for the next level of care; and the stay is being denied by the Health Plan Medical Director. In addition, it must be clearly documented in the member's medical record that the inpatient facility has attempted to secure the next level of care but has been repeatedly refused by all network available facilities. Providers must submit daily documentation, including weekends, of reaching out to providers for an available placement for the member. The documentation must be submitted to reviewer every 3 days throughout duration of administrative stay.

1. Discuss with the provider's UM reviewer about the member's lack of disposition per the finding of a facility available at time of discharge and request administrative days.
2. The provider will be notified upon approval.
3. It is the provider's obligation to submit continued information on who is being contacted for bed placement daily, with the name of the facility, phone number, who was spoken with, and reason for not accepting member.
4. Documentation of reaching out to providers for placement, including the information specified above, must be submitted daily, including weekends, and must also be submitted to the reviewer every 3 days throughout duration of administrative stay.

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.

SECTION IX: Medical Operations

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

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.

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.

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.

SECTION IX: Medical Operations

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.

Augmentative and Alternative Communication (AAC) Devices

Medically necessary Augmentative and Alternative Communication (AAC) devices are a covered benefit including:

- Evaluations for speech-generating and non-speech-generating AAC devices
- Therapeutic service(s) for the use of speech-generating and non-speech-generating devices, including programming and modification, and devices such as hearing aids, cochlear implants, speech-generating and non- speech-generating.

Members and providers can contact the health plan for assistance in locating a qualified specialist for AAC evaluations and devices.

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.

UTILIZATION REVIEW CRITERIA

Care1st has adopted utilization review criteria developed by InterQual® products to determine medical necessity for healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. The Medical Director, or other healthcare professional that

has appropriate clinical expertise in treating the Participant's condition or disease, reviews all potential adverse determination and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

Practitioners may obtain the full criteria used to make a specific adverse determination by contacting the Prior Authorization department at 1-866-560-4042 (Option 5, 6). Examples of criteria that may be utilized are Care1st Clinical Policies and InterQual® criteria appropriate to clinical condition and member's unique needs (e.g. Adult, Geriatric, Child, Adolescent, and Behavioral Health/Psychiatry). Practitioners also have the opportunity to discuss any adverse decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. The Medical Director may be contacted by calling Care1st's main toll-free phone number at 1-866-560-4042 and asking for a Peer Review with the Medical Director. A care manager may also coordinate communication between the Medical Director and requesting practitioner.

Members or healthcare professionals, with the Member's consent, may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing to:

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

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)

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/providers/resources/disease-managment1.html.

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

PREFERRED DRUG LIST

The Care1st Preferred Drug List (PDL) , 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 preferred drug list. 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. If submitting a Drug Prior authorization request, submit PA form 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 (PDL) as mandated by AMPM Policy 310-V. Our website contains a link to the AHCCCS website and the AHCCCS Drug List. .

The Care1st Preferred Drug Lists:

1. Are determined by the AHCCCS Pharmacy and Therapeutics Committee and provides a list of safe, cost-effective and efficacious medications that are available to members..
2. AHCCCS' goal is to use the Drug Lists to assist providers when selecting clinically appropriate medications for members.
3. The Care1st Drug List is not an all-inclusive list of medications.
4. The Care1st 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 members.
5. Health plans are required to cover all medically necessary, clinically appropriate, cost-effective medications that are federally and state reimbursable.

Care1st's Drug lists are more extensive than the AHCCCS PDL – it includes 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 Care1st.

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 for medical necessity against specific prior authorization criteria 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: All antipsychotics medications must be prescribed by an in-network behavioral 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 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 designation, 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.

9. Medications for Weight Loss

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:

- Submitted via Electronic Prior Authorization (ePA) through Cover My Meds http://www.covermymeds.com/main/prior-authorization-forms/

- Faxed to Care1st at 602-778-8387 using the Pharmacy Prior Authorization Request Form or

- Phoned in by calling the Pharmacy Department at 866-560-4042 (Options 5, 5)

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 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.

For any requests that do not meet medical necessity, providers may request a peer-to-peer call with a Medical Director to further discuss the medication denial.

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

AcariaHealth is the Care1st Preferred Specialty Pharmacy:

AcariaHealth	Multiple Locations Nationwide	1-800-511-5144

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

PHARMACEUTICAL REQUIREMENTS

Providers are required to comply with various pharmaceutical requirements within the Care1st Provider Manual, AHCCCS AMPM Policy 310-V and the Arizona Opioid Epidemic Act SB1001/HB2001.

E-Prescribing Software

Utilize e-prescribing software systems to submit prescriptions to pharmacies. This includes compliance with HB2075, which requires prescribing clinicans to send all prescriptions for CII Opioids to the pharmacy electronically using e-prescribing as required by Federal Law or regulation. Exceptions include federal facilities such as Indian Health Services, the Department of

Veterans Affairs and the Department of Defense.

Tamper-Resistant Prescription Pads

Providers are required to ensure that processes are in place for the use of Tamper Resistant Prescription Pads (TRPP) for any non-electronic prescriptions. Written and non-electronic prescriptions are required to contain all three of the following characteristics:

- One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.
- One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber, and
- One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

The tamper resistant requirement does not apply when a prescription is communicated by the prescriber to the pharmacy electronically, verbally, by fax or in most situations when drugs are provided in designated institutional and clinical settings and paid for as part of a bundled or per diem payment methodology. The guidance also allows emergency fills with non-compliant written prescriptions as long as the prescriber provides a verbal, faxed, electronic or compliant written prescription to the pharmacy within 72 hours.

Free Samples

Providers must ensure that no "free samples" of brand name medications will be provided to Care1st members, and that Pharmaceutical Company Representatives are not allowed to provide, or make available, marketing materials of brand name medications to Care1st members. The Provider must also ensure that Care1st members do not participate in Pharmaceutical Company sponsored activities, such as free lunches or giveaways. In order to prevent drug representatives from having undue influence on prescribing practices, provider staff serving Care1st members also are discourage from participating in Pharmaceutical sponsored activities, such as free lunches or giveaways.

The Health Plan Preferred Drug List (PDL)

Providers are required to abide by the Health Plan's Preferred Drug List (PDL) as applicable, when prescribing medications for members in accordance with this Provider Manual. Providers are also required to adhere to the requirements of the AHCCCS Psychotropic Medication informed consent requirements in accordance with this Provider Manual.

Prescriber Appointments

Providers must ensure that members are scheduled for Prescriber appointments in a time frame that ensures the member is evaluated for the need for medications so that the member does not experience a decline in behavioral health status, and the member does not run out of medication.

Physician Oversight

Providers are required to provide physician oversight when providing medical treatments,

including methadone, medications, and detoxification to ensure services are rehabilitative in focus and directed to long-erm recovery management, when applicable.

Medication Assisted Treatment

Providers are required to ensure Behavioral Health Medical Professionals assisting members with Substance Use Disorders provide Medication Assisted Treatment when appropriate to support members' recovery.

Registration with Controleed Substance Prescription Monitoring Program

All medical practitioners are required to register and utilize the Arizona Controlled Substance Prescription Monitoring Program (CSPMP, PMP). Practitioners must obtain a patient utilization report for the preceding 12 months from the controlled substances PMP central database tracking system before prescribing opioid analgesics or benzodiazepines in schedules II-IV. Practitioners are not required to obtain a report if the patient is:

- Receiving hospice care or being treated for cancer or cancer-related illness;
- If the practitioner will administer the controlled substance;
- If the patient is receiving the controlled substance during the course of inpatient or residential treatment in a hospital, nursing care facility or mental health facility;
- If the medical practitioner, under specific legislation, prescribed controlled substances for no more than five days after oral surgery, and
- As outlined in AHCCCS AMPM Chapter 300, Policy 310-FF

https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/

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 InterQual® 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.

SECTION IX: Medical Operations

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 InterQual® 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

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.

Network Practitioners and Providers are contractually required to cooperate with all Quality Improvement (QI) activities to improve the quality of care and services and member experience. This includes the collection and evaluation of performance data and participation in the Care1st's QI programs. Practitioner and Provider contracts, or a contract addendum, also require that Practitioners and Providers allow Care1st the use of their performance data for quality improvement activities.

As part of this program, providers and practitioners are required to cooperate with Quality Improvement (QI) activities and allow the Care1st to use their performance data.

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

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.

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.

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.

SECTION X: Quality Improvement

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 by Allwell 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

Claims may be submitted electronically from your clearing house using Payer ID 68069

Note: Faxed claims are not accepted.

Dental (J430D) Claims

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

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

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.

CLAIM ADDRESSES

Medical Claims:

Direct CMS 1500 and UB-04 claim forms (initial submissions and resubmissions) and medical records to:
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. Include the original claim number and the appropriate resubmission indicator or bill type.

- Records for facility and clinic-based services may mailed to:
  Attention Claims Department
  PO Box 8070
  Farmington, MO 63640-8070

SECTION XI: Billing, Claims And Encounters

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:
(833) 619-0416
Monday - Friday 8am-5pm outside DST
Monday - Friday 7am-5pm during DST

CLAIM LIAISON

For ACC or RHBA members, Our *Claim Liaison* is an excellent resource and is available to assist your office via 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

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 90 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

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)
19	Rendering provider NPI for provider types (05, 29, 77, C2, IC) Note: These are new requirements for 05,77, IC effective 01/01/23
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

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
8	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)
18-28	Condition Codes
31-34	Occurrence Codes/ Date
39-41	Value Code/ Amount
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
53	Assignment of Benefits - Tiertiary
54	Prior Payments
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
70	Reason code
71	PPS Code
72	External Cause of Injury Code
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. When coordinating benefits, Care1st follows AHCCCS policy in ACOM 203 for complete care members:

- For contracted providers: Unless the providers contract with Care1st specifies otherwise, we will pay the difference between the primary insurance payment and the provider's contracted rate, not to exceed the contracted rate.
- For non-contracted providers: Care1st will pay the difference between the AHCCCS capped fee for service rate and the primary insurance paid amount, not to exceed the AHCCCS capped fee for service rate.

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 90 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.

SECTION XI: Billing, Claims And Encounters

When a member is WellCare by AllWell 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.

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**.

SECTION XI: Billing, Claims And Encounters

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.

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
- 90 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.

SECTION XI: Billing, Claims And Encounters

EXPLANATION OF REMITTANCE ADVICE

The Remittance Advice (RA) is an explanation of the payment arrangements that is sent out with the claim 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

HEADER

Company	The line of business (Care1st), logo and address
Run Date	Check payment Date
Payee ID	A unique internal number identifying the pay to Provider
IRS#	Tax identification number
Beginning Negative Services Balance	Amount of overpayment
Beginning Prepayment Balance	Claims used to satisfy the overpayment
Total Beginning Balance	Claims that are identified as overpayment
Closing Balance	Balance after offset

CLAIM PAYMENT DETAIL

Insured Name	Subscriber Name
Member ID	AHCCCS Patient ID
DRG	The DRG assigned for payment (when applicable)
Claims No.	The Care1st internal claim number assigned to the claim
Patient Name	Member Name
PCN	Patient Control Number
Provider ID	The Care1st internal unique provider ID number
Service Provider	The rendering provider
NPI	Servicing Provider NPI
Group	Member Group Number
Serv	The service line on claim
Dates	Date of Service
Procedure	The revenue code, HCPCS, or CPT code submitted on the claim
Modifiers	Modifier code submitted on the claim
Days Ct/Qty	The total quantity/ units submitted for the service
Charged	The billed amount for the procedure
Allowed	The eligible allowed amount for the procedure
Deduct Copay	The member deductible/copayment amount
Disallow/Discount	The total amount withheld for discounts (i.e. quick payment discount, contractual discount, etc.)
Interest	Additional payment amount remitted if claims paid outside of contractual claims payment timeline
Med Allow/Med Paid	The payment amount for the service submitted
TPP	Third Party Payer (COB)
Denied	The payment amount denied for services submitted
Payment Codes	Explanation code that defines claim payment
Payment	The payment amount for the service submitted

REMITTANCE ADVICES AVAILABLE ON WEBSITE

Medical

Providers are encouraged to register to receive The Health Plan Electronic RA (ERA) through PaySpan. Providers can sign up for PaySpan via their website at www.PaySpanHealth.com or providers can contact PaySpan provider support at 1-877-331-7154.

Dental
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

Care1st follows ACOM policy 432 for coordination of benefits for ACC and RBHA members, as indicated in **Attachment A, matrix of financial responsibility, responsibility by party.**

http://www.azahcccs.gov/ > Plans/Providers > Guides-Manuals-Policies > AHCCCS Contractor Operational Manual (ACOM) > Chapter 400 Operations > 432 Benefit 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.

SECTION XI: Billing, Claims And Encounters

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.

PRIOR AUTHORIZATION

- Prior authorization guidelines are published on our website at www.care1staz.com

- 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. The 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, & XU based on AHCCCS guidelines.

MODIFIER 76 **(repeat procedure by same physician)**
Modifier 76 is required to identify repeat procedures performed 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 are billed on one 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 & GN (Therapy code modifiers)
Modifier GP is required to identify physical therapy services and is appended to the appropriate therapy code. Modifier GO is required to identify occupational therapy services and is appended to the appropriate therapy code. Modifier GN is required to identify speech therapy services and is appended to the appropriate therapy code. Please refer to your billing guidelines for coding requirements for case rate reimbursement.

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 Anesthesia, 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/MEDICAL RECORDS

An operative report and/or medical is required for the following

- Services billed with modifier 59, XE, XS, XU

- Any unlisted procedure

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 Health Plan
Attn: Finance Refund and Recovery
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.

- 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.

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 01/01/2023 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

Examples:
Non-registerable providers, populate ten 9's, followed by last,name.
9999999999SMITH,JOHN

Registerable providers, populate XXNPI followed by last,first name.
XX1234567899DOE,JANE

- 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 by Allwell and Care1st coverage, the secondary claim must be submitted to Care1st on paper with a copy of the Liberty remittance advice.

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.

SECTION XI: Billing, Claims And Encounters

INTEGRATED CLINICS, BEHAVOIRAL HEALTH OUTPATIENT CLINICS & CLINICS

Claims where the individual practitioner who performed the services associated with the clinic visit is not reported, will be denied.

In addition, if the service is rendered in a school, Place of Service 03, the School ID is required to be submitted.

Exhibit 10-1 (https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/Exhibit10-1.pdf) of the AHCCCS Fee-For-Service Provider Billing Manual provides billing instructions for accurate claims submissions, including examples.

Reminders:

1. The rendering provider on the claims is the IC, BHOP or Clinic, not the practitioner. The site-specific NPI and/or the IC, BHOP or Clinic entity name is placed in the following fields of the claims:

Medical Paper Claims	***Dental Paper Claims***	***Medical & Dental EDI Claims***
Box 24J and 32	Box 54 and 56	Loop 2310B

2. The participating/performing practitioner information is listed in the following fields of the claim:

Medical Paper Claims	***Dental Paper Claims***	***Medical & Dental EDI Claims***
Box 19	Box 35	Loop 2300 NTE segment

3. When submitting a paper claim, populated box 31 on medical and box 53 on dental claims with 'Signature on file'.

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).

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.

59410 Vaginal delivery only (with or without episiotomy), forceps or breech delivery including postpartum care. Use when there are fewer than five prenatal visits.

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.

59515 Cesarean delivery only including postpartum care. Use when there are fewer than five prenatal visits.

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:

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-services
- 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 PROFESSIONAL REIMBURSEMENT (NP'S, PA'S, CNM'S, CRNA'S, AUD'S, DC'S, RD'S)

NPs, PAs, CNMs, AUDs, DCs, & RDs) 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)

- 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

- 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.

- Planned surgeries require their own prior authorizations. Surgical trays (A4550) are not reimbursable.

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

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 Arizona: 602-417-4045
  - Toll free Outside of Arizona Only: 888-ITS-NOT-OK or 888-487-6686
- AHCCCS Member Fraud Hotline:
  - In Arizona: 602-417-4193
  - Toll free Outside of Arizona Only: 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 as prescribed by federal or state law.
- 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.