Chapter 18:

Behavioral Health Services

Reviewed/Revised: 10/1/18, 3/4/19, 7/25/19, 9/23/19, 1/1/20, 7/15/20, 1/1/21, 2/1/21, 5/1/21, 6/1/21, 6/30/21, 10/29/21, 1/13/22, 3/1/22, 4/15/22, 5/16/22, 6/1/22, 10/1/22, 1/01/23, 7/01/23

18.0 INTRODUCTION

The State of Arizona has contracted with BCBSAZ Health Choice (the Plan) to administer the AHCCCS Complete Care (ACC) plan, an integrated delivery system of care including physical health, behavioral health, and substance abuse services. BCBSAZ Health Choice's geographic service area for integrated care includes Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pinal, and Yavapai counties.

Regional Behavioral Health Authorities (RBHAs) and Tribal Regional Behavioral Health Authorities (TRBHAs) will continue to manage integrated physical and behavioral health service provision for individuals with a Serious Mental Illness (SMI) designation, for American Indians who have choice between health plans, individuals deemed DDD with case management support only, and crisis services. The RBHAs will also continue to manage grant administration and housing support services (until October 2022). BCBSAZ Health Choice offers a full range of behavioral health services to our members who are both Medicaid-only eligible, non-Medicaid, and dual eligible for Medicaid and Medicare. American Indian AHCCCS members may elect to enroll in an ACC managed care plan or the American Indian Health Program (AIHP) and a TRBHA where available.

The Plan is committed to providing high quality services and access to comprehensive, community based behavioral and physical health care for our members. Our service delivery system is designed to meet the CMS Mental Health and Substance Use Disorder Parity Requirements for Medicaid. We use a holistic approach to care, focusing on members' goals with an understanding of their unique and specific needs, including the social determinants of health, as well as established partnerships with providers and community resources to ensure those needs are met.

The BCBSAZ Health Choice Provider Manual is applicable to defined populations that may access public behavioral health/integrated care services. These populations include:

- Title XIX and Title XXI members
- Behavioral health members receiving emergency/crisis services
- Other populations, based on the availability of funding and the prioritization of available funding.

The Plan contracted providers will comply with laws and government program participation standards: Provider shall, always during the Term, arrange for the delivery of Covered Services in accordance with Applicable Laws. Furthermore, Provider will implement reasonable procedures to monitor that the Provider Professionals deliver health care services to Members in accordance with Applicable Laws, including, but not limited to, the State Managed Care Requirements and the Government Program Requirements. Without limiting the generality of this Section, Provider further agrees as follows:

1. State Managed Care Requirements. Provider agrees that it, the Provider Professionals, and any subcontractors of Provider shall be bound by State Managed Care Requirements applicable to the Health Benefit Plans in which Provider is participating under this Agreement. Provider understands and agrees that such State Managed Care Requirements shall apply to all employees, independent contractors and subcontractors of Provider who provide or arrange, or who may provide or arrange, for Covered Services to such Members. Provider and BCBSAZ Health Choice agree that, in the event of any inconsistent or contrary language between applicable State Managed Care Requirements and any other part of this Agreement (including Exhibits, Schedules, and Attachments), such State Managed Care Requirements as then applicable shall govern and be controlling.
2. Government Program Requirements. Provider acknowledges and understands that Health Choice has or shall seek contracts with Governmental Authorities for the purpose of offering Health Benefit Plans to beneficiaries of Government Programs. To the extent Health Choice participates in a specific Government Program, Provider agrees that it, the Provider Professionals, and any subcontractors of Provider shall be bound by Government Program Requirements applicable to such Health Benefit Plans. Provider understands and agrees that such Government Program Requirements shall apply to all employees, independent contractors and subcontractors of Provider who provide or arrange, or who may provide or arrange, for Covered Services to such Members. Provider shall require each Provider Professional and subcontractor of Provider to meet and comply with the Government Program Requirements applicable to such Health Benefit Plans from time to time subject to this Agreement, including, but not limited, to those Government Program Requirements applicable to Provider as a First Tier Entity. Provider and Health Choice agree that, in the event of any inconsistent or contrary language between the applicable Government Program Requirements and any other part of this Agreement (including Exhibits, Schedules and Attachments), such Government Program Requirements as then applicable shall govern and be controlling.

18.0.1 SYSTEM VALUES AND GUIDING PRINCIPLES

All healthcare services must be delivered in accordance with AHCCCS system values, principles, and goals:

1. Timely access to care,
2. Culturally competent and linguistically appropriate care,
3. Identification of the need for and the provision of comprehensive care coordination for physical and behavioral health service delivery,
4. Integration of clinical and non-clinical health care related services,

5. Education and guidance to providers on service integration and care coordination,
6. Provision of chronic disease management including self-management support,
7. Provision of preventive and health promotion and wellness services,
8. Adherence with the Adult Behavioral Health Service Delivery System -Nine Guiding Principles as described below,
9. Adherence with the Arizona Vision-Twelve Principles for Children Behavioral Health Service Delivery as outlined in AMPM Policy 430,
10. Promotion of evidence-based practices through innovation,
11. Expectation for continuous quality improvement,
12. Improvement of health outcomes,
13. Containment and/or reduction of health care costs without compromising quality,
14. Engagement of member and family members at all system levels,
15. Collaboration with the greater community,
16. Maintains, rather than delegates, key operational functions to ensure integrated service delivery,
17. Embraces system transformation, and
18. Implementation of health information technology to link services and facilitate improved communication between treating professionals, and between the health team, the member and member caregivers.

18.0.2 ADULT SYSTEM OF CARE PRINCIPLES

The service delivery system shall operate in accordance with the following principles for adults with behavioral health disorders and their families:

1. **Respect**
   Respect is the cornerstone. Meet the person where they are without judgment, with great patience and compassion.
2. **Persons In Recovery Choose Services and Are Included in Program Decisions and 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.
3. **Focus On Individual as A Whole Person, While Including and/or Developing Natural Supports**
   A person in recovery 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.
4. **Empower Individuals Taking Steps Toward Independence and Allowing Risk Taking Without Fear of Failure**
   A person in recovery finds 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.

5. **Integration, Collaboration, And Participation with the Community of One's Choice**
   A person in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscore 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.
6. **Partnership Between Individuals, Staff, And Family Members/Natural Supports for Shared Decision Making with A Foundation of Trust**
   A person in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.
7. **Persons In Recovery Define Their Own Success**
   A person in recovery -- by their own declaration -- discovers success, in part, by quality of life, community, and greater self-determination. Persons in recovery are the experts on themselves, defining their own goals and desired outcomes.
8. **Strengths-Based, Flexible, Responsive Services Reflective of an Individual's Cultural Preferences**
   A person in recovery 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.
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 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.

18.0.3 ARIZONA VISION-TWELVE PRINCIPLES FOR CHILDREN SERVICE DELIVERY

1. **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. Parent 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.
2. **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.
3. **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, parents, any foster parent, and 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 Child Protective Service and/or Division of Developmental Disabilities case worker, and the child's probation officer. The team develops a common assessment of the child's and family's strengths and needs, develops an Individualized Service Plan, and monitors the implementation of the plan and adjusts the plan as needed.

4. **Accessible Services**: Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need. Case management is provided as needed. Behavioral health services plans identify transportation the parents and the 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.
5. **Best Practices:** Behavioral health services are provided by competent individuals who are adequately trained and supervised. 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 are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, the need for stability and the need to promote permanency in the class members' lives, especially class members in foster care. Behavioral health services are continuously evaluated and modified if ineffective in achieving desired outcomes.
6. **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 meet 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 needs.
7. **Timeliness:** Children identified as needing behavioral health services are assessed and served promptly.
8. **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.
9. **Stability:** Behavioral health service places strive to minimize multiple placements. Service plans identify whether a class 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 crisis 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 the criminal justice system. Behavioral health service plans anticipate and appropriately plan for transition in children's lives, including transitions to new schools and new placements, and transitions to adult services.
10. **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.

11. **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 needs for training and support to participate as partners in the assessment process, and in the planning and delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with the understanding of written materials, will be made available.
12. **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.

18.1 COVERED SERVICES RELATED TO BEHAVIORAL HEALTH AND SUBSTANCE USE

BCBSAZ Health Choice is responsible for assessing the service needs in our regions and developing a plan to meet those needs. The Plan contracts with a network of behavioral health care providers, outpatient clinics, inpatient facilities, peer, and family run agencies, residential facilities, and other community services to deliver a full range of behavioral health services. Please refer to AMPM 310-B TITLE XIX/XXI Behavioral Health Benefit, Behavioral Health Services. Refer to the AHCCCS FFS Provider Billing Manual Chapter 19 and related content https://azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html for additional guidance, information and requirements.

The AHCCCS Provider Billing Manuals

- Chapter 19, Behavioral Health Services, of the Fee-For-Service Provider Billing Manual
- Chapter 12, Behavioral Health Services, of the IHS/Tribal Provider Billing Manual
- Appropriate Policies as necessary.
    - i.e., Service benefit information, including transportation and transportation billing information pertinent to MCOs and FFS providers: AMPM 310-BB Transportation.

18.2 EMERGENCY DEPARTMENT SERVICES

When BCBSAZ Health Choice members present to an emergency department (ED) setting, the Plan is responsible for the reimbursement of those services which includes all physical and behavioral health services. Prior authorization is not required for emergency services. In an emergency, members should go to the nearest emergency department.

In Northern Arizona (Coconino, Mohave, Navajo, Yavapai, and Apache counties), Care 1st ACC-RBHA manages the behavioral health crisis system. Mercy Care ACC-RBHA manages the behavioral health crisis system in Gila, Maricopa, and Pinal Counties. Arizona Complete Health ACC-RBHA manages the behavioral health crisis system in Southern Arizona (Cochise, Graham,

Greenlee, La Paz, Pima, Santa Cruz, and Yuma counties). Crisis services for the entire state can be accessed by calling Solari Crisis and Human Services via the statewide crisis hotline: 1-844-534-4673 or 1-844-534-HOPE.

Note: Any member, regardless of eligibility, may be referred to an Emergency Department for evaluation and possible admission/treatment of an acute behavioral health condition.

NOTIFICATION OF MEMBERS IN ED >24 HOURS AWAITING BEHAVIORAL HEALTH SERVICES:

BCBSAZ Health Choice utilizes several methods to obtain information to identify members in Emergency Departments (ED) who are awaiting placement for behavioral health services. For Maricopa and Pinal Counties, BCBSAZ Health Choice identifies members through Crisis Preparation Recovery's (CPR) ED live database and receives daily email reports from Phoenix Children's Hospital of behavioral health discharges. For our ACC members in Northern Arizona who have been cleared medically and are awaiting behavioral health services beyond 24 hours, Emergency Departments, Behavioral Health Homes/outpatient service providers, crisis teams, and other system stakeholders are to notify Health Choice of the delay. This is done by submitting an ED notification to hchhciccrisis@azblue.com . [See BCBSAZ Health Choice website for the Plan ED notification form.] The Plan will assign a Behavioral Health Care Manager to assist the ED with placement referral, coordination, and identification of necessary covered services.

18.3 PCP SCREENING AND MANAGEMENT OF BEHAVIORAL HEALTH DISORDERS, INCLUDING PSYCHOTROPIC MEDICATION PRESCRIBING

Using a population based medical care approach, PCPs are required to screen all members for behavioral health conditions or disorders using standardized screening tools for:

- Whole person health and Social Determinants of Health (Health Risk Assessment)
- Depression and anxiety (PHQ-2/9, GAD-7, Edinburg Perinatal Depression Scale)
- Developmental needs (EPSDT, CALOCUS, M-CHAT, ADOS, PEDS, ASQ)
- Substance use (AUDIT, DAST, ASAM)
- Trauma (Adverse Childhood Events)

For members under age 21 years, the EPSDT (“well-child visits”) Clinical Sample Template is completed for all empaneled children to identify early hearing, dental, vision and nutritional problems, developmental delays, autism spectrum disorder, behavioral health disorders, and special health care needs. The PCP must assess children’s health needs, provide preventive screening and all required immunizations, initiate needed referrals and complete recommended medical treatment and coordinate care.

It is important the PCP indicate behavioral health concerns on the EPSDT Clinical Sample Template. If the primary concern is a behavioral problem (i.e., Oppositional Defiant Disorder, Conduct Disorder, Bipolar Disorder), AHCCCS members should be referred to a BCBSAZ Health Choice contracted behavioral health provider first rather than a developmental specialist. The behavioral health provider will assess the member to identify immediate interventions and

resources to address the behavioral issues. The behavioral health specialist may refer to a developmental specialist as appropriate. If the primary concern is depression, anxiety, and/or Attention Deficit Hyperactivity Disorder (ADHD), the PCP may manage the member's behavioral health condition.

When the PCP decides scope of treatment falls outside the comfort level of the PCP and the member requires services from a behavioral health provider, the member should be referred to a BCBSAZ Health Choice contracted behavioral health provider for ongoing behavioral health assessment and services. BCBSAZ Health Choice ensures that the network includes experts who are Masters and Doctoral level clinicians in the fields of social work, counseling, and psychology trained in implementation of best practices for medically and behaviorally complex conditions such as intellectual/cognitive disabilities, trauma-related disorders, substance use disorders, sexual disorders, and special age groups such as transition age youth and birth to five-year-old members.

Members who are dual eligible for Medicare and Medicaid, should be referred to a licensed behavioral health provider who is part of their Medicare contracted network. Within the scope of his or her practice, a Primary Care Provider (PCP) may provide medication management to members with the following behavioral health disorders:

- Attention Deficit Hyperactivity Disorder (ADHD)
- Depression (including peripartum and postnatal depression)
- Anxiety
- Substance Use Disorders/Opioid Use Disorder

BCBSAZ Health Choice has a robust list of covered medications, which includes all the AHCCCS preferred medications to treat each disorder. PCPs who treat members for a covered behavioral health condition may provide the following medication management services:

- Laboratory and other diagnostic tests
- Prescriptions

PCPs who are treating members with medication-assisted treatment (MAT) for opioid use disorder (OUD) must meet all regulatory requirements established for MAT administration. MAT services are defined as both medication management with FDA approved OUD medications and psychological and behavioral therapies. PCPs can provide MAT services alone or in conjunction with therapies.

If the PCP is providing medication management services only, they must refer the member to a behavioral health provider for the psychological and behavioral therapy component.

The Plan has step therapy processes in place when a behavioral health provider feels a member is clinically stable on their current medication regimen and the member has a diagnosis of anxiety, depression, opioid use disorder or ADHD. The following outlines The BCBSAZ Health Choice process for transitioning members between behavioral health providers and PCPs for medication management as per AMPM Policy 520. Upon notification from a behavioral health

provider or PCP that a member is clinically stable and ready for transition back to the PCP for ongoing behavioral health medication management, or would benefit from transfer from a PCP to a behavioral health provider, the Plan ensures:

- The current provider consulted with the accepting provider, regarding the case and course of treatment.
- All pertinent records will be sent to the PCP, from the behavioral health provider, or from the PCP to the behavioral health provider prior to the member's transition appointment.
- Plan care management staff will coordinate with the providers and ensure they agree to manage the member's behavioral health condition.
- Care management staff will confirm the member agrees to transition to the new PCP/behavioral health provider for on-going management of their behavioral health medications.
- The PCP must continue the medication at the same brand and dosage unless a change in medical condition occurs and if the behavioral health provider has documented that step therapy has already been completed or that it is medically contraindicated.
- The PCP can also utilize step therapy to treat a member until the anxiety, depression or ADHD is stabilized.

When a PCP chooses to medically manage a member with ADHD, opioid use disorder, depression, and/or anxiety, AHCCCS outlines the provider's responsibilities for documentation and maintenance of a medical record.

As required by AHCCCS policies, the Plan must monitor PCPs for proper diagnosis and management of behavioral health disorders.

We highly recommend treating providers consider:

- Utilizing the AHCCCS-approved reference, policy, and operation manuals.
- The Plan website has valuable resources for providers which can assist in the management of behavioral health conditions

18.4 PSYCHOTROPIC MEDICATION PRESCRIBING AND MONITORING

When a member requires a behavioral health medication that is listed as needing "prior approval", the provider must request prior authorization. A prior authorization form must be completed and submitted with the appropriate supporting documentation (see also Chapter 6: Authorizations and Notifications).

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 consistent with AHCCCS Appointment and Timeliness standards.

PCPs and 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 addition of agents when the member is known to be receiving opioid pain medications or another controlled substance from a secondary prescriber. It is strongly encouraged to check the CSPMP on every client at every visit. It is also strongly encouraged that the clinics EMR incorporates the CSPMP as part of the patient chart. If the provider is told that the member is on a controlled substance prescribed by another provider, it is also strongly encouraged that the BHMP checks the CSPMP at that time. This will ensure the safety of the member.

Reassessments must ensure the provider prescribing psychotropic medication documents 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 which 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
- Psychotropic medication monitoring parameters (heart rate, blood pressure, weight, BMI, serum levels as indicated, and labs as indicated)
- Rationale for the use of polypharmacy; especially in the case of the use of multiple sedating

medications
- Evidence the PCP or BHMP reviewed, signed, and addressed labs and tests, especially abnormal labs, and tests
- Evidence the member was notified of abnormal labs and tests, and actions to be taken
- Coordination of care with other providers, PCP, clinical team, family members, etc. CSPMP is checked when adding or changing doses of controlled substances at every visit.

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

On initiation of any medication and at each 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 that may significantly affect prolongation of the QTc (i.e., methadone, ziprasidone, levofloxacin) an EKG is recommended or consultation with a cardiologist.

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
- Follow the Clozaril REMS guidelines for ANC levels on those taking clozaril
- Abnormal Involuntary Movements (AIMS) for members on any antipsychotic medication, including a suggestion to complete when member changing to new antipsychotic medication or stopping an antipsychotic medication

Children are more vulnerable than adults regarding developing several antipsychotic induced side effects. These included higher rates of sedation, extrapyramidal side effects (except for akathisia), withdrawal dyskinesia, prolactin elevation, weight gain and at least some metabolic abnormalities. (Journal of Clinical Psychiatry 72:5 May 2011)

Members with developmental disabilities on antipsychotic medications need to be identified for risk of, or development of, Metabolic Syndrome prior to, and while, being prescribed a "new generation/second generation" antipsychotic medication regardless of the reason that medication is being prescribed.

- Documentation must include justification of the choice of and continued use of the specific medications prescribed.
- Basic health parameter screening requirements are the same as for all persons on psychotropic medications (heart rate, weight, blood pressure, BMI, waist circumference, fasting glucose and/or Hgb A1c, and lipids).
- At-risk members showing emerging abnormalities, Metabolic Syndrome, or trends towards Metabolic Syndrome, need to be followed more closely, including educating the member, guardian, and caregivers on self-management strategies, such as diet, exercise, sleep hygiene, stress management and consideration of alternatives to antipsychotic medications for symptom management.
- Results of lab values, especially abnormal labs, should be coordinated with the member's primary care practitioner.
- For risk factors and lab values indicating additional interventions, see Metabolic Syndrome Screening and Monitoring Tool developed by the State of Missouri Department of Mental Health. Use of this tool is not required, but identifying risk, Metabolic Syndrome and interventions are required.
- Boys and girls BMI charts may be obtained from the Centers for Disease Control at http://www.cdc.gov/growthcharts/.
- Adult BMI chart may be obtained from the national Institutes of Health (National Heart, Lung, and Blood Institute) at http://www.nhlbi.nih.gov/

Type of Medication	Monitoring Action
Controlled Substances	Prescribers should check **the Arizona Pharmacy Board's Controlled Substance Prescription Monitoring Program (CSPMP)** when initiating a controlled substance (i.e., amphetamines, opiates, benzodiazepines, etc.) that will be used on a regular basis, and then at least annually or whenever there appears to be a significant change or concern in the person's presentation. Medical decision-making regarding the results should be documented in the medical record. It is strongly encouraged to check the CSPMP on every client. It is also strongly encouraged that the clinics EMR incorporates the CSPMP as part of the patient chart. If the provider is told that the member is on a controlled substance prescribed by another provider, it is also strongly encouraged that the BHMP checks the CSPMP at that time. This will ensure the safety of the member. Health Plans may consider members for **single pharmacy/provider locks**. Send requests for consideration to the BCBSAZ Health Choice Pharmacy Director. **Naloxone (Narcan):** Naloxone should be considered for all members on opioid medications, including opiate dependence medications, especially with a Morphine Equivalent Daily Dosage (**MEDD) score greater than or equal to 50**, or a history of overdose or opiate misuse/abuse/dependence for opiate overdose rescue. Naloxone intranasal spray is available for all AHCCCS members without a prescription.
Opiate dependence medications	It is not necessary for medical practitioner to perform an assessment on a member who is being referred to an Opiate Maintenance Program prior to that referral. 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 to minimize the risks of relapse and physiologic jeopardy. **Naloxone (Narcan):** Naloxone should be considered for all members on opiate dependence medications, especially those with a Morphine Equivalent Daily Dosage (**MEDD) score greater than or equal to 50**, or a history of overdose or opiate misuse/abuse/dependence for opiate overdose rescue. Naloxone intranasal spray is available for all AHCCCS members without a prescription. **Crisis Stabilization Services**: Methadone, buprenorphine, naloxone and Vivitrol must be available. **Courtesy Dosing of Methadone:** A person receiving methadone administration services who is not a recipient of take-home medication may receive up to two courtesy doses of methadone from a ACC-RBHA opiate replacement treatment provider while the person is traveling out of the home ACC-RBHA area. All incidents of provision of courtesy dosing must be reported to the home ACC-RBHA. The home ACC-RBHA must reimburse the ACC-RBHA providing the courtesy doses upon receipt of properly submitted bills or encounters.

Type of Medication	Monitoring Action
Transition of medications when person loses medication benefit	Providers ensure members who need to be dis-enrolled or who lose their 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.
Out-of-area prescription refills of non-controlled medications	BCBSAZ Health Choice maintains a comprehensive pharmacy network that includes many pharmacy chains. Members needing to fill prescriptions while out-of-area should have their prescription transferred to a pharmacy chain located in the area where the prescription will be picked up. Members who run out or lose their medications while out-of-area should contact their prescriber to determine the appropriateness of calling in a prescription to a contracted pharmacy near the member's location or to a local pharmacy with a chain pharmacy in that area. Members needing urgent after-hour or weekend refills of medications may call the Health Pharmacy for a limited number of over-rides or receive compassionate dispensing of limited supplies of non-controlled substances, at the discretion of the dispensing pharmacist. Other options include presenting to local behavioral health agencies or urgent care centers. Use of emergency rooms for dispensing of routine psychotropic medications is discouraged. Valid member-incurred costs for covered medications can be reimbursed by sending a copy of the receipt and relevant documentation to the BCBSAZ Health Choice Pharmacy Director.
Out-of-area prescription refills of Schedule CII medications, and Schedule CIII-V	Schedule II medications, such as stimulants, are tightly controlled by federal and state regulations. These medications require a current printed and signed prescription, or a valid electronic prescription. Prescribers may not call these medications into pharmacies and running out of these medications is typically not a behavioral health emergency; therefore, members should be advised to plan to ensure adequate supplies of these medications. Options include presenting to local behavioral health agencies or urgent care centers. Use of emergency rooms for dispensing of routine psychotropic medications is discouraged. Schedule CIII-V medications are also tightly regulated and will require a valid prescription prior to dispensing. Lost and stolen controlled substances require a new prescription, or verification of the original prescriber's consent by the BCBSAZ Health Choice pharmacy prior to dispensing

Type of Medication	Monitoring Action
Discharge medications from inpatient facilities	Inpatient facilities should dispense at least a 3 to 5 day's supply of medications at discharge for the convenience of families and members and ensure that enough medications and/or refills last until the first scheduled prescriber appointment. As per policy, this should be within seven days (and in no case more than 30 days). If the prescriber is concerned about safety issues, then give smaller quantities per prescription but with more refills AND ensure the member is prioritized to receive a post-discharge follow-up within clinically appropriate time frames. If the member is on stimulants give enough to last until the first prescriber appointment because stimulants cannot be refilled or written in advance and because members will have to be seen by a prescriber to get a stimulant prescription. Having this medication run out before the prescriber appointment creates an administrative emergency for families and providers which is not necessary. Electronically send the outpatient facility the discharge prescriptions and medications dispensed so it will know if members are running out of medications inappropriately early.
Medications during transitions between Health Plans, agencies, or prescribers	It is the responsibility of the member's current prescriber, including the PCP, to ensure 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 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.
Psychotropic medications for persons without a pharmacy benefit who are experiencing a serious decline in functioning	Persons can be evaluated at any time during their care for SMI eligibility, not just at enrollment. Substance use disorders carry a high risk of morbidity and mortality and may obscure the ability to determine if a person has a qualifying SMI diagnosis. Requiring a person be substance-free prior to the initiation of services is not a best practice. Providers may determine a person is SMI pending receipt of information and response to treatment. Providers can contact BCBSAZ Health Choice about compassionate dispensing options.
Use of samples	Providers are strongly discouraged from using medication samples for medications not on the BCBSAZ Health Choice Drug List, as members may not be able to continue those medications as part of the prior authorization process. Providers who consistently use non-preferred drug list samples may be subject to corrective action.

For further assistance, providers may call the BCBSAZ Health Choice Member Services Department at (800) 322-8670, and request to speak to the Behavioral Health Department for assistance.

18.5 APPOINTMENT STANDARDS AND TIMELINESS

BCBSAZ Health Choice ensures an effective referral and intake process for behavioral health services and provides members the right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment. We ensure behavioral health assessments, treatment/service planning, and service delivery is strength-based, member-centered, family-friendly, culturally, and linguistically appropriate and clinically supervised. The Provider Relations Department monitors appointment standards to ensure members are being seen timely as per AHCCCS **ACOM 417 Appointment Availability, Monitoring and Reporting** .

Appointment Availability Standards for Behavioral Health Providers for Non-Hospitalized Persons.

Immediate:

- WHO: All persons requesting assistance unless determined not to be eligible. At the time of determination that an immediate response is needed, a person's eligibility and enrollment status may not be known. Behavioral health providers must respond to all persons in immediate need of behavioral health services until the situation is clarified the behavioral health provider is not financially responsible.
- WHAT: Services can be telephonic or face-to-face; the response may include any medically necessary covered behavioral health service identified in AHCCCS AMPM Exhibit 300-2A for TXIX/XXI persons, or AHCCCS AMPM Exhibit 300-1 for Covered Services with Special Circumstances.
- WHEN: Behavioral health services provided within a timeframe indicated by need, but no later than 2 hours from identification of need or as quickly as possible when a response within 2 hours is geographically impractical.

Urgent ADES/DCS Child Referral:
DCS Comprehensive Health Plan (DCS-CHP) is responsible for integrated physical and behavioral health services for children in the custody of DCS.

- WHO: Upon notification from ADES/DCS a child has been or will imminently be taken into the custody of ADES/DCS, regardless of the child's Title XIX or Title XXI eligibility status.
- WHAT: 72-Hour Rapid Response assessment.
- WHEN: 72- Hour Rapid Response assessment must be provided within 72 hours after notification by DCS to Solari Crisis and Human Services for a child has been or will be removed from their home.

Urgent – All Other Requests:

- WHO: **Referrals for hospitalized persons not currently T/RBHA enrolled**, all Title XIX/XXI eligible persons
- WHAT: Includes any medically necessary covered behavioral health service identified in AHCCCS AMPM Exhibit 300-2A for TXIX/XXI persons. or AHCCCS AMPM Exhibit 300-1 for Covered Services with Special Circumstances.
- WHEN: **Behavioral health services** provided within a timeframe indicated by behavioral

health condition but no later than 24 hours from identification of need.

Routine – Services:

- **WHO**: All Title XIX/XXI
- **WHAT**: Includes any medically necessary covered behavioral health service including medication management and/or additional services.
- **WHEN**: The **first behavioral health service** following the initial Assessment with BHP appointment within timeframes indicated by clinical need, but no later than 23 days of the initial assessment (no later than 21 days for persons in custody of DCS and adopted children).

All **subsequent behavioral health services** within time frames according to the needs of the person, but no longer than 45 days from identified need (no later than 21 calendar days for persons in custody of DCS and adopted children).

72-Hour Rapid Behavioral Health Response for Children Taken into DES/DCS Custody
DCS Comprehensive Health Plan (DCS-CHP) is responsible for integrated physical and behavioral health services for children in the custody of DCS.

A rapid response (within 72 hours) is required for all children who are taken into the custody of ADES/DCS regardless of Title XIX or Title XXI eligibility status. The purpose for this rapid response is to:

- Identify immediate safety needs and presenting problems of the child, to stabilize behavioral health crises and to be able to offer immediate services the child may need
- Provide behavioral health services to each child with the intention of reducing the stress and anxiety the child may be experiencing, and offering a coherent explanation to the child about what is happening and what can be expected to happen in the near-term
- Provide needed behavioral health services to each child's new caregiver, including guidance about how to respond to the child's immediate needs in adjusting to foster care, behavioral health symptoms to watch for and report, assistance in responding to any behavioral health symptoms the child may exhibit, and identification of a contact within the behavioral health system
- Initiate the development of the CFT for each child (see **The AMPM 220 Child and Family Team Behavioral Health Practice Tool**) and
- Provide the ADES/DCS Specialist with findings and recommendations for medically necessary covered behavioral health services for the initial Preliminary Protective Hearing, which usually occurs within 5 to 7 days of the child's removal.

Response for Referrals or Requests for Appointments for Psychotropic Medications
For eligible members who may need to be seen by a Behavioral Health Medical Practitioner (BHMP), it is required the person's need for medication be assessed immediately and, if clinically indicated, the person be scheduled for an appointment within a timeframe that ensures:

- The person does not run out of any needed psychotropic medications; or
- The person is evaluated for the need to start medications to ensure the person does not experience a decline in his/her behavioral health condition, but no later than 30 days from the identification of need as per **ACOM 417 Appointment Availability, Monitoring and Reporting**.
    - WHO: All Title XIX/XXI eligible persons, enrolled with a T/RBHA, all persons determined to have a Serious Mental Illness and any person in an emergency or crisis.
    - WHAT: Screening, consultation, assessment, medication management, medications, and/or lab testing services as appropriate.
    - WHEN: Have a BHMP assess the urgency of the need immediately. Provide an appointment with a BHMP within a timeframe indicated by clinical need, but no later than 30 days from the identified need.

Referrals for Hospitalized Persons

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

- Initial face-to-face contact, an assessment and disposition prior to discharge.
- ***For persons referred for eligibility determination of Serious Mental Illness while hospitalized:***
  Initial face-to-face contact and an assessment must occur within 24 hours of the referral/request for services. Determination of SMI eligibility must be made within timeframes consistent with and in accordance with SMI Eligibility Determination and upon the determination the person is eligible for services and the person needs continued behavioral health services, the person must be enrolled, and the effective date of enrollment must be no later than the date of first contact.

Wait Times

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

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

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

Referrals from PCP

All referrals from a person's primary care provider (PCP) requesting a psychiatric evaluation

and/or psychotropic medications must be accepted and acted upon in a timely manner according to the needs of the person, and the response time must help ensure the person does not experience a lapse in necessary psychotropic medications, as described above.

"Wait Lists"—Not Allowed

Title XIX and Title XXI persons must never be placed on a "wait list" for any Title XIX/XXI covered behavioral health service. If the T/RBHA network is unable to provide medically necessary covered behavioral health services for Title XIX or Title XXI persons, it must ensure timely and adequate coverage of needed services through an alternative provider until a network provider is contracted. In this circumstance, the T/RBHA must ensure coordination with respect to authorization and payment issues. In the event a covered behavioral health service is temporarily unavailable to a Title XIX/XXI eligible person, the behavioral health provider must adhere to the following procedure:

- The provider agency should first refer to the Health Choice Central and Northern Arizona GSA Behavioral Health Resource Directory, which includes in-network providers contracted and available on the Health Choice website: https://www.healthchoiceaz.com/ , under the 'Provider' section -> Behavioral Health Resources.

  If an in-network contracted provider is not available, please contact our Network Department or Member Services Department for assistance in obtaining necessary services. The provider agency may request a Single Case Agreement so the needed service can be provided by a non-network provider in a timely manner.

18.6 COORDINATION OF CARE BETWEEN THE PCP AND BEHAVIORAL HEALTH PROVIDERS

PCPs are responsible for coordinating the medical care of the AHCCCS members assigned to them, including at a minimum:

- Oversight of drug regimens to prevent negative interactive effects
- Follow-up for all emergency services
- Coordination of inpatient care
- Coordination of services provided on a referral basis, and
- Assurance care rendered by specialty providers is appropriate and consistent with each member's health care needs.

For T/RBHA enrolled persons not eligible for Title XIX or Title XXI coverage, coordination and communication should occur with any known health care provider(s). BCBSAZ Health Choice is responsible, through the Behavioral Health Department, to serve as a liaison between the PCP, the member, and all providers, to ensure all parties have information specific to the care of the member related to their behavioral health services.

The PCP should establish a medical record when behavioral health information is received from a behavioral health provider about an assigned member, even if the PCP has not yet seen the assigned member.

In lieu of actually establishing a medical record, such information may be kept in an appropriately labeled file but must be associated with the member's medical record as soon as one is established. We will assist behavioral health providers with obtaining PCP information when appropriate.

The Plan expects providers to also send updated clinical information to the member's assigned behavioral health provider and/or the PCP when there is a significant change in the member's health status or at least annually. The update must include at a minimum, diagnosis of chronic conditions, medications, laboratory results, most recent provider visit, and information about recent hospital and emergency department visits.

We will provide coordination of care with members who are transitioning between health plans, including but not limited to individuals involved with the Department of Child Safety (DCS), Native Americans who have choice between health plans, members who become involved with Arizona Long term Care (ALTCS), or who would like to opt out of a plan.

COORDINATING CARE BY BEHAVIORAL HEALTH PROVIDERS WITH PCP

- If the identity of the person's primary care provider (PCP) is unknown, subcontracted providers must contact the Member Services Department to determine the name of the person's assigned PCP. This information is also available on the Provider Portal. For information on our secure provider portals, visit www.HealthChoiceAZ.com under the 'Provider' section of our website.
- Members who have never contacted their PCP prior to entry into the behavioral health system should be encouraged to seek a baseline medical evaluation. Members should also be prompted to visit their PCP for routine medical examinations annually or more frequently if necessary.
- Behavioral health providers should request medical information from the person's assigned PCP. Examples include current diagnosis, medications, pertinent laboratory results, last PCP visit, Early Periodic Screening, Diagnosis and Treatment (EPSDT) screening results and last hospitalization. If the PCP does not respond to the request within 10 days, the subcontracted provider should contact Member Services for assistance.

SHARING INFORMATION WITH PCPS AND OTHER TREATING PROFESSIONALS AND INVOLVED STAKEHOLDERS

To support quality medical management and prevent duplication of services, behavioral health providers are required to disclose relevant behavioral health information pertaining to Title XIX and Title XXI eligible persons to the assigned PCP, other treating professionals, and other involved stakeholders within the following required timeframes:

- **Urgent** – requests for intervention, information, or response within 24 hours.
- **Routine** – Requests for intervention, information, or response within 10 days.

Providers must provide the required information:

- **Annually**, and/or
- When there is a **significant change** in the person's diagnosis and/or prescribed medications.

Coordination of Care for Members with a Serious Mental Illness

For all behavioral health recipients referred by the PCP and have been determined to have a Serious Mental Illness and/or a diagnosis of a chronic medical condition, the following information must be provided to the person's assigned PCP:

1. The person's diagnosis; and
2. The person's current prescribed medications (including strength and dosage).

Coordination of Care for All Title XIX/XXI Members

Subcontracted providers are required to:

- Notify the assigned PCP of the results of PCP initiated behavioral health referrals
- Coordinate the placement of persons in out-of-state treatment settings
- Notify, consult with, or disclose information to the assigned PCP regarding persons with Pervasive Developmental Disorders and Developmental Disabilities, such as the initial assessment and treatment plan and care and consultation between specialists
- Provide a copy to the PCP of any executed advance directive, or documentation of refusal to sign an advance directive, for inclusion in the behavioral health recipient's medical record
- Notify, consult with, or disclose other events requiring medical consultation with the person's PCP
- If member was referred by the PCP, the behavioral health provider must provide no later than 10 days from request:
    - Critical laboratory results as defined by the laboratory and required by specific medications and
    - Changes in the class of medications prescribed.

Coordination of Care for All Title XIX/XXI Enrolled Members

Upon request by the PCP or member, information for any enrolled member must be provided to the PCP consistent with 42 CFR and HIPAA requirements. When contacting or sending any of the above referenced information to the person's PCP, subcontracted providers must provide the PCP with an agency contact name and telephone number in the event the PCP needs further information.

18.6.1 COORDINATING MEMBERS WITH ADVERSE DRUG EVENT OR REACTIONS / "RED-FLAGS"

For members experiencing or who have been reported to experience an adverse drug event or reaction/red flag (slurred speech, falling, nodding, intoxication, drooling, severe agitation, altered mental status, etc.) due to possible drug interaction or intoxication, a BHMP/PCP is notified within 24 hours (urgent response), or earlier if clinically indicated, to directly address the concerns.

Interventions by the BHMP/PCP may include:

- Doing what ***YOU*** can do to decrease risk—not expecting someone else to act
- Changing or limiting medications to address identified risks
- Checking the **CSPMP**
- Prescribing **NARCAN** if on opiates
- Simplifying medication regimen to improve ability to self-monitor
- Giving the statewide crisis hotline (1-844-534-4673) and RN Advice line (1-855-354-9006)
- Coordinating care with the clinical team including all prescribing clinicians
- Determining the appropriate level of care (ASAM level) and referring for indicated services
- Requesting a second expert opinion from a different medical provider or BHMP
- Developing an overdose plan and sharing it with family, friends, caregivers, all prescribing clinicians
- Inviting family members or partners to participate in appointments
- Conveying a caring attitude, medications are only one part of a successful treatment program
- If medications are discontinued, assuring member treatment for the presenting symptoms or condition will continue and making sure the services are IN PLACE
- Following up or visiting to check risk, status, further red flags, processing concerns, expressing care and a **recovery perspective**, assessing safety/suicidal ideation or homicidal ideation
- Completing an Incident, Accident or Death (IAD) report and submitting to BCBSAZ Health Choice within 48 hours.

18.7 COORDINATION OF CARE WITH GOVERNMENTAL AGENCIES

Annually BCBSAZ Health Choice develops joint protocols with stakeholders and posts those protocols on our website.

18.7.1 ARIZONA DEPARTMENT OF CHILD SAFETY (DCS)

When a child receiving behavioral health services is also receiving services from DCS, the subcontracted provider must work towards effective coordination of services with the DCS Specialist and DCS-CHP.

Providers are expected to:

- Coordinate the development of the behavioral health service plan with the child welfare case plan to avoid redundancies and/or inconsistencies.
- Ensure a rapid response for children and their families upon a child being removed from their home as per **ACOM Policy 417 Appointment, Availability, Monitoring and Reporting.**
- Provide the DCS Specialist and the juvenile court with preliminary findings and recommendations on behavioral health risk factors, symptoms and service needs for hearing.
- 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, temporary caretakers 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) and Family Group Meetings (as appropriate) 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, communicate and expedite necessary services to stabilize in-home and out-of-home placements provided by DCS.
- Provide behavioral health services in support of family reunification and/or other permanency plan identified by DCS. Ensure behavioral health needs of eligible parents, out-of-home placement or adoptive(s), other protective caregivers and family members are identified and met.
- Unless refused by the guardian, Children in DCS custody shall receive at least one documented behavioral health service per month for 6 months following removal, to assess and detect possible delayed reactions to the traumatic experience.
- Ensure responsive coordination activities and service delivery that supports the DCS child and family plans and facilitates adherence to DCS established timeframes (see ACOM Policy 417 and Practice Tools: Transition into Adulthood, **The Unique Behavioral Health Service Needs of Children, Youth, and Families Involved with DCS**, and the CFT. (**The AMPM 220 Child and Family Team Behavioral Health Practice Tool**;
- Coordination activities should include coordination with the adult service providers rendering services to adult family members.

18.7.2 DCS/ADHS ARIZONA FAMILIES F.I.R.S.T. (FAMILIES IN RECOVERY SUCCEEDING TOGETHER) PROGRAM

Providers must ensure that behavioral health providers 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 abuse treatment for parents and caregivers referred by DCS and the ADES/Family Assistance Administration (FAA) Jobs Program. AHCCCS participates in statewide implementation of the program with DCS (see **A.R.S. 8-881**). BCBSAZ Health Choice and providers must:

- Accept referrals for Title XIX and Title XXI eligible and enrolled members and families referred through AFF
- Collaborate with DCS, the ADES/FAA JOBS Program and Substance Abuse Treatment providers to minimize duplication of assessments and achieve positive outcomes for families
- Collaborate and coordinate care for members with behavioral health needs involved with Arizona Department of Juvenile Corrections (ADJC) and the Administrative Offices of the Court (AOC) and
- Develop procedures for collaboration in the referral process to ensure effective service delivery through the BCBSAZ Health Choice system of care. Appropriate authorizations to

release information must be obtained prior to releasing information.

Substance use treatment for families involved with DCS must be family centered, provide for sufficient support services, and must be provided in a timely manner to promote permanency for children, stability for families, to protect the health and safety of abused and/or neglected children and promote economic security for families.

18.7.3 ARIZONA DEPARTMENT OF EDUCATION (ADE), SCHOOLS OR OTHER LOCAL EDUCATIONAL AUTHORITIES

AHCCCS has delegated the functions and responsibilities as a State Placing Agency to BCBSAZ Health Choice for members in the Northern 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. BCBSAZ Health Choice and providers must work in collaboration with the ADE in support of school environments that promote behavioral health for children and to assist with resources and referral linkages for the placement of children with behavioral health needs.

Providers must ensure that subcontracted providers collaborate with schools and help a child achieve success in school by:

- Working in collaboration with the school and sharing information to the extent permitted by law and authorized by the child's parent or legal guardian (see https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/900/940.pdf
- 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
- For children receiving special education services, participate with the school in developing the child's IEP and share the behavior treatment plan interventions, if applicable
- Inviting teachers and other school staff to participate in the CFT if agreed to by the child and legal guardian
- Having a clear understanding of the IEP requirements as described in the Individuals with Disabilities
- Ensuring that students with disabilities who qualify for accommodations under of the Section 504 of the Rehabilitation Act of 1973 are provided adjustments in the academic requirements and expectations to accommodate their needs and enable them to participate in the general education program; and
- Ensuring that transitional planning occurs prior to and after discharge of an enrolled child from any out-of-home placement.

Behavioral Health Services for School-Aged Children

Providers shall ensure the availability of behavioral health services for school-aged children in school settings, and the use of appropriate billing and coding for these services, including place of service codes and the use of County, Town, District, Site (CTDS) numbers by the billing provider. Providers shall collaborate with schools to determine the extent of the services to be

provided in individual schools and assist in a referral process, removing barriers to the referral process and improve access to care in school settings. Providers will submit a deliverable regarding the number of school referrals received updates on efforts to provide resources for school-based services and summer programming to Health Choice.

18.7.4 ARIZONA DEPARTMENT OF ECONOMIC SECURITY/DIVISION OF DEVELOPMENTAL DISABILITIES (ADES/DDD)

DDD/ALTCS Health Plans are managed by United Health Care DDD and Mercy Care DDD. Contact DDD or one of their contracted health plans for additional information.

Members qualifying for services through DDD can fall into several different categories based on their eligibility status and the extent of their diagnosed disability. Here are the three general groupings and the services offered to those members:

Eligibility Category	**What behavioral health services are available?**	**Who is responsible for providing the behavioral health services?**
Title XIX and eligible for ALTCS	All Title XIX covered services	The DDD designated Health Plans
Title XIX and not eligible for ALTCS	All Title XIX covered services	AHCCCS ACC Plan and subcontracted providers
*Note: DDD members who are Title XIX eligible and not eligible for ALTCS services will continue to receive behavioral health services from the ACC Plan they are enrolled with.		

**DDD American Indian members, title XIX and XXI, on- or off-reservation, eligible to receive services, may choose to receive services at any time through a Tribal Regional Behavioral Health Authority (TRBHA)*

*** See **AHCCCS Policy 320-T2, Non-Discretionary Federal Grants***

Behavioral health providers coordinate member care (not eligible for ALTCS) with DDD by:

- Working in collaboration with DDD staff and service providers involved with the member
- Aiding DDD providers in managing difficult behaviors
- Inviting DDD staff to participate in the development of the behavioral health service plan and all subsequent planning meetings as members of the member's clinical
- Incorporating information and recommendations in the Individual or Family Support Plan (ISP) developed by DDD staff, when appropriate, while developing the member's ISP
- Ensuring that the goals of the ISP, of a member diagnosed with developmental disabilities who is receiving psychotropic medications, includes reducing behavioral health symptom and achieving optimal functioning, not merely the management and control of challenging behavior
- Actively participating in DDD team meetings and
- For members diagnosed with Pervasive Developmental Disorders and Developmental Disabilities, sharing all relevant information from the initial assessment and ISP with DDD to ensure coordination of services.

18.7.5 DEPARTMENT OF DEVELOPMENTAL DISABILITIES/ARIZONA EARLY INTERVENTION PROGRAM (DDD/AZEIP)

Providers must ensure that behavioral health providers coordinate member care with AzEIP by:

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

18.7.6 COURTS AND CORRECTIONS

BCBSAZ Health Choice and behavioral health providers are expected to collaborate and coordinate care for behavioral health members involved with:

- The Arizona Department of Corrections (ADOC) & Community Corrections (Parole)
- Arizona Department of Juvenile Corrections (ADJC), or
- Northern and Central GSA County Jails & Correctional Health Services
- The Arizona Superior Court & Northern and Central GSA County Probation Offices
- Municipal Mental Health Courts and Drug Courts

Providers must ensure behavioral health providers work with court and/or correctional agencies by:

- Working in collaboration with the appropriate staff involved with the member
- Inviting probation or member's parole officer to participate in the development of the IRP/ ISP and all subsequent planning meetings as members of the member's CFT or for adults, the ART, with member's approval
- Actively considering information and recommendations contained in probation or parole case plans when developing the IRP/ ISP
- Ensuring children and their families continue to receive services while children are in detention including services and planning for release and
- Ensuring 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.

BCBSAZ Health Choice and the Arizona Department of Corrections (ADOC) have an established mutually agreed upon protocol to ensure effective and efficient delivery of behavioral health services. The Collaborative Protocol between the Plan and Arizona Department of Corrections (ADC) defines the respective roles and responsibilities of each party and is available on our website.

The Plan and the Arizona Department of Juvenile Corrections (ADJC) have an established mutually agreed upon protocol to ensure effective and efficient delivery of behavioral health services.

18.7.7 ARIZONA COUNTY JAILS

In Maricopa County, behavioral health providers must assist the member with serious mental illness (SMI) by:

- Working in collaboration with the appropriate staff involved with the member
- Ensuring screening and assessment services, medications and other behavioral health needs are provided to jailed members upon request
- Ensuring the member has a viable discharge plan, there is continuity of care if the member is discharged or incarcerated in another correctional institution, and pertinent information is shared with all staff involved with the member's care or incarceration with member approval and
- Determining whether the member is eligible for the Jail Diversion Program.

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

For further information regarding enrolled members who are incarcerated, please contact the Justice Liaison Department by contacting Member Services.

18.7.8 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.

Behavioral health providers coordinate member care by:

- Working in collaboration with vocational rehabilitation (VR) counselors or employment specialists in the development and monitoring of the member's employment goals
- Ensuring all related vocational activities are documented in the comprehensive clinical record
- Requiring vocational administrator, RSA/VR Behavioral Health Counselors and Provider employment personnel to attend the bi-annual regional coordination meeting
- Inviting RSA staff to be involved in planning for employment programming to ensure there is coordination and consistency with the delivery of vocational services
- Participating and cooperating with RSA in the development and implementation of a Regional Vocational Service Plan inclusive of RSA services available to adolescents and
- Allocating space and other resources for VR counselors or employment specialists working with enrolled members who have been determined to have a Serious Mental Illness.

18.7.9 ARIZONA DEPARTMENT OF HEALTH SERVICES/BUREAU OF RESIDENTIAL FACILITIES LICENSING

When a member receiving behavioral health services is residing in an assisted living facility, providers and behavioral health providers must coordinate with the Bureau of Residential Facilities Licensing to ensure the facility is licensed and to ensure there are no existing violations or legal orders. Providers and behavioral health providers must also determine and ensure the member living in an assisted living facility is at the appropriate level of care. The provider and the behavioral health provider can coordinate with the Bureau of Residential Facilities Licensing to determine the level of care a particular assisted living facility is licensed to provide.

For further information regarding members who are seeking Assisted Living services, please call Member Services.

Providers, members, and community stakeholders should contact the Health Choice Housing Department through Member Service at 1-800-640-2123 to report unsafe conditions.

18.8 BEHAVIORAL HEALTH REFERRALS

There are several ways a member may initiate services with a behavioral health provider:

- The medical provider may contact Member Services and request a Behavioral Health Care Manager to assist with referral, or the provider may fax/email a Care Manager Referral Form found on the website
- The member is encouraged to contact the Member Services Dept directly for information on how to establish care with a contracted behavioral health provider
- Schools or State agencies may also refer members by directly contacting Member Services at 1-800-322-8670
- After completion of initial paperwork for behavioral health services, the behavioral health provider will ask the member or guardian to sign a release of information that will allow the provider to share information with all involved members of the treatment team.
- The behavioral health provider will verify member eligibility and follow contractual appointment standards
- The parent or guardian must accompany any member under the age of 18 to the evaluation appointment

A developmental and behavioral assessment/screening for members up to 21 years of age shall be documented through skilled observation at all Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/Well Child visits. It is important the PCP document behavioral health concerns on the EPSDT Clinical Sample Template or in the EMR.

If the primary concern is a behavioral problem (e.g., Oppositional Defiant Disorder, Conduct Disorder, Bipolar Disorder), members will be referred to a contracted behavioral health provider rather than a developmental specialist. If the primary concern is depression, anxiety, and/or Attention Deficit Hyperactivity Disorder (ADHD), the PCP may manage the member's

behavioral health condition. When the PCP decides the member requires services from a behavioral health provider, the member should be referred to a behavioral health provider for on-going behavioral health assessment and services. Members who are dual eligible for Medicare and Medicaid, should be referred to a licensed behavioral health provider who is part of their Medicare contracted network.

18.8.1 REFERRAL TO A PROVIDER FOR SECOND OPINION

Title XIX/XXI health care members are entitled to a second opinion. Upon a Title XIX/XXI - member's request or at the request of the treating physician, a second opinion is obtained from a healthcare professional within the network or arranged for the member to obtain one outside the network, at no cost to the member.

18.8.2 NON-EMERGENCY REFERRALS

Referrals are a means of communication between two providers servicing the same member. Although BCBSAZ Health Choice encourages the use of a written referral, we recognize some providers use telephone calls and other types of communication to coordinate the member's care. This is acceptable if the communication between providers is documented and maintained in the members' medical records and, for behavioral health services, the services are documented on the member's service plan or interim service plan.
Referrals must meet the following conditions:

- The referral must be requested by a participating medical provider or behavioral health clinical team.
- The service must be in accordance with the requirements of the member's benefit plan (covered benefit) and treatment needs.
- The member must be enrolled in BCBSAZ Health Choice on the date of service (s) and eligible to receive the service.
- The behavioral health services must be included on the member's service plan or interim service plan.

If BCBSAZ Health Choice network does not have a provider to perform the requested services, members may be referred to out of network providers if:

- The services required are not available within the network
- The Plan prior authorizes the services or establishes a single case agreement or contract with the service provider
- The provider has or obtains an AHCCCS Provider ID

If out of network services are not prior authorized, or if no single case agreement/contract is established by BCBSAZ Health Choice without a referral:

- The referring and servicing providers may be responsible for the cost of the service; unless the service is provided to a child in DCS custody or requested by an adoptive parent as per A.R.S. §8-512.01.
- The member may not be billed if the provider fails to follow BCBSAZ Health Choice policies.
- Both referring and receiving providers must comply with Plan policies, documents, and

requirements that govern referrals (paper or electronic) including prior authorization.

- Failure to comply may result in delay in care for the member, a delay or denial of reimbursement or costs associated with the referral being charged to the referring provider.
- **Exception for crisis, outreach, engagement, and reengagement services:** providers who are contracted by BCBSAZ Health Choice for crisis, outreach, engagement, and reengagement services may provide and bill contracted services for up to 10 business days while attempting to complete a member referral to initial evaluation (intake), assessment or services at a health home, without the services being on the health home's interim or completed service plan. [Applies to contracted providers including Peer Run Organizations, Family Run Organizations, and crisis providers.] Allowable services are as per the provider's contract with and may include crisis services, initial evaluation/intake, assessment, case management, family support and peer support. Non-allowed services include:
    - All prior authorized services such as non-emergency hospitalizations, behavioral health inpatient facility admissions and ECT
    - Behavioral health residential facilities
    - Chemical dependency residential facilities
    - Therapeutic Foster Care
    - Respite

Referring Provider's Responsibilities

- Confirm the required service is covered under the member's benefit plan prior to referring the member.
- Confirm the receiving provider is contracted with BCBSAZ Health Choice.
- Obtain prior authorization for services that require prior authorization or are performed by a non-participating provider. See also on BCBSAZ Health Choice website. www.HealthChoiceAZ.com under the 'Provider' section of our website.
- For behavioral health services, the services need to be documented on the member's individual service plan
    - *"Urgent" - Requests for intervention, information, or response within 24 hours*
    - *"Routine" - Requests for intervention, information, or response within 10 days*

Receiving Provider's Responsibilities

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

- Schedule and deliver the medically necessary services in compliance with BCBSAZ Health Choice requirements and standards related to appointment availability as per ACOM 417 Appointment Availability, Monitoring and Reporting.
- Verify the member's enrollment and eligibility for the date of service. If the member is not enrolled with BCBSAZ Health Choice on the date of service, we will not render payment regardless of referral or prior authorization status.

- Verify the service is covered under the member's benefit plan.
- Verify the prior authorization has been obtained, if applicable, and includes the prior authorization number on the claim when submitted for payment.
- Inform the referring provider of the consultation or service by sending a report and applicable medical records to allow the referring provider to continue the member's care.

18.8.3 REFERRALS INITIATED BY THE DEPARTMENT OF CHILD SAFETY (DCS) PENDING THE REMOVAL OF A CHILD

DCS Comprehensive Health Plan (DCS-CHP) is responsible for integrated physical and behavioral health services for children in the custody of DCS.

Upon notification from the Department of Child Safety (DCS) a child has been, or is at risk of being taken into the custody of the Department of Child Safety (DCS), behavioral health providers shall- respond in an urgent manner as per A.R.S. §8-512.01 and ACOM Policy 449 Behavioral Health Services for Children in DCS Safety Custody and Adopted Children and ACOM Policy 417 Appointment Availability, Monitoring and Reporting. Foster caregivers and adoptive parents may call for and consent to an urgent crisis response and/or 72 hour rapid response in accordance with ACOM Policy 449 Behavioral Health Services for Children in DCS Safety Custody and Adopted Children. For additional information see AMPM 220 Child and Family Team Behavioral Health Practice Tool and The AMPM 260 Unique Behavioral Health Service Needs of Children, Youth, and Families Involved with DCS Behavioral Health Practice Tool

18.8.4 REFERRALS REGARDING INDIVIDUALS ADMITTED TO HOSPITAL FOR PSYCHIATRIC REASONS

Providers must attempt to conduct a face-to-face intake evaluation with the individual prior to discharge from the hospital. Providers should utilize the information gathered by the hospital to complete the intake and to not delay enrollment, discharge planning or service planning to complete an outpatient intake.

BCBSAZ Health Choice contracts with **Crisis Preparation and Recovery, Inc. (CPR)** to respond to ED and adult psychiatric inpatient referrals and can complete intake evaluations, discharge planning, SMI Determination referrals, transfers, and outpatient medication management services during transitional period while members are connected to new providers in Maricopa County.

- **CPR Central Arizona Crisis Line at 800-327-9254**

18.8.5 ACCEPTING REFERRALS

Providers are required to accept referrals for behavioral health services 24 hours a day, 7 days a week. Providers may call BCBSAZ Health Choice to assist with the behavioral health referral. The following information will be collected from referral sources:

- Date and time of referral
- Information about the referral source including name, telephone number, fax number, affiliated agency, and relationship to the member being referred
- Name of the member being referred, address, telephone number, gender, age, date of birth and, when applicable, name and telephone number of parent or legal guardian
- Whether or not the member, parent or legal guardian is aware of the referral
- Include a summary of any identified special needs for assistance due to impaired mobility, visual/hearing impairments or developmental or cognitive impairment
- Accommodations due to cultural uniqueness and/or the need for interpreter services
- Information regarding payment source (i.e., AHCCCS, private insurance, Medicare, or self-pay) including the name of the AHCCCS health plan or insurance company
- Name, telephone number and fax number of AHCCCS primary care provider (PCP) or 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; 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

While the information listed above will facilitate evaluating the urgency and type of practitioner the person may need to see, timely triage and processing of referrals must not be delayed because of missing or incomplete information. When psychotropic medications are a part of an enrolled member's treatment or have been identified as a need by the referral source, behavioral health providers must respond as outlined in AHCCCS ACOM Policy 417 Appointment Availability, Monitoring and Reporting.

When a member or his/her family member, legal guardian, or significant other contacts BCBSAZ Health Choice or provider about accessing behavioral health services, the Plan or provider will use an engaging and welcoming approach to obtain the necessary information about the person in need of services.

18.8.6 SMI ELIGIBILITY DETERMINATIONS

When an SMI eligibility determination is being requested as part of the referral or by the member directly, BCBSAZ Health Choice and providers must conduct an eligibility determination for SMI in accordance with AMPM Policy 320-P Serious Mental Illness Eligibility Determination. The SMI eligibility assessment, and pending determination, must not delay behavioral health service delivery to the member, regardless of Title XIX or Title XXI eligibility as funding allows. SMI Determinations are completed by Solari Crisis and Human Services.

18.8.7 RESPONDING TO REFERRALS

Follow-Up for No Shows

When a request for behavioral health services is initiated but the member does not appear for the initial appointment, the provider must attempt to contact the member and implement engagement activities.

Final Dispositions to Stakeholder Referral Sources

Within 30 days of receiving the initial intake evaluation, or if the member declines behavioral health services, the provider must notify the following applicable referral sources of the final disposition:

- AHCCCS health plan
- Behavioral Health Coordinator
- AHCCCS PCP
- Arizona Department of Economic Security/Department of Child Safety and adoption subsidy
- Arizona Department of Economic Security/Division of Developmental Disabilities
- Arizona Department of Corrections
- Arizona Department of Juvenile Corrections
- Administrative Offices of the Court
- Arizona Department of Economic Security/Rehabilitation Services Administration
- Arizona Department of Education and affiliated school districts

The final disposition must include:

- The date the member was seen for the intake evaluation and
- The name and contact information of the provider who will assume primary responsibility for the - behavioral health care, or
- If no services will be provided, the reason why.

The member's authorization to release information will be obtained prior to communicating the final disposition to the referral sources referenced above as per **AHCCCS AMPM Policy 940 Medical Records and Communication of Clinical Information.**

DOCUMENTING AND TRACKING REFERRALS

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

- Member's name and, if available, AHCCCS identification number
- Name and affiliation of referral source
- Date of birth
- Type of referral (immediate, urgent, routine) as defined in **ACOM Policy 417 Appointment Availability, Monitoring and Reporting.**
- 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
- Final disposition of the referral

18.9 TRANSFER OF BEHAVIORAL HEALTH CARE TO AND FROM PCP

When a member is referred to a behavioral health provider for ongoing behavioral health services it is required the PCP coordinates the transfer of care. PCPs must notify the behavioral health provider of the member's referral which should include, at a minimum the following information:

- The reason for the referral
- All relevant medical information
- Current medications and timeframes for dispensing and refilling the medications
- Full medication history of tried and failed medications

The member's medical record must be made available for the behavioral health provider in observance of confidentiality regulations. The transition of prescription medications must be seamless, with notification to the behavioral health provider regarding current medications, dose, and next refill due date. This coordination must, at a minimum, ensure the member does not run out of prescribed medications prior to their first appointment with the behavioral health provider. All information should be forwarded to the appropriate behavioral health provider prior to the member's first evaluation appointment.

If the behavioral health provider feels the member is clinically stable on their current medication regimen and the member has a diagnosis of ADHD, opioid use disorder, depression or anxiety, a transfer of care back to the PCP may be appropriate. Prior to this transfer of care the behavioral health provider is required to notify the member's PCP and discuss the member's current treatment plan. Both the assigned PCP and BCBSAZ Health Choice Medical Director or designee, must agree the member is clinically stable for transfer. If deemed appropriate by the PCP, who is assuming the member's ongoing behavioral health care, the Plan shall continue to authorize the medication at the dosage at which the member was stabilized on, unless there has been a significant change in the member's medical condition. We must monitor PCPs to ensure they continue to prescribe the medication at the dosage, in which the member was stabilized on.

18.10 OUT-OF-STATE PLACEMENTS

BCBSAZ Health Choice provides coordination of care to ensure member's behavioral health and medical needs are met in the event an out-of-state placement (OOS) is clinically necessary.

The following factors may be considered for temporary OOS placements:

- The member requires specialized programming not currently available in Arizona to effectively treat a specified behavioral health condition
- An OOS placement's approach to treatment incorporates and supports the unique cultural heritage of the member
- There is a lack of current in-state bed capacity
- Geographical proximity encourages support and facilitates family involvement

Prior to all OOS placements, the Plan will work with the behavioral health provider to ensure coordination of all medical and behavioral health care and provide ongoing management and monitoring to ensure monthly reviews and discharge planning. We will ensure documentation in the behavioral health clinical records indicates the conditions are met prior to a referral according to AMPM Chapter 400. This includes:

- All less restrictive, clinically appropriate approaches have either been provided or considered by the CFT or ART and are found not to meet the member's needs
- A minimum of three (3) in-state facilities have declined to accept the member
- The CFT or ART has been involved in the service planning process and in agreement with the out-of-state placement
- The CFT or ART has determined how they will remain active and involved in service planning once the out-of-state placement has occurred
- ISP or care plan has been developed that includes a discharge plan for when the member returns in-state for services
- For minors, the Arizona Department of Education has been consulted to ensure the educational program meets standards and the specific educational needs of the member
- Coordination has occurred with all state agencies involved with the member
- Coordination with the member's primary care provider to develop a plan for the provision of any necessary, non-emergency medical care
- The non-emergent medical provider is an AHCCCS registered provider
- The out-of-state placement is an AHCCCS registered provider
- The prior authorization requirements have been met

As part of prior authorization review, the BCBSAZ Health Choice Medical Management Specialist will participate and coordinate with all state agencies involved with the member and will review the member's care and needs with the Behavioral Health Medical Director. The Medical Management Specialist will coordinate with the member's primary care provider and develop a plan for any necessary, non-emergency medical care and ensure all providers shall be registered AHCCCS providers. BCBSAZ Health Choice will continue to manage and monitor the case and ensure there is a current ISP/care plan developed that shows discharge planning and monthly reviews. The member's ISP/care plan must include the following:

Discharge planning is initiated at the time of admission, including:

- The treatment goals are measurable and include criteria for discharge back to in-state services,
- The possible or proposed in-state residence where the member will be returning,
- The recommended services and supports required when the member returns from the out-of-state placement,
- How effective strategies implemented in the out-of-state placement will be transferred to the in-state placement,
- The actions necessary to integrate the member into family and community life upon discharge,
- The CFT or ART reviews the member's progress with the out-of-state clinical staff every 30

days upon admit.

The member's family/guardian is involved throughout the duration of the placement.

- This can include family counseling in person or by teleconference or videoconference
- Is afforded meaningful participation in the CFT or ART
- Has home passes as clinically appropriate
- For American Indian children, there is coordination of care to include face to face meeting with children in residential facilities located off tribal lands, ensuring the child has communication with the tribal community.
- The member's needs, strengths, and cultural considerations have been addressed.

18.11 CARE MANAGEMENT MODEL

Our care management design promotes and supports seamless care coordination across the entire delivery system by establishing a central point of contact at BCBSAZ Health Choice for member outcomes. Data and support are shared between the providers and Plan to eliminate blind spots and gaps in medically necessary care. We achieve this through a step-by-step approach that begins with an initial assessment to determine the member's specific care coordination or care management needs and the development of an Integrated Individual Care Management Plan for members who have high needs/high costs or special health care needs.

Health Choice utilizes the SAMHSA/HRSA Four Quadrant Model of Integrated Care as a theoretical framework for understanding the needs of our members and organizing our care management programs. Individual members' needs vary over time; therefore, members may move between quadrants as their needs change. We have adopted a No Wrong Door approach to referrals, so members referred by any source are reviewed and routed to the appropriate care or disease management staff.

The Plan uses both real-time and predictive analytic data feeds to support care management, population health analytics, risk stratification and performance benchmarking from Contexture, BCBSAZ Health Choice's pharmacy benefit manager, and predictive modeling programs.

Our care management strategy uses Integrated Care Managers (ICMs), supported by committed and experienced BCBSAZ Health Choice Medical Directors who have a public health and member-centered perspective, and provide expertise and oversight, increased system coordination, and resources for members in care management. The care management team assists treatment teams and stakeholders in developing a holistic approach to understanding and organizing members' needs and services based on member/guardian/family preferences and evidence-based practices or guidelines.

Care Management is an administrative function that is not the day-to-day duties of case management or service delivery.

BCBSAZ Health Choice's "Member First" Integrated Care Management program is designed to improve quality, decrease costs, and reduce hospital admissions and unnecessary emergency department (ED) visits and crisis services through care management, member education and provider monitoring, and to effectively transition members from one level of care to another, including the Arizona State Hospital and justice systems.

The assigned BCBSAZ Health Choice ICM will complete an initial case review of the member's health conditions, service and pharmacy utilization including CSPMP data, social environment, support network, current functioning, and overall needs. If the member has not yet established care with a PCP, the ICM will ensure the member's provider case manager, or a Health Choice Health Buddy will assist the member with setting up a new patient appointment.

The BCBSAZ Health Choice ICMs will oversee and assist members' clinical teams by:

- Effectively transitioning members between health plans, levels of care or providers
- Streamlining, monitoring, and adjusting Integrated Care Management Plans based on progress and outcomes
- Providing teams and members with proper disease-specific self-management tools and education related to disease progression and importance of adherence to recommended treatment options
- Identifying and communicating important clinical information and test results, such as discharge summaries, critical lab results, medications, ED visits, etc. to the clinical team
- Updating the member's team on changes in member status, such as eligibility, court-ordered treatment, guardianship, Advance Directives, transition to adulthood, significant medication changes, incarceration, pregnancy, out of state treatment, all cause hospitalizations
- Ensuring members are scheduled for preventive services, EPSDT/well-child visits, disease management and health promotion activities, based on identified needs
- Analyzing predicted and actual outcomes and cost-effectiveness of a member's interventions
- Services based on best practices.

Members identified as high need/high cost have an Interdisciplinary Care Team (ICT) that is based on the member's needs. The ICT may consist of the member and family, provider case managers, peer/family supports, and physical and behavioral health providers. The Interdisciplinary Care Team is supported by BCBSAZ Health Choice's ICM. The ICT provides more intensive clinical oversight and coordination for the period when the member's need or risk is greatest, including development of an integrated care plan.

BCBSAZ Health Choice requires coordination of care to occur both at the system level and the provider level to best address members' needs, goals, and functional status. ICMs and provider clinical staff work together to coordinate care with PCPs, specialists, health plans, AzEIP, DES/DDD, tribal nations, justice and law enforcement, peer and family run organizations,

stakeholders, DCS and other child-serving organizations. Care coordination and collaboration ensures:

- Early identification of health risk factors and special health care needs
- Coordination of covered services with community and social services
- Timely and confidential communication of clinical information between providers on progress, services, labs, medications, and member needs
- Monitoring member health status and implementation/revision of service plans
- Participation in transitions and discharge planning from hospitals, jails, or other institutions to ensure timely services post-discharge, member engagement and avoidance of gaps in care
- Referral management for providers, services, and community resources
- Outreach and engagement of members who would benefit from services.

18.12 OUTREACH, ENGAGEMENT, RE-ENGAGEMENT AND CLOSURE

18.12.1 OUTREACH

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

Outreach activities may include, but are not limited to:

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

18.12.2 ENGAGEMENT

BCBSAZ Health Choice or their subcontracted providers will actively engage the following in the treatment planning process:

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

Behavioral health providers must:

- Provide services in a culturally competent manner in accordance with BCBSAZ Health Choice's Cultural Competency Plan.
- 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, age and gender
- Provide an environment that 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 ensuring 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, 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
- 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
- Provide the member with choice when selecting a provider and the services they participate in
- Establish Member and Family Advisory Councils to provide direction, feedback, and

meaningful influence to their senior management team

- Demonstrate documentary evidence (agenda, sign in sheets, minutes) to show that Member and Family Advisory Councils are being held at least monthly
- Maintain a written Plan that includes a method to verify Members and families attend regular meetings with clinical leadership and are authorized to make recommendations.
- Recruit leaders from provider's Member and Family Advisory Councils to regularly attend The Health Plan monthly regional Member/Family Advocacy Council

Providers must collaborate with Peer-Run and Family-Run Organizations, involving them in program development activities, peer support and family support training, staff trainings, committee meetings and strategic planning.

18.12.3 RE-ENGAGEMENT

Behavioral health providers must attempt to re-engage persons that have withdrawn from participation in the treatment process prior to the successful completion of treatment, refused services or failed to appear for a scheduled service. All attempts to re-engage persons 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 person by:

- Communicating in the person's preferred language
- Contacting the person or the person's legal guardian by telephone, at times when the person may reasonably be expected to be available (e.g., after work or school)
- Whenever possible, contacting the person or the person's legal guardian face-to-face, if telephone contact is insufficient to locate the person or determine acuity and risk
- 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, contacting the person designated to provide Special Assistance for his/her involvement in re-engagement efforts.

If the above activities are unsuccessful, the behavioral health provider must make further attempts to re-engage persons determined to have a Serious Mental Illness (SMI), children, pregnant substance using women/teenagers, or any person determined to be at risk of relapse, decompensation, deterioration or a potential harm to self or others. Further attempts may include contacting the person or person's legal guardian face to face or contacting natural supports who the member has given permission to the provider to contact. All attempts to re-engage these members shall be clearly documented in the comprehensive clinical record.

If the person 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 person to seek inpatient care voluntarily. If this is not a viable option for the person and the clinical standard is met, initiate the pre-petition screening or petition for treatment process a part of Pre-Petition Screening, Court-Ordered Evaluation, and Court-Ordered Treatment.

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

When all re-engagement efforts fail, the provider must notify the health plan a person deemed SMI has been closed from their system by faxing the closure letter to the member's RBHA Plan.

Timeframes and Maintenance of Clinical Continuity For all members who miss a regularly scheduled appointment, the clinical team must attempt a telephonic contact with member, within one business day, following any missed appointment. If clinical team is unable to reach the member telephonically, additional phone calls, written correspondence or a face to face/home visit is completed based on an assessment of clinical acuity or risk **(**emergent, urgent, and routine time frames), but no later than seven days. Clinical staff should review members who miss appointments with clinical supervisors to ensure re-engagement efforts are completed as clinically appropriate and continuity of care is maintained.

18.12.4 FOLLOW-UP AFTER SIGNIFICANT AND/OR CRITICAL EVENTS

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

- Discharged from inpatient services in accordance with the discharge plan and within seven days
- Involved in a behavioral health crisis within timeframes based upon the person's clinical needs, but no later than seven days
- Refusing prescribed psychotropic medications within timeframes based upon the person's clinical needs and individual history
- Released from local and county jails and detention facilities within 72 hours
- For members experiencing or who have been reported to experience an adverse event/red flag (slurred speech, falling, nodding, intoxication, drooling, severe agitation, altered mental status, etc.) due to possible drug interaction or intoxication, a BHMP/PCP is notified within 24 hours (urgent response), or earlier if clinically indicated, to directly address the concerns.

18.12.5 FOLLOW-UP FROM INPATIENT HOSPITAL OR SUB-ACUTE FACILITIES

Additionally, for persons to be released from inpatient care, behavioral health providers must help establish priority prescribing clinician appointments within seven days of the person's release to ensure client stabilization, medication adherence, and to avoid re-hospitalization.

BCBSAZ Health Choice behavioral health providers are expected to:

- Involve the member, their families, or significant others in transition or aftercare planning
- For extenuating circumstances involving crisis calls, follow up within 24 hours and if the member is unreachable, initiate a welfare check that could include utilizing law enforcement services, family members and significant others as designated by the recipient
- Commence discharge planning at the time of intake
- Within 24 hours of notification of admission, the behavioral health clinical team contacts the inpatient social worker to schedule discharge planning staffing
- Within 72 hours of notification of admission, the clinical team coordinates with a Plan Medical Management Specialist to provide an initial discharge plan
- Involve the member and/or family members in the selection of aftercare providers and appointment times, and make sure aftercare appointments meet established access standards
- Formalize discharge planning in writing with a discharge summary and follow up actions clearly indicated with scheduled aftercare appointments
- Ensure recipients have sufficient medications or a prescription to last until the follow-up BHMP appointment. This includes coordination with the inpatient treating physician and may include prior authorization requests to the Plan Pharmacy Department
- No later than seven days of discharge, a BHMP completes a face-to-face evaluation of the member and addresses any medication and/or treatment issues
- Update the member's Individualized Recovery Plan/ Individual Service Plan and immediately implement increased service frequency and intensity as per Plan protocols to reduce readmissions, and as consistent with member needs and preferences.
- For members receiving Court Ordered Evaluation (COE) services in an inpatient setting and Court Ordered Treatment (COT) services in an inpatient and outpatient setting, BCBSAZ Health Choice will assist with care coordination and ensure the member has established outpatient care.
- We provide care coordination and care management services for members discharging from the Arizona State Hospital (AzSH). BCBSAZ Health Choice provides ongoing high touch care management services to members who are released from the AzSH on a Conditional Release Plan (CRP) and provides monthly comprehensive status reporting to the Psychiatric Security Review Board (PSRB).
- In the event a member violates any term of their CRP we will notify the PSRB and AHCCCS immediately of the violation. Our designated point of contact, the Arizona State Hospital Liaison, will ensure a smooth member transition back to the community.

Transition of Care (TOC) BCBSAZ Health Choice Post-Discharge Follow-Up Outreach
A Transition of Care (TOC) staff who is a nurse or behavioral health professional completes an outreach call to members within three days of discharge from an inpatient facility. The outreach call is to check on the well-being of the member, identify any needs, ensure medications have been received if needed, answer questions about post-discharge services and DME, ensure member knows about post-discharge appointments and engage the member in ongoing care. The goal of this program is to assure team implementation of the discharge plan including any required follow-up care, and to assist in coordination of any needed care or service to prevent adverse outcomes or unnecessary re-admissions.

18.12.6 SERVING PERSON PREVIOUSLY ENROLLED IN BEHAVIORAL HEALTH SYSTEM

Some persons who have previously withdrawn from participation in the behavioral treatment process may need to re-engage with behavioral health services. The process used is based on the length of time a person has been out of the behavioral health system.

For persons not receiving services the past six months:

- If the person has not received a behavioral health assessment in the past six months, conduct a new behavioral health assessment and revise the person's service plan as needed.
- If the person has received a behavioral health assessment in the last six months and there has not been a significant change in the person'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 person, and if needed, coordinate the development of a revised service plan with the person's clinical team.
- Continue the person's SMI status if the person was previously determined to have a Serious Mental Illness (SMI).
- Submit new demographic data.

For persons not receiving services in more than six months:

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

18.13 INTAKE, ASSESSMENT AND SERVICE PLANNING

Definitions (Per **AHCCCS AMPM 580 Behavioral Health Referral and Intake Process, AMPM 320-O Behavioral Health Assessments, Service and Treatment Planning):**

ASSESSMENT	The ongoing collection and analysis of a person's medical, psychological, psychiatric, and social conditions to initially determine if a health disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensure the person's service plan is designed to meet the person's (and family's) current needs and long-term goals.
INITIAL EVALUATION (INTAKE)	The collection by Provider trained staff of basic demographic information and preliminary determination of the member's needs.

ELIGIBILITY SCREENING

Persons who are not already determined eligible for Title XIX/XXI must be screened at the time of the intake interview for Title XIX/XXI eligibility.

The individual conducting the intake interview must request the supporting documentation listed below and explain to the applicant supporting documentation will only be used for the purpose of assisting in applying for Title XIX/XXI benefits through AHCCCS:

- Verification of gross family income for the last month and current month (e.g., paycheck stubs, social security award letter, retirement pension letter)
- For those who have other health insurance, bring the corresponding health insurance card (e.g., Medicare card)
- For all applicants, documentation to prove United States citizenship or immigration status and identity in accordance with AHCCCS Eligibility Policy and Procedure Manual
- For those who pay for dependent care (e.g., adult or child daycare), proof of the amount paid for the dependent care
- Verification of out-of-pocket medical expenses

INTAKE – BEHAVIORAL HEALTH

Behavioral health providers must be appropriately trained by their agency in accordance with ACOM 407 Workforce Development to meet requirements for competency-based workforce systems. Providers will conduct intake interviews in an efficient and effective manner that is both "person friendly" and strength-based, ensuring the accurate collection of all required information necessary for the intake. The intake process must:

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

Minimum elements needed for an outpatient behavioral health intake
There is no requirement that only a behavioral health home must conduct an in-person intake or assessment. A behavioral health home/outpatient service provider can utilize other service providers to gather necessary information when engaging a member in behavioral health services.

As stated above, make use of readily available information such as crisis service, 72 Hour DCS Removal assessment, SMI determinations, emergency visits, hospital psychiatric evaluation, hospital assessment and discharge summary. Many data fields accepted by BCBSAZ Health Choice can be completed with N/A or none if necessary, including non-principal treating diagnoses and updated later. Please refer to sections included within this chapter 18.0 for more specifics.

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

- The collection of contact information and insurance information
- The reason the member, parent/guardian is seeking services and information on any accommodations the member may require to effectively participate in treatment services (i.e., need for oral interpretation or sign language services, consent forms in large font, etc.).
- The collection of required demographic information and reporting through the AHCCCS Drugless Portal (**AHCCCS DUGless Portal Guide**)
- The completion of any applicable authorizations for the release of information to other parties (see section 18.24 Confidentiality)
- The dissemination of a Member Handbook to the member (refer to Chapter 2 Member Eligibility and Member Services)
- The review and completion of a general consent to treatment (see 18.25 General and Informed Consent to Treatment)
- The collection of financial information, including the identification of third-party payers and information necessary to screen and apply for AHCCCS, when necessary (see Chapter 2 Member Eligibility and Member Services, Chapter 14 Medicare, and Other Insurance Liability)
- The review and dissemination of BCBSAZ Health Choice Notice of Privacy Practices (NPP) and the AHCCCS HIPAA Notice of Privacy Practices (NPP) in compliance with **45 CFR 164.520 (c)(1)(B)**
- The review of the rights and responsibilities as a member of behavioral health services, including an explanation of the grievance and appeal process.

The member and/or the member's legal guardian/family member, advocate, and/or person providing special assistance, may complete some of the paperwork associated with the intake evaluation, if acceptable to the member and/or the member's legal guardian/family members, advocate, and/or person providing special assistance as referenced in AMPM 320-R.

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

ASSESSMENTS

All individuals being served in the public behavioral health system must have a behavioral health assessment upon an initial request for services. For individuals who continue to receive behavioral health services, updates to the assessment must occur at least annually. Behavioral health assessments must be utilized to collect necessary information that will inform providers of how to plan for effective care and treatment of the individual.
BCBSAZ Health Choice does not mandate a specific assessment tool or format be used but requires certain minimum elements. Providers must collect and submit all required demographic information in accordance with the criteria outlined in the (**AHCCCS DUGless Portal Guide**.

The initial and annual assessment must be completed by a behavioral health professional (BHP) or behavioral technician (BHT) under the clinical oversight of a BHP, who is trained on the minimum elements of a behavioral health assessment. If an assessment is conducted and documented by a BHT, a BHP must review and sign the assessment information that was documented by the BHT within 72 hours of the assessment completion.

18.13.1 MINIMUM ELEMENTS OF THE BEHAVIORAL HEALTH ASSESSMENT

The following minimum elements must be included in a comprehensive behavioral health assessment and documented in the comprehensive clinical record, in accordance with BCBSAZ Health Choice Medical Record Standards; AHCCCS Medical Policy Manual Chapter 320; Arizona Administrative Code Chapters **R9-10-1011** Outpatient Treatment Centers-Behavioral Health Services, **R9-10-707** Behavioral Health Residential Facilities, **R9-10-307** Behavioral Health Inpatient Facilities, and **R9-21** Persons with SMI; and/or ACOM 417, as applicable.

An assessment shall, at minimum, include an evaluation of the member's:

- Presenting concerns,
- Strengths and needs, and of the strengths and needs of the member's family,
- History of present illness (including review of major psychiatric symptoms (i.e., mood, depression, anxiety, psychosis, suicidal ideation, homicidal ideation, and other behavioral health symptoms) and frequency/duration of symptoms),
- Behavioral health treatment,
- Medical conditions and treatment,
- Current medications (including over the counter (OTC) medications),
- Allergies and other adverse reactions,
- Sexual behavior and, if applicable, sexual abuse,
- Substance abuse, if applicable (including type of substance, duration, frequency, route of administration, longest period of sobriety, and previous treatment history),
    - Standardized substance use screen for children aged 11 to 18 and referral for

comprehensive assessment when screened positive;
    - Substance use screen for adults aged 18 and older using the American Society of Addiction Medicine (ASAM) Third Edition – Revised of Patient Placement Criteria (ASAM PPC-3R) when indicated;
- Living environment,
- Educational and vocational training,
- Employment,
- Interpersonal, social, and cultural skills,
- Developmental history,
- Family History,
- Criminal justice history,
- Public (e.g., unemployment, food stamps, etc.) and private (e.g., faith based, natural supports, etc.) resources,
- 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),
- Legal history, (e.g., custody/guardianship status, pending litigation, Court Ordered Evaluation/Court Ordered Treatment (COE/COT) history, criminal justice history, and any history of sex offender adjudication),
- Housing status/living environment,
- Language and communication capabilities, and
- ICD-10 diagnoses.

The assessment shall include the date, begin time, and end time of the assessment, as well as the printed name, signature, and professional credentials of the provider completing the behavioral health assessment.

If a privileged BHT completes the assessment, the assessment must also include a printed name, signature, professional credential, date, and time of the privileged BHP who reviewed the assessment information.

Additional components of the assessment shall, if indicated, include:
- Risk assessment of the member the potential risk of harm to self or others based on self-reports, clinical symptoms, personality factors, history, substance abuse, criminogenic factors, etc.),
- Mental status examination of the member,
- Labs/ Diagnostics,
- A summary of impressions, and observations,
- Recommendations for next steps,
- Diagnostic impressions of the qualified clinician,
- Identification of the need for further or specialty evaluations, and
- Any other information determined to be relevant.

In situations when a specific assessment is duplicated (e.g., developmental assessment, CALOCUS), the results of such assessments shall be discussed collaboratively with any other provider that may have completed an assessment, to address clinical implications for treatment needs. Differences shall be addressed within the "team" with participation from both the health home and behavioral health provider outside of the health home

When applicable, the assessment shall include the use of standardized tools/screens e.g.:

- Whole person health and Social Determinants of Health (BCBSAZ Health Choice Health Apraisal- Adult or Pediatric)
- Depression and anxiety (PHQ-2/9, GAD-7, Edinburg Perinatal Depression Scale)
- Developmental needs (EPSDT, CALOCUS, M-CHAT, ADOS, PEDS, ASQ)
- Substance use (AUDIT, DAST, ASAM, CRAFFT)
- Trauma (Adverse Childhood Experiences)

REQUIRED FOR ALL SMI MEMBERS:

- Indication that a need for special assistance has been assessed

REQUIRED FOR ALL TITLE XIX/XXI MEMBERS:

- Primary Care Provider (PCP) name and contact information.
- Involvement with other agencies (e.g., Department of Child Safety, Probation, Division of Developmental Disabilities).

REQUIRED FOR CHILDREN AGED 0 TO 5: Developmental screening for children age Birth-5 with a referral for further evaluation when developmental concerns are identified. These evaluations could be by the child's PCP, the Arizona Early Intervention Program (AzEIP) for children age birth to three, or the public school system for children aged three to five. A developmental screening, such as Early Childhood Screening Intensity Instrument (ESCII), most recent versions of the Ages and Stages Questionnaires (ASQ), or the chosen screening tool of the health home is completed at the initial assessment and updated every six months, anytime there is a change in the child's needs or at the request of the Child and Family Team (CFT).

Health Choice contracted providers serving Birth-5 age children will follow all relevant AMPM 200 Behavioral Health Practice tools and AHCCCS AMPM 210 Birth to 5 Working with the Birth Through Five Population Behavioral Health Practice Tools, and are encouraged to seek Infant Toddler Mental Health Coalition of Arizona Birth-5 Endorsement or another accredited Birth-5 endorsement for evidenced based treatment.

REQUIRED FOR CHILDREN AGED 6 TO 18: Child and Adolescent Level of Care Utilization System (CALOCUS) score and date during the initial assessment and updated at a minimum of **every six months** or anytime there is a change in the child's needs.

REQUIRED FOR CHILDREN WITH CALOCUS SCORE OF 4 OR HIGHER:

- Strength, Needs and Culture Discovery Document
- Referral to a High Needs Case Manager
- High Needs Case Manager client ratio needs to be 1:25, with the ideal caseload size of 1:15

HIGH NEEDS CASE MANAGEMENT

Children:

- High needs case management is a requirement of HC and AHCCCS for children with high service intensity needs. High service intensity needs are identified as:
- **Children Birth through five years of age with one or more of the following:**
    - Other agency involvement; specifically: AzEIP, DCS, and/or
    - Out of home placement (within past six months), and/or
    - Psychotropic medication utilization (two or more medications), and/or
    - Evidence of severe psycho-social stressors (e.g., family member serious illness, disability, death, job loss, eviction)
- **Children six through 17 years of age:**
    - CALOCUS level of 4, 5, or 6

SMI: Only if Indicated: Seriously Mentally Ill Determination for persons who request SMI determination or have an SMI qualifying diagnosis, functional impairment, or are at risk for deterioration.

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, per BCBSAZ Health Choice Appointment Standards. 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 his/her clinical supervisor or a licensed medical practitioner with prescribing privileges.

18.13.2 SERVICE PLANNING

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

The behavioral health member must be included in the development of the service plan. In addition, family members, designated representatives, agency representatives and other involved parties, as applicable, may be invited to participate in the development of the service plan. Behavioral health providers must coordinate with the person's health plan, PCP or others involved in the care or treatment of the individual, as applicable, regarding service planning

recommendations**.**

In BCBSAZ Health Choice's model of care where members and Adult Recovery Teams/Child and Family Teams jointly participate in the development of services, the accuracy, comprehensiveness, and timeliness of the service plan is very important. The service plan:

- Identifies the covered services that are medically necessary based on an assessment and the member's preferences and needs
- Honors the culture, preferences, and values of the member and their family/natural support system
- Informs the member as to what services they can expect to receive, by whom and at what frequency
- Allows members to choose among in-network service providers and to be informed of alternate locations for receiving covered services
- Documents which services and referrals the health home will coordinate and cover financially (as indicated)
- Communicates the member's diagnoses, needs, treatment goals and expected services to non-Health Home providers who are also treating the member, for the purposes of coordination, billing, and reassessment

Interim Service Plan

If a person is in immediate or urgent need of behavioral health services, an interim service plan may need to be developed to document services until a complete service plan is developed. A complete service plan, however, must be completed no later than 90 days after the initial appointment.

The interim service plan must be sent to all the non-behavioral health home service providers on the plan in a timely manner:

- *"Urgent" - within 24 hours*
- *"Routine" - within 10 days*

For additional assistance with receiving a copy of the interim plan, please contact BCBSAZ Health Choice Behavioral Health Member Services at (800) 923-1400.

Minimum elements of the service plan for Title XIX/XXI Members determined to have SMI who have an assigned Case Manager

Service plans must be completed by BHPs or BHTs who are trained on the behavioral health service plan and meet BCBSAZ Health Choice credentialing requirements. In the event a BHT completes the service plan, a BHP must review and sign the service plan.

The service plan must be documented in the comprehensive clinical record in accordance with BCBSAZ Health Choice medical record standards, be based on the current assessment, and contain the following elements:

- The person/family vision that reflects the needs and goals of the person/family
- Identification of the person's/family's strengths
- Measurable objectives and timeframes to address the identified needs of the person/family
- If any needs are identified on the BCBSAZ Health Choice Health Risk Assessment, goals are established on the member's individualized service plan/recovery plan. The member may decline to address concerns identified; the declination will be documented in the medical record
- Identification of the specific services to be provided and the frequency with which the services will be provided
- The signature of the person/guardian and the date it was signed
- Documentation of whether or not the person/guardian is in agreement with the plan
- The signature of a clinical team member and the date it was signed
- The signature of the person providing Special Assistance, for persons determined to have Serious Mental Illness who are receiving Special Assistance
- The **Service Plan** is dated and signed by the person or guardian, the person who filled out the service plan, and a BHP if a BHT fills out the service plan.

The behavioral health member must be provided with a copy of their plan. Questions regarding service plans or member rights should be directed to BCBSAZ Health Choice's Member Service line at 800-640-2123.

The service plan must be sent to all the non-behavioral health home service providers on the plan in a timely manner:
- *"Urgent" - within 24 hours*
- *"Routine" - within 10 days*

For additional assistance with receiving a copy of the interim plan, please contact BCBSAZ Health Choice Member Services at (800) 640-2123. ***Appeals or Service Plan Disagreements*** Every effort should be taken to ensure t 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 a member and/or legal or designated representative disagree with any aspect of the service plan, including the inclusion or omission of services, the team should make reasonable attempts to resolve the differences and actively address the person's and/or legal or designated representative's concerns.

Despite a BHP's best effort, it may not be possible to achieve consensus when developing the service plan. In cases where the member and/or legal or designated representative disagree with some or all the Title XIX/XXI covered services included in the service plan, the member and/or legal or designated representative **must** be given a **Notice of Action** by the behavioral health representative on the team (see Chapter 15 Claim Disputes, Member Appeals and Member Grievances).

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

18.13.3 UPDATES TO ASSESSMENT AND SERVICE PLAN

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

18.13.4 HEALTH RISK ASSESSMENT INITIAL AND ANNUAL UPDATES

BCBSAZ Health Choice providers ensure administration of the **BCBSAZ Health Choice Health Appraisal** to all members, as well as completion of an annual HRA around the time of the annual comprehensive assessment based on the date of initial assessment. The HRA process is designed to identify enrollees with complex, chronic and/or serious medical or behavioral conditions needing further care coordination. This policy is in accordance with 42 CFR 422.112 and all regulatory agency requirements.

18.13.5 SAFETY PLANS/CRISIS PLANS

A safety plan is a document developed to address actions that need to be taken in the event the member is experiencing a behavioral health crisis. Safety plans are required for individuals with special designations within the system. A Wellness Recovery Action Plan (WRAP) is permitted as a substitute to a formal safety plan if the WRAP includes information that would be covered in a safety plan. For individuals whose treatment teams feel there is a clinically appropriate reason why no safety plan or WRAP is needed, the reason must be clearly documented in the clinical record in the service plan or on an otherwise blank safety plan. The following members, if actively engaged in behavioral health care, require safety plan, WRAP or justification for not needing a safety plan is present in the clinical record.

- Children with an CALOCUS scores of 4, 5, and 6
- A person who had more than 2 mobile or face-to-face crisis contacts in a 30-day period in the prior 3 months
- A person who called the crisis telephone system more than three times weekly in the prior 3 months
- A person on Court Ordered Treatment (COT)
- A person who has been hospitalized within the past year in an inpatient psychiatric facility, as part of the discharge plan.
- Any person the clinical treatment team deems to be at risk.

18.14 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 ensure stabilization, and/or other therapeutic and supportive services to prevent, reduce or eliminate a crisis situation. Other crisis intervention services may include 23-hour, 59 minutes crisis observation/stabilization, including detoxification services, and up to 72 hours of additional crisis stabilization, as funding is available for mental health and substance abuse related services. 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.

- In Northern Arizona (Coconino, Yavapai, Mohave, Navajo, and Apache counties), Care1st ACC-RBHA manages the behavioral health crisis system. In Gila, Maricopa, and Pinal counties, Mercy Care ACC-RBHA manages the behavioral health crisis system. In Southern Arizona (Pima, Yuma, Santa Cruz, Cochise, Graham, La Paz, Greenlee counties), Arizona Complete Health ACC-RBHA manages the behavioral health crisis system. All crisis services in Arizona can be access via the statewide crisis hotline at 1-844-534-4673 or 1-844-534-HOPE. Regional crisis hotlines will remain in operation at least through October 1, 2023. The regional crisis hotlines are as follows: Northern Arizona Crisis Hotline: 1-877-756-4090
- Maricopa Crisis Hotline: 1-800-631-1314 or 602-222-9444
- Southern Arizona Crisis Hotline: 1-866-495-6735

All ACC-RBHAs are responsible for the delivery of crisis services for all Title XIX/XXI members during the first 24 hours and all Non-Title XIX/XXI for the first 72 hours. Crisis services include 24/7 crisis hotline, 24/7 mobile crisis services, and 24/7 facility-based crisis services. All requirements for the delivery of crisis services via the ACC-RBHAs are outlined in AHCCCS Medical Policy Manual 590 (AMPM 590).

Follow up and Coordination of Care

All ACC-RBHAs will provide notification to the member's plan of enrollment, providers, and other appropriate parties when an individual engages with the crisis system. This notification will occur within 24 hours of an individual first engaging in the crisis system, seven days a week, 365 days a year, including weekends and holidays. Additionally, the ACC-RBHAs will ensure individuals receive a Post-Crisis Care Plan, which will include information related to the individual's needs, interventions, prescription medications, and referrals. BCBSAZ Health Choice will utilize the Post-Crisis Care Plan to identify, and address needed services.

In addition to the notification and plan, BCBSAZ Health Choice employs TOC staff to complete outreach calls to members within three days of notification of discharge from an inpatient facility. The purpose of the call is to check on the well-being of the member, identify any needs, ensure medications have been received if needed, answer questions about post-discharge

services and DME, make sure the member is aware of post-discharge appointments, and engage the member in ongoing care.

Operations During Adverse Conditions and Critical Incidents
In the case of adverse conditions, including but not limited to forest fires, emergency evacuations, snow, rain, and ice, it is imperative community stakeholders, behavioral health providers and emergency responders work in unity to provide the best possible mobile crisis response to members of the community.

In the event of critical incidents, disasters, and other emergencies, BCBSAZ Health Choice will collaborate with the ACC-RBHAs, community stakeholders, emergency responders and behavioral health providers to determine the necessity and activation of services for the community. Lead on any community disaster response will remain with the ACC-RBHA in which the disaster occurred.

18.15 FAMILY AND YOUTH INVOLVEMENT IN THE CHILDREN'S BEHAVIORAL HEALTH SYSTEM AND 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.

Additional guidance on Child and Family Team process can be found at AHCCCS AMPM 220 Child and Family Team Behavioral Health Practice Tool

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

- Ensure families have access to information on the CFT process and can 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 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
- Assess the family's need for 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 inclusive of the provider agency, the Plan, and AHCCCS at intake and throughout the CFT process.
- Work with BCBSAZ Health Choice to develop training in family engagement and participation, roles and partnerships for provider staff, parents/caregivers, youth, and young adults

RESPONSIBILITIES OF BCBSAZ HEALTH CHOICE 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 family members, youth and young adults are provided with training and information to develop the skills needed, BCBSAZ Health Choice 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 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 BCBSAZ HEALTH CHOICE

- 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
- Develop and make available to providers, policies, and procedures specific to these requirements.

ORGANIZATIONAL COMMITMENT TO EMPLOYMENT TO FAMILY MEMBERS

BCBSAZ Health Choice 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 chapter will be measured using 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/RBHA contracts or BCBSAZ Health Choice IGAs.

18.16 REPORTING AND MONITORING THE USES OF SECLUSION AND RESTRAINT

DEFINITIONS:

DRUG USED AS A RESTRAINT

Pharmacological restraint as used in A.R.S. §36-513 that is not standard treatment for a member's medical condition or behavioral health issue and is administered to:

- Manage the member's behavior in a way that reduces the safety risk to the member or others,
- Temporarily restrict the member's freedom of movement as defined in A.A.C. R9-21-101(26).

MECHANICAL RESTRAINT

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

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

PERSONAL RESTRAINT

The application of physical force without the use of any device, for the purpose of restricting the free movement of a member's body, but for a behavioral health agency licensed as a level 1 RTC or a Level I sub-acute agency according to A.A.C. R9-20-102 does not include:

- Holding a member for no longer than five minutes,
- Without undue force, in order to calm or comfort the member, or
- Holding a member's hand to escort the member from one area to another as defined in A.A.C. R9-21-101(50).

SECLUSION
The involuntary confinement of a behavioral health recipient in a room or an area from which the person cannot leave.

SECLUSION OF INDIVIDUALS DETERMINED TO HAVE A SERIOUS MENTAL ILLNESS
The restriction of a behavioral health recipient to a room or area using locked doors or any other device or method which precludes a person from freely exiting the room or area, or which a person reasonably believes precludes his/her unrestricted exit. In the case of an inpatient facility, confining a behavioral health recipient to the facility, the grounds of the facility, or a ward of the facility does not constitute seclusion. In the case of a community residence, restricting a behavioral health recipient to the residential site, according to specific provisions of an individual service plan or court order, does not constitute seclusion.

REPORTING TO BCBSAZ HEALTH CHOICE
As per **AHCCCS AMPM Policy 962 Reporting Seclusion and Restraint**, licensed behavioral health programs authorized to use seclusion and restraint must report each occurrence of seclusion and restraint and information on the debriefing subsequent to the occurrence of seclusion or restraint to BCBSAZ Health Choice's Quality Management Department within five (5) days of the occurrence.

The AHCCCS AMPM Policy 962 Attachment A, Seclusion and Restraint Individual Reporting form must be submitted within 5 days of the incident.

In the event use of seclusion or restraint requires face-to-face monitoring, a report detailing face-to-face monitoring must be attached. The face-to-face monitoring form must include the requirements as per **42 CFR 482.13**, **42 CFR § 483 Subpart G**, **R9-20-602** and **R9-21-204**, outlined in **Seclusion and Restraint Monitoring Requirements**.

18.17 REPORTING OF INCIDENTS, ACCIDENTS, AND DEATHS

BCBSAZ Health Choice and providers shall ensure reportable IADs and Internal Referrals (IRF)s are submitted via the AHCCCS QM Portal. IADs and IRFs shall be submitted into the QM Portal within two business days of the occurrence or notification to the Contractor or provider of the occurrence. Sentinel IADs (listed below) shall be submitted by the Contractor or provider into the AHCCCS QM Portal within one business day of the occurrence or becoming aware of the occurrence. The Contractor shall notify AHCCCS of all sentinel events via email at CQM@azahcccs.gov immediately, but within 24 hours of notification of the occurrence.

1. An IAD is reportable if it includes any of the following:

    a. Allegations of abuse, neglect, or exploitation of a member,
    b. Death of a member,
    c. Delays or difficulties in accessing care (e.g., outside of the timeline specified in ACOM Policy 417),

d. Healthcare acquired conditions and other provider preventable conditions (refer to AMPM Policy 960 and AMPM Policy 1020),
e. Serious injury,
f. Injury resulting from the use of a personal, physical, chemical, or mechanical restraint or seclusion (refer to AMPM Policy 962),
g. Medication error occurring at a licensed residential Provider site including:
    i. Behavioral Health Residential Facility (BHRF),
    ii. DDD Group Home,
    iii. DDD Adult Developmental Home,
    iv. DDD Child Developmental,
    v. Assisted Living Facility (ALF),
    vi. Skilled Nursing Facility (SNF),
    vii. Adult Behavioral Health Therapeutic Home (ABHTH), or
    viii. Therapeutic Foster Care Home (TFC), and any other alternative Home and Community Based Service (HCBS) setting as specified in AMPM Policy 1230-A,
h. Missing person from a licensed Behavioral Health Inpatient Facility (BHIF), BHRF, DDD Group Home, ALF, SNF, ABHTH, or TFC,
i. Member suicide attempt,
j. Suspected or alleged criminal activity, and
k. Any other incident that causes harm or has the potential to cause harm to a member.
l. Adverse Drug Event or Reactions/"Red Flags" for members with suspected drug overdoses.

2. Sentinel IADs include:

a. Member death or serious injury associated with missing person,
b. Member suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting,
c. Member death or serious injury associated with a medication error,
d. Member death or serious injury associated with a fall while being cared for in a healthcare setting,
e. Any stage 3, stage 4, and any unstageable pressure ulcers acquired after admission or presentation to a healthcare setting,
f. Member death or serious injury associated with the use of seclusion and/or restraints while being cared for in a healthcare setting,
g. Sexual abuse/assault on a member during the provision of services.
h. Death or serious injury of a member resulting from a physical assault that occurs during the provision of services, and
i. Homicide committed by or allegedly committed by a member

Upon receipt of an IAD Report from providers, BCBSAZ Health Choice must:

1. Conduct an initial review of all IADs within one business day of provider submission. An initial review shall include the following:
   a. Identify any immediate health and safety concerns and ensure the safety of the individuals involved in the incident, which may include that immediate care and recovery needs are identified and provided,
   b. Determine if the IAD report needs to be returned to the provider for additional information (e.g., report is assigned to the wrong Contractor, enrollment category is not selected, incident type is not correct or not selected, information is missing or incorrect through the report),
   c. Determine if the IAD report requires further investigation through a Quality of Care (QOC) investigation (refer to AMPM Policy 960),
   d. Determine if the IAD needs to be linked to a corresponding Seclusion and Restraint (SAR) Individual Reporting Form (refer to AMPM Policy 962), or
   e. Determination if the IAD report does not need further documentation or review and closure of the report.
2. Follow up on all IADs returned to the provider within one business day to ensure the provider is aware that the report has been returned and are working on the corrections.
3. Take immediate actions to ensure the immediate safety of members where allegations of harm or potential harm exist regardless of status assigned to the IAD, including those returned to provider.
4. Ensure that all suspected cases of abuse, neglect, and exploitation of a member be reported to all appropriate authorities, by the provider directly or by the Plan if not completed by the provider, including but not limited to: Adult Protective Services (APS), Department of Child Safety (DCS), and the Arizona Department of Health Services (ADHS).
5. Track and trend all IADs to identify and address systemic concerns or issues within the provider network.
6. Provide IAD reports to the appropriate Independent Oversight Committee (IOC) as specified in contract and AMPM Policy 960.

** Failure to submit IADs timely may result in a financial sanction for late submission of a contract deliverable.

18.18 WORKFORCE DEVELOPMENT

Workforce Development (WFD) All Lines of Business

This following information applies to health care providers contracted with BCBSAZ Health Choice for the Arizona Health Care Cost Containment System (AHCCCS), AHCCCS Complete Care (ACC), Regional Behavioral Health Authority (RBHA), Arizona Long Term Care Services (ALTCS) Elderly/Physically Disabled (E/PD), and/or Developmental Disability (DD)). It discusses the requirements, expectations, and recommendations in developing the workforce.

The initiatives align with Workforce Development Policy ACOM 407 & ACOM 407 Attachment A.

BCBSAZ Health Choice Workforce Development Operation (WFDO) implements, monitors, and regulates Provider WFD activities and requirements. In addition, the Plan evaluates the impact of the WFD requirements and activities to support Providers in developing a qualified, knowledgeable, and competent workforce.

In collaboration with AHCCCS, BCBSAZ Health Choice AWFDA's, ensures all course content is culturally appropriate, has a trauma informed approach and is developed using adult-learning principles and guidelines. Additionally, it aligns 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 Advisory Council—ALTCS (AWFDAC—ALTCS) is organized by AHCCCS and includes members from: the four ALTCS Manager Care Organizations (MCOs), Community Stakeholders and LTC Advocacy Groups. The purpose of this group is to share resources, develop strategies and support state-wide initiatives in Long-Term Care that are aligned with Arizona's Plan for an Aging Population: Aging 2020 and AHCCCS Policies:

> ACOM 429 and ACOM 407: Direct Care Worker Training and Testing Program. Additionally, this committee will offer advice and recommendations on initiatives set by the MCOs.

AZ Workforce Development Advisory Committee—ACC, ACC-RBHA (AWFDAC—ACC, ACC/RBHA) is comprised of leaders, stakeholders, and experts who provide guidance and direction on strategic items important to the ongoing partnership and success around the use of Relias solutions and services, as well as Workforce Development initiatives. This Committee is responsible for maintaining a working relationship and alignment with statewide goals and objectives, as well as providing input to AHCCCS on policies and initiatives related to Workforce Development.

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 offers valuable training programs through our AZ Workforce Development Alliance—ACC, ACC-RBHA, and supplies assistance and resources to enhance the long-term care workforce through the AZ Workforce Development Alliance—ALTCS.

Arizona Healthcare Workforce Development Coalition (AHWFDC) is organized by the WFD Department at AHCCCS, the AzAHP and includes members from the eight MCOs. This group represents ACC, ALTCS, DCS CHP, DES/DDD and RBHA lines of business. Together, the Coalition ensures initiatives across the state of Arizona align with all lines of business.

AzAHP Workforce Development Alliance (AWFDA) A name given to the WFD Administrators from each Contractor that jointly plan and conduct WFD activities for a particular line of business.

Currently there are four AWFDAs:

- The **AWFDA—ACC, ACC-RBHA** includes the WFD Administrators from ACC, RBHA, and DCS CHP Contractors. In addition to conducting joint WFD planning, the ACC, ACC-RBHA/DCS CHP AWFDA collectively manages the contract between the AzAHP and the Learning Management System (LMS) vendor.
- The **AWFDA—ALTCS** includes WFD Administrators from the DDD and ALTCS E/PD Contractors.
- The **AWFDA—DCS CHP** includes WFD Administrators from AHCCCS, DCS and Plans with CHP contracts
- The **AWFDA—DD** includes WFD Administrators from Plans with DD contracts

Definitions

Competency is defined as worker's demonstrated ability to perform the basic requirements of a job intentionally, successfully, and efficiently, multiple times, at or near the required standard of performance.

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 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

Prevention of Abuse and Neglect

- The Provider workforce shall have access to and be compliant with all workforce training and/or competency requirements specified in federal and state law, AHCCCS policies, guidance documents, manuals, contracts, plans such as network development, quality improvement, corrective action, and/or special initiatives.

- Providers shall have processes for documenting training, verifying the qualifications, skills, and knowledge of personnel; and retaining required training and competency transcripts and records.

Residential Care (24-Hour Care Facilities) Annual Requirements

- Crisis prevention/de-escalation employee training for all member-facing employees prior to serving members. For facilities where restraints are approved, a nationally approved restraint training for all member-facing employees. This curriculum should include non-verbal, verbal, and physical de-escalation techniques.

Division of Licensing Services (DLS) Required Training

- 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.

Community Service Agencies (CSAs)

- CSAs must submit documentation as part of the first and annual CSA application. The documentation must show that all direct service employees 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.

Child and Adolescent Level of Care Utilization System (CALOCUS)

- 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. On-going competency assessments are also required to evaluate a staff member's knowledge and skills.
- Any other trained provider (PCP, specialty provider) 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.
- 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 service acuity instruments. The agreement includes the licensing of both CALOCUS/LOCUS online, though AHCCCS 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).

- Providers can implement LOCUS/CALOCUS in one of two ways.
  - The first is via the web-based version which can be accessed at locus.azahcccs.gov.
  - The second is via an EHR integration.
- Regardless of which option you choose, you must first reach out to Deerfield and sign their end user license agreement as soon as possible. There is no cost associated with this agreement. Matthew Monago will be your contact at Deerfield and his email is mmonago@journeyhealth.org. Please be sure to identify your organization as an AHCCCS provider when emailing.

- Per AHCCCS communication on 10/8/21: "Due to discussions between AHCCCS, BCBSAZ Health Choice (WFD) Administrator, members of the American Academy of Child and Adolescent Psychiatry (AACAP) and American Association of Community Psychiatrists, it has been determined that 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."
  - For Children's Providers serving children in the Department of Child Safety Comprehensive Health Plan, BCBSAZ Health Choice 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.
  - If there are questions regarding CALOCUS training requirements related to the AHCCCS contract, provider agencies should be instructed to please reach out to the Contract Compliance Officer at the contracted Health Plan.

Monitoring Process

All Health Plans will monitor the CALOCUS certification process. Each Health Plan will run Relias reports to monitor those who have completed, as well as have not completed the requirement in the 30-day periodThese reports will then be compared to the Deerfield completion report, ensuring fidelity to this AHCCCS requirement. In addition to the 30-day time frame, employees must also meet the 2.5-hour minimum time commitment when attending the training through Deerfield. *It is suggested that those who have completed the Deerfield CALOCUS training prior to July 1, 2022, also be enrolled and marked complete in the training plan for monitoring, tracking, and record transferability.

Provider Agency Requirements

- All child and adolescent provider agencies who meet the requirements for the CALOCUS training will need to do the following:
  - Enroll employees who are required to take the Deerfield CALOCUS training in the *AZAHP – CALOCUS Training Requirement (30 Days) training plan in Relias.
  - Once the employee has been enrolled and completes the CALOCUS training through

Deerfield the provider agency's supervisor/administrator will mark them complete in the Relias CALOCUS Training Requirement module.

- 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 (ACC). A portion of this data will be supported by the Provider Workforce Development Plan (as applicable to LOB), the AZ Healthcare Workforce Goals and Metrics Assessment, and any additional means that are identified.

AZ Healthcare Workforce Goals and Metrics Assessment (AHWGMA)

BCBSAZ Health Choice requires that all contracted provider types listed on our 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 for the most up-to-date information, including a list of required Provider Types and a link to the assessment.

AHWGMA Webpage: https://azahp.org/azahp/ahwdfc/az-healthcare-workforce-goals-and-metrics-assessment/

ADHOC Initiatives

BCBSAZ Health Choice 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 BCBSAZ Health Choice 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 P-WFDP requirement, training plans and the provider forums, or to discuss technical assistance needs, please reach out to our WFDO at Jenny Elkins @ Jennifer.Elkins@azblue.com

Behavioral Health (BH) ACC, ACC-RBHA Providers: *Please refer to the ACC, ACC-RBHA Addendum for ACC, ACC-RBHA BH specific Workforce Development information.*

ACC, ACC-RBHA Behavioral Health Addendum
Training/Compliance Requirements

Relias Learning Management System (LMS)

The AWFDA— ACC, ACC-RBHA Providers, under the provider types listed at the link below, ensure that all employees who work in programs that support, oversee, or are paid by the Health Plan contract have access to Relias and are enrolled in the AzAHP Training Plans listed in this addendum. This includes, but is not limited to, full time/part time/on-call, direct care, clinical, medical, administrative, leadership, executive and support employees.

Provider types:
https://azahp.org/azahp/azahp-accrhba-awfda/resources-2/

Exceptions:
- Any employee(s) hired for temporary services working less than 90 days is required to complete applicable training at the discretion of the Provider.
- Any employee(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 consider 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 BCBSAZ Health Choice Workforce Development Administrator for further assistance. The request should include the following information:

- Provider Agency Name
- Contract Start Date
- Address
- Key WFD Contact
    - Name
    - Phone Number
    - Email Address
- Contract Type (ACC, ACC-RBHA)
- Provider Type (GMH/SU, Children's, Integrated Health Home, etc.)
- Number of Users (# employees at the agency who need Relias access)
- List of Health Plans provider is contracted with (if known)

BH provider agencies with 20 or more users will be required to purchase access to Relias Learning for a one-time fee of $1500 for full-site privileges. A full site is defined as a site in which the agency may have full control of course customizations and competency development.

Provider agencies with 19 or fewer users will be added to AzAHP Relias Small Provider Portal at no cost with limited-site privileges. A limited-site is defined as one in which the courses and competencies are set-up according to the standard of the plan with no customization or course development provided. Contact workforce@azahp.org to do so.

Provider agencies that expand to 20 or more users will be required to purchase full site privileges to Relias Learning immediately upon expansion.

*Fee is subject to change if a Provider requires additional work beyond a standard sub-portal implementation.

AzAHP Core Training Plans

AzAHP–Core Training Plan (90 Days)

The Training Plan below is set to auto-enroll all NEW Relias users in your system who have been assigned one (or more) of the 7 Health Plans under the "Plan" field in their user profile. If the employee hired has a previous account under another agency, please ensure that you have their transcripts transferred (there is a job aid available at www.azahp.org).

- Welcome to Relias (Due within 7 days of hire date)
- *AHCCCS –Health Plan Fraud (0.75hrs)
- *AHCCCS –NEO –Rehabilitation Employment (0.5hrs)
- *AzAHP –AHCCCS 101 (2.0hrs)
- *AzAHP –Client Rights, Grievances and Appeals (1.25hrs)
- *AzAHP –Cultural Competency in Health Care (1.0hrs)

- *AzAHP –Quality of Care Concern (1.0hr)
- Corporate Compliance: The Basics (0.5hrs)
- HIPAA: The Basics (0.5hrs)
- Integrating Primary Care with Behavioral Healthcare (1.25hrs)

AzAHP –Core Training Plan (Annual)
The Training Plan below is set to auto-enroll all Relias users in your system who have been assigned one (or more) of the 7 Health Plans under the "Plan" field in their user profile.

- HIPAA: The Basics (0.5hrs) Due: January 31st
- Abuse and Neglect: Preventing, Identifying and Responding to Abuse and Neglect (1.0hrs) Due: April 30th
- Corporate Compliance: The Basics (0.5hrs) Due: May 31st
- *AzAHP –Cultural Competency in Health Care (1.0hrs) Due: July 31st
- *AHCCCS –Health Plan Fraud (0.75hrs) Due: October 31st
- *AzAHP –Quality of Care Concern (1.0hr) Due: December 31st

Quarterly Reports

The ACC, 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, ACC-RBHA AWFDA will run this report on 4/30**
- **04/01-06/30 – ACC, ACC-RBHA AWFDA will run this report on 7/31**
- **07/01- 09/30 – ACC, ACC-RBHA AWFDA will run this report on 10/31**
- **10/01-12/31 – ACC, ACC-RBHA AWFDA will run this report on 1/31**

If any of the reporting dates fall on a weekend or holiday, the ACC, ACC-RBHA AWFDA reserves the right to run the report on the following business day.

Provider agencies who fall 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).

Child and Family Team (CFT) Initiatives

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 Facilitators 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 course to newly hired employees at a 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 cease the utilization of their CFT curriculum no later than December 31, 2022 and utilize the AHCCCS approved training curriculum (ACOM 220, Section F # 2), which will be made available to the CFT Champion upon completion of their CFT 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 for the new 2-day CFT Facilitator Course. These sessions are intended for employees who will be delivering the 2-day CFT training 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 certainly 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 Course 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 course will be required for all new **and** existing leaders at the agency once the agency has a CFT Champion who successfully completes the Supervisor TtT session. The training will provide guidance related to identified competency measurements.
- **Initiative 4: CFT Supervisor Facilitator Train the Trainer**
    - The CFT Supervisor TtT session will be 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 in the training plan.
        - Within the training plan there are three module requirements:
            - The *AzAHP- CFT Overview (a self-paced course expected to be completed before attending the TtT session),
            - *AZAHP- CFT Facilitator TtT, and
            - *AZAHP- CFT Supervisor Facilitator 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 a 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 and 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 220 (F), Attachment C & D).

- **Monitoring Process**
    - **CFT Champion Certification**
        - All agencies who are required to have CFT Champion 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**
    - The Supervision Tool requirements will be tracked in Relias for all employees who facilitate/lead CFT's.
- **CFT Facilitator Training Hardship Waiver**
    - In the event the 2 Day CFT training becomes a barrier or hardship for an organization, provider organizations may request a CFT Facilitator Training Hardship Waiver. Within the waiver, providers will need to identify why delivering the course as originally designed presents a hardship. They must also supply a detailed plan of what changes they will make to the 2 Day CFT Facilitator training while still meeting all the elements of the training. The plan will be submitted to the Workforce Development Team at workforce@azahp.com. Provider organizations must obtain approval before the training occurs.

General Mental Health (GMSH)/Substance Use (SU)

Employees completing assessments of substance use disorders and subsequent levels of care must complete the American Society of Addiction Medicine (ASAM) criteria-specific training. This training is required before staff may use the assessment tool with members. They must also complete any approved substance use/abuse course every year. The assessment should align with the most recent ASAM criteria.

Network Workforce Data Collection

Provider Workforce Development Plan (P-WFDP)

The 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 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).

The ACC, ACC-RBHA Providers, under the provider types listed at the link below, complete the annual P-WFDP. The P-WFDP Template is provided for this deliverable by the AWFDA—ACC, ACC-RBHA AWFDA 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 ACC, ACC-RBHA AWFDA.

- **Extension Requests**: must be submitted to the workforce@azahp.org email before the date specified by the ACC, ACC-RBHA AWFDA 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.

Required ACC, ACC-RBHA Provider Types can be found at this link: https://azahp.org/wp-content/uploads/2022/07/AZAHP-Website-All-LOB-Provider-Types-Requirements-Tracker-2022-1.xlsx
Failure to submit your completed annual P-WFDP deliverable by the annual due date may result in corrective action and/or sanctions (including suspension, fines, or termination of contract).

ACC, ACC-RBHA AWFDA Provider Forums
The ACC/RHBA AWFDA consists of representatives from the AzAHP, Relias, and the Workforce Development Administrators from all seven ACC Health Plans. Providers are encouraged to attend the virtual ACC, ACC-RBHA AWFDA provider forum on the second Thursday of each month for up-to-date information on WFD related topics, including: WFD initiatives, professional development, training, Relias, and opportunities to receive technical assistance. To review previous forums, you may access the recordings at the following link: https://azahp.org/azahp/azahp-accrhba-awfda/resources-2/

18.19 PEER/RECOVERY SUPPORT TRAINING, CREDENTIALING AND SUPERVISION REQUIREMENTS

PEER /RECOVERY SUPPORT SPECIALIST QUALIFICATIONS
Individuals training PRSS, or individuals seeking credentialing and employment as a PRSS shall:

Qualify as a Behavioral Health Paraprofessional (BHPP), Behavioral Health Technician (BHT), or Behavioral Health Professional (BHP), and Self-identify as an individual who:

- Has lived experience of mental health conditions, and/or substance use, for which they have sought help or care, and
- Has an experience of sustained recovery to share.
- The Contractor shall ensure PRSS credentialing program operators:
    - Utilize Attachment B to determine if applicants are qualified for admission,
    - Admit only individuals completing and fulfilling all requirements of Attachment B, and
    - Maintain a record of issued credentials.
- Final determination for admission rests with the credentialing program operator.
- AHCCCS recognizes PRSS credentials issued by credentialing programs in compliance with this Policy. The Contractor and providers shall recognize credentialing from any PRSS credentialing program in compliance with this Policy. If there are regional, agency or culturally specific training requirements exclusive to the Contractor, service provider or tribal community, the additional requirements shall not prevent recognition of a PRSS credential issued in compliance with this Policy.
- The PRSS credentialing process is not a service.

PEER SUPPORT EMPLOYMENT TRAINING PROGRAM APPROVAL PROCESS

AHCCCS/DCAIR, OIFA, oversees the approval of all credentialing materials including curriculum and testing tools. AHCCCS/DCIAR, OIFA, bases approval solely on a program's compliance with all requirements as specified in this Policy. Peer Support employment training is not a billable service for costs associated with training an agency's own employees.

- To be considered for review, AHCCCS registered providers intending to operate a PRSS credentialing program shall submit its training curriculum to AHCCCS/DCAIR, OIFA. The program curriculum materials shall include but are not limited to:
    - Student and trainer manuals,
    - Handouts,
    - Homework,
    - Final exam,
    - Any other classroom materials, or
    - Descriptions of reasonable of accommodations or alternative formats for the accessibility of program materials by all audiences
- If a program makes substantial changes (e.g., change to content,) to its curriculum or if there is an addition to required elements the program shall submit the updated content to AHCCCS/DCAIR, OIFA for review and approval.
- If there are regional or culturally specific training requirements exclusive to the Contractor, or tribal community, the additional training requirements shall not prevent

employment or transfer of a PRSS credential based on the additional elements or standards.

COMPETENCY EXAM

Individuals seeking credentialing and employment as a PRSS shall complete and pass a competency exam with a minimum score of 80% upon completion of required training. Each PSETP has the authority to develop a unique competency exam. All exams shall include at least one question related to each of the curriculum core elements listed in subsection D of this policy. If an individual does not pass the competency exam, the PSETP may allow the individual to retake or complete additional training prior to taking the competency exam again.

Upon completion of each class, all AHCCCS registered providers operating a PSETP shall utilize Attachment C to submit the names of trainees and dates of graduation to AHCCCS/DCAIR, OIFA, via email at oifa@azahcccs.gov. These reports shall contain no other information apart from what is required.

INTERSTATE RECIPROCITY

AHCCCS/DCAIR, OIFA, recognizes credentials issued by states and/or training programs which comply with CMS's requirements, as specified in SMDL #07-011. Individuals credentialed in another state shall submit their credential to AHCCCS/DCAIR, OIFA, via email at oifa@azahcccs.gov.

PEER SUPPORT EMPLOYMENT TRAINING CURRICULUM STANDARDS

A Peer Support Employment Training Program curriculum must include the following core elements:

1. A PRSS credentialing program shall include the following core elements:
    - Concepts of hope and recovery:
        - Instilling the belief that recovery is real and possible,
        - The history of social empowerment movements, and their connection to peer and recovery support, including but not limited to the following movements:
            i. Self-Help,
            ii. Consumer/Survivor/Ex-Patient,
            iii. Neurodiversity,
            iv. Disability Rights, and
            v. Civil Rights.
        - Varied ways that behavioral health has been viewed and treated over time and in the present,
        - Appreciating diverse paradigms and perspectives of recovery and other ways of thinking about health (e.g., harm reduction, 12-step recovery, neurodiversity),
        - Knowing and sharing one's story of a recovery journey and how one's story can assist others in many ways,
        - Holistic approach to recovery addressing behavioral, emotional, and physical health, and

    - Member-driven/person-centered service planning.
- Advocacy and systems perspective:
    - State and national health systems' infrastructure - the history of Arizona's health systems,
    - Confronting and countering discrimination, prejudice, bias, negative stereotypes, and other social injustices against those with behavioral health and substance use disorders – combating internalized stigma and oppression,
    - Organizational change- how to utilize person-first and identity-first language to educate provider staff on recovery principles and the role and value of peer support,
    - Creating a sense of community in a safe and supportive environment,
    - Forms of advocacy and effective strategies – consumer rights and navigating health systems,
    - The Americans with Disabilities Act (ADA), and
    - Social Determinants of Health (SDOH).
- Psychiatric rehabilitation skills and service delivery:
    - Strengths based approach, identifying one's own strengths and helping others identify theirs, building resilience,
    - Trauma-informed care,
    - Distinguishing between sympathy and empathy; emotional intelligence,
    - Understanding learned helplessness; how it is taught and how to assist others in overcoming its effects,
    - Motivational interviewing; communication skills and active listening,
    - Healing relationships – building trust and creating mutual responsibility,
    - Combating negative self-talk - noticing patterns and replacing negative statements about oneself, using mindfulness to gain self-confidence and relieve stress,
    - Group facilitation skills,
    - Culturally & Linguistically Appropriate Services (CLAS) standards; the role of culture in recovery, and
    - Understanding and supporting individuals with Intellectual and Developmental Disabilities (I/DD).
- Professional Responsibilities of the PRSS and self-care in the workplace:
    - Professional boundaries and code of ethics unique to the role of a PRSS,
    - Confidentiality laws and information sharing – understanding the Health Insurance Portability and Accountability Act (HIPAA),
    - Responsibilities of a mandatory reporter; what to report and when,
    - Understanding common signs and experiences of:
        i. Mental health disorders,
        ii. Substance Use Disorders (SUD),
        iii. Opioid Use Disorder (OUD),
        iv. Addiction,
        v. Dissociation,
        vi. Trauma,

vii. Intellectual and Developmental Disabilities (I/DD), and
viii. Abuse/exploitation and neglect,
- Familiarity with commonly used medications and potential side effects, informed consent as specified in AMPM Policy 320-Q,
- Guidance on proper service documentation; billing and using recovery language throughout documentation.
- Self-care skills:
    i. Coping practices for helping professionals,
    ii. The importance of ongoing supports for overcoming stress in the workplace,
    iii. Using boundaries to promote personal and professional resilience, and
    iv. Using self-awareness to prevent burnout, compassion fatigue, and secondary traumatic stress

2. PRSS employed in Community Service Agencies shall complete additional trainings as required in the AMPM Policy 965. PSETP shall not duplicate training required of individuals for employment with a licensed agency or Community Service Agency.
3. Contractors shall develop and make available policies and procedures as well as additional resources for development of curriculum, including Contractor staff contacts for questions or assistance.
4. For a list of references to assist in developing a curriculum, refer to the AHCCCS suggested curriculum development resource list.
   BCBSAZ Health Choice's Office of Individual and Family Affairs Manager oversees the implementation, training and monitoring of peer support services and ensures that peers have the necessary knowledge and skills to successfully provide quality behavioral health services in the public behavioral health system. The contractor can request, receive and review curriculum of contracted PSETPs.
   - Signed attestation from each PRSS Credentialing Training Program acknowledging this requirement with assigned point person for Program.
       - Must submit curriculum zip file format within 14 days of request.
   - PRSS Credentialing Training Programs can:
       - Request feedback on their curriculum at any time.
       - Request assistance with their curriculum content at any time.
       - OIFA@azblue.com

While peer support employment training programs must not duplicate training required of licensed agencies or CSAs, it is possible licensed agencies and/or CSAs may consider training completed as part of the peer support employment training program as meeting the agencies' training requirements.

SUPERVISION OF CREDNETIALED PEER RECOVERY SUPPORT SPECIALIST

Supervision is intended to provide support to Peer/Recovery Support Specialists (PRSS) in meeting treatment needs of behavioral health recipients receiving care from PRSSs. Supervision provides an opportunity for growth within the agency and encouragement of recovery efforts.

Agencies employing PRSSs must have a qualified individual (behavioral health professional (BHP) or behavioral health technician (BHT)) level individual designated to provide PRSS supervision. Supervision must be documented and inclusive of both clinical and administrative supervision.

- BCBSAZ HC requirement: 2 hours of clinical supervision per month and 2 hours of administrative supervision per month.

Each provider agency will need to create a process of tracking this requirement and will submit to the Health Plan upon request.

CONTINUING EDUCATION AND ONGOING LEARNING REQUIREMENTS

Similar to other practitioners, requirements shall be established for individuals employed as PRSS to obtain continuing education and ongoing learning relevant to peer support, including physical health and wellness

- The Contractor shall develop and make available to providers' policies and procedures describing requirements for individuals employed as PRSS to obtain a minimum of four hours of continuing education and ongoing learning relevant to peer support, per year. At least one hour shall cover ethics and boundaries related to the practice of peer support.
- The Contractor shall ensure providers and individuals employed as a PRSS have access to a minimum of four hours of continuing education and ongoing learning, relevant to peer support, per year.
    - Each provider agency will need to create a process of tracking this requirement and will be required to submit the data to BCBSAZ Health Choice OIFA quarterly.

18.20 PARENT AND FAMILY SUPPORT TRAINING, CREDENTIALING, AND SUPERVISION REQUIREMENTS

PARENT PEER/FAMILY SUPPORT PROVIDER AND TRAINER QUALIFICATIONS

The peer-to-peer support relationship is available to primary caregivers of Medicaid-eligible children and natural supports of Medicaid-eligible Adults and, as:

1. A parent or primary caregiver with lived experience who has raised or is currently raising a child with emotional, behavioral health, and/or Substance Use Disorders (SUD), or
2. An individual who has lived experience as a primary natural support for an adult with emotional, behavioral health, and/or SUD.
3. AHCCCS/DCAIR, OIFA has established training requirements and credentialing standards for providing Credentialed Parent Peer/Family Support services within the AHCCCS programs.
4. Parent Peer/Family Support Services are defined and not limited to:
    a. Assisting the family to adjust to the individual's needs,
    b. Developing skills to effectively interact, and/or

5. Guide the individual's:
    a. Understanding of the causes and treatment of behavioral health challenges,
    b. Understanding and effective utilization of the system, or
    c. Planning for ongoing and future supports for the individual and the family.

All individuals employed as a CPPFSP or as a Trainer in the Children System or Adult System shall meet the definition of a family member. To be eligible to train individuals as CPPFSP you must have lived experience as an adult who is the primary supporter of a child or the primary supporter of an adult who has experience navigating the adult and or child systems of care.

CREDENTIALED PARENT PEER/FAMILY SUPPORT PROVIDER TRAINING PROGRAM APPROVAL PROCESS

- A CPPFSP Training Program shall submit its program curriculum, competency exam, and exam-scoring methodology (including an explanation of accommodations or alternative formats of program materials available to individuals who have special needs) to AHCCCS/DCAIR, OIFA, at OIFA@azahcccs.gov. AHCCCS/DCAIR, OIFA shall issue feedback or approval of the curriculum, competency exam, and exam-scoring methodology as specified in this Policy.
- A CPPFSP Training Curriculum shall not be combined with any other training and shall be recognized as a stand-alone program. A CPPFSP Curriculum shall be specific to the delivery of Parent/Family Support Services.
- If a program makes substantial changes (e.g. change to content, classroom time) to its curriculum or if there is an addition to required elements, the program shall submit the updated content to AHCCCS/DCAIR, OIFA, at OIFA@azahcccs.gov for review and approval before the changed or updated curriculum is to be utilized.
- Approval of the curriculum, competency exam, and exam-scoring methodology is based on the elements required in this Policy. If a CPPFSP Training Program requires regional or culturally specific training exclusive to a Geographical Service Area, (GSA) or specific population, the specific training cannot prevent employment or transfer of Parent/Family Support credentials based on the additional elements or standards.
- A Training program operator shall ensure that the curriculum is maintained and as substantial changes in the Integrated System of Care (ISOC) occur the curriculum is revised. The program shall submit the updated content to AHCCCS/DCAIR, OIFA, at OIFA@azahcccs.gov for review and approval before the changed or updated curriculum is to be utilized.

COMPETENCY EXAM

Individuals seeking employment as a CPPFSP shall complete and pass a competency exam with a minimum score of 80 percent upon completion of required training. Each CPFSP Training Program has the authority to develop a unique competency exam. However, all exams shall include questions related to each of the curriculum core elements as specified in this Policy. Agencies employing CPPFSP who are providing Parent Peer/Family Support Services are required to ensure that its employees are competently trained to work with the populations served.

Upon completion of each class, all AHCCCS registered providers operating a CPPFSP program shall utilize Attachment B to submit the names of trainees and dates of graduation to AHCCCS/DCAIR, OIFA, via email at oifa@azahcccs.gov. These reports shall contain no other information apart from what is required.

CREDENTIALED PARENT PEER/FAMILY SUPPORT PARTNER EMPLOYMENT TRAINING CURRICULUM STANDARDS

A CPPFSP Training Program curriculum shall include the following core elements:

- Arizona Vision,
- Twelve Principles for Children Behavioral Health Service Delivery,
- Communication Techniques
- System History Overview and history of the Arizona Behavioral Health System,
- System Transformation because of the Jason K. Lawsuit, Jacob's Law, Jake's Law
- Children's System of Care (CSOC) - Vision and Guiding Principles for Child and Family Team (CFT),
- CSOC Levels of Care, Covered Services, referrals
- DES/DDD, DCS/CHP,
- Adult System of Care - Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems and Adult Recovery Team (ART),
- Arnold v. Sarn,
- Office of Human Rights and Special Assistance (OHR)
- Office of Individual and Family Affairs
- Family and peer movements and the role of advocacy in systems transformation,
- Introduction to the Americans with Disabilities Act (ADA) and funding sources for behavioral health systems,
- Rights of the caregivers and individual,
- Transition Aged Youth i. Guardianship, and
- Timelines of transition to adulthood into the ASOC, role changes when bridging the ASOC and CSOC at transition for an individual, family, and team.
- Building Collaborative Partnerships and Relationships
- Empowerment:
    - Individuals first, strengths-based language, using respectful communication, demonstrating care and commitment,
- Active listening skills, by having the ability to demonstrate empathy, provide empathetic responses and differentiate between sympathy and empathy, listening non-judgmentally, and
- Use of self-disclosure effectively, sharing one's story when appropriate.
- Engagement, identification, and utilization of strengths,
    - Utilization and modeling of conflict resolution skills, and problem-solving skills,
    - Understanding of:
        - Individual and family culture, biases, stigma, and systems' cultures, and

    - Trauma informed care approaches,
    - Identification, building, and connecting individuals and families, including families of choice, to community and natural/informal supports.
- Empowerment of family members and other supports to identify their needs, and promote self-reliance, and
- Identification and understanding of stages of change, and unmet needs.
- Wellness:
    - Understanding of:
        - The stages of grief and loss,
        - Self-care and stress management,
        - Compassion, fatigue, and burnout,
        - Resiliency and recovery, and
        - Healthy personal and professional boundaries.

CPPFSP Training Programs shall not duplicate training required of individuals for employment with a licensed agency or Community Service Agency, (CSA). Training elements in this Policy are specific to the CPPFSP role in the AHCCCS Programs and instructional for CPPFSP interactions.

Contractors shall develop and make available policies and procedures as well as additional resources for development of curriculum, including Contractor staff contacts for questions or assistance.

SUPERVISION OF
CREDENTIALED PARENT PEER/FAMILY SUPPORT PARTNER

Contractors shall establish amount and duration of supervision of CPPFSP and follow the requirements outlined below:

- Agencies employing CPPFSP shall provide supervision by individuals qualified as BHT or BHP. Supervision shall be appropriate to the services being delivered and the qualifications of the CPPFSP as a BHT, BHP, or BHPP. Supervision shall be documented and inclusive of both clinical and administrative supervision.
- Individuals providing supervision shall receive training and guidance to ensure current knowledge of best practices in providing supervision to CPPFSP.

Contractors shall develop and make available to the providers policies, and procedures regarding resources available to agencies for establishing supervision requirements and any expectations for agencies regarding Contractor monitoring/oversight activities for this requirement.

- BCBSAZ Health Choice requirement: 2 hours of clinical supervision per month and 2 hours of administrative supervision per month
- Each provider agency will need to create a process of tracking this requirement.

PROCESS FOR SUBMITTING EVIDENCE OF CREDENTIALING

- Contractors shall ensure provider agencies maintain documentation of required qualifications and credentialing for CPPFSP.
- Contractors shall develop and make available to providers policies and procedures that describe monitoring and auditing/oversight activities and where records specific to supervision and training of CPPFSP are reviewed and maintained.
- Contractors shall submit information noting Credentialed Parent Peer/Family Support Specialist Involvement in service delivery as specified in Contract and utilizing Attachment A.

CONTINUING EDUCATION AND ONGOING LEARNING REQUIREMENTS

Ongoing training requirements of current best practices, like other practitioners, shall be established for individuals employed as CPPFSP to obtain continuing education and ongoing learning relevant to family support.

The Contractor shall develop and make available to providers' policies and procedures describing requirements for individuals employed as CPPFSP to obtain a minimum of 8 hours of continuing education and ongoing learning relevant to family support, per year. At least one hour shall cover ethics and boundaries related to the practice of family support.

- Each provider agency will need to create a process of tracking this requirement and will be required to submit the data to BCBSAZ Health Choice OIFA quarterly.

18.21 PRE-PETITION SCREENING, COURT-ORDERED EVALUATION, AND COURT-ORDERED TREATMENT

At times, it may be necessary to initiate civil commitment proceedings to ensure the safety of a person, or the safety of other persons, due to a person's mental disorder when that person is unable or unwilling to participate in treatment. In accordance with the A.A.C. R9-21-101 and A.R.S 36-533 any responsible person to apply for pre-petition screening when another person 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 are found in this Policy under Subsection J, Court-Ordered Treatment for American Indian Tribal Members in Arizona.

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

If the pre-petition screening indicates 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 for court-ordered treatment on behalf of the person. A hearing, with the person and his/her legal representative and the physician(s) treating the person, will be conducted to determine whether the person will be released and/or whether the agency will petition the court for court-ordered treatment. For the court to order ongoing treatment, the person must be determined, because of the evaluation, to be DTS, DTO, PAD, or GD. Court-ordered treatment may include a combination of inpatient and outpatient treatment.
Inpatient treatment days are limited contingent on the person's designation as DTS, DTO, PAD, or GD. Persons 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
- 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 person's outpatient treatment. In some cases, the mental health agency may be a RBHA; however, before the court can order a mental health agency to supervise the person's outpatient treatment, the agency medical director must agree and accept responsibility by submitting a written treatment plan to the court.

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

County agencies and BCBSAZ Health Choice contracted agencies responsible for pre-petition screening and court-ordered evaluations must use the following forms prescribed in **9 A.A.C. 21, Article 5** for persons determined to have a Serious Mental Illness; agencies may also use these forms for all other populations. Links to the forms are available on **AHCCCS AMPM**

Policy 320-U Pre-Prepetition Screening, COE, and COT:

- Application for Involuntary Evaluation
- Application for Voluntary Evaluation
- Application for Emergency Admission for Evaluation
- Petition for Court-Ordered Evaluation
- Petition for Court-Ordered Treatment
- Psychiatric Evaluation Affidavit, with Addendum No. 1 for PAD and Addendum No. 2 for Gravely Disabled.

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 the individual is court ordered to treatment, or programs, as a result of being charged with a crime and appears to be an "alcoholic". BCBSAZ Health Choice providers' responsibilities for the provision and coverage of those services are described in the Court Ordered Evaluation section as well as the Court Domestic Violence Offender Treatment section below.

LICENSING REQUIREMENTS

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

COUNTY CONTRACTS

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 AHCCCS. 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 fiscal 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, Gila, Navajo, Coconino, Yavapai, and Mohave counties. BCBSAZ Health Choice is not contracted with the county governments in this GSA to provide pre-petition screenings and court-ordered evaluation services, except for Coconino County and Mohave County. BCBSAZ Health Choice has been informed either by the counties or by their subcontractors the counties have made the following arrangements for pre-petition screening and court ordered evaluation services:

- Apache County has made arrangements with Little Colorado Behavioral Health Services, Inc. to accept pre-petition screenings and to assist with the court ordered evaluation process
- Navajo County has contracted with ChangePoint Integrated Health, Inc. to provide pre-petition screenings and court-ordered evaluations

- Coconino County has an intergovernmental agreement with AHCCCS for these services. In-turn, AHCCCS contracts with BCBSAZ Health Choice to provide pre-petition screening and court ordered evaluation services. BCBSAZ Health Choice has contracted with The Guidance Center, Inc. to be the lead provider for pre-petition screenings and court-ordered evaluations. Encompass Health Services may provide pre-petition screenings in the northern part of Coconino County
- Yavapai County has contracted with Pronghorn Psychiatry to provide pre-petition screenings and court-ordered evaluations
- Mohave County contracted with BCBSAZ Health Choice and Southwest Behavioral & Health Services to provide pre-petition screenings and court-ordered evaluations
- In Gila County, Community Bridges, Inc. is the designated screening agency; however other behavioral health agencies may be granted permission upon request to the Gila County Attorney's Office
- In Maricopa County, Mercy Care Plan manages the T36 processes.
- In Pinal County, Arizona Complete Health – Complete Care Plan manages the T36 processes.

Based upon the county of location of the person to be screened and or evaluated behavioral health providers should contact the entities listed above to refer for pre-petition screening or court-ordered evaluation.

Pre-Petition Screening

Any behavioral health provider who receives an application for court-ordered evaluation (see AMPM Policy 320-U,) must immediately refer the applicant for pre-petition screening and petitioning for court-ordered evaluation to the BCBSAZ Health Choice designated pre-petition screening agency or county facility.

The pre-petition screening agency must follow these procedures:

- Provide pre-petition screening within forty-eight hours excluding weekends and holidays
- Prepare a report of opinions and conclusions. If pre-petition screening was not possible, the screening agency must report reasons why the screening was not possible, including opinions and conclusions of staff members who attempted to conduct the pre-petition screening
- Have the medical director or designee of the pre-petition screening agency review the report if, it indicates 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 pre-petition screening agency determines the person, due to a mental disorder, including a primary diagnosis of dementia and other cognitive disorders, is DTS, DTO, PAD, or GD**.** AMPM Policy 320-U, documents pertinent information for court-ordered evaluation
- If the pre-petition screening agency determines there is reasonable cause to believe the person, without immediate hospitalization, is likely to harm himself/herself or others, the pre-petition screening agency must ensure completion of AMPM Policy 320-U, and take all

reasonable steps to procure hospitalization on an emergency basis

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

EMERGENT/CRISIS PETITION FILING PROCESS FOR CONTRACTORS CONTRACTED AS EVALUATING AGENCIES

When it is determined there is reasonable cause to believe 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 Contractor.

- Only applications indicating DTS and/or DTO can be filed on an emergent basis.
- The applicant must have personally seen or witnessed the behavior of the person that is a danger to self or others and not base the application on secondhand information.
- The applicant must complete the Application for Involuntary Evaluation as per AMPM Policy 320-U.
- The applicant and all witnesses identified in the application as direct observers of the dangerous behavior, may be called to testify in court if the application results in a petition for COE Within 48 hours of receipt of AMPM Policy 320-Uand all corroborating documentation necessary to successfully complete a determination, the admitting physician will determine if enough evidence exists for an emergency admission for evaluation. If there is enough evidence to support the emergency admission for evaluation, the facility is not currently operating at or above its allowable member capacity, and the person does not require medical care; then, facility staff will immediately coordinate with local law enforcement for the detention of the person and transportation to the appropriate facility.
- If the person requires a medical facility, or if placement cannot be arranged within 48 hours after the approval of AMPM Policy 320-U, the Medical Director of the Contractor will be consulted arrange for a review of the case.
- An AMPM Policy 320-U, may be discussed by telephone with the facility admitting physician, the referring physician, and a police officer to facilitate transportation of the person to be evaluated.
- A person proposed for emergency admission for evaluation may be apprehended and transported to the facility under the authority of law enforcement using the written AMPM Policy 320-U.
- A 23-hour emergency admission for evaluation begins at the time the person is detained involuntarily by the admitting physician who determines there is reasonable cause to believe the person, as a result of a mental disorder, is a DTS or DTO and during the time necessary to complete prescreening procedures the person is likely, without immediate hospitalization, to suffer harm or cause harm to others.
- During the emergency admission period of up to 23 hours the following will occur:
    - The person's ability to consent to voluntary treatment will be assessed.
    - The person shall be offered and receive treatment to which he/she may consent. Otherwise, the only treatment administered involuntarily will be for the safety of the person or others, i.e. seclusion/restraint or pharmacological restraint in accordance

with A.R.S § 36-513.
    - The psychiatrist will complete the Evaluation within 24 hours of determination the person no longer requires involuntary evaluation.

COURT-ORDERED EVALUATION

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

BCBSAZ Health Choice and its subcontracted behavioral health provider must follow these procedures:

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

BCBSAZ Health Choice is not responsible to pay for the costs associated with Court Ordered Evaluation outside of the limited "medication only" benefit package available for Non-Title XIX persons determined to have SMI, unless other prior payment arrangements have been made with another entity (e.g. County, hospital, provider).

- For any Title XIX enrolled member, who has been admitted to an evaluation agency under a petition for court ordered treatment, the evaluation period is deemed to end upon the filing of a petition for court ordered treatment by the evaluation agency. At this time, the RBHA must pay for all medically necessary services associated with the period between the filing of the Petition for Court Ordered Evaluation and the hearing set for the purposes of a judicial determination for the need for Court Ordered Treatment.
- BCBSAZ Health Choice's responsibility for payment of medically necessary days begins on the day a Petition for Court Ordered Treatment is filed following the completion of the COE, as opposed to being automatically linked to the end of the 72-hour COE period.
- Fiscal responsibility for acute/physical medical services provided during the COE process remains with BCBSAZ Health Choice and is not the responsibility of the County of origin.
- The issue of voluntarily participating in treatment is not a factor in the determination of medical necessity; and
- The refusal of the Title XIX member to accept medication is not, in and of itself, a factor in rejecting the encounter or determining the medical necessity of the service.

Voluntary Evaluation

Any BCBSAZ Health Choice contracted behavioral health provider who receives an application for voluntary evaluation must immediately refer the person to the facility responsible for voluntary evaluations in the region where the person is located. The evaluation agency must obtain the individual's informed consent prior to the evaluation (see AMPM Policy 320-U, Exhibit 320-U-7) and provide evaluation at a scheduled time and place within five days of the notice the person will voluntarily receive an evaluation.
For inpatient evaluations, the evaluation agency must complete evaluations in less than seventy-two hours of receiving notice the person will voluntarily receive an evaluation; and if a behavioral health provider conducts a voluntary evaluation service as described in this section, the comprehensive clinical must include:

- A copy of the application for voluntary evaluation, AMPM Policy 320-UA completed informed consent form (see AMPM Policy 320-Q) 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 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)
- 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)
- 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

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

When a person referred for court-ordered treatment is Title XIX/XXI eligible and/or determined or suspected to have a Serious Mental Illness, BCBSAZ Health Choice will work with the required providers and agencies to:

- Conduct an evaluation to determine if the person has a Serious Mental Illness in accordance with section 18.8.6 SMI Eligibility Determinations, and conduct a behavioral health assessment to identify the person's service needs in conjunction with the person's clinical team, as described in section 18.13 Intake, Assessments and Service Planning
- Provide necessary court-ordered treatment and other covered behavioral health services in accordance with the person's needs, as determined by the person's clinical team, the behavioral health member, family members, and other involved parties (see section 18.13

Intake, Assessments and Service Planning); and
- Perform, either directly or by contract, all treatment required by **A.R.S. Title 36, Chapter 5, Article 5** and **9 A.A.C. 21, Article 5**.

Transfer from one behavioral health provider to another

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

- The person does not have a court appointed guardian
- The medical director of the receiving behavioral health provider accepts the transfer; and
- The consent of the court for the transfer is obtained as necessary (see section 18.30 Inter-RBHA Coordination of Care for more details).
- To coordinate a transfer of a person under court-ordered treatment to ALTCS or a RBHA, the behavioral health recipient's clinical team will coordinate with the BCBSAZ Health Choice Court Coordinator/Liaison at 928-774-7128 or toll-free 1-800-640-2123.

COURT-ORDERED TREATMENT FOR PERSONS CHARGED WITH OR CONVICTED OF A CRIME

BCBSAZ Health Choice 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 the individual is court ordered to treatment, or programs, because of being charged with a crime and appears to be an "alcoholic."

Domestic Violence Offender Treatment

Domestic violence offender treatment may be ordered by a court when an individual is convicted of a misdemeanor domestic violence offense. Although the order may indicate the domestic violence (DV) offender treatment is the financial responsibility of the offender under A.R.S. § 13-3601.01, BCBSAZ Health Choice 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. See the **AHCCCS Contractor Operations Manual (ACOM) Policy 423** for clarification regarding the financial responsibility for the provision of specific mental health treatment/care when such treatment is ordered as a result of a judicial ruling.

Court ordered substance abuse evaluation and treatment

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

COURT-ORDERED TREATMENT FOR AMERICAN INDIAN TRIBAL MEMBERS IN ARIZONA
Arizona tribes are sovereign nations, and tribal courts have jurisdiction over their members residing on reservation. Tribal court jurisdiction, however, does not extend to tribal members residing off the reservation or to state court ordered evaluation or treatment ordered because of a behavioral health crisis occurring off reservation.

Although some Arizona tribes have adopted procedures in their tribal codes, which are similar to Arizona law for court ordered evaluation and treatment, each tribe has its own laws which must be followed for the tribal court process. Tribal court ordered treatment for American Indian tribal members in Arizona is initiated by tribal behavioral health staff, the tribal prosecutor or other 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, BCBSAZ Health Choice 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, **A.R.S. § 12-136 Domestication or Recognition of Tribal Court Order** is a flow chart demonstrating the communication between tribal and state entities.

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

This process must run concurrently with the tribal staff's initiation of the tribal court ordered process to communicate and ensure clinical coordination with the BCBSAZ Health Choice. This clinical communication and coordination with the BCBSAZ Health Choice 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." BCBSAZ Health Choice will partner with American Indian tribes and tribal courts in their geographic service areas to collaborate in finding appropriate treatment settings for American Indians in need of behavioral health services. Due to the options American Indians have regarding their health care, including behavioral health services, payment of behavioral health services for AHCCCS eligible American Indians may be covered through a T/RBHA, RBHA or IHS/638 provider.

See on the AHCCCS website under Tribal Court Procedures for Involuntary Commitment-Tribal Court Procedures for Involuntary Commitment-Tribal Court Procedures for Involuntary Commitment for a diagram of payment structures.

18.22 CONFIDENTIALITY

Information and records obtained while providing or paying for covered health services to a person is confidential and is only disclosed according to the provisions of this policy and procedure and applicable federal and state law. In the event of an unauthorized use/disclosure of unsecured PHI the covered entity responsible for the breach, BCBSAZ Health Choice and must notify all affected persons.

Medical records must be maintained in accordance with written protocols pertaining to their care, custody, and control as mandated by **Arizona Revised Statues Title 36, Chapter 32**.

OVERVIEW OF CONFIDENTIALITY

BCBSAZ Health Choice employees and subcontracted behavioral health providers must keep medical and behavioral health records and all information contained in those records confidential and cannot disclose such information unless permitted or required by federal or state law. The law regulates two major categories of confidential information:

- Information obtained when providing Healthcare services not related to alcohol or drug abuse referral, diagnosis, and treatment; and
- Information obtained in the referral, diagnosis and treatment of alcohol or drug abuse.

Protected Health Information Not Related to Alcohol and Drug Treatment
Information obtained when providing Healthcare services not related to alcohol and drug abuse treatment is governed by state law and the **HIPAA Privacy Rule, 45 C.F.R., Part 164, Subparts A and E, Part 160 Subparts A and B ("the HIPAA Rule")**. The HIPAA Rule permits a covered entity (health plan, Healthcare provider, and health care clearinghouse) to use or disclose protected health information with or without patient authorization in a variety of circumstances, some of which are required and others that are permissive. Many of the categories of disclosures contain specific words and phrases defined in the HIPAA Rule. Careful attention must be paid to the definitions of words and phrases to determine whether disclosure is allowed. In addition, the HIPAA Rule may contain exceptions or special rules that apply to a particular disclosure. State law may affect a disclosure. For example, the HIPAA Rule may preempt a state law, or a state law may preempt the HIPAA Rule. In addition, a covered entity must, with certain exceptions, make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the disclosure.

Before disclosing protected health information, it is good practice to consult the specific citation to the HIPAA Rule, state law and consult with legal counsel before disclosing an individual's protected health information. See **DISCLOSURE OF INFORMATION NOT RELATED TO ALCOHOL OR SUBSTANCE ABUSE TREATMENT** for more detail regarding the disclosure of behavioral health information not related to alcohol or drug referral, diagnosis, or treatment.

Drug and Alcohol Abuse Information
Information regarding treatment for alcohol or drug abuse is afforded special confidentiality by Federal statute and regulation. This includes any information concerning a person's diagnosis or treatment from a federally assisted alcohol or drug abuse program or referral to a federally assisted alcohol or drug abuse program.

GENERAL PROCEDURES FOR ALL DISCLOSURES
Unless otherwise exempted by state or federal law, all information obtained about a person related to the provision of healthcare services to the person is confidential whether the information is in oral, written, or electronic format.

All records generated as a part of the BCBSAZ Health Choice grievance and appeal processes are legal records, not medical records, although they may Arizona contain copies of portions of a person's medical record. To the extent these legal records contain personal medical information, we will redact or de-identify the information to the extent allowed or required by law.

List of Persons Accessing Records
Providers are required to maintain a list of every person or organization that inspects a currently or previously enrolled person's records other than the person's clinical team, how the information is to be used, and the staff person authorizing access. The access list must be

placed in the enrolled person's record and must be made available to the enrolled person, their guardian or other designated representative. Providers must retain consent and authorization medical records as prescribed in **A.R.S. § 12-2297.**

Disclosure to Clinical Teams

Disclosure of information to members of a clinical team may or may not require an authorization depending upon the type of information to be disclosed and the status of the receiving party. Information concerning diagnosis, treatment or referral for drug or alcohol treatment may only be disclosed to members of a clinical team with patient authorization as prescribed in **DISCLOSURE OF ALCOHOL AND DRUG INFORMATION**.

Information not related to drug and alcohol treatment may be disclosed without patient authorization to members of a clinical team for purposes of treatment, payment, or Healthcare operations, as permitted by and in compliance with §164.506 of the HIPAA Rule.

Unless otherwise prescribed in federal regulations or statute, it is not necessary to obtain a signed release to share behavioral health related information with the member's parent/legal guardian, primary care provider (PCP), the member's Health Plan Behavioral Health Coordinator acting on behalf of the PCP or authorized state social service agencies. Disclosure to members of a clinical team for purposes other than treatment, payment, or Healthcare operations, as permitted by and in compliance with §164.506 of the HIPPA Rule requires the authorization of the person or the person's legal guardian or parent as prescribed in below in **DISCLOSURE OF INFORMATION NOT RELATED TO ALCOHOL AND DRUG TREATMENT**.

Disclosure to Persons in Court Proceedings

Disclosure of information to persons involved in court proceedings including attorneys, probation or parole officers, guardians' ad litem and court appointed special advocates may or may not require an authorization depending upon the type of information to be disclosed and whether the court has entered orders permitting or requiring the disclosure.

DISCLOSURE OF INFORMATION NOT RELATED TO ALCOHOL AND DRUG TREATMENT

Overview of Types of Disclosure

The HIPAA Rule and state law allow a covered entity to disclose protected health information under a variety of conditions. This is a general overview and does not include an entire description of legal requirements for each disclosure. The latter part of this chapter contains a more detailed description of circumstances likely to involve the use or disclosure of behavioral health information.

Below is a general description of all required or permissible disclosures:

- To the individual and the individual's health care decision maker
- To health, mental health and social service providers for treatment, payment, or health care operations
- Incidental to a use or disclosure otherwise permitted or required by 45 C.F.R. Part 164, Subpart E
- To a person or entity with a valid authorization
- Provided the individual is informed in advance and can agree or prohibit the disclosure:
- For use in facility directories
- To persons involved in the individual's care and for notification purposes
- When required by law
- For public health activities
- About victims of child abuse, neglect, or domestic violence
- For health oversight activities
- For judicial and administrative proceedings
- For law enforcement purposes
- About deceased persons
- For cadaveric organ, eye, or tissue donation purposes
- For research purposes
- To avert a serious threat to health or safety or to prevent harm threatened by patients
- To a human rights committee
- For purposes related to the Sexually Violent Persons program
- With communicable disease information
- To personal representatives including agents under a Healthcare directive
- For evaluation or treatment
- To business associates
- To the Secretary of Health and Human Services or designee to investigate or determine compliance with the HIPAA Rule
- For specialized government functions
- For worker's compensation
- Under a data use agreement for limited data
- For fundraising
- For underwriting and related purposes
- To the Arizona Center for Disability Law in its capacity as the State Protection and Advocacy Agency
- To a third-party payer to obtain reimbursement
- To a private entity that accredits a Healthcare provider
- To the legal representative of a Healthcare entity in possession of the record for the purpose of securing legal advice
- To a person or entity as otherwise required by state or federal law
- To a person or entity permitted by the federal regulations on alcohol and drug abuse

treatment (42 C.F.R. Part 2)

- To a person or entity to conduct utilization review, peer review and quality assurance pursuant to Section 36-441, 36-445, 36-2402 or 36-2917
- To a person maintaining health statistics for public health purposes as authorized by law
- To a grand jury as directed by subpoena

Disclosure of Behavioral Health Information

Below is a description of the circumstances in which behavioral health information is likely to be required or permitted to be disclosed:

- Disclosure to an individual or the individual's health care decision maker
- A covered entity is required to disclose information in a designated record set to an individual when requested unless contraindicated. Contraindicated means access is likely to endanger the life or physical safety of the patient or another person (A.R.S. § 36-507(3); 45 C.F.R. § 164.524); A covered entity should read and carefully apply the provisions in 45 C.F.R. §164.524 before disclosing protected health information in a designated record set to an individual.
- An individual has a right of access to his or her designated record set, except for psychotherapy notes and information compiled for pending litigation (45 C.F.R. § 164.524(a)(1) and Section 13405(e) of the HITECH Act). Under certain conditions a covered entity may deny an individual access to the medical record without providing the individual an opportunity for review (45 C.F.R. § 164.524(a) (2)). Under other conditions, a covered entity may deny an individual access to the medical record and must provide the individual with an opportunity for review (45 C.F.R. § 164.524(a)(3)). A covered entity must follow certain requirements for a review when access to the medical record is denied (45 C.F.R. § 164.524(a)(4)).
- An individual must be permitted to request access or inspect or obtain a copy of his or her medical record (45 C.F.R. § 164.524(b)(1)). A covered entity is required to act upon an individual's request in a timely manner (45 C.F.R. § 164.524(b)(2)).
- An individual may inspect and be provided with one free copy per year of his or her own medical record, unless access has been denied.
- A covered entity must follow certain requirements for providing access, the form of access and the time and manner of access (45 C.F.R. § 164.524(c)).
- A covered entity is required to make other information available in the record when access is denied must follow other requirements when making a denial of access, must inform an individual of where medical records are maintained and must follow certain procedures when an individual requests a review when access is denied (45 C.F.R. § 164.524(d)).
- A covered entity is required to maintain documentation related to an individual's access to the medical record (45 C.F.R. § 164.524(e)).

Disclosure with Individual's or Individual's Authorization or Individual's Health Care Decision Maker

The HIPAA Rule allows information to be disclosed with an individual's written authorization. For all uses and disclosures not permitted by the HIPAA Rule, patient authorization is required (45 C.F.R. §§ 164.502(a)(1)(iv); and 164.508). An authorization must contain all of the elements in 45 C.F.R. § 164.508.

A copy of the authorization must be provided to the individual. The authorization must be written in plain language and must contain the following elements:

- A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion
- The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure
- The name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested use or disclosure
- A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose
- An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. The statement "end of the research study," "none," or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research repository
- Signature of the individual and date. If the authorization is signed by a personal representative of the individual, a description of the representative's authority to act for the individual must also be provided

In addition to the core elements, the authorization must contain statements adequate to place the individual on notice of all the following:

- The individual's right to revoke the authorization in writing, and either:
    - The exceptions to the right to revoke and a description of how the individual may revoke the authorization; or
    - A reference to the covered entity's notice of privacy practices if the notice of privacy practices tells the individual how to revoke the authorization.
- The ability or inability to condition treatment, payment, enrollment, or eligibility for benefits on the authorization, by stating either:
    - The covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs the authorization when the prohibition on conditioning of authorizations in 45 C.F.R. § 164.508 (b)(4) applies; or
    - The consequences to the individual of a refusal to sign the authorization when, in accordance with 45 C.F.R. § 164.508 (b) (4), the covered entity can condition treatment, enrollment in the health plan or eligibility for benefits on failure to obtain such authorization.

- The potential for information disclosed pursuant to the authorization to be subject to re-disclosure by the member.

Disclosure to Health, Mental Health, and Social Service Providers
Disclosure is permitted without patient authorization to health, mental health and social service providers involved in caring for or providing services to the person for treatment, payment or Healthcare operations as defined in the HIPAA Rule. These disclosures are typically made to primary care physicians, psychiatrists, psychologists, social workers (including the Arizona Department of Economic Security (DES) and DES Division of Developmental Disabilities (DDD)) or other behavioral health professionals. Particular attention must be paid to 45.

- §164.506(c) and the definitions of treatment, payment, and Healthcare operations to determine the scope of disclosure. For example, a covered entity is allowed to disclose protected health information for its own treatment, payment, or Healthcare operations (45
- § 164.506(c)(1)). A covered entity may disclose for treatment activities of a Healthcare provider including providers not covered under the HIPAA Rule (45 C.F.R. § 164.506(c)(2)).

A covered entity may disclose to both covered and non-covered Healthcare providers for payment activities (45 C.F.R. § 164.506(c)(3)). A covered entity may disclose to another covered entity for the Healthcare operations activities of the receiving entity if each entity has or had a direct treatment relationship with the individual and the disclosure is for certain specified purposes in the definition of healthcare operations (45 C.F.R. § 164.506(c)(4)).

If the disclosure is not for treatment, payment, or Healthcare operations or required by law, patient authorization is required.

The HIPAA Rule does not modify a covered entity's obligation under A.R.S. § 13-3620 to report child abuse and neglect to the DES Department of Child Safety (DCS)or disclose a child's medical records to DC for investigation of child abuse cases.

Similarly, a covered entity may have an obligation to report adult abuse and neglect to DES Adult Protective Services (A.R.S. § 46-454). The HIPAA Rule imposes other requirements in addition to those contained in A.R.S. § 46-454, primarily that the individual be notified of the making of the report or a determination by the reporting person that it is not in the individual's best interest to be notified (45 C.F.R. § 164.512(c)).

Disclosure to Other Persons
A covered entity may disclose protected health information without authorization to other persons including family members actively participating in the patient's care, treatment, or supervision. Prior to releasing information, an agency or non-agency treating professional or that person's designee must have a verbal discussion with the person to determine whether the person objects to the disclosure. If the person objects, the information cannot be disclosed. If the person does not object, or the person lacks capacity to object, the treating

professional must perform an evaluation to determine whether disclosure is in that person's best interests. A decision to disclose or withhold information is subject to review pursuant to A.R.S. § 36-517.01.

An agency or non-agency treating professional may only release information relating to the person's diagnosis, prognosis, need for hospitalization, anticipated length of stay, discharge plan, medication, medication side effects and short-term and long-term treatment goals (A.R.S. § 36-509(7)).

The HIPAA Rule imposes additional requirements when disclosing protected health information to other persons including family members. A covered entity may disclose to a family member or other relative the protected health information directly relevant to the person's involvement with the individual's care or payment related to the individual's health care. If the individual is present for a use or disclosure and has the capacity to make health care decisions, the covered entity may use or disclose the protected health information if it obtains the individual's agreement, provides the individual with the opportunity to object to the disclosure and the individual does not express an objection.

If the individual is not present, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the individual's incapacity or an emergency circumstance, the covered entity may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the individual and, if so, disclose only the protected health information directly relevant to the person's involvement with the individual's health care (45 C.F.R. § 164.510(b)).

Disclosure to Agent under Healthcare Directive

A covered entity may treat an agent appointed under a Healthcare directive as a personal representative of the individual (45 C.F.R. § 164.502(g)). Examples of agents appointed to act on an individual's behalf include an agent under a health care power of attorney (A.R.S.§ 363221 *et seq.)*; surrogate decision makers (A.R.S. § 36-323); and an agent under a mental health care power of attorney (A.R.S. § 36-3281).

Disclosure to a Personal Representative

Un-emancipated Minors: A covered entity may disclose protected health information to a personal representative, including the personal representative of an un-emancipated minor, unless one or more of the exceptions described in 45 C.F.R. §§ 164.502(g)(3)(i) or 164.502(g)(5) applies. See 45 C.F.R.§

- The general rule is that if state law, including case law, requires or permits a parent, guardian or other person acting *in loco parentis* to obtain protected health information, then a covered entity may disclose the protected health information (See 45 C.F.R. § 164.502(g)(3)(ii)(A)).
- Similarly, if state law, including case law, prohibits a parent, guardian or other person acting

in loco parentis from obtaining protected health information, then a covered entity may not disclose the protected health information (45 C.F.R. § 164.502(g)(3)(ii)(B)).

- When state law, including case law, is silent on whether protected health information can be disclosed to a parent, guardian or other person acting *in loco parentis,* a covered entity may provide or deny access under 45 C.F.R. § 164.524 to a parent, guardian or other person acting *in loco parentis* if the action is consistent with State or other applicable law, provided such decision must be made by a licensed Healthcare professional, in the exercise of professional judgment (45 C.F.R. § 164.502(g)(3)(ii)(C)).

Adults and Emancipated Minors: If under applicable law, a person has authority to act on behalf of an individual who is an adult or an emancipated minor in making decisions related to health care, a covered entity must treat such persons as a personal representative with respect to protected health information relevant to such personal representation (45 C.F.R. § 164.502(g)(2)). Simply stated, if there is a state law that permits the personal representative to obtain the adult or emancipated minor's protected health information, the covered entity may disclose it. A covered entity may withhold protected health information if one or more of the exceptions in 45 C.F.R. § 164.502(g)(5) applies.

Deceased persons: If under applicable law, an executor, administrator, or other person has authority to act on behalf of a deceased individual or of the individual's estate, a covered entity must treat such persons as a personal representative with respect to protected health information relevant to the personal representation (45 C.F.R. § 164.502(g)(4)). A covered entity may withhold protected health information if one or more of the exceptions in 45 C.F.R. § 164.502(g)(5) applies. A.R.S. §§ 12-2294 (D) provides certain persons with authority to act on behalf of a deceased person.

Disclosure for Court Ordered Evaluation or Treatment

An agency in which a person is receiving court ordered evaluation or treatment is required to immediately notify the person's guardian or agent or, if none, a member of the person's family the person is being treated in the agency (A.R.S. § 36-504(B)). The agency shall disclose any further information only after the treating professional or that person's designee interviews the person undergoing treatment or evaluation to determine whether the person objects to the disclosure and whether the disclosure is in the person's best interests. A decision to disclose or withhold information is subject to review pursuant to section A.R.S. § 36-517.01.

If the individual or the individual's guardian makes the request for review, the reviewing official must apply the standard in 45 C.F.R. § 164.524(a)(3). If a family member makes the request for review, the reviewing official must apply the "best interest" standard in A.R.S. § 36-517.01. The reviewer's decision may be appealed to the superior court (A.R.S. § 36-517.01(B)). The agency or non-agency treating professional must not disclose any treatment information during the period an appeal may be filed or is pending.

Disclosure for Health Oversight Activities

A covered entity may disclose protected health information without patient authorization to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions or other activities necessary for appropriate oversight of entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards (45 C.F.R. § 164.512(d)).

Disclosure for Judicial and Administrative Proceedings Including Court Ordered Disclosures

A covered entity may disclose protected health information without patient authorization during any judicial or administrative proceeding in response to an order of a court or administrative tribunal, provided the covered entity discloses only the protected health information expressly authorized by the order (45 C.F.R. § 164.512(e)). In addition, a covered entity may disclose information in response to a subpoena, discovery request or other lawful process without a court order if the covered entity receives satisfactory assurances the requesting party has made reasonable efforts to provide notice to the individual or has made reasonable efforts to secure a qualified protective order; see 45 C.F.R. §§ 164.512(e)(1)(iii), (iv) and (v) for what constitutes satisfactory assurances.

Disclosure to Persons Doing Research

A covered entity may disclose protected health information to persons doing research without patient authorization provided it meets the de-identification standards of 45 C.F.R. § 164.514(b). If the covered entity wants to disclose protected health information that is not de-identified, patient authorization is required or an Institutional Review Board or a privacy board in accordance with the provisions of 45 C.F.R. § 164.512(i)(1)(i) can waive it.

Disclosure to Prevent Harm Threatened by Patients

Mental health providers have a duty to protect others against the harmful conduct of a patient (A.R.S. § 36-517.02). When a patient poses serious danger of violence to another person, the provider has a duty to exercise reasonable care to protect the foreseeable victim of the danger. *Little v. All Phoenix South Community Mental Health Center, Inc.,* 186 Ariz. 97, 919 P.2d 1368 (1996). A covered entity may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information without patient authorization if the covered entity, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat, or is necessary for law enforcement authorities to identify or apprehend an individual (See 45 C.F.R.§§ 164.512(j)(1)(ii); 164.512(f)(2) and (3) for rules that apply for disclosures made to law enforcement; see 45 C.F.R. § 164.512(j)(4) for what constitutes a good faith belief).

Disclosure to Human Rights Committees
Protected health information may be disclosed to a human rights committee without patient authorization provided personally identifiable information is redacted or de-identified from the record (A.R.S. §§ 36-509(10) and 41-3804). In redacting personally identifiable information, a covered entity must comply with the HIPAA Rule de-identification standards in 45 C.F.R. § 164.514(b) and not state law.

If a human rights committee wants non-redacted identifiable health information for official purposes, it must first demonstrate the information is necessary to perform a function related to the oversight of the behavioral health system, and in that case, a covered entity may disclose protected health information to the human rights committee in its capacity as a health oversight agency (45 C.F.R. § 164.512(d)(1)). For additional information see **AHCCCS Policy, Section 7, Chapter 1800, Policy 1806**.

Disclosure to the Arizona Department of Corrections
Protected health information may be disclosed without patient authorization to the state department of corrections in cases where prisoners confined to the state prison are patients in the state hospital on authorized transfers either by voluntary admission or by order of the court (A.R.S. § 36-509(5)). The HIPAA Rule limits disclosure to correctional institutions to certain categories of information contained in 45 C.F.R. § 164.512(k)(5).

Disclosure to Governmental Agency or Law Enforcement to Secure Return of Patient
Protected health information may be disclosed to governmental or law enforcement agencies if necessary to secure the return of a patient who is on unauthorized absence from any agency where the patient was undergoing court ordered evaluation or treatment. According to A.R.S. § 36-509 (6)(A), a covered entity may disclose limited information without patient authorization to law enforcement to secure the return of a missing person (45 C.F.R. § 164.512(f)(2)(i)). In addition, a covered entity is permitted limited disclosure to governmental agencies to prevent or lessen a serious and imminent threat to the health or safety of a person or the public (45 C.F.R. § 164.512(j)).

Disclosure to Sexually Violent Persons (SVP) Program
Protected health information may be disclosed to a governmental agency or a competent professional, as defined in A.R.S. § 36-3701, in order to comply with the SVP Program (A.R.S., Title 36, Chapter 37; A.R.S. § 36-509(9)).
A "competent professional" is a person who may be a psychologist or psychiatrist, is approved by the Superior Court and is familiar with the state's sexually violent persons' statutes and sexual offender treatment programs. A competent professional is either statutorily required or may be ordered by the court to perform an examination of a person involved in the sexually violent persons program and must be given reasonable access to the person in order to conduct the examination and must share access to all relevant medical and psychological records, test data, test results and reports (A.R.S. § 36-3701(2)).

In most cases, the disclosure of protected health information to a competent professional or made in connection with the sexually violent persons program is required by law or ordered by the court. In either case, disclosure under the HIPAA Rule without patient authorization is permitted. See 45 C.F.R. § 164.512(a) (disclosure permitted when required by law) and 45 § 164.512(e) (disclosure permitted when ordered by the court).

If the disclosure is not required by law/ordered by the court or is to a governmental agency other than the sexually violent persons program, the covered entity may have the authority to disclose if the protected health information is for treatment, payment, or health care operations. See 45 §164.506(c) to determine rules for disclosure for treatment, payment, or Healthcare operations.

Disclosure of Communicable Disease Information

A.R.S. § 36-661 et seq. includes a number of provisions that address the disclosure of communicable disease information. The general rule is a person who obtains communicable disease related information in the course of providing a health service or pursuant to a release of communicable disease related information must not disclose or be compelled to disclose that information (A.R.S. § 36-664(A)).

Certain exceptions for disclosure are permitted to:

- The individual or the individual's health care decision maker
- AHCCCS or a local health department for the purpose of notifying a Good Samaritan
- An agent or employee of a health facility or a Healthcare provider
- A health facility or a Healthcare provider
- A federal, state, or local health officer
- Government agencies authorized by law to receive communicable disease information
- Persons authorized pursuant to a court order
- The Department of Economic Security for adoption purposes
- The Industrial Commission
- The Arizona Department of Health Services to conduct inspections
- Insurance entities
- A private entity that accredits a Healthcare facility or a Healthcare provider

A.R.S. § 36-664 also addresses issues with respect to the following:

    - Disclosures to the Department of Health Services or local health departments are also permissible under certain circumstances:
        - Authorizations
        - Re-disclosures
        - Disclosures for supervision, monitoring and accreditation

    - Listing information in death reports
    - Reports to the Department
    - Applicability to insurance entities
- An authorization for the release of communicable disease related the protected person must sign information or, if the protected person lacks capacity to consent, the person's health care decision maker (A.R.S. § 36-664(F)). If an authorization for the release of communicable disease information is not signed, the information cannot be disclosed. An authorization must be dated and must specify to whom disclosure is authorized, the purpose for disclosure and the time period during which the authorization is effective. A general authorization for the release of medical or other information, including communicable disease related information, is not an authorization for the release of HIV-related information unless the authorization specifically indicates its purpose as authorization for the release of HIV-related information and complies with the requirements of A.R.S. § 36-664(F).
- The HIPAA Rule does not preempt state law with respect to disclosures of communicable disease information; however, it may impose additional requirements depending upon the type, nature, and scope of disclosure. It is advisable to consult with the HIPAA Compliance Officer and/ or legal counsel prior to disclosure of communicable disease information.
- For example, if a disclosure of communicable disease information is made pursuant to an authorization, the disclosure must be accompanied by a statement in writing which warns the information is from confidential records which are protected by state law that prohibits further disclosure of the information without the specific written consent of the person to whom it pertains or as otherwise permitted by law. A.R.S. § 36-664(H) affords greater privacy protection than 45 C.F.R. § 164.508(c)(2)(ii), which requires the authorization to contain a statement to place the individual on notice of the potential for re-disclosure by the member and thus, is no longer protected. Therefore, any authorization for protected health information that includes communicable disease information must contain the statement that re-disclosure of that information is prohibited.

DISCLOSURE TO BUSINESS ASSOCIATES

The HIPAA Rule allows a covered entity to disclose protected health information to a business associate if the covered entity obtains satisfactory assurances the business associate will safeguard the information in accordance with 45 C.F.R. § 164.502(e) and the HITECH Act. See the definition of "business associate" in 45 C.F.R. § 160.103. Also see 45 C.F.R. § 164.504(e) and Section 13404 of the HITECH Act for requirements related to the documentation of satisfactory assurances through a written contract or other written agreement or arrangement.

DISCLOSURE TO THE ARIZONA CENTER FOR DISABILITY LAW*, Acting in its Capacity as the State Protection and Advocacy Agency Pursuant to 42 U.S.C. § 10805*

Disclosure is allowed when:

- An enrolled person is mentally or physically unable to consent to a release of confidential information, and the person has no legal guardian or other legal representative authorized to provide consent; and

- A complaint has been received by the Center or the Center asserts that the Center has probable cause to believe the enrolled person has been abused or neglected.

DISCLOSURE TO THIRD PARTY PAYERS

Disclosure is permitted to a third-party payer to obtain reimbursement for health care, mental health care or behavioral health care provided to a patient (A.R.S. § 36-509(13)).

DISCLOSURE TO ACCREDITATION ORGANIZATION

Disclosure is permissible to a private entity that accredits a Healthcare provider and with whom the Healthcare provider has an agreement that requires the agency to protect the confidentiality of patient information (A.R.S. § 36-509(14)).

DISCLOSURE OF ALCOHOL AND DRUG INFORMATION

BCBSAZ Health Choice and subcontracted providers who provide drug and alcohol screening, diagnosis or treatment services that are federally assisted alcohol and drug programs must ensure compliance with all provisions contained in the Federal statutes and regulations referenced in this chapter.

The Plan and subcontracted providers must notify persons seeking and/or receiving alcohol or drug abuse services of the existence of the federal confidentiality law and regulations and provide each person with a written summary of the confidentiality provisions. The notice and summary must be provided at admission or as soon as deemed clinically appropriate by the person responsible for clinical oversight of the person.

BCBSAZ Health Choice and subcontracted providers may require enrolled persons to carry identification cards while the person is on the premises of an agency. A subcontracted provider may not require enrolled persons to carry cards or any other form of identification when off the subcontractor's premises that will identify the person as a recipient of drug or alcohol services.

The Plan and subcontracted providers may not acknowledge that a currently or previously enrolled person is receiving or has received alcohol or drug abuse services without the enrolled person's authorization.

BCBSAZ Health Choice and subcontracted providers must respond to any request for a disclosure of the records of a currently or previously enrolled person that is not permissible under this policy or federal regulations in a way that will not reveal an identified individual has been or is being diagnosed or treated for alcohol or drug abuse.

Release of information concerning diagnosis, treatment or referral from an alcohol or drug abuse program must be made only as follows:

- The currently or previously enrolled person or their guardian authorizes the release of information. In this case, authorization must be documented on an authorization form which has not expired or been revoked by the patient. The proper authorization form must be in writing and must contain each of the following specified items:
    - The Plan or subcontracted provider must advise the person or guardian of the special protection given to such information by federal law.
    - Authorization must be documented on an authorization form that has not expired or been revoked by the patient. The proper authorization must be in writing and must contain each of the following specified items:
- The name or general designation of the program making the disclosure
- The name of the individual or organization that will receive the disclosure
- The name of the person who is the subject of the disclosure
- The purpose or need for the disclosure
- How much and what kind of information will be disclosed
- A statement the person may revoke the authorization at any time, except to the extent the program has already acted in reliance on it
- The date, event, or condition upon which the authorization expires, if not revoked before
- The signature of the person or guardian
- The date on which the authorization is signed

DISCLOSURE

Any disclosure, whether written or oral made with the person's authorization as provided above must be accompanied by the following written statement: "This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. part 2).

The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

If the person is a minor, authorization must be given by both the minor and his or her parent or legal guardian.

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

- A court appointed executor, administrator or another personal representative; or
- If no such appointments have been made, by the person's spouse; or
- If there is no spouse, by any responsible member of the person's family.

CIRCUMSTANCES WHERE NO AUTHORIZATION REQUIRED

Authorization is not required under the following circumstances:

- **Medical Emergencies:** Information may be disclosed to medical personnel who need the information to treat a condition which poses an immediate threat to the health of any individual, not necessarily the currently or previously enrolled person, and which requires immediate medical intervention. The disclosure must be documented in the person's medical record and must include the name of the medical person to whom disclosure is made and his or her affiliation with any healthcare facility, name of the person making the disclosure, date and time of the disclosure and the nature of the emergency. After emergency treatment is provided, written confirmation of the emergency must be secured from the requesting entity.
- **Research Activities:** information may be disclosed for the purpose of conducting scientific research according to the provisions of 42 C.F.R. § 2.52.
- **Audit and Evaluation Activities:** Information may be disclosed for the purposes of audit and evaluation activities according to the provisions of 42 C.F.R. § 2.53.
- **Qualified Service Organizations:** Information may be provided to a qualified service organization when needed by the qualified service organization to provide services to a currently or previously enrolled person.
- **Internal Agency Communications:** The staff of an agency providing alcohol and drug abuse services may disclose information regarding an enrolled person to other staff within the agency, or to the part of the organization having direct administrative control over the agency, when needed to perform duties related to the provision of alcohol or drug abuse diagnosis, treatment, or referral for treatment to a person. For example, an organization that provides several types of services might have an administrative office that has direct administrative control over each unit or agency that provides direct services.
- Information concerning an enrolled person that does not include any information about the enrolled person's receipt of alcohol or drug abuse diagnosis, treatment or referral for treatment is not restricted under this chapter. For example, information concerning an enrolled person's receipt of medication for a psychiatric condition, unrelated to the person's substance abuse, could be released as provided in **DISCLOSURE OF INFORMATION NOT RELATED TO ALCOHOL AND DRUG TREATMENT** of this chapter.
- **Court-ordered disclosures:** A state or federal court may issue an order that authorizes an agency to make a disclosure of identifying information that would otherwise be prohibited. A subpoena, search warrant or arrest warrant is not sufficient standing alone, to require or permit an agency to make a disclosure.
- **Crimes Committed by a Person on an Agency's Premises or Against Program Personnel:** Agencies may disclose information to a law enforcement agency when a person who is

receiving treatment in a substance abuse program has committed or threatened to commit a crime on agency premises or against agency personnel. In such instances, the agency must limit the information disclosed to the circumstances of the incident. It may only disclose the person's name, address, last known whereabouts, and status as a person receiving services at the agency.

- **Child Abuse and Neglect Reporting:** Federal law does not prohibit compliance with the child abuse reporting requirements contained in A.R.S. § 13-3620.

A general medical release form or any authorization form that does not contain all of the elements listed in **DISCLOSURE OF ALCOHOL AND DRUG INFORMATION** above is not acceptable.

SECURITY BREACH NOTIFICATION

BCBSAZ Health Choice and their subcontracted providers, in the event of an impermissible use/disclosure of unsecured PHI, must provide notification to any and all persons affected by the breach in accordance with Section 13402 of the HITECH Act.

TELEMEDICINE

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

- The videoconferencing room door must remain closed at all times
- If the room is used for other purposes, a sign must be posted on the door, stating t a clinical session is in progress.

Telemedicine should be restricted to dedicated utilities with built-in controls to ensure a third party is unable to intrude on the session or watch the service as it is being provided.

18.23 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 behavioral health care, including the right to refuse treatment.

It is important for members seeking behavioral health services to agree to those services and be made aware of the service options and alternatives available to them as well as specific risks and benefits associated with these services.

DEFINITIONS

General Consent is a one-time agreement to receive certain services, including but not limited to behavioral health services that is usually obtained from a member during the intake process at the initial appointment, and is always obtained prior to the provision of any behavioral

health services. General consent must be obtained from a member's behavioral health recipient's or legal guardian's signature.

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

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

Any member aged 18 years and older, in need of behavioral health services must give voluntary general consent to treatment, demonstrated by the member's or legal guardian's signature on a general consent form, before receiving behavioral health services.

For members under the age of 18, the parent, legal guardian, or a lawfully authorized custodial agency (including foster care givers A.R.S. 8.514.05(C)) must give general consent to treatment, demonstrated by the parent, legal guardian, or a lawfully authorized custodial agency representative's signature on a general consent form prior to the delivery of behavioral health services.

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

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

Emergency: Providers treating members in an emergency are not required to obtain general consent prior to the provision of emergency services. Providers treating members pursuant to court order must obtain consent, as applicable, in accordance with **A.R.S. Title 36, Chapter 5.**

Documentation: 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** for:

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

Children in DCS Custody: A foster parent, group home staff, foster home staff, relative, or other member or agency in whose care a child is currently placed may give consent for:

- Evaluation and treatment for emergency conditions that are not life threatening, and
- Routine medical and dental treatment and procedures, including Early Periodic Screening Diagnosis and Treatment (EPSDT) services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (A.R.S. §8-514.05(C)).

To ensure timely delivery of services, consent for intake and routine behavioral health services may be obtained from either the foster caregiver or the Department of Child Safety Specialist (DCSS) whomever is available to do so immediately upon request (A.R.S. § 8-514.05(C)).
Foster or kinship caregivers can consent to evaluation and treatment for routine medical and dental treatment and procedures, including behavioral health services. Examples of behavioral health services in which foster, or kinship can consent to include:

- Assessment and service planning
- Counseling and therapy
- Rehabilitation services
- Medical Services
- Psychiatric evaluation
- Psychotropic medication
- Laboratory services
- Support Services
- Case Management
- Member Care Services
- Family Support
- Peer Support
- Respite
- Sign Language or Oral Interpretive Services

- Transportation
- Crisis Intervention Services
- Behavioral Health Day Programs

A foster parent, group home staff, foster home staff, relative, or other member or agency in whose care a child is currently placed shall not consent to:

- General Anesthesia
- Surgery
- Testing for the presence of the human immunodeficiency virus
- Blood transfusions
- Abortions

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 members, 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 the required information was given, and 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.

Required Information

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

- Behavioral health member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions
- Information about the member's diagnosis and the proposed treatment, including the intended outcome, nature and all available procedures involved in the proposed treatment
- The risks, including any side effects, of the proposed treatment, as well as the risks of not proceeding
- The alternatives to the proposed treatment, particularly alternatives offering less risk or

other adverse effects
- That any consent given may be withheld or withdrawn in writing or orally at any time. When this occurs, the provider must document the member's choice in the medical record
- The potential consequences of revoking the informed consent to treatment
- A description of any clinical indications that might require suspension or termination of the proposed treatment

Informed consent and how it is documented
- Members, or if applicable the client's parent, guardian, or custodian shall give informed consent for treatment by signing and dating an acknowledgment he or she has received the information and gives informed consent to the proposed treatment.
- When informed consent is given by a third party, the identity of the third party and the legal capability to provide consent on behalf of the member must be established. If the informed consent is for psychotropic medication or telemedicine and the member, or if applicable, the member's guardian refuses to sign an acknowledgment and gives verbal informed consent, the medical practitioner shall document in the member's record that the information was given, the client refused to sign an acknowledgment and that the client gives informed consent to use psychotropic medication or telemedicine.

Providing informed consent and how it is communicated
When providing information that forms the basis of an informed consent decision for the circumstances identified above, the information must be:
- Presented in a manner understandable and culturally appropriate to the member, parent, legal guardian, or an appropriate court; and
- Presented by a credentialed behavioral health practitioner or a registered nurse with at least one year of behavioral health experience. It is preferred the prescribing clinician provide information forming the basis of an informed consent decision. In specific situations that are not possible or practical, information may be provided by another credentialed behavioral health practitioner or registered nurse with at least one year of behavioral health experience.

Psychotropic Medications, Complementary and Alternative Treatment and Other Services with Substantial Risks or Side Effects
Unless treatments and procedures are court ordered, providers must obtain written informed consent, and if written consent is not obtainable, providers must obtain oral informed consent. If oral informed consent is obtained instead of written consent from the member, parent, or legal guardian, it must be documented in written fashion. Informed consent is required in the following circumstances:
- Prior to the initiation of any psychotropic medication or initiation of Complementary and Alternative Treatment (CAM) (see **AMPM Policy 310-V Prescription Medications/Pharmacy Services**). The AMPM Policy 310-V Attachment A is recommended as a tool to review and document informed consent for psychotropic medications.

- Prior to the delivery of behavioral health services through telemedicine
- Prior to the delivery of any other procedure or service with known substantial risks or side effects.

Electroconvulsive Therapy (ECT), research activities, voluntary evaluation and procedures or services with known substantial risks or side effects

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

- Before the provision of ECT
- Prior to the involvement of the member in research activities
- Prior to the provision of a voluntary evaluation for a member. The use **of AMPM 320 Att 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
- Prior to the delivery of any other procedure or service with known substantial risks or side effects.

Informed Consent for Telemedicine

Before a health care provider delivers health care via telemedicine, verbal or written informed consent from the member or their health care decision maker must be obtained. As per **AMPM Policy 320-I Telehealth and Telemedicine**, informed consent may be provided by the behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience. When providing informed consent, it must be communicated in a manner the member and/or legal guardian can understand and comprehend.

Exceptions to this consent requirement include:

- If the telemedicine interaction does not take place in the physical presence of the member,
- In an emergency situation in which the member or the member's health care decision maker is unable to give informed consent, or
- To the transmission of diagnostic images to a health care provider serving as a consultant or the reporting of diagnostic test results by that consultant.

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) has placed the child
- 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:

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

Representative Type	**Documentation Required**
Legal guardian	Copy of court order assigning custody
Relatives	Copy of power of attorney document
Other person/agency	Copy of court order assigning custody
DCS Placements (for children removed from the home by DCS), such as: Foster parents/Group home staff/Foster home staff/Relatives/Other person/agency in whose care DES/DCS has placed the child	None Required (See above) *

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

Emergency Situations

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

INFORMED CONSENT DURING INVOLUNTARY TREATMENT

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

CONSENT FOR BEHAVIORAL HEALTH SURVEY OR EVALUATION FOR SCHOOL-BASED PREVENTION PROGRAMS

Written consent must be obtained from a child's parent or legal guardian for any behavioral health survey, analysis or evaluation conducted in reference to a school-based prevention program administered by AHCCCS.

AMPM Exhibit 320-Q Attachment B, Substance Abuse Prevention Program and Evaluation Consent must be used to gain parental consent for evaluation of school-based prevention programs. Providers may use an alternative consent form only with the prior written approval of AHCCCS. The written consent must satisfy all of the following requirements:

- Contain language that clearly explains the nature of the screening program and when and where the screening will take place
- Be signed by the child's parent or legal guardian
- Provide notice a copy of the actual survey, analysis, or evaluation questions to be asked of

the student is available for inspection upon request by the parent or legal guardian.

Completion of the **Substance Abuse Prevention Program and Evaluation Consent** applies solely to consent for a survey, analysis, or evaluation only, and does not constitute consent for participation in the program itself.

18.24 SERIOUS MENTAL ILLNESS (SMI) DETERMINATIONS

GENERAL REQUIREMENTS

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

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

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

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

Behavioral health providers must complete a comprehensive assessment to determine the person's diagnosis (if any), functional impairment, and the need for behavioral health services as a screening mechanism for identifying persons (including enrolled children upon reaching 17 and one-half years of age) who may have functional impairments indicative of an SMI designation.

The SMI eligibility determination record must include all the documentation considered during the review of the determination as well as any current and/or historical treatment records used in consideration of the determination. All documentation used in consideration of the determination must be maintained in hardcopy or electronic format. The documentation should also include a recent psychiatric evaluation done by a qualified behavioral health medical practitioner.

Computation of time is as follows:

- Day Zero: Initial assessment date with a qualified clinician regardless of time of the assessment
- Day One: The next business day after the initial assessment is completed. The initial assessment and all other required documents must be provided to **Solari Crisis and Human**

Services as soon as practicable, but no later than 11:59PM on Day One.

- Day Three: The third business day after the initial assessment is completed. Solari Crisis and Human Services will complete the final determination no later than Day Three.

NOTE: Determination due date = Three (3) business days from Day Zero (0), excluding weekends and holidays. This can be amended if an extension has been approved as below.

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

NOTE FOR HOSPITALIZED INDIVIDUALS:
For referrals seeking an SMI Eligibility determination for individuals admitted to a hospital for psychiatric reasons, the entity scheduling the evaluation ensures documented efforts are made to schedule a face-to-face SMI Assessment with the member while still hospitalized. For individuals in out of area hospitals, providers can refer to BCBSAZ Health Choice-contracted **Crisis Preparation and Recovery, Inc. (CPR) (480-804-0326)** to provide in-hospital initial assessments for SMI Determination Referrals.

During the initial meeting with the person by a qualified **clinician**, the **clinician** must:

- Make a clinical assessment whether the person is competent enough to participate in an evaluation unless the person has been ordered to undergo evaluation as part of Court Ordered Treatment proceedings
- Obtain written consent from the person or, if applicable, the person's guardian to conduct an evaluation by completing the **Solari Crisis and Human Services Consent for Assessment**
- Provide to the person and, if applicable, the person's guardian, the information required in A.A.C. R9-21-301(D)(2), a client rights brochure, and the appeal notice required by A.A.C. R9-21-401(B); and Obtain a release of information (see AMPM 940, Medical Records and Communication of Clinical Information) for any documentation that would assist in the determination.
- Conduct an assessment if one has not been completed within the last six months
- Complete the **Solari Crisis and Human Services SMI Determination Forms** as per **AMPM Exhibit 320-P Serious Mental Illness Determination** which must be signed and dated by a licensed clinician
- Determine if the individual would benefit from a psychiatric evaluation and make that referral

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

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

18.24.1 A COMPLETE SMI DETERMINATION PACKET INCLUDES:

- **Solari Crisis and Human Services Consent for Assessment Form**
- **SMI Determination Form**
- Comprehensive assessment must be dated within 6 months of the submission.
- Psychiatric evaluation or psychiatric evaluation and management visit that addresses the current and recurrent functional impairments, risk of deterioration and qualifying diagnoses of the individual
- Recent hospital records or treatment records demonstrating individual's level of functioning and evidence of deterioration
- **Waiver of the Three-Day Determination Form**- applicants are encouraged to waive their right to a 3-day determination so Solari Crisis and Human Services can pursue historical treatment records and have additional time to review the requests
- **Demographic Form (optional)** to assist Solari Crisis and Human Services with contacting the individual and other involved parties during the determination process
- **Releases of Information Form** for Solari Crisis and Human Services to communicate with emergency contact, family members or prior inpatient and outpatient providers.

SUBMISSION OF THE SMI DETERMINATION REQUEST

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

18.24.2 CRITERIA FOR SMI ELIGIBILITY DETERMINATION

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

Functional Criteria for SMI Eligibility

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

- **Inability to live in an independent or family setting without supervision** – neglect or disruption of ability to address basic needs. Needs assistance in caring for self.
- **Unable to care for self in safe or sanitary manner** -- housing, food and clothing must be provided or arranged for by others. Unable to address 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** – seriously disruptive to family and/or community. Pervasively or imminently dangerous to self or others' bodily safety. Regularly engages in assaultive behavior. Has been arrested, incarcerated, hospitalized or at risk of confinement because of dangerous behavior. Persistently neglectful or abusive towards others in the person's care. Severe disruption of daily life due to frequent thoughts of death, suicide, or self-harm, often with behavioral intent and/or plan. Affective disruption causes significant damage to the person's education, livelihood, career, or personal relationships.
- **Dysfunction in role performance** – frequently disruptive or in trouble at work or at school. Frequently terminated from work or suspended/expelled from school. Major disruption of role functioning. Requires structured or supervised work or school setting. Performance significantly below expectation for cognitive/developmental level. Unable to work, attend school, or meet other developmentally appropriate responsibilities; or

Risk of Deterioration for SMI Eligibility

- A qualifying diagnosis with probable chronic, relapsing, and remitting course.
- Co-morbidities (like mental retardation, substance dependence, personality disorders, etc.).
- Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors (life-threatening or debilitating medical illnesses, victimization, etc.).
- Other (past psychiatric history; gains in functioning have not solidified or are a result of current compliance only; court-committed; care is complicated and requires multiple providers; etc.).

The following reasons are not sufficient in and of themselves for denial of SMI eligibility:

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

Person with Co-occurring Substance Abuse

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

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

SMI ELIGIBILITY DETERMINATION FOR INMATES IN THE DEPARTMENT OF CORRECTION (DOC)
An SMI eligibility designation/determination is done for purposes of determining eligibility for community-based behavioral health services. The Arizona Department of Health Services (**ADHS**) recognizes the importance of evaluating and determining the SMI eligibility for inmates in the **Department of Corrections (DOC)** with impending release dates in order to appropriately coordinate care between the DOC and the community based behavioral health system. Inmates of DOC **pending release within 6 months**, who have been screened or appear to meet the diagnostic and functional criteria, **will now be permitted to be referred** for an SMI eligibility evaluation and determination.

Inmates of DOC whose release date exceeds 6 months are not eligible to be referred for an SMI eligibility evaluation and determination.

18.24.3 COMPLETION PROCESS OF FINAL SMI ELIGIBILITY DETERMINATION

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

- A face-to-face assessment or reviewing a face-to-face assessment by a Solari Crisis and Human Services qualified assessor (see **AMPM Policy 950 Credentialing and Recredentialing Processes**); and
- A review of current and historical information, if any, obtained orally or in writing by the

assessor from collateral sources, and/or present or previous treating clinicians.

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

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

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

ISSUES PREVENTING TIMELY COMPLETION OF SMI ELIGIBILITY DETERMINATION:

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

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

NOTE: Insufficient diagnostic information means the information available to the reviewer is suggestive of two or more equally likely working diagnoses, only one of which qualifies as SMI, and an additional piece of existing historical information or a face-to-face psychiatric evaluation is likely to support one diagnosis more than the other.

Solari – Crisis & Human Services must:

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

Additional information and extensions:

- Solari Crisis and Human Services can request and obtain additional information needed and/or perform or obtain any necessary psychiatric or psychological evaluations.
- The designated Solari Crisis and Human Services reviewing psychiatrist, psychologist, or nurse practitioner must communicate with the person's current treating clinician, if any, prior to an SMI determination, if there is insufficient information to determine the person's level of functioning.
- SMI eligibility must be determined within 3 days of obtaining sufficient information, but no later than the end date of the extension.
- Clinicians and behavioral health medical providers must make every effort to respond to Solari Crisis and Human Services' requests for additional information or clarification before the end of the business day
- If the person refuses to grant an extension, SMI eligibility is determined based on the available information.
- 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 diagnosis, the person is notified by Solari Crisis and Human Services the determination, with the agreement of the person, be extended for up to 90 calendar days.

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

18.24.4 NOTIFICATION OF SMI ELIGIBILITY DETERMINATION

If the eligibility determination results in approval of SMI status, the SMI status must be reported to the person in writing, including notice of his/her right to appeal the decision (see **ACOM Policy 444 Notice and Appeal Requirements (Serious Mental Illness Appeals)**.

If the eligibility determination results in a denial of SMI status, crisis Solari Crisis and Human Services shall include in the notice above:

- The reason for denial of SMI eligibility (see AMPM Exhibit 320-P-1);

- The right to appeal (see **ACOM Policy 414 Notices of Action and Notices of Extension for Service Authorization, ACOM Policy 444 Notice and Appeal Requirements (Serious Mental Illness Appeals)**; and
- Title XIX/XXI eligible persons will continue to receive Title XIX/XXI covered services.

18.24.5 SMI DECERTIFICATION

There are two ways for removing an SMI designation, one clinical and the other administrative as follows:

Clinical Decertification

A member who has an SMI designation or an individual from the member's clinical team may request an SMI clinical decertification. An SMI decertification applies to those members who no longer meet SMI criteria. If, because of a review, the person is determined to no longer meet the diagnostic and/or functional requirements for SMI status, then:

- The assigned health home (HH) must perform an assessment to determine if the member remains SMI
- The assigned health home must submit decertification documentation through the Solari Crisis and Human Services portal
- Solari Crisis and Human Services will send written notice of the determination and the right to appeal to the affected person with an effective date of 30 days after the date the written notice was issued
- BCBSAZ Health Choice will continue services if an appeal is filed on time and ensure that services are appropriately transitioned as part of the discharge planning process

SMI Administrative Decertification

A member who has an SMI designation may request an **SMI Administrative Decertification** if the member has not received behavioral health services for a period of two or more years.

- BCBSAZ Health Choice members can contact Member Services to request a decertification at 1-800-640-2123
- Upon receipt of a request for **AMPM Exhibit 320-P Att C: Administrative Decertification Form,** the Plan directs the member to contact AHCCCS DHCM Customer Service at 1-800-867-5808
- AHCCCS evaluates the member's request, reviews data sources and informs the member of changes that may result with the removal of the member's SMI designation. Based upon review, the following occurs:
- In the event the member has not received a behavioral health service within the previous two years, the member is provided with **AMPM Exhibit 320-P Att C Administrative Serious Mental Illness Decertification Form**. The member completes the form and returns it to AHCCCS.
    - In the event the review finds the member has received behavioral health services within the prior two years, the member is notified that they may seek decertification

of their SMI status through the Clinical Decertification process.

RE-ENROLLMENT OR TRANSFER
If the person's status is SMI at disenrollment, disengagement from behavioral health services, or upon transfer from another T/RBHA, the person's status continues as SMI upon re-enrollment, re-engagement in behavioral health services, or transfer.

18.24.6 REVIEW OF SMI ELIGIBILITY DETERMINATION

BCBSAZ Health Choice or a contracted provider may seek a review of a person's SMI eligibility from Solari Crisis and Human Services:

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

Frequency of SMI Determination review requests:

- A review of the determination by Solari Crisis and Human Services may not be requested by the TRBHA, Contractor or their contracted behavioral health providers within six months from the date an individual has been determined SMI eligible.

If, because of such review, the person is determined to no longer meet the diagnosis and functional requirements for SMI status, BCBSAZ Health Choice must ensure:

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

BCBSAZ HEALTH CHOICE MONITORING OF SMI DETERMINATION PROCESS
BCBSAZ Health Choice monitors provider performance on the identification of individuals who may require an SMI Determination; the quality and timeliness of assessments, and submissions and responsiveness to Solari Crisis and Human Services. The Plan also monitors Solari Crisis and Human Services' decision-making process to ensure uniform application of criteria.
The Plan Health Choice may request:

- More information be provided to Solari Crisis and Human Services on certain cases
- An appeal or reconsideration
- Resubmission by the provider if submitted incorrectly or insufficiently

BCBSAZ Health Choice will continually train the providers about policy changes regarding SMI determination and eligibility. Results of provider and Solari Crisis and Human Services performance are reviewed through the Qualityl Management Committee and are subject to performance improvement and corrective action.

18.24.7 VERIFICATION OF SMI ELIGIBILITY DETERMINATIONS

When a person is determined to have a Serious Mental Illness (SMI), the person receives a behavioral health category assignment of "SMI" in Arizona's public behavioral health system. A behavioral health category is used for various purposes, such as determining potential eligibility for Medicaid benefits, determining coverage of services with Non-Title XIX/XXI funding, and requiring or excluding individuals from having to pay co-payments for services. SMI eligibility determinations must be completed using the **Serious Mental Illness Determination Verification**. The purpose of this form is to allow BCBSAZ Health Choice and contracted providers to verify updated diagnostic and functional status for individuals who have previously been determined SMI. The form does not replace the SMI Determination but enables the Plan and providers to "verify" a member's SMI status when they are unable to locate the member's original SMI determination documentation or when the SMI determination is more than 10 years old from the current date (as required by AHCCCS for eligibility/enrollment for benefits).

A licensed psychiatrist, psychologist, or nurse practitioner must complete and submit the form to BCBSAZ Health Choice for approval. The Plan is responsible for monitoring and validating the forms. Since AHCCCS may require BCBSAZ Health Choice to submit documents as part of random sample audits, we retain copies of validated Serious Mental Illness Determination Verification forms.

18.25 ARIZONA STATE HOSPITAL (AzSH) ADMISSIONS AND DISCHARGES

When a Health Home or other referral source believes a civilly committed or voluntarily admitted adult is a candidate to be transferred from another Level I Inpatient Hospital or Sub-Acute facility for treatment at AzSH, the agency will contact the BCBSAZ Health Choice Medical Management department to discuss the recommendation for admission to AzSH. The Plan will initiate the AzSH review process and we must be in agreement with the other referral source that admission to AzSH is necessary and appropriate.

BCBSAZ Health Choice AzSH Liaison and/or other referral sources must contact the AzSH Admissions Office and forward a completed packet of information regarding the referral to the Admissions Office. If the member was determined to be SMI and previously assessed as requiring Special Assistance, then the existing Special Assistance form should be included in the package.

AzSH cannot accept any person for admission without copies of the necessary legal documents. Members referred for admission must have a minimum of forty-five (45) inpatient court ordered treatment days remaining to qualify for admission.

- The AzSH Chief Medical Officer or Acting Designee will review the information within two (2) business days after receipt of the completed packet and determine whether the information supports admission and whether AzSH can meet the behavioral health member's treatment and care needs.
- If the AzSH Chief Medical Officer or Acting Designee determines the behavioral health

member does not meet criteria for admission, the Chief Medical Officer or Acting Designee will provide a written statement to the referral source explaining why the behavioral health member is not being accepted for admission, and the referral source will be offered the opportunity to request reconsideration by submitting additional information or by conferring with the AzSH Chief Medical Officer or Acting Designee. If the admission is denied, the AzSH Admissions Office will send the denial statement to the referral source.

- If the admission is approved, the Admissions Office will send the acceptance statement from the Chief Medical Officer or Acting Designee to the referral source.
- A Court Order for transfer is not required by AzSH when the proposed behavioral health member is already under a Court Order for treatment with forty-five (45) remaining inpatient days. However, in those jurisdictions in which the court requires a court order for transfer be issued, the referring agency will obtain a court order for transfer to AzSH.
- If a Court Order for transfer is not required, the AzSH Admissions Office will set a date and time for admission. It is the responsibility of the referring agency to make the appropriate arrangements for transportation to AzSH.
- When AzSH is unable to admit the accepted behavioral health member immediately, AzSH shall establish a pending list for admission. If the behavioral health member's admission is pending for more than 15 days, the referral agency must provide AzSH a clinical update in writing, including if any alternative placements have been explored while pending, and if the need for placement at AzSH is still necessary.

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 behavioral health member is expected to benefit from proposed treatment at AzSH (A.R.S. § 36-202).
- The behavioral health member must have completed 25 days of mandatory treatment in a local mental health treatment agency under T-36 Court Ordered Treatment (COT), unless waived by the court as per A.R.S. § 36-541 or, if PAD, waived by the Chief Medical Officer of AzSH.
- AzSH must be the least restrictive alternative available for treatment of the 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 behavioral health member.
- The behavioral health member must not suffer more serious harm from proposed care and treatment at AzSH. (A.A.C. R9-21-507(B)(1)).
- Hospitalization at AzSH 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 (A.A.C. R9-21-507(B)(2)).

TREATMENT AND COMMUNITY PLACEMENT PLANNING

AzSH will begin treatment and community placement planning immediately upon admission, utilizing the Adult Clinical Team model. All treatment is patient-centered and is provided in accordance with AHCCCS-established five principles of person-centered treatment for adult behavioral health members determined to have Serious Mental Illness (SMI).

Behavioral health 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.

The health home is required to be involved in all aspects of the member's care while hospitalized at AzSH, including discharge planning and reintegration into the community.

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

AzSH will provide all treatment plans to the members health home. The health home should indicate review of an agreement/disagreement with the treatment plan on the document. Any disagreements should be discussed as soon as possible and resolved as outlined in **9 A.A.C. 21**. Treatment plans are reviewed and revised collaboratively with the member's Adult Recovery Team as required by AzSH. Any noted difficulties in collaboration with the outpatient provider treatment teams will be brought to the attention of BCBSAZ Health Choice AzSH Liaison to be addressed. The Plan's AzSH Liaison will monitor the participation of the outpatient team and

assist when necessary.

Through the Adult Recovery Team, AzSH will actively address the identified symptoms and behaviors which led to the admission and link them to the community rehabilitation and recovery goals whenever possible.

AzSH will actively seek to engage the behavioral health member and all involved parties to establish understandable, realistic, achievable, and practical treatment, discharge goals and interventions.

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

TRANSITION TO COMMUNITY PLACEMENT SETTING

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

- The agreed upon discharge goals set at the time of admission have been met
- 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.
- All legal requirements have been met.

Once a member is placed on the Discharge Pending List, BCBSAZ Health Choice must immediately take steps necessary to transition the behavioral health member into community-based treatment as soon as possible. The Plan has up to thirty (30) days to transition the behavioral health member out of AzSH. The BCBSAZ Health Choice clinical 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 behavioral health member has not been placed in a community placement setting within 30 days, a quality-of-care concern will be initiated by AHCCCS.

Arizona State Hospital (AzSH) Discharges: The BCBSAZ Health Choice State Hospital Liaison coordinates all discharges with the Arizona State Hospital (AzSH) to ensure a smooth transition back to the community and for continuity of care purposes.

Upon notification a BCBSAZ Health Choice member is in the AzSH and is on the discharge ready list the Arizona State Hospital Liaison:

- Contacts the assigned Case Manager at the appropriate health home to discuss discharge planning and the AzSH Social Worker assigned to the member to start facilitating discharge planning.
- Attends all staffing prior to discharge to assist with developing a discharge plan. All glucometer, testing supplies and diabetic medication coordination will occur prior to discharge back to the community.
- Convenes an Interdisciplinary Care Team to develop a Care Management Plan consistent with the member's needs and preferences.
- Determines the medical providers the member will need to follow up with and assigns a PCP near where the member will be residing and/or associated with the member's Health Home.
- Works in conjunction with the health home Case Manager in securing new patient appointments with their PCP and psychiatrist within seven days of discharge.
- If the member requires Diabetic supplies and medications BCBSAZ Health Choice will authorize the same glucometer, testing supplies and medications the member was on while in the AzSH.
- When deemed appropriate to meet the member's skilled medical needs, assesses and allocates ongoing nursing services as needed in accordance with the member's needs and discharge plan.
- Ensures all authorizations and referrals are completed prior to discharge, including medications. BCBSAZ Health Choice issues the same brand and model of glucometer test supplies the member was trained to use while in the hospital

18.25.1 ARIZONA STATE HOSPITAL (AzSH) CONDITIONAL RELEASE AND PSYCHIATRIC SECURITY REVIEW BOARD

When BCBSAZ Health Choice is notified of a member meeting this criteria, the member's assigned Health Home is required to:

- Assign a designated behavioral health professional as the member's clinical lead responsible for coordinating, monitoring, and reporting.
- Coordinate with AzSH in the development and implementation of conditional release plans and discharge planning prior to discharge.
- Monitor, outreach, and engage the member to ensure compliance with all the specific requirements outlined in the Conditional Release Plan (CRP).
- Convene a monthly Adult Recovery Team (ART) to review compliance of the CRP.
- Develop or modify the member's Individual Service Plan (ISP) so it complies with the (CRP).
- Any violations of the Conditional Release, psychiatric decompensation or use of alcohol, illegal substances or prescription medication not prescribed to the member are required to be reported to BCBSAZ Health Choice and PSRB immediately.
- Health Homes are to submit AMPM Policy 1020 1021 Att A Psychiatric Security Review

Board/GEI Conditional Release Monthly Report, most recent BHMP note and drug urine screen no later than the 5th day of the following month to BCBSAZ Health Choice

18.26 PERMANENT SUPPORTIVE HOUSING PROGRAMS AND COORDINATION

AHCCCS HOUSING PROGRAM (AHP)

Managed Care Organization Responsibilities

BCBSAZ Health Choice complies with the following requirements to effectively manage limited housing funds through AHP and statewide housing initiatives:

- Enters into an agreement with the Statewide Housing Administrator to share data on member referrals, service coordination, and prioritization for members high-cost high-needs and/or special healthcare needs.
- Follows protocol in AHCCCS Housing Program Guidebook for AHP, including eligibility requirements:
    - Have an SMI designation or be determined Title XIX GMHSU by a qualified provider,
    - Be a United States citizen or have eligible immigrant status,
    - Be at least 18 years of age at the time of referral, and
    - Have an identified housing need documented by the member's clinical provider
- When providing coordination, BCBSAZ Health Choice ensures housing to be safe, stable, and consistent with the member's recovery goals and be the least restrictive environment necessary to support the member.
- Housing coordination efforts include an array of local and statewide housing programs, including but not limited to AHCCCS Housing Program, Arizona Public Housing Authority (Section 8), US Department of Housing and Urban Development (HUD), Oxford House Inc., coordinated re-entry, and rapid re-housing programs.
- Ensure contracted behavioral health providers deliver a range of housing services and present available options to members, consistent with the individual's goals and needs identified in the Individual Service Plan.
- Collaborate with State, County, and local government agencies to support housing initiatives and resolve housing issues, concerns and complaints that affect members.
- Actively develops new housing capacity, program initiatives and options when needed in collaboration with AHCCCS, ADOH and local HUD Continuum of Care (CoC).
- Enrollment and participation by BCBSAZ Health Choice Housing Staff in the Homeless Management Information System (HMIS), including ensuring providers timely entry into the system.
- BCBSAZ Health Choice Housing Staff participate in AHCCCS Quarterly Housing Meetings in accordance with ACC Contract # YH19-0001.
- Submits Quarterly Supportive Housing Reports for all members who have requested or been referred for housing assistance in accordance with ACC Contract # YH19-0001.

Provider Responsibilities

Behavioral health providers comply with the following requirements to effectively manage limited housing funds through AHP and statewide housing initiatives:

- Deliver housing coordination services and present available options to members, consistent with the individual's goals and needs identified in the Individual Service Plan.
- Maintain ongoing communication with their members who need, who qualify for, and who are currently receiving supported housing services (rent/utility subsidies and relocation services) to ensure adequate coordination of care for these members.
- When providing coordination, ensure housing to be safe, stable, and consistent with the member's recovery goals and be the least restrictive environment necessary to support the member.
- Follows protocol in AHCCCS Housing Program Guidebook for AHP, including eligibility requirements.
- Collaborate with State, County, and local government agencies to support housing initiatives and resolve housing issues, concerns and complaints that affect members.
- Enrollment and participation in the Homeless Management Information System (HMIS), including timely entry into the system.

FEDERAL PROGRAMS AND ASSISTANCE

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

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

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

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

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

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

Federal HUD Housing Choice Voucher Program

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

18.27 TRANSITIONAL CARE

18.27.1 TRANSITION FROM CHILD TO ADULT SERVICES

Planning for the transition into the adult behavioral health system must begin for any child involved in behavioral health care when the child reaches the age of 16. Planning must begin immediately for youth entering behavioral health care who are 16 years or older at the time they enter care.

A transition plan starts with an **Ansel-Casey Life Skills Assessment** of self-care and independent living skills, social skills, work and education plans, and an assessment of earning potential and psychiatric stability. This information must be incorporated in the child's individual service plan (ISP). All youth who are 16 years old must have an Ansel-Casey Life Skills Assessment completed and used to inform the required transition plan.

What elements should be addressed as part of the child's transition plan?
Not all children transfer to the adult Serious Mental Illness (SMI) or General Mental Health/Substance Abuse (GMH/SU) system, but for children who do, providers must ensure a smooth transition. In order to accomplish a smooth transition, providers must develop a clear

and explicit process and procedure to ensure and support the delivery of children's and adult services during the transition period. Providers must ensure adult system staff attend and are a part of the Child and Family Team (CFT) (during the four to six months prior to the child turning 18) in order to provide information and be part of the service planning, development and coordination effort that needs to take place so the individualized needs of that child can be met on the day they turn 18 years of age.

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

- Identifying the child's behavioral health needs into adulthood.
- Identifying personal strengths that will assist the child when he/she transitions to the adult system. Identifying staff who will coordinate services after the child reaches age 18, including any changes in the behavioral health provider, clinical team, guardian, or family involvement.
- Identifying and collaborating with other involved state agencies and stakeholders to jointly establish a behavioral health service plan and prevent duplication of services.
- Establishing how the transition will be implemented.
- Planning for where the child will reside upon turning 18 and how he/she will support him/herself. If an SMI eligibility determination is made, consider initiating a referral for housing, if needed.
- Identifying the need for referrals to and assistance with applications for Supplemental Security Income (SSI), Rehabilitation Services Administration (RSA), SMI eligibility determination, Title XIX and Title XXI eligibility, housing, guardianship, training programs, etc. In addition, the team and/or behavioral health provider should assist in gathering necessary information to expedite these applications/determinations when the time comes to apply, including obtaining medical and school records to substantiate these needs. The team and/or behavioral health provider begin to develop a timeline and task list for when appointments are needed.
- Identifying the need for transportation to appointments and other necessary activities.
- Identifying special needs that the child may have and/or whether the child will require special assistance services.
- Identifying whether the child has appropriate life skills, social skills and employment, housing or education plans.
- Taking necessary action if the child is not eligible for Title XIX or Title XXI benefits and/or Social Security Disability Income (SSDI) and is not determined to have a SMI. Identifying supports needed to be in place for a successful transition.
- Following guidelines established in AHCCCS policy AMPM 280 Behavioral Health Practice Tool Transition to Adulthood
- Meeting the provisions of the Settlement Agreement Arizona 12 Principles and the services that have been planned, developed, and provided for the child can continue to be provided after the child has turned 18 years of age, assuming continuation of these services is the choice of the young person when he/she reached the age of majority. Providers shall

properly encounter and receive payment for the provision of services.

Providers are responsible for the provision of services for Title XIX/XXI eligible members 18 years of age through 20 years of age (who are still a part of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program) regardless of their designation as SMI or GMH/SU. Services include case management services, and all other medically necessary covered services the person's treatment team determines to be needed to meet individualized needs.

What needs to happen during the year before the child transitions to adult services?
When a child receiving behavioral health services reaches the age of 17, behavioral health providers must determine whether the child is potentially eligible for services as an adult with a Serious Mental Illness. If so, behavioral health providers must refer the child for an SMI eligibility determination pursuant to AHCCCS 320-P SMI Determination.

When a child receiving behavioral health services reaches 17 and a half, the CFT and/or the behavioral health provider must:

- Assist the child and/or family or guardian in applying for potential benefits (e.g., SSI, food stamps, etc.)
- Assist the child and/or family in applying for Title XIX or Title XXI benefits; if the child and/or family is already eligible, determine if eligibility will continue for the child once he/she turns 18
- For children receiving ALTCS/DDD services, confer with the DD Support Coordinator regarding continuation of eligibility for ALTCS/DDD services after the age of 18
- Address any new authorization requirements for sharing protected health information due to the child turning 18 to ensure the clinical team can continue to share information.

Educate and obtain informed consent for psychotropic medications
Youth under the age of 18 are educated on options, allowed to provide input, and encouraged to assent to medication(s) being prescribed. Information is discussed with the youth in a clear and age-appropriate manner consistent with the developmental needs of the youth. Discussion of the youth's ability to give consent for medications at the age of 18 years old is begun no later than age 17 ½ years old, especially for youth who are not in the custody of their parents. There should be special attention to the effect of medications on reproductive status and pregnancy, as well as long term effects on weight, abnormal involuntary movements, and other health parameters.

Young Adults Experiencing First Episode Psychosis
Health Choice Health Homes will implement screening and assessment practices and tools to identify young adults who are experiencing psychosis. Health Homes will provide effective early intervention services to these members. Services may include:

- Supported education/employment
- Psychosis focused family psychoeducation (individual and group)
- Medication management
- Nursing and wellness strategies
- Individual skills training
- Individual psychosis focused therapy
- Family therapy
- Other support services such as respite, family support, etc.
- All transition practices for youth ages 16-25 must be in accordance with Health Choice policy and AHCCCS policy AMPM 280 Behavioral Health Practice Tool Transition to Adulthood

18.27.2 TRANSITION DUE TO A CHANGE OF THE BEHAVIORAL HEALTH PROVIDER OR THE BEHAVIORAL HEALTH CATEGORY ASSIGNMENT

Upon changes of a person's behavioral health provider or behavioral health category assignment, the behavioral health provider must:

- Review the current individual service plan and, if needed, coordinate the development of a revised individual service plan with the person, clinical team, and the receiving behavioral health provider
- Ensure the person's comprehensive clinical record is transitioned to the receiving behavioral health provider
- Ensure the transfer of responsibility for court ordered treatment, if applicable
- Coordinate the transfer of any other relevant information between the behavioral health provider and other provider agencies, if needed.

18.27.3 MEDICAL RECORD TRANSFER FROM/TO PRIMARY CARE PROVIDERS OR FACILITIES

Medical records will be forwarded by the relinquishing Primary Care Provider (PCP) when there is a significant consequence to current treatment or if requested by the receiving PCP or specialty provider. The cost of copying and transmitting the medical record information specified in this policy will be the responsibility of the relinquishing PCP unless otherwise noted.

Required portions of the medical record will be forwarded to the PCP as requested immediately following the member's transition. Required portions of the chart to include, but not limited to, the following:

- Diagnostic Tests and Determinations
- Current Treatment Services
- Immunizations
- Hospitalizations with Concurrent Review Data and Discharge Summaries
- Medications
- Current Specialist Services

- Behavioral Health History
- Emergency Care

18.27.4 MEMBER TRANSFERS BETWEEN FACILITIES

As per AMPM 530 Member Transfers between Facilities initiated by BCBSAZ Health Choice or FFS provider between:

- **Inpatient hospital facilities following emergency hospitalization may be made when the following criteria are met**:
    - The attending emergency physician, or the attending provider treating the member, determines the member is sufficiently stabilized for transfer and will remain stable for the period of time required for the distance to be traveled. Such determination is binding on the Contractor responsible for coverage and payment. The Contractor shall comply with Medicaid Managed Care guidelines regarding the coordination of post stabilization care (42 CFR 438.114, 42 CFR 422.113),
    - The receiving physician agrees to the member transfer,
    - Transportation orders are prepared specifying the type of transport, training level of the transport crew and level of life support, and
    - A transfer summary accompanies the member.
- **Transfer to a lower level of care facility (e.g., Tertiary to Secondary or Primary, or Secondary to Primary Hospital, or transfer to a Skilled Nursing Facility) may be made when the following criteria are met:**
    - Member's condition does not require the full capabilities of the transferring facility, or
    - Member's condition has stabilized or reached a plateau and will not benefit further from intensive intervention in the transferring facility, and
    - The receiving physician agrees to the member transfer, and
    - Transportation orders are prepared specifying the type of transport, training level of the transport crew and level of life support, and
    - A transfer summary accompanies the member.
- **Transfers to a higher level of care facility (e.g., Primary to Secondary or Tertiary, or Secondary to Tertiary Hospital) may be made when the following criteria are met:**
    - The transferring hospital cannot provide the level of care needed to manage the member beyond stabilization required to transport, or cannot provide the required diagnostic evaluation and consultation services needed,
    - The receiving physician agrees to the member transfer,
    - Transport orders are prepared which specify the type of transport, the training level of the transport crew and the level of life support, and
    - A transfer summary accompanies the member.
- **For transfers initiated by BCBSAZ Health Choice**, the attending emergency physician or the attending provider treating the member and the BCBSAZ Health Choice Medical Director or designee is responsible for determining whether a particular case meets criteria established in policy. In the event of a request for a decision by AHCCCS on the transfer of a particular

member, AHCCCS will apply the criteria listed in this subsection and A.R.S. §36-2909(B).

18.27.5 TRANSITION TO ALTCS PROGRAM CONTRACTORS

This section applies to persons enrolled in the Arizona Long Term Care Services/Division of Developmental Disabilities (ALTCS/DDD). ALTCS/DDD eligible persons receive all covered behavioral health services through The Division of Developmental Disabilities (DDD)

Once a person is determined eligible and becomes enrolled with the Arizona Long Term Care Services/Elderly or Physically Disabled (ALTCS/END) Program or the Division of Developmental Disabilities (ALTCS/DDD) Program, behavioral health providers must not submit claims or encounters for Title XIX covered services to the T/RBHA. To determine if a person is ALTCS/EPD eligible, providers use the AHCCCS Online portal (https://azweb.statemedicaid.us./), Medical Electronic Verification System (https://www.changehealthcare.com/contact-us.) or call 1-800-331-5090.

18.28 COORDINATION OF CARE WITH AHCCCS HEALTH PLANS, PCPS AND MEDICARE PROVIDERS

Holistic treatment requires integration of physical health with behavioral health to improve the overall health of an individual. Behavioral health recipients may be receiving care from multiple health care entities. Duplicative medication prescribing, contraindicated combinations of prescriptions and/or incompatible treatment approaches could be detrimental to a person.

For this reason, communication, and coordination of care between behavioral health providers, PCPs and Medicare providers must occur on a regular basis to ensure safety and positive clinical outcomes for persons receiving care.

For T/RBHA enrolled persons not eligible for Title XIX or Title XXI coverage, coordination and communication should occur with any known health care provider(s).

PCPs are responsible for coordinating the medical care of the AHCCCS members assigned to them, including at a minimum:

- Oversight of drug regimens to prevent negative interactive effects
- Follow-up for all emergency services
- Coordination of inpatient care
- Coordination of services provided on a referral basis, and
- Assurance care rendered by specialty providers is appropriate and consistent with each member's health care needs.

COORDINATING CARE WITH AHCCCS HEALTH PLANS

The following procedures will assist behavioral health providers in coordinating care with AHCCCS Health Plans:

- If the identity of the person's primary care provider (PCP) is unknown, subcontracted providers must contact the AHCCCS Health Plan of the person's designated health plan to determine the name of the person's assigned PCP.
- BCBSAZ Health Choice subcontracted providers should request medical information from the person's assigned PCP. Examples include current diagnosis, medications, pertinent laboratory results, last PCP visit, Early Periodic Screening, Diagnosis and Treatment (EPSDT) screening results and last hospitalization. Providers can contact the health plan's Behavioral Health Coordinator or their Network Provider Performance Representative for assistance.
- The Plan's subcontracted providers must address and attempt to resolve coordination of care issues with AHCCCS Health Plans and PCPs at the lowest possible level. If problems persist, contact the BCBSAZ Health Choice Member Services at 928-774-7128 or 1.800.322.8670 (TTY: 711).

SHARING INFORMATION WITH PCPS, AHCCCS ACUTE HEALTH PLANS, OTHER TREATING PROFESSIONALS, AND INVOLVED STAKEHOLDERS

To support quality medical management and prevent duplication of services, behavioral health providers are required to disclose relevant behavioral health information pertaining to Title XIX and Title XXI eligible persons to the assigned PCP, AHCCCS Health Plans, other treating professionals, and other involved stakeholders within the following required timeframes:

- **Urgent** – requests for intervention, information, or response within 24 hours.
- **Routine** – Requests for intervention, information, or response within 10 days.

T/RBHAs and/or subcontracted providers must provide the required information:
Annually, and/or behavioral health recipients in the Medicare Fee-for-Service program may receive services from Medicare registered providers in the BCBSAZ Health Choice provider network.

Inpatient Psychiatric Services

Medicare has a lifetime benefit maximum for inpatient psychiatric services. When the benefit is exhausted, AHCCCS becomes the primary payer. Cost sharing responsibilities and billing for inpatient psychiatric services may be required. BCBSAZ Health Choice will coordinate inpatient care and discharge planning care with the inpatient team for Medicare recipients receiving inpatient services with Medicare providers.

Outpatient Behavioral Health Services

Medicare provides some outpatient behavioral health services and AHCCCS covered behavioral health services. Cost sharing responsibilities and billing for outpatient behavioral health services may be required. The Plan will coordinate outpatient care with Medicare providers for Medicare recipients receiving covered behavioral health services.

Prescription Medication Services
Medicare eligible behavioral health recipients must enroll in a Medicare Part D Prescription Drug Plan (PDP) or a Medicare Advantage Prescription Drug Plan (MA-PD) to receive the Part D benefit. PDPs only provide the Part D benefit, and any Medicare registered provider may prescribe medications to behavioral health recipients enrolled in PDPs. Some MA-PDs may contract with BCBSAZ Health Choice or subcontracted providers to provide the Part D benefit to Medicare eligible behavioral health recipients.

While PDPs and MA-PDs are responsible for ensuring prescription drug coverage to behavioral health recipients enrolled in their plans, there are some prescription medications are not included on plan formularies (non-covered) or are excluded Part D drugs. BCBSAZ Health Choice is responsible for covering non-covered or excluded Part D behavioral health prescription medications listed on the Plan formulary, in addition to Part D cost sharing.

18.29 COORDINATION OF CARE FOR MEMBERS WHO ARE INCARCERATED

Incarcerating agencies are required to provide all necessary care, including behavioral health care, to their inmates.[1] BCBSAZ Health Choice Health Homes will support the coordination of care for enrolled members during their incarceration as well as post-release. This includes coordinating care with medical staff, probation, peer support and treatment services upon release. BCBSAZ Health Choice Care Managers coordinate services for GMHSU members.

Working with members to assist in understanding and addressing their barriers to success and reducing recidivism post-release can be accomplished through reentry and transition planning efforts, which can lead to lessening the chance of being released back into the same state of crisis in which they were arrested. Many tools for transition planning can be found through SAMSHA's GAINS Center for Behavioral Health and Justice Transformation: https://www.samhsa.gov/gains-center.

Health Choice emphasizes the importance in working with this vulnerable population through:
- Outreach, Engagement, Re-Engagement (AHCCCS AMPM 1040)
- Coordination of Care with Other Government Entities (AHCCCS AMPM 541)

Criminal Justice System "Reach-In" Care Coordination
The behavioral health provider must provide reach-in care coordination for members who have been incarcerated in the adult correctional system for 20 days or longer, have an anticipated release date, and meet reach-in care criteria as outlined below.

Reach-in care coordination activities shall begin upon knowledge of a member's anticipated release date. BCBSAZ Health Choice:
- Determines which members need reach-in care through application of the criteria below.

- Develops an individualized Justice Involved Risk Identification Plan.
- Notifies providers of members needing reach-in care coordination.
- Providers receive the **Justice Involved Risk Identification Plan** which contains information provided by the AHCCCS 834 file data as well as data received by the county detention centers and the AZ Department of Corrections that is matched with demographic and claims data, to determine persons requiring reach-in care coordination.

The behavioral health provider shall collaborate with criminal justice partners (e.g., Jails, Sheriff's Office, Correctional Health Services, Arizona Department of Corrections, Community Supervision, Probation, Courts, etc.), to engage with justice-involved members in the adult criminal justice system with physical and/or behavioral health chronic and/or complex care needs prior to member's release.

Criteria for members receiving reach-in care coordination includes members who have:

- An SMI determination
- An SMI determination with high-risk chronic needs such as heart disease, diabetes, asthma, COPD, obesity, HIV, Hepatitis C, and pregnancy
- Enrollment with the Department of Developmental Disabilities
- Substance abuse risk such as:
    - Past inpatient detoxification
    - Past chemical dependency residential treatment
    - Past opiate replacement services, like methadone, Vivitrol or buprenorphine
    - Past Controlled Substances Prescription Monitoring Program (CSPMP) indicating high risk morphine equivalent daily dosing (MEDD) and/or high-risk diazepam daily dosing (DEDD) scores

Behavioral health providers must:

- Within 72 business hours of receiving a Justice Involved Risk Identification Plan or referral for reach in services, provider will contact the county jail or the AZ Dept. of Corrections to initiate communication with the member.
    - Communication must occur at least 7 days prior to release.
    - Communication can occur in person, via phone, or via videoconference
- Provide member education regarding care, services, resources, appointment information and health plan case management contact information
- During pre-release communication, schedule an initial outpatient appointment based on the member's needs to occur within seven days of the member's release, as per Provider Manual 18.13 Intake, Assessment and Service Planning.
- Post release, assist the member with accessing and scheduling necessary services as identified in the member's care plan as per 18.12 Outreach, Engagement and Re-Engagement.
- Should re-incarceration occur, outreach to re-engage the member and maintain care coordination as per 18.12 Outreach, Engagement and Re-Engagement.

- Continuously work to improve appropriate utilization of services for the justice involved population as per as per Provider Manual 18.13 Intake, Assessment and Service Planning.
- Continuously work to reduce incarceration recidivism within the member population by strategies incorporated.
- For non-TXIX Non-SMI members, if the incarcerated member requires post-release behavioral health services, including medications and individual therapy, coordinate with the detention facility's medical staff with a request the member's needs are communicated to the outpatient providers upon release/reinstatement of AHCCCS benefits.

BILLING AND ENCOUNTERING SERVICES FOR MEMBERS WHILE INCARCERATED:
Medicaid funds cannot be used while someone is incarcerated, and Value of Service cannot be encountered towards T-XIX funds during incarceration.

However:
- Crisis funds may be used for any crisis assessments, regardless of enrollment status or diagnosis (including GMH/SU).

The following should be applied when encountering Value of Service and submitting claims for members while incarcerated:
- Place of Service Code 99 is to be used for all services provided to all members who are considered inmates of a detention facility, regardless of the billing code. This will result in the encounter being paid or granted service value with non-Title XIX funding sources, if available.
- Place of Service Code 09 is only to be used for members covered by Targeted Investment Funding.

State-Only enrolled children and adults in detention and jail may receive case management for coordination of care, discharge/re-entry planning, pre-employment planning, etc.

If the incarcerated member is not State-Only eligible but requires ongoing behavioral health services including medications and individual therapy, these needs are expected to be communicated to the detention facility's medical staff with a request the member's needs are communicated back to the providers upon release/reinstatement of AHCCCS benefits.

Incarcerated Adults:
TXIX Adults incarcerated with an SMI diagnosis will need to be State-Only (NTXIX) enrolled if behavioral health services are to be provided during their incarceration. TXIX Behavioral Health coverage will be suspended during the incarceration period. Providers must submit a new 834 to BCBSAZ Health Choice to enroll the member as State-Only (NTXIX).

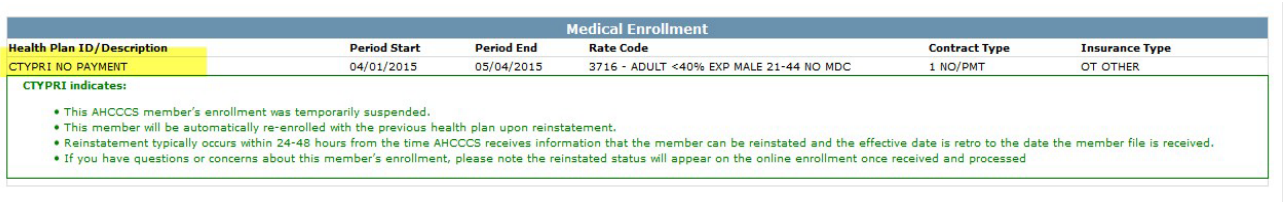
Note: Persons incarcerated awaiting trial (e.g., denied or unable to make bond) ***are*** considered inmates.

Incarcerated Children and Youth:
Children and youth members who have pre-adjudicated status (those who are not yet sentenced) may be eligible for continued services through Non-TXIX funding.

AHCCCS SUSPENSION INTER-GOVERNMENTAL AGREEMENTS
Through Inter-Governmental Agreements between County Governments and AHCCCS, some jails can "suspend" rather than terminate the member's AHCCCS benefits upon incarceration. Upon release from jail and notification to AHCCCS by the releasing facility, the member's AHCCCS will be immediately re-instated. However, it can take up to 24 hours for the eligibility/enrollment to appear in the system.

To identify if a member's Behavioral Health coverage has been suspended due to incarceration, service providers should verify a member's eligibility via the AHCCCS Online Member Verification portal or by contacting BCBSAZ Health Choice. A state-only enrollment segment should remain open for those with SMI, and an enrollment segment may also remain open for those members who will be receiving case management and other services through the other funding opportunities as listed above.

- To verify eligibility through BCBSAZ Health Choice, call 928-774-7128 and request "Eligibility."
- The member's Health Plan Medical Enrollment will be listed as "CTYPRI NO PAYMENT" with information about the suspension.



Medical Enrollment

Health Plan ID/Description	Period Start	Period End	Rate Code	Contract Type	Insurance Type
CTYPRI NO PAYMENT	04/01/2015	05/04/2015	3716 - ADULT <40% EXP MALE 21-44 NO MDC	1 NO/PMT	OT OTHER

CTYPRI indicates:

- This AHCCCS member's enrollment was temporarily suspended.
- This member will be automatically re-enrolled with the previous health plan upon reinstatement.
- Reinstatement typically occurs within 24-48 hours from the time AHCCCS receives information that the member can be reinstated and the effective date is retro to the date the member file is received.
- If you have questions or concerns about this member's enrollment, please note the reinstated status will appear on the online enrollment once received and processed

- Under the Behavioral Health Services tab, the member's enrollment information will only indicate there is "NO BHS ENROLLMENT" without supporting information.

Behavioral Health Services

NO BHS ENROLMENT

AZ State Behavioral Health Services

NO SBH FOUND

<u>Note:</u> If a suspension has not been entered, this does NOT mean in and of itself Federal Financial Participation (TXIX) is available. Persons can remain "eligible" for Medicaid and nonetheless not qualify for Federal Financial Participation due to incarceration. Also, if you think a suspension or revocation should have occurred but has not, report the matter BCBSAZ Health Choice and AHCCCS through your compliance officer. Also, please note both adults and juveniles who are admitted to inpatient facilities *that are not part of the correctional system* may receive TXIX payment if otherwise eligible, even though the patient might return to jail after the hospitalization.

If this occurs and AHCCCS is not reactivated for the hospitalization, contact BCBSAZ Health

Choice and AHCCCS and alert your compliance officer.

For further technical assistance or any questions, please contact BCBSAZ Health Choice Court Services Coordinator.

AHCCCS MEDICAID RULES REGARDING INCARCERATED INDIVIDUALS

Individuals do not lose their Medicaid eligibility based on incarceration alone. A state may enroll, or continue enrollment of, an inmate of a public institution who is otherwise eligible for Medicaid into a Medicaid MCO. Section 1905(a)(A) of the Social Security Act specifically excludes Medicaid for medical care provided to inmates of a public institution, except when the inmate is a patient in a medical institution. Because the statute generally prohibits Medicaid funding for incarcerated individuals, it is often misinterpreted the person is no longer eligible for Medicaid. In fact, the law does not specify, nor imply, Medicaid eligibility is precluded for those individuals who are inmates of a public institution. Accordingly, inmates of a public institution may be eligible for Medicaid if the appropriate eligibility criteria are met.

Thus, whether an individual is suspended or disenrolled from the Medicaid program is a separate inquiry from whether a service is billable to the Medicaid program. Even if eligibility or MCO enrollment remains in place, Medicaid cannot pay for services to inmates if the individual meets the definition of that term.

BENEFIT COORDINATION AND FISCAL RESPONSIBILITY FOR BEHAVIORAL HEALTH SERVICES AND PHYSICAL HEALTH SERVICES

The AHCCCS Contractor Operations Manual (ACOM) 432 delineates financial responsibility for AHCCCS covered AHCCCS covered physical and behavioral health services provided to AHCCCS members who are not enrolled in an integrated line of business.

Therefore, this Policy does not delineate payment responsibility for services for members who are enrolled in a single entity for both physical and behavioral health services (e.g., members determined to have a Serious Mental Illness who are enrolled with a RBHA) as that single entity is the responsible payer for both physical and behavioral health services for that member.

Additionally, ACOM 432 does not apply to services provided through Indian Health Services (IHS) or Tribally owned and/or operated facilities.

ACOM 432 also applies to AHCCCS Complete Care (ACC) Contractors solely for those limited situations when members are not integrated for both physical and behavioral health. In these instances, the ACC Contractor meets the Enrolled Entity definition of this Policy and the RBHA or TRBHA, as applicable is the Behavioral Health Entity.

Please visit the AHCCCS website at www.azahcccs.gov to reference ACOM 432 (including a matrix of financial responsibility).