CHAPTER 18:

Behavioral Health Services
Reviewed/Revised: 10/1/18, 3/4/19, 7/25/19, 9/23/19, 1/1/20, 4/1/20

18.0 INTRODUCTION

The State of Arizona has contracted with Health Choice Arizona to administer the AHCCCS Complete Care (ACC) plan, an integrated delivery system of care including physical health, behavioral health and substance abuse services. Health Choice Arizona’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 Serious Mental Illness (SMI), and behavioral health service provision for children who are involved with the Department of Child Safety (DCS), for American Indians who have choice between health plans, individuals deemed DDD with targeted support coordination only, and crisis services. The RBHAs will also continue to manage housing support services and grant administration. Health Choice Arizona, through its RBHA contract for northern Arizona, will continue to manage those populations in Apache, Coconino, Gila, Mohave, Navajo and Yavapai counties.

Health Choice Arizona 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.

Health Choice Arizona 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.

For behavioral health services not delivered or managed by a members PCP, Health Choice members may choose or be assigned to an Integrated Health Home or Behavioral Health Home. Contracted Integrated/Behavioral Health Home providers serve as an intake agency. They provide or coordinate the provision of covered behavioral health services, and coordinate care with the primary care provider for adults and/or children with behavioral health needs.
The Health Choice Arizona 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
- Non-Title XIX persons determined to have a Serious Mental Illness
- Special populations, including persons receiving services through the Mental Health and Substance Abuse Block Grants (MHBG and SABG)
- Non-enrolled persons participating in prevention sponsored activities
- Non-enrolled persons participating in HIV Early Intervention services
- Other populations, based on the availability of funding and the prioritization of available funding

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 INTEGRATED HEALTH CARE SERVICE DELIVERY PRINCIPLES FOR PERSONS WITH SERIOUS MENTAL ILLNESS (SMI)

Health Choice Arizona utilizes an integrated care approach to positively impact the health and quality of life of our high-risk members determined to be living with SMI.

The overarching system goals for individual SMI members and the SMI population are to improve whole health outcomes and reduce or eliminate health care disparities between SMI members and the general population in a cost-effective manner. Health Choice Arizona ensures services in Northern Arizona are accessible, offer choice to members, are wellness and recovery oriented, are culturally relevant, include specialty services, and are fully integrated or co-located.

- Behavioral, physical, and peer support providers must share the same mission to place the member’s whole-health needs above all else as the focal point of care.
- All aspects of the member experience from engagement, treatment planning, service delivery and customer service must be designed to promote recovery and wellness as communicated by the member.
- Member input must be incorporated into developing individualized treatment goals, wellness plans, and services.
- Peer and family voice must be embedded at all levels of the system.
- Recovery is personal, self-directed, and must be individualized to the member.
- Family member involvement, community integration and a safe affordable place to live are integral components of a member’s recovery and must be as important as any other single medicine, procedure, therapy or treatment.
- Providers of integrated care must operate as a team that functions as the single-point of whole-health treatment and care for all of a member’s health care needs. Co-location or making referrals without coordinating care through a team approach does not equate to integrated care.
- The team must involve the member as an equal partner by using appropriate levels of care management, comprehensive transitional care, care coordination, health promotion and use of technology as well as provide linkages to community services and supports and individual and family support to help a member achieve his or her whole health goals.

18.0.3 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 underscores one’s role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism is valued.

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 the life experience and creates the environment for uncommon and unexpected positive outcomes to be made real. A person in recovery is held as boundless in potential and possibility.

18.0.4 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 makes adjustments in the plan if it is not succeeding.

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**

Health Choice Arizona is responsible for assessing the service needs in our regions and developing a plan to meet those needs.
Health Choice Arizona 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. 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.

*Please Note*
In 2019 and 2020, information contained within the AHCCCS Covered Behavioral Health Services Guide (CBHSG) will be transitioned into the following areas:

- AMPM 310-B, Behavioral Health Services Benefit
- AMPM 320-T, Non-Title XIX/XXI Behavioral Health Services Benefit
  - Non-Title XIX/XXI service information will be transferred to AMPM 320-T.

The AHCCCS Provider Billing Manuals

- Billing information for Fee-For-Service providers will be transferred to the 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, will be transferred to AMPM 310-BB.

Services include:

- Wellness and prevention programs for adults and children
- A full continuum of services for community members with substance use disorders
- General mental health treatment for adults and children that are fully integrated to meet the needs of members
- Support services (personal care, family support, peer support, respite care, interpreter services)
- Behavioral Health Case Management Services
- Behavioral Health Nursing Services
- Inpatient Psychiatric Hospital and Sub-Acute Facility Services (which may include general psychiatric care, or medical detoxification)
- Emergency/Crisis Intervention Services (mobile, community based, stabilization, facility-based or telephonic)
- Emergency Transportation and NEMT to all medically necessary appointments
- Evaluation, Assessment, and Screening Services
- Psychiatric Evaluation and Management
- Individual, Family, and Group Counseling
• Level I Inpatient Psychiatric Residential Treatment Centers
• Behavioral Health Residential Treatment (Levels II, III, IV)
• Home Care Training to the Home Care Client (HCTC, “therapeutic foster care”)
• Supported Housing
• Alcohol and/or Drug Assessment
• Laboratory and Radiology Services
• Opioid Agonist Treatment/ Medication Assisted Treatment
• Behavioral Health Day Programs (supervised, therapeutic, and community psychiatric supportive treatment and medical day programs)
• Rehabilitation Services (skills training and development, cognitive rehabilitation, prevention/ health promotion education and medication training, psychoeducational services and supported employment services)
• Medication Services
• ECT
• Medication Adjustment and Monitoring
• Respite Care

18.2 EMERGENCY DEPARTMENT SERVICES

When Health Choice Arizona 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, Gila, and Apache counties), the Health Choice Arizona RBHA function manages the behavioral health crisis system. [See Provider Manual Section 18.15 Crisis Intervention Services.] Mercy Care RBHA manages the behavioral health crisis system in Maricopa County. Arizona Complete Health –Complete Care Plan RBHA manages the behavioral health crisis system in Southern Arizona (Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz, and Yuma counties)

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:

In the northern region, Health Homes are required to report any individual who has been waiting in the ED longer than 24 hours to HCA Medical Management Department at HCHHCICMMReporting@healthchoiceaz.com. In the central region, CPR, crisis facilities and hospitals can notify through HCHHCICCCrisis@healthchoiceaz.com to increase coordination of care and provide assistance for securing appropriate placement or wrap-around services.
Information required: time and date of admission and “medical clearance for behavioral health admission,” legal status, barriers to discharge from ED, facilities contacted for admission and reason for denial, wrap-around services recommended, contact information for care coordinator, time and date of discharge from ED and disposition. [See Health Choice Arizona website for form.]

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 Risk Assessment)
- Depression and anxiety (PHQ-2/9, GAD-7, Edinburg Perinatal Depression Scale)
- Developmental needs (EPSDT, ECSII (Targeted Investment Providers only), CASII, 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”) Tracking Form is completed for all empaneled children in order 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 that the PCP indicate behavioral health concerns on the EPSDT Tracking Form. If the primary concern is a behavioral problem (i.e. Oppositional Defiant Disorder, Conduct Disorder, Bipolar Disorder), AHCCCS members should be referred to a Health Choice Arizona 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 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 Health Choice Arizona contracted behavioral health provider for ongoing behavioral health assessment and services. Health Choice Arizona 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 perinatal and postpartum depression)
- Anxiety
- Substance Use Disorders/Opioid Use Disorder

Health Choice Arizona 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.

Health Choice Arizona 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 Health Choice Arizona’s 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, Health Choice Arizona ensures:

1. The current provider consulted with the accepting provider, regarding the case and course of treatment.
2. 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.
3. Health Choice Arizona care management will coordinate with the providers and ensure they are in agreement to manage the member’s behavioral health condition.
4. Care management staff will confirm the member is in agreement to transition to the new PCP/behavioral health provider for on-going management of their behavioral health medications.
5. 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.

6. 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 Health Choice Arizona member with ADHD, opioid use disorder, depression, and/or anxiety, AHCCCS outlines the provider’s responsibilities for documentation and maintenance of a medical record. Health Choice Arizona, as required by AHCCCS policies, must monitor PCPs for proper diagnosis and management of behavioral health disorders.

Health Choice Arizona highly recommends treating providers consider:

- Utilizing the AHCCCS-approved reference manuals and nationally recognized clinical guidance for assessment and treatment of ADHD, depression, anxiety, and post-partum depression.
- The Health Choice Arizona 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 Health Choice Arizona 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.

Reassessments must ensure that the provider prescribing psychotropic medication notes in the member’s record:

• The reason for the use of each medication and the effectiveness of that medication
• The appropriateness of the current dosages
• An updated medication list that includes all prescribed medications, dose and frequency prescribed by the PCP and medical specialists, OTC medications, and supplements being taken
• Any side effects such as weight gain and/or abnormal involuntary movements if treated with an anti-psychotic medication;
• Psychotropic medication monitoring parameters (heart rate, blood pressure, weight, BMI, labs as indicated)
• Rationale for the use of polypharmacy
• Evidence that the PCP or BHMP reviewed and addressed labs and tests, especially abnormal labs and tests
• Evidence that 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., as indicated
Psychotropic Medication Monitoring

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

On initiation of any medication and at each evaluation and monitoring visit:
- Heart Rate
- Blood Pressure
- Weight

On initiation of any medication and at least every six months thereafter, or more frequently as clinically indicated:
- Body Mass Index (BMI)

On initiation of any medication affecting this parameter and at least annually thereafter or more frequently as clinically indicated:
- Fasting glucose
- Lipids
- Complete Blood Count (CBC)
- Liver function
- Lithium level, including with any significant change in dose
- Thyroid function, including within one month of initiation of lithium or a thyroid medication
- Renal function, including within one month of initiation of lithium
- Valproic acid or divalproex level, including with any significant change in dose
- Carbamazepine level, including with any significant change in dose
- Abnormal Involuntary Movements (AIMS) 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 with regard to developing a number of antipsychotic induced side effects. These included higher rates of sedation, extrapyramidal side effects (except for akathisia), withdrawal dyskinesia, prolactin elevation, weight gain and at least some metabolic abnormalities. (Journal of Clinical Psychiatry 72:5 May 2011)

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/

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<th>Type of Medication</th>
<th>Monitoring Action</th>
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<tr>
<td>Controlled Substances</td>
<td>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. Health Plans may consider members for single pharmacy/provider locks. Send requests for consideration to Health Choice Arizona Pharmacy Director. <strong>Naloxone (Narcan):</strong> 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.</td>
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<td>Opiate dependence medications</td>
<td>It is not necessary that a medical practitioner must always perform an assessment on a member who is being referred to an Opiate Maintenance Program prior to that referral, as the Opiate Maintenance Program medical practitioner is the treating physician who will make the determination as to the appropriateness of opiate maintenance medications. Methadone and other opiate dependence medications, such as buprenorphine, are provided</td>
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<td>Type of Medication</td>
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<td>as per federal and licensure standards. When opiate dependence medications are discontinued, they are tapered in a safe manner in order to minimize the risks of relapse and physiologic jeopardy. <strong>Naloxone (Narcan):</strong> 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. <strong>C Crisis Stabilization Services:</strong> Methadone, buprenorphine, naloxone and Vivitrol must be available.</td>
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<td>Transition of medications when person loses medication benefit</td>
<td>Providers ensure that 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.</td>
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<td>Out-of-area prescription refills of non-controlled medications</td>
<td>Health Choice Arizona 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 that is 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 Health Choice Arizona by sending a copy of the receipt and relevant documentation to the Health Choice Arizona Pharmacy Director.</td>
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<tr>
<td>Out-of-area prescription refills of Schedule CII medications, and Schedule CIII-V</td>
<td>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 in to pharmacies and running out of these medications is typically not a behavioral health emergency; therefore members should be advised to plan ahead to ensure adequate supplies of these medications. Options include presenting to local behavioral health agencies or urgent care centers.</td>
</tr>
<tr>
<td>Type of Medication</td>
<td>Monitoring Action</td>
</tr>
<tr>
<td>--------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>centers. Use of emergency rooms for dispensing of routine psychotropic medications is discouraged. Schedule CII-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 Health Choice Arizona pharmacy prior to re-issuing.</td>
<td></td>
</tr>
<tr>
<td>Discharge medications from inpatient facilities</td>
<td>Inpatient facilities should dispense at least a 3 to 5 day’s supply of medications for the convenience of families and members at discharge. Give members prescriptions with enough medications and/or refills to 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 that 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 that it will know if members are running out of medications inappropriately early.</td>
</tr>
<tr>
<td>Medications during transitions between Health Plans, agencies or prescribers</td>
<td>It is the responsibility of the member’s current prescriber, including the PCP, to ensure that persons transitioning have adequate supplies of medications to last until the appointment with the next prescriber. It is the responsibility of the provider assuming the person’s care to ensure that the person is scheduled with an appointment within clinically appropriate time frames such that the person does not run out of medications, does not experience a decline in functioning and in no case longer than 30 days from identification of need.</td>
</tr>
<tr>
<td>Psychotropic medications for persons without a pharmacy benefit who are experiencing a serious decline in functioning</td>
<td>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 that a person be substance-free prior to the initiation of services is not a best practice. Providers may determine that a person is SMI pending receipt of information and response to treatment. Providers can contact Health Choice Arizona about compassionate dispensing options.</td>
</tr>
<tr>
<td>Use of samples</td>
<td>Providers are strongly discouraged from using medication samples for medications not on the Health Choice Arizona Drug List, as members may not</td>
</tr>
</tbody>
</table>
For further assistance, providers may call the Health Choice Arizona Member Services Department at (800) 322-8670, and request to speak to the Behavioral Health Department for assistance.

### 18.5 APPOINTMENT STANDARDS AND TIMELINESS

Health Choice Arizona 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. Health Choice Arizona ensures behavioral health assessments, treatment/service planning, and service delivery is strength-based, member-centered, family-friendly, culturally and linguistically appropriate and clinically supervised. The Health Choice Arizona Provider Relations Department monitors appointment standards to ensure members are being seen timely as per [ACOM 417-3 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 that the behavioral health provider is not financially responsible.
- **WHAT:** Services can be telephonic or face-to-face; the response may include any medically necessary covered behavioral health service identified in [AHCCCS Exhibit 300-2A](#) for TXIX/XXI persons, [AHCCCS Exhibit 300-2B](#) for Non-Title XIX/XXI persons, or [AHCCCS 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:**

- **WHO:** Upon notification from ADES/DCYF/DCS that a child has been, or will imminently be taken into the custody of ADES/DCYF/DCS, regardless of the child’s Title XIX or Title XXI eligibility status.
- **WHAT:** 72-Hour Rapid Response assessment.
- **WHEN:** 72 Hr Rapid Response Assessment must be provided within 72 hours after notification by DCS to CRN that 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 and all non-Title XIX/XXI persons determined to have a Serious Mental Illness
- **WHAT:** Includes any medically necessary covered behavioral health service identified in AHCCCS Exhibit 300-2A for TXIX/XXI persons, AHCCCS Exhibit 300-2B for Non-Title XIX/XXI persons, or AHCCCS 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 – Assessments:

- **WHO:** All Title XIX/XXI persons and all Non-Title XIX/XXI persons
- **WHAT:** Includes any allowable assessment service as identified in AHCCCS Exhibit 300-2A for TXIX/XXI persons, AHCCCS Exhibit 300-2B for Non-Title XIX/XXI persons, or AHCCCS Exhibit 300-1 for Covered Services with Special Circumstances.
- **WHEN:** Appointment for initial assessment within 7 days of referral or request for behavioral health services

Routine – Services:

- **WHO:** All Title XIX/XXI persons and all Non-Title XIX/XXI persons
- **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).

Note: Standards for persons receiving services as part of Substance Abuse Block Grant (SABG) funding are in this chapter under section 18.14 Special Populations.

**72-Hour Rapid Behavioral Health Response for Children Taken into DES/DCS Custody**

An rapid response (within 72 hours) is required for all children who are taken into the custody of ADES/DCYF/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 that the child may be experiencing, and offering a coherent explanation to the child about what is happening and what can be expected to happen in the near-term;
• Provide 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 Child and Family Team Protocol); and
• Provide the ADES/DCYF/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 that the person’s need for medication be assessed immediately and, if clinically indicated, that 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 that 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 417-3 Appointment Availability, Monitoring and Reporting.
• WHO: All Title XIX/XXI eligible persons, all Non-Title XIX/XXI 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 must occur within 24 hours of the referral/request for services.

• 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 AMPM 320-P SMI Eligibility Determination and upon the determination that the person is eligible for services and the person is in need of 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 that 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 that 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 that 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 HCA Central and Northern Arizona GSA Behavioral Health Resource List, which includes in-network providers contracted and available on the Health Choice website: https://www.healthchoiceaz.com/providers/behavioral-health-resources/.
If an in-network contracted provider is not available please contact Health Choice Arizona’s Network Department or Member Services Department for assistance in obtaining necessary services. The provider agency may request a Single Case Agreement so that the needed service can be provided by a non-network provider in a timely manner.

**Substance Abuse Block Grant (SABG) Populations**

Health Choice Arizona receives some funding for behavioral health services through the Federal Substance Abuse Block Grant (SABG). SABG funds are used to provide substance abuse services for Non-Title XIX/XXI eligible persons. As a condition of receiving this funding, certain populations are identified as priorities for the timely receipt of designated behavioral health services. Currently, not all T/RBHAs receive SABG Block Grant funding; any providers contracted with a T/RBHA or for SABG funds must follow the requirements found in this chapter. For all other contracted behavioral health providers that do not currently receive these funds, the following expectations do not apply.

Per **AMPM 320-T**, the following populations are prioritized and covered under the Substance Abuse Block Grant (SABG) funding:

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

Response Times for Designated Behavioral Health Services under the Substance Abuse Block Grant (SABG) (based on available funding) per **AMPM 320-T** are as follows:

- **WHO:** Pregnant women/teenagers referred for substance abuse treatment (including pregnant injection drug users and pregnant substance abusers) and substance-using females with dependent children, including those attempting to regain custody of their child(ren).
- **WHAT:** Any needed covered behavioral health service, including admission to a residential program if clinically indicated.
- **WHEN:** Behavioral health services provided within a timeframe indicated by clinical need, but no later than 48 hours from the referral/initial request for services.

If a residential program is temporarily unavailable, an attempt shall be made to place the person within another provider agency facility, including those in other geographic service areas.

If capacity still does not exist, the person shall be placed on an actively managed wait list and interim services must be provided until the individual is admitted.
Interim services must be offered within 48 hours of the request for treatment and shall include: counseling/education about HIV and Tuberculosis (include the risks of transmission), the risks of needle sharing and referral for HIV and TB treatment services if necessary, counseling on the effects of alcohol/drug use on the fetus and referral for prenatal care.

- **WHO:** All other injection drug users.
- **WHAT:** Any needed covered behavioral health services including admission to a clinically appropriate substance abuse treatment program (can be residential or outpatient based on the person’s clinical needs).

If a residential program is temporarily unavailable, interim services must be offered within 48 hours of the request for treatment and shall include education/interventions with regard to HIV and tuberculosis and the risks of needle sharing.

- **WHEN:** Behavioral health services provided within a timeframe indicated by clinical need but no later than 14 days following the initial request for services/referral. All subsequent behavioral health services must be provided within timeframes according to the needs of the person.

All other persons in need of substance abuse treatment will be provided any needed covered behavioral health service(s) within a timeframe indicated by clinical need but no later than 23 days following the initial assessment.

### 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 that 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). Health Choice Arizona 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. Health Choice Arizona will assist behavioral health providers with obtaining PCP information when appropriate.

Health Choice Arizona 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.

Health Choice Arizona 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 Health Choice Arizona Member Services to determine the name of the person’s assigned PCP. This information is also available on the Health Choice Arizona Provider Portal. For information on our secure provider portals, visit [www.HealthChoiceAZ.com](http://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.
- Health Choice Arizona 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 Health Choice Arizona Member Services for assistance.
- All releases of information regarding substance use diagnosis and treatment information must be in accordance with applicable privacy regulations, including 42 CFR Part 2. When applicable, consent to release substance use diagnosis and treatment information should be documented in the member’s record.
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 and Non-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 down, 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, in order 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 take action
- 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 county crisis number and RN Advice line (1-855-458-0622)
- 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 that medications are only one part of a successful treatment program
- If medications are discontinued, assuring member that treatment for the presenting symptoms or condition will still 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 Health Choice Arizona within 48 hours.
18.7 COORDINATION OF CARE WITH THE GOVERNMENTAL AGENCIES

Health Choice Arizona on an annual basis develops joint protocols with stakeholders and posts those protocols on the Health Choice Arizona 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. 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 that 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, in order 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, AMPM Policy 580 Behavioral Health Referral and Intake Process and Practice Tools: Transition into Adulthood, The Unique Behavioral Health Service Needs of Children, Youth, and Families Involved with DCS, and the CFT. (The Child and Family Team Protocol;)
- Coordination activities should include coordination with the adult service providers rendering services to adult family members.
Additional information on collaborating with DCS can be found in the HCA/CDS/CMDP Joint Protocol on the HCA website. [www.healthchoiceaz.com](http://www.healthchoiceaz.com)

### 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). Health Choice Arizona and providers must:

- Accept referrals for Title XIX and Title XXI eligible and enrolled members and families referred through AFF;
- Accept referrals for Non-Title XIX and Non-Title XXI members and families referred through AFF and provide services, if eligible (see section 18.14 Special Populations);
- Ensure that services made available to members who are Non-Title XIX and Non-Title XXI eligible are provided by maximizing available federal funds before expending state funding as required in the [Governor's Executive Order 2008-01](http://example.com), ensuring that TXIX is the payer of first resort for all TXIX eligible individuals;
- 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 Health Choice Arizona 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 Health Choice Arizona 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. Health Choice Arizona 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 AMPM Policy 550 Member Records and Confidentiality);
- 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 Education Act (IDEA) of 2004;
- Ensuring that students with disabilities who qualify for accommodations under 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.

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

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:
<table>
<thead>
<tr>
<th>Eligibility Category</th>
<th>What behavioral health services are available?</th>
<th>Who is responsible for providing the behavioral health services?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title XIX and eligible for ALTCS</td>
<td>All Title XIX covered services</td>
<td>The DDD designated Health Plans</td>
</tr>
<tr>
<td>Title XIX and not eligible for ALTCS</td>
<td>All Title XIX covered services</td>
<td>AHCCCS ACC Plan and subcontracted providers</td>
</tr>
</tbody>
</table>

*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.

| Non-Title XIX | Services provided based on eligibility for services* | Health Choice Arizona (AHCCCS ACC Plan) and subcontracted providers based on eligibility for services* |

*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-T, 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;
- Providing assistance to 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 so as to avoid duplicative processes between systems.

18.7.6 COURTS AND CORRECTIONS

Health Choice Arizona 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 that children and their families continue to receive services while children are in detention including services and planning for release; and
• Ensuring that the behavioral health provider evaluates and participates in transition planning prior to the release of eligible members and arranges and coordinates enrolled member care upon the member’s release.

Health Choice Arizona 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 Health Choice Arizona and Arizona Department of Corrections (ADC) defines the respective roles and responsibilities of each party and is available on the Health Choice Arizona website.

Health Choice Arizona 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

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

For further information regarding Health Choice Arizona enrolled members who are incarcerated, please contact the Justice Liaison Department through Health Choice Arizona 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.

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

- Working in collaboration with the vocational rehabilitation (VR) counselors or employment specialists in the development and monitoring of the member’s employment goals;
- Ensuring that 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 that 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 that the facility is licensed and that 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 that a particular assisted living facility is licensed to provide.

For further information regarding Health Choice Arizona enrolled members who are seeking Assisted Living services, please call Health Choice Arizona Member Services. Providers, members, and community stakeholders should contact the Health Choice Arizona 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 Health Choice Arizona Member Services and request a Behavioral Health Care Manager to assist with referral, or the provider may fax/email a Case Manager Referral Form that can be found online: HCHCaseManagementReferral@healthchoiceaz.com or fax 480-317-3358
- The member is encouraged to contact the Health Choice Arizona Member Services 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 Health Choice Arizona 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 indicate behavioral health concerns on the EPSDT Tracking Form.
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, Health Choice Arizona must provide for a second opinion from a healthcare professional within the network, or arrange 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 Health Choice Arizona encourages the use of a written referral, we recognize that some providers use telephone calls and other types of communication to coordinate the member’s care. This is acceptable to Health Choice Arizona as long as 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 home 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 Health Choice Arizona 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 Health Choice Arizona network does not have a provider to perform the requested services (please refer to the HCA Central and Northern Arizona GSA Behavioral Health Resource List https://www.healthchoiceaz.com/providers/behavioral-health-resources/), members may be referred to out of network providers if:

- The services required are not available within the Health Choice Arizona network;
- Health Choice Arizona prior authorizes the services or establishes a single case agreement or contract with the service provider; AND
- 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 Health Choice Arizona or if services are provided by a non-behavioral health home 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 Health Choice Arizona policies.
- Both referring and receiving providers must comply with Health Choice Arizona 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 to do crisis, outreach, engagement and reengagement 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 that the required service is covered under the member’s benefit plan prior to referring the member.
- Confirm that the receiving provider is contracted with Health Choice Arizona.
- Obtain prior authorization for services that require prior authorization or are performed by a non-participating provider. See also on Health Choice Arizona website [www.HealthChoiceAZ.com](http://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 Health Choice Arizona 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 Health Choice Arizona on the date of service, Health Choice Arizona will not render payment regardless of referral or prior authorization status.
- Verify that the service is covered under the member’s benefit plan.
- Verify that the prior authorization has been obtained, if applicable, and includes the prior authorization number on the claim when submitted for payment.
- Inform the referring provider of the consultation or service by sending a report and applicable medical records to allow the referring provider to continue the member’s care.

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

Upon notification from the Department of Child Safety (DCS) that a child has been, or is at risk of being taken into the custody of 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 *Child and Family Team Practice Protocol* and *The Unique Behavioral Health Service Needs of Children, Youth, and Families Involved with DCS Practice Protocol*.

**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 as per AHCCCS Policy 580 III.B. Behavioral Health Referral and Intake Process.

Members hospitalized at in-network hospitals should utilize the information gathered by the hospital to complete the intake and to not delay enrollment, discharge planning or service planning in order to complete an outpatient intake.
Health Choice Arizona contracts with **Crisis Preparation and Recovery, Inc. (CPR)** to respond to ED 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.

### 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 Health Choice Arizona 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;
- 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 Health Choice Arizona or provider about accessing behavioral health services, Health Choice Arizona 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, Health Choice Arizona and providers must conduct an eligibility determination for SMI in accordance with ACOM 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 Crisis Response Network (CRN).

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, Health Choice Arizona 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 AMPM Policy 550 Member Records and Confidentiality.
DOCUMENTING AND TRACKING REFERRALS

Health Choice Arizona 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 Health Choice Arizona 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, Health Choice Arizona 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.
Health Choice Arizona 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

Health Choice Arizona 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, Health Choice Arizona 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. Health Choice Arizona 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:

1. 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
2. A minimum of three (3) in-state facilities have declined to accept the member
3. The CFT or ART has been involved in the service planning process and in agreement with the out-of-state placement
4. The CFT or ART has determined how they will remain active and involved in service planning once the out-of-state placement has occurred
5. ISP or care plan has been developed that includes a discharge plan for when the member returns in-state for services
6. 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
7. Coordination has occurred with all state agencies involved with the member
8. Coordination with the member’s primary care provider to develop a plan for the provision of any necessary, non-emergency medical care
9. The non-emergent medical provider is an AHCCCS registered provider
10. The out-of-state placement is an AHCCCS registered provider
11. The prior authorization requirements have been met
As part of prior authorization review, the Health Choice Arizona 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 Director of Medical Management and 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. The member’s Behavioral Health Home must complete AMPM Policy 450, Exhibit 450-1 form for AHCCCS submission and approval.

Health Choice Arizona 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 video-conference
- 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 Health Choice Arizona for member outcomes. Data and support are shared between the providers and Health Choice Arizona in order 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 Arizona uses both real-time and predictive analytic data feeds to support care management, population health analytics, risk stratification and performance benchmarking from Health Current, Health Choice Arizona’s pharmacy benefit manager and predictive modeling programs.

Our care management strategy uses Integrated Care Managers (ICMs), supported by committed and experienced Health Choice Arizona 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.

Health Choice Arizona’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.

Members in need of ongoing care management are referred to Top Tier Care Management for review against Health Choice Arizona’s high need/high cost criteria which incorporates information from the HRA and Predictive Modeling software. The assigned Health Choice Arizona 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 Healthcare Buddy will assists the member with setting up a new patient appointment.

The Health Choice Arizona 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 and
• 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 Health Choice Arizona’s ICM. The ICT provides more intensive clinical oversight and coordination for the period of time when the member’s need or risk is greatest, including development of an integrated care plan.

Health Choice Arizona requires coordination of care to occur both at the system level and the provider level to best address members’ needs, goals and functional status. Health Choice Arizona 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; and
• 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.
Health Choice Arizona will disseminate information to the general public, other human service providers, school administrators and teachers and other interested parties regarding the behavioral health services that are available to eligible persons.

Outreach activities conducted by Health Choice Arizona 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 comorbid medical and behavioral health disorders and those who have been determined to have a Serious Mental Illness (SMI) within Health Choice Arizona’s geographic service area, including persons who reside in jails, homeless shelters, county detention facilities or other settings;
- Outreach by integrated health home/behavioral health homes to high risk persons who have been determined to have SMI but are not currently engaged in behavioral health services at an Health Choice Arizona integrated health home/behavioral health home and could benefit from services;
- Provision of information to mental health advocacy organizations; and
- Development and coordination of outreach programs to Native American tribes in Arizona to provide services for tribal members.

18.12.2 ENGAGEMENT

Health Choice Arizona 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; and,
- 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 Health Choice Arizona’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; and
- Provide the member with choice when selecting a provider and the services they participate in.

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; and
• Sending a letter to the current or most recent address requesting contact, if all attempts at personal contact are unsuccessful, except when a letter is contraindicated due to safety concerns (e.g., domestic violence) or confidentiality issues. The provider will note safety or confidentiality concerns in the progress notes section of the clinical record and include a copy of the letter sent in the comprehensive clinical record;
• For persons determined to have a Serious Mental Illness who are receiving Special Assistance, 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. 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.

**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 7 days. Clinical staff should review members who miss appointments with clinical supervisors to ensure re-engagement efforts are completed as clinically appropriate and that 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 time-frames:

- Discharged from inpatient services in accordance with the discharge plan and within 7 days but no later than 30 days;
- Involved in a behavioral health crisis within timeframes based upon the person’s clinical needs, but no later than 7 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; and
- For members experiencing or who have been reported to experience an adverse event/red flag (slurred speech, falling down, 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, in order 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 7 days of the person’s release to ensure client stabilization, medication adherence, and to avoid re-hospitalization.

Health Choice Arizona 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 Health Home clinical team contacts the inpatient social worker to schedule discharge planning staffing;
- Within 72 hours of notification of admission, the Health Home clinical team coordinates with a Health Choice Arizona 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 that aftercare appointments meet established access standards;
- Formalize discharge planning in writing with a discharge summary and follow up actions clearly indicated with scheduled aftercare appointments;
• Ensure 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 Health Choice Arizona Pharmacy Department;
• No later than 7 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 Health Choice Arizona 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, Health Choice Arizona will assist with care coordination and ensure the member has established outpatient care.
• Health Choice Arizona provides care coordination and case management services for members discharging from the Arizona State Hospital (AzSH). Health Choice Arizona 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 Health Choice Arizona will notify the PSRB and AHCCCS immediately of the violation. Health Choice Arizona has a designated point of contact, the Arizona State Hospital Liaison, to ensure a smooth member transition back to the community.

Health Choice Arizona Post-Discharge Follow-Up Outreach
A “Buddy” who is a Member Services Representative does outreach calls to members within 3 days of notification 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, make sure member knows about post-discharge appointments and engage the member in ongoing care. If the member is in ’s Top Tier Care Management Program, the Integrated Care Manager also ensures the member’s assigned HH case manager engages the member within a few days of discharge. 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 that a person has been out of the behavioral health system.
For persons not receiving services for less than 6 months:

- If the person has not received a behavioral health assessment in the past 6 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 for 6 months or longer:

- 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 Behavioral Health Referral and Intake Process](#)):

**ASSESSMENT**

The ongoing collection and analysis of a person’s medical, psychological, psychiatric and social conditions in order to initially determine if a health disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensure that 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., pay check 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 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, in order 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) in order 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 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 Health Choice Arizona 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 Drugless 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);
• Advising Non-Title XIX/XXI members determined SMI that they may be assessed a co-payment (see Chapter 2 Member Eligibility and Member Services).
• The review and dissemination of Health Choice Arizona Notice of Privacy Practices (NPP) and the AHCCCS HIPAA Notice of Privacy Practices (NPP) in compliance with 45 CFR 164.520 (c)(1)(B); and
• 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.

ASSSESSMENTS
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.

Health Choice Arizona does not mandate that 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 Health Choice Arizona Medical Record Standards and **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.

- Presenting issues/concerns;
- History of present illness including review of major psychiatric symptoms (i.e., mood, depression, anxiety, psychosis, suicidal ideation, homicidal ideation, and other behavioral health symptoms) and frequency/duration of symptoms;
- Use of standardized tools/screens:
  - Whole person (Health Choice Arizona Health Risk Assessment- Adult or Pediatric)
  - Depression and anxiety (PHQ-2/9, GAD-7, Edinburg Perinatal Depression Scale)
  - Developmental needs (EPSDT, ECSII (recommended but not required), CASII, M-CHAT, ADOS, PEDS, ASQ)
  - Substance use (AUDIT, DAST, ASAM)
  - Trauma (Adverse Childhood Events)
- Psychiatric history, including history of previous psychiatric hospitalization(s) and psychotropic medication trial(s);
- Medical history;
- Current medications, including over the counter (OTC) medications;
- Allergies and other adverse reactions;
- Developmental history for children/youth under the age of 18 and with other populations if clinically relevant;
- Family history;
- Educational history/status;
- Employment history/status;
- Housing status/living environment;
- Social history;
- Legal history, including custody/guardianship status, pending litigation, Court Ordered Evaluation/Court Ordered Treatment (COE/COT) history, criminal justice history, and any history of sex offender adjudication;
• Substance abuse history including type of substance, duration, frequency, route of administration, longest period of sobriety, and previous treatment history;
• Standardized substance use screen for children age 11 to 18 and referral for comprehensive assessment when screened positive;
• Substance use screen for adults age 18 and older using the American Society of Addiction Medicine (ASAM) Third Edition – Revised of Patient Placement Criteria (ASAM PPC-3R);
• Labs/ Diagnostics, if applicable;
• Mental Status Examination;
• Risk Assessment: the potential risk of harm to self or others based on self-reports, clinical symptoms, personality factors, past history, substance abuse, criminogenic factors, etc.;
• Brief summary/Bio-Psycho-Social formulation;
• ICD-10 diagnoses; and
• Date, begin, and end time of the assessment and printed name, signature, and professional credential of the provider completing the behavioral health assessment.
• If a privileged BHT completes the assessment, the assessment must also include a printed name, signature, professional credential, date and time of the privileged BHP who reviewed the assessment information. (*Additionally, the BHP must confirm that sexual abuse/behavior information was documented as part of the person’s Family, Educational, and Social History.)

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 ALL TITLE XIX SMI MEMBERS:
• Special Assistance assessment

REQUIRED FOR CHILDREN AGE 0 TO 5: Developmental screening for children age Birth to 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 age three to five. A developmental screening, such as, the 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 to 5 age children will follow all relevant AHCCCS Birth to 5 practice tools, and are encouraged to seek Infant Toddler Mental Health Coalition of Arizona Birth to 5 Endorsement or another accredited Birth to 5 endorsement for evidenced based treatment.
REQUIRED FOR CHILDREN AGE 6 TO 18: Child and Adolescent Service Intensity Instrument (CASII) 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 ECSII/CASII 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 1:20, with the ideal caseload size of 1:15
  - High Needs Case Management is a requirement of HCA and AHCCCS for children with high service intensity needs. High service intensity needs are identified as:

  **Children 0 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: CASII level of 4, 5, or 6.**

**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 Health Choice Arizona 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. Health Choice Arizona 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 Health Choice Arizona’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 Services Provided by Non-Behavioral Health Home Providers**

Providers who are contracted by Health Choice Arizona to do crisis, outreach, engagement and reengagement 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 Health Choice Arizona and may include crisis services, 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
Members who self-refer to the non-behavioral health home services must be directed to the behavioral health home for assessment and service planning at the time of first contact with the non-behavioral health home provider.

All reasonable efforts to engage the member to complete the initial evaluation or assessment need to be demonstrated in the provider’s medical records.

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 of 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 Health Choice Arizona Behavioral Member Services at (800) 923-1400.

Minimum elements of the service plan for Title XIX/XXI Members and for Non-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 Health Choice Arizona credentialing requirements. In the event that 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 Health Choice Arizona 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 Health Choice Arizona 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; and
• 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 Health Choice Arizona's Member Service line at 800-640-2123.

The service plan must be sent to all of 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 Health Choice Arizona Member Services at (800) 640-2123.

**Minimum elements of the service plan for Non-Title XIX/XXI persons determined to have SMI who do not have an assigned Case Manager**

Service plans for Non-Title XIX/XXI persons determined to have SMI who do not have an assigned Case Manager can be incorporated into the psychiatric progress notes completed by the BHMP as long as the treatment goals reflect the needs identified on the assessment, are clearly documented, and summarize the progress made. The BHMP must document when a clinical goal has been achieved and when a new goal has been added.

Additionally, non-Title XIX/XXI persons determined to have SMI, who do not have an assigned Case Manager shall have the option of accessing peer support services to assist them in developing a peer-driven, self-developed proposed service plan to be shared with their BHP for approval, adoption, and implementation. These peer-driven, self-developed service plans are not required to contain all minimum elements as outlined above for those that have assigned Case Managers; however, they should consider the member-specific needs for and expected benefits from community-based support services including, but not limited to, supported employment, peer support, family support, permanent supportive housing, skills training, health promotion, personal assistance, and respite care. Peer-driven, self-developed proposed service plans should also address natural supports that can be leveraged and strengthened as well as outline crisis prevention approaches (e.g., warm line availability) and how the emergence of a potential crisis will be addressed.

These services should be incorporated into the peer-driven, self-developed proposed service plan as appropriate. It is recommended that a standardized process be used to develop peer-driven, self-developed proposed service plans.
Additionally, the peer-driven, self-developed proposed service plan must be reviewed with and approved by the BHP and maintained in the medical record. Progress and outcomes related to the approved peer-driven, self-developed service plan must be tracked and documented by the BHP.

**Appeals or Service Plan Disagreements**

Every effort should be taken to ensure that the service planning process is collaborative, solicits and considers input from each team member and results in consensus regarding the type, mix and intensity of services to be offered. In the event that a member and/or legal or designated representative disagree with any aspect of the service plan, including the inclusion or omission of services, the team should make reasonable attempts to resolve the differences and actively address the 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 that the member and/or legal or designated representative disagree with some or all of 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 cases that a member determined to have a Serious Mental Illness and/or legal or designated representative disagree with some or all of the Non-Title XIX/XXI covered services included in the service plan, the member and/or legal or designated representative must be given a Notice of Decision and Right to Appeal (For Individuals With a Serious Mental Illness) as per ACOM Policy 444, Attachment C, by the behavioral health representative on the team. In either case, the member and/or legal or designated representative may file an appeal within 60 days of the action.

18.13.3 UPDATES TO ASSESSMENT AND SERVICE PLAN

The Health Homes must complete an annual assessment and **Health Choice Arizona Health Risk Assessment** 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

Health Choice Arizona providers ensure administration of the **Health Choice Arizona Health Risk Assessment** 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 that is developed to address actions that need to be taken in the event that 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 as long as 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, that 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 CASII score 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 that the clinical treatment team deems to be at risk.

18.14 SPECIAL POPULATIONS – SABG AND MHBG

As per AHCCCS Medical Policy for Covered Services, Policy 320-T Non-Discretionary Federal Grants, AHCCCS receives Federal grants and State appropriations to deliver behavioral health services to special populations in addition to Federal Medicaid (Title XIX) and the State Children’s Health Insurance Program (Title XXI) funding. The grants are awarded by a Federal agency and made available to AHCCCS, which then disburses the funding throughout Arizona for the delivery of covered behavioral health services in accordance with the requirements of the fund source.

18.14.1 SUBSTANCE ABUSE BLOCK GRANT (SABG)

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

**Coverage and Prioritization**

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

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

People must indicate active substance use within the previous 12-month to be eligible for SABG funded services. This also includes individuals who were incarcerated and reported using while incarcerated. The 12 month standard may be waived if the member is on medically necessary methadone maintenance.

**Eligibility Requirements**

All members receiving SABG-funded services are required to have a Title XIX/XXI eligibility screening completed and documented in their clinical record at the time of intake and annually. Members can be served through SABG while awaiting a determination of Title XIX/XXI eligibility. However, upon Title XIX/XXI eligibility determination when the retroactive covered dates of Title XIX/XXI eligibility includes dates when Title XIX/XXI covered services were billed to SABG, the Contractor is required to reverse the billing for those services and cover them under their Title XIX/XXI funding.

The SABG is specifically allocated to provide services that are not otherwise covered by Title XIX/XXI funding. This includes substance use services for members who do not qualify for Title XIX/XXI eligibility, as well as the non-Medicaid reimbursable services identified by AHCCCS in the Covered Behavioral Health Services Guide. The SABG is to be used as the payer of last resort. Members must indicate active substance use within the previous 12-months to be eligible for SABG services. This also includes individuals who were incarcerated and reported using while incarcerated. The 12-month standard may be waived for members on medically necessary methadone maintenance upon assessment for continued necessity as well as members incarcerated for longer than 12 months that indicate substance use in the 12 months prior to incarceration.

Members shall not be charged a copayment, or any other fee, for substance use treatment services funded by the SABG.
All members must be enrolled with Health Choice in order to receive services under SABG. For Non-Title XIX members, Health Homes will complete a State-only enrollment. For assistance in the State-only enrollment process or for questions about this process, contact Health Choice’s eligibility department by email at HCHHCICproduction@healthchoiceaz.com, or call the Member Services department.

**Choice of Substance Use Providers**
Members receiving substance abuse treatment services under the SABG have the right to receive services from a provider to whose religious character they do not object. Behavioral health subcontractors providing substance abuse services under the SABG must notify members of this right using AHCCCS AMPM Policy 320-T Attachment A, Charitable Choice. Providers must document that the member has received notice in the member’s comprehensive clinical record.

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

**Required Available Services**
Behavioral health providers must provide specialized, gender-specific treatment and recovery support services for females who are pregnant or have dependent children and their families in outpatient/residential treatment settings. Services are also provided to mothers who are attempting to regain custody of their children. Services must treat the family as a unit. As needed, providers must admit both mothers and their dependent children into treatment. The following services are provided or arranged as needed:

- Referral for primary medical care for pregnant females;
- Referral for primary pediatric care for children;
- Gender-specific substance abuse treatment; and
- Therapeutic interventions for dependent children
- SABG may be used for youth members in detention facilities who have pre-adjudicated status with any pending court cases (not yet sentenced)

Health Choice Arizona is required to ensure the following issues do not pose barriers to access to obtaining substance abuse treatment:

- Child care
- Case management
- Transportation

Health Choice Arizona publicizes the availability of gender-based substance abuse treatment services for females who are pregnant or have dependent children. Publicizing will include at a minimum the posting of fliers at each site notifying the right of pregnant females and females with dependent children to receive substance abuse treatment services at no cost.
Subcontracted providers must notify Health Choice Arizona if, on the basis of moral or religious grounds, the provider elects to not provide or reimburse for a covered service.

Behavioral Health Service Providers may call Health Choice Arizona at (877) 923-1400 with questions regarding specialty program services for women and children.

SABG funding should be directed to service delivery. The Contractor should utilize other fund sources to provide medications. Medication Assisted Treatments (MAT) identified by AHCCCS as SABG-covered medications are excluded from this restriction, these include methadone, buprenorphine, disulfiram, acamprosate, naloxone and naltrexone.

**Childcare**

Per AHCCCS Medical Policy Manual, Chapter 300, Exhibit 300-2B and the AHCCCS Behavioral Health Services Matrix, childcare services are limited to TXIX or SABG enrolled members who are receiving MAT or Outpatient treatment for substance use where the family is being treated as a whole, but the dependent children are not enrolled members who are receiving other billable services from the Provider. Additionally, the member must not have means of other childcare available to them during the time when they are receiving treatment services. Place of Service code “99 – Other” shall be used when billing for childcare services. Only these provider types may bill for childcare:

- C2 – Federally Qualified Health Center (FQHC)
- 29 – Rural Health Clinic

Childcare services should be provided by a behavioral health paraprofessional or above, as defined in A.A.C. R9-101. A staff member providing childcare services may care for more than one child at a time; however, a single staff member may not provide childcare for more than 5 children at one time to remain in-line with the current state-mandated caregiver-to-child ratios, as stated in ARS Title 36 – Public Health and Safety, Chapter 7.1 for Child Care Programs.

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

The purpose of interim services is to reduce the adverse health effects of substance abuse, promote the health of the individual, and reduce the risk of transmission of disease. Interim services are available for Non-Title XIX/XXI priority populations who are maintained on an actively managed wait list. Title XIX/XXI eligible members who also meet a priority population type may not be placed on a wait list. The minimum required interim services include education that covers:

- Prevention of and types of behaviors which increase the risk of contracting HIV, Hepatitis C and other sexually transmitted diseases;
- Effects of substance use on fetal development;
- Risk assessment/screening;
- Referrals for HIV, Hepatitis C, and tuberculosis screening and services; and
- Referrals for primary and prenatal medical care.
SABG Reporting Requirements
Providers must promptly submit information for Priority Population Members (Pregnant Women, Women with Dependent Child(ren) and Intravenous Drug Users) who are waiting for placement in a Residential Treatment Center, to the online AHCCCS SABG Waitlist System, or in a different format upon written approval by AHCCCS.

- Title XIX/XXI members may not be added to the wait list. Priority Population Members must be added to the wait list if Health Choice Arizona or its providers are not able to place the member in a Level II Residential Treatment Center within the timeframes prescribed in ACOM Policy 417, Appointment Availability, Monitoring and Reporting.
- For pregnant women the requirement is within 48 hours
- For women with dependent children the requirement is within 5 calendar days
- For all IVDUs the requirement is within 14 calendar days
- Non-Title XIX/XXI members may be added to the wait list if there are no available services.

Other SABG Requirements
Health Choice Arizona has designated the Health Choice Arizona Adult Programs Coordinator to be the:

- A lead substance abuse treatment coordinator who is responsible for ensuring Health Choice Arizona compliance with all SABG requirements
- A women’s treatment coordinator
- An opiate treatment coordinator
- An HIV early intervention services coordinator

The prevention services administrator is the Health Choice Arizona Prevention Specialist.

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

Eligibility for HIV Early Intervention Services
- Services are provided exclusively to populations with substance use disorders.
- HIV services may not be provided to incarcerated populations.

Requirements for Providers Offering HIV Early Intervention Services
HIV early intervention service providers who accept funding under the Substance Abuse Block Grant (SABG) must provide HIV testing services.

Behavioral health providers must administer HIV testing services in accordance with the Clinical Laboratory Improvement Amendments (CLIA) requirements, which requires that any agency that performs HIV testing must register with CMS to obtain CLIA certification. However agencies may apply for a CLIA Certificate of Waiver which exempts them from regulatory oversight if they meet certain federal statutory requirements. Many of the Rapid HIV tests are waived.
For a complete list of waived Rapid HIV tests please see http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/analyteswaived.cfm. Waived rapid HIV tests can be used at many clinical and non-clinical testing sites, including community and outreach settings. Any agency that is performing waived rapid HIV tests is considered a clinical laboratory.

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

The HIV Prevention Counseling training provided through AHCCCS must be completed by Health Choice Arizona HIV Coordinators, provider staff and provider supervisors whose duties are relevant to HIV services. Staff must successfully complete the training with a passing grade prior to performing HIV testing, HIV education and pre/post-test counseling.

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

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

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

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

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

**Monitoring Requirements for HIV Early Intervention Services**
Health Choice Arizona is required to collect monthly progress reports from subcontracted providers and submit quarterly progress reports to AHCCCS.
Site visits to providers offering HIV Early Intervention Services must be conducted bi-annually. The AHCCCS HIV Coordinator, Health Choice Arizona HIV Coordinator, provider staff and supervisors relevant to HIV services must be in attendance during staff visits. A budget review and description/justification for use of funding must be made available by the provider as part of the site visit.

Minimum Performance Expectations
Health Choice Arizona is expected to administer a minimum of 1 test per $600 in HIV funding.

Considerations when delivering services to Substance Abuse Block Grant (SABG) Populations
SABG treatment services must be designed to support the long-term recovery needs of eligible members. Specific requirements apply regarding preferential access to services and the timeliness of responding to a member’s identified needs. Behavioral health providers must also submit specific data elements to identify special populations and record limited clinical information (see AHCCCS Technical Interface Guidelines (TIG) for requirements for requirements).

18.14.2 MENTAL HEALTH BLOCK GRANT (MHBG)
The MHBG provides funds from SAMHSA to provide non-Title XIX mental health services to children with serious emotional disturbances (SED) and adults with serious mental illness (SMI). These funds are used to:
- Carry out the State plan contained in the application;
- Evaluate programs and services, and;
- Conduct planning, administration, and educational activities related to the provision of services.

Coverage and Prioritization
MHBG funds are only to be used for allowable services identified in the AHCCCS AMPM Covered Non-Title XIX/XXI Behavioral Health Services Exhibit 300-2B for Non-Title XIX/XXI members with SMI or SED or Non-Title XIX/XXI services for Title XIX/XXI members. Members shall not be charged a copayment, or any other fee, for treatment services funded by the MHBG.

Qualifying SMI diagnoses are listed in the AHCCCS AMPM 320-P Serious Mental Illness Eligibility Determination Attachment A. For more information, see AHCCCS AMPM 320-P.

Per AHCCCS AMPM 320-T, the definition of SED is as follows:
“Designation for persons from birth until the age of 18 who currently meet or at any time during the past year have met criteria for a mental disorder – including within developmental and cultural contexts – as specified within a recognized diagnostic classification system (e.g. most recent editions of the Diagnostic and Statistical Manual of Mental Disorders [DSM], the International Statistical Classification of Diseases and Related Health Problems [ICD]), and who displays functional impairment,
as determined by a standardized measure, which impedes progress towards recovery and substantially interferes with or limits the person’s role or functioning in family, school, employment, relationships, or community activities. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance, substance use disorder, are attributable to an intellectual developmental disorder, autism spectrum disorder, or are attributable to another medical condition.”

Health Choice requires a Child and Adolescent Service Intensity Instrument (CASII) of 4 or more to determine functional impairment.

All members must be enrolled with Health Choice in order to receive services under MHBG. For Non-Title XIX members, Health Homes will complete a State-only enrollment. For assistance in the State-only enrollment process or for questions about this process, contact Health Choice’s eligibility department by email at HCHCICproduction@healthchoiceaz.com, or call the Member Services department.

The MHBG Block Grant must be used:

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

Restrictions on use of Substance Abuse Block Grant (SABG) and Mental Health Services Block Grant (MHBG). See also SABG FAQ 02/20/2017.
The State and Health Choice Arizona shall not expend SABG and MHBG Block Grant funds on the following activities:

• To provide inpatient hospital services, with the exception of detox services if provided in a free-standing Level 1 sub-acute facility;
• To make cash payments to intended recipients of health services;
• To purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
• To satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds (Maintenance of Effort);
• To provide financial assistance to any entity other than a public or nonprofit private entity;
• To provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for AIDS;
• To pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of Executive Level I of the Executive Salary Schedule for the award year; see http://grants.nih.gov/grants/policy/salcap_summary.htm;
• To purchase treatment services in penal or correctional institutions of the State of Arizona;
• To provide acute care or physical health care services including payments of co-pays; AND
• To provide Patient Assistance Funds.

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

Health Homes receiving MHBG-FEP funds will follow requirements set forth by Health Choice and AHCCCS.

18.15 CRISIS INTERVENTION SERVICES

In Northern Arizona (Coconino, Yavapai, Mohave, Navajo, Gila and Apache counties), the Health Choice Arizona RBHA function manages the behavioral health crisis system. In Maricopa County, Mercy Care manages the behavioral health crisis system. In Southern Arizona (Pinal, Pima, Yuma, Santa Cruz, Cochise, Graham, La Paz, Greenlee counties), Arizona Complete Health manages the behavioral health crisis system.

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.

Note: 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.
The trauma-informed philosophy of care for provision of crisis services is to keep individuals in crisis safe, stabilize individuals as quickly as possible and assist them in returning to their baseline of functioning, and supporting the transition of care into ongoing treatment. Health Choice Arizona endorses a perspective that is recovery-oriented, culturally competent and trauma-informed.

GENERAL REQUIREMENTS
To meet the needs of individuals, Health Choice Arizona will ensure that the following crisis services are available:

**Telephone Crisis Intervention Services:**
Telephonic crisis intervention through Crisis Response Network (CRN), including a toll-free number, available 24 hours per day, seven days a week: toll free (877) 756-4090.
- The intervention may include triage, referral and dispatch of service providers and patch capabilities to and from 911 and other crisis providers or crisis systems as applicable.
- Answer calls within three (3) telephone rings (equivalent to 18 seconds), with a call abandonment rate of less than three (3) %.
- Offer interpretation or language translation services to persons who do not speak or understand English and for the deaf and hard of hearing.

Telephonic nursing triage services are available 24 hours per day, seven days a week: toll free (855)-458-0622.

**Mobile Crisis Intervention Services**
Mobile crisis intervention services available 24 hours per day, seven days a week via the toll-free northern Arizona crisis hotline: (877) 756-4090. Please note the following:
- All crisis and mobile dispatch requests must be routed through the crisis hotline.
- The telephonic service provider will make a determination as to the most appropriate intervention for the situation, to include the necessity of a mobile team dispatch.
- All providers are expected to publicize the single, toll-free northern Arizona crisis hotline phone number.

Mobile crisis services may include screening and assessment; coordination of care; 23-hour, 59 minutes crisis observation/stabilization services, including detoxification services; and up to 72 hours of additional crisis stabilization as funding is available for mental health and substance abuse related services.

Mobile crisis teams will respond within emergent timeframes of less than two (2) hours; however, mobile crisis teams strive to maintain an average response time of one and one-half (1 1/2) hours to psychiatric crises in the community.
- If a two-person team responds, one person may be a Behavioral Health Paraprofessional, including a peer or family member, provided he/she has supervision and training as currently required for all mobile team members.
**Specialty Mobile Crisis Services**
To provide premium crisis services to individuals in emergent need, Health Choice Arizona utilizes specialty providers for mobile crisis services in Coconino, Mohave, Yavapai and Gila Counties:
- During business hours health homes respond to crises on their own premises, while the specialty provider responds to all other calls in the community.
- The specialty provider responds to all community crises outside of regular business hours.
- Mobile crisis service outcomes are reported to Health Choice Arizona in order to assure quality and timely delivery of service.

**Mobile Crisis Services via Health Homes**
To provide coverage of crisis services across the northern GSA, Health Choice Arizona also utilizes health home crisis services:
- During business hours health homes respond to crises on their own premises.
- For areas in which a specialty mobile crisis provider is not available, health homes may be expected to mobilize crisis services to respond to mobile dispatch requests via CRN.
  - Health homes will maintain a permanent single point of contact per site for the dispatch of mobile crisis intervention services from CRN.
- Mobile crisis service outcomes are reported to Health Choice Arizona in order to assure quality and timely delivery of service.

Health Choice Arizona and mobile crisis providers will work collaboratively with community stakeholders, local emergency departments and first responders.

**Crisis Stabilization Units**
A Crisis Stabilization Unit (CSU) is a 23-hour, 59 minute observation center available to anyone experiencing a mental health crisis. Walk-ins and referrals are accepted 24 hours a day, 7 days a week. Facilities must adhere to a “no wrong door” approach for all referrals.

Short-term crisis stabilization services are provided in an effort to resolve the crisis and return the individual to the community. Services may include, but are not limited to: safety and risk assessments, crisis stabilization and observation, detoxification services and referrals to care. A higher level of care may become necessary for the individual’s safety and stabilization.

**Psychiatric and Substance Use Emergency Admissions**
Individuals requiring an emergency admission are admitted to the closest in-network facility to where the person is located. Each inpatient facility has a defined primary service area; however, individuals may be admitted to any in-network facility if the primary facility is full. In the event that all in-network inpatient facility beds in the region are full, based on member eligibility, individuals may be eligible for admission to other out-of-network inpatient facilities.
Follow up and Coordination of Care
CRN will notify the member’s assigned health home of the disposition of the crisis within 24 hours of the crisis. If a face to face assessment is necessary, CRN will coordinate with the contracted crisis providers, to complete the assessment and triage the situation.

The mobile crisis providers will notify the member’s assigned health home within 24 hours of admission into an inpatient facility. It is the health home’s responsibility to ensure appropriate services are available when the member is discharged from the inpatient facility; they will be required to have an appointment with the member’s primary care provider and/or a mental health provider within 7 days of discharge and within 30 days of discharge.

In addition, Health Choice Arizona employs member service representatives to complete outreach calls to members within 3 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 that community stakeholders, behavioral health providers and emergency responders work in unity to provide the best possible mobile crisis response to members of the community.

During adverse conditions, it may become unsafe for community providers to use town, city and rural roads. In these cases, Health Choice Arizona will collaborate with city and county governments, law enforcement and mobile crisis providers to assess the risk and safety issues presented. Mobile crisis providers will remain open and provide contracted services until such time that the coordinating parties have determined that a safety issue exists and that it would endanger mobile crisis providers. At that time, Health Choice Arizona will coordinate with the parties involved to make informed decisions about the most appropriate course of action.

In the event of critical incidents, disasters and other emergencies, Health Choice Arizona will collaborate with community stakeholders, emergency responders and behavioral health providers to determine the necessity and activation of mobile crisis services into the community. Should the activation of mobile crisis services occur, providers will:
- Make necessary arrangements to provide services to the best of their ability and according to the directive provided by Health Choice Arizona.
- Maintain communication with local law enforcement, hospitals and emergency departments.
- Provide Health Choice Arizona with updates on service capabilities, accomplished tasks and anticipated changes.
MANAGEMENT OF CRISIS SERVICES
While Health Choice Arizona must provide a standard set of crisis services to ensure the availability of these services throughout the state, Health Choice Arizona will also be able to meet the specific needs of communities located within their service area. Health Choice Arizona will utilize the following in managing crisis services:

- Allocate and manage funding to maintain the availability of required crisis services for the entire fiscal year;
- Work collaboratively with local hospital-based emergency departments to determine whether a Health Choice Arizona-funded crisis provider should be deployed to such locations for crisis intervention services;
- Work collaboratively with local inpatient hospitals to determine whether and for how many hours such locations are used for crisis observation/stabilization services;
- Coordinate with other Health Plans to ensure timely notification and care coordination;
- Ensure providers are informed of member’s engagement with crisis services for follow up within 24 hours; and
- When Non-Title XIX/XXI eligible individuals are receiving crisis services and require medication, Health Choice Arizona may provide medications on the Health Choice Arizona medication formulary.

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

Behavioral Health Crisis Resources – Northern GSA
Health Choice Arizona maintains a Behavioral Health Provider Resource List detailing available facilities serving all populations in crisis, including hospitals, substance abuse transitional facilities, residential treatment facilities, outpatient treatment centers, peer and family run organizations, etc. on the Health Choice Arizona website.

Please also refer to the below list of crisis resources for each county Health Choice Arizona serves.
In Maricopa County, crisis services are provided by Mercy Care. Members can call the crisis line: (800)-631-1314.

In Pinal County (and all southern counties), crisis services are provided by Arizona Complete Health – Complete Care Plan.

Members can call the crisis line: 866-495-6735.
18.16 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.

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

- Ensure that families have access to information on the CFT process and have the opportunity to fully participate in all aspects of service planning and delivery.
- Approach services and view the enrolled child in the context of the family rather than isolated in the context of treatment.
- Recognize that families are the primary decision-makers in service planning and delivery.
- Provide culturally and linguistically relevant services that appropriately respond to a family’s unique
- 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, Health Choice Arizona, and AHCCCS at intake and throughout the CFT process.
- Work with Health Choice Arizona to develop training in family engagement and participation, roles and partnerships for provider staff, parents/caregivers, youth and young adults

RESPONSIBILITIES OF HEALTH CHOICE ARIZONA AND PROVIDERS

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

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

RESPONSIBILITIES OF HEALTH CHOICE ARIZONA

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

ORGANIZATIONAL COMMITMENT TO EMPLOYMENT TO FAMILY MEMBERS

Health Choice Arizona 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 through the use of one or more of the following:
- Analysis of the behavioral health system, including the Annual Network Inventory and Analysis of Family Roles and System of Care Practice Reviews.
- Other sources as required by the AHCCCS/RBHA contracts or Health Choice Arizona IGAs.

18.17 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 that 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 through the use of 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 HEALTH CHOICE ARIZONA
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 Health Choice Arizona’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 that a 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.

REPORTING TO OFFICE OF HUMAN RIGHTS
Health Choice Arizona will submit individual reports received from providers involving enrolled children and individuals determined to have a Serious Mental Illness to the Office of Human Rights. This will be done on a weekly or monthly basis, as arranged with the Office of Human Rights.

The Arizona State Hospital (AzSH) must submit individual reports involving individuals determined to have a Serious Mental Illness and children to the Office of Human Rights. This must be done on a weekly or monthly basis, as arranged with the Office of Human Rights. The Arizona State Hospital or Health Choice Arizona must ensure that the disclosure of protected health information is in accordance with applicable rules on confidentiality.

Health Choice Arizona and AzSH must also submit monthly summary reports to the Office of Human Rights by the 15th day of each month.

18.18 REPORTING OF INCIDENTS, ACCIDENTS, AND DEATHS
Healthcare providers must report any incident, accident or death as defined by this chapter, of a healthcare recipient to Health Choice Arizona within 48 hours as per AHCCCS AMPM 960 Quality Management and Performance Improvement.
Providers must submit to Health Choice Arizona, via the Quality Management System (QMS) Portal all Incident, Accident, and Death (IAD) reports that pertain to the following for all behavioral health members:

- Deaths;
- Medication error(s);
- Abuse or neglect allegation made about staff member(s);
- Suicide attempt;
- Self-inflicted injury;
- Injury requiring emergency treatment;
- Physical injury that occurs as the result of personal, chemical or mechanical restraint;
- Unauthorized absence from a licensed behavioral health facility, group home or HCTC of children or recipients under court order for treatment;
- Suspected or alleged criminal activity;
- Discovery that a client, staff member, or employee has a communicable disease as listed in R9-6-202 (A) or (B);
- Incidents or allegations of violations of the rights as described in A.A.C. State Licensing Regulations and/or in A.A.C. R9-21, Article 2;
- Discrimination;
- Exploitation;
- Coercion;
- Manipulation;
- Retaliation for submitting complaint to authorities;
- Threat of discharge/transfer for punishment
- Treatment involving denial of food;
- Treatment involving denial of opportunity to sleep;
- Treatment involving denial of opportunity to use toilet;
- Use of restraint or seclusion as retaliation;
- Health Care-Acquired and Provider Preventable Conditions as described in the AHCCCS AMPM Chapter 900;
- Adverse Drug Event or Reactions/“Red Flags” for members with suspected drug overdoses.

Health Choice Arizona will submit Incidents, Accidents and Death (IAD) reports regarding “sentinel events” to AHCCCS weekly through the QMS web portal. A sentinel event is defined as any of the following:

- Suicide or significant suicide attempt by a member;
- Homicide committed by a member;
- Unauthorized absence of a member from a locked behavioral health inpatient facility;
- Sexual assault while a member is a resident of a locked behavioral health inpatient facility;
- Death of a member.
Upon receipt of an IAD Report from providers, Health Choice Arizona must:

- Take action necessary to ensure the safety of the persons involved in the incident.
- Ensure that the information required on the IAD form is fully and accurately completed as required.
- IADs are reviewed to determine if they are submitted within required timelines and are properly completed. For those forms not properly completed, the IAD will be rejected in the portal with a request to resubmit with required information. Failure to submit IADs timely may result in a financial sanction for late submission of a contract deliverable.
- Submit the IAD Reports upon completion of the screening via the QMS web portal but no later than on a weekly basis.

18.19 WORKFORCE DEVELOPMENT

This chapter applies to AHCCCS Complete Care (ACC) and RBHA contracted Providers. The purpose of this chapter is to describe Provider requirements, expectations and recommendations in developing the workforce. Initiatives in this chapter align with AHCCCS Workforce Development Policy ACOM 407.

The Health Choice Arizona’s Workforce Development Department implements and monitors workforce development initiatives, which includes activities and requirements listed in this chapter. Workforce Development provides coaching and training in order to better develop a competent, qualified, knowledgeable, culturally proficient and trauma-informed workforce. Health Choice Arizona’s comprehensive workforce development coaching and training content is adult-learning focused, evidenced based, trauma-informed, culturally competent and aligned with company guidelines, federal and state requirements and the requirements of the following agencies, entities and legal agreements:

- Centers for Medicare and Medicaid Services (CMS)
- Culturally and Linguistic Appropriate Services (CLAS) Standards
- Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS)
- Arizona Health Care Cost Containment System (AHCCCS)
- Arizona Association of Health Plans Workforce Development Alliance (AzAHP Alliance)
- Arnold v. ADHS and JK v. Humble settlement agreements
- Maricopa County Superior Court
- Arizona System Principles for Children
- Nine Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems

The Arizona Workforce Development Alliance

The Arizona Workforce Development Alliance (AWFDA) was formed in response to the new AHCCCS requirements for ACC/RBHA contracted Health Plans.
The AWFDA is organized by the Office of Healthcare Workforce Development Department at AHCCCS and includes members from Relias Learning, Arizona Association of Health Plans (AzAHP), Arizona Complete Health, Banner University Family Care, Care 1st, Magellan Complete Care, Mercy Care, Health Choice Arizona and United Healthcare Community Plan. The AWFDA (Arizona Workforce Development Alliance) has established initiatives to support and drive the future of Workforce Development through AHCCCS’ ACOM & AMPM Policies.

**Providers Workforce Development Plan**

All RBHA/ACC Contracted Providers will be responsible for creating and submitting a Workforce Development Plan. The criteria and due date for this annual deliverable will be determined by the Arizona Workforce Development Alliance and communicated to Providers by the Arizona Workforce Development Alliance. Workforce Development is an approach to improving healthcare outcomes of our members by enhancing the training, skills and competency of our workforce. It is a collaborative effort between all departments to set goals and initiatives to improve the workforce to provide better member services and care. Exceptions to the above include: Individual practitioners, hospitals, and transportation, housing, and prevention agencies.

**Relias Learning**

All AHCCCS Complete Care (ACC)/ Regional Behavioral Health Authority (RBHA) Behavioral Health (BH) providers must have access to Relias Learning. This is the Learning Management System used by the ACC/RBHA Health Plans and their contracted Providers through the Arizona Association of Health Plans (AzAHP). Agencies must designate a Relias Administrator to manage and maintain their Relias Learning portal. This includes activating and deactivating users as well as enrollment and disenrollment of courses/events. All contracted Health Choice Arizona Providers must be set up to use Relias Learning to report all training activities for their staff to include but not limited to:

- Attendance, course completion and training content for:
  - Technology based/Online Courses
  - Web Conferences
  - Live Training, Seminars, Conferences and/or Events

**Requesting Relias Access for Newly Contracted Providers:**

1. Health Choice Arizona’s Provider Relations Representative makes a request, for Relias access, through the Workforce Development Coordinator (Amanda.steavenson@healthchoiceaz.com).

The request should include the following information:

   a. Provider Agency Name
   b. Contract Start Date
   c. Address
   d. CEO and/or Key WFD Contact
      - Name
      - Phone Number
      - Email Address
   e. Contract Type (ACC/RBHA)
f. Provider Type (GMH/SU, Children’s, SMI, Integrated Health Home, etc.)
g. Number of Users (# employees at the agency who need Relias access)
h. List of Health Plans provider is contracted with (if known)

2. The Health Choice Arizona Workforce Development Coordinator notifies the AzAHP Administrator that a contracted Provider is requesting a Relias Sub-Portal and provides the information outlined above in items “a-h.”
3. The AzAHP Administrator submits request to Relias Client Success Manager.
4. The Relias Client Success Manager will notify the Relias Account Owner.
5. The Relias Account Owner sets up an account in Salesforce under AzAHP Enterprise and issues a one-time implementation fee agreement of $1,500 directly to the provider*.
   a. 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. b. 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.
   c. Provider agencies that expand to 20 or more users will be required to purchase full-site privileges to Relias Learning immediately upon expansion.
6. Provider signs agreement and remits payment to Relias when invoiced.
7. Following Relias Legal and Finance Approval - Relias Professional Services sets up a subportal in the AzAHP Enterprise and provides administrator training to the appropriate Provider contact.

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

Relias Required Training
Health Choice Arizona ACC/RBHA providers must ensure that all staff who work in programs that support, oversee, or are paid by the Health Plan contract have access to Relias and are enrolled in the AzAHP Training Plans listed below. (This includes, but is not limited to, full time/part time, direct care, clinical, administrative and support staff).

Exceptions:
• Any staff member(s) hired for temporary services working less than 90 days is required to complete applicable training at the discretion of the provider.
• Any staff member(s) hired as an intern or Independent Contractor (IC) is required to complete applicable training at the discretion of the provider.

AzAHP Core Training Plan (First 90 Days)
- Welcome to Relias
- AzAHP – Limited English Proficiency (LEP)
- AzAHP – AHCCCS 101
- AzAHP – Quality of Care Concern
- AzAHP – Client Rights, Grievances and Appeals
AzAHP – Culturally and Linguistically Appropriate Services (CLAS) Standards
• Corporate Compliance: The Basics
• Cultural Competence
• Customer Service
• Personalized Learning: Understanding the HIPAA Regulations
• *AHCCCS – Health Plan Fraud
• *AHCCCS – NEO – Employment Rehabilitation
• Ethical Decision Making: The Basics

AzAHP – Core Training (Annual)
• Abuse and Neglect: What to Look for and How to Respond
• AzAHP – Quality of Care Concern
• AzAHP – Cultural and Linguistically Appropriate Services (CLAS) Standards
• Corporate Compliance: The Basics
• Cultural Competence
• Personalized Learning: Understanding the HIPAA Regulations
• Ethical Decision Making: The Basics
• *AHCCCS – Health Plan Fraud

Relias Learning Assistance
For technical assistance with the functionality of your Relias Learning portal, please contact Relias directly at: 1-800-381-2312 or online via Relias Connect.

Health Choice Arizona Workforce Development and Quality Management Collaboration
The Health Choice Arizona Quality Management Department works in conjunction with the Workforce Development Department to provide initial and ongoing development for contracted Provider agencies. Providers’ training and workforce development goals, activities, and training/coaching requirements will be evaluated through, but not limited to:
• Provider Workforce Development Plan (for more information see WFD Plan section below)
• Relias Learning Management System
• Quality of Care concerns
• Requests from System of Care Leadership
• Provider requests

Required Training: AHCCCS Complete Care and Regional Behavioral Health Authority (Program Specific)
Additional course requirements and competencies are listed below as relevant to each staff member’s job duties, scope of work and responsibilities. Providers may decide to assign additional courses or competencies based upon individual needs and initiatives. The Provider is responsible for tracking and documenting all attended trainings.
Children’s System of Care

- **Birth to 5**
  - Staff members completing Birth to 5 assessments are required to have training in this area prior to using the assessment tool with members within 90-days of the staff member’s hire date. On-going competency assessments are also required to evaluate a staff member’s knowledge and skills.

- **Child and Adolescent Service Intensity Instrument (CASII)**
  - Staff members completing CASII assessments are required to have training in this area prior to using the assessment tool with members within 90-days of the staff member’s hire date and annually thereafter to maintain fidelity. On-going competency assessments are also required to evaluate a staff member’s knowledge and skills.

- **Child and Family Team (CFT)**
  - Staff members who facilitate Child and Family Team meetings are required to complete this course within 90-days of the staff member’s hire date.
  - Provider supervisors will follow AHCCCS requirements for using the Supervision Tool within 90 days of hire, at 6 months and annually and enter documentation into Relias. Please refer to the AHCCCS Child and Family Team Practice Tool. Please note the updates to Section F “Training and Supervision Expectations”.
  - Supervisors and their staff will adhere to the Health Choice Arizona Child and Family Team Facilitator Relias Training Plans (Initial, 6 Month Follow Up, and Annual Follow Up).

- **Unique Needs of Children Involved with DCS**
  - Providers servicing children and families involved with Department of Child Safety (DCS) are required to complete this course within 90-days of the staff member’s hire date.

Community Service Agencies
Community Service Agencies (CSAs) must submit documentation as part of the initial and annual CSA application indicating that all direct service staff and volunteers have completed training specific to CSAs prior to providing services to members. For a complete description of all required training specific to CSAs, see the AMPM Policy 965 Community Service Agencies.

Division of Licensing Services (DLS) Required Training
It is the provider’s responsibility to be aware of all training requirements that must be completed and documented in accordance with all additional licensing or accrediting licensing agencies, i.e., Bureau of Medical Facilities Licensing (BMFL) / Bureau of Residential Facilities Licensing (BRFL), Joint Commission, grant requirements and other entities, as applicable.

General Mental Health/Substance Use (GMH/SU)

- **American Society of Addiction Medicine (ASAM)**
  - Staff members completing assessments of substance use disorders and subsequent levels of care, are required to complete ASAM Criteria training.
This course is required prior to a staff member using the assessment tool with members within 90-days and annually thereafter to maintain fidelity. The assessment used should be consistent with the most recent edition American Society of Addiction Medicine (ASAM) Criteria.

- **Substance Abuse Block Grant (SABG)**
  - Health Choice Arizona’s expectation is that all contracted general mental health/substance use providers are knowledgeable about the Substance Abuse Block Grant (SABG). This includes requiring all employees who are member-facing to take the online RELIAS training (within 90-days of employment and annually thereafter).

- **Mental Health Block Grant (MHBG)**
  - The MHBG provides funds from SAMHSA to provide non-Title XIX mental health services to children with serious emotional disturbances (SED), adults with serious mental illness (SMI), and incarcerated children with Seriously Emotionally Disturbed (SED) diagnosis. Health Choice Arizona’s expectation is that all contracted general mental health/substance use providers are knowledgeable about the Mental Health Block Grant (MHBG). This includes requiring all employees who are member-facing to take the online RELIAS training (within 90-days of employment and annually thereafter).

**Residential Care (24hr care facilities)**

- Crisis Prevention/de-escalation training is required for all member facing staff prior to serving members and annually thereafter.
- For facilities where restraints are approved, a nationally approved restraint training is required initially and annually for all member facing staff. This curriculum should include non-verbal, verbal and physical de-escalation techniques.

**Special Assistance**

All Providers working with an adult diagnosed with SMI must have Special Assistance training. Staff members completing Special Assistance assessments for SMI members are required to complete this course prior to completing an assessment with members within 90-days of hire and annually thereafter to maintain fidelity. The initial and annual course must be a curriculum approved by Health Choice Arizona.

**Training Expectations for Clinical and Recovery Practice Protocols**

Under the direction of the AHCCCS Chief Medical Officer, the Department publishes national practice guidelines and clinical guidance documents to assist Health Choice Arizona Providers. These can be found on the AHCCCS website under the AHCCCS Behavioral Health System Practice Tools web page.

**Additional Expectations**

Specific situations will necessitate the need for additional trainings or coaching. For example, quality improvement initiatives that may require focused training efforts; or new regulations that impact the public healthcare system (e.g., the Balanced Budget Act (BBA),
Medicaid Modernization Act (MMA), the Affordable Care Act (ACA) and Deficit Reduction Act (DRA)).

Additional trainings may be required, as determined by the geographic service area identified needs. The data that can be collected includes, but is not limited to:

- Case Reviews
- Complaints
- Utilization Management
- Grievance and Appeal
- System of care data
- Quality of care data
- Court system data

**Master Facilitator**

As of 10/1/2019, all AHCCCS Complete Care (ACC)/ Regional Behavioral Health Authority (RBHA) Behavioral Health (BH) providers, contracted with Health Choice Arizona, who have 50 or more staff members, must have at least 1 individual at their agency complete the Health Choice Arizona Master Facilitator Workshop.

- Exemptions may be granted for staff who hold a degree in Education, Instructional Design or Facilitation and/or have taught courses at a collegiate level (years of experience would not be a qualifier).
- If you believe you/your employee(s) might qualify, please email: Amanda.steavenson@healthchoiceaz.com.

About the Course:
The Master Facilitator Workshop takes place over two (2) consecutive days. Prior to the workshop, participants will be given prerequisites in order to successfully complete the course. Additionally, participants will learn skills to facilitate adult learning, and to develop and deliver course content. This course is beneficial for all skill levels as it will teach participants new skills or challenge them to refine skills that they already possess. The objectives for the training are demonstrated through development and delivery of course content in a 10-minute presentation that is implemented once during the workshop.

Workshop Learning Objectives:

- Apply adult learning model throughout the design and instruction process
- Design performance-based learning objectives
- Develop instructional components that enable knowledge transfer
- Implement facilitation strategies to increase participant engagement and manage diverse classroom behaviors

Benefits to completing this course: Anyone who completes this 2-day workshop will be qualified to attend and complete any and all HCA *Train the Trainer* courses and provide in-house training at their agency.
Health Choice Arizona/AHCCCS Ownership of Any Intellectual Property

This chapter will serve as disclosure of ownership of any intellectual property created or disclosed during the course of the service contract such as educational materials created for classroom training and/or learning programs.

Exceptions:
- Cases in which the production of such materials is part of sponsored programs;
- Cases in which the production of such materials is part of a Health Choice Arizona paid subscription to online learning content;
- Cases in which substantial University resources were used in creating educational materials; and
- Cases which are specifically commissioned by contracted vendors or done as part of an explicitly designated assignment other than normal contactor educational pursuits.

Supplemental Provider Training and Education

Providers have access to technical assistance and additional training to improve skill development as well as continued education opportunities. The provider may select from additional courses (theoretical and skills based) through a variety of ways, including e-learning, webinars, on-line tools and instructor lead training. All courses developed by Health Choice Arizona are delivered using a trauma informed approach in a culturally competent manner.

Workforce Development Consultation/Coaching

Health Choice Arizona has two employees in their Workforce Development Department. Both employees serve as WFD Consultants that implement and oversee compliance and competency initiatives. Your agency will be assisted with:
- Technical Assistance
- Course Development
- Competency Consultation
- Collaboration Initiatives
- Assistance with Workforce Development Plan and Implementation
- Professional Development Tracks

On-Site Training/Coaching Requests

All requests will be reviewed and responded to within 5-7 business days. Submit On-site request to Amanda.steavenson@healthchoiceaz.com, the form can be emailed to you upon request. On-site training can only be provided if a minimum of 8 individuals are registered for the training. Requests for less than 8 individuals will not be scheduled.

The procedure for cancelling an on-site training request hosted by Health Choice Arizona is as follows:
- Sick and Inclement Weather Policy – we reserve the right to cancel the training due to contagious illness or inclement weather with less than 24 hour notice.
• Please allow Trainer(s) in the training room 30 minutes before the training starts and 30 minutes after the training ends for proper set up and take down.
• *Please refer to form for additional guidelines

*In the event the Provider does not comply with all of the Health Choice Arizona’s training request guidelines, the opportunity to gain on-site training in the future could be limited.

18.20 PEER/RECOVERY SUPPORT TRAINING, CREDENTIALING AND SUPERVISION REQUIREMENTS

PEER SUPPORT SPECIALIST/RECOVERY SUPPORT SPECIALIST QUALIFICATIONS

Individuals seeking to be certified and employed as Peer Support Specialists/Recovery Support Specialists must:

• Be self-identified as a “peer”; and
• Meet the requirements to function as a behavioral health paraprofessional, behavioral health technician, or behavioral health professional.

Individuals meeting the above criteria may be certified as a Peer Support Specialist/Recovery Support Specialist by completing training and passing a competency test through an AHCCCS/OIFA approved Peer Support Employment Training Program. AHCCCS/OIFA will oversee the approval of all credentialing materials including curriculum and testing tools. Individuals are certified by the agency in which he/she completed the Peer Support Employment Training Program; however, credentialing through an AHCCCS/OIFA approved Peer Support Employment Training Program is applicable statewide, regardless of which program a person has gone through for credentialing. Some agencies may wish to employ individuals prior to the completion of credentialing through a Peer Support Employment Training Program. However, required trainings must be completed prior to delivering behavioral health services (see Subsection E, PEER SUPPORT EMPLOYMENT TRAINING CURRICULUM STANDARDS). An individual must be credentialed as a Peer Support Specialist/Recovery Support Specialist under the supervision of a qualified individual prior to billing Peer Support Services (see Subsection E, PEER SUPPORT EMPLOYMENT TRAINING CURRICULUM STANDARDS).

PEER SUPPORT EMPLOYMENT TRAINING PROGRAM APPROVAL PROCESS

A Peer Support Employment Training Program must submit their program curriculum, competency exam, and exam scoring methodology (including an explanation of accommodations or alternative formats of program materials available to individuals who have special needs) to AHCCCS/OIFA, and AHCCCS/OIFA will issue feedback or approval of the curriculum, competency exam and exam scoring methodology in accordance with PEER SUPPORT EMPLOYMENT TRAINING CURRICULUM STANDARDS.
Approval of curriculum is binding for no longer than three years. Three years after initial AHCCCS approval and thereafter, the program must resubmit their curriculum for review and re-approval to AHCCCS. If a program makes substantial changes (meaning change to content, classroom time, etc.) to their curriculum or if there is an addition to required elements (see Subsection E of **PEER SUPPORT EMPLOYMENT TRAINING CURRICULUM STANDARDS**) during this three year period, the program must submit the updated content to AHCCCS/OIFA for review and approval. AHCCCS/OFIA will base approval of the curriculum, competency exam and exam scoring methodology only on the elements included in this chapter. If a Peer Support Employment Training Program requires regional or culturally specific training exclusive to a GSA or tribal community, the specific training cannot prevent employment or transfer of Peer Support Specialist/Recovery Support Specialist approval based on additional elements or standards.

**COMPETENCY EXAM**

Individuals seeking credentialing and employment as a Peer/Recovery Support Specialist must complete and pass a competency exam with a minimum score of 80% upon completion of required training. Each Peer Support Employment Training Program has the authority to develop a unique competency exam. However, all exams must include at least one question related to each of the curriculum core elements listed in Subsection E of **PEER SUPPORT EMPLOYMENT TRAINING CURRICULUM STANDARDS**. If an individual does not pass the competency exam, the Peer Support Employment Training Program may require that the peer repeat or complete additional training prior to taking the competency exam again. For individuals certified in another state, credentials must be sent to AHCCCS/OIFA. The individual must demonstrate their state’s credentialing standards meet those of AHCCCS prior of recognition of their credential.

**PEER SUPPORT EMPLOYMENT TRAINING CURRICULUM STANDARDS**

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

1. A Peer Support Employment Training Program curriculum must include the following core elements:
   a. Concepts of Hope and Recovery
      i. Instilling the belief that recovery is real and possible,
      ii. The history of the recovery movement and the varied ways that behavioral health issues have been viewed and treated over time and in the present,
      iii. Knowing and sharing one’s story of a recovery journey and how one’s story can assist others in many ways,
      iv. Mind-Body-Spirit connection and holistic approach to recovery, and
      v. Overview of the Individual Service Plan (ISP) and its purpose.

   b. Advocacy and Systems Perspective
      i. Overview of state and national behavioral health system infrastructure and the history of Arizona’s behavioral health system,
ii. Stigma and effective stigma reduction strategies: countering self-stigma; role modeling recovery and valuing the lived experience,
iii. Introduction to organizational change - how to utilize person-first language and energize one’s agency around recovery, hope, and the value of peer support,
iv. Creating a sense of community; creating a safe and supportive environment.
v. Forms of advocacy and effective strategies – consumer rights and navigating the behavioral health system, and
vi. Introduction to the Americans with Disabilities Act (ADA).

c. Psychiatric Rehabilitation Skills and Service Delivery
i. Strengths based approach; identifying one’s own strengths and helping others identify theirs; building resilience,
ii. Distinguishing between sympathy and empathy, emotional intelligence,
iii. Understanding learned helplessness; what it is, how it is taught and how to assist others in overcoming its effects,
iv. Introduction to motivational interviewing; communication skills and active listening,
v. Healing relationships – building trust and creating mutual responsibility,
vi. Combating negative self-talk: noticing patterns and replacing negative statements about one’s self; using mindfulness to gain self-confidence and relieve stress,
 vii. Group facilitation skills, and
viii. Introduction to Culturally & Linguistically Appropriate Services (CLAS) Standards. The role of culture in recovery.

d. Professional Responsibilities of the Peer Support Employee and Self Care in the Workplace. Qualified individuals must receive training on the following elements prior to delivering any covered behavioral health services:
i. Professional boundaries and ethics - the varied roles of the helping professional, collaborative supervision and the unique features of the Peer/Recovery Support Specialist,
ii. Confidentiality laws and information sharing – understanding the Health Insurance Portability and Accountability Act (HIPAA),
iii. Responsibilities of a mandatory reporter; what to report and when,
iv. Understanding common signs and experiences of mental illness, substance abuse, addiction and trauma, orientation to commonly used medications and potential side effects,
 v. Guidance on proper service documentation, billing and using recovery language throughout documentation,
vi. Self-care skills and coping practices for helping professionals, the importance of ongoing supports for overcoming stress in the workplace, resources to promote personal resilience; and, understanding burnout and using self-awareness to prevent compassion fatigue, vicarious trauma and secondary traumatic stress.
**Professional Responsibilities of the Peer Support Employee and Self Care in the Workplace**

Qualified peers must receive training on the following elements prior to delivering any covered healthcare services:

- Professional boundaries & ethics—the varied roles of the helping professional; Collaborative supervision and the unique features of the Peer/Recovery Support Specialist;
- Confidentiality laws and information sharing - understanding the Health Insurance Portability and Accountability Act (HIPAA);
- Mandatory reporting requirements; what to report and when;
- Understanding common symptoms of mental illness and substance use and orientation to commonly used medications and potential side effects;
- Service documentation/billing and using recovery language throughout documentation; and
- Self-care and the use of ongoing supports; dealing with stress in the workplace; resources to promote personal resilience; and, understanding burnout and using self-awareness to prevent compassion fatigue, vicarious trauma and secondary traumatic stress.

Some curriculum elements include concepts included in required training, as described in **TRAINING REQUIREMENTS FOR RBHAS AND BEHAVIORAL HEALTH PROVIDERS**. Peer support employment training programs must not duplicate training required of peers for employment with a licensed agency or Community Service Agency (CSA). Training elements in this chapter must be specific to the peer role in the public healthcare system and instructional for peer interactions.

For a list of references to assist in developing a curriculum that addresses the topics listed in the Curriculum Standards, see AHCCCS AMPM 1060 Policy, **TRAINING REQUIREMENTS FOR RBHAS AND BEHAVIORAL HEALTH PROVIDERS**.

Health Choice Arizona must develop and make available policies and procedures as well as additional resources for development of curriculum, including Health Choice Arizona staff contacts for questions and assistance. For questions or additional information, please contact the Health Choice Arizona Peer Support Administrator at (928) 774-7128.

While peer support employment training programs must not duplicate training required of licensed agencies or CSAs, it is possible that 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 CERTIFIED PEER SUPPORT SPECIALIST/RECOVERY SUPPORT SPECIALIST**

Supervision is intended to provide support to Peer Support Specialists/Recovery Support Specialists in meeting treatment needs of behavioral health recipients receiving care from Peer Support Specialists/Recovery Support Specialists. Supervision provides an opportunity for growth within the agency and encouragement of recovery efforts.
Agencies employing Peer Support Specialists/Recovery Support Specialists must have a qualified individual (behavioral health professional (BHP) or behavioral health technician (BUT)) level individual designated to provide Peer Support Specialist/Recovery Support Specialist supervision. Supervision must be documented and inclusive of both clinical and administrative supervision.

The individual providing supervision must also complete training and pass a competency test through an approved Peer Support Employment Training Program.

**PROCESS FOR SUBMITTING EVIDENCE OF CREDENTIALING**
Agencies employing Peer Support Specialists/Recovery Support Specialists who are providing peer support services are responsible for keeping records of required qualifications and credentialing. Health Choice Arizona ensures that Peer Support Specialists/Recovery Support Specialists meet qualifications and have credentialing, as described in this chapter.

**18.21 PARENT AND FAMILY SUPPORT TRAINING, CREDENTIALING, AND SUPERVISION REQUIREMENTS**

**FAMILY SUPPORT PROVIDER AND TRAINER QUALIFICATIONS**
Individuals seeking to be certified as Parent/Family Support Providers and Trainers in the children’s system must:

- Be a parent or primary caregiver with lived experience who has raised or is currently raising a child with emotional, behavioral, mental health or substance abuse needs; and
- Meet the requirements to function as a behavioral health professional, behavioral health technician, or behavioral health paraprofessional.

Individuals seeking credentialing and employment as a Parent/Family Support Provider or Trainer in the adult system must:

- Have lived experience as a primary natural support for an adult with emotional, behavioral, mental health or substance abuse needs; and
- Meet the requirements to function as a behavioral health professional, behavioral health technician, or behavioral health paraprofessional.

Individuals meeting the above criteria may be certified as a Parent/Family Support Provider by completing training and passing a competency test through an AHCCCS approved Parent/Family Support Provider Training Program. Individuals are certified by the agency in which he/she completed the Parent/Family Support Provider Training Program; however, credentialing through an AHCCCS approved Parent/Family Support Provider Training Program is applicable statewide, regardless of which program a person has gone through for credentialing. Some agencies may wish to employ individuals prior to the completion of certification through a Parent/Family Support Provider Training Program.
However, required trainings must be completed prior to delivering behavioral health services (see **PEER/FAMILY, CSA TRAINING, CREDENTIALING, AND OVERSIGHT REQUIREMENTS**).

**PARENT/FAMILY SUPPORT PROVIDER TRAINING PROGRAM APPROVAL PROCESS**

A Parent/Family Support Training Program must submit their program curriculum, competency exam, and exam scoring methodology (including an explanation of accommodations or alternative formats of program materials available to individuals who have special needs) to AHCCCS, and AHCCCS will issue feedback or approval of the curriculum, competency exam and exam scoring methodology in accordance with **PEER/FAMILY, CSA TRAINING, CREDENTIALING, AND OVERSIGHT REQUIREMENTS**.

Approval of curriculum is binding for no longer than three years. Three years after initial approval and thereafter, the program must resubmit their curriculum for review and re-approval. If a program makes substantial changes (meaning change to content, classroom time, etc.) to their curriculum or if there is an addition to required elements (see **PARENT/FAMILY SUPPORT PROVIDER TRAINING CURRICULUM STANDARDS**) during this three year period, the program must submit the updated content to ADHS/DBHS for review and approval no less than 60 days before the changed or updated curriculum is to be utilized. ADHS/DBHS will base approval of the curriculum, competency exam and exam scoring methodology only on the elements included in this chapter. If a Parent/Family Support Provider Training Program requires regional or culturally specific training exclusive to a GSA or tribal community, the specific training cannot prevent employment or transfer of Parent/Family Support Provider credentialing.

**COMPETENCY EXAM**

Individuals seeking credentialing and employment as a Parent/Family Support Provider must complete and pass a competency exam with a minimum score of 80% upon completion of required training. Each Parent/Family Support Training Program has the authority to develop a unique competency exam. However, all exams must include at least one question related to each of the curriculum core elements listed in **PARENT/FAMILY SUPPORT PROVIDER TRAINING CURRICULUM STANDARDS**. For individuals certified in another state, credentialing may be obtained after passing the competency exam. If an individual does not pass the competency exam, the Parent/Family Support Provider Training Program may require that the individual repeat or complete additional training prior to taking the competency exam again.

**PEER SUPPORT EMPLOYMENT TRAINING CURRICULUM STANDARDS**

A Parent/Family Support Provider Employment Training Program curriculum must include, at a minimum, the following core elements for persons working with both children and adults:

*Communication Techniques:*
  - Person first, strengths-based language; using respectful communication; demonstrating care and commitment;
  - Active listening skills: The ability to demonstrate empathy, provide empathetic responses and differentiate between sympathy and empathy; listening non-judgmentally;
• Using self-disclosure effectively; sharing one’s story when appropriate;

System Knowledge:
• Overview and history of the Arizona Behavioral Health (BH) System: Jason K. Arizona Vision and 12 Principles and the Child and Family Team (CFT) process; Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, Adult Recovery Team (ART), and Arnold v. Sarn; Introduction to the Americans with Disabilities Act (ADA); funding sources for behavioral health systems:
• Overview and history of the family and peer movements; the role of advocacy in systems transformation.
• Individual Service Planning (ISP); tailored to meet the individual needs;
• Rights of the caregiver/enrolled member; complaints, grievances and the appeal processes; life planning guardianship, powers of attorney, special needs trusts, mental health advanced directives;
• Transition Aged Youth: Role changes when bridging the Adult System of Care (ASOC) and Children’s System of Care (CSOC) at transition for an enrolled member, family and team;
• Integrated health care services/integrated care;
• Trauma Informed Care
• Introduction to adult and child serving systems: Department of Child Safety (DCS); Division of Developmental Disabilities (DDD), Juvenile Probation and the Juvenile Justice System; Justice System, Court Ordered Treatment (COT), Mental Health Court, Corrections, Probation, Parole; Adult Protective Services; Social Security;
• Overview of confidentiality laws and information sharing; Health Insurance Portability and Accountability Act (HIPAA); mandated reporting requirements;
• Professional responsibilities regarding disclosure and sharing of information and records unique to adult family support;
• Codes of Ethics;
• Overview of Individualized Education Programs (IEP); Section 504;
• Overview of documentation and billing requirements.

Building Collaborative Partnerships and Relationships:
• Engagement; Identifies and utilizes strengths;
• Utilize and model conflict resolution skills, interest-based negotiation skills, problem solving skills, and shared decision making;
• Cultural diversity; cultural awareness; understanding individual and family culture; social culture; biases; perceptions; system’s cultures;
• The ability to identify, build and connect individuals and families, including families of choice to natural, community and informal supports;
• Family finding techniques;
• Family-Driven/youth-guided care.
Crisis Prevention, Intervention and Safety Planning:

- Positive behavioral reinforcement, stabilization and de-escalation techniques;
- Overview of suicide prevention;
- Overview of crisis planning;
- Overview of 24-hour safety planning

Goal Setting and Empowerment:

- Coaching family members and other supports to identify their needs, develop goals and promote self-reliance;
- Identify and understand stages of change;
- Identify and use natural supports;
- Ability to identify unmet needs when progress is not being made.
- Understanding developmental milestones for infants, children, adolescents and adults;
- Understand how to assist individual or family member to access information related to diagnoses or treatments including the use of medications;
- Attributes of meaningful involvement: Access, voice and ownership.

Wellness:

- The Substance Abuse and Mental Health Services Administration (SAMHSA) Eight (8) Dimensions of Wellness:
- Understanding the stages of grief and loss; and
- Understanding self-care and stress management;
- Addressing stigma;
- Understanding compassion fatigue, burnout, and trauma;
- Resiliency and recovery;
- Planning and managing for personal safety;
- Healthy personal and professional boundaries.

Some curriculum elements include concepts included in required training, as described in TRAINING REQUIREMENTS FOR RBHAS AND BEHAVIORAL HEALTH PROVIDERS. Parent/Family Support Provider training programs must not duplicate training required of individuals for employment with a licensed agency or Community Service Agency (CSA) [Note: While parent/family support provider training programs must not duplicate training required of licensed agencies or CSAs, it is possible that licensed agencies and/or CSAs may consider training completed as part of the parent/family support provider training program as meeting the agencies' training requirements]. Training elements in this chapter must be specific to the family support role in the public healthcare system and instructional for family support interactions.

For a list of references to assist in developing a curriculum that addresses the topics listed in the Curriculum Standards, see PEER/FAMILY, CSA TRAINING, CREDENTIALING, AND OVERSIGHT REQUIREMENTS.
Health Choice Arizona must develop and make available policies and procedures as well as additional resources for development of curriculum, including Health Choice Arizona staff contacts for questions and assistance. For questions or additional information, please contact the Health Choice Arizona Office of Individuals and Family Affairs (OIFA) Administrator at (928) 774-7128.

SUPERVISION OF CERTIFIED PARENT/FAMILY SUPPORT PROVIDERS

Supervision is intended to provide support to Parent/Family Support Providers in meeting treatment needs of behavioral health recipients receiving care from Parent/Family Support Providers, and provides an opportunity for growth within the agency and encouragement of recovery efforts.

Agencies employing Parent/Family Support Providers must provide supervision by individuals qualified as a behavioral health professional (BHP) or behavioral health technician (BHT). Supervision must be appropriate to the services being delivered and the qualification of the Parent/Family Support Provider as a BHP or BHT, or Behavioral Health Paraprofessional. Supervision must be documented and inclusive of both clinical and administrative supervision. The individual providing supervision must also complete training and pass a competency test through an approved Parent/Family Support Provider Training Program.

PROCESS FOR SUBMITTING EVIDENCE OF CREDENTIALING

Agencies employing Parent/Family Support Providers who are support services are responsible for keeping records of required qualifications and credentialing. Health Choice Arizona ensures that Parent/Family Support Providers meet qualifications and have credentialing, as described in this chapter.

18.22 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 submit an application 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 as a result of a mental disorder.

If the pre-petition screening indicates that the person may be DTS, DTO, PAD, or GD, the screening agency will file an application for a court-ordered evaluation. Based on the immediate safety of the person or others, an emergency admission for evaluation may be necessary. The screening agency, upon receipt of the application shall act as prescribed within 48 hours of the filing of the application excluding weekends and holidays as described in A.R.S. §36-520.

Based on the court-ordered evaluation, the evaluating agency may petition 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, as a result of the evaluation, to be DTS, DTO, PAD, or GD. Court-ordered treatment may include a combination of inpatient and outpatient treatment. Inpatient treatment days are limited contingent on the 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; and
- GD may be ordered up to 365 inpatient days per year.

If the court orders a combination of inpatient and outpatient treatment, a mental health agency may be identified by the court to supervise the 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 Health Choice Arizona 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 Exhibit 320-U-1
- Application for Voluntary Evaluation Exhibit 320-U-7
- Application for Emergency Admission for Evaluation Exhibit 320-U-2
- Petition for Court-Ordered Evaluation Exhibit 320-U-3
- Petition for Court-Ordered Treatment Exhibit 320-U-4
- Psychiatric Evaluation Affidavit Exhibit 320-U-5, 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 that the individual is court ordered to treatment, or programs, as a result of being charged with a crime and appears to be an “alcoholic”. Health Choice Arizona 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 financial responsibility for the provision of medically necessary behavioral health services rendered after completion of a Court Ordered Evaluation.

The Northern Arizona Geographic Service Area is comprised of Apache, Gila, Navajo, Coconino, Yavapai, and Mohave counties. Health Choice Arizona 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. Health Choice Arizona has been informed either by the counties or by their subcontractors that the counties have made the following arrangements for pre-petition screening and court ordered evaluation services:
• Apache County has made arrangements with Little Colorado Behavioral Health Services, Inc. to accept pre-petition screenings and to assist with the court ordered evaluation process
• Navajo County has contracted with ChangePoint Integrated Health, Inc. to provide pre-petition screenings and court-ordered evaluations
• Coconino County has an intergovernmental agreement with AHCCCS for these services. In-turn, AHCCCS contracts with Health Choice Arizona to provide pre-petition screening and court ordered evaluation services. Health Choice Arizona 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 has contracted with Health Choice Arizona 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 that receives an application for court-ordered evaluation (see AMPM Policy 320-U, Exhibit 320-U-1) must immediately refer the applicant for pre-petition screening and petitioning for court-ordered evaluation to the Health Choice Arizona 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 that there is no reasonable cause to believe the allegations of the applicant for the court-ordered evaluation;
Prepare a petition for court-ordered evaluation and file the petition if the pre-petition screening agency determines that 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, Exhibit 320-U-3, documents pertinent information for court-ordered evaluation;

If the pre-petition screening agency determines that there is reasonable cause to believe that 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, Exhibit 320-U-2, and take all reasonable steps to procure hospitalization on an emergency basis;

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

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

When it is determined that there is reasonable cause to believe that the person being screened is in a condition that without immediate hospitalization is likely to harm themselves or others, an emergent application can be filed. The petition must be filed at the appropriate agency as determined by the 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 second hand information.
- The applicant must complete the Application for Involuntary Evaluation Exhibit 320-U-1 as per AMPM Policy 320-U.
- The applicant and all witnesses identified in the application as direct observers of the dangerous behavior, may be called to testify in court if the application results in a petition for COE within 48 hours of receipt of AMPM Policy 320-U, Exhibit 320-U-2 and all corroborating documentation necessary to successfully complete a determination, the admitting physician will determine if enough evidence exists for an emergency admission for evaluation. If there is enough evidence to support the emergency admission for evaluation, the facility is not currently operating at or above its allowable member capacity, and the person does not require medical 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, Exhibit 320-U-2, the Medical Director of the Contractor will be consulted to arrange for a review of the case.
- An AMPM Policy 320-U, Exhibit 320-U-2, may be discussed by telephone with the facility admitting physician, the referring physician and a police officer to facilitate transportation of the person to be evaluated.
- A person proposed for emergency admission for evaluation may be apprehended and transported to the facility under the authority of law enforcement using the written AMPM Policy 320-U, Exhibit 320-U-2.
• A 23 hour emergency admission for evaluation begins at the time the person is detained involuntarily by the admitting physician who determines there is reasonable cause to believe that the person, as a result of a mental disorder, is a DTS or DTO and that during the time necessary to complete prescreening procedures the person is likely, without immediate hospitalization, to suffer harm or cause harm to others.

• During the emergency admission period of up to 23 hours the following will occur:
  a. The person’s ability to consent to voluntary treatment will be assessed.
  b. The person shall be offered and receive treatment to which he/she may consent. Otherwise, the only treatment administered involuntarily will be for the safety of the person or others, i.e. seclusion/restraint or pharmacological restraint in accordance with A.R.S § 36-513.
  c. The psychiatrist will complete the Evaluation within 24 hours of determination that the person no longer requires involuntary evaluation.

COURT-ORDERED EVALUATION

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

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

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

Health Choice Arizona is not responsible 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 of time 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.
• Health Choice Arizona’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 Health Choice Arizona and is not the responsibility of the County of origin.
• The issue of voluntarily participating in treatment is not, in itself, 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 Health Choice Arizona contracted behavioral health provider that 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 that 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 that the person will voluntarily receive an evaluation; and if a behavioral health provider conducts a voluntary evaluation service as described in this section, the comprehensive clinical must include:

- A copy of the application for voluntary evaluation, AMPM Policy 320-U, Exhibit 320-U-7
- A completed informed consent form (see AMPM Policy 320-Q)
- A written statement of the person’s present medical condition.

**COURT-ORDERED TREATMENT FOLLOWING CIVIL PROCEEDINGS UNDER A.R.S. TITLE 36**
Based on the court-ordered evaluation, the evaluating agency may petition for court-ordered treatment. The behavioral health provider must follow these procedures:
- Upon determination that an individual is DTS, DTO, GD, or PAD, and if no alternatives to court-ordered treatment exist, the medical director of the agency that provided the court-ordered evaluation must file a petition for court-ordered treatment (see AMPM Policy 320-U, Exhibit 320-U-4)
- Any behavioral health provider filing a petition for court-ordered treatment must do so in consultation with the person’s clinical team prior to filing the petition;
- The petition must be accompanied by the affidavits of the two physicians who conducted the examinations during the evaluation period and by the affidavit of the applicant for the evaluation (see AMPM Policy 320-U, Exhibit 320-U-5);
- A copy of the petition, in cases of grave disability, must be mailed to the public fiduciary in the county of the patient’s residence, or the county in which the person was found before evaluation, and to any person nominated as guardian or conservator; and
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, Health Choice Arizona will:

- 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; and
- 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).

In order to coordinate a transfer of a person under court-ordered treatment to ALTCS or another RBHA, the behavioral health recipient’s clinical team will coordinate with the Health Choice Arizona 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

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

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

Domestic Violence Offender Treatment

Domestic violence offender treatment may be ordered by a court when an individual is convicted of a misdemeanor domestic violence offense. Although the order may indicate that the domestic violence (DV) offender treatment is the financial responsibility of the offender under A.R.S. § 13-3601.01, Health Choice Arizona 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 Health Choice Arizona 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, Health Choice Arizona liaison(s), and tribal court representatives can be found on the AHCCCS web page titled, Tribal Court Procedures for Involuntary Commitment: Information Center.

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

The process for establishing a tribal court order for treatment under the jurisdiction of the state is a process of recognition, or “domestication” of the tribal court order (see A.R.S. § 12-136). Once this process occurs, the state recognized tribal court order is enforceable off reservation. The state recognition process is not a rehearing of the facts or findings of the tribal court.
Treatment facilities, including the Arizona State Hospital, must provide treatment, as identified by the tribe and recognized by the state. AMPM Policy 320-U, Exhibit 320-U-6, A.R.S. § 12-136 Domestication or Recognition of Tribal Court Order is a flow chart demonstrating the communication between tribal and state entities.

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

This process must run concurrently with the tribal staff’s initiation of the tribal court ordered process in an effort to communicate and ensure clinical coordination with the Health Choice Arizona. This clinical communication and coordination with the Health Choice Arizona 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." Health Choice Arizona 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.

18.23 SPECIAL ASSISTANCE FOR MEMBERS DETERMINED TO HAVE A SERIOUS MENTAL ILLNESS (SMI)

Health Choice Arizona, the Arizona State Hospital (AzSH) and subcontracted providers must identify and report to the Arizona Health Care Cost Containment System (AHCCCS) Office of Human Rights (OHR) members determined to have a Serious Mental Illness (SMI) who meet the criteria for Special Assistance. If the member’s Special Assistance needs appear to be met by an involved family member, friend, designated representative or guardian, Health Choice Arizona or behavioral health providers must still notify OHR.

Health Choice Arizona and subcontracted providers must ensure that the agency/person designated to provide Special Assistance is involved at key stages. AHCCCS Office of Human Rights has prepared a Special Assistance Brochure and Resources (revised 10-26-2017).
GENERAL REQUIREMENTS

Criteria for Identifying Need for Special Assistance
A member who has been determined to have a SMI is in need of Special Assistance if he/she is unable to do any of the following:

- Communicate preferences for services;
- Participate effectively in Service Planning or Inpatient Treatment Discharge Planning (ITDP); or
- Participate effectively in the appeal, grievance, or investigation processes;

AND the member’s limitations are due to any of the following:

- Cognitive ability/intellectual capacity (such as cognitive impairment, borderline intellectual functioning, or diminished intellectual capacity);
- Language barrier (an inability to communicate, other than the need for an interpreter/translator); or
- Medical condition (including, but not limited to traumatic brain injury (TBI), dementia or severe psychiatric symptoms).

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

Similarly, if Health Choice Arizona or its subcontracted provider recommends a member with a SMI for a general guardianship or a guardianship for that member is in the legal process (in accordance with Arizona Administrative Code R9-21-206 and A.R.S. § 14-5305), the member automatically satisfies the criteria for Special Assistance.

The existence of any of the following circumstances for a member should prompt Health Choice Arizona and its subcontracted providers to more closely review the member’s need for Special Assistance:

- Developmental disability involving cognitive ability;
- Residence in a 24-hour setting;
- Limited guardianship;
- Health Choice Arizona or its subcontracted provider is recommending and/or pursuing the establishment of a limited guardianship; or
- Existence of a serious medical condition that affects his/her intellectual and/or cognitive functioning (such as dementia, traumatic brain injury, etcetera).

Person Qualified to Make Special Assistance Determinations
The following persons may deem a member to be in need of Special Assistance:

- A qualified clinician providing treatment to the member;
- A case manager of Health Choice Arizona or subcontracted provider;
- The member’s clinical team;
- Health Choice Arizona;
A program director of a subcontracted provider (including AzSH); The Deputy Director of AHCCCS or designee; or A hearing officer assigned to an appeal involving a member determined to have an SMI.

**Screening for Special Assistance**

Health Choice Arizona's subcontracted providers shall screen whether members determined to have a SMI are in need of Special Assistance on an ongoing basis. Minimally this screening must occur at the following stages:

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

**Documentation**

Health Choice Arizona’s subcontracted providers shall document in the member’s comprehensive clinical record each time a member is screened for Special Assistance, indicating what factors were considered and the conclusion reached. If it is determined that the member is in need of Special Assistance, they must notify OHR by completing the [Notification of Members in Need of Special Assistance](#) through the AHCCCS Quality Management OHR Portal in accordance with the procedures outlined below.

Before submitting the Notification Health Choice Arizona’s subcontracted providers shall check if the member is already identified as in need of Special Assistance. Each subcontracted provider is required to keep a record of their members on Special Assistance. A notation of Special Assistance designation and a completed Notification should already exist in the member’s comprehensive clinical record. However, if it is unclear, subcontracted providers must review the Health Choice Arizona data or contact Health Choice Arizona to inquire about the member’s current status. Health Choice Arizona shall maintain a database on members in need of Special Assistance and share this data with subcontracted providers on a regular basis, at a minimum quarterly.

**NOTIFICATION TO OFFICE OF HUMAN RIGHTS**

If the member is in need of or not correctly identified as needing Special Assistance, Health Choice Arizona’s subcontracted providers must notify OHR using [Notification of Members in Need of Special Assistance Part A](#) submitted through the AHCCCS Quality Management OHR Portal within five working days of identifying a member in need of Special Assistance.
If the member’s Special Assistance needs require immediate support, Part A of the original Notification shall be submitted immediately with a notation indicating the urgency. T/RBHAs and subcontracted providers shall document on the original Notification whether that member was informed of the Notification and explained the benefits of having another agency/person involved who can provide them Special Assistance.

If the member is under a guardianship or one is in process, the documentation of such shall also be submitted through the AHCCCS Quality Management OHR Portal. However, if the documentation is not available at the time of submission of the Notification, the Notification shall be submitted within the required timeframes, followed by submittal of the guardianship documentation within the allotted five working days. If the subcontracted providers encounter delays in submitting the guardianship documentation to OHR, they shall document reasons for the delay.

The OHR administration (Bureau Chief or Lead Advocate) reviews the Notification to confirm that a complete description of the necessary criteria is included. In the event necessary information is not provided, OHR shall contact the subcontracted staff member submitting the Notification to obtain clarification. OHR shall respond to the Health Choice Arizona subcontracted provider by completing Notification of Members in Need of Special Assistance Part B within the portal within five working days of receipt of Notification and any necessary clarifying information from Health Choice Arizona. If the need for Special Assistance is urgent, OHR will respond as soon as possible, but generally within one working day of receipt of the notification form.

The notification process is complete only when OHR completes the Notification Part B. The Health Choice Arizona subcontracted providers should follow up with OHR if no contact is made or Part B of the Notification is not received within five working days.

OHR designates which agency/person will provide Special Assistance when processing the Notification. When the agency/person designated to provide Special Assistance changes, OHR needs to process an “updated Part B” to document the change. This can be done via e-mail to OHRts@azahcccs.gov requesting an “updated Part B”. In the event the agency/person currently designated as providing Special Assistance is no longer actively involved, Health Choice Arizona or subcontracted provider must notify OHR. If an OHR advocate is also assigned, notification to the advocate is sufficient.

MEMBERS NO LONGER IN NEED OF SPECIAL ASSISTANCE
The Health Choice Arizona subcontracted provider must notify the OHR within ten business days of an event or a determination that a member is no longer in need of Special Assistance using Notification of Members in Need of Special Assistance Part C (with Parts A & B completed when first identified), submitted to the AHCCCS Quality Management OHR Portal, noting:

- The original reason member met criteria;
- The reasons why Special Assistance is no longer required;
- The effective date;
• That the member, and if applicable their OHR advocate, was informed that due to a change in circumstances he/she no longer meets criteria for Special Assistance, and understands implications of the change
• The name, title, phone number and e-mail address of the subcontracted staff person completing the Notification as well as the agency name, and clinical director’s name and email address; and
• The date the form is completed.

The following are instances that should prompt Health Choice Arizona subcontracted providers to submit a Part C of the Notification:
• The original basis for the member meeting Special Assistance criteria is no longer applicable and the member does not otherwise meet criteria. The subcontracted provider shall first discuss the determination with the agency/person designated to provide Special Assistance to obtain any relevant input; this includes when a member is determined to no longer be a member with a SMI (proper notice and appeal rights must be provided and the time period to appeal must have expired);
• The member passes away;
• The member moves out of state and no longer receives services in Arizona;
• Member elects not to receive services from Health Choice Arizona, and is not transferred to another contracted provider, T/RBHA, and ALTCS; or
• Submission of Part C of the Notification is not needed when a member transfers to another T/RBHA or ALTCS, as the Special Assistance designation follows the member.)

The Health Choice Arizona subcontracted providers must first perform all required re-engagement efforts, which includes contacting the person providing Special Assistance, per the Health Choice Arizona Provider Manual, Chapter 18.12 Outreach, Engagement, and Re-Engagement, proper notice and appeal rights must be provided and the time period to appeal must have expired prior to submission of Part C of the Notification.

Upon receipt of Part C of the Notification, the OHR administration reviews the content to confirm accuracy and completeness, and approves the Part C in the AHCCCS QM OHR Portal, resulting in an email notification of the subcontracted staff person that submitted it.

REQUIREMENTS OF HEALTH CHOICE ARIZONA AND SUBCONTRACTED PROVIDERS TO HELP ENSURE THE PROVISION OF SPECIAL ASSISTANCE

The Health Choice Arizona subcontracted providers shall maintain open communication with the agency/person (guardian, family member, friend, OHR advocate, etc.) designated to meet the member’s Special Assistance needs.

This involves providing timely notification to the agency/person designated to provide Special Assistance to ensure involvement in the following stages:
• **Service Plan development, updates and review:** Including any instance when the member makes a decision about service options and/or denial/modification/termination of services; (service options include not only a specific service but also potential changes to provider, site, doctor and case manager assignment), which shall be in accordance with [AMPM Policy 320-O](#) and requires a signature;

• **ITDP planning:** Which includes any time the member is admitted to a psychiatric inpatient facility, and involvement throughout the member’s stay and discharge;

• **Appeal process:** Includes circumstances that may warrant the filing of an appeal, so all Notices of Adverse Benefit Determination (NOAs) or Notices of Decisions (NODs) issued to the member shall also be sent agency/person designated to provide Special Assistance; and

• **Investigation or Grievance:** Includes when an investigation/grievance is filed and circumstances when initiating a request for investigation/grievance may be warranted.

Health Choice Arizona requires that any Service Plan update or the original Service Plan shall have the signature of the agency/person designated to provide the member’s Special Assistance needs. This signature can be digital.

In the event that such procedures are delayed, and in order to ensure the participation of the agency/person providing Special Assistance, the Health Choice Arizona subcontracted provider must document the reason for the delay in the member’s comprehensive clinical record, or the investigation, grievance or appeal file. The Health Choice Arizona’s subcontracted providers shall ensure the member continues to receive the needed services in the interim.

Health Choice Arizona's subcontracted providers shall provide relevant details and a copy of the original Notification (both Parts A and B) to the receiving entity and when applicable, case manager, when a member in need of Special Assistance is:

- Admitted to an inpatient facility;
- Admitted to a residential treatment setting; or
- Transferred to a different T/RBHA, case management provider site or case manager.

Subcontracted providers shall periodically review whether the member’s Special Assistance needs are being met by the agency/person designated to meet those needs. If a concern arises, the Health Choice Arizona subcontracted provider shall initially address the concern with the agency/person designated to provide Special Assistance. If the issue is not promptly resolved, they shall take further action to address the issue which may include contacting the OHR administration for assistance.

Both Health Choice Arizona and the subcontracted providers shall assign an individual as the SME for purposes of this policy. This individual is to be the single point of contact for that subcontracted provider with regards to Special Assistance and this policy.
This individual is responsible for being up to date on this policy, maintaining open communication with Health Choice Arizona and AHCCCS OHR as appropriate, and being available for other staff at the subcontracted provider for questions and clarifications. The subcontracted provider is responsible for designating that individual, and if it changes, to notify Health Choice Arizona in a timely manner.

CONFIDENTIALITY REQUIREMENTS
Health Choice Arizona and subcontracted providers shall grant OHR access to clinical records of members in need of Special Assistance in accordance with all federal and state confidentiality laws per AMPM Policy 550. OHR and their advocates have access to members and member records no later than ten working days from the date of request of the records. Human Rights Committees (HRCs) and their members shall safeguard the monthly list that contains the names of those members in need Special Assistance regarding any Protected Health Information (PHI). HRCs shall inform AHCCCS in writing of how they will maintain confidentiality of the Special Assistance lists. If HRCs request additional information that contains PHI and is not included in the monthly report, they shall do so in accordance with the requirements set out in AMPM Policy 960.

BEHAVIORAL HEALTH OFFICE OF GRIEVANCE AND APPEALS (BHGA) AND HEALTH CHOICE ARIZONA REPORTING REQUIREMENTS
Upon receipt of a request for investigation, grievance or an appeal, the Health Choice Arizona Grievance and Appeals Administrator and the AHCCCS BHGA shall review whether the member is already identified as in need of Special Assistance. If so, Health Choice Arizona or AHCCCS BHGA must ensure that:

- A copy of the request for investigation or grievance is sent to OHR within five days of receipt of the request. Health Choice Arizona or AHCCCS BHGA shall also forward a copy of the final investigation or grievance decision to OHR within five days of issuing the decision;
- A copy of an appeal for a member with Special Assistance is sent to OHR upon occurrence; and
- The results of the Informal Conference (IC) regarding appeals are sent to OHR. Health Choice Arizona or AHCCCS BHGA shall also forward a copy of any subsequent notice of hearing.

DOCUMENTATION AND REPORTING REQUIREMENTS
Health Choice Arizona’s subcontracted providers shall maintain a copy of the completed Notification (Parts A, B and updated B, if any) in the member’s comprehensive clinical record. In the event a member was identified as no longer needing Special Assistance and a Part C of the Notification was completed, Health Choice Arizona and subcontracted providers must maintain a copy of the Notification in the member’s comprehensive clinical record.
Health Choice Arizona's subcontracted providers must also clearly document in the comprehensive clinical record (i.e. in the member’s assessment, Service Plan, ITDP, face sheet) and case management/client tracking system if a member is identified as needing Special Assistance, the name of the agency/person currently designated to provide Special Assistance, their relationship with the member, their contact information of phone number, mailing address and e-mail address if appropriate. This information should be easy to view in the case management/client tracking system so that every individual working at the subcontracted provider can view that the member is identified as needing Special Assistance.

In order to support Health Choice Arizona and OHR in maintaining accurate and up-to-date information on members in need of Special Assistance, subcontracted providers are required to follow Health Choice Arizona’s quarterly procedures for data updates about currently identified/active members in need of Special Assistance. Subcontracted providers are required to keep a list of every individual receiving Special Assistance and update it monthly, including changes in the member’s address, phone, residence type, guardianship status, eligibility, case manager, clinical supervisor, site location, new Part A of the Notification, updated Part B’s of the Notification, Part C of the Notification, intra- and inter-T/RBHA transfers, and those that are In-Process. Every month Health Choice Arizona’s subcontracted providers are required to send a list of enrolled members in need of Special Assistance to the Health Choice Arizona SME. This must be sent by the 5th of the month for the previous month.

Health Choice Arizona shall share Special Assistance data with its subcontracted providers who provide case management to members determined to have a SMI and verify that a process exists at each case management provider to ensure this data is accessible by direct care provider staff (quarterly at a minimum). Health Choice Arizona shall also establish a process with such subcontracted providers to obtain quarterly updates on members currently identified as needing Special Assistance to support the T/RBHA’s quarterly data updates process with OHR.

**OTHER REQUIREMENTS**

The HRCs shall make periodic visits to members in need of Special Assistance placed in residential settings to determine whether the services meet their needs and to determine their satisfaction with their residential environment. Health Choice Arizona provides training for all appropriate staff on the requirements related to Special Assistance. Subcontracted providers are required to train their staff on the requirements related to Special Assistance periodically.

**18.24 CONFIDENTIALITY**

Information and records obtained in the course of 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, Health Choice Arizona 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
Health Choice Arizona 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 that are defined in the HIPAA Rule. Careful attention must be paid to the definitions of words and phrases in order to determine whether disclosure is allowed. In addition, the HIPAA Rule may contain exceptions or special rules that apply to a particular disclosure. State law may affect a disclosure. For example, the HIPAA Rule may preempt a state law or a state law may preempt the HIPAA Rule. In addition, a covered entity must, with certain exceptions, make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the disclosure.

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 Health Choice Arizona 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, Health Choice Arizona 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, the uses to be made of that information 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 in order to share behavioral health related information with the member’s parent/legal guardian, primary care provider (PCP), the member’s Health Plan Behavioral Health Coordinator acting on behalf of the PCP or authorized state social service agencies. Disclosure to members of a clinical team for purposes other than treatment, payment, or healthcare operations, as permitted by and in compliance with §164.506 of the 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 that are likely to involve the use or disclosure of behavioral health information.

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

- To the individual and the individual’s health care decision maker;
- To health, mental health and social service providers for treatment, payment or health care operations;
- Incidental to a use or disclosure otherwise permitted or required by 45 C.F.R. Part 164, Subpart E;
- To a person or entity with a valid authorization;
- Provided the individual is informed in advance and has the opportunity to agree or prohibit the disclosure:
  - For use in facility directories;
  - To 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; and
• To a grand jury as directed by subpoena.

**Disclosure of Behavioral Health Information**

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

• Disclosure to an individual or the individual’s health care decision maker;
• A covered entity is required to disclose information in a designated record set to an individual when requested unless contraindicated. Contraindicated means that access is reasonably likely to endanger the life or physical safety of the patient or another 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 that are not permitted by the HIPAA Rule, patient authorization is required (45 C.F.R. §§ 164.502(a)(1)(iv); and 164.508). An authorization must contain all of the elements in 45 C.F.R. § 164.508.

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

- A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion;
- 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; and
- Signature of the individual and date. If the authorization is signed by a personal representative of the individual, a description of the representative’s authority to act for the individual must also be provided.

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

- The individual’s right to revoke the authorization in writing, and either:
  - The exceptions to the right to revoke and a description of how the individual may revoke the authorization; or
  - A reference to the covered entity’s notice of privacy practices if the notice of privacy practices tells the individual how to revoke the authorization.
The ability or inability to condition treatment, payment, enrollment or eligibility for benefits on the authorization, by stating either:
  o 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
  o 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 that is 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 that such decision must be made by a licensed healthcare professional, in the exercise of professional judgment (45 C.F.R. § 164.502(g)(3)(ii)(C)).

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

**Disclosure to 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 a 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 to A that the information is necessary to perform a function that is related to the oversight of the behavioral health system, and in that case, a covered entity may disclose protected health information to the human rights committee in its capacity as a health oversight agency (45 C.F.R. § 164.512(d)(1)). 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 that are contained in 45 C.F.R. § 164.512(k)(5).

**Disclosure to Governmental Agency or Law Enforcement to Secure Return of Patient**
Protected health information may be disclosed to governmental or law enforcement agencies if necessary to secure the return of a patient who is on unauthorized absence from any agency where the patient was undergoing court ordered evaluation or treatment. According to A.R.S. § 36-509 (6)(A), a covered entity may disclose limited information without patient authorization to law enforcement to secure the return of a missing 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 that 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; and
• A private entity that accredits a healthcare facility or a healthcare provider.
• A.R.S. § 36-664 also addresses issues with respect to the following:
  • Disclosures to the Department of Health Services or local health departments are also permissible under certain circumstances:
    o Authorizations;
    o Re-disclosures;
    o Disclosures for supervision, monitoring and accreditation;
    o Listing information in death reports;
    o Reports to the Department; and
    o 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 that the information is from confidential records which are protected by state law that prohibits further disclosure of the information without the specific written consent of the 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 that 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 that 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**

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

Health Choice Arizona 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.

Health Choice Arizona 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.

Health Choice Arizona 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.
Health Choice Arizona 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 that an identified individual has been, or is being diagnosed or treated for alcohol or drug abuse.

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

- The currently or previously enrolled 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:
  - Health Choice Arizona 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 that the person may revoke the authorization at any time, except to the extent that the program has already acted in reliance on it;
    - The date, event or condition upon which the authorization expires, if not revoked before;
    - The signature of the person or guardian; and
    - The date on which the authorization is signed.

**RE-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 other 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](https://www.legislature.az.gov/). 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**
Health Choice Arizona 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 that a clinical session is in progress.

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

**18.25 GENERAL AND INFORMED CONSENT TO TREATMENT**

**GENERAL REQUIREMENTS:** As per [AHCCCS AMPM 320-Q General and Informed Consent](https://www.ahcccs.gov/Providers-and-Businesses/Standards-and-Requirements), 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:

1. Complementary and Alternative Medicine (CAM),
2. Psychotropic medications,
3. Electro-Convulsive Therapy (ECT),
4. Use of telemedicine,
5. Application for a voluntary evaluation,
6. Research,
7. Admission for medical detoxification, an inpatient facility or a residential program (for members determined to have a Serious Mental Illness), and
8. 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 situation.

**Emergency:** Providers treating members in an emergency situation 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.

Foster or kinship caregivers may not consent to terminate behavioral health treatment. The termination of behavioral health treatment requires Department of Child Safety (DCS) consultation and agreement.

If the foster or kinship caregiver disagrees on the behavioral health treatment being recommended through the Child and Family Team (CFT), the CFT including the foster or kinship caregiver and DCS caseworker should reconvene and discuss the recommended treatment plan. Only DCS can refuse consent to medically recommended behavioral health treatment.

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

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

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

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

**Informed consent and how is it documented**

• Members, or if applicable the client’s parent, guardian or custodian shall give informed consent for treatment by signing and dating an acknowledgment that he or she has received the information and gives informed consent to the proposed treatment.
• 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 that is understandable and culturally appropriate to the member, parent, legal guardian or an appropriate court; and
• Presented by a credentialed behavioral health practitioner or a registered nurse with at least one year of behavioral health experience. It is preferred that the prescribing clinician provide information forming the basis of an informed consent decision. In specific situations in which that are not possible or practicable, information may be provided by another credentialed behavioral health practitioner or registered nurse with at least one year of behavioral health experience.
Psychotropic Medications, Complementary and Alternative Treatment and 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 Exhibit 320-Q-1, Application for Voluntary Evaluation is required for members determined to have a Serious Mental Illness and is recommended as a tool to review and document informed consent for voluntary evaluation of all other populations; and
- Prior to the delivery of any other procedure or service with known substantial risks or side effects.

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 that the member and/or legal guardian can understand and comprehend.

Exceptions to this consent requirement include:

- If the telemedicine interaction does not take place in the physical presence of the member,
- In an emergency 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; or
- Government agency authorized by the court.

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

- 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 that 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 into a lawful contract of marriage, whether or not that marriage has been dissolved subsequently emancipated youth or any homeless minor may provide general and, when applicable, informed consent to treatment without parental consent (A.R.S. § 44-132).

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

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.

**18.26 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; and

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 Crisis Response Network, 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 of the documentation that was considered during the review of the determination as well as any current and/or historical treatment records used in consideration of the determination. All documentation used in consideration of the determination must be maintained in hardcopy or electronic format. The documentation should also include a recent psychiatric evaluation done by a qualified behavioral health medical practitioner. Please see the CRN Provider Submission Checklist for a complete list.

**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 CRN 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. CRN 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 that 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 Health Choice Arizona-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 Crisis Response Network 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 Policy 550 Member Records and Confidentiality) for any documentation that would assist in the determination
- Conduct an assessment if one has not been completed within the last six months
- Complete the SMI Determination Form as per AMPM Exhibit 320-P-1 Serious Mental Illness Determination which must be signed and dated by a licensed clinician
- 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

18.26.1 A COMPLETE SMI DETERMINATION PACKET INCLUDES:

- Crisis Response Network Consent for Assessment Form
- SMI Determination Form
- Comprehensive assessment that must be dated within 6 months of the submission- CRN has an example form that may be used
- Psychiatric evaluation or psychiatric evaluation and management visit that addresses the current and recurrent functional impairments, risk of deterioration and qualifying diagnoses of the individual
- Recent hospital records or treatment records demonstrating individual’s level of functioning and evidence of deterioration
- Waiver of the Three Day Determination Form- applicants are encouraged to waive their right to a 3 day determination so that CRN can pursue historical treatment records and have additional time to review the requests
- Demographic Form (optional) to assist CRN with contacting the individual and other involved parties during the determination process
- Releases of Information Form for CRN 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 Crisis Response Network SMI Provider Submission Portal or by CRN 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

18.26.2 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, as a result of a qualifying SMI diagnosis, dysfunction in at least one of the following four domains, for most of the past twelve months or for most of the past six months with an expected continued duration of at least six months:

• **Inability to live in an independent or family setting without supervision** – neglect or disruption of ability to attend to basic needs. Needs assistance in caring for self.

• **Unable to care for self in safe or sanitary manner** – housing, food and clothing must be provided or arranged for by others. Unable to attend to the majority of basic needs of hygiene, grooming, nutrition, medical and dental care. Unwilling to seek prenatal care or 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.
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:
  o The severity, frequency, duration or characteristics of symptoms contributing to the functional impairment cannot be attributed to the qualifying mental health diagnosis; or
  o The assessor can demonstrate, based on a historical or prospective period of treatment, that the functional impairment is present only when the person is abusing substances or experiencing symptoms of withdrawal from substances.
- For all other mental disorders not covered above, functional impairment is presumed to be due to the co-occurring substance use unless:
  o The symptoms contributing to the functional impairment cannot be attributed to the substance abuse disorder; or
  o The functional impairment is present during a period of cessation of the co-occurring substance use of at least 30 days; or
  o 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.

18.26.3 COMPLETION PROCESS OF FINAL SMI ELIGIBILITY DETERMINATION
The licensed psychiatrist, psychologist, or nurse practitioner designated by Crisis Response Network must make a final determination as to whether the person meets the eligibility requirements for SMI status based on:

- A face-to-face assessment or reviewing a face-to-face assessment by a CRN 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 that 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 that 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; or
- There is insufficient functional or diagnostic information to determine SMI eligibility within the required time periods.

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

Crisis Response Network 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 that the person does not meet the criteria for SMI eligibility (because the determination was not made within the time standards).

Additional information and extensions:
- CRN can request and obtain additional information needed and/or perform or obtain any necessary psychiatric or psychological evaluations.
- The designated CRN 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 CRN’s 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 CRN that 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.

18.26.4 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, the Crisis Response Network 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.

18.26.5 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, as a result 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 CRN portal
• CRN 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
• HEALTH CHOICE Arizona 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 a SMI designation may request a SMI Administrative Decertification if the member has not received behavioral health services for a period of two or more years.

- Health Choice Arizona members can contact Health Choice Arizona Member Services to request a decertification at 1-800-640-2123
- Upon receipt of a request for AMPM Exhibit 320-P-3 Administrative Decertification Form, Health Choice Arizona 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 that the member has not received a behavioral health service within the previous two years, the member is provided with AMPM Exhibit 320-P-3 Administrative Serious Mental Illness Decertification Form. The member completes the form and returns it to AHCCCS.
  - In the event the review finds that 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.

18.26.6 REVIEW OF SMI ELIGIBILITY DETERMINATION
Health Choice Arizona or a Health Choice Arizona contracted provider may seek a review of a person’s SMI eligibility from CRN:
- 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 that 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 CRN 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, as a result of such review, the person is determined to no longer meet the diagnosis and functional requirements for SMI status, Health Choice Arizona must ensure that:
• Services are continued depending on Title XIX/XXI eligibility, Health Choice Arizona service priorities and any other requirements
• 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.

HEALTH CHOICE ARIZONA MONITORING OF SMI DETERMINATION PROCESS
Health Choice Arizona 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 CRN. Health Choice Arizona also monitors CRN’s decision-making process to ensure uniform application of criteria.

Based on those reviews, Health Choice Arizona may request:
• More information be provided to CRN on certain cases
• An appeal or reconsideration
• Resubmission by the provider if submitted incorrectly or insufficiently

Health Choice Arizona will continually train the providers in their network about policy changes regarding SMI determination and eligibility. Results of provider and CRN performance are reviewed through the Health Choice Arizona Medical Management Committee and are subject to performance improvement and corrective action.

18.26.7 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 have to be completed using the Serious Mental Illness Determination Verification. The purpose of this form is to allow Health Choice Arizona 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 Health Choice Arizona 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 Health Choice Arizona for approval. Health Choice Arizona is responsible for monitoring and validating the forms. Since AHCCCS may require Health Choice Arizona to submit documents as part of random sample audits, Health Choice Arizona keeps copies of validated Serious Mental Illness Determination Verification forms.

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18.26.8 HEALTH CHOICE ARIZONA OPT OUT PROCESS

Health Choice Arizona adheres to **ACOM 442 Member with a Serious Mental Illness Request to Opt Out from a RBHA to an Acute Care Contractor** when an Health Choice Arizona member with a Serious Mental Illness (SMI) requests to transfer his/her physical health care services from Health Choice Arizona to an Acute Care Contractor. This is called an opt out request.

Under exceptional circumstances, currently enrolled SMI members may opt out of the integrated plan and transfer his/her physical health care to an Acute Care Contractor. These circumstances include:

- Health Choice Arizona network limitations and restrictions
- Inability of Health Choice Arizona to fulfill a physician’s or provider’s course of care recommendations; and/or
- The member demonstrates that due to his/her enrollment with Health Choice Arizona, actual harm or the potential for discriminatory or disparate treatment exists with regards to
  - The access to, continuity, or availability of acute care covered services
  - Exercising client choice of plan
  - Privacy Rights
  - Quality of care provided
  - Or client’s rights under **A.A.C. Title 9, Chapter 21, Article 2**

A member, or his/her designee, must demonstrate that discriminatory or disparate treatment has occurred or must establish the plausible potential of such treatment. It is insufficient for a member to establish actual harm or the potential for discriminatory or disparate treatment solely on the basis that he/she is enrolled in Health Choice Arizona.

**Requesting an Opt Out**

When a member verbally requests an opt out, the contracted provider directs the member to call Health Choice Arizona Member Services at 1-800-640-2123. The member services department then discusses the reasons for the request with the member and explores all options to resolve the member’s concerns regarding the availability and accessibility of services; and/or the course of medical care or delivery issues; and/or any policy or practice that results in the actual or perceived discriminatory or disparate treatment of the individual as a result of his/her enrollment with Health Choice Arizona.

If the member qualifies for an opt out from the Health Choice Arizona SMI Integrated plan, the OPT OUT FORM located on the web-based AHCCCS Client Portal is submitted to the web-based **AHCCCS Client Portal** as per **ACOM 442 Member with a Serious Mental Illness Request to Opt Out from a RBHA to an Acute Care Contractor**. If AHCCCS grants the opt out request, Health Choice Arizona works with the contracted provider to ensure an appropriate transition and continuity of care.
Health Choice Arizona maintains a record of all approved and denied requests to transfer to an Acute Care Contractor. If denied, AHCCCS mails a denial letter to the member’s home address with instructions for an appeal. The appeal must take place 30 days upon receipt of the denial letter. The member may request an Administrative Hearing if they are denied an opt out from the SMI Integrated Plan.

Health Choice Arizona may request documentation from the health home regarding the opt out request, services, records and other documentation to help with the administrative hearing.

PROCEDURES
Members receive information about the opt out process which is outlined in the Health Choice Arizona Member Handbook. Health Choice Arizona takes the following actions relative to a member’s request to opt-out:

- If the member does not submit a written opt out request, then the member’s verbal request is put into writing which includes the member’s complete basis for his/her request to opt out of enrollment in Health Choice Arizona. The member or the member’s qualified representative can submit this information.
- Complete an SMI Member Request to Transfer from a RBHA to an AHCCCS Acute Care Contractor form as per ACOM 442 Member with a Serious Mental Illness Request to Opt Out from a RBHA to an Acute Care Contractor.
- Confirm and document the member’s enrollment with Health Choice Arizona SMI Integrated program.
- Investigate the basis provided by the member and make reasonable efforts to resolve the member’s concern(s).
- Include any additional evidence which in any way relates to the member’s request to opt out.
- Make a recommendation to approve or issue a decision to deny the request.
- When a request to opt out is granted and a member enrolled in the Health Choice Arizona SMI Integrated Plan is permitted to transfer to an Acute Care Contractor, Health Choice Arizona ensures appropriate transition and continuity of care, as per ACOM Policy 402 Member Transition for Annual Enrollment Choice and Eligibility Changes.
- When Health Choice Arizona issues a decision to deny a member’s request to opt out, Health Choice Arizona submits the completed decision packet to the AHCCCS Client Portal and issues a written notice to the member within 10 calendar days from the date of receipt of the member’s request. The decision includes the reasons for the denial and appeal/hearing rights, as outlined in ACOM 442 Member with a Serious Mental Illness Request to Opt Out from a RBHA to an Acute Care Contractor.
- When a member appeals to Health Choice Arizona decision to deny an opt out request, Health Choice Arizona appears at the administrative hearing and defends its denial of the request. This includes legal representation at the administrative hearing and any subsequent proceedings.
For a Health Choice Arizona recommendation to approve an opt out request, the completed packet must be submitted to AHCCCS for a decision within seven calendar days from the date of the member’s request.

Where Health Choice Arizona makes a determination and recommends that a member’s opt out request be granted, Health Choice Arizona and AHCCCS take the following actions:

- Health Choice Arizona is to provide AHCCCS with its completed recommendation packet and any other available information AHCCCS may request. AHCCCS reviews the completed recommendation packet and makes a final decision to approve or deny the request.
- AHCCCS provides the member with written notice of the decision within 3 calendar days of the request. Denials will include the reasons for the denial and appeal/hearing rights.
- If a hearing is requested and received by Health Choice Arizona, Health Choice Arizona promptly forwards the request to AHCCCS Administration which will then schedule the matter for hearing with the Office of Administrative Hearings (OAH). The Notice of Hearing is sent by AHCCCS to the requesting party and Health Choice Arizona.

Following the Administrative Hearing, AHCCCS Administration issues a Director’s Decision within 30 calendar days of receipt of the Administrative Law Judge (ALJ) Decision.

18.27 ARIZONA STATE HOSPITAL (AzSH) ADMISSIONS AND DISCHARGES

When a Health Home or other referral source believes that 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 Health Choice Arizona Medical Management to discuss the recommendation for admission to AzSH. Health Choice Arizona will initiate the AzSH review process. Health Choice Arizona must be in agreement with the other referral source that a referral for admission to AzSH is necessary and appropriate.

Health Choice Arizona 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 that the behavioral health member does not meet criteria for admission, the Chief Medical Officer or Acting Designee will provide a written statement to the referral source 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 Health Choice Arizona 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, in order to facilitate enhanced coordination of care and successful discharge planning. Health Home staff are expected to submit documentation of each staffing meeting to the Health Choice Arizona AzSH Liaison.
- Treatment goals and recommended assessment/treatment interventions must be carefully developed and coordinated with the outpatient providers (including Health Choice Arizona, 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 Health Choice Arizona AzSH Liaison to be addressed. Health Choice Arizona 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 considered to be ready for community placement and is placed on the Discharge Pending List when the following criteria are met:

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

Once a behavioral health member is placed on the Discharge Pending List, Health Choice Arizona must immediately take steps necessary to transition the behavioral health member into community-based treatment as soon as possible. Health Choice Arizona has up to thirty (30) days to transition the behavioral health member out of AzSH. Health Choice Arizona outpatient treatment team should identify and plan for community services and supports with the member’s inpatient clinical team 60 – 90 days out from the member’s discharge date. This will allow sufficient time to identify appropriate community covered behavioral health services. When the 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 Health Choice Arizona 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 that a Health Choice Arizona 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 happen 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 Health Choice Arizona 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. Health Choice Arizona issues the same brand and model of glucometer test supplies that the member was trained to use while in the hospital.

18.27.1 ARIZONA STATE HOSPITAL (AZSH) CONDITIONAL RELEASE AND PSYCHIATRIC SECURITY REVIEW BOARD

When Health Choice Arizona 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 that 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 Health Choice Arizona and PSRB immediately.
• Health Homes are to submit AMPM Policy 1020 1020 1020 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 Health Choice Arizona at HCHHCICMMReporting@healthchoiceaz.com

18.28 HOUSING FOR MEMBERS DETERMINED TO HAVE SERIOUS MENTAL ILLNESS (SMI)

Recovery often starts with safe, decent and affordable housing so that individuals are able to live, work, learn, and participate fully in their communities. Safe, stable, and familiar living arrangements are critical to a person's ability to benefit from treatment and support services. For persons determined to have SMI who are able to live independently, Health Choice Arizona has a number of programs to support independent living, such as rent subsidy programs, supported housing programs, bridge subsidy housing assistance while obtaining federal funding, and provider owned or leased homes and apartment complexes that combine housing services with other covered behavioral health services. Similarly, T/RBHA housing programs include rent subsidy programs, owner occupied home repairs, move-in assistance, and eviction prevention programs coupled with needed supported housing services to maintain independent living.

AHCCCS supports permanent supportive housing and has adopted the SAMHSA Permanent Supporting Housing Program model which includes the following 12 Key Elements:

1. Tenants have a lease in their name, and, therefore, they have full rights of tenancy under landlord-tenant law, including control over living space and protection against eviction.
2. Leases do not have any provisions that would not be found in leases held by someone who does not have a psychiatric disability.
3. Participation in services is voluntary and tenants cannot be evicted for rejecting services.
4. House rules, if any, are similar to those found in housing for people who do not have psychiatric disabilities and do not restrict visitors or otherwise interfere with a life in the community.
5. Housing is not time-limited, and the lease is renewable at tenants’ and owners’ option.
6. Before moving into Permanent Supportive Housing, tenants are asked about their housing preferences and are offered the same range of choices as are available to others at their income level in the same housing market.
7. Housing is affordable, with tenants paying no more than 30 percent of their income toward rent and utilities, with the balance available for discretionary spending.
8. Housing is integrated. Tenants have the opportunity to interact with neighbors who do not have psychiatric disabilities.
9. Tenants have choices in the support services that they receive. They are asked about their choices and can choose from a range of services, and different tenants receive different types of services based on their needs and preferences.
10. As needs change over time, tenants can receive more intensive or less intensive support services without losing their homes.
11. Support services promote recovery and are designed to help tenants choose, get, and keep housing.
12. The provision of housing and the provision of support services are distinct.

AHCCCS HOUSING REQUIREMENTS
State Funded Supported Housing Programs
Health Choice Arizona complies with the following requirements to effectively manage limited housing funds in providing supported housing services to enrolled individuals:

- Accepts all persons determined to have an SMI into a State Funded Housing Program, subject to funding availability.
- Health Choice Arizona uses supported housing allocations for individuals with a SMI and according to any restrictions pertaining to the funding source. For example, a particular allocation may require it be used for Title XIX/XXI persons with GMH/SA eligibility, while another allocation may require it be used for Non-Title XIX persons.
- Housing must be safe, stable, and consistent with the member’s recovery goals and be the least restrictive environment necessary to support the member. Shelters, hotels, and similar temporary living arrangements do not meet this expectation.
- Health Choice Arizona and its subcontracted providers must not actively refer or place individuals determined to have SMI in a homeless shelter, licensed supervisory care homes, unlicensed board and care homes, or other similar facilities. [Note: When a behavioral health member chooses to reside in an unlicensed board and care home, Health Choice Arizona and/or its subcontracted providers must report any observations of unsafe conditions or provision of services that require licensure to the local housing authority and the **ADHS Division of Licensing Services** (DLS) at (602) 364-2595.]
- Health Choice Arizona may charge up to, but not greater than, 30% of a tenant’s income towards rent. If a rent payment is increased in state funded housing programs, Health Choice Arizona subcontracted providers must provide the tenant with a 30-day notice at the time of the tenant’s annual recertification.
- Health Choice Arizona does not use supported housing allocations for room and board charges in residential treatment settings (Level II and Level III facilities). However, Health Choice Arizona may allow residential treatment settings to establish policies, which require that persons earning income contribute to the cost of room and board.
- Health Choice Arizona may provide move-in assistance and eviction prevention services to those members in permanent housing. When move-in assistance is provided, Health Choice Arizona prioritizes assistance with deposits and payment for utilities over other methods of assistance, such as move-in kits or furnishings, consisting of pots and pans, dishes, sheets, etc.
Health Choice Arizona encourages its subcontracted providers to seek donations for necessary move-in/home furnishing items whenever possible. Health Choice Arizona does not use supported housing allocations or other funding received from AHCCCS (including block grant funds) to purchase furniture.

- Health Choice Arizona must ensure that contracted housing providers deliver a range of housing services and present available options to persons determined to have SMI, consistent with the individual’s goals and needs identified in the Individual Service Plan.
- Health Choice Arizona assures that providers maintain all housing units currently in use in the GSA, including units acquired through the State of Arizona housing funds specifically for members determined to have a SMI or other eligible populations served by the provider as funding permits.
- Health Choice Arizona collaborates with State, County and local government agencies to support housing initiatives and resolve housing issues, concerns and complaints that affect members.
- Health Choice Arizona actively develops new housing capacity, program initiatives and options when needed in collaboration with AHCCCS, ADOH and local HUD Continuum of Care (CoC).
- Health Choice Arizona Housing Staff participate in AHCCCS Quarterly Housing Meetings.
- For appeals related to support housing services, Health Choice Arizona and its subcontracted providers must follow the requirements in ACOM Policy 444.
- Housing related grievances and requests for investigation for persons determined to have SMI must be addressed in accordance with ACOM Policy 446.

**Other AHCCCS Housing Requirements**

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

**HEALTH CHOICE ARIZONA HOUSING PROGRAMS AND REQUIREMENTS**

Health Choice Arizona housing programs include specialized housing units to meet the needs of persons determined to have SMI who have specialized needs for placement in the community partly due to crime free/drug free ordinances and specific behavioral health related service needs. Current specialized housing includes housing that is specifically designed to provide and accommodate the following services or conditions for persons determined to have SMI:

- Housing for females with co-occurring disorders who are homeless;
- Apartment complexes for persons determined to have SMI with criminal backgrounds released from jail with a major biological disorder;
- Housing for persons determined to have SMI who are hearing impaired or deaf;
- Housing for persons determined to have SMI who have sexualized behaviors and are in need of on-site support;
- Gender based house model living for older females determined to have SMI;
- Apartment complex housing and services to 18-25 year old adults transitioning from the children’s system of care to the adult system of care;
• Respite homes for persons with developmental disabilities who are determined to have SMI (joint AHCCCS, DES/DD program);
• Specialized homes for polydipsia;
• Homes that specialize in dialectical behavioral therapy;
• Housing for persons determined to have SMI with limited English proficiency; and
• Housing suited to meet medical needs of persons determined to have SMI with diabetes and other chronic diseases. For additional information specific to Health Choice Arizona Housing Programs and Requirements see the Health Choice Arizona Care Housing Plan Desktop Reference or contact Health Choice Arizona Housing Administrator 928-774-7128 or toll-free 1-800-640-2123.

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.
Health Choice Arizona 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.

Health Choice Arizona 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.

To receive additional information regarding these programs contact Health Choice Arizona Housing Administrator at 928-774-7128 or toll-free 1-800-640-2123.

### 18.29 INTER-RBHA COORDINATION OF CARE

#### 18.29.1 TRANSITION TO OTHER RBHA, T/RBHA FOR MEMBERS NOT IN INTEGRATED CARE HEALTH PLAN

**General provisions of timeframes**
Computation of Time – In computing any period of time prescribed or allowed by this chapter, the period begins the day after the act, event, or decision occurs and includes all calendar days and the final day of the period. If the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or a legal holiday. If the period of time is not designated as calendar days and is less than 11 days, then intermediate Saturdays, Sundays, and legal holidays must not be included in the computation.

**Jurisdictional responsibilities**
For adults (persons 18 years and older), the T/RBHA jurisdiction is determined by the person's current place of residence, except persons who are unable to live independently must not be transferred to another T/RBHA with the exception of persons who are unable to live independently but are involved with Arizona Department of Economics Security/Division of Developmental Disabilities (DES/DDD). This is applicable regardless of where the adult guardian lives.
Responsibility for service provision, other than crisis services, remains with the home T/RBHA when the enrolled person is visiting or otherwise temporarily residing in a different T/RBHA area but:

- Maintains a place of residence in his or her previous location with an intent to return and
- The anticipated duration of the temporary stay is less than three months.
- When an Arizona Long Term Care System (ALTCS)/DDD member is placed temporarily in a group home while a permanent placement is being developed in the home T/RBHA service area, covered services remain the responsibility of the home T/RBHA.
- For children (ages 0-17 years), T/RBHA responsibility is determined by the current place of residence of the child’s parent(s) or legal guardian.
- Inter-T/RBHA transfers must be completed within 30 days of referral by the home T/RBHA. The home T/RBHA must ensure that activities related to arranging for services or transferring a case does not delay a person’s discharge from an inpatient or residential setting.

### INTER-T/RBHA TRANSFER

A transfer will occur when:

- An adult person voluntarily elects to change their place of residence to an independent living setting from one T/RBHA's area to another.
- Members who are unable to live independently but clearly express an intent/desire to permanently relocate to another service area can be transferred. However, the home T/RBHA must make arrangements for housing and consider this to be a temporary placement for 3 months. After 3 months, if the person continues to clearly express an intent/desire to remain in this new service area, the inter-RBHA transfer can proceed.
- The parent(s) or legal guardian(s) of a child change their place of residence to another T/RBHA’s area; or
- The court of jurisdiction of a dependent child changes to another T/RBHA’s area.

### Timeframes for initiating an Inter-T/RBHA transfer

The home T/RBHA shall initiate a referral for an Inter-T/RBHA transfer:

- 30 days prior to the date on which the person will move to the new area; or
- If the planned move is in less than 30 days, immediately upon learning of the person’s intent to move.

### Inter-RBHA Process

As per [AHCCCS Policy 520 Member Transitions](#), the referral is initiated when the home T/RBHA provides a completed [Enrollment Transition Information (ETI) form](#) and a Member Transfer Packet. The ETI form must be completed in its entirety with no blanks.

In addition, the following information must be provided to the receiving T/RBHA as quickly as possible:

1. Face Sheet/Behavioral Health Services Referral Form
2. Medication Sheet (for past 6 months)
3. Behavioral Health Professional Progress Notes (past 6 months)
4. Psychiatric Evaluation
5. Psychiatric Progress Notes (for past 6 months)
6. Psychosocial Comprehensive Assessment
7. Assessment Update (if Comp. Assess. is over 1 year old)
8. Title 14 and Title 36 information (if applicable)
9. Current ISP/Treatment Plan
10. SMI Determination Summary (SMI)
11. Acute Care Enrollment Transition Info Form (ETI) (SMI Only)
12. GAF Scores (if available)
13. Authorization to disclose information/Release of Information (ROI)
14. Number of days of service in an IMD for the contract year (Title XIX persons age 21 – 64 only)
15. Number of hours of respite service received for the contract year
16. Demographic Info. (834 and most recent Companion data)

All outgoing ETI forms will be complete and sent to the receiving health plan no later than ten (10) business days from receipt of the AHCCCS notification.

Members who have Serious Mental Illness (SMI) and who are transitioning to a Regional Behavioral Health Authority (RBHA) shall have a fourteen (14) day transition period to ensure effective communication between contractors and care providers.

Transitioning members can obtain emergency medical care in accordance with AHCCCS standards. This includes members who have moved out of the contractor’s service area.

Relinquishing contractors or its subcontracted providers who fail to notify the receiving contractors of transitioning members with special circumstances, or fail to send the completed ETI form, will be responsible for covering the member’s care resulting from the lack of notification up to thirty (30) days.

Within 14 days of receipt of the referral for an Inter-T/RBHA transfer, the receiving T/RBHA or its subcontracted providers must:

- Schedule a meeting to establish a transition plan for the person. The meeting must include:
  - The person or the person’s guardian or parent, if applicable;
  - Representatives from the home T/RBHA, if applicable;
  - Representatives from the Arizona State Hospital (AzSH), when applicable;
  - The behavioral health provider and representatives of the CFT/adult recovery team;
  - Other involved agencies; and
• Any other relevant participant at the person’s request or with the consent of the person’s guardian.

Establish a transition plan that includes at least the following:
• The person’s projected moving date and place of residence;
• Treatment and support services needed by the person and the timeframe within which the services are needed;
• A determination of the need to request a change of venue for court ordered treatment and who is responsible for making the request to the court, if applicable;
• Information to be provided to the person regarding how to access services immediately upon relocation;
• The enrollment date, time and place at the receiving T/RBHA and the formal date of transfer, if different from the enrollment date;
• The date and location of the person’s first service appointment in the receiving T/RBHA’s GSA;
• The individual responsible for coordinating any needed change of health plan enrollment, primary care provider assignment and medication coverage;
• The person’s behavioral health provider in the receiving T/RBHA’s GSA, including information on how to contact the behavioral health provider;
• Identification of the person at the receiving T/RBHA who is responsible for coordination of the transfer, if other than the person’s behavioral health provider;
• Identification of any special authorization required for any recommended service (e.g., non-formulary medications) and the individual who is responsible for obtaining needed authorizations; and,
• If the person is taking medications prescribed for a behavioral health issue, the location and date of the person’s first appointment with a practitioner who can prescribe medications. There must not be a gap in the availability of prescribed medications to the person.

If the person scheduled for transfer is not located or does not show up for his/her appointment on the date arranged by the T/RBHAs to transfer the person, the T/RBHAs must collaborate to ensure appropriate re-engagement activities occur as per AHCCCS AMPM 1040 Outreach, Engagement, Re-Engagement and Closure for Behavioral Health and proceed with the inter-T/RBHA transfer, if appropriate. Each T/RBHA must designate a contact person responsible for the resolution of problems related to enrollment and disenrollment.

When a person presents for crisis services, providers must first deliver needed behavioral health services and then determine eligibility and T/RBHA enrollment status. Persons enrolled after a crisis event may not need or want ongoing behavioral health services through the T/RBHA. Providers must conduct re-engagement efforts as described in AHCCCS AMPM 1040 Outreach, Engagement, Re-Engagement and Closure for Behavioral Health.
Persons who will receive ongoing behavioral health services will need to be referred to the appropriate T/RBHA and an inter-T/RBHA transfer initiated, if the person presented for crisis services in a GSA other than where the person resides.

Timeframes specified above cover circumstances when behavioral health recipients inform their provider or T/RBHA prior to moving to another service area. When behavioral health recipients inform their provider or T/RBHA less than 30 days prior to their move or do not inform their provider or T/RBHA of their move, the designated T/RBHA must not wait for all of the documentation from the previous T/RBHA before scheduling services for the behavioral health member.

18.29.2 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 that starts with an 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/SA) 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 that will ensure and support the delivery of children’s and adult services during the transition period. Providers must ensure that adult system staff attend and are a part of the Child and Family Team (CFT) (during the four to six months prior to the child turning 18) in order to provide information and be part of the service planning, development and coordination effort that needs to take place so the individualized needs of that 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 that 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 actually 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 or not the child will require special assistance services.
• Identifying whether the child has appropriate life skills, social skills and employment 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 Transition to Adulthood Practice Tool.
• 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 that 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/SA. Services include case management services and all other covered services that 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 that 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 that 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 Practice Tool – Transition to Adulthood.
18.29.3 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 that 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; and
- Coordinate the transfer of any other relevant information between the behavioral health provider and other provider agencies, if needed.

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

Medical records will be forwarded by the relinquishing Primary Care Physician (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:

1. Diagnostic Tests and Determinations
2. Current Treatment Services
3. Immunizations
4. Hospitalizations with Concurrent Review Data and Discharge Summaries
5. Medications
6. Current Specialist Services
7. Behavioral Health History
8. Emergency Care

18.29.5 MEMBER TRANSFERS BETWEEN FACILITIES

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

- Inpatient hospital facilities following emergency hospitalization may be made when the following criteria are met:
  a. The attending emergency physician, or the attending provider treating the member, determines that 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),

b. The receiving physician agrees to the member transfer,

c. Transportation orders are prepared specifying the type of transport, training level of the transport crew and level of life support, and
d. 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:**
   a. Member's condition does not require the full capabilities of the transferring facility, or
   b. Member's condition has stabilized or reached a plateau and will not benefit further from intensive intervention in the transferring facility, and
   c. The receiving physician agrees to the member transfer, and
   d. Transportation orders are prepared specifying the type of transport, training level of the transport crew and level of life support, and
   e. 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:**
   a. 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,
   b. The receiving physician agrees to the member transfer,
   c. Transport orders are prepared which specify the type of transport, the training level of the transport crew and the level of life support, and
   d. A transfer summary accompanies the member.

• **For transfers initiated by Health Choice Arizona,** the attending emergency physician or the attending provider treating the member and the Health Choice Arizona 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).

**18.29.6 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 web based verification or call 1-800-331-5090.

The behavioral health provider must, however, continue to provide and encounter needed non-Title XIX covered SMI services (e.g. housing) to persons determined to have a Serious Mental Illness.

Behavioral health providers who contract as an ALTCS provider must not submit encounters for an ALTCS/EPD and/or an ALTCS/DDD enrolled person to the T/RBHA after a person transfers to ALTCS, but must submit bills/claims for payment to the ALTCS Program Contractor who in turn submits the encounters to AHCCCS.

18.29.7 OUT OF AREA SERVICE PROVISION

Crisis Services

Crisis services must be provided without regard to the person’s enrollment status. When a person presents for crisis services the T/RBHA will:

- Provide needed crisis services;
- Ascertain the person’s enrollment status with all T/RBHAs and determine whether the person’s residence is temporary or permanent.
- If the person is enrolled with another T/RBHA, notify the home T/RBHA within 24 hours of the person’s presentation. The home T/RBHA or their contracted providers is fiscally responsible for crisis services and must:
  - Make arrangements with the T/RBHA at which the person presents to provide needed services, funded by the home T/RBHA;
  - Arrange transportation to return the person to the home T/RBHA area; or
- Determine if the person intends to live in the new T/RBHA and if so, initiate a transfer. Persons who are unable to live independently but clearly express an intent/desire to permanently relocate to another service area can be transferred. However, the home T/RBHA must make arrangements for housing and consider this a temporary placement for three months. After three months, if the person continues to clearly express an intent/desire to remain in this new service area, the inter-T/RBHA transfer can proceed.
  - If the person is not enrolled with any T/RBHA, lives in the Northern GSA and has presented for services, behavioral health providers must initiate an enrollment. Providers should notify Health Choice Arizona at 1-800-640-2123.
• If the person is not enrolled with any T/RBHA, lives outside of the Northern GSA and is presenting for crisis services, Health Choice Arizona must enroll the person, provide needed crisis services and initiate the inter-T/RBHA transfer.
• In the event that T/RBHA or provider receives a referral regarding a hospitalized person whose residence is located outside the GSA, the T/RBHA or provider must immediately coordinate the referral with the person’s designated T/RBHA.

**Non-Emergency Services**
If the person is not enrolled with a T/RBHA, lives outside of the service area, and requires services other than a crisis or urgent response to a hospital, the T/RBHA must notify the designated T/RBHA associated with the person’s residence within 24 hours of the person’s presentation. The designated T/RBHA must proceed with the person’s enrollment if determined eligible for services. The designated T/RBHA is fiscally responsible for the provision of all medically necessary covered services including transportation services for eligible persons.

**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 T/RBHA opiate replacement treatment provider while the person is traveling out of the home T/RBHA’s area. All incidents of provision of courtesy dosing must be reported to the home T/RBHA. The home T/RBHA must reimburse the T/RBHA providing the courtesy doses upon receipt of properly submitted bills or encounters.

**Referral for Service Provision**
If a home T/RBHA initiates a referral to another T/RBHA or a service provider in another T/RBHA’s area for the purposes of obtaining behavioral health services, the home T/RBHA must:

• Maintain enrollment and financial responsibility for the person during the period of out-of-area behavioral health services,
• Establish contracts with out-of-area service providers and authorize payment for services,
• Maintain the responsibilities of the behavioral health provider, and
• Provide or arrange for all needed services when the person returns to the home T/RBHA’s area.

**18.30 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 that 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.
- Health Choice Arizona 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. Health Choice Arizona encourages subcontracted providers to use the [Request for Information from PCP or Medicare Plan/Provider Form](#) if the PCP does not respond to the request within 10 days, the subcontracted provider should contact the health plan’s Behavioral Health Coordinator for assistance.
- Health Choice Arizona 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 Health Choice Arizona Member Services at 928-774-7128 or 800-640-2123.
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 Health Choice Arizona 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. Health Choice Arizona implements cost sharing responsibilities and billing for inpatient psychiatric services. Health Choice Arizona 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 that are also AHCCCS covered behavioral health services. Health Choice Arizona implements cost sharing responsibilities and billing for outpatient behavioral health services. Health Choice Arizona 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 Health Choice Arizona 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 that are not included on plan formularies (non-covered) or are excluded Part D drugs. Health Choice Arizona is responsible for covering non-covered or excluded Part D behavioral health prescription medications listed on the Health Choice Arizona formulary, in addition to Part D cost sharing.
18.31 COORDINATION OF CARE FOR MEMBERS WHO ARE INCARCERATED

Incarcerating agencies are required to provide all necessary care, including behavioral health care, to their inmates.\(^1\) Health Choice Arizona Behavioral Health Homes (BHHs) will support the coordination of care for Health Choice Arizona 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.

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](https://www.samhsa.gov/gains-center).

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 30 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:

- Health Choice Arizona determines which members need reach-in care through application of the criteria below.
- Health Choice Arizona 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
- An 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
  - Utilization of services based on SABG enrollment

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 video-conference
- 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 that the member’s needs are communicated to the outpatient providers upon release/reinstatement of AHCCCS benefits.
BILLING AND ENCOUNTERING SERVICES FOR MEMBERS WHILE INCARCERATED:

- **Place of Service Code 99:** use for all services provided to all adolescent members who are in a Juvenile Detention Facility, regardless of the billing service code. This will result in encounters being paid or granted service value with Non-Title XIX funding sources, if available.
- **Place of Service Code 09:** only to be used for members covered by Targeted Investment funding.
- Health Choice Arizona will determine the funding source based on the member’s eligibility and enrollment status.
- Medicaid funds cannot be used while someone is incarcerated.
- State-Only Non-TXIX funds, if available, may be used for Incarcerated adult members with an SMI diagnosis.
- Mental Health Block Grant (MHBG) may be used for:
  - Children identified as Seriously Emotionally Disturbed (SED).
- Substance Abuse Block Grant (SABG) may be used for:
  - Children who meet criteria for services under SABG.
- Crisis funds may be used for:
  - Any crisis assessments, regardless of enrollment status or diagnosis (including GMH/SA).
- If available, Health Choice Arizona Community Reinvestment Funds may be used for:
  - Non-TXIX /Non-SMI members—(intake, assessments, and case management for coordination of care, discharge/re-entry planning, pre-employment planning, etc. services) during incarceration.

**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 terminated during the incarceration period, and the member will be enrolled in a state-only enrollment. Providers must submit an 834 to Health Choice Arizona to enroll the member as State-Only (NTXIX). **Place of Service 99 will be used for all encounters.**

**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. Per AHCCCS AMPM 320-T, SABG and MHBG can be used to for services provided in Juvenile Detention Facilities which meet the Office of Juvenile Justice and Delinquency Prevention (OJJDP) definition of detention center: “a short-term facility that provides temporary care in a physically restricting environment for juveniles in custody pending court disposition and, often, for juveniles who are adjudicated delinquent and awaiting disposition or placement elsewhere, or are awaiting transfer to another jurisdiction,” because these facilities are not penal or correctional institutions.
SABG/MHBG funding cannot be used to provide services in what the OJJDP defines as long-term secure facilities: “a specialized type of facility that provides strict confinement for its residents. Includes training schools, reformatories, and juvenile correctional facilities.” For additional information on the distinction between Detention Facilities and Correctional Facilities, refer to the National Institute for Corrections.

Children and youth must meet the criteria for SABG or MHBG. If a child or youth member meets criteria for SABG or MHBG they will be enrolled as State-Only NTXIX (this would be initiated by the provider) and MHBG/SABG/state crisis dollars can be used for services provided to them in detention facilities.

AHCCCS SUSPENSION INTER-GOVERNMENTAL AGREEMENTS
Through Inter-Governmental Agreements between County Governments and AHCCCS, some jails are able to “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 Health Choice Arizona. 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 Health Choice Arizona, 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.

- Under the Behavioral Health Services tab, the member’s enrollment information will only indicate that there is “NO BHS ENROLLMENT” without supporting information.

<table>
<thead>
<tr>
<th>Medical Enrollment</th>
<th>Health Plan ID/Description</th>
<th>Period Start</th>
<th>Period End</th>
<th>Rate Code</th>
<th>Contract Type</th>
<th>Insurance Type</th>
</tr>
</thead>
<tbody>
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<td>04/01/2019</td>
<td>09/04/2019</td>
<td>3116</td>
<td>1 NO IMPR</td>
<td>OT OTHER</td>
<td></td>
</tr>
</tbody>
</table>

- This AHCCS member’s enrollment was temporarily suspended.
- The member’s Health Plan Medical Enrollment 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 fills are 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.

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Note: If a suspension has not been entered, this does NOT mean in and of itself that Federal Financial Participation (TXIX) is available. Persons can remain “eligible” for Medicaid and nonetheless not qualify for Federal Financial Participation due to incarceration. Use of Place of Service 09 will help avoid inadvertent errors. Also, if you think a suspension or revocation should have occurred but has not, report the matter Health Choice Arizona and AHCCCS through your compliance officer. Also, please note that 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 Health Choice Arizona and AHCCCS and alert your compliance officer.

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

AHCCCS MEDICAID RULES REGARDING INCARCERATED INDIVIDUALS
Indians do not lose their Medicaid eligibility based on incarceration alone. 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 that the person is no longer eligible for Medicaid. In fact, the law does not specify, nor imply, that 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.

A state may enroll, or continue enrollment of, an inmate of a public institution who is otherwise eligible for Medicaid into a Medicaid MCO. However, in most instances, it is more practical and appropriate either not to enroll or to disenroll that individual from the Medicaid managed care program in order to avoid paying per member per month rates to the MCO since only costs for inpatient services delivered outside of the penal institution are reimbursable while the individual is incarcerated.

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).