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*Contract services are funded in part under contract with the State of Arizona.*
Section 1 - INTRODUCTION TO CENPATICO INTEGRATED CARE

Cenpatico of Arizona, Inc. dba Cenpatico Integrated Care (Cenpatico IC) is an Arizona-based, locally-operated Managed Health Services company dedicated to verifying that Members receive ready access to high quality and culturally responsive care. Cenpatico IC in collaboration with its parent company, Centene Corporation, and partner, Banner University of Arizona Health Plans, is committed to bringing the best care possible to vulnerable populations through a focus on innovative programs and services delivered through Medicaid (Title XIX), Medicare, CHIP (Title XXI), and other programs for low income adults and families. Cenpatico IC serves eight Southern Arizona counties—Pima, La Paz, Yuma, Santa Cruz, Cochise, Greenlee, Graham, and Pinal Counties—and recognizes that the needs of each county are uniquely based on the county’s resources and challenges. Cenpatico IC tailors services to meet the needs of each community and supports local community-based efforts to effectively coordinate care.

Cenpatico IC developed this Provider Manual in support of its provider agreements and in conformance with the Arizona Health Care Cost Containment System (AHCCCS) - Contractor Operations Manual (ACOM Manual).

Cenpatico IC’s Provider Manual is applicable to defined populations that may access public services through Cenpatico IC. These populations include the following:

- Title XIX/XXI eligible Members in Cenpatico IC’s Geographic Service Area;
- Title XIX/XXI Members enrolled with Cenpatico IC;
- Members receiving emergency/crisis services in Cenpatico IC’s Geographic Service Area;
- Non-Title XIX/XXI persons determined to have a Serious Mental Illness enrolled with Cenpatico IC;
- Special populations, including persons receiving services through the Substance Abuse Prevention and Treatment Performance Partnership (SABG) block grant in Cenpatico IC’s Geographic Service Area;
- Non-enrolled persons participating in State prevention sponsored activities in Cenpatico IC’s Geographic Service Area;
- Non-enrolled persons participating in State HIV Early Intervention services in Cenpatico IC’s Geographic Service Area; and
- Other populations in Cenpatico IC’s Geographic Service Area, based on the availability of funding and the prioritization of available funding.

Providers are obligated to adhere to and comply with all terms and conditions of the Cenpatico IC Provider Manual, the provider’s agreement with Cenpatico IC, and all applicable federal and State laws and regulations. In addition, providers are obligated to understand and comply with all Arizona Health Care Cost Containment System requirements. Please refer to: AHCCCS ACOM located at www.ahcccs.gov for additional information regarding State requirements.
1.1 Overview of the Arizona Public Health System

The Arizona Health Care Cost Containment System (AHCCCS) is the single state Medicaid Agency and provides funding to administer benefits for persons who are Title XIX/XXI eligible.

AHCCCS contracts with the Regional Behavioral Health Authorities to secure a network of providers, clinics, and other appropriate facilities and services to deliver behavioral health services to eligible Members within contracted geographic services areas. AHCCCS additionally has Intergovernmental Agreements with Tribal RBHAs (TRBHAs) for the provision of behavioral health services to eligible members of some of Arizona’s American Indian Tribes.

Arizona state law requires AHCCCS to administer community-based treatment services for adults who have been determined to have a Serious Mental Illness (see [AAC R9-21](#)).

AHCCCS is responsible for the oversight of the administration of behavioral health services for several populations funded through various sources. These sources include the Substance Abuse and Mental Health Services Administration (SAMHSA), which provides funding to the State through two block grants:

- The Substance Abuse Block Grant (SABG) supports a variety of substance abuse services in both specialized addiction treatment and more generalized behavioral health settings, and primary prevention, and HIV Early Intervention and Testing is provided onsite to persons enrolled in substance abuse treatment or on a wait list for such treatment. Intake providers are required to permit the Cenpatico IC HIV Early Intervention subcontractor to provide such services, in a confidential area, on a scheduled basis.
- The Mental Health Block Grant (MHBG) supports Non-Title XIX/XXI services to children determined to have Serious Emotional Disturbance (SED) and adults determined to have a Serious Mental Illness (SMI).

AHCCCS administers other federal, State and locally funded services. More information about AHCCCS programs is available online at [www.ahcccs.gov](http://www.ahcccs.gov).

1.1.1 Integrated Physical and Behavioral Health Services

AHCCCS and the RBHA/Health Plan have entered into an Intergovernmental Agreement (IGA) to design a new health care service delivery system that provides integrated physical and behavioral health services to Medicaid eligible adults with a Serious Mental Illness (SMI). This includes coordinating Medicare and Medicaid benefits for dual-eligible Members. Integrating the delivery of behavioral and physical health care to adults with SMI is a significant step forward in improving the overall health of adults with SMI. From a Member perspective, this approach will improve individual health outcomes, enhance Coordination of Care and increase Member satisfaction. From a system perspective, it will increase efficiency, reduce administrative burden, and foster transparency and accountability.

American Indians determined to have a SMI can choose to enroll as follows: 1) in an Integrated RBHA/Health Plan to receive both physical health services and behavioral health services, 2) in an Acute Care Contractor for physical health services and receive behavioral health services
American Indians enrolled in Medicaid and Medicare and receiving general mental health and substance use treatment services, can choose to enroll as follows: 1) in an Acute Care Contractor to receive both physical health services and behavioral services (adults 18 and over only), 2) in an Acute Care Contractor for physical health services and receive behavioral health services from a T/RBHA/Health Plan; or in AIHP for physical health services and receive behavioral health services from a T/RBHA/Health Plan.

1.1.2 Tribal and Regional Behavioral Health Authorities (T/RBHAs)/Health Plans

AHCCCS contracts with Regional Behavioral Health Authorities (RBHA/Health Plans) to deliver services to assigned Service Regions. Each RBHA/Health Plan is required to have a network of providers to deliver all covered services. RBHA/Health Plans contract with providers to provide the full array of covered services.

ADHS also contracts with Tribal Regional Behavioral Health Authorities (T/RBHAs). The Tribal RBHAs include Pascua Yaqui Tribe of Arizona, Gila River Indian Community and the White Mountain Apache Tribe. As of July 1, 2004, the Navajo Nation transitioned from a Tribal RBHA to a Tribal Contractor providing Medicaid and state-only services to members of the Navajo Nation through a new intergovernmental agreement (IGA). The State also has an IGA with the Colorado River Indian Tribe (CRIT) to provide covered services to Non-Title XIX/XXI persons who are affiliated with the Tribal Contractor by virtue of being federally-recognized Tribal members, who live on the Tribal Contractor's reservation and who are assessed as needing covered services in accordance with the AHCCCS Covered Behavioral Health Services Guide.

T/RBHA/Health Plans by County:

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<td>Health Choice Integrated Care</td>
<td>Gila, Mohave, Coconino, Apache, Navajo, Yavapai</td>
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<tr>
<td>Mercy Maricopa Integrated Care</td>
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<td>Gila River Indian Community</td>
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<tr>
<td>Pascua Yaqui Tribe of Arizona</td>
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<td>White Mountain Apache Tribe</td>
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AHCCCS, in partnership with the Tribal and Regional Behavioral Health Authorities (T/RBHAs)/Health Plans, promotes collaboration and encourages family centered, personalized and culturally relevant healthcare services that result in positive outcomes for Members. The expected outcomes include, but are not limited to:

- Improved functioning;
1.1.3 Overview of Cenpatico Integrated Care

Cenpatico of Arizona, Inc. dba Cenpatico IC is the Regional Behavioral Health Authority serving Pima, Pinal, La Paz, Greenlee, Graham, Cochise, Yuma and Santa Cruz counties. Cenpatico IC’s mission statement is, “Empowering Communities... Inspiring Hope”. Cenpatico IC believes it will be the most successful in helping people reach their recovery and wellness goals when Members, system partners, stakeholders, and providers have an equal voice in the system.

Cenpatico IC’s network structure is designed to promote recovery, resiliency and wellness through maximizing “voice and choice.” Cenpatico IC wants Members to have a choice of providers and services and be in charge of their individual service plans. Cenpatico IC’s network is designed to remove barriers that prevent people from reaching their wellness and recovery goals and help Members lead productive lives in their communities. Cenpatico IC has three types of provider contracts in its network: Health Home (Intake and Care Coordination Agency), Specialty Behavioral Health Provider, and Physical Health Provider contracts.

Members are asked to select a Health Home to assist them in receiving the services that will support their recovery and wellness goals. Members can elect to receive services from any provider in the Cenpatico IC network, regardless of which agency they select to serve as their Health Home provider. Health Homes are responsible for completing enrollments and demographics; establishing and maintaining individualized treatment teams; providing clinical intakes, assessments, service planning, coordination of care, psychiatric services, transportation, case management and coordinating care with physical health providers; verifying Members are receiving the services they need to live safely and successfully in their communities; and verifying Members reach their recovery, resiliency and wellness goals.

Specialty Behavioral Health Providers are responsible for delivering specialty services and programs as identified on individual service plans, regularly reporting progress to Health Home treatment teams, coordinating services with Health Homes and attending treatment team meetings as appropriate.

Physical health providers offer an array of physical health care to adults with SMI, with the goal of providing clinical integration of services and improving the overall health of adults with SMI.

Cenpatico IC monitors provider performance to verify Members are receiving timely access to quality services that support recovery, resiliency and wellness. For more information about Cenpatico IC and its services, please visit www.cenpaticointegratedcareaz.com.

1.1.4 Arizona System Values and Guiding Principles

The following values, guiding system principles, and goals are the foundation of the public health system. Providers shall administer and deliver services consistent with these values, principles and goals:

- Member and family member involvement at all system levels;

- Reduced symptoms stemming from behavioral health problems;
- Improved overall health, both behavioral and physical; and
- Improved quality of life for families and individuals.
- Collaboration with the greater community;
- Effective innovation by promoting evidence-based practices;
- Expectation for continuous quality improvement;
- Cultural competency;
- Improved health outcomes;
- Reduced health care costs;
- System transformation;
- Transparency; and
- Prompt and easy access to care.

In addition, providers must follow the Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems and The Arizona Vision-Twelve Principles for Children Service Delivery.

1.1.5 Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems

AHCCCS requires that providers implement adult services consistent with the AHCCCS Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems. Those nine guiding principles are listed below:

1. Respect;
2. Persons in recovery choose services and are included in program decisions and program development efforts;
3. Focus on individual as a whole person, while including and/or developing natural supports;
4. Empower individuals taking steps towards independence and allowing risk taking without fear of failure;
5. Integration, collaboration, and participation with the community of one's choice;
6. Partnership between individuals, staff, and family members/natural supports for shared decision making with a foundation of trust;
7. Persons in recovery define their own success;
8. Strengths-based, flexible, responsive services reflective of an individual's cultural preferences; and
9. Hope is the foundation for the journey towards recovery.

1.1.6 The Arizona Vision-Twelve Principles for Children Service Delivery

The State requires that services be delivered to all children consistent with the “Arizona Vision" and according to the twelve Arizona Children’s Principles. The Arizona Vision states: “In collaboration with the child and family and others, Arizona will provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Services will be tailored to the child
The Twelve Principles for Children Service Delivery are:

1. Collaboration with the child and family;
2. Functional outcomes;
3. Collaboration with others;
4. Accessible services;
5. Evidenced-Based Best Practices;
6. Most appropriate setting;
7. Timeliness;
8. Services tailored to the child and family;
9. Stability;
10. Respect for the child and family’s unique cultural heritage;
11. Independence; and
12. Connection to natural supports.

1.1.7 Arizona Integrated Health Care Service Delivery Principles for Persons with a Serious Mental Illness

Coordinating and integrating primary and behavioral health care is expected to produce improved access to primary care services, increased prevention, early identification, and intervention to reduce the incidence of serious physical illnesses, including chronic disease. Increasing and promoting the availability of integrated, holistic care for Members with chronic behavioral and physical health conditions will help Members achieve better overall health and an improved quality of life. The principles below describe AHCCCS’s vision for integrated care service delivery. However, many of them apply to all populations for all services in all settings. For example, concepts such as recovery, Member input, family involvement, person-centered care, communication and commitment are examples that describe well-established expectations AHCCCS has in all of its behavioral health care service delivery contracts.

While these principles have served as the foundation for successful behavioral health service delivery, providing whole-health integrated care services to individuals with SMI—primarily because of chronic, preventable, physical conditions—is a challenge that calls for a new approach that will improve health care outcomes in a cost-effective manner. To meet this challenge, Cenpatico IC is required be creative and innovative in its oversight and management of the integrated service delivery system, AHCCCS expects Cenpatico IC and providers to embrace the principles below and demonstrate an unwavering commitment to treat each and every Member with dignity and respect as if that Member were a relative or loved one seeking care.

Cenpatico IC and providers must embed the following principles in implementing an integrated health care service delivery system:
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, Coordination of Care, 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.

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.

Cenpatico IC and providers are further required to incorporate the following elements into the integrated health care service delivery system approach:

- A treatment team, which includes a psychiatrist or equivalent behavioral health medical professional and an assigned primary care physician with an identified single point of contact;
- Member and family voice and choice;
- Whole-person oriented care;
- Quality and safety;
- Accessible care;
- Effective use of a comprehensive Care Management Program;
- Coordination of care;
- Health education and health promotion services;
- Improved whole health outcomes of Members;
- Utilize peer and family delivered support services;
- Make referrals to appropriate community and social support services; and
- Utilize health information technology to link services.
In addition, providers must maximize the use of existing behavioral and physical health infrastructure including clinics, primary care physicians currently serving adults with SMI, Community Health Centers, and peer and family run organizations.

Strategies providers shall use to achieve these system goals include:

- Earlier identification and intervention that reduces the incidence and severity of serious physical, and mental illness;
- Use of health education and health promotion services;
- Increased use of primary care prevention strategies;
- Use validated screening tools;
- Focused, targeted, consultations for behavior health conditions;
- Cross-specialty collaboration;
- Enhanced discharge planning and follow-up care between provider visits;
- Ongoing outcome measurement and treatment plan modification;
- Coordination of Care through effective provider communication and management of treatment; and
- Member, family, and community education.

Achievement of system goals will result in outcomes such as reduced rates of unnecessary or inappropriate emergency room use, reduced need for repeated hospitalization and re-hospitalization, reduction or elimination of duplicative health care services and associated costs, and improved Member’s experience of care and individual health outcomes.

1.2 Provider Manual

1.2.1 Terminology

Consistent terminology throughout Cenpatico IC’s Provider Manual is used to the extent possible. Persons receiving services are generally referred to as “Members”; however, Members are sometimes referenced as “participants,” “individuals,” or simply as “persons.”

1.2.2 Revisions to Cenpatico Integrated Care Provider Manual

Policies established as medical policies are updated annually or more frequently, if changes are necessary. Other sections of the Cenpatico IC Provider Manual are updated on an ongoing basis, but at a minimum, each section will be reviewed every two years. Cenpatico IC issues Provider Manual Clarification Memoranda to contracted providers and posts them to Cenpatico IC’s website at www.cenpaticointegratedcareaz.com. In addition, AHCCCS issues Policy Clarification Memoranda and posts them on the AHCCCS website at: https://www.azahcccs.gov/PlansProviders/GuidesManualsPolicies/guidesandmanuals.html. Cenpatico IC incorporates these changes upon receipt and as appropriate into the Cenpatico IC Provider Manual.

Providers, stakeholders, and others may provide comments and request for revisions to the Cenpatico IC Provider Manual by contacting the Contracts Department at 1-866-495-6738. The
The most current revision to the Provider Manual can be obtained at www.cenpaticointegratedcareaz.com.

Any policies developed by Cenpatico IC that establish requirements for the provision of behavioral health services are required to be submitted to the AHCCCS Policy Office prior to implementation.

*Cenpatico IC has no policies that prevent providers from advocating on behalf of Members as specified in 42 CFR 438.102.*

### 1.3 Provider Services

Cenpatico IC customer service provider relations staff are responsible to receive and track all provider inquiries and verify timely responses. Provider relations staff are available 8:00 AM to 5:00 PM to provide immediate responses to provider inquiries. Cenpatico IC seeks to resolve each request for information during the initial call. If additional information is needed to respond to the provider’s inquiry the call will be logged and routed to the subject matter expert best able to answer the provider’s question. The Cenpatico IC customer service provider relations staff track all inquiries referred to subject matter experts to verify timely responses and satisfaction with the responses. Cenpatico will acknowledge all provider calls within three (3) business days of receipt and will communicate the final resolution the provider within thirty (30) business days of receipt (including provider referrals from AHCCCS).

Provider complaints received by the customer service provider relations staff are logged and routed to the Grievance and Appeals Department for research and resolution.

### 1.4 Joining the Cenpatico Provider Network

The process to join the Cenpatico IC Provider Network begins with the submission of an application to join the network submitted through our Network Development Department. Applications to join the Cenpatico IC Network are available on our website at www.Cenpaticointegratedcareaz.com. All applications are reviewed at the quarterly Cenpatico IC Prospective Provider Committee. The Committee reviews the application and the needs of the Network and issues a determination, which may include approval to move forward, denial, or pended for more information. If approved, the application request is given to the Contracts department to work with the applicant to start the credentialing process and prepare and execute the contract.

### 1.5 Cenpatico Organizational Structure

Cenpatico IC’s organizational structure has been established to facilitate effective integration of behavioral health and physical health care, promote recovery, maximize member and family voice and promote continuous quality improvement. The leadership team includes the Plan President, Executive Director, Chief Medical Officer, Chief Officer of Integrated Care, Vice President of Medical Management, Senior Director of Finance, and Corporate Compliance Officer. The leadership team under the direction of the Plan President is responsible and accountable for the direction and oversight of Cenpatico IC. The Chief Medical Officer is responsible for clinical oversight. Providers are encouraged to call the customer service provider.
services department for assistance at 866-495-6738. The Plan President, Executive Director and the Chief Officer of Integrated Care serve as the points of contact for critical Cenpatico IC communication.

Section 2 - COVERED SERVICES AND RELATED PROGRAM REQUIREMENTS

2.1  Covered Behavioral Health Services Based on Eligibility

AHCCCS has developed a comprehensive array of covered behavioral health services to meet the individual needs of eligible persons. Covered services assist and encourage each person to achieve and maintain the highest possible level of health and self-sufficiency. The type of service covered is contingent on each person’s current eligibility status and, for some persons, is based on available funding. All behavioral health services are required to be medically necessary, based upon the needs of the person. Providers are required to operate within their scope of practice.

The AHCCCS Covered Behavioral Health Services Guide contains information regarding each of the covered services that are available through the publicly funded health care system including: a definition of each service; the requirements of individuals or agencies providing the service; and any limitations to using or billing for the service. Providers must deliver covered services in accordance with the AHCCCS Covered Behavioral Health Services Guide, the AHCCCS Policy and Procedures Manual, the AHCCCS Medical Policy Manual, the AHCCCS Contractor Operations Manual, and the requirements of any other funding source (i.e., Medicare Advantage requirements for dual eligible Members).

2.1.1  Eligibility Requirements

Providers must screen individuals for AHCCCS eligibility and, as applicable, assist individuals with applying for AHCCCS and/or enrolling in Medicare Part D \textit{Section 3.1 — Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage and the Limited Income Subsidy Program}).

Services for Non-Title XIX/XXI persons determined to have a Serious Mental Illness (SMI) are subject to available funding, as appropriated by the Arizona Legislature. T/RBHA/Health Plans are required to verify that Non-Title XIX/XXI funding allocated by the State for each geographic service area (GSA) is available for services throughout the fiscal year.

Decisions made with respect to the coverage and provision of services are subject to \textit{Section 15.4 — Notice and Appeal Requirements (SMI and GMH/SA Non-Title XIX/XXI))}.

Services must be provided in collaboration with other agencies to coordinate the culturally appropriate delivery of covered behavioral health services with other services provided to the person and the person’s family.

Covered behavioral health services may be available to family members of Title XIX/XXI eligible persons enrolled with a T/RBHA/Health Plan to the extent that services are provided in support of the treatment goals of the identified eligible or enrolled person.
### 2.1.2 COVERED BEHAVIORAL HEALTH SERVICES TABLE

The Covered Behavioral Health Services Table below lists the available covered services for Cenpatico IC enrolled Members and Non-Title XIX/XXI, persons determined to have a Serious Mental Illness. These services must be provided by AHCCCS-registered providers, ADHS-only providers or Medicare registered providers. The Covered Services Table is a condensed summary of available services and related funding sources. Providers may reference the AHCCCS Covered Behavioral Health Services Guide for more detailed information.

**Available Behavioral Health Services**

<table>
<thead>
<tr>
<th>BEHAVIORAL HEALTH SERVICES</th>
<th>TITLE XIX/XXI CHILDREN AND ADULTS</th>
<th>NON-TITLE XIX/XXI PERSONS DETERMINED TO HAVE SMI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TREATMENT SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Counseling and Therapy</td>
<td>Individual: Available</td>
<td>Provided based on available funds*</td>
</tr>
<tr>
<td></td>
<td>Group: Available</td>
<td>Provided based on available funds*</td>
</tr>
<tr>
<td></td>
<td>Family: Available</td>
<td>Provided based on available funds*</td>
</tr>
<tr>
<td>Behavioral Health Screening, Mental Health Assessment and Specialized Testing</td>
<td>Behavioral Health Screening:</td>
<td>Provided based on available funds*</td>
</tr>
<tr>
<td></td>
<td>Mental Health Assessment:</td>
<td>Available</td>
</tr>
<tr>
<td></td>
<td>Specialized Testing: Available</td>
<td>Provided based on available funds*</td>
</tr>
<tr>
<td>Other Professional</td>
<td>Traditional Healing: Available</td>
<td>Provided based on available funds*</td>
</tr>
</tbody>
</table>

*Provided based on available funds*
### Auricular Acupuncture
- Provided based on available funds*

#### REHABILITATION SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>Individual</th>
<th>Available</th>
<th>Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skills Training and Development</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>Available</td>
<td>Available</td>
<td>Available</td>
</tr>
<tr>
<td>Extended</td>
<td>Available</td>
<td>Available</td>
<td>Available</td>
</tr>
<tr>
<td>Cognitive Rehabilitation</td>
<td>Available</td>
<td>Available</td>
<td>Available</td>
</tr>
<tr>
<td>Behavioral Health Prevention/Promotion</td>
<td>Available</td>
<td>Available</td>
<td>Available</td>
</tr>
<tr>
<td>Psycho Educational Services and Ongoing Support to Maintain Employment</td>
<td>Psycho Educational</td>
<td>Available</td>
<td>Available</td>
</tr>
<tr>
<td></td>
<td>Ongoing Support to Maintain Employment</td>
<td>Available</td>
<td>Available</td>
</tr>
</tbody>
</table>

#### MEDICAL SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>Available**</th>
<th>Available**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Services**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab, Radiology and Medical Imaging</td>
<td>Available</td>
<td>Available</td>
</tr>
<tr>
<td>Medical Management</td>
<td>Available**</td>
<td>Available**</td>
</tr>
<tr>
<td>Electro-Convulsive Therapy</td>
<td>Available</td>
<td>Provided based on available funds*</td>
</tr>
</tbody>
</table>

#### SUPPORT SERVICES

<p>| Service                                      | Available | Available | Available |
|----------------------------------------------|          |          |          |
| Case Management                              | Available | Available | Available |
| Personal Care                                | Available | Available | Available |
| Home Care Training (Family)                  | Available | Available | Available |
| Self Help/Peer Services                      | Available | Available | Available |
| Home Care Training to Home Care Client (HCTC) | Available | Provided based on available funds* | |
| Respite Care                                 | Available*** | Available*** | |
| Supported Housing                            | Provided based on available funds* | Provided based on available funds* |</p>
<table>
<thead>
<tr>
<th>Service</th>
<th>Availability</th>
<th>Funding Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sign Language or Oral Interpretive Service</td>
<td>Provided at no charge to the Member</td>
<td>Provided at no charge to the Member</td>
</tr>
<tr>
<td>Flex Fund Services</td>
<td>Provided based on available</td>
<td>Provided based on available funds*</td>
</tr>
<tr>
<td>Transportation</td>
<td>Emergency Available</td>
<td>Limited to crisis service-related transportation</td>
</tr>
<tr>
<td></td>
<td>Non-Emergency Available</td>
<td>Available</td>
</tr>
</tbody>
</table>

**Crisis Intervention Services**

- Crisis Intervention – Mobile: Available
- Crisis Intervention - Telephone: Available
- Crisis Intervention - Stabilization: Available

**Inpatient Services**

- Hospital: Available
- Behavioral Health Inpatient Facility: Available but limited††

**Residential Services**

- Behavioral Health Residential Facility: Available
- Room and Board: Provided based on available funds* | Provided based on available funds*

**Behavioral Health Day Programs**

- Supervised Day: Available
- Therapeutic Day: Available | Provided based on available funds*
- Medical Day: Available | Provided based on available funds*

* Services not available with TXIX/XXI funding, but may be provided based upon available grant funding and approved use of general funds.
** See the Cenpatico IC Formulary for further information on covered medications.
*** Respite Care – Respite care is offered as a temporary break for caregivers to take time for themselves. A member’s need is the basis for determining the number of respite hours used. The maximum number of hours available is 600 hours within a 12 month period of time. The 12 months will run from October 1 through September 30 of the next year.

*A person may be assigned a Health Care Coordinator (case manager), based on his/her needs.

†Coverage is limited to 23 hour crisis observation/stabilization services, including detoxification services. Up to 72 hours of additional crisis stabilization may be covered based upon the availability of funding.

2.1.3 Second Responder and Community Stabilization Services

Second responder and community stabilization services are community based services designed to help members live successfully in the community and avoid the need for a higher level of care.

Second responder services are provided following a crisis. Crisis services include Crisis Mobile Team, Community Observation Center (COS) or Crisis Living Room services. Second Responder Services must end on or before 45 days after the first day of the crisis episode. Second Responder Services are considered crisis services and crisis paperwork requirements apply to these services. Services should be documented clearly as crisis services.

Community Stabilization Services are designed to prevent a crisis following the observation of crisis warning signs. Members at risk of a crisis event are eligible for Community Stabilization Services. Community Stabilization Services may be obtained by contacting the specialty provider directly. Community Stabilization Services may be requested by Health Homes or system partners. The services can be added to the Individualized Service Plan created by the Health Homes or they can be added to a Specialty Service Plan created by the specialty agency.

When billing for Second Responder and Community Stabilization Services, the diagnosis on the claim must match the diagnosis in the treating provider’s clinical chart. Program descriptions and coverage areas are listed in the below table.

<table>
<thead>
<tr>
<th>Program</th>
<th>County Location</th>
<th>Eligible Population</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer Crisis AfterCare</td>
<td>Pima</td>
<td>All adult members: T19 and NT19</td>
<td>NT19 &amp; T19</td>
</tr>
<tr>
<td>Foster Care Stabilization</td>
<td>Pima</td>
<td>All Medicaid Enrolled Children in Foster Care</td>
<td>T19</td>
</tr>
<tr>
<td>IDD &amp; Behavior Management</td>
<td>Pima</td>
<td>All Medicaid Enrolled Adults and Children with IDD</td>
<td>T19</td>
</tr>
<tr>
<td>Housing Support</td>
<td>Pima</td>
<td>All Medicaid Adults and Adolescents and NT19 Adults with SMI</td>
<td>T19 &amp; NT19 SMI</td>
</tr>
</tbody>
</table>
2.1.4  Medicare Part D Prescription Drug Coverage

Persons eligible for Medicare Part D must access the Medicare Part D prescription drug coverage by enrolling with a Medicare Prescription Drug Plan (PDP) or Medicare Advantage Prescription Drug plan (MA-PD). Persons eligible for both Medicare Part D and Title XIX/XXI (AHCCCS) will continue to have coverage of the following excluded Part D drugs through Title XIX/XXI, if not included in the PDP or MA plans’ formulary:

- Benzodiazepines;
- Barbiturates; and
- Certain over the counter drugs.

2.1.5  Support Funds

Providers may provide support funds based on available funding. Support funds may only be used for non-medically necessary goods and/or services that are described in the person’s service plan and cannot be purchased by any other funding source. The goods and/or services to be provided using support funds must be related to one or more of the following outcomes:

- Success in school, work, or other occupation;
- Living at the person’s own home or with family;
- Development and maintenance of personally satisfying relationships;
- Prevention or reduction in adverse outcomes; and/or
- Becoming or remaining a stable and productive member of the community.

Support funds must not be used for:

- Inpatient or other covered behavioral health services;
- The purchase or improvement of land;
- The purchase, construction, or permanent improvement of any building or other facility (with the exception of minor remodeling consistent with this section);
- The purchase of major medical equipment; and
- Any other prohibited activity as detailed in 45 CFR Part § 96.135 et seq.

Providers must use support funds for the direct purchase of goods and/or services and may not provide flex funds as direct cash payments to Members or their families. See the AHCCCS Covered Behavioral Health Services Guide for additional information regarding flex funds and applicable billing limitations.

Support fund services may be approved in an amount up to $1,525 per individual/family per year. Cenpatico IC places Support Funds in provider agreements based on availability of funds. Support Fund requests must be reviewed by the provider’s Clinical Director and treatment team to verify all community resources and alternatives have been exhausted prior to requesting Support Funds.

Cenpatico IC reviews Support Fund utilization by monitoring claims on a monthly basis and reviewing clinical records during chart audits on a quarterly basis. Cenpatico IC limits the use of
Support Fund to goods or services not reimbursable through Medicaid, other pay sources, family members, or local resources. Support Funds cannot be used for drugs, food, vacations, cell phones, computers, plane tickets, or gifts. Support Funds are not an entitlement and cannot be used to cover ongoing living, educational, or recreational expenses. Support Funds can only be used for one-time expenditures that remove barriers to helping Members reach their recovery goals.

Provider requests for Support Funds in excess of $1,525 per year are required to be submitted in writing to Cenpatico IC’s contracts department for review and submission to the State for final approval.

2.2 Covered Physical Health Services for Title XIX/XXI Adults with SMI

The table below lists physical health care services available for eligible Members determined to have a Serious Mental Illness (SMI), who are receiving both behavioral health and physical health care services from Cenpatico IC (see the AHCCCS Covered Services, Acute Care, listed in the AHCCCS Medical Policy Manual, for further information on covered physical health care services and dental services). These services must be provided by AHCCCS registered providers, ADHS-only providers or Medicare registered providers. Physical health providers may reference the AHCCCS Medical Policy Manual for more detailed information.

<table>
<thead>
<tr>
<th>Available Physical Health Care Services</th>
<th>TITLE XIX/XXI Adults with SMI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age 18-20</td>
</tr>
<tr>
<td>Audiology</td>
<td>X</td>
</tr>
<tr>
<td>Breast Reconstruction after Mastectomy</td>
<td>X</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>X</td>
</tr>
<tr>
<td>Cochlear Implants</td>
<td>X</td>
</tr>
<tr>
<td>Emergency Dental Services</td>
<td>X</td>
</tr>
<tr>
<td>Preventative &amp; Therapeutic Dental Services</td>
<td>X</td>
</tr>
<tr>
<td>Limited Medical and Surgical Services by a Dentist (for Members Age 21 and older)</td>
<td></td>
</tr>
<tr>
<td>Supplemental Dental Coverage Based on Criteria Established by Cenpatico IC</td>
<td>X</td>
</tr>
<tr>
<td>Dialysis</td>
<td>X</td>
</tr>
<tr>
<td>Emergency Services – Medical</td>
<td>X</td>
</tr>
<tr>
<td>Emergency Eye Exam</td>
<td>X</td>
</tr>
<tr>
<td>Vision Exam/Prescriptive Lenses</td>
<td>X</td>
</tr>
<tr>
<td>Lens Post Cataract Surgery</td>
<td>X</td>
</tr>
<tr>
<td>Treatment for Medical Condition of the Eye</td>
<td>X</td>
</tr>
<tr>
<td>PHYSICAL HEALTH CARE SERVICES</td>
<td>TITLE XIX/XXI Adults with SMI</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td></td>
<td>Age 18-20</td>
</tr>
<tr>
<td>Health Risk Assessment &amp; Screening Tests (for Members age 21 and older)</td>
<td></td>
</tr>
<tr>
<td>Preventive Examinations in the Absence of any Known Disease or Symptom</td>
<td>X</td>
</tr>
<tr>
<td>HIV/AIDS Antiretroviral Therapy</td>
<td>X</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>X</td>
</tr>
<tr>
<td>Hospice</td>
<td></td>
</tr>
<tr>
<td>Hospital Inpatient Medical</td>
<td>X</td>
</tr>
<tr>
<td>Hospital Observation</td>
<td>X</td>
</tr>
<tr>
<td>Hospital Outpatient Medical</td>
<td>X</td>
</tr>
<tr>
<td>Hysterectomy (medically necessary)</td>
<td>X</td>
</tr>
<tr>
<td>Immunizations</td>
<td>X</td>
</tr>
<tr>
<td>Laboratory</td>
<td>X</td>
</tr>
<tr>
<td>Maternity Services</td>
<td>X</td>
</tr>
<tr>
<td>Family Planning</td>
<td>X</td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnosis and Treatment (Medical Services)</td>
<td>X</td>
</tr>
<tr>
<td>Other Early and Periodic Screening, Diagnosis and Treatment Services Covered by Title XIX/XXI</td>
<td>X</td>
</tr>
<tr>
<td>Medical Foods</td>
<td>X</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>X</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>X</td>
</tr>
<tr>
<td>Prosthetic</td>
<td>X</td>
</tr>
<tr>
<td>Orthotic Devices</td>
<td>X</td>
</tr>
<tr>
<td>Nursing Facilities (up to 90 days)</td>
<td>X</td>
</tr>
<tr>
<td>Non-Physician First Surgical Assistant</td>
<td>X</td>
</tr>
<tr>
<td>Physician Services</td>
<td>X</td>
</tr>
<tr>
<td>Foot and Ankle Services</td>
<td>X</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>X</td>
</tr>
<tr>
<td>Primary Care Provider Services</td>
<td>X</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>X</td>
</tr>
<tr>
<td>Radiology and Medical Imaging</td>
<td>X</td>
</tr>
<tr>
<td>Occupational Therapy – Inpatient</td>
<td>X</td>
</tr>
<tr>
<td>Occupational Therapy – Outpatient</td>
<td>X</td>
</tr>
<tr>
<td>PHYSICAL HEALTH CARE SERVICES</td>
<td>TITLE XIX/XXI Adults with SMI</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td></td>
<td>Age 18-20</td>
</tr>
<tr>
<td>Physical Therapy – Inpatient</td>
<td>X</td>
</tr>
<tr>
<td>Physical Therapy – Outpatient</td>
<td>X</td>
</tr>
<tr>
<td>Speech Therapy – Inpatient</td>
<td>X</td>
</tr>
<tr>
<td>Speech Therapy – Outpatient</td>
<td>X</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>X</td>
</tr>
<tr>
<td>Total Outpatient Parenteral Nutrition</td>
<td>X</td>
</tr>
<tr>
<td>Non-Experimental Transplants Approved for</td>
<td></td>
</tr>
<tr>
<td>Title XIX/XXI Reimbursement*</td>
<td></td>
</tr>
<tr>
<td>Transplant Related Immunosuppressant Drugs</td>
<td>X</td>
</tr>
<tr>
<td>Transportation – Emergency</td>
<td>X</td>
</tr>
<tr>
<td>Transportation – Non-emergency</td>
<td>X</td>
</tr>
<tr>
<td>Triage</td>
<td></td>
</tr>
<tr>
<td>Well Exams</td>
<td></td>
</tr>
</tbody>
</table>

*See the AHCCCS Medical Policy Manual, Chapter 300, Policy 310, 310-DD, Covered Transplants and Related Immunosuppressant Medications.

### 2.3 Maternity Services for Title XIX/XXI Adults with SMI

Maternity care services include, but are not limited to, pregnancy identification, prenatal services, treatment of pregnancy related conditions, labor and delivery services, postpartum depression screening, and postpartum care.

#### 2.3.1 Maternity Care Provider Standards

Health Home Providers must confirm that adults with SMI who are receiving physical health care services and who are pregnant have a designated maternity care provider for the duration of the Member’s pregnancy and postpartum care. Members have a choice to be assigned a PCP that provides obstetrical care consistent with the freedom of choice requirements for selecting health care professionals so as not to compromise the Member’s continuity of care. For anticipated low-risk deliveries, Members may elect to receive labor and delivery services in their home from their maternity provider and may also elect to receive prenatal care, labor and delivery, and postpartum care by certified nurse midwives or licensed midwives.

Women will receive up to 48 hours of inpatient hospital care after a routine vaginal delivery and up to 96 hours of inpatient care after a cesarean delivery. The attending health care provider, in consultation with the mother, may discharge the mother prior to the minimum length of stay.
For Members receiving maternity services from a certified nurse midwife or a licensed midwife, Cenpatico IC will assign a PCP to provide other health care and medical services. A certified nurse midwife may provide those primary care services that he or she is willing to provide and that the Member elects to receive from the certified nurse midwife. Members receiving care from a certified nurse midwife may also elect to receive some or all of her primary care from the assigned PCP. Licensed midwives may not provide any additional medical services as primary care that are not within their scope of practice.

All physicians and certified nurse midwives who perform deliveries are required to have OB hospital privileges or a documented hospital coverage agreement for those practitioners performing deliveries in alternate settings. Licensed midwives perform deliveries only in the Member’s home. Physicians, certified nurse practitioners, and certified nurse midwives within the scope of their practice may provide labor and delivery services in the Member's home.

All Maternity Care Providers are required to coordinate care with the member’s Health Care Coordinator and behavioral health treatment team throughout the pregnancy, delivery and postpartum treatment. Particular attention should be given to the screening, assessment and treatment of perinatal mood disorders, to include post-partum depression.

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

2.3.2 General Obstetrical Standards of Care

All providers must follow the American College of Obstetrics and Gynecology (ACOG) standards of care, which include, but are not limited to the following:

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

Routine prenatal visits with blood pressure, weight, fundal height (tape measurement), fetal heart tones, urine dipstick for protein and glucose, ongoing risk assessment with any change in pregnancy risk recorded and an appropriate management plan.

Providers providing pre-natal and post-natal care must submit a monthly report regarding the member’s pregnancy and postpartum care. PMF2.3.1 identifies each data point and when it is due to Cenpatico. PMF 2.3.1 starts with notification of pregnancy and continues through postpartum follow-up between 21 and 56 days after delivery, postpartum screening for depression and referrals for women who have been screened positive for postpartum
depression. Postpartum screening must be done according to the AHCCCS Tool Kit for the Management of Adult Postpartum Depression.

In addition, providers must educate Members about healthy behaviors during pregnancy, including proper nutrition, effects of alcohol and drugs, the physiology of pregnancy, the process of labor and delivery, breast feeding, and other infant care information. Providers are also required to educate Members about elective deliveries prior to 39 weeks and/or C-sections unless medically necessary; signs and symptoms of preterm labor; effects of smoking, diabetes, hypertension on pregnancy and/or fetus/infant; prenatal and postpartum visits. Providers are required to offer HIV/AIDS testing and confidential post testing counseling to all Members.

### 2.3.3 Maternity Appointment Standards

For maternity care appointments for initial prenatal care for pregnant SMI Members:

- First trimester: within fourteen (14) days of request;
- Second trimester: within seven (7) days of request;
- Third trimester: within three (3) days of request; and
- High risk pregnancies: within three (3) days of a maternity care provider’s identification of high risk or immediately if an emergency exists.

### 2.3.4 Newborns

A normal newborn may be granted an extended stay in the hospital of birth when the mother’s continued stay in the hospital is beyond the 48 or 96 hour stay. However, for payment purposes, inpatient limits will apply to the extent consistent with EPSDT.

The newborn will not be covered under Cenpatico IC but will be covered by another AHCCCS Health Plan. Prior to the birth of the baby, the mother will be asked to select a PCP for the newborn. The newborn is assigned to the pre-selected PCP after delivery. The mother may elect to change the assigned PCP at any time.

### 2.3.5 High Risk Maternity and Perinatal Care Management

Cenpatico IC Integrated Care Managers, together with providers, identify pregnant women who are at risk for adverse pregnancy outcomes. Cenpatico IC assists providers in managing the care of at risk pregnant Members due to medical conditions, social circumstances, severe mental illness or non-compliant behaviors. Cenpatico IC evaluates At Risk Members for ongoing follow up during their pregnancy.

Cenpatico IC’s perinatal care management provides comprehensive care management services to high risk pregnant Members, for the purpose of improving maternal and fetal birth outcomes. The perinatal care management team consists of a social worker, care management associates, and professional registered nurses skilled in working with the unique needs of high risk pregnant women. Perinatal Integrated Care Managers take a collaborative approach in working with Health Home Health Care Coordinators and PCPs to engage high risk pregnant Members throughout their pregnancy and post-partum period. Members who present with high risk perinatal conditions should be referred to perinatal care management. These conditions include:

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

2.3.6 Reporting High Risk and Non-Adherent Behaviors in Pregnant Women

Health Home Health Care Coordinators, obstetrical physicians and practitioners must refer all “at risk” pregnant Members to Cenpatico IC. The following types of situations must be reported to Cenpatico IC for Members that:

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

2.3.7 Outreach, Education and Community Resources for Pregnant Women

Cenpatico IC is committed to maternity care outreach. Maternity care outreach is an effort to identify currently enrolled pregnant women and to enter them into prenatal care as soon as possible, but no later than within the first trimester or 42 days after enrollment. Health Home Health Care Coordinators, PCPs, and other treating providers are expected to ask about pregnancy status when Members call for appointments, to report positive pregnancy tests to Cenpatico IC, and to provide general education and information about prenatal care, when
appropriate, during Member office visits. Pregnant Members will continue to receive primary care services from their assigned PCP during their pregnancy.

Cenpatico IC is involved in many community efforts to increase the awareness of the need for prenatal care. PCPs are strongly encouraged to actively participate in these outreach and education activities, including the WIC Nutritional Program. Please encourage Members to enroll in this program. Various other services are available in the community to help pregnant women and their families. Please call Cenpatico IC for information about how to help your patients use these services.

Questions regarding the availability of community resources may also be directed to the Arizona Department of Health Services (ADHS) Hot Line at 800-833-4642.

2.3.8 Loss of AHCCCS Coverage During Pregnancy

Members may lose AHCCCS eligibility during pregnancy. Although Members are responsible for maintaining their own eligibility, providers are encouraged to notify Cenpatico IC if they are aware that a pregnant Member is about to lose or has lost eligibility. Cenpatico IC member services can assist in coordinating or resolving eligibility and enrollment issues so that pregnancy care may continue without a lapse in coverage. Please call Member Services at 866-495-6738 to report eligibility changes for pregnant Members.

2.4 Family Planning for Title XIX/XXI Adults with SMI

Cenpatico IC covers family planning services in accordance with the AHCCCS Medical Policy Manual for all Members (male and female) who choose to delay or prevent pregnancy. Services include, but are not limited to, contraceptive counseling, medication and supplies (such as oral and injectable contraceptives, subdermal implantable contraceptives, intrauterine devices, diaphragms, condoms, foams and suppositories), medical and laboratory examinations, treatment of complications resulting from contraceptive use (including emergency treatment), natural family planning education and referrals to health professionals, and post-coital emergency oral contraception within 72 hours after unprotected sexual intercourse (RU 486 is not a post-coital emergency oral contraception).

Family planning services do not include infertility services, pregnancy termination counseling, pregnancy terminations, or hysterectomies.

2.4.1 Requirements for Providing Family Planning Services

Providers are required to collaborate with Cenpatico IC to implement effective family planning services which includes:

1. Notifying Members of reproductive age of the specific covered family planning services available and how to request them. Notification must be in accordance with ARS § 36.2904(L). The information provided to Members should include, but is not limited to:
   a. A complete description of covered family planning services available;
   b. Information advising how to request/obtain these services;
   c. Information that assistance with scheduling is available; and
d. A statement that there is no charge for these services.

2. Provide family planning services that are:
   a. Provided in a manner free from coercion or behavioral/mental pressure;
   b. Available and easily accessible to Members;
   c. Provided in a manner which assures continuity and confidentiality;
   d. Provided by, or under the direction of, a qualified physician or practitioner; and
   e. Documented in the medical record. In addition, documentation must be recorded that each Member of reproductive age was notified verbally or in writing of the availability of family planning.

3. Provide translation/interpretation of information related to family planning in accordance with the requirements of the cultural competency policy. (See Section 3.15 — Cultural Competence).

4. Have a process for ensuring prior to insertion of intrauterine and subdermal implantable contraceptives, the family planning provider has provided proper counseling to the eligible Member to minimize the likelihood of a request for early removal. Counseling information is to include a statement to the Member indicating if the implant is removed within two years of insertion, the Member may not be an appropriate candidate for reinsertion for at least one year after removal.

5. Establish procedures for referral of those Members who may lose AHCCCS eligibility to low-cost/no-cost agencies for family planning services.

In addition, providers are responsible for the following:

- Making appropriate referrals to health professionals who provide family planning services.
- Keeping complete medical records regarding referrals.
- Verifying and documenting a Member’s willingness to receive family planning services.
- Providing medically necessary management of Members with family planning complications.
- Notifying Members of available contraceptive services and making these services available to all Members of reproductive age using the following guidelines:
  - Information for Members between 18 and 55 years of age must be provided directly to the Member or legal guardian. Whenever possible, contraceptive services should be offered in a broad-spectrum counseling context, which includes discussion of mental health and sexually transmitted diseases, including HIV/AIDS.
  - Members of any age whose sexual behavior exposes them to possible conception or STDs should have access to the most effective methods of contraception.
  - Every effort should be made to include male or female partners in such services.
• Providing counseling and education to Members of both genders that is age appropriate and includes information on prevention of unplanned pregnancies.

• Counseling should include the following:
  - The Member’s short- and long-term goals;
  - Spacing of births to promote better outcomes for future pregnancies; and
  - Preconception counseling to assist Members in deciding on the advisability and timing of pregnancy, to assess risks and to reinforce habits that promote a healthy pregnancy.
  - Sexually transmitted diseases, to include methods of prevention, abstinence, and changes in sexual behavior and lifestyle that promote the development of good health habits.

Contraceptives should be recommended and prescribed for sexually active Members. Providers are required to discuss the availability of family planning services annually. If a Member’s sexual activity presents a risk or potential risk, the provider should initiate an in-depth discussion on the variety of contraceptives available and their use and effectiveness in preventing sexually transmitted diseases (including AIDS). Such discussions must be documented in the Member’s medical record.

2.4.2 Sterilization

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

• The Member is at least 21 years of age at the time the consent is signed.
  - For Members under the age of 21, the provider must be able to demonstrate medical necessity for the procedure with supporting documentation including Prior Authorization. The medical necessity prior authorization and supporting documentation must be submitted to AHCCCS with the Monthly Sterilization Report;

• Mental competency is determined;

• Voluntary consent was obtained without coercion; and

• Thirty (30) days, but not more than 180 days, have passed between the date of informed consent and the date of sterilization, except in the case of a premature delivery or emergency abdominal surgery. Members may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since they gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

Any Member requesting sterilization must sign an ACOM, Chapter 400, Exhibit 420-1, AHCCCS Sterilization Consent Form, with a witness present when the consent is obtained. Suitable arrangements must be made to ensure that the information in the consent form is effectively communicated to Members with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds, as well as Members with visual and/or auditory limitations. Prior to signing the consent form, a Member must first have been offered factual information that includes all of the following:
• Consent form requirements;
• Answers to questions asked regarding the specific procedure to be performed;
• Notification that withdrawal of consent can occur at any time prior to surgery without affecting future care and/or loss of federally funded program benefits;
• A description of available alternative methods;
• A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used;
• A full description of the advantages or disadvantages that may be expected as a result of the sterilization; and
• Notification that sterilization cannot be performed for at least 30 days post consent.

Sterilization consents may NOT be obtained when a Member:
• Is in labor or childbirth;
• Is seeking to obtain, or is obtaining, a pregnancy termination; or
• Is under the influence of alcohol or other substances that affect the Member’s state of awareness.

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

Hysteroscopic tubal sterilization is not immediately effective upon insertion of the sterilization device. It is expected that the procedure will be an effective sterilization procedure three months following insertion. At the end of the three months, confirmatory testing, a hysterosalpingogram, will be performed confirming that the Member is sterile and reported on the monthly sterilization report.

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

Prior authorization is required for pregnancy termination except in emergency situations where the life of the mother is threatened. In these situations, authorization may be sought post procedure. Prior authorization must be obtained before the services are rendered or the services will not be eligible for reimbursement. Pregnancy termination services are covered when one of the following occurs:
• The pregnancy is a result of incest.
• The pregnancy is a result of rape.
• The pregnancy termination is medically necessary according to the medical judgment of a licensed physician, who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or mental health problem for the pregnant Member by:
  o Creating a serious physical or mental health problem for the pregnant Member;
  o Seriously impairing a bodily function of the pregnant Member;
- Causing dysfunction of a bodily organ or part of the pregnant Member;
- Exacerbating a health problem of the pregnant Member; or
- Preventing the pregnant Member from obtaining treatment for a health problem.

Providers must submit a request for medically necessary pregnancy termination to Cenpatico IC including a written explanation describing why the procedure is medically necessary, a copy of the Member’s medical record and written informed consent from the Member. The provider is required to obtain the written informed consent and retain it in the Member’s medical record for all pregnancy terminations. For pregnant Members younger than 18 years of age, or those 18 or older and considered incapacitated, providers must secure a dated signature of the pregnant Member's parent or legal guardian or a certified copy of a court order indicating approval of the pregnancy termination procedure.

When Mifepristone is administered, the following documentation is also required: duration of pregnancy in days, the date IUD was removed if the Member had one, the date mifepristone was given, the date misoprostol was given, and documentation that pregnancy termination occurred.

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

### 2.4.4 Prior Authorization Requirements for Sterilization and Pregnancy Termination.

Prior authorization is required for sterilization of Members under the age of 21 or pregnancy termination. Prior authorization must be obtained before the services are rendered or the services will not be eligible for reimbursement.

To obtain authorization for sterilization or pregnancy termination, complete the applicable forms:
- For sterilization: ACOM, Chapter 400, Exhibit 420-1 Sterilization Consent Form and ACOM, Chapter 800, Exhibit 820-1 Hysterectomy Consent Form found at [http://www.azdhs.gov/bhs/bqmo/specifications-manual.htm](http://www.azdhs.gov/bhs/bqmo/specifications-manual.htm)

For pregnancy termination: A completed AHCCCS Certificate of Necessity for Pregnancy Termination (AHCCCS Medical Policy Manual (AMPM), Policy 410, Exhibit 410-4)

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

### 2.5 EPSDT for Adults with SMI 18, 19 & 20 Years of Age

Early Preventative Screening Diagnostic Treatment (EPSDT) is a federally mandated program that provides comprehensive and preventative health care services for children under the age of 21 who are enrolled in Medicaid.
2.5.1 EPSDT Services

EPSDT services include screenings (comprehensive history, developmental/behavioral health screening, physical examination), vision services, dental services, hearing services and all other medically necessary, mandatory, and optional services listed in 42 U.S.C. § 1396d(a) to correct or ameliorate defects and physical and behavioral/mental illnesses and conditions identified in an EPSDT screening, whether or not the services are covered under AHCCCS. EPSDT ensures that children and adolescents receive appropriate preventative, medical, dental, mental health, vision, hearing, developmental, and specialty services.

Through primary prevention, early intervention, diagnosis and medically necessary treatments aid to correct or ameliorate defects and physical or mental illness discovered by the EPSDT screenings.

EPSDT includes, but is not limited to, coverage of: inpatient and outpatient hospital services, laboratory and x-ray services, physician services, nurse practitioner services, medications, dental services, therapy services, behavioral health services, medical supplies, prosthetic devices, eyeglasses, transportation, and family planning services. EPSDT also includes diagnostic, screening, preventive and rehabilitative services. However, EPSDT services do not include services that are experimental, solely for cosmetic purposes, or that are not cost effective when compared to other interventions or treatments.

2.5.2 PCP Requirements

Providers must verify that Members receive EPSDT services in compliance with the AHCCCS EPSDT periodicity schedule and the AHCCCS Dental Periodicity Schedule (Exhibit 430-1 in the AHCCCS Medical Policy Manual). Providers must complete all applicable EPSDT reports as required by the AHCCCS Medical Policy Manual located at: https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/AppendixB.pdf. The EPSDT Tracking form and submit a copy to the Cenpatico IC, Medical Management Department by secure fax at 1-866-601-0111. EPSDT providers must document immunizations in the Arizona State Immunization Information System (ASIIS) and enroll every year in the Vaccine for Children (VFC) program.

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

As outlined in the AHCCCS Medical Policy Manual, Provider Requirements, “EPSDT members who present to a providers office for a physical exam with the physician, physician’s assistant or nurse practitioner (PCP), an oral health screening must be part of an EPSDT screening conducted by a PCP; however, it does not replace the need for examination through direct referral to a Dentist. PCPs are expected to refer EPSDT members for appropriate services based on needs identified through the screening process and for routine dental care based on the AHCCCS EPSDT Periodicity Schedule. Evidence of this referral must be documented on the EPSDT tracking form.”
PCP’s are required to do an Oral Screening as part of an Annual Well Visit until the member’s twenty first (21) birthdate. As part of the Well Visit, the PCP is required to complete an EPSDT tracking form. The Well Visit must include an Oral Screening and visual findings must be documented on the EPSDT tracking form and in the member’s medical record (see the AHCCCS BQI Specifications Manual). Completed EPSDT tracking forms must be submitted by PCP to Cenpatico IC within 10 days.

**EPSDT Oral Health Screen Dental Referrals**

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

- **EMERGENT**-Within 24 hours of request
- **URGENT**-Within three days of request
- **ROUTINE**-Within 45 days of request

Document evidence of dental referrals on the EPSDT tracking form. Encourage eligible Members under the age of 21 to see a dentist regularly. Follow the AHCCCS EPSDT Periodicity Schedule to verify Members are referred appropriately. Encourage Members who call for a dental referral to obtain any routine or follow up care and document all referrals in the Member’s medical record.

**Title XIX/XXI Eligible EPSDT Members age 18, 19, 20 years old with SMI**

Members may select a dentist within the Cenpatico IC contracted network and receive preventive dental services without a referral. If prior authorization is required, a PCP provider must obtain appropriate prior authorization before rendering non-emergency services, provide an oral health screening as part of a medical exam and refer members for:

- Appropriate dental services based on needs identified through the screening process.
- Routine dental care.
- Document evidence of referrals in medical records.
- May refer Members for a dental assessment if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/or treatment by a dental professional.
- Should encourage eligible Members to see a dentist regularly.
- Should encourage Members who call for a dental referral to obtain any routine or follow up care and document all referrals in the Member’s medical record.

In addition to referrals by PCPs or Behavioral Health practitioners, Members may self-refer to a Cenpatico IC contracted dentist.

**2.6 Dental Services for Title XIX/XXI Adults with SMI**

Cenpatico IC has a comprehensive dental network for Members with dental benefits. To serve the needs of its members, Cenpatico IC partners with sister company Envolve Health who administers the Cenpatico IC’s dental plan. Dental Providers must submit claims and prior authorizations to Envolve Health, Claims Office, P.O. Box 20132, Tampa, FL 33622-0132.
If a member does not qualify under their dental eligibility and a medical condition is present, medical necessity is determined by Cenpatico IC. Medical documentation is required and must be submitted directly to Cenpatico IC for review and prior authorization determination.

Title XIX/XXI Eligible EPSDT Members age 18, 19 & 20 old with SMI
EPSDT eligible members have comprehensive dental service. These services include preventative, therapeutic and emergency dental services.

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

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

2.6.1.2 Appointment Availability
Routine dental appointments are to be available within forty five (45) days of a request. Urgent dental appointments are to be available within three days of a request per ACOM Policy 417

Emergency and general dental services for Title XIX/XXI eligible adults with SMI 18, 19 and 20 years of age are described below and should be provided in accordance with the AHCCCS EPSDT Dental Periodicity Schedule available on the AHCCCS website https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap400.pdf, along with the guidelines presented below.

2.6.1.3 Health Home Requirements
- Facilitate preventative dental utilization for members 18, 19 & 20 years of age who have not had a dental visit in over six months.
- Ensure members’ transportation needs to and from dental appointments are addressed.
- Document evidence of referrals in the member’s medical record.
- Notify members or responsible parties of due dates of biannual (one visit every six months) dental visits. If a dental visit has not taken place, a second notice must be sent.
- Encourage members or responsible parties to schedule the next dental exam at the current dental office.
- Notify Cenpatico IC’s Oral Health Liaison of missed dental appointments.

2.6.1.4 Dental Home Assignment for Title XIX/XXI Eligible EPSDT Members age 18, 19, 20 years old with SMI
Title XIX/XXI Eligible adults with SMI 18, 19 & 20 years of age can choose a dental provider from within the Cenpatico IC Dental Provider Network. Eligible members who do not select a dental home will be automatically assigned to a dental home upon enrollment with Cenpatico IC in accordance with the AHCCCS Dental Periodicity Schedule (see the AHCCCS BQ&I Specifications...
Members may change dental providers by contacting Cenpatico IC’s Customer Service at (866)495-6738. Dental home provider change will become effective no later than the first of the month following the request for change. Cenpatico IC will verify all Title XIX/XXI Eligible members with SMI ages 18, 19 and 20 (EPSDT members) are enrolled in a dental home and are mailed a dental home assignment letter.

The goal of assigning dental homes is to establish an ongoing relationship between each member and dentist, to promote comprehensive care, coordinated services and continuity of care for optimal oral health. If a member’s dental home provider is not available when the member needs services, the member may receive care from another Cenpatico IC network provider and that provider will receive reimbursement. Members should visit their dental home every six months for periodic exams, including a cleaning and fluoride treatment.

### 2.6.1.5 Provider Request for Change In Dental Home Assignment of Member

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

### 2.6.1.6 Preventive Care For Title XIX/XXI EPSDT Eligible Adults with SMI 18, 19 & 20 Years of Age

Preventive dental services specified in the AHCCCS Dental Periodicity Schedule are covered benefits and are listed on the Covered Services Guide located in AMPM, Chapter 300, Exhibit 300-3, Dental HCPC Codes Information. In general, these services include:

1. Diagnostic services: comprehensive and periodic exams that include two oral examinations per year (i.e. every six months).

2. Radiology services for diagnosis of dental abnormalities and pathologies. Radiology services include: panoramic or full mouth x-rays, supplemental bitewing x-rays, occlusal or periapical x-rays. Radiology services must follow recommended standards set by the American Academy of Pediatrics.

3. Preventative services:
   
   i. Two adult oral prophylaxis per year (i.e. every six months). Prophylaxis appointment should include oral hygiene instruction and oral health recommendations with member and legal guardian or caregiver. Oral prophylaxis must be performed by a dentist or dental hygienist.

   ii. Topical application of Fluoride, twice per year (i.e. every six months). Fluoride rinse is not a covered service.

   iii. Dental sealants must be deemed medically necessary and require prior authorization through Cenpatico IC’s dental plan administrator Envolve Health.
iv. Space maintainers when deemed medically necessary and require prior authorization through Cenpatico IC’s dental plan administrator Envolve Health.

Dental providers may utilize teledentistry for triage, dental treatment planning and referral. Teledentistry does not replace the dental exam by the dentist. Limited, periodic and comprehensive examinations cannot be reimbursed by the use of teledentistry alone. Information regarding teledentistry is located on the AHCCCS website (AHCCCS Medical Policy Manual 320-1 section 6; Teledentistry).

2.6.1.7 Therapeutic Dental Services For Title XIX/XXI EPSDT Eligible Adults with SMI 18, 19 & 20 Years of Age

Therapeutic dental services are covered when considered medically necessary by Envolve Health or AHCCCS Division of Fee for Service Management for FFS Members and may require prior authorization. Therapeutic dental services include, but are not limited to the following:

- Periodontal procedures, scaling/root planing, curettage, gingivectomy, and osseous surgery.
- Crowns: When appropriate, stainless steel crowns may be used for both primary and permanent posterior teeth; prefabricated stainless steel crowns with a resin window or esthetic coating should be used for anterior primary teeth.
- Precious or cast semi-precious crowns may be used on functional permanent endodontic treated teeth, except third molars, for Members who are 18 through 20 years of age.
- Endodontic services including pulp therapy for permanent and primary teeth, except third molars (unless a third molar is functioning in place of a missing molar).
- Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restoration. (Exceptions are if the Member is age 18 through 20 years of age and has had endodontic treatment).
- Dentures (both complete and partial), when medically necessary and determined to be the primary treatment of choice or an essential part of an overall treatment plan developed by both the PCP and the dentist in consultation with each other.

2.6.1.8 Emergency Dental Services for Title XIX/XXI EPSDT Eligible Adults with SMI 18, 19 & 20 Years of Age

The following emergency dental services are covered for Title XIX/XXI Adults with SMI 18, 19 & 20 years of age:

- Treatment for pain, infection, swelling and/or injury;
- Extraction of symptomatic (including pain), infected and non-restorable primary and permanent teeth, as well as retained primary teeth (extractions are limited to teeth which are symptomatic); and
- General anesthesia, conscious sedation or anxiolysis (minimal sedation, patients respond normally to verbal commands) when local anesthesia is contraindicated or when management of the patient requires it.
2.6.1.9 Orthodontic Services For Title XIX/XXI EPSDT Eligible Adults with SMI 18, 19 & 20 Years of Age

Orthodontic services are not covered when the primary purpose is cosmetic. Orthodontic services and orthognathic surgery are covered only when these services are necessary to treat a handicapping malocclusion. Services must be medically necessary and determined to be the primary treatment of choice or an essential part of an overall treatment plan developed by both the PCP and the dentist in consultation with each other.

Examples of conditions that may require orthodontic treatment include the following:
- Congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services.
- Trauma requiring surgical treatment in addition to orthodontic services.
- Skeletal discrepancy involving maxillary and/or mandibular structures.

2.6.1.10 Dental Services Not Covered For Title XIX/XXI EPSDT Eligible Adults with SMI 18, 19 & 20 Years of Age

- Orthodontic treatment and extraction of non-symptomatic teeth are generally not covered services. This includes third molars.
- Services or items furnished solely for cosmetic purposes are not covered.

2.6.1.11 Emergency Dental Coverage for Title XIX/XXI Adults with SMI 21 Years And Over

Cenpatico IC covers medical and surgical services furnished by a dentist only to the extent that such services:
- May be performed under State law by either a physician or by a dentist and
- The services would be considered physician services if furnished by a physician.
- Cenpatico IC also covers limited dental services as a prerequisite to AHCCCS covered transplantation and when they are in preparation for radiation treatment for certain cancers.

Amount, Duration and Scope
Dental services must be related to the treatment of a medical condition (excluding Temporomandibular Joint Dysfunction (TMJ) pain) such as:
- Acute pain
- Infection
- Fracture of the jaw
- Complex oral surgical procedures such as treatment of maxillofacial fractures.

Covered services include:
- A limited problem focused examination of the oral cavity
- Required radiographs
- Complex oral surgical procedures such as treatment of maxillofacial fractures
- Administration of an appropriate anesthesia
- Prescription of pain medication and antibiotics.
- Diagnosis and treatment of TMJ is not covered except for reduction of trauma.
Exceptions for Transplants and Members with Cancer

A. Transplant Cases
For members who require medically necessary dental services as a pre-requisite to AHCCCS covered organ or tissue transplantation, covered dental services are limited to the elimination of oral infections and the treatment of oral disease. Covered dental services are limited to the following:

- Dental cleaning (Prophylaxis)
- Treatment of periodontal disease
- Medically necessary extractions
- Simple restorations. A simple restoration means silver amalgam and/or composite resin fillings, stainless steel crowns or preformed crowns.

Cenpatico IC covers these services only after a transplant evaluation determines that the member is an appropriate candidate for organ or tissue transplantation.

B. Cancer Cases
Covered dental services are limited to the following:

- Prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head is also covered.

Limitations
Except for limited dental services covered for pre-transplant candidates and for members with cancer of the jaw, neck or head described above, covered services furnished by dentists to members 21 years of age and older do not include services that physicians are not generally competent to perform such as dental cleanings, routine dental examinations, dental restorations including crowns and fillings, extractions, pulpotomies, root canals, and the construction or delivery of complete or partial dentures. Diagnosis and treatment of TMJ is not covered except for reduction of trauma.

2.6.1.12 Criteria for Employment Dental Benefit
Title XIX/XXI adults with SMI 21 years of age and older are eligible for a $700 per year additional dental benefit if employed at least ¼ time (10 + hours per week) as indicated on provider/Member demographics and enrolled at with a Health Home. Eligibility will begin on the first day of the month following a successful demographic submission verifying the Member is employed ¼ time. Eligibility will terminate on the last day of the month following receipt of a demographic verifying that a Member is no longer employed at least one-fourth (1/4th) time. Adults with SMI may be eligible for dental benefits upon completion of a Cenpatico IC-approved six month pre-employment program. Eligibility under this criteria will begin on the first of the month following verification of the completion of the training program, continue for twelve months and will terminate on the last day of the twelve month period unless the Member becomes employed at least ¼ time in the interim. Members are eligible for one twelve month extension upon completion of a second advanced six month pre-employment training program.
2.6.1.13 **Preventive Care For Title XIX/XXI Eligible Adults with SMI 21 Years of Age & Older with added Employment Benefit**

Preventive dental services are covered benefits for Title XIX/XXI Eligible adults with SMI 21 years of age and older enrolled with Cenpatico IC and who meet the eligibility criteria outlined above. In general, these include:

- Diagnostic services: two oral examinations per year and x-rays
- Two oral prophylaxis and fluoride treatments per year

2.6.1.14 **Therapeutic Dental Services For Title XIX/XXI Eligible Adults with SMI 21 Years of Age & Older with added Employment Benefit**

- Therapeutic dental services require prior authorization by Envolve Health, dental administrator for Cenpatico IC. Crowns: covered crowns include porcelain/ceramic substrate, porcelain fused to metal. Teeth covered: front teeth # 6-11 and #22-27.
- Extraction of symptomatic (including pain), infected and non-restorable primary and permanent teeth, as well as retained primary teeth (extractions are limited to teeth which are symptomatic); and
- General anesthesia, conscious sedation or anxiolysis (minimal sedation, patients respond normally to verbal commands) when local anesthesia is contraindicated or when management of the patient requires it.

2.6.1.15 **Dental Services Not Covered For Title XIX/XXI Eligible Adults with SMI 21 Years of Age or Older with Added Employment Benefit**

- Orthodontic treatment
- Extraction of non-symptomatic teeth are generally not covered services. This includes third molars.
- Services or items furnished solely for cosmetic purposes are not covered.

2.7 **Optical Services for Title XIX/XXI Adults with SMI**

Cenpatico IC covers eye and optometric services provided by qualified eye/optometry professionals within certain limits based on Member age and eligibility.

Emergency eye care, which meets the definition of an emergency medical condition, is covered for all Members. For Members who are 21 years of age or older, treatment of medical conditions of the eye, excluding eye examinations for prescriptive lenses and the provision of prescriptive lenses, are covered. Vision examinations and the provision of prescriptive lenses are covered for Members under the EPSDT program and for adults when medically necessary following cataract removal. Cataract removal is covered for all eligible Members under certain conditions. For more information, visit the AHCCCS website under Medical Policy for AHCCCS Covered Services.

2.7.1 **Coverage For Title XIX/XXI Adults with SMI 18, 19 & 20 Years Of Age**

- Medically necessary emergency eye care, vision examinations, prescriptive lenses and treatments for conditions of the eye.
PCPs are required to provide initial vision screening in their office as part of the EPSDT program. Vision exams provided in a PCP’s office during an EPSDT visit are not a separately billable service.

Members 18-20 years of age with vision screening of 20/60 or greater should be referred to the contracted vision provider for further examination and possible provision of glasses.

Replacement of lost or broken glasses is a covered benefit.

Contact lenses are not a covered benefit.

2.7.2 Coverage for Title XIX/XXI Adults with SMI 21 Years And Over

- Emergency care for eye conditions when the eye condition meets the definition of an emergency medical condition; for cataract removal and/or medically necessary vision examinations; and for prescriptive lenses if required following cataract removal.
- Routine eye exams and glasses are not a covered service for adults.
- Adults 21 years of age and older should be referred to Envolve Vision (Cenpatico IC’s Managed Optical Care Vendor) for the diagnosis and treatment of eye diseases as well.

2.8 Vaccines for Children’s Program and the Arizona State Immunization Information System (ASIIS)

Through the Vaccines for Children (VFC) Program, the federal and State governments purchase, and make available to providers at no cost, vaccines for Medicaid eligible Members under age nineteen (19). Cenpatico IC members, 18 years of age, are eligible to receive VFC vaccines.

- Cenpatico IC providers must coordinate with the Arizona Department of Health Services (ADHS) Vaccines for Children (VFC) program in the delivery of immunization services.
- Providers must enroll and re-enroll annually with the VFC program in accordance with AHCCCS Contract requirements. Cenpatico IC will not utilize AHCCCS funding to purchase VFC vaccines for members over 19 years of age.
- Providers shall maintain a sufficient supply of vaccines for Cenpatico IC members.
- Immunizations must be provided according to the Advisory Committee on Immunization Practices (ACIP) Recommended Schedule or when medically necessary for the member’s health.
- Providers are encouraged to offer simultaneous administration of all vaccines for which a member 18 years of age is eligible at the time of EPSDT visit.
- Cenpatico IC Providers must enroll with and document EPSDT member’s immunizations in the Arizona State Immunization Information System (ASIIS) and maintain the ASIIS immunization records of each EPSDT member in ASIIS in accordance with A.R.S. Title 36, Section 135.
- The ADHS ASIIS immunization registry can be accessed by the providers to obtain accurate immunization records for Cenpatico IC EPSDT members.

2.9 Crisis Intervention Services

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

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

2.9.1 To whom this Applies

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

2.9.2 Overview of Crisis Intervention Services

To meet the needs of individuals in communities throughout Arizona, Cenpatico IC provides the following crisis services:

- Telephone crisis intervention services provided by the Cenpatico contracted Crisis Call Center, including a toll-free number, 1-866-495-6735, available 24 hours per day, seven days a week;
- Mobile crisis intervention services, available 24 hours per day, seven days a week;
  - If one person responds, this person shall be a Behavioral Health Professional or a Behavioral Health Technician; and
  - 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.
- Crisis stabilization/observation services, including detoxification services;
  - Cenpatico IC provides crisis stabilization and detoxification services through Behavioral Health Inpatient Facilities, Behavioral Health Hospital Facilities, and Substance Abuse Transitional Facilities. Call the Crisis Call Center, toll free at 1-866-495-6735 to make arrangements.
- Up to 72 hours of additional crisis stabilization as funding is available for mental health and substance abuse related services.

For program requirements related to Cenpatico IC’s Crisis Intervention Services, see Section 6 — Program Specific Requirements.
2.9.3 Management of Crisis Services

Cenpatico IC maintains availability of crisis services in each county served. Cenpatico IC utilizes the following in managing crisis services:

- Cenpatico IC allocates and manages funding to maintain the availability of required crisis services for the entire fiscal year;
- Cenpatico IC works collaboratively with local hospital-based emergency departments to determine whether a Cenpatico IC-funded crisis provider should be deployed to such locations for crisis intervention services;
- Cenpatico IC works collaboratively with local Behavioral Health Inpatient Facilities to determine whether and for how many hours such locations are used for crisis observation/stabilization services; and
- When Non-Title XIX/XXI eligible individuals are receiving crisis services and require medication, Cenpatico IC uses the generic medication formulary identified in the Non-Title XIX/XXI SMI benefit (see Section 10.11.9 — Cenpatico IC’s Drug Lists).

Cenpatico IC seeks to ensure Members receive crisis services on a timely basis and, when appropriate, in their homes and communities. Crisis mobile teams are available to help Members obtain the appropriate crisis services. Cenpatico IC discourages providers from sending Members to emergency rooms for non-medical reasons.

2.10 State-Funded Housing for Adults

AHCCCS and Cenpatico IC have worked collaboratively to develop and make available a number of housing options and support services. 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.

State-funded housing rules are outlined and must be adhered to by Cenpatico IC Providers (ADHS Housing Desktop Manual or ACOM Policy 448). For Members experiencing or at-risk of homelessness who are able to live independently, Cenpatico IC 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 services.

2.10.1 State-Funded Housing Assistance

2.10.1.1 Permanent Supportive Housing

AHCCCS believes in supportive housing and has adopted the SAMHSA model for permanent supportive housing programs. Housing providers are required to maintain fidelity to the SAMHSA Supportive Housing Elements. The 12 Key Elements of the SAMHSA Permanent Supportive Housing Program are:

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; and
12. The provision of housing and the provision of support services are distinct.

2.10.1.2 Short-Term Housing Assistance
Providers may provide short-term housing assistance to Members in order to 1) prevent imminent homelessness (e.g. eviction prevention), 2) rapidly rehouse Members who have lost housing but can reestablish independent housing stability with brief or one-time financial assistance, 3) assist Members transitioning from homelessness into housing (e.g. deposits, move-in assistance), 4) provide short-term housing (up to 90 days as directed by the Cenpatico IC Housing Department) for individuals awaiting identified permanent supportive housing.

2.10.2 General Housing Requirements
Providers must collaborate with community system partners, State agency partners, federal agencies and other entities to identify, apply for or leverage alternative funding sources for housing programs.

2.10.2.1 Staffing
Providers are required to have professional staff dedicated to overseeing the housing program. Housing programs must employ separate housing management and service delivery staff:

- Housing management staff are responsible for Housing Quality Standard inspections, signing and renewing of leases, collection of rent and completion of maintenance requests.
- Service delivery staff are responsible for ensuring the delivery of services a Member needs to meet their treatment goals, including but not limited to, living independently and adhering to stipulations outlined in the rental agreement/lease.

Staff Training
Providers must provide annual training to housing staff on the following topics: property acquisition, maintaining units on Housing Quality Standards, Fair Housing Laws, and the Arizona Residential Landlord Tenant Act. Providers will be required to demonstrate that annual training on these topics is provided to housing staff.

Clinical & Administrative Managers shall demonstrate: Knowledge of the basic concepts found in the Federal Fair Housing Law and the Arizona Landlord Tenant Act as they apply to members and their contracted providers by passing a posttest conducted after an orientation session.

BHP’s, BHT’s & BHPP’s shall demonstrate competency, by passing a posttest after training, in the following areas: Knowledge of basic concepts found in the Arizona Landlord Tenant Act and Federal Fair Housing Laws describing the rights of tenants and landlords, The general rights of members afforded by these laws, and The principles and availability of Housing support services.

Health Care Coordinator shall demonstrate that they capably: Understand the basic concepts found in the Arizona Landlord Tenant Act and Federal Fair Housing Laws describing the rights of tenants and landlords. Explain lease requirements and rights of tenancy to Members in language they understand and can act upon, Visit members and schedule service appointments at their homes consistent with the law, Determine eviction risk and arrange for skill and or support service assistance to Members in coordination with Housing Providers, Document and involve the Member in investigating complaints originated by the Member or Landlord, and Pass a posttest conducted after training and thereafter during routine clinical supervision.

Housing Specialists and Health Care Coordinator shall also demonstrate that they can capably conduct and use the current and emerging tools and best practices such as the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) by passing a post test conducted after Specialized Training program and thereafter during routine clinical supervision.

2.10.2.2 Property Management

All housing programs/units must be managed by a separate property management department or company. The property management department/company must be staffed and operated separate and apart from the delivery of housing support services as outlined in the SAMSHA Permanent Supported Housing Evidence-Based Practice Guidelines.

2.10.2.3 Accounting

Providers must develop and maintain an automated electronic accounting system with software that records all financial data, including but not limited to the provider’s income and expense data, cost allocations, payments and expenditures which also equitably allocates common expenses between funding sources and housing units in substantial compliance with GAAP. The provider’s accounting system must provide a detailed audit trail that allows reported financial data to be verified. The accounting system must maintain a segregation of revenue and expenditures by fund source. Allocation of costs to fund sources shall be consistently applied among fund sources in accordance with the provider’s accounting system.
2.10.2.4 Grievances and Appeals

Providers must assist in the resolution of grievances and appeals of Members, including appeals, submitted through Cenpatico IC, HUD, Arizona Department of Housing (ADOH), and the State.

2.10.2.5 Compliance With Laws, Rules, Regulations, and Policies

Providers must comply with the Arizona Residential Landlord Tenant Act, A.R.S. §33-1301 et seq., the Arizona Mobile Home Residential Landlord and Tenant Act, A.R.S. §33-1401 et seq., as applicable, applicable provisions of the Americans with Disabilities Act, applicable provisions of the Arizona and Federal Fair Housing Laws, and the grievance resolution requirements. Providers must also comply with the AHCCCS Housing Desk Top Manual, the AHCCCS Bridge Subsidy Program Policies and Procedures Manual. In the event that applicable federal, State or local law or regulations change, providers must comply with such changes.

Providers must comply with Cenpatico IC’s Housing Policies and Procedures and any Rental Agreement shall include provisions obligating the Subcontractor to comply with Cenpatico IC’s Housing Policies and Procedures. Providers must comply with Cenpatico IC Housing Quality Standards for Covered Persons.

2.10.2.6 Non-Discrimination

Providers must not illegally or unconstitutionally discriminate against or segregate any person or group of persons on account of gender, marital status, race, age, disability, color, religion, creed, national origin or ancestry in the sale, lease, sublease, transfer, use, occupancy, tenure or enjoyment of property herein conveyed, nor shall provider establish or permit any such practice or practices of discrimination or segregation, location, number, use or occupancy of tenants, lessees, subtenants or vendees in the property.

2.10.3 State Funded Permanent Supported Housing Programs

Cenpatico IC complies with the following requirements to effectively manage limited housing funds in providing supported housing services to eligible individuals:

- Cenpatico IC uses supported housing allocations for individuals and according to any restrictions pertaining to the funding source. For example, a particular allocation may require it be used for TXIX/XXI persons, while another allocation may require it be used for Non-TXIX 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;
- Cenpatico IC and its providers must not actively refer or house individuals in a shelter, licensed supervisory care home, unlicensed board and care home, or other similar facilities.¹

¹ When a behavioral health member chooses to reside in an unlicensed board and care home, Cenpatico Integrated Care and/or its subcontracted providers must report any observations of unsafe conditions or provision of services that require licensure to the local code enforcement, local housing authority, and the Arizona Division of Licensing Services (DLS). Providers must also provide Cenpatico IC with ad hoc Board and Care Home Census reports on the prescribed form as requested to confirm services provided to the member as well as relocation/transition assistance if/as requested by the member. Providers should visit Members in Board and
• Cenpatico IC Providers 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, provider must provide the tenant with a 30-day notice at the time of the tenant’s annual recertification.

• Cenpatico IC and its providers must not use supported housing allocations to pay for telephones or telephone usage fees.

• Cenpatico IC does not use supported housing allocations for room and board charges in Behavioral Health Residential Facilities. However, Cenpatico IC may allow residential treatment settings to establish policies, which require that persons earning income contribute to the cost of room and board.

• Cenpatico IC Providers may provide move-in assistance and eviction prevention services to those Members in permanent housing. When move-in assistance is provided, Cenpatico IC prioritizes assistance with deposits and payment for utilities over other methods of assistance, such as move-in kits or furnishings. Cenpatico IC encourages its providers to seek donations for necessary move-in/home furnishing items whenever possible. Cenpatico IC cannot use supported housing allocations or other funding received from AHCCCS (including block grant funds) to purchase furniture.

• For appeals related to supported housing services, Cenpatico IC providers must follow requirements in Section 15.4 — Notice and Appeal Requirements (SMI and GMH/SA Non-Title XIX/XXI).

• Housing related grievances and requests for investigation for persons with SMI must be addressed in accordance with Section 15.2 – Grievances and Investigations Concerning Individuals with Serious Mental Illness.

2.10.3.1 State Subcontracting Requirements

Staffing
Providers must maintain a sufficient number of dedicated staff of housing professionals with knowledge, expertise, experience, and skills to comply with the terms of the terms of the providers’ agreement with Cenpatico IC and to collaborate with behavioral health and physical health service and housing providers, Arizona Department of Housing, and AHCCCS.

Member Referrals
Providers must accept all persons referred from the Cenpatico IC Housing Department for State Funded Housing Programs, subject to funding availability. Providers must deliver a range of housing services and present available options for housing to individuals consistent with the individual’s goals and needs in the Individual Service Plan.

Providers must participate in a Member's treatment team in order to identify available housing units to the Member and to place Member in affordable appropriate living environment upon discharge from an institutional setting.

Care Homes regularly and document living conditions, services offered, and any concerns. Cenpatico IC housing audits and monitoring will include a review of the Board and Care Home Census and progress notes.
Providers must provide individuals determined to have SMI who have been discharged from the Arizona State Hospital, supervisory care homes or unlicensed board and care homes with housing options that promote independent living. A person with SMI shall not be housed in a homeless environment or in an unlicensed board and care home or other similar facility.

In addition, providers will use the monitoring tools approved by Cenpatico IC to evaluate adult residential services and community living housing programs to assist individuals in stepping down to lower level of care and submit a summary of the evaluation to the Cenpatico IC Housing Department.

**Collaboration**

Providers must participate in the development of Cenpatico IC's Annual Housing Plan and Annual Housing Spending Plan and provide all housing data and information requested by Cenpatico IC.

Upon AHCCCS's or Cenpatico IC's request; providers must also participate in the AHCCCS Housing Review Committee. In addition, providers will collaborate with State, County, and local government agencies to support housing initiatives and resolve housing issues, concerns, and complaints that affect Members. Providers are required to develop new housing capacity, program initiatives, and options when needed in collaboration with Cenpatico IC, the AHCCCS Housing Unit, and the ADOH.

Providers shall also collaborate with Public Housing Authorities ("PHA") contracted through the piloted Housing Bridge Subsidy Program in accordance with the Program Policies & Procedures Manual for the Bridge Subsidy Program / Tenant-Based Rental Assistance.

**Inspections**

Providers must conduct regular inspections of housing units including tenant living situations to determine whether the Member has access to basic needs and whether the living environment is safe, secure, and the least restrictive environment consistent with the treatment goals in the Member's Individualized Service Plan. Providers must conduct or arrange for Housing Quality Standards (HQS) inspections at least annually and upon renting the unit to a new tenant. Providers must maintain at least one person on staff:

- Certified as a Section 8 HCV Housing Quality Standards Specialist by Nancy McKay and Associates, Inc. and NMA University, and
- Performs the HQS inspections within seventy-two (72) hours of request, and within twenty-four (24) hours of the request in the event of priority move-ins.

In the event the provider does not have a qualified person on staff, the provider must receive an exemption from Cenpatico IC and must arrange for HQS inspections within the required time frames. The provider must maintain records of the results of walk through inspections of the property and all housing units.

In addition, providers must conduct randomly selected inspections of units each year and maintain all State funded housing programs in accordance with standards of the local planning and zoning authorities and standards in the AHCCCS Housing Desktop Manual.
Prior Approval
Providers must notify and obtain Cenpatico IC approval prior to program implementation, property acquisition, or placing Members with SMI in a residential program that occupies more than eight (8) adults or where more than twenty-five percent (25%) of an apartment complex houses Members with SMI.

Property Requirements
In August 2000, the State developed a permanent housing property acquisition program that allowed the RBHA/Health Plans and their non-profit partners to purchase property for the first time in the history of Arizona, specifically for persons determined to have a SMI (HB 2003).

Providers must ensure any housing units acquired or constructed with HB 2003 funds are used for the benefit of persons with SMI. Providers must comply with the applicable terms and conditions of any contracts, deeds, and declarations of covenant conditions and restrictions executed in connection with the acquisition or construction of housing units. Members must not be required to move when treatment/rehabilitation goals are achieved and will not be evicted solely based on substance use or dependence. Housing options obtained through HB 2003 implementation must be sustained without additional funding appropriations for a period of fifteen (15) years.

Providers must submit prior to the purchase of any new property leveraged with funds provided by Cenpatico IC a Provider Manual Form 2.10.1, AHCCCS Property Acquisition Rehab Application, which is required to include the following:

- The funding source used to purchase the property, specifically whether the purchase is to be made with funds provided under the provider’s agreement with Cenpatico IC or other funds.
- The financing arrangements made prior to purchase of the property
- Prior approval from Cenpatico IC if the property is purchased with funds provided under the provider’s agreement with Cenpatico IC.
- A deed containing the use restrictions and covenants, conditions, or restrictions, or another legal instrument that verifies the property is used solely for the benefit of Members and that failure to comply with the use restrictions allows the State to take title to the property or otherwise enforce the restrictions.

Cenpatico IC and ADOH retain the right of prior approval and refusal on all housing units proposed to be purchased by the provider using funds awarded through ADOH or the State.

Providers must demonstrate that for real property, housing for Members, or buildings and improvements purchased by the provider with funds provided by Cenpatico IC (excluding net profits earned) the following exists:

- A use restriction in the deed, and
- Covenants, Conditions and Restrictions, or
- Another legal instrument subject to prior written approval by Cenpatico IC that requires the property to be used solely for the benefit of Members; and
- An application for funding consisting of an intended use plan.
2.10.4 Cenpatico Integrated Care State Set-Aside Housing Programs and Requirements

Cenpatico IC housing programs include state set-aside housing units to meet the needs of persons determined to have a SMI who are difficult to house in the community partly due to crime free/drug free ordinances and specific behavioral health related service needs. Providers must coordinate with the Cenpatico IC Housing Department to identify Members most vulnerable and in need of housing managed by the provider. A housing roster of tenants and housing openings must be submitted on a monthly basis to Cenpatico IC Housing on the prescribed Deliverable form.

2.10.4.1 Rental Agreements

Providers must develop, prepare, and execute a Rental Agreement with each Member residing in a Housing Unit. The Rental Agreement is required to comply with the provisions of the Arizona Residential Landlord and Tenant Act and thereafter enforce and administer the Rental Agreement for the benefit of Cenpatico IC enrolled individuals.

Providers must ensure that the total monthly rental payment under a Rental Agreement shall not exceed the Fair Market Rent (established annually by HUD). The Rent payable by the Member to the provider must be strictly limited to the HUD formula for his or her adjusted gross income or the percentage of adjusted income authorized by the housing funding source. Providers must inform each Member of his or her rent and/or utility payments and allowances, and must charge a Member a security or utility deposit in accordance with Arizona Residential Landlord Tenant Act. Providers must not charge applicants for costs associated with accepting and processing applications or verifying income and eligibility, including application fees, credit report charges, or other costs associated with these functions. Providers may collect damage and key deposits in accordance with Arizona law and may invoice a Member for a check returned for insufficient funds only for the amount the bank charges for processing the returned check. Providers may charge a Member a fee (not to exceed $100.00) if a Member wishes to move from a Housing Unit to another Housing Unit before the expiration of the Rental Agreement term. This fee is incurred for breakage of the Rental Agreement and is required to be utilized solely to offset any expenses the provider incurs in turning the Housing Unit.

2.10.4.2 Eviction Notices

Providers must provide all notices and documents required by the Arizona Residential Landlord and Tenant Act and Cenpatico IC regarding evictions. Additionally, prior to initiating any eviction proceeding, the Members' clinical team must be notified and a staffing must be held. Providers must be represented at that staffing. Finally, all evictions notices must be submitted to the Cenpatico IC Housing Department at least three (3) days prior to the potential eviction.

2.10.4.3 Grievances of Damages

Members are liable for damages caused by the Member or for which Member is otherwise responsible. Providers must investigate, evaluate, and resolve all grievances of damages to housing units occupied by Members. In the event the provider has incurred any cost associated with court filings, attorney and Sheriff fees, maintenance, repair or clean-up services for a housing unit, the provider must maintain all documentation of costs for review of the Cenpatico IC Housing Coordinator, itemizing all costs actually incurred. Providers are required to be
responsible for turning a housing unit if a Member vacates a housing unit during the rental agreement term within a reasonable timeframe in order to maximize use of housing units and to reduce the wait list for housing units.

Providers must operate an informal and formal hearing process for the resolution of Member matters handled by Cenpatico IC. Providers must maintain copies of the Cenpatico IC grievance procedures and make them available to any applicant or Member who has indicated dissatisfaction with the services of the provider.

2.10.4.4 Member Files

Providers must maintain complete housing file on each Member referred to the provider and additionally, are required to maintain a file on each housing unit under a rental agreement. Providers must make any and all housing records available to Cenpatico IC for review upon request.

Providers, however, must not accept or maintain medical records in the Member's housing file except for the minimum amount of information necessary to verify eligibility for the housing program and to assess housing unit accessibility needs, if appropriate. Providers must decline to participate in conversations regarding a Member's medical history. Information that is received by the provider from a Member or other third party that is of a clinical nature should be referred to the certified Health Care Coordinator (Case Manager) or Clinical Team and be maintained in the individual's clinical record.

2.10.4.5 Housing Maintenance Policies and Other Compliance

Providers must maintain a Housing Maintenance Policy, including a provision for 24-hour or other on-call availability to Member, Administrators, Housing Managers and Health Care Coordinators regarding housing emergencies for housing units. Providers must maintain the property(ies) in compliance with city, county and/or state zoning ordinances and with any ordinance relating to real property maintenance, health and safety.

Providers must ensure that all Member based rental agreements, housing assistance payment contracts, occupancy agreements, and sponsor based rental agreements are executed, maintained, and performed in compliance with approved Cenpatico IC policies.

Providers may implement any modifications to the housing programs, whether program wide or specific to an individual Member, only as mutually agreed upon with Cenpatico IC.

2.10.4.6 Cooperation with Cenpatico Integrated Care and other Agencies

Providers must cooperate with all Cenpatico IC, State, ADOH, the Arizona State Auditor General and other appropriate monitoring activities, including record review training sessions, and site-visits. Providers must cooperate with Cenpatico IC staff, clinical teams, support service contractors, Adult Probation, Vocational Rehabilitation, and others for the overall acquisition/construction and success of the Housing Program and the Members participating in the program. Providers are required to respond promptly to calls from these persons and promptly report Member information to the Health Care Coordinators and other appropriate contractors, especially when Members activity is affecting housing eligibility, tenancy status, or is indicative of a clinical problem; cooperate with and initiate as necessary an individualized
service planning process or a staffing for any Member who may be jeopardizing his or her housing eligibility by violations of the housing program standards. Providers must attend meetings, including grievance, appeal and Service Plan hearings. Appropriate notice shall be given to providers requesting meeting attendance.

2.10.5 State-Funded Short Term Housing Assistance Project Administration Requirements

Providers must serve as the Housing Assistance Project Administrator and effectively implement the following Short Term Housing Assistance Program.

2.10.5.1 Housing Assistance Program

Providers must develop and implement a Short Term Housing Assistance Program providing Housing Stability, Move-in Assistance, and/or Eviction Prevention to persons who would otherwise not have access to housing assistance. The Short Term Housing Assistance Program is intended to be a short term program for individuals who need approximately three (3) months of housing assistance prior to obtaining employment, being awarded benefits, or accessing other resources to cover rental costs. Up to three extensions may be provided contingent upon the recommendation of Members Clinical Team and approval from the Cenpatico IC Housing Administrator. However, because funding must be reauthorized by the state on an annual basis, the assistance offered during the final state FY quarter (April, May, June) must be managed so that no aid is assumed beyond June 30 in any given year.

Providers must ensure the following persons will have priority to receive housing subsidies:

- Persons who are homeless or at risk of becoming homeless.
- Young Adults (aged 18-24) transitioning into the adult system from the children’s system (particularly those who have been in foster care).
- Persons who are currently employed or in a program to prepare for employment (particularly those who are having difficulty maintaining stable housing or employment due to the requirement to pay for their vocational, physical health and/or behavioral health services).

2.10.5.2 Capacity to Manage Assistance Funds

Providers must maintain an organizational infrastructure, physical space, equipment, and human resources to successfully implement the administration and management of the Assistance Funds.

2.10.5.3 Assistance Fund Sources and Limitations

Providers must ensure that someone from the Member’s Adult Recovery Team (Coach, Peer Support Specialist, Employment Coordinator, etc.) verifies that there are no other fund sources available to cover the Assistance Payment and documents recommendation for Assistance Payment in Member’s clinical record.

Providers must ensure the following funding limitations are followed:

- Funding is limited to Medicaid enrolled Members.
• Funds shall not be given directly to the individual. Funds must be paid directly to the Landlord and/or Vendor.
• Cost of Rental Units shall not exceed Fair Market Rent.
• Per Arizona Landlord and Tenant Act, when the Member moves out of the housing unit, any remaining deposit funds shall be paid back to the provider and re-distributed through the Housing Subsidy Program.

The following are examples of allowable uses of Assistance Funds:
• Move – In Assistance
  o Rental, Utility and/or Deposits
  o Start-Up furnishings: (Dishes, Pots and Pans, Utensils, Bedding, Dish and Bath Towels, Cleaning Supplies)
• Moving Expenses
• First and Last Month Rent Subsidy
• Housing Stability/Eviction Prevention
• Temporary Housing Vouchers/Costs while awaiting identified Permanent Housing
• Rental Assistance
• Back Rent or Fees
• Member’s Legal Fees
• Repairs and/or purchases that would bring housing into HQS Compliance and stop eviction (such as plumbing repairs, air conditioner purchase and/or repair, etc.)

2.10.5.4  Housing Quality Standards
Providers must ensure that each Housing Unit meets HQS and any other housing quality standards established by Cenpatico IC and HUD.

2.10.5.5  Rental Agreement Records
Providers must maintain complete, accurate, and timely Records on each Rental Agreement, and each Member, as required by the statutes and regulations applicable to property acquisition/construction agents under the Arizona Real Estate statutes ("Records"). Providers must maintain all records, including summary records, for at least five (5) years following the termination of the provider’s agreement with Cenpatico IC unless otherwise extended by law, HUD, ADOH, the State, and AHCCCS.

2.10.5.6  Access to Facility and Audit of Funds
 Providers must grant Cenpatico IC and any other appropriate agent of the State or Federal government, or any of their duly authorized representatives, access to the provider’s facilities for the purpose of inspecting facilities and reviewing records. Providers must allow Cenpatico IC to inspect, audit, monitor, and evaluate the Housing Assistance funds received and expended pursuant to the Cenpatico IC Participating Provider Agreement during the term of the agreement, and within 365 days after the termination of the agreement. Providers must make available to Cenpatico IC, HUD or State copies of all requested Housing Assistance Records within five (5) business days of any request at no charge. Cenpatico IC, the State, ADOH and
HUD shall have full and complete rights to analyze, reproduce, duplicate, adapt, distribute, display, disclose and otherwise use all reports, information, data and material prepared by the provider in the performance of the Cenpatico IC Participating Provider Agreement.

### 2.10.6 Coordination with Federally Funded Housing: VI SPDAT and HMIS Requirements

Cenpatico Integrated Care requires that Providers complete the US Department of Housing and Urban Development (HUD) adopted assessment tool for any Member experiencing homelessness. The tool, known as the Vulnerability Index Service Prioritization Decision Assistance Tool (VI SPDAT), must be completed with the Member. The Provider must then enter the VI SPDAT assessment for each Member into the HUD Continuum of Care Homeless Management Information System (HMIS) database. This step will open housing opportunities beyond the state-funded and Cenpatico IC housing programs for Members experiencing homelessness, assist Providers in maintaining contact with those Members, and ensure heightened coordination and collaboration with the full network of homeless and housing services available in local communities.

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

2.10.6.1 **Federal Subcontracting Requirements**

**Staffing**
Providers must employ a sufficient number of staff with knowledge, expertise and experience to participate in and administer a variety of affordable housing programs for persons with disabilities. Providers must also employ a sufficient number of staff with financial management, screening and referral skills, knowledge of Federal wait lists, grant writing knowledge for reapplying to maintain current HUD grants as they come up for renewal, and to apply for new funds as they come available in the future.

**HUD Grants**
Providers are responsible for providing a dollar for dollar cash match in the form of supportive services in order to qualify for federal rent subsidies (Shelter Plus Care grants and other McKinney-Vento Homeless Continuum of Care grants). Providers must submit commitment letters to Cenpatico IC in a timely manner in order that Cenpatico IC can submit letters to the HUD Continuum of Care committee on behalf of renewal and new grant applications in the GSA.

**HUD Reporting**
Cenpatico IC and its 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. Providers must develop and maintain an accounting system of all Members in its housing program and of all its housing and support service providers and submit that data in an approved format to ADHS on a monthly basis.

**Collaboration**
Providers must collaborate and partner with other agencies participating in the HUD Homeless Continuum of Care Planning Process, HMIS Advisory and User's committees to maintain and expand housing resources.

2.10.6.2 **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 (PHAs) through a waiting list.
- Initial screening is conducted by the PHA; however, the final decision is the responsibility of the landlord.
- A Crime Free - Drug Free Lease Addendum is required.
Section 3 - BEHAVIORAL HEALTH NETWORK PROVIDER SERVICE DELIVERY REQUIREMENTS

3.1 Eligibility Screening For AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Low Income Subsidy Program

Eligibility status is essential for knowing the types of services a person may be able to access. In Arizona’s public behavioral health system, a person may:

- Be eligible for Title XIX/XXI (Medicaid) or Title XXI covered services;
- Not qualify for Title XIX/XXI services, but be eligible for services as a person determined to have a Serious Mental Illness (SMI);
- Be covered under another health insurance plan or “third party” (including Medicare and plans available via the Federal Health Insurance Marketplace); or
- Be without insurance or entitlement status and asked to pay a percentage of the cost of services.

Determining current eligibility and enrollment status is one of the first things to be completed upon receiving a request for services. For persons who are not Title XIX/XXI eligible, a financial screening and eligibility application must be filed with the appropriate eligibility agency (e.g., Arizona Health Care Cost Containment System (AHCCCS), the Department of Economic Security (DES)).

Medicare eligible Members, including persons who are dually eligible for Medicare (Title XVIII), Medicaid (Title XIX), and CHIP (Title XXI) receive Medicare Part D prescription drug benefits through Medicare Prescription Drug Plans (PDPs) or Medicare Advantage Prescription Drug Plans (MA-PDs).

The following information will assist providers of covered services in:

- Accessing and interpreting eligibility and enrollment information;
- Conducting financial screenings and assisting persons with applying for Title XIX/XXI or other benefits; and
- Assessing potential eligibility for Medicare Part D Prescription Drug coverage and the Low Income Subsidy (LIS) program.

Providers must coordinate with AHCCCS acute care contractors, PCPs, ALTCS contractors, service providers and eligible persons to share specific information to determine eligibility for Title XIX/XXI services and behavioral health coverage. In addition, providers must notify AHCCCS and Cenpatico IC of a Member’s death, incarceration or relocation out-of-state that may affect a Member’s eligibility status. Providers are required to have a policy and/or process in place for monitoring AHCCCS Eligibility and conducting timely screenings.

3.1.1 Title XIX/XXI Screening and Eligibility Procedures

Providers must screen persons requesting covered services for Medicaid and Medicare eligibility in conformance with Section 3.1 - Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Limited Income Subsidy Program.
1. Verify the person’s Title XIX/XXI eligibility for all persons referred for services and at least monthly thereafter;

2. For those persons who are not Title XIX/XXI eligible, screen for potential Title XIX/XXI or other eligibility; and

3. As indicated by the screening tool, assist persons with applications for a Title XIX/XXI or other eligibility determination.

### 3.1.2 Step #1 - Accessing Title XIX/XXI or Other Eligibility Information

Providers who need to verify the eligibility and enrollment of an AHCCCS Member can use one of the alternative verification processes 24 hours a day, 7 days a week. These processes include:

- **AHCCCS Web-based Verification (Customer Support 602-417-4451):** This web site allows the providers to verify eligibility and enrollment. To use the web site, providers must create an account before using the applications. To create an account, go to: [https://azweb.statemedicaid.us/Home.asp](https://azweb.statemedicaid.us/Home.asp) and follow the prompts. Once providers have an account they can view eligibility and claim information (claim information is limited to FFS). Batch transactions are also available. There is no charge to providers to create an account or view transactions. For technical web based issues, contact AHCCCS Customer Support at 602-417-4451 Monday – Friday from 7:00 a.m. to 5:00 p.m.

- **AHCCCS Subcontracted Medical Electronic Verification Service (MEVS):** The AHCCCS Member card can be “swiped” by providers to automatically access the AHCCCS Prepaid Medical Management System (PMMIS) for up to date eligibility and enrollment. For information on MEVS, contact the MEVS vendor: Emdeon at 1-800-444-4336.

- **Interactive Voice Response (IVR) System:** IVR allows unlimited verification information by entering the AHCCCS Member’s identification number on a touch-tone telephone. This allows providers access to AHCCCS’s PMMIS system for up to date eligibility and enrollment. There is no charge for this service. Providers may call IVR within Maricopa County at 602-417-7200 and all other counties at 1-800-331-5090.

- **Medifax:** Medifax allows providers to use a PC or terminal to access the AHCCCS PMMIS system for up to date eligibility and enrollment information. For information on EVS, contact Emdeon at 1-800-444-4336.

- **AHCCCS 270/271 Eligibility Look-up.**

If a person’s eligibility status still cannot be determined using one of the above methods, a provider must:

- Call Cenpatico IC Customer Service at 886-495-6738 for assistance during normal business hours (8:00 a.m. through 5:00 p.m. Monday-Friday); or

- Call the AHCCCS Verification Unit, which is open Monday through Friday, from 7:00 a.m. to 7:00 p.m. The Unit is closed Saturdays and Sundays and on the following holidays: New Year’s Day, Memorial Day, Independence Day, Thanksgiving Day, and Christmas Day. Call 1-800-962-6690, or 602-417-7000 in Maricopa County, and remain on the line for the next available representative. When calling the AHCCCS
Verification Unit, the provider must be prepared to provide the verification unit operator the following information:

- The provider’s identification number,
- The Member’s name, date of birth, AHCCCS identification number, and social security number (if known), and
- Dates of service(s).

### 3.1.3 Step #2 - Interpreting eligibility information

A provider accesses important pieces of information when using the eligibility verification methods described in Step #1 above: AHCCCS eligibility key codes and/or AHCCCS rate codes. The [AHCCCS Codes and Values (CV) 13 Reference System](https://example.com) includes a key code index that may be used by providers to interpret AHCCCS eligibility key codes and/or AHCCCS rate codes. Cenpatico IC will ensure that providers have access to and are familiar with the codes as they may help indicate provider responsibility for the delivery of Title XIX/XXI covered services.

If eligibility status and provider responsibility is confirmed, the provider must provide any needed covered services in accordance with the Cenpatico IC Provider Manual, the AHCCCS Covered Behavioral Health Services Guide, and the [AHCCCS Medical Policy Manual](https://example.com).

There are some circumstances whereby a person may be Title XIX/XXI eligible but the State behavioral health system is not responsible for providing covered services. This includes persons enrolled as elderly or physically disabled (EPD) under the Arizona Long Term Care System (ALTCS) Program and persons eligible for family planning services only through the Sixth Omnibus Reconciliation Act (SOBRA) Extension Program. A person who is Title XIX/XXI eligible through ALTCS must be referred to his/her ALTCS case manager to arrange for provision of Title XIX/XXI services. However, ALTCS-EPD individuals who are determined to have a SMI may also receive Non-Title XIX/XXI SMI services from Cenpatico IC. ALTCS-Division of Developmental Disabilities (DDD) persons’ services are provided through the AHCCCS behavioral health system.

If the person is not currently Title XIX/XXI eligible, proceed to Step #3 and conduct a screening for Title XIX/XXI or other eligibility.

### 3.1.4 Step #3 - Screening for Title XIX/XXI eligibility: When and Who to Screen for Title XIX/XXI or Other Eligibility

Cenpatico IC Providers are required to screen all Non-Title XIX/XXI persons using the [Health-e Arizona PLUS (HEAPlus) online application](https://example.com):

- Upon initial request for services,
- At least annually or during each Federal Health Insurance Marketplace open enrollment period thereafter, if still receiving services, and
- When significant changes occur in the person’s financial status.

A screening is not required at the time an emergency service is delivered, but must be initiated within 5 days of the emergency service if the person seeks or is referred for ongoing services.
To conduct a screening for Title XIX/XXI or other eligibility, the provider meets with the person and completes AHCCCS eligibility screening through the Health-e Arizona PLUS online application for all Non-Title XIX/XXI persons. Documentation of AHCCCS eligibility screening must be included in a person’s comprehensive clinical record upon completion after initial screening, annual screening and screening conducted when a significant change occurs in a person’s financial status (see Section 9.2 — Medical Record Standards). Cenpatico IC will assist providers with contact information to obtain HEAPlus assistor modules and training from AHCCCS. Once completed, the screening tool will indicate:

- **That the person is potentially AHCCCS eligible.** Pending the outcome of the Title XIX/XXI or other eligibility determination, the person may be provided services in accordance with Section 8.2 — Copayments. Upon the final processing of an application, it is possible that a person may be determined ineligible for AHCCCS health insurance. If the person is determined ineligible for Title XIX/XXI or other benefits, the person may be provided services in accordance with Section 8.2 — Copayments.

- **That the person does not appear Title XIX/XXI or AHCCCS eligible.** If the screening tool indicates that the person does not appear to have Title XIX/XXI or any other AHCCCS eligibility, the person may be provided services in accordance with Section 8.2 — Copayments. However, the person may submit the application for review by DES and/or AHCCCS regardless of the initial screening result. Additional information requested and verified by DES/AHCCCS may result in the person receiving AHCCCS eligibility and services after all.

### 3.1.5 Reporting Requirements for Title XIX/XXI Eligibility Screening

The number of applicant screenings for Title XIX/XXI, SMI, and Federal Health Insurance Marketplace eligibility completed must be documented by providers and reported to Cenpatico IC on a monthly basis as outlined in Section 16 – Deliverable Requirements. Technical assistance is available by calling the Cenpatico IC’s Contracts Department.

The reporting is required to include the following elements:

1. Number of applicants to be screened for AHCCCS eligibility;
2. Number of applicant screenings for AHCCCS eligibility completed;
3. Number of applicant screenings for AHCCCS eligibility to be completed;
4. Number of AHCCCS eligible applicants as a result of the screening;
5. Number of applicants to be screened for health coverage via the Federal Health Insurance Marketplace;
6. Number of applicant screenings for health coverage via the Federal Health Insurance Marketplace completed;
7. Number of applicant screenings for health coverage via the Federal Health Insurance Marketplace to be completed; and
8. Number of applicants eligible for health coverage via the Federal Health Insurance Marketplace as a result of the screening.
3.1.6 Medicare Part D Prescription Drug Coverage and Low Income Subsidy (LIS) Eligibility

Persons must report to Cenpatico IC or the provider if they are eligible or become eligible for Medicare as it is considered third party insurance. See Section 8.3 — Third Party Liability and Coordination of Benefits regarding how to coordinate benefits for persons with other insurance including Medicare. If a Member is unsure of Medicare eligibility, Cenpatico IC or providers may verify Medicare eligibility by calling 1-800-MEDICARE (1-800-633-4227), with a Member’s permission and needed personal information. Once a person is determined Medicare eligible, Cenpatico IC providers must offer and provide assistance with Part D enrollment and the LIS application upon a Member’s request. Cenpatico IC providers shall track Part D enrollment and LIS application status of Members, and report tracking activities when required by AHCCCS.

3.1.6.1 Enrollment in Part D

All persons eligible for Medicare must be encouraged to and assisted in enrolling in a Medicare Part D plan to access Medicare Part D Prescription Drug coverage. Enrollment must be in a Prescription Drug Plan (PDP), which is fee-for-service Medicare plan or a Medicare Advantage Prescription Drug Plan (MA-PD), which is a managed care Medicare plan. Upon request, providers must assist Medicare eligible persons in selecting a Part D plan. The Centers for Medicare and Medicaid Services (CMS) developed web tools to assist with choosing a Part D plan that best meets the person’s needs. The web tools can be accessed at www.medicare.gov. For additional information regarding Medicare Part D Prescription Drug coverage, call Medicare at 1-800-633-4227 or the Arizona State Division of Aging and Adult Services at 602-542-4446 or toll free at 1-800-432-4040.

3.1.6.2 Applying for the Low Income Subsidy (LIS)

- The LIS is a program in which the federal government pays all or a portion of the cost sharing requirements of Medicare Part D on behalf of the person. If the provider determines that a person may be eligible for the LIS (see the Social Security Administration (SSA) website at www.ssa.gov for income and resource limits), the provider must offer to assist the person in completing an application.
- Applications can be obtained and submitted through the following means:
  - Online at https://secure.ssa.gov/i1020/start;
  - By calling 1-800-772-1213 or TTY 1-800-325-0078, Monday – Friday, 7 AM – 7 PM.
  - In person at a SSA local office;
  - By mailing a paper application to the SSA.

3.1.6.3 Reporting Part D Enrollment and LIS Applications

Providers must track Part D enrollment and LIS application status for Medicare eligible Members. AHCCCS has developed Provider Manual Form 3.1.1, Tracking of Medicare Part D Enrollment which can be used by Cenpatico IC or the provider to track persons eligible for Medicare. This will assist Cenpatico IC to ensure that Medicare eligible persons are enrolled in a Part D plan and apply for the LIS program, if applicable. Provider Manual Form 3.1.2, Tracking of Low Income Subsidy Status is also available to assist providers.
3.1.6.4  **Federal Health Insurance Marketplace**

Providers must educate and encourage Non-Title SMI Members to apply for health coverage from a qualified health plan using the application process located at the Federal Health Insurance Marketplace and offer assistance for those choosing to enroll during open enrollment periods and qualified life events. Members enrolled in a qualified health plan through the Federal Health Insurance Marketplace may continue to be eligible for Non-Title XIX/XXI covered services that are not covered under the Federal Health Insurance Marketplace plan.

3.1.7  **Refusal to Participate With Screening and/or Application Process for Title XIX/XXI or Other AHCCCS Eligibility or Enrollment in a Part D Plan**

On occasion, a person may decline to participate in the AHCCCS eligibility screening and application process or refuse to enroll in a Medicare Part D plan. In these cases, the provider must actively encourage the person to participate in the process of screening and applying for AHCCCS health insurance coverage or enrolling in a Medicare Part D plan.

Arizona state law provides that persons who refuse to participate in the AHCCCS screening and eligibility application process or to enroll in a Medicare Part D plan are ineligible for state funded services (see **A.R.S. § 36-3408**). As such, an individual who refuses to participate in the AHCCCS screening and eligibility application or enrollment in Medicare Part D, if eligible, will not be enrolled with Cenpatico IC during his/her initial request for services or will be dis-enrolled if the person refuses to participate during an annual screening. The following conditions do not constitute a refusal to participate:

- A person’s inability to obtain documentation required for the eligibility determination;
- A person is incapable of participating as a result of his/her mental illness and does not have a legal guardian; and/or
- A person who is enrolled in a qualified health plan through the Federal Health Insurance Marketplace and refuses to take part in the AHCCCS screening and application process will not be eligible for Non-Title XIX/XXI SMI funded services.

If a person refuses to participate in the screening and/or application process for Title XIX/XXI or other eligibility, or to enroll in a Part D plan, the provider must ask the person to sign the **Provider Manual Form3.1.3, Decline to Participate in AHCCCS Screening or Referral Process**. If a person refuses to sign the form, the provider must document his/her refusal to sign in the comprehensive clinical record (See **Section 9.2 — Medical Records Standards**).

3.1.7.1  **Special Considerations for Persons Determined to Have a Serious Mental Illness (SMI)**

If a person who is eligible for or requesting services as a person determined to have a SMI is unwilling to complete the eligibility screening or application process for Title XIX/XXI or to enroll in a Part D plan and does not meet the conditions above, the provider must request a clinical consultation by a Behavioral Health Medical Professional. If the person continues to refuse following a clinical consultation, the provider must request that the person sign the **Provider Manual Form3.1.3, Decline to Participate in AHCCCS Screening or Referral Process**. Prior to the termination of services for persons with a SMI who have been receiving behavioral health services and subsequently decline to participate in the screening/referral process, Cenpatico IC
must provide written notification of the intended termination using the Provider Manual Form 15.3.1, Notice of Decision and Right to Appeal (see Section 15.4 — Notice and Appeal Requirements (SMI and GMH/SA Non-Title XIX/XXI)).

3.1.7.2 Persons Who Refuse to Cooperate With the AHCCCS Eligibility and/or Application Process or Who Do Not Enroll in a Part D Plan

The provider must inform the person who he/she can contact in the behavioral health system for an appointment if the person chooses to participate in the eligibility and/or application process in the future. Members may call the behavioral health provider, Cenpatico IC Customer Services at 1-866-495-6738, 8:00 a.m. – 5:00 p.m., Monday – Friday, or the Crisis Call Center at 866-495-6735 for assistance.

3.2 Appointment Standards and Timeliness of Service

It is vital that the State behavioral health system be responsive and accessible to all the persons it serves. It is the expectation of the State that provider response to a person’s identified behavioral health service need is timely and based on clinical need, resulting in the best possible behavioral health outcomes for that person.

Response time is always determined by the acuity of a person’s assessed behavioral health condition at the moment he/she is in contact with the provider. The State has organized responses into three categories: immediate responses, urgent responses, and routine responses.

Please note that at the time it is determined that an immediate response is needed, a person’s eligibility and enrollment status may not be known. Providers must respond to all persons in immediate need until the situation is clarified that the provider is not financially responsible. Persons who are determined ineligible for covered services may be referred to applicable community resources.

Per Cenpatico’s Appointment Availability policy, providers will be monitored for appointment availability standards quarterly through telephonic surveys and reviews of provider schedules during face-to-face site visits. Results of the surveys are reviewed in the Quality Management Performance Improvement Committee Meeting to determine the need for performance improvement projects, corrective actions or closing of panels. Appointment Availability concerns will be address in subsequent technical assistance sessions with the assigned provider relations staff. Appointment Availability trends will be reported in the Monthly Essential Provider Call.

Providers must develop and implement policies and procedures to monitor the availability and timeliness of appointments for Members and providers must disseminate information regarding appointment standards to Members, service providers, and Out-of-Network providers. Providers also must clearly post hours of operation in a location accessible to Members. For more information on appointment standards, see the AHCCCS Policy on Appointment Standards and Timeliness of Services.
### 3.2.1 Type of response by a behavioral health provider (non-hospitalized persons)

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<tr>
<th>WHEN</th>
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<tr>
<td><strong>IMMEDIATE</strong></td>
<td>Behavioral health services provided within a timeframe indicated by behavioral health condition, but no later than 2 hours from identification of need or as quickly as possible when a response within 2 hours is geographically impractical.</td>
<td>Services can be telephonic or face-to-face; the response may include any medically necessary covered behavioral health service.</td>
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<tr>
<td><strong>DES/DCS Behavioral Health Appointments</strong></td>
<td>Behavioral Health services/Rapid Response must be provided within a timeframe indicated by behavioral health condition but no later than 72 hours after notification by DES/DCS that a child has been or will be removed from their home. Initial Evaluation should occur within 7 calendar days after referral or request for behavioral health services. The Initial Appointment should occur within timeframes indicated by clinical need but no later than 21 calendar days after the initial evaluation. Subsequent Behavioral Health Services within the timeframes according to the needs of the person, but no longer than 21 calendar days from the identification of need.</td>
<td>Includes medically necessary covered services.</td>
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<td><strong>URGENT</strong>&lt;br&gt;All other urgent responses&lt;br&gt;Behavioral health services provided within a timeframe indicated by behavioral health condition but no later than 24 hours from identification of need.&lt;br&gt;Emergency appointments must be provided within 24 hours of a referral</td>
<td>Includes any medically necessary covered behavioral health service.</td>
<td>• Referrals for hospitalized persons not currently enrolled in Cenpatico IC;&lt;br&gt;• All Title XIX/XXI eligible persons; and&lt;br&gt;• All Non-Title XIX/XXI persons determined to have a SMI</td>
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<td><strong>ROUTINE</strong>&lt;br&gt;Appointment for initial assessment within 7 days of referral or request for behavioral health services.</td>
<td>Includes any allowable assessment service as identified in the AHCCCS Covered Behavioral Health Services Guide.</td>
<td>• All Title XIX/XXI eligible persons;&lt;br&gt;• All Non-Title XIX/XXI persons determined to have a SMI; and&lt;br&gt;• All persons referred for determination as a person with a SMI</td>
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<tr>
<td>The first behavioral health service following the initial assessment appointment within timeframes indicated by clinical need, but no later than 23 days after the initial assessment.</td>
<td>Includes any medically necessary covered behavioral health service including additional assessment services.</td>
<td>• All Title XIX/XXI persons; and&lt;br&gt;• All Non-Title XIX/XXI persons determined to have a SMI</td>
</tr>
<tr>
<td>All subsequent behavioral health services within time frames according to the needs of the person.</td>
<td>Includes any medically necessary covered behavioral health service.</td>
<td>• All Title XIX/XXI persons; and&lt;br&gt;• All Non-Title XIX/XXI persons determined to have a SMI</td>
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*Note: Standards for persons receiving services as part of SABG Grant funding are in Section 3.10 — Special Populations.*

### 3.2.2 Health Home Appointment Availability and Scheduling

In accordance with the requirements in this Provider Manual, providers must maintain adequate immediate, urgent, and routine outpatient office and in-home appointments to meet the needs of Members in their areas. For more information regarding Appointment Availability Requirements see ACOM Policy 417.

At all clinics open four or more days per week, Health Home providers must provide intake and clinical office services during evenings (until at least 7:00 PM and at least two (2) nights per
week) and on Saturdays. Health Home providers providing routine outpatient services must verify that at least fifteen percent (15%) of a clinic’s scheduled hours of operation are outside of regular business hours (8:00 AM – 5:00 PM, Monday through Friday) in each community served.

Health Home providers must maintain daily appointment slots for immediate and urgent treatment appointments in each community served. Health Home providers also must make available additional urgent psychiatric appointments each week of at least thirty (30) minute duration each and not fill the urgent appointment slots prior to two (2) business days before the date of the urgent appointment.

Health Home providers must collaborate with Cenpatico IC in maintaining a centralized after-hours urgent and emergent appointment scheduling system to facilitate after-hours urgent and emergent appointment scheduling. The Health Home provider must review and monitor the online centralized schedule at least twice a day to facilitate effective coordination of care. In each community served, a Health Home provider must “block” one (1) hour per day of scheduling time in the late afternoon to allow Cenpatico IC and/or its crisis telephone vendor to schedule urgent and emergent psychiatric and intake appointments. If by 8:00 AM on a given day no appointment has been booked in the “blocked” time, the Health Home provider may release the “blocked” time for other appointments.

3.2.3 Wait Times

The State has established standards so that persons presenting for scheduled appointments do not have to wait unreasonable amounts of time. Unless a provider is unavailable due to an emergency, a person appearing for an established appointment must not wait for more than one hour. Providers are required to monitor wait times via a daily log to include the time the member arrived, the time of the scheduled appointment and the time the member was taken back to appointment. Providers offering open access or walk-in appointments must carefully monitor wait times and offer Members the opportunity to schedule an appointment if the waiting time is anticipated to exceed two hours.

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.
- Providers must develop and implement a quarterly performance auditing protocol to evaluate compliance with the standard for all subcontracted transportation vendors/brokers and require corrective action if standards are not met.

3.2.4 72-Hour Urgent Behavioral Health Response for Children Taken into DES/DCS Custody

An urgent response known as “Rapid Response” (within 72 hours) is required for all children who are taken into the custody of ADES/DCYF/DCS regardless of Title XIX/XXI eligibility status.
The purpose for this rapid response service is to identify immediate safety needs and presenting problems of the child, to stabilize behavioral health crises, and to establish services that will lead to family reunification, when appropriate.

More specific details and requirements of the 72-Hour Rapid Response can be found in PM Section 6.2, 72-Hour Rapid Response Requirements for Children Removed by DCS.

### 3.2.5 Appointments for Psychotropic Medications

For persons 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 verify that the person does not experience a decline in his/her behavioral health condition.

### Response for Referrals or Requests for Psychotropic Medications:

<table>
<thead>
<tr>
<th>WHEN</th>
<th>WHAT</th>
<th>WHO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral for psychotropic medications</td>
<td>Assess the urgency of the need immediately. If clinically indicated, provide an appointment with a BHMP within a timeframe indicated by clinical need, but no later than 30 days from the referral/initial request for services.</td>
<td>Screening, consultation, assessment, medication management, medications, and/or lab testing services as appropriate. &lt;br&gt;• All Title XIX/XXI eligible persons; &lt;br&gt;• All Non-Title XIX/XXI persons enrolled with Cenpatico IC &lt;br&gt;• All persons determined to have a SMI; and &lt;br&gt;• Any person in an emergency or crisis.</td>
</tr>
<tr>
<td>All initial assessments and treatment recommendations that indicate a need for psychotropic medications</td>
<td>The initial assessment and treatment recommendations must be reviewed by a BHMP within a timeframe based on clinical need.</td>
<td>Screening, consultation, assessment, medication management, medications, and/or lab testing services as appropriate. &lt;br&gt;• All Title XIX/XXI eligible persons; &lt;br&gt;• All persons determined to have a SMI; and &lt;br&gt;• Any person in an emergency or crisis.</td>
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### 3.2.6 Referrals for Hospitalized Persons

Providers must quickly respond to referrals pertaining to eligible persons not yet enrolled in Cenpatico IC or Title XIX/XXI eligible persons who have not been receiving 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:

- For referrals of Title XIX/XXI eligible persons and persons previously determined to have a SMI, initial face-to-face contact, an assessment and disposition must occur within 24 hours of the referral/request for services.
• For referrals of Non-Title XIX/XXI eligible persons and persons referred for eligibility determination of SMI:
  o 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 Section 3.6 — SMI Eligibility Determination; and
  o 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.

3.2.7 Other Requirements

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 in Section 3.2.5 — Appointments for Psychotropic Medications.

Title XIX/XXI persons must never be placed on a “wait list” for any Title XIX/XXI covered behavioral health service. If Cenpatico IC network is unable to provide medically necessary covered services for Title XIX/XXI persons, Cenpatico IC must ensure timely and adequate coverage of needed services through an alternative provider until a network provider is subcontracted. In this circumstance, Cenpatico IC 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 provider must adhere to the following procedure:

1. Maintain the current level of services being provided to the person;
2. Identify and provide any supportive services needed by the person while securing the needed service;
3. Verify the creation of a service plan and a crisis plan for the Title XIX/XXI Member and verify that the person understands how to access crisis services during this time; and
4. Contact Cenpatico IC’s UM Department at 1-866-495-6738 to coordinate and track care while securing the service, and to discuss needs for any non-contracted services, including for persons who are in an inpatient or residential facility and are awaiting a referral for outpatient services.

3.2.8 Special Populations

The State receives some funding for services through the Federal Substance Abuse Block Grant (SABG). SABG funds are used to provide substance abuse services for Non-Title XIX/XXI eligible persons. As a condition of receiving this funding, certain populations are identified as priorities for the timely receipt of designated services. Any providers contracted with Cenpatico IC for SABG funds must follow the requirements found in this Section. For all other providers that do not currently receive these funds, the following expectations do not apply.

3.2.8.1 SABG Block Grant Populations
The following populations are prioritized and covered under the SABG Block Grant:

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

### Response Times for Designated Behavioral Health Services under the SABG Block Grant:

<table>
<thead>
<tr>
<th>When</th>
<th>What</th>
<th>Who</th>
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<tbody>
<tr>
<td>Behavioral health services provided within a timeframe indicated by clinical need, but no later than 48 hours from the referral/initial request for services.</td>
<td>Any needed covered behavioral health service, including admission to a residential program if clinically indicated; If a residential program is temporarily unavailable, an attempt shall be made to place the person within another provider agency facility, including those in other geographic service areas. If capacity still does not exist, the person shall be placed on an actively managed wait list and interim services must be provided until the individual is admitted. Interim services include: counseling/education about HIV and Tuberculosis (include the risks of transmission), the risks of needle sharing and referral for HIV and TB treatment services if necessary, counseling on the effects of alcohol/drug use on the fetus and referral for prenatal care.</td>
<td>Pregnant women/teenagers referred for substance abuse treatment (includes pregnant injection drug users and pregnant substance abusers) and substance-using females with dependent children, including those attempting to regain custody of their child(ren).</td>
</tr>
<tr>
<td>Behavioral health services provided within a timeframe indicated by clinical need but no later than 14 days following the initial request for services/referral. All subsequent services must be provided within timeframes according to the needs of the person.</td>
<td>Includes any needed covered behavioral health services; Admit to a clinically appropriate substance abuse treatment program (can be residential or outpatient based on the person’s clinical needs); if unavailable, interim services must be offered to the person. Interim services shall minimally include education/interventions with regard to HIV and tuberculosis and the risks of needle sharing and must be offered within 48 hours of the request for treatment.</td>
<td>All other injection drug users</td>
</tr>
</tbody>
</table>
### When

Behavioral health services provided within a timeframe indicated by clinical need but no later than 23 days following the initial assessment.

All subsequent behavioral health services must be provided within timeframes according to the needs of the person.

### What

Includes any needed covered behavioral health services.

### Who

All other persons in need of substance abuse treatment

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### 3.3 Referral and Intake Process

The referral process serves as the principal pathway by which persons are able to gain prompt access to publicly supported services. The intake process serves to collect basic demographic information from persons in order to enroll them in the AHCCCS system, screen for Title XIX/XXI AHCCCS eligibility and determine the need for any copayments (See Section 8.2 — Copayments). It is critical that both the referral process and intake process are culturally sensitive, efficient, engaging, and welcoming to the person and/or family member seeking services, and leads to the provision of timely and appropriate services based on the urgency of the situation.

A “referral” is any oral, written, faxed or electronic request for services made by the Member or Member’s legal guardian, family member, an AHCCCS Acute Contractor, PCP, hospital, court, Tribe, IHS, school, or other state or community agency.

Providers must resolve referral disputes promptly. Cenpatico IC will promptly intervene and resolve any dispute between a provider and a referring source when those parties cannot informally resolve disputes regarding the need for emergency, urgent, or routine appointments.

#### 3.3.1 To Whom This Applies

This Section applies to all Title XIX/XXI eligible persons; and Non-Title XIX/XXI persons referred for an eligibility determination for SMI.

Cenpatico IC providers are responsible for managing referrals and wait lists for Non-Title XIX/XXI persons in accordance with the SABG Block Grant for identified priority populations when services are temporarily unavailable. If the Cenpatico IC network is unable to provide medically necessary services to Title XIX/XXI persons, Cenpatico IC will verify timely and adequate
coverage of needed services through an out-of-network provider until a network provider is contracted (See Section 3.2 — Appointment Standards and Timeliness of Service).

3.3.2 Objectives

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

- Communicating to potential referral sources the process for making referrals (e.g., centralized intake, identification of providers accepting referrals);
- Collecting enough basic information about the person to determine the urgency of the situation and subsequently scheduling the initial assessment within the required timeframes and with an appropriate provider (See Section 3.2 — Appointment Standards and Timeliness of Service);
- Adopting a welcoming and engaging manner with the person and/or person’s legal guardian/family member;
- Ensuring that intake interviews are culturally appropriate and delivered by providers that are respectful and responsive to the Member’s cultural needs (see Section 3.15 — Cultural Competence);
- Keeping information or documents gathered in the referral process confidential and protected in accordance with applicable federal and State statutes, regulations and policies;
- Informing, as appropriate, the referral source about the final disposition of the referral; and
- Conducting intake interviews that ensure the accurate collection of all the required information necessary and ensure Members who have difficulty communicating because of a disability or who require language assistance are afforded appropriate accommodations to assist them in fully expressing their needs.

3.3.3 Where to Send Referrals

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

Individuals may access services by directly contacting a Health Home. Contracted Health Homes are identified on the Cenpatico IC website (www.cenpaticointegratedcareaz.com) and in the Cenpatico IC Member Handbook. Individuals may also call Cenpatico IC Customer Service at 1-866-495-6738, 24 hours a day/7 days a week, and receive a referral to a contracted Health Home. During normal business hours, Cenpatico IC will transfer callers to an intake provider. After-hour referrals are provided to Health Home providers who are expected to follow up on the referral. The Crisis Call Center staff tracks referrals to verify the caller is appropriately connected with a Health Home. In addition, the Crisis Call Center has access to emergent and
urgent psychiatric appointments at intake provider sites and can schedule these appointments on the Member’s behalf.

Providers are required to notify Cenpatico IC of any changes that would alter or change information provided through the directory. Three-day notice is required for changes in telephone number, fax number, email address, service changes, staff changes, service capacity changes or ability to accept new referrals. (See Section 16 — Deliverable Requirements.)

3.3.4 Choice of Providers

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

3.3.5 Referral to a Provider for a Second Opinion

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

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

A behavioral health provider can arrange for a second opinion in-network or can contact Cenpatico IC Customer Service at 1-866-495-6738, 8:00 a.m. – 5:00 p.m. Monday – Friday, for assistance. Out-of-Network requests should be submitted to Cenpatico IC Medical Management department for review and processing. A provider must maintain a record identifying both (1) the date of service for the second opinion and (2) the name of the provider who provided the second opinion. There must be documentation in the clinical chart of the following:

- Rationale for the use of two medications from the same pharmacological class;
- Rationale for the use of more than three different psychotropic medications in adults; and
- Rationale for the use of more than one psychotropic medication in the child and adolescent population.

3.3.6 Referrals Initiated by DES/DCYF Pending the Removal of a Child

Upon notification from DES/Division of Children, Youth and Families (DCYF) that a child has been, or is at risk of being taken into the custody of DES/DCYF/Department of Child Safety (DCS), providers are expected to respond in an urgent manner (for additional information, see Section
3.2 — Appointment Standards and Timeliness of Service and AHCCCS Practice Protocol, Unique Needs of Children, Youth and Families Involved with Child Protective Services).

### 3.3.7 Accepting Referrals

Providers must establish written procedures for accepting and acting upon referrals, including emergency referrals. Providers must accept referrals for services as identified in the provider’s contract with Cenpatico IC, unless Cenpatico IC grants a written waiver or suspension of this requirement. Providers must accept referrals, regardless of diagnosis, level of functioning, age, Member’s status in family, or level of service needs. (See 42 CFR 438.210 (a)(3)(iii))

Providers must accept and respond to emergency referrals of Title XIX/XXI eligible Members and Non-Title XIX/XXI Members with SMI twenty-four (24) hours a day, seven (7) days a week. Emergency referrals do not require prior authorization. Emergency referrals include those initiated for Title XIX/XXI eligible and Non-Title XIX/XXI with SMI Members admitted to a hospital or treated in the emergency room. Providers must respond within twenty-four (24) hours upon receipt of an emergency referral.

The following information shall be collected from referral sources:

- Date and time of referral;
- Information about the referral source including name, telephone number, fax number, affiliated agency, and relationship to the person being referred;
- Name of person being referred, address, telephone number, gender, age, date of birth and, when applicable, name and telephone number of parent or legal guardian;
- Whether or not the person, parent, or legal guardian is aware of the referral;
- Transportation and other special needs for assistance due to impaired mobility, 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;
- Medications prescribed by the Member’s PCP or other medical professional including the reason why the medication is being prescribed; and
- The names and telephone numbers of individuals the Member, parent, or guardian may wish to invite to the initial appointment with the referred Member.

*Don’t Delay* . . . Providers should act on a referral regardless of how much information you have. While the information listed above will facilitate evaluating the urgency and type of practitioner the Member may need to see, timely triage and processing of referrals must not be delayed because of missing or incomplete information.
When psychotropic medications are a part of an enrolled person’s treatment or have been identified as a need by the referral source, providers must respond as outlined in Section 3.2 — Appointment Standards and Timeliness of Service.

For the convenience of referral sources (e.g., AHCCCS health plans and AHCCCS primary care providers, state agencies, hospitals) Cenpatico IC has developed a form to facilitate referrals (See Provider Manual Form 3.3.1, ADHS Referral for Behavioral Health Services). Providers must make this form available to referral sources. This form can be faxed to the Crisis Call Center at 866-615-8773. Referral sources, however, may use any other written format, or they may contact the Crisis Call Center by phone at 844-882-5354 or providers directly by telephone.

In situations in which the person seeking services or his/her family member, legal guardian, or significant other contacts a provider directly about accessing services, provider shall ensure that the protocol used to obtain the necessary information about the person seeking services is engaging and welcoming.

When a SMI eligibility determination is being requested as part of the referral or by the person directly, providers must conduct an eligibility determination for SMI in accordance with Section 3.6 — SMI Eligibility Determination. The SMI assessment and pending determination will not delay behavioral health service deliver to the Member.

### 3.3.8 Responding to Referrals

**Follow-Up:** When a request for services is initiated but the Member does not appear for the initial appointment, the provider must attempt to contact the Member and implement engagement activities consistent with Section 3.4.1 — Outreach, Engagement, Re-engagement and Ending an Episode of Care. The provider must also attempt to notify the entity that made the referral.

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

- AHCCCS health plans;
- AHCCCS PCPs;
- Arizona Department of Economic Security/Division of Children, Youth and Families;
- Arizona Department of Child Safety;
- Arizona Department of Economic Security/Division of Developmental Disabilities;
- Arizona Department of Corrections;
- Arizona Department of Juvenile Corrections;
- County Adult and Juvenile Detention Centers;
- Administrative Offices of the Court;
- Arizona Department of Economic Security/Rehabilitation Services Administration; and
- Arizona Department of Education and affiliated school districts.
The final disposition must include 1) the date the Member was seen for the initial assessment; and 2) the name and contact information of the provider who will assume primary responsibility for the Member’s behavioral health care, or 3) if no services will be provided, the reason why. When required, authorization to release information will be obtained prior to communicating the final disposition to the referral sources referenced above. (See Section 9.2.4 — Disclosure of Records).

3.3.9 Documenting and Tracking Referrals

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

- Person’s name and, if available, AHCCCS identification number;
- Name and affiliation of referral source;
- Date of birth;
- Type of referral (immediate, urgent, routine) as defined in Section 3.2 — Appointment Standards and Timeliness of Service;
- Date and time the referral was received;
- If applicable, date and location of first available appointment and, if different, date and location of actual scheduled appointment; and
- Final disposition of the referral.

3.3.10 Eligibility Screening and Supporting Documentation

Persons who are not already AHCCCS eligible must be asked to bring supporting documentation to the screening interview to assist the provider in identifying if the person could be AHCCCS eligible (See Section 3.1 — Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Limited Income Subsidy Program). Explain to the person that the supporting documentation will only be used for the purpose of assisting the person in applying for AHCCCS health care benefits. Let the person know that AHCCCS health care benefits may help pay for services, and ask the person to bring the following supporting documentation to the screening interview:

- Verification of gross family income for the last month and current month (e.g., pay check stubs, social security award letter, retirement pension letter);
- Social security numbers for all family members (social security cards if available);
- 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);
- For those who pay for dependent care (e.g., adult or child daycare), proof of the amount paid for the dependent care; and
- Verification of out-of-pocket medical expenses.

3.3.11 Intake Interviews

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

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

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

- The collection of contact information, insurance information, the reason why the person is seeking services and information on any accommodations the person may require to effectively participate in treatment services (i.e., need for oral interpretation or sign language assistance, consent forms in large font, etc.).
- The collection of required demographic information and completion of client demographic information sheet, including the Member’s primary/preferred language (see Section 13.1 - Enrollment, Disenrollment and other Data Submission);
- The completion of any applicable authorizations for the release of information to other parties (see Section 9.2.4 — Disclosure of Records);
- The dissemination of a Cenpatico IC Member Handbook to the person (see Section 14 — Cenpatico IC Member Handbook);
- The review and completion of a general consent to treatment (see Section 3.7 — 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 health insurance, when necessary (see Section 3.1 — Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Limited Income Subsidy Program and Section 8.3 — Third Party Liability and Coordination of Benefits);
- Advising Non-Title XIX/XXI persons determined to have a SMI that they may be assessed a copayment (see Section 8.2 — Copayments).
- The review and dissemination of Cenpatico IC 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 person’s rights and responsibilities as a Member of services, including an explanation of the appeal process.

The person and/or family members may complete some of the paperwork associated with the intake, if acceptable to the person and/or family members.
Providers conducting intakes must be appropriately trained, approach the person and family in an engaging manner, and possess a clear understanding of the information that needs to be collected.

### 3.3.12 Specialty Behavioral Health Agency Referrals

All Cenpatico IC-contracted providers are responsible for ensuring timely and appropriate service delivery as requested by the member and/or as determined necessary to meet the member’s needs. Specialty Behavioral Health Agencies are responsible for determining medical necessity for specialty services, either through the development of a Specialty Assessment and Specialty Service Plan, or through clinical documentation provided by the member’s Health Home. Specialty Providers are responsible for delivering medically-necessary specialty services and programs as identified on service plans, regularly reporting progress to Health Home treatment teams, coordinating services with Health Homes and attending treatment team meetings as appropriate.

The process to ensure this coordination of care is as follows:

**The referral process for Individuals who are not currently enrolled with a Health Home or in an Open Episode of Care (OEC) that self-refer to a Specialty Provider that conducts Specialty Assessments and Specialty Service Plans** is as follows:

**Referral Process for Individuals Not in an Open Episode of Care (OEC)**

- When an individual self refers to a specialty provider for services, the specialty provider should confirm eligibility for services and determine medical necessity. If the member is not currently enrolled and the specialty provider delivers services, they should understand they may not receive payment for the services provided.
- If the individual is not currently enrolled in AHCCS, the specialty provider should refer the individual to a health home agency to be screened for AHCCCS or grant funding, for an SMI determination (if appropriate) and/or to assist with getting the individual enrolled into the Federal Marketplace.
- If the individual is eligible for services the Specialty Agency should check the Cenpatico Provider Portal to determine if the individual is currently in an Open Episode of Care (OEC) with a Cenpatico IC health home agency.
- If the individual is not currently enrolled with a Health Home Agency, but is eligible for services, the Specialty Agency can proceed in conducting their Specialty Assessments and Specialty Service Plan with reasonable confidence they will be paid for the services provided.
- If the member is not in an OEC with a Health Home Agency, the Specialty Provider must then refer the member to a Health Home Agency within 7 days of first seeing the member. The Health Home Agency then has 7 days to complete their intake and open an episode of care (OEC) per the AHCCCS Referral to Intake expectations for a routine intake.
- If the Specialty Agency does not assist the member in completing an intake with the Health Home Agency to get an OEC within 30 days then the Specialty Agency may be subject to corrective action. Specialty agencies are responsible for ensuring members obtain an OEC within 30 days of initial contact with the member.
• The Specialty Agency should assist the individual in scheduling this intake. The Specialty Agency can provide transportation to this intake with the Health Home Agency, if this is medically necessary, or by calling Cenpatico Customer Service for transportation assistance.

• To complete the referral to the Health Home Agency, the Specialty Agency should complete the PM Form 3.3.1 and send to the Health Home Agency’s designated Referral Email Address or Referral fax number.
Referral Process for Members in an Open Episode of Care (OEC) self-referring to a Specialty Agency that conducts Specialty Assessments and Specialty Service Plans:

- If the member is in an OEC with a Health Home Agency than the Specialty Agency can proceed in completing a Specialty Assessment and the Specialty Service Plan.
- Once the Specialty Assessment and the Specialty Service Plan are complete, the Specialty Provider is required to send these documents, along with the PM 3.3.3 Monthly Summary Progress note, to the Health Home Agency. These documents must be sent to the Health Home Agency within 30 days per the Provider Manual but it is recommended that these documents be sent to the Health Home Agency as soon as possible.
- The Specialty Agency is required to continue to send the Monthly Summary Progress Note to the Health Home Agency every 30 days to coordinate care and provide service updates.
- The Specialty Agency is required to put both the Monthly Summary Progress note and evidence that it was sent in their EHR.
- Ongoing coordination of care between the Specialty Agency and the Health Home Agency is critical. This should be done at a minimum through the Monthly Summary Progress Notes. ART/CFT Meetings will need to occur as needed. Either agency has freedom to schedule ART/CFT meetings. Cenpatico IC will audit for this coordination and service planning activity through review of Monthly Summary Progress Notes and ART/CFT Progress Notes in both provider EHRs.
- Referral Process to Specialty Agencies that do not conduct Specialty Assessments and Specialty Service Plans for members assigned to a Health Home and in an OEC is as follows: Members, family and/or system partners are expected to coordinate services with the CFT/ART team, when a member has an established team.
- Specialty agencies are required to contact the Health Home within 7 days of the first service to coordinate care and provide treatment updates.
- All requests for planned out of home placements must be made through the member’s established CFT/ART team.
- If a specialty service is necessary to meet the member’s needs, the Health Home is expected to coordinate the request for the referral/services by contacting the Specialty Provider to assist the member in setting up an initial appointment. This coordination must occur within 7 days of the member’s request; however, it is recommended that efforts be made to begin this coordination much sooner to ensure unnecessary delays to services to not occur.
- Coordination between the Health Home and the Specialty Provider should include a discussion of the member’s needs, goals and desired services. Coordination can be in the form of a CFT/ART Meeting or telephone call including the Specialty Provider, with or without the member present.
- At a minimum, the Health Home must coordinate with the Specialty Agency and document the meeting and recommendations, including services to be provided and frequency for service plan development.
- Health Homes are required to send a current Comprehensive Assessment signed by a BHP and a completed ISP to the Specialty Provider within 2 business days of request by
the Specialty Provider. (This is required only if the Specialty Provider is unable to complete a Specialty Assessment and Specialty Service Plan or the information is necessary to effectively coordinate care.)

- The Specialty Behavioral Health Agency must notify the Health Home (referral agency) of the member’s first appointment date and the initiation of services by sending the Health Home a copy of the Specialty Provider-developed individual service plan and assessment within 14 business days of first appointment, as applicable.
- The Health Home must invite the Specialty Behavioral Health Agency to CFT/ART meetings.
- All system partners must be invited to CFT/ART meetings.
- The Specialty Agency must send the Health Home the PM Form 3.3.X, Monthly Summary Progress Note within 30 days of service delivery each month.
- The Health Home has up to 10 business days to respond to the Specialty Agency regarding any questions, or requests by the Specialty Provider as indicated on the Monthly Summary Form.

If the Specialty Behavioral Health Agency is unable to contact the member, 3 to 5 outreach attempts must be made and documented in the record within 30 days. Following unsuccessful outreach attempts, the Specialty Behavioral Health Agency must notify the Health Home using the PM Form 3.3.3 Specialty Behavioral Health Agency Monthly Summary Form or discharge summary.

### 3.3.13 Referrals for Screening and/or Diagnosis of Autism Spectrum Disorders

Cenpatico Integrated Care covers medically necessary behavioral health services for all AHCCCS-eligible children and adults, including the diagnosis and treatment for individuals who may have an autism spectrum disorder (ASD).

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

Children and adults not currently engaged with a behavioral health provider in the Cenpatico system of care should first see their primary care provider, who can then refer the child and family to a specialized ASD diagnosing provider, as referenced in Provider Manual Attachment 3.3.1, Process for ASD Diagnosis in Cenpatico Network.

Completion of an intake at a Health Home is not required for families seeking a one-time consultation for the diagnosis or rule out of ASD.

A list of specialized ASD diagnosing providers within the Cenpatico system of care is available within Provider Manual Attachment 3.3.2, Cenpatico Specialized ASD Diagnosing Providers List.
3.4 Outreach, Engagement, Re-Engagement, and Ending an Episode of Care and Disenrollment

The activities described within this section are an essential element of clinical practice. Outreach to vulnerable populations, establishing an inviting and non-threatening clinical environment, and re-establishing contact with persons who have become temporarily disconnected from services are critical to the success of any therapeutic relationship.

This section addresses five critical activities that providers must incorporate when delivering services within Arizona’s public behavioral health system:

1. Expectations for outreach activities directed to persons who are at risk for the development or emergence of behavioral health disorders;
2. Expectations for the engagement of persons seeking or receiving services;
3. Procedures to re-engage persons in an episode of care who have withdrawn from participation in the treatment process;
4. Conditions necessary to end an episode of care for a person in the behavioral health system; and
5. Expectations for serving persons who are attempting to re-enter the behavioral health system.

3.4.1 Outreach Activities

Health Home providers must provide outreach activities to inform the public of the benefits and availability of services and how to access them. Cenpatico IC disseminates and requires providers to disseminate information to the general public, other human service providers, school administrators and teachers, and other interested parties regarding the services that are available to eligible persons.

Outreach activities conducted by Cenpatico IC and providers may include, but are not limited to:

- Participation in community events, 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, state prisons, county detention facilities, law enforcement agencies, emergency departments and local and county DCS offices and programs, including participating in effective release planning;
- Routine interaction with agencies that have contact with substance abusing pregnant women/teenagers;
- Conduct home visits;
• Development and implementation of outreach programs that identify persons with co-morbid medical and behavioral health disorders and those who have been determined to have a SMI within Cenpatico IC’s geographic service area, including persons who reside in jails, homeless shelters, county detention facilities, or other settings;
• 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.

In addition to the above outreach activities, the Crisis Call Center telephonically conducts outreach to new AHCCCS enrollees to educate them about the availability of behavioral health services and how to access services, and to assist in removing stigma associated with obtaining services.

3.4.2 Engagement

Providers must provide services in a culturally competent manner in accordance with Cenpatico IC’s Cultural Competency Plan (see Section 3.15 — Cultural Competence).

Behavioral health providers are required to:
• Provide a courteous, welcoming environment that provides persons with the opportunity to explore, identify, and achieve their personal goals;
• Engage persons in an empathic, hopeful, and welcoming manner during all contacts;
• Provide culturally relevant care that addresses and respects language, customs, and values and is responsive to the person’s unique family, culture, traditions, strengths, age and gender (see Section 3.15 — Cultural Competence);
• 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 verifying that they understand all clinical and administrative information (see Section 3.15 — Cultural Competence);
• 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; and
• Provide information on available services and assist the person and/or the person’s legal guardian, the person’s family, and the entire clinical team in identifying services that help meet the person’s goals.

3.4.3 Re-Engagement

Providers must attempt to re-engage persons in an episode of care who have withdrawn from participation in the treatment process prior to the successful completion of treatment, refused services or failed to appear for a scheduled service. 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 provider must attempt to re-engage the person by:

• Communicating in the person’s preferred language;
• Contacting the person or the person’s legal guardian by telephone, at times when the person may reasonably be expected to be available (e.g., after work or school);
• Whenever possible, contacting the person or the person’s legal guardian face-to-face, if telephone contact is insufficient to locate the person or determine acuity and risk;
• Sending a letter to the current or most recent address requesting contact, if all attempts at personal contact are unsuccessful, except when a letter is contraindicated due to safety concerns (e.g., domestic violence) or confidentiality issues. The provider will note safety or confidentiality concerns in the progress notes section of the clinical record and include a copy of the letter sent in the comprehensive clinical record; and
• For persons determined to have a Serious Mental Illness who are receiving Special Assistance (see Section 3.11 — Special Assistance for Persons Determined to have a Serious Mental Illness), contacting the person designated to provide Special Assistance for his/her involvement in re-engagement efforts.

If the above activities are unsuccessful, the provider must make further attempts to re-engage persons determined to have a SMI, persons under court ordered treatment, children (including children in foster care), 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. Further attempts may include contacting the person or person’s legal guardian, face-to-face visits, 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 make attempts as appropriate to engage the person to voluntarily seek inpatient care. If this is not a viable option for the person and the clinical standard is met, the provider must initiate the pre-petition screening or petition for treatment process described in Section 3.9 — Pre-petition Screening, Court Ordered Evaluation and Court Ordered Treatment.
All attempts to re-engage persons determined to have a 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. Providers are required to have a clearly defined outreach and engagement policy.

Re-Engagement for Members on Court Ordered Treatment:

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

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

3.4.3.1 Follow-Up After Missed Appointments

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

3.4.3.2 Follow-Up After Significant and/or Critical Events

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

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

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

3.4.3.3 Provider Requirements to Notify the Crisis Call Center of At-Risk Situations

Providers are required to notify the Crisis Call Center by telephone call within 2 hours of any enrolled persons determined to be a danger to self or others and supply an updated crisis plan. Providers are also required to notify the Crisis Call Center by telephone call and report a Member who has withdrawn from treatment and presents a potential risk to self, others, or the community; including, all persons with a SMI, all children at risk, all pregnant substance abusing women/teenagers, and any person determined to be at risk of relapse. The Crisis Call Center will assist with telephonic engagement activities, assist providers in developing appropriate intervention strategies, and coordinate with Cenpatico IC to bring additional resources to assist effective engagement in treatment.

3.4.4 Ending an Episode of Care for a Person in the Behavioral Health System

Providers may not end a member’s Episode of Care (EOC) because of an adverse change in the member’s health status or because of the member’s utilization of medical services, diminished capacity, or uncooperative or disruptive behavior. However, under certain circumstances, it may be appropriate or necessary to dis-enroll a person or end an episode of care from services for administrative reasons, or after re-engagement efforts described above have been expended. The episode of care can be ended for both Non-Title XIX/XXI and Title XIX individuals, but Title XIX/XXI eligible individuals no longer in an episode of care for services remain enrolled with AHCCCS.
3.4.4.1  Clinical Factors: Treatment Completed

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

3.4.4.2  Clinical Factors: Further Treatment Declined

A person’s episode of care must be ended if the person or the person’s legal guardian decides to refuse ongoing services. A Non-Title XIX/XXI person would also be dis-enrolled from services when the episode of care closes. Prior to ending the episode of care or dis-enrolling a person for declining further treatment, the provider must ensure the following:

- All applicable and required re-engagement activities described in above have been conducted and clearly documented in the person’s comprehensive clinical record; and
- The person does not meet clinical standards for initiating the pre-petition screening or petition for treatment process described in Section 3.9 — Pre-petition Screening, Court Ordered Evaluation and Court Ordered Treatment.

Upon receiving a request from a Department of Child Safety (DCS) case manager or representative in writing to discontinue services and/or dis-enroll a child in foster care, the provider will conduct a Child Family Team (CFT) staffing to determine if this is clinically appropriate.

3.4.4.3  Clinical Factors: Lack of Contact

A person’s episode of care may be ended if the provider is unable to locate or make contact with the person after ensuring that all applicable and required re-engagement activities described in Section 3.4.3 — Re-engagement have been conducted. A Non-Title XIX/XXI individual would also be dis-enrolled from services upon closure of the episode of care.

3.4.4.4  Administrative Factors

A person’s episode of care may be ended based on eligibility/entitlement information changes, including the following:

- Loss of eligibility, if other funding is not available to continue services; and
- Persons who become or are enrolled as elderly or physically disabled (EPD) under the Arizona Long Term Care System (ALTCS) must be dis-enrolled from Cenpatico IC after ensuring appropriate coordination and continuity of care with the ALTCS program contractor, except for ALTCS members with Developmental Disabilities ALTCS/DD, who receive behavioral health treatment through the RBHA/Health Plan system. An ALTCS/EPD eligible person may remain enrolled with Cenpatico IC as Non-Title XIX/XXI if the person has been determined to have a SMI and will continue to receive Non-Title XIX/XXI covered SMI services through Cenpatico IC.
- Providers may dis-enroll Non-Title XIX/XXI eligible persons for non-payment of assessed copayments per Section 8.2 — Copayments, under the following conditions:
The person is not eligible as a person determined to have a SMI per Section 3.6 — SMI Eligibility Determination; and

Attempts at reasonable options to resolve the situation, (e.g., informal discussions) do not result in resolution. All efforts to resolve the issue must be documented in the person’s comprehensive clinical record, in accordance with Section 9.2 — Medical Records Standards.

3.4.4.5 Out-of-State Relocations

A person’s episode of care must be ended for a person who relocates out-of-state after appropriate transition of care. A Non-Title XIX/XXI individual would also be dis-enrolled. This does not apply to persons placed out-of-state for purposes of providing behavioral health treatment (see Section 3.13 — Out-of-State Placements for Children and Young Adults).

3.4.4.6 Inter-RBHA Transfers

A person who relocates to another T/RBHA/Health Plan and requires ongoing health services must be closed from one T/RBHA/Health Plan and transferred to the new T/RBHA/Health Plan. Services must be transitioned per Section 4.2 — Transition of Persons.

3.4.4.7 Arizona Department of Corrections Confinements

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

3.4.4.8 Children Held at County Detention Facilities

A child who was served by Cenpatico IC prior to detainment in a county detention facility will remain in an open episode of care as long as the child remains Title XIX/XXI eligible. Providers must check the AHCCCS Pre-paid Medical Management Information System (PMMIS) to determine eligibility for treatment services prior to the delivery of each behavioral health service to a child who is held in a county detention facility.

Contact Cenpatico IC for assistance when a child loses their Title XIX/XXI eligibility while in detention. Children who lose their eligibility or have their eligibility suspended while temporarily in detention may be eligible for MHBG funded services, depending on availability of funds. Health Homes are required to maintain contact with children in detention and during the 30-day period prior to release to facilitate appropriate release planning. These coordination of care services are funded through state funds and block grant funds.

3.4.4.9 Inmates of Public Institutions

AHCCCS has implemented an electronic inmate of public institution notification system developed by the AHCCCS Division of Member Services (DMS). If a Member is eligible for AHCCCS covered services during the service delivery period, Cenpatico IC is obligated to cover the services regardless of the perception of the Members’ legal status.

In order for AHCCCS to monitor any change in a Members’ legal status, and to determine eligibility, Cenpatico IC providers are required to notify Cenpatico IC and AHCCCS via e-mail, and if they become aware that an AHCCCS eligible Member is incarcerated. Email Cenpatico IC at
CAZMembership@cenpatico.com. AHCCCS has established an email addresses for this purpose as well. Please note that there are two separate AHCCCS e-mail addresses based on the Members’ age. For children less than 18 years of age, please use DMSJUVENILEincarceration@azahcccs.gov. For adults age 18 years and older, please use DMSADULTIncarceration@azahcccs.gov. Notifications must include the following Member information:

- AHCCCS ID;
- Name;
- Date of Birth;
- Incarceration date; and
- Name of public institution where incarcerated.

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

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

3.4.4.10 Deceased Persons

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

3.4.4.11 Crisis Episodes

For persons who are enrolled as a result of a crisis episode, the person’s episode of care would end if the following conditions have been met:

- The provider conducts all applicable and required re-engagement activities described in Section 3.4.3 — Re-engagement and such attempts are unsuccessful; or
- The provider and the person (or the person’s legal guardian) mutually agree that ongoing services are not needed; a Non-Title XIX/XXI individual would be disenrolled from the system.

3.4.4.12 One-Time Consultations

For persons who are in the system for the purpose of a one-time consultation as described in Section 4.3 — Coordination of Care with AHCCCS Health Plans, Primary Care Providers, and Medicare Providers, the person’s episode of care may be ended if the provider and the person (or the person’s legal guardian) mutually agree that ongoing services are not needed. The Non-Title XIX/XXI individual would also be disenrolled.
3.4.4.13  **Data Submission**
Providers must follow all applicable data submission procedures as described in Section 13.1 — Enrollment, Disenrollment and Other Data Submission and the AHCCCS Demographic and Outcome Data Set User Guide following a decision to end an episode of care or disenrollment.

3.4.4.14  **Engagement and Re-Engagement Activity Verification**
Health Homes are required to complete Provider Manual Form 3.4.1 Engagement and Re-engagement Review or equivalent upon completion of treatment and prior to ending an episode of care for all Members. The Clinical Team is required to coordinate with the Clinical Director (or an independently licensed BHP designated by the Clinical Director) to determine if all attempts to engage/re-engage a person in services have been exhausted. If there is agreement that all attempts have been exhausted the provider must complete Provider Manual Form 3.4.1 Engagement and Re-engagement Review or equivalent. The Clinical Director or licensed BHP designee is required to verify by signature that all engagement and re-engagement activities have been exhausted, particularly for members that are being closed due to a Lack of Contact or Unable to Locate. If a closure is to occur as a result of Lack of Contact or Unable to Locate member than the provider is expected to conduct at a minimum, 3 phone calls to member or legal guardian, send 1 outreach and engagement letter, conduct 2 attempts for face-to-face contact in the community and if applicable call family members, friends or other providers where there is a Release of Information (ROI) on file in an attempt to locate and/or engagement the members. If a person has moved out of State, there must be documentation that the provider attempted to assist the person in obtaining services in their new state when possible (i.e. helped to schedule an intake with a receiving provider; provided the person with a list of mental health resources in their new state); and verified adequate supply of medications to allow time to complete the transition. A copy of the completed form, Provider Manual Form 3.4.1 Engagement and Re-engagement Review or equivalent must be easily identifiable and is required to be entered into the Member’s electronic health record.

3.4.5  **Serving a Person Previously Enrolled in the Behavioral Health System**
Some persons who have ended their episode of care or were dis-enrolled may need to re-enter the behavioral health system. The process used is based on the length of time that a person has been out of the behavioral health system.
<table>
<thead>
<tr>
<th>For persons not receiving services for less than six months</th>
<th>For persons not receiving services for six months or longer</th>
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<tbody>
<tr>
<td>If the person has not received a behavioral health assessment in the past six months, conduct a new behavioral health assessment consistent with Section 3.5 — Assessment and Service Planning, and revise the person’s service plan as needed.</td>
<td>Conduct a new intake, behavioral health assessment and service plan consistent with Section 3.5 — Assessment and Service Planning.</td>
</tr>
<tr>
<td>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, Cenpatico IC or 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 (see Section 3.5 - Assessment and Service Planning).</td>
<td>Continue the person’s SMI status if the person was previously determined to have a SMI (see Section 3.6 — SMI Eligibility Determination).</td>
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<tr>
<td>Continue the person’s SMI status if the person was previously determined to have a SMI (see Section 3.6 — SMI Eligibility Determination). or If the person presents at a different Cenpatico IC provider, obtain new general and informed consent to treatment (see Section 3.7 — General and Informed Consent to Treatment).</td>
<td>Continue the person’s SMI status if the person was previously determined to have a SMI (see Section 3.6 — SMI Eligibility Determination). Obtain new general and informed consent to treatment, as applicable (see Section 3.7 — General and Informed Consent to Treatment).</td>
</tr>
<tr>
<td>If the person presents at a different Cenpatico IC provider, obtain new authorizations to disclose confidential information, as applicable (see Section 9.2 — Disclosure of Records).</td>
<td>Obtain new authorizations to disclose confidential information, as applicable (see Section 9.2 — Disclosure of Records).</td>
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<tr>
<td>Submit new demographic and enrollment data (see Section 13.1 — Enrollment, Disenrollment and Other Data Submission).</td>
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### 3.5 Assessment and Service Planning

AHCCCS supports a model for assessment, service planning, and service delivery that is strength-based, person-centered, family friendly, culturally and linguistically appropriate, and clinically sound and supervised. The model is based on four equally important components:

- Input from the person regarding his/her individual needs, strengths, and preferences;
• Input from other persons involved in the person’s care who have integral relationships with the person;
• Development of a therapeutic alliance between the person and provider that fosters an ongoing partnership built on mutual respect and equality; and
• Clinical expertise.

The model incorporates the concept of a “team,” established for each person receiving services. For children, this team is the Child and Family Team (CFT) and for adults, this team is the Adult Recovery Team (ART). At a minimum, the functions of the CFT and ART include:

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

### 3.5.1 Assessments

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

AHCCCS does not mandate that a specific assessment tool or format be used but requires certain minimum elements. Providers must collect and submit all required demographic information in accordance with the criteria outlined in the AHCCCS Demographic and Outcome Data Set User Guide (DUG) and Section 13.1 — Enrollment, Disenrollment and Other Data Submission.

The initial and annual assessment must be completed by a behavioral health professional (BHP) or behavioral health technician (BHT) under the clinical oversight of a BHP, who are trained on the minimum elements of a behavioral health assessment and meets requirements in Section 7 — Credentialing and Re-credentialing and Section — Training Requirements.

3.5.1.1 Minimum elements of the behavioral health assessment

AHCCCS has established the following minimum elements that must be included in a comprehensive behavioral health assessment and documented in the comprehensive clinical record, in accordance with AHCCCS Policy and Procedures Manual Policy 105, Assessment and Service Planning. Providers are required to have policies in place to monitor accuracy and completion of the behavioral health assessment.

For persons referred for or identified as needing ongoing psychotropic medications for a behavioral health condition, the assessor must establish an appointment with a licensed medical practitioner with prescribing privileges, in accordance with Section 3.2 — Appointment Standards and Timeliness of Service. If the assessor is unsure regarding a person’s need for psychotropic medications, then the assessor must review the initial assessment and treatment recommendations with his/her clinical supervisor or a licensed medical practitioner with prescribing privileges.

3.5.2 Service Planning

All persons 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 persons who continue to receive behavioral health services. AHCCCS 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. Provider Manual Attachment 3.5.1 Service Plan Rights Acknowledgment Template is available to use.

If a person is in immediate or urgent need of services (see Section 3.2 — Appointment Standards and Timeliness of Service), 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.

At a minimum, the Member, his/her guardian (if applicable), advocates (if assigned), and a qualified behavioral health representative 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. 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 (see Section 4.3 — Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers).

3.5.2.1 Minimum Elements of the Service Plan for Title XIX/XXI Members

Service plans must be completed AHCCCS Policy and Procedures Manual Policy 105, Assessment and Service Planning and the AHCCCS BQI Specifications Manual found on the AHCCCS Resources website. Providers must have policies in place to monitor the timely completion of service plans.

The Member must be provided with a copy of his/her plan. Questions regarding service plans or Member rights should be directed to Cenpatico IC’s customer service line at 1-866-495-6738.

3.5.2.2 Optional element that can be included in the Service Plan

A Functional Behavioral Assessment (FBA) can be requested by any member of the treatment team and included in the member’s Individualized Service Plan. The purpose of an FBA is to ascertain the purpose or reason behind problem behaviors that a family, care giver or team may be unable to identify. An FBA allows teams to determine the why, how, where, when and what a members behavior means. It uses a variety of techniques to understand what is behind the behavior and how to find ways to change the behavior. An FBA can be completed for the member at any time with updates being made as needed after completion of the assessment. PMA 3.5.8 Functional Behavioral Assessment Guidance Document is included in the attachments.

3.5.2.3 Minimum Elements of the Service Plan for Non-Title XIX/XXI Persons Determined to Have a SMI That Do Not Have an Assigned Health Care Coordinator

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

Non-Title XIX/XXI persons determined to have a SMI, who do not have an assigned Health Care Coordinator (Case Manager) shall have the option of accessing peer support services to assist them in developing a Peer-Driven, Self-Developed Proposed Service Plans ("PDSDPs") to be shared with their BHMP for approval, adoption, and implementation. PDSDPs are not required to contain all minimum elements as outlined above for those that have assigned Health Care Coordinators; 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, living skills training, health promotion, personal assistance, and respite care. PDSDPs 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 PDSDPs as appropriate.
It is recommended that a standardized process be used to develop PDSDPs. Providers serving Non-Title XIX/XXI Adults with SMI must ensure all services outlined on PDSDSPs are reviewed and Member wishes identified on the PDSDSPs are included on individualized service plans.

Additionally, the PDSDSPs must be reviewed with and approved by the behavioral health medical practitioner and maintained in the medical record. Progress and outcomes related to the approved PDSDSPs must be tracked and documented by the behavioral health medical practitioner.

3.5.2.4 Appeals or Service Plan Disagreements

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

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

In cases that a person determined to have a SMI and/or legal or designated representative disagree with some or all of the Non-Title XIX/XXI covered services included in the service plan, the person and/or legal or designated representative must be given a PM Form 15.3.1 Notice of Decision and Right to Appeal (For Individuals with a Serious Mental Illness), by the behavioral health representative on the team.

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

3.5.2.5 Updates to the Assessment and Service Plan

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

Some additional forms and attachments that can be used to assist in the assessment and service planning process are Provider Manual Form 3.5.3 CFT Planning Meeting Note; Provider Manual Form 3.5.4 CFT Crisis Plan; Provider Manual Form 3.5.5 Strengths, Needs and Cultural Discovery;
Provider Manual Form 3.5.6 AHCCCS Notification to Waive Medicare Part D Co-Payments for Members in a Medical Institution that is Funded by Medicaid; Provider Manual Attachment 3.5.6 Health Plan and RBHA Medical Institution for Dual Eligible Members; Provider Manual Attachment 3.5.7 Voluntary Prescription Drug Benefit Program Benefits and Costs for People with Medicare; Provider Manual Form 3.5.7 ADHS Form MH-209 Notice of Discrimination Prohibited; and Provider Manual Form 3.5.8 ADHS Form MH-211 Notice of Legal Rights for Persons with Serious Mental Illness.

3.6 SMI Eligibility Determination

A critical component of the service delivery system is the effective and efficient identification of persons who have special behavioral health needs due to the severity of their behavioral health disorder. One such group is persons with Serious Mental Illness (SMI). Without receipt of the appropriate care, these persons are at high risk for further deterioration of their physical and mental condition, increased hospitalizations, and potential homelessness and incarceration. For this reason, Cenpatico IC contracted Health Homes are required to provide a SMI screening/assessment to any person requesting a SMI determination at no cost to the requesting person.

In order to ensure that persons with a SMI are promptly identified and enrolled for services, AHCCCS has developed a standardized process for the referral, evaluation, and determination for SMI eligibility. The requirements associated with the referral for a SMI evaluation and SMI eligibility determination are set forth in AHCCCS Medical Policy Manual Policy 320-P, SMI Eligibility Determination.

3.6.1 Criteria for SMI Eligibility

The determination of SMI requires both a qualifying SMI diagnosis and functional impairment as a result of the qualifying diagnosis (see Provider Manual Attachment 3.6.1, SMI Qualifying Diagnoses for a list of qualifying diagnoses).

3.6.1.1 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, as described below, for most of the past twelve (12) months or for most of the past six (6) months with an expected continued duration of at least six (6) 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; or

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

The following reasons shall not be 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.

### 3.6.1.2 Considerations for Person with Co-occurring Substance Abuse

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

For psychotic diagnoses (bipolar I disorder with psychotic features, delusional disorder, major depression, recurrent, severe, with psychotic features, schizophrenia, schizoaffective disorder and psychotic disorder not due to a substance or know psychological condition) 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:

i. The severity, frequency, duration or characteristics of symptoms contributing to the functional impairment cannot be attributed to the qualifying mental health diagnosis, or

ii. The assessor can demonstrate, based on a historical or prospective period of treatment, that the functional impairment is present only when the 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:
i. The symptoms contributing to the functional impairment cannot be attributed to the substance use disorder, or

ii. The functional impairment is present during a period of cessation of the co-occurring substance use of at least 30 days, or

iii. The functional impairment is present during a period of at least 90 days of reduced use and is unlikely to cause the symptoms or level of dysfunction.

3.6.2 Completion Process of Final SMI Determination

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

The following must occur if the designated reviewing psychiatrist, psychologist, or psychiatric nurse practitioner has not conducted a face-to-face assessment and has a disagreement with the qualified assessor and/or the treating Behavioral Health Professional 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 based upon a face-to-face functional evaluation conducted by a designated psychiatrist, psychologist, or nurse practitioner. The psychiatrist, psychologist, or nurse practitioner shall document the specific reason(s) for the disagreement in the person’s comprehensive clinical record.

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 in accordance with the next section of this policy.

3.6.3 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 (see Section 3.4 — Outreach, Engagement, Re-Engagement, and Ending an Episode of Care);
• 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.

The AHCCCS contracted SMI Evaluation Agency (CRN) 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).

In situations in which the extension is due to insufficient information:
• The AHCCCS contracted SMI Evaluation Agency (CRN) shall request and obtain the additional documentation needed (e.g., current and/or past medical records) and/or perform or obtain any necessary psychiatric or psychological evaluations;
• The designated reviewing psychiatrist, psychologist, or nurse practitioner must communicate with the person’s current treating clinician, if any, prior to the determination of SMI, if there is insufficient information to determine the person’s level of functioning; and
• SMI eligibility must be determined within three (3) days of obtaining sufficient information, but no later than the end date of the extension.

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

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

Insufficient diagnostic information shall be understood to mean that the information available to the reviewer is suggestive of two or more equally likely working diagnoses, only one of which qualifies as SMI, and an additional piece of existing historical information or a face-to-face psychiatric evaluation is likely to support one diagnosis more than the other(s).
qualifying mental health diagnosis, the person shall be notified that the determination may, with the agreement of the person, be extended for up to 90 (calendar) days.³

3.6.4 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 Section 15.3 — Notice Requirements and Appeal Process (SMI and Non-SMI/Non-Title XIX).

If the eligibility determination results in a denial of SMI status, the AHCCCS contracted SMI Evaluation Agency (CRN) shall include in the notice above:

- The reason for denial of SMI eligibility (see Provider Manual Form 3.6.1, SMI Determination);
- The right to appeal (see Section 15.1 — Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons and Section 15.3 — Notice Requirements and Appeal Process (SMI and Non-SMI/Non-Title XIX); and
- The statement that Title XIX/XXI eligible persons will continue to receive needed Title XIX/XXI covered services. In such cases, the person’s behavioral health category assignment must be assigned based on criteria in Section 13.1 — Enrollment, Disenrollment and Other Data Submission.

3.6.5 Re-Enrollment or Transfer

If the person’s status is SMI at disenrollment or upon transfer from another T/RBHA/Health Plan, the person’s status shall continue as SMI.

A person shall retain their SMI status unless a determination is made by a Determining Entity that the person no longer meets criteria.

3.6.6 Review of SMI Eligibility

A review of SMI eligibility made by Cenpatico IC for individuals currently enrolled as a person with a SMI may be initiated by Cenpatico IC or our contracted behavioral health providers:

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

A review of the determination may not be requested by Cenpatico IC or their contracted behavioral health providers within six (6) months from the date an individual has been determined SMI eligible.

³ This extension may be considered a technical re-application to verify compliance with the intent of Rule. 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.
If, as a result of a review, the person is determined to no longer meet the diagnosis and functional requirements for SMI status, Cenpatico IC must ensure that:

- Services are continued depending on eligibility, Cenpatico IC service priorities and any other requirements as described in Section 2 — Covered Services and Section 4.2 — Inter-RBHA Coordination of Care and Section 3.10 — Special Populations.
- Written notice of the determination made on review with the right to appeal is provided to the affected person with an effective date of thirty (30) days after the date the written notice is issued.

### 3.6.7 SMI Decertification

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

A member who has a SMI designation or an individual from the member’s clinical team may request a SMI Clinical Decertification. A SMI Clinical Decertification is a determination that a member who has a SMI designation no longer meets SMI criteria. If, as a result of a review, the person is determined to no longer meet the diagnostic and/or functional requirements for SMI status:

i. The Determining Entity (CRN) shall ensure that written notice of the determination and 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,

ii. Services are continued in the event an appeal is timely filed, and services are appropriately transitioned as part of the discharge planning process.

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.

i. Upon receipt of a request for Administrative Decertification, the Contractor shall direct the member shall be directed to contact AHCCCS DHCM Customer Service,

ii. AHCCCS will evaluate the member’s request and review data sources to determine the last date the member received a behavioral health service. AHCCCS will inform the member of changes that may result with the removal of the member’s SMI designation. Based upon review, the following will occur:

i. In the event the member has not received a behavioral health service within the previous two years, the member will be provided with AMPM Exhibit 320-P-3. This form must be completed by the member and returned to AHCCCS,

ii. In the event the review finds that the member has received behavioral health services within the prior two year period, the member will be notified that they may seek decertification of their SMI status through the Clinical Decertification process.

Providers are highly encouraged to use SMI forms located on the CRN website [http://www.crisisnetwork.org/smi/provider/#forms](http://www.crisisnetwork.org/smi/provider/#forms)
3.7 General and Informed Consent to Treatment

Each Member has the right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment (42 CFR 438.100(b)(2)(iv)). It is important for persons seeking 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.

AHCCCS recognizes two primary types of consent: general consent and informed consent.

General consent is a one-time agreement to receive services that is usually obtained from a person during the intake process at the initial appointment and is always obtained prior to the provision of any services. General consent must be verified by a Member’s or legal guardian’s signature.

Informed consent must be obtained before the provision of a specific treatment that has associated risks and benefits. Informed consent is required prior to the provision of the following services and procedures:

- Complementary and Alternative Medicine (CAM);
- Psychotropic medications;
- Electro-convulsive therapy (ECT);
- Use of telemedicine;
- Application for a voluntary evaluation;
- Research;
- Admission for medical detoxification, an inpatient facility or a residential program (for persons with a SMI); and
- Procedures or services with known substantial risks or side effects.

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 person 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 person agrees or does not agree to the specific treatment must be included in the comprehensive clinical record, as well as the person’s/guardian’s signature when required.

Active Parent Consent

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.

Completion of 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.

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

### 3.7.1 General Requirements

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

For persons under the age of 18, the parent, legal guardian, or a lawfully authorized custodial agency must give general consent to treatment, demonstrated by the parent, legal guardian, or lawfully authorized custodial agency representative’s signature on a general consent form prior to the delivery of services.

Any person aged 18 years and older or the person’s legal guardian, or in the case of persons 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 services.

Any person aged 18 years and older or the person’s legal guardian, or in the case of persons 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.

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

All evidence of informed consent and general consent to treatment must be documented in the comprehensive clinical record per **Section 9.2 — Medical Record Standards**.

In initiating general care for Cenpatico IC Members, providers are required to use informed consent forms that include all the elements identified in the **Provider Manual Form 3.7.1, Consent for Treatment**.

Providers prescribing medications for Cenpatico IC Members are required to use informed consent forms that include all the elements identified in the **Provider Manual Form 3.7.2, Informed Consent for Medication Treatment**.

### 3.7.2 General Consent

Administrative functions associated with a Member’s enrollment do not require consent, but before any services are provided, general consent must be obtained. General consent is usually obtained during the intake process and represents a person’s, or if under the age of 18, the person’s parent, legal guardian or lawfully authorized custodial agency representative’s, written agreement to participate in and to receive non-specified (general) services. Providers are required to use **Provider Manual Form 3.7.1, Consent for Treatment** and to have a policy in place to monitor completion of general consents.
3.7.3  Informed Consent

3.7.3.1  What Information Must Be Provided to Obtain Informed Consent?

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

- 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 person’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 person’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.

3.7.3.2  Who Can Give Informed Consent, and How Is It Documented?

Persons, 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 person, must be established. If the informed consent is for psychotropic medication or telemedicine and the person or the person’s guardian (if applicable) refuses to sign an acknowledgment and gives verbal informed consent, the medical practitioner shall document in the person’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.

3.7.3.3  Who Can Provide Informed Consent and How Is It 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 person, parent, legal guardian or an appropriate court; and
- Presented by a credentialed behavioral health medical practitioner or a registered nurse with at least one year of behavioral health experience. It is preferred that the prescribing clinician provide information forming the basis of an informed consent decision. In a specific situation in which that is not possible or practicable,
information may be provided by another credentialed behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience.

3.7.3.4 Psychotropic Medications, Complementary and Alternative Treatment and Telemedicine

Unless treatments and procedures are court ordered, providers must obtain written informed consent, and if written consent is not obtainable, providers must obtain oral informed consent. If oral informed consent is obtained instead of written consent from the person, 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 Section 3.8 — Psychotropic Medications: Prescribing and Monitoring). The use of Provider Manual Form 3.7.1, Consent for Treatment is recommended as a tool to review and document informed consent for psychotropic medications; and
- Prior to the delivery of services through telemedicine.

3.7.3.5 Electro-Convulsive Therapy (ECT), Research Activities, Voluntary Evaluation and Procedures or Services with Known Substantial Risks or Side Effects

Written informed consent must be obtained from the person, 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 person in research activities;
- Prior to the provision of a voluntary evaluation for a person. The use of AHCCCS Policy Form 107.2, MH-103 is required for persons with SMI 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.

3.7.3.6 Additional Provisions

Written informed consent must be obtained from the person, legal guardian, or an appropriate court prior to the person’s admission to any medical detoxification, inpatient facility, or residential program operated by a behavioral health provider.

3.7.3.7 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 person. In such cases, treatment may be phased out to avoid any harmful effects.

3.7.4 Special Requirements for Children Related to Consents

In accordance with A.R.S. § 36-2272, except as otherwise provided by law or a court order, no person, corporation, association, organization or state-supported institution, or any individual
employed by any of these entities, may procure, solicit to perform, arrange for the performance of or perform mental health screening in a nonclinical setting or mental health treatment on a minor without first obtaining consent of a parent or a legal custodian of the minor child. If the parental consent is given through telemedicine, the health professional must verify the parent’s identity at the site where the consent is given. This section does not apply when an emergency exists that requires a person to perform mental health screening or provide mental health treatment to prevent serious injury to or save the life of a minor child.

3.7.4.1 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:

<table>
<thead>
<tr>
<th>Individual/Entity</th>
<th>Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal guardian</td>
<td>Copy of court order assigning custody</td>
</tr>
<tr>
<td>Relatives</td>
<td>Copy of power of attorney document</td>
</tr>
<tr>
<td>Other person/agency</td>
<td>Copy of court order assigning custody</td>
</tr>
<tr>
<td>DES/DCS Placements (for children removed from the home by DES/DCS), such as:</td>
<td>None required⁴</td>
</tr>
<tr>
<td>Foster parents</td>
<td></td>
</tr>
<tr>
<td>Group home staff</td>
<td></td>
</tr>
<tr>
<td>Foster home staff</td>
<td></td>
</tr>
<tr>
<td>Relatives</td>
<td></td>
</tr>
<tr>
<td>Other person/agency in whose care DES/DCS has placed the child</td>
<td></td>
</tr>
</tbody>
</table>

⁴ If 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
For any child who has been removed from the home by DCS, the foster parent, group home staff, foster home staff, relative, or other person or agency in whose care the child is currently placed may give consent for the following 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).

3.7.4.2 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.

3.7.5 Informed Consent During Involuntary Treatment

At times, involuntary treatment can be necessary to protect safety and meet needs when a person, 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.

3.7.6 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 Cenpatico IC Provider.

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.
Provider Manual Form 3.7.3, Substance Abuse Prevention Program and Evaluation Consent must be used to gain parental consent for evaluation of school based prevention programs. Providers may use an alternative consent form only with the prior written approval of AHCCCS. The consent must satisfy all 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 Provider Manual Form 3.7.3, Substance Abuse Prevention Program and Evaluation Consent applies solely to consent for a survey, analysis, or evaluation only, and does not constitute consent for participation in the program itself.

### 3.8 Psychotropic Medication: Prescribing and Monitoring

AHCCCS has developed guidelines and minimum requirements designed to guide the R/RBHA/Health Plans in developing appropriate psychotropic medication use policies and procedures to:

- Promote the safety of persons taking psychotropic medications;
- Reduce or prevent the occurrence of adverse side effects;
- Promote positive clinical outcomes for behavioral health recipients who are taking psychotropic medications;
- Monitor the use of psychotropic medications to foster safe and effective use; and
- To clarify that medication will not be used for the convenience of the staff, in a punitive manner or as a substitute for other services and shall be given in the least amount medically necessary with particular emphasis placed on minimizing side effects which otherwise would interfere with aspects of treatment, as stated in R9-21-207(C).

See Provider Manual Attachment 3.8.5 – Minimum Laboratory Monitoring for Psychotropic Medications.

#### 3.8.1 Basic Requirements

Medications may only be prescribed by Cenpatico IC credentialed and licensed physicians, licensed physician assistants, or licensed nurse practitioners. See Section 7 — Credentialing and Re-Credentialing Requirements for more information regarding credentialing requirements.

Psychotropic medication will be prescribed by a licensed psychiatrist, psychiatric nurse practitioner, physician assistant, or other physician trained or experienced in the use of psychotropic medication. The prescribing clinician must have seen the Member and is familiar with the Member’s medical history or, in an emergency, the prescribing clinician is at least familiar with the Member’s medical history.
When a Member on psychotropic medication receives a yearly physical examination, the results of the examination will be reviewed by the physician prescribing the medication. The physician will note any adverse effects of the continued use of the prescribed psychotropic medication in the Member’s record (see Section 9.2 — Medical Record Standards).

Whenever a prescription for medication is written or changed, a notation of the medication, dosage, frequency or administration, and the reason why the medication was ordered or changed will be entered in the Member’s record (see Section 9.2 — Medical Record Standards).

3.8.2 Assessments

Reasonable clinical judgment, supported by available assessment information, must guide the prescribing of psychotropic medications. To the extent possible, candidates for psychotropic medication use must be assessed prior to prescribing and providing psychotropic medications. Psychotropic medication assessments must be documented in the person’s comprehensive clinical record per Section 9.2 — Medical Record Standards and must be scheduled in a timely manner consistent with Section 3.2 — Appointment Standards and Timeliness of Service. Behavioral Health Professionals (BHPs) 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 or other medications including any reported side effects and/or potential drug-drug interactions and all medications (including medications prescribed by the PCP and medical specialists, OTC medications, and 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; and
- 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 client is known to be receiving opioid pain medications or another controlled substance from a secondary prescriber.

Reassessments require the prescribing clinician of psychotropic medication notes in the Member’s record the following (see Section 9.2 — Medical Record Standards):

- The reason for and the effectiveness of the medication;
- The clinical appropriateness of the current dosage;
- All medication (including medications prescribed by the PCP and medical specialists, OTC medications, and supplements) being taken and the appropriateness of the combination of the medications;
- Any side effects such as weight gain and/or abnormal/involuntary movements if treated with an anti-psychotic medication; and
- Minimum requirements as per Section 3.8 — Psychotropic Medication Monitoring;
- Rationale for the use of two medications from the same pharmacological class and
- Rationale for the use of more than three different psychotropic medications in adults, and
- Rationale for the use of more than one psychotropic medication in the child and adolescent population.

### 3.8.3 Informed Consent

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

The comprehensive clinical record must include documentation of the essential elements for obtaining informed consent (see Section 9.2 — Medical Record Standards). Essential elements for obtaining informed consent for medication are contained within Provider Manual Form 3.8.1, Informed Consent for Psychotropic Medication Treatment. The use of Provider Manual Form 3.8.1 is recommended as a tool to document informed consent for psychotropic medications. If Provider Manual Form 3.8.1 is not used to document informed consent, the essential elements for obtaining informed consent must be documented in the person’s individual comprehensive clinical record in an alternative fashion (see Section 9.2 — Medical Record Standards).

For more information regarding informed consent, see Section 3.7 — General and Informed Consent to Treatment.

### 3.8.4 Youth and Psychotropic Medications

- Youth under the age of 18 are to be 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.
- The information to be shared should be consistent with the information shared in obtaining informed consent from adults.
- Discussion of the youth’s ability to give consent for medications at the age of 18 years old is begun no later than age 17½ 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 the reproductive status and pregnancy, as well as long term effects on weight, abnormal involuntary movements and other health parameters.

• Evidence of the youth’s consent to continue medications after his/her 18th birthday may be documented through use of AHCCCS Policy Form 108.1, Informed Consent/Assent for Psychotropic Medication Treatment, a recommended tool to review and document informed consent for psychotropic medications.

### 3.8.5 Psychotropic Medication Monitoring

Per national guidelines and to address the monitoring of psychotropic medications and metabolic parameters, the provider must establish policies and procedures for monitoring of lithium, valproic acid, carbamazepine, renal function, liver function, thyroid function, glucose metabolism, screening for metabolic syndrome and movement disorders. See Provider Manual Attachment 3.8.5 Minimum Laboratory Monitoring for Psychotropic Medication.

Medications prescribed for Youth must be monitored for efficacy, side effects and adverse events at each visit with a registered nurse, physician assistant, psychiatric nurse practitioner, or physician.

### 3.8.6 Reporting Requirements

Cenpatico IC has established the AHCCCS system requirements for monitoring the following:

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

The above referenced events must be identified, reported, tracked, reviewed and analyzed by Cenpatico IC.

An incident report must be completed for any medication error, adverse drug event and/or adverse drug reaction that results in harm and/or emergency medical intervention (See Section 9.10 — Reporting of Incidents, Accidents and Deaths for more information).

### 3.8.7 Complementary and Alternative Medicine (CAM)

Complementary and alternative medicine (CAM) is not AHCCCS reimbursable.

When a BHP uses Complementary and Alternative Medicine (CAM), (See Arizona Medical Board’s Guidelines For Physicians Who Incorporate Or Use Complementary Or Alternative Medicine In Their Practice) informed consent must be obtained from the person or guardian, when applicable, for each CAM prescribed (See Section 10.11.9 — Cenpatico IC’s Drug Lists).

When obtaining informed consent, behavioral health medical practitioners must communicate in a manner that the person and/or legal guardian can easily understand. The comprehensive clinical record must include documentation of the essential elements for obtaining informed consent (see Section 9.2 — Medical Record Standards).
Essential elements for obtaining informed consent for medication are contained within Provider Manual Form 3.8.1, Informed Consent for Psychotropic Medication Treatment.

The use of Provider Manual Form 3.8.1, Informed Consent for Psychotropic Medication Treatment is recommended as a tool to document informed consent for CAM. If Provider Manual Form 3.8.1 is not used to document informed consent, the essential elements for obtaining informed consent must be documented in the person’s individual comprehensive clinical record in an alternative fashion (see Section 9.2 — Medical Record Standards).

3.9 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 Arizona, State law permits 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 Section 3.9.10 — 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. Otherwise, an evaluation will be arranged for the person by a designated evaluation agency within timeframes specified by State law.

Based on the court-ordered evaluation, the evaluating agency may petition for court-ordered treatment on behalf of the 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/Health Plan; 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 agrees in writing to receive a voluntary evaluation.

County agencies and RBHA/Health Plan subcontracted agencies responsible for pre-petition screening and court-ordered evaluations must use the following forms prescribed in AAC R9-21, Article 5 for persons determined to have a Serious Mental Illness:

- **Provider Manual Form 3.9.1 Application for Involuntary Evaluation**
- **Provider Manual Form 3.9.2, Application for Emergency Admission for Evaluation;**
- **Provider Manual Form 3.9.3, Petition for Court-Ordered Evaluation;**
- **Provider Manual Form 3.9.4, Petition for Court-Ordered Treatment;** and
- **Provider Manual Form 3.9.5, Affidavit**

Agencies may also use these forms for all other populations. 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.” The responsibilities of Cenpatico IC and its providers for the provision and coverage of those services is described in Section 3.9.7 — Court-Ordered Treatment for Persons Charged with or Convicted of a Crime.

The intent of this section is to provide a broad overview of the pre-petition screening, court-ordered evaluation, and court-ordered treatment process. Depending on a provider’s designation as a screening, evaluation, or court-ordered treatment agency, the extent of involvement with persons receiving pre-petition screening, court-ordered evaluation, and court-ordered treatment services will vary.
3.9.1 Licensing Requirements

Providers who are licensed by the Arizona Department of Health Services/Division of Licensing Services as a court-ordered evaluation or court-ordered treatment agency must adhere to ADHS Licensing requirements.

3.9.2 Pre-Petition Screening

Arizona counties are responsible for managing, providing, and paying for pre-petition screening and court-ordered evaluations and are required to coordinate provision of services with the State system. Some counties contract with RBHA/Health Plans to process pre-petition screenings and petitions for court-ordered evaluations.

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

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

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

The pre-petition screening agency must conduct the following procedures:

- Provide pre-petition screening within forty-eight hours of the request excluding weekends and holidays;
- Prepare a report of the clinical assessment, professional opinions and conclusions. If pre-petition screening was not possible, the screening agency must report reasons why the screening was not possible, including opinions and conclusions of staff members who attempted to conduct the pre-petition screening;
- Request the Cenpatico IC medical director or designee review the report if it indicates that there is no reasonable cause to believe the allegations of the applicant for the court-ordered evaluation;
- Prepare a petition for court-ordered evaluation and file the petition if Cenpatico IC determines that the person, due to a mental disorder, including a primary diagnosis of dementia and other cognitive disorders, is a Danger to Self (DTS), Danger to Others (DTO), Persistently or Acutely Disabled (PAD), or Gravely Disabled (GD).
  Provider Manual Form 3.9.3, Petition for Court-Ordered Evaluation documents pertinent information for court-ordered evaluation;
- If Cenpatico IC determines that there is reasonable cause to believe that the person, without immediate hospitalization, is likely to harm himself/herself or others, the screening agency will verify completion of the Provider Manual Form 3.9.2, Application for Emergency Admission for Evaluation, and take all reasonable steps to procure hospitalization on an emergency basis; and
• Contact the county attorney prior to filing a petition if it alleges that a person is a Danger to Others.

### 3.9.3 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.

If a county should subcontract with Cenpatico IC to provide court-ordered evaluations, Cenpatico IC or its provider must follow these procedures:

- A person being evaluated on an inpatient basis must be released within seventy-two hours 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 the RBHA/Health Plan medical director or designee; and
- Title XIX/XXI funds must not be used to reimburse court-ordered evaluation services.

RBHA/Health Plans are not responsible for the costs associated with court-ordered evaluation outside of the limited “medication only” benefit package available for Non-Title XIX/XXI persons determined to have a SMI, unless other prior payment arrangements have been made with another entity (e.g. county, hospital, provider).

### 3.9.4 Voluntary Evaluation

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

Cenpatico IC providers must follow these procedures:

- The evaluation agency must obtain the individual’s informed consent prior to the evaluation (see Provider Manual Form 3.9.13, Application for Voluntary Evaluation) and provide evaluation at a scheduled time and place within five days of the notice that the person will voluntarily receive an evaluation; and
- For inpatient evaluations, the evaluation agency must complete evaluations in less than seventy-two hours of receiving notice that the person will voluntarily receive an evaluation.

If a provider conducts a voluntary evaluation service as described in this section, the comprehensive clinical record (see Section 9.2 — Medical Record Standards) must include:

- A copy of the application for voluntary evaluation, Provider Manual 3.9.13, Application for Voluntary Evaluation;
- A completed informed consent form (see Section 3.7 — General and Informed Consent to Treatment); and
• A written statement of the person’s present medical condition.

3.9.5 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 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 Provider Manual Form 3.9.14, Petition for Court-Ordered Treatment);

• Any 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 Provider Manual Form 3.9.5, Affidavit);

• A copy of the petition, in cases of grave disability, must be mailed to the public fiduciary in the county of the patient’s residence, or the county in which the patient was found before evaluation, and to any person nominated as guardian or conservator; and

• A copy of all petitions must be mailed to the superintendent of the Arizona State Hospital.

Background

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

Each County must have a process in place for:

• Involuntary mental health treatment requests and evaluations

• Court proceedings to satisfy the statutory requirements under Title 36 for individuals under court-ordered evaluation and court-ordered treatment

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

The RBHA/Health Plan is responsible for treatment of an eligible person* once placed under a Title36 civil commitment or court-ordered treatment (COT). Per Arizona Administrative Code (R9-21-504) the RBHA/Health Plan “shall provide, either directly or by contract all treatment required by A.R.S. Title 36, Chapter 5, Article 5.”

* Populations eligible for RBHA/Health Plan services per the Cenpatico IC Provider Manual Section 2.1.1-2:

• Title XIX/XXI enrolled individuals

• Persons determined to have a Serious Mental Illness

• Special populations, including individuals receiving services through the Substance Abuse Block Grant(SABGT)
Overview
Each Health Home per the Cenpatico IC contract scope of service is required to designate a staff person to serve as COT/COE Coordinator and Liaison for Title 36 and Court-Ordered services.

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

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

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

Individuals on COT are one of the most at-risk populations served and per the Cenpatico IC screening tool, will always qualify to be served by a High Needs Recovery Center.

- Individuals on COT must be seen every 30 days by the Medical Director or designee (must be a Prescriber)
- Outreach and engagement with these individuals should be assertive and follow the re-engagement processes within the Cenpatico IC Provider Manual (Section 3.4). The goal is to avoid re-hospitalization and improve the quality of life for the individual.
- A solid crisis plan must be developed that includes what works and does not work for this individual, supports that can help, and types of outreach that should be attempted if the individual has an increase in symptoms or disengages from treatment.
- Cenpatico IC has developed crisis protocols for every County served that include detailed descriptions about the way the crisis system works in each respective County. There are extensive sections on involuntary treatment that should be referenced for details on how each County facilitates the COT process. The protocols are located on the Cenpatico IC website at https://www.cenpaticointegratedcareaz.com/providers/provider-resources.html
- Providers must closely monitor COT expiration dates. Pursuant to A.R.S 36-540 (D), a court order cannot exceed 365 days, but some counties may order fewer days. Providers must ensure they understand the County’s interpretation of the COT expiration date. Providers must monitor expiration dates to schedule annual reviews to determine if the individual’s COT should continue for another year. Additionally, it gives Providers enough time to file a Petition for Continued Treatment with Court for individuals who were found Persistently or Acutely Disable or Gravely Disabled.
- Cenpatico IC will monitor and audit COT requirements and will issue Corrective Action Letters and/or Sanctions for failure to follow the requirements.
Requirements
Each Provider is responsible for maintaining a current list of individuals who are receiving court-ordered treatment.

PIMA COUNTY: Providers are responsible for establishing a group generic email box to receive minute entries from the Court. An example is MinuteEntries@[provider name].com. Pima County providers are required to contract with Cenpatico IC’s approved Pima County law firm to properly manage COT paperwork that will be submitted to Court. Cenpatico IC identifies a law firm to provide legal representation in filing post-hearing documents and coordinating with the Pima County Superior Court on behalf of Providers serving as Supervising Providers.

Provider Participation in Hearings
The Individual’s assigned case manager must attend all COT hearings, including the original hearing for court-ordered treatment, judicial reviews, and Petitions for Continued Treatment of Gravely Disabled (GD) or Persistently or Acutely Disabled (PAD). It is expected the Health Care Coordinator follows courtroom rules of decorum. The Health Care Coordinator should be prepared to provide information/clarification to Court regarding facts relevant to the hearing and the proposed outpatient treatment plan. The Health Care Coordinator must be present to receive orders set forth by the Judge/Commissioner and specific orders regarding the submitted outpatient treatment plan. In Pinal and Yuma Counties, this also includes the dates COT status reports are to be submitted to the Court.

Treatment Plan Development and Filing
Prior to the date of the hearing, the Health Care Coordinator is responsible for coordinating an Adult Recovery Team (ART) meeting for enrolled individual to develop discharge plans and ensure that those plans are included in the individual’s Individual Service Plan (ISP). The ISP must be discussed/reviewed with the Provider Medical Director or physician designee. The individual’s inpatient team must be involved in and agree to discharge decisions.

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

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

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

PIMA COUNTY: For individuals who are TXIX/TXXI eligible, the Health Care Coordinator develops a COT outpatient treatment plan using Provider Manual Form 3.9.6 PIMA County-COT Plan Ind. Receiving AHCCCS Benefits and Provider Manual Form 3.9.7 PIMA County-COT Plan Ind. NOT Receiving AHCCCS Benefits provided at the end of the Provider Manual, which outlines the behavioral health benefits provided to this population. In the event Persons who are Non-Title
XIX/XXI eligible but are determined to have a Serious Mental Illness (SMI), the Health Care Coordinator develops a COT outpatient treatment plan using Provider Manual Form 3.9.6 PIMA County-COT Plan Ind. Receiving AHCCCS Benefits and Provider Manual Form 3.9.7 PIMA County-COT Plan Ind. NOT Receiving AHCCCS Benefits provided at the end of the Provider Manual, which outlines the behavioral health benefits provided to this population. The Health Care Coordinator is to be submit to Court the original COT outpatient treatment plan to the Judge/Commissioner for signature, with 5 copies 1) County Attorney, 2) Defense Attorney, 3) Hospital T-36 Liaison, 4) Individual, 5) Cenpatico IC, totaling six treatment plans.

Amendments/Revocations (see the County Crisis Protocols or County specific sections of this guide for a detailed description of the process) Refer to ARS 36-540 depending on the County process.

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

- It is important the provider track the numbers of days a member has spent in an inpatient setting, because there are a limited amount of inpatient days the court may order pursuant to A.R.S. 36-540:
  - DTS up to 90 days
  - DTO & PAD up to 180 days
  - GD up to 365 days

- If there are no more inpatient days available, the Medical Director must determine if the individual requires continued court-ordered treatment. If the individual is DTO/DTS the provider can follow the process for an Emergency Application for Evaluation for Admission. If the individual is PAD/GD the provider can initiate the Annual Review process or follow the Pre-Petition Screening process.

- Amended outpatient treatment orders do not increase the total period of commitment originally ordered by Court.

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

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

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

PIMA COUNTY: Use Provider Manual Form 3.9.8-PIMA County-Emergent Amendment

PIMA COUNTY: Verbal Revocation Process

When a member is in crisis at their placement, the following steps shall be taken: 1) The Out of Home (OOH) Placement shall assess if the Health Home is able to become involved. 2) If the Health Home can respond, they will follow their process for determining what steps need to be taken next. 3) If the Health Home cannot be involved, the OOH placement shall call NurseWise, who shall triage the situation and dispatch the CMT.

If CMT is dispatched, CMT shall assess if the member can be stabilized at the OOH placement. If member cannot be stabilized at the placement, the CMT shall consult on revocation recommendations with the Health Home doc on call. If the Health Home doctor does not recommend revocation, the CMT shall determine next steps needed.

If the Health Home doctor does recommend revocation, the CMT shall call the CRC Intake Coordinator and staff member’s care. The CRC shall complete their internal paperwork to document the verbal revocation. The CRC shall contact law enforcement to request Verbal Revocation Transport. Law Enforcement shall verify name, date of birth, and authorizing doctor and Health Home with the CMT. Law Enforcement shall transport the member to the CRC.

The Health Home shall be responsible the next business day for completing and filing with the courts the amendment in order to complete the verbal revocation process.

Non-Emergent Amendment/Revocation A.R.S. 36-540 (E)(4)

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

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

When an individual is hospitalized pursuant to an amended order, the provider must inform the individual of the right to judicial review and the right to consult with counsel pursuant to A.R.S. 36-546.
**PIMA COUNTY:** For non-emergent amendments use **Provider Manual Form 3.9.9 PIMA County-Non-Emergent Amendment.** The request for amendment to outpatient treatment plan must be signed by the outpatient psychiatrist and notarized. The provider submits the notarized form to the Cenpatico IC approved law firm. Court requires specific information/facts regarding the individual’s lack of compliance with the outpatient treatment plan. The preparer of the amended request should avoid using conclusions such as “delusional,” “non-compliant,” “AWOL,” “disruptive,” “inappropriate,” etc. The request should contain information regarding outreach attempts, attempts to engage the individual in treatment, or to offer hospitalization on a voluntary basis.

**PIMA COUNTY:** If Provider staff obtains updated information as to the individual’s location after the amendment to the outpatient treatment plan has been filed with Court, the Provider should contact Pima County Mental Health Support Team (MHST) to provide updated information. When providing updated location information, staff should inform the MHST officer that an amendment to the outpatient treatment plan has been filed with Court. The MHST officer may request a copy of the amendment, which is permissible.

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

**PIMA COUNTY:** If 90 days has expired since the last amendment, the Provider is required to submit a written statement to the Cenpatico IC approved law firm requesting to quash the previous amended and transport order. At this time the Provider may file a new amendment with the court for another 90 days. If an individual becomes incarcerated at Pima County Adult Detention Center (PCADC) during the timeframe of the amended outpatient treatment plan, a court order to quash the transport is not required if the current amendment does not indicate the address of PCADC. The Provider is responsible for notifying Pima County’s MHST of the change in location of the individual. The Provider must email the amended pleading to MHST and PCADC records.

**Judicial Reviews A.R.S. 36-546**
Providers must inform the individual of the right to Judicial Review every 60 days and must document this in the clinical record. Judicial Reviews are to be calendared and offered every 60 days from the date of the original court order. The days from the court order are as follows: 60, 120, 180, 240, 300, and 360. It is the responsibility of the Provider to track the Judicial Review dates and ensure a Judicial Review is offered to an individual under Court-Ordered Treatment (COT) every 60 days. If an individual is hospitalized pursuant to an amendment to the outpatient treatment plan the Provider must inform the individual of the right to judicial review and the right to consult with counsel pursuant to A.R.S. 36-546. This Judicial Review does not change the count of the 60 days set from the date of the court order. It is considered an exception per statute and is permitted before the 60 days.
If the individual requests Judicial Review, the Health Care Coordinator completes the Provider Manual Form 3.9.10 – Judicial Review-right to Speak to Legal Counsel. The form includes the following information:

a. The individual being treated and the treating Provider.
b. The individual to whom the request for release was made.
c. The individual making the request for release, indicating whether the individual is the individual being treated or someone acting on the individual’s behalf.

The individual completes his/her current address and signs the form. The Health Care Coordinator must schedule an appointment for the individual to be evaluated by the Provider’s BHMP. The appointment cannot be scheduled with a Nurse Practitioner or Physician’s Assistant. The completed PM form and psychiatric report must be completed and submitted to the County Attorney within 72 hours of the request and by the filing deadline.

For PIMA County, the completed PM Form and psychiatric report is submitted to the law firm within 72 hours of the request and by the filing deadline.

For GREENLEE, GRAHAM, LA PAZ, SANTA CRUZ, and YUMA Counties; Provider Manual Form, “The Treatment Team Recommendation for Judicial Review for COT”, should be completed and submitted along with the following documents:

1. Letter from Medical Director
2. The Right to Notification of Judicial Review form
3. The last progress note from the BHMP proving the Judicial review was discussed with Member and reporting recommendations

For PINAL County, the following documents should be completed and submitted:

1. The Right to Notification of Judicial Review form
2. The last 30-day BHMP appointment that provides a psychiatric exam of the member. This is counted as the current “psychiatric exam”.

As a reminder, the Court could request additional documentation.

For COCHISE County; Provider Manual Form The Psychiatric Reports RE: Request for Judicial Review must be completed and filed with the clerk of court along with the following documents:

2. The Right to Notification and Legal Counsel of Judicial Review form
3. The last psychiatric evaluation that was completed

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

If the individual declines a Judicial Review, the case manager completes the same Provider Manual Form 3.9.10 – Judicial Review-right to Speak to Legal Counsel, and the individual signs this form. The individual provides his/her current address and location. The Provider maintains this form in the clinical record. If the individual is unavailable at the time the Judicial Review is
due, the Health Care Coordinator completes the same Provider Manual Form 3.9.10 – Judicial Review-right to Speak to Legal Counsel. The Health Care Coordinator must provide reasons why the individual was not available for the Judicial Review and include outreach and re-engagement attempts made. The Provider maintains this form in the clinical record. It should match the progress notes regarding outreach.

Court requires the psychiatric report to contain sufficient clinical information to render a decision regarding whether the individual needs continued court-ordered treatment or not. This psychiatric report can be in the form of a progress note. At a minimum the Judicial Review must include information regarding individual’s insight regarding his/her mental illness and information regarding adherence to court-ordered treatment plan. If the individual does not attend the Judicial Review appointment, the BHMP must complete a chart review to provide this information. If an individual is hospitalized pursuant to an amended outpatient treatment plan and requests a Judicial Review, merely stating the individual is involuntarily hospitalized is not enough factual information for Court to render a decision. The BHMP should attempt to contact the inpatient BHMP to gather information for the Judicial Review. Failure to provide sufficient evidence of need for continued treatment could result in Court requesting a hearing on the matter. A hearing can be set by the Judge/Commissioner on his/her own or if requested by the defense attorney.

**Status Reports**

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

- **Pinal County** court requires status reports due to the court at 30, 90, 180, 270 days. If the Provider fails to complete the status report to the court, the judge can order the person to appear and provide an in person status report regarding the treatment and process of the consumer.
- **Yuma County** requires status reports to be completed the first is 30 days, 90 days, 180 days, and lastly at 270 days.
- As this time, the following counties do not require a status report: Cochise, Graham, Greenlee, La Paz and Pima.

**Annual Review A.R.S. 36-543**

Within 90 days of the expiration of the court order, the provider must conduct an annual review of an individual who was court-ordered to treatment as Gravely Disabled or Persistently or Acutely Disabled (GD & PAD) to determine if continuation of COT is appropriate and assess the needs of the individual for guardianship or conservatorship or both. The annual review includes a review of the mental health treatment and clinical records contained in the individual’s treatment file.

If the Medical Director believes that continuation of the court-ordered treatment is appropriate, the Medical Director appoints one or more psychiatrists (depending on the County) to carry out a psychiatric examination of the individual. Each psychiatrist participating in the psychiatric examination must submit a report to the Medical Director that includes the following:
1) The psychiatrist’s opinions as to whether the individual continues to have a grave disability or persistent or acute disability as a result of a mental disorder and is in need of continued COT
2) A statement as to whether suitable alternatives to COT are available
3) A statement as to whether voluntary treatment would be appropriate
4) Review of the individual’s need for a guardian or conservator or both
5) Whether the individual has a guardian with mental health powers that would not require continued COT
6) The result of any physical examination that is relevant to the psychiatric condition of the individual

To ensure this review has taken place the provider submits to Cenpatico IC via email the progress note indicating the BHMP met with the individual 45-90 days prior to expiration of the court order. Progress notes for the annual review can be emailed as soon as the annual review has been completed, but no later than the 2nd business day of the following month the annual review must have been completed.

Additionally, the individual’s clinical team shall hold a service planning meeting, not less than 45 days prior to the expiration of the court-ordered treatment to determine if the court order should continue. The following information must be indicated and written in the BHMP progress notes of the service planning meeting for the annual review that you submit:

- That this appointment is for the 45/90 day face to face annual review appointment
- That the recommendation is either to roll/continue the members COT or to allow the COT expire
- That the recommendation was discussed with the member

If the Medical Director believes after reviewing the annual review that continued COT is appropriate, the Medical Director files with Court, no later than forty-five days before the expiration of the court order for treatment, an application for continued court-ordered treatment and the psychiatric examination conducted as part of the annual review. If the individual is under guardianship, the Medical Director must mail a copy of the application to the individual’s guardian.

The annual exam must have current contact information for the individual. This includes full address, zip code, and telephone number. If the individual’s location and/or other contact information changes, provider staff must contact the individual’s attorney with this new information.

Annual Review Missing or Incarcerated Members:
For the Annual Review requirement, please ensure that the Psychiatrist/BMHP does the following within the allotted time frame (45-90 days) of the Annual Review dates:

1. For Incarcerated members:
   Write a note in the chart that consists of the following information:
   a. This is an annual review
   b. Circumstances as to why the member was not present
c. Indicate the date the member was booked to jail and that the member is still incarcerated

d. Indicate whether his recommendation is to roll the order or to allow it to expire. If the recommendation is to roll based on the member’s clinical record and you are not able to file a Petition for Continued Treatment with the Court, indicate that due to lack of coordination from the jail, this is not possible.

e. Indicate the date when you attempted to reach out to the jail psychiatrist to discuss member’s annual review

f. File in the Member’s medical Record

g. Send a copy to the Title 36 Coordinator indicating this is an annual review for an incarcerated member

2. For MIA members for whom you have not closed or the Court has not agreed to term the COT early:

Write a note in the chart that consists of the following information:

a. This is an annual review

b. Circumstances as to why the member was not present

c. Date that a revocation was filed with the Court

d. Psychiatrist has not seen the member for XX months due to the member being MIA.

e. Indicate whether his recommendation is to roll the order or to allow it to expire. If recommendation would be to roll, indicate that due to lack of contact with the member, this is not possible

f. Indicate that re-engagement protocols have been attempted to locate the member (A request for progress notes to review re-engagement attempts may be asked for)

g. File in the Member’s medical record

h. Send a copy to the Title 36 Coordinator indicating this is an annual review for a missing member

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

NOTE: You should still enter these reviews as the annual review in the Provider Portal COT Span event.

A hearing is conducted if requested by the individual’s attorney on behalf of the request of the individual or otherwise ordered by Court.

For individuals determined DTS and/or DTO the provider must initiate the pre-petition screening process pursuant to Arizona Administrative Code.

**PIMA COUNTY:** For continued treatment examinations for individuals found to be GD, utilize Provider Manual Form 3.9.11-PIMA County Psych Exam for Annual Review for GD Persons. For continued treatment examinations for individuals found to be PAD, utilize Form 6-PIMA County Psych Exam for Annual Review for PAD Persons. Cenpatico IC’s law firm will forward to the provider the conformed copy of the petition and order. The provider is required to give the paperwork to the individual and obtain a signature using Provider Manual Form 3.9.12-
**Confirmation of Receipt.** This form provides evidence to Court and defense counsel the individual is aware of the petition and his/her right to speak to his/her attorney. This original signed form must submit to Cenpatico IC’s law firm within five (5) business days of receipt. If set for hearing, the Provider’s BHMP who completed the Annual Exam must testify at the hearing. The COT/COE Liaison is responsible for coordinating the hearing with Cenpatico IC’s law firm, provider staff and the BHMP. The case manager must inform the individual of the hearing and arrange for his/her transport to the hearing. The case manager may be called as a witness.

**Termination/Release from Court Ordered Treatment A.R.S. 36-541.01**

Upon written request of the individual’s BHMP, a Court may order an individual to be released from court-ordered treatment prior to the expiration of the court-ordered period. Specifically, the Title 36 Statute states “A patient who is ordered to undergo treatment pursuant to this article may be released from treatment before the expiration of the period ordered by the court if, in the opinion of the medical director of the mental health treatment agency, the patient no longer is, as a result of a mental disorder, a danger to others or a danger to self or no longer has a persistent or acute disability or a grave disability. A person who is ordered to undergo treatment as a danger to others may not be released or discharged from treatment before the expiration of the period for treatment ordered by the court unless the medical director first gives notice of intention to do so as provided by this section.”

**Termination from Reporting a member who is on Court Ordered Treatment**

There are certain circumstances when an Agency may no longer be required to report to Cenpatico a member who is on Court Ordered Treatment. These conditions would be as follows: 1) a member has been sentenced to the Department of Corrections, 2) a member has died, 3) the member has lost AHCCCS benefits, is NOT Severely Mentally Ill (SMI) and does not meet SMI criteria.

**Termination/Release for Lack of Contact – All Counties**

Health Homes in Cochise, Pinal, Santa Cruz, Graham and Greenlee who wish to request an early dismissal, must notify the Cenpatico IC T-36 Coordinator of the request. The Coordinator will review previous non-adherence notes and if necessary the Coordinator may request additional progress notes to review re-engagement attempts. Once notes have been reviewed, the Coordinator will inform the Health Home of the decision. The Court will make the ultimate decision as regarding the request.

Pima, Yuma and La Paz County Courts typically do not allow for early termination of court ordered treatment. Health Homes should coordinate closely with County Courts or County Attorneys regarding members who are missing.

**Transfers**

**Provider to Provider**

- **Note:** The following are general guidelines-each County has the right to request additional or different documentation. When the specific County process is known, it shall be included in this guide.
- Before a COT individual can be transferred from one treating Provider to another, the sending Provider must have verification that the Medical Director of the receiving Provider has accepted the member and accepted responsibility for overseeing treatment under the court order. This must happen before the transfer is completed.
• This is best accomplished by requesting a “Letter of Intent to Treat (LOI)”. The LOI can be a letter from the Medical Director of the receiving HNRC that includes:
  o Name and DOB of the individual on COT
  o COT start and end date
  o The standard under which the person is court ordered (DTO; /DTS; PAD; GD)
  o Printed name and signature of the receiving Provider’s Medical Director
  o Effective transfer date (date of intake)
  o The letter can read simply: “This letter is to verify that Dr. X and Provider Y has agreed to provide court ordered treatment to member Z”
  o The HNRC must keep a copy of the letter in the clinical record.

• The Medical Director of the receiving Provider notifies Court in writing that there has been a change in oversight of the individuals COT. It is recommended that an official document from the court be requested that reflects the current treatment Provider/Medical Director as the responsible party overseeing the court ordered treatment.

Also see Section 4.1.4 - Transition of Persons Receiving Court Ordered Services for additional details for Transfers

Arizona State Hospital (AzSH)
AzSH PSRB GEI-If a person is being released from AzSH after serving a sentence under the guilty except insane (GEI) standard, the release of this person is generally reviewed by the Psychiatric Security Review Board. (PSRB) The PSRB will make recommendations for the individuals release into the community. This will often include a referral to the RBHA/Health Plan where the individual plans to reside upon release and often consideration for court ordered treatment. In these situations, the local County Attorney’s office is notified by AzSH to initiate the court ordered evaluation process.

PIMA COUNTY: A transfer hearing must be set if a COT individual objects to the transfer to ASH.

Change of Venue – Counties other than Pima
When a client transfers from one County to another, the receiving provider must agree to accept the individual on COT through an LOI and, once transferred, must request the change of venue from the County in which the COT originated. Although, Change of Venue is a Court jurisdiction process, the receiving provider must follow-up with Court to ensure the change of venue is completed to ensure there is an accurate record of COT individuals by provider.

Change of venue from Pima County to another County
Change of venue should be requested by the outpatient provider at the time of the initial COT hearing. The provider should appear in court with an outpatient treatment plan and request the judge to change the venue to the receiving County. If a change of venue needs to occur after the initial COT hearing, the outpatient provider must submit: 1) Motion for approval of court-ordered outpatient treatment plan, accompanied by a Court Ordered Treatment Plan, 2) Motion to Change Venue, Order to Change Venue, accompanied by a Letter of Intent. The documents must be mailed to the Cenpatico approved law firm to file with the Court.

Reporting
Per ADHS, monthly reporting is required for all persons on court ordered treatment. All providers must identify and track treatment engagement of COT individuals.

Cenpatico IC has developed a portal-based submission for monthly reports for all COT individuals:

- Provider can complete/submit updates at any time during the reporting month, but all updates (updates include portal data entry and required documentation) must be completed and submitted no later than the 2nd business day of the next month.
- Provider must submit initial or continuing COTs as soon as they are received from Court (ensure there is an Open Episode of Care with Cenpatico IC)
- It is highly recommended that each Provider designate a backup designee for the COT/COE Coordinator and Liaison to manage report submission and any questions from the Cenpatico IC T-36 Coordinator if the Provider’s COT/COE Coordinator and Liaison not be available.
- It is recommended that the COT/COE Coordinator and Liaison and their backup designee be responsible to submit the data via the Provider Portal
- There can be multiple updates per member per month depending on the number of events occurring in the reporting month
- The Monthly Deliverable due on the 2nd business day of the next month is to ensure that updates and documents are entered/submitted no later than this date.

### 3.9.6 Persons Who Are Title XIX/XXI Eligible or Non-Title XIX/XXI and/or Determined to Have a Serious Mental Illness (SMI).

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

- Conduct an evaluation to determine if the person has a Serious Mental Illness in accordance with **Section 3.6 — SMI Eligibility Determination**, 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 3.5 — Assessment and Service Planning**;
- Provide necessary court-ordered treatment and other covered services in accordance with the person’s needs, as determined by the person’s clinical team, the Member, family Members, and other involved parties (see **Section 3.5 — Assessment and Service Planning**); and
- Perform, either directly or by contract, all treatment required by ARS Title 36, Chapter 5, Article 5 and 9 AAC 21, Article 5.

### 3.9.7 Court-Ordered Treatment For Persons Charged with or Convicted of a Crime

Cenpatico IC or 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.”
3.9.8 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, Cenpatico IC 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.

3.9.9 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 AHCCCS or Cenpatico IC receives a claim for such services, the claim will be denied with instructions to the provider to bill the responsible county, city, or town.

3.9.10 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 that 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, Cenpatico IC liaisons, 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. Provider Manual Attachment 3.9.1, A.R.S. § 12-136 Domestication or Recognition of Tribal Court Order is a flow chart demonstrating the communication between tribal and State entities.

Cenpatico IC and Cenpatico IC providers must comply with State recognized tribal court orders for Title XIX/XXI and Non-Title XIX/XXI SMI persons. When tribal providers are also involved in the care and treatment of court-ordered tribal members, Cenpatico IC and Cenpatico IC providers must involve tribal providers to verify 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 appropriate RBHA/Health Plan. This clinical communication and coordination with the RBHA/Health Plan 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.” RBHA/Health Plans are expected to 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 services.

Due to the options American Indians have regarding their health care, including services, payment of services for AHCCCS eligible American Indians may be covered through a TRBHA, RBHA/Health Plan or IHS/638 provider (see Behavioral Health Services Payment Responsibilities on the AHCCCS Tribal Court Procedures for Involuntary Commitment web page for a diagram of these different payment structures).

### 3.10 Special Populations

The State receives Federal grants and State appropriations to deliver 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 the State. The State then disburses the funding throughout Arizona for the delivery of covered services in accordance with the requirements of the fund source.

This section is intended to present an overview of the major Federal grants that provide the State and the public behavioral health system with funding to deliver services to persons who may otherwise not be eligible for covered services: the Substance Abuse Block Grant (SABG), the Community Mental Health Services Block Grant (MHBG), and the Projects for Assistance in Transition from Homelessness (PATH) Program. These are all annual formula grants authorized by the United States Congress. The Substance Abuse and Mental Health Services Administration (SAMHSA) facilitates these grant awards to states in support of a national system of mental health and substance abuse prevention and treatment services. All entities receiving SABG and MHBG funds must obtain and maintain an Inventory of Behavioral Health Services (I-BHS)
number through SAMHSA. See Provider Manual Form 3.10.1 Quarterly PATH Report, and PM Attachment 3.10.1 PATH Program Administrators Contact List.

It is important for providers to be aware of the following:

- Who is eligible to receive services through these funding sources;
- How the funds are prioritized; and
- What services are available through each funding source.

### 3.10.1 Substance Abuse Block Grant (SABG)

The SABG supports primary prevention services and treatment services for persons 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.

#### 3.10.1.1 Coverage and Prioritization

Substance use treatment services shall be available to all Members based upon medical necessity and the availability of funds. 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 persons 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).

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

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

#### 3.10.1.2 Choice of Substance Abuse Providers

Persons 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. Providers providing substance abuse services under the SABG must notify persons of this right in writing. Providers must document that the person has received notice in the person’s comprehensive clinical record.

If a person receiving services under the SABG objects to the religious character of a provider, the provider must refer the person to an alternate provider within 7 days, or earlier when clinically indicated, after the date of the objection. Upon making such a referral, providers must notify Cenpatico IC the referral and confirm that the person makes contact with the alternative provider.
Intake Providers must utilize the Cenpatico IC web-based Member transfer system to facilitate all transfers between provider agencies, including transfers associated with religious considerations (see Section 4.1 — Transition of Persons).

3.10.1.3 Program and Financial Management Policies

Providers must establish program and financial management policies and procedures for services funded by the SABG to meet all requirements in the provider agreement, the Provider Manual and the requirements of The Children’s Health Act of 2000, P.L. 106-310 Part B of Title XIX of the Public Health Service Act (42 USC 300 et seq.) and 45 CFR Part 96 as amended. The policies and procedures should include, but are not limited to, a listing of prohibited expenditures, references to the SABG FAQs, monitoring and reporting of funds by priority populations and funding category; and if applicable, monitoring of flex funds, and reporting; including, required approvals when exceeding the annual limit per Member and prohibited flex fund expenditures.

Procedures must include reporting and monitoring requirements to track encountering of SABG funds and to verify that treatment services are delivered at a level commensurate with funding under the SABG. Providers must submit SABG related program reports. These reports must be submitted in a format prescribed by Cenpatico IC.

Cenpatico IC must submit an annual plan regarding outreach activities and coordination efforts with local substance abuse coalitions. Cenpatico IC may ask providers receiving SABG funds for information for this report.

3.10.1.4 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 Behavioral Health Inpatient Facility to the State SABG Waitlist System, or in a different format upon written approval by the State.

- Title XIX/XXI persons may not be added to the wait list;
- Priority Population Members must be added to the wait list if Cenpatico IC or its providers are not able to place the person in a Behavioral Health Residential facility within the timeframes prescribed in Section 3.2 — Appointment Standards and Timeliness of Service; and
- Non-Title XIX/XXI persons may be added to the wait list if there are no available services.

3.10.1.5 Considerations When Delivering Services to SABG Populations

SABG treatment services must be designed to support the long-term recovery needs of eligible persons and meet the requirements set forth in Cenpatico IC Provider Manual Section. Specific requirements apply regarding preferential access to services and the timeliness of responding to a person’s identified needs (see Section 3.2 — Appointment Standards and Timeliness of Service). Providers must also submit specific data elements to identify special populations and record limited clinical information (see Section 13.1 — Enrollment, Disenrollment and Other Data Submission for requirements).
3.10.1.6  Services Available to SABG Special Populations

Treatment programs must include the following minimum core components: outreach, screening, referral, early intervention, case management, relapse prevention, child care services and continuity of addiction treatment. These are critical components for treatment programs targeting substance-using individuals. In addition, medical providers must be included in the treatment planning process from the initial contact for services to verify continuity and coordination of care.

Providers must refer persons with substance use disorders for tuberculosis screening. In addition, provider must deliver services to persons with HIV in accordance to this Provider Manual.

The overall goal in a continuum of comprehensive addiction treatment is improved life functioning and wellbeing, as measured by reductions in the medical, psychosocial, spiritual, social, and family consequences of addiction.

3.10.1.7  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 persons who also meet a priority population type may not be placed on a wait list (see Section 3.2 — Appointment Standards and Timeliness of Service). Provision of interim services must be documented in the Member’s chart as well as reported to the State through the online waitlist. The minimum required interim services include education that covers the following:

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

3.10.1.8  Program Requirements for Pregnant Women and Women with Dependent Children

Providers must comply with Program Requirements for Pregnant Women and Women with Dependent Children in accordance with this Provider Manual as follows:

- Engage, retain, and treat pregnant women and women with dependent children who request and are in need of substance use disorder treatment.
- Deliver outreach, specialized evidence-based treatment, and recovery support services for pregnant women, women with dependent children or women attempting to regain custody of children.
• Deliver services to the family as a unit and for residential treatment programs, admit both women and their children into treatment.

• Deliver medically necessary covered services to each pregnant woman who requests and is in need of substance use disorder treatment within forty-eight (48) hours of the request.

• Deliver medically necessary covered services for women with dependent children within five (5) days.

• Publicize the availability and accessibility of SABG-funded substance abuse services to the community and referral sources including, at a minimum, schools, substance abuse coalitions, and medical providers. Publicize the availability of gender-based substance use disorder treatment services for pregnant women or women who have dependent children. Publication must include, at minimum, the posting of fliers at each SABG service delivery site notifying pregnant women or women with dependent children of the availability and right to receive substance use disorder treatment services at no cost.

• Deliver the following services as needed: referral for primary medical care for women and primary pediatric care for children; gender-specific substance use treatment; therapeutic interventions for children; and case management and medically-necessary transportation to access medical and pediatric care.

• Eliminate barriers to access treatment through incorporation of child care, case management and medically-necessary transportation to medical and pediatric care and treatment services.

• Prioritize services available for substance use disorder treatment services for pregnant women pursuant to A.R.S. § 36-141.

Providers are required to ensure the following issues do not pose barriers to access to obtaining substance abuse treatment:

• Child care;
• Case management; and
• Transportation.

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

3.10.1.9  Program Requirements for Persons Involved with Injection Drug Use

Providers must engage in evidence-based best practice outreach activities to encourage individuals in need of services to undergo treatment and deliver medically necessary covered services to persons involved with injection drug use who request and are in need of substance use disorder treatment within fourteen (14) calendar days. Providers must notify Cenpatico IC when an intravenous drug use program has reached ninety percent (90%) of its capacity. Providers are prohibited from using SABG funds to supply individuals with hypodermic needles or syringes to use illegal drugs.
3.10.1.10  **HIV Early Intervention Services**

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

- **Accessing HIV Early Intervention Services**

Provider agencies must provide locations and specified times for Members to access HIV Early Intervention services. Providers shall inform Members of the opportunity to receive HIV education, screenings and early intervention services and facilitate Members’ access to the services. Substance use treatment providers must make their facilities available for HIV Early Intervention providers contracted with Cenpatico IC and verify Members have access to HIV Early intervention services.

**Requirements for Providers Offering HIV Early Intervention Services**

- **HIV Testing Services**

HIV early intervention service providers who accept funding under the SABG must provide HIV testing services. Providers must administer HIV testing services in accordance with the Clinical Laboratory Improvement Amendments (CLIA) requirements, which requires that any agency that performs HIV testing must register with CMS to obtain CLIA certification. However agencies may apply for a CLIA Certificate of Waiver, which exempts them from regulatory oversight if they meet certain federal statutory requirements.

Many of the Rapid HIV tests are waived. For a complete list of waived Rapid HIV tests please see [http://www.fda.gov/cdrh/clia/cliawaived.html](http://www.fda.gov/cdrh/clia/cliawaived.html). Waived rapid HIV tests can be used at many clinical and non-clinical testing sites, including community and outreach settings. Any agency that is performing waived rapid HIV tests is considered a clinical laboratory. Any provider planning to perform waived rapid HIV tests must develop a quality assurance plan, designed to verify any HIV testing will be performed accurately. (See Centers for Disease Control Quality Assurance Guidelines).

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

Cenpatico IC is expected to administer a minimum of one test per $600 in HIV funding.

- **HIV Education and Pre/Post-Test Counseling**

The HIV Prevention Counseling training provided through ADHS must be completed by all Cenpatico IC 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. Cenpatico IC HIV Coordinators and provider staff delivering HIV Early Intervention Services for the SABG also must attend an HIV Early Intervention Services Webinar issued by the State on an annual basis, or as
indicated by the State. The Webinar will be recorded and made available by the State. New staff assigned to duties pertaining to HIV services must view the Webinar as part of their required training prior to delivering any HIV Early Intervention Services reimbursed by the SABG.

**Community Involvement**

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

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

  The number of the confirmatory lab slip 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**
  
  Provider is required to submit monthly progress reports to Cenpatico IC. Cenpatico IC will conduct bi-annual site visits to providers offering HIV Early Intervention Services. The State HIV Coordinator, Cenpatico IC HIV Coordinator, provider staff, and supervisors relevant to HIV services must be in attendance during site visits. As part of the site visit, provider must make available a budget review and a description/justification for use of the SABG funding.

**3.10.1.11 Other Populations**

Providers must deliver evidence-based services to other populations requiring substance use interventions and supports, including homeless individuals, individuals with sight limitations, who are deaf or hard of hearing, persons with criminal justice involvement and persons with co-occurring mental health disorders, subject to the availability of SABG funds.

**3.10.1.12 Restrictions on the Use of SABG Grant Funds**

Providers may not expend SABG funds on the following activities:

- To provide inpatient hospital services, with the exception of detox services;
- 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;
- To 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 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; and
- To provide acute care or physical health care services, including payment of co-pays.

Room and Board (H0046 SE) services funded by the SABG are limited to children/adolescents with a Substance Use Disorder (SUD), and adult priority population Members (pregnant females, females with dependent child(ren), and intravenous drug users with a SUD) to the extent in which funding is available.

### 3.10.2 Community Mental Health Services Block Grant (MHBG)

The MHBG Block Grant provides funds to establish or expand an organized community-based system of care for providing Non-Title XIX/XXI mental health services to children with serious emotional disturbances (SED) and adults with a Serious Mental Illness (SMI). The MHBG Block Grant funds are used to: (1) carry out the State plan contained in the application; (2) evaluate programs and services; and (3) conduct planning, administration, and educational activities related to the provision of services. The MHBG Block Grant requires the State to maintain a statewide planning council with representation by Members, family members, State employees and providers.

#### 3.10.2.1 Populations Covered and Prioritized

In serving children with SED and adults with SMI, MHBG funds must be used for the following:

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

3.10.2.2 Restrictions on the Use of MHBG Block Grant Funds

Providers must ensure that MHBG Block Grant funds are not expended on the following activities:

• To provide inpatient hospital services, with the exception of detox services;
• To make cash payments to intended recipients of health services;
• To purchase or improve land or to purchase, construct, or permanently improve (other than minor remodeling) any building or other facility;
• To 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 Level I of the Executive Salary Schedule for the award year (see http://grants.nih.gov/grants/policy/salcap_summary.htm); and
• To purchase treatment services in penal or correctional institutions of the State of Arizona Room and Board services funded by the MHBG Block Grant are limited to children with SED;
• To provide acute care or physical health care services, including payment of co-pays
• Room and Board services funded by the MHBG are limited to children with SED.

3.10.2.3 Provider Management of MHBG Funds

Providers must comply with all terms, conditions, and requirements of the MHBG including the Children's Health Act of 2000, P.L. 106-310 Part B of Title XIX of the Public Health Service Act (42 U.S.C. 300 et seq.) and 45 CFR Part 96 as amended. Providers must retain documentation of compliance with Federal requirements, and produce upon Cenpatico IC request, financial, performance, and program data that is subject to audit. These services will be available based upon medical necessity and the availability of funds.

Providers must report MHBG and SABG funds and services separately and report or produce information related to block grant expenditures to Cenpatico IC upon request. Providers must manage the MHBG funds during each fiscal year to make funds available for obligation and expenditure until the end of the fiscal year for which the funds were paid.

Providers must have internal MHBG policies and procedures that should include, but are not limited to, a listing of prohibited expenditures, references to the MHBG FAQs, monitoring and
reporting of funds by priority populations and funding category; and if applicable, monitoring of flex funds, and reporting, including required approvals when exceeding the annual limit per Member and prohibited flex fund expenditure. Copayments, or any other fee, are prohibited for the provision of services funded by MHBG Block Grants.

3.10.3 Projects for Assistance in Transition from Homelessness (PATH) Grant

The PATH Grant provides outreach services designed to assist individuals who are homeless or at imminent risk of becoming homeless who are suspected to have or have been determined to have a Serious Mental Illness (SMI) or co-occurring SMI and substance use disorder. The services are to be provided in locations where persons who are homeless gather, such as food banks, parks, vacant buildings and the streets.

PATH grant funds are allocated by the State based on a competitive request for proposals (RFP) process and direct provider contract. Cenpatico IC does not currently receive this funding therefore there are no PATH providers in our service areas.

3.11 Special Assistance for Persons Determined to Have a Serious Mental Illness

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

Health Homes are expected to follow the policies and procedures outlined in the AHCCCS Medical Policy Manual, Chapter 300, Policy 320-R Special Assistance for Persons Determined to Have a Serious Mental Illness and all other applicable AHCCCS policies, Arizona Revised Statutes and AAC 9R-21.

3.11.1 General Requirements

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

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

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

The person’s limitations described above must also be due to any of the following:

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

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

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

• Developmental disability involving cognitive ability,
• Residence in a 24 hour setting,
• Limited guardianship, or Cenpatico IC or the Health Home is recommending 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 or traumatic brain injury).

3.11.2 Persons Qualified to Make a Special Assistance Determination

Specific staff and agencies are qualified to screen for and make a determination as to whether a person qualifies for Special Assistance (See AHCCCS Medical Policy Manual, Chapter 300, Policy 320-R Special Assistance for Persons Determined to Have a Serious Mental Illness).

3.11.3 Screening for Special Assistance

Health Homes perform screenings to assess whether persons determined to have a SMI are in need of Special Assistance, in accordance with the criteria set out in AHCCCS Medical Policy Manual, Chapter 300, Policy 320-R Special Assistance for Persons Determined to Have a Serious Mental Illness. PMA 3.11.1 Special Assistance Guidance Document is available to assist Health Homes in screening for Special Assistance in addition to the required use of PMF 3.11.2 Special Assistance Screening Tool.

Health Homes that receive 3 or more PMF 3.11.1 DNMC (Does Not Meet Criteria) Part B responses within a quarter will be subject to additional Special Assistance training.

Special Assistance documentation and record keeping policies and procedures are referenced in AHCCCS Medical Policy Manual, Chapter 300, Policy 320-R Special Assistance for Persons Determined to Have a Serious Mental Illness.

If a person is currently identified as a person in need of Special Assistance a notation of “Special Assistance” and a completed Cenpatico IC PMF 3.11.1 or a completed AMPM Exhibit 320-R-6 should already exist in the clinical record. However, if it is unclear, Health Homes can contact the Cenpatico IC HRC Liaison to inquire about current status. Cenpatico IC maintains a database on persons in need of Special Assistance and shares data with Health Homes on a regular basis (at a minimum quarterly).
3.11.4 Notification Requirements to the Office of Human Rights

Health Homes are expected to follow the policies and procedures for notifying the Office of Human Rights as outlined in AHCCCS Medical Policy Manual, Chapter 300, Policy 320-R Special Assistance for Persons Determined to Have a Serious Mental Illness.

3.11.5 Persons No Longer in Need of Special Assistance

Health Homes are expected to follow the policies and procedures for notifying the Office of Human Rights when a person no longer meets Special Assistance criteria, as outlined in AHCCCS Medical Policy Manual, Chapter 300, Policy 320-R Special Assistance for Persons Determined to Have a Serious Mental Illness.

3.11.6 Ensuring the Provision of Special Assistance

Health Homes collaborate with and involve the person (guardian, family member, friend, OHR advocate, etc.) meeting Special Assistance needs in all relevant Behavioral Health planning and processes. Health Homes are expected to follow the policies and procedures within AHCCCS Medical Policy Manual, Chapter 300, Policy 320-R Special Assistance for Persons Determined to Have a Serious Mental Illness to ensure the provision of Special Assistance.

3.11.7 Health Home Reporting Requirements

Health Homes are expected to follow all reporting requirements listed within the AHCCCS Medical Policy Manual, Chapter 300, and Policy 320-R Special Assistance for Persons Determined to Have a Serious Mental Illness.

To support Cenpatico IC and OHR in maintaining accurate and up-to-date information on persons in need of Special Assistance, Health Homes are required to submit monthly updates on persons in need of Special Assistance using Cenpatico IC deliverable template “CA-907 Monthly Update on Persons Receiving Special Assistance”. Health Homes responsible for completing form CA-907 as required in Section 16. Health Homes who will receive form CA-907 for completion meet at least one of the following criteria:

- Health Homes with enrolled member(s) actively receiving Special Assistance
- Health Homes with enrolled member(s) that have a pending Special Assistance notification form
- Health Homes with enrolled member(s) currently on the Special Assistance waitlist

To monitor Special Assistance documentation and coordination requirements Health Homes are required to complete deliverable “CA-908 Special Assistance Form”. The CA-908 Form and instructions are located on the Cenpatico IC website under “Provider Forms, Attachments and Deliverables”. Health Homes with enrolled members actively receiving Special Assistance are responsible for completing CA-908.

Health Homes with consecutive occurrences of not meeting/succeeding the Special Assistance MPS of 85% will be required to attend a live Special Assistance training facilitated by Cenpatico.
IC. All Cenpatico IC identified Health Home staff are required to attend the live training within 2 months of the notification.

3.11.8 Confidentiality Requirements

Health Homes shall grant access to clinical records of persons in need of Special Assistance to the OHR in accordance with federal and state confidentiality laws (see AHCCCS Medical Policy Manual, Policy 550).

Human Rights Committees receive confidential information related to Special Assistance members and are expected to safeguard the information in accordance with the requirements set out in AHCCCS Contractor Operations Manual, Policy 447.

3.11.9 Other Procedures

Health Homes must follow the training requirements related to Special Assistance, as outlined in the AHCCCS Medical Policy Manual, Policy 320-R Special Assistance for Persons Determined to Have a Serious Mental Illness.

Health Homes must assign one staff member to act as the Special Assistance Single Point of Contact. The Single Point of Contact must be proficient in all Special Assistance policies and procedures outlined in AHCCCS Medical Policy Manual, Policy 320-R Special Assistance for Persons Determined to Have a Serious Mental Illness and all other applicable Special Assistance policy. The Single Point of Contact verifies OHR requests for further information and/or timely submission of documents.

The Single Point of Contact reviews each PMF 3.11.1, Notification of Persons in Need of Special Assistance and PMF 3.11.2, Special Assistance Screening Tool prior to submission to AHCCCS OHR to ensure member meets criteria. Health Home Single Point of Contact staff are required to attend the Special Assistance Single Point of Contact Monthly Conference Call. Health Homes should notify the Cenpatico IC HRC Liaison of any changes in Single Point of Contact staff.

3.12 Arizona State Hospital

AzSH is a Level I facility currently licensed under applicable State and local law, is accredited by The Joint Commission and certified by the Centers for Medicare and Medicaid Services (CMS). AzSH is a long-term inpatient psychiatric hospital that provides the most restrictive setting for care in the State. Coordination between AzSH and Cenpatico IC must occur in a manner that ensures persons being admitted meet medical necessity criteria. Those individuals referred for admission must have a mental disorder as defined in A.R.S. §36-501(26), and must be able to benefit from care and treatment at AzSH (A.R.S. § 36-202). The level of care provided at AzSH must be the most appropriate and least restrictive treatment option for the person (A.R.S. § 36-501(22)). The provision of appropriate, medically necessary covered behavioral health services must be consistent with treatment goals outlined on the admission application and individual needs identified in the course of treatment of individuals admitted to AzSH.
The goal of all hospitalizations of persons at AzSH is to provide comprehensive evaluation, treatment, and rehabilitation services to assist each behavioral health recipient in his/her own recovery, and to achieve successful placement into a less restrictive community-based treatment option.

3.12.1 Admissions

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

- The Member must not require acute medical care beyond the scope of medical care available at AzSH.
- The referral source must make reasonable good-faith efforts to address the individual’s target symptoms and behaviors in an inpatient setting(s).
- For Members who are also enrolled with the Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD), the DES/DDD Director or designee agrees with the recommendation for admission.
- The referral source must complete Utilization Review of the potential admission referral and recommend admission to the AzSH as necessary and appropriate, and as the least restrictive option available for the person given his/her clinical status.
- When a community provider agency or other referral source believes that a civilly committed or voluntarily admitted adult is a candidate to be transferred from another inpatient facility for treatment at AzSH, the agency will contact Cenpatico IC to discuss the recommendation for admission to AzSH. Cenpatico IC must be in agreement with the referral source that a referral for admission to AzSH is necessary and appropriate. If the candidate is not T/RBHA/Health Plan enrolled, the Member will be referred for SMI determination and the enrollment process prior to application or at the latest within twenty-four (24) hours of admission pursuant to Section 3.2 — Appointment Standards and Timeliness of Service to AzSH. The enrollment date is effective the first date of contact by a Cenpatico IC-contracted Health Home. The Cenpatico IC Health Home is required to also complete a Title XIX/XXI application once enrollment is completed. For all non-T/RBHA/Health Plan enrolled Tribal behavioral health recipients, upon admission to AzSH, the hospital will enroll the person, if eligible in the AHCCCS Indian Health Program.
- For TRBHA (Tribal RBHA only) enrolled Members, AHCCCS must also be in agreement with the referring agency that admission to AzSH is necessary and appropriate, and AHCCCS must prior authorize the person’s admission (see Section 10.1 — Securing Services and Prior Authorization/Retrospective Authorization).
- Cenpatico IC 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, and if determined to be SMI and previously assessed as requiring Special Assistance, then the existing Special Assistance form should be included in the package. If the form has not been completed, please refer to Section 3.11 — Special Assistance for Persons Determined to have a Serious Mental Illness for further instructions.
- The Admissions Office confirms receipt of the complete packet and notifies the referral source of missing or inadequate documentation within two business days of
receipt. AzSH cannot accept any person for admission without copies of the necessary legal documents.

- For TXIX enrolled persons, the **Certification of Need (CON)** (see **Provider Manual Form 3.12.1, Certification of Need**) should be included in the application for admission. Cenpatico IC needs to generate a Letter of Authorization (LOA) or issue a denial. The LOA should be provided to the AzSH Admissions Department with the application for admission to AzSH.

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

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

- If the AzSH Chief Medical Officer or Acting Designee determines that the Member does not meet criteria for admission, the Chief Medical Officer or Acting Designee will provide a written statement to the referral source explaining why the 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 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 to 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 recipient immediately, AzSH shall establish a pending list for admission. If the behavioral health recipient’s admission is pending for more than 15 days, the referral agency must provide 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.
### 3.12.2 Adult Members Under Civil Commitment

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

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

The Member must not suffer more serious harm from proposed care and treatment at AzSH. ([AAC R9-21-507(B)(1)](https://www.az.gov/sites/default/files/docs/AAC%20R9-21-507%20%281%29%204%2F1%202017.pdf)).

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 ([AAC R9-21-507(B)(2)](https://www.az.gov/sites/default/files/docs/AAC%20R9-21-507%20%282%29%204%2F1%202017.pdf)).

### 3.12.3 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 Members determined to have SMI.

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

- Consideration of comprehensive information regarding previous treatment approaches, outcomes and recommendations/input from Cenpatico IC 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 in order to facilitate enhanced coordination of care and successful discharge planning.
- Treatment goals and recommended assessment/treatment interventions must be carefully developed and coordinated with the outpatient providers (including Cenpatico IC, ALTCS Health Plan, DDD, other providers), the Member’s legal guardian, family members, significant others as authorized by the Member and advocate/designated representative whenever possible.
- The first ITDP meeting, which is held within 10 days of the Member’s admission, should address specifically what symptoms or skill deficits are preventing the Member from participating in treatment in the community and the specific
goals/objectives of treatment at 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 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 responsible agency. The responsible agency should indicate review of an agreement/disagreement with the treatment plan on the document. Any disagreements should be discussed as soon as possible and resolved as outlined in AAC9R-21.

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

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

Through the Adult Clinical 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 Member and all involved parties to establish understandable, realistic, achievable and practical treatment, discharge goals and interventions.

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

### 3.12.4 Recertification of Need (RON)

The AzSH Utilization Manager is responsible for the recertification process for all Title XIX/XXI eligible persons and is the contact for AzSH for all Cenpatico IC continued stay reviews.

The AzSH Utilization Manager will work directly with the Member’s attending physician to complete the **Provider Manual Form 3.12.2, Recertification of Need (RON)**. The RON will be sent to Cenpatico IC within five (5) days of expiration of the current CON/ RON. If required by Cenpatico IC, the Utilization Manager will send to Cenpatico IC Utilization Review staff additional information/documentation needed for review to determine continued stay.

All Cenpatico IC decisions with regard to the approval or denial for continued stay will be rendered prior to the expiration date of the previous authorization and upon receipt of the RON for those Members. Cenpatico IC authorization decisions are based on review of chart documentation supporting the stay and application of the AHCCCS Level Continued Stay criteria. If continued stay is approved, Cenpatico IC sends a LOA to the AzSH Utilization Management Department with the completed RON and updated standard nomenclature diagnosis codes (if applicable). Denials will be issued upon completion of the denial process described in Section 10.1 — Securing Services and Prior Authorization.
3.12.5 Transition to Community Placement Setting

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

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

Once a Member is placed on the Discharge Pending List, Cenpatico IC must immediately take steps necessary to transition the Member into community-based treatment as soon as possible. Cenpatico IC has up to thirty (30) days to transition the Member out of AzSH. Cenpatico IC’s 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 Members discharge date. This will allow sufficient time to identify appropriate community covered behavioral health services.

When the Member has not been placed in a community placement setting within 30 days, a quality of care concern will be initiated by AHCCCS.

3.13 Out-of-State Placements for Children and Young Adults

At times, it may be necessary to consider an out-of-state placement for a child or young adult to meet the person’s unique circumstances or clinical needs, as outlined in the AHCCCS Contractor’s Operations Model (ACOM) Policy 408, Out of State Placements.

3.13.1 Initial Notification to AHCCCS Office of Medical Management

Providers are required to assist Cenpatico IC in gathering the required information to notify the AHCCCS Office of Medical Management prior to a referral for out-of-state placement using Provider Manual Form 3.13.1, Out-of-State Placement, Initial Notice. Prior authorization must be obtained prior to making a referral for out-of-state placement, in accordance with Cenpatico IC criteria (See Section 10.1 — Securing Services and Prior Authorization).

3.13.1.1 Process for Providing Initial Notification to the State

For providers subcontracted with Cenpatico IC, the provider notifies Cenpatico IC of the intent to make a referral for out-of-state placement on Provider Manual Form 3.13.1, Out-of-State Placement, Initial Notice.

Prior to placing the child or young adult the Health Home provider must complete Provider Manual Form 3.13.1, Out-of-State Placement, Initial Notice and submit it to Cenpatico IC.
Cenpatico IC will review the documentation and forward it to AHCCCS Office of Medical Management for approval of the out-of-state placement request. Cenpatico IC will also submit an electronic copy to AHCCCS Office of Medical Management, via secure e-mail, for approval of planned out-of-state placements.

3.13.2 Periodic Updates to AHCCCS Office of Medical Management

In addition to providing initial notification, the provider is required to submit updates to Cenpatico IC for review. The updates will be forwarded to the AHCCCS Office of Medical Management regarding the person’s progress in meeting the identified criteria for discharge from the out-of-state placement every 30 days. To adhere to this requirement, providers must use Provider Manual Form 3.13.2, Out-of-State Placement, 30-Day Update.

Once completed, the Health Home must submit the form to the Cenpatico IC Medical Management department every 30 days the person continues to remain in out-of-state placement. The 30 day update timelines will be based upon the date of approval by AHCCCS of the out-of-state placement. Cenpatico IC will review the form and forward it to the AHCCCS Office of Medical Management.

3.13.3 Required Reporting of an Out-of-State Provider

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

3.14 Discharge Planning

Discharge planning refers to the assessment of and preparation for Members’ needs after discharge from an inpatient setting or out-of-home placement. Inpatient and out-of-home facilities must begin discharge planning upon admission of a Member to the facility so that the Member is able to be discharged as soon as is clinically appropriate. Examples of Member needs at discharge include outpatient appointments, prescriptions, medical equipment, housing, home health care, residential treatment, family interventions and support, and connection to outpatient organizations and programs. Facilities must work with outpatient providers, including the Health Homes, to develop and implement a discharge planning process to address the post-discharge clinical and social needs of Members upon discharge.

Inpatient and out-of-home residential facilities must complete and fax to 844-893-5855 Provider Manual Form 10.1.10, Discharge Plan, at 72 hours post admission, every 10 days (for inpatient facilities) or at concurrent review (for out-of-home facilities), and at discharge. If a required service is not currently available, the plan must clearly state this and identify the steps to be taken (when and by whom) to get the required service in place to prevent delays in discharge. Entries such as "deferred until patient stabilizes," "to be determined," or "placement pending," are not acceptable. Appropriate discharge plans must contain contingencies in case the primary plan cannot be executed or is delayed.

Inpatient and out-of-home residential facilities must provide sufficient staff to discharge the member when the member is clinically ready, including weekends and holidays, and the facility...
must ensure medication records are faxed at discharge to the assigned Health Home to allow coordination of care upon transition to the community. Requests for prior authorization for residential placements after inpatient hospitalization may be initiated by the Health Home or by the inpatient facility as part of the concurrent review and discharge planning process with Cenpatico IC.

Each Health Home must employ a discharge planner/hospital liaison (see Sections 3.17.5.22-24) who works with the facility to ensure that continuing care needs have been accurately determined. The Health Home discharge planner/hospital liaison must appropriately document discharge plans in the Member’s medical record prior to discharge. The Health Home discharge planner/hospital liaison must include as part of this process:

- Proactive discharge assessment by qualified healthcare professionals identifying and assessing the specific post discharge bio-psychosocial and medical needs of the Member prior to discharge. This process shall include the involvement and participation of the Member and representative(s), as applicable. The Member and representative(s) must be provided with the written discharge plan instructions and recommendations identifying resources, referrals, and possible interventions to meet the Member’s assessed and anticipated needs after discharge.
- The coordination and management of the care that the Member receives following discharge from any out of home setting. This may include:
  - Providing appropriate post discharge community referrals and resources or scheduling follow up appointments with the Member’s primary care provider and/or other outpatient healthcare providers within 7 days or sooner of discharge;
  - Coordination of care involving effective communication of the Member’s treatment plan and medical history across the various outpatient providers to ensure that the Member receives medically-necessary services that are both timely and safe after discharge. This includes access to nursing services and therapies;
  - Coordination with the Member’s outpatient clinical team to explore interventions to address the Member’s needs such as case management, disease management, placement options, and community support services.
  - Access to prescribed discharge medications;
  - Coordination of care with the acute care plan when applicable; and
  - Post discharge follow up contact to assess the progress of the discharge plan according to the Member’s assessed clinical (physical health care) and social needs.
  - Access to Durable Medical Equipment (DME)

- Individuals who are discharged from the Arizona State Hospital (AzSH) must be provided with the same brand and model glucometer and supplies the individual was trained on while in the hospital.

**Avoidable Days**

At times, there are delays in discharging Members because necessary outpatient services are not yet available. As long as the inpatient or out-of-home facility has carried out discharge
planning activities in a timely and thorough manner, Cenpatico IC will continue to authorize inpatient care for Members who cannot be discharged due to the lack of necessary outpatient services. However, if delays in discharge are deemed to be the direct result of the failure of discharge planning on the part of the inpatient or out-of-home facility, Cenpatico IC may cease to authorize further inpatient or residential bed days. If there are delays in discharge deemed to be the direct result of the Health Home’s failure to engage in appropriate discharge planning, Cenpatico IC will continue to authorize inpatient or out-of-home care but may sanction the Health Home for the cost of the avoidable bed days.

3.14.1 Discharge Planning for American Indian Members in out of home placement

- If an American Indian member is concurrently receiving services from a Cenpatico Health Home and a tribal provider (tribal and/or IHS), providers are required to work in collaboration with the tribal provider.
- When American Indian members are placed out of home, the provider is expected to include the tribal provider in ongoing discharge planning and ongoing service planning.
- If you need assistance connecting with tribal providers, contact a member of the Cenpatico Tribal Programs Team.

3.15 Cultural Competence

Cenpatico IC and its providers must respond to the unique cultural, ethnic, and linguistic characteristics of the population they serve to ensure that services are culturally competent for diverse, underserved, and underrepresented populations.

In 2000, the Office of Minority Health published the first National Standards for Culturally and Linguistically Appropriate Services in Health Care (National CLAS Standards), which provided a framework for all health care organizations to best serve the nation’s increasingly diverse communities. Cenpatico IC has adopted the CLAS Standards as its cultural competency framework to support a more consistent and comprehensive approach to cultural and linguistic competence in health care.

Health Equity & Culturally and Linguistically Appropriate Services (CLAS)

Health inequities in our nation are well documented, and the provision of culturally and linguistically appropriate services (CLAS) is one strategy to help eliminate health inequities. By tailoring services to an individual's culture and language preference, health professionals can help bring about positive health outcomes for diverse populations. The provision of health care services that are respectful of and responsive to the health beliefs, practices and needs of diverse patients can help close the gap in health care outcomes. The pursuit of health equity must remain at the forefront of our efforts; we must always remember that dignity and quality of care are rights of all and not the privileges of a few.

Through ongoing data collection and community collaboration, Cenpatico IC has determined that disparities and/or gaps exist with regard to access to effective, quality services that are inclusive of all traditions, cultural beliefs, diverse cultures, and races and ethnicities. Therefore, Cenpatico IC continues to focus on new initiatives and programs, based on data driven goals and
outcomes, to provide a comprehensive range of inclusive and high quality services for all underserved/underrepresented populations identified within Arizona’s geographic regions.

The *Annual Effectiveness Review of the Cultural Competency Plan* and *Cenpatico IC’s Annual Cultural Competency Plan* are resources for determining areas of accomplishment and areas of improvement. Cenpatico IC also makes available tools for individual and organizational self-assessments.

### 3.15.1 Culturally and Linguistically Appropriate Services (CLAS) Standards

The CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for individuals as well as health and health care organizations to implement culturally and linguistically appropriate services. The CLAS Standards are a comprehensive series of guidelines that inform, guide, and facilitate practices related to culturally and linguistically appropriate health services. Providers are required to adhere to and implement the CLAS standards:

- **Principal Standard (Standard 1):** Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs;

- **Governance, Leadership, and Workforce (Standards 2-4):** Provide greater clarity on the specific locus of action for each of these Standards and emphasizes the importance of the implementation of CLAS as a systemic responsibility, requiring the investment, support, and training of all individuals within an organization;

- **Communication and Language Assistance (Standards 5-8):** Provides a broader understanding and application of appropriate services to include all communication needs and services, including sign language, braille, oral interpretation, and written translation; and

- **Engagement, Continuous Improvement, and Accountability (Standards 9-15):** Underscores the importance of establishing individual responsibility in verifying that CLAS is supported, while retaining the understanding that effective delivery of CLAS demands actions across an organization. These Standards focus on the supports necessary for adoption, implementation, and maintenance of culturally and linguistically appropriate policies and services regardless of one’s role within an organization or practice. All individuals are accountable for upholding the values and intent of the CLAS Standards.

### 3.15.2 Culturally Competent Care

To comply with the Culturally Competent Care requirements, Cenpatico IC and its providers must:

- Recruit, promote, and support culturally and linguistically diverse representation within governance, leadership, and the workforce that is responsive to the population in the service area(s);

- Educate and train representatives within governance, leadership, and the workforce in culturally and linguistically appropriate policies and practices on an ongoing basis. Providers with direct care responsibilities must complete mandated Cultural
Competency training (see Section 11.1 — Training Requirements and the Cultural Competency Plan), and verify that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery;

- Guarantee a Member’s right to be treated fairly without regard to age, ethnicity, race, sex (gender), religion, national origin, creed, tribal affiliation, ancestry, gender identity, sexual orientation, marital status, genetic information, socio-economic status, physical or intellectual disability, ability to pay, mental illness, and/or cultural and linguistic need; Provide culturally relevant and appropriate services for Members of various populations including but not limited to: age groups, gender and sexual minorities, persons with disabilities, racial and ethnic groups, veterans, religious affiliations, socio-economic statuses, tribal nations, etc.

3.15.3 Organizational Supports for Cultural and Linguistic Need

Under State guidance, and to comply with the Organizational Supports for Cultural Competence, Cenpatico IC and providers must:

- Establish culturally and linguistically appropriate goals, policies, and management accountability and infuse them throughout the organization’s planning and operations;
- Conduct ongoing assessments of the organization’s CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities;
- Partner with the community to design, implement, and evaluate policies, practices, and services to verify cultural and linguistic appropriateness;
- Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area;
- Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints;
- Communicate the organization’s progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public;
- Verify the use of multi-faceted approaches to assess satisfaction of diverse individuals, families, and communities, including the identification of minority responses in the analysis of client satisfaction surveys, the monitoring of service outcomes, Member grievances, provider feedback and/or employee surveys;
- Include prevention strategies by analyzing data to evaluate the impact on the network and service delivery system, with the goal of minimizing disparities in access to services and improving quality; and
- Consult with diverse groups to develop relevant communications, outreach and marketing strategies that review, evaluate, and improve service delivery to diverse individuals, families, and communities, and address disparities in access and utilization of services.
### 3.15.3.1 Workforce Development and Training

Cenpatico IC and its Providers must:

- Ensure all staff receive training in cultural competence and culturally and linguistically appropriate services during new employee orientation;
- Provide ongoing and annual training on Cultural Competence, to include at least the following: the Cultural Competence requirements in this Provider Manual, the CLAS standards, use of oral interpretation and translation services, and alternative formats and services for Members with Limited English Proficiency (LEP). Providers must ensure that all staff members have completed the annual training and achieved a passing score of at least 80% on the post-test score;
- Provide annual training to all staff in diversity awareness and culturally relevant topics customized to meet the needs of their service area;
- Ensure all staff have access to resources for Members with diverse cultural needs;
- Recruit, retain, and promote, at all levels of the organization, a culturally competent, diverse staff and leadership that reflects the cultural background of Members served;
- Maintain full compliance with all mandatory trainings (see Section 11.1 — Training Requirements);
- Develop and implement cultural-related trainings/curriculums as determined by the State, R/THA/Health Plans, Cultural Competence Committees, policies, and contract requirements.

### 3.15.3.2 Documenting Clinical Cultural and Linguistic Need

To advance health literacy, reduce health disparities, and identify the individual’s unique needs, Cenpatico IC and providers are required to do the following:

- Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery;
- Verify documentation of the cultural (for example: age, ethnicity, race, national origin, sex (gender), gender identity, sexual orientation, tribal affiliation, veteran status, disability) and linguistic (for example, primary language, preferred language, language spoken at home,) needs within the medical records;
- Maintain documentation within the medical record of oral interpretation provided in a language other than English- by certified bilingual staff or an interpretation vendor. Documentation must include the date of service, interpreter name, type of language provided, interpretation duration, and type of interpretation assistance provided;
- Report Appropriately for Language Assistance - T1013, Interpretation
  - T1013 must be reported (by applicable provider types) - when providing language assistance delivered by certified bilingual staff or provided by a language vendor. This code is used to track language assistance that is being provided (languages other than English, including ASL).
- Interpretation is an administrative cost included in the billing of the services provided with the interpretation. Interpretation must be reported in conjunction with another service, never a standalone code.

- Ensure that the cultural needs of Members and their families are assessed and included in the development of treatment plans; and

- Assess the unique needs of the GSA, as communities’ cultural needs are critical in the development of goals and strategies of prevention within documentation of cultural and linguistic need.

### 3.15.4 Communication and Language Assistance

To comply with the communication and language assistance requirements in the CLAS Standards, and the Affordable Care Act Section 1557, Cenpatico IC and its providers must do the following:

- **Post nondiscrimination notices.** Notices must include a nondiscrimination statement, the availability of interpretive services for patients with limited English proficiency (LEP), and the availability of auxiliary aids and services for individuals with disabilities, and informing them how to obtain the aids and services. The statement must include the availability of a grievance procedure for allegations of discrimination and information about how to file a grievance. The notice must also contain information regarding how to file a grievance with the HHS Office of Civil Rights (OCR).

- **Post taglines.** These statements notify individuals of the availability of language assistance in at least the top 15 languages.

- **Identify Prevalent Non-English Language Needs.** Providers must identify the prevalent non-English language(s) within the provider service areas to ensure service capacity meets those needs.

- **Provide Services in a Culturally Competent Manner.** Providers must give consideration for Members with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds, including those who identify with deaf culture, as well as Members with visual or auditory limitations. Culturally competent care includes providing access to a qualified language interpreter, a person proficient in sign language for individuals who are deaf or hard of hearing, and written materials available in Braille for individuals who are blind or in different formats, as appropriate. Providers must also provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the provider’s service area. Members have the right to know which providers speak languages other than English.

- **Offer Language Assistance.** Providers must clearly inform Members of the availability of language assistance in their preferred language, verbally and in writing. A provider must offer language assistance to individuals who have limited English proficiency and/or other communication needs such as sign language interpreters and American Sign Language-fluent staff, at no cost to them, to facilitate timely access to all health care services. Language assistance must be available during all hours of operation. If a Provider does not have certified bilingual
staff to make language assistance available, the Provider is required to contract with language assistance vendors to meet these needs.

- **Document Language Assistance Needs.** Providers must document in a Member’s medical record if the person has a preferred language other than English. If the Member care requires the presence of a legal parent or guardian who does not speak English (e.g., when the patient/Member is a minor or severely disabled), Cenpatico IC and providers must document the language not only of the Member but also of the guardian or legal appointed representative. Providers must also maintain documentation within the medical record of oral interpretation provided in a language other than English - by certified bilingual staff or an interpretation vendor whether to the Member or the legal parent or guardian. Documentation must include the date of service, interpreter name, type of language provided, interpretation duration, and type of interpretation assistance provided.

- **Ensure Competence and Proficiency of Those Providing Language Assistance.** Provider must ensure that qualified oral interpreters and bilingual staff as well as certified sign language interpreters provide access to oral interpretation, translation, sign language and disability-related assistance, and provide auxiliary aids and alternative formats on request. The use of untrained individuals and/or minors as interpreters should be avoided. An interpreter must be certified at the appropriate level of proficiency to be qualified to provide interpretation or to provide direct services in a language other than English. Cenpatico IC requires that persons who provide oral interpretation are certified through language testing by ALTA Services with a score of eight (8) or higher, with a higher level of proficiency needed for the provision of more complex verbal interchange, such as psychiatric services and psychological testing. Providers can register for testing at www.Altalang.com. The charge for the testing is the provider agency’s responsibility. Certificates of proficiency indicating level/testing scores shall be maintained in personnel records and/or subcontractor’s files and made available to Cenpatico IC. Cenpatico IC will audit providers to verify they are using certified bilingual staff at the appropriate level of proficiency to provide the language assistance or that they are using a language vendor.

- **Develop Policies for Staff to Provide Interpreting Services.** Each agency must develop and have available at the time of the Administrative Audit, a policy outlining in detail the steps an employee should take to:
  - Provide American Sign Language (ASL) interpretation for individuals who are deaf or hard of hearing;
  - Provide oral interpretation for anyone whose preferred language is one other than English; and
  - Obtain certification that the employee meets the required level of proficiency to provide language assistance in either ASL or a language other than English.

- **Report Appropriately for Language Assistance - T1013, Interpretation.** Oral interpretation and sign language are provided at no charge to Arizona Health Care Cost Containment System (AHCCCS) eligible persons and persons determined to have a Serious Mental Illness (SMI). Interpretation is an administrative cost included in the billing of the services provided with the interpretation. Interpretation code T1013 must be submitted in conjunction with another service, never as a standalone code.
o T1013 must be reported (by applicable provider types) - when providing language assistance delivered by certified bilingual staff or provided by a language vendor. This code is used to track language assistance that is being provided in a language other than English, including ASL.

3.15.5 Accessing Oral Interpretation Services

In accordance with Title VI of the Civil Rights Act, Prohibition against National Origin Discrimination, the President’s Executive Order 13166, and Section 1557 of the Patient Protection and Affordable Care Act, Cenpatico IC and its providers must make oral interpretation services available to persons with Limited English Proficiency (LEP) at all points of contact. Oral interpretation services are provided at no charge to AHCCCS eligible persons and Non-Title XIX/XXI persons determined to have a Serious Mental Illness (SMI). Members must be provided with information instructing them how to access these services.

All providers must have their own interpretation and translation assistance resources available during all hours of operation. If a Provider does not have certified bilingual staff or licensed American Sign Language interpreters for language assistance needs, the Provider is required to contract with language vendors to meet these needs.

Cenpatico IC has customer service representatives who are available to speak to members/family members in their preferred language, or will conference in an interpreter. Anyone can call Customer Service at 1-866-495-6738 for assistance and information. The Crisis Call Center, at 866-495-6735, also has the ability to conference in an interpreter, as needed.

3.15.6 Accessing Interpretation Services For Individuals Who Are Deaf or Hard of Hearing

Cenpatico IC and its providers must adhere to the rules established by the Arizona Commission for the Deaf and Hard of Hearing, in accordance with A.R.S. § 36-1946, which cover the following:

- Classification of interpreters for individuals who are deaf or hard of hearing based on the level of interpreting skills acquired by that person;
- Establishment of standards and procedures for the qualification and licensure of each classification of interpreters;
- Utilizing licensed interpreters for individuals who are deaf or hard of hearing; and
- Providing auxiliary aids or licensed sign language interpreters that meet the needs of the individual upon request. Auxiliary aids include computer-aided transcriptions, written materials, assistive listening devices or systems, closed and open captioning, and other effective methods of making aurally delivered materials available to persons with hearing loss.

- The Arizona Commission for the Deaf and the Hard of Hearing provides a listing of licensed interpreters, information on auxiliary aids and the complete rules and regulations regarding the profession of interpreters in the State of Arizona. (Arizona Commission for the Deaf and the Hard of Hearing www.acdhh.org or 602-542-3323 (V/TTY)).
- Cenpatico IC can be contacted via TDD/TTY line, 24 hours a day, 7 days a week at 877-613-2070.
3.15.7 Translation of Written Materials

Cenpatico IC and its providers must ensure that written materials disseminated to Members meet cultural competence and LEP requirements. Cenpatico IC and providers must translate all Member informational materials when a language other than English is spoken by 3,000 people or 10%, whichever is less, of Cenpatico IC’s Members who also have LEP.

Cenpatico IC and providers must translate all vital materials when a language other than English is spoken by 1,000 people or 5%, whichever is less, of Cenpatico IC’s Members who also have LEP (42 CFR 438.10(3)). Vital materials include the following:

- notices for denials, reductions, suspensions or terminations of services;
- Individual Service Plans (ISPs);
- consent forms;
- communications requiring a response from the Member;
- all grievance, appeal and request for State fair hearing documentation;
- the Member Handbook; and
- a detailed description of Early Periodic Screening, Diagnostic and Treatment (EPSDT) services.

In addition, all written notices informing Members of their right to interpretation and translation services must be translated when 1000 people or 5%, whichever is less, of Cenpatico IC’s Members speak that language and who also have LEP.

Members with LEP, whose languages are not considered commonly encountered, must be provided written notice in their primary or preferred language of the right to receive competent translation of written material and provide instructions for obtaining culturally competent materials. In general, any document that requires the signature of the Member, and that contains vital information such as the treatment, medications or notices, or service plans must be translated into their preferred/primary language. Both the English and translated versions must be maintained in the Member’s record.

3.15.7.1 Assessment

If the Member requests a copy of the assessment, those documents must be provided to the Member in his/her primary/preferred language. Documentation in the assessment also must be made in English; both versions must be maintained in the Member’s record. This will verify that if any persons, who must review the Member’s record for purposes such as coordination of care, emergency services, and auditing, have an English version available.

3.15.7.2 Individual Service Plan (ISP) and Inpatient Treatment and Discharge Plan (ITDP)

The State Individual Service Plan (ISP) is intended to fulfill several functions, which include identification of necessary behavioral health services (as evaluated during the assessment and through participation from the person and his/her team), documentation of the person’s agreement or disagreement with the plan, and for Persons in the Program for Serious Mental
Illness, Notice of Decision and Right to Appeal (see Section 15.3 — Notice and Appeal Requirements (SMI and GMH/SA Non-Title XIX)) if the person does not agree with the plan.

If the Member’s primary/preferred language is other than English and any of the service plans have been completed in English, the provider must ensure the service plans are translated into the Member’s primary/preferred language for his/her signature. Providers must also maintain documentation of the ISP in both the preferred/primary language as well as in English. Service plans specifically incorporate a person’s rights to disagree with services identified on the plan. If the plan is not in the person’s preferred language, the person has not been appropriately informed of services he/she will be provided and afforded the opportunity to exercise his/her rights when there is a disagreement.

These requirements apply also to the ITDP (Inpatient Treatment and Discharge Plan), in accordance with the 9 AAC 21, Article 3.

### 3.15.8 Cultural Competency Reporting and Accountability

#### 3.15.8.1 Reporting and Accountability Measures

Reporting and accountability measures are intended to track, monitor, and verify access to quality and effective care. Equity in the access, delivery, and utilization of services is accomplished by Cenpatico IC and providers:

- Conducting annually and ongoing strategic planning in Cultural Competency with the inclusion of national level priorities, contractual requirements, stakeholder input, community involvement and initiative development in areas, including but not limited to: Continuing Education, Training, Community Involvement, Health Integration, Outreach, Prevention, Data Analysis/Reporting, Health Literacy, and Policies/Procedures Development;
- Capturing and reporting on language assistance which includes: linguistic needs (primary language, preferred language, language spoken at home, alternative language); interpretation (which includes submitting the appropriate codes with each service provided either by an interpreter or by certified bilingual staff in a language other than English); written translation; and maintaining documentation on how to access qualified/licensed interpreters and translators; and
- Assessing and developing reports quarterly and annually within the areas of cultural competency and workforce development to review the initiatives, activities, and requirements impacting diverse communities, geographical services areas (GSAs), and the individuals accessing and receiving services.
  - Continuous and ongoing reporting provides insight to strengths, gaps, and needs within communities served by Cenpatico IC and Cenpatico IC providers with a goal of health and wellness for all.

#### 3.15.8.2 Cultural Competency Plan

On an annual basis, Cenpatico IC will develop and implement a written Cultural Competency Plan.
Cenpatico IC providers must complete, implement and maintain a Cultural Competency Plan to monitor the quality and effectiveness of covered services and to ensure the delivery of covered services are culturally competent in accordance with the requirements of this Provider Manual. The provider Cultural Competency Plan must meet the following requirements:

- Be based on the Federal CLAS Standards and address language, ethnicity, gender, sexual orientation, religion and the culture of poverty. (See Provider Manual Form 3.15.8.2 Cultural Competency Plan)
- Be an outcome-based format including expected results, measurable outcomes and outputs with a focus on the priorities and initiatives identified in Cenpatico IC’s CCP; 
- Include an effectiveness assessment of current services provided by the agency in the GSA that focuses on culturally competent care delivered in the network, as part of outreach services and other programs, which includes an assessment of timely access, hours of operation and twenty-four (24) hour, seven (7) days a week availability for all provider and staff types delivering covered services (42 CFR 438.206(c)); 
- Be data-driven and the data sources utilized to determine goals and objectives; 
- Include strategies to deliver services that are culturally competent and linguistically appropriate including methods for evaluating the cultural diversity of Members and to assess needs and priorities in order to continually improve provision of culturally competent care; and 
- Include methods to deliver linguistic and disability-related assistance by qualified personnel.

– See Section 16 – Deliverable Requirements- for submission requirements and due dates.

Providers must monitor the Cultural Competency Plan at least quarterly, update it annually. The annual update must include an evaluation of the prior year’s efforts. Providers must seek out and obtain feedback from peer support and family support staff in completing the annual update. The update must include the provider’s level of success in matching the cultural needs of each community and future plans to address the outstanding cultural needs of the communities served.

3.15.8.3 Language Proficiency Inventory

Cenpatico IC providers must maintain an inventory identifying staff that speak a language other than English, (including ASL) - identifying if employees have been tested for language proficiency and their skill level with speaking, interpretation, and/or translation. Inventory should include testing organization and testing date. The interpretation/translation organization(s) and or language vendor(s) used by the agency must also be maintained.

Health Homes and Specialty Behavioral Health Providers are required to submit the Language Proficiency Inventory (RF-1020).

See Section 16 – Deliverable Requirements - for submission requirements and due dates.
3.15.9 Laws Addressing Discrimination and Diversity

Cenpatico IC and provider agencies must abide by the following referenced federal and state applicable rules, regulations and guidance documents:

- Title VI of the Civil Rights Act prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance;
- Department of Health and Human Services - Guidance to Federal Financial Assistance Members Regarding Title VI Prohibition Against National Origin Discrimination afecting Limited English Proficient Persons;
- Title VII of the Civil Rights Act of 1964 prohibits employment discrimination based on race, color, religion, sex, or national origin by any employer with 15 or more employees. (The Civil Rights Act of 1991 reverses in whole or in part several Supreme Court decisions interpreting Title VII, strengthening and improving the law and providing for damages in cases of intentional employment discrimination);
- President’s Executive Order 13166 improves access to services for persons with Limited English Proficiency. The Executive Order requires each Federal agency to examine the services it provides and develop and implement a system by which persons with Limited English Proficiency can meaningfully access those services consistent with, and without unduly burdening, the fundamental mission of the agency;
- State Executive Order 99-4 and President’s Executive Order 11246 mandates that all persons regardless of race, color, sex, age, national origin or political affiliation shall have equal access to employment opportunities;
- The Age Discrimination in Employment Act (ADEA) prohibits employment discrimination against employees and job applicants 40 years of age or older. The ADEA applies to employers with 20 or more employees, including state and local governments. The Older Workers Benefit Protection Act (Pub. L. 101-433) amends the ADEA to prohibit employers from denying benefits to older employees;
- The Equal Pay Act (EPA) and A.R.S. § 23-341 prohibit sex-based wage discrimination between men and women in the same establishment who are performing under similar working conditions;
- Section 503 of the Rehabilitation Act prohibits discrimination in the employment or advancement of qualified persons because of physical or mental disability for employers with federal contracts or subcontracts that exceed $10,000. All covered contractors and subcontractors must also include a specific equal opportunity clause in each of their nonexempt contracts and subcontracts;
- Section 504 of the Rehabilitation Act prohibits discrimination on the basis of disability in delivering contract services; and
- The Americans with Disabilities Act prohibits discrimination against persons who have a disability. Providers must deliver services so that they are readily accessible to persons with a disability. Cenpatico IC and its providers who employ less than fifteen persons and who cannot comply with the accessibility requirements without making significant changes to existing facilities may refer the person with a disability to other providers where the services are accessible. Cenpatico IC or its provider who employs fifteen or more persons must designate at least one person to
coordinate its efforts to comply with federal regulations that govern anti-discrimination laws.

- Section 1557 of the Patient Protection and Affordable Care Act is the nondiscrimination provision of the Affordable Care Act (ACA). The law prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Section 1557 is the first federal civil rights law to prohibit discrimination on the basis of sex, including gender identity and sexual stereotypes. Section 1557 builds on long-standing and familiar Federal civil rights laws: Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975. Section 1557 extends nondiscrimination protections to individuals participating in any health program or activity any part of which receive federal funding.

3.16 Business Continuity/Recovery Plan and Emergency Response/ Pandemic Plan / Heat Plan Requirements

3.16.1 To Whom This Section Applies
Health Home Providers and Specialty Behavioral Health Providers must develop, maintain and annually test a Business Continuity/Disaster Recovery and Emergency Response Plan to manage unexpected events that may negatively and significantly impact its ability to deliver services to Members.

3.16.2 Disaster Recovery
Health Home Providers and Specialty Behavioral Health Providers must contract with an independent disaster recovery certification company to perform annual audits of the provider’s disaster recovery plan and processes, including redundancy, data storage and data backup, and obtain annual certification that the provider’s processes meet industry standards and State and federal regulations for the storage and retrieval of Member information. This certification must be submitted to Cenpatico on an annual basis.

Provider must develop, maintain, and annually test a Business Continuity/Recovery and Emergency Response Plan to manage unexpected events that may negatively and significantly impact its ability to deliver services to Members. Provider must develop a process to train key personnel and organizational staff to be familiar with and implement the Business Continuity/Recovery Plan and Emergency Response when necessary.

The Business Continuity and Emergency Response Plan must specify, at a minimum, strategies to address the following:

1) Indicate that the Plan is reviewed annually and updated
2) The Plan contains staff training requirements including how often training is conducted.
3) The Plan is specific to the Contractor’s operations in Arizona and references local resources.
4) The Plan contains planning and training for:
   a. Electronic/telephonic failure at the Contractor’s main place of business and any satellite offices in or out of State.
   b. Complete loss of use of the main site and any satellite offices out of State.
   c. Loss of primary computer system/records.
   d. Extreme weather conditions
   e. How the Contractor will communicate with Cenpatico IC during a business disruption.
   f. Directing the Contractor staff to contact AHCCCS Security at 602-417-4888 in the event of a disruption outside of normal business hours.
   g. Provisions for periodic testing, at least annually. Results of the tests are documented.

5) The Plan must address key customer priorities and key factors that could cause disruption, including access to the following key customer priorities:
   a. Member Services
   b. Scheduling
   c. Clinic and/or Physician Visits
   d. Transportation Services
   e. Prior Authorization
   f. Outpatient or Inpatient Procedures
   g. Utilization Review/ Concurrent Review
   h. Provider Services/Claims/ Provider Payments
   i. Grievance/Appeals and Quality of Care Concerns
   j. Any other critical services identified by the Contractor

6) The Plan addresses emergency plan provisions for facilities and hospitals in the event members are displaced in an emergency.

7) The Plan includes timelines for resumption of services including percentages of recovery.

8) The Contractor has designated a Business Continuity Planning Coordinator and includes contact information in the Plan.

Health Home Providers and Specialty Behavioral Health Providers must submit a Business Continuity and Recovery Plan Summary that is no more than 5 pages in length and contains all of the information enumerated in sections 1 through 8 of this policy.

(See the adjacent link for details; refer to ACOM Policy 104, Attachment A for additional template. http://www.azahcccs.gov/shared/ACOM/Chapter100.aspx

3.16.4 Pandemic

In the event of a pandemic, as declared the Governor of Arizona, U.S. Government or the World Health Organization, which makes performance of any term outlined in the AHCCCS Contract with Cenpatico IC impossible or impracticable, the State shall have the following rights:
• After the official declaration of a pandemic, the State or Cenpatico IC may temporarily void the provider agreement in whole or specific sections, if the provider cannot perform to the standards agreed upon in the initial terms.

• The State and Cenpatico IC shall not incur any liability if a pandemic is declared and emergency procurements are authorized by the Director as per A.R.S. 41-2537 of the Arizona Procurement Code.

• Once the pandemic is officially declared over and/or the provider can demonstrate the ability to perform, the State or Cenpatico IC, at their sole discretion, may reinstate the temporarily voided provider agreement.

• The State or Cenpatico IC, at any time, may request to see a copy of the written plan from the provider. The provider shall produce the written plan within seventy-two (72) hours of the request.

3.16.5 Emergency Preparedness

Under the direction of Cenpatico IC, the State, or a Cenpatico IC designee, the provider must participate in health emergency response planning, preparation, and deployment in case of a Presidential, State, or locally-declared disaster. The preparedness action must include:

• Participation in development of a comprehensive disaster response plan, including specific measures for:
  o Member management and transportation,
  o Plans for access to medications for displaced Members, and
  o Provision of critical incident interventions for Members exposed to a disaster.

• Collaboration with local hospitals, emergency rooms, fire, and police to provide emergency mental health supports for first responders.

• Coordination with other providers to assist in a disaster in Maricopa County or in the event of a disaster in another region of the State.

3.16.6 Heat Plan Requirements

Health Homes must have a Heat Plan in place to mitigate the effects of extreme heat on members. This plan must be reviewed and updated on an annual basis. The Heat Plan must include, at a minimum, 1) a process to ensure medically-necessary routine transportation availability for individuals who are at increased risk, and unable to access public transportation, 2) a process to ensure distribution of information on extreme heat protection to Members, and 3) a method to identify and outreach Members particularly at risk due to living conditions.

3.17 Health Home Requirements

Cenpatico IC has several requirements for contracted Health Home providers. These include recovery support, access to care, outreach and engagement, enrollment, staffing, and system partner coordination of care.
3.17.1 Screening and Serving Members with High Needs

Adults with High Needs will be identified by Cenpatico IC utilizing the Integrated and Non-Integrated Risk Rosters. The risk rosters will be uploaded to the provider FTP sites monthly. Providers must review the uploaded documents to determine if any members have been added or removed to the rosters.

All children must be screened for High Needs at the time of the initial comprehensive assessment and every 6 months thereafter using the Child and Adolescent Service Intensity Instrument (CASII) for children ages 6-17. Providers must use PM Form 3.17.3, Birth through Five High Needs Screening Tool to assess for High Needs for children Birth through 5.

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

Providers must develop and implement service plans for Members with High Needs that include strategies to address a crisis and deliver all appropriate services to help the Member remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and the criminal justice system.

3.17.1.1 Declination of Intensive Services

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

3.17.1.2 Dedicated Health Care Coordinators

Health Homes providing services to children are responsible for ensuring that the ratio of DHCC’s to Children with High Needs does not exceed 1:20. A ratio of 1:15 is preferred.

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

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

3.17.1.3 Requirements for Health Homes in Meeting the Needs of High Needs Members

Health Homes are expected to:

- Provide 24/7/365 services as clinically appropriate when planned in advance.
• Maintain low Dedicated Health Care Coordinator to member ratios. The AHCCCS “Meet Me Where I Am Initiative” (MMWIA) requires Health Homes that serve children with High Needs to ensure that the ratio of DHCC’s to Children with High Needs does not exceed 1:20. A ratio of 1:15 is preferred.
• Provide Intensive Community Based Support that improves member outcomes and reduces the number of members in Out Of Home placements, reduces Emergency Department visits, and reduces Inpatient stays by providing appropriate support in the member’s community and home.
• Maintain an adequate number of Direct Support Staff to meet the needs of adult High Needs members.

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

Health Homes serving this population should reference the PMA 3.17.3 Cenpatico Transition to Adulthood Guidance Document to ensure appropriate Member engagement and service provision.

3.17.1.5 Additional Health Home Requirements
Additional requirements providers must follow are:
• Attend all scheduled CEO meetings in person or send a decision-maker to attend in person
• Supply email addresses for all staff providing care to Members and verify all staff members have access to computers to retrieve emails.
• Ensuring all services and documentation meet data validation audit requirements, and ensure they have no more than a 10% error rate on data validation audits or claims medical record reviews.

3.17.2 Health Home Access to Care Requirements
Providers must adhere to the following access to care requirements:

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

If a screening yields positive results, members must receive a more comprehensive assessment to include substance use history, use and trauma, in accordance with Section 3.5 – Assessments, AHCCCS Clinical Guidance Document, Comprehensive Assessment and Treatment of Adults with Substance Use Disorders and AHCCCS Clinical Guidance Document, Comprehensive Assessment and Treatment for Substance Use Disorders in Children and Adolescents.

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

3.17.2.2 Referrals

• Establish written criteria and procedures for accepting and acting upon referrals, including emergency referrals. The written criteria must include the definition of a referral for health services as described by the State.

• When a Member requests to access Covered Services, there shall be no wrong door. Cenpatico and Provider are required to respond when a Member requests Covered Services and follow through to ensure the Member receives appropriate services. Provider is required to assist any Member with obtaining Covered Services for which the Member is eligible, from the Participating Health Care Providers best suited to deliver effective services to Member.

• Health Home providers must accept all referrals for intakes and services for populations identified provider’s contract with Cenpatico IC, unless Cenpatico IC grants a written waiver or suspension of this requirement.

• Accept all referrals regardless of diagnosis, level of functioning, age, Member's status in family or level of service needs.

• Providers serving non-Title XIX/XXI must accept and respond to emergency referrals twenty-four (24) hours a day, seven (7) days a week.

• Make appropriate referrals to and schedule appointments with In-Network Specialty Providers to meet Members' treatment needs and effectively coordinate care.

• Have a process to verify all Network options have been explored and exhausted before completing a request for out-of-Network services. Provider must notify Cenpatico IC of all Out-of-Network requests.

• Provider understands that all community residents, including visitors are eligible to receive crisis services and provider must assist anyone experiencing a crisis in obtaining crisis services through a Cenpatico IC contracted crisis provider by calling the Crisis Call Center.
3.17.2.3 **Outpatient Services**

Providers must offer outpatient services identified in the provider’s agreement with Cenpatico IC, including intakes, comprehensive assessments, service planning, Coordination of Care and outpatient services to all populations specified in the provider’s agreement with Cenpatico IC.

3.17.2.4 **Transportation**

Providers must offer transportation when a Title XIX/XXI Member or non-Title XIX/XXI adult with SMI needs medically necessary transportation for services including pharmacy. Providers must contract with at least one taxi cab or transportation service or be able to provide/arrange twenty-four (24) hour, seven (7) days per week, 365 days per year transportation services within their agency for Members. Providers must complete and submit to AHCCCS an AHCCCS Group Billing Packet located at [https://www.azahcccs.gov/PlansProviders/NewProviders/packet.html](https://www.azahcccs.gov/PlansProviders/NewProviders/packet.html) in order to bill for subcontracted transportation services. The subcontracted transportation provider is required to be credentialed with Cenpatico. When billing for the transportation services, the rendering provider field must include the NPI of the subcontracted transportation provider.

3.17.2.5 **Answering Service**

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

3.17.3 **Health Home Outreach, Engagement, Re-Engagement and Closure Requirements**

In addition to the requirements of [Section 3.4 – Outreach, Engagement, Re-Engagement, and Ending an Episode of Care and Disenrollment](#), Providers must cooperate with the State and Cenpatico IC outreach and marketing initiatives, and conduct outreach, engagement, re-engagement and closure as described in this Provider Manual. Providers funded to employ dedicated outreach staff must work closely with all community system partners and residents, including incarcerated community members to educate them about services and help them get enrolled in Medicaid and/ or the Health Exchange. Providers must offer outreach and engagement services to persons who are homeless, involved in the criminal justice system, experiencing co-occurring mental health disorders and at risk populations. Providers must offer regular contact with Members residing in detention centers with a sentence of six months or less, and resume contact with Members at least thirty (30) days prior to release for sentences greater than six months. Upon request, providers must provide outreach and dissemination of information to the general public, other human service providers, county and state governments, school administrators and teachers and other interested parties regarding available services.

Providers will be notified daily when a member in an open episode of care (active) or a member not currently in an active status (inactive) has been booked into a detention center. For those members who are active, the provider must hold an emergency ART meeting within one (1) business day of notification of release. For those members who are inactive, the provider must
outreach the individual upon notification of booking and schedule an intake to be held within seven (7) days of release.

Providers must facilitate and document in the Member’s clinical record effective engagement, including obtaining and maintaining accurate support system names and contact information, up-to-date demographics with contact information, following up after missed appointments, and engaging peers and support systems to facilitate effective engagement.

In addition, providers must become a CMS Certified Application Counselor Organization and designate customer service, outreach and benefit specialists to be Certified Application Counselors and assist Non-Title XIX/XXI community Members get enrolled in the Health Exchange.

3.17.3.1 Data Driven Approach

Providers must collect, analyze, track and trend data to evaluate the effectiveness of outreach activities utilizing penetration rates and other quality management performance measures. Providers must develop and implement a data driven outreach policy and procedure plan to inform persons in a culturally and linguistically appropriate manner regarding the availability of services. In addition, providers must demonstrate performance of outreach activities to persons in high-risk groups including, at a minimum, the homeless, substance using pregnant women, and others identified as high risk.

3.17.3.2 Marketing Limitations

Providers must comply with various outreach and marketing limitations. Any outreach or incentive item given to its Members shall not exceed $50.00. Any marketing item given away by the provider shall not exceed $10.00. The total cost of all marketing and outreach/incentive items given to each Member, at each event, may not exceed $50.00 per Member. All marketing materials shall identify the provider as a Cenpatico IC, AHCCCS and the State provider.

In addition, all marketing materials produced by the provider that refer to the services defined in the agreement must specify that the services are funded through the provider agreement with Cenpatico IC. Provider is also required to list Cenpatico IC and the State as the funding source on all brochures, flyers, and other promotional materials that involve services funded by Cenpatico IC and the State. Provider must include the Cenpatico IC logo on these promotional documents.

3.17.4 Health Home Enrollment, Demographic, Connectivity, Software, Web and EHR Requirements

3.17.4.1 Enrollment and Demographics

Providers must meet all enrollment and demographic requirements as outlined by the State and Cenpatico IC, verifying the integrity and reliability of the data. At a minimum, providers must:

- Submit all enrollment (834) demographics electronically. Cenpatico IC shall have the right to reject any claims without a current enrollment and/or demographic on record.
- Submit an Open Episode of Care Demographic (Type 1) within Seven (7) calendar days after the completion of a clinical assessment. Complete an Update
Demographic (Type 2) within no more than 365 days of the assessment date submitted on the Type 1 Open Episode of Care Demographic and submit the Update Demographic within seven (7) calendar days of completion of the annual clinical assessment.

- Complete subsequent Type 2 Annual Update Demographics within no more than 365 days following the completion date of the prior year’s Type 2 Annual Updated Demographic assessment date and within seven (7) calendar days of completion of the annual clinical assessment or within seven (7) calendar days of becoming aware of a change in the Member’s status. Type 2 demographic submissions should be used for assessment date and value updates, as well as minor changes not related to, or interim to, the annual assessment update.

- Submit Closure Demographics (Type 4) within seven (7) calendar days after closing the Member’s episode of care at the agency, unless the Member is being transferred to another agency. If the Member is remaining in an episode of care and being transferred to another agency, a closure is not needed. The receiving agency must submit a Type 2 demographic upon their completed intake.

- Complete and submit the Enrollment (834) transaction for all non-Medicaid Members within two (2) calendar days of the completion of a clinical intake. Provider must submit a Closure (834) transaction within two (2) calendar days after closing a non-Medicaid Member’s episode of care at the agency, unless the Member is being transferred to another agency or otherwise remains eligible for services in a Cenpatico IC GSA.

- Verify all critical Member contact information is updated with each visit, including, change of address, phone number, emergency contacts, and support system contacts and submit an updated Demographic within two (2) calendar days of collecting the updated Member contact information.

- Have detailed Procedures which outline the process to effectively address the agency's processing of "dot (. ) bad" and "dot (. ) good" demographic and 834 enrollment response files. Provider must review, correct, and resubmit "dot (. ) bad" demographic and 834 enrollment records within three (3) business days of delivery of the files – or otherwise notify the Cenpatico IC Eligibility department as to the barrier related to not meeting this requirement.

### 3.17.4.2 EHR and HIE Requirements

Providers must meet various requirements regarding paper and electronic records. Providers must:

- Have a fully operational EHR; including, electronic signature, and remote access. In addition, allow the State and Cenpatico IC staff remote read-only access to the EHR for the purpose of conducting audits.

- Ensure all paper files are fully archived and the provider is no longer dependent on paper files to conduct or document treatment services.

- Ensure provider is EHR is certified to fully meet the Federal "Meaningful Use Requirements".

- Facilitate the effective, daily transmission of electronic data to Cenpatico IC’s Community Health Record (Passport) through a dedicated facsimile server that
meets the specification required by Cenpatico IC. Provider must transmit to Cenpatico IC through the facsimile server completed and/or updated Comprehensive Assessments, Crisis and WRAP Plans, Annual Assessment Updates, Individualized Service Plans and Child and Family Team/Adult Recovery Team notes within twenty-four (24) hours of the date and time of the appointment/event.

- Explain to Members, families and staff the "coordination of care" and "emergency services" benefits of enrolling in Passport, the Cenpatico IC Community Health Record, and encourage participation in Passport.

- Establish and maintain membership with, and bi-directional data connectivity to, the state Health Information Exchange, “The Network/AZHeC”.

3.17.4.3 Software

Providers must meet various requirements regarding equipment and licenses. Providers must:

- Ensure each outpatient clinic location licensed by the ADHS Office of Licensing has access to video equipment to facilitate treatment and treatment team meetings for persons with health, or disability limitations and special circumstances that prevent them from traveling to an office. Provider must maintain availability of telemedicine and video equipment to meet this requirement.

- Ensure Members have access to specialty services and consultation services through telemedicine, portable telemedicine, or video equipment and not be required to travel more than thirty miles to receive specialty services (except when required by state or federal law). In addition, utilize clinical expertise through consultants when appropriate to provide treatment services in the community, prevent out-of-home placements and allow Members to remain in their communities.

- Ensure that each outpatient clinic location licensed by the ADHS Office of Licensing is equipped with at least one (1) fully functional Polycom Speaker Phone system with (2) two microphones to facilitate effective communication during treatment team meetings to allow access to system partners and family members who desire to attend treatment team meetings telephonically.

3.17.4.4 Transfers of Members

Providers must follow protocols outlined in this Provider Manual for the transfer of eligible persons from one contracted provider to another. The transferring provider may not internally close the file until the receiving provider has accepted the transfer through the Cenpatico IC Provider Portal. The referring provider must send copies of all pertinent clinical records to the receiving provider within two (2) work days. Providers must track the transfer of enrolled Members to other Cenpatico IC Intake agencies through the Cenpatico IC Provider Portal and continue providing coordination and treatment services until the receiving agency has fully accepted the transfer as indicated in the Provider Portal.

3.17.4.5 Access to Web and Website

Providers must make available to the Benefits Coordinator and Members at least one computer with internet access at each outpatient facility licensed by the ADHS Office of Licensing. The computers must be available during hours of operation to conduct eligibility screening activities through Health-e Arizona. Providers must make available easy access of information by
Members, family members, providers, system partners, and the general public in compliance with the American with Disabilities Act ("ADA").

In addition, providers must develop and maintain a website and include the following information on its website that is easy to find, understand and navigate:

- Identify Cenpatico IC as the RBHA/Health Plan for your service area and provide a link to the Cenpatico IC website.
- Toll-free customer service telephone number and a Telecommunications Device for the Deaf ("TDD") telephone number.
- General customer service information, including information on community resources, how to file a grievance or grievance, and interpreter services.
- Crisis phone numbers and how to access the crisis services.
- Identify site locations and services provided to Members.

3.17.4.6 Management Information System (MIS) and Performance Criteria

Providers must meet the following MIS and performance criteria:

- Use a Cenpatico IC approved MIS to collect, analyze, integrate, and report data.
- Utilize electronic transactions in conformance with requirements.
- Prior to implementation, notify Cenpatico IC of planned MIS changes, the estimated impact upon the interface process, and test with Cenpatico IC, if the provider plans to make any modifications that may affect any of the data interfaces. Provider shall not implement the proposed change until Cenpatico IC evaluates and approves such.
- Verify that changing or making upgrades to or implementing new systems that are or are related to the core MIS, claims processing, or any other business component, will be accompanied by a plan which includes a timeline, milestones, and adequate testing before implementation date, the Provider must provide the system change plan to Cenpatico IC for review and comment.
- Notify Cenpatico IC in advance of the exact implementation date of all changes and cooperate with Cenpatico IC if Cenpatico IC elects to monitor MIS changes for operability and sustainability.

3.17.4.7 Compliance with HIPAA

Providers must comply with all federal HIPAA requirements, verifying the safety of all Member information.

3.17.4.8 Notice of Changes

Cenpatico IC shall provide provider with at least ninety (90) days' notice before implementing a change to its MIS system unless Cenpatico IC determines that the system change must be implemented sooner, and in that instance, provide provider with as much notice as possible under the circumstances.
3.17.5 Health Home Staffing Requirements

Health Homes are required to have organizational, management, and administrative systems capable of meeting all contract requirements with clearly defined lines of responsibility, authority, communication, and coordination within and between departments, units, or functional areas of operation. Health Home’s resource allocation must be adequate to achieve outcomes in all functional areas within the organization. Adequacy will be evaluated based on outcomes and compliance with contract requirements, including the requirement to provide culturally competent services. Provider is required to have sufficient staff and utilize appropriate resources to comply with contract requirements. Provider must require all staff, whether employed or under contract, to have the training, education, experience, orientation, and credentialing, as applicable, to perform assigned job duties.

3.17.5.1 Benefits Coordinator

Providers must employ adequate staff in each County trained in the use of Health-e Arizona, knowledgeable about entitlements and available to help Members obtain benefits. The benefits coordinator must be certified by Cenpatico IC and must oversee eligibility screenings and track applications to assist Members in maximizing their access to entitlements.

3.17.5.2 Certified Health Care Coordinators

Providers must maintain a sufficient number of Certified Health Care Coordinators who are able to coordinate services for Members. Providers must verify the Professional job responsibilities associated with the role of Certified Health Care Coordinator are clearly defined and include:

- A clear understanding of how to help facilitate an effective treatment team meeting.
- The empowerment of Members to direct their own care.
- Monitoring of treatment to verify services are identified and performed in accordance to the wishes of Members and clinical Evidenced Based Practices.
- Verify the availability of direct supports including support and rehabilitation services to optimize opportunities for recovery and increased resiliency.
- Verify appropriate coordination among providers of care and Stakeholders.
- Verify adult persons are encouraged to obtain employment, engage in meaningful activities and demonstrate altruism.
- Verify children have the resources and services to progress to be successful adults.

3.17.5.3 Behavioral Health Professionals

Providers must assign credentialed Behavioral Health Professionals to provide clinical oversight in the Member’s care and monitor progress towards meeting goals in the Service Plan coordinate and communicate with other systems where clinical knowledge of the Member’s care is important (42 CFR 438 208(b) (1)); and verify that all services provided to the Member, including Transportation meet medical necessity.

Providers must verify Behavioral Health Medical Professionals, Behavioral Health Professionals, Behavioral Health Technicians and Behavioral Health paraprofessionals meet all of the
requirements as identified by the ADHS Division of Licensing. Verify all persons hired into these roles meet the requirements as defined by state regulation.

Providers must employ an adequate number of Cenpatico IC-Credentialed, Independently Licensed Behavioral Health Professionals to verify all Members are seen by a Cenpatico IC Credentialed, Independently Licensed Professional within 7 and 23 days following the opening of a Type 1 Demographic.

3.17.5.4 **Child and Family Team & Adult Recovery Team Facilitators**

Providers must verify an adequate number of staff are trained and certified as CFT Facilitators, and/or ART Facilitators.

3.17.5.5 **Administrator on Call**

Providers must maintain an administrator–on-call to address any after-hours, weekend or holiday concerns or issues related to coordination of care or the health and/or safety of Members. The Administrator-on-call must respond to all requests, including requests from Cenpatico IC's contracted Crisis Line Provider, within one (1) hour of being called.

3.17.5.6 **Independently Licensed Staff**

Provider must verify the availability of Cenpatico IC credentialed independently licensed staff to determine medical necessity, provide adequate oversight and supervision of service delivery.

3.17.5.7 **Clinical Supervisors**

Providers must verify all Clinical Supervisors meet the requirements of the appropriate Arizona Licensing Board to conduct Clinical Supervision.

3.17.5.8 **Medical Director**

Providers must employ a Medical Director to oversee prescribing practices at the provider’s facilities, process COT documents, provide clinical consultation and serve as the collaborating physician for Nurse Practitioners in the agency. Medical Directors, or their designee, need to be available after hours for revocations of outpatient court ordered treatment under Title 36. A.R.S. § 36-540. Providers must verify the Medical Director Attends the Pharmacy and Therapeutic Committee meetings by telephone and regular Medical Director Meetings with Cenpatico IC.

3.17.5.9 **COT/COE Coordinator**

Providers must designate a staff person to serve as COT/COE Coordinator and Liaison for Title 36 and Court Ordered services.

3.17.5.10 **Information Liaison of the Day/Point of Contact**

Providers must designate one person to serve as the Information Liaison of the Day (point-of-contact) for system partners, foster families seeking services, and specialty providers to call to obtain information about services, referrals, updated Comprehensive Assessments, Individualized Service Plans and monthly reports. They must provide the name and contact number for the Information Liaison of the Day monthly to Cenpatico IC as part of the key
contact list. The phone number for the Information Liaison of the Day must be live answered. All calls to the Information Liaison of the Day must be addressed and resolved within one (1) business hour of the call. Callers must be warm line transferred to the Information Liaison of the Day and callers are not to be told to call another number.

3.17.5.11 Peer Support

Health Homes are required to educate members about the role of Peer Support / Recovery Support Specialists and are required to make Peer Support / Recovery Support Specialists available to all members receiving services and to ensure members are introduced to Peer and Family Run Organizations.

In addition, providers must demonstrate that Peer Support Specialists and Family Support Specialists meet minimum training requirements. Providers must empower Members and family members to take "personal ownership" of their Individualized Service Plans, Crisis and WRAP Plans, treatment services, recovery strategies, and advocate for themselves. For further guidance regarding the optimal use of Peer Support services, please see the Cenpatico PMA 3.17.5 Peer Support Guidance Document.

3.17.5.12 Parent/Family Support Partners

Health Homes are required to educate members about the role of Parent/Family Support Partners and are required to make Parent/Family Support Partners available to all families of members receiving services. Adult members' families are defined as “families of choice”, determined by the adult member. For further guidance regarding the optimal use of Parent/Family Support Partner services, please see the PMA 3.17.4 Cenpatico Family Support Guidance Document.

3.17.5.13 Substance Use Treatment Staff

Providers serving adults and youth with substance use disorders must train 100% of all Assessors, and Behavioral Health Professionals in the Best Practice of ASAM through a training program approved by Cenpatico IC. In addition, providers providing substance use treatment services must verify that services are delivered by staff competent to assess and treat substance use disorders in individuals and families. Providers serving adults must employ or make available an adequate number of registered/waved Buprenorphine Prescribers to meet the needs of Members with substance use disorders under the Provider’s care.

3.17.5.14 Nursing Staff

Providers must employ or make available adequate nursing staff to administer injectable psychotropic medications at all Outpatient Treatment Centers.

3.17.5.15 Ombudsman Program

Providers must establish a centralized Ombudsperson program and employ adequate staff to address all grievances received by the provider. The Ombudsperson shall seek to resolve all Member grievances and system partner grievances and advocate as necessary for resolution of the grievances.
3.17.5.16 Psychiatrists

Providers must employ a sufficient number of psychiatrists to meet member access to care standards. Providers must monitor, track and be able to report the number of FTE psychiatrists as an ad hoc deliverable with the specified Cenpatico timeframe.

3.17.5.17 Telemedicine

Providers delivering telemedicine services must ensure adequately and appropriately trained staff are available prior to the provision of the telemedicine service to conduct any required vitals.

Providers delivering telemedicine services must adhere to confidentiality expectations of the telehealth session by ensuring no other person, other than those agreed to by the member receiving services, will observe or monitor the service either electronically or from “off camera. For more information regarding confidentiality during a telemedicine session. Please see AHCCCS Medical Policy Manual (AMPM) Policy 320-1 and 550 for more information regarding confidentiality safeguards.

The provider must however, offer the member the option of having a telepresenter present during the telehealth session. A telepresenter is defined as a designated individual who is familiar with the member’s case and has been asked to present the member’s case at the time of telehealth service delivery if the member’s originating site provider is not present. The telepresenter must be familiar, but not necessarily a medical expert with the member’s medical condition, in order to present the case accurately. The telepresenter also is required to assist the member after the telehealth session in scheduling any required follow-up appointments and/or getting prescriptions filled.

In addition, providers must verify that BHMPs and BHPs providing eighteen or more hours a week of telemedicine services on behalf of the provider must host semi-annual one-day “meet and greet” events “in person” in the communities where the telemedicine services are provided to give Members and system partners the opportunity to meet telemedicine BHMPs and BHPs in person. Exceptions to this requirement must be approved in writing by Cenpatico IC.

3.17.5.18 Onboarding and Training

Providers must employ sufficient number of trainers to develop an effective employee onboarding and training program and conduct required AHCCCS and Cenpatico IC trainings. The trainer must successfully complete all applicable Cenpatico IC train-the-trainer training programs.

3.17.5.19 Dedicated Population Health Management Administrator

Provider must employ a Dedicated Population Health Management Administrator, if funded by Cenpatico IC in the provider’s contract with Cenpatico IC. The Population Health Management Administrator must participate in regular technical assistance calls. The Provider must develop and maintain a Population Health Management System; access actionable data provided by Cenpatico IC through the Cenpatico IC web-based FTP site and Provider Portal; and use the data to improve service delivery, the quality of services, and Member outcomes.
In addition to the requirements of Section 3.14 – Discharge Planning, the Health Home discharge planner/hospital liaison is also responsible for the following:

- Health Home Discharge Planner/hospital liaison serves as the lead for coordination of care for members for the duration of hospitalization upon notification of admission.
- Health Home discharge planner/hospital liaison is responsible to notify the Health Care Coordinator of member’s inpatient status.
- Health Home discharge planner/hospital liaison is responsible to send the clinical packet of information to inpatient facility. Documents include:
  - Most recent psychiatric evaluation,
  - History & Physical from Primary Care Physician, if available,
  - Medications list from Behavioral Health Medical Provider & PCP,
  - Most recent BHMP note,
  - List of current diagnoses,
  - Current Individualized Service Plan & Crisis Plan,
  - Allergies or past poor reactions to medications,
  - Anticipated target level of functioning upon discharge from hospital services,
  - Tentative Discharge Plan
- Health Home discharge planner/hospital liaison is required to make contact with members within 48 hours of admission date/time. This can be via phone if admission occurs out of county or state, preferred method is a face to face visit. Contact between the Health Home discharge planner/hospital liaison and the member is required to occur every 48 hours after initial contact.
- Health Home discharge planner/hospital liaison is required to document discharge planning efforts in the Member’s medical record.
- Health Home discharge planner/hospital liaison is required to connect with the Cenpatico IC Discharge Integrated Care Managers to provide an update on the initial discharge plan at 72 hours from date and time of admission, and to communicate updated discharge plans prior to discharge. The Health Home Discharge Planner/hospital liaison is required to communicate any barriers to discharge to the Cenpatico IC Discharge Integrated Care Managers. If the Health Home discharge planner/hospital liaison encounters barriers related to the discharge plan and resources, the Cenpatico IC Discharge Integrated Care Managers will outreach the Utilization Management Reviewer and/or the Integrated Care Managers/Care Coordinator for assistance.
- Health Home discharge planner/hospital liaison schedules an Adult Recovery Team Meeting (ART) /Child & Family Team (CFT) meeting to take place at the inpatient facility, for every behavioral health (BH) admission and as clinically needed for physical health (PH) admissions. Attendees required to attend for both PH and BH ART/CFT Meetings, should include the following at a minimum:
  - Representation from inpatient facility such as hospital social worker/discharge planner/case manager (with updates on member status, medication changes, doctor recommendations, estimated discharge date),
• Health Home Discharge Planner/Hospital Liaison, Health Home Health Care Coordinator, & Member, (Guardian if under 18, POA, Public Fiduciary or Title 14.)

• The Health Home Discharge Planner/hospital liaison facilitates ART/CFT. Other attendees may include therapist, peer support, member’s natural support, and inpatient facility unit charge nurse.

• Health Home discharge planner/hospital liaison is required to facilitate scheduling a conversation between the Health Home BHMP and Attending Psychiatrist, PCP and attending physician, as requested or if the team is unable to agree on a safe disposition plan. Health Home medical director and Cenpatico IC medical director may take part in these discussions, as appropriate.

• Health Home discharge planner/hospital liaison is required to create a new ISP & Crisis Plan that provides additional resources and supports to decrease chance of member readmission in addition to updating the annual assessment.

• Health Home discharge planner/hospital liaison is required to work closely with Health Home UM Point of Contact and Cenpatico IC UM Reviewer regarding authorizations related to step down from the hospital to another level of care. Requests, which may come from the Health Home or the inpatient or out-of-home facility, are required to be submitted via Provider Portal or via fax according to instruction in Provider Manual Attachment Medical Management Forms Matrix 10.1.7. Any questions related to receipt of authorization requests, status updates, or general questions related to authorization procedure or required documents should go to Cenpatico IC UM PA #: 1-866-495-6738, option 4 for provider, option 7 for prior authorization.

  o Modification for type of authorization: It is the responsibility of the Health Home discharge planner/hospital liaison to submit the request for authorization for Behavioral Health placement, and other behavioral health needs on the ISP;

  o It is the responsibility of the Hospital SW/Discharge planner/Case Manager to submit authorization request for PH placement, DME, Home Health IC Inpatient UM reviewer to follow up with Cenpatico IC outpatient reviewer on status of authorizations related to discharge plan, such as placement, medical equipment, etc.

• Health Home discharge planner/hospital liaison must provide the member with the following appointments:

  o For Behavioral Health Admission: behavioral health medical Provider within 7 calendar days of member’s discharge from facility.

  o For Physical Health Admission: primary care physician within 7 calendar days of member’s discharge unless medically indicated to see provider sooner.

• Health Home discharge planner/hospital liaison is required to complete a verbal and written handoff to the ongoing RC upon member discharge, including review of the discharge summary from the hospital.

• Ongoing, the Health Care Coordinator is required to outreach the member to ensure follow through with aftercare plan including but not limited to placement, behavioral health services, pharmacy issues, outpatient appointments, and medical equipment.
• Ongoing, the Health Care Coordinator is required to outreach Cenpatico IC Integrated Care Managers/Care Coordinators with a status update on the member’s discharge and aftercare within 14 business days from date of discharge.

3.17.5.21  Health Home Requirements Related to the Discharge Planner/Hospital Liaison Role

• Discharge planning begins at the time of notification of admission to any inpatient facility for Physical and Behavioral Health needs.

• All Health Home discharge planners/hospital liaisons are required to have a dedicated phone number with voicemail and email address to communicate with the inpatient facility and Cenpatico IC Utilization Management Reviewer & Cenpatico IC Integrated Care Managers/Care Coordinator.

• Providers are required to review their dedicated discharge planner/hospital liaison ratios on a bi-annual basis at the start of each fiscal year, July 1st and again mid-year January 1st based on the total number of Open Episodes of Care and hire additional discharge planners/hospital liaisons as needed.

• The Health Home discharge planner/hospital liaison must be a Behavioral Health Technician or Behavioral Health Professional; complete the Discharge Planning Curriculum in Relias Learning Management System and pass post-test with at least 80% accuracy; and have at least two years of clinical experience. If the position is filled by a Behavioral Health Technician, all clinical forms related to the discharge planning process must be reviewed and signed by a Behavioral Health Professional at the Health Home. This includes but is not limited to: Individualized Service Plan, Crisis Plan- Reference PM Form 9.1.2, Wellness Recovery, Crisis Plan and Advance Directives for recommended elements in a Crisis and Safety Plan. Provider Manual Form 3.5.4, CFT Crisis Plan; and Updated Annual Assessment.

3.17.5.22  Health Home Dedicated Discharge Planner/Hospital Liaison Ratios

Health Homes are required to employ adequate staff to assist in Inpatient Notification and Discharge Planning needs in accordance with the below requirements:

• Health Homes with fewer than 750 members are required to identify a Designated Utilization Management (UM) staff point of contact for Inpatient Notification and Discharge Planning Needs that will act in a supporting capacity to the member’s Health Care Coordinator, who is responsible for the discharge planner/hospital liaison functions.

• Health Homes with between 750 members and 1499 members in treatment are required to employ a .25 FTE Discharge Planner/Hospital Liaison responsible for all discharge planning functions in addition to other duties within the Health Home for the remaining hours of each week.

• Health Homes with between 1500 members and 2999 members in treatment are required to employ a .5 FTE Discharge Planner/Hospital Liaison responsible for all discharge planning functions in addition to other duties within Health Home for remaining hours of each week.

• Health Homes with over 3000 members in treatment are required to employ a 1.0 plus FTE Discharge Planner/Hospital Liaison at 40 hours per week solely in this role with the responsible for all discharge planning functions. Health Homes with over 3000 members
in treatment are required to employ additional Discharge Planners/Hospital Liaisons in order to meet the 3000:1 Member to Dedicated Discharge Planner/Hospital Liaison ratio.

3.17.6 Health Home Requirements Related to Member and Family Involvement

Providers must verify that Members, their family members, and peers provide input and assist with decision making.

3.17.6.1 Member and Family Involvement

Providers must develop a process for Members to have regular and ongoing input to assist in decision making, program development, and enhancement of customer service at each provider site where Case Management services are delivered.

Providers must also collaborate with families, children and Members as partners, including Family-Run Organizations to facilitate child and family involvement in all aspects of the assessment process, service planning, service delivery, and the evaluation of services and the system.

Providers must verify that the following member-involvement activities are performed as part of the service delivery process:

- Ongoing engagement of the Member, family and others who are significant in meeting the needs of the Member, including active participation in decision-making process.
- Develop and implement service plans that address likely events in a Member's life including transitions to different stages of life, new relationships, new schools, new placements, and transitions to other service delivery systems.
- For Members referred for or identified as needing ongoing psychotropic medications for a health condition, verify the review of the initial assessment and treatment recommendations by a licensed medical practitioner with prescribing privileges.
- Members on psychotropic medications receive an updated annual psychiatric evaluation before the twelve (12) month anniversary of the date of last evaluation;
- Continuous evaluation of the effectiveness of treatment through the ongoing assessment of the Member and input from the Member and other relevant persons resulting in modification to the Treatment Plan, if necessary.
- Child and Family Team/Adult Recovery Team Meetings are scheduled within three (3) business days for all Members placed in Brief Intervention Programs or the Assessment Intervention Center.
- Transfers out-of-area, or to an ALTCS Contractor, as applicable.
- Development and implementation of transition discharge, and aftercare plans prior to discontinuation of services.
- Documentation of the above is maintained in the Member's health record by the point of contact.
- Assist Members locate and obtain permanent housing.
• Providers must accept all transfer following a 24 hour mobile crisis intervention and engage member into services within seven (7) days.

Additional provider requirements include:

• Demonstrate documentary evidence to show participation of at least one peer or family member in the interview process when hiring all direct service staff positions. Maintain interview sign-in sheets and produce the sign-in sheets to document compliance with this expectation.
• Verify that every T19 adult has a Peer Support Specialist available to be involved with the Member’s Adult Recovery Team.
• Verify that Members, families and youth have a voice in their individual treatment decisions and a voice in the operations of the delivery system.
• Obtain and document in the Member's record, Member and family input in treatment decisions.
• Providers providing substance use treatment must involve peer support staff in all aspects of the treatment process; including outreach, engagement, assessing readiness for treatment, maintaining sobriety and re-engagement.
• Assess the Member's perspective on treatment progress, in order to verify that the Member and family's perspectives are honored and they are effectively engaged in treatment planning and in the process of care.

3.17.6.2 Councils and Meetings

Health Homes are required to:
• Establish Member and Family Advisory Councils with representatives from each community served by Cenpatico IC, to provide direction, feedback and meaningful influence to the senior management team.
• Demonstrate documentary evidence (agenda, sign in sheets, minutes) to show that Member and Family Advisory Councils are being held at least monthly.
• Maintain a written Plan that includes a method to verify Members and families attend regular meetings with clinical leadership and are authorized to make recommendations.
• Recruit leaders from provider’s Member and Family Advisory Councils to regularly attend Cenpatico IC’s monthly regional Member and Family Advisory Councils
• Facilitate regular attendance of these provider Member and Family Advisory Council leaders to Cenpatico IC’s monthly regional Member and Family Advisory Councils.

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

• Health Homes that serve youth are required to have a Youth Advisory Council (YAC). Members no younger than 14 and no older than 17 are eligible to participate in the Health Home’s Youth Advisory Council. All youth that meet this criteria at the Health Home are encouraged to participate.
• Health Home Youth Advisory Council must meet at a minimum of one time per month, but may meet as often as determined by the Youth Advisory Council.
• Each Health Home must have a sufficient amount of facilitators to assure safety and growth of the Youth Advisory Council.

Providers are expected to assist members to attend provider and Cenpatico IC committee meetings, provider Member and Family Advisory Councils, and Cenpatico IC Member and Family Advisory Councils and Boards.

3.17.7 Health Home Requirements Related to System Partner Coordination of Care

3.17.7.1 Co-Location
Providers are encouraged to seek out and facilitate opportunities to co-locate with state agencies (The Department of Child Safety, Juvenile Probation, and Adult Probation), first responder settings (police, fire, emergency service) or other community settings that facilitate coordination of care between and among systems of care for Members receiving services through multiple systems.

3.17.7.2 Contract with ADES/RSA
Providers must have systems in place to ensure effective collaboration with system partners in accordance with Provider Manual Section 4.4, Coordination with Other Governmental Agencies, by communicating appropriate clinical information, to individuals or entities that are involved in the Member’s care including primary care providers, schools, child welfare, juvenile or adult probations, ADES/DDD, ADOC, ADJC, ADES/RSA, ADES/DCS and other service providers.

3.17.8 Health Home Requirements Related to Delivery of Care

3.17.8.1 Medically Necessary Covered Services
Providers must provide all Members with medically necessary covered services that are:

- In accordance with this Provider Manual;
- In accordance with the State System Principles in this Provider Manual;
- Identified in collaboration with the Member and other persons identified by the Member that (a) determine strengths, needs and goals of the Member and (b) identify the need for further evaluations necessary for Service Plan development;
- Identified with clinical involvement by a credentialed and trained clinician who is either a BHP or a BHT under the supervision of a BHP (42 CFR 438.208 (2) and (3)); and
- Strengths-based and include an emphasis on goals to increase Members quality of life and involvement in meaningful community activities, including goals related to living, learning, working, and social connectedness. Goals must reflect the Member’s hopes, dreams, and recovery vision.

3.17.8.2 Service Plans
Providers must verify Service Plans meet State, AHCCCS and Cenpatico IC requirements as outlined in PM Section 3.5, Assessment and Service Planning.
3.17.8.3 **Transportation**

Providers must provide medically-necessary transportation services to Members receiving services as appropriate to facilitate access to care, including evenings and weekends as necessary.

3.17.8.4 **Assessment**

Providers must assess all Members for the need for specialty services and ensure the provision and monitoring of the quality and reliability of specialty services. Providers must also ensure that Members are assessed for co-occurring mental health conditions and physical disability/disease and these co-occurring issues are addressed.

3.17.8.5 **Psychiatric Care for Persons with Developmental Disabilities**

Providers must verify that all children and adults with Developmental Disabilities who are on psychotropic medications or need to be screened for the need for psychotropic medications receive treatment services from a psychiatrist trained specifically to work with children or adults (appropriate to the Member’s age) and with persons with Developmental Disabilities.

3.17.8.6 **Support Funds**

Providers must make available and track Support Funds to facilitate quality care as outlined in Section 2.1.4 — Support Funds.

3.17.8.7 **Alternatives to Out-of-Home Care**

Providers must promote community-based alternatives to out-of-home care. In situations where a more restrictive level of care is temporarily necessary, providers must work with the Member to transition back into community-based care settings as rapidly as is clinically feasible and partner with community provider agencies to develop and offer services that are alternatives to more restrictive institutionally based care.

Providers must deliver services to the extent possible, in the Member’s home and community in order to minimize out-of-home placements and facilitate a rapid return to the home and community when a Member is in an out-of-home placement. Providers must notify Cenpatico IC’s UM department within 2 business days of placing a Cenpatico IC Member into an out-of-home placement.

3.17.8.8 **High Cost/Risk Members**

Providers must identify 20 high cost/high risk Members as directed by Cenpatico IC and develop goals for reducing the high utilization of services for these Members. Providers must develop effective interventions for addressing the appropriate and timely care for these individuals, including coordinating care with the Member’s service providers, Medicare Plan and AHCCCS Health Plan. Providers must employ appropriately trained staff to facilitate effective coordination of care. Providers must report measurable outcomes as a result of the application of interventions to reduce high utilization/costs and submit reports, including any ad hoc reports on Cenpatico IC approved templates as specified in the Deliverables.
3.17.9 Health Home Requirements Related to Medical Integration

Providers must provide the following services related to medical integration:

- Encourage all adult Members to receive a full physical examination with labs at least once per year, facilitate, and coordinate access to PCP’s to reach this goal and monitor Member compliance with this expectation.
- Develop and maintain a list of Members with chronic conditions including obesity, cardiac conditions, pulmonary conditions, and diabetes.
- Identify reasonable target dates for achieving medical integration goals and maintain acceptable progress toward reaching those goals.
- Collect and maintain vital signs for all adults including blood pressure, pulse and BMI.
- Collect and monitor lab results specific to any chronic condition including HbA1c, Cholesterol, LDL, HDL, and Triglyceride.
- Incorporate the eight dimensions of wellness into each Title XIX/XXI adult Member’s Comprehensive Assessment and Individualized Service Plan.
- Collaborate with Cenpatico IC to reduce the use of emergency rooms for non-life threatening behavioral or medical reasons.
- Collect and submit outcome data as outlined by Cenpatico IC.
- Become a primary care provider or work with community health clinics to coordinate behavioral health and physical health services and provide integrated behavioral health and physical health care to Members.
- Maintain wellness programs and wellness equipment to serve Members in each community in which the Provider has an outpatient clinic licensed by the ADHS Office of Licensing.
- Ensure Health Care Coordinators are skilled in promoting wellness and coordinating health and wellness Treatment Plans, and are able to accompany Members to PCP appointments, arrange for other health care as needed and monitor health outcomes.

3.17.10 Health Home Training and Information Dissemination Requirements

Providers must utilize the Cenpatico IC approved web-based "e-learning" training program to verify compliance with Cenpatico IC training requirements and the training requirements outlined in this Provider Manual. New employees have ninety (90) days from the date of hire to complete the assigned competencies to their user profiles. Existing employees have ninety (90) days from the date that new training curriculums have been assigned to their profiles to complete the training modules. All provider required trainings must be registered through Cenpatico IC's web-based e-learning training software program.

Providers must demonstrate evidence of employee orientation and training, which may include the number of Members, Member list, training calendars and sign-in sheets. Providers must also demonstrate evidence of all training to personnel, service providers and Members which may include the number of Members, Member list, training calendars and sign-in sheets. Providers must run quarterly compliance reports to monitor staff compliance with training competencies and meet a compliance standard of ninety percent (90%).
3.17.10.1 **Annual Training Plan**

Providers must develop, and maintain an annual training plan that incorporates all Cenpatico IC and State training requirements including involvement of Members and family members in the development and delivery of trainings. Providers must maintain a Train-the-Trainer program to verify adequate capacity to provide training, orient new staff and verify all staff Members have the skills to perform the requirements outlined in the Agreement.

3.17.10.2 **Practice Protocols**

Providers must train staff and implement the identified service expectations on the Clinical and Recovery Practice Protocols as appropriate and relevant to services provided. All staff must receive training on all Practice Protocols within six (6) months of hire date. Providers must review the appropriate Practice Protocols annually. Additionally, providers must verify existing staff review new Practice Protocols within six (6) months of a new Practice Protocol being published. Providers must track initial training and annual review of the Practice Protocols by using the "e-learning" training program.

3.17.10.3 **Verify Attendance and Completion**

Providers must verify attendance at all required trainings and trainings for which staff have enrolled. Providers must also verify all staff complete an annual Fraud & Abuse Training and maintain documentation verifying completion of the training.

3.17.10.4 **ASAM and CASII**

Providers must maintain at least one current ASAM and/or CASII manual at each clinic location. Providers must conduct inter-rater reliability tests for all staff conducting CASII or ASAM assessments at least semi-annually. Provider shall require staff to achieve an inter-rater reliability score of above 80% to continue to provide CASII or ASAM assessments.

3.17.11 Health Home Requirements Related to Hospital Admissions

Providers must comply with all UM and Out-of-Home Provider requirements, per this Provider Manual.

3.17.11.1 **Information Upon Admission**

Providers must provide the following clinical information to the Licensed Hospital, or BH Inpatient Facility and unit staff for all Members admitted into the facility on the day of notification of the admission:

- Most recent psychiatric evaluation
- History and Physical from the Primary Care Physician (PCP), if available
- Current psychotropic medications to include dosages and frequencies from the Behavioral Health Medical Provider and current physical health medications from the PCP
- Most recent BHMP
- List of current diagnoses
- Current individualized Service Plan (ISP) and Crisis Plan
• Allergies or past poor reactions to medications
• Anticipated target level of functioning upon discharge from Hospital services
• Initial, tentative Discharge Plan

3.17.11.2 Performance Requirements
Providers must meet the following performance requirements:

• Demonstrate that 50% of Members that discharge from a Hospital facility keep a follow-up appointment within seven (7) days of that discharge.
• Provide a Member a minimum of two (2) appointments within eight (8) to thirty (30) days of discharge from a Hospital Facility.
• Demonstrate that 70% of Members that discharge from a Hospital Facility keep follow-up appointments within eight (8) to thirty (30) days of that discharge.
• Demonstrate that readmissions within thirty (30) days do not exceed 12.5% of all Hospital admissions for provider members.

3.17.12 Health Home Requirements Related to Facilities (Licensed Hospital Facility, BH Inpatient Facility, BH Residential Facility, BH Supportive Homes, and HCTC Admissions)

Providers must submit the Out Of Home ("OOH") request packet to Cenpatico IC within two work days following a treatment team request for out-of-home placements, and receive prior authorization for BH Inpatient Facilities (formerly RTC), Licensed Hospital Facilities (formerly Level I Inpatient), BH Inpatient Facility (formerly Level I Sub-Acute Facilities), BH Residential, BH Supportive Home and HCTC services before admitting a Member, unless exemption in writing to this requirement is provided by Cenpatico IC. See Provider Manual Form 3.17.2, Request for Out-of-Home Placement- Adult or Provider Manual Form 3.17.3, Request for Out-of-Home Placement – Child/Adolescent.

Providers must verify all Child and Family Team (CFT) meetings and Adult Recovery Team (ART) meetings are coordinating regularly with the facility. In addition, providers must verify that all CFT/ART meetings involving persons admitted into out-of-home care include, at a minimum: Member and legal guardian, collateral parties, such as Juvenile Probation Officer (JPO), Division of Developmental Disabilities (DDD), or out-of-home facility staff, and provider agency staff who have clinical knowledge and a relationship with the Member. The Member's family/natural supports must be included in out-of-home treatment services once the Member is admitted.

In addition, providers must verify that an agency representative with clinical knowledge and a relationship with the Member attend all scheduled juvenile/adult court hearings in which participation of provider staff would be beneficial to the Courts.

3.17.12.1 Discharge Plans/Outpatient Follow Up
Providers must identify and develop discharge aftercare plans prior to admission to an out-of-home placement and must provide outpatient clinical services within seven (7) days of a Member’s discharge from a facility. Providers must submit Provider Manual Form 10.1.10, Discharge Plan by secure fax within:
• 72 hours of admission, and
• at time of concurrent review or if the discharge plan is revised
• upon discharge
This form must be completed fully and comprehensively.

3.17.12 Performance Requirements
Providers must meet the following performance requirements:

- Demonstrate that at least 50% of Members that discharge from a facility keep a follow-up appointment within seven (7) days of that discharge.
- Provide a Member a minimum of two (2) appointments within eight (8) to thirty (30) days of discharge from a facility.
- Demonstrate that at least 70% of Members that discharge from a facility keep follow-up appointments within thirty (30) days of that discharge.

3.17.13 Integrated Health Care Service Delivery for Health Homes
Providers must incorporate several elements into its Integrated Health Care service delivery system approach. This includes effective use of a comprehensive Care Management Program. There must be a Treatment Team with an identified single point of contact. The team must include a Psychiatrist or equivalent Behavioral Health Medical Professional and an assigned Primary Care Physician. Care must be whole person oriented and encompass Member and family voice and choice, plus use of peer and family delivered support services. There must be an emphasis on quality and safety, accessible care, coordination of care, health education and health promotion services, referrals to appropriate community and social support services, use of health information technology to link services, and improved whole health outcomes of Members.

3.17.13.1 Health Education and Health Promotion
Providers must provide assistance and education for appropriate use of health care services; health risk-reduction and health lifestyle choices including tobacco cessation and screening for tobacco use with the Ask, Advise, and Refer model and refer to the Arizona Smokers Helpline utilizing the proactive referral process; to Adults with SMI to access Cenpatico IC’s Crisis Line Provider; for self-care and management of health conditions including wellness coaching; EPSDT services for Members including identifying providers that are trained and use AHCCCS approved developmental screening tools; about maternity care programs and services for pregnant women; and self-help programs or other community resources that are designed to improve health and wellness.

3.17.14 Additional Health Home Referral Requirements
3.17.14.1 Written Procedures for Referrals to Physical Health Specialists
Providers must establish and implement written procedures for referrals to specialists or other services, to include, at a minimum, the following:

- Use of referral forms clearly identifying the provider;
- Referrals to Specialty Physician Services must be from a PCP, except that women have direct access to in-network OB/GYN providers, including Physicians, Physician Assistants and Nurse Practitioners within the scope of their practice, without a referral for preventive and routine services (42 CFR 438.206(b)(2)).
• Adults with SMI that need a specialized course of treatment or regular care monitoring have a mechanism for direct access to a Specialist (for example through a standing referral or an approved number of visits) as appropriate for the Member’s condition and identified needs. Any waiver of this requirement by Cenpatico IC is required be approved in advance by Cenpatico IC.

• A process for the Member's PCP to receive all Specialist and Consulting reports and a process for the PCP to follow-up on all referrals. A process to refer any Member who requests information or is about to lose AHCCCS eligibility or other benefits to options for low-cost or no-cost health care services.

3.17.14.2 Notification of Change
Provider shall notify and obtain written approval from Cenpatico before making any material change in the size, scope, or configuration of Provider’s services. Provider is required to notify Cenpatico in writing within one (1) day of knowledge of or anticipation of the following: (i) any unexpected material change or deficiency; (ii) any material change to Provider’s license, certification or registration; (iii) any condition which terminates, suspends or limits Provider from effectively participating in the network, including the necessity for transition of Members to a different provider; (iv) any situation which develops involving Provider when notice of that situation must be given to any regulatory body with authority over Provider; or (v) when a change in Provider’s license to operate is affected, or may reasonably be affected, as a result of any investigation conducted by, or complaint filed with, the official body with regulatory authority over Provider.

Providers of behavioral health services shall submit notification to Cenpatico Integrated Care 75 days prior to the effective date of change via the Notification of Change deliverable (RF-1016) for any material change to (i) the Provider’s license, certification or registration; (ii) a change in programming or population served; (iii) a site move, closure, or opening of a new site; or (iv) the addition or closure of a program.

All providers must update credentialing or other personnel information filed with Cenpatico within 15 days of new hires or terminations by the provider agency. Providers are responsible for the maintaining the accuracy of their staff and facility information, so that the provider listings made available to members by Cenpatico Integrated Care is current and relevant.

3.18 Laboratory Provider Requirements

3.18.1 CLIA Certificate
Providers must have either a CLIA certificate or waiver or a certificate of registration along with a CLIA Identification number. In addition, providers must meet all the requirements of 42 CFR § 493, Subpart A. Providers must provide verification of CLIA Licensure or Certificate of Waiver during the provider registration process. Failure to do so shall result in termination of the Agreement and denial of laboratory claims.

3.18.2 Rules
Pass-through billing or other similar activities with the intent to avoid the requirements listed above is prohibited. Laboratories with certificates of waiver are limited to providing only the types of tests permitted under the terms of their waiver. Laboratories with certificates of
registration are allowed to perform a full range of laboratory tests. Providers must manage and oversee the administration of all laboratory services in accordance with all state and federal laws.

Medical tests ordered for diagnosis, screening or monitoring of a condition will be paid by Cenpatico IC as defined and limited in the AHCCCS Covered Behavioral Health Services Guide and in accordance with the fee schedule in provider’s agreement with Cenpatico IC.

3.18.3 Service Standards/Provider Qualifications

Laboratory and medical imaging services may be prescribed by a licensed physician, nurse practitioner, or physician assistant within the scope of his/her practice. With the exception of specimen collections in a medical practitioner’s office, laboratory services must be provided in CLIA approved hospitals, medical laboratories and other health care facilities that meet state licensure requirements as specified in A.R.S. Title 36, Chapter 4, Federal Clinical Laboratory Improvement Amendments in AAC R9-14-101 and the Federal Code of Regulations 42 CFR 493, Subpart A.

3.18.4 Billing/Coding Specific Information

CPT codes are restricted to independent practitioners with specialized training and licenses as outlined in the AHCCCS B-2 Allowable Procedure Code Matrix.

3.19 Specialty Provider Requirements

3.19.1 Specialty Providers

3.19.1.1 Staffing Requirements

Specialty Agencies are required to have organizational, management, and administrative systems capable of meeting all contract requirements with clearly defined lines of responsibility, authority, communication, and coordination within and between departments, units, or functional areas of operation. Specialty Agency’s resource allocation must be adequate to achieve outcomes in all functional areas within the organization. Adequacy will be evaluated based on outcomes and compliance with the requirements of this section, including the requirement to provide culturally competent services. Provider is required to have sufficient staff and utilize appropriate resources to comply with this Provider Manual. Provider must require all staff, whether employed or under contract, to have the training, education, experience, orientation, and credentialing, as applicable, to perform assigned job duties.

3.19.1.2 Referrals

Providers must accept all referrals for specialty services that are consistent with its program admission criteria, licensure status, and level of care.

Specialty Providers are responsible for ensuring their agency’s compliance with medical records standards mandated by licensure and/or certification authorities at all times. Crisis providers must obtain appropriate documentation to effectively provide and bill for Crisis Services.
3.19.1.3  Refusal/Termination of Services

Providers are not allowed to refuse to serve a referred person except for good cause related to inability of the provider to meet the person's needs safely and professionally, or due to inability to serve the member due to capacity restrictions. Providers may not refuse or terminate services to a Cenpatico IC-enrolled Member or discharge a Cenpatico IC-enrolled Member without first coordinating and arranging interim, follow-up or alternative services.

3.19.1.4  After-Hours Services

Providers must provide after-hours clinical on-call services to address Member concerns and facilitate treatment services as needed. Providers must maintain an administrator–on-call to address any after-hours, weekend or holiday concerns or issues related to coordination of care or the health and/or safety of Members.

3.19.1.5  Individualized Service Plan

Providers must ensure services identified on the Individualized Service Plan are provided in the timeframe, frequency, and duration as identified on the Service Plan. Providers must contact the Health Homes immediately and request an updated Individualized Service Plan, if the Member's Individualized Service Plan is not consistent with the services being requested and scheduled to be delivered.

3.19.1.6  Child and Family Team & Adult Recovery Team Participation

Providers must participate in person or telephonically in Child and Family Team or Adult Recovery Team meetings pertaining to Members receiving services from the provider.

3.19.1.7  Monthly Treatment Updates

Providers must provide the Health Homes with regular treatment updates at least monthly in writing related to services rendered to Members using Provider Manual Form 3.3.3, Specialty Provider Monthly Summary, or its equivalent.

3.19.1.8  Coordination with Agencies

Providers must coordinate with the Health Homes before adding a diagnosis or recommending changes in diagnosis. The treatment provided must correspond to a diagnosis identified on the Comprehensive Assessment. Providers must obtain a copy of the updated Comprehensive Assessment containing the updated diagnosis following such a change or addition.

3.19.1.9  Diagnosis on Claims

Providers must ensure claims submitted for services contain a diagnosis identified on either the Health Homes Comprehensive Assessment or the Specialty Agency Assessment at the time of the date of service. Failure to meet this requirement can result in recoupment of payment. Crisis providers must obtain appropriate documentation to effectively provide and bill for Crisis Services.

3.19.1.10  Community-Based Alternatives

Providers must promote community-based alternatives instead of treatments that remove the Members from their family and community. In situations where a more restrictive level of care
is temporarily necessary, providers must work with the Member to transition back into community-based care settings as rapidly as is clinically feasible and will partner with community provider agencies to develop and offer services that are alternatives to more restrictive institutionally based care. Providers must facilitate a rapid return to the home and community when a Member is in and out-of-home placement.

3.19.1.11  Continuity of Care

Providers must ensure coordination and continuity within and between service providers and natural supports to reduce premature discharge/disenrollment and support continuity of care over time.

3.19.1.12  Individualized Services and Member Involvement

Providers must ensure services are individualized to meet the needs of Members and families. In addition, providers must assess the Member's perspective on treatment progress, in order to verify that the Member's perspectives are honored and they are effectively engaged in treatment planning and in the process of care. Providers must obtain and document ongoing engagement of the Member, family and others who are significant in meeting the needs of the Member, including active participation in treatment decisions which may result in modifications to the Member's service plan.

3.19.1.13  HIV Education and Screening

Providers must provide or make available HIV education and screening services to all persons receiving SUD treatment services. Providers must work with Cenpatico IC contracted providers of HIV education and screening services to verify all persons have access to the services.

3.19.1.14  SUD Treatment Services

Specialty Providers offering SUD treatment services must ensure adherence to Cenpatico IC Provider Manual Section 6.14, Substance Use Disorder Treatment Requirements.

3.19.1.15  Quality Improvement Activities

Provider must participate in clinical quality improvement activities that are designed to improve outcomes for Arizona Members.

3.19.1.16  Notification of Change

Provider shall notify and obtain written approval from Cenpatico before making any material change in the size, scope, or configuration of Provider's services. Provider is required to notify Cenpatico in writing within one (1) day of knowledge of or anticipation of the following: (i) any unexpected material change or deficiency; (ii) any material change to Provider's license, certification or registration; (iii) any condition which terminates, suspends or limits Provider from effectively participating in the network, including the necessity for transition of Members to a different provider; (iv) any situation which develops involving Provider when notice of that situation must be given to any regulatory body with authority over Provider; or (v) when a change in Provider's license to operate is affected, or may reasonably be affected, as a result of any investigation conducted by, or complaint filed with, the official body with regulatory authority over Provider.
3.19.1.17  **EHR**

Providers are encouraged to have in place a fully operational EHR; including, electronic signature, and remote access, as required to meet Federal Medicaid and Medicare requirements. In addition, providers must allow the State and Cenpatico IC staff access to the EHR for the purpose of conducting audits.

Providers are required to establish and maintain membership with, and bi-directional data connectivity to, the state Health Information Exchange, “The Network/AZHeC”.

3.19.1.18  **Peer Support Training**

Providers must verify that all staff and family of Members who provide Peer Support or Family Support have adequate training to support them in successfully fulfilling the requirements of their position.

3.19.2  **BH Inpatient Facilities and Licensed Hospitals**

Providers must comply with Cenpatico IC’s quality improvement programs and the utilization control and review procedures specified in 42 CFR, Parts 441 and 456, as implemented by AHCCCS and the State. Providers must participate in periodic Quality Management audits and respond to Corrective Action Letters (“CALs”) related to trends in average length of stay and Member satisfaction, polypharmacy, timeliness of staffings, discharge planning and quality care. Providers must not arbitrarily or prematurely reject or eject a Member from services without prior authorization of Cenpatico IC.

Providers must comply with all UM and facility requirements as outlined in this Provider Manual. This includes the following:

- Timeliness for submission of the CON and RON.
- Required contact with Cenpatico IC UM Department to discuss clinical rationale for emergent admissions.
- Appropriate documentation of the need for emergent services, including admitting psychiatric evaluation and other clinical data.
- Documentation required within seventy-two (72) hours of the admission date.

3.19.2.1  **Inpatient Care Assessments**

Providers delivering inpatient care (AHCCCS provider types 2, 71, B1, B2, B3, B5 and B6) must provide a comprehensive assessment and treatment plan involving close daily (including holidays and weekends) psychiatric and/or medical supervision based upon provider type and reason for admission. Failure to provide a daily psychiatric and/or medical claim or encounter verifying daily contact with the physician or nurse practitioner will result in a denial of payment.

3.19.2.2  **Lab Work**

All lab work for Members must be conducted within industry standards for completeness and timeliness. For example, therapeutic blood levels must be reported within thirty-six to forty-eight (36-48) hours.
3.19.2.3  

**One-to-One Services**

The provision of one-to-one services is included in the facility contracted rate. A rate adjustment may be requested if the frequency of one-to-one services has exceeded ten percent (10%) of the total Cenpatico IC bed days for the preceding quarter. It is understood that one-to-one services are limited to situations where such services must successfully monitor Members in BH Inpatient Facility and Licensed Hospital settings and prevent disruption from the setting.

3.19.2.4  

**Discharge Planning**

In addition to the requirements of **Section 3.14 – Discharge Planning**, providers must demonstrate that discharge planning is started at the time of admission for emergent admissions. Provider must submit the discharge plan to Cenpatico IC within forty-eight (48) hours of discharge from the facility.

3.19.2.5  

**Medical Care Evaluation Study Methodology and Study Results**

Providers must submit the Medical Care Evaluation Study Methodology and Study Results in accordance with this Provider Manual, State Policy and Procedures, AHCCCS Quality Management/Utilization management Plan as requested by Cenpatico IC.

3.19.3  

**Licensed Hospitals – Specific Requirements**

3.19.3.1  

**Licensing**

Providers must meet the requirements of 42 CFR 440.10 and Part 482 and be licensed pursuant to A.R.S. 36, Chapter 4, Articles 1 and 2; or,

- For adults age twenty-one (21) or over, certified as a provider under Title XVIII of the Social Security Act; or,
- For adults age twenty-one (21) or over, currently determined by ADHS Assurance and Licensure to meet such requirements.

Providers must be licensed as a Hospital by the ADHS Office of Licensing if providing emergency inpatient services beyond seventy-two (72) hours. If providers maintain a freestanding psychiatric facility, providers must meet the specific requirements of the ADHS Office of Licensing (i.e., provision of psychiatric acute care). If seclusion and restraint is provided, the facility must meet the requirements set forth by the ADHS Office of Licensing

3.19.3.2  

**Billing**

Providers must abide by the billing limitations as outlined in the AHCCCS Covered Behavioral Health Services Guide; including the following limitations:

- Medical supplies provided to a person while in a hospital/psychiatric hospital are included in the per diem rate and cannot be billed separately.
- Laboratory, Radiology and Medical Imaging provided by the hospital/psychiatric hospital are included in the per diem rate and cannot be billed separately.
- Medication provided/dispensed by the hospital/psychiatric hospital are included in the per diem rate and cannot be billed separately.
- The hospital/psychiatric hospital cannot bill for therapeutic leave/bed hold.
3.19.3.3  **Medical Clearance**  
Providers must maintain capacity to provide basic medical clearance, including vitals, medical history and review of symptoms. Providers must not require Members to obtain a medical clearance prior to accepting the Member unless there is an obvious identifiable present or past medical concerns warranting formal medical evaluation or medical tests.

3.19.4  **BH Hospital Facilities – Specific Requirements**  
Providers must provide continuous treatment to a person who is experiencing acute and severe behavioral health and/or substance use symptoms. Crisis services may include: emergency reception and assessment; crisis intervention and stabilization; individual, group and family counseling; detoxification and referral.

3.19.4.1  **Accreditation and Licensing**  
Providers must ensure all BH inpatient facilities are accredited by the Joint Commission ("JCAHO"), CARF, or a similar agency and licensed by the ADHS Office of Licensing as a BH Inpatient Facility. Providers must meet the requirements set forth by the ADHS Division of Licensing in accordance with 42 CFR 441 and 483 for seclusion and restraint, if the facility has been authorized by ADHS Office of Licensing to provide seclusion and restraint. Crisis intervention services may be provided in a setting licensed as a BH Inpatient Facility, but which does not require the Member to be admitted to the facility.

3.19.4.2  **Laboratory Services**  
Providers must complete routine lab services and not refer to emergency rooms to complete routine labs. Laboratory and medical imaging services may be prescribed by a licensed physician, nurse practitioner, or physician assistant within the scope of his/her practice. With the exception of specimen collections in a medical practitioner’s office, provider must verify laboratory services are provided in CLIA approved hospitals, medical laboratories and other health care facilities that meet state licensure requirements as specified in A.R.S. Title 36, Chapter 4, Clinical Laboratory Improvement Amendments in AAC R9-14-101 and the federal code of regulations 42 CFR 493, Subpart A.

3.19.4.3  **Medical Clearance Exams**  
Providers must maintain capacity to provide basic medical clearance, including vitals, medical history and review of symptoms. Providers must not require Members to obtain a medical clearance prior to accepting the Member unless there are obvious identifiable present or past medical concerns warranting formal medical evaluation or medical tests. Providers must conduct uncomplicated medical clearance examinations and refer to emergency rooms for medical clearance only when medical complications warrant such a referral.

3.19.4.4  **Billing**  
Providers must comply with the billing limitations as outlined in the AHCCCS Covered Behavioral Health Services Guide; including the following limitations:

- Medical services provided to a person while in a hospital/psychiatric hospital are included in the per diem and cannot be billed separately.
- Laboratory, Radiology and Medical Imaging provided by the hospital/psychiatric hospital are included in the per diem rate and cannot be billed separately.
- Medication provided/dispensed by the hospital/psychiatric hospital are included in the per diem rate and cannot be billed separately.
- The hospital/psychiatric hospital cannot bill for therapeutic leave/bed hold.

3.19.4.5 Weekend and Holiday Discharges
Providers must facilitate weekend and holiday discharges from BH Inpatient Facilities, and coordinating discharges through Cenpatico IC’s Crisis Line provider and the Member’s affiliated Health Homes.

3.19.5 BH Inpatient Facilities – Specific Requirements
Providers must provide an integrated residential inpatient program of therapies, activities, and experiences provided to Members who are under twenty-one (21) years of age and have severe or acute behavioral health symptoms.

3.19.5.1 Notification of Placement
Providers must notify Cenpatico IC’s UM department within 2 business days of accepting placement of a Cenpatico IC Member into provider’s facility.

3.19.5.2 Accreditation and Licensing
Providers’ BH inpatient facilities must be accredited by the JCAHO and licensed by the ADHS Office of Licensing as a BH Inpatient Facility meeting the specific requirements of the ADHS Office of Licensing. BH Inpatient Facilities must meet the requirements set forth by the ADHS Office of Licensing, and in accordance with 42 CFR 441 and 483 for seclusion and restraint, if the facility has been authorized by the ADHS Office of Licensing to provide seclusion and restraint.

3.19.5.3 Bed Holds
Providers must reserve a Member’s bed (bed hold) in the BH Inpatient Facility while the Member is on an authorized/planned overnight leave. Payment for bed holds is limited to:
- Therapeutic leave to enhance psychosocial interaction or as a trial basis for discharge planning, or
- Admittance to a hospital for a short stay.

Payment for bed hold leave days is limited to up to twenty-one (21) days per year (July 1st through June 30th) per Member. In addition, Providers must manage bed hold days so as to verify billed bed hold days do not exceed twenty-one (21) days per year.

3.19.5.4 Coordination with Health Care Coordinators
Providers must create opportunities for Health Home Health Care Coordinators to provide face-to-face contact at least once a month with all Members placed in out-of-home care.
3.19.5.5  **Involvement of Family and Other Parties**

Providers make reasonable efforts to verify that all Child and Family Team meetings involving children placed in BH Licensed Facilities include, at a minimum: Member and legal guardian, collateral parties, such as JPO, DDD, or out-of-home facility staff, and provider agency staff who has clinical knowledge and a relationship with the child. Providers must make reasonable efforts to verify that at least one facility staff Member who has clinical knowledge and a relationship with the Member attends all scheduled court hearings. Providers must make reasonable efforts to verify that the child’s family/natural supports are included in out-of-home treatment services while the child is in placement.

3.19.5.6  **Discharge Plans**

Providers must assist in the development of discharge aftercare plans prior to accepting a referral. Providers must make reasonable efforts to provide continuity of care services for children who are placed in detention and assist with discharge and transitional planning to an alternative setting if they are not able to treat the Member upon discharge from the detention facility.

3.19.6  **Residential Facilities – Specific Requirements**

Providers must provide an integrated residential program of therapies, activities, and experiences to Members in compliance with all relevant provisions in A.R.S § 36-1201.

3.19.6.1  **Services**

Providers must verify that treatment is provided to all Members while in the facility including daily life skills training, behavioral management training, emotional regulation training, vocational/academic preparation and support, and social skills training. All Members must receive regular medical (PCP) examinations and treatment, as appropriate.

Providers must assist Members in preparing for employment as appropriate and in accordance with AHCCCS protocols. In addition, providers must verify educational resources are available and accessible based upon the individual needs of the Member. Provider must provide tutoring at the facility Monday through Friday, as appropriate, to meet the Members’ educational needs.

3.19.6.2  **Referrals**

Providers may not arbitrarily or prematurely reject or eject a Member from services without prior approval by Cenpatico IC. Providers must notify Cenpatico IC’s UM department within 2 business days of accepting placement of a Cenpatico IC Member into a facility. Providers must immediately notify the Cenpatico IC Crisis Line provider whenever a Member leaves a facility against medical advice (or AMA), is hospitalized or arrested. Providers must make a reasonable effort to limit referrals to only persons with behavioral health issues in order to maintain a clinically sound program.

3.19.6.3  **Prior Authorization and Continued Stay Requirements**

Providers must meet all prior authorization and continued stay requirements for residential services as spelled out in this Provider Manual, unless granted an exception to this requirement in writing from Cenpatico IC. Only prior authorized services are eligible for payment by
Cenpatico IC. Respite services provided in a Residential facility do not require prior authorization.

### 3.19.6.4 Treatment Setting and Supervision

Providers must provide residential services that provide a structured treatment setting with twenty-four (24) hour supervision and counseling or other therapeutic activities for persons who do not require on-site medical services, under the supervision of an on-site or on-call Behavioral Health Professional.

### 3.19.6.5 Licensing and Staffing

Residential facilities must be licensed by the ADHS Office of Licensing as a BH Residential Facility. Providers must provide appropriate staffing (including one-on-one staff as needed) to accommodate all referrals who do not require a higher level of care.

### 3.19.6.6 Billing

Case management, medical services, family support and peer support services may be billed on the same day as H0018 as long as they are billed through an Outpatient Clinic (77) and not excluded on the AHCCCS B-5 matrix (billing limitations). Providers must accept the Medicaid payment as “payment in full” for all Medicaid enrolled Members receiving residential services and cannot bill the Member for any ancillary costs.

### 3.19.6.7 Program Outcomes

Providers must promote the following program outcomes:

- Improved self-regulation.
- Development of appropriate social skills.
- Expeditious return to less restrictive environment.
- Minimal readmission rate.
- Increase in Member self-sufficiency.
- Development of health leisure activities.
- Engagement in ongoing services.
- Decreased risk factors (less runaway behavior, self-harm, aggressive behavior).
- Increased community connections and readiness for employment.

### 3.20 Requirements for Service Delivery on the Tohono O’Odham Nation

Per the Memorandum of Agreement between the Tohono O’odham Nation and Cenpatico Integrated Care, any provider wishing to deliver services within the exterior boundaries of the Tohono O’odham Nation will need prior approval from Cenpatico and the Tohono O’odham Nation.
3.20.1 Approved Providers
A listing of providers approved by Cenpatico and the Tohono O’odham Nation to provide services within the boundaries of the Nation can be located on the Cenpatico Integrated Care website at https://www.cenpaticointegratedcareaz.com/inthecommunity/system-partner-resources.html.

3.20.2 Quarterly Reporting
All approved providers must submit a quarterly service report using the designated template outlined in Provider Manual section 16 – Deliverable Requirements.

3.20.3 Requesting Approval
Any provider that would like to request approval to deliver services on the Nation should contact Cenpatico Tribal Program Development to initiate the process.

3.21 Requirements of Agencies Providing Employment Services
Health Homes must employ an adequate number of Employment Specialists in the counties they serve to ensure that all adult members have timely access to employment services. Health Homes must verify Employment Specialists have one year of experience in providing rehabilitation services and employment-related supports. A year of experience as a Peer Support Specialist meets this requirement.

- Maintain accurate and reliable data by monitoring and updating employment service utilization & employment demographic status.
- Ensure employment services meet SAMHSA Supported Employment fidelity.
- Meet the requirements listed in all employment Technical Assistance Documents.
- Contracted Agencies who provide employment services will make all reasonable efforts to become mutually contracted with ADES/RSA.

Employment Specialists must:
- Obtain certification from Cenpatico IC as an Employment Specialist.
- Provide individualized supports to assist members in obtaining and maintaining competitive employment. Provider is highly encouraged to refer members to Specialty Agencies including Peer Run Organizations with supported employment programs.
- Fulfill responsibilities listed in the ISA/Collaborative Protocol with ADES/RSA and refer all adults interested in employment services to the RSA VR Program. Track all submitted referrals and monitor Extended Supported Employment (ESE’s) agreements.
- Attend Quarterly Supported Employment Steering Committee meetings and Bi-Annual Vocational Task Force meetings.
Section 4 - BEHAVIORAL HEALTH PROVIDER COORDINATION OF CARE REQUIREMENTS

4.1 Transition of Persons

Persons receiving services in the State system may experience transitions during the course of their care and treatment. Examples of transitions of care include changing service providers, establishing eligibility under Arizona Long Term Care Services (ALTCS), and moving out of Cenpatico IC’s geographic service area. During transitions of care, providers must ensure that services are not interrupted and that the person continues to receive needed services. Coordination and continuity of care during transitions are essential in maintaining a person’s stability and avoiding relapse or decompensation in functioning.

Transition of Enrollment for Persons Turning 18

Regardless of the youth’s decision regarding their continued behavioral health enrollment, an updated AHCCCS application must be submitted prior to the youth’s 18th birthday and with sufficient time to allow for AHCCCS to process the application (at least 45 days). The application should be completed at least six months prior to the child’s 18th birthday. The provider must assist the member in applying for AHCCCS coverage at the appropriate interval.

Upon turning 18 years of age, if the person is not eligible for services as a person determined to have a Serious Mental Illness or the person has been determined ineligible for Title XIX/XXI services, providers can continue to provide services under block grant funds (as applicable) or per Section 8.2 - Copayments.

When the youth turns 18, the provider must ensure that new consents and release of information documents are signed and a new demographic form is completed, reflecting correct diagnosis codes and behavioral health category consistent with Section 13.1 - Enrollment, Disenrollment and other Data Submission. Once the child’s behavioral health category assignment has been changed, ongoing behavioral health service appointments must be provided according to the timeframes for routine appointments in Section 3.2 - Appointment Standards and Timeliness of Services.

4.1.1 Transition Due to a Change of the Behavioral Health Provider or the Behavioral Health Category Assignment

Upon changes of a Member’s provider or behavioral health category assignment, the 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 provider and other provider agencies, if needed.
Cenpatico IC agency changes are coordinated between the Cenpatico IC agencies.

4.1.2 Transition to ALTCS Program Contractors

This section does not apply to persons enrolled in the Arizona Long Term Care Services/Division of Developmental Disabilities (ALTCS/DDD). ALTCS/DDD eligible persons receive all covered services through Cenpatico IC and their providers.

Once a person is determined eligible and becomes enrolled with the Arizona Long Term Care Services/Elderly or Physically Disabled (ALTCS/EPD) Program, providers must not submit claims or encounters for Title XIX/XXI covered services to Cenpatico IC. To determine if a person is ALTCS/EPD eligible, providers shall contact Cenpatico IC Customer Service for assistance at 1-866-495-6738. The provider must, however, continue to provide and encounter needed non-Title XIX/XXI covered SMI services (e.g. housing) to persons determined to have a Serious Mental Illness.

Providers who contract as an ALTCS provider must not submit encounters for an ALTCS/EPD enrolled person to Cenpatico IC 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.

Providers must facilitate effective transitions for Members who became eligible for ALTCS services. Providers must complete the following coordination efforts for ALTCS-eligible Members:

- Provide continuity of care between inpatient and outpatient settings, services, and supports;
- Develop and implement transition, discharge, and aftercare plans prior to discontinuation of services in accordance with this Provider Manual;
- Include the Member in transition planning and provide any available information about changes in physician, services, etc.;
- Ensure that the clinical and fiscal responsibility for Title XIX/XXI services shifts to the ALTCS Program Contractor;
- Complete a transfer packet and letter of transition that providers clinical information to the ALTCS Program Contractor regarding the person’s on-going needs for services to assist them in effectively meeting the ongoing health and cultural needs of the Member and ensure continuity of care during the transition period;
- Review the current treatment plan and, if needed, coordinate the development of a revised treatment plan with the clinical team and the receiving ALTCS provider and/or case manager;
- Transfer responsibility for any court ordered treatment;
- Coordinate the transfer of records to the ALTCS program contractor; and
- Provide information as follows:
  - For Title XIX/XXI eligible 21-64 year olds, the number of days the person has received services in an Institution for Mental Disease (IMD) in the contract year (October 1 – September 30);
For all persons, the number of hours of respite received in the contract year (October 1 - September 30); and

Whether there is a signed authorization for the release of information contained in the comprehensive behavioral health record pursuant to Section 12.6.1 - Disclosure of Health Information.

### 4.1.3 Transition to CRS Program Contractors

Once a person is determined eligible and becomes enrolled with the Children’s Rehabilitative Services (CRS) Program, providers must submit claims or encounters for Title XIX/XXI covered services to the AHCCCS CRS Program Contractor. These claims or encounters must not be submitted to Cenpatico IC. To determine if a person is CRS eligible, providers shall contact Cenpatico IC Customer Service for assistance at 1-866-495-6738. The provider must, however, continue to provide and encounter needed non-Title XIX/XXI covered SMI services (e.g. housing) to persons determined to have a Serious Mental Illness.

The provider may continue to provide Non-Title XIX/XXI covered services funded through the SABG or MHBG to persons who meet the Grant’s population requirements (see Section 3.10 - Special Populations) as funding is available.

All restrictions on these funds, and adherence to priority population requirements, as specified in Section 3.10 - Special Populations must be applied to this population. The Member must be a child/adolescent with a Serious Emotional Disturbance (SED) or an adult with SMI to receive MHBG-funded services; SABG funds may only be expended on Members with a diagnosed Substance Use Disorder.

The RBHA/Health Plan and provider(s) are required to receive prior approval from ADHS for any flex fund expenditures exceeding $1,525.00 per Member per contract year (see Section 2.1.4 Flex Funds

These Non-Title XIX/XXI covered services must be encountered to Cenpatico IC. Cenpatico IC must successfully submit a State-Only 834 enrollment for these Members prior to encountering for these services.

When a person who has been receiving services through Cenpatico IC becomes enrolled in the CRS Program, the provider must:

- Provide continuity of care between inpatient and outpatient settings, services, and supports;
- Develop and implement transition, discharge, and aftercare plans prior to discontinuation of services in accordance with this Provider Manual;
- Include the Member in transition planning and provide any available information about changes in physician, services, etc.;
- Ensure that the clinical and fiscal responsibility for Title XIX/XXI services shifts to the CRS Program Contractor;
- Complete a transfer packet and letter of transition that provides clinical information to the CRS Program Contractor regarding the person’s on-going needs.
for services to assist them in effectively meeting the ongoing health and cultural needs of the Member and ensure continuity of care during the transition period;

- Review the current treatment plan and, if needed, coordinate the development of a revised treatment plan with the clinical team and the receiving CRS provider and/or case manager;
- Transfer responsibility for any court ordered treatment;
- Coordinate the transfer of records to the CRS program contractor; and
- Provide information as follows:
  - For Title XIX/XXI eligible 21-64 year olds, the number of days the person has received services in an Institution for Mental Disease (IMD) in the contract year (October 1 – September 30);
  - For all persons, the number of hours of respite received in the contract year October 1 – September 30; and
  - Whether there is a signed authorization for the release of information contained in the comprehensive behavioral health record pursuant to Section 12.6.1 - Disclosure of Health Information.

### 4.1.4 Transition of Persons Receiving Court Ordered Services

This Section pertains to court ordered treatment under A.R.S. § 36, Chapter 5 (see Section 3.9, Pre-petition Screening, Court Ordered Evaluation and Treatment) and the Arizona Administrative Code R9-21-507.

A person ordered by the court to undergo treatment and who is without a guardian may be transferred from one provider to another provider, as long as the medical director of the provider initiating the transfer has established that:

- The member’s Court Ordered Treatment is not expiring within 90 days of the transfer,
- There is no reason to believe that the person will suffer more serious physical harm or serious illness as a result of the transfer;
- The person is being transitioned to a level and kind of treatment that is more appropriate to the person’s treatment needs; and
- The medical director of the receiving provider has accepted the person for transition.

The medical director of the provider requesting the transition must have been the provider that the court committed the person to for treatment or have obtained the court’s consent to transition the person to another provider as necessary.

The medical director of the provider requesting the transition must provide notification to the receiving provider allowing sufficient time (but no less than 3 days) for the transition to be coordinated between the providers. Notification of the request to transition must include:

- A summary of the person’s needs;
- A statement that, in the medical director’s judgment, the receiving provider can adequately meet the person’s treatment needs;
- A modification to the individual service plan, if applicable;
• Documentation of the court’s consent, if applicable;
• A written compilation of the person’s treatment needs and suggestions for future treatment by the medical director of the transitioning provider to the medical director of the receiving provider. The medical director of the receiving provider must accept this compilation before the transition can occur; and
• Transportation from the initiating provider to the receiving provider is the responsibility of the initiating behavioral health provider.

4.1.5 Transition of Persons Being Discharged from Inpatient Settings
Discharge planning and communication with the Adult Clinical Team or CFT must begin at admission to ensure a smooth transition for Members being discharged from inpatient settings. Furthermore, re-engagement activities must occur for persons who are discharged from inpatient settings in accordance with Section 3.4 - Outreach, Engagement, Re-engagement and Ending an Episode of Care and Disenrollment. If a Member will be moving to a GSA other than where he/she has been receiving inpatient treatment services, coordination must occur between RBHA/Health Plans, if applicable, to verify appropriate services/placement and necessary re-engagement activities occur upon discharge and must not occur while member is in an inpatient setting (see Section 4.2 - Inter-RBHA Coordination of Care). Contact the Cenpatico IC Inter-RBHA Coordinator at 1-866-495-6738 for assistance.

4.1.6 Transition of Persons Receiving Behavioral Health Services from Indian Health Services
American Indian persons may choose to receive services through a RBHA/Health Plan, TRBHA or at an IHS or 638 tribal provider. Cenpatico IC providers must respond to referrals in accordance with Section 3.3 – Referral and Intake Process, and ensure necessary coordination of care occurs. The Cenpatico IC telephone number is 1-866-495-6738.

4.1.7 Inter-Agency Coordination of Care Transfers (Transferring Member Coordination of Care Responsibility to a Different Agency)
All coordination of care inter-agency transfers between Health Home Providers must be completed through the Provider Portal. Each transfer is required to be posted to the portal by the transferring agency and accepted or rejected by the receiving agency within 7 days of the date the transfer was entered into the transfer system.

A Cenpatico IC Network Development Coordinator will monitor inter-agency transfers to ensure the transfer is complete within 7 days from the date the transfer was entered into the system. The transfer is considered timely when the receiving agency accepts or rejects the transfer within 7 days. The following steps must be documented in the medical record to ensure compliance with requirements.

4.1.7.1 Sending Agency Requirements
• Evidence the sending agency staff discussed the transfer with the Member and documented the conversation and Member request in the medical record.
• Documentation that the assigned staff from the sending agency coordinated with the receiving agency within 7 business days of the Member request.
• Evidence the sending agency gathered the required documentation, including the full completion of the PMF 4.1.1 Inter-agency Transfer Checklist; and evidence the sending agency provided the transfer packet to the receiving agency.
  o Evidence the PMF 4.1.1 Inter-agency Transfer Checklist and packet were completed by the sending agency and provided to the receiving agency no later than the date of the transfer CFT/ART.
  o Evidence the receiving agency documented confirmation of receipt of the transfer packet documents, or a follow up plan for missing documents required as part of the Inter-agency Transfer Checklist. Missing documentation should not delay a transfer from occurring.

• Evidence the sending agency coordinated with the Member/guardian, system partners, and receiving agency to verify a transfer CFT/ART occurred.
  o Evidence that once the documentation was provided and the transfer CFT/ART was completed with the receiving agency, the sending agency submitted the transfer through the Provider Portal. The sending agency is required to submit the transfer through the Provider Portal within 2 days following the transfer CFT/ART.

4.1.7.2 Receiving Agency Requirements

• Documentation that the receiving agency coordinated with the sending agency to schedule a transfer Child and Family Team/Adult Recovery Team (CFT/ART) appointment.

• Evidence the receiving agency CFT/ART included the following:
  o Attendance by:
    ▪ Member/guardian,
    ▪ Sending agency staff,
    ▪ Receiving agency staff, and
    ▪ Other system partners as appropriate.
  o Completion of an Inter-agency Transfer Checklist/SBAR (Situation, Background, Assessment, Recommendation) Tool in its entirety.
  o Completed Inter-agency Transfer Checklist/SBAR Tool was filed in the medical record within 7 days of completion and is easily accessible.

• Evidence that once the transfer CFT/ART was completed and paperwork was confirmed by the receiving agency, the transfer was accepted by the receiving agency on the Provider Portal.

• Evidence Transfer was accepted or rejected by the receiving agency within 5 days following the receipt of request.

• Evidence the intake appointment was completed. The intake appointment may be combined with the transfer CFT/ART.

• Evidence the receiving agency scheduled the next appointment within 7 days following the transfer.
4.1.8 At Risk Member Transitions

Cenpatico IC Health Homes are required to notify the Cenpatico IC Coordination of Care department immediately anytime a high risk member is scheduled to be transferred between providers, or payers. Health Homes are required to contact the Cenpatico IC Coordination of Care Department by calling 866-495-6738. Notification is required for the all at risk members including but not limited to the following members:

- Members with significant medical conditions such as, a high-risk pregnancy or pregnancy within the last trimester, the need for organ or tissue transplantation, chronic illness resulting in hospitalization or nursing facility placement, etc.
- Members who are receiving ongoing services such as dialysis, home health, chemotherapy and/or radiation therapy, or who are hospitalized at the time of transition;
- Members who frequently contact AHCCCS, State and local officials, the Governor’s Office and/or the media;
- Members who have received prior authorization for services such as scheduled surgeries, post-surgical follow-up visits, out-of-area specialty services, or nursing home admission; and Continuing prescriptions, Durable Medical Equipment (DME) and medically necessary transportation ordered for the transitioning member by the relinquishing Contractor; and
- Members transitioning to CMDP.

Cenpatico IC Health Homes are required to fully cooperate with Cenpatico IC, “receiving and sending providers and health plans” and proactively coordinate care to meet the member’s needs throughout the transition. Health Homes are required to timely release medical records of the transitioning member (the cost, if any, of reproducing and forwarding medical records shall be the responsibility of the provider).

4.2 Inter-RBHA Coordination of Care

Coordination between T/RBHA/Health Plans must occur in a manner that ensures the provision of continuous covered services that are consistent with the treatment goals and identified needs for persons who:

- Receive services outside of the GSA served by their designated T/RBHA/Health Plan (non-enrolled persons),
- Receive services outside of the GSA served by their home T/RBHA/Health Plan (enrolled persons), or
- Move to another GSA.

4.2.1 Computation of Time

In computing any period of time prescribed or allowed by this policy, the period begins the day after the act, event, or decision occurs and includes all calendar days and the final day of the period. If the final day of the period is a weekend or a 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.

4.2.2 Jurisdictional Responsibilities

For adults (persons 18 years and older), T/RBHA/Health Plan responsibility is determined by the person’s current place of residence, except persons who are unable to live independently but are involved with ADES/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/Health Plan when the enrolled person is visiting or otherwise temporarily residing in a different T/RBHA/Health Plan area but:

- Maintains a place of residence in his/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/Health Plan service area, covered services remain the responsibility of the home T/RBHA/Health Plan.

For children (ages 0-17 years), T/RBHA/Health Plan responsibility is determined by the current place of residence of the child’s parent(s) or legal guardian. For children who have been adjudicated as dependent by a court, the location of the child’s court of jurisdiction determines which T/RBHA/Health Plan has responsibility.

Cenpatico IC may agree to coordinate an Inter-RBHA transfer for individuals unable to live independently on a case-by-case basis. Inter-RBHA transfers must be completed within 30 days of referral by the home T/RBHA/Health Plan. The home /RBHA/Health Plan 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.

4.2.3 Out-of-Area Service Provision

4.2.3.1 Crisis Services

Crisis services must be provided without regard to the person’s enrollment status. When a person presents for crisis services, providers must:

- Provide needed crisis services;
- Ascertain the person’s enrollment status with all RBHA/Health Plans and determine whether the person’s residence in the current area is temporary or permanent;
- If the person is enrolled with another RBHA/Health Plan, the provider is required to notify the home RBHA/Health Plan within 24 hours of the person’s presentation. The home RBHA/Health Plan is fiscally responsible for crisis services and must:
  - Make arrangements with the RBHA/Health Plan at which the person presents to provide needed services, funded by the home RBHA/Health Plan;
  - Arrange transportation to return the person to the home RBHA/Health Plan area; or
Determine if the person intends to live in the new RBHA/Health Plan’s geographic service area 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 RBHA/Health Plan 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-RBHA transfer can proceed.

- If the person is not enrolled with the RBHA/Health Plan and lives within the service area of RBHA/Health Plan at which the person presented for services, providers must notify the RBHA/Health Plan to initiate enrollment. A person can obtain a referral by calling Cenpatico IC Customer Service at 1-866-495-6738.
- If the person is not enrolled with RBHA/Health Plan and lives outside of the service area of the RBHA/Health Plan at which the person presented for crisis services, providers must enroll the person, provide needed crisis services and initiate the Inter-RBHA transfer.
- In the event that Cenpatico IC or a provider receives a referral regarding a hospitalized person whose residence is located outside Cenpatico IC’s GSA, the provider must immediately coordinate the referral with the person’s designated T/RBHA/Health Plan.

4.2.3.2 Non-Emergency Services

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

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

4.2.3.4 Referral to Another T/RBHA/Health Plan for Service Provision

If a Cenpatico IC provider initiates a referral to another T/RBHA/Health Plan or a service provider in another T/RBHA/Health Plan’s area for the purposes of obtaining behavioral health services, the Cenpatico IC provider 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 Cenpatico IC’s area.

4.2.4 Inter-T/RBHA Transfer

A transfer will occur when:
• An adult person voluntarily elects to change his/her place of residence to an independent living setting from one T/RBHA/Health Plan’s area to another.
• 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/Health Plan 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.
• Persons who are unable to live independently and are involved with ADES/DDD can be transferred to another T/RBHA/Health Plan. Persons involved with ADES/DDD who are permanently placed and reside in a supervised setting are the responsibility of the T/RBHA/Health Plan in which the supervised setting is located. This is applicable regardless of where the adult guardian resides.
• The parent(s) or legal guardian(s) of a child change their place of residence to another T/RBHA/Health Plan’s area; or
• The court of jurisdiction of a dependent child changes to another T/RBHA/Health Plan’s area.

Inter-T/RBHA transfers are not to be initiated when a person is under pre-petition screening or court ordered evaluation (see Section 3.9 - Pre-petition Screening, Court Ordered Evaluation and Court Ordered Treatment).

4.2.4.1 Timeframe

The home T/RBHA/Health Plan or its providers must initiate a referral for an Inter-T/RBHA transfer within the following timeframes:
• At least 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.

4.2.4.2 Inter-T/RBHA Process

An adult person enrolled with Cenpatico IC, family, guardian, behavioral health provider, state agency staff or other health provider staff is responsible for initiation an Inter-T/RBHA transfer. The referral is initiated when the home T/RBHA/Health Plan provides a completed Provider Manual Form 4.2.1, Inter-T/RBHA Transfer Request Form. In addition, the following information must be provided to the receiving T/RBHA/Health Plan as quickly as possible:
• The person’s comprehensive clinical record;
• Consents for release of information pursuant to Section 12.6 - Confidentiality;
• For Title XIX/XXI eligible persons between the ages of 21 and 64, the number of days
  the person has received services in an IMD in the contract year (October 1 –
  September 30); and
• The number of hours of respite care the person has received in the contract year
  (October 1 – September 30).

The receiving T/RBHA/Health Plan must not delay the timely processing of an Inter-T/RBHA
transfer because of missing or incomplete information.

Upon receipt of the transfer packet, the T/RBHA/Health Plan must:
• Notify the home T/RBHA/Health Plan within seven calendar days of receipt of the
  referral for Inter-T/RBHA transfer,
• Proceed with making arrangements for the transfer, and
• Notify the home T/RBHA/Health Plan if the information contained in the referral is
  incomplete.

Within 14 days of receipt of the referral for an Inter-RBHA transfer, the receiving T/RBHA/Health
Plan or its providers must:
• Schedule a meeting to establish a transition plan for the person. The meeting must
  include:
  o The person or the person’s guardian or parent, if applicable;
  o Representatives from the home T/RBHA/Health Plan;
  o Representatives from the Arizona State Hospital (AzSH), when applicable;
  o The provider and representatives of the CFT/adult clinical team;
  o Other involved agencies; and
  o Any other relevant Member at the person’s request or with the consent of
    the person’s guardian.
• Establish a transition plan that includes at least the following:
  o The person’s projected moving date and place of residence;
  o Treatment and support services needed by the person and the timeframe
    within which the services are needed;
  o 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;
  o Information to be provided to the person regarding how to access services
    immediately upon relocation;
  o The enrollment date, time and place at the receiving RBHA/Health Plan and
    the formal date of transfer, if different from the enrollment date;
  o The date and location of the person’s first service appointment in the
    receiving T/RBHA/Health Plan’s GSA;
The individual responsible for coordinating any needed change of health plan enrollment, primary care provider assignment, and medication coverage;

- The person’s provider in the receiving RBHA/Health Plan’s GSA, including information on how to contact the behavioral health provider;

- Identification of the person at the receiving T/RBHA/Health Plan 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 the person’s 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.

On the official transfer date, the home T/RBHA/Health Plan must enter a closure and disenrollment into CIS. The receiving T/RBHA/Health Plan must enter an intake and enrollment into CIS at the time of transfer. 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/RBHA/Health Plans to transfer the person, the T/RBHA/Health Plans must collaborate to ensure appropriate re-engagement activities occur (see Section 3.4, Outreach, Engagement, Re-Engagement and Ending an Episode of Care) and proceed with the inter-T/RBHA transfer, if appropriate. Each T/RBHA/Health Plan must designate a contact person responsible for the resolution of problems related to enrollment and disenrollment. Contact the Cenpatico IC Inter-RBHA Coordinator at 866-495-6738 for assistance.

When a person presents for crisis services, providers must first deliver needed behavioral health services and then determine eligibility and T/RBHA/Health Plan enrollment status. Persons enrolled after a crisis event may not need or want ongoing behavioral health services through the T/RBHA/Health Plan. Providers must conduct re-engagement efforts as described in Section 3.4, Outreach, Engagement, Re-Engagement and Ending an Episode of Care however; persons who no longer want or need ongoing behavioral health services must be dis-enrolled (i.e., closed in the CIS) and an inter-T/RBHA transfer must not be initiated. Persons who will receive ongoing behavioral health services will need to be referred to the appropriate T/RBHA/Health Plan 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 in subsection 4.1.2.1 cover circumstances when Members inform their provider or T/RBHA/Health Plan prior to moving to another service area. When Members inform their provider or T/RBHA/Health Plan less than 30 days prior to their move or do not inform their provider or T/RBHA/Health Plan of their move, the designated T/RBHA/Health Plan must not wait for all of the documentation from the previous T/RBHA/Health Plan before scheduling services for the Member. Contact the Cenpatico IC Inter-RBHA Coordinator at 1-866-495-6738 for assistance.
4.2.4.3  **Behavioral Health Provider’s Responsibilities During an Inter-RBHA Transfer**

- As part of an Inter-RBHA transfer, the provider must (see Provider Manual Inter-T/RBHA Coordination of Services):
- Schedule a meeting to establish a transition plan for the person. Include the person in transition planning and provide any available information about changes in physician, services, etc.;
- Provide information regarding the person’s on-going needs for services to verify continuity of care during the transition period;
- Review the current treatment plan and, if needed, coordinate the development of a revised treatment plan with the clinical team and the receiving provider;
- Transfer responsibility for any court ordered treatment;
- Coordinate the transfer of records to the new behavioral health provider; and
- Provide information as follows:
  - For Title XIX/XXI eligible 21-64 year olds, the number of days the person has received services in an Institution for Mental Disease (IMD) in the contract year October 1 – September 30;
  - For all persons, the number of hours of respite received in the contract year October 1 - September 30; and
  - Any signed authorizations for the release of information contained in the person’s comprehensive clinical record pursuant to Section 12.6.1 - Disclosure of Health Information.

4.2.5  **Complaint Resolution**

A person determined to have SMI that is the subject of a request for out-of-area service provision or Inter-T/RBHA transfer may file an appeal as provided for in Section 15.3 - Notice Requirements and Appeal Process for Title XIX/XXI Eligible Persons. Any party involved with a request for out-of-area service provision or Inter-T/RBHA transfer may initiate the grievance procedure. Parties include the home T/RBHA/Health Plan, receiving T/RBHA/Health Plan, person being transferred, or the person’s guardian or parent, if applicable; the Arizona State Hospital (AzSH), if applicable, and any other involved agencies.

The following issues may be addressed in the grievance resolution process:
- Any timeframe or procedure contained in this policy, 
- Any dispute concerning the level of care needed by the person, and
- Any other issue that delays the person’s discharge from an inpatient or residential setting or completion of an Inter-T/RBHA transfer.

4.2.5.1  **Procedure for Non-Emergency Disputes**

**First Level**

- A written grievance shall be addressed to:
  - The person’s provider at the home T/RBHA/Health Plan, or other individual identified by the T/RBHA/Health Plan, if the issue concerns out-of-area service provision, or
The identified provider at the receiving T/RBHA/Health Plan, or other individual identified by the T/RBHA/Health Plan, if the issue concerns an Inter-T/RBHA transfer.

- The provider must work with involved parties to resolve the issue within five days of receipt of the grievance.
- If the problem is not resolved, the provider must, on the fifth day after the receipt of the request, forward the grievance to the second level.

**Second Level**

- Issues concerning out-of-area service provision must be forwarded to the Chief Executive Officer, or designee, of the home T/RBHA/Health Plan.
- Issues concerning Inter-T/RBHA transfers must be forwarded to the Chief Executive Officer, or designee, of the receiving T/RBHA/Health Plan.
- The Chief Executive Officer must work with the Chief Executive Officer of the other involved T/RBHA/Health Plan to resolve the issue within five days of receipt of the grievance.
- If the problem is unresolved, the Chief Executive Officer must, on the fifth day after the receipt of the request, forward the request to the Deputy Director of the AHCCCS.

**Third Level**

- The Deputy Director of the AHCCCS, or designee, will convene a group of financial and/or clinical personnel as appropriate based on the grievance.
- The Deputy Director will issue a final decision within five days of receipt of the request.

### 4.2.5.2 Procedure for Emergency Disputes

An emergency dispute includes any issue in which the person is at risk of decompensation, loss of residence, or being in violation of a court order. The home T/RBHA/Health Plan must ensure that medically necessary behavioral health services continue pending the resolution of an emergency dispute between T/RBHA/Health Plans.

**First Level**

- Issues concerning out-of-area service provision must be forwarded to the Chief Executive Officer, or designee, of the home T/RBHA/Health Plan.
- Issues concerning Inter-T/RBHA transfers must be forwarded to the Chief Executive Officer, or designee, of the receiving T/RBHA/Health Plan.
- The Chief Executive Officers of the involved T/RBHA/Health Plans must work to resolve the issue within two days of receipt of the grievance.
- If the problem is unresolved, the Chief Executive Officer must, on the second day after the receipt of the request, forward the request to the Deputy Director of the AHCCCS.

**Second Level**
• The Deputy Director of the AHCCCS, or designee, will convene a group of financial and/or clinical personnel as appropriate based on the grievance, to address and resolve the issue.
• The Deputy Director will issue a final decision within two days of receipt of the request.

4.3 Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers

In Arizona, the acute care Medicaid program (Title XIX) and the State Children’s Health Insurance Program (KidsCare/SCHIP/Title XXI) were developed as behavioral health “carve-outs,” a model in which eligible persons receive general medical services through health plans and covered services through behavioral health managed care organizations, also known as T/RBHA/Health Plans. Because of this separation in responsibilities, communication and coordination between providers, the Arizona Health Care Cost Containment System (AHCCCS), Health Plan Primary Care Providers (PCPs) and Behavioral Health Coordinators is essential to ensure the well-being of persons receiving services from both systems.

Some Members are Medicaid (Title XIX) and Medicare (Title XVIII) eligible and are referred to as “dual eligible” persons. Medicare covers limited inpatient services, outpatient services, and prescription medication coverage. Medicare covered services are provided on either a fee-for-service basis or a managed care basis (through Medicare Advantage Plans). The term Medicare provider refers to both the fee-for-service Medicare providers and the Medicare Advantage Plans. Coordination of care must also occur with Medicare providers to achieve positive health outcomes for Medicare eligible Members.

Holistic treatment requires integration of physical health with behavioral health to improve the overall health of an individual. Members 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 providers, PCPs, and Medicare providers must occur on a regular basis to ensure safety and positive clinical outcomes for persons receiving care. For Cenpatico IC enrolled persons not eligible for Title XIX/XXI coverage, coordination and communication should occur with any known health care provider(s).

4.3.1 Coordinating Care with AHCCCS Health Plans

Cenpatico IC employs an Acute Health Plan and Provider Coordinator as the single point of contact with Health Plans for members who receive their medical services through an acute AHCCCS health plan and behavioral health services through the RBHA/Health Plan. This contact person’s main role is to respond to coordination of care inquiries from AHCCCS Health Plans, primary care providers (PCPs) and other involved clinicians to facilitate clinical coordination of care. When coordinating care with the person’s PCP, Medicare provider or other health care provider, information must be disclosed in accordance with Section 12.6.1 - Disclosure of Health Information.
The following procedures, however, will assist providers in coordinating care with AHCCCS Health Plans:

- If the identity of the person’s primary care provider (PCP) is unknown, a provider must contact the Acute Health Plan and Provider Coordinator(s) for Cenpatico IC or the Behavioral Health Coordinator of the person’s designated health plan to determine the name of the person’s assigned PCP. See the Provider Manual Attachment 4.3.1, AHCCCS Contracted Health Plans for contact information for the Behavioral Health Coordinators for each AHCCCS Health Plan;
- Cenpatico IC enrolled persons who have never contacted their PCP prior to entry into the behavioral health system should be encouraged to seek a baseline medical evaluation. Cenpatico IC enrolled persons should also be prompted to visit their PCP for routine medical examinations annually or more frequently if necessary;
- 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. A sample request form that may be utilized for this purpose (see Provider Manual Form 4.3.2, Request for Information from PCP or Medicare Provider). If the PCP does not respond to the request, contact the health plan’s Behavioral Health Coordinator for assistance; and
- 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 Plan Coordinator by calling 1-866-495-6738 and ask to be connected with the designated Cenpatico IC Health Plan Coordinator.

4.3.2 The Cenpatico Integrated Care Acute Health Plan and Provider Coordinator

Cenpatico IC has designated an Acute Health Plan and Provider Coordinator who gathers, reviews, and communicates clinical information requested by PCPs, Acute Care Plan Behavioral Health Coordinators and other treating professionals or involved stakeholders (see Provider Manual Attachment 4.3.2, Cenpatico IC Acute Health Plan and Provider Coordinator Contact Information).

Cenpatico IC maintains a designated and published phone number to contact the Acute Health Plan and Provider Coordinator and has a clearly recognized prompt on an existing phone number that facilitates prompt access to the Acute Health Plan and Provider Coordinator that is staffed during business hours.

Cenpatico IC Acute Health Plan and Provider Coordinators receive training which includes, at a minimum, the following elements:

- Provider inquiry processing and tracking (including resolution timeframes);
- Cenpatico IC procedures for initiating provider contracts or AHCCCS provider registration;
- Claim submission methods and resources (see Section 6.2 - Submitting Claims and Encounters to the RBHA/Health Plan);
- Claim dispute and appeal procedures (Section 15.5- Provider Claims Disputes); and
- Identifying and referring quality of care issues.
Cenpatico IC utilizes the following training modules that providers are required to complete, in order to understand the above listed elements:

- Provider Performance Improvement;
- Claims and Encounters;
- NOA and Grievance and Appeals;
- Quality of Care; and
- Overview of RBHA/Health Plan, ADHS and Cenpatico IC.

In addition, Cenpatico IC meets quarterly with each Health Plan to identify barriers or issues that exist within the delivery of care system for health plan Members and behavioral health enrolled Members.

4.3.3 Sharing Information with PCPs, AHCCCS Acute Health Plans, Other Treating Professionals, and Involved Stakeholders

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

- “Urgent” – Requests for intervention, information, or response within 24 hours; and
- “Routine” – Requests for intervention, information, or response within 10 days.

4.3.3.1 Coordination of Care for Members with a Serious Mental Illness

For all Members referred by the PCP and determined to have a Serious Mental Illness and/or a diagnosis of a chronic medical condition on Axis III, the following information must be provided to the person’s assigned PCP:

- The Member’s diagnosis;
- Critical lab results as defined by the laboratory and prescribed medications; and
- Changes in class of medications.

Providers with the assistance of Cenpatico IC must provide the required information annually, and/or when there is a significant change in the person’s diagnosis and/or prescribed medications.

Providers are required to pro-actively coordinate behavioral health and medical care for Members with a Serious Mental Illness and/or a diagnosis of a chronic medical condition on Axis III. This includes helping Members identify their health and wellness goals, include those goals in the Members’ Individualized Service Plans, and coordinating with medical professionals to help Members achieve those goals.

4.3.3.2 Coordination of Care for Title XIX/XXI Members

For all Title XIX/XXI enrolled persons, providers are required to:
- Notify the assigned PCP of the results of PCP initiated behavioral health referrals;
- Provide a final disposition to the health plan Behavioral Health Coordinator in response to PCP initiated behavioral health referrals, (for more information on the referral process, see Section 3.3 – Referral and Intake Process);
- Coordinate the placement of persons in out-of-state treatment settings as described in Section 3.13 - Out-of State Placement for Children and Young Adults;
- 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 Member’s medical record; and
- Notify, consult with, or disclose other events requiring medical consultation with the person’s PCP.

Upon request by the PCP or Member, information for any enrolled Member must be provided to the PCP consistent with requirements outlined in Section 12.6.1 - Disclosure of Health Information.

When contacting or sending any of the above referenced information to the person’s PCP, providers must provide the PCP with an agency contact name and telephone number in the event the PCP needs further information.

AHCCCS has developed a communications form (Provider Manual Form 4.3.2, Communications Document) for coordinating care with the AHCCCS Health Plan PCP or Behavioral Health Coordinator. The form includes the required elements for coordination purposes and must be completed in full for coordination of care to be considered to occur. For complex problems, direct provider-to-provider contact is recommended to support written communications.

Provider Manual Form 4.3.2, Communications Document will not have to be used if there is a properly documented progress note. To be considered properly documented the progress note must:
- Include a header that states “Coordination of Care”;
- Be legible; and
- Include all of the required elements contained in Provider Manual Form 4.3.2, Communications Document.

Cenpatico IC tracks/logs all the requests received from PCPs, AHCCCS Acute Health Plans, other treating professionals and other involved stakeholders, (see Provider Manual Form 4.3.3 Cenpatico IC Acute Health Plan and Provider Inquiry Monthly Log) and submits the log to the State in accordance with contract requirements Cenpatico IC submits the Acute Health Plan and Provider Inquiry Logs in accordance with AHCCCS requirements. AHCCCS communicates items of concern with T/RBHA/Health Plans, if there are systemic issues evident in the information submitted on the T/RBHA/Health Plan Acute Health Plan and Provider Inquiry Monthly Log. T/RBHA/Health Plans are required to resolve identified systemic issues.
4.3.4 Responsibility for Fee-for-Service Persons

Cenpatico IC provides fee-for-service services to Title XIX/XXI eligible persons not enrolled with an AHCCCS Health Plan. Cenpatico IC provides all inpatient emergency services for fee-for-service persons with psychiatric or substance abuse diagnoses. Cenpatico IC provides services to tribal Title XIX/XXI eligible persons referred by an Indian Health Services (IHS) or tribal facility for emergency services rendered at non-IHS facilities.

4.3.5 Responsibility for Persons Enrolled in an AHCCCS Health Plan

Services which may have been covered by the AHCCCS Health Plan Contractor for Prior Period Coverage will now be the responsibility of Cenpatico IC. This is limited to the services only after the individual has been medically cleared. The Health Plan Contractor is still obligated to provide all necessary medical services.

The rules below apply for other areas of coverage.

4.3.5.1 Pre-Petition Screenings and Court Ordered Evaluations

Cenpatico IC works closely with each county to collaborate regarding pre-petition screenings and court ordered evaluations. Payment for pre-petition screenings and court ordered evaluations are the responsibility of the county except for Pima County. Cenpatico IC facilitates and pays for pre-petition screenings in Pima County. Cenpatico IC develops protocols with each county to effectively coordinate crisis services. Cenpatico IC contracted providers are required to adhere to the county crisis protocols and facilitate constructive collaboration to meet the needs of members in each county. The county protocols can be located on the Cenpatico IC website (www.cenpaticointegratedcareaz.com).

4.3.5.2 Emergency Behavioral Health Services

When a Title XIX/XXI eligible person presents in an emergency room setting, the person’s AHCCCS Health Plan is responsible for all emergency medical services including triage, physician assessment, and diagnostic tests.

Cenpatico IC, or when applicable, its designated behavioral health provider, is responsible for psychiatric and/or psychological evaluations in emergency room settings provided to all Title XIX/XXI persons enrolled with Cenpatico IC.

Cenpatico IC is responsible for providing all non-inpatient emergency services to Title XIX/XXI eligible persons. Examples of non-inpatient emergency services include assessment, psychiatric evaluation, mobile crisis, peer support and counseling.

Cenpatico IC is responsible for providing all inpatient emergency services to persons with psychiatric or substance abuse diagnoses for all Title XIX/XXI eligible persons.

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5 Note: in inpatient settings, these services would be included in the per diem rate.
Emergency transportation of a Title XIX/XXI eligible person to the emergency room (ER) when the person has been directed by Cenpatico IC or a Cenpatico IC provider to present to this setting in order to resolve a behavioral health crisis is the responsibility of Cenpatico IC. Cenpatico IC or its provider directing the person to present to the ER must notify the emergency transportation provider of Cenpatico IC fiscal responsibility for the service.

Emergency transportation of a Title XIX/XXI eligible person required to manage an acute medical condition, which includes transportation to the same or higher level of care for immediate medically necessary treatment, is the responsibility of the person’s AHCCCS Health Plan.

For information on emergency services for Non-Title XIX/XXI persons see Section 2.9, Crisis Intervention Services.

4.3.5.3 Non-Emergency Behavioral Health Services

For Title XIX/XXI eligible persons, Cenpatico IC is responsible for the provision of all non-emergency services.

If a Title XIX/XXI eligible person is assessed as needing inpatient psychiatric services by Cenpatico IC or its provider prior to admission to an inpatient psychiatric setting, Cenpatico IC is responsible for authorization and payment for the full inpatient stay, as per Section 10.1 - Securing Services and Prior Authorization.

When a medical team or health plan requests a behavioral health or psychiatric evaluation prior to the implementation of a surgery, medical procedure, or medical therapy to determine if there are any behavioral health contraindications, Cenpatico IC is responsible for the provision of this service. Surgeries, procedures, or therapies can include gastric bypass, interferon therapy or other procedures for which behavioral health support for a patient is indicated.

4.3.5.4 Non-Emergency Transportation

Transportation of a Title XIX/XXI eligible person to an initial behavioral health intake appointment is the responsibility of Cenpatico IC.

4.3.5.5 Medical Treatment for Persons in Behavioral Health Treatment Facilities

When a Title XIX/XXI eligible person is in a behavioral health residential treatment center and requires medical treatment, the AHCCCS Health Plan is responsible for the provision of covered medical services.

If a Title XIX/XXI eligible person is in a behavioral health inpatient facility and requires medical treatment, those services are included in the per diem rate for the treatment facility. If the person requires inpatient medical services that are not available at the behavioral health inpatient facility, the person must be discharged from the psychiatric facility and admitted to a medical facility. The AHCCCS Health Plan is responsible for medically necessary services received at the medical facility, even if the person is enrolled with Cenpatico IC.
4.3.6  PCPs Prescribing Psychotropic Medications

Within their scope of practice and comfort level, an AHCCCS Health Plan PCP may elect to treat select behavioral health disorders. The select behavioral health disorders that AHCCCS Health Plan PCPs can treat are:

- Attention-Deficit/Hyperactivity Disorder;
- Uncomplicated depressive disorders; and
- Anxiety disorders.

4.3.6.1  The “Agreed Conditions”

Certain requirements and guiding principles regarding medications for psychiatric disorders have been established for persons under the care of both a health plan PCP and behavioral health provider simultaneously. The following conditions apply:

- Title XIX/XXI eligible persons must not receive medications for psychiatric disorders from the health plan PCP and provider simultaneously. If a person is identified to be simultaneously receiving medications from the health plan PCP and behavioral health provider, the provider must immediately contact the PCP to coordinate care and agree on who will continue to medically manage the person’s behavioral health condition.
- Medications prescribed by providers within the Cenpatico IC system must be filled by Cenpatico IC subcontracted pharmacies under Cenpatico IC pharmacy benefit (see exceptions to this requirement for dual eligible persons in Section 4.3.7 - Coordination of Care with Medicare Providers). This is particularly important when the pharmacy filling the prescription is part of the subcontracted pharmacy network for both the prescribing provider and the person’s AHCCCS Health Plan. Cenpatico IC and its providers must take active steps to ensure that prescriptions written by providers within Cenpatico IC system are not charged to the person’s AHCCCS Health Plan.

4.3.6.2  Transitions of Persons with ADHD, Depression, and/or Anxiety to the Care of Their Primary Care Physician

Members who have a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), depression, and/or anxiety and who are stable on their medications may transition back to the care of their PCP for the management of these diagnoses, as long as the Member, their guardian or parent, and the PCP agree to this treatment transition. Cenpatico IC is required to facilitate this process and to ensure that the following steps are taken:

- Cenpatico IC must contact the Member’s PCP to discuss the Member’s current medication regime and to confirm that the PCP is willing and able to provide treatment for the Member’s ADHD, depression, and/or anxiety;
- If the PCP agrees to transition treatment for the Member’s diagnosis of ADHD, depression and/or anxiety, Cenpatico IC must provide the PCP with a transition packet that includes (at a minimum):
  - A written statement indicating that the Member is stable on a medication regime;
- A medication sheet or list of medications currently prescribed by a Cenpatico IC Behavioral Health Medical Practitioner (BHMP);
- A psychiatric evaluation;
- Any relevant psychiatric progress notes that may assist in the ongoing treatment of the Member; and
- A discharge summary outlining the Member’s care and any adverse responses the Member has had to treatment or medication.

- A copy of the packet must be sent to the Member’s AHCCCS Health Plan Behavioral Health Coordinator as well as to the Member’s PCP;
- Cenpatico IC will verify that the Member’s transition to the PCP is seamless, and that the Member does not go without medications during this transition period; and
- Each month, Cenpatico IC will complete Provider Manual Form 4.3.4, Recipient Transition from RBHA/Health Plan to PCP Log and submit it to the State in order to monitor the transition process.

### 4.3.6.3 Steps for Health Homes to Ensure Member’s Eligibility for Transition from Cenpatico Integrated Care to Member’s PCP

When the requirements below are met, the Member is eligible to transition back to the care of their PCP:

- The person’s assigned Health Home Provider must confirm that the person has a diagnosis of ADHD, depression, and/or anxiety;
- The person’s assigned Health Home Provider must confirm that the person has been stable for at least six months. Indicators for stability are as follows:
  - No medication changes or dosage changes;
  - No inpatient admissions; and
  - No crisis episodes.
- The behavioral health prescriber who is actively prescribing psychiatric medications for the enrolled person must contact the person’s assigned PCP telephonically to discuss the person’s current prescription regimen. The behavioral health prescriber must confirm that the PCP is willing and able to provide medication management services to the person.

When a person is determined eligible to have their PCP prescribe their psychotropic medications, the person’s Health Home Provider must confirm with the person at the time of the transition that he or she is willing to transition back to the care of their PCP.

Cenpatico IC’s Health Home Providers are responsible for submitting the referral packet to the PCP and the Acute Care Plan Behavioral Health Coordinator listed in Provider Manual Attachment 4.3.1, AHCCCS Contracted Health Plan).

Cenpatico IC’s Health Home Providers must verify that the person has sufficient medications to cover the transition period.
Cenpatico IC’s Health Homes must Provider Manual Form 4.3.4, Recipient Transition from RBHA/Health Plan to PCP Log monthly and submit the completed form to azdeliverables@Cenpatico.com by the 10th day of the month. All unsuccessful transition attempts must also be documented.

4.3.6.4 General Psychiatric Consultations
Behavioral health medical practitioners must be available to AHCCCS Health Plan PCPs to answer diagnostic and treatment questions of a general nature.

General psychiatric consultations are not person specific and are usually conducted over the telephone between the PCP and the behavioral health medical practitioner.

4.3.6.5 One-Time Face-to-Face Psychiatric Evaluations
Providers must be available to conduct a face-to-face evaluation with a Title XIX/XXI eligible person upon his/her PCPs request in accordance with Section 3.2 - Appointment Standards and Timeliness of Service.

A one-time face-to-face evaluation is used to answer PCPs specific questions and provide clarification and evaluation regarding a person’s diagnosis, recommendations for treatment, need for behavioral health care, and/or ongoing behavioral health care or medication management provided by the PCP.

The PCP must have seen the person prior to requesting a one-time face-to-face psychiatric evaluation with the behavioral health provider.

AHCCCS Health Plan PCPs must be provided current information about how to access psychiatric consultation services. The Cenpatico IC Customer Care Department maintains all current information on how to access psychiatric consultation services in the Cenpatico IC geographic service area. Customer Care can be contacted by calling 1-866-495-6738. Cenpatico IC is obligated to offer general consultations and one-time face-to-face psychiatric evaluations and must provide direct and timely access to behavioral health medical practitioners (physicians, nurse practitioners and physician assistants) or other behavioral health practitioners if requested by the PCP.

For additional information on how to obtain a one-time consultation for the evaluation and diagnosis of Autism Spectrum Disorder, please reference Provider Manual Section 3.3.13.

4.3.7 Coordination of Care with Medicare Providers

4.3.7.1 Medicare Advantage Plans
Medicare health plans, also known as Medicare Advantage (MA) plans, are managed care entities that have a Medicare contract with the Centers for Medicare and Medicaid Services (CMS) to provide services to Medicare beneficiaries. MA plans provide the full array of Medicare benefits, including Medicare Part A, hospital insurance, and Medicare Part B, medical insurance. As of January 1, 2006, MA plans also included Medicare Part D, prescription drug coverage.
Many of the AHCCCS Contracted Health Plans are MA plans. These plans provide Medicare Part A, Part B and Part D benefits in addition to Medicaid services for dual eligible persons and are referred to as MA-PD SNPs (Medicare Advantage- Prescription Drug/Special Needs Plans).

Cenpatico IC offers a Medicare Advantage Dual Eligible Special Needs Plan through University of Arizona Health Plans, University Care Advantage.

4.3.7.2 Medicare Fee-for-Service Program

Instead of enrolling in a Medicare Advantage plan, Medicare eligible Members may elect to receive all Medicare services (Parts A, B and/or D) through any provider authorized to deliver Medicare services. Therefore, Members in the Medicare Fee-for-Service program may receive services from Medicare registered providers in the Cenpatico IC provider network.

4.3.7.3 Inpatient Psychiatric Services

Medicare has a lifetime benefit maximum for inpatient psychiatric services. Cenpatico IC’s cost sharing responsibilities and billing for inpatient psychiatric services must be in accordance with Section 8.3 - Third Party Liability and Coordination of Benefits, and Section 8.1 - Submitting Claims and Encounters to Cenpatico IC.

Cenpatico IC requires all contracted providers to bill all third parties prior to billing Cenpatico IC. Cenpatico IC is the payer of last resort. When a member has primary insurance through another Health Plan and Cenpatico IC has been notified of the member’s admission to the hospital, Cenpatico IC will coordinate with that other Health Plan. Cenpatico IC will coordinate with the hospital staff to ensure that member’s needs upon discharge are coordinated and meet their needs.

4.3.7.4 Outpatient Behavioral Health Services

Medicare provides some outpatient services that are also State covered services. Cenpatico IC cost sharing responsibilities and billing for outpatient services must be in accordance with Section 8.3 - Third Party Liability and Coordination of Benefits and Section 8.1 - Submitting Claims and Encounters to Cenpatico IC.

Cenpatico IC requires all contracted providers to bill all third parties prior to billing Cenpatico IC. Cenpatico IC is the payer of last resort.

4.3.7.5 Prescription Medication Services

Medicare eligible Members 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 Members enrolled in PDPs. Some MA-PDs may contract with RBHA/Health Plans or their providers to provide the Part D benefit to Medicare eligible Members.

While PDPs and MA-PDs are responsible for verifying prescription drug coverage to Members enrolled in their plans, there are some prescription medications that are not included on plan formularies (non-covered) or are excluded Part D drugs. The RBHA/Health Plan is responsible for covering non-covered or excluded Part D behavioral health prescription medications listed on
the RBHA/Health Plan formulary, in addition to Part D cost sharing, in accordance with Section 8.3 - Third Party Liability and Coordination of Benefits.

4.4 Coordination of Care with Other Governmental Entities

Effective communication and coordination of services are fundamental objectives for providers when serving Members involved with other government entities. When providers coordinate care efficiently, the following positive outcomes can occur:

- Duplicative and redundant activities, such as assessments, service plans, and agency meetings are minimized;
- Continuity and consistency of care are achieved;
- Clear lines of responsibility, communication, and accountability across service providers in meeting the needs of the Member and family are established and communicated; and
- Limited resources are effectively utilized.

Cenpatico IC recognizes the importance of a responsive behavioral health system, especially when the needs of vulnerable Members have been identified by other government entities. For example, the State strongly supports the timely response and coordination of services for children who have been, or imminently will be, removed from their homes by the Arizona Department of Child Safety (see Section 3.2 - Appointment Standards and Timeliness of Service). The State expects all providers to collaborate and provide any necessary assistance when DCS initiates requests for covered services or supports.

The intent of this Section is to communicate Cenpatico IC’s expectations for providers who must cooperate and actively work with other agencies serving Members. Cenpatico IC expects any system partner involved with a member to be invited to Child and Family Team (CFT)/Adult Recovery Team (ART) meetings.

AHCCCS has Intergovernmental Agreements (IGAs), Interagency Service Agreements (ISAs), and Memorandums of Understanding (MOUs) with several State, county, tribal, and local agencies to collaborate while serving Members involved with multiple systems. Cenpatico IC and Cenpatico IC contracted providers are required to adhere to the applicable provisions of the IGAs, ISAs and MOUs.

In addition, providers are required to adhere to collaborative protocols established between Cenpatico IC and with community and state stakeholders. These protocols can be accessed at www.Cenpaticointegratedcareaz.com/stakeholder-protocols.

4.4.1 Department of Child Safety (DCS)

When a child Member receiving services is also receiving services from DCS, the provider must work toward effective coordination of services with the DCS Specialist. Providers are expected to provide 72 Hour Rapid Response in accordance with PM Section 6.2, 72-Hour Rapid Response Requirements coordination of care and services in accordance with Cenpatico’s Department of Child Safety Collaborative Protocol.

The AFF program provides expedited access to substance abuse treatment for parents and caregivers referred by DCS and the ADES/FAA Jobs Program. AHCCCS participates in statewide implementation of the program with ADES (see A.R.S. § 8-881). Cenpatico IC providers who are contracted with AFF are required to:

- Accept referrals for Title XIX/XXI eligible and enrolled Members and families referred through AFF;
- Accept referrals for Non-Title XIX and Non-Title XXI persons and families referred through AFF and provide services, if eligible;
- Ensure that services made available to persons 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;
- Collaborate with ADES/DCYF/DCS, the ADES/FAA JOBS Program and Substance Use Treatment providers to minimize duplication of assessments and achieve positive outcomes for families; and
- Develop procedures for collaboration in the referral process to verify effective service delivery through Cenpatico IC. Appropriate authorizations to release information must be obtained prior to releasing information.

Cenpatico IC and the Department of Child Safety (DES/DCS) Central, Southeast and Southwest Districts have combined efforts to establish a mutually agreed upon protocol to verify effective and efficient delivery of behavioral health services. “Collaborative Protocol between Cenpatico IC Behavioral Health of Arizona and the Department of Child Safety (DCS)” defines the respective roles and responsibilities of each party. This document is located at https://www.cenpaticointegratedcareaz.com/content/dam/centene/cenpaticoaz/Documents/CI-C-DCS-Collaborative-Protocol-Final.pdf

The goal of the AFF Program is to promote permanency for children, stability for families, protect the health and safety of abused and/or neglected children and promote economic security for families. Substance abuse treatment for families involved with DCS must be family centered, provide for sufficient support services and must be provided in a timely manner (see Section 3.2 – Appointment Standards and Timeliness of Service and Section 3.10 - Special Populations).

4.4.2 Arizona Department of Education (ADE), Schools, or Other Local Educational Authorities

AHCCCS has delegated the functions and responsibilities as a State Placing Agency to Cenpatico IC for Members in Cenpatico IC’s Geographic Service Areas. Cenpatico IC works in collaboration with the ADE for the placement of children with behavioral health service providers.
Providers serving children can gain valuable insight into an important and substantial element of a child’s life by soliciting input from school staff and teachers. Providers can 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 Section 12.6.1 - Disclosure of Health Information);
- For children receiving special education services, actively consider information and recommendations contained in the Individual Education Plan (IEP) during the ongoing assessment and service planning process (see Section 3.5, Assessment and Service Planning);
- For children receiving special education services, ensuring that the provider or designee participates 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 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.

4.4.3 Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD)

Persons qualifying for services through DDD can fall into several different categories based on their eligibility status and the extent of their diagnosed disability. There are three general groupings:

<table>
<thead>
<tr>
<th>Type of DDD Eligibility</th>
<th>What services are available?</th>
<th>Who is responsible for providing the services?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title XIX/XXI and eligible for ALTCS</td>
<td>All Title XIX/XXI covered services</td>
<td>Cenpatico IC and providers</td>
</tr>
<tr>
<td>Title XIX/XXI and not eligible for ALTCS</td>
<td>All Title XIX/XXI covered services</td>
<td>Cenpatico IC and providers</td>
</tr>
<tr>
<td>Non-Title XIX</td>
<td>Services available through special funding (i.e. Substance Abuse Block Grant, Non-Title XIX SMI funds)</td>
<td>Cenpatico IC and providers receiving special funding</td>
</tr>
</tbody>
</table>

Providers must ensure effective coordination of services with Members receiving services through DDD as outlined in the Collaborative Protocol between Cenpatico IC and DDD.
4.4.3.1 Consultation and Clinical Intervention Program Requirements

To enhance collaboration efforts between Cenpatico IC and DDD, and meet the need of members often at greatest risk of placement disruption or institutionalization due to behavioral issues, the Consultation and Clinical Intervention (CCI) program was developed in compliance with AHCCCS Medical Policy Manual (AMPM), Policy 570, Community Collaborative Care Teams. For more information about the Consultation and Clinical Intervention (CCI) Program, reference PM Attachment 4.4.2, Consultation and Clinical Intervention Program Requirements.

4.4.4 Department of Economic Security/Arizona Early Intervention Program (ADES/AzEIP).

Providers can work toward effective coordination of care for children identified as having, or likely having, disabilities or developmental delays 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 services as part of the AzEIP evaluation process receive appropriate and timely service delivery (see Section 3.2 – Appointment Standards and Timeliness of Service);
- Ensuring that, if an AzEIP team has been formed for the child, the provider will coordinate team functions so as to avoid duplicative processes between systems; and
- Coordinating enrollment in Cenpatico IC’s children’s system of care when a child transfers to the children’s DDD system.

4.4.5 Courts and Corrections

Cenpatico IC and its providers are expected to collaborate and coordinate care for Members involved with:

- The Arizona Department of Corrections (ADC);
- Arizona Department of Juvenile Corrections (ADJC); or
- Administrative Offices of the Court (AOC).

When a Member receiving services is also involved with a court or correctional agency, providers work towards effective coordination of services by:

- Working in collaboration with the appropriate staff involved with the Member;
- Inviting probation or parole members to participate in the development of the ISP and all subsequent planning meetings as members of the Member’s clinical team with Member’s approval;
- Actively considering information and recommendations contained in probation or parole case plans when developing the ISP; and
- Ensuring that the provider evaluates and participates in transition planning prior to the release of eligible Members and arranges and coordinates care upon the person’s release (see Section 3.3 – Referral and Intake Process). For a copy of the
Criminal Justice Release of Information Form, see Form 4.4.6 Authorization for Use or Disclosure of Protected Health Information – Criminal Justice System Referral.

Criminal Justice Reach-In Care Coordination Program and the Arizona Department of Corrections:

- Cenpatico IC Staff will receive a notification when a member meeting Reach-In criteria is identified as nearing release. Cenpatico IC staff will schedule the member’s Intake and Assessment appointment via MyHealthDirect (Cenpatico IC’s provider office scheduling vendor) to occur within seven days post release with the member’s chosen Health Home.

- The provider shall conduct the Intake and Assessment appointment. During the Intake and Assessment appointment, the provider must educate the member on the benefits of peer support and submit an automatic referral for peer support services through a Health Home or Specialty Provider, if the member consents.

- The provider shall schedule an ART meeting to occur within 10 days post release. With authorization from the member, the provider must make every attempt to include the Cenpatico IC Care Coordinator, the member’s Health Plan (if not an integrated member), probation/parole officer and other partners the provider identifies as supports to participate in the ART meeting.

- If transportation assistance is required for the member to attend any of the appointments, the provider must coordinate and provide for the transportation. For integrated members, those designated SMI, the provider must provide coordination and services for both behavioral and physical health. For members that are not receiving integrated services, the provider must connect with Health Plan Behavioral Health Coordinators or other designated point of contact to coordinate care with the health plan.

- If the member does not appear for a scheduled appointment/service, the provider must attempt to contact the member no fewer than three times. Attempts must be assertive and not simply a phone call, but documented in person attempts and other avenues utilized for communication. For those members identified as not attending the required 7 day appointment, provider must coordinate with the Cenpatico IC Justice Team to identify and document the reason for the missed appointment.

- The provider must continue to engage the member and provide services identified on the ISP.

4.4.6 Arizona County Jails

When someone detained in jail is believed by jail personnel to have a behavioral health diagnosis and the person does not have alternative means to obtain services, jail personnel may request the assistance of Cenpatico IC’s contracted providers to coordinate care as outlined below. In addition, Cenpatico IC Health Home Providers are required to proactively assist persons detained in jail who are determined to have, or perceived to have, a Serious Mental Illness (see Section 3.6 - SMI Eligibility Determination). Health Home Providers are required to accept all requests for Coordination of Care assistance from county jails and perform the following duties:
• Timely and proactively collaborate with the appropriate jail and court staff involved with the Member;
• Proactively ensure that screening, assessment, and coordination of care services are provided;
• Provide consultation services to advise jail staff related to diagnosis, medications, and the provision of other behavioral health services to jailed Members upon request;
• Verify that the Member has a viable release plan, that includes access to medications, peer support services, counseling, transportation, and housing;
• Facilitate continuity of care if the Member is discharged or incarcerated in another correctional institution;
• Share pertinent information with all staff involved with the Member’s care or incarceration with Member approval and in accordance with Section 12.6.1 - Disclosure of Health Information. For a copy of the Criminal Justice Release of Information Form, see Form 4.4.6 Authorization for Use or Disclosure of Protected Health Information – Criminal Justice System Referral.; and
• Provide assistance in the determination of whether the Member is eligible for Mental Health Court or a Jail Diversion Program.
• Assure systems and processes are designed for discussion with detention and detention healthcare staff of services and resources needed for individuals to safely transition into the community upon release from jail if those individuals are designated as seriously mentally ill (SMI) or are categorized as General Mental Health (GMH) and/or substance abuse and have one or more of the following complicated/high cost medical needs: skilled nursing facility level of care, continuous oxygen, invasive treatment for cancer, kidney dialysis, home health services (i.e., infusions, wound vats), terminal hospice care, HIV positive, pregnant, insulin dependent diabetic, or seizure disorder.

Criminal Justice Reach-In Care Coordination Program and the County Detention Centers:
• Providers will be notified weekly when a member meeting Reach-In criteria is identified as nearing release from a detention center. Notification will include members in an open episode of care (active) and members not currently in an active status (inactive). The Cenpatico contracted provider Jail Liaisons will serve as the hub for Reach-In coordination and receive a weekly list of all eligible Reach-In members. The Jail Liaisons will meet with each member in person, when permissible by the detention center, within five business days of notification that a member is nearing release. If an in person meeting is not permissible by the detention center, the Jail Liaisons must meet with the member via video conference and within five business days.
• During the in person meeting, the Jail Liaisons will work diligently to engage the member into services to include: Provide education regarding behavioral health services; discuss the importance of physical health services; discuss services available such as peer support, housing, employment and other resources available; provide appointment scheduling and health plan information, if applicable; and education on the importance of obtaining medications or prescriptions and
discharge plan from detention center treating provider. The Jail Liaisons will schedule the members Intake and Assessment appointment via MyHealthDirect to occur within seven days post release with the members chosen Health Home.

- The provider shall conduct the Intake and Assessment appointment. During the Intake and Assessment appointment, the provider must educate the member on the benefits of peer support and submit an automatic referral for peer support services through a Health Home or Specialty Provider, if the member consents.

- The provider shall schedule an ART meeting to occur within 10 days post release. With authorization from the member, the provider must make every attempt to include the Cenpatico IC Care Coordinator, the member’s Health Plan (if not an integrated member), probation/parole officer and other partners the provider identifies as supports to participate in the ART meeting.

- If transportation assistance is required for the member to attend any of the appointments, the provider must coordinate and provide for the transportation. For integrated members, those designated SMI, the provider must provide coordination and services for both behavioral and physical health. For members that are not receiving integrated services, the provider must connect with Health Plan Behavioral Health Coordinators or other designated point of contact to coordinate care with the health plan.

- If the member does not appear for a scheduled appointment/service, the provider must attempt to contact the member no fewer than three times. Attempts must be assertive and not simply a phone call, but documented in person attempts and other avenues utilized for communication. For those members identified as not attending the required 7 day appointment, provider must coordinate with the Cenpatico IC Justice Team to identify and document the reason for the missed appointment.

- The provider must continue to engage the member and provide services identified on the ISP.

For additional information or assistance regarding providing coordination services to incarcerated Members, contact the Court Liaison at 866-495-6738.

4.4.7 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.

Supportive employment services available through the AHCCCS system are distinct from vocational services available through RSA. Please refer to the AHCCCS Covered Behavioral Health Services Guide for more details.

When a Member determined to have a Serious Mental Illness is receiving services and is concurrently receiving services from RSA, the provider ensures effective coordination of 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 (see Section 9.2 - Medical Record Standards);

• Inviting RSA staff to be involved in planning for day 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; 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.

4.4.8 Arizona Department of Health Services/Office of Assisted Living Licensing

When a Member receiving services is residing in an assisted living facility, providers must coordinate with the Office of Assisted Living Licensing to ensure that the facility is licensed and that there are no existing violations or legal orders. Providers must also determine and verify that the Member living in an assisted living facility is at the appropriate level of care. The provider can coordinate with the Office of Assisted Living Licensing to determine the level of care that a particular assisted living facility is licensed to provide.

4.4.9 First Responders and Community Agencies

Cenpatico IC and its providers proactively collaborate with municipal first responders: police, fire, EMS and community agencies, such as: acute AHCCCS health plans and hospital emergency departments. Providers are expected to develop strong, effective relationships with first responders and community agencies in the communities they serve. Further information and assistance in engaging with first responders and community agencies may be obtained by contacting Cenpatico IC’s Justice Services and System Partner Relations department at 866-495-6738.

4.4.10 Veterans Administration

The Veteran’s Administration (VA) is a federally funded health system that provides benefits to persons who served in the active military, naval, or air service, and who were discharged or released under conditions other than dishonorable (Congressional Research Center, 2012). Cenpatico IC Members with Veteran benefits can receive services from Cenpatico IC contracted providers. Veterans have a choice from whom they prefer to receive services. Veterans can receive mental health benefits through Cenpatico IC’s network and physical health services through the VA, or medication only from one or the other, or any combination thereof. Cenpatico IC and its contracted providers are responsible to work collaboratively with the VA to share information and coordinate care.

4.4.11 Indian Health Services

Indian Health Services (IHS) is an agency within the Department of Health and Human Services and is responsible for providing federal health services to American Indians and Alaskan Natives. Individuals who are eligible for IHS benefits through an IHS provider or 638 licensed facility and
are eligible to receive services from Cenpatico IC’s contracted providers have a choice in whom they prefer to receive services. American Indian and Alaskan Natives can receive mental health benefits through Cenpatico IC’s network and physical health services through the IHS, or medication only from one or the other, or any combination thereof. Cenpatico IC and its contracted providers are responsible to work collaboratively with IHS to share information and coordinate care. See Section 4.1 - Transition of Persons for more information.

4.5 Partnerships with Families and Family-Run Organizations in the Children’s Behavioral Health System

Arizona holds a distinction in the United States for promoting various family roles within the children’s behavioral health system. The involvement of families is credited as making a significant contribution in improving the service system. Providers should reference AHCCCS Practice Protocol, Family and Youth Involvement in the Children’s Behavioral Health System found on the AHCCCS website.

Section 5 - PHYSICAL HEALTH PROVIDER REQUIREMENTS

Cenpatico IC’s network includes various different behavioral and physical health care providers to meet the needs of the membership, including Primary Care Providers, Health Homes and Specialty Providers.

5.1 Primary Care Provider (PCP) Requirements

Cenpatico IC’s contracted PCPs provide integrated delivery of behavioral and physical health care for SMI Members. PCPs are required to meet various requirements, which are described below.

5.1.1 Provider Type

PCPs are required to be (a) Arizona licensed as allopathic or osteopathic physicians that generally specialize in family practice, internal medicine, obstetrics, gynecology, or pediatrics; (b) certified nurse practitioners or certified nurse midwives; or (c) physician’s assistants.

5.1.2 PCP Assignments

Members are auto-assigned to PCPs based on PCP and member location. Auto-assignment is also based on PCP Panel size. Members are auto-assigned to PCPs that have panel sizes under 1000 members. When determining assignments to a PCP, Cenpatico IC also considers the PCP’s ability to meet AHCCCS appointment availability, wait times and Quality of Care (QOC) standards. Cenpatico IC PCP Panel Size and will adjust the size of a PCP’s panel, as needed, for the PCP to meet AHCCCS appointment and clinical performance standards. Cenpatico IC will only assign Members diagnosed with AIDS or as HIV positive to PCPs that comply with criteria and standards set forth in the AHCCCS Medical Policy Manual.
5.1.3 Freedom of Choice Within Network

Cenpatico IC offers Members freedom of choice in selecting a PCP within the network and does not restrict PCP choice unless a Member has shown an inability to form a relationship with a PCP, as evidenced by frequent changes, or when there is a medically necessary reason.

Cenpatico IC informs each Member in writing of his or her enrollment and PCP assignment within five days of Cenpatico IC’s receipt of notification of a new member assignment by AHCCCS. Cenpatico IC informs each Member in writing of any PCP change, and allows Members to make the initial PCP selection and any subsequent PCP changes verbally or in writing.

5.1.4 PCP Required Activities

PCPs shall be responsible for:

- Consent form requirements;
- Supervising, coordinating and providing of care to each assigned Member (except for dental services provided to EPSDT Members without a PCP referral);
- Initiating referrals for medically necessary specialty care in accordance to AMPM Policy 510 ;
- Maintaining continuity of care for each assigned Member;
- Maintaining each assigned Member’s medical record, including documentation of all services provided to the Member by the PCP, as well as any specialty or referral services;
- Utilizing the AHCCCS-approved ACOM, Appendix B, EPSDT Tracking Forms to document services provided and compliance with AHCCCS standards when serving EPSDT Members (see Section 2.8 - EPSDT for Adults with SMI 18, 19 & 20 Years of Age);
- Providing clinical information regarding a Member’s health and medications to a treating provider, including behavioral health providers, within ten business days of a request from the provider;
- In lieu of developing a medical record when a PCP receives behavioral health information on a Member before seeing the Member, a PCP may establish a separate file to hold behavioral health information. The behavioral health information must, however, be added to the Member’s medical record when the Member becomes an established patient (see Section 9.2 - Medical Record Standards); and
- Enrolling as a Vaccines for Children (VFC) provider for Members, age eighteen only.

5.1.5 Additional Referral Requirements for SMI Members

For SMI Members receiving physical health care services, Providers must follow the following procedures for referrals to specialists or other services. Providers shall use the Specialist Referral Form and refer the Member to the appropriate provider (a provider directory is available on Cenpatico IC’s website).

- Referrals to specialty physician services must be from a PCP, except as follows: Women will have direct access to in-network OB/GYN providers, including
physicians, physician assistants and nurse practitioners within the scope of their practice, without a referral for preventive and routine services.

- SMI Members that need a specialized course of treatment or regular care monitoring may directly access a specialist (i.e. through a standing referral or an approved number of visits) as appropriate for the Member’s condition and identified needs. Specialty physicians cannot begin a course of treatment for a medical condition other than that for which the Member was referred, unless approved by the Member’s PCP.

5.1.6 Referrals to Entities Where Providers Have a Financial Relationship

Providers shall comply with all applicable physician referral requirements and conditions defined in §§ 1903(s) and 1877 of the Social Security Act and corresponding regulations which include, but are not limited to, 42 CFR Part 411, Part 424, Part 435 and Part 455. §§ 1903(s) and 1877 of the Act prohibits physicians from making referrals for designated health services to health care entities with which the physician or a member of the physician’s family has a financial relationship. Designated health services include, at a minimum, clinical laboratory services; physical therapy services; occupational therapy services; radiology services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics and prosthetic devices and supplies; home health services; outpatient prescription drugs, and inpatient and outpatient hospital services.

5.1.7 Appointment Requirements Applicable to Physical Health Providers (Non-Hospitalized Persons)

For SMI Members eligible to receive physical health care services, the following appointment requirements apply:

For Primary Care Appointments:
- Emergency: same day of request or within twenty-four (24) hours of the Member’s phone call or other notification
- Urgent: within two (2) days of request; and
- Routine: within twenty-one (21) days of request.

For Specialty Care Appointments:
- Emergency: within twenty-four (24) hours of referral;
- Urgent: within three (3) days of referral; and
- Routine: within forty-five (45) days of referral.

For Dental Appointments to SMI Members under age twenty-one (21).
- Emergency: within twenty-four (24) hours of request;
- Urgent: within three (3) days of request; and
- Routine: within forty-five (45) days of request.

For Maternity Care Appointments, see Section 2.3 - Maternity Services for Title XIX/XXI Adults with SMI.
Section 6 - SPECIFIC BEHAVIORAL HEALTH PROGRAM REQUIREMENTS

6.1 Urgent Engagement (UE) Program Requirements

Urgent Engagement is the process of engaging people into care who have experienced a crisis or have been admitted to an inpatient facility. It is intended to engage persons into care, rather than fulfilling an administrative function. The process includes ensuring effective coordination of care, engagement, discharge planning, an SMI screening when appropriate (reference Provider Manual section 3.6), screening for eligibility, referral as appropriate, and prevention of future crises. Once the Health Home completes the urgent engagement process, the Health Home is the entity that is responsible for coordination of necessary service and discharge planning. Urgent Engagements are required to be started within one hour (at a Community Observation Center) or 24 hours (at a Behavioral Health Inpatient Facility).

6.1.1 Health Home UE Responsibility

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

_Urgent Engagement is a no wrong door approach and therefore, all persons are eligible, regardless of benefit or assigned health plan._ If the member is enrolled with another health plan or private insurance, the Health Home role is to coordinate care with the current provider and health plan, determine the need for an SMI evaluation, and work directly with the health plan to ensure the member is receiving needed services and follow up. For persons who are not yet enrolled in Medicaid, Block Grant programs or the Marketplace, Health Homes are required to continue to pursue coverage for the person for up to 45 days.

Providers should bill for Urgent Engagement services by using the Y indicator (to indicate a crisis service) until they have successfully engaged the person into an Open Episode of Care as evidenced by a Type 1 demographic or closure. Services provided with a Y indicator cannot exceed 45 days.

One Hour Urgent Engagements at a Community Observation Center (COC)

Every person who receives services at a Community Observation Center and is not in an open episode of care must be referred for urgent engagement. The Health Home must arrive within one hour of the request. Once a Health Home makes contact with the member, they are responsible for discharge planning for that member, including transportation and a follow up appointment. The urgent engagement at a COC should be an abbreviated intake in order to quickly gather the information needed. The engagement process can be completed in a follow up appointment (preferably within the next 24-48 hours).

24 hour Urgent engagements at a Behavioral Health Inpatient Facility (BHIF)

Every person who lives in a Cenpatico covered service area and is hospitalized at a Behavioral Health Inpatient Facility for psychiatric reasons, and is not in an open episode of care with a Health Home, is eligible for an urgent engagement. The Health Home has 24 hours to arrive at the facility.
6.1.2 Capacity to Travel
Health Homes must maintain capacity to travel to locations within Arizona to complete Urgent Engagements.

6.1.3 Enrollment
Health Homes must open an episode of care for all Medicaid-enrolled Members (without a current Cenpatico IC open episode of care) by submitting an Open Episode of Care Demographic (Type 1) within one (1) work day after completing the Urgent Engagement. Provider is also required to complete and submit the Enrollment (834) transaction and Type 1 Open Episode of Care Demographic for all non-Medicaid Members within one (1) calendar day of the completion of the 24 Hour Mobile Urgent Intake service.

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

6.2 CMDP Eligible Children Involved with DCS

6.2.1 72-Hour Rapid Response Requirements for Children
Cenpatico Health Homes must provide a rapid response within 72 hours for all children who are taken into the custody of ADES/DCYF/DCS, regardless of Title XIX/XXI eligibility status. Within 72-hours of Cenpatico IC dispatch, the Health Home must conduct a face-to-face visit with the child in their placement in order to:

- Complete an assessment 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 or arrange 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;
- Ensure that each child and family is referred for ongoing behavioral health services as indicated by the assessment and service plan and ensure that services start within 21 days of the Rapid Response Assessment.
- Initiate the development of the CFT for each child (see Child and Family Team Practice Protocol); and
- Provide the ADES/DCYF/DCS Specialist with written findings and recommendations for medically necessary covered services within 24 hours of Rapid Response. This information shall be utilized during the initial Preliminary Protective Hearing, which
occurs within 5 to 7 days of the child’s removal. (See Provider Manual Attachment 3.2.1, DCYF Child Welfare Timelines for more information).

Additionally, Health Homes are expected to engage the family from which the child was removed within 5 days of the Rapid Response in order to engage them in the assessment process and invite them to participate in the Child and Family Team meeting. The Health Home is expected to help the parents identify appropriate services and support them in the enrollment process.

Health Homes are required to attend the Pre-Hearing Conference and Preliminary Protective Hearing to present their assessment and recommendations and continue to engage the family.

NurseWise must provide a monthly report of all Rapid Response Activities on Deliverable EC-301-4.

6.2.1.1 Capacity to Travel
Health Homes must maintain capacity to travel to locations within Arizona to complete a 72 Hour DCS Mobile Rapid Response services.

6.2.1.2 Enrollment
Health Homes must open an episode of care for all Medicaid-enrolled Members (without a current Cenpatico IC open episode of care) by submitting an Open Episode of Care Demographic (Type 1) within one (1) calendar day after completing the 72 Hour DCS Rapid Response service. Health Homes are also required to complete and submit the Enrollment (834) transaction and Type 1 Open Episode of Care Demographic for all non-Medicaid Members within one (1) calendar day of the completion of the 72 Hour DCS Rapid Response service. Refer to Provider Manual section 3.17.4.1.

6.2.1.3 Tracking of Transfers
When applicable following a Rapid Response, Health Homes must track the transfer of enrolled Members to other Cenpatico IC Intake agencies through the Cenpatico IC Provider Portal and continue providing coordination and treatment services until the receiving agency has fully accepted the transfer as indicated in the Provider Portal.

6.2.1.4 Computer and Wireless Specifications
Health Homes must verify Rapid Response staff have access to a laptop, mobile printer and wireless web connectivity to allow access to electronic medical information in the field. Computer and wireless specifications must meet or exceed Cenpatico IC requirements 6.2.2 Ongoing Service Requirements for CMDP Eligible DCS Involved Children. Health Homes are expected to provide services for a period of at least six months unless services are refused by the guardian in writing when the child is no longer in Department of Child Safety custody.

6.2.2 Ongoing Service Requirements for CMDP Eligible DCS Involved Children
Behavioral Health Services for DCS involved children must stay open for at least six months from the time of Rapid Response unless the Health Homes receives a written request form the guardian or the case closes.
DCS Involved Children must receive at least one service, identified on their service plan each calendar month.

Health Homes must ensure that services are provided to children within 21 days of the following:

- Rapid Response
- Initial/Intake Assessment
- Update of the Comprehensive Assessment
- Agreement of the Child Family Team

Health Homes are expected to participate in all court hearings as appropriate throughout the episode of care.

Health Homes are expected to engage the biological parents, foster parents, kinship parents and adoptive parents throughout the course of the case. The purpose of this engagement is to engage the parents and caretakers in the assessment process and invite them to participate in the Child and Family Team meeting. The Health Home is expected to help the parents identify appropriate services and support them in the enrollment process.

When the DCS Specialist/ Legal Guardian is not available, the Health Home must recognize the signature of the foster or kinship placement for the purpose of coordinating outpatient behavioral health services. Foster and kinship placements may sign a release of information, consent to treat and the service plan and other necessary documentation. If there is a disagreement between the placement and the DCS Specialist about services, the Legal Guardian/ DCS Specialist shall make the final decision.

The DCS Specialist/ Legal Guardian must be the one to sign a child in the legal custody of DCS in to HCTC, BHRF, BHIP or a hospital.

6.2.3 Requirements of Jacobs Law/ ACOM Policy 449

6.2.3.1 Requirements of the Foster Care Hotline

NurseWise shall maintain a Foster Care Hotline for the specific purpose of answering calls about DCS Involved Children from Foster, Kinship and Adoptive Parents. The Foster Care Hotline shall be available 24/7 to meet the needs of the child and family.

Appropriate calls to the NurseWise Foster Care Hotline may include but are not limited to:

- Initiate a Rapid Response, not previously initiated by DCS
- Placement initiated Request for 72 Hour Out of Home Determination due to dangerous or threatening behaviors
- Request for Crisis Mobile team
- Request for referral to a Secondary Responder/Placement Stabilization Program

When a foster parent, kinship placement, group home or law enforcement official calls the Foster Care Hotline to initiate a Rapid Response, the Foster Care Hotline staff must immediately email the Cenpatico IC Crisis Department.
6.2.3.2 **ACOM Policy 449 Requires**

- The Foster Care Hotline is required to send out a Crisis Mobile Team if a foster, kinship or adoptive parent requests a 72 Hour Out of Home Determination.
- The Crisis Mobile Team shall determine if the child needs to go to a hospital, CRC or BIP to ensure the safety of the child while the team meets to determine further clinical needs of the child.
- The Crisis Mobile Team shall immediately inform the Health Home and the Cenpatico CMDP Liaison of the call and the need for an Emergency CFT.
- The Health Home is required to have an Emergency CFT to identify the needs of the member and if appropriate follow the Cenpatico IC process for securing the appropriate level of care for the member.

6.2.3.3 **Crisis Response for DCS Involved Members and Adopted Children**

When the NurseWise Crisis Line or Foster Care Hotline is called because the member is in crisis or is showing dangerous or threatening behaviors, a crisis mobile team shall be dispatched.

- Crisis Mobile Team providers are required to arrive within 2 hours of dispatch.
- Crisis Mobile Teams that do not arrive within 2 hours are expected to call the Foster Care Hotline and report the missed timeframe.

6.2.3.4 All calls received by the NurseWise Foster Care Hotline must be tracked and reported to Cenpatico using Deliverable EC-301-25 Foster Care Hotline Call Report.

6.3 **Behavioral Health Supportive Home Program Requirements**

Behavioral Health Supportive Home Providers must meet the requirements of AAC R9-10-1601 – 1611.

6.3.1 **Authorization and Continued Stay Requirements**

Behavioral Health Supportive Home providers must meet all prior authorization and continued stay requirements for Behavioral Health Supportive Homes as spelled out in this Provider Manual and as directed by Cenpatico IC.

6.4 **Birth To Five Provider Program Requirements**

Birth to Five providers must provide screening, assessment, service planning, interventions and practices specifically designed to meeting the unique needs of children age Birth to Five and their families. Providers are required to utilize the AHCCCS Practice Tool “**Working with the Birth to Five Population**” (Revised on 3/15/2015) for additional guidance.

Birth to Five providers must demonstrate active participation in state, regional and community sponsored best practices development and committed to working to build community knowledge base and expertise.
6.5 Brief Intervention Provider Program Requirements

Brief Intervention Program providers must maintain an intensive treatment program to deliver services 24 hours a day, 7 days a week, 365 days a year with the purpose of helping persons live successfully in the community. Brief Intervention Program providers must deliver supportive and treatment services necessary to support the Member in the community and must verify access to the services 24 hours a day, 7 days a week, 365 days a year to respond to crises, as appropriate.

6.5.1 Staffing
Brief Intervention Program providers must provide adequate staffing to maintain the safety of the Members and protect them from harm.

6.5.2 Participation Limit
Brief Intervention Program providers must limit participation in the program to ten (10) days per episode. Members cannot be readmitted to a Brief Intervention Program within 72 hours of discharge from any Brief Intervention Program.

6.5.3 Coordination with Teams and Family
Brief Intervention Program providers must coordinate with treatment teams and family members, as appropriate, to verify continuity of care. Child and Family Teams/Adult Recovery Teams must be conducted within 72 business hours after admission. Each Brief Intervention Program provider must submit a report – see Section 16 – Deliverables

6.6 Consumer Operated Provider Program Requirements

Providers can be considered “Consumer Operated” if they comply with the requirements as outlined in the SAMHSA Consumer Operated Services Evidence-Based Practices Kit. Consumer Operated Providers can hold a behavioral health license from the Arizona Department of Health Division of Licensing, or in some situations can be certified as a Community Service Agency per AHCCCS Medical Policy 961, Community Service Agency Title XIX Certification. Community Service Agency Application forms can be found on the AHCCCS website at https://azahcccs.gov/shared/MedicalPolicyManual/.

6.7 Crisis Line Provider Program Requirements

6.7.1 General Requirements for Crisis Line providers

6.7.1.1 Referrals
Crisis Line providers must comply with the requirements outlined in PM Section 6.7, Substance Use Disorder Treatment Requirements.

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

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

6.7.1.4 SUD Services

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

6.7.1.5 Coordination of Care

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

6.7.1.6 Community-Based Alternatives

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

6.7.1.7 Staff Requirements and Training

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

Crisis Line providers must notify Cenpatico IC of any staff changes or incidents impacting credentialing involving Behavioral Health Professionals or Behavioral Health Medical Professionals within forty-eight (48) business hours of any additions, terminations or changes.
6.7.1.8  **Quality Improvement**

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

6.7.1.9  **EHR**

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

6.7.2  **Service Requirements**

Crisis Line providers must maintain a twenty-four (24) hours per day, seven (7) days per week crisis response system that has a single toll-free crisis telephone number and the discretion to establish a local crisis telephone number. The crisis line must:

- Be widely publicized within the covered service area and included prominently on Cenpatico IC’s website, the Member Handbook, Member newsletters, and as a listing in the resource directory of local telephone books;
- Be staffed with a sufficient number of staff to manage a telephone crisis response line to comply with the requirements of the Agreement;
- Be answered within three (3) telephone rings, or within 15 seconds on average, with an average call abandonment rate of less than 3% for the month.
- Include triage, referral and dispatch of service providers and patch capabilities to and from 911 and other crisis providers as applicable;
- Offer interpretation or language translation services to persons who do not speak or understand English and for the deaf and hard of hearing; and
- Provide Nurse On-Call services twenty-four (24) hours per day, seven (7) days per week to answer general healthcare questions from SMI Members receiving physical health care services and to provide them with general health information and self-care instructions.

6.7.2.1  **Staff Requirements**

Crisis Line providers must follow the requirements below:

- Establish and maintain the appropriate ADHS Office of Licensing license to provide required services.
- Maintain appropriate Arizona licensed medical staff, Arizona licensed Behavioral Health Professionals, ADHS Office of Licensing facility licenses, qualified Behavioral Health Technicians and Paraprofessionals, and Peer Support staff to adequately address and triage Member calls and verify the safe and effective resolution of calls.
- Maintain bilingual (Spanish/English) capability on all shifts and employee interpreter services to facilitate crisis telephone counseling for all callers.
- Provide consistent clinical supervision to verify services are in compliance with the Arizona Principles and all ADHS Office of Licensing, and State supervision requirements are met.
• Employ adequate staff to implement the Crisis AfterCare Recovery program.
• Employ one (1) full-time American Indian Warm-line Program Coordinator and part-time tribal Member employees representing the seven (7) tribes served by Cenpatico IC who have tribal Members living on tribal lands in Arizona.

6.7.2.2 Telephone Call Response Requirements

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

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

6.7.2.3 Crisis Counseling, Triage, Tracking, Mobile Team Dispatch and Resolution

Crisis Line providers must meet the following requirements:
• Provide crisis counseling, triage and telephonic follow-up 24/7/365. All crisis calls must be live answered. Crisis callers must not receive a prompt, voice mail message, or be placed in a phone queue.
• Provide crisis counseling and triage services to all persons calling the Cenpatico IC Crisis Line, regardless of the caller’s eligibility for Medicaid services.
• Review Wellness Recovery Action Plans ("WRAP Plans") and Crisis Plans identified in the Cenpatico IC data system to assist with crisis resolution and suggest appropriate interventions.
• Dispatch mobile team services delivered by provider agencies and must track mobile team intervention resolution in compliance with protocols established or approved by Cenpatico IC. Crisis Line providers must report on a weekly and monthly basis these dispatches in a format approved by Cenpatico IC. Daily reports may be required as needed.
• Assess the safety of a crisis scene prior to mobile team dispatch and track mobile teams to monitor the safety of the mobile team staff.
• Follow-up with Members, crisis mobile team staff, Integrated Care Managers, and system partners to verify appropriate follow-up and coordination of care.
• Assess Member dangerousness to self and others and provide appropriate notification to Cenpatico IC, Health Home Health Care Coordinator, and obtain information on Member’s consistent use of medications to minimize dangerousness and promote safety to the Member and community.
• Follow community standards of care and best practice guidelines to warn and protect Members, family members and the community due to threats of violence.
• Document all interactions and triage assessments to facilitate effective crisis resolution and validate interventions.

• Conduct a follow-up call within seventy-two (72) hours to make sure the caller has received the necessary services. Verify Members are successfully engaged in treatment before closing out the crisis episode and follow-up to verify system partner and Member satisfaction with the care plan.

• Support the mobile teams and arrange for transports, ambulance, etc.

• Dispatch and track requests for 72 Hour DCS Rapid Response Assessments and 24 Hour Urgent Referral Assessments.

• Monitor and make best efforts to verify that 72 Hour DCS Rapid Response Assessments are conducted within seventy-two (72) hours of notification by DCS and 24 Hour Urgent Referral Assessments are completed within twenty-four (24) hours of notification by health plans, hospitals, or detention centers. Provider must document and report any reported response delay reasons.

• Track all 72 Hour DCS Rapid Response and 24 Hour Urgent Referral requests to verify Members are engaged in follow-up care.

• Provide reports that track and summarize the requests for 72 Hour DCS Rapid Response, 5 day face to face parent engagement, 23 day meaningful service requirements, daily pending inpatient report, daily call statistics report, CMT timeliness report, re-entry reports, urgent response report, acute health plan inquiry log, crisis indicator data report, client activity report, second responder tracking and 24 Hour Mobile Urgent Intake requests the disposition of such assessments in a format established or approved by Cenpatico IC.

• Make reasonable attempts to verify that the dispositions and intake appointments are completed.

• Document and report any delay reasons to Cenpatico IC in real time for all Community Re-Entry, Rapid and Urgent Response requests.

6.7.3 Customer Service, Member Outreach, Engagement

6.7.3.1 Customer Service

Crisis Line providers must provide customer service functions on behalf of Cenpatico IC when Cenpatico IC offices are closed. Crisis Line providers must complete transactions for Customer Service after-hours without referring anyone to call back during regular business hours unless the call is regarding a claim. The Cenpatico IC Customer Service telephone number must be forwarded to The Crisis Call Center whenever the Cenpatico IC offices are closed and occasionally, as arranged in advance, through Work Force Management ("WFM").

6.7.3.2 Safety Net

Crisis Line providers must serve as a "safety net" to Cenpatico IC Members by re-engaging Members into treatment, as identified by Cenpatico IC and per data provided by Cenpatico IC.
6.7.3.3 **Documentation and Monitoring**
Crisis Line providers must document and monitor consistent use of crisis services for persons identified as High Need by Cenpatico IC, provider agencies or by family report. All High Need situations involving dangerousness to self or others must be staffed immediately with an independent licensed supervisor and the supervision must be documented in the record.

6.7.3.4 **Grievances and Service Gaps**
Crisis Line providers must notify Cenpatico IC through the Cenpatico IC data systems of any service delivery problems, grievances, service gaps and concerns raised by Members, family members, and system partners.

6.7.3.5 **Tracking**
Crisis Line providers must enter into Cenpatico IC's High Needs data tracking system any Member with High Needs to help monitor their safety and the safety of the community.

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

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

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

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

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

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

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

6.7.3.11  Peer Outreach and Coordination
Crisis Line providers must conduct peer-to-peer outbound calls and peer-to-peer support calls to facilitate Member engagement in treatment, instill hope and promote recovery.

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

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

6.7.3.13  Certified Health Care Coordinator
Crisis Line providers must support and strengthen the role of the Certified Health Care Coordinator through care facilitation, being careful to not diminish the relationship between the Member and the Health Care Coordinator.

6.7.3.14  American Indian Warm-line Program (aka Tribal Warm Line)
Providers must successfully implement an American Indian Warm-line Program and transfer system that includes (at least) part-time tribal Member employees (aka Tribal Support Partners) from the tribes served by Cenpatico IC. Tribal Support Partners must conduct calls (inbound/outbound) to facilitate member engagement in treatment, instill hope and promote recovery.

6.7.3.14.1 Tribal Warm Line (TWL) Service Requirements
- The TWL must be answered by a Tribal Support Partner Monday through Friday, 9:00 AM to 9:00 PM.
• Outside of these hours, the TWL must be answered by the crisis line, with a follow-up call by a Tribal Support Partner during the TWL operating hours.
• Tribal Support Partners must be trained in identifying crisis calls and transferring calls between systems.
• Tribal Warm Line staff must participate in all trainings and coordination meetings required or requested by the State and/or Cenpatico IC.

6.7.3.15 24/7 Online Scheduling System
Crisis Line providers must successfully implement a 24/7 online scheduling system to schedule emergent follow-up appointments and urgent intake assessments with an outpatient provider following a crisis episode.

6.8 Crisis Mobile Team Provider Program Requirements

Crisis Mobile Team providers must provide crisis mobile team services in the assigned geographic areas and in accordance to State and Cenpatico IC requirements.

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

6.8.2 Crisis Mobile Team Provider
Crisis Mobile Team providers must coordinate all services through the Cenpatico IC Crisis Mobile Team provider and follow crisis protocols established by Cenpatico IC. Crisis Mobile Team providers must work collaboratively with the Cenpatico IC Crisis Line Provider to receive mobile team dispatches, coordinate all services, and facilitate crisis resolution planning. Crisis Mobile Team providers must report all staffing changes to Cenpatico IC Network Development Department and must report scheduling changes for Crisis Mobile Team Staff to the Crisis Line Provider in real time. Crisis mobile team providers are required to carry, and use as required, GPS enabled phones provided by crisis line provider. Crisis Mobile Team Agencies are required to have a super-user available within their agency for technical support. GPS phones will enable one number electronic dispatching from the crisis line provider. GPS phones must be kept with crisis mobile team staff on shift at all times. Crisis Mobile Team staff must be trained in appropriate use of the GPS phones. Crisis Mobile Team providers are required to cover the cost of damaged or lost GPS phones as requested by the Cenpatico IC crisis phone provider. If you are assigned a GPS enabled cellular device, it is a condition precedent that you read and sign your specific User Agreement prior to receiving any such cellular device or devices.

6.8.3 Coordination Calls and Coordination with Outpatient Department
Crisis Mobile Team providers must participate in crisis coordination calls and meetings to facilitate effective working relationships. Crisis Mobile Team providers must verify mobile team
services are closely linked to the provider’s outpatient department and that coordination of care is occurring with outpatient providers for members who have been in a crisis.

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

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

6.8.6 Title 36 Screenings
Crisis Mobile Team providers must ensure Title 36 screenings are conducted by staff other than mobile team staff unless Cenpatico IC holds a contract with the applicable County, in which case the mobile crisis team should follow the requirements specified in that contract. See Section 3.9 - Pre-Petition Screening.

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

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

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

6.8.10 Billing
Crisis Mobile Team providers must bill all mobile team services utilizing crisis service codes, including follow up services performed by the mobile team.
6.8.11 Services
Crisis Mobile Teams must respond on site within one (1) hour in cities, one and a half (1.5) hours in rural or outlying areas. Law Enforcement calls take priority and the response time shall be no more than thirty (30) minutes. Crisis Mobile Teams must have the ability to assess and provide immediate crisis intervention and make reasonable efforts to stabilize acute psychiatric or behavioral symptoms, evaluate treatment needs, and develop plans to meet the individual’s needs. Crisis Mobile Team providers must deliver crisis response, crisis assessment and crisis stabilization services that facilitate resolution, not merely triage and transfer. Crisis Mobile Team providers must initiate and maintain collaboration with fire, law enforcement, emergency medical services, hospital emergency departments, AHCCCS Acute Care Health plans and other providers of public health and safety services to inform them of how to use the crisis response system, to coordinate services and to assess and improve the crisis services.

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

6.9 Crisis Stabilization/Crisis Living Room Provider Program Requirements
Crisis Stabilization providers must provide crisis stabilization services in the assigned areas on a 24/7/365 basis and in accordance to State and Cenpatico IC requirements. Crisis assessment and crisis services must facilitate resolution, not merely triage and transfer. Crisis Living Rooms must be furnished to resemble a home living area, including the following: showers, rest rooms, living room furniture, kitchen, refrigerator, dining table, microwave oven, and exercise equipment.

6.9.1 Supervision and Staffing
Crisis Stabilization providers must verify that the Crisis Living Room Program is clinically supervised by a Cenpatico IC Credentialed Independently Licensed Behavioral Health Professional. Crisis Stabilization providers must verify all Crisis Living Room Assessments are reviewed and signed off by a Cenpatico IC Credentialed, Independently Licensed Behavioral Health Professional. Crisis Stabilization providers must verify adequate staff capacity to meet variations in the demand for services. Crisis Stabilization providers must verify all direct care crisis staff are CISM trained.

6.9.2 Coordination through Crisis Line Provider
Crisis Stabilization providers must coordinate all services through the Cenpatico IC Crisis Line Provider and follow crisis protocols established by Cenpatico IC. Crisis Stabilization providers must work collaboratively with the Cenpatico IC Crisis Line Provider to coordinate all services, and facilitate crisis resolution planning.

6.9.3 Outpatient Coordination and Follow Up
Since the Crisis Living Room is an outpatient facility, Crisis Stabilization providers must verify Members are not allowed to remain in the living room for more than 23 hours a day. Crisis
Stabilization providers must verify crisis living room services are closely linked to the provider's outpatient department and that coordination of care is occurring with outpatient providers for members who have been in a crisis. Crisis Stabilization providers must verify all Members are effectively engaged in follow-up care before terminating crisis services.

6.9.4 Accepting Referrals
Crisis Stabilization providers must embrace a "No Wrong Door" philosophy and accept all voluntary referrals, regardless of ability to pay, clinical presentation, degree of intoxication, or benefit status. Crisis Stabilization providers must accept all referrals from law enforcement and the community.

In a health emergency, Provider is required to verify eligibility for Covered Services in accordance with the Cenpatico Provider Manual and with federal, State, and local laws relating to the provision of Emergency Medical Services (including but not limited to A.A.C. R9-22-201 et seq. and 42 CFR 438.114), provided that nothing in this provision shall be deemed to require Provider to violate federal or State law regarding the provision of Emergency Medical Services. Provider is required to notify the Cenpatico IC-designated crisis hotline provider within twenty-four (24) hours or by the next business day of rendering or learning of the rendering of Emergency Medical Services to a Member.

6.9.5 Transportation
Crisis Stabilization providers must provide and maintain transportation to facilitate or coordinate transports.

6.9.6 Participation in Training and Coordination Calls
Crisis Stabilization providers must participate in training events sponsored by Cenpatico IC and the State to enhance the performance of the crisis system. Crisis Stabilization providers must participate in crisis coordination calls and meetings to facilitate effective working relationships.

6.9.7 Tracking and Electronic Medical Information
Crisis Stabilization providers must maintain adequate licenses to allow Crisis Living Room staff to utilize the Cenpatico IC Risk Management /High Needs Tracking System to effectively coordinate care for Members in crisis. Crisis Stabilization providers must verify the Crisis Living Room is equipped with a computer, printer and web connectivity to allow access to electronic medical information.

6.10 Crisis Transportation Provider Program Requirements
Crisis Transportation providers must provide medically-necessary transportation services in the assigned geographic areas and in accordance to State and Cenpatico IC requirements. Crisis Transportation providers must establish and maintain appropriate licenses to provide transportation services identified in the Scope of Work.
6.10.1 Coordination
Crisis Transportation providers must coordinate all services through the Cenpatico IC Crisis Line Provider and follow crisis protocols established by Cenpatico IC. Crisis Transportation providers must participate in crisis coordination calls and meetings to facilitate effective working relationships as requested.

6.10.2 Staff Requirements
Staffing must consistently meet AHCCCS, the State, ADHS Office of Licensing, and Cenpatico IC requirements. Crisis Transportation providers must verify staff capacity to meet availability requirements as identified in provider’s contract with Cenpatico IC. Crisis Transportation providers must maintain appropriately trained, supervised, and ADHS Office of Licensing qualified Behavioral Health Technicians and Paraprofessionals to conduct transports.

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

6.10.3 Training
Crisis Transportation providers must participate in training events sponsored by Cenpatico IC and the State as requested, and verify staff complete all required trainings and document trainings through Relias Learning Management System.

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

6.10.5 Billing and Paperwork
Crisis Transportation providers must bill all medically-necessary transportation services utilizing transportation service codes. Crisis Transportation providers must maintain appropriate paperwork in accordance with State and AHCCCS regulations. Crisis Transportation providers must encounter and document all services in compliance with the AHCCCS Covered Behavioral Health Service Guide.

6.11 Health Education, Health Promotion And Counseling Program Requirements Related To HIV
Behavioral Health providers must make available HIV education, screening and counseling services to Cenpatico IC-enrolled Members.

6.11.1 HIV Risk Assessments
Behavioral Health Providers must make available HIV Risk Assessments to Members which includes pre-test discussions and counseling that assists the client in identifying the behaviors that may have possibly exposed the person to HIV.
6.11.2 Health Education, Health Promotion and Counseling

Health Education and Health Promotion services (including assistance and education about health risk reduction and lifestyle choices) must be provided to Members at substance use, mental health and community facilities in Arizona. Providers must make available to Members information regarding HIV transmission and prevention, and should assist Members in identifying the behaviors that may expose them to HIV.

Behavioral Health providers must make available Pre-Test Counseling to Members to assist in identifying the behaviors that may have possible exposed them to HIV, focusing on the Member's own unique circumstances and risk and helping the Member set and reach an explicit behavior-change goal to reduce the chance of acquiring or transmitting HIV. Provider must make available to Members information regarding HIV transmission and prevention and the meaning of HIV test results. In addition, providers must help the Member to identify the specific behaviors putting them at risk for acquiring or transmitting HIV and commit to steps to reduce their risk.

Providers must make available Post-Test Counseling including summarization of identified risks, review of the Member's risk reduction plan, discussion of next test time or when the confirmation blood draw shall occur if the Member tested positive for HIV, scheduling an appointment for receiving future results, obtaining information on sexual or drug using contacts to enable partner notification process to occur, and providing information and assistance in accessing the HIV Care System.

6.11.3 Prevention Case Management

Providers must provide HIV Prevention Case Management services to any individual requesting assistance from the provider in obtaining resources and accessing needed social services.

6.11.4 CLIA

Providers of HIV testing services must obtain and retain a Clinical Laboratory Improvement Amendments ("CLIA") certificate and verify all HIV Testing is administered in accordance with the CLIA requirements.

6.12 Home Care Training to Home Care Client (HCTC) Services to Children – Program Requirements

6.12.1 Authorization and Continued Stay Requirements

HCTC Providers must meet all licensing and scope of work requirements as outlined by licensing, the Covered Behavioral Health Services Guide, and all prior authorization and continued stay requirements for HCTC as listed in Provider Manual Section 10 and as directed by Cenpatico IC.
6.13 Substance Use Disorder Treatment Requirements

Providers are required to provide culturally-competent, evidence-based substance use treatment to a person who is experiencing acute and severe behavioral health and/or substance use symptoms, which may include emergency reception and assessment; crisis intervention and stabilization; individual, group and family counseling; outpatient detoxification and referral. Services provided to each member must be individualized to meet the member’s unique treatment needs.

Substance use disorders may include a range of conditions that vary in severity over time, from problematic, short-term use of substances, to severe and chronic disorders requiring long-term and sustained treatment and recovery management.

All substance use treatment programs delivered by any provider within the Cenpatico IC system of care must:

- Provide for:
  - Member and family education and involvement;
  - Brief intervention;
  - Acute stabilization and treatment;
  - Assessment of other needs including housing and vocational interests and goals;
  - A focus on life factors that support long-term recovery to facilitate reduction of the intensity, severity and duration of substance use and the number of relapse events; and
  - A return of the member to the workplace or school, as appropriate;
- Monitor member retention in treatment, provide engagement efforts and outcomes of treatment, modify treatment approaches as needed;
- Provide physician oversight of medical treatment including methadone, medication and detoxification services, as clinically appropriate;
- Provide or make available TB, HIV, and Hepatitis B and C education, screenings and treatment services;
- Coordinate continuity of care between service providers and other agencies;
- Utilize the ASAM in assessing persons with substance use disorders. In addition, the provider must screen all persons with SUDs for the need for residential treatment services and document the screening. All Members seeking treatment for Substance Use Disorders must receive an ASAM assessment at intake and at least every six months during treatment;
- Promote the use of Motivational Interviewing Principles in substance use treatment; verify access to new treatment alternatives targeted to the needs of specific high-risk populations, such as Members with co-occurring substance use and mental illness, according to the Arizona Principles for behavioral health care;
- Demonstrate which evidence based practice is utilized, how training is conducted and how fidelity is monitored;
- Document in each member record which evidence based practice is being utilized during treatment of the member, and;
• Be provided by clinicians who are overseen by a BHP with experience in substance use disorders and treatment.

Providers must maintain the capacity to conduct drug screening/testing on members, as defined by AHCCCS Covered Behavioral Health Services Guide and as deemed clinically appropriate by the member’s treatment team.

While not required, Cenpatico IC supports the use of drug screening during the substance use screening, assessment and treatment process.

6.13.1.1 Psychosocial Outpatient Services

Substance use treatment providers must make individualized outpatient services available to assist the client in reducing or eliminating substance use/abuse. A continuum of services including therapy (individual, group, family), case management, peer support, vocational services and any other service identified in the AHCCCS Covered Behavioral Health Services Guide must be available and must utilize and maintain fidelity to evidence-based methods.

6.13.1.2 Intensive Outpatient Services

Substance use treatment providers that offer intensive outpatient programming must ensure that operates at least three (3) hours per day and at least three (3) times per week, as required by AHCCCS Covered Behavioral Health Services Guide.

6.13.1.3 Residential Services Treatment

Residential Substance Use Treatment services are available to adults and adolescents who are TXIX eligible and to individuals who are NTXIX, but eligible for Substance Abuse Block Grant (SABG) funds, as described in Provider Manual 3.10, Special Populations, and who are screened using the ASAM as needing this level of care.

Behavioral health residential facilities (BHRFs) providing substance use treatment must ensure length of stay is consistent with member’s needs and meets medical necessity. Treatment must remain individualized for each member, dependent upon ASAM placement criteria and treatment needs.

All residential treatment facilities are subject to Utilization Management review as per Provider Manual Section 10.

6.13.1.4 Substance Abuse Transitional Facilities

Substance Abuse Transitional Facility Providers must provide SUD treatment services through a licensed Substance Abuse Transitional Facility on a 24/7/365 basis. See R9-10-1401 et seq. Substance Abuse Transitional Facility Providers must verify appropriate clinical supervision to safely administer treatment services and verify availability of medical staff to provide appropriate medical consultation and supervision. To verify Members receive appropriate follow
up care, providers must verify coordination of care. Substance Abuse Transitional Facility Providers must utilize Peer Support staff to maximize opportunities for Members to understand and embrace recovery. Immediate and ongoing detoxification and psychiatric crisis stabilization services must be provided in the least restrictive setting, consistent with individual and family need and community safety.

6.13.1.5 Continuing care, Discharge Planning, Aftercare Planning

Designated staff at the treatment provider engages the member, family/guardian and natural supports to actively participate in discharge planning. Discharge planning begins at the time of admission and continues to be an active part of the treatment/service planning process. It is recommended that agencies reference PM Form 9.1.2 Wellness Recovery, Crisis Plan and Advance Directives for recommended elements of a Crisis and Safety Plan to create a more individualized, medically and clinically comprehensive crisis plan as part of discharge planning.

At a minimum the discharge plan must:
- Include realistic/quantifiable/measurable goals and objectives to inform when the member is discharge ready;
- Identify specific skills and supports the member needs in order to be successful upon discharge from a specific level of care;
- Include referrals to community resources, including 12-step programs and/or SMART Recovery;
- Reflects active coordination of care with providers and all involved agencies; and
- Include arrangements for therapy and other applicable psychiatric services provided in a timely manner.

6.13.1.6 Developing a Relapse Prevention Plan

At a minimum the relapse prevention plan:
- Includes the member’s identification of what relapse would look like;
- Identifies possible stressful events and triggers;
- Describes signs and symptoms that a relapse is imminent;
- Describes recommended interventions and the persons responsible;
- Identifies resources or supports to contact if in crisis, including phone numbers;
- Identifies interventions to avoid; and
- Assesses for potential safety issues.

6.13.1.7 Program Requirements for Providers of IV Drug and Opioid Treatment Services

Providers must fully educate the Member about all treatment options and strategies to promote recovery from opiate abuse; including, health risks, relapse risks, and alternative treatments.

IV Drug and Opioid Treatment Providers (OTPs) must maintain current policies and procedures designed to verify adherence to Cenpatico IC Provider Manual, 42 CFR Par 8, SAMHSA - Treatment Improvement Protocol 49, AHCCCS Practice Protocol - Buprenorphine Guidance, the American Psychiatric Association Practice Guideline - Treatment of Patients with Substance Use
Disorders, the Drug Enforcement Administration (DEA) and any applicable accreditation requirements.

IV Drug and Opioid Treatment Providers must also ensure Members have access to any medically necessary lab or physical health screening as referenced in the SAMHSA Treatment Improvement Protocol 49.

All Opioid Treatment Providers must have in place written policies and procedures describing their agency’s Diversion Control Program.

All OTPs must have information on the Dangers of Street Drugs posted in their clinic lobbies.

6.13.1.8 Promotion of Recovery

Treatment must promote recovery, minimizing the impact of substances on the Member’s life and assisting the Member in reaching the maximum level of functioning in life appropriate for the Member.

6.14 Program Requirements for Providers of Services to Adolescents Who Act Out Sexually

Providers of services to adolescents who act out sexually must provide counseling to adolescents who act out sexually for youth (ages 8-17) and their families who are adjudicated and non-adjudicated youth who have engaged in inappropriate sexual behaviors. Services include assessments of youth and families related to inappropriate sexual behavior, treatment planning, family supports, and transition planning to community supports and from higher levels of care.

Treatment must be supervised by qualified clinicians using acceptable treatment modalities based on Evidenced Based Practices for the treatment of adolescents who act out sexually and in accordance with State and Federal laws. Treatment teams must include Licensed Clinicians, Health Care Coordinators, and in-home family support staff. Providers of services to adolescents who act out sexually must verify Treatment and Discharge Planning is developed through Child and Family Team Practice.

Providers of services to adolescents who act out sexually must develop an effective Safety Plan that safeguards the Member and community from re-offending. Providers of services to adolescents who act out sexually must place the adolescent in a treatment program with adolescents of similar age and developmental maturity level, when group treatment is prescribed by the treatment provider.

Providers of services to adolescents who act out sexually must comply with the professional Code of Ethics of the Association for the Treatment of Sexual Abusers. Reference: www.atsa.com.
6.15 Program Requirements for Providers of Services to Adults Who Act Out Sexually

Providers of services to adults who act out sexually are must provide adults who act out sexually treatment services geared toward preventing further offenses and safeguarding the community from harm. Services must include assessments related to inappropriate sexual behavior treatment planning, family support services, community support services and transition services.

Treatment must be supervised by qualified clinicians using acceptable treatment modalities based on Evidenced Based Practices for the treatment of adults who act out sexually and in accordance with State and Federal laws. Providers of services to adults who act out sexually must verify treatment teams include Licensed Clinicians, Health Care Coordinators, and in home family support staff. Treatment and Discharge Planning must be provided through Adult Recovery Teams.

Providers of services to adults who act out sexually must develop an effective Safety Plan that safeguards the Member and community from re-offenses. Providers of services to adults who act out sexually must place the adult in a treatment program with adults of similar age and developmental maturity level, when group treatment is prescribed by the treatment provider.

6.16 Community Observation Centers

6.16.1 Purpose Of Program
To provide crisis intervention services to a person for the purpose of stabilizing or preventing a sudden, unanticipated, or potentially dangerous behavioral health condition, episode, or behavior. These intensive and time limited services are designed to prevent, reduce, or eliminate a crisis situation and are provided 24 hours a day, 7 days a week, 365 days a year.

6.16.2 Services To Be Provided

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

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

6.16.2.3 Crisis Intervention Services

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

6.16.2.4 Provider Title 36 Emergency Petition

If licensed to provide court ordered evaluation and treatment, the provider shall verify that services and examinations necessary to fulfill the requirements of ARS §36-524 through ARS §36-528 for emergency applications for admission for involuntary evaluation are provided in the least restrictive setting available and possible with the opportunity for the individual to participate in evaluation and treatment on a voluntary basis. Prior to seeking an individual’s admission to a Behavioral Health Inpatient facility for Court Ordered Evaluation (COE) Provider shall make all reasonable attempts to engage the individual in voluntary treatment and discontinue the use of the involuntary evaluation process.

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

6.16.3 Reporting Requirements

Provider shall submit all documents, reports and data in accordance with the Deliverable Schedule. All deliverables shall be submitted in the format prescribed by Cenpatico and within the time frames specified. Provider is required to submit any additional documents and/or ad hoc reports as requested by Cenpatico.

6.16.4 Capacity Requirements

6.16.4.1 Pima County Banner UMC Crisis Response Center Capacity

Provider shall have a capacity of 34 (chairs) for adults, 18 years or older, and eight (8) chairs for children, to provide accommodations for overnight stay as mandated by ADHS/DLS in accordance with AAC Title 9, Chapter 10. Provider shall have capacity to provide facility-based 23-hour crisis observation/stabilization services for at least 34 adults and at least eight (8) children at any one time.
6.16.4.2  **Pima County CBI Center Capacity**

Provider shall have a capacity of 12 (chairs) for adults, 18 years or older, to provide accommodations for overnight stay as mandated by ADHS/DLS in accordance with AAC Title 9, Chapter 10. Provider shall have capacity to provide facility-based. 23-hour crisis observation/stabilization services for at least 12 adults at any one time.

6.16.4.3  **Yuma County Horizon Health and Wellness Capacity**

Provider shall have a capacity of 14 (chairs) and one patient bedroom for adults, 18 years or older, to provide accommodations for overnight stay as mandated by ADHS/DLS in accordance with AAC Title 9, Chapter 10. Provider shall have capacity to provide facility-based. 23-hour crisis observation/stabilization services for at least 15 adults at any one time.

6.17  **ACT (Assertive Community Treatment)**

6.17.1  **Program Requirements**

Providers delivering ACT Team services are required to establish ACT teams that comply with the requirements outlined in the **SAMHSA Assertive Community Treatment (ACT) Evidence-Based Practices Kit**, in communities approved by Cenpatico.

6.18  **Fidelity to the Model**

Providers delivering ACT Team services shall participate in SAMSHA EBP fidelity audits coordinated with C-IC on an annual basis at minimum.

6.19  **Reporting Requirements**

Provider shall submit all documents, reports and data in accordance with the Deliverable Schedule. All deliverables shall be submitted in the format prescribed by Cenpatico and within the time frames specified. Provider is required to submit any additional documents and/or ad hoc reports as requested by Cenpatico.

6.20  **Other Requirements**

ACT Team providers must participate in all trainings and meetings required or requested by AHCCCS and/or Cenpatico IC. ACT Team providers must coordinate for continuity of care between provider, member’s Health Home, stakeholders (Adult Protective Services, Probation Officer, Department of Corrections, and other agencies), and other Specialty Providers (both physical and behavioral health) involved with the member.
6.21 Agencies Contracted to Employ Engagement Specialists

6.21.1 Program Requirements

Engagement Specialists are required to adhere to the parameters outlined in the Engagement Specialist Guide.

- Outcomes of the Engagement Program include:
  - Increase access to behavioral health and physical health services,
  - Reduce number of citizens without medical coverage, and
  - Increase engagement into services.

6.21.2 Staff Requirements

Agencies must verify that Engagement Specialists complete the following required trainings and credentials:

- Mental Health First Aid,
- Certified Application Counselor,
- Arizona Department of Insurance Certified Application Counselor License, and
- Veteran Navigator through the Arizona Coalition for Military Families.

6.21.3 Deliverables

Engagement Specialist Log must be completed by each provider – see Section 16 - Deliverables.
Section 7 - CREDENTIALING AND RE-CREDENTIALING REQUIREMENTS

7.1 Introduction and Processes

The credentialing and re-credentialing processes are integral components of the Cenpatico IC quality management program. The credentialing and re-credentialing processes help to verify that qualified providers, who are capable of meeting the needs of the persons who are seeking and/or receiving services, participate in the Cenpatico IC provider network.

Credentialing and re-credentialing is an ongoing review process to assure the current competence of practitioners by validating the training and competence of individual practitioners in particular specialty areas. This level of review is intended to provide verification that the appropriate training, experience, qualifications, and ongoing competence has been demonstrated by individual practitioners for the services they provide.

The credentialing and re-credentialing requirements differ depending on the type of provider. Physicians, nurse practitioners, physician assistants, psychologists and all other health professionals who are registered to bill independently or provide services for which they are licensed to perform must be credentialed prior to providing services to members.

7.2 To Whom this Applies

This section applies to providers providing services to persons enrolled in the AHCCCS health system or AHCCCS Health Plan. Provider types subject to credentialing and re-credentialing requirements include, but are not limited to:

- Physicians (MD and DO);
- Doctor of Podiatric Medicine (DPM)
- Licensed Psychologists;
- Nurse Practitioners (Nurse Practitioners must have certifications that align with their Scope of Practice);
- Physician Assistants;
- Licensed Clinical Social Workers (only required if they will be billing independently);
- Licensed Professional Counselors (only required if they will be billing independently);
- Licensed Marriage and Family Therapists (only required if they will be billing independently);
- Licensed Independent Substance Abuse Counselors (only required if they will be billing independently);
- Board Certified Behavior Analysts (BCBAs);
- Occupational Therapists;
- Speech and Language Pathologists;
- Physical Therapists; Behavioral Health Residential Facilities;
- Behavioral Health Outpatient Clinics;
• Free standing psychiatric hospitals;
• Psychiatric and addiction disorder units;
• Hospitals and units in general hospitals;
• Ambulatory Surgical Centers
• Home Health and Long Term Care Providers
• Psychiatric and addiction disorder residential treatment centers;
• Non-emergency transportation vendor;
• Laboratories;
• Federally Qualified Health Centers
• Community/Rural/Mental Health Clinics (Centers); Level 1 Sub-Acute Facilities;
• Community Service Agency;
• Integrated Clinics; and
• Any non-contracted provider that is rendering services and sees 50 or more of Cenpatico IC members per contract year

7.3 Delegation of Credentialing

If Cenpatico IC delegates any of the credentialing/re-credentialing or selection of provider responsibilities, Cenpatico IC is required retain the right to approve, suspend, or terminate any providers selected and may revoke the delegated function if the delegated performance is inadequate.

7.4 Initial Credentialing Process and Requirements

Providers wishing to join the Cenpatico IC Network must complete the Potential Provider Application for review and approval prior to applying for credentialing, located here: https://www.cenpaticointegratedcareaz.com/providers/join-our-network.html. Initial applications will not start the formal credentialing process unless approved by Cenpatico IC’s Potential Provider Committee.

The initial credentialing process includes verification of information submitted on the credentialing application and a site visit (if applicable), and is completed before the effective date of the initial contract. An application must be complete, signed, and dated. Credentials with expiration dates must have at least 60 days remaining upon receipt. Initial credentialing is completed within 90 calendar days from receipt of a complete application, accompanied by the designated documents, to render a decision for approval or denial.

Cenpatico IC is required to utilize the Arizona Health Plan Association’s Credentialing Verification Organization (CVO) as part of the credentialing process. As part of this process, it is required that all individual applicants be enrolled in the Council for Affordable Quality Healthcare (CAQH) and maintain a current CAQH application and attestation in order to be credentialled. Cenpatico IC’s Credentialing Department reserves the right to specify exceptions to this process to meet network needs.
For organizational provider types not requiring CAQH registration, a credentialing demographic form must be completed in its entirety and submitted along with all required documentation. This form can be found on the Cenpatico IC website, here: https://www.cenpaticointegratedcareaz.com/providers/join-our-network/credentialing-program.html.

Any provider that has changed its NPI, License Number, or AHCCCS Number; or Organizational Providers who have moved locations, must submit a new credentialing application. Providers that have failed to re-credential timely, must also complete the initial credentialing process.

The initial credentialing process may include verification the following:

- Application Completeness,
- License,
- Work History,
- Insurance Coverage,
- Drug Enforcement Administration (DEA) Certificate (if applicable),
- Controlled Substance Certificate (if applicable),
- Board Certification (if applicable),
- Education,
- Sanction Information,
- Malpractice History,
- Site Survey,
- CLIA License (if applicable)
- Pharmacy License (if applicable)
- W-9

### 7.5 Additional Credentialing Requirements for Organizational Providers

Hospitals and other licensed health care facilities are included in this process. Prior to contracting with an organizational provider, Cenpatico IC verifies that organizations have been reviewed and approved by a recognized accrediting body or meet Cenpatico IC’s standards for participation, and are in good standing with state and federal agencies. Organizational providers include, at a minimum, hospitals, outpatient treatment centers, home health agencies, skilled nursing facilities, nursing homes, crisis services providers, freestanding surgical centers and behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory care setting. Once approved to join the Cenpatico IC network, an organization demographic form must be completed in its entirety, along with all required documents. This form and detailed submission information can be found here: https://www.cenpaticointegratedcareaz.com/providers/join-our-network/credentialing-program.html.

The initial credentialing process may include verification the following:

- Application Completeness,
- License,
- Accreditation of JCAHO/CARF/COA/or AOA (If applicable);
- Site Survey not more than 3 years old;
- Insurance Coverage,
- CLIA License (If applicable);
• Pharmacy License (if applicable);
• W-9

For organizational providers that are not accredited and do not have a current Center for Medicare and Medicaid Services (CMS) certificate, or do not have an AHCCCS license that denotes a recent Site Survey, an onsite inspection will be done by Provider Relations or a Network Specialist determine the scope of services available at the facility, physical plant safety, review of the quality improvement program for adequate mechanisms to credential practitioners delivering care in the facility, identify and manage situations involving risk, and assess the medical record keeping practices.
Community Service Agencies are subject to additional requirements, for more information see the AHCCCS AMPM Chapter 900, Policy 950.7.6

7.6 Temporary/Provisional Credentialing Process and Requirements

Occasionally, it is in the interest of members to allow practitioners availability in the network prior to completion of the entire initial credentialing process. Provisional credentialing is intended to ensure member service delivery and provider availability in medically underserved areas, based on Cenpatico IC network sufficiency.

Provider types that may qualify for provisional credentialing include, but not limited to:
• Federally Qualified Health Centers (FQHC);
• FQHC Look-Alike organizations;
• Hospital employed physicians (when appropriate);
• Providers needed in medically underserved areas (determined by network sufficiency)
• Covering or substitute providers providing services during a provider absence

Provisional credentialing is completed within 14 calendar days from receipt of a complete application accompanied by the designated documents to render a decision regarding temporary or provisional credentialing. Practitioners applying to the network for the first time are eligible for provisional credentialing. A practitioner may only be provisionally credentialled once and practitioners may not be held in a provisional credentialing status for more than 60 calendar days. Providers that are in a provisional status, that do not clear the Initial Credentialing Requirements will be terminated.

7.7 Recredentialing Process and Requirements

The recredentialing of providers is completed every 36 months. As part of the recredentialing process, providers are notified 120 days in advance of the expiration of their credentials. The Credentialing Department will mail, fax or email notifications to the providers at least three times within the notification cycle. In order to avoid a lapse in network participation status, the recredentialing application and required documents must be received 30 calendar days prior to the expiration month of their credentials. Any provider that fails recredential timely, will have to undergo the initial credentialing process. Providers that fail to recredential cannot request provisional credentialing status. The provider will be required to complete and submit demographic forms, any applicable applications and all required documentation. The forms and
detailed submission instructions can be found here:

Cenpatico IC is required to utilize the Arizona Health Plan Association’s Credentialing Verification Organization (CVO) as part of the recredentialing process. As part of this process, it is required that all individual applicants be enrolled in the Council for Affordable Quality Healthcare (CAQH) and maintain a current CAQH application and attestation in order to be credentialed. Cenpatico IC’s Credentialing Department reserves the right to specify exceptions to this process to meet network needs.

For organizational provider types not requiring CAQH registration, a credentialing demographic form must be completed in its entirety and submitted along with all required documentation. This form can be found on the Cenpatico IC website, here:

The recredentialing process includes the verification of all the elements included during initial credentialing, with the addition of member concern/grievances, utilization management, performance improvement, results of medical record audits, and quality of care concerns.

### 7.8 Credentialing Approval/Denial Process

Completed credentialing and recredentialing requests are presented to the Credentialing Committee Chair, or designee, for review prior to presentation at Credentialing Committee. Initial credentialing files that were not considered adverse, may receive approval during the review. Recredential files and credentialing files that exceed the credentialing standards (adverse) must be taken to the Credentialing Committee for review and determination. It is the responsibility of the Credentialing Committee to review the issues/concerns and qualifications of each applicant presented and make approval or denial determinations.

All applicants receive notice of his/her/their status in writing within 14 calendar days of the Credentialing Committee decision.

When there are extenuating circumstances that preclude the practitioner from meeting minimum participation criteria, but do not preclude the practitioner from providing quality care and service for Cenpatico IC Members, the Medical Director/ Credentialing Committee Chair/Credentialing Committee may decide to extend an offer of participation. If such a need exists, each criterion for selection shall be examined on an individual basis taking into account the following:

- Malpractice claims history: less than three claims in a six year period, or claims judged to be of nuisance value;
- If there is a history of drug or alcohol abuse, the applicant must be involved in a credible program to correct impairment with concurrent and present monitoring by the medical society or state board. There should be no evidence of recidivism;
- Previous sanction activity: the nature of the sanction and remedy; and
Office site visit: a plan to remedy any deficiencies with provisional approval until the remedy is achieved.

If the Credentialing Committee requires additional information prior to making a determination, the application will be pended in order to obtain additional information or clarification for the Credentialing Committee. Once the requested information has been obtained, the file will be presented to the Credentialing Committee at a future Credentialing Committee meeting. The Credentialing Committee will review and grant exceptions on an individual basis, depending on the outcome of the review.

7.9 Fairness of Process

Cenpatico IC or its designee shall maintain fair credentialing and re-credentialing processes which:

- Do not discriminate against a provider solely on the basis of the professional’s license or certification; or due to the fact that the provider serves high-risk populations and/or specializes in the treatment of costly conditions;
- Afford the provider the right to review information gathered related to his/her credentialing application and to correct erroneous information submitted by another party. The organization is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by law;
- Notify the provider when the information obtained through the primary source verification process varies substantially from what the provider provided;
- Verify credentialing/re-credentialing information is kept confidential; and
- State that practitioners have a right to be informed of the status of their application upon request, and must describe the process for responding to such request, including information that the organization may share with practitioners with the exception that this does not require the organization to allow a practitioner to review references, recommendations or other peer-review protected information.

7.10 Notification Requirement

Cenpatico IC is required to have procedures for reporting to appropriate authorities, including the Arizona Health Care Cost Containment System (AHCCCS), the provider’s regulatory board or agency, Adult Protective Services (APS), Child Protective Services (CPS), Office of the Attorney General (OAG), any serious quality deficiencies that could result in a provider’s suspension or termination from Cenpatico IC’s network. If the issue is determined to have criminal implications, a law enforcement agency must also be notified. Cenpatico IC is required to:

- Maintain documentation of implementation of the procedure, as appropriate;
- Have a reconsideration process for instances in which Cenpatico IC chooses to alter the provider’s contract based on issues of quality of care and/or service; and
- Inform the provider of the reconsideration process.
7.11 Additional Standards

Other standards related to the credentialing process include the following:

- The credentialing process must be in compliance with federal requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid:
  - Documentation must show that the following sites have been queried. Any provider that is found to be on any of the lists below may be terminated without the right to appeal:
    - Health and Human Services–Office of Inspector General (HHS–OIG) List of Excluded Individuals/Entities (LEIE); and
    - General Services Administration (GSA) Excluded Parties List System (EPLS).
  - Mechanisms must be put in place to verify that licensed providers renew licenses or certifications required by the appropriate licensing/certifying entity and continuously practice under a current and valid license/certification; and
  - Health care providers who are part of Cenpatico IC network are subject to an initial site visit as part of the initial credentialing process or in the case of adverse findings on the States Site Survey or on the CMS Site Survey Report.

7.12 Provider’s Right for Reconsideration

Cenpatico IC’s Medical Director or Credentialing Committee may decide not to extend participation status to an applicant. The Credentialing Committee Chair or designee will notify the practitioner of the Credentialing Committee denial decision within 14 calendar days of the Credentialing Committee’s decision.

The letter of denial shall include information on the practitioner’s right to review information obtained by Cenpatico IC to evaluate the practitioner’s credentialing and/or re-credentialing application, and right to request reconsideration and/or correct any erroneous information submitted by another party in the event the practitioner believes any of the information is erroneous or if any documents gathered during the primary source verification process differ from those submitted by the practitioner. A copy of the letter will be retained in the practitioner’s closed file and maintained in the monthly Credentialing Committee folders for future reference.

Information obtained from any outside primary source will be released to a practitioner only if the practitioner has submitted a written and signed request to Cenpatico IC’s Credentialing Department.

New applicants who are declined participation for reasons such as quality of care, their credentials have exceeded threshold limits or liability claims issues have the right to request a reconsideration of the decision in writing within thirty 30 calendar days of the formal notice of denial. All written requests will need to include additional supporting documentation in favor of the applicant’s reconsideration for network participation. Reconsiderations will be reviewed by the Chief Medical Officer, Medical Director Designee or at the next regularly scheduled
Committee meeting, but in no case later than 60 calendar days from the receipt of the additional documentation. Applicants will be notified within 14 calendar days of the committee decision. The provider does not have the any further recourse if the decision is to uphold the initial decision.

Should any information gathered as part of the primary source verification process differ from that submitted by the practitioner on the application, the practitioner must provide a written explanation detailing the error or the difference in information within 30 calendar days of receipt of the committee decision.

Providers who are denied initial participation may reapply for admission into the Cenpatico IC network within a year from the Credentialing Committee final decision date.

Recredentialing Applicants:
Current Practitioners whose participation is suspended, reduced, or terminated, shall have the right to request reconsideration of the decision in writing within 30 calendar days of receipt of the formal termination notice. All written requests for reconsideration will need to include additional supporting documentation in favor of the applicant’s request for continued network participation. The reconsideration review will be scheduled no later than 60 days after the receipt of the request. The final recommendation will be based upon the practitioner’s submitted credentials, the credentialing committee’s recommendations and supporting documentation submitted by the provider. The reconsideration determination will be by an affirmative vote of the majority of the members of the panel. The provider does not have the any further recourse if the decision is to uphold the recredentialing denial.

Terminations that cannot be reconsidered
Per AHCCCS/Medical Policy Manual (AMPM) Chapter 900-950, any provider that is found to be on the Health and Human Services Office of Inspector General (HHS-OIG) list of Excluded Individual/Entities (LEIE) or the General Services Administration (GSA) Excluded Parties List Systems (EPLS) will be terminated without the right to appeal, in accordance with the AHCCCS ACOM Policy 103.

7.13 Ongoing Monitoring Process Between Re-Credentialing Cycles

Cenpatico IC’s Credentialing Department monitors on a monthly basis:
- Practitioner Medicare/Medicaid sanctions;
- Limitations or sanctions on State licensure;
- The Compliance Department submitted report of OIG and EPLS checks;
- Items eligible for expiration

Reports are provided to the Credentialing Committee. The CMO or designee working with the Credentialing Committee will initiate appropriate corrective action for providers when occurrences of poor quality are identified. The CMO, designee or Credentialing Committee reviews sanctions during regularly scheduled meetings or via an Ad Hoc emergency meeting. For records that have been submitted to the Credentialing Committee, the Committee’s members will be asked for their professional feedback and be given an opportunity to vote on whether or not the provider should be allowed continuation in Cenpatico IC’s Network or be placed on administrative review or corrective action.
Providers will be immediately terminated if they are found to be excluded from the Medicaid/Medicare programs via the OIG or EPLS checks conducted. For reconsideration, a release from the reporting agency must be submitted. Corrective action plans (CAPs) in progress are not considered a release from the reporting agency.

7.14 Notice of Requirements (Limited to Providers)

Cenpatico IC has procedures for reporting (in writing) to appropriate authorities (AHCCCS, the provider’s regulatory board or agency, OAG, etc.) any known serious issues and/or quality deficiencies. If the issue/quality deficiency results in a provider’s suspension or termination from Cenpatico IC’s Network, it must be reported. If the issue is determined to have criminal implications, a law enforcement agency must also be notified.

- Cenpatico IC is required maintain documentation of implementation of the procedure, as appropriate;
- Cenpatico IC is required have an appeal process for instances in which Cenpatico IC chooses to alter the provider’s contract based on issues of quality of care and/or service; and
- Cenpatico IC is required to inform the provider of the reconsideration process.

Section 8 - FINANCE/BILLING

8.1 General Information

This section contains general information related to Cenpatico billing rules and requirements for Claims or Encounters.

Payment responsibilities for AHCCCS covered behavioral health services provided to AHCCCS members are pursuant to and clarified in ACOM Policy 432. This policy includes general requirements regarding the payment responsibility of:

- physical and behavioral health services
- physical health services that are provided to members that are also receiving behavioral health services
- specific circumstances regarding payment for behavioral health services, and
- specific circumstances regarding payment for physical health services at the Arizona State Hospital.
8.2 To Whom This Applies

All providers contracted with Cenpatico IC that submit claim or encounter data.

8.3 Additional Information


8.4 Claims versus Encounters

A Claim is a detailed invoice that providers must submit to Cenpatico IC to illustrate what services were rendered to our members. Claims have a direct dollar amount tied to them as cash value typically under Fee For Service (FFS payment methodologies).

Encounters have zero cash value as they are used as proof of monies earned through different contracting means such as block purchase, per member per month (PMPM) agreements, grant funds, or otherwise alternate payment methodologies as required.

8.5 Claim or Encounter Submission Requirements

Claims or Encounters that are not legible or not submitted on the correct form type or not submitted in conformance with the Health Insurance Portability and Accountability Act (HIPAA) transactions requirements, National Uniform Claim Committee Edits (NUCC) and 5010 Standards, will be returned to providers without being processed. This is known as a claim or encounter rejection.

Rejected Claims or Encounters do not count as a clean initial submission. Timely filing guidelines are not considered for rejected claims.

Applicable form types for claim or encounter submissions are as follows:

- HIPAA Format 837P or HCFA 1500 is used to bill or encounter non-facility services, including professional services, transportation, housing and independent laboratories.
- HIPAA Format 837I or UB04 Forms is used to bill or encounter hospital inpatient, outpatient, emergency room, hospital-based clinics and Behavioral Health Inpatient Facility services.
- HIPAA Format NCPDP is used by pharmacies to bill or encounter pharmacy services using NDC codes.
• HIPAA Format 837D or the ADA Dental Claim Form is used by dental providers to bill or claims or encounters for dental service.

Paper Claims are to be mailed to Cenpatico Integrated Care, PO Box 6500, Farmington, MO 63640. Paper claims or copies that contain highlighter or color marks, copy overexposure marks, or dark edges or are handwritten are not legible claim submission. Liquid paper correction fluid ("White Out") may not be used. If the claim or encounter is submitted in this manner, the claim will be rejected and returned to the provider.

Payor ID for Submission of 837I or 837P is 68068. Legacy Providers that were established as a direct submitter prior to 1/1/2015 utilize Payor ID68048. If a provider has any questions as to which payor ID they should utilize, please contact Cenpatico’s Claim Department at CAZClaims@cenpatico.com.

Providers also have the option to enroll for access to our Provider Portal to direct key entry claims and supporting supplemental documents. Providers can request access to the Provider Portal by going to Cenpatico Integrated Care website at https://www.cenpaticointegratedcareaz.com/providers.html. Select the option “For Providers” then select “Provider Portal” then Create An Account.

Any documentation submitted with a claim or encounter is imaged and linked to the claim image.

8.6 Claim Submission Time Frames

In accordance with AHCCCS Requirements, claim and encounter services provided to a Cenpatico Integrated Care members must be received in a timely manner. Cenpatico IC timely filing guidelines are as follows:

• Claims or Encounters must be accepted as a clean claim within 180 days from the end date service or from the date of eligibility posting whichever is later, unless there is a contractual exception. For hospital inpatient claims, date of service means the date of discharge of the patient.
• Claim or Encounter Resubmissions: Claims or Encounters must be accepted as a clean claim within 365 days from the date of provision of the covered service or eligibility posting deadline, whichever is later.
• If the member has primary insurance (i.e. insurance in addition to Cenpatico IC), claims or encounters must be submitted to Cenpatico IC within 180 days from the date of service or 30 days from the date of the primary payer’s EOP, whichever one is later. Secondary claims that are not received within 180 days from the date of service or 30 days from the date of the primary payer’s EOP will be denied for timely filing.
8.7 Remittance Advice and Electronic Funds Transfer (EFT)

Cenpatico IC will prepare remittance advice or the appropriate responses that describes its payments, denials or reject reason which will include:

- A description of the rejection, denial or adjustments;
- The reasons for the rejection, denial and adjustments;
- The amount billed;
- The amount paid if applicable;
- Application of coordination of benefits and copays if applicable; and
- Provider rights to assert a claim dispute only in the case the claim was processed.

Cenpatico IC will submit the related remittance advice with the payment, unless the payment is made by Electronic Funds Transfer (EFT), in which case the remittance will be mailed, or otherwise sent to the provider, no later than the date of the EFT.

Upon request by a provider, an electronic Health Care Claim Payment/Advice 835 transaction will be provided to a provider in accordance with HIPAA requirements if the provider submits an 837I or 837P.

8.8 Billing AHCCCS Recipients

Arizona Revised Statue 36-2903.01(K) prohibits providers from billing AHCCCS recipients including Qualified Medicare Beneficiary (QMB) recipients for covered services. Upon oral or written notice from the member that the patient feels the claim or encounter can be covered by Cenpatico IC, a contracted or non-contracted provider shall not do either of the following unless the provider has verified through Cenpatico IC that the member has been determined ineligible, has not yet been determined eligible or was not eligible at the time services were rendered:

- Charge, submit a claim to or demand to collect payment from the member.
- Refer or report a member who has been determined as eligible to a collection agency or credit reporting agency for the failure of the member or person who has been determined eligible to pay charges for services covered.

8.9 Resubmissions, Replacements and Voids

Cenpatico IC Claim and Encounter Adjudication will deny claims with errors that are identified during the editing process. These errors will be reported to Providers on their Remittance Advice. Provider should correct claims error and resubmit the correction to Cenpatico IC within 365 days from the date of provision.

When resubmitting a denied claim or encounter, providers must submit a new claim form containing all previously submitted lines. The original claim reference number must be included on the claim or encounter to enable Cenpatico IC system to identify the claim being resubmitted. Otherwise the claim will be entered as a new claim and may be denied for being received beyond the initial submission time frame.
8.10 Submissions for Non-Title XIX/XXI Enrolled Persons

Submitted encounters or claims for services delivered to Non-Title XIX/XXI enrolled persons must be submitted in the same manner and timeframes as described in the sections above.

8.10.1.1 Pseudo Identification Numbers for Non-Title XIX/XXI Eligible Persons

Pseudo identification numbers are only applicable to providers under contract with Cenpatico IC.

On very rare occasions, usually following a crisis episode, basic information about a Member may not be available. When the identity of a Member is unknown, a provider may use a pseudo identification number to register an unidentified person. This allows an encounter to be submitted to AHCCCS, allowing Cenpatico IC and the provider to be reimbursed for delivering certain covered services. Covered services that can be encountered/billed using pseudo identification numbers are limited to:

- Crisis Intervention Services (Mobile);
- Case Management; and
- Transportation.

Pseudo identification numbers must only be used as a last option when other means to obtain the needed information have been exhausted. Inappropriate use of a pseudo identification number may be considered a fraudulent act. Cenpatico IC’s pseudo identification number for the South GSA in Greater Arizona is [AHCCCS ID FOR SOUTH ARIZONA GSA – NR010126M0 for service dates after 10/1/2015]

8.11 Provider Preventable Conditions and Fraud Waste and Abuse Edits

42 CFR Section 447.26 prohibits payment for services related to Provider-Preventable Conditions. A Provider-Preventable Condition is a condition that meets the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC). These terms are defined as follows:

- **Health Care-Acquired Condition (HCAC)** – means a Hospital Acquired Condition (HAC) under the Medicare program, with the exception of Deep Vein Thrombosis/Pulmonary Embolism following total knee or hip replacement for pediatric and obstetric patients, which occurs in any inpatient hospital setting and which is not present on admission. Refer to Chapter 900, Policy 960 for the list of HCACs.

- **Other Provider-Preventable Condition (OPPC)** – means a condition occurring in the inpatient and outpatient health care setting which AHCCCS has limited to the following:
  - Surgery on the wrong Member,
  - Wrong surgery on a Member; and
  - Wrong site surgery.
A Member’s health status may be compromised by hospital conditions and/or medical personnel in ways that are sometimes diagnosed as a “complication”. If it is determined that the complication resulted from an HCAC or OPPC, any additional hospital days or other additional charges resulting from the HCAC or OPPC will not be reimbursed. If it is determined that the HCAC or OPPC was a result of mistake or error by a hospital or medical professional, Cenpatico IC will conduct a quality of care investigation and report the occurrence and results of the investigation to the AHCCCS Clinical Quality Management Unit.

8.11.1.1 Fraud Waste and Abuse (FWA) Claim or Encounter Edits

As part of our Contract Requirement, claims and encounters are cycled through our editing software which is based on National Correct Coding Initiatives (NCCI). NCCI procedure-to-procedure (PTP) edits that define pairs of Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons. The “National Correct Coding Initiative Policy Manual for Medicare Services” is updated annually. The PTP code pair edits, MUE tables, and NCCI manual are accessed through the National Correct Coding Initiative Edits webpage at cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html on the CMS website.

Providers can request formal reconsideration of these denials by sending a written reconsideration letter with medical records to Centene mailroom: PO Box 3000 Appeals, Farmington MO 63640.

Providers should reference the Control Reference Number (Claim #) in their cover letter. Actual copies of the claim or encounter is not needed.

8.12 Copayments

8.12.1 Introduction

The purpose of this policy is to describe copayment requirements for health care services provided by Cenpatico IC. A copayment is a monetary amount that a Member pays directly to a provider at the time covered services are rendered. This policy covers AHCCCS copayments for the Title XIX/XXI (Medicaid)/XXI (KidsCare) population and also covers the AHCCCS copayments for the Non-Title XIX/XXI population. Although persons may be exempt from AHCCCS copayments, these individuals may still be subject to Medicare copayments. Most Medicaid eligible Members remain exempt from copayments, such as SMI Members and Members under the age of nineteen (19), while others are subject to an optional and mandatory copayment.

Prior to billing and before attempting to collect copayments from a Member, providers are required to verify the Member is not exempt or eligible to be exempt from being charged for copayments. Furthermore, providers must apply copayments for Members in conformance with the AHCCCS Policy on copayments and AAC R9-22-711.
8.12.2 AHCCCS Copayments for Non-Title XIX/XXI Eligible Persons with a Serious Mental Illness (SMI)

- For individuals who are Non-Title XIX/XXI eligible persons with SMI, AHCCCS has established a copayment to be charged to these Members for covered services (A.R.S. 36-3409).
- Copayment requirements are not applicable to services funded by the Substance Abuse Block Grant (SABG), Mental Health Block Grant (MHBG) or Project for Assistance in Transition from Homelessness (PATH) federal block grant.
- Copayments are not assessed for crisis services or collected at the time crisis services are provided.
- Persons with SMI must be informed prior to the provision of services of any fees associated with the services (R9-21-202(A) (8)), and providers must document such notification to the person in his/her comprehensive clinical record.
- Copayments assessed for Non-Title XIX/XXI persons with SMI are intended to be payments by the Member for all covered health services, but copayments are only collected at the time of the psychiatric assessment and psychiatric follow up appointments.
- Copayments are:
  - A fixed dollar amount of $3;
  - Applied to in-network services; and
  - Collected at the time services are rendered.
- Providers will be responsible for collecting copayments. Any copayments collected are reported in the encounter. Providers will:
  - Assess the fixed dollar amount per service received, regardless of the number of units encountered. Collect the $3 copayment at the time of the psychiatric assessment or the psychiatric follow up appointment;
  - Take reasonable steps to collect on delinquent accounts, as necessary;
  - Collect copayments as an administrative process, and not in conjunction with a person’s health treatment;
  - Clearly document in the person’s comprehensive clinical record all efforts to resolve non-payment issues, as they occur; and
  - Not refuse to provide or terminate services when an individual states he or she is unable to pay copayments described in this section. Cenpatico IC encourages a collaborative approach to resolve non-payment issues, which may include the following:
    - Engage in informal discussions and avoid confrontational situations;
    - Re-screen the person for AHCCCS eligibility; and
    - Present other payment options, such as payment plans or payment deferrals, and discuss additional payment options as requested by the person.
8.12.3 AHCCCS Copayments for Title XIX/XXI Members

Persons who are Title XIX/XXI eligible will be assessed a copayment in accordance with AAC R9-22-711. Certain populations and certain services are exempt from copayments. AHCCCS copayments are not charged to the following persons for any service:

1. Persons under age 19;
2. Persons that are Seriously Mentally Ill (SMI);
3. Individuals up through age 20 eligible for the Children’s Rehabilitative Services Program (CRS);
4. Acute care members who are placed in nursing facilities or residential facilities such as an Assisted Living Home when such placement is made as an alternative to hospitalization. The exemption from copayments for these members is limited to 90 days in a contract year.
5. Persons who are enrolled in the Arizona Long Term Care System (ALTCS);
6. People who are eligible for Qualified Medicare Beneficiary (QMB) A.A.C. Title 9, Chapter 29
7. Persons receiving hospice care;
8. American Indian Members who are active or previous users of the Indian Health Service, tribal health programs operated under a tribal 638 facility, or urban Indian health programs;
9. Individuals in the Breast and Cervical Cancer Treatment Program;
10. Adults eligible under AAC R9-22-1427(E). These individuals are known as the Adult Group. Persons in the Adult Group are individuals 19-64, who are not pregnant, do not have Medicare, and are not eligible in any other eligibility category and whose income does not exceed 133% of the federal poverty level (FPL). The adult group includes individuals who were previously eligible under the AHCCCS Care program with income that did not exceed 100% of the FPL, as well as other adults described in R9-22-1427(E) with income above 100% FPL, but not greater than 133% FPL;
11. Individuals receiving child welfare services under Part B Title IV of the Social Security Act, on the basis of being a child in foster care without regard to age;
12. Individuals receiving adoption or foster care assistance under Part E of Title IV of the Social Security Act without regard to age; and
13. Individuals who are pregnant through the postpartum period.

Copayments are not charged for the following services:

1. Hospitalizations,
2. Emergency Services
3. Family Planning services and supplies
4. Pregnancy related health care and health care for any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for pregnant women
5. Services paid on a Fee-For-Services basis
6. Preventive services, such as well visits, immunizations, pap smear, colonoscopies and mammograms and
7. Provider preventable services
8.12.4 Non-Mandatory (Nominal/Optional) Copayments

Individuals eligible for AHCCCS through any of the populations listed below may have nominal (optional) copayments for certain services. Nominal copayments are also referred to as optional copayments (see Table 1 below). Providers are prohibited from refusing services to Members who have nominal (optional) copayments if the Member states he or she is unable to pay the copayment.

Persons with nominal (optional) copayments are:

1. Caretaker relatives eligible under [AAC R9-22-1427(A)] (also known as AHCCCS for Families with Children under section 1931 of the Social Security Act);
2. Individuals eligible under the Young Adult Transitional Insurance (YATI) for young adults who were in foster care;
3. Individuals eligible for the State Adoption Assistance for Special Needs Children who are being adopted;
4. Individuals receiving Supplemental Security Income (SSI) through Social Security Administration for people who are age 65 or older, blind or disabled;
5. Individuals receiving SSI Medical Assistance Only (SSI MAO) who are age 65 or older, blind or disabled; and
6. Individuals in the Freedom to Work (FTW) program.

<table>
<thead>
<tr>
<th>Service</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2.30</td>
</tr>
<tr>
<td>Out-patient services for physical, occupational and speech therapy</td>
<td>$2.30</td>
</tr>
<tr>
<td>Doctor or other provider outpatient office visits for evaluation and management of your care. This excludes emergency room/emergency department visits</td>
<td>$3.40</td>
</tr>
</tbody>
</table>

8.12.5 Mandatory Copayments for Certain AHCCCS Members

Persons with higher income who are determined eligible for AHCCCS through the Transitional Medical Assistance (TMA) program will have mandatory copayments for some medical services (see Table 2 below). TMA Members are described in [AAC R9-22-1427(B)].

When a Member has a mandatory copayment, a provider can refuse to provide a service to a Member who does not pay the mandatory copayment. A provider may choose to waive or reduce any copayment under this section.

<table>
<thead>
<tr>
<th>Service</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2.30</td>
</tr>
<tr>
<td>Doctor or other provider outpatient office visits for evaluation and management of your care. This excludes emergency room/emergency department visits</td>
<td>$4.00</td>
</tr>
<tr>
<td>Physical, Occupational and Speech Therapies</td>
<td>$3.00</td>
</tr>
</tbody>
</table>
8.12.6 Copayment Limits

Members subject to copays will not be required to pay additional copayments once the total amount of copayments made is more than 5% of the gross family income (before taxes and deductions) during a calendar quarter (January through March, April through June, July through September, and October through December).

Cenpatico IC will track each member’s specific copayment levels by service type to identify those members who have reached the 5% copayment limit. With the exception of prescription drugs (where a copay is charged for each drug received), only one copay may be assessed for services received during a visit. If the coding for the visit falls within more than one copayment category, the member is responsible for the highest copayment amount.

8.13 Third Party Liability and Coordination of Benefits

Third party liability refers to situations in which persons enrolled in the public health care system also have health care service coverage through another health insurance plan, or “third party”. The third party can be liable or responsible for covering some or all the services a person receives, including medications. Providers are responsible for determining and verifying if a person has third party health insurance before using other sources of payment such as Medicaid (Title XIX), KidsCare (Title XXI) or State appropriated health care funds. Pursuant to federal and State law, Medicaid is the payer of last resort except under limited situations, meaning that Medicaid funds shall be used as a source of payment for covered services only after all other Sources of payment have been exhausted.

The intent of this section is to describe the requirements for providers to:

- Determine if a person has third party health insurance coverage before using federal or State funds;
- Coordinate services and assign benefit coverage to third party payers when information regarding the existence of third party coverage is available; and
- Submit billing information that includes documentation that third party payers were assigned coverage for any covered services that were rendered to the enrolled person.
- Coordinate benefits for persons enrolled with Medicare Part A, Part B, and/or Part D.
- Coordinate benefits for persons enrolled in a qualified health plan through the federal health insurance exchange.

8.13.1 Additional Information

- If third party information becomes available to the provider at any time for Title XIX/XXI eligible persons, that information must be reported to the AHCCCS Administration within 10 days from the date of discovery.
• An online Medical Insurance Referral should be completed and submitted to AHCCCS through the Health Management Systems (HMS) website whenever an AHCCCS Member is discovered to have other medical insurance, or whenever other medical insurance has terminated or changed. HMS has launched a new Third Party Liability (“TPL”) Referral Web Portal. The site to gain this access is https://www.azahcccs.gov/PlansProviders/HealthPlans/tpl.html

• AHCCCS has also established a process for Cenpatico IC to report third party information for Title XIX/XXI eligible persons daily to the AHCCCS on a Third Party Leads submission file. After submitting the file to AHCCCS for verification of the information, Cenpatico IC will receive notification of updated information on the TPL files. Cenpatico IC makes third party payer information available to all providers involved with the person receiving services.

• Third parties include, but are not limited to, private health insurance, Medicare, employment related health insurance, medical support from non-custodial parents, court judgments or settlements from a liability insurer, state worker’s compensation, first party probate-estate recoveries, long term care insurance and other federal programs.

• For those Medicare Part A and Part B services that are also covered under Title XIX, there is no cost sharing obligation if Cenpatico IC has a contract with the Medicare provider and the provider’s subcontracted rate includes Medicare cost sharing as specified in the contract.

• As of January 1, 2006, Medicare Part D Prescription Drug coverage became available to all Medicare eligible persons. Medicare is considered third party liability and must be billed prior to use of Title XIX/XXI or state funds.

• Children who qualify for Adoption Subsidy will be eligible for Title XIX/XXI benefits. In addition, their families may also have private insurance. Simultaneous use of the private insurance and Title XIX/XXI coverage may occur through the coordination of benefits. Following an intake and assessment, providers must determine the services and supports needed. Any necessary services that are not covered through the private insurance, including copayments and deductibles, may be covered under Title XIX.

8.13.2 Identifying Other Health Insurance

Providers are responsible for determining and verifying if a person has third party health insurance before using other sources of payment such as Medicaid (Title XIX), Title XXI or State appropriated health funds.

• Providers must identify the existence of potentially liable parties through the use of trauma code edits, utilizing diagnostic codes 800 to 999.9 (excluding code 994.6), external causes of injury codes E000 through E999, and other procedures.

• If third party information becomes available to the provider at any time for Title XIX/XXI eligible persons, that information must be reported to the AHCCCS Administration within 10 days from the date of discovery.

• Providers must report third party information via the following website: https://www.azahcccs.gov/PlansProviders/HealthPlans/tpl.html. From this link, you
can navigate to Health Management Systems (HMS), where you can enter a Member’s TPL information.

Cenpatico IC will receive notification of updated information on the TPL files. Cenpatico IC makes third party payer information available to all providers involved with the person receiving services.

Providers must inquire about a person’s other health insurance coverage during the initial appointment or intake process. When providers attempt to verify a person’s Title XIX/XXI eligibility, information regarding the existence of any third party coverage is provided through AHCCCS’s automated eligibility verification systems. If a person is not eligible for Title XIX/XXI benefits, he/she will not have any information to verify through the automated systems. Therefore, the existence of third party payers must be explored with the person during the screening and application process for AHCCCS health insurance.

8.13.3 Services Covered by Other Health Insurance Party

Third party health insurance coverage may cover all or a portion of the health services rendered to a person. Providers must contact the third party directly to determine what coverage is available to the person. At times, Cenpatico IC may incur the cost of copayments or deductibles for a Title XIX/XXI eligible person or person with SMI, while the cost of the covered service is reimbursed through the third party payer. However, payments by another State agency are not considered third party and in this circumstance, AHCCCS and Cenpatico IC are not the payer of last resort.

- In an emergency situation, the provider must first provide any medically necessary covered services, and then coordinate payment with any potential third party payers.
- When coverage from a third party payer has been verified, there are two methods used in the coordination of benefits:
  - Cost avoidance - Providers must cost avoid all claims or services that are subject to third-party payment. Cenpatico IC may deny payment to a provider if a provider is aware or unaware of third party liability and submits a claim or encounter to Cenpatico IC. In emergencies, providers must provide the necessary services and then coordinate payment with the third party payer; or
  - Post-payment recovery is necessary in cases where a health provider has not established the probable existence of third party coverage at the time services were rendered or paid for, or was unable to cost avoid.

If a third-party insurer requires a person to pay a copayment, coinsurance or deductible, Cenpatico IC is responsible for covering those costs for Title XIX/XXI eligible persons if the third party payer is not another State agency. AHCCCS and Cenpatico IC are required to be the payers of last resort for Title XIX/XXI and Non-Title XIX/XXI covered services. Payment by another State agency is not considered third party and, in this circumstance, AHCCCS and Cenpatico IC are not the payer of last resort.
8.13.4 Billing Requirements

Upon determination that a person has third party coverage, a provider must submit proper documentation to demonstrate that the third party has been assigned responsibility for the covered services provided to the person. An Explanation of Payments (EOP) and an Explanation of Benefits (EOB) are the only suitable documents that can be submitted for coordination of benefits.

Initial third party claims received after 180 days from date of service or 30 days from the primary payer’s EOP will be denied for Past Filing Deadline (PFD) regardless of primary insurance coverage.

The following guidelines must be adhered to by health providers regarding third party payers:

- Providers must bill claims for any covered services to any third party payer when information on that third party payer is available. Documentation that such billing has occurred must accompany the claim when submitted for payment. Such documentation includes a copy of the Explanation of Payment or Explanation of Benefits (EOB) from the third party payer. The only exceptions to this billing requirement are:
  - When it is determined that the person had relevant third party coverage after services were rendered or reimbursed;
  - When a Member eligible for both Medicaid and Medicare (dual eligible) receives services in a Behavioral Health Inpatient facility that is not Medicare certified. Non-Medicare certified facilities may be utilized for dual eligible members when a Medicare certified facility is not available; or
  - When a Member is receiving covered services from a preferred provider (i.e., the provider is close to person’s home) and the provider is unable to bill the person’s third party payer;

- Cenpatico IC may deny payment to a provider if a provider is aware of third party liability and submits a claim to Cenpatico IC. However, if the provider knows that the third party payer will not pay for or provide a medically necessary covered service, the provider must not decline to render the service to the member.

- If the provider does not know whether a particular medically necessary covered service is covered by the third party payer, the provider must contact the third party payer rather than requiring the person receiving services to do so.

- Providers may not employ cost avoidance strategies that limit or deny a person eligible for services from receiving timely, clinically appropriate, accessible, medically necessary covered services.

8.13.5 Discovery of Third Party Liability After Services Were Rendered or Reimbursed

If it is determined that a person has third party liability after services were rendered or reimbursed, providers must identify all potentially liable third party payers and pursue reimbursement from them. In instances of post-payment recovery, the provider must submit an adjustment to the original claim, including a copy of the Explanation of Payment (EOP) or the Explanation of Benefits (EOB). Providers shall not pursue recovery in the following
circumstances, unless the case has been referred to the Cenpatico IC and the provider by AHCCCS or AHCCCS’s authorized representative:

- Uninsured/underinsured motorist insurance;
- Restitution Recovery;
- First- and third-party liability insurance;
- Worker’s Compensation;
- Tortfeasors, including casualty;
- Estate Recovery; or
- Special Treatment Trust Recovery.

The provider must report any cases involving the above circumstances to Cenpatico IC, which will then report such cases to AHCCCS’s authorize representative for determination of a “total plan” case. Providers may be asked to cooperate with AHCCCS and/or AHCCCS in third party collection efforts.

8.13.6 Copayments, Premiums, Coinsurance and Deductibles for Non-Title XIX/XXI Persons with SMI for Which There Is Third Party Liability

The copayment assessed for Non-Title XIX/XXI persons with SMI is intended to be paid by the Member for services covered in the medication only benefit (e.g., psychiatric assessments, medication management, medications), but copayments are only collected at the time of the psychiatric assessment and psychiatric follow up appointments.

Non-Title XIX/XXI persons with SMI may be assessed the AHCCCS copayment in accordance with Section 8.12 - Copayments, or may be assessed copayments, premiums, coinsurance and/or deductibles for services covered by the third party insurer. When a Non-Title XIX/XXI person with SMI is assessed the AHCCCS copayment, he/she will pay the AHCCCS copayment or the copayment required by the third party insurer, whichever is less (see Provider Manual Attachment 8.14, Third Party Liability and Coordination of Benefits, Non-Title XIX/XXI Eligible Persons Determined to have a Serious Mental Illness).

Additionally, when a Non-Title XIX/XXI person with SMI is assessed a copayment for a generic medication that is also on the AHCCCS Non-Title XIX/XXI Formulary, he/she will pay the AHCCCS copayment or the copayment required by the third party insurer, whichever is less. Cenpatico IC is responsible for covering the difference between the AHCCCS copayment and the third party copayment when the third party copayment is greater than the AHCCCS copayment.

Members are responsible for third party copayments for services that are not services that the AHCCCS covers (see AHCCCS Guidelines to the RBHA/Health Plans and Providers for Services to Non-Title XIX/XXI Members with a Serious Mental Illness) and third party premiums, coinsurance and deductibles, if applicable.

When Non-Title XIX/XXI persons with SMI have difficulty paying copayments, the provider must re-screen the individual for Title XIX/XXI eligibility.
8.13.7 Medicaid Eligible Persons with Medicare Part A and Part B

Providers are responsible for identifying whether Members are enrolled in Medicare Part A or Medicare Part B and covering services accordingly. For Medicaid eligible persons with Medicare Part A, Part B, and/or Part D:

- Title XIX/XXI eligible person may receive coverage under both Medicaid (AHCCCS) and Medicare. These persons are sometimes referred to as “dual eligibles” or “Duals”. In most cases, providers are responsible for payment of Medicare Part A and Part B coinsurance and/or deductibles for covered services provided to dual eligible persons. However, there are different cost sharing responsibilities that apply to dual eligible persons for a variety of situations. Unless prior approval is obtained from AHCCCS or Cenpatico IC, providers must limit their cost sharing responsibility according to ACOM Policy 201 and Policy 202. Providers shall have no cost sharing obligation if the Medicare payment exceeds what the provider would have paid for the same service of a non-Medicare Member.

- Some dual eligible AHCCCS Members may have Medicare Part B only. As these Members do not have Medicare Part A, Medicaid is the primary payer for services which generally would be covered under Part A including hospitalizations, skilled nursing facilities, and hospice. A claim should not be denied for a lack of Medicare Explanation of Payment (EOP) when the Member is not enrolled in Medicare Part A;

- In the same way, if Members have Medicare Part A only, Medicaid is the primary payer for services which are generally covered under Part B including physician visits and durable medical equipment; and

- In the event that a Title XIX/XXI eligible person also has coverage through Medicare, providers must ensure adherence with the requirements described in this subsection.

Qualified Medicare Beneficiary (QMB) Duals are entitled to all AHCCCS and Medicare Part A and B covered services. Cenpatico IC is responsible for payment of Medicare cost sharing for all Medicare covered services regardless of whether the services are covered by AHCCCS. Cenpatico IC only has responsibility to make payments to providers registered with AHCCCS to provide services to AHCCCS eligible Members. The payment of Medicare cost sharing must be provided regardless of whether the provider is in Cenpatico IC’s network or prior authorization has been obtained.

**QMB Dual Cost Sharing Matrix**

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Cenpatico IC Responsibility</th>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Only—not covered by AHCCCS</td>
<td>Cost sharing responsibility only</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>AHCCCS Only—not covered by Medicare, including pharmacy and other prescribed services</td>
<td>Reimbursement for all medically necessary services</td>
<td>YES</td>
<td>NO*</td>
</tr>
<tr>
<td>AHCCCS and Medicare covered Service (except for emergent)</td>
<td>Cost sharing responsibility only</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>
Cenpatico IC is responsible for the payment of the Medicare cost sharing for AHCCCS covered services for Non-QMB Duals that are rendered by a Medicare provider within Cenpatico IC’s network.

**Non-QMB Dual Cost Sharing Matrix**

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Cenpatico IC Responsibility</th>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Only—not covered by AHCCCS</td>
<td>No cost sharing responsibility</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>AHCCCS Only—not covered by Medicare, including pharmacy and other prescribed services</td>
<td>Reimbursement for all medically necessary services</td>
<td>YES*</td>
<td>NO*</td>
</tr>
<tr>
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<td>YES</td>
<td>NO*</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>Cost sharing responsibility only</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>

*Subject to Cenpatico IC Policy*

8.13.7.1  **Limits on Cost Sharing:**

Cenpatico IC shall have no cost sharing obligation if the Medicare payment exceeds Cenpatico IC’s contracted rate for the services. Cenpatico IC’s liability for cost sharing plus the amount of Medicare’s payment shall not exceed Cenpatico IC’s contracted rate for the service. There is no cost sharing obligation if Cenpatico IC has a contract with the provider, and the provider’s contracted rate includes Medicare cost sharing.

The exception to these limits on payments as noted above is that Cenpatico IC shall pay 100% of the Member copayment amount for any Medicare Part a Skilled Nursing Facility (SNF) days (21 through 100) even if Cenpatico IC has a Medicaid Nursing Facility rate less than the amount paid by Medicare for a Part a SNF day.

Cenpatico IC can require prior authorization, but if the Medicare provider determines that a service is medically necessary, Cenpatico IC is responsible for Medicare cost sharing, even if Cenpatico IC determines otherwise. If Medicare denies a service for lack of medical necessity, Cenpatico IC will apply its own criteria to determine medical necessity. If criteria support medical necessity, then Cenpatico IC shall cover the cost of the service.

For QMB Dual Members, Cenpatico IC has cost sharing responsibility regardless of whether the services were provided by an in or out of network provider. For AHCCCS covered services rendered by an out of network provider to a non-QMB Dual, Cenpatico IC is not liable for any Medicare cost sharing unless Cenpatico IC has authorized the Member to obtain services out of network. If a Member has been advised of Cenpatico IC’s network, and the Member’s
responsibility is delineated in the Member handbook, and the Member elects to go out of network, Cenpatico IC is not responsible for paying the Medicare cost sharing amount.

8.13.8 Medicare Part D Prescription Drug Coverage

8.13.8.1 Cost sharing and coordination of benefits for persons enrolled in Medicare Part D:

Title XIX/XXI funds are not available to pay any cost sharing of Medicare Part D.

Cenpatico IC will utilize available Non-Title XIX/XXI funds to cover Medicare Part D copayments for Title XIX and Non-Title XIX persons with SMI, with the following limitations:

- Copayments are to be covered for medications on the AHCCCS Behavioral Health Drug List. Copayments are to be covered for medications prescribed by in-network providers. Cenpatico IC may utilize Non-Title XIX/XXI funds for coverage of medications during the Medicare Part D coverage gap; and
- If a request for an exception has been submitted and denied by the Medicare Part D plan, Cenpatico IC may utilize Non-Title XIX/XXI funds to cover the cost of the non-covered Part D medication for persons with SMI, regardless of Title XIX/XXI eligibility.

Cenpatico IC may utilize at its discretion Non-Title XIX/XXI funds for coverage of medications during the Medicare Part D coverage gap. If a request for an exception has been submitted and denied by the Medicare Part D plan, Cenpatico IC may utilize at its discretion Non-Title XIX/XXI funds to cover the cost of the non-covered Part D medication for persons with SMI, regardless of Title XIX/XXI eligibility.

8.13.9 Cenpatico IC and Cenpatico IC Providers’ Enrollment Responsibilities

Cenpatico IC and Cenpatico IC providers must educate and encourage Non-Title XIX/XXI Members with SMI to enroll in a qualified health plan through the federal health insurance exchange and offer assistance for those choosing to enroll during open enrollment periods and qualified life events. The following applies for Members who enroll in a qualified health plan through the federal health insurance exchange:

- Members enrolled in a qualified health plan through the Federal Health Insurance Marketplace continue to be eligible for Non-Title XIX/XXI covered services that are not covered under the exchange plan.
- Non-Title XIX/XXI funds may not be used to cover premiums or copays associated with qualified health plans through the Federal Health Insurance Marketplace or other third party liability premiums or copays other than Medicare Part D for Members with SMI.
- Cenpatico IC is required issue approval prior to any utilization of Non-Title XIX/XXI funding for services otherwise covered under a qualified plan through the Federal Health Insurance Marketplace.
8.14 Transportation

Providers shall maintain all records in compliance with the noted specifications for record keeping related to transportation services. It is the responsibility of the provider to maintain documentation that supports each transport provided. Transportation providers put themselves at risk of recoupment of payment if the required documentation is not maintained or covered services cannot be verified.

Cenpatico IC will cover medically necessary non-emergency ground and air transportation to and from a required medical service for most recipients. Non-emergency transportation providers must bill the number of trips and the number of loaded miles as units of service on the CMS 1500 claim form or 837P. Loaded mileage is defined as the distance traveled, measured in statute miles, with a recipient on board the vehicle and being transported to receive medically necessary covered services.

Transportation billing guidelines related to Third Party Liability and Coordination of Benefits are the same. Providers must identify all potentially liable third party payers and pursue reimbursement from them.

Providers must provide and retain fiscal responsibility for transportation for Title XIX/XXI persons in order for the person to receive a covered health service reimbursed by a third party, including Medicare.

8.15 Refunds or overpayments on services rendered

Providers that have received payment in error or been overpaid for a service, should immediately contact Cenpatico IC Claims Technical Assistance at CAZClaims@cenpatico.com. Claims will be reviewed and if applicable adjustments will be made to the claim. If a provider chooses to submit a refund as opposed to having Claims Technical Assistance do the review for adjustment, payments should be made to Cenpatico Integrated Care, P.O. Box 301001 Los Angeles, CA 90030-1001.
Section 9 - QUALITY MANAGEMENT REQUIREMENTS

9.1 Advance Directives

An advance directive is a written set of instructions developed by an adult member in the event the member becomes incapable of making decisions regarding his or her health care. An advance directive instructs others regarding the member’s wishes, if he/she becomes incapacitated and can include the appointment of a friend or relative to make health care decisions for the member. An adult member prepares an advance directive when competent and capable of making decisions, and the directive is followed when the member is incapable of making treatment decisions. This section outlines the requirements of providers with regard to advance directives.

9.1.1 Health Care Power of Attorney

A health care power of attorney gives an adult member, not under legal guardianship, the right to designate another adult person to make health care treatment decisions on his or her behalf. The designee may make health care decisions on behalf of the adult member if/when he or she is found incapable of making these types of health care decisions. However, the designee must not be a provider directly involved with the health treatment of the adult member at the time the health care power of attorney is executed.

See A.R.S. § 36-3281 for additional information regarding a mental health power of attorney and a member who is “found incapable” of making his/her own health care decisions.

9.1.2 Power and Duties of Designees

The designee:

- May act in this capacity until his or her authority is revoked by the adult member, a legal guardian or by court order;
- Has the same right as the adult member to receive information and to review the adult member’s medical records regarding proposed health treatment and to receive, review and consent to the disclosure of medical records relating to the adult member’s treatment;
- Must act consistently with the wishes of the adult member or legal guardian as expressed in the mental health care power of attorney or health care power of attorney. However, if the adult member’s wishes are not expressed in a mental health care power of attorney or health care power of attorney and are not otherwise known by the designee, the designee must act in good faith and consent to treatment that he or she believes to be in the adult member’s best interest; and
- May consent to admitting the adult member to an Inpatient Facility licensed by the Arizona Department of Health Services if this authority is expressly stated in the mental health care power of attorney or health care power of attorney.

See A.R.S. § 36-3283 for a complete list of the powers and duties of an agent designated under a mental health care power of attorney.
9.1.3  Information Regarding Advance Directives

At the time of enrollment, all adult members, and when the member is incapacitated or unable to receive information, the member’s family or surrogate, must receive the following information regarding advance directives (see 42 CFR § 422.128 and AHCCCS Medical Policy Manual, Policy 640):

- The member’s rights, in writing, regarding advance directives under state law;
- A description of the applicable state law and information regarding the implementation of these rights;
- The member’s right to file grievances directly with AHCCCS; and
- Written policies including a clear and precise statement of limitations if the provider cannot implement an advance directive as a matter of conscience. This statement, at a minimum, should:
  - Clarify institution-wide conscientious objections and those of individual physicians;
  - Identify state legal authority permitting such objections; and
  - Describe the range of medical conditions or procedures affected by the conscience objection.

Written information regarding advance directives shall be provided to members at the time of enrollment with the member handbook. Refer to Section 14 – Cenpatico IC Member Handbook and ACOM Policy 404 for member information and member handbook requirements.

If an adult member is incapacitated at the time of enrollment, providers may give advance directive information to the member’s family or surrogate in accordance with state law. Providers must also follow up when the member is no longer incapacitated and verify that the information is given to the member directly.

9.1.4  Assistance with Developing and Executing an Advance Directive

Providers must assist adult members or their legal guardians who are interested in developing and executing an advance directive. Providers must maintain written policies that address the rights of adult members to make decisions about medical care, including the right to accept or refuse medical care and the right to execute an advance directive. Members must be provided information about formulating advance directives (see AHCCCS Medical Policy Manual, Policy 930).

For members in a HCBS or a behavioral health residential setting that have completed an advance directive, the document must be kept confidential but be readily available. For example: in a sealed envelope attached to the refrigerator.

Providers may utilize Provider Manual Attachment 9.1.1 Sample Verbal Explanation About Mental Health Advance Directives, Provider Manual Form 9.1.1 Advance Directives, Provider Manual Form 14.1.1 Cenpatico IC Member Handbook Receipt, Provider Manual Form 9.1.2 Wellness Recovery, Crisis Plan and Advance Directives or any other relevant document the provider offers to the adult member in order to meet requirements regarding advance directives upon enrollment.
Additional information regarding advance directives can be obtained by calling Cenpatico IC Customer Service at 1-866 495-6738.

9.1.5 Other Requirements Regarding Advance Directives

Providers must: (see AHCCCS Medical Policy Manual, Policy 640)

- Document in the adult member’s medical record whether or not the adult member was provided the information and whether an advance directive was executed;
- Not condition provision of care or discriminate against an adult member because of his or her decision to execute or not execute an advance directive;
- Provide a copy of a member’s executed advanced directive or documentation of refusal, to the acute care primary care provider (PCP) for inclusion in the member’s medical record; and
- Provide education to staff on issues concerning advance directives including notification of direct care providers of services, such as home health care and personal care, of any advance directives executed by member’s to whom they are assigned to provide services.

9.2 Medical Record Standards

The purpose of this section is to ensure that providers maintain medical records that document medical needs, changes and the delivery of medically necessary services. Medical records must be complete accurate, accessible and permit systematic retrieval of information while maintaining confidentiality. Documentation in the medical record facilitates diagnosis and treatment, coordination of care, supports billing reimbursement information, provides evidence of compliance during periodic medical record reviews and can protect practitioners against potential litigation.

The medical record contains clinical information pertaining to a member’s physical and behavioral health. Maintaining current, accurate and comprehensive medical records assists providers in successfully treating and supporting member care.

Providers must maintain legible, signed and dated medical records in paper or electronic format that are written in a detailed and comprehensive manner; conform to good professional practices; permit effective professional review and audit processes; and facilitate an adequate system for follow up treatment.

9.2.1 To Whom This Applies

All providers contracting with Cenpatico IC providing services in Arizona’s public health system.

9.2.2 Adequacy and Availability of Documentation

All providers must maintain and store records and data that document and support the services provided to members and the associated encounters/billing for those services. In addition to any records required to comply with providers’ contracts with Cenpatico IC, there must be
adequate documentation to support that all billings or reimbursements are accurate, justified and appropriate.

All providers must prepare, maintain and make available to Cenpatico IC or AHCCCS, adequate documentation related to services provided and the associated encounters/billings.

Adequate documentation is electronic records and “hard-copy” documentation that can be readily discerned and verified with reasonable certainty. Adequate documentation must establish medical necessity and support all medically necessary services rendered and the amount of reimbursement received (encounter value/billed amount) by a provider; this includes all related clinical, financial, operational and business supporting documentation and electronic records. It also includes clinical records that support and verify that the member’s assessment, diagnosis and Individual Service Plan (ISP) are accurate and appropriate and that all services (including those not directly related to clinical care) are supported by the assessment, diagnosis and ISP.

For monitoring, reviewing and auditing purposes, all documentation and electronic records must be made available at the same site at which the service is rendered. If requested documents and electronic records are not available for review at the time requested, they are considered missing. All missing records are considered inadequate. If documentation is not available due to off-site storage, the provider must submit their applicable policy for off-site storage, demonstrate where the requested documentation is stored and arrange to supply the documentation at the site within twenty-four (24) hours of the original request.

A provider’s failure to prepare, retain and provide to Cenpatico IC or AHCCCS adequate documentation and electronic records for services encountered or billed, may result in the recovery and/or voiding (not to be resubmitted) of the associated encounter values or payments for those services not adequately documented and/or result in financial sanctions to the provider and Cenpatico IC.

Inadequate documentation may be determined to be evidence of suspected fraud or program abuse that may result in notification or reporting to the appropriate law enforcement or oversight agency. These requirements continue to be applicable in the event the provider discontinues as an active participating and/or provider as the result of a change of ownership or any other circumstance.

9.2.3 Paper or Electronic Format

Records may be documented in paper or electronic format. Paper medical records and documentation must include:

- Date and time;
- Signature and credentials;
- Legible text written in blue or black ink or typewritten;
- Corrections with a line drawn through the incorrect information, a notation that the incorrect information was an error, the date when the correction was made and the initials of the person altering the record. Correction fluid or tape is not allowed; and
If a rubber-stamp signature is used to authenticate the document or entry, the individual whose signature the stamp represents is accountable for the use of the stamp.

A progress note is documented on the date that an event occurs. Any additional information added to the progress note is identified as a late entry.

Electronic medical records and documentation must require that:
- Safeguards are in use to prevent unauthorized access;
- The date and time of an entry in a medical record is recorded as noted by the computer's internal clock;
- The record is recorded only by personnel authorized to make entries using Cenpatico IC or its providers' established policies and procedures;
- The record indicates the identity of the person making an entry; and
- Electronic signatures used to authenticate a document are properly safeguarded and the individual whose signature is represented is accountable for the use of the electronic signature.

Electronic medical records and systems must also:
- Ensure that the information is not altered inadvertently;
- Track when, and by whom, revisions to information are made; and
- Maintain a backup system including initial and revised information.

Providers must meet all federal electronic health record requirements. The federal government may impose penalties on the provider of service in the form of rate reductions for non-compliance.

9.2.4 Comprehensive Clinical Record

The provider of care must verify the development and maintenance of a comprehensive clinical record for each member. The comprehensive clinical record, whether electronic or hard copy, may contain information contributed by several service providers involved with the care and treatment of a member. This section describes categories of information to be included in a member’s comprehensive clinical record: (a) the minimum information; (b) physical health information; (c) the behavioral health record; and (d) information from CSAs, HCTC providers and Habilitation providers.

9.2.4.1 Minimum Information

The comprehensive clinical record must include the following to the fullest extent possible:
- Member identification information on each page of the record (i.e., member’s name and AHCCCS/CIS identification number);
- Documentation of identifying demographics including a member’s name, address, telephone number, AHCCCS identification number, gender, age, date of birth, marital status, next of kin and, if applicable, guardian or authorized representative;
• Initial history for the member that includes family medical/behavioral health history, social history and laboratory screenings (the initial history of a member under age 21 should also include prenatal care and birth history of the member’s mother while pregnant with the member);
• Past medical/behavioral health history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received;
• Current presenting concerns;
• Documentation of review of the Controlled Substances Prescription Monitoring Program (CSPMP) data base prior to prescribing a controlled substance or another medication that is known to adversely interact with controlled substances;
• Documentation of any review of behavioral health record information by any person or entity (other than members of the clinical team) that includes the name and credentials of the person reviewing the record, the date of the review and the purpose of the review; and
• Identification of other Stakeholder involvement (DES/DDD, Juvenile Probation Officer/ Department of Corrections(DOC), Department of Child Safety(DCS), DES Adult Protective Services (APS), etc.).

9.2.4.2 Physical Health Information for the Integrated Provider

In addition to the minimum information requirements above, the comprehensive clinical record must include the following physical health information for the integrated provider:
• Initial history for the member as defined in section 9.2.4.1;
• Past medical history for the member as defined in section 9.2.4.1;
• Immunization records (required for children; recommended for adult members if available);
• Current medical and behavioral health problem list;
• Current physical and behavioral health medications;
• Current and complete Early and Periodic Screening, Diagnostic and Treatment (EPSDT) forms (required for members age 18 through 20 years);
• Documentation in the comprehensive medical record must be initialed and dated by the Member’s Cenpatico IC-contracted PCP, to signify review of:
  o Diagnostic information including:
    ▪ Laboratory tests and screenings;
    ▪ Radiology reports;
    ▪ Physical examination notes;
    ▪ Behavioral health information received from the behavioral health provider; and
    ▪ Other pertinent data.
  o Reports from referrals, consultations and specialists;
  o Emergency and urgent care reports;
o Hospital discharge summaries;
o Behavioral health referrals and services provided, if applicable, including
notification of behavioral health providers, if known, when a member’s
health status changes or new medications are prescribed;
o Behavioral health history and behavioral health information received from
an Integrated Regional Behavioral Health Authority (Integrated
RBHA/Health Plan) or Regional Behavioral Health Authority (RBHA/Health
Plan) behavioral health provider who is also treating the member.

- Documentation as to whether or not an adult member has completed advance
directives and location of the document;
- Documentation related to requests for release of information and subsequent
releases, including retaining consent and authorization for medical records as
prescribed in A.R.S. § 12-2297. HIPAA related documents must be retained for a
period of six years per 45 CFR 164.530(j)(2);
- Documentation that reflects that diagnostic, treatment and disposition information
related to a specific member was transmitted to the PCP and other providers,
including behavioral health providers, as appropriate to promote continuity of care
and quality management of the member’s health care;
- Obstetric providers complete a standardized, evidence-based risk assessment tool
for obstetrics members (i.e. Mutual Insurance Company of Arizona [MICA] Obstetric
Risk Assessment Tool or American College of Obstetricians and Gynecologists
[ACOG]). Also, lab screenings for members requiring obstetric care must conform to
ACOG guidelines; and
- Contact information for the member’s assigned Health Home.

9.2.4.3 Behavioral Health Record
Any information maintained in a behavioral health provider’s record must also be maintained in
the comprehensive clinical record. For General Mental Health/ Substance Abuse (GMH/SA) and
Integrated Health where the provision of behavioral health services is separate from the
provision of physical health services, in addition to the minimum information listed above, the
following information must be maintained and forwarded for inclusion in the comprehensive
clinical record:

Intake Paperwork documentation that includes:
- For members receiving substance abuse treatment services under the Substance
Abuse Block Grant (SABG), documentation that notice was provided regarding the
member’s right to receive services from a provider to whose religious character the
member does not object (See Section 3.10 - Special Populations);
- Documentation of the member’s receipt of the Cenpatico IC Member Handbook and
receipt of the Notice of Privacy Practice; and
- Contact information for the member’s primary care provider (PCP), if applicable.

Assessment documentation that includes:
- Documentation of all information collected in the behavioral health assessment, any applicable addenda and required demographic information (see Section 3.3 – Referral and Intake Process, Section 3.5 - Assessment and Service Planning, and Section 13.1 - Enrollment, Disenrollment and Other Data Submission);
- Documentation of all information collected in the annual update to the behavioral health assessment including any applicable addenda and updated demographic information;
- Diagnostic information including psychiatric, psychological and medical evaluations;
- Copies of Provider Manual Form 3.11.1, Notification of Persons in Need of Special Assistance (see Section 3.11 – Special Assistance for Persons Determined to have a Serious Mental Illness), as applicable;
- An English version of the assessment and/or service plan if the documents are completed in any language other than English; and
- For members receiving services via telemedicine, copies of electronically recorded information of direct, consultative or collateral clinical interviews.

_Treatment and Service Plan documentation that includes:_

- The member’s treatment and service plan;
- Child and Family Team (CFT) documentation;
- Adult Recovery Team (ART) documentation; and
- Progress reports or service plans from all other additional service providers.

_Progress Note documentation that includes:_

- Documentation of the type of services provided;
- The diagnosis, including an indicator that clearly identifies whether the progress note is for a new diagnosis or the continuation of a previous diagnosis. After a primary diagnosis is identified, the member may be determined to have co-occurring diagnoses. The service providing clinician will place the diagnosis code in the progress note to indicate which diagnosis is being addressed during the provider session. The addition of the progress note diagnosis code (accurate to all digits of the specific ICD-10/DSM-V code that applies) should be included;
- The date the service was delivered;
- Duration of the service (time increments) including the code used for billing the service;
- A description of what occurred during the provision of the service related to the member’s treatment plan;
- In the event that more than one provider simultaneously provides the same service to a member, documentation of the need for the involvement of multiple providers including the name and roles of each provider involved in the delivery of services;
- The member’s response to service; and
- For members receiving services via telemedicine, electronically recorded information of direct, consultative or collateral clinical interviews.
Medical Services Documentation:
- Laboratory, x-ray, and other findings related to the member’s physical and behavioral health care;
- The member’s treatment plan related to medical services;
- Physician’s orders;
- Requests for service authorizations;
- Documentation of facility-based or inpatient care;
- Documentation of preventative care services;
- Medication record, when applicable; and
- Documentation of Certification of Need (CON) and Re-Certification of Need (RON), (see Section 10.1 - Securing Services and Prior Authorization), when applicable.

Reports from other agencies that includes:
- Reports from providers of services, consultations, and specialists;
- Emergency/urgent care reports; and
- Hospital discharge summaries.

Paper or electronic correspondence that includes:
- Documentation of the provision of diagnostic, treatment and disposition information to the PCP and other providers to promote continuity of care and quality management for the member; and
- Documentation of any requests for and forwarding of behavioral health record information.

Financial documentation that includes:
- Documentation of the results of a completed Title XIX/XXI screening as required in Section 3.1 – Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Low Income Subsidy Program; and
- Information regarding establishment of any copayments assessed, if applicable (see Section 8.2 - Copayments).

Legal documentation that includes:
- Documentation related to requests for release of information and subsequent releases;
- Copies of any advance directives, health care power of attorney or mental health care power of attorney as defined in Section 9.1 - Advance Directives, if applicable including:
  - Documentation that the adult member was provided the information on advance directives and whether an advance directive was executed;
  - Documentation of authorization of any health care power of attorney that appoints a designated person to make health care decisions (not including mental health) on behalf of the member if they are found to be incapable of making these decisions; and
- Documentation of authorization of any mental health care power of attorney that appoints a designated person to make behavioral health care decisions on behalf of the member if they are found to be incapable of making these decisions.
- Documentation of general and informed consent to treatment pursuant to Section 3.7 – General and Informed Consent to Treatment and Section 3.8 – Psychotropic Medications: Prescribing and Monitoring;
- Authorization to disclose information pursuant to Section 12.6 - Confidentiality; and
- Any extension granted for the processing of an appeal must be documented in the case file, including the Notice regarding the extension sent to the member and his/her legal guardian or authorized representative if applicable (see Section 15.3 - Notice Requirements and Appeal Process for Title XIX/XXI Eligible Persons).

9.2.4.4 Requirements for Community Service Agencies (CSA), Home Care Training to Home Care Client (HCTC) Providers and Habilitation Providers

CSAs, HCTC Provider and Habilitation Provider clinical records must conform to the following standards:
- Each record entry must be:
  - Dated and signed with credentials noted;
  - Legible text, written in blue or black ink or typewritten; and
  - Factual and correct.
- If required records are kept in more than one location, the agency/provider shall maintain a list indicating the location of the records.
- CSAs, HCTC Providers and Habilitation Providers must maintain a record of the services delivered to each behavioral health member. The minimum written requirement for each behavioral health member’s record must include:
  - The service provided (including the code used for billing the service) and the time increment;
  - Signature and the date the service was provided;
  - The name title and credentials of the person providing the service;
  - The member’s T/RBHA/Health Plan or CIS identification number and AHCCCS identification number;
  - Cenpatico IC ensures that services provided by the agency/provider are reflected in the member’s behavioral health service plan. CSAs, HCTC Providers and Habilitation Providers must keep a copy of each member’s behavioral health service plan in the member’s record; and
  - Daily documentation of the service(s) provided and monthly summary of progress toward treatment goals.
- Provider Manual Form 9.2.1, Clinical Record Documentation Form is a recommended format that may be utilized to meet requirements identified in this section.
Every thirty (30) days, a summary of the information required in this section must be transmitted from the CSA, HCTC Provider or Habilitation Provider to the member’s clinical team for inclusion in the comprehensive clinical record.

9.2.5 Transportation Service Documentation

For providers that supply transportation services for members using provider employees (i.e. facility vans, drivers, etc.) and providers that use subcontracted transportation services, for non-emergency transport of members, that are not direct employees of the provider (i.e. cab companies, shuttle services, etc.) documentation for the member record must include a summary log of the transportation event received from the transportation provider that includes all elements listed as follows:

- Complete service provider’s name and address;
- Signature and credentials of the driver who provided the service;
- Vehicle identification (car, van, wheelchair van, etc.);
- Member’s Arizona Health Cost Containment System (AHCCCS) identification number;
- Complete date of service, including month, day and year;
- Complete address of pick up site;
- Complete address of drop off destination;
- Odometer reading at pick up;
- Odometer reading at drop off;
- Type of trip – round trip or one way;
- Escort (if any) must be identified by name and relationship to the member being transported; and
- Signature of the member, parent and/or guardian/caregiver, verifying services were rendered. If the member refuses to sign the trip validation form, then the driver should document his/her refusal to sign and this documentation must be placed into the comprehensive medical record.

It is the provider’s responsibility to maintain documentation that supports each transport provided. Transportation providers put themselves at risk of recoupment of payment if the required documentation is not maintained or covered services cannot be verified.

9.2.6 PCP Medication Management and Coordination of Care with Behavioral Health Providers

Cenpatico IC Primary Care Providers must maintain a medical record that incorporates behavioral health information when received from a behavioral health provider about an assigned member even if the provider 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.

When a PCP has initiated medical management services for a member to treat a behavioral health disorder, and it is subsequently determined by the PCP and Cenpatico IC that the
member should receive care through the behavioral health system for evaluation and/or continued medication management services, providers will assist the PCP with the coordination of the referral and transfer of care. The PCP will document in the medical record the coordination of care activities and transition of care. The PCP must document the continuity of care (See Section 4.3 - Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers).

9.2.7 Transition of Medical Records

Transfer of a member’s medical records due to transitioning of the member to a new T/RBHA/Health Plan and/or provider (see Section 4.1 - Transition of Persons for additional information on Inter-RBHA transfers) or due to Cenpatico IC terminating the provider contract, is important to ensure that there is minimal disruption to the member’s care and provision of services. The medical record must be transferred in a timely manner that ensures continuity of care.

When a member changes his or her provider, the member’s medical record or copies of it must be forwarded to the new provider within ten (10) business days from receipt of the request for transfer of the medical record.

Federal and State law allow the transfer of medical records from one provider to another, without obtaining the member’s written authorization if it is for treatment purposes (45 C.F.R. § 164.502(b), 45 C.F.R. § 164.514(d) and A.R.S. 12-2294(C)). Generally, the only instance in which a provider must obtain written authorization is for the transfer of alcohol/drug and/or communicable disease treatment information (see Section 12.6. – Confidentiality for other situations that may require written authorization).

The original provider must send that portion of the medical record that is necessary to the continuing treatment of the member. In most cases, this includes all communication that is recorded in any form or medium and that relates to patient examination, evaluation or behavioral or physical health treatment. Records include medical records that are prepared by a health care provider or other providers. Records do not include materials that are prepared in connection with utilization review, peer review or quality assurance activities, including records that a health care provider prepares pursuant to section A.R.S. § 36-441, A.R.S. § 36-445, A.R.S. § 36-2402 or A.R.S. § 36-2917.

Federal privacy law indicates that the Designated Record Set (DRS) is the property of the provider who generates the DRS. Therefore originals of the medical record are retained by the terminating or transitioning provider. The cost of copying and transmitting the medical record to the new provider shall be the responsibility of the transitioning provider (see AHCCCS Contractors Operation Manual, Policy 402).

9.2.8 Medical Record Audits

Cenpatico IC will conduct routine medical record audits to assess compliance with established standards. Medical records may be requested when Cenpatico IC or AHCCCS are conducting audits or investigating quality of care issues. Providers must respond to these requests within seven (7) days. Medical records must be made available to AHCCCS for quality review upon request.
Behavioral health providers must send copies of any information maintained in their own behavioral health record that must also be maintained in the comprehensive clinical record.

9.2.9 Disclosure of Records

All medical records, data and information obtained, created or collected by the provider related to the member, including confidential information must be made available electronically to Cenpatico IC, AHCCCS or any government agency upon request.

Health records must be maintained as confidential and must only be disclosed according to the following provisions:

- When requested by a member’s behavioral health provider, primary care provider or the member’s DES/DDD/ALTCS support coordinator, the member’s health record or copies of health record information must be forwarded within ten (10) business days of the request. The response should include all pertinent information, including, but not limited to, current diagnoses, medications, laboratory results, last provider visit and recent hospitalizations (see Section 4.3 – Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers and AHCCCS Medical Policy Manual, Policy 940 for more information).

- Providers must obtain consent and authorization to disclose protected health information in accordance with 42 CFR 431, 42 CFR part 2, 45 CFR parts 160 and 164 and A.R.S. § 36-509. Unless otherwise prescribed in federal regulations or statute, it is not necessary to obtain a signed release in order to share health related information with the member’s parent/legal guardian, behavioral health provider, primary care provider (PCP), the Member’s Health Plan Behavioral Health Coordinator acting on behalf of the PCP or authorized state social service agency.

AHCCCS or its designee may inspect Title XIX/XXI medical records at any time during regular business hours at the offices of AHCCCS, Cenpatico IC or its providers. The Department of Economic Security, Division of Developmental Disabilities (DES/DDD) or its designee may inspect the medical records of their enrolled Title XIX, Title XXI, and DES/DDD Arizona Long Term Care Services (ALTCS) members at any time during regular business hours at the offices of AHCCCS, Cenpatico IC or its providers.

Cenpatico IC has the discretion to obtain a copy of a member’s medical records without written approval by the member if the reason for such request is directly related to the administration of service delivery. Furthermore, Cenpatico IC has the discretion to release information related to fraud and abuse so long as protected HIV-related information is not disclosed (see A.R.S. § 36-664) and substance abuse information is only disclosed consistent with federal and state law, including but not limited to 42 CFR 2.1, et seq.

Additionally, providers must provide each member who makes a request one copy of his or her medical record free of charge annually.

Upon request, providers must allow members to view and amend their medical record as specified in 45 C.F.R. § 164.524, 45 C.F.R. § 164.526 and A.R.S. § 12-2293 and must have policies in place indicative of such.
9.2.10 Medical Record Maintenance

All providers must retain the original or copies of a member’s medical records as follows:

- For an adult, for at least six (6) years after the last date the adult member received medical or health care services from Cenpatico IC or a provider; and
- For a child, either for at least three (3) years after the child’s eighteenth (18th) birthday or for at least six (6) years after the last date the child received medical or health care services from Cenpatico IC or a provider, whichever occurs later.

The maintenance and access to the member’s medical record shall survive the termination of a provider’s contract with Cenpatico IC, regardless of the cause of the termination.

9.3 Member Surveys

This policy is intended for contracted providers that deliver covered services to eligible persons. The information collected from the surveys is used to design quality improvement activities.

9.3.1 Member Satisfaction Survey

As requested by Cenpatico IC, providers shall participate in member satisfaction surveys in accordance with the Statewide Consumer Survey protocol [42 CFR §438.10] and [A.A.C R9-22-522 (B) (1) and (5)]. For these surveys:

- Cenpatico IC may conduct surveys of a representative sample of the membership and providers.
- Cenpatico IC may provide the survey tool or require the providers to develop the survey tool, which shall be approved in advance.
- The results of the surveys will become public information and available to all interested parties on the Cenpatico IC website. Providers may be required to participate in workgroups and efforts that are initiated as a result of the survey results.
- Providers shall participate in additional surveys requested by Cenpatico IC.

9.3.2 Additional Member Surveys

In addition to the Member Satisfaction Survey addressed above, providers shall perform annual, general or focused member surveys. For these surveys:

- Cenpatico IC may conduct surveys of a representative sample of the membership and providers.
- Cenpatico IC may provide the survey tool or require the providers to develop the survey tool, which shall be approved in advance.
- A scope of work and a timeline for the survey project is submitted if the survey is not initiated by Cenpatico IC. Cenpatico IC may require inclusion of certain questions.
- Data, results and the analysis of the results is submitted to Cenpatico IC within 45 days of the completion of the project.
- Providers shall bear all costs associated with the survey.
• Note that surveys may include Home and Community Based (HCBS) Member experience surveys, HEDIS Experience of Care Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys.

• Survey findings may result in the provider being required to develop a corrective action plan (CAP) to improve any areas noted by the survey or a requirement to participate in workgroups and efforts as a result of the survey results. Failure of the provider to develop a corrective action plan (CAP) and improve the area may result in regulatory action.

• Please refer to section 9.11.5 Satisfaction Surveys for additional survey requirements and information.

9.4 Performance Improvement Projects

9.4.1 Purpose

Cenpatico IC is committed to establishing high quality services. One method for achieving this is through adherence to the standards and guidelines set by the Centers for Medicare and Medicaid Services (CMS) and AHCCCS, which includes implementation of performance improvement projects (PIP) specific to member needs and data identified through internal/external surveillance of trends (42 CFR 438.240; AM/PM Section 980). PIP methodologies are developed according to CMS and AHCCCS requirements. This policy provides information regarding the responsibilities of Cenpatico IC and providers in implementing and reporting PIPs as required by CMS or AHCCCS, or Cenpatico IC topics approved by AHCCCS.

9.4.2 General Information about PIPs

A Performance Improvement Project (PIP) is a systematic, standardized process designed to identify, plan and implement system interventions through ongoing measurement and intervention to:

- Improve the quality of care and services provided to members;
- Evaluate and monitor the effectiveness of system interventions and data on an ongoing basis; and
- Result in significant performance improvement sustained over time.

PIPs are designed to achieve two primary goals. The first goal is to demonstrate achievement and sustainment of improvement for significant aspects of clinical care and non-clinical services, with the expectation of improved health outcomes and member satisfaction. A second goal is to correct significant systemic issues.

A clinical study topic would be one for which outcome indicators measure a change in behavioral or physical health acute or chronic conditions, health status or functional status; high risk services; or continuity and coordination of care. A non-clinical or administrative study topic would be one for which indicators measure changes in availability, accessibility and adequacy of the service delivery system, cultural competency of service, inter-personal aspects of care, and appeals, grievances or complaints.

PIP topics may come to the attention of AHCCCS in part through data from the AHCCCS functional areas (e.g.: network, medical director’s office); statewide contractor performance
data and contract monitoring activities; tracking and trending of grievance and appeal data and quality of care concerns; provider credentialing and profiling as well as other oversight activities, such as chart reviews; Quality Management/Medical Management data analysis and reporting; and member and/or provider satisfaction surveys and feedback.

Cenpatico IC providers play an integral role in the implementation of AHCCCS PIPs. When applicable, contracted providers are expected to collaborate with Cenpatico IC, other providers, stakeholders, and community members to identify, plan and implement recommended improvement strategies that are developed as a result of an identified performance improvement project.

Specific information concerning current PIPs can be found in the AHCCCS and Cenpatico IC Quality Management Plans and AHCCCS Utilization Management Plans. The process for carrying out a PIP is documented in the AHCCCS Medical Policy Manual (AM/PM), Section 980. Cenpatico IC and its providers will utilize a Plan-Do-Study-Act (PDSA) cycle, to test changes (interventions) quickly and refine them as necessary. It is expected that this process will be implemented in as short a time frame as practical based on the PIP topic. The process for carrying out a PIP is documented in the AHCCCS AM/PM, Section 980, Exhibit 980-1, Protocol for Conducting Performance Improvement Projects (PIP), including steps:

i. Plan: Plan the change(s) or intervention(s), including a plan for collecting data. State the objective(s) of the intervention(s).
ii. Do: Try out the intervention(s) and document any problems or unexpected results.
iii. Study: Analyze the data and study the results. Compare the data to predictions and summarize what was learned.
iv. Act: Refine the change(s)/intervention(s), based on what was learned, and prepare a plan for retesting the intervention(s).
v. Repeat: Continue the cycle as new data becomes available until improvement is achieved.

All PIPs conducted by Cenpatico IC and its providers must use the PIP reporting templates included in the AHCCCS Medical Policy Manual, Section 980-2.

9.5 Evidenced Based Practices and Practice Protocols

Evidenced Based Practices are interventions recognized as effective in treating a specific health-related condition based on scientific research; the skill and judgment of care health professionals; and the unique needs, concerns and preferences of the person receiving services (AHCCCS Contract General Requirements Exhibit 1-Definitions). Clinical practice guidelines are systematically developed statements to assist practitioners and member decisions about appropriate health care for specific circumstances.

Providers must ensure they coordinate and provide member access to quality health care services, regardless of type, amount, duration, scope, service delivery method and population served, that are informed and supported by evidence-based practice guidelines; will reasonably prevent injury and result in improved health outcomes; and are cost effective (AHCCCS Contract General Requirements 4.2.1 & 10.1.2.2). The delivery of services should be consistent with values, principles and goals of effective, innovation promoting, evidence-based practices. (AHCCCS Contract System Values and Guiding Principles 1.2). Providers should complete
member service plans with written descriptions of all covered health services and other informal supports which reflect applicable evidence-based practice guidelines (AHCCCS Contract System Values and Guiding Principles 1.2).

9.5.1 Evidenced Based Practices and Protocols

Cenpatico IC and providers must ensure the following:

- Monitor, at a clinical and system level, each individual’s health status and service utilization to determine use of evidence-based care and ensure all services to members are consistent with acuity, and evidenced-based outcome expectations (AHCCCS Contract Care Management 5.1);
- Review Clinical Practice Guidelines annually to determine that they remain applicable and reflect the best practice standards, 42 CFR 438.236 (b) (AHCCCS Contract Practice Guidelines 8.9);
- Ensure PCP providers treating members with anxiety, depression and ADHD are aware of clinical tool kits available in the AHCCCS AM/PM and/or are utilizing other recognized, clinical tools/ evidenced-based guidelines. Also have a monitoring process in place to ensure that evidence-based guidelines/recognized clinical tools are used when prescribing medications to treat depression, anxiety, and ADHD (AHCCCS Contract 4.13.2).
- Behavioral health providers should receive training on the AHCCCS National Practice Guidelines and Clinical Guidance Documents with required elements before providing services, but must receive training within six months of the staff person's hire date (protocol training is only required if pertinent to populations served) (http://www.azdhs.gov/bhs/guidance; AM/PM Policy 1060).

Providers are required to also verify all services are performed in accordance and in compliance with State Clinical and Recovery Practice Protocols and any revisions or additions to the State Clinical and Recovery Practice Protocols.

Providers must adopt and implement the following practices as appropriate:

- AHCCCS Clinical Practice Protocols with required service expectations selected by AHCCCS for targeted implementation on an annual basis; and incorporated by reference into the Agreement at http://www.azdhs.gov/bhs/guidance
- American Society of Addiction Medicine Patient Placement Criteria ("ASAM") http://www.asam.org/
- American Psychiatric Association https://www.psychiatry.org/
- Substance Abuse Mental Health Services Administration (SAMHSA) http://www.samhsa.gov/

9.5.2 Dissemination of Evidenced Based Practices and Protocols

Cenpatico IC and providers shall disseminate to members and potential members upon request, Clinical Practice Guidelines based on valid and reliable clinical evidence or a consensus of health
care professionals in the field that considers member needs, 42 CFR 438.236 (c) (AHCCCS Contract Practice Guidelines 8.9). Providers must be able to provide a basis for consistent decisions for utilization management, member education, coverage of services and other areas to which the guidelines apply, 42 CFR 438.236 (d) (AHCCCS Contract Practice Guidelines 8.9; AHCCCS Contract Drug Utilization Review 8.15).

9.5.3 Monitoring for Effectiveness

The effectiveness of AHCCCS Clinical Practice Protocols and Evidenced Based Practices are monitored by Cenpatico IC and contracted providers in the following ways:

- Monitor required service expectations selected by AHCCCS for targeted implementation annually using Cenpatico IC approved tools and methodologies as requested;
- Identify new or enhanced interventions that will be implemented in order to bring performance up to at least minimum level established by AHCCCS including evidence-based practices that will be effective in the same/similar populations (AHCCCS AM/PM Policy 970.2.ii);
- Participate in the monitoring of the effectiveness of other Evidenced Based Practices using monitoring processes and methodologies approved by Cenpatico IC and AHCCCS and developed in collaboration with Cenpatico IC and AHCCCS;
- Implement interventions to improve performance, based on an evaluation of barriers to care/use of services and evidence-based approaches to improving performance (AHCCCS AM/PM Policy 980 E.2).

9.6 Peer Review

Cenpatico IC has established and maintains a Peer Review Committee. Cenpatico IC’s committee is responsible for the clinical review of the appropriateness of the services provided by health professionals within Cenpatico IC’s provider network.

Matters appropriate for peer review may include, but are not limited to:

- Questionable clinical decisions;
- Lack of care and/or substandard care;
- Inappropriate interpersonal interactions or unethical behavior;
- Trends of over or under utilization of services;
- Information from fraud and abuse investigations by AHCCCS;
- Physical, psychological, verbal, or sexual abuse by provider staff;
- Allegations of criminal or felonious actions related to practice;
- Issues that immediately impact the Member and that are life threatening or dangerous;
- Unanticipated death of a Member;
- Issues that have the potential for adverse outcome; or
- Allegations from any source that bring into question the standard of practice.

Cenpatico IC also must implement recommendations made by the AHCCCS Peer Review Committee. Some AHCCCS Peer Review recommendations may be appealable agency actions.
under State law. A Cenpatico IC provider may appeal such a decision through the administrative process described in A.R.S. § 41-1092, et seq.

All aspects of the peer review process are confidential and are not discussed outside of committee except for the purposes of implementing recommendations made by a Peer Review Committee. Cenpatico IC’s Peer Review Committee also follows all other AHCCCSAHCCCS policies regarding peer review. Confidentiality must be extended to, but is not limited to, all of the following:

- Peer review reports;
- Meeting minutes;
- Documents;
- Discussions;
- Recommendations; and
- Committee member information.

9.6.1 Procedures for Cenpatico Integrated Care Peer Review

Cenpatico IC will ensure fair, impartial, and professional peer review of services provided to members by providers’ healthcare professionals.

Evidence of a quality deficiency in the care or service provided, or the omission of care or service, by a healthcare professional or provider is subject to peer review. The evidence may include, but is not limited to, information received in a report from a State regulatory board or agency, Medicare/Medicaid sanctions, the National Practitioner Data Bank (NPDB), a member grievance, provider complaint, observations by individuals working for or on behalf of Cenpatico IC, or other federal, State, or local government agencies.

The Cenpatico IC Peer Review Committee is chaired by the Chief Medical Officer (CMO) and the membership includes independently licensed health professionals from within Cenpatico IC and Cenpatico IC’s geographic service area. Cenpatico IC’s CMO may invite providers with a special scope of practice to participate when necessary. A Primary Care Physician (PCP) must be part of the Peer Review Committee when a physical health care case is being reviewed. A Behavioral Health Medical Professional (BHMP) must be part of the Peer Review Committee when a behavioral health case is being reviewed.

Provider Medical Directors may attend the Cenpatico IC Peer Review Committee meetings either in person or telephonically when cases or other concerns under their jurisdiction are addressed. The Peer Review Committee is scheduled to meet monthly and will convene at least once a quarter.

As the chairperson of the Peer Review Committee, the CMO directs and actively participates in, or oversees, all aspects of the confidential peer review process. Each member of the Peer Review Committee signs a statement at all Peer Review Committee meetings acknowledging agreement with Cenpatico IC’s confidentiality and conflict of interest standards. Committee members may not participate in peer review activities if they have a direct or indirect interest in the peer review outcome.
The Peer Review Committee is responsible for making recommendations to the CMO. The Committee must determine appropriate action which may include, but is not limited to corrective action such as peer contact, education and/or sanctions. Recommendations may also include referral to the Credentialing Committee for possible removal from the provider network or referral to the appropriate licensing authority. Notification must occur when the Peer Review Committee determines care was not provided according to community standards. Initial notification may be verbal but must be followed by a written report. The CMO is responsible for implementing the actions.

9.6.2 Peer Review Grievance Procedure

Committee recommendations to the CMO may include some form of corrective action. Recommendations could be for actions that might affect the reviewed professional’s participation in Cenpatico’s provider network. This would be most likely to occur in one of two situations.

If the CMO reported the reviewed professional to their licensing board for further review and/or intervention. If the licensing board’s review were to result in action on the professional’s license, notice and hearing procedures would be accorded the professional by that licensing board.

If the CMO referred the reviewed professional to the Credentialing Committee for possible removal from Cenpatico’s provider network. If the Credentialing Committee were to approve removal of the professional from Cenpatico’s provider network, notice would be given to the reviewed professional. A review of this decision would be accorded the professional as outlined in the Cenpatico Credentialing Program Description.

The Quality Management (QM) department is responsible for the initial referral evaluation of quality and utilization concerns, generation of healthcare professional or provider notification letters, referral review, and presentation of quality and utilization concerns to the CMO. The CMO recommends cases that need to go to Peer Review.

The QM Department schedules Peer Review Committee meetings and coordinates peer review support operations by processing, researching, and documenting referrals. The QM Department also assists with peer review follow-up activities in accordance with Cenpatico IC policies and procedures, or as directed by the CMO. The Peer Review Committee must evaluate the case referred to peer review based on all information made available through the quality management process.

The Peer Review Committee is responsible for making recommendations to the CMO. Together they must determine appropriate action which may include, but are not limited to: peer contact, education, credentials, limits on new Member enrollment, sanctions, or other corrective actions. The CMO is responsible for implementing the actions.

The Peer Review Committee is responsible for making appropriate recommendations for Cenpatico IC’s CMO to make referrals to AHCCCS, CSFS, DCS, APS, ADHS Division of Licensing Services (DLS), and/or the appropriate regulatory agency or board for further investigation or action if not already referred during the Quality of Care (QOC) process. Notification must occur.
when the Peer Review Committee determines care was not provided according to community standards. Initial notification may be verbal but must be followed by a written report.

Cenpatico IC will make peer review documentation available to AHCCCS for purposes of quality management, monitoring and oversight.

**Peer Review Committee Recommendations**
Based upon the presented information, the Peer Review Committee may:
- Request additional information.
- Assign or adjusting the severity level.
- Request an outside peer review consultation and report prior to rendering a decision, if such a consultation was not already ordered by the CMO or Cenpatico IC Medical Director.
- Require the CMO to develop an action plan, which may include, but is not limited to the following:
  - **Peer contact:** The Committee may recommend that the Cenpatico IC medical director or CMO personally contact the healthcare professional or provider to discuss the Committee’s action.
  - **Education:** The Committee may recommend that information or educational material be sent to the healthcare professional or provider or that the healthcare professional or provider seek additional training. Confirmation of the completed training will be required to be sent to Cenpatico IC.
  - **Committee appearance:** The Committee may recommend that the healthcare professional or provider attend a Committee meeting to discuss the issue with Committee members.
  - **Credentials action:** The Committee may recommend that Cenpatico IC reduce, restrict, suspend, terminate, or not renew the healthcare professional’s Cenpatico IC credentials necessary to treat Members as a participating provider.

The provider may be required to develop a Corrective Action Plan (CAP) to:
- Ensure the specific Member issue has been adequately resolved.
- Reduce/eliminate the likelihood of the issue reoccurring.
- Determine, implement and document appropriate interventions.
- Be reviewed at the following Quality Management Committee.
- The QM department monitors the success of the CAP/interventions.
- The Peer Review Committee may require new interventions/approaches when necessary.

### 9.6.3 Peer Review Grievance Procedure
- **Notice of Action.** The Peer Review Committee will provide to a physician a notice stating (1) that an adverse Peer Review Committee action has been proposed to be taken against the physician and the reasons for the proposed action, (2) that the physician may request a hearing before a panel appointed by the Peer Review Committee within 30 days of receiving the notice, and (3) a summary of the physician’s rights in the hearing.
- **Notice of Hearing.** If a hearing is requested, the Peer Review Committee will provide notice to the physician of (1) the place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, and (2) a list of the witnesses (if any) expected to testify at the hearing at the request of the Peer Review Committee.
- **Hearing Procedures.** If a hearing is timely requested, the physician shall have the right to (1) representation by an attorney or other person of the physician’s choice, (2)
record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof, (3) call, examine, and cross-examine witnesses, (4) present evidence determined to be relevant by the panel, regardless of its admissibility in a court of law, and (5) submit a written statement at the close of the hearing.

- **Decision.** Upon completion of the hearing, the physician involved has the right to receive the written recommendation of the panel, including a statement of the basis for the recommendations, and a written decision of the Peer Review Committee, including a statement of the basis for the decision.

### 9.7 Quality of Care Concerns

The Quality Management department responds to quality of care concerns received from Members and providers or issues identified during routine clinical review of Members’ care, or received from anywhere within Cenpatico IC our from anywhere in the community. If substantiated as a true quality of care issue, the concern will be tracked and trended or may be forwarded to the Peer Review Committee. Summary information on quality of care reviews is furnished to the Credentialing Committee at the time of the providers’ re-credentialing. All of these activities concerning provider information may be used for future Performance Improvement Projects.

#### 9.7.1 Documentation Related to Quality of Care Concerns

Quality of Care (QOC) concerns may be referred by State agencies, internal AHCCCS sources (e.g., Customer Service, the Office of the Deputy Director), and external sources (e.g., Members; providers; other stakeholders; Incident, Accident, and Death reports).

Upon receipt of a QOC concern, Cenpatico IC follows the procedures below.

First, Cenpatico IC documents each issue raised, when and from whom it was received, and the projected time frame for resolution. Cenpatico IC then promptly determines whether the issue is to be resolved through one or more of the following operational areas: Quality of Care; Customer Service; Grievance and Appeal process; and/or Fraud, waste, and program abuse.

Cenpatico IC then acknowledges receipt of the issue and explains to the Member or provider the process that will be followed to resolve his or her issue through written correspondence. If the issue is being addressed as other than a QOC investigation, Cenpatico IC explains to the Member or provider the process that will be followed to resolve their issue using written correspondence. QOC related concerns remain with the Quality Management department due to state and federal regulations: 42 U.S.C. 1320c-9, 42 U.S.C. 11101 et seq., A.R.S. §36-2401, A.R.S. §36-2402, A.R.S. §36-2403, A.R.S. §36-2404, A.R.S. §36-2917.

Cenpatico IC assist the Member or provider as needed to complete forms or take other necessary actions to obtain resolution of the issue. Cenpatico IC ensures the confidentiality of all Member information and informs the Member or provider of all applicable mechanisms for resolving the issue.
Cenpatico IC documents all processes (include detailed steps used during the investigation and resolution stages) implemented to verify complete resolution of each issue, including but not limited to the following:

- Corrective action plan(s) or action(s) taken to resolve the concern;
- Documentation that education/training was completed (including but not limited to in-service training objectives and attendance sheets, and
- New policies and/or procedures.

Finally, Cenpatico IC documents all follow-up with the Member that includes, but is not limited to: assistance as needed to verify that the immediate health care needs are met, and a closure/resolution letter that provides sufficient detail to verify all covered, medically necessary care needs are met and a contact name/telephone number to call for assistance or to express any unresolved concerns.

9.7.2 Process of Evaluation and Resolution of Quality of Care Concerns

The quality of care concern process at Cenpatico IC includes documentation of identification, research, evaluation, intervention, resolution, and trending of Member and provider issues. Resolution must include both Member and system interventions when appropriate. The quality of care process must be a standalone process and shall not be combined with other agency meetings or processes.

Cenpatico IC completes the following actions in the QOC process:

- Identification of the quality of care issues;
- Initial assessment of the severity of the quality of care issue;
- Prioritization of action(s) needed to resolve immediate care needs when appropriate;
- Review of trend reports to determine possible trends related to the provider(s) involved in the allegation(s) including: type(s) of allegation(s), severity and substantiation, etc.;
- Research, including, but not limited to: a review of the log of events, documentation of conversations, and medical records review, mortality review, etc.; and
- Quantitative and qualitative analysis of the research, which may include root cause analysis.

For substantiated QOC allegations it is expected that some form of action is taken, for example:

- Developing an action plan to reduce/eliminate the likelihood of the issue reoccurring;
- Determining, implementing, and documenting appropriate interventions;
- Monitoring and documenting the success of the interventions;
- Incorporating interventions into the organization’s Quality Management (QM) program if appropriate, or
- Implementing new interventions/approaches, when necessary.
Each issue/allegation must be resolved; Member and system resolutions may occur independently from one another. The following determinations should be used for each allegation in a QOC concern:

- **Substantiated** – The alleged complaint (allegation) or reported incident was verified or proven to have happened based on evidence and had a direct effect on the quality of the Members health care. Substantiated allegations require a level of intervention such as a corrective action plan of steps to be taken to improve the quality of care or service delivery and/or to verify the situation will not likely happen again.

- **Unable to Substantiate** – There was not enough evidence at the time of the investigation to show whether a QOC allegation did occur or did not occur. The evidence was not sufficient to prove or disprove the allegation. No intervention or corrective action is needed or implemented.

- **Unsubstantiated** – There was enough credible evidence (preponderance of evidence) at the time of the investigation to show that a QOC allegation did not occur. The allegation is based on evidence, verified or proven, to have not occurred. No intervention or corrective action is needed or implemented.

Cenpatico IC, as an active participant in this process, will use the following to determine the level of severity of the quality of care issue:

- **Level 0 (Track and Trend Only)** – An issue no longer has an immediate impact and has little possibility of causing, and did not cause, harm to the recipient and/or other recipients, an allegation that is unsubstantiated or unable to be substantiated when the QOC is closed.

- **Level 1** – Concern that MAY potentially impact the Member and/or other Members if not resolved.

- **Level 2** – Concern that WILL LIKELY impact the Member and/or other Members if not resolved promptly.

- **Level 3** – Concern that IMMEDIATELY impacts the Member and/or other Members and is considered potentially life threatening or dangerous.

- **Level 4** – Concern that NO LONGER impacts the Member. Death or an issue no longer has an immediate impact on the Member, an allegation that is substantiated when the QOC is closed.

Cenpatico IC, as an active participant in the process, will report issues to the appropriate regulatory agency including Adult Protective Services, AHCCCS, Department of Child Safety, the Attorney General’s Office, or law enforcement for further research/review or action. Initial reporting may be made verbally, but must be followed by a written report within one business day.

Cases are referred to the Peer Review Committee when appropriate. Referral to the Peer Review Committee shall not be a substitute for implementing interventions. (See Section 9.6, Peer Review)

Cenpatico IC, as an active participant in the process, must notify AHCCCS of any adverse action taken against a provider.
Upon receiving notification that a health care professional’s organizational provider or other provider’s affiliation with their network is suspended or terminated as a result of a quality of care issue, Cenpatico IC, as an active participant in the process, is required to notify AHCCCS of the same.

Cenpatico IC, as an active participant in the process, is expected to submit a closing letter to AHCCCS. These letters will include the following:

- A description of the issues/allegations, including new issues/allegations identified during the investigation/review process,
- A substantiation determination and severity level for each allegation
- An overall substantiation determination and level of severity for the case.
- Written response from or summary of the documents received from referrals made to outside agencies such as accrediting bodies, or medical examiner.

### 9.7.3 Tracking/Trending of Quality of Care Issues

Cenpatico IC uses data pulled from the QOC database to monitor the effectiveness of QOC-related activities to include grievances and allegations received from Members and providers, as well as from outside referral sources. Cenpatico IC, as an active participant in the QOC process, also tracks and trends QOC data and reports trends and potential systemic problems to AHCCCS.

The data from the QOC database will be analyzed and evaluated to determine any trends related to the quality of care or service in Cenpatico IC’s service delivery system or provider network, and aggregated for AHCCCS. When problematic trends are identified through this process, will incorporate the findings in determining systemic interventions for quality improvement. Cenpatico IC, as an active participant in the QOC process, also incorporates trended data into systemic interventions.

As evaluated trended data is available, Cenpatico IC will prepare and present analysis of the QOC tracking and trending information for review and consideration of action by the Quality Management Committee and Chief Medical Officer, as Chairperson of the Quality Management Committee.

Quality tracking and trending information from all closed quality of care issues within the reporting quarter will be submitted to AHCCCS/Division of Health Care Management/Clinical Quality Management (AHCCCS/DHCM/CQM) utilizing the Quarterly Quality Management Report. The report will be submitted within 45 days after the end of each quarter and will include the following reporting elements:

- Types and numbers/percentages of substantiated quality of care issues
- Interventions implemented to resolve and prevent similar incidences, and
- Resolution status of “substantiated”, “unsubstantiated” and “unable to substantiate” QOC issues.
If a significant negative trend is found, Cenpatico IC may choose to consider it for a performance improvement activity to improve the issue resolution process itself, and/or to make improvements that address other system issues raised during the resolution process.

Cenpatico IC will submit to AHCCCS CQM all pertinent information regarding an incident of abuse, neglect, exploitation and unexpected death as soon as aware of the incident. Pertinent information must not be limited to autopsy results only, but must include a broad review of all issues and possible areas of concern. Delays in the receipt of autopsy results shall not result in a delay in the investigation of a quality of care concern by Cenpatico IC. As Cenpatico IC receives delayed autopsy results, it will use them to confirm the resolution of the QOC concern. If the cause and manner of death gives reason to change the findings of the QOC concern, Cenpatico IC will notify AHCCCS and resubmit a revised resolution report. Cenpatico IC will send a cause and manner of death report to AHCCCS monthly, including the results of all reports received during the past month. Cenpatico IC will also revise closing letters to AHCCCS if the cause and manner of death changes the findings of a QOC investigation.

Cenpatico IC, as an active participant in the QOC process, must verify that Member health records are available and accessible to authorized staff of their organization and to appropriate State and federal authorities, or their delegates, involved in assessing quality of care or investigating Member or provider quality of care concerns, grievance and appeals, allegations of abuse, neglect, exploitation grievances and Healthcare Acquired Conditions (HCAC). Member record availability and accessibility must be in compliance with federal and State confidentiality laws, including, but not limited to, Health Insurance Portability and Accountability Act (HIPAA) and 42 C.F.R. 431.300 et seq.

9.7.4 Provider-Preventable Conditions

If a Health Care Acquired Condition (HCAC) or Other Provider-Preventable Condition (OPPC) is identified, Cenpatico IC will conduct a quality of care investigation and report the occurrence and results of the investigation to the AHCCCS Clinical Quality Management Unit.

9.8 Medical Institution Reporting of Medicare Part D

Medicare eligible Members, including persons who are dually eligible for Medicare (Title XVIII) and Medicaid (Title XIX) receive Medicare Part D prescription drug benefits through Medicare Prescription Drug Plans (PDPs) or Medicare Advantage Prescription Drug Plans (MA- PDs). Medicare Part D coverage includes copayment and coinsurance requirements. However, Medicare Part D copayments are waived when a dual eligible person enters a Medicaid funded medical institution for at least a full calendar month. The facility must notify the Arizona Health Care Cost Containment System (AHCCCS) when a dual eligible person is expected to be in the medical institution for at least a full calendar month to verify copayments for Part D are waived. See Provider Manual Form 9.8.1 AHCCCS Notification to Waive Medicare Part D Co-Payments for Members in a Medicaid Funded Medical Institution. The waiver of copayments applies for the remainder of the calendar year, regardless of whether the person continues to reside in a medical institution. Given the limited resources of many dual eligible persons and to prevent the unnecessary burden of additional copay costs, it is imperative that these individuals are identified as soon as possible.
The objective of this policy is to inform providers designated as medical institutions of reporting and tracking requirements for dual eligible persons to verify Medicare Part D copays are waived.

9.8.1 Reporting Requirements

To verify that dual eligible persons’ Medicare Part D copayments are waived when it is expected that dual eligible persons will be in a medical institution, funded by Medicaid, for at least a full calendar month, the facility must notify AHCCCS immediately upon admittance. Reporting must be done using BHS Policy Form 1701.1: AHCCCS Notification to Waive Medicare Part D Copayments for Members in a Medical Institution That Is Funded by Medicaid. Providers must not wait until the person has been discharged from the medical institution to submit the form. Reporting must be done on behalf of the following:

- Persons who have Medicare Part “D” only;
- Persons who have Medicare Part “B” only;
- Persons who have used their Medicare Part “A” lifetime inpatient benefit; and
- Persons who are in continuous placement in a single medical institution or any combination of continuous placements that are identified below.

Medical institutions include the following providers:

- Acute Hospital
- Psychiatric Hospital – Non-IMD
- Psychiatric Hospital – IMD
- Residential Treatment Center – IMD
- Residential Treatment Center – Non-IMD
- Skilled Nursing Facility

Additional information regarding Medicare cost sharing for members covered by Medicare and Medicaid can be found in AHCCCS Contractor Operations Manual, Policy 201.

9.9 Seclusion and Restraint Reporting

Seclusion and restraint are high-risk interventions that must be used to address emergency safety situations only when less restrictive interventions have been determined to be ineffective, in order to protect Members, staff members or others from harm. All persons have the right to be free from seclusion and restraint, in any form, imposed as a means of coercion, discipline, convenience or retaliation by staff. Seclusion or restraint may only be imposed to ensure the immediate physical safety of the person, a staff member or others and must involve the least restrictive intervention, and be discontinued at the earliest possible time (42 CFR §482.13).

This section includes seclusion and restraint reporting requirements for contracted behavioral health inpatient facilities (42 CFR §482.13) (A.A.C. R9-21) and behavioral health inpatient facilities serving persons under the age of 21 (42 CFR §483 Subpart E).
### 9.9.1 Additional Information

- Trauma associated with seclusion and restraint can trigger Post Traumatic Stress Disorder;
- Each state has a designated protection and advocacy system. In Arizona, the Arizona Center for Disability Law serves as the designated protection and advocacy agency;
- R9-21-204 require that all staff members and medical professionals involved in ordering, providing, monitoring or evaluating seclusion or restraint complete and document education and training to include: understanding behavioral and environmental risk factors, nonphysical interventions, the safe use of seclusion or restraint and responding to emergency situations;
- In 2003, the Substance Abuse and Mental Health Services Administration (SAMHSA) published the Roadmap to Seclusion and Restraint Free Mental Health Services. Developed by administrations, experts and Members, the training is a resource for mental health service direct care staff, administrators, and Members on alternatives to the use of seclusion or restraint, as well as a tool for mental health system transformation;
- A staff member employing any method that results in a person either being precluded from exiting an area in fact or left with the reasonable belief of being prohibited from being able to exit freely (for example – a staff member’s use of his/her body to block an individual’s exit from a specified area) constitutes seclusion, R9-21-101.B.56;
- A.R.S. § 36-513 and A.R.S. § 36-528 require that a person under emergency detention or court ordered evaluation may not be treated without consent, except that pharmacological restraint may be used to protect the safety of that person and others in an emergency. Therefore, psychiatric medications given involuntarily to persons under emergency detention or court ordered evaluation must be considered chemical restraint and documented as such;
- 42 CFR 482.13 clarifies that a drug or medication used as a restraint is not a standard treatment or dosage for a Member’s condition. Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN); and
- Cenpatico IC is also required to collect certain aggregate data that compiles total seclusion and restraints for the reporting period, and forward that data to the State.

### 9.9.2 Reporting to Cenpatico Integrated Care

Contracted behavioral health inpatient facilities shall follow local, state and federal regulations and requirements related to seclusion and restraint.

Contracted behavioral health inpatient facilities authorized to use seclusion and restraint shall report the following to Cenpatico IC:

- Each occurrence of seclusion and restraint to Cenpatico IC within five (5) calendar days of the occurrence, via email CAZQualityManagement@cenpatico.com, attention Quality Management.
- Reports of seclusion and restraint are to be submitted using the Cenpatico IC Provider Manual Form 9.9.1, Seclusion and Restraint Reporting Form.
The Provider Manual Form 9.9.1, Seclusion and Restraint Reporting Form must be completed in its entirety and include the required information detailed on AHCCCS Policy Attachment 1702A.

In the event that a use of seclusion or restraint requires face-to-face monitoring, a report detailing face-to-face monitoring must be completed using the Provider Manual Form 9.9.1, Seclusion and Restraint Reporting Form or attached to the reporting form. The face-to-face monitoring form must include the requirements as per 42 CFR 482.13, 42 CFR § 483 Subpart 12, and R9-21-204.

Cenpatico IC may also request copies of provider agency Policies and Procedures pertaining to the use of seclusion and restraint, evidence of staff trainings, and any corrective actions taken to reduce the frequency of usage.

9.9.3 Reporting a Serious Occurrence or Death

Because of the high-risk nature of seclusion and restraint interventions, it is possible that a person may be injured or that a serious occurrence may occur during a seclusion and restraint event.

Contracted behavioral health inpatient facilities authorized to use seclusion and restraint shall report any occurrence of injury or serious occurrence during a seclusion and restraint following the guidelines in Section 9.10 - Reporting of Incidents, Accidents and Deaths.

Behavioral health inpatient facilities must be aware of what constitutes an event that requires reporting to the following entities:

- **Cenpatico IC**
  
  Behavioral health inpatient facilities must report any incident, accident or death that pertain to the following, of an enrolled Member to Cenpatico IC within 2 business days, following the guidelines in Section 9.10 – Reporting Of Incidents, Accidents and Deaths.

- **AHCCCS**
  
  Licensed behavioral health inpatient facilities are required to report a serious occurrence, including a death, following a seclusion and/or restraint event, to AHCCCS no later than one working day following the serious occurrence. Staff must document in the person’s record and in the incident/accident report log that the serious occurrence was reported to AHCCCS, and include the names of the individuals who received the report. For reporting of serious occurrences:

  - AHCCCS: fax number 602-417-4162 Attention DHCM Senior Clinical and Quality Consultant

- **ADHS Division of Licensing**
  
  Licensed behavioral health inpatient facilities must notify the ADHS Division of Licensing within one working day of discovering a serious occurrence that requires medical services, or death that occurs as a result of a seclusion and/or restraint. This notification must be followed up by a written ADHS Division of Licensing report within five days of initial notification. Reporting to ADHS Licensing would not utilize the QMS Portal or the ADHS Incident, Accident, Death report form.

- **Arizona Center for Disability Law (ACDL)**
  
  Licensed behavioral health inpatient facilities are required to report a serious occurrence, including a death, following a seclusion and/or restraint event, to The ACDL no later than one working day following the serious occurrence. Staff must document in the person’s record and
in the incident/accident report log that the serious occurrence was reported to The ACDL, and include the names of the individuals who received the report. For reporting of serious occurrences:

- The Arizona Center for Disability Law: fax number 602-274-6779 Attention Mental Health Team

**Centers for Medicare and Medicaid Services (CMS)**

In the case of a person’s death, the information must be reported to the Center for Medicare and Medicaid Services (CMS) Regional Office. The program must report:

- Each death that occurs while a resident is in restraint or seclusion;
- Each death that occurs within 24 hours after the resident has been removed from restraint or seclusion; and
- Each death known to the facility that occurs within one week after the restraint or seclusion where it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to a resident’s death. “Reasonable to assume” in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or deaths related to chest compression, restriction of breathing or asphyxiation.

Each death must be reported to CMS by telephone within one working day following knowledge of the resident’s death. All staff must document the death in the program’s incident/accident log. Staff must document in the member’s medical record the date and time the death was reported to CMS, and the names of the individuals who received the report.

- CMS Regional Office (to report a death only): Division of Survey & Certification phone: 415-744-3501.

Licensed behavioral health inpatient facilities must know what information is to be reported, including any applicable forms and/or reports; where the requisite information must be sent within the agencies identified above and the reporting timeframes.

### 9.10 Reporting of Incidents, Accidents and Deaths

Significant events, such as accidents, injuries, allegations of abuse, human rights violations, and deaths require careful examination and review to ensure the protection of Members. The State, as well as other federal and State agencies, require the prompt reporting of significant events involving persons receiving services within the public health system. The reporting of significant events to the State, such as incidents, accidents, and deaths, serves the following purposes:

- The collection of relevant information facilitates a comprehensive review and investigation when indicated;
- Compliance with notification requirements to the Centers for Medicare and Medicaid Services (CMS), Arizona Health Care Cost Containment System (AHCCCS), the Arizona Center for Disability Law, and ADHS Division of Licensing as applicable; and
- The trending and analysis of significant events can identify opportunities for behavioral health system improvements.
The intent of this section is to identify reporting requirements for providers following an incident, accident, or death involving a Member. In addition, Cenpatico IC may require providers to submit a written summary of their review of deaths of adult Non-Seriously Mentally Ill Members.

Providers must be aware of what constitutes an event that requires reporting to:

- CMS;
- AHCCCS;
- The Arizona Center for Disability Law; or
- ADHS Division of Licensing
- Division of Developmental Disabilities (DDD)

Providers must know what information is to be reported, including any applicable forms and/or reports; and where the requisite information must be sent within the agencies identified above.

**9.10.1 Additional Information**

- All deaths, regardless of whether the enrolled Member is a child, adult with SMI or adult without SMI, are reviewed by the State Medical Director or designee, and selected cases are reviewed for potential action, in accordance with the State’s established quality assurance process;
- ADHS Division of Licensing Behavioral Health Inpatient Facilities are required to report any serious occurrence that occurs as a result of a seclusion and restraint event, in accordance with Section 9.9 - Seclusion and Restraint Reporting;
- Upon recognition of abuse, neglect or exploitation of an incapacitated person, providers must immediately report the allegation to the appropriate authorities (i.e., police or protective services worker) in accordance with A.R.S. § 46-454. The oral reports must be followed up by a written report within 48 hours. See Section 12.4 - Duty to Report Abuse, Neglect or Exploitation; and
- Each state has a designated protection and advocacy system. In Arizona, the Arizona Center for Disability Law serves as the designated protection and advocacy agency.

**9.10.2 Reporting Incidents, Accidents and Deaths to Cenpatico IC**

Providers must report any incident, accident or death that pertain to the following, of an enrolled Member to Cenpatico IC within 2 business days:

- 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. R9-20-203 or in A.A.C. R9-21, Article 2;
- Discrimination;
- Exploitation;
- Coercion;
- Manipulation;
- Retaliation for submitting grievances 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; and/or
- Health Care-Acquired and Provider Preventable Conditions as described in the AHCCCS AMPM Chapter 900.

Additionally, providers must submit incident, accident, or death reports involving “sentinel events” within 6 hours of the occurrence. 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; or
- Death while a Member is a resident of a Behavioral Health Inpatient Facility or other psychiatric hospital or other inpatient institution.

9.10.3 Reporting Incidents, Accidents and Deaths During Prevention Activities

Providers are required to report to Cenpatico IC any incident, accident or death of a Member participating in a Cenpatico IC provider sponsored prevention activity, as defined in this section, regardless of his or her enrollment status with Cenpatico IC, within 2 business days.

Providers are responsible for reporting incidents, accidents, and deaths of behavioral health Members through the QMS Portal. The QMS Portal is intended for the use of providers reporting IADs to Cenpatico IC. This system is administered by AHCCCS. Access to the QMS Portal is at: https://app.azdhs.gov/QMPortal/. The QMS Portal has links for: Registration Guide, Quick Start-Creating an IAD, Current Build Release Notes and Technical Assistance.
9.10.4 Reporting Allegations of Abuse Towards Persons with SMI

Allegations of abuse concerning persons with SMI must be reported within 2 business days to Cenpatico IC.

9.10.5 Reporting Incidents, Accidents and Deaths to the Office Of Behavioral Health Licensure

Providers are responsible for reporting incidents, accidents, and deaths of behavioral health members through the QMS Portal. The QMS Portal is intended for the use of providers reporting IADs to T/RBHA/Health Plans. This system is administered by the AHCCCS. Access to the QMS Portal is at: https://app.azdhs.gov/QMPortal/.

The QMS Portal has links for: Registration Guide, Quick Start-Creating an IAD, Current Build Release Notes and Technical Assistance. Providers must maintain a copy of the written incident report on the premises or at the administrative office for at least 12 months after the date of the written incident report.

9.10.6 Reporting Deaths and Serious Occurrences in ADHS Division of Licensing Behavioral Health Inpatient Facilities

This subsection is applicable to Title XIX/XXI certified ADHS Division of Licensing Behavioral Health Inpatient Facilities that provide inpatient psychiatric services to persons under the age of 21.

9.10.6.1 Reporting Serious Occurrences Of Members:

Title XIX/XXI certified/ADHS Division of Licensing Behavioral Health Inpatient Facilities that provide inpatient psychiatric services to persons under the age of 21 are required to report any serious occurrences involving a Member to:

- AHCCCS;
- The Arizona Center for Disability Law; and
- CMS Regional Office (for deaths only).

9.10.6.2 Timeframes

Any serious occurrence involving a Member in a Behavioral Health Inpatient Facility must be reported to AHCCCS, the Arizona Center for Disability Law, and the CMS Regional Office (for deaths only) no later than close of business of the next business day following the serious occurrence.

9.10.6.3 Where to Send the Report

For serious occurrence reporting, send information to:

- AHCCCS: fax number 602-417-4162 Attention DHCM Behavioral Health Administrator;
- The Arizona Center for Disability Law: fax number 602-274-6779 Attention Investigator; and
- CMS Regional Office (to report a death only): fax number 415-744-2692 Attention Survey & Certification Coordinator.
9.10.6.4 Other Considerations

Specific documentation requirements apply to ADHS Division of Licensing licensed provider records. Please see Section 9.2 - Medical Record Standards.

In the case of a minor (person under the age of 18), the behavioral health inpatient facility must also notify the person’s parent(s) or legal guardian(s) as soon as possible, but no later than 24 hours from the serious occurrence.

Note that these reporting requirements pertain only to serious occurrences (see definition). Reports of non-serious occurrences and other events are not made to AHCCCS, the Arizona Center for Disability Law, or CMS.

9.11 Health Home Quality Management Plan Requirements

Health Home providers must develop, implement and maintain a quality management program that includes quality management processes to assess, measure, and improve the quality of care provided to Members in accordance with the AHCCCS Bureau of Quality and Integration Specifications Manual, Section 9.4 - Performance Improvement Projects, and the AHCCCS QM requirements in the AMPM, Chapter 900.

Providers must utilize the Plan Do Study Act ("PDSA") model of continuous quality improvement to identify and resolve systems issues or receive permission from Cenpatico IC to use an alternative system. Providers must use data to conduct comprehensive evaluation and analysis to develop and implement actions to continuously improve the quality of care provided to Members.

Providers must develop and maintain regular mechanisms to solicit feedback and recommendations from key system partners, providers, Members and family members to monitor service quality and develop strategies to improve Member outcomes and quality improvement activities related to the quality of care and system performance.

Providers must comply with reporting requirements for all quality management data submitted to Cenpatico IC for calculating contract performance measures and other quality reporting.

9.11.1 Quality Management Plan

Health Home providers must have a Quality Management ("QM") Plan in place that is reviewed and updated on an annual basis. The QM Plan must include specific activities related to State Performance Improvement Projects. The QM Plan must also include:

- Analysis of provider, State and Cenpatico IC data; including data from the State and Cenpatico IC chart audits, Quarterly Member Services Report, JK Settlement outcome measures and directives, and other State, Cenpatico IC, and provider quality measures.
- Clearly identified data sources, responsible party, date of completion, and frequency of monitoring. All performance measures must be aligned with the Cenpatico IC and State requirements.
• QM Plan Description as evidenced by the document.
• Process to verify implementation of the QM Plan, as evidenced by meeting notes, finding summaries or other documentation to confirm activity completion.
• Providers must actively perform monitoring, tracking, trending and reporting of AHCCCS Performance Measures utilizing the standardized methodology for each performance measure as approved by Cenpatico IC.
• Process that allows for an executive management review of any Members at risk for OOH placement or who have been re-admitted to an acute care setting. The executive team should review all available resources to help the Member live safely in the community and their homes and provide that information to the treatment team through the Recovery Coach.

9.11.2 Minimum Performance Standard
Health Home providers must meet each Minimum Performance Standard ("MPS") for both the Integrated and Non-Integrated Plans as identified below.

<table>
<thead>
<tr>
<th>Behavioral Health Performance Measures (Non-Integrated)</th>
<th>Minimum Performance Standard</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Behavioral Health Professional Services, 7 days</td>
<td>75%</td>
<td>85%</td>
</tr>
<tr>
<td>Access to Behavioral Health Professional Services, 23 days</td>
<td>90%</td>
<td>95%</td>
</tr>
<tr>
<td>Follow Up After Hospitalization for Mental Illness, 7 Days</td>
<td>85%</td>
<td></td>
</tr>
<tr>
<td>Follow up After Hospitalization for Mental Health, 30 Days</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Use of Multiple Concurrent Antipsychotics in Children and Adolescents</td>
<td>2.5%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Mental Health Utilization</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer</td>
<td>TBD</td>
<td>TBD</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Integrated Care Performance Measures</th>
<th>Minimum Performance Standard</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congestive heart failure admissions (discharges/100,000 member months)</td>
<td>215.53</td>
<td></td>
</tr>
<tr>
<td>Timeliness of prenatal care-prenatal care visit in the first trimester or within 42 days of enrollment</td>
<td>80%</td>
<td>90%</td>
</tr>
<tr>
<td>Postpartum Care</td>
<td>64%</td>
<td>90%</td>
</tr>
<tr>
<td>Metric</td>
<td>Rate 1</td>
<td>Rate 2</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>EPSDT Participation</td>
<td>68%</td>
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</tr>
<tr>
<td>Inpatient Utilization (days/1,000 member months)</td>
<td>51</td>
<td>46</td>
</tr>
<tr>
<td>Emergency Department Utilization (visits/1,000 member months)</td>
<td>110</td>
<td>100</td>
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<tr>
<td>Plan All-Cause Hospital Readmissions (w/n 30 days of discharge)</td>
<td>.20</td>
<td>.18</td>
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<tr>
<td>Asthma in Younger Adult Admission (discharges/100,000 member months)</td>
<td>494</td>
<td></td>
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<tr>
<td>Follow-up After Hospitalization for Mental Health, 7 Days</td>
<td>85%</td>
<td></td>
</tr>
<tr>
<td>Follow-up After Hospitalization for Mental Health, 30 days</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Diabetes Admissions, short term complications (discharges/100,000 member months)</td>
<td>72.2</td>
<td></td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD) admissions (discharges/100,000 member months)</td>
<td>324</td>
<td></td>
</tr>
<tr>
<td>Annual Monitoring for Patients on Persistent Medications: Combo Rate</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Access to Behavioral Health Professional Services, 7 days</td>
<td>75%</td>
<td>85%</td>
</tr>
<tr>
<td>Access to Behavioral Health Professional Services, 23 days</td>
<td>90%</td>
<td>95%</td>
</tr>
<tr>
<td>Adult Access to Preventive Care</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Flu Shots for Adults: Age 18 and older</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Chlamydia Screening</td>
<td>63%</td>
<td>70%</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>50%</td>
<td>60%</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>64%</td>
<td>70%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>65%</td>
<td></td>
</tr>
<tr>
<td>Mental Health Utilization</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>Use of Opioids From Multiple Providers at High Dosage in Persons Without Cancer</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication</td>
<td>80%</td>
<td>85%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Management: HbA1c Testing</td>
<td>77%</td>
<td>89%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Management: Eye Exam</td>
<td>49%</td>
<td>68%</td>
</tr>
</tbody>
</table>
9.11.2.1  **Integrated Care Performance Measures Member Outreach**

Health Homes providing Integrated Care must conduct member outreach at least quarterly on the following performance measures to ensure provision of services:

- Diabetic Care: HbA1C Testing
- Diabetic Care: Eye Exam
- Adult Access to Preventive/Ambulatory Care
- Colorectal Cancer Screening
- Chlamydia Screening
- Breast Cancer Screening
- Cervical Cancer Screening

Outreach must be tracked using EC-324 Deliverable: Integrated Performance Measures Outreach Monitoring Tool and reported to Cenpatico IC on the 5th day following each quarter (e.g. January 5th, 2017 for reporting period Q1, October – December 2016).

**9.11.3 Improvement Activities**

Health Home providers must participate in Cenpatico IC or State process improvement projects as requested and engage in Practice Improvement Processes to generate positive improvement in provider practices. Providers must participate in clinical quality improvement activities that are designed to improve outcomes for Arizona Members. Providers are also required to participate in the Children's System of Care Practice Reviews; including, at a minimum, participation in family interviews, chart reviews, team observation, providing accurate contact information, and participating in Feedback Meetings, as requested.

**9.11.4 Corrective Action and Audits**

Health Home providers must respond to all Corrective Action Letters as requested and develop effective Corrective Action Plans, utilizing PM Form 9.11.4 CAP Template, to overcome the identified problems. Providers must cover the cost of a second Cenpatico IC audit resulting from provider’s failure to pass the minimum performance standards associated with a Cenpatico IC audit, and must cover the travel costs associated with the repeat/second audit which may include hotel, meals, car rental and gasoline.

**9.11.5 Satisfaction Surveys**

Health Home providers must complete monthly satisfaction Surveys as directed by Cenpatico IC utilizing Cenpatico IC-approved satisfaction survey and verifying every site is surveyed at least quarterly. Health Home providers will administer the Monthly Member Survey to enrolled members and guardians, utilizing the approved survey tool, PM Form 9.11.5. The Monthly Member Survey will be available in two forms:

- Hard Copies available on-site at Health Home locations (drop box required on-site)
- Online via Member Portal website.
Survey results require entry online via Survey Monkey link and any completed hard copies will need to be entered by Health Home staff.

Survey results are required to be entered monthly, 15 days after the end of each month. Due dates that fall on the weekend or holiday will be extended to the next business day. Agencies with no survey entries for a period of three consecutive months will be subject to corrective action.
Section 10 - MEDICAL MANAGEMENT/UTILIZATION MANAGEMENT REQUIREMENTS

10.1 Securing Services and Prior Authorization/Retrospective Authorization

The Cenpatico Integrated Care Utilization Management (UM) program is designed to ensure members receive access to the right care at the right place and right time. Our program is comprehensive and applies to all eligible members across all product types, age categories, and range of diagnoses. The UM program incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, and ancillary care services.

Our UM initiatives are focused on optimizing each member’s health status, sense of well-being, encouraging self-management skills, productivity, and access to quality health care, while at the same time actively managing cost trends. The UM program aims to provide Covered Services that are medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

UM program goals include:

- Monitoring utilization patterns to guard against over-or under-utilization
- Development and distribution of clinical practice guidelines to providers to promote improved clinical outcomes and satisfaction
- Identification and provision of Care and/or disease management for members at risk for significant health expenses or ongoing care
- Development of an infrastructure to ensure that all Cenpatico Integrated Care members establish a relationship with their PCP to obtain preventive care
- Implementation of programs that encourage preventive services and chronic condition self-management
- Creation of partnerships with members/providers to enhance cooperation and support for UM goals

10.2 Securing Services that do not require Prior Authorization

It is important that persons receiving services have timely access to the most appropriate services. It is also important that limited resources are allocated in the most efficient and effective ways possible.

The clinical team (Health Home), or PCP in coordination with the clinical team, is responsible for identifying and securing the service needs of each behavioral health or integrated member through the assessment and service planning processes. During the treatment planning process, the clinical team may use established tools and nationally recognized standardized criteria to guide clinical practice and to help determine the types of services and supports that will result in positive outcomes for the member. Clinical teams should make decisions based on a member’s unique and individual identified needs and should not use these tools as criteria to deny or limit services. Rather than identifying pre-determined services, the clinical team should focus on
identifying the underlying needs of the behavioral health member, including the type, intensity, and frequency of support and treatment needed.

As part of the service planning process, it is the clinical team’s responsibility to identify available resources and the most appropriate provider(s) for services using Cenpatico IC’s network of participating healthcare providers. This is done in conjunction with the clinical team, the PCP (as needed), the behavioral health member, family, and/or natural supports. If the service is available through a contracted provider the member can access the services directly. If the requested service is only available through a non-contracted provider, the clinical team is responsible for coordinating with Cenpatico IC to obtain the requested services as outlined below.

Prior authorization is not required for the following physical health services:

- Emergency Services
- Medical Observation stays

### 10.2.1 Securing Services with a Non-Contracted Outpatient Provider

In cases where Cenpatico IC does not have a contracted participating healthcare provider and it is necessary to secure services through a non-contracted provider in order to provide the needed, covered, medically necessary physical or behavioral health service or to fulfill a clinical team’s request. Non-contracted service requests are prior authorized and a member may be referred if:

- The services required are not available within the Cenpatico IC network
- Cenpatico IC prior authorized the services.

In order to prior authorize the service, a provider must be AHCCCS registered in order to receive reimbursement for service delivery. Cenpatico IC is not required to offer services outside the contracted provider network if the service is available within the contracted network.

If non-contracted services are not prior authorized, the referring and servicing providers may be responsible for the cost of the service. The member may not be billed if the provider fails to follow Cenpatico IC policies. Both referring and receiving providers must comply with Cenpatico IC’s policies, documents, and requirements that govern referrals (paper or electronic), including prior authorization. If the clinical team has made all attempts to find a contracted provider for a medically necessary service and is unable to secure the service within the required timeframes, the clinical team may submit a Single Case Agreement to Cenpatico IC for the service.

Cenpatico IC requires the following information in order to process the prior authorization request:

- Requested services, including covered service codes and units.
- Provider information, including name, license, address, phone number, and AHCCCS ID. If the provider does not have an AHCCCS ID, they can be directed to the AHCCCS Provider Registration website for instructions on how to apply.
- Copy of the service plan indicating needed services have been documented.
- Reason for going to a non-contracted provider (i.e., specialty no available in network).
- Timeframes for processing the request:
Expedited Prior Authorization request – A decision is made within 3 business days after receipt of the request. Extension of 14 calendar days may be granted if it is in the best interests of the member.

Standard Prior Authorization request – A decision is made within 14 calendar days after receipt of the request. Extension of 14 calendar days may be granted if it is in the best interests of the member.

The process for securing behavioral health and physical health services through a non-contracted provider is as follows:

- Authorization requests have to be made no more than 60 days before the intended service date.
- If a needed covered outpatient service is unavailable within Cenpatico IC’s contracted provider network, the provider submits a completed **Provider Manual Form 10.1.15 OON Request Attachment** to Cenpatico IC’s Medical Management Department. This form is submitted as an attachment to the completed prior authorization forms. Refer to **Provider Manual Attachment 10.1.7 Medical Management Forms Matrix** for further instructions or refer to the Cenpatico Integrated Care website for instruction;
- A completed Request contains pertinent clinical information on the Member, the requested out-of-network service(s) and the requested out-of-network provider. The request must be accompanied by the current service plan and/or any relevant clinical records, including reasons why a contracted provider cannot provide the requested services;
- All requested providers must be licensed by the applicable Arizona licensing board. All providers must have an AHCCCS Provider ID Number and a National Provider ID (NPI) Number, failure to have an AHCCCS provider ID will result in denial of the request. All non-contracted providers must agree to provide the requested services, possess appropriate insurance, and agree to Cenpatico IC-approved reimbursement rates. If for any reason Cenpatico IC’s Contracts Department is unable to establish a single case agreement with an authorized but non-contracted provider, the Medical Management Department will notify the requesting Provider and/or clinical team.
- The clinical team will then meet to consider alternative services. The clinical team is responsible for ensuring that a similar level of equivalent services is in place for the Member; and
- Cenpatico IC secures services through and provides payment to non-contracted providers through single case agreements. If a provider applies for an AHCCCS provider ID, the request for provided services will be reviewed retrospectively.
- Cenpatico notifies the requesting provider and the servicing provider of prior authorization approvals. The requesting provider is expected to notify the member of the approval of the service(s).

In the event that a request to secure covered services through a non-contracted provider is denied, Cenpatico IC will provide notice of the decision in accordance with **Section 1531 - Notice Requirements and Appeal Process for Title XIX/XXI Eligible Persons**, and **Section 15.4 - Notice and Appeal Requirements (SMI and GMH/SA Non-Title XIX)**.
Claims are not eligible for payment (does not apply to emergency services) unless the single case agreement is in place and the authorization has been obtained.

10.3 Purpose of Utilization Review Process

The purpose of the prior authorization function is to monitor the use of designated services before services are delivered in order to confirm they are:

- Provided in an appropriate level of care and place of service;
- Included in the defined benefits;
- Appropriate, timely and cost effective;
- Coordinated as necessary with additional departments such as Quality Management;
- Accurately documented in order to facilitate accurate and timely reimbursement

Prior authorization processes are used to promote appropriate utilization of physical and behavioral health services while effectively managing associated costs. Except during an emergency situation, Cenpatico IC requires prior authorization before accessing inpatient services in a licensed inpatient facility and for accessing medications reflected as requiring prior authorization on Cenpatico IC’s Behavioral Health Drug List (for non-integrated members) or Cenpatico IC’s Comprehensive Drug List (for integrated members). In addition, Cenpatico IC also requires prior authorization of covered physical and behavioral health services other than inpatient services.

- Prior authorization (PA) is a request to the Cenpatico Integrated Care Utilization Management (must be obtained prior to the delivery of certain elective and scheduled services. Authorizations can be submitted through the secure web portal or by use of a fax form available on our website under Provider Resources. Prior authorization should be requested at least five (5) business days before the scheduled service delivery date or as soon as need for service is identified. Most services that require Cenpatico Integrated Care’s authorization are listed in the following table. Our website offers a pre-screen tool that provides authorization requirements at the billing code level. (Please see further in this Manual for authorization requirements for home health, physical, occupational and speech therapy prior authorization information.)UM) department for approval of certain services before the service is rendered. Authorization

When it is determined that a person is in need of a physical and/or behavioral health service requiring prior authorization, a utilization management professional applies the designated medical necessity criteria to approve the provision of the covered service. When appropriate, Cenpatico IC will provide a consultation with the requesting provider to gather additional information to make a determination. A decision to deny a prior authorization request must be made by Cenpatico IC’s Chief Medical Officer or physician or dentist Medical Director designee. In addition, when system partners, including guardians, disagree with a treatment decision, resulting in the denial of a prior authorized level of care, the provider is obligated to send the request to the Cenpatico IC Medical Management department. The request must include the provider’s recommendation and supporting evidence.
10.3.1 Emergency Situations

Definition of Emergency Medical Condition

Cenpatico Integrated Care defines *emergency medical condition* as follows: Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part. (42 CFR 1396-u2(b)(2)(C), as amended).

Members may access emergency services at any time without prior authorization or prior contact with Cenpatico Integrated Care. If members are unsure as to the urgency or emergency of the situation, they are encouraged to contact their Primary Care Provider (PCP) and/or Cenpatico Integrated Care’s 24 hour Nurse Line, NurseWise at 1-877-644-4613 for assistance. However, this is not a requirement to access emergency services.

Emergency services are covered by Cenpatico Integrated Care when furnished by a qualified provider, including non-network providers, and will be covered until the member is stabilized. Any screening examination services conducted to determine whether an emergency medical condition exists will also be covered by Cenpatico Integrated Care. Emergency services will be covered and will be reimbursed regardless of whether the provider is in Cenpatico Integrated Care’ provider network. Cenpatico Integrated Care will not deny payment for treatment obtained under either of the following circumstances:

1. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of Emergency Medical Condition; or

2. A representative from the Plan or NurseWise instructs the member to seek emergency services.

Once the member’s emergency medical condition is stabilized, Cenpatico Integrated Care requires notification for hospital admission or Prior Authorization for follow-up care as noted elsewhere in this handbook.

10.3.2 Prior Authorization Process

Authorizations are not a guarantee of payment, the member must be eligible on the date the service is provided and the services provided must be aligned with the prior authorized service request. Prior authorization seeks to ensure that persons are treated in the most appropriate, least restrictive and most cost effective setting, with sufficient intensity of service and supervision to safely and adequately treat the person’s physical and/or behavioral health condition. Failure to obtain authorization may result in administrative claim denials. Cenpatico Integrated Care providers are contractually prohibited from holding any Cenpatico Integrated
Care member financially liable for any service administratively denied by Cenpatico Integrated Care for the failure of the provider to obtain timely authorization.

10.3.3. Accessing services that require prior authorization

Prior authorization seeks to ensure that persons are treated in the most appropriate, least restrictive and most cost effective setting, with sufficient intensity of service and supervision to safely and adequately treat the person’s physical and/or behavioral health condition. When a clinical team initiates a request for a service requiring prior authorization, the request must immediately be forwarded to the personnel responsible for making prior authorization decisions. Authorizations are not a guarantee of payment.

10.3.4. Availability of Prior Authorization

Cenpatico IC has appropriate utilization management professionals, including licensed nurses and physicians available 24 hours a day, seven days a week to receive requests for any service that requires prior authorization.

10.3.5. Prior Authorization Decisions Making

A Cenpatico IC utilization management professional is required to prior authorize services unless it issues a decision to deny. A decision to deny a service is required to be made by a Cenpatico IC physician or physician designee.

Cenpatico IC has Arizona licensed prior authorization staff that includes a nurse or nurse practitioner, physician or physician assistant, pharmacist or pharmacy technician, or licensed behavioral health professional with appropriate training to apply Cenpatico IC’s medical criteria or make medical decisions.

10.3.6. Criteria Used in Prior Authorization Decisions

Cenpatico IC uses nationally recognized standardized criteria through McKesson’s InterQual, The American Society of Addiction Medicine (ASAM), adopted practice guidelines and/or other AHCCCS approved criteria to make determinations for prior authorizations of services. Cenpatico IC’s Medical Management Committee reviews medical necessity criteria at least annually.

10.3.7. Prior Authorization When Cenpatico Integrated Care is not the Primary Payer

Cenpatico Integrated Care does not require prior authorization when Cenpatico is not the primary payer. Providers are required to pursue payment and submit the EOB (explanation of benefits) from all primary payers prior to billing Cenpatico IC any co-pays and deductibles. In instances when the member has exhausted the primary payer’s benefit, a provider may submit prior authorization to Cenpatico Integrated Care for primary coverage. All Cenpatico prior authorization requirements are required. The provider MUST submit evidence of the member’s primary benefits being exhausted.

10.3.8. Timeframes for Decisions
Decisions to prior authorize services must be made according to these guidelines:

- **Standard Requests:** A decision must be made as expeditiously as the member’s health condition requires, but not later than fourteen (14) calendar days after the receipt of the authorization request. A possible extension of up to fourteen (14) calendar days can be requested by the member or provider, or if Cenpatico IC justifies a need for additional information and the delay is in the member’s best interest. Cenpatico IC or the provider may determine that using the standard timeframe could seriously jeopardize the member’s life and/or health or ability to attain, maintain or regain maximum function, in this case the authorization can be changed to an expedited request.

- **Expedited Requests:** A decision must be made as expeditiously as the member’s health condition requires, but not later than three (3) business days after the receipt of the authorization request. A possible extension of up to fourteen (14) calendar days can be requested by the member or provider, or if Cenpatico IC justifies a need for additional information and the delay is in the member’s best interest. If Cenpatico IC receives an expedited request for authorization and the requested service is not of an urgent medical nature, Cenpatico IC may downgrade the expedited request to a standard request. Prior to the request being downgraded, Cenpatico IC will contact the provider immediately to discuss the authorization being downgraded to a standard request. If the provider agrees with the downgrade it is documented in the authorization request and changed to a standard request. If the provider disagrees with the downgrade and supplies additional information regarding the urgent nature of the request it is documented in the authorization request and processed as an expedited request.

10.3.9. Authorization procedures for providers contracted by Cenpatico IC

10.3.9.1. **Services that must be authorized**

- Acute Inpatient Hospital Services: Notification of Admission and continued stay, pre-scheduled admissions must be approved by Prior Authorization at least 5 days prior to the admission;
- Sub-acute services: Notification of Admission and continued stay, pre-scheduled admissions must be approved by Prior Authorization at least 5 days prior to the admission;
- BHIF residential treatment services: Notification of Admission and continued stay, pre-scheduled admissions must be approved by Prior Authorization at least 5 days prior to the admission;
- BHRF (excluding BHRFs for SUD treatment) services: Notification of Admission and continued stay, pre-scheduled admissions must be approved by Prior Authorization at least 5 days prior to the admission;
- BHRF for SUD treatment services: Notification of Admission and continued stay, pre-scheduled admissions must be approved by Prior Authorization at least 5 days prior to the admission;
- BHHTH and HCTC services: Notification of Admission and continued stay, pre-scheduled admissions must be approved by Prior Authorization at least 5 days prior to the admission;
- Initiation and continuation of **Out of Network** inpatient, observation and outpatient services.
- Skilled Nursing Facilities, Long Term Acute Care Facilities and Rehabilitation Facilities: Notification of Admission and continued stay, pre-scheduled admissions must be approved by Prior Authorization at least 5 days prior to the admission
- Physical Health Services listed below:

<table>
<thead>
<tr>
<th>Cenpatico Integrated Care</th>
<th>Physical Health Services that Require Prior-Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ancillary Services</strong></td>
<td></td>
</tr>
<tr>
<td>Cochlear Implant</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME) (includes medical supplies, enteral and parenteral pumps, wound vacs, bone growth stimulator, customized equipment)</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Fixed Wing non-emergency air transport</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Hearing Aid Devices (benefit coverage limitations)</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Home health care (includes infusions, home health aide,)</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Hospice services - other than inpatient facility</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Hyperbaric oxygen treatment (outpatient)</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Implantable devices (infusion pumps, intraocular implant/shunt, neuromuscular stimulator, spinal stimulator for pain management, testicular/penile prosthesis, vagus nerve stimulator)</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Orthotics &amp; Prosthetics (benefit coverage limitations)</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td><strong>Facility Services</strong></td>
<td></td>
</tr>
<tr>
<td>Elective/planned hospitalizations (notification at least 5 business days prior to the scheduled date of admit)</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Emergency Admissions (notification within 1 business day of admission)</td>
<td>Prior Authorization is not required but notification for authorization is required within 1 business day of admission</td>
</tr>
<tr>
<td><strong>Pharmaceuticals</strong></td>
<td></td>
</tr>
<tr>
<td>Specialty Pharmaceuticals</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Selected Injectable therapy/biopharmaceuticals - i.e.; Synagis, Growth Hormone</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Enteral/Parenteral Formulas (Pumps and supplies - see DME)</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td><strong>Physician Services</strong></td>
<td></td>
</tr>
<tr>
<td>Office services (not called out procedures)</td>
<td>Prior Authorization required for non-participating physicians</td>
</tr>
<tr>
<td>Chiropractic (benefit coverage limitations apply)</td>
<td>Prior Authorization Required</td>
</tr>
<tr>
<td>Infertility Treatment</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Transplants and Transplant related services (Evaluation, testing, etc.)</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td><strong>Radiology &amp; Laboratory Services</strong></td>
<td></td>
</tr>
<tr>
<td>MRI, MRA, Nuclear Cardiology, Nuclear Radiology, PET scan</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Genetic/Molecular Diagnostic Testing</td>
<td>Prior Authorization required</td>
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<tr>
<td>MR-guided focused ultrasound (MRgFUS) to treat uterine fibroid</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>OB Ultrasounds (over 2) except when rendered by perinatologist</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Quantitative Drug Screening, except for LabCorp</td>
<td>Prior Authorization required</td>
</tr>
</tbody>
</table>

**Surgery & Procedures**

<table>
<thead>
<tr>
<th>Description</th>
<th>Prior Authorization required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ablative techniques for treating Barrett’s Esophagus and for treating primary and metastatic liver malignancies.</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>ALCAT Allergy Testing</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Bariatric surgery</td>
<td>Prior Authorization required</td>
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<tr>
<td>Capsule endoscopy</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>General Anesthesia- with a Dental diagnosis</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Hyperhidrosis treatment</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Joint replacement - outpatient and inpatient joint replacement procedures in addition to total hip and knee</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Lung volume reduction surgery</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Maze procedure (for atrial fibrillation)</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Muscle flap procedure</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Orthognathic surgery (treatment of maxillofacial (jaw) functional impairment)</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Pain Management Services</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Potentially Cosmetic or plastic surgery e.g.: Blepharoplasty, Blepharoptosis repair, Brow Lift, Breast surgery or reconstruction other than post mastectomy, cranial/facial/jaw procedures, nasal/sinus surgery, panniculectomy and lipectomy/diastasis recti repair, vein procedures.</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Potentially Experimental Treatment/Clinical Trials</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Sleep apnea procedures and surgeries</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Sleep Studies</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Spinal surgery</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Surgeries/procedures performed in Outpatient facilities or ambulatory Surgery Centers e.g.: arthroscopy, gender reassignment, joint replacement, obstructive sleep apnea surgery, potentially cosmetic or plastic surgery, TMJ, transcatheter uterine artery embolization, vein procedures and others to be listed.</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Tonsillectomies</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Uvulopalatopharyngoplasty (UPP)</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Ventriculectomy,cardiomyoplasty</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Wearable cardioverter-defibrillators</td>
<td>Prior Authorization required</td>
</tr>
</tbody>
</table>

**Therapy Services (PT, OT, ST)**

<table>
<thead>
<tr>
<th>Description</th>
<th>Prior Authorization required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy Services (PT, OT, ST covered in the inpatient setting with no authorization</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Physical Therapy in an outpatient setting or at home - limited to 15 visits per year for restoration and/or 15 visits per year to acquire or maintain function</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Occupational Therapy and Speech Therapy in an outpatient setting or at home are limited to 18-21 y.o.</td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>Occupational Therapy and Speech Therapy in an outpatient setting or at home is not a covered benefit</td>
<td>Prior Authorization required</td>
</tr>
</tbody>
</table>

**Out of Network Providers & Services**

<table>
<thead>
<tr>
<th>Description</th>
<th>Prior Authorization required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of network Providers &amp; Services</td>
<td>Prior Authorization required</td>
</tr>
</tbody>
</table>
10.3.1 Notice of Admission

All facilities are required to send a notification of admission to Cenpatico IC within 1 business day of the admission. The notice of admission must include the member’s name, date of birth, AHCCCS ID#, facility name, NPI of facility, date of admission, admitting diagnosis and level of care admitted to. The notice of admission can be completed by any of the following means:

- Enter the admission via the Cenpatico Web Portal
- Fax a facesheet to 1-800-308-5560, Out of Home services – fax to 1-844-752-4293
- Fax a Notice of Admission form, Provider Manual form 10.1.3 to the above fax numbers
- A CON (Certificate of Need) can be submitted as notice of admission but it **MUST** be received within 1 business day of the admission. The form must be signed by a treating provider and have appropriate clinical documentation regarding the need for admission.

A CON must be completed within 72 hours of an admission for members age 21 and older and within 14 days of admission for members under the age of 21 years. A notice of admission **MUST** be received within 1 business day of the admission to the facility.

A CON must be completed if a member applies for Medicaid Assistance (AHCCCS) while in the hospital, before Medicaid (AHCCCS) funding is authorized. The facility **MUST** notify Cenpatico IC of the admission as soon as the member receives AHCCCS eligibility. If the member is still hospitalized when eligibility starts, notification of admission to Cenpatico IC must occur immediately so medical review and discharge planning can be initiated. In cases where eligibility confirmation occurs after discharge, the facility may submit for retrospective review, these requests must be received within 30 days of the eligibility determination.

Prior authorization will never be applied in an emergency situation. A retrospective review may be conducted after the person’s immediate health needs have been met. If upon review of the circumstances, the physical and/or behavioral health service did not meet admission authorization criteria, payment for the service may be denied. The provider must notify Cenpatico within 1 business day of an inpatient admission or demonstrate why timely notification was not possible. If the provider fails to timely notify Cenpatico of admission or demonstrate why it was not possible, a request for retrospective review may be denied. The test for appropriateness of the request for emergency services must be whether a prudent layperson, similarly situated, would have requested such services.

10.3.11 Certification of Need (CON) for Services

A CON is a certification made by a physician that inpatient services are or were needed at the time of the person’s admission. Although a CON must be submitted prior to a person’s admission (except in an emergency), a CON is not an authorization tool designed to approve or deny an inpatient service, rather it is a federally required attestation by a physician that inpatient services are or were needed at the time of the person’s admission. The decision to authorize a service is dependent on the individualized clinical documentation meeting the medical necessity criteria for admission. Providers must use **Provider Manual Form 10.1.1, Certification of Need (CON) for Level I Facilities**.

In the event of an emergency, the CON must be submitted:
- For persons age 21 or older, within 72 hours of admission; and
• For persons under the age of 21, within 14 calendar days of admission.

10.3.12. Re-certification of Need (RON) for Services

A RON is a re-certification made by the treating physician, nurse practitioner or physician assistant. The RON must recertify for each applicant or beneficiary that inpatient services are needed. A RON must be completed at least every 60 days for a person who is receiving services in an inpatient facility. An exception to the 60-day timeframe exists for inpatient services provided to persons under the age of 21. The treatment plan (individual plan of care) for persons under the age of 21 in an inpatient facility must be completed and reviewed every 30 days. The completion and review of the treatment plan in this circumstance meets the requirement for the re-certification of need. Providers must use Provider Manual Form 10.1.2, Re-certification of Need (RON) for Level I Facilities.

10.3.13. Documentation on a CON or RON for Behavioral Health Services

Providers must utilize the Cenpatico IC CON and RON forms for Behavioral Health Inpatient Facility and Licensed Hospital Services requests. The following documentation is needed on a CON and RON:

- Proper treatment of the person’s health condition requires services on an inpatient basis under the direction of a physician;
- The service can reasonably be expected to improve the person’s condition or prevent further regression so that the service will no longer be needed;
- Outpatient resources available in the community do not meet the treatment needs of the person;
- CONs must have a dated physician’s signature; and
- RONs must have a dated signature by a physician, nurse practitioner or physician assistant.

Additional CON requirements:

- If a person becomes eligible for Title XIX/XXI (AHCCCS) services while receiving inpatient services, the CON must be completed and submitted to Cenpatico IC’s Medical Management Department prior to the authorization of payment; and
- Federal rules set forth additional requirements for completing CONs when persons under the age of 21 are admitted to, or are receiving inpatient psychiatric services in a Behavioral Health Inpatient Facility. These requirements include the following:
  - For an individual who is Title XIX/XXI eligible when admitted, the CON must be completed by the clinical team that is independent of the facility and must include a physician who has knowledge of the person’s situation and who is competent in the diagnosis and treatment of mental illness, preferably child psychiatry;
  - For emergency admissions, the CON must be completed by the team responsible for the treatment plan within 14 days of admission. This team is defined in 42 CFR §441.156 as “an interdisciplinary team of physicians and other personnel who are employed by, or provide services to patients in the facility”; and
For persons who are admitted and then become Title XIX/XXI eligible while at the facility, the team responsible for the treatment plan must complete the CON. The CON must cover any period of time for which claims for payment are made.

10.3.14. Continued Stay When Medically Necessary Services are not available at Discharge

If a person receiving hospital or sub-acute services no longer requires such services under the direction of a physician, but services suitable to meet the person’s physical and/or behavioral health needs are not available or the person cannot return to the person’s residence because of a risk of harm to self or others, services may continue to be authorized as long as there is an ongoing, active attempt to secure a suitable discharge placement or residence in collaboration with the community or other state agencies as applicable and is documented daily. In these instances, the facilities may request “Administrative Days”. The request must be made while the member is still hospitalized, all requests MUST be made to the Cenpatico IC UM reviewer who will review for approval with the Cenpatico IC Medical Director. The Cenpatico IC contracts team will negotiate a payment rate comparable to the level of care the member’s condition requires. Upon approval of the “Administrative Days” the initial authorization will be terminated and a new authorization will be issued for “Administrative Days”, Providers must bill separately for these services.

10.3.15. Issuance of a Notice of Action

For Title XIX/XXI covered services requested by persons who are Title XIX/XXI eligible or persons with SMI, Cenpatico IC provides the person(s) requesting services with a Notice of Action as described in PM Section 15.3.

10.3.16. Further considerations for Denials of Requested Services

Inpatient Facilities Denials for Unplanned Admission or Continued Stay - After Cenpatico IC notifies a facility of a denial for an unplanned admission or a continued stay, the requesting clinician has the opportunity to contact the Cenpatico IC physician to discuss the decision. This request should occur within 24 hours of the issuance of the denial but providers are encouraged to contact Cenpatico as soon as possible. Cenpatico IC will ensure 24 hour access to a delegated physician for any denials of hospital admission.

Providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management department at 1-877-644-4613. Practitioners also have the opportunity to discuss any adverse decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. Please call the number on the denial notice to set up a ‘peer to peer’ discussion.

After this collaboration, the Cenpatico IC physician may rescind the denial or let the denial stand. If the denial is not rescinded, the requesting provider may appeal the decision as outlined in Section 15.3 of the Provider Manual.

Outpatient Authorizations and Planned Admissions - After Cenpatico IC notifies a provider of the decision to deny a requested authorization the requesting provider has several options.
• The provider can resubmit another authorization request with additional clinical documentation to substantiate the request;
• The provider can request reconsideration either in writing or via a peer to peer with the Cenpatico IC physician who issued the denial; and/or
• The provider can appeal the denial as outlined in Section 15.3.

10.3.16 Special Instructions for submitting documentation to support medical necessity.

Cenpatico IC must receive individualized clinical documentation of the member’s status in order to conduct clinical review for medical necessity.

Supporting documentation includes:

Behavioral Health and Physical Health Inpatient/Sub-acute Admissions

- Notice of Admission – facesheet, Notification of Admission form Provider Manual or CON;
- Admission notes that support the current level of care;
- Progress notes, including supporting labs, radiology reports, etc.;
- Case management activities, including discharge planning, CFT/ART notes;
- Any other supporting relevant clinical information.

Initial inpatient stays are based on the adopted criteria, the member’s specific conditions, and the projected discharge date. Reviews will occur on a schedule dictated by the member’s diagnosis and condition. Emergency initial concurrent reviews are completed within one (1) business day of Cenpatico IC receipt of notification of admission. Subsequent reviews will be determined based on the member’s specific condition. Providers are notified of the next review date and are responsible for providing updated clinical information on the scheduled review date (last covered day).

Behavioral Health Residential Facilities:

- Notice of Admission – facesheet, Notification of Admission form Provider Manual or CON;
- Admission notes that support the current level of care;
- The most current behavioral health individual service plan;
- Documentation showing member’s most recent intense outpatient treatments (90 days) and the results of the services rendered;
- Most recent psychiatric evaluation and progress notes;
- Case management and CFT progress notes;
- Psychological or psycho-educational evaluations;
- Hospital or residential discharge summaries;
- Any other relevant clinical information.

Initial behavioral health stays are based on the adopted criteria, the member’s specific conditions, and the projected discharge date. Reviews will occur on a schedule dictated by the member’s diagnosis and condition. Initial concurrent reviews are completed within one (1) business day of Cenpatico IC receipt of notification of admission. Subsequent reviews will be determined based on the member’s specific condition. Providers are notified of the next review date and are responsible for providing updated clinical information on the scheduled review date (last covered day).
date and are responsible for providing updated clinical information on the scheduled review date (last covered day).

For requests for continued stay, RONs are submitted as outlined above:

- Hospital, sub-acute service and residential BHIF providers submit additional clinical information to Cenpatico IC’s Medical Management Department verbally at 866-495-6738 or by secure fax to according to instruction in Provider Manual Attachment Medical Management Forms Matrix 10.1.7.

**Skilled Nursing Facility (SNF);**

Cenpatico provides medically necessary skilled nursing facility services for integrated members receiving physical healthcare services, including when the member has ALTCS pending. Ongoing reviews of members in skilled nursing facilities are conducted on a schedule dictated by the members’ diagnosis and condition, not to exceed 7 days. Providers are notified of the next review date and are responsible for providing updated clinical information on the scheduled review date.

Cenpatico IC tracks the number of SNF days utilized by a member in a contract year and will only be responsible for reimbursement during the time the member is enrolled with Cenpatico IC and if the member becomes ALTCS eligible and is enrolled with an ALTCS contractor before the end of the maximum ninety (90) days per contract year. The ninety (90) days per AHCCCS contract year limitation is monitored and will be applied for nursing facility services. AHCCCS is notified electronically when a member has been residing in a nursing facility for forty-five (45) days and ninety (90) days.

Only the information necessary to certify the length of stay, frequency or duration of services, or continued stay in authorized services will be collected and will be accepted from any reasonably reliable source that can assist in the authorization process.

Cenpatico IC makes a decision to authorize or deny coverage of these services based on available clinical information utilizing the policies and procedures developed for determining medical necessity for ongoing institutional care.

The Medical Management team will ensure a process to share all clinical and demographic information on individuals in hospital, BHIF, BHRF, BHTH, SNF and HCTC services among its various clinical and administrative departments that have a need to know, to avoid duplicate requests for information from consumers and providers, exceptions include substance use and HIV information. Cenpatico IC bases concurrent review determinations solely on the medical information obtained by the reviewer at the time of the review determination. Cenpatico IC verifies that the frequency of reviews for the extension of the initial determinations is based on the severity or complexity of the member’s condition or on necessary treatment and discharge planning activity but will also meet the prescribed review timelines according to InterQual® criteria. Authorization for hospital and institutional stays will have a specified date by which the need for continued stay will be reviewed and this will be documented in and relayed to the requesting provider to ensure coordination and understanding of when additional member condition updates are required. Admission reviews must be conducted within one business day
after notification is provided to the Contractor by the hospital or institution (this does not apply to pre-certifications) (42 C.F.R. 456.125).

For members being transferred for respite or other reasons a notice of transfer must be submitted within three (3) business days of the admission.

All Cenpatico Integrated Care Provider Manual Forms contain the correct fax numbers to send documents.

Attachments:
- Provider Manual Attachment 10.1.1 Admission Psychiatric Acute Hospital & Sub-Acute Criteria,
- Provider Manual Attachment 10.1.2 Continued Psychiatric Acute or Sub-Acute Facilities Authorization Criteria,
- Provider Manual Attachment 10.1.3 Prior Authorization Criteria for Admission and Continued Stay for Behavioral Health Residential Facilities,
- Provider Manual Attachment 10.1.4 Prior Authorization Criteria for Behavioral Health Supportive Homes,
- Provider Manual Attachment 10.1.5 Prior Authorization Criteria for Continued Stay for HCTC
- Provider Manual Attachment 10.1.6 Authorization Criteria for Behavioral Health Inpatient Facilities

Forms:
- Provider Manual Form 10.1.1 Certificate of Need UPDATED
- Provider Manual Form 10.1.2 Recertification of Need
- Provider Manual Form 10.1.3 Notice of Admission to ALL LEVELS OF CARE - UPDATED
- Provider Manual Form 10.1.6 Request for Out-of Home Admission UPDATED
- Provider Manual Form 10.1.8 BIP extension, outpatient, and out of home concurrent review UPDATED
- Provider Manual Form 10.1.10 Inpatient Discharge Summary
- Provider Manual Form 10.1.11 Request for Expedited Authorization
- Provider Manual Form 10.1.12 Outpatient Medicaid Prior Authorization Fax Form
- Provider Manual Form 10.1.13 Inpatient Medicaid Prior Authorization Fax Form
- Provider Manual Form 10.1.14 Intensive Staffing UPDATED
- Provider Manual Form 10.1.15 Out-of-Network Request
- Provider Manual Form 10.1.16 Transfer/Readmit Form NEW

10.3.17. Prior Authorizing Medications

Cenpatico IC has developed drug lists for use by all providers. These lists denote all drugs which require prior authorization. These prior authorization criteria have been developed by the statewide AHCCCS pharmacy and therapeutics committee or AHCCCS pharmacy and therapeutics committee, and must be used by Cenpatico IC’s providers. Medications or other prior authorization criteria cannot be added to Cenpatico IC’s medication list. For specific information on medications requiring prior authorization, see Section 10.11.9 – Cenpatico IC’s
**Drug Lists.** The approved prior authorization criteria are posted on the Cenpatico IC website. The prior authorization requirements for availability, decision timelines and provision of Notice are the same as that outlined for prior authorized services. Cenpatico IC and providers must assure that a person will not experience a gap in access to prescribed medications due to a change in prior authorization requirements. Cenpatico IC and providers are required to ensure continuity of care in cases in which a medication that previously did not require prior authorization is now required to be prior authorized.

**10.3.18. Notification of Prior Authorization Changes**

Cenpatico IC makes every effort to give providers at least thirty days’ notice, when possible, of changes in authorization processes or criteria through monthly Essential Provider Communication Meetings. Updated materials are posted to the Cenpatico IC website for provider and Member access.

**10.4. Technology**

Cenpatico IC reviews and considers adoption of new technologies and/or adoption of new uses to existing technologies utilizing evidence-based research and guidelines. The process includes evaluation of the FDA approved use, evidence based research, guidelines and analyses of related peer reviewed literature published in the United States. Peer-reviewed medical literature must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale.

New technologies include new delivery systems of medications if that delivery system is a device. Newly developed non-delivery systems (such as microspheres, oral dissolving systems) are not considered new technologies and aren’t subject to these requirements.

Providers may initiate a request for Cenpatico IC coverage of new approved technologies including the usage of new applications for established technologies by submitting the proposal in writing to Cenpatico IC’s Medical Director for review. The proposals shall include:

- FDA approval of the new technology and the approved indication;
- Medical necessity criteria and supporting documentation;
- A cost analysis including the financial impact to the provider for the new technology;
- Peer reviewed literature indicating the efficacy of the new technology or the modification in usage of the existing technology, if available; and
- Relevant coverage decisions made by Medicare intermediaries and carriers, national Medicare coverage decisions, and Federal and State Medicaid coverage decisions.

Cenpatico IC will participate in the review of newly requested technologies, including the usage of new applications for established technologies through the Cenpatico IC Pharmacy and Therapeutics Committee (P&TC) and the Medical Management Committee. Cenpatico IC will consider coverage rules, practice guidelines, payment policies and procedures, utilization management, and oversight that allows for the individual member’s medical needs to be met during this review.
Cenpatico IC will review requests for the use of a new technology at the quarterly Pharmacy and Therapeutics Committee meeting following the request. Cenpatico IC requests AHCCCS approval for the adoption of any new technology within thirty days of any P&TC recommendation for adoption of the new technology. Providers are informed of AHCCCS approval of new technology and any applicable prior authorization criteria through the P&TC, the monthly Essential Provider Communication Call, and a quarterly BHMP visit by the Pharmacy Administrator. Discussion reflecting consideration of a new FDA approved technology, including the usage of a new application for established technology and Cenpatico IC’s determination of coverage will be documented in the P&TC meeting minutes and the Medical Management Committee meeting minutes.

Consideration for systemic implementation of the coverage of the technology will be prioritized for consideration by AHCCCS based on member needs, utilization trends, financial considerations, and the meta-analysis of peer reviewed literature.

10.5 Retrospective Review

Cenpatico IC completes retrospective reviews (review after services have initiated or been provided) in response to a provider request for authorization of services after the initiation of services or after services have been rendered or to investigate quality of care concerns, as addressed in policy CAZ.MA.QM.005. Services eligible for retrospective review are outlined below:

- All services rendered during a member’s Prior Period Coverage (PPC) when the request is received within 30 days of the Add-on Date;
  - Post-discharge physical health or behavioral health hospital services (“hospital services”) and behavioral health inpatient facility sub-acute services (“BHIF-SAF services”) when Cenpatico received timely notification of admission (within 72 hours) and when the request is received no later than 30 days after the date of discharge;
  - Continuation of hospital services or BHIF-SAF services (pre-discharge) when Cenpatico did not receive timely notification of admission;
- Outpatient services requiring prior authorization when an authorization is requested after initiation of, but prior to completion of, a course of a treatment when the provider asserts completion of the course of treatment is necessary to ensure continuity of care (“course of treatment outpatient services”);
- Post-discharge out-of-home treatment that does not require prior authorization but does require notification of admission when Cenpatico received timely notification of admission and when the request is received no later than 30 days after the date of discharge; and
- Continuation (pre-discharge) of out-of-home treatment that does not require prior authorization but does require notification of admission when Cenpatico did not receive timely notification of admission.

Upon receipt of a written request for retrospective review, Cenpatico IC will screen the request to determine if it is eligible for retrospective review. If it is not eligible for retrospective review
based on the above criteria, a denial letter will be sent to the provider. The denial letter will explain the appeal process.

Upon receipt of a verbal request for retrospective review, Cenpatico IC will ask the provider to explain the reason for the request and will describe to the provider the circumstances under which Cenpatico will conduct a retrospective review. If Cenpatico IC believes the request is eligible for retrospective review, the provider will be given instructions about how to submit the written request. If Cenpatico IC does not believe the request is eligible for retrospective review, but the provider nevertheless would like to submit a written request, Cenpatico IC will provide information to the provider about how to submit the request.

Upon determining a request is eligible for retrospective review, Cenpatico IC will review the submitted records within seven (7) calendar days of receipt to ascertain if Cenpatico has received all clinical information necessary to conduct an adequate review. If the provider fails to submit sufficient information to render an authorization determination, Cenpatico IC will notify the provider and specifically describe the information needed. The facility will be given up to fourteen (14) calendar days to submit the additional information or to inform Cenpatico why the information cannot be submitted for review. Cenpatico IC will make a one-time request if clinical information is not sufficient to make a decision.

Review decisions are rendered within 30 days of the initial receipt of request for retrospective review. Cenpatico’s UM Reviewers can be reached Monday – Friday, 8am to 5pm, for prior authorization, continued stay authorization, and technical assistance at 866-495-6738. After hours, providers may contact Cenpatico at 866-495-6738, 24 hours per day, 365 days per year to request assistance. After hours calls are handled by Cenpatico IC’s crisis line contractor, NurseWise.

10.5. Pre-Admission Screening and Resident Review

The PASRR screening consists of a two-stage identification and evaluation process and is conducted to assure appropriate placement and treatment for those identified with Serious Mental Illness (SMI) and/or Mental Retardation (MR).

- PASRR Level I screenings are used to determine whether the person has any diagnosis or other presenting evidence that suggests the potential presence of SMI and/or MR.
- PASRR Level II evaluations are used to confirm whether the person indeed has SMI and/or MR. If the person is determined to have SMI and/or MR, this stage of the evaluation process determines whether the person requires the level of services in a Nursing Facility (NF) and/or specialized services (inpatient/hospital psychiatric treatment).

Medicaid certified NFs must provide PASRR Level I screening, or verify that screening has been conducted, in order to identify SMI and/or MR prior to initial admission of persons to a nursing facility bed that is Medicaid certified or dually certified for Medicaid/Medicare.
10.5.3. PASRR Level I Screenings


PASRR Level I screenings can be performed by the following professionals:

- Arizona Long Term Care System (ALTCS) Pre-Admission Screening (PAS) assessors, or case managers;
- Hospital discharge planners;
- Nurses;
- Social workers; or
- Other NF staff that have been trained to conduct the Level I PASRR screening and make Level II PASRR referrals.

ALTCS PAS assessors or case managers may conduct Level I PASRR screenings, but it is the ultimate responsibility of the facility where the Member is located to ensure that the Level I and Level II PASRR is completed prior to the Member being admitted into the receiving NF.

A PASRR Level I screening is not required for readmission of persons who were hospitalized and are returning to the NF, or for inter-facility transfers from another NF, if there has not been a significant change in their mental condition. The PASRR Level I screening form and PASRR Level II evaluation must accompany the readmitted or transferred person.

A PASRR Level I screening is required if a person is being admitted to a NF for a convalescent period, or respite care, not to exceed 30 days. If later it is determined that the admission will last longer than 30 days, a new PASRR Level I screening is required. The PASRR Level II evaluation must be done within 40 calendar days of the admission date.

10.5.3.1. Review

Upon completion of a PASRR Level I screening, documents are forwarded to the PASRR Coordinator within the AHCCCS Bureau of Quality Management Operations. If necessary, referrals for a PASRR Level II evaluation to determine if a person has a SMI diagnosis are forwarded to the AHCCCS Office of the Medical Director. Alternatively, referrals for a PASRR Level II evaluation are forwarded to the Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD) PASRR Coordinator to determine if a person has Intellectual Disability (formerly known as mental retardation). For dually diagnosed persons (both SMI and MR), referrals for a PASRR Level II evaluation are forwarded to both ADES/DDD and AHCCCS.

When a PASRR Level I screening is received by AHCCCS, the PASRR Coordinator reviews it and, if needed, consults with the AHCCCS Medical Director or designee (must be a Board-eligible or Board-certified psychiatrist and have an unrestricted, active license to practice medicine in Arizona) to determine if a PASRR Level II evaluation is necessary. If it is determined that a PASRR Level II evaluation should be conducted, the PASRR coordinator must:

- Forward copies of the PASRR Level I screening and any other documentation to the RBHA/Health Plan; and
- Send a letter to the person/legal representative that contains notification of the requirement to undergo a Level II PASRR evaluation.

10.5.4. PASRR Level II Screenings

Cenpatico IC must develop an administrative process for conducting PASRR Level II evaluations and must ensure that:

- They are completed within 5 working days of receipt of the PASRR Level I screening;
- If the person is awaiting discharge from a hospital, the evaluation should be completed within 3 working days; and
- The criteria used to make the decision about appropriate placement are not affected by the availability of placement alternatives.

10.5.4.1. Criteria

The PASRR Level II evaluation includes the following criteria:

- The evaluation report must include the components of the Level II PASRR Psychiatric Evaluation (Provider Manual Form 10.5.1);
- The evaluation must be performed by a physician who is a Board-eligible or Board-certified psychiatrist and has an unrestricted, active license to practice medicine in Arizona;
- The evaluation can only be performed by a psychiatrist who is independent of and not directly responsible for any aspect of the care or treatment of the person being evaluated;
- The evaluation and notices must be adapted to the cultural background, language, ethnic origin, and means of communication used by the individual being evaluated;
- The evaluation must involve the individual being evaluated, the individual’s legal representative, if one has been designated under state law, and the individual’s family, if available and if the individual or the legal representative agrees to family participation;
- Evaluators may use relevant evaluative data, obtained prior to initiation of preadmission screening or resident reviews, if the data are considered valid and accurate and reflect the current functional status of the individual. However, in the case of individualized evaluations, to supplement and verify the currency and accuracy of existing data, the State's PASRR program may need to gather additional information necessary to assess proper placement and treatment.
- Evaluators are to follow AHCCCS Policy 1106 Pre-Admission Screening and Residential Review (PASRR) complete the AHCCCS Policy Form 1106.2, Level II PASRR Psychiatric Evaluation

10.5.4.2. Review

The AHCCCS Medical Director or designee reviews all evaluations and makes final Level II placement determinations prior to the proposed/current placement.

AHCCCS must provide copies of the completed PASRR Level II evaluation to the referring agency, Arizona Health Care Cost Containment System, Division of Health Care Management
(AHCCCS/DHCM) PASRR Coordinator, facility, primary care provider, and person/legal representative.

**10.5.5. Cease Process And Documentation**

If at any time in the PASRR process it is determined that the person does not have a SMI, or has a principal/primary diagnosis identified as an exemption in the Level I screening, the evaluator must cease the PASRR process of screening and evaluation and document such activity.

**10.5.6. SMI Determination**

AHCCCS reviews each person determined to have a SMI on an annual basis, or when a significant change in the resident’s physical or mental condition has been noted in order to ensure the continued appropriateness of nursing home level of care and the provision of appropriate behavioral health services.

**10.5.7. Reporting**

Cenpatico IC shall report monthly to AHCCCS concerning the number and disposition of residents (1) not requiring nursing facility services, but requiring specialized services for SMI, (2) residents not requiring nursing facility services or specialized services for SMI, and (3) any appeals activities and dispositions of appeal cases.

**10.5.8. Discharge**

Per 42 C.F.R. 483.118 (1 and 2), AHCCCS will work with the facility to arrange for the safe and orderly discharge of the resident. The facility in accordance with 42 C.F.R. 483.12(a) will prepare and orient the resident for discharge.

Per 42 C.F.R. 483.118 (c) (i-iv), AHCCCS will work with the facility to provide an alternative disposition plan for any residents who require specialized services and who have continuously resided in a NF for at least 30 months prior to the determination as defined in 42 C.F.R. 483.120. AHCCCS, in consultation with the resident’s family or legal representative and caregivers, offer the resident the choice of remaining in the facility or of receiving services in an alternative appropriate setting.

**10.5.9. Recommendations**

The AHCCCS Level II PASRR Psychiatric Evaluation includes the recommendations of services for lesser intensity by the evaluating Psychiatrist as per 42 C.F.R.483.120, 128(h)(i) (4 and 5). The AHCCCS Medical Director or designee (must be a Board-eligible or Board-certified psychiatrist and have an unrestricted, active license to practice medicine in Arizona) will determine if the person requires nursing facility level of care and if specialized services are needed based on individualized evaluations or advance group determinations in accordance with 42 C.F.R. § 483.130-134. Individual evaluations or advance group determinations may be made for the following circumstances:

- The person has been diagnosed with a terminal illness; or
- Severe physical illness results in a level of impairment so severe that the person could not benefit from specialized services. The person will be reassessed when notified by the nursing facility of an improvement in their condition; and
• Other conditions as listed in 42 C.F.R. § 483.130-134.

10.5.10. Appeal and Notice Process Specific To PASRR Evaluations

AHCCCS shall send a written notice no later than three (3) working days following a PASRR determination in the context of either a preadmission screening or resident review that adversely affects a Title XIX/XXI eligible person.

Appeals shall be processed, consistent with the requirements in Section 15.3 – Notice Requirements and Appeal Processes for Title XIX/XXI Eligible Persons and Section 15.4 - Notice and Appeal Requirements (SMI and GMH/SA Non-Title XIX/XXI).

Cenpatico IC will provide AHCCCS with any requested information, and will make available witnesses necessary to assist with the defense of the decision on appeal, in the event that a person appeals the determination of the PASRR evaluation.

10.5.11. Retention

Cenpatico IC will retain case records for all Level II evaluations for a period of 6 years in accordance with A.R.S. § 12-2297.

Cenpatico IC will permit authorized AHCCCS personnel reasonable access to files containing the reports received and developed.

10.5.12. Training

Training will be provided to psychiatrists and any other medical professionals that conduct Level II evaluations as needed.

10.5.13. Provider Requirements

Providers are required to follow PASRR requirements for Members who require services in a skilled nursing facility. Those requirements are:

• The provider is required to administer the PASRR Residential evaluations as requested and meet required time frames for assessment and submission to Cenpatico IC.

• The provider is required to determine the appropriateness of admitting persons with mental impairments to Medicaid-certified nursing facilities, to determine if the level of care provided by the nursing facility is needed and whether specialized services for persons with mental impairments are required.

• The provider is required to demonstrate that a licensed physician who is Board-Certified or Board-eligible in Psychiatry conducts PASRR Residential evaluations in accordance with 42 CFR Part 483, Subpart C and the AHCCCS Policy and Procedures Manual section on Pre-Admission Screening and Resident Review (PASRR).

• The provider is required to conduct PASRR Residential evaluations in person where the referred person is located.
10.6. Inter-Rater Reliability Testing

To make utilization decisions, Cenpatico IC uses written criteria as required by contract with AHCCCS. Cenpatico IC evaluates the application of Medical Necessity Criteria annually, and maintains and uses a standardized instrument for measuring Medical Management staff's application of the current Medical Necessity Criteria. A different measurement tool will be utilized during each measurement of Inter-Rater Reliability to maintain continuous objectivity in the evaluation.

10.7. CARE MANAGEMENT AND CARE COORDINATION SERVICES

10.7.3. Definition

Care Management and Care Coordination services are available for all Title XIX/XXI Adults with SMI. Care Management and Care Coordination are services provided by Cenpatico IC Medical Management staff. Care Management and Care Coordination encompasses a variety of activities for coordinating services and providers to assist a member in achieving his or her recovery goals described in the Individual Recovery Plan. These activities, which can occur both at a clinical and system level, are performed by Adult Recovery Team (treatment team) members depending on a member’s needs, goals, and functional status. Regardless of who performs care management and care coordination, the Care Manager and Care Coordinator are required to have expertise in member self-management approaches, member advocacy and be capable of navigating complex systems and communicating with a wide spectrum of professional and lay persons including family members, physicians, specialists and other health care professionals.

10.7.4. Role and Function of Care Management and Care Coordination

The Cenpatico IC Care Management/Care Coordination program is designed to help Title XIX/XXI Adults with SMI achieve their recovery goals and assist eligible members in receiving appropriate treatment for chronic conditions (both primary and secondary chronic conditions) by providing proactive support to Health Home Adult Recovery Teams. Care Management and Care Coordination involves identifying the health needs of members, providing clinical support and recommendations to provider agency treatment teams, verifying necessary referrals are made and appropriate services are provided, maintaining health history, and facilitating access to additional evaluation/diagnosis and treatment when necessary.

10.7.5. Provider Responsibilities Related to Care Management and Care Coordination

Health Homes are required to collaborate effectively with Cenpatico IC Care Managers and Care Coordinators. This collaboration includes collaborating on the following duties:

- Assist members in the completion of Health Risk Assessments
- Identify members who may qualify for Care Management services
- Align Cenpatico IC Care Plans with Member Individual Recovery Plans
- Assist members in obtaining necessary physical health and behavioral health services, including specialty care, preventive care, and well person visits
- Assist members in achieving medication adherence
- Verify members complete lab tests as appropriate
• Provide or arrange transportation for members to receive medically necessary services
• Facilitate effective transitions among providers and levels of care
• Participate in Care Plan Rounds as requested
• Communicate regularly with Care Managers and Care Coordinators as requested
• Develop and implement disease management and wellness programs to meet the needs of members in the provider’s care
• Develop and implement 24/7 community based programs to reduce justice system involvement, and unnecessary emergency department utilization and hospitalizations
• Facilitate effective coordination of care with PCPs through health homes
• Engage the member to participate in service planning
• Monitor and facilitate adherence to treatment goals including medication adherence
• Develop the initial service package, continuing or additional services and suggest or create service alternatives when appropriate
• Establish a process to verify coordination of member care needs across the continuum based on early identification of health risk factors or special care needs.
• Monitor individual health status and service utilization to determine use of evidence-based care and adherence to or variance from the Individual Recovery Plan.
• Monitor member services and placements to assess the continued appropriateness, medical necessity and cost effectiveness of the services.
• Identify and document the member’s primary care and specialty care providers to make sure the information is current and accurate.
• Communicate among behavioral and physical health service providers regarding member progress and health status, test results, lab reports, medications and other health care information when necessary to promote optimal outcomes and reduce risks, duplication of services or errors;
• Track the member’s eligibility status for covered benefits and assist with eligibility applications or renewals.
• Communicate with the member’s assigned Care Manager, treatment team members or other service providers to ensure management of care and services including addressing and resolving complex, difficult care situations.
• Participate in discharge planning from hospitals, jail or other institutions and follow up with members after discharge.
• Verify applicable services continue after discharge.
• Verify that periodic re-assessment occurs at least annually or more frequently when the member’s psychiatric and/or medical status changes.
• Communicate with family members and other system stakeholders that have contact with the member including, state agencies, other governmental agencies, tribal nations, schools, courts, law enforcement, and correctional facilities.
• Verify that members discharged from Arizona State Hospital with diabetes are issued appropriate equipment and supplies they were trained to use while in the facility.
• Coordinate medical care for members who are inpatient at the Arizona State Hospital in accordance with ACOM 4322.
• Coordinate outreach activities to members not engaged, but who would benefit from services.
• Coordinate care for dual eligible members turning eighteen (18) years of age and for newly eligible dual members transitioning to an Acute Care Contractor for their behavioral health services.

10.7.6. Care Management

Care Management is essential to successfully improving healthcare outcomes for a specifically defined segment of Title XIX/XXI eligible adults with SMI enrolled with Cenpatico IC. Care Management is designed to cover a wide spectrum of episodic and chronic health care conditions for members in the top tier of high risk/high cost members with an emphasis on proactive health promotion, health education, disease management, and self-management resulting in improved physical and behavioral health outcomes. Care Management is an administrative function and not a billable service. It is performed by Cenpatico IC’s Care Managers. While Care Managers can provide consultation to a member’s Treatment Team, they should not perform the day-to-day duties of case management or service delivery. Cenpatico IC assigns and monitors Care Management to member ratios based upon national standards and consistent with a member’s acuity and complexity of need for Care Management. Care Management resources are allocated to members consistent with acuity, and evidence-based outcome expectations. Technical assistance is provided to Care Managers including treatment review, continuous education, training and supervision.

Title XIX/XXI Adults with SMI identified as having the highest needs receive Care Management Services. The top tier of high need/high cost Title XIX/XXI adults with Serious Mental Illness (SMI), estimated at twenty percent (20%), are assigned Care Managers to serve this population based on the member’s acuity and complexity of need. Cenpatico IC assigns Care Management resources to members consistent with the acuity and evidence-based outcome expectations. Members in this group typically include:

• Members at high risk of poor health outcomes and high utilization;
• Members with an acute or chronic diagnosis or condition;
• Members who have struggled unsuccessfully to manage their health care, and require more complex or frequent healthcare and services.

Cenpatico IC utilizes data from multiple sources to identity members who may benefit from care management to meet their individualized needs. These tools allow for members to be stratified into a case registry and their specific risks identified, including chronic co-morbid conditions (both primary and secondary chronic conditions), over utilization of behavioral health and physical health services, adverse events, high costs and specific gaps in care. Members may be identified through population-based tools (i.e., predictive modeling) and individual-based tools (i.e., Health Risk Assessment [HRA]). On a monthly basis, HRAs are incorporated into predictive modeling reports to further identify members that may need Care Management. These reports also assist in identifying the appropriate Care Management/Care Coordination level, particularly...
for those members with the greatest potential for improved health outcomes and increased cost-effective treatment.

In addition, members may be identified for Care Management through various referral sources from within Cenpatico IC and through external sources. These referral sources include, but are not limited to, the following:

- Member self-referral
- Family and/or caregiver
- Adult Recovery Teams
- Utilization Management (UM) referral
- Quality Management (QM) referral
- Various other Cenpatico IC departments
- Discharge planner referral
- Provider submissions of the American College of Obstetricians and Gynecologists [ACOG] comprehensive assessment tool
- Provider submission of an Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Tracking Form
- AHCCCS
- American Indian Health Program
- Inpatient facilities, emergency departments, crisis providers
- Department of Economic Security (DES)/Division of Developmental Disabilities

Referrals for Care Management (Title XIX/XXI adults with SMI with the highest needs) can be made by calling the Care Management Referral Line at (866) 495-6738. Upon receipt of a referral for Care Management, Cenpatico IC will assess the member’s eligibility and provide written notification of the decision within 30 days of referral.

10.7.7. **Disenrollment From Care Management**

Members are dis-enrolled from the Care Management Program when they show successful completion of care management goals and a reduction of risk and utilization. Upon disenrollment from the Care Management Program and the member’s ongoing care is monitored by Cenpatico IC’s Care Coordination Team. Members are dis-enrolled from the Care Management and Care Coordination teams when they expire, move out of state, transfer to another Integrated RBHA/Health Plan, or are decertified as SMI (determined to no longer qualify for the SMI program).

10.7.8. **Coordination of Care**

Title XIX/XXI Adults with SMI identified as having less acute needs receive Care Coordination Services. This group of Title XIX/XXI adults with Serious Mental Illness (SMI), estimated at eighty percent (80%) is assigned Care Coordinators to serve this population. Members in this group typically have been more successful at managing their health care but may be at risk of developing chronic conditions.
10.7.9. Care Management/Care Coordination Team Responsibilities

The Cenpatico IC Care Management and Care Coordination Teams under the direction of the Cenpatico IC Chief Medical Officer and Medical Management Administrator perform the following functions:

- Research claims data and clinical information to identify care gaps and opportunities for better coordination of care, better access to services and better treatment alternatives;
- Communicate findings to Health Home treatment teams and collaborates with treatment teams to identify opportunities to enhance care and engage members into disease management and other treatment programs;
- Identify opportunities with the Health Home treatment teams to assist members in making lifestyle changes that enhance recovery and support wellness;
- Assist Health Home treatment teams in identifying opportunities to improve medication adherence, reduce unnecessary emergency department and inpatient utilization;
- Assist Health Home treatment teams in identifying opportunities to decrease and eliminate justice system involvement and arrests, and use of crisis services;
- Facilitate and track completion of Health Risk Assessments;
- Report program needs to the Network department to facilitate the development of new programs and services;
- Collaborate effectively with all Cenpatico IC departments, including Quality Management;
- Monitor member transitions from one level of care to another;
- Provide through Health Home treatment teams members with the tools to self-manage care in order to safely live, work, and integrate into the community;
- Complete a comprehensive Care Plan review for each member enrolled in the Care Management Program on a quarterly basis. The Care Plan review shall include, at a minimum:
  - A medical record chart review;
  - Consultation with the member’s treatment team;
  - Review of administrative data such as claims/encounters; and
  - Demographic and customer service data.

10.7.10. Care Planning

Care Managers and Care Coordinators collaborate with members of the Health Home Adult Recovery Teams to develop the care plan which is designed to prioritize goals that consider the member’s and caregiver’s strengths, treatment needs, recovery and wellness goals, and preferences. All providers participating in the member’s care will receive a copy of the Care Plan. The Care Plan is expected to align with the member’s Individual Recovery Plan/Individual Service Plan, but will be neither a part of nor a substitute for that Plan. The Care Plan describes the clinical interventions recommended to the clinical team; identifies the coordination gaps, strategies to improve coordination of care among service providers; and strategies required to
monitor referrals and follow-up for specialty care and routine health care services, including medication monitoring.

As part of the care planning process, the Care Manager/Care Coordinator documents a schedule for follow up with the treatment team and convenes Care Plan reviews at intervals consistent with the identified member care needs and to ensure progress and safety. Care Plan reviews are pre-scheduled and designed to evaluate progress toward Care Plan goals and meeting member needs. The Care Plan can be revised/adjusted at any point based on member progress and outcomes. The Care Plan identifies the next point of review and is saved in the member’s electronic record in the Cenpatico IC Care Management business application system.

10.7.11. Care Plan Rounds

A member’s unique care needs can also be addressed through formal interdisciplinary Care Plan Rounds. In Care Plan Rounds, both treatment and non-treatment staff may present member treatment concerns to their treatment peers and treatment leaders to seek guidance and recommendations on how to best address the member’s physical, behavioral and social care needs. Care Plan Rounds typically focus on members who are at high risk, have complex co-morbid conditions and/or have difficulty sustaining an effective working relationship with treatment and/or non-treatment staff. Care Plan Rounds may also include representatives from the member’s treatment team. Care Plan Rounds are scheduled bi-weekly, twice a month.

10.7.12. Additional Services Available to EPSDT Eligible Title XIX/XXI Adults with SMI

EPSDT eligible Title XIX Adults with SMI are eligible to receive additional services. Cenpatico IC Care Managers and Care Coordinators facilitate access to these services. These services include:

- **CHIROPRACTIC SERVICES**: Chiropractic services are available to members eligible for EPSDT services when ordered by the member’s PCP and approved by Cenpatico IC in order to ameliorate the member’s medical condition.

- **PERSONAL CARE SERVICES**: Personal care services are available for members eligible for EPSDT services as approved by Cenpatico IC.

- **INCONTINENCE BRIEFS**: Incontinence briefs, including pull-ups, are covered in order to prevent skin breakdown and to enable participation in social, community, therapeutic and educational activities under the following circumstances:
  - The member is incontinent due to a documented disability that causes incontinence of bowel and/or bladder
  - The PCP or attending physician has issued a prescription ordering the incontinence briefs
  - Incontinence briefs do not exceed 240 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 240 briefs per month for a member diagnosed with chronic diarrhea or spastic bladder
  - The member obtains incontinence briefs from providers in the Cenpatico IC network
  - Prior authorization has been obtained as required by Cenpatico IC.
10.7.12.1. Medically Necessary Therapies

Physical therapy, occupational therapy and speech therapy are available when necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services area. Therapies are covered under both an inpatient and outpatient basis when medically necessary and approved by Cenpatico IC.

10.7.12.2. Tuberculin Skin Testing

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

- Confirmed or suspected of TB;
- In jail during the last five years;
- Living in a household with an HIV-infected person or the member is infected with HIV; and
- Traveling/emigrating from, or having significant contact with persons indigenous to, endemic countries.

Establish and maintain a Care Management Program (CMP). See Exhibit 1, Definitions for an explanation of “Care Management Program”.

10.8. Disease Management

Cenpatico IC has a disease management program available to Members that focuses on Members with high risk and/or chronic conditions. The program includes intervention plans that target chronic behavioral and physical health conditions such as, depression, obesity cardiac disease, chronic heart failure, chronic obstructive pulmonary disease, diabetes mellitus and asthma.

The goal of the program is to employ strategies such as health coaching and wellness to facilitate behavioral change to address underlying health risks and to increase Member self-management as well as improve practice patterns of providers, thereby improving healthcare outcomes for Members.

Cenpatico IC has methodologies to evaluate the effectiveness of these programs including education specifically related to the identified Member’s ability to self-manage disease and measurable outcomes

10.9. Out-of-Home Services Requirements

Providers providing out-of-home services are required to provide the following additional documentation as identified below to Cenpatico IC:

- The Admission Face Sheet within two (2) work days following admission.
- The Out-of-Home Program Intake Summary within three (3) work days following admission.
- The Psychiatric Evaluation within three (3) work days following completion.
- The Discharge Plan within forty-eight (48) hours of discharge from the facility.

10.10. Pharmaceutical Requirements

Providers are required to comply with various pharmaceutical requirements, including the following:

10.10.3. E-Prescribing Software

Utilize e-prescribing software systems to submit prescriptions to pharmacies.

10.10.4. Tamper-Resistant Prescription Pads

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

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

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

10.10.5. Free Samples

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

10.10.6. Cenpatico Integrated Care Drug Lists (Formulary)

Providers are required to abide by Cenpatico IC's drug lists (formularies) as applicable, when prescribing medications for Members in accordance with this Provider Manual. Providers are also required to adhere to the requirements of the AHCCCS/ADHS Psychotropic Medication Initiative in accordance with this Provider Manual.
10.10.7.    Prescriber Appointments
Providers must ensure that Members are scheduled for Prescriber appointments in a time frame that ensures that (1) the Member is evaluated for the need for medications so that the Member does not experience a decline in behavioral health status, and (2) the Member does not run out of medication.

10.10.8.    Physician Oversight
Providers are required to provide physician oversight when providing medical treatments, including methadone, medications, and detoxification to ensure services are rehabilitative in focus and directed to long-term recovery management, when applicable.

10.10.9.    Medication Assisted Treatment
Providers are required to ensure Behavioral Health Medical Professionals assist Members with Substance Use Disorders receive Medication Assisted Treatment when appropriate to support Members’ recovery.

10.10.10.   Registration with Controlled Substance Prescription Monitoring Program
All medical practitioners are required to register and utilize the Arizona Controlled Substance Prescription Monitoring Program (CSPMP, PMP). Practitioners must obtain a patient utilization report for the preceding 12 months from the controlled substances PMP central database tracking system before prescribing opioid analgesics or benzodiazepines in schedules II-IV. Practitioners are not required to obtain a report if the patient is receiving hospice care or being treated for cancer or cancer-related illness; if the practitioner will administer the controlled substance; if the patient is receiving the controlled substance during the course of inpatient or residential treatment in a hospital, nursing care facility or mental health facility; or if the medical practitioner, under specific legislation, prescribed controlled substances for no more than five days after oral surgery. Medical practitioners may be subject to liability or disciplinary action for failing to request or receive prescription monitoring data from the PMP, or for acting or failing to act on the basis of the PMP monitoring data provided. Evidence of registration is required to be maintained in personnel records.

10.10.11.   Cenpatico Integrated Care’s Drug Lists
Cenpatico IC’s Drug Lists ensure the availability of safe, cost-effective and efficacious medications for eligible Members. AHCCCS may add or delete medications from the list based on factors such as obsolescence, toxicity, and substitution of superior products or newer treatment options.

Medicare eligible Members, including persons who are dually eligible for Medicare (Title XVIII) and Medicaid (Title XIX), receive Medicare Part D prescription drug benefits through Medicare Prescription Drug Plans (PDPs) or Medicare Advantage Prescription Drug Plans (MA-PDs). Prescription drug coverage for Medicare eligible Members enrolled in Part D is based on the Part D plans’ drug lists (formularies). There may be an occasion when a Member’s prescribed drug is not available through his/her Part D plan’s formulary. This is considered a non-covered Part D drug. Cenpatico IC and/or providers must make attempts to obtain a drug not on a Part D plan’s formulary by requesting an exception from the Part D plan.
To ensure coverage of medications through Cenpatico IC, providers are required to utilize the Cenpatico IC drug lists. These drug lists can be found on Cenpatico IC’s website as PMA_10-11-1, Comprehensive Drug List by Drug Name; or PMA_10-11-2 Comprehensive Drug List by Drug Class PMA_10-11-3 Behavioral Health Drug List by Drug Name; or PMA_10-11-4 Behavioral Health Drug List by Drug Class; or PMA_10-11-5 PIMA and YUMA County Crisis Medication List.

Title XIX/XXI eligible persons receiving medication(s) have the right to notice and appeal when a decision affects coverage for medication(s), in accordance with Section 15.3 - Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons. Non-Title XXI/XXI persons determined to have a SMI have the right to notice and appeal when a decision affects medication coverage, in accordance with Section 15.4 - Notice and Appeal Requirements (SMI and GMH/SA Non-Title XIX).

Members with third party coverage, such as Medicare and private insurance, will have access to medications on their health plan’s formulary through their third party insurer. If the desired/recommended prescription drug is not included on the health plan’s formulary but may be covered by requesting an exception or submitting an appeal, the provider is required to attempt to obtain an exception for the medication or assist the Member in submitting an appeal with the health plan, Cenpatico IC will cover medications for persons determined to have a SMI, regardless of Title XIX/XXI eligibility, when their third party insurer will not grant an exception for a medication that is a medication on the Behavioral Health Drug List or Cenpatico IC Drug List.

Applicable copayments must only be collected in accordance with Section 8.2 - Copayments. For Persons with Coverage from Third Party Payers, copayments are collected in accordance with Section 8.3 - Third Party Liability and Coordination of Benefits.

Cenpatico IC shall not require prior authorization processes for medications which have been approved for payment under Medicare plans.

10.10.12. Prior Authorization

AHCCCS requires the RBHA/Health Plans to prior authorize coverage of those medications indicated in the AHCCCS Behavioral Health Drug List and Cenpatico IC Drug Lists as requiring prior authorization and those that have age limits. See PMF 10-11-1, Non-Specialty Medication Prior Authorization Request; PMF_10-11-2 Specialty Medication Prior Authorization Request; PMF_10-11-3 Exclusive Pharmacy Prescriber Request; PMF_10-11-4 Makena Request; and PMA_10-11-1 Comprehensive Drug List by Drug Name; or PMA_10-11-2 Comprehensive Drug List by Drug Class; or PMA_10-11-3 Behavioral Health Drug List by Drug Name; or PMA_10-11-4 Behavioral Health Drug List by Drug Class; or PMA_10-11-5 PIMA & YUMA County Crisis Medication List; or Provider Manual PMA_10-11-7 ADHD Medications in Children Under 6 Years Old; or PMA_10-11-8 Antipsychotic Medications in Children Under 6 Years Old; or PMA_10-11-9 Buprenorphine Prior Authorization Criteria; or PMA_10-11-10 Concomitant Antipsychotic Treatment; or PMA_10-11-11 Concomitant Antidepressant Treatment; or PMA_10-11-12 Cytochrome P450 Mediated Drug Interactions; or PMA_10-11-13 Quantity Limits Supply Limits; or PMA_10-11-14 Long Acting Injectable Antipsychotics; or PMA_10-11-15 Rexulti Prior Authorization Criteria; or PMA_10-11-16 Belsomra Prior Authorization Criteria; or PMA_10-11-

When these prior authorization criteria are utilized, the requirements outlined in Section 10.1 - Securing Services and Prior Authorization, Section 15.3 - Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons, and Section 15.4 - Notice and Appeal Requirements (SMI and GMH/SA Non-TXIX/TXXI), must be met.

10.10.13. Input from Cenpatico Integrated Care Contracted Providers
Cenpatico IC contracted providers can offer suggestions for adding or deleting medications to/from the AHCCCS Behavioral Health Drug List or the Cenpatico IC Drug Lists.

To propose additions or deletions to the Cenpatico IC Drug Lists, providers shall submit a written request to Cenpatico IC’s Pharmacy Administrator:

Pharmacy Administrator
Cenpatico Integrated Care
1501 W. Fountainhead Parkway, Suite 360
Tempe, Arizona 85282

Requests for additions must include the following information:
- Medication requested (trade name and generic name, if applicable);
- Dosage forms, strengths and corresponding costs of the medication requested;
- Average daily dosage;
- Indications for use (including pharmacological effects, therapeutic uses of the medication and target symptoms);
- Advantages of the medication (including any relevant research findings if available);
- Adverse effects reported with the medication;
- Specific monitoring required; and
- The drugs on the current formulary that this medication could replace.

Requests for deletions must include a detailed summary of the reason for requesting the deletion.

The Cenpatico IC Pharmacy Administrator will present requests, as determined appropriate, to the AHCCCS Pharmacy and Therapeutics Committee.

Cenpatico IC also must provide specific information for their providers regarding requests and changes to the AHCCCS Behavioral Health Drug List (BHDL) or AHCCCS Drug List.
10.11. Utilization Data Analysis and Data Management

10.11.3. Compliance with Cenpatico Integrated Care, Agency Requirements and Laws

Providers must comply with various utilization management requirements, including Chapter 1000 of the AMPM, the QM/MM/UM Performance Improvement Specifications Manual, this Provider Manual, Cenpatico IC’s Utilization Management Plan, and Federal utilization control requirements limiting respite services to six hundred (600) hours per Member per year.

10.11.4. Communication of Guidelines

Cenpatico IC will communicate guidelines, including any admission, continued stay and discharge criteria to all affected providers and to Members when appropriate and to individual Members upon their request. Decisions regarding utilization management, Member and provider education, coverage of services, provision of services, and other areas to which guidelines are applicable must be consistent with 42 CFR 438.230(c) and (d). Providers must also communicate notice of decision requirements as described in this Provider Manual, and federal and State laws and regulations, including federal requirements regarding Utilization Review Plans, Utilization Review Committees, Plan of Care and Medical Care Evaluation studies as prescribed in 42 CFR, Parts 441 and 456.

10.11.5. Emergency Room Utilization

Cenpatico IC tracks emergency room utilization, including waiting times members are in an emergency room awaiting a behavioral health inpatient placement. Cenpatico IC tracks emergency department utilization by members and Health Home, providing reports to Health Homes on a monthly basis. Health Homes are required to proactively work with members to minimize unnecessary utilization of emergency rooms by providing members 24/7 access to physicians and developing and utilizing alternative 24/7 community based services to help members manage crises and receive appropriate medical care. Cenpatico IC reports appropriate and non-appropriate use of emergency departments to Health Homes regarding individual members. Non-appropriate and repeat appropriate use of emergency departments by individual members is reported to providers through the provider portal. Health Homes are required to review the data and help members receive the most appropriate care in the most appropriate settings and facilitate access to preventive care services to reduce the need for emergency department utilization.

10.11.6. Responsibilities Of Cenpatico Integrated Care MM/UM Committees

Cenpatico IC convenes Medical Management/Utilization Management (MM/UM) Committee meetings on a regularly scheduled and ongoing basis. Cenpatico IC discusses data submitted to AHCCCS as part of the MM/UM Committee. Cenpatico IC’s MM/UM Committee is expected to conduct the following Utilization Data Management Activities specific to data that is reported to AHCCCS:

- Review and analyze data to identify trends;
- Interpret variances;
- Review Outcomes;
- Determine, based on the review of data, if action (new or changes to current intervention) is required to improve the efficient utilization of services;
• Develop and/or approve corrective action and interventions based on findings; and
• Review and evaluate the effectiveness/outcomes of the intervention.

Both AHCCCS and Cenpatico IC’s evaluation of findings and interventions must include a review of the impact to service utilization, quality, and outcome.

Both AHCCCS and Cenpatico IC’s intervention strategies are to address both over and under-utilization of services and must be integrated throughout the organization. All strategies must have measurable outcomes and must be reported in MM/UM minutes. Cenpatico IC must also incorporate its evaluation of over and under-utilization into its annual Medical Management Plan and summarize action taken to correct areas of concern.

Minimum Required Utilization Data Elements include, but are not limited to:
• Over- and Under-utilization of services and costs;
• Avoidable hospital admissions and readmissions, and average length of stay for all psychiatric inpatient stays;
• Follow-up after discharge;
• Court-ordered treatment;
• Emergency Department utilization and crisis services;
• Prior Authorization, denials and notices of action;
• Pharmacy Utilization
• Lab and diagnostic utilization
• Medicare Utilization;
• Serious Mental Illness Eligibility Determination; and
• Bed days per 1000 admissions.
Section 11 - TRAINING AND PEER SUPPORT SUPERVISION REQUIREMENTS

11.1 Training Requirements

In order to effectively meet the requirements of AHCCCS, Cenpatico IC is required participate in development, implementation and support of trainings providers to verify appropriate training, education, technical assistance and workforce development opportunities. Specifically to:

- Promote a consistent practice philosophy; provide voice and empowerment to staff and Members;
- Verify a qualified, knowledgeable and culturally competent workforce;
- Provide timely information regarding initiatives and Evidenced Based Practices; and
- Verify that services are delivered in a manner that results in achievement of the Arizona System Principles, which include the 9 Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems and Arizona Children’s Vision and Principles.

The intent of this section is to provide information to providers regarding the scope of required training topics, how training needs are identified for providers and how providers may request specific technical assistance from Cenpatico IC.

11.1.1 To Whom This Applies

This section applies to Cenpatico IC and its providers delivering covered services within the AHCCCS and behavioral health systems.

11.1.2 Additional Information

- AHCCCS monitors Cenpatico IC to verify providers receive all required training;
- AHCCCS requires Cenpatico IC to consult with providers regarding what training topics are necessary, how training curricula are developed and how training content is presented;
- Information concerning the qualifications required of Cenpatico IC and provider trainers is determined by Cenpatico IC;
- In addition to the required training content areas, Cenpatico IC is required to verify that appropriate training/technical assistance is available to providers when deficiencies are identified;
- Providers involved in ordering, providing, monitoring or evaluating seclusion or restraint must complete and document education and training. Education and training must include the following: understanding behavioral and environmental risk factors, nonphysical interventions, the safe use of seclusion or restraint and responding to emergency situations (see Section 9.9 - Seclusion and Restraint Reporting); and
- Family members, peer-run, family-run, and parent-support organizations must be utilized to provide technical assistance, training, coaching and support to peers, family members and youth who assume leadership roles within the behavioral health system (i.e., roles or membership on Boards of Directors and advisory groups which develop and implement programs, policies, and quality management activities). For more
information, see the AHCCCS Office of Individual and Family Affairs.

Cenpatico IC will monitor and implement training activities and requirements outlined in this section and its subsections. In addition, Cenpatico IC will annually evaluate the impact of the training requirements and activities in order to develop a qualified, knowledgeable and culturally competent workforce.

11.1.3 Required Initial Training for Providers

Cenpatico IC and its providers must ensure the following within 90 days of the staff person’s hire date, as relevant to each staff person’s job duties and responsibilities and annually as applicable (see Section 11.1.6 Training Requirements Applicable to Home Care Training to Home Care Client (HCTC) Providers and Section 11.1.7 for Training Requirements Applicable to Community Service Agencies):

11.1.3.1 Basic Core Training (All RBHA/Health Plan and Contracted Provider Staff)

- Annual Fraud, Waste and program abuse recognition and reporting requirements and protocols;
- Managed care concepts, including information on Cenpatico IC and the public health system, including an overview of AHCCCS;
- Cultural competency; including Cultural Competency 101: Embracing Diversity (State curriculum);
- Interpretation and translation services;
- AHCCCS Demographic Data Set, including required timeframes for data submission and valid values; and
- Covered services (including information on how to assist persons in accessing all medically necessary covered services regardless of a person’s behavioral health category assignment or involvement with any one type of service provider);
- Rights and responsibilities of eligible and enrolled Members, including rights for persons with SMI;
- Grievance and Appeal processes (see );
- Customer service;
- Coordination of care requirements with Primary Care Providers (PCPs) (see Section 4.3, Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers);
- Third party liability and coordination of benefits (see Section 8.3, Third Party Liability and Coordination of Benefits);
- Other involved agencies and government entities (see Section 4.4, Coordination of Care with other Governmental Entities);
- Claims/encounters submission process (see Section 8.1 - Submitting Claims and Encounters to Cenpatico IC);
- Confidentiality/Health Information Portability and Accountability Act (HIPAA);
- Sharing of treatment/medical information;
• Overview of Arizona behavioral health system policies and procedures in the Arizona Vision and 12 Principles in the children’s system;
• Overview of Arizona’s behavioral health system policies and procedures in the 9 Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems in the adult system;
• Adult learning methods.
• **Plus Additional Cenpatico Integrated Care Required Trainings:**
  - Ethical Behavior and Boundaries;
  - Annual Cultural Competency training;
  - Destination: Recovery and Wellness training and
  - Managed Care.

11.1.3.2 **Clinical Staff (BHPP, BHT and BHP Must Complete the Basic Core Trainings as Well)**

• Screening for eligibility, enrollment for covered services (when eligible), and referral when indicated;
• Overview of partnership with Department of Economic Services/Rehabilitative Services Administration (DES/RSA);
• Identification and reporting of quality of care concerns and the quality of care concerns investigation process.
• Use of assessment and other screening tools (e.g., substance-related, crisis/risk, developmental, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program etc.), including the Birth-to-Five Assessment depending upon population(s) served;
• Use of effective interview and observational techniques that support engagement and are strengths-based, recovery-oriented, and culturally sensitive;
• Application of diagnostic classification systems and methods depending upon population(s) served;
• Evidenced Based Practices in the treatment and prevention of behavioral health disorders;
• Service planning and implementation which includes family vision and voice, developed in collaborations with the individual/family needs as identified through initial and ongoing assessment practices;
• Overview of Substance Abuse Prevention and Treatment Block Grant (SABG): priority placement criteria, interim service provision, Member wait list reporting, and expenditure restrictions of the SABG in accordance with requirements in Section 3.10 - Special Populations; Section 3.2 – Appointment Standards and Timeliness of Service and; 45 CFR Part 96;
• Providers should receive training on the AHCCCS National Practice Guidelines and Clinical Guidance Documents with required elements before providing services, but must receive training within six months of the staff person’s hire date. (Protocol training is only required if pertinent to populations served);
• Clinical training as it relates to specialty populations including but limited to conditions based on identified need;
• Information regarding the appropriate clinical approaches when delivering services to children in the care and custody of the Arizona Department of Economic Security/Division of Children Youth and Families (ADES/DCYF); and
• Understanding behavioral and environmental risk factors, nonphysical interventions, and the safe use of seclusion or restraint and responding to emergency situations in accordance with Section 9.9 - Seclusion and Restraint Reporting.
• Health record documentation requirements (see Section 9.2 - Medical Record Standards);
• Coordination of service delivery for persons with High Needs (e.g. persons at risk of harm to self and others, court ordered to receive treatment);
• Advance Directives (see Section 9.1 - Advance Directives);
• Identification and reporting of persons in need of Special Assistance for individuals with SMI and verifying involvement of persons providing Special Assistance (see Section 3.11 - Special Assistance for Persons Determined to Have a Serious Mental Illness);
• Providers delivering services through distinct programs (e.g., Assertive Community Treatment teams, Dialectical Behavioral Therapy, Multi-Systemic Therapy, developmental disabilities, trauma, substance abuse, children age birth to five, and Behavioral Health Inpatient Facilities); and
• Member benefit options trainings: such as Medicare Modernization Act (MMA), Department of Economic Security/Rehabilitation Services Administration (DES/RSA) and Substance Abuse Block Grant (SABG).
• Additional Cenpatico IC Required Trainings:
  o Arizona State Hospital (ASH);
  o Cenpatico IC Pharmacy Department;
  o Medical Management Department;
  o Out of Home Placement;
  o Psychopharmacology;
  o Re-engagement;
  o Relapse Prevention for Therapists: Helping Your Client Develop a Prevention and Recovery Plan;
  o Community Resources;
  o Cenpatico IC Community Reentry (CRE) Program;
  o Trauma Informed Care Training; and
  o Coordination of Services for Persons Involved with the Courts and Jail/Detention/Prison Facilities.

Specific situations may necessitate the need for additional trainings. For example, quality improvement initiatives that may require focused training efforts and/or new regulations that impact the public health 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 geographic service area identified needs.
11.1.4 Annual and Ongoing Training Requirements

In addition to training required within the first 90 days of hire, all Cenpatico IC providers are required to undergo and provide ongoing training for the following content areas:

- AHCCCS Demographic Data Set, including required timeframes for data submission, valid values and as changes occur;
- Monthly trainings concerning procedures for submissions of encounters as determined by AHCCCS;
- Annual cultural competency and linguistically appropriate training updates for staff at all levels and across all disciplines respective to underrepresented/underserved populations;
- Identification and reporting of Quality of Care Concerns and the Quality of Care Concerns investigations process;
- Inter-rater reliability:
- American Society of Addition Medicine Patient Placement Criteria (ASAM PPC-2R); and
- Child and Adolescent Service Intensity Instrument (CASII).
- Ticket to Work/Disability Benefits 101;
- Peer, family member, peer-run, family-run and parent-support training and coaching;
- Identification and reporting of persons in need of Special Assistance for individuals who have been determined to have a Serious Mental Illness (SMI) and verifying involvement of persons providing Special Assistance (see Section 3.11 - Special Assistance for Persons With Serious Mental Illness); and
- Workforce Development trainings specific to hiring, support, continuing education and professional development.

Specific situations may necessitate the need for additional trainings. For example, quality improvement initiatives that may require focused training efforts and/or new regulations that impact the public behavioral health 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 geographic service area identified needs.

11.1.5 ADHS Division of Licensing required training

Training must be completed and documented in accordance with requirements and the ADHS Division of Public Health Services, Licensing Services website. Additional Cenpatico IC required trainings include the following:

- State System Principles;
- Health Record Documentation;
- CFT Practice & Clinical Approaches PO-C;
- Client and Enrolled Rights Responsibilities;
- Co-Occurring Disorders;
11.1.6 Required Training Specific To Professional Foster Homes Providing HCTC Services

11.1.6.1 Children

Medicaid reimbursable Home Care Training to Home Care Client (HCTC) services for children are provided in professional foster homes licensed by the Arizona Department of Economic Security/Office of Licensing, Certification and Regulation which must comply with training requirements as listed in A.A.C. R6-5-5850. All agencies that recruit and license professional foster home providers must provide and credibly document the following training to each provider:

- CPR and First Aid Training; and
- 18 hours of pre-service training utilizing the Arizona Home Care Training to Client Service Curriculum.

The provider delivering HCTC services must complete the above training prior to delivering services. In addition, the provider delivering HCTC services for children must complete and credibly document annual training as outlined in AAC R6-5-5850, Special Provisions for a Professional Foster Home.

11.1.6.2 Adults

Medicaid reimbursable HCTC services for adults are provided in Adult Behavioral Therapeutic Homes licensed by ADHS Division of Licensing, and must comply with training requirements as listed in AAC R9-20-1502:

- Protecting the person’s rights;
- Providing services that the Adult Behavioral Therapeutic Home is authorized to provide and the provider delivering HCTC services is qualified to provide;
- Protecting and maintaining the confidentiality of clinical records;
- Recognizing and respecting cultural differences;
- Recognizing, preventing or responding to a situation in which a person:
  - May be a danger to self or a danger to others;
Behaves in an aggressive or destructive manner;
May be experiencing a crisis situation; or
May be experiencing a medical emergency.

- Reading and implementing a person’s treatment plan; and
- Recognizing and responding to a fire, disaster, hazard or medical emergency.

In addition, providers delivering HCTC services to adults must complete and credibly document annual training as required by AAC R9-20-1502.

### 11.1.7 Required Training Specific to 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. A complete description of all required training specific to CSAs is as follows:

- Client rights;
- Providing services in a manner that promotes client dignity, independence, individuality, strengths, privacy and choice;
- Recognizing common symptoms of and differences between a mental disorder, personality disorder, and/or substance abuse;
- Protecting and maintaining confidentiality of client records and information;
- Record keeping and documentation;
- Ethical behavior such as staff and client boundaries and the inappropriateness of receiving gratuities from a client; and
- Recognizing, preventing or responding to a client who may be a danger to self or a danger to others; behave in an aggressive or destructive manner; need crisis services or be experiencing a medical emergency.

- **Additional Cenpatico Integrated Care Required Trainings:**
  - Community Service Agency Training;
  - Customer Relations;
  - Confidentiality Duty to Report-Warn Med Info PO-C;
  - Cenpatico IC Crisis System;
  - Special Assistance (For those who serve the SMI population);
  - Cultural Competency (*Annual Requirement);
  - Fraud and Abuse (*Annual Requirement);
  - Limited English Proficiency; and
  - Welcome to the Relias Learning Management System (RLMS).

### 11.1.8 Training Expectations for AHCCCS Clinical and Recovery Practice Protocols

Under the direction of AHCCCS Chief Medical Officer, the Department publishes national practice guidelines and clinical guidance documents to assist providers. These documents, some with required elements can be accessed at [https://www.azahcccs.gov/PlansProviders/Guides ManualsPolicies/guidesandmanuals.html](https://www.azahcccs.gov/PlansProviders/GuidesManualsPolicies/guidesandmanuals.html)
Providers providing services to children and families involved with Department of Child Safety (DCS) will be required to attend “Unique Needs of Children Involved with DCS” training that is offered by Cenpatico IC on a regular basis. (See AHCCCS Practice Protocol, The Unique Behavioral Health Service Needs to Children, Youth, and families Involved with CPS https://www.azahcccs.gov/PlansProviders/GuidesManualsPolicies/guidesandmanuals.html

Training on Child and Family Team (CFT) practice can be differentiated based on the role (BHMP, BHT, Coaches, Family Support Partners, Supervisors, etc.) of training participation provided in CFT Practice. Curriculums and certification processes shall be approved by Cenpatico IC and AHCCCS.


11.1.8.1 De-escalation Training

Providers must verify that all Direct Care Staff are appropriately trained in De-escalation Training within 90 days of employment.

11.1.9 Training Requests

For additional training requests and/or technical assistance specific to the trainings listed above and/or identified area of need, contact Cenpatico IC.

11.1.10 Workforce Development

11.1.10.1 Training Expert

Cenpatico IC will employ a training expert/contact as key personnel and point of contact to implement and oversee compliance with the training requirements and training plan, and to participate in the Training Coordinators committees.

11.1.10.2 Training Development Plan

Cenpatico IC will develop, implement and submit an Annual Training Plan that provides information and documentation of all trainings.

11.1.10.3 Training Quarterly Updates

Cenpatico IC will submit a Workforce Development Quarterly Update, which includes information specific to initiatives and activities specific to training. Quarterly updates will be submitted 30 days after quarter end.

11.1.10.4 State Ownership of Any Intellectual Property

This policy will serve as the 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:
Those cases in which the production of such materials is part of sponsored programs;
Those cases in which substantial University resources were used in creating educational materials; and
Those cases which are specifically commissioned by contacted vendors or done as part of an explicitly designated assignment other than normal contactor educational pursuits.

11.2 Peer Support/Recovery Support Training, Certification and Supervision Requirements

The State has developed training requirements and certification standards for Peer Support Specialists/Recovery Support Specialists providing Peer Support Services, as described in the AHCCCS Covered Behavioral Health Services Guide. Peers serve an important role as providers, and AHCCCS and Cenpatico-IC expects consistency and quality in peer-delivered services and support for peer-delivered services statewide.

11.2.1 To Whom This Applies

All providers delivering training services for certification of individuals as Peer Support Specialists/Recovery Support Specialists within the AHCCCS public behavioral health system.

11.2.2 Additional Information

People who have achieved and sustained recovery can be a powerful influence for individuals seeking their own path to recovery (see Center for Mental Health Services (MHBG) Consumer Affairs E-News October 2, 2007, Vol. 07-158). By sharing personal experiences, peers help build a sense of self-worth, community connectedness, and an improved quality of life.

Peer services are supported on a statewide and national level. The Centers for Medicare and Medicaid Services (CMS) issued a letter to states recognizing the importance of peer support services as a viable component in the treatment of mental health and substance abuse issues. In the letter, CMS provides guidance to states for establishing criteria for peer support services, including supervision, care-coordination and training/credentialing (see SMDL #07-011 for a full copy of the letter).

11.2.3 Peer Support Specialist/Recovery Support Specialist Qualifications

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

- Self-identify as a peer; and

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6 Peer Support Services are also billed by family members who provide services in the public behavioral health system (see Section 4.5 - Partnerships with Families and Family-Run Organizations in the Children’s Behavioral Health System for additional information). Training and certification requirements described in this policy, however, are specific to peers, as defined in this policy.
• 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/Office of Individual and Family Affairs (OIFA) approved Peer Support Employment Training Program. AHCCCS/OIFA will oversee the approval of all certification materials including curriculum and testing tools. Certification through AHCCCS/OIFA approved Peer Support Employment Training Program is applicable statewide.

Some agencies may wish to employ individuals prior to the completion of certification through a Peer Support Employment Training Program. However, required trainings must be completed prior to delivering services (see Section 11.2.6, Title). An individual must be certified as a Peer Support Specialist/Recovery Support Specialist or currently enrolled in a AHCCCS/OIFA-approved Peer Support Training Program under the supervision of a qualified individual (see Section 11.2.7, Title) prior to billing Peer Support Services.

11.2.4 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 Section 11.2.6.

Approval of curriculum is binding for no longer than three years. Three years after initial approval and thereafter, the program must resubmit its curriculum for review and re-approval. If a program makes substantial changes (meaning change to content, classroom time, etc.) to its curriculum or if there is an addition to required elements (see Section 11.2.6.) during this three-year period, the program must submit the updated curriculum to AHCCCS/OIFA for review and approval.

AHCCCS/OIFA will base approval of the curriculum, competency exam and exam-scoring methodology only on the elements included in AHCCCS Policy 961. 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 certification based on the additional elements or standards.

11.2.5 Competency Exam

Individuals seeking certification and employment as a Peer Support Specialist/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 Section 11.2.6. Individuals certified in another state may obtain certification after passing a competency exam. If an individual does not pass the competency exam, the Peer Support Employment Training Program
may require the individual to repeat or complete additional training prior to taking the competency exam again.

11.2.6 Peer Support Employment Training Curriculum Standards

A Peer Support Employment Training Program curriculum must include, at a minimum, the following core elements:

- **Concepts of Hope and Recovery:**
  - Instilling the belief that recovery is real and possible;
  - 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;
  - Knowing and sharing one’s story of a recovery journey and how one’s story can assist others in many ways;
  - Mind-Body-Spirit connection and holistic approach to recovery; and
  - Overview of the Individual Service Plan (ISP) and its purpose.

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

- **Psychiatric Rehabilitation Skills and Service Delivery:**
  - Strengths based approach; identifying one’s own strengths and helping others identify theirs; building resilience;
  - Distinguishing between sympathy and empathy; emotional intelligence;
  - Understanding learned helplessness; what it is, how it is taught and how to assist others in overcoming its effects;
  - Introduction to motivational interviewing; communication skills and active listening;
  - Healing relationships – building trust and creating mutual responsibility;
  - Combating negative self-talk; noticing patterns and replacing negative statements about one’s self, using mindfulness to gain self-confidence and relieve stress;
  - Group facilitation skills; and
  - Introduction to Culturally & Linguistically Appropriate Services (CLAS) Standards; creating a safe and supportive environment.
• **Professional Responsibilities of the Peer Support Employee and Self Care in the Workplace:**
  
  o Qualified individuals must receive training on the following elements prior to delivering any covered services:
    
    ▪ Professional boundaries & ethics - the varied roles of the helping professional; Collaborative supervision and the unique features of the Peer Support Specialist/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 signs and experiences of mental illness, substance abuse, addiction and trauma; orientation to commonly used medications and potential side effects;
    
    ▪ Guidance on proper service documentation; billing and using recovery language throughout documentation; and
    
    ▪ 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.

Some curriculum elements include concepts included in required training, as described in **Section 11.1, Training Requirements.** Peer Support Employment Training Programs must not duplicate training required of individuals for employment with a licensed agency or Community Service Agency (CSA). Training elements in this section must be specific to the Peer Support Specialist/Recovery Support Specialist’s role in the public behavioral health system and instructional for peer support interactions. See **Provider Manual Attachment 11.2.1 Suggested Curriculum Development References** for additional information.

Supervision is intended to provide support to Peer Support Specialists/Recovery Support Specialists in meeting treatment needs of Members 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 provide supervision by individuals qualified as Behavioral Health Technicians or Behavioral Health Professionals. Supervision must be appropriate to the services being delivered and the Peer Support Specialist/Recovery Support Specialist’s qualifications as a Behavioral Health Technician,

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7 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.
Behavioral Health Professional or Behavioral Health Paraprofessional. Supervision must be documented and inclusive of both clinical and administrative supervision.

Individuals providing supervision must receive training and guidance to ensure current knowledge of Evidenced Based Practices in providing supervision to Peer Support Specialist/Recovery Support Specialists. (For more information, see AHCCCS Practice Protocol, Clinical Supervision.)

11.2.7 Process for Submitting Evidence of Certification

Agencies employing Peer Support Specialists/Recovery Support Specialists who are providing peer support services are responsible for keeping records of required qualifications and certification. Cenpatico IC must ensure that Peer Support Specialists/Recovery Support Specialists meet qualifications and have certification, as described in this policy.

11.3 Parent/Family Support Training, Certification and Supervision Requirements

AHCCCS/OIFA has developed training requirements and certification standards for Family Support roles providing Family Support Services, as described in the AHCCCS Covered Behavioral Health Services Guide. AHCCCS and Cenpatico IC recognizes the importance of the Certified Family Support role as a viable component in the delivery of integrated services and expects statewide support for these roles. AHCCCS and Cenpatico IC expect consistency and quality in parent/family delivered support of integrated services in both the Children’s and Adult Systems statewide.

11.3.1 To Whom This Applies

All providers delivering training services for certification of individuals as Parent/Family Support Specialists with the AHCCCS public behavioral health system.

11.3.2 Parent/Family Support Provider and Trainer Qualifications

11.3.2.1 Children’s System

Individuals seeking certification and employment as a Parent/Family Support Provider or Trainer 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.

11.3.2.2 Adult System

Individuals seeking certification 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 Specialist by completing training and passing a competency test through an AHCCCS/OIFA approved Parent/Family Support Training Program. AHCCCS/OIFA will oversee the approval of all certification materials including curriculum and testing tools. Certification through AHCCCS/OIFA approved Parent/Family Support Employment Training Program is applicable statewide.

11.3.3 Parent/Family Support Provider Training Program Approval Process

- A Parent/Family Support Provider Training Program must submit their program curriculum, competency exam, and exam-scoring methodology (including an explanation of accommodations or alternative formats of program materials available to individuals who have special needs) to AHCCCS/OIFA. AHCCCS/OIFA will issue feedback or approval of the curriculum, competency exam, and exam-scoring methodology in accordance with 11.3.5 below.

- 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 11.3.4) during this three-year period, the program must submit the updated content to AHCCCS/OIFA for review and approval no less than 60 days before the changed or updated curriculum is to be utilized.

- AHCCCS/OIFA will base approval of the curriculum, competency exam, and exam-scoring methodology only on the elements included in this policy. If a Parent/Family Support Provider Training Program requires regional or culturally specific training exclusive to a GSA or specific population, the specific training cannot prevent employment or transfer of family support certification based on the additional elements or standards.

11.3.4 Competency Exam

- Individuals seeking certification and employment as a Parent/Family Support Provider must complete and pass a competency exam with a minimum score of 80% upon completion of required training. Each Parent/Family Support Provider Training Program has the authority to develop a unique competency exam. However, all exams must include questions related to each of the curriculum core elements listed in subsection 11.3.5. Agencies employing Parent/Family Support Providers who are providing family support services are required to ensure that their employees are competently trained to work with their population.

- Individuals certified or credentialed in another state must submit their credential to AHCCCS/OIFA. The individual must demonstrate their state’s credentialing standards meet those of AHCCCS prior to recognition of their credential. If that individual’s credential/certification doesn’t meet Arizona’s standard the individual may obtain certification after passing a competency exam. If an individual does not pass the competency exam, the Parent/Family Support Provider Training Program shall require that the individual complete additional training prior to taking the competency exam again.

11.3.5 Parent/Family Support Provider Training Curriculum Standards

A Parent/Family Support Provider Employment Training Program curriculum must include 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,
  - Rights of the caregiver/enrolled member
  - 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.

- **Building Collaborative Partnerships and Relationships:**
  - Engagement; Identifies and utilizes strengths;
  - Utilize and model conflict resolution skills, and problem solving skills,
  - Understanding individual and family 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;

- **Empowerment:**
  - Empower family members and other supports to identify their needs, and promote self-reliance,
  - Identify and understand stages of change and
  - Be able to identify unmet needs.

- **Wellness:**
  - Understanding the stages of grief and loss; and
  - Understanding self-care and stress management;
  - Understanding compassion fatigue, burnout, and trauma;
  - Resiliency and recovery;
  - Healthy personal and professional boundaries.

Some curriculum elements may include concepts that are part of AHCCCS required training, as described in AHCCCS AMPM Policy 1060 and the Behavioral Health Practice Tool on Unique Needs of Children, Youth and Families Involved with DCS. Credentialed Parent/Family Support Provider training programs must not duplicate training required
of individuals for employment with a licensed agency or Community Service Agency (CSA). Training elements in this section must be specific to the Family Support role in the public behavioral health system and instructional for family support interactions. See Provider Manual Attachment 11.3.1 Suggested Parent/Family Support Curriculum Development References for additional information.

11.3.6 Supervision of Certified Parent/Family Support Providers

Agencies employing Parent/Family Support Providers must provide supervision by individuals qualified as Behavioral Health Technicians or Behavioral Health Professionals. Supervision must be appropriate to the services being delivered and the qualifications of the Parent/Family Support Provider as a Behavioral Health Technician, Behavioral Health Professional, or Behavioral Health Paraprofessional. Supervision must be documented and inclusive of both clinical and administrative supervision. Individuals providing supervision must receive training and guidance to ensure current knowledge of best practices in providing supervision to Parent/Family Support Providers. (For more information, see AHCCCS Practice Protocol, Clinical Supervision.)

11.3.7 Process of Certification

Agencies employing Certified Parent/Family Support Providers who are providing family support services are responsible for keeping records of required qualifications and certification.
Section 12 - COMPLIANCE

12.1  Member Rights

The following are member rights in accordance with 42 CFR Section 438.100:

- Be treated with respect and with recognition of the member’s dignity and need for privacy. (42 CFR 438.100(b)(2)(ii));
- The right to privacy includes protection of any information that identifies a particular member except when otherwise required or permitted by law.
- Cenpatico IC and its providers must ensure the confidentiality of health, service and medical records and of other member information. (Refer to the Medical Records Requirements included in Policy 940 of the AHCCCS AMPM Chapter 900.)
- Receive information such as all enrollment notices, informational materials, and instructional materials in a manner and format that may be easily understood. (42 CFR 438.10);
- Notified that oral interpretation is available for any language and written information is available in prevalent languages and alternate formats and how to access those services. (42 CFR 438.10);
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member’s condition and ability to understand (42 CFR 438.100(b)(2)(iii));
- Participate in decisions regarding his or her health care, including the right to refuse treatment (42 CFR 438.100(b)(2)(iv));
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation (42 CFR 438.100(b)(2)(v));
- Request and receive a copy of his or her medical records, and to request that the record be amended or corrected, as specified in 45 CFR part 164 and applicable state law (42 CFR 438.100(b)(2)(vi)); and
- Exercise his or her rights and that the exercise of those rights shall not adversely affect service delivery to the Member (42 CFR 438.100(c)).

Cenpatico IC recognizes the member rights and responsibilities as set forth in the AHCCCS AMPM Chapter 900 - Policy 930. The expectation is that all providers are informed and have implemented processes to ensure that all elements described in Policy 930 are integral part of their operation.

12.2  Verification of U.S. Citizenship or Lawful Presence for Public Behavioral Health Benefits

In the State of Arizona, verification of United States (U.S.) Citizenship or Lawful Presence of non-citizens is mandatory prior to a person being able to receive public health benefits (A.R.S. § 1-502). In addition to citizenship/lawful presence, the Arizona Health Care Cost Containment System, (AHCCCS) requires verification of a person’s identification in order to determine
eligibility. A person who has verified both citizenship/lawful presence and identification and has been found eligible for AHCCCS may:

- Be eligible for Title XIX/XXI (Medicaid) or Title XXI (KidsCare) covered services; or
- Not qualify for Title XIX/XXI entitlements, but be eligible for services.

Cenpatico IC and its providers must verify U.S. citizenship or lawful presence in the U.S. of all persons applying for publicly funded services.

12.2.1 Eligibility to Receive Public Services with Verification Of U.S. Citizenship/Lawful Presence

The following individuals are eligible for public services:

- Persons determined to be eligible for AHCCCS; and
- Persons not eligible for AHCCCS but with SMI AND who can provide documentation of citizenship/lawful presence (see Provider Manual Attachment 12.2.1, Documents Accepted by AHCCCS to Verify Citizenship).

12.2.2 Eligibility to Receive Public Services Without Verification

Persons not eligible for AHCCCS and NOT with SMI, but who qualify to receive behavioral health services funded through the Substance Abuse Block Grant (SABG) or the Projects for Assistance in Transition from Homelessness (PATH) Program are eligible to receive services in accordance with Section 3.10 - Special Populations. However, persons receiving services funded by SABG or PATH must still be screened for AHCCCS eligibility in accordance with Section 3.1 - Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage and the Limited Income Subsidy Program.

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

12.2.3 Completing an AHCCCS Eligibility Determination Screening as Part of the Verification Process

If a person is currently enrolled with AHCCCS and has been assigned to a T/RBHA/Health Plan, verification of citizenship/lawful presence has already been completed.

For an illustration on how the verification process works, see Provider Manual Attachment 12.2.2, Citizenship/Lawful Presence Verification Process Through Health-e-Arizona PLUS.

For a list of those persons who are exempt from citizenship verification, see Provider Manual Attachment 12.2.3, Persons Who Are Exempt from Verification of Citizenship during the Prescreening and Application Process.

Providers must complete an eligibility determination screening for all persons who are not identified as being currently enrolled with AHCCCS using the subscriber version of the Health-e-Arizona PLUS online application. An eligibility screening will be conducted:

- Upon initial request for services;
• At least annually thereafter, if still receiving services; and
• When significant changes occur in the person’s financial status.

12.2.3.1 What Is the Process for Completing the Eligibility Screening Using Health-E-Arizona PLUS?

Cenpatico IC or its provider meet with the person and complete the Health-e- Arizona PLUS online application. Once the online application screening has been completed, the Health-e-Arizona PLUS online application tool will indicate:

• If the person is potentially AHCCCS eligible, Cenpatico IC or its provider must obtain from the applicant:
  o Documentation of identification and U.S. Citizenship needed if the person claims to be a U.S. citizen (see Provider Manual Attachment 12.2.1, Documents Accepted by AHCCCS To Verify Citizenship and Identity); or
  o Documentation needed of identification and lawful presence in the U.S. if the applicant states that he/she is not a U.S. citizen (see Provider Manual Attachment 12.2.4, Non-Citizen/Lawful Presence Verification Documents).

• The required U.S. citizenship/lawful presence documents are considered “permanent documents”. Permanent documents include proof of age, Social Security Number, U.S. citizenship or immigration status. These are eligibility factors that typically do not change and only need to be verified once, and

• When providers use the online Member verification system and enter a Member’s social security number, the Member’s photo, if available from the Arizona Department of Motor Vehicles (MVD), will be displayed on the AHCCCS eligibility verification screen along with other AHCCCS coverage information. The added photo image assists providers to quickly validate the identity of a Member.

If the Health-e-Arizona PLUS online screening tool indicates that the person may not be eligible for AHCCCS, the person may:

• Choose to continue with the AHCCCS eligibility application, in which case the provider must assist the person in completing the application process and obtain the required identification and citizenship/lawful presence documents as indicated above or those required for Non-Title XIX/XXI Eligible individuals as outlined in Provider Manual Attachment 12.2.1 Documents Accepted by AHCCCS to Verify Citizenship and Identity); or

• Decide to not continue with the online application process. The provider will need to determine if the person is eligible for services as described in ADHS Policy 110 Special Populations. The provider must continue to work with the person to obtain the required citizenship/lawful presence documents whenever possible for future eligibility status need.

12.2.3.2 Inability to Provide the Required Identification or Citizenship/Lawful Presence Documents at the Time of Application

To the extent that it is practicable, Cenpatico IC or its providers are expected to assist applicants in obtaining required documentation of identification and citizenship/lawful presence within the
timeframes indicated by Health-e-Arizona PLUS (30 days from date of application submission unless otherwise stated).

Persons who are unable to provide required documentation of citizenship or lawful presence are not eligible for publicly funded services unless they meet the criteria outlined in this section. If the person obtains the required documentation at a later date he/she may reapply for AHCCCS eligibility using Health-e-Arizona PLUS (and submit all required documentation with the reapplication, with no waiting period).

Pending the outcome of the AHCCCS eligibility determination, a person may be provided services in accordance with Section 3.10 - Special Populations.

12.2.4 Documentation Requirements

Documentation of screening a Member through Health-e-Arizona PLUS must be included in medical record, including the Application Summary and final Determination of eligibility status notification printed from the Health-e-Arizona PLUS website.

If a person has refused to participate in the screening process, the documented refusal to participate in the screening and/or application process must be maintained in accordance with Section 3.1 - Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage and the Limited Income Subsidy Program.

The State and/or Cenpatico IC may conduct unscheduled, periodic process and documentation audits to ensure that Cenpatico IC and/or its providers are in compliance with this section. Cenpatico IC may enforce all available contract remedies against a provider, up to and including termination for failure to comply with this section.

12.3 Reporting Discovered Violations of Immigration Status

Employees of Cenpatico IC and its providers are considered agents of the State, and therefore, must report discovered violations of immigration status to AHCCCS, which is responsible for submitting the reports to the U.S. Immigration and Customs Enforcement (ICE) agency. Failure to report a discovered violation is a Class 2 Misdemeanor.

12.3.1 Identification of Violations

Cenpatico IC and its providers must refrain from conduct or actions that could be considered discriminatory behavior. It is unlawful and discriminatory to deny persons services, exclude persons from participation in those services, or otherwise discriminate against any person based on grounds of race, color or national origin.

Cenpatico IC and its providers must not use any information obtained about a person’s citizenship or lawful presence for any purpose other than to provide a person with services. Factors that must NOT be considered when identifying a potential violation:

- The person’s primary language is a language other than English;
- The person was not born in the United States;
- The person does not have a Social Security number;
• The person has a “foreign sounding” name;
• The person cannot provide documentation of citizenship or lawful presence;
• The person is identified by others as a non-citizen; and
• The person has been denied AHCCCS eligibility for lack of proof of citizenship or lawful presence.

If a person applying for services, in the course of completing the application process or while conducting business with Cenpatico IC or a Cenpatico IC provider, voluntarily reveals that he or she is not lawfully present in the United States then and only then may Cenpatico IC or its providers consider it to be a reportable violation.

Cenpatico IC and its providers must not require documentation of citizenship or lawful presence from persons who are not personally applying for services, but who are acting on behalf of or assisting the applicant (for example, a parent applying on behalf of a child).

It is not the responsibility of Cenpatico IC or its providers to ensure the validity of the submitted documents. Documents must be copied for files and submitted, as requested, to the appropriate agency, as instructed through Health-e-Arizona PLUS (see Section 12.2 - Verification of U.S. Citizenship or Lawful Presence for Public Behavioral Health Benefits).

The criteria for screening and applying for AHCCCS eligibility are not changed by these reporting requirements. Further, the documentation requirements for verifying or establishing citizenship or lawful presence are not changed by this process (see Section 12.2 - Verification of U.S. Citizenship or Lawful Presence for Public Behavioral Health Benefits).

Cenpatico IC and its providers must follow the expectations outlined in this policy when identifying and reporting violations. Questions regarding reporting requirements may be submitted via email to the AHCCCS Corporate Compliance Officer at reportfraud@azdhs.gov.

### 12.3.2 Reporting Process

Cenpatico IC or a provider that identifies a violation must submit a report to AHCCCS via secure email to AHCCCS Corporate Compliance at reportfraud@azdhs.gov that contains the following information:

• First and last name of identified individual;
• Residential address/street, address of identified individual, including city, state, and zip code; and
• Reason for referral.

### 12.3.3 Documentation Expectations

Cenpatico IC or its providers must document in the person’s medical record (if a provider) or in the Corporate Compliance Office (Cenpatico IC) the following:

• Reason for making a report, including how the information was obtained and whether it was an oral or written declaration;
• The date the report was submitted to AHCCCS;
• Any actions taken as a result of the report; and
• A copy of the email to AHCCCS that contains the report.

12.4 Duty to Report Abuse, Neglect or Exploitation

Any employee of Cenpatico IC or its providers who has been informed of, or has a reasonable basis to believe that abuse, neglect, exploitation, injuries, and unexpected death of an incapacitated or vulnerable adult or minor child has occurred shall immediately report the incident to a peace officer, the Department of Economic Security/ Adult Protective Services (DES/APS) or the Department of Economic Security/Division of Youth and Families/Department of Child Safety (DES/DCYF/DCS) worker as appropriate, as well as to Cenpatico IC. Cenpatico IC will then report it to AHCCCS Quality Management.

12.4.1 Duty to Report Abuse, Neglect or Exploitation of a Vulnerable Adult

Providers responsible for the care of adults, including incapacitated or vulnerable adults, and who have a reasonable basis to believe that abuse or neglect of the adult has occurred or that exploitation of the adult's property has occurred shall report this information immediately either in person or by telephone. This report shall be made to a peace officer or to a protective services worker within APS. Information on how to contact APS to make a report is located by going to the webpage for the APS Central Intake Unit. A written report must also be mailed or delivered within forty-eight hours or on the next working day if the forty-eight hours expire on a weekend or holiday. The report shall contain:

• The names and addresses of the adult and any persons who have control or custody of the adult, if known;
• The adult's age and the nature and extent of his/her incapacity or vulnerability;
• The nature and extent of the adult's injuries or physical neglect or of the exploitation of the adult's property; and
• Any other information that the person reporting believes might be helpful in establishing the cause of the adult's injuries or physical neglect or of the exploitation of the adult's property.

Upon written and signed request for records from the investigating peace officer or APS worker, the person who has custody or control of medical or financial records of the incapacitated or vulnerable adult for whom a report is required shall make such records, or a copy of such records, available (see Section 4.1, Disclosure of Health Information). Records disclosed are confidential and may be used only in a judicial or administrative proceeding or investigation resulting from the report. If psychiatric records are requested, the custodian of the records shall notify the attending psychiatrist, who may remove the following information from the records before they are made available:

• Personal information about individuals other than the patient; and
• Information regarding specific diagnoses or treatment of a psychiatric condition, if the attending psychiatrist certifies in writing that release of the information would be detrimental to the patient's health or treatment.
If any portion of a psychiatric record is removed, a court, upon request of a peace officer or APS worker, may order that the entire record or any portion of such record containing information relevant to the reported abuse or neglect be made available to the peace officer or APS worker investigating the abuse or neglect.

Additionally, providers must report to Cenpatico IC healthcare acquired conditions, abuse, neglect, exploitation, injuries, high profile cases and unexpected death of adults as required under Section 9.10 - Reporting of Incidents, Accidents, and Death.

12.4.2 Duty to Report Abuse, Neglect, Exploitation, Injuries, Denial or Deprivation of Medical or Surgical Care or Nourishment, and Unexpected Death of a Minor

Any provider who reasonably believes that any of the following incidents has occurred shall immediately report this information to a peace officer or to a Department of Child Safety (DCS) worker by calling the Arizona Child Abuse Hotline, and must also notify Cenpatico IC of:

- Any physical injury, abuse, reportable offense or neglect involving a minor that cannot be identified as accidental by the available medical history; or
- A denial or deprivation of necessary medical treatment, surgical care or nourishment with the intent to cause or allow the death of an infant.

In the event that a report concerns a person who does not have care, custody or control of the minor, the report shall be made to a peace officer only. Reports shall be made immediately by telephone or in person and shall be followed by a same-day progress note in the Member’s Health Record. The report shall contain:

- The names and addresses of the minor and the minor’s parents or the person(s) having custody of the minor, if known;
- The minor’s age and the nature and extent of the minor’s abuse, physical injury or neglect, including any evidence of previous abuse, physical injury or neglect; and
- Any other information that the person believes might be helpful in establishing the cause of the abuse, physical injury or neglect.

If a physician, psychologist, or behavioral health professional receives a statement from a person other than a parent, stepparent, or guardian of the minor during the course of providing sex offender treatment that is not court ordered or that does not occur while the offender is incarcerated in the State Department of Corrections or the Department of Juvenile Corrections, the physician, psychologist, or behavioral health professional may withhold the reporting of that statement if the physician, psychologist, or behavioral health professional determines it is reasonable and necessary to accomplish the purposes of the treatment.

Upon written request by the investigating peace officer or DCS worker, the person who has custody or control of medical records of a minor for whom a report is required shall make the records, or a copy of the records, available (see Section 12.6.1 - Disclosure of Health Information). Records are confidential and may be used only in a judicial or administrative proceeding or investigation resulting from the required report. If psychiatric records are requested, the custodian of the records shall notify the attending psychiatrist, who may remove the following information before the records are made available:

- Personal information about individuals other than the patient; and
• Information regarding specific diagnoses or treatment of a psychiatric condition, if the attending psychiatrist certifies in writing that release of the information would be detrimental to the patient’s health or treatment.

If any portion of a psychiatric record is removed, a court, upon request by a peace officer or DCS worker, may order that the entire record or any portion of the record that contains information relevant to the reported abuse, physical injury or neglect be made available for purposes of investigation.

Additionally, providers must report to Cenpatico IC healthcare acquired conditions, abuse, neglect, exploitation, injuries, high profile cases, denial or deprivation of medical or surgical care or nourishment, and unexpected death of minors as required under Section 9.10 - Reporting of Incidents, Accidents, and Death.

12.5 Duty to Warn

Any mental health provider employed or subcontracted by Cenpatico IC or a provider of a mental health provider that has determined that a patient poses a serious danger of violence to others shall take reasonable actions to protect the potential victim(s) of that danger.

12.5.1 To Whom This Applies

This applies to all Cenpatico IC providers, and any provider of a provider in Arizona’s public behavioral health system.

12.5.2 Duty to Protect Potential Victims of Physical Harm

All mental health providers employed or subcontracted by Cenpatico IC, or providers of mental health providers have a duty to protect others against the violent conduct of a patient under certain circumstances. When a mental health provider employed or subcontracted by Cenpatico IC or a provider of a mental health provider determines, or under applicable professional standards, reasonably should have determined that a patient poses a serious danger to others, he/she bears a duty to exercise care to protect the foreseeable victim of that danger. The foreseeable victim need not be specifically identified by the patient, but may be someone who would be the most likely victim of the patient’s violent conduct.

While the discharge of this duty may take various forms, mental health providers employed or subcontracted by Cenpatico IC or a provider of a mental health provider need only exercise that reasonable degree of skill, knowledge and care ordinarily possessed and exercised by Members of that professional specialty under similar circumstances. Any duty owed by a mental health provider employed or subcontracted by Cenpatico IC or a provider of a mental health provider to take reasonable precautions to prevent harm threatened by a patient can be discharged by any of the following, depending upon the circumstances:

• Communicating, when possible, the threat to all identifiable victims;
• Notifying a law enforcement agency in the vicinity where the patient or any potential victim resides;
• Taking reasonable steps to initiate proceedings for voluntary or involuntary hospitalization, if appropriate, and in accordance with Section 3.9 - Pre-petition Screening, Court Ordered Evaluation and Court Ordered Treatment; or
• Taking any other precautions that a reasonable and prudent mental health provider would take under the circumstances.

Cenpatico IC contracted providers are required to immediately notify by telephone the Cenpatico IC crisis line provider (The Crisis Call Center) when a patient is identified as a potential danger to self or others, and update The Crisis Call Center as appropriate based on the level of risk to the Member and the community. Providers are required to report to The Crisis Call Center all relevant information; including, information about the person’s access to weapons, names and addresses of potential victims, attempts to protect victims, police involvement, relevant clinical information and support system information.

12.6 Confidentiality

12.6.1 Disclosure of Health Information

This section is intended to provide guidance to protect the privacy of persons who receive services, guidance as to whom information can be disclosed and when authorization\(^8\) is required prior to that disclosure, and guidance on the notification of those persons in the event their unsecured Protected Health Information (PHI) is breached. It is not all-inclusive of the HIPAA and State Laws; the references throughout are available for providers to access and examine the applicable laws for more detail.

Information and records obtained in the course of providing or paying for services to a person are confidential and are only disclosed according to the provisions of applicable federal and State law. In the event of an unauthorized use/disclosure of unsecured PHI, Cenpatico IC’s providers must notify all affected persons.

12.6.2 Overview of Confidentiality Information

Cenpatico IC and its providers must keep medical records, payment records, behavioral health records and all information contained in those records, and any other personal health and enrollment information that may identify a particular Member or subset of Members confidential and cannot disclose such information unless permitted or required by federal or State law. Providers must verify that all emails being sent by the provider with Protected Health Information ("PHI") are sent using a secure email program and must use an individualized secure business domain email, and not use public email entities (such as Google or Yahoo) to conduct business and transmit PHI.

The law regulates two major categories of confidential information:

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\(^8\) For purposes of uniformity and clarity, the term “authorization” is used throughout this section to reference a person’s permission to disclose medical records and protected health information and has the same meaning as “consent” which is used in 42 C.F.R. Part 2.
• Information obtained when providing 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.

Cenpatico IC also requires its providers to have policies and procedures in place to protect the privacy of individuals verified to be in the Address Confidentiality Program. See 41 A.R.S. § 161 et seq.

12.6.2.1 Health Information Not Related to Alcohol and Drug Treatment

Information obtained when providing 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, health care provider, or 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 State law or State law may preempt the HIPAA Rule. HIPAA, when read together with State law, may impose additional requirements for disclosure. 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. See Section 12.6.4 below for more detail regarding the disclosure of health information not related to alcohol or drug referral, diagnosis or treatment.

12.6.2.2 Drug and Alcohol Abuse Information

Information regarding treatment for alcohol or drug abuse is afforded special confidentiality by federal statute and regulation (42 U.S.C. § 290 dd-3, 290 ee-3, 42 C.F.R. Part 2). 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. See Section 12.6.5 below for more detail regarding the disclosure of drug and alcohol abuse information.

12.6.3 General Procedures for All Disclosures

Unless otherwise accepted by State or federal law, all information obtained about a person related to the provision of services to the person is confidential whether the information is in oral, written, or electronic format.

All records generated as a part of the State or Cenpatico IC grievance and appeal processes are legal records, not medical or payment records, although they may contain copies of portions of a person’s medical record. To the extent these legal records contain personal medical
information, the State or Cenpatico IC will redact or de-identify the information to the extent allowed or required by law.

### 12.6.3.1 List of Persons Accessing Records

Cenpatico IC’s providers must verify that a list is kept 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.

### 12.6.3.2 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 authorization from the enrolled person as prescribed in Section 12.6.5 below. Information not related to drug and alcohol treatment may be disclosed without patient authorization to Members of a clinical team who are providers of health, mental health or social services, provided the information is for treatment purposes as defined in the HIPAA Rule. Disclosure to Members of a clinical team who are not providers of health, mental health or social services requires the authorization of the person or the person’s legal guardian or parent as prescribed in Section 12.6.4 below.

### 12.6.3.3 Disclosure to Persons Involved 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 the disclosure.

### 12.6.4 Disclosure of Information Not Related to Alcohol and Drug Treatment

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. 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 160 and 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 State or federal 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, if the activity is conducted pursuant to applicable federal or State laws and regulations governing research;
• 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 health care 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 the payer’s contractor to obtain reimbursement;
• To a private entity that accredits a health care provider;
• To the legal representative of a health care 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 CFR Part 2);
• To a person or entity to conduct utilization review, peer review and quality assurance pursuant to A.R.S. §§ 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.
12.6.4.1 Disclosure to an Individual

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 (See A.R.S. § 36-507(3); 45 CFR § 164.524; A covered entity should read and carefully apply the provisions in 45 CFR §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. See 45 CFR § 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. See 45 CFR § 164.524(a)(2); ARS § 12-2293. 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. See 45 CFR § 164.524(a)(3). A covered entity must follow certain requirements for a review when access to the medical record is denied. See 45 CFR § 164.524(a)(4).

An individual must be permitted to request access or inspect or obtain a copy of his or her medical record. See 45 CFR § 164.524(b)(1). A covered entity is required to act upon an individual’s request in a timely manner. See 45 CFR § 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. See 45 CFR § 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. See 45 CFR § 164.524(d).

A covered entity is required to maintain documentation related to an individual’s access to the medical record. See 45 CFR § 164.524(e).

12.6.4.2 Disclosure with an Individual’s or the Individual’s Health Care Decision Maker’s Authorization

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. See 45 CFR §§ 164.502(a)(1)(iv); and 164.508. An authorization must contain all of the elements in 45 CFR § 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:

- 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 CFR § 164.508 (b)(4) applies; or
- The consequences to the individual of a refusal to sign the authorization when, in accordance with 45 CFR § 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.

12.6.4.3 Disclosure to Health, Mental Health and Social Service Providers for Treatment, Payment or Health Care Operations; Reports of Abuse and Neglect

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 health care operations as defined in the HIPAA Rule. These disclosures are typically made to primary care physicians, psychiatrists, psychologists, social workers (including DES and DDD) or other behavioral health professionals. Particular attention must be paid to 45 CFR §164.506(c)
and the definitions of treatment, payment and health care 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 health care operations. See 45 CFR §164.506(c)(1). A covered entity may disclose for treatment activities of a health care provider including providers not covered under the HIPAA Rule. See 45 CFR § 164.506(c)(2). A covered entity may disclose to both covered and non-covered health care providers for payment activities. See 45 CFR § 164.506(c)(3). A covered entity may disclose to another covered entity for the health care 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 health care operations. See 45 CFR § 164.506(c)(4).

If the disclosure is not for treatment, payment, or health care operations or required by law, patient authorization is required unless otherwise allowed by law.

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

Similarly, a covered entity may have an obligation to report adult abuse and neglect to Adult Protective Services. See 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. See 45 CFR § 164.512(c).

### 12.6.4.4 Disclosure to Other Persons Including Family Members Who Are Actively Participating in The Patient's Care, Treatment, or Supervision

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, or in an emergency circumstance, 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. See 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. See 45 CFR § 164.510(b).

12.6.4.5 Disclosure to an Agent Under a Health Care Directive

A covered entity may treat an agent appointed under a health care directive as a personal representative of the individual. See 45 CFR § 164.502(g). Examples of agents appointed to act on an individual’s behalf include an agent under a health care power of attorney, see A.R.S. § 36-3221 et seq.; surrogate decision makers, see A.R.S. § 36-3231; and an agent under a mental health care power of attorney, see A.R.S. § 36-3281.

12.6.4.6 Disclosure to a Personal Representative

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 CFR §§ 164.502(g)(3)(i) or 164.502(g)(5) applies. See 45 CFR § 164.502(g)(1).

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 CFR § 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. See 45 CFR § 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 CFR § 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 health care professional, in the exercise of professional judgment. See 45 CFR § 164.502(g)(3)(ii)(C).

12.6.4.7 Disclosure to a Personal Representative, 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. See 45 CFR § 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 CFR § 164.502(g)(5) applies.
12.6.4.8  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. See 45 CFR § 164.502(g)(4). A covered entity may withhold protected health information if one or more of the exceptions in 45 CFR § 164.502(g)(5) applies. A.R.S. § 12-2294 (D) provides certain persons with authority to act on behalf of a deceased person.

12.6.4.9  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. See 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 CFR § 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. See 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.

12.6.4.10  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. See 45 CFR § 164.512(d).

12.6.4.11  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. See 45 CFR § 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 CFR §§ 164.512(e)(1)(iii),(iv) and (v) for what constitutes satisfactory assurances.
12.6.4.12 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 CFR § 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 CFR § 164.512(i)(1)(i) can waive it.

12.6.4.13 Disclosure to Prevent Harm Threatened by Patients

Mental health providers have a duty to protect others against the harmful conduct of a patient under certain circumstances. See 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 CFR § 164.512(j)(1)(ii); 164.512(f)(2) and (3) for rules that apply for disclosures made to law enforcement. See 45 CFR § 164.512(j)(4) for what constitutes a good faith belief.

12.6.4.14 Disclosures 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. See 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 CFR §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 AHCCCS that the information is necessary to perform a function that is related to the oversight of the 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. See 45 CFR §164.512(d)(1).

12.6.4.15 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. See A.R.S. § 36-509(5) The HIPAA Rule limits disclosure to correctional institutions to certain categories of information that are contained in 45 CFR § 164.512(k)(5).

12.6.4.16 Disclosure to a Governmental Agency or Law Enforcement To Secure Return of a 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. See A.R.S. § 36-509(6). A covered entity may disclose limited information without patient authorization to law enforcement to secure the return of a missing person. See 45 CFR § 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. See 45 CFR § 164.512(j).

12.6.4.17 Disclosure to a 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 (Arizona Revised Statutes, Title 36, Chapter 37). See 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 person’s 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. See 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 CFR § 164.512(a) (disclosure permitted when required by law) and 45 CFR § 164.512(e) (disclosure permitted when ordered by the court). If the disclosure is not required by law or 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 CFR § 164.506(c) to determine rules for disclosure for treatment, payment or health care operations.

12.6.4.18 Disclosure to Third Party Payors

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

12.6.4.19 Disclosure to Accreditation Organization

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

12.6.4.20 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. See A.R.S. § 36-664(A). Certain exceptions for disclosure are permitted to:

- The individual or the individual’s health care decision maker;
- ADHS or a local health department for the purpose of notifying a Good Samaritan;
- An agent or employee of a health facility or a health care provider;
- A health facility or a health care 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 Department of Health Services to conduct inspections;
- Insurance entities;
- A private entity that accredits a health care facility or a health care provider; and
- A person or entity for research only if the research is conducted pursuant to applicable federal or State laws governing research.

A.R.S. § 36-664 also addresses issues with respect to Disclosures to the Department of Health Services or local health departments. These disclosures are also permissible under certain circumstances:

- Authorizations;
- Re-disclosures;
- Disclosures for supervision, monitoring and accreditation;
- Listing information in death reports;
- Reports to the Department; and
- Applicability to insurance entities.

An authorization for the release of communicable disease related information must be signed by the protected person or, if the protected person lacks capacity to consent, the person’s health care decision maker (see 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 CFR § 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.

12.6.4.21 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 CFR § 164.502(e) and the HITECH Act. See the definition of “business associate” in 45 CFR § 160.103. Also see 45 CFR § 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.

12.6.4.22 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 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
- Allowed when a grievance 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.

12.6.5 Disclosures of Alcohol and Drug Information

Cenpatico IC and its providers that provide drug and alcohol screening, diagnosis or treatment services are federally assisted alcohol and drug programs and must ensure compliance with all provisions contained in the federal statutes and regulations referenced in this section.

Cenpatico IC and its providers must notify persons seeking and/or receiving alcohol or drug abuse services of the existence of the federal confidentiality laws 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.

Cenpatico IC or its providers may require enrolled persons to carry identification cards while the person is on the premises of an agency. Cenpatico IC or its provider may not require enrolled persons to carry cards or any other form of identification when off Cenpatico IC or its provider’s premises that will identify the person as a member of drug or alcohol services.

Cenpatico IC or its 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 as provided in this section.

Cenpatico IC or its 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.

The Cenpatico IC or its providers must advise the person or guardian of the special protection
given to such information by federal law.

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:
  - Cenpatico IC or its providers 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 which has not expired or been revoked by the patient. The proper authorization form must be in writing and must contain each of the following specified items:
    - The 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 CFR 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 CFR 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;
- 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.

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 health care 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 CFR § 2.52;
- Audit and Evaluation Activities – information may be disclosed for the purposes of audit and evaluation activities according to the provisions of 42 CFR § 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; and
- 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 section. 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 above in Section 12.6.4.
- Court-ordered disclosures. A State or federal court may issue an order that authorizes an agency to make a disclosure of identifying information that would otherwise be prohibited. A subpoena, search warrant or arrest warrant is not sufficient standing alone, to require or permit an agency to make a disclosure.
- Crimes committed by a person on an agency’s premises or against program personnel. Agencies may disclose information to a law enforcement agency when a person who is receiving treatment in a substance abuse program has committed or threatened to commit a crime on agency premises or against agency personnel. In such instances, the agency must limit the information disclosed to the
circumstances of the incident. It may only disclose the person’s name, address, last known whereabouts and status as a person receiving services at the agency.

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

A general medical release form or any authorization form that does not contain all of the elements listed above is not acceptable.

### 12.6.6 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;
- If a recording of the session is made, an authorization, signed by the Member, shall be obtained;
- All videoconferencing equipment shall be set to automatically mute its microphone(s) when answering any incoming calls;
- All videoconferencing equipment shall be set not to automatically answer multipoint calls;
- All videoconferencing equipment with internet access that is used for telemedicine shall be set to not allow remote monitoring; and
- All videoconferencing equipment in rooms used for telemedicine or Member services shall have the camera lens covered and the microphone muted or must be turned off whenever the equipment is not in use.

### 12.6.7 Security Breach Notification

Cenpatico IC and its 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.

Any questions or incidents concerning Member rights, protected health information (PHI) and/or the use and disclosure of such information may be obtained by contacting the Cenpatico IC Compliance Officer at 1-866-495-6738 or by writing to Cenpatico IC:

Cenpatico Integrated Care  
Attn: Compliance Officer  
333 E. Wetmore, Suite 500  
Tucson, AZ 85705-1799  
Fax Number: (800) 398-6182  
CAZCompliance@Cenpatico.com

### 12.6.8 Pledge to Protect Confidential Information

If requested by the ADHS Procurement Office, providers must sign a “Pledge to Protect Confidential Information” and abide by the statements addressing the creation, use and
disclosure of confidential information, including information designated as protected health information and all other confidential or sensitive information as defined in policy. In addition, if requested, providers must attend or participate in HIPAA training offered by ADHS or provide written verification that the provider has attended or participated in job-related HIPAA training that is: (1) intended to make the provider proficient in HIPAA for purposes of performing the services required and (2) presented by a HIPAA Privacy Officer or other person or program knowledgeable and experienced in HIPAA and who has been approved by the ADOA-ASET Arizona State Chief Information Security Officer.

12.7 Fraud and Program Abuse Reporting

The reporting of suspected fraud and program abuse is a requirement of the Arizona Health Care Cost Containment System (AHCCCS). Under the requirements of the Corporate Compliance Program, and in accordance with A.R.S. §36-2918.01, §36-2932, §36-2905.04 and ACOM Policy 103, Cenpatico IC, its subcontractors and providers are required to immediately notify the AHCCCS Office of Inspector General (AHCCCS-OIG) regarding all allegations of fraud, waste or abuse involving the AHCCCS Program.

Providers must be cognizant of the potential for fraud, waste and abuse within the public health system. Fraud as defined by Federal law and as recognized in the State of Arizona is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable State or Federal law, as defined in 42 CFR 455.2.

Individuals and/or entities found to be submitting fraudulent claims for services will be reported to AHCCCS-OIG and may be subject to an investigation that will lead to an exclusion to participate in any program associated with federal Medicare/Medicaid funding.

Under the federal provisions for civil FCA, no specific intent to defraud is required. The civil FCA defines "knowing" to include not only actual knowledge but also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information. Further, the civil FCA contains a whistleblower provision that allows a private individual to file a lawsuit on behalf of the United States and entitles that whistleblower to a percentage of any recoveries.

In the context of this section of the Provider Manual, persons receiving care in the public health system can also commit acts of fraud, waste and abuse (e.g., by loaning or selling their AHCCCS identification card).

Cenpatico IC’s providers are responsible for ensuring that mechanisms are in place for the identification, prevention, detection and reporting of fraud, waste and abuse. All employees of providers must be familiar with the types of fraud, waste, and abuse that could occur during their normal daily activities. Cenpatico IC has designated a Compliance Officer and a Compliance Committee responsible for the development and implementation of the Corporate Compliance Program which addresses fraud, waste and abuse prevention, detection and reporting.
Under the applicable law of the state of Arizona, a person may not present cause to be presented to this state or to a contractor:
1. A claim for a medical or other item or service that the person knows or has reason to know was not provided as claimed.
2. A claim for a medical or other item or service that the person knows or has reason to know is false or fraudulent.
3. A claim for payment that the person knows or has reason to know may not be made by the system because:
   (a) The person was terminated or suspended from participation in the program on the date for which the claim is being made.
   (b) The item or service claimed is substantially in excess of the needs of the individual or of a quality that fails to meet professionally recognized standards of health care.
   (c) The patient was not a member on the date for which the claim is being made. ARS 36-2918

The state may impose civil penalties and assessments or both, pursuant to R9-22-1101. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims. This Article applies to prohibited acts as described under A.R.S. § 36-2918(A), and submissions of encounters to the Administration. The Administration considers a person who aids and abets a prohibited act affecting any of the AHCCCS programs or Health Care Group to be engaging in a prohibited act under A.R.S. § 36-2918(A).

### 12.7.1 Methods for Reporting Fraud, Waste and Abuse

Cenpatico IC’s providers are required to immediately report all suspected fraud, waste and abuse involving any Title XIX/XXI and NTXIX/XXI funds, AHCCCS providers, or AHCCCS Members to the AHCCCS Office of Inspector General (OIG) in writing using the AHCCCS reporting form available at: [https://azahcccs.gov/Fraud/ReportFraud/](https://azahcccs.gov/Fraud/ReportFraud/), and which may be submitted online, or via the following methods:

**Mail:**
Arizona Health Care Cost Containment System (AHCCCS)
Inspector General
Office of Inspector General (OIG)
801 E. Jefferson St., Mail Drop 4500
Phoenix, AZ, 85034

**To Report Provider Fraud:**
- In Maricopa County: 602-417-4045
- Outside of Maricopa County: 888-ITS-NOT-OK or 888-487-6686

**To Report Member Fraud:**
- In Maricopa County: 602-417-4193
- Outside of Maricopa County: 888-ITS-NOT-OK or 888-487-6686

**Email:** [AHCCSFraud@azahcccs.gov](mailto:AHCCSFraud@azahcccs.gov)
**Fax:** 602-417-4102
**Website:** [https://azahcccs.gov/Fraud/ReportFraud/](https://azahcccs.gov/Fraud/ReportFraud/)
This includes acts of suspected fraud, waste and/or abuse that were resolved internally but involved AHCCCS funds or AHCCCS providers. Failure to comply with the requirement to report suspected fraud, waste and abuse may result in the penalty described in A.R.S. § 36-2992.

### 12.7.2 Reporting Fraud, Waste and Abuse to Cenpatico Integrated Care

In addition to notifying AHCCCS, providers must immediately notify Cenpatico IC of all suspected fraud, waste, and/or program abuse. Cenpatico IC providers must report suspected fraud, waste, and program abuse to:

Cenpatico Integrated Care  
Attn: Compliance Officer  
333 E. Wetmore, Suite 500  
Tucson, AZ 85705-1799  
Fraud and Abuse Hotline: (866) 685-8664  
- Hotline is available 24/7, all calls are confidential and can be made anonymously  
Fax Number: (800) 398-6182  
Email: CAZFWA@cenpatico.com

The public, members, staff, and providers may report fraud, waste and abuse cases confidentially and anonymously by submitting information to the above address.

Providers must also develop, maintain and publicize a confidential and anonymous reporting process for the public, members, employees and contractors to report fraud, waste and abuse.

Once Cenpatico IC has referred a suspected case of fraud, waste or program abuse to AHCCCS's OIG, Cenpatico IC will take no action to recoup or otherwise offset any suspected overpayments until AHCCCS provides notice to Cenpatico IC of the fraud, waste and abuse case disposition status.

### 12.7.3 AHCCCS-OIG Communications

Cenpatico IC’s providers shall report to Cenpatico IC (ATTN: Vice President, Compliance) and the AHCCCS-OIG, within ten (10) days of notification, any and all contact made by AHCCCS-OIG in reference to any open/closed fraud, waste and abuse case, a voluntary self-disclosure or settlement, and/or any other type of fraud, waste and abuse activity involving official communications by AHCCCS-OIG.

Cenpatico IC (ATTN: Vice President, Compliance) shall be advised of the final disposition of any case and/or settlement agreement made between a provider and AHCCCS-OIG.

### 12.7.4 Cooperation with AHCCCS and Cenpatico Integrated Care

Providers must respond timely to all Cenpatico IC, and AHCCCS-OIG requests for interviews, information, data or documents as a part of any investigation, inquiry, or audit. AHCCCS-OIG may conduct an audit review or investigation on-site without notice and the provider must provide access to all records, documents, and data related to the provider’s contract at all times.
Upon request, providers must furnish any and all documents to include original copies, to representatives of Cenpatico IC and AHCCCS-OIG at no cost. Cenpatico IC or AHCCCS-OIG will establish the designated timeframe to copy the requested documents, which will not exceed twenty (20) business days, from the date of the Cenpatico IC or AHCCCS-OIG request.

In addition, providers must verify that all emergent phone calls from Cenpatico IC to the provider’s point of contact are returned within 4 hours; all urgent phone calls returned within one work day and all routine calls are returned within two work days. Providers must verify that all emails sent from Cenpatico IC staff are addressed timely with responses from the provider received within three work days.

12.8 Provider Corporate Compliance Program

12.8.1 Corporate Compliance Plan

Providers must have a Corporate Compliance Plan that is reviewed and updated annually as indicated in Section 16 – Deliverable Requirements. The Corporate Compliance Plan must include, at a minimum, the following elements:

- Designated Corporate Compliance Officer.
- Provisions of the Deficit Reduction Act of 2007 and the Federal False Claims Act provisions, the administrative remedies for false statements; State laws relating to civil or criminal penalties for false claims and statements; and whistleblower protections. Business Ethics and Conduct Policy, including the establishment of Codes of Conduct.
- Establishment of an effective training and education program as a systematic means for educating and training agency employees and subcontractor employees to identify and report suspected waste, fraud and abuse.
- A process to conduct periodic monitoring of claims/encounters, claims medical review and other operations for compliance with laws, regulations and payer requirements, such as conducting periodic internal audits.
- A process for employees to receive information on how to identify and report incidents of suspected waste, fraud and abuse through Cenpatico Integrated Care’s (Cenpatico IC’s) Ethics and Compliance Hotline.
- Compliance committee to include key administrative staff as committee members.
- Verify all staff and subcontractor staff have been trained annually regarding fraud, waste, abuse, false claims act, whistleblower protections and State laws relating to civil or criminal penalties for false claims and statements.

12.8.2 Identifying Fraud, Waste and Abuse

Providers must conduct internal monitoring and auditing in accordance with 42 CFR 438.608 and must include elements and audit steps to discover or identify suspected fraud, waste and program abuse within the provider’s organization. Providers must develop and implement a data analytics tool to evaluate encounters/claims data or other administrative data to identify trends or behavior at all system levels that indicate fraud, waste and/or program abuse.
12.8.2.1 Additional Requirement for Behavioral Health Specialty Providers and Crisis Providers

Behavioral health specialty providers and crisis care providers must also contract with an independent auditor to conduct an annual claims review to verify compliance with all State and federal laws, regulations and payer requirements.

12.8.3 Corporate Compliance Program

Providers must have a comprehensive Corporate Compliance Program, which meets the requirements in 42 CFR 438.608, supported by other administrative procedures, that is designed to deter, detect and prevent fraud, waste and program abuse. Providers must include, at a minimum, the following:

- Written policies, procedures, and standards of conduct that articulate the organization's commitment to processes for, complying with all applicable federal and State Standards;
- A Corporate Compliance Committee that meets regularly and reports to provider’s senior management. The Corporate Compliance Committee members, at a minimum, shall include the Corporate Compliance Officer; staff with experience and expertise in finance and budgets; and other executive staff with the authority to commit resources;
- An effective education and training program for the Corporate Compliance Officer and provider’s employees on the detection, prevention and reporting of fraud, waste and program abuse. The training must include the False Claims Act provisions, administrative remedies for false claims and statements, Arizona laws relating to civil or criminal penalties for false claims and statements and the whistleblower protections under such laws.
- A process for the monthly screening of all provider existing staff, potential staff and subcontractors against the List of Excluded Individuals and Entities (LEIE) & The System for Award Management (SAM) formerly known as The Excluded Parties List (EPLS) databases for those that have been debarred, suspended or otherwise excluded as well as any other databases as required/requested by Cenpatico, AHCCCS or CMS. All potential staff and subcontractors must be checked before hire and all existing staff and subcontractors must be checked on a monthly basis;
- Unfettered access and open lines of communication between the Corporate Compliance Officer and the provider’s employees;
- A mechanism for enforcement of standards through well-publicized disciplinary guidelines;
- In accordance with A.R.S. §36-2918.01 and ACOM Policy 103, have a process to, upon discovery, promptly address and notify Cenpatico IC and AHCCCS-OIG of any instances of an excluded provider or employee that is, or appears to be, in a prohibited relationship with the Subcontractor (42 CFR 455.17);
- Have a process to confirm the identity and determine the exclusion status of any person with an ownership or control interest in the Contractor and with regard to its fiscal agents, to identify, obtain and report the exclusion status on persons convicted of crimes; and
• Develop and maintain robust internal controls and mechanisms in order to consistently identify, prevent, deter and detect fraud, waste and program abuse that includes the implementation of corrective action plans (42 CFR 438.608).

12.8.4 Corporate Compliance Officer

Providers must establish written criteria for selecting a Compliance Officer and job description that clearly outlines the responsibilities and authority of the position. The Compliance Officer shall have the authority to assess records and independently refer suspected Member fraud, provider fraud, waste and Member abuse cases to Cenpatico IC and the AHCCCS-OIG. The Corporate Compliance Officer shall not have any title, duties or responsibilities that could constitute a potential or actual conflict of interest. Providers must require the Corporate Compliance Officer to be responsible for the following:

• Provide training and ongoing education to employees in identifying and reporting fraud, waste and program abuse.
• Oversee internal and external compliance audits
• Record, track and trend all fraud, waste and abuse related complaints received including those initiated by Cenpatico IC or a subcontractor, which shall capture and maintain the following information, at a minimum;
  o Contact information of complainant;
  o Name and identifying information of person or entity suspected of fraud, waste and/or program abuse;
  o Date and time complaint was received;
  o Nature of the allegations and summary of concern;
  o Potential estimated dollar loss amount and specific identification of funding source(s) involved;
  o Subcontractor’s unique case identifying number;
  o The department or agency in which the complaint has been reported, and
  o Date in which the case was referred to Cenpatico IC or AHCCCS-OIG.

Providers must ensure the Corporate Compliance Officer has complete access to all information, databases, files, records and documents in order to conduct audits and to strategically structure the position to report suspected fraud, waste and program abuse directly to Cenpatico IC and AHCCCS-OIG independently (42 CFR 455.17).

12.8.5 Other Activities

The provider must conduct additional activities, such as:
• Regular fraud, waste and abuse awareness activities (i.e. campaigns, newsletters)
• Develop and maintain internal control assessments
• Risk assessments
• Act as a liaison with the Cenpatico IC Compliance Committee
• Notify Cenpatico IC of any CMS compliance issues related to HIPAA transactions and code set complaints or sanctions
• Communicate with Cenpatico IC and AHCCCS OIG on the final disposition of the research and advice of actions, if any, taken by the provider
• Submit the Corporate Compliance Plan deliverable related to Corporate Compliance in accordance with Section 16 – Deliverable Requirements.
• Contract with an independent auditor to conduct an annual claims review to verify compliance with all State and federal laws, regulations and payer requirements.

12.9 Encounter Validation Studies

The Centers for Medicare and Medicaid Services (CMS) requires the Arizona Health Care Cost Containment System (AHCCCS) to conduct encounter validation studies as a condition for receiving federal Medicaid funding. AHCCCS requires Cenpatico IC to conduct encounter validation studies of their providers.

The purpose of encounter validation studies is to compare recorded utilization information from a clinical record or other source with submitted encounter data. The review “validates” or confirms that covered services are encountered timely, correctly and completely. The purpose of this section is to:

- Inform providers that encounter validation studies may be performed by AHCCCS, Cenpatico IC and/or AHCCCS staff; and
- Convey the AHCCCS’ expectation that providers cooperate fully with any encounter validation review that AHCCCS, Cenpatico IC and/or AHCCCS may conduct.

12.9.1 Criteria Used in Encounter Validation Studies

The criteria used in encounter validation studies include timeliness, correctness, and omission of encounters, in addition to encountering for services not documented in the medical record. These criteria are defined as follows:

- **Timeliness** - The time elapsed between the date of service and the date that the encounter is received. Cenpatico IC is required to provide specific information for providers on Timeliness standards;
- **Correctness** - A correct encounter contains a complete and accurate description of a covered behavioral health service provided to a person. Correctness errors frequently identified include, but are not limited to, invalid procedure or revenue codes and ICD-10 diagnoses not reported to the correct level of specificity;
- **Omission** - Provider documentation shows a service was provided, however, an encounter was not submitted; and
- **Lack of Documentation** - A description of adequate documentation is referenced in Section 9.2 – Medical Records Standards.

In addition, assessment compliance must be monitored by Cenpatico IC in accordance with Section 3.5 - Assessment and Service Planning. Providers may be subject to sanctions for failure to meet the criteria used in encounter audits, which may include timeliness, correctness, and omission of encounters.
12.9.2 Provider Responsibilities

Providers must deliver covered services in accordance with the AHCCCS Covered Behavioral Health Service Guide located at https://www.azahcccs.gov/PlansProviders/GuidesManualsPolicies/guidesandmanuals.html

Providers must document adequate information in the clinical record and submit encounters in accordance with AHCCCS Policy 501, Encounters to the RBHA/Health Plan. Any audit findings that indicate suspected fraud, waste and/or program abuse must be reported to Cenpatico’s Compliance Department.

12.10 Provider Reporting of Moral Or Religious Objection

Providers must notify Cenpatico IC if, on the basis of moral or religious grounds, the provider elects not to provide coverage of a covered counseling or referral service pursuant to 42 CFR 438.102(a)(2). If the provider elects not to provide coverage of a covered counseling or referral service pursuant to 42 CFR 438.102(a)(2), the provider is required to make alternative arrangements with another entity to provide the service. A provider must notify Cenpatico IC prior to entering into a contract or adopting a policy as described above during the term of the provider’s contract with Cenpatico IC. The notification and policy must be consistent with the provisions of 42 CFR 438.10; must be provided to Members during their initial appointment; and must be provided to Members at least thirty (30) days prior to the effective date of the policy.
Section 13 - DATA SYSTEMS/REPORTING REQUIREMENTS

13.1 Enrollment, Disenrollment and Other Data Submission

With respect to decisions on enrollment providers shall defer to AHCCCS, which has exclusive authority to enroll and dis-enroll Medicaid eligible members in accordance with the rules set forth in A.A.C., R9-22, Article 17 and R9-31, Articles 3 and 17. Providers shall also defer to AHCCCS, which has exclusive authority to designate who will be enrolled and dis-enrolled as Non-Medicaid eligible members.

The collection and reporting of accurate, complete and timely enrollment, demographic, clinical, and disenrollment data is of vital importance to the successful operation of the AHCCCS health service delivery system. It is necessary for providers to submit specific data on each person who is actively receiving services from the health system. As such, it is important for provider staff (e.g., intake workers, clinicians, data entry staff) to have a thorough understanding of why it is necessary to collect the data, how it can be used and how to accurately label the data. This policy has particular relevance for those providers that conduct assessments, ongoing service planning, and annual updates. This data in turn is used by the AHCCCS to:

- Monitor and report on outcomes of individuals in active care (e.g., changes in diagnosis, employment/educational status, behavioral health category, substance use);
- Comply with federal and state funding and/or grant requirements;
- Assist with financial-related activities such as budget development and rate setting;
- Support quality management and utilization management activities; and
- Respond to requests for information.

The intent of this section is to describe requirements for providers to submit the following data in a timely, complete, and accurate manner:

- Non-Title XIX/XXI 834 batch enrollment and dis-enrollments; and
- Demographic and clinical data, including changes in a person’s behavioral health status.

Cenpatico IC’s Management Information System has the capability to automatically receive and load data from a provider’s EHR to collect demographic data for submission to AHCCCS. Cenpatico providers required to transmit 834 and demographic records to Cenpatico, must have a certified EHR and use their system to electronically send data in the required format.

Additionally, Cenpatico IC and AHCCCS shall have access privileges and user-rights to any and all Member information within Contractor’s MIS system, and that of any MIS/EHR system operated by a subcontracted provider. At a minimum, Cenpatico IC and AHCCCS shall be permitted real-time access to client level demographics, claims and billing, service planning, assessment, and grievance and appeal data.
13.1.1 Enrollment And Disenrollment Transactions

13.1.1.1 General Requirements:

- Arizona Health Care Cost Containment System (AHCCCS) enrolled individuals are considered enrolled with Cenpatico IC at the onset of their eligibility. They are provided an AHCCCS identification card listing their assigned RBHA/Health Plan. This assignment is sent daily from AHCCCS to Cenpatico IC.

- For a Non-Title XIX/XXI eligible person to be enrolled, providers must submit an 834 enrollment transaction to Cenpatico IC. All AHCCCS enrolled individuals with a mental health benefit are considered enrolled with Cenpatico IC at the time of their AHCCCS eligibility.

- For a Non-Title XIX/XXI eligible person who receives a covered service, he/she must be enrolled effective the date of first contact by a provider.

- All persons who are served through the AHCCCS behavioral health system must have an active episode of care, even if the person only receives a single service (e.g., crisis intervention, one time face-to-face consultation).

- An episode of care is the start and end of services for a behavioral health need as documented by transmission of a demographic record. For both AHCCCS enrolled and Non-Title XIX/XXI eligible individuals, the individuals must have an open episode of care starting at the first date of service and ending with the last service.

13.1.1.2 When to Collect Enrollment Information

For Non-Title XIX/XXI eligible individuals, information necessary to complete an 834 transaction is usually collected during the intake and assessment process (see Section 3.5 - Assessment and Service Planning). Provider Manual Attachment 13.1.1, 834 Transaction Data Requirements, contains a list of the data elements necessary to create an 834 enrollment transaction.

For AHCCCS enrolled individuals, the 834 information will be provided to Cenpatico IC by AHCCCS.

13.1.1.3 Data Included in an 834

The data fields that are included in the 834 transmittals are dictated by HIPAA and consist, in part, of:

- Key client identifiers used for file matching (e.g., person’s name, address, date of birth);
- Basic demographic information (e.g., gender, marital status); and
- Information on third party insurance coverage.

Reference the Cenpatico 834 file specification document for full details on what to collection and how to submit Non-Title 834 files. You can obtain a current version of the 834 file specifications by contact CAZMembership@cenpatico.com.

13.1.1.4 Lack of Information to Complete an Enrollment

Providers must actively secure any needed information to complete the enrollment (834 transaction) for a Non-Title XIX/XXI eligible individual. An 834 transaction will not be accepted
by Cenpatico IC if required data elements are missing. For Title XIX/XXI eligible individuals, the 834 information will be provided to Cenpatico IC by AHCCCS.

13.1.1.5 Timeframes for Submitting Enrollment and Disenrollment Data for A Non-Title XIX/XXI Eligible Individual

- The following data submittal timeframes apply to the enrollment/disenrollment transactions: The 834-enrollment transaction must be submitted to Cenpatico IC within 7 calendar days of the first contact with a member.
- The 834 disenrollment transaction must be submitted to Cenpatico IC within 7 calendar days of the person being dis-enrolled from the system; and any changes to the enrollment/disenrollment transaction data fields (e.g., change in address, insurance coverage) must be submitted 7 calendar days from the date of identifying the need for the change.

13.1.1.6 Other Events Requiring a Submittal of an 834 Transaction For A Non-Title XIX/XXI Eligible Individual

In addition to submitting an 834 transaction at enrollment and disenrollment, an 834 transaction must also be submitted when any of the following elements of the 834 transaction have changed:

- Name;
- Address;
- Date of birth;
- Gender;
- Marital status; or
- Third party insurance information.

13.1.1.7 Other Considerations for Both Non-Title XIX/XXI Eligible and AHCCCS Enrolled Individuals

For an AHCCCS enrolled individual, AHCCCS will notify Cenpatico of changes to the above information.

When a person in an episode of care permanently relocates from one RBHA/Health Plan’s geographic area to another RBHA/Health Plan’s geographic area, an Inter-RBHA transfer must occur (see Section 4.2 – Inter-RBHA Coordination of Care). The steps that are necessary to facilitate an Inter-RBHA transfer include the following data submission requirements:

- The home T/RBHA/Health Plan must submit an 834 disenrollment transaction effective on the date of transfer and end the episode of care;
- The receiving T/RBHA/Health Plan must submit an 834 enrollment transaction on the date of accepting the person for services and start an episode of care; and
- AHCCCS will notify Cenpatico IC when a Cenpatico IC enrolled person is determined eligible for the Arizona Long Term Care System (ALTCS) Elderly and Physically Disabled (EPD) Program. This information will be passed to Cenpatico IC in a daily file.
13.1.1.8  Technical Assistance Available to Help with Problems Associated with Electronic Data Submission

At times, technical problems or other issues may occur in the electronic transmission of the data from the provider to the Cenpatico IC. If a provider requires assistance for technical related problems or issues, please email the Cenpatico IC Membership team at CAZMembership@Cenpatico.com.

13.1.2  Demographic and Clinical Data

13.1.2.1  When Demographic and Clinical Data Is Collected

Demographic and clinical data will be collected starting at the first date of service. For Non-Title XIX/XXI eligible individuals, an 834 must be completed. For both AHCCCS enrolled and Non-Title XIX/XXI eligible individuals, a demographic record must be collected and submitted to Cenpatico IC within 7 calendar days of the first service.

13.1.2.2  Specific Data Elements

The AHCCCS Demographic & Outcomes Data Set User Guide https://www.azahcccs.gov/PlansProviders/GuidesManualsPolicies/guidesandmanuals.html describes state minimum required data elements that comprise the demographic data set, in part. Cenpatico IC must ensure that providers collect state required demographic data set elements in accordance with the AHCCCS Demographic Data Set User Guide. When AHCCCS issues updates to the demographic data set, Cenpatico IC is responsible for communicating changes to its providers. Cenpatico also collects data in addition to what is outlined in the AHCCCS Demographic Data Set User Guide. Contact CAZMembership@cenpatico.com for a current format and submission guidelines of the Cenpatico Demographic file.

NOTE: Cenpatico only accepts demographic records in the form of a structured file format. Cenpatico will not accept paper forms.

13.1.2.3  Timeframes for Submitting Demographic and Clinical Data

- The following timeframes apply to demographic and clinical data submissions: All required demographic data submitted to Cenpatico IC within 7 calendar days of the initial intake for all enrolled persons;
- Outcome measures, for children birth through age 17, submitted to Cenpatico IC within 7 calendar days of the 6 month anniversary date of the last demographic submission (see Section 3.5- Assessment and Service Planning);
- All required demographic data submitted to Cenpatico IC within 7 calendar days of the annual update (see Section 3.5 - Assessment and Service Planning);
- All required demographic data submitted to Cenpatico IC within 7 calendar days of a recorded change in the person’s demographic data record. Providers must verify that the person’s medical record matches the demographic data set on file with the AHCCCS; and
• All required data elements submitted to Cenpatico IC within 7 calendar days of the end of the episode of care. The required data elements include the reason for the person’s disenrollment.

13.1.2.4 Determining a Member’s Behavioral Health Category Assignment

Providers must designate a person’s behavioral health category assignment during the assessment process as well as at any other times that necessitate changes to the person’s assignment (e.g., transition to adulthood). Behavioral health categories include:

• Child;
• Seriously Emotionally Disturbed (SED) Child (see Provider Manual Attachment 13.1.4 SED Qualifying ICD-10 Diagnoses Table);
• Adult with Serious Mental Illness (SMI) (see Provider Manual Attachment 13.1.5 SMI Qualifying ICD-10 Diagnoses Table);
• Adult, non-SMI with general mental health need; and
• Adult, non-SMI with substance abuse (see Provider Manual Attachment 13.1.6, Substance Abuse Disorders Qualifying ICD-10 Diagnoses Table).

Providers must initially assign and update, as necessary, behavioral health category assignments as follows (see the AHCCCS Demographic Data Set User Guide for more detailed instructions on assignment of behavioral health categories):

• For a child who is non-SED, enter “C”;
• For a child who is SED, enter ”Z”;
• For a person with SMI in accordance with Section 3.6 — SMI Eligibility Determination, enter “S”, then enter “A” or “B”;
• For an adult non-SMI person with a general mental health need (who does not have a substance abuse problem) enter “M”; and
• For an adult non-SMI person with a reported substance abuse problem enter “G”.

13.1.2.5 How to Use Demographic and Clinical Data

Providers are encouraged to utilize demographic and clinical data to improve operational efficiency and gain information about the Members. Providers may consider:

• Utilizing and integrating collected demographic data into the person’s assessments;
• Monitoring the nature of the provider’s Member population; and
• Evaluating the effectiveness of the provider’s services towards improving the clinical outcomes of persons enrolled in the State system.

13.1.2.6 Technical Assistance Available To Help With Problems Associated With Demographic And Clinical Data Submission

At times, technical problems or other issues may occur in the electronic transmission of the clinical and demographic data from the provider to Cenpatico IC. If a provider requires assistance for technical related problems or issues, please email the Cenpatico IC Membership team at CAZMembership@Cenpatico.com.
Section 14 - CENPATICO INTEGRATED CARE MEMBER HANDBOOK

The purpose of this section is to establish the responsibility of providers to distribute Member handbooks to new enrollees and all Cenpatico IC enrolled Members receiving health care services.

The Cenpatico IC Member Handbook is intended to provide information to Members and potential enrollees regarding the availability of services in the public health care system. The Cenpatico IC Member Handbook provides information regarding how to obtain services, what services are available, what service limitations exist for Title XIX and Non-Title XIX persons, and Member rights and responsibilities, among other topics. This information is imperative in verifying that services are accessible.

14.1 General

Cenpatico IC produces the Cenpatico IC Member Handbook. It is printed in a type-style and size which can easily be read by Members with varying degrees of visual impairment, such as large print and other alternative formats included by not limited to audio and/or Braille.

14.2 Distribution

Cenpatico IC Member handbooks must be distributed to persons receiving services as follows (see AHCCCS ACOM Chapter 400, Policy 404 for more information):

- For Non-Title XIX/XXI Members or Title XIX/XXI Members enrolled with an AHCCCS Health Plan, within twelve (12) business days of the Member receiving the initial behavioral health covered service; and
- For Members with SMI receiving physical health care services, within twelve (12) business days of receipt of notification of the date of the initial covered service (42 CFR 438.10(f)(3)).

Documentation of receipt of the Member handbook must be filed in the Member’s record. Please see Provider Manual Form 14.1.1, Cenpatico IC Member Handbook Receipt for the minimum requirements to document Members’ receipt of the handbook. Provider must have a process in place to monitor the delivery of the Member Handbook to its members.

Cenpatico IC Member Handbooks must be available and easily accessible to Members at all provider locations. Upon request, copies must be made available to known Member and family advocacy organizations and other human service organizations.

The Cenpatico IC Member Handbook must be made available in identified prevalent non-English languages when Cenpatico IC is aware that another language is spoken by three thousand (3,000) or ten percent (10%), whichever is less, of the Members in a geographic region who also have Limited English Proficiency (LEP).
Persons receiving behavioral/physical health services have the right to request and obtain a Cenpatico IC Member Handbook at least annually. Cenpatico IC is required to notify persons of their right to request and obtain a Cenpatico IC Member Handbook at least annually by publishing this information using Cenpatico IC communications such as Cenpatico IC webpage, newsletter, etc.

AHCCCS may require Cenpatico IC to revise the Cenpatico IC Member Handbook and distribute it to all current enrollees if there is a significant program change. AHCCCS determines if a change qualifies as significant.

14.3 Cenpatico Integrated Care Member Handbook Review

Cenpatico IC Member Handbooks are reviewed annually, and if needed, updated by AHCCCS and Cenpatico IC. Any approved revisions or updated versions of Cenpatico IC Member Handbook will be posted to the Cenpatico IC website by the effective date of such revisions or updates.
Section 15 - GRIEVANCE AND APPEAL SYSTEM

Cenpatico IC members and providers have access to a grievance system that fairly and efficiently reviews and resolves identified issues. Cenpatico IC grievance system staff address member, provider, and stakeholder concerns in a courteous, responsive, effective, and timely manner. This section provides an overview of the following grievance system processes:

- Member Grievances and Provider Complaints;
- Grievances and Investigations Concerning Persons with Serious Mental Illness;
- Notice Requirements and Appeal Process (TXIX/XXI);
- Notice Requirements and Appeal Process (Non-Title XIX/XXI (SMI and GMH/SA));
- Provider Claim Disputes

Providers must understand the Cenpatico IC grievance system in order to assist Cenpatico IC members who wish to utilize a grievance system process. Grievance system processes also afford Providers a formal process for expressing dissatisfaction, including but not limited to dissatisfaction regarding nonpayment of a claim, imposition of sanctions, and service denials.

Providers are required to fully cooperate with Cenpatico IC grievance and appeal system staff with respect to grievance system processes. This includes, but is not limited to:

- Ensuring Cenpatico IC members are provided all Enrollee rights as provided for in 42 C.F.R. § 438.100. See also PM Section 12.1, Member Rights.
- Providing education to Cenpatico IC members about their rights and making that information readily available to members upon request. This includes, but is not limited to, providing and posting PM Form 3.5.7 – Notice of Nondiscrimination and PM Form 3.5.8 – Notice of Legal Rights for Persons with Serious Mental Illness (refer to each form for requirements);
- Assisting Cenpatico IC members who wish to utilize a grievance system process. This includes, but is not limited to, assisting a member with reducing a grievance or appeal to writing and/or assisting a member with calling Cenpatico Customer Service;
- Responding to inquiries from Cenpatico IC staff within the specified timeframe and if no timeframe is specified, within a reasonable amount of time;
- Producing clinical records to grievance system staff upon request when review of such records, in Cenpatico IC’s discretion, is necessary to resolve a member or provider concern;
- Making staff available to respond to Cenpatico IC inquires upon request;
- Adhering to all corrective actions or directives imposed by Cenpatico IC within the specified timeframes; and
- Adopting policies and procedures to ensure compliance with Cenpatico IC and AHCCCS policy, including policies that prohibit retaliation against members or other persons who file grievances.
Providers who fail to cooperate with grievance system staff may be subject to corrective actions, sanctions, or other remedies as described in this manual and in the Participating Provider Agreement.

Cenpatico IC does not retaliate against any member or provider who exercises his or her rights. Cenpatico IC does not take punitive action against a provider who supports a TXIX/XXI eligible person’s appeal or who supports an expedited resolution of an appeal. Similarly, Cenpatico IC providers shall not take punitive action against any person who exercises his or her rights in any manner, including through an established grievance system process.

15.1 Member Grievance and Provider Complaint Process

Any person may file a grievance to express dissatisfaction with any aspect of a member or prospective member’s care. Similarly, providers may file grievances for any reason including dissatisfaction with Cenpatico IC with respect to its customer service or operations as it relates to the provider’s care or treatment of a Cenpatico IC member.

A grievance may be initiated by contacting Cenpatico IC Customer Service at (866) 495-6738. The Customer Service Representative (CSR) will transfer the caller to the appropriate department if the CSR is unable to resolve the caller’s concern.

A grievance may also be filed by writing to Cenpatico IC at the following address:

Cenpatico Integrated Care  
Attn: Grievance and Appeal Department  
333 E. Wetmore, Suite 500  
Tucson, AZ 85705-1799  
Fax Number: (866) 714-7998

Please note the following exclusions:

- Member or provider dissatisfaction with an authorization decision made by Cenpatico IC are not treated as grievances but may be appealed as described in Sections 15.3 and 15.4.
- Providers that are dissatisfied with respect to Cenpatico IC’s adjudication of its claim(s) may challenge the processing of the claim(s) as described in Section 15.5.
- For Cenpatico IC members in the SMI Program, additional or alternative grievance procedures may apply as outlined in Section 15.2.
- For Quality of Care Concerns, Cenpatico IC follows the Quality of Care Concern process described in Section 9.7.

15.1.1 Cenpatico IC Grievance Resolution Process

Cenpatico IC follows all AHCCCS requirements with respect to the processing of member and provider grievances. Specifically, Cenpatico IC adheres to the following grievance resolution process:

- **Acknowledgement.** All grievances are acknowledged within 5 business days. Grievances are acknowledged verbally or in writing based on the member’s (or other
person’s) preference. Grievances received orally (in-person or by telephone) are verbally acknowledged when possible.

- **Communication and Information.** Cenpatico IC assures effective communication.
  - Cenpatico IC follows requirements outlined in Section 3.15 - Cultural Competence regarding oral interpretation services, translation of written materials, and services for the deaf and hard of hearing.
  - All information is provided in a manner and format that may be easily understood and readily accessible to members as required by AHCCCS ACOM 405 and 42 C.F.R. § 438.10.

- **Resolution.** Cenpatico IC addresses all identified issues as quickly as the circumstances dictate.
  - Grievances that identify an immediate clinical need or health or safety concern are addressed immediately upon receipt through an established grievance and appeal process or through another internal or external process or authority.
  - Cenpatico IC resolves most grievances within 10 days and all grievances are resolved within 90 days. Resolutions are communicated verbally or in-writing based on the preference of the grievant.
  - In delivering notification of resolution to the grievant, Cenpatico IC staff provide the member or other individual with information describing other internal or external agencies or departments that may be available to the grievant if he or she is dissatisfied with Cenpatico IC’s resolution.

- **Decisionmaking.** Grievance system staff consult appropriate subject-matter experts and individuals with appropriate clinical expertise when necessary to resolve a grievance and take into account all available information in reaching a resolution.
  - Individuals making decisions about grievances that involve the denial of an expedited resolution of an appeal or that involve clinical issues are health care professionals with the appropriate clinical expertise in treating the recipient’s condition.
  - Individuals who make decisions regarding grievances and appeals are individuals not involved in any previous level of review or decision making, or a subordinate of such individual(s) (See PM Sections 15.3 and 15.4).
  - Individuals who make decisions on grievances and appeals take into account all comments, documents, records, and other information submitted by the member or his/her representative without regard to whether such information was submitted or considered in the initial adverse benefit determination (See PM Sections 15.3 and 15.4).

In the event a grievant is dissatisfied with Cenpatico IC’s resolution of his or her grievance, the issue(s) in dispute may still be referred to applicable appeal and grievance processes.

Cenpatico IC does not route or otherwise encourage the direct filing of grievances with Arizona Health Care Cost Containment System (AHCCCS) except in limited circumstances.
15.2 Grievances and Investigations Concerning Persons with SMI

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

Filing Requirements:

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

Any person may request an SMI Grievance Investigation by completing PM Form 15.4.1 – Appeal or SMI Grievance and delivering it to Cenpatico IC at the following address:

Cenpatico Integrated Care  
Attn: Grievance and Appeal Department  
333 E. Wetmore, Suite 500  
Tucson, AZ 85705-1799  
Fax: (866) 714-7998

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

Cenpatico IC and its providers are required to report Quality of Care Concerns and Incidents, Accidents, and Deaths to Cenpatico IC Quality Management. (See Section 9 – Quality Management Requirements.). The provider’s obligation to request an SMI Grievance Investigation as described above is separate from the provider’s reporting requirements described in Section 9 – Quality Management.

Please note the following exclusions:

- This process does not apply to allegations asserting a violation relating to the right to receive services, supports and/or treatment that are State-funded and are no longer funded by the State due to limitations on legislative appropriation;
- This process does not apply to service planning disagreements more appropriately managed as appeals as described in Sections 15.3 and 15.4 and A.A.C. R9-21-405;
- This process is only available for allegations involving behavioral health services. Grievances involving physical health services or services for persons who are not in the SMI Program are managed according to Section 15.1.
Notice of Decision and Right to Appeal:

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

If the member or authorized representative is not satisfied with the outcome of Cenpatico IC’s Investigation, the grievant has access to an administrative review and/or an administrative hearing as described in ACOM 446. To request an administrative review or administrative hearing, the appellant must send his or her written request to Cenpatico IC at the following address:

Cenpatico Integrated Care  
Attn: Grievance and Appeal Department  
333 E. Wetmore, Suite 500  
Tucson, AZ 85705-1799  
Fax: (866) 714-7998

Upon receipt of a request for an administrative review or administrative hearing, Cenpatico IC transmits the request and the file, if any, to AHCCCS Office of Administrative Legal Services pursuant to ACOM 445.

15.3 Notice Requirements and Appeal Process (Title XIX/XXI)

Cenpatico IC issues Notice of Action (NOA) (also referred to as “Notice of Adverse Benefit Determination”) to Cenpatico IC members whenever Cenpatico IC makes a decision to deny or limit an authorization request or reduce, suspend, or terminate previously authorized services (collectively referred to as “actions” or “adverse benefit determinations.”). The NOA details Cenpatico IC’s decision and the member’s right to appeal the adverse decision in easily understood language. Cenpatico IC issues NOA and processes Title XIX/XXI Appeals consistent with ACOM 414.

Cenpatico IC members or providers may complain about the adequacy of an NOA. If a Title XIX/XXI Member complains about the adequacy of a NOA or its ability to be understood, Cenpatico IC reviews the NOA to ensure it meets all contractual requirements as described in ACOM 414. If Cenpatico IC determines the original NOA is inadequate or deficient, Cenpatico IC issues an amended NOA. If an amended NOA is required, the timeframe for the Member to appeal and request continuation of services (if applicable), starts to run from the date the amended NOA was received by the member or guardian.

If a member complains to Cenpatico IC about the adequacy of the amended NOA, Cenpatico IC is required to promptly inform AHCCCS Division of Health Care Management/Medical Management Unit (DHCM/MM) of the complaint. Additionally, Cenpatico IC is required to
inform the member of his or her right to contact the AHCCCS DHCM/MM unit if the issue is not resolved to the member’s satisfaction.

15.3.1 Notice of Action Requirements

Cenpatico IC issues an NOA following:

- The denial or limited authorization of a requested service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner;
- The failure to act within the timeframes provided in § 438.408(b)(1) and (2) for the standard resolution of grievances and appeals;
- For a resident of a rural area with only one MCO, the denial of an enrollee’s request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network; and
- The denial of an enrollee’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

15.3.2 Timing of NOA:

Cenpatico IC issues NOA within the following timeframe as required by ACOM 414:

- For termination, suspension, or reduction of a previously authorized service, the notice must be mailed at least 10 days before the date of the proposed termination, suspension, or reduction except for situations in 42 CFR 210 providing exceptions to advance notice. [42 CFR 431.213; 42 CFR 431.214; 42 CFR 438.404 (c)(1)].
- For standard service authorization decisions that deny or limit services, within 14 days from the receipt of the request unless there is a Notice of Extension (refer to Notice of Extension in this manual and in 42 CFR 438.404 (c)(3)).
- After a Notice of Extension has been issued, within 14 days of issuance of the NOE and in no event later than the 28th day after receipt of the request.

15.3.3 Title XIX/XXI Appeal and State Fair Hearing Process

A Title XIX/XXI eligible person may appeal the following actions with respect to Title XIX/XXI covered services:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service that is not Title XIX/XXI covered;
- The failure to provide Title XIX/XXI services in a timely manner;
- The failure to act within the timeframes required for standard and expedited resolution of appeals and standard disposition of grievances; and
• The denial of a Title XIX/XXI enrollee’s request to obtain services outside Cenpatico IC’s provider network.

A Title XIX/XXI eligible person adversely affected by PASRR determination in the context of either a preadmission screening or a resident review may file an appeal.

15.3.4 Responsibility for Processing Appeals
Cenpatico IC is responsible for processing all appeals; Cenpatico IC does not delegate this function. However, appeals that relate to PASRR determinations must be filed with and processed by AHCCCS. Information gathered during the appeal process is considered confidential and the person’s rights to privacy are protected throughout the process. The information below is provided to familiarize providers with the Title XIX/XXI appeal process.

15.3.5 Filing an Appeal
The following persons or representatives may file an appeal regarding an action:
• A Title XIX/XXI eligible person;
• A legal or authorized representative, (e.g., Department of Economic Security/Division of Children, Youth and Families/Department of Child Safety Specialist and/or advocate for persons with a SMI requiring special assistance), including a provider, acting on behalf of the person, with the person’s or legal representative’s written consent.

15.3.6 Timeframe for filing an appeal
A Title XIX/XXI eligible person has up to 60 days after the date of the Notice of Action to file a standard appeal. The appeal may be filed orally or in writing.

Cenpatico Integrated Care
Attn: Grievances and Appeals
333 E. Wetmore, Suite 500
Tucson, AZ 85705-1799
Fax Number: (866) 714-7998
Phone: (866) 495-6738
Email: CAZgrievanceandappeals@cenpatico.com

15.3.7 Standard and Burden of Proof
The burden of proof on all issues on appeal shall be the preponderance, or the greater weight, of the evidence. The burden of proof for all issues on appeal is on the appellant (individual or agency).

15.3.8 Denial of Request for Appeal
In the event Cenpatico IC refuses to accept a late appeal or determines that the decision being appealed does not constitute an action subject to these appeal requirements, Cenpatico IC will inform the appellant in writing by sending a Notice of Appeal Resolution.
15.3.9 Timeframe for resolution of a standard appeal
Cenpatico IC will acknowledge receipt of a standard appeal in writing within 5 working days of receipt.

Cenpatico IC will resolve standard appeals no later than 30 days from the date of receipt of the appeal, unless an extension is approved. A Notice of Appeal Resolution will be delivered within 30 days after the day the appeal is received.

15.3.10 Extension of standard appeal resolution timeframe
If a Title XIX/XXI eligible person requests an extension of the 30-day timeframe, Cenpatico IC will extend the timeframe up to an additional 14 days. If Cenpatico IC needs additional information and the extension is in the best interest of the member, Cenpatico IC may extend the 30-day timeframe up to an additional 14 days. If Cenpatico IC extends the timeframe it will provide a written notice to the Title XIX/XXI eligible person of the reason for the delay and issue and carry out its decision as expeditiously as the persons’ health condition requires, but no later than the date the extension expires.

15.3.11 Failure to send Notice of Appeal Resolution
If the Notice of Appeal Resolution is not sent within the timeframes set forth above, the appeal shall be considered denied on the date that the timeframe expires.

15.3.12 Circumstances for expediting an appeal
Cenpatico IC conducts an expedited appeal if:

- Cenpatico IC determines or the requesting provider indicates that taking the time for a standard appeal resolution could seriously jeopardize the person’s life, physical or mental health, or ability to attain, maintain, or regain maximum function;

15.3.13 Denial of request for an expedited appeal
If Cenpatico IC denies a request for expedited resolution of an appeal from a Title XIX/XXI eligible person, Cenpatico IC will resolve the appeal within the resolution timeframes set forth above and make reasonable efforts to give the person prompt oral notice of the denial. Within two calendar days, Cenpatico IC will follow up with written notice of the denial.

Objections to the denial of a request for expedited resolution of an appeal shall be processed as grievances, as set forth in Section 15.1.

15.3.14 Timeframe for resolution of an expedited appeal
Cenpatico IC will provide a written acknowledgment of the receipt of an expedited appeal within one working day after it receives the appeal.

Cenpatico IC will resolve expedited appeals and deliver written Notices of Appeal Resolution to the Member within three working days after Cenpatico IC receives the appeal. Cenpatico IC will also make reasonable efforts to provide prompt oral notice.
15.3.15 Extension of expedited appeal resolution timeframe

If a Title XIX/XXI eligible person requests an extension of the three working day timeframe, Cenpatico IC will extend the timeframe up to an additional 14 days. If Cenpatico IC needs additional information and the extension is in the best interest of the person, Cenpatico IC is required extend the three working day timeframe up to an additional 14 days. If Cenpatico IC extends the timeframe it will provide a written notice to the Title XIX/XXI eligible person of the reason for the delay and issue and carry out its decision as expeditious as the person’s health condition requires, but no later than the date the extension expires.

15.3.16 Notice of Appeal Resolution

A Notice of Appeal Resolution must contain:

- The results of the resolution process and the date it was completed; and
- For those appeals not resolved wholly in favor of the Title XIX/XXI eligible person:
  - The Title XIX/XXI eligible person’s right to request a State Fair Hearing by submitting a written request to the RBHA/Health Plan no later than 30 days from the date of receipt of the RBHA/Health Plan’s Notice of Appeal Resolution;
  - The right to request to receive services while the State Fair Hearing is pending, if applicable, and how to do so;
  - The factual and legal basis for the decision; and
  - An explanation that the Title XIX/XXI eligible person may be held liable for the cost of benefits being appealed if the State Fair Hearing decision results in the RBHA/Health Plan decision being upheld.

15.3.17 Requesting a State Fair Hearing

A Title XIX/XXI eligible person, legal or authorized representative may request a State Fair Hearing following Cenpatico IC’s resolution of an appeal. The request must be in writing and submitted to:

Cenpatico Integrated Care
Attn: Grievances and Appeals
333 E. Wetmore, Suite 500
Tucson, AZ 85705-1799
Fax Number: (866) 714-7998
Phone: (866) 495-6738
Email: CAZgrievanceandappeals@cenpatico.com

The request must be received by Cenpatico IC no later than 30 days after the date that the person received the Notice of the Appeal Resolution. Cenpatico IC will forward the request for hearing to AHCCCS Office of Administrative Legal Services.

15.3.18 What assistance must be provided to Title XIX/XXI eligible persons in filing an appeal and/or requesting a State Fair Hearing?

Reasonable assistance must be provided to Title XIX/XXI eligible persons in completing forms and other procedural steps during the appeal process. Reasonable assistance includes, but is not
limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD (teletypewriter/telecommunications device for the deaf and text telephone) and interpreter capability. Reasonable assistance may be offered by a provider or referred to Cenpatico IC Grievance and Appeals utilizing one of the methods indicated above.

15.3.19 Continuation of Services During the Appeal or State Fair Hearing Process

Cenpatico IC will ensure that benefits under appeal or in the State Fair Hearing process continue unless continuation of services would jeopardize the health or safety of the person or another person if the following conditions are met:

- The person files the appeal before the later of 10 days after the delivery of the Notice of Action or the effective date of the action, as indicated in the Notice of Action;
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment or the appeal involves a denial if the provider asserts the denial represents a necessary continuation of a previously authorized service;
- The services were ordered by an authorized provider; and
- The person requests continuation of services.

If a person wishes services to continue during appeal, they must request the continuation of services when the appeal is initially filed, and again at the time of any request for a State Fair Hearing.

15.3.20 At What Point Will a Person’s Services No Longer Be Continued during the Appeal or State Fair Hearing Process?

Cenpatico IC will continue services until any of the following occurs:

- The Title XIX/XXI eligible person withdraws the appeal;
- The Title XIX/XXI eligible person makes no request for continued benefits within 10 days of the delivery of the Notice of Appeal Resolution; or
- The AHCCCS Administration issues a State Fair Hearing decision adverse to the Title XIX/XXI eligible person.

If Cenpatico IC’s or the AHCCCS Director’s decision upholds a decision to deny authorization of services, and if the services were furnished solely because of the continuation requirements of Section 15.4. above. Cenpatico IC may recover the cost of the continued services furnished to a Title XIX/XXI eligible person.

15.3.21 Reversal of Decision to Deny Authorization of Services by the State

If Cenpatico IC or the State Fair Hearing decision reverses a decision to deny, limit or delay services not furnished while the appeal was pending, Cenpatico IC will authorize or provide the services promptly and as expeditiously as the Title XIX/XXI eligible person’s health condition requires.

If Cenpatico IC’s or AHCCCS Director’s Decision reverses a decision to deny, limit, or delay authorization of services, and the Member received the disputed services while an appeal was pending, Cenpatico IC shall process a claim for payment from the provider in a manner
consistent with Cenpatico IC’s or Director’s Decision and applicable statutes, rules, policies, and contract terms (See ARS § 36-2904).

The provider shall have 90 days from the date of the reversed final agency decision to submit a clean claim to Cenpatico IC for payment. For all claims submitted as a result of a reversed final agency decision, Cenpatico IC is prohibited from denying claims as untimely if they are submitted within the 90-day timeframe.

Cenpatico IC is also prohibited from denying claims submitted by providers as a result of a reversed decision because the Member chooses not to request continuation of services during the appeals/hearing process: a Member’s failure to request continuation of services during the appeals/hearing process is not a valid basis to deny the claim.

15.3.22 Cooperation with AHCCCS
Cenpatico IC and its providers must fully cooperate with AHCCCS in the event AHCCCS decides to intervene in, participate in or review any Notice, Grievance, Appeal, SMI Grievance, or Claim Dispute or any other grievance system process or proceeding. Cenpatico IC will comply with or implement any AHCCCS directive within the time specified pending formal resolution of the issue.

15.4 Notice Requirements and Appeal Process (SMI and GMH/SA Non-Title XIX/XXI)

15.4.1 General Requirements for Notice and Appeals
Providers must be aware of general requirements guiding notice and appeal rights for the populations covered in this section. Providers may have direct responsibility for designated functions (i.e., sending notice) as determined by Cenpatico IC and/or may be asked to provide assistance to persons who are exercising their right to appeal.

15.4.1.1 Time Computed
In computing any time prescribed or allowed in this section the period begins the day after the act, event or decision occurs. If the period is 11 days or more, the time period must be calculated using calendar days, which means that weekends and legal holidays are counted. If, however, the period of time is less than 11 days, the time period is calculated using working days, in which case, weekends and legal holidays must not be included in the computation. In either case, if the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or a legal holiday.

15.4.1.2 Language, Format and Comprehensive Clinical Record Requirements
Notice and related forms must be available in each prevalent, non-English language spoken in Cenpatico IC’s geographic service area (GSA). As designated by Cenpatico IC, providers must provide free oral interpretation services to all persons who speak non-English languages for purposes of explaining the appeal process and/or information contained in the notice. Cenpatico IC is responsible for providing oral interpretation services at no cost to the person receiving such services.
Notice and other written documents pertaining to the appeal process must be available in alternative formats, such as Braille, large font or enhanced audio and must take into consideration any special communication needs of the person applying for or receiving services. Cenpatico IC is responsible for ensuring the availability of these alternative formats. The provision of notice must be documented by placing a copy of the notice in the person’s comprehensive clinical record.

15.4.1.3 Delivery of Notices and Appeal Decisions

All notices and appeal decisions must be personally delivered or mailed by certified mail to the required party, at their last known residence or place of business. In the event that it may be unsafe to contact the person at his or her home, or the person has indicated that he or she does not want to receive mail at home, the alternate methods identified by the person for communicating notices must be used.

Notices pursuant to this section shall be delivered to:

- The eligible person; or
- The eligible person’s legal or authorized representative and for persons identified as in need of Special Assistance, this includes the person designated to meet the Special Assistance needs.

Provision of notice shall be evidenced by retaining a copy of the notice in the comprehensive clinical record of the person receiving or requesting services. See Provider Manual Form 15.3.1 Notice of Decision and Right to Appeal.

15.4.2 Notice Requirements for Persons Being Evaluated For or with Serious Mental Illness

The following provisions apply to notice requirements for persons with SMI and for persons for which an SMI eligibility determination is being considered.

A Notice of Decision and Right to Appeal (for Individuals with a Serious Mental Illness) (Provider Manual Attachment 15.3.1 Notice of SMI Grievance and Appeal Procedure) must be provided to persons with SMI or to persons applying for SMI services when:

- Initial eligibility for SMI services is determined. The notice must be sent within 3 days of the eligibility determination;
- A decision is made regarding fees or waivers;
- The assessment report, service plan or individual treatment and discharge plan is developed, provided or reviewed;
- A decision is made to modify the service plan, or to reduce, suspend or terminate any service that is a covered service funded through Non-Title XIX/XXI funds. In this case, notice must be provided at least 30 days prior to the effective date unless the person consents to the change in writing or a qualified clinician determines that the action is necessary to avoid a serious or immediate threat to the health or safety of the person receiving services or others;
- A decision is made that the person is no longer eligible for SMI services; and
- A Pre-Admission Screening and Resident Review (PASRR) determination in the context of either a preadmission screening or an annual resident review, which adversely affects the person.
15.4.2.1 Additional Notices

The following additional notices must be provided to persons with SMI or persons applying for SMI services:

- Provider Manual Form 3.5.8 Notice of Legal Rights for Persons with Serious Mental Illness at the time of admission to a behavioral health provider agency for evaluation or treatment. The person receiving this notice must acknowledge in writing the receipt of the notice and the behavioral health provider must retain the acknowledgement in the person’s comprehensive clinical record. All providers must post the Notice of Legal Rights for Persons with Serious Mental Illness in both English and Spanish, so that it is readily visible to behavioral health recipients and visitors;

- Provider Manual Form 3.5.7 Notice of Discrimination Prohibited posted in English and Spanish so that it is readily visible to persons visiting the agency, and a copy provided at the time of discharge from the behavioral health provider agency.

15.4.3 Notice Requirements for Non-Title XIX/XXI/Non-SMI Population

Notice is not required to persons who are not eligible for Title XIX/XXI or SMI services under this policy.

15.4.4 Appeal Requirements

Appeals must be filed with Cenpatico IC. Cenpatico IC adheres to the requirements and procedures outlined in ACOM Section 444 when managing appeals pursuant to this section.

Title XIX/XXI eligible persons applying for or who have been determined to have a SMI and who are appealing an action affecting Title XIX/XXI covered services may elect to use either the Title XIX/XXI appeal process (see Section 15.3 – Notice Requirements and Appeal Process for Title XIX/XXI Eligible Persons) or the appeal process for persons with SMI described in this Section 15.3, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI).

15.4.4.1 Filing Persons and Entities

The following persons and entities may file an appeal:

- An adult applying for or receiving behavioral health services, their legal guardian, guardian ad litem, designated representative or attorney if Special Assistance, the person meeting Special Assistance needs;

- A legal guardian or parent who is the legal custodian of a person under the age of 18 years;

- A court appointed guardian ad litem or an attorney of a person under the age of 18 years;

- A State or governmental agency that provides behavioral health services through an Interagency Service Agreement/Intergovernmental Agreement (ISA/IGA) with AHCCCS, but which does not have legal custody or control of the person, to the extent specified in the ISA/IGA between the agency and the AHCCCS; and
• A provider, acting on the behavioral health recipient’s behalf and with the written authorization of the person.

15.4.4.2 Timeframes for Appeals
Appeals must be filed orally or in writing with Cenpatico IC within 60 days from the date of the decision being appealed. Late appeals must be accepted upon showing good cause.

An extension of the appeal timeframes required in this policy may be secured either at the request of the appellant or with the permission of the Cenpatico IC Director or AHCCCS Director or designee. An extension of time may only be approved upon a showing of necessity and upon a showing that the delay will not pose a threat to the safety or security of the behavioral health recipient. Documentation of the reason for and approval of the extension of time must be maintained in the appeal case record.

15.4.5 Appeal Process for Persons with Serious Mental Illness
An appeal may be filed concerning one or more of the following:
• Decisions regarding the person’s SMI eligibility determination (this type of appeal is managed by the Crisis Response Network);
• Sufficiency or appropriateness of the assessment;
• Long-term view, service goals, objectives or timelines stated in the Individual Service Plan (ISP) or Inpatient Treatment and Discharge Plan (ITDP);
• Recommended services identified in the assessment report, SP or ITDP;
• Actual services to be provided, as described in the ISP, plan for interim services or ITDP;
• Access to or prompt provision of services;
• Findings of the clinical team with regard to the person’s competency, capacity to make decisions, need for guardianship or other protective services or need for Special Assistance;
• Denial of a request for a review of, the outcome of, a modification to or failure to modify, or termination of an SP, ITDP or portion of an ISP or ITDP;
• Application of the procedures and timeframes for developing the ISP or ITDP;
• Implementation of the ISP or ITDP;
• Decision to provide service planning, including the provision of assessment or case management services to a person who is refusing such services, or a decision not to provide such services to the person;
• Decisions regarding a person’s fee assessment or the denial of a request for a waiver of fees;
• Denial of payment of a claim;
• Failure of Cenpatico IC or AHCCCS to act within the timeframes regarding an appeal; or
• A PASRR determination, in the context of either a preadmission screening or an annual resident review, which adversely affects the person.
15.4.6 Continuation of Services during Appeal Process

For persons with SMI, the person’s behavioral health services will continue while an appeal of a modification to or termination of a covered service is pending unless:

- A qualified clinician determines the modification or termination is necessary to avoid a serious or immediate threat to the health or safety of the person or another individual; or
- The person or, if applicable, the person’s guardian, agrees in writing to the modification or termination.

15.4.7 Standard Appeal Process

Within 5 working days of receipt of an appeal, Cenpatico IC must inform the appellant in writing that the appeal has been received and of the procedures that will be followed during the appeal. In the event Cenpatico IC refuses to accept a late appeal or determines that the issue may not be appealed, Cenpatico IC must inform the appellant in writing that they may, within 10 days of their receipt of Cenpatico IC’s decision, request AHCCCS conduct an Administrative Review of the decision.

If a timely request for Administrative Review is filed with AHCCCS of Cenpatico IC’s decision, AHCCCS shall issue a final decision of within 15 days of the request (for persons requiring Special Assistance, see Section 3.11 - Special Assistance for Persons Determined to Have a Serious Mental Illness).

15.4.8 Informal Conference with Cenpatico Integrated Care

Within 7 days of receipt of an appeal, Cenpatico IC shall hold an informal conference with the person, guardian, any designated representative, case manager or other representative of the service provider, if appropriate.

Cenpatico IC must schedule the conference at a convenient time and place and inform all participants in writing, two days prior to the conference, of the time, date and location, the ability to participate in the conference by telephone or teleconference, and the appellant’s right to be represented by a designated representative of the appellant’s choice.

The informal conference shall be chaired by a representative of Cenpatico IC with authority to resolve the issues under appeal, who shall seek to mediate and resolve the issues in dispute. Cenpatico IC representative shall record a statement of the nature of the appeal, the issues involved, any resolution(s) achieved, the date by which the resolution(s) will be implemented, and identify any unresolved issues for further appeal.

If the issues in dispute are resolved to the satisfaction of the person or guardian, if applicable, Cenpatico IC shall issue a dated written Notice of Appeal Resolution to all parties, which shall include a statement of the nature of the appeal, the issues involved, the resolution achieved and the date by which the resolution will be implemented.

If the issues in dispute are not resolved to the satisfaction of the person or guardian and the issues in dispute do not relate to the person’s eligibility for behavioral health services, the person or guardian shall be informed that the matter will be forwarded for further appeal to
AHCCCS for informal conference, and of the procedure for requesting a waiver of the AHCCCS informal conference.

If the issues in dispute are not resolved to the satisfaction of the person or guardian and the issues in dispute relate to the person’s eligibility for SMI services or the person or guardian has requested a waiver of the AHCCCS informal conference in writing, Cenpatico IC shall:

- Provide written notice to the person or guardian of the process to request an administrative hearing.
- Determine at the informal conference whether the person or guardian is requesting Cenpatico IC to request an administrative hearing on behalf of the person or guardian and, if so, file the request with AHCCCS within 3 days of the informal conference.
- For a person who is in need of special assistance, send a copy of the appeal, results of information conference and notice of administrative hearing to the Office of Human Rights (OHR).
- In the event the person appealing fails to attend the informal conference and fails to notify Cenpatico IC of their inability to attend prior to the scheduled conference, Cenpatico IC shall reschedule the conference. If the person appealing fails to attend the rescheduled conference and fails to notify Cenpatico IC of their inability to attend prior to the rescheduled conference, Cenpatico IC will close the appeal docket and send written notice of the closure to the person appealing.
- In the event the appellant requests the appeal be re-opened due to not receiving the informal conference notification and/or due to good cause, Cenpatico IC can re-open the appeal and proceed with the informal conference.
- For all appeals unresolved after an informal conference with Cenpatico IC, Cenpatico IC must forward the appeal case record to the AHCCCS OGA within three days from the conclusion of the informal conference.

15.4.9 AHCCCS Informal Conference

Unless the person or guardian waives an informal conference AHCCCS or the issue on appeal relates to eligibility for SMI services, AHCCCS shall hold a second informal conference within 15 days of the notification from Cenpatico IC that the appeal was unresolved.

At least 5 days prior to the date of the second informal conference, AHCCCS shall notify the participants in writing of the date, time and location of the conference.

The informal conference shall be chaired by a representative of AHCCCS with authority to resolve the issues under appeal who shall seek to mediate and resolve the issues in dispute.

The AHCCCS representative shall record a statement of the nature of the appeal, the issues involved, any resolution(s) achieved, the date by which the resolution(s) will be implemented, and identify any unresolved issues for further appeal.

If the issues in dispute are resolved to the satisfaction of the person or guardian, AHCCCS shall issue a dated written notice to all parties, which shall include a statement of the nature of the appeal, the issues involved, the resolution achieved and the date by which the resolution will be
implemented. For a person in need of Special Assistance, AHCCCS shall send a copy of the informal conference report to the OHR.

If the issues in dispute are not resolved to the satisfaction of the person or guardian, AHCCCS shall:

- Provide written notice to the person or guardian of the process to request an administrative hearing.
- Determine at the informal conference whether the person or guardian is requesting AHCCCS to request an administrative hearing on behalf of the person or guardian and, if so, file the request within 3 days of the informal conference.
- For a person who is in need of Special Assistance, send a copy of the notice to the OHR.
- In the event the person appealing fails to attend the informal conference and fails to notify AHCCCS of their inability to attend prior to the scheduled conference, AHCCCS may issue a written notice, within 3 working days of the scheduled conference, which contains a description of the decision on the issue under appeal and which advises the appellant of their right to request an Administrative Hearing.
- In the event the appellant requests the appeal be re-opened due to not receiving the informal conference notification and/or due to good cause, the AHCCCS can re-open the appeal and proceed with the informal conference.

**15.4.10 Requests for Administrative Hearing**

A written request for administrative hearing shall be filed with Cenpatico IC for forwarding to AHCCCS. The hearing request must contain the following information:

- Case name (name of the applicant or person receiving services, name of the appellant and the AHCCCS docket number);
- The decision being appealed;
- The date of the decision being appealed; and
- The reason for the appeal.

Cenpatico IC shall ensure that the written request for hearing, appeal case record and all supporting documentation is received by the AHCCCS OALS within 3 days from such date.

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

**15.4.11 Expedited appeals**

A person, or a provider on the person’s behalf, may request an expedited appeal for the denial or termination of crisis or emergency services, the denial of admission to or the termination of a continuation of inpatient services, if inpatient services are a covered benefit, or for good cause.

Within 1 day of receipt of a request for an expedited appeal, Cenpatico IC must inform the appellant in writing that the appeal has been received and of the time, date and location of the informal conference, or issue a written decision stating that the appeal does not meet criteria as an expedited appeal and that the appellant may request an Administrative Review from AHCCCS.
of this decision within 3 days of the decision. The appeal shall then proceed according to the standard process described in this section.

15.4.12 Cenpatico Integrated Care Expedited Informal Conference
Within 2 days of receipt of a written request for an expedited appeal, Cenpatico IC shall hold an informal conference to mediate and resolve the issues in dispute.

15.4.13 AHCCCS Expedited Informal Conference
Within two days of notification from Cenpatico IC, AHCCCS shall hold an informal conference to mediate and resolve the issue in dispute, unless the appellant waives the conference at this level, in which case the appeal shall be forwarded within one day to the ADHS Director to schedule an administrative hearing.

Within one day of the informal conference with AHCCCS, if the conference failed to resolve the appeal, the appeal shall be forwarded to the ADHS Director to schedule an administrative hearing.

15.4.14 Requests for Administrative Hearing
A written request for an administrative hearing shall be filed with Cenpatico IC and must contain the following information:

- Case name (name of the applicant or person receiving services, name of the appellant and the AHCCCS docket number);
- The decision being appealed;
- The date of the decision being appealed; and
- The reason for the appeal.

Cenpatico IC shall ensure that the written request for hearing, appeal case record and all supporting documentation is received by the AHCCCS OGA within 3 days.

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

15.4.15 Non-SMI/Non-Title XIX/XXI Member Appeals
This process applies to actions or decisions related to determination of need for Non- SMI, Non-Title XIX/XXI funded, covered behavioral health services.

Cenpatico IC must:

- Inform the appellant in writing within 5 working days of receipt that the appeal has been received and of the procedures that will be followed during the appeal;
- Provide the appellant a reasonable opportunity to present evidence and allegations of fact or law in person and in writing; and
- Provide a written decision no later than 30 days from the day the appeal is received. The decision shall include a summary of the issues involved, the outcome of the appeal, and the basis of the decision. For appeals not resolved wholly in favor of the appellant, Cenpatico IC will advise the appellant in writing of their right to request
an administrative hearing with the AHCCCS Administration no later than 30 days from the date of Cenpatico IC’s decision, and how to do so.

15.5 Provider Claims Disputes

The provider claim dispute process affords providers the opportunity to challenge a decision by Cenpatico IC that impacts the provider for issues involving:

- Payment or nonpayment of a claim;
- The recoupment of payment on a claim; and
- The imposition of sanctions.

Providers may submit a claim dispute to Cenpatico IC, which does not delegate its claim-dispute responsibilities, when:

- Challenging a decision of Cenpatico IC; or
- Disputing a claim payment issue for services provided to persons enrolled with Cenpatico IC.

This section does not apply to disputes between Cenpatico IC and a prospective provider made in connection with Cenpatico IC’s contracting process.

Once Cenpatico IC or AHCCCS makes a decision regarding a provider claim dispute, the provider may request another review of the decision, referred to as an administrative hearing.

Many times, disagreements between a provider and Cenpatico IC or AHCCCS can be resolved through an informal process. Providers are encouraged to try and resolve issues at the informal level before initiating the formal provider claim dispute process. However, providers should be aware that the formal process contains very specific timeframes within which to file for a review and/or hearing and resolving issues through an informal process does not suspend or postpone these timeframes.

The intent of this section is to describe the options available to providers to resolve issues and other events related to a decision of Cenpatico IC or AHCCCS. The section is organized to delineate the process for filing a claim dispute:

- For providers disputing a decision of Cenpatico IC; and
- The process for requesting an administrative hearing in the event a provider does not agree with the claim dispute decision of Cenpatico IC or AHCCCS.

Cenpatico IC provides non-contracted providers with its claim dispute policy with a remittance advice within 45-days of receipt of a claim.

15.5.1 Prior To Filing An Initial Claim Dispute

All providers are encouraged to seek informal resolution of a concern by first contacting the appropriate entity responsible for the decision. For concerns regarding claims, it is important for providers to understand why the claim was denied before initiating a claim dispute. Denied claims may be the result of filing errors or missing supporting documentation, such as an
explanation of benefits (EOB) or an invoice. Resubmitting claims with the requested information or corrections can result in resolution of the issue and full payment of the claim. To get assistance with the informal resolution of a decision, please contact:

Cenpatico Integrated Care
Attn: Claims Department
333 E. Wetmore, Suite 500
Tucson, AZ 85705-1799
Email: CAZclaims@cenpatico.com

Providers are also encouraged to discuss concerns about claim processing with a Provider Mentor.

15.5.2 General Requirements

15.5.2.1 Computation of Time

A written claim dispute is considered filed when it is received by Cenpatico IC, as established by a date stamp or other record of receipt. Providers must use the following methodology in computing any period of time described in this chapter:

- Computation of time for calendar day begins the day after the act, event or decision 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 an issue is unable to be resolved informally, providers may dispute the decision by filing a written claim dispute. For all provider claim disputes related to decisions of Cenpatico IC, the provider must file the claim dispute with Cenpatico IC at:

Cenpatico Integrated Care
Attn: Grievances and Appeals
333 E. Wetmore, Suite 500
Tucson, AZ 85705-1799
Fax Number: (866) 714-7998
Phone: (866) 495-6738

Cenpatico IC utilizes a unique Docket Number for each claim dispute filed. All documentation received during the claim dispute resolution process is date stamped upon receipt.

All claim dispute case records are filed in secured locations and retained for five years after the most recent decision has been rendered.

15.5.2.2 Notification of Right to File Claim Dispute

Cenpatico IC provides an affected provider a remittance advice that includes providers’ right to file a claim dispute and how to do so, upon the payment, denial or recoupment of payment of a claim. Cenpatico IC notifies an affected provider of the right to file a claim dispute and how to do so when a decision is made to impose a sanction.
15.5.2.3 Initiating Claim Dispute

It is important for providers to ensure the claim dispute is submitted in writing and contains all required information and is filed within the required timeframes. Failure to do so will result in the denial of the claim dispute.

A notice of claim dispute must specify the statement of the factual and legal basis for the claim dispute and the relief requested. Claim disputes may be denied if the filing party has failed to provide a comprehensive factual or legal basis for the dispute.

15.5.2.4 Timeframes for Initiating Claim Dispute

The claim dispute must be filed within the following established timeframes:

- Within 60 days of the date of notice advising that a sanction will be imposed, or
- For challenges relating to the payment, denial or recoupment of a claim, the later of the following:
  - 12 months of the date of delivery of the service;
  - 12 months after the date of eligibility posting; or
  - Within 60 days after the payment or denial of a timely claim submission, or the recoupment of payment, whichever is later.

15.5.3 Claim Disputes of Cenpatico Integrated Care Decisions

Within 5 days of receipt of a claim dispute, Cenpatico IC’s issues a written acknowledgment that the claim dispute has been received, will be reviewed and that a decision will be issued within 30 days of receipt of the claim dispute, absent extension of the timeline.

If Cenpatico IC determines that it was not responsible for the claim dispute, it will immediately forward the claim dispute to the responsible RBHA/Health Plan or to AHCCCS with an explanation of why the claim dispute is being forwarded. A copy of the transmittal is sent by Cenpatico IC to the party filing the claim dispute. The receiving RBHA/Health Plan or AHCCCS must ensure that a decision is rendered within 30 days of Cenpatico IC’s receipt of the notice of claim dispute, unless an extension has been granted.

15.5.3.1 Cenpatico Integrated Care Decision

Cenpatico IC shall issue a written, dated decision which must be mailed by certified mail to all parties no later than 30 days after the provider files a claim dispute with Cenpatico IC, unless the provider and Cenpatico IC have agreed to an extension. The Decision must include and describe in detail, the following:

- The nature of the claim dispute;
- The issues involved;
- Cenpatico IC’s decision and the reasons supporting Cenpatico IC’s decision, including references to applicable statutes, rules, contractual provisions, and policies and procedures;
• The provider’s right to request a hearing by filing a written request for hearing to AHCCCS no later than 30 days after the date the provider receives Cenpatico IC’s decision;
• The provider’s right to request an informal settlement conference prior to hearing; and
• If the claim dispute is overturned, the requirement that Cenpatico IC must reprocess and pay the claim(s), with interest, when applicable, in a manner consistent with the Decision within 15 business days of the date of the decision.

15.5.4 Extension of Time
The time to issue a decision may be extended upon agreement between the parties. Documentation of the agreement to the extension of time must be maintained in the claim dispute case record.

15.5.5 Requests for Administrative Hearing
If the party filing a claim dispute is dissatisfied with an AHCCCS or Cenpatico IC decision, or if a decision is not received within 30 days after the claim dispute is filed, absent an extension of time, a request for an administrative hearing may be filed, in writing, with Cenpatico IC. Cenpatico IC will forward the request for hearing to AHCCCS OALS.

15.5.5.1 Timeframes for Requesting an Administrative Hearing
The provider’s request for a hearing must be filed in writing and received by AHCCCS no later than 30 calendar days of the date of receipt of the AHCCCS or Cenpatico IC decision, absent an extension of time, or in the event no decision is rendered, within 30 days of the date of filing the claim dispute, absent an extension.

15.5.5.2 Scheduling of an Administrative Hearing
Pursuant to A.R.S. § 41-1092.03, upon receipt of a request for an administrative hearing, an administrative hearing will be scheduled pursuant to A.R.S. § 41-1092.05.

AHCCCS OALS shall accept a written request for withdrawal from the filing party if the request is received prior to AHCCCS scheduling and mailing of a Notice of Hearing. Otherwise, a filing party who wishes to withdraw must send a written request (motion) for withdrawal to the Office of Administrative Hearings consistent with AAC R2-19-106(A)(3).

If Cenpatico IC’s decision regarding a claim dispute is reversed through the claim dispute or hearing process, Cenpatico IC will reprocess and pay the claim(s) with interest, when applicable, in a manner consistent with the decision within 15 business days of the date of the decision unless a different timeframe is specified.

15.5.6 Administrative Process
The Administrative Hearing Process is conducted according to A.R.S. Title 41, Chapter 6, Article 10.
15.5.7 Detecting Fraud And Program Abuse

Cenpatico IC tracks, trends and analyzes claim disputes for purposes of detecting fraud and program abuse. Cenpatico IC reports all suspected fraud, waste and/or program abuse involving any Title XIX funds to the AHCCCS Office of the Inspector General (OIG) consistent with the requirements in Section 12.7 – Corporate Compliance.
Section 16 - DELIVERABLE REQUIREMENTS

The following table is a summary of the periodic reporting requirements and is subject to change at any time during the term of the contract. The table is presented for convenience only and should not be construed to limit provider’s responsibilities in any manner. Content for all deliverables is subject to ongoing review. All contractual obligations apply. Reports are to be submitted to cazdeliverables@cenpatico.com, unless otherwise noted, in the following format: DELIVERABLE #, DUE DATE, PROVIDER NAME -example: ND601_120115_ABCCOUNSELING.

“Days” means calendar days unless otherwise specified. If the due day is a weekend or a State of Arizona holiday, the period is extended until the end of the next day that is not a weekend or a legal holiday.

<table>
<thead>
<tr>
<th>Report #</th>
<th>Deliverable Name</th>
<th>Providers Required to Submit</th>
<th>Cenpatico IC Required Form</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA-802</td>
<td>Annual Cultural Competency Plan</td>
<td>Health Home Providers</td>
<td>Yes</td>
<td>For new providers within 30 days of contract start date; October 15th thereafter</td>
</tr>
<tr>
<td>CA-905</td>
<td>RSS Inventory Utilization Committee Referral Report – PFRO</td>
<td>Specialty Behavioral Health Providers &amp; CSA Providers that employ Peer and/or Family Supports</td>
<td>Yes</td>
<td>5th calendar day after quarter end</td>
</tr>
<tr>
<td>CA-906</td>
<td>RSS Inventory Utilization Committee Referral Report - Health Home</td>
<td>Health Homes (except CPR)</td>
<td>Yes</td>
<td>5th calendar day after quarter end</td>
</tr>
<tr>
<td>CA-907</td>
<td>Persons Receiving Special Assistance</td>
<td>Health Home Providers that receive CA-907 form from Cenpatico</td>
<td>Yes – Will be sent from Cenpatico on the 15th day of each month.</td>
<td>28th day of each month, In addition to the cazdeliverables mailbox, also copy to <a href="mailto:melisbrown@cenpatico.com">melisbrown@cenpatico.com</a></td>
</tr>
<tr>
<td>CA-908</td>
<td>Special Assistance Form Deliverable</td>
<td>Health Home Providers with active Special Assistance members</td>
<td>Yes</td>
<td>5th day of the month for the previous months data, In addition to the cazdeliverables mailbox, also copy to <a href="mailto:melisbrown@cenpatico.com">melisbrown@cenpatico.com</a></td>
</tr>
<tr>
<td>CC-901</td>
<td>Annual Corporate Compliance Plan Update</td>
<td>Health Home Providers &amp; Specialty Behavioral Health Providers</td>
<td>No</td>
<td>Within thirty (30) days of contract start date; October 1st thereafter</td>
</tr>
<tr>
<td>CD-501</td>
<td>Accord Certificate of Liability Insurance</td>
<td>All Providers</td>
<td>No</td>
<td>Annually - within (15) fifteen calendar days</td>
</tr>
<tr>
<td>Report #</td>
<td>Deliverable Name</td>
<td>Providers Required to Submit</td>
<td>Cenpatico IC Required Form</td>
<td>Due Date</td>
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</tr>
<tr>
<td>CD-502</td>
<td>Department of Economic Security - Professional Foster Care Home License</td>
<td>HCTC &amp; BH Therapeutic Homes</td>
<td>No</td>
<td>Within 15 calendar days prior to expiration of each license</td>
</tr>
<tr>
<td>CO-115</td>
<td>Justice Services Report</td>
<td>Community Health Associates</td>
<td>Yes</td>
<td>5th calendar day of the Month</td>
</tr>
<tr>
<td>EC-301-1</td>
<td>Emergency Room Wait Times Report</td>
<td>NurseWise</td>
<td>Yes</td>
<td>3rd calendar day of month for previous month’s data</td>
</tr>
<tr>
<td>EC-301-1b</td>
<td>Daily Pending Inpatient Placement Report</td>
<td>NurseWise</td>
<td>Yes</td>
<td>Daily by 10am for previous day. Send to Email Distribution List as agreed upon by parties</td>
</tr>
<tr>
<td>EC-301-2</td>
<td>Mobile Team Timeliness Report</td>
<td>NurseWise</td>
<td>Yes</td>
<td>21st calendar day of month for previous month</td>
</tr>
<tr>
<td>EC-301-5</td>
<td>Urgent Response Report</td>
<td>NurseWise</td>
<td>Yes</td>
<td>15th calendar day of month for previous month</td>
</tr>
<tr>
<td>EC-301-6</td>
<td>Acute Health Plan &amp; Provider Inquiry Log and Detail</td>
<td>NurseWise</td>
<td>Yes</td>
<td>20th calendar day of month for previous month</td>
</tr>
<tr>
<td>EC-301-7</td>
<td>Crisis Call Report</td>
<td>NurseWise</td>
<td>Yes</td>
<td>5th calendar day of month for previous month</td>
</tr>
<tr>
<td>EC-301-8</td>
<td>Client Activity Report</td>
<td>NurseWise</td>
<td>Yes</td>
<td>5th calendar day of month for previous month</td>
</tr>
<tr>
<td>EC-301-11</td>
<td>Cenpatico IC Customer Service Phone Reporting</td>
<td>NurseWise</td>
<td>Yes</td>
<td>5th calendar day of month for previous month</td>
</tr>
<tr>
<td>EC-301-11b</td>
<td>Cenpatico IC Customer Service Phone Reporting</td>
<td>NurseWise</td>
<td>Yes</td>
<td>Daily by 10am for previous day to Email Distribution as agreed upon</td>
</tr>
<tr>
<td>EC-301-12</td>
<td>Crisis Implementation Oversight Includes: Daily Policy Call Notification</td>
<td>NurseWise</td>
<td>Yes</td>
<td>Daily by 10am for previous day to Email Distribution as agreed upon</td>
</tr>
<tr>
<td>EC-301-16</td>
<td>MyHealthDirect Urgent Scheduling</td>
<td>NurseWise</td>
<td>Yes</td>
<td>10th calendar day of month for previous month</td>
</tr>
<tr>
<td>EC-301-17</td>
<td>Secondary Responder Activation Report</td>
<td>Devereux, La Frontera EMPACT, LifeShare, Hope, Inc., Old Pueblo &amp; TLCR</td>
<td>Yes</td>
<td>10th of month for previous month</td>
</tr>
<tr>
<td>Report #</td>
<td>Deliverable Name</td>
<td>Providers Required to Submit</td>
<td>Cenpatico IC Required Form</td>
<td>Due Date</td>
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<tr>
<td>EC-301-19</td>
<td>Report for Pima County-COE detail</td>
<td>NurseWise</td>
<td>Yes</td>
<td>20th calendar day of month for previous month</td>
</tr>
<tr>
<td>EC-301-20</td>
<td>Pima County Crisis Line Report</td>
<td>NurseWise</td>
<td>Yes</td>
<td>20th calendar day of month for previous month</td>
</tr>
<tr>
<td>EC-301-22</td>
<td>Crisis Notifications to Providers</td>
<td>NurseWise</td>
<td>No</td>
<td>Daily by 10am to individual/applicable providers</td>
</tr>
<tr>
<td>EC-301-23</td>
<td>Crisis Notification to Health Plan</td>
<td>NurseWise</td>
<td>No</td>
<td>Daily by 10am to all acute plans</td>
</tr>
<tr>
<td>EC-301-25</td>
<td>Foster Care Hotline Call Report</td>
<td>NurseWise</td>
<td>Yes</td>
<td>5th calendar of the month for the previous month</td>
</tr>
<tr>
<td>EC-301-26</td>
<td>Tribal Crisis Call Template</td>
<td>NurseWise</td>
<td>Yes</td>
<td>7th calendar day of the month for the previous month</td>
</tr>
<tr>
<td>EC-302</td>
<td>COT Title 36 Reporting</td>
<td>Health Home Providers that have members on COT</td>
<td>No</td>
<td>2nd Calendar day of the month. All COT portal entries not yet entered for the current reporting month and all required documents that have not yet been submitted for the current reporting month. In addition to the cazdeliverables mailbox, also sent to <a href="mailto:CAZTitle36@Cenpatico.com">CAZTitle36@Cenpatico.com</a> mail box.</td>
</tr>
<tr>
<td>EC-304</td>
<td>Prevention Report</td>
<td>Prevention Providers (except COPE &amp; SAAF)</td>
<td>Yes</td>
<td>15th calendar day after month end</td>
</tr>
<tr>
<td>EC-305</td>
<td>Annual Prevention Report</td>
<td>Prevention Providers</td>
<td>Yes</td>
<td>Submission by August 31st</td>
</tr>
<tr>
<td>EC-306</td>
<td>Prevention Program Description/Logic Model</td>
<td>Prevention Providers</td>
<td>Yes</td>
<td>Submission by April 1st</td>
</tr>
<tr>
<td>EC-307</td>
<td>Disaster Recovery Certification</td>
<td>Health Home Providers &amp; Specialty Behavioral Health Providers</td>
<td>No</td>
<td>June 15th</td>
</tr>
<tr>
<td>EC-308</td>
<td>Business Continuity/Recovery Plan Checklist</td>
<td>Health Home Providers &amp; Specialty</td>
<td>Yes</td>
<td>June 15th</td>
</tr>
<tr>
<td>Report #</td>
<td>Deliverable Name</td>
<td>Providers Required to Submit</td>
<td>Cenpatico IC Required Form</td>
<td>Due Date</td>
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</tr>
<tr>
<td>EC-309</td>
<td>Business Continuity/Recovery Plan Summary</td>
<td>Behavioral Health Providers</td>
<td>No</td>
<td>June 15th</td>
</tr>
<tr>
<td>EC-310</td>
<td>Annual Heat Plan Update</td>
<td>Health Home Providers &amp; Specialty Behavioral Health Providers</td>
<td>Yes</td>
<td>April 15th</td>
</tr>
<tr>
<td>EC-311</td>
<td>PCP Transition Log</td>
<td>Health Home Providers (except CPR)</td>
<td>No</td>
<td>10th calendar day after month end</td>
</tr>
<tr>
<td>EC-312</td>
<td>Crisis Mobile Team Readiness Review</td>
<td>Providers with Crisis Mobile Teams (ACT, CBI, CHA, HHW)</td>
<td>No</td>
<td>August 1st &amp; February 1st</td>
</tr>
<tr>
<td>EC-313</td>
<td>Coalition Detailed Implementation Plan</td>
<td>Prevention Providers</td>
<td>Yes</td>
<td>Submission online September 15th or 30 days after approved program changes</td>
</tr>
<tr>
<td>EC-314</td>
<td>HIV Early Intervention Monthly Report</td>
<td>HIV Early Intervention Providers COPE SAAF</td>
<td>Yes</td>
<td>5th calendar day after month end</td>
</tr>
<tr>
<td>EC-317</td>
<td>ACT Team Program Report</td>
<td>Telecare, CPCC &amp; COPE</td>
<td>Yes</td>
<td>10th calendar day after month end</td>
</tr>
<tr>
<td>EC-319</td>
<td>Evidence Based Prevention Assessment</td>
<td>Prevention Providers</td>
<td>Yes</td>
<td>15th of July</td>
</tr>
<tr>
<td>EC-320</td>
<td>Urgent Transportation Report</td>
<td>AMT, Saguaro, &amp; TLC-R</td>
<td>No</td>
<td>10th calendar day after month end</td>
</tr>
<tr>
<td>EC-321</td>
<td>T36 Pre-Petition Data</td>
<td>CBI</td>
<td>Yes</td>
<td>Last day of the month for previous month’s data</td>
</tr>
<tr>
<td>EC-322</td>
<td>Scorecard</td>
<td>CRC, HHW, CBI</td>
<td>Yes – one for each provider</td>
<td>29th calendar day after month end</td>
</tr>
<tr>
<td>Report #</td>
<td>Deliverable Name</td>
<td>Providers Required to Submit</td>
<td>Cenpatico IC Required Form</td>
<td>Due Date</td>
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</tr>
<tr>
<td>EC-323</td>
<td>Crisis Mobile Team Activity Log</td>
<td>ACTS, CBI, CHA, HHW</td>
<td>Yes</td>
<td>5th calendar day after month end</td>
</tr>
<tr>
<td>EC-324</td>
<td>Integration Performance Measures Outreach Monitoring Tool</td>
<td>Health Home Providers (except CPR)</td>
<td>Yes</td>
<td>5th calendar day after quarter end</td>
</tr>
<tr>
<td>EC-325</td>
<td>Living Room Center Admission Report</td>
<td>CHA</td>
<td>Yes</td>
<td>10th day of the month for previous month</td>
</tr>
<tr>
<td>FN-101</td>
<td>Month End Financial Statements (including supplemental schedules &amp; liquidity and profit percentage)</td>
<td>Health Home Providers Block Providers (except CPR)</td>
<td>Yes</td>
<td>30th calendar day after month end 40th calendar day after month end for SEC registered providers</td>
</tr>
<tr>
<td>FN-401</td>
<td>Quarterly Financial Statements (including liquidity and profit percentage):</td>
<td>All Specialty Block Providers plus CPR</td>
<td>Yes</td>
<td>30th calendar day after quarter end</td>
</tr>
<tr>
<td>FN-402</td>
<td>*Final Audited Financial Statements *Final Audited Financial Statements for All Related Parties Earning Revenue under this Contract <em>Final Supplemental Reports to the Audited Financial Statements</em>Liquidity Ratios and Profit Percentage</td>
<td>All Providers</td>
<td>No</td>
<td>Health Home &amp; Specialty Block – 120 days after provider’s fiscal year end. FFS providers upon request.</td>
</tr>
<tr>
<td>FN-403</td>
<td>Non-Title Funding Expenditure Report</td>
<td>Providers that received SABG, MHBG, NT SMI Block Funding</td>
<td>Yes</td>
<td>30th calendar day after quarter end</td>
</tr>
<tr>
<td>FN-405</td>
<td>OMB A-133 Audit</td>
<td>Providers that received over $750,000 federal grant funds (SABG or MHBHG)</td>
<td>No</td>
<td>150 days after provider’s fiscal year end</td>
</tr>
<tr>
<td>Report #</td>
<td>Deliverable Name</td>
<td>Providers Required to Submit</td>
<td>Cenpatico IC Required Form</td>
<td>Due Date</td>
</tr>
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</tr>
<tr>
<td>FN-407</td>
<td>OMB A-133 Audit</td>
<td>Banner Healthcare Only</td>
<td>No</td>
<td>210 days after provider’s fiscal year end</td>
</tr>
<tr>
<td>IT-702</td>
<td>7 Day Access to Care</td>
<td>Health Home Providers (except CPR)</td>
<td>Yes</td>
<td>10th calendar day after month end</td>
</tr>
<tr>
<td>ND-601</td>
<td>Staff Listing Form</td>
<td>Health Home Providers &amp; Specialty Block Providers (except NW)</td>
<td>Yes</td>
<td>Ad hoc as staff are added and removed</td>
</tr>
<tr>
<td>ND-602</td>
<td>Staff Listing Attestation</td>
<td>Health Home Providers &amp; Specialty Block Providers (except NW)</td>
<td>Yes</td>
<td>15th calendar day after Quarter End</td>
</tr>
<tr>
<td>OI-201</td>
<td>Child Dedicated Recovery Coach Inventory</td>
<td>Health Home Providers (except Banner, CBI, COPE, CPR, CRM, Desert Senita, El Rio &amp; Hope Inc.)</td>
<td>Yes</td>
<td>2nd calendar day of the Month</td>
</tr>
<tr>
<td>OI-206</td>
<td>Housing Roster Report</td>
<td>ACHIEVE, Horizon Health and Wellness, SEABHS, Marana Health, CODAC, COPE, La Frontera, CPCC, MHRI, HOPE, Old Pueblo Community Services, CBI, Wellness Connections, TLCR, Pinal Hispanic Council</td>
<td>Yes</td>
<td>2nd calendar day of the Month</td>
</tr>
<tr>
<td>OI-214</td>
<td>Quarterly Rehab Progress Report</td>
<td>Health Home Providers</td>
<td>No</td>
<td>2nd calendar day after quarter end</td>
</tr>
<tr>
<td>OI-217</td>
<td>Tohono O’odham Nation Quarterly Report</td>
<td>Assurance I-Hope Transportation Intermountain Centers for Human Development, Horizon Health &amp; Wellness 101 Wall Services, LLC Community Bridges Community Health Associates Native American Advancement Foundation</td>
<td>Yes</td>
<td>5th calendar day after quarter end</td>
</tr>
<tr>
<td>Report #</td>
<td>Deliverable Name</td>
<td>Providers Required to Submit</td>
<td>Cenpatico IC Required Form</td>
<td>Due Date</td>
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</tr>
<tr>
<td>OI-218</td>
<td>Tribal Warm Line Outreach Report</td>
<td>NurseWise</td>
<td>Yes</td>
<td>5th calendar day after month end</td>
</tr>
<tr>
<td>OI-230</td>
<td>Monthly CCCT/CCI Program Report</td>
<td>Casa De Los Niños, CPES, Intermountain &amp; Pathways</td>
<td>Yes</td>
<td>5th calendar day after month end</td>
</tr>
<tr>
<td>OI-235</td>
<td>VR Referral Tracker</td>
<td>All Adult Health Homes, with county-specific detail in report</td>
<td>Yes</td>
<td>5th calendar day of the month following</td>
</tr>
<tr>
<td>OI–236</td>
<td>MAT Census Report</td>
<td>CBI, La Frontera, COPE, CODAC, CMS, HHW, New Hope BH, Wellbeing</td>
<td>Yes</td>
<td>5th calendar day after month end</td>
</tr>
<tr>
<td>OI-238</td>
<td>R.E.S.P.E.C.T Report</td>
<td>CHA</td>
<td>Yes</td>
<td>5th calendar day after month end</td>
</tr>
<tr>
<td>OI-239</td>
<td>Work Adjustment Training Programs</td>
<td>Marana, HHW, Coyote Taskforce, DKA, WEDCO, Beacon Group, SEACRS, TLCR</td>
<td>Yes</td>
<td>5th calendar day after month end</td>
</tr>
<tr>
<td>OI-240</td>
<td>Health Home Services Monitoring Report</td>
<td>All Health Homes</td>
<td>Yes</td>
<td>5th calendar day after month end (starting 2/5/17)</td>
</tr>
<tr>
<td>RF-101</td>
<td>Weekly BIP Report</td>
<td>CBI, Cope, CODAC, LFC, CPCC, Devereux, ICHD &amp; Park Place</td>
<td>Yes</td>
<td>Every Friday</td>
</tr>
<tr>
<td>RF-103</td>
<td>AIC Weekly Census</td>
<td>Devereux, CPES and Intermountain</td>
<td>Yes</td>
<td>Every Tuesday</td>
</tr>
<tr>
<td>RF-1002</td>
<td>Engagement Specialist Tracking Log</td>
<td>CHA, Coyote, Hope, PPEP, CCS, Old Pueblo, NAMI, CBI, Wellness, NazCare, HHW, PHC, TLCR</td>
<td>Yes</td>
<td>5th calendar day after month end</td>
</tr>
<tr>
<td>RF-1005</td>
<td>Incidents, Accidents, and Death Report</td>
<td>All Providers</td>
<td>No</td>
<td>Within (2) two business days of the incident and the IAD must be entered into the AHCCCS QMS Portal <a href="https://app.azdhs.gov/QMPortal/">https://app.azdhs.gov/QMPortal/</a></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Report #</th>
<th>Deliverable Name</th>
<th>Providers Required to Submit</th>
<th>Cenpatico IC Required Form</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>RF-1008</td>
<td>Notification of Persons in Need of Special Assistance</td>
<td>Health Home Providers (except CPR)</td>
<td>Form.3.11.1, Part A</td>
<td>Due to OHR within (5) five business days of identifying need for special assistance, copy to Cenpatico IC via secure email to <a href="mailto:melisbrown@cenpatico.com">melisbrown@cenpatico.com</a></td>
</tr>
<tr>
<td>RF-1009</td>
<td>Notification of Persons No Longer in Need of Special Assistance</td>
<td>Health Home Providers (except CPR)</td>
<td>Form 3.11.1 Part C</td>
<td>Due to OHR within (10) business days of identifying individual is no longer in need of special assistance, copy to Cenpatico IC via secure email to <a href="mailto:melisbrown@cenpatico.com">melisbrown@cenpatico.com</a></td>
</tr>
<tr>
<td>RF-1010</td>
<td>Complaint Resolution Confirmation Response</td>
<td>All Providers</td>
<td>No</td>
<td>Within two (2) business days of the request</td>
</tr>
<tr>
<td>RF-1011</td>
<td>Title XIX/XXI Screening and Referral Report</td>
<td>Health Home Providers (except CPR)</td>
<td>Yes</td>
<td>10th calendar day after month end</td>
</tr>
<tr>
<td>RF-1012</td>
<td>AzSH Progress Report</td>
<td>Health Home Providers (except CPR)</td>
<td>No</td>
<td>Monthly, if working with participant in AzSH</td>
</tr>
<tr>
<td>RF-1013</td>
<td>PASRR Level II Evaluations completed by a Psychiatrist</td>
<td>Health Home Providers (except CPR)</td>
<td>No</td>
<td>When requested by AHCCCS or Cenpatico IC, complete evaluation within (3) three business days for hospitalized individuals and within 5 business days for all others. Fax to (866) 601-0111</td>
</tr>
<tr>
<td>RF-1015</td>
<td>Notification by email or letter of an unexpected material facility change that could impact the Provider Network</td>
<td>All Providers</td>
<td>No</td>
<td>Within one (1) business day of becoming aware of the unexpected change.</td>
</tr>
<tr>
<td>RF-1016</td>
<td>Notification of Change Form</td>
<td>All Providers</td>
<td>Yes</td>
<td>At least (75) seventy-five calendar days prior to the anticipated change that could impact the Provider Network.</td>
</tr>
<tr>
<td>RF-1018</td>
<td>Ad Hoc Reports not listed</td>
<td>All Providers</td>
<td>TBD</td>
<td>Within requested time frame, as</td>
</tr>
<tr>
<td>Report #</td>
<td>Deliverable Name</td>
<td>Providers Required to Submit</td>
<td>Cenpatico IC Required Form</td>
<td>Due Date</td>
</tr>
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</tr>
<tr>
<td>RF-1019</td>
<td>Bridge Subsidy Program (BSP) Report</td>
<td>Health Home Providers (except CPR)</td>
<td>Yes</td>
<td>Within two (2) business days after a participant has been accepted into a Bridge Subsidy Program and 5th day after month end as long as participant is enrolled</td>
</tr>
<tr>
<td>RF-1020</td>
<td>Language Proficiency Inventory</td>
<td>Health Home Providers &amp; Specialty Providers</td>
<td>Yes</td>
<td>Within thirty (30) days of contract start date; January 15 and July 15 thereafter</td>
</tr>
<tr>
<td>RF-1021</td>
<td>System of Care Practice Review (SOCPR) Practice Improvement Plan Updates</td>
<td>Children’s Health Home Providers participating in annual practice review process</td>
<td>Yes</td>
<td>Initial Plan due: upon request. Plan Updates due upon request</td>
</tr>
<tr>
<td>RF-1022</td>
<td>Medicare Advantage D-SNP Member Pre-Service Appeals Report</td>
<td>Banner</td>
<td>No</td>
<td>10th calendar day of the month</td>
</tr>
<tr>
<td>TR-001</td>
<td>Call Stats - Service Level</td>
<td>Transportation Provider - Veyo</td>
<td>No</td>
<td>15th of the month for previous month</td>
</tr>
<tr>
<td>TR-002</td>
<td>Complaints &amp; Grievances</td>
<td>Transportation Provider - Veyo</td>
<td>No</td>
<td>15th of the month for previous month</td>
</tr>
<tr>
<td>TR-003</td>
<td>Executive Summary</td>
<td>Transportation Provider - Veyo</td>
<td>No</td>
<td>15th of the month for previous month</td>
</tr>
<tr>
<td>TR-004</td>
<td>Detail and Summary Trip Report</td>
<td>Transportation Provider - Veyo</td>
<td>No</td>
<td>15th of the month for previous month</td>
</tr>
<tr>
<td>TR-005</td>
<td>Quarterly Executive Summary</td>
<td>Transportation Provider - Veyo</td>
<td>No</td>
<td>15th of the month following quarter end for previous quarter</td>
</tr>
</tbody>
</table>
**Section 17 - REFERENCES**

**17.1  Statutory And Regulatory References**

17.1.1  Federal Statutes and Regulations

American Recovery and Reinvestment Act of 2009 (HITECH Act), Title XIII, Subtitle D
ADA Accessibility Guidelines
Affordable Care Act (P.L. 111-148)
Age Discrimination in Employment Act (ADEA)
Americans with Disabilities Act
Balanced Budget Act of 1997
Centers for Medicare & Medicaid Services (42 CFR § 400, et seq.)
Confidentiality of Drug and Alcohol Abuse Patient Records (42 CFR Part 2)
Civil Rights Act, Title VI and Title VII
Equal Pay Act (EPA)
Federal Block Grants
  - Mental Health Block Grant pursuant to Division B, Title XXXII, Section 3204 of the
    Children’s Health Act of 2000 (MHBG).
  - Substance Abuse Block Grant pursuant to Division B, Title XXXIII, Section 3303 of the
    Children’s Health Act of 2000 and pursuant to Section 1921-1954 of the Public Health
    Service Act and (45 CFR Part 96) Interim Final Rules (SABG)
  - Project for Assistance in Transition from Homelessness Grant (PATH)
Federal Health Insurance Marketplace
Health Insurance Portability and Accountability Act (HIPAA) Privacy, Security, and Enforcement
  Rules (45 CFR §§ 160 and 164)
Social Security Act, Sections 1903 and 1877 (42 U.S.C. §§ 1395nn and 1396b)

17.1.2  State Administrative Rules

A.A.C. R2-19 Administrative Hearing Rules
A.A.C. R9-20 Behavioral Health Service Agencies: Licensure
A.A.C. R9-21 Behavioral Health Services for Persons with Serious Mental Illness
A.A.C. R9-22 AHCCCS Rules for the Title XIX/XXI acute program
A.A.C. R9-28 AHCCCS Rules for the Title XIX/XXI DDD ALTCS Program
A.A.C. R9-31 AHCCCS Rules for the Title XXI program
A.A.C. R9-34 AHCCCS Rules for the Grievance System
Title 41, Chapter 23 Arizona Procurement Code

17.2  Reference Documents

The following documents, and any subsequent amendments, modifications, and supplements to
these documents adopted by AHCCCS (as applicable), are incorporated and made a part of this
Product Manual by reference:

17.2.1  AHCCCS Documents

Accounting and Auditing Procedures Manual
Accounting and Auditing Exhibits 1-10
Annual Effectiveness Review of the Cultural Competency Plan FY2012-2013 Template
Annual Training Plan FFY2013-2014 Template
Behavioral Health Drug List
Bureau of Corporate Compliance Operations and Procedures Manual
Bureau of Quality and Integration Specifications Manual
   Bureau of Quality and Integration Reporting Templates
Center for Metal Health Services Frequently Asked Questions
Client Information System File Layouts and Specifications Manual
Covered Behavioral Health Services Guide
Cultural Competency Plan FFY2013-2014 Narrative Template
Cultural Competency Plan FFY2013-2014 Work Plan Initiatives Template
Cultural Competency Plan FFY2013-2014 Evaluation Template
Cultural Competency and Workforce Development Quarterly Report Template FY 2014
Cultural Competency and Workforce Development Quarterly Update Report FY 2014
Demographic and Outcomes Data Set User Guide
Financial Reporting Guide for Greater Arizona
   Appendix A-I
Housing Desktop Manual
Medical Management Plan/Utilization Work Plan Evaluation 2013
Medical Management-Utilization Management Work Plan, FY 14
Medical Management-Utilization Plan 2014
Member Handbook Template
Network Development and Management Plan RBHA Checklist
Office of Grievance and Appeals Docket Tracking Application User’s Guide
Policy and Procedures Manual
   Section 8 Attachments and Forms
Quality Management Plan, Evaluation, Work plan, and Checklist
Quality Management Plan, FY 2014
System of Care Strategic Plan
Substance Abuse Prevention and Treatment Block Grant/Community Mental Health Block Grant Application FY 14 (MHBG)
Strategic Prevention Framework Model

17.2.2  AHCCCS Documents
Approved EPSDT Tracking Form
Claims Dashboard Reporting Guide
   Claims System Dashboard Reporting Template
   Claims System Reporting Dashboard Cover Letter
Contractor Operations Manual
Drug List Non Behavioral
Dual Eligible Drug List Non Behavioral
Encounter Manual
Enrollment Rate Codes
Fee for Service Provider Manual
Financial Reporting Guide for Acute Care Contractors
   Appendix - Financial Reporting Instructions
   Appendix - FQHC/RHC Member Months
   Mapping Matrix
   Medicare SNP Template
   Appendix G - Related party Transactions
Grievance System Reporting Guide
   Grievance System Reporting Guide Attachments
   Grievance System Report Cover Letter
HIPAA Transaction Companion Guides & Trading Partner Agreements
   270-271 Batch Eligibility Request and Response Guide
   277 Unsolicited Encounter Status Companion Guide
   276-277 Batch Eligibility Request and Response Companion Guide
   837 Counter Companion Guide
   834-820 Enrollment and Capitation Companion Guide
IT Guidance Document Supplemental Websites Medical and Policy Manual
Minimum Required Prescription Drug List
NCPDP Post Adjudicated History Transaction Guide
Program Integrity Reporting Guide
Provider Affiliation Transmission Manual

17.2.3 Interagency Service Agreements
ADHS and AHCCCS HS832007
ADHS and ADOC 100063DC
ADHS and ADOH HS832423
ADHS and ADOH HS032035
ADHS and ADOH 132006
ADHS and ADE 14-14ED
ADHS and ASAP HS432015

17.2.4 Intergovernmental Agreements
ADHS and ADES-RSA HG232026
ADHS and Pima County Health Department HG932279
ADHS and University of Arizona 059652
ADHS and University of Arizona 059974
17.2.5 Clinical Guidance Documents

Children’s Out-of-Home Services  
Family and Youth Involvement in the Children’s Behavioral Health System  
Support and Rehabilitation Services for Children, Adolescents and Young Adults  
The Child and Family Team  
The Unique Behavioral Health Services Needs of Children, Youth and Families involved in CPS  
Youth Involvement in Arizona Behavioral Health System
Section 18 - PROVIDER MANUAL FORMS & ATTACHMENTS

18.1 FORMS

2.3 Maternity Services for Title XIX/XXI Adults with SMI
   • Provider Manual Form 2.3.1 Monthly Pregnancy & Delivery Form

2.10 Housing for ADULTS with a Serious Mental Illness
   • Provider Manual Form 2.10.1 ADHS Property Acquisition Rehab Application

3.1 Eligibility Screening For AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Low Income Subsidy Program
   • Provider Manual Form 3.1.1 Tracking of Medicare Part D Enrollment
   • Provider Manual Form 3.1.2 Tracking of Low Income Subsidy Status
   • Provider Manual Form 3.1.3 Decline to Participate in AHCCCS Screening or Referral Process
   • Provider Manual Form 3.1.4 Notice of Decision and Right to Appeal

3.3 Referral and Intake Process
   • Provider Manual Form 3.3.1 Referral for Behavioral Health Services
   • Provider Manual Form 3.3.2 Specialty Agency Referral Checklist
   • Provider Manual Form 3.3.3 Specialty Agency Monthly Summary

3.4 Outreach, Engagement, Re-Engagement, and Ending an Episode of Care and Disenrollment
   • Provider Manual Form 3.4.1 Engagement and Re-engagement Review

3.5 Assessment and Service Planning
   • Provider Manual Form 3.5.3 CFT Planning Meeting Note
   • Provider Manual Form 3.5.4 CFT Crisis Plan
   • Provider Manual Form 3.5.5 Strengths, Needs and Cultural Discovery
   • Provider Manual Form 3.5.7 Notice of Discrimination Prohibited
   • Provider Manual Form 3.5.8 Notice of Legal Rights for Persons with Serious Mental Illness
   • Formulario Policy 3.5.8 MH-211: Notificación de Derechos Legales para Personas con Enfermedad Mental Grave

3.6 SMI Eligibility Determination
   • Provider Manual Form 3.6.1 SMI Determination
   • Provider Manual Form 3.6.2 SMI Eligibility Determination Verification
   • Provider Manual Form 3.6.3 Consent For Assessment For SMI Eligibility & Waiver Of 3-Day Timeline
3.7 General and Informed Consent to Treatment

- Provider Manual Form 3.7.1 Consent for Treatment
- Provider Manual Form 3.7.1 Consent for Treatment - Spanish
- Provider Manual Form 3.7.2 Informed Consent for Medication Treatment
- Provider Manual Form 3.7.3 Substance Abuse Prevention Program and Evaluation Consent
- Provider Manual Form 3.7.3 Substance Abuse Prevention Program and Evaluation Consent - Spanish
- Provider Manual Form 3.7.4 Application for Voluntary Evaluation
- Formulario Policy 3.7.4 Solicitud de Una Evaluación Voluntaria

3.8 Psychotropic Medication: Prescribing and Monitoring

- Provider Manual Form 3.8.1 Informed Consent for Psychotropic Medication Treatment (Updated 12/1/15)
- Provider Manual Form 3.8.1 Informed Consent for Psychotropic Medication Treatment – Spanish (Updated 12/1/15)

3.9 Pre-Petition Screening, Court-Ordered Evaluation, and Court-Ordered Treatment

- Provider Manual Form 3.9.1 Application for Involuntary Evaluation
- Provider Manual Form 3.9.2 Application for Emergency Admission for Evaluation;
- Provider Manual Form 3.9.3 Petition for Court-Ordered Evaluation
- Provider Manual Form 3.9.4 Petition for Court-Ordered Treatment; and
- Provider Manual Form 3.9.5 Affidavit
- Provider Manual Form 3.9.6 PIMA County-COT Plan Ind. Receiving AHCCCS Benefits
- Provider Manual Form 3.9.7 PIMA County-COT Plan Ind. NOT Receiving AHCCCS Benefits
- Provider Manual Form 3.9.8 PIMA County-Emergent Amendment
- Provider Manual Form 3.9.9 PIMA County-Non-Emergent Amendment
- Provider Manual Form 3.9.10 PIMA County-Judicial Review Right to Speak to Legal Counsel (Updated 12/1/15)
• Provider Manual Form 3.9.11 PIMA County Psych Exam for Annual Review for GD Persons
• Provider Manual Form 3.9.12 Pima County Psych Exam for Annual Review for PAD Persons
• Provider Manual Form 3.9.13 Application for Voluntary Evaluation
• Formulario Policy 3.9.13 Confirmation of Receipt for Petition of Continued Treatment
• Provider Manual Form 3.9.14 ADHS-DBHS MH-110, Petition for Court Ordered Treatment
• Provider Manual Form 3.9.15 Tx Team Request for Judicial Review of COT
• Provider Manual Form 3.9.16 Psychiatric Report from Judicial Review of COT

3.10 Special Populations
• Provider Manual Form 3.10.1 Quarterly PATH Report

3.11 Special Assistance for Persons Determined to Have a Serious Mental Illness
• Provider Manual Form 3.11.1, Notification of Persons in Need of Special Assistance
• Provider Manual Form 3.11.2, Special Assistance Screening Form for Adult SMI Members

3.12 Arizona State Hospital
• Provider Manual Form 3.12.1 Certification of Need (CON)
• Provider Manual Form 3.12.2 Recertification of Need (RON)

3.13 Out-of-State Placements for Children and Young Adults
• Provider Manual Form 3.13.1 Out-of-State Placement, Initial Notice
• Provider Manual Form 3.13.2 Out-of-State Placement, 30-Day Update

3.15 Cultural Competence
• Provider Manual Form 3.15.8.2 Cultural Competency Plan
• Provider Manual Form 3.15.8.3 Language Proficiency Inventory

3.17 Health Home Requirements
• Provider Manual Form 3.17.1 High Needs Screening Form
• Provider Manual Form 3.17.2 Non-Emergency Transportation Request Form

4.1 Transition of Persons
• Provider Manual Form 4.1.1 Inter-Agency Transfer & Transition Checklist
• Provider Manual Form 4.1.2 Transitioning to Adulthood Checklist

4.2 Inter-RBHA Coordination of Care
• Provider Manual Form 4.2.1 Inter-T/RBHA Transfer Request Form
• Provider Manual Form 4.2.2 Inter-T/RBHA Coordination of Services

4.3 Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers
  • Provider Manual Form 4.3.1 Request for Information from PCP or Medicare Provider
  • Provider Manual Form 4.3.2 Communications Document
  • Provider Manual Form 4.3.3 Cenpatico IC-RBHA Acute Health Plan and Provider Inquiry Monthly Log
  • Provider Manual Form 4.3.4 Recipient Transition from RBHA/Health Plan to PCP Log

4.4 Coordination of Care with Other Governmental Entities
  • Provider Manual Form 4.4.1 CCI Referral Form
  • Provider Manual Form 4.4.2 CCI Release of Information Form (Large Print)
  • Provider Manual Form 4.4.2 CCI Release of Information Form (Spanish)
  • Provider Manual Form 4.4.6 Auth for Use or Disclosure of Protected Health Info Criminal Justice System Referral (New 12/1/15)

7.1 Credentialing and Re-Credentialing – Introduction and Processes
  • Provider Manual Form 7.1.2 Supervision of Clinical Liaisons
  • Provider Manual Form 7.1.3 BHT Case Supervision

8.1 Submitting Claims and Encounters to Cenpatico IC
  • Cenpatico 837 Institutional Claim Companion Guide
  • Cenpatico 837 Professional Claim Companion Guide

8.3 Third Party Liability and Coordination of Benefits

9.1 Advance Directives
  • Provider Manual Form 9.1.1 Advance Directives
  • Provider Manual Form 9.1.2 Wellness Recovery, Crisis Plan and Advance Directives

9.2 Medical Record Standards
  • Provider Manual Form 9.2.1 Clinical Record Documentation Form

9.8 Medical Institution Reporting of Medicare Part D
  • Provider Manual Form 9.8.1 AHCCCS Notification to Waive Medicare Part D Co-Payments for Members in a Medicaid Funded Medical Institution

9.9 Seclusion and Restraint Reporting
  • Provider Manual Form 9.9.1 Seclusion and Restraint Reporting-Behavioral Health Inpatient Facilities
9.11 Health Home Quality Management Plan Requirements
   - Provider Manual Form 9.11.4 Corrective Action Plan Template
   - Provider Manual Form 9.11.5 Monthly Member Survey

10.1 Securing Services and Prior Authorization/Retrospective Authorization
   - Provider Manual Form 10.1.1 Certification of Need (CON)
   - Provider Manual Form 10.1.2 Recertification of Need (RON)
   - Provider Manual Form 10.1.3 Notice of Admission to BIP, AIC, HCTC, BHTH
   - Provider Manual Form 10.1.6 Out-of-Home Admission
   - Provider Manual Form 10.1.8 Out-of-Home Concurrent Review Form
   - Provider Manual Form 10.1.10 Inpatient Discharge Summary
   - Provider Manual Form 10.1.11 Request for Expedited Authorization
   - Provider Manual Form 10.1.12 Outpatient Prior Authorization Fax Form
   - Provider Manual Form 10.1.13 Inpatient Prior Authorization Fax Form
   - Provider Manual Form 10.1.14 Intensive Staff
   - Provider Manual Form 10.1.15 Out-of-Network Request
   - Provider Manual Form 10.1.16 Transfer Readmit Form

10.5 Pre-Admission Screening and Resident Review
   - Provider Manual Form 10.5.1 Level II PASRR Psychiatric Evaluation

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Section 19 - DEFINITIONS & ACRONYMS

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- **24 Hour Urgent Referral** is a referral that results in an intake that opens an episode of care and enrollment that must be completed in a community setting within 24 hours of the request. It includes care coordination, discharge planning services and an SMI screening when appropriate. The 24 Hour Mobile Team Urgent Referral services are provided in hospitals, nursing homes, foster homes, detention facilities and other community settings.

- **72 Hour CPS Rapid Response** is a mobile response that includes an intake, opens an episode of care or enrollment and must be completed in a community setting within 72 hours of the request. It includes care coordination services and coordination with CPS and the courts. The 72 Hour Mobile Team Rapid Response services are provided in hospitals, homes, shelters and other community settings.

- **834 Transaction Enrollment/Disenrollment** means a HIPAA compliant transmission, by a health care provider to a T/RBHA and by a T/RBHA to AHCCCS that contains information to establish or terminate a person’s enrollment in the AHCCCS service delivery system.


- **Action** means 1) the denial or limited authorization of a requested service, including the type or level of service; 2) the reduction, suspension or termination of a previously authorized service; 3) the denial, in whole or in part, of payment for a service; 4) the failure to provide services in a timely manner as defined by the State; 5) the failure of Cenpatico IC to act within the timeframes; or 6) the denial of a Medicaid enrollee’s request to obtain services outside Cenpatico IC’s network: (a) from any other provider (in terms of training, experience, and specialization) not available within Cenpatico IC’s network; (b) from a provider not part of Cenpatico IC’s network who is the main source of a service to the recipient, provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join Cenpatico IC’s network or does not meet the qualifications, the enrollee is given a choice of participating providers and is transitioned to a participating provider within 60 days; (c) because the only plan or provider available does not provide the service because of moral or religious obligations; (d) because the recipient’s provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within Cenpatico IC’s network; (e) the State determines that other circumstances warrant out-of-network treatment.

- **AHCCCS – Cenpatico IC Contract** means Contract No. YH17-0001 entered into between AHCCCS and Cenpatico IC, including all attachments and exhibits thereto, as such contract may be amended or supplemented from time to time.

- **Administrative Costs** means administrative expenses incurred to manage the health system, including, but not limited to: provider relations and contracting; provider billing; accounting; information technology services; processing and investigating
grievances and appeals; legal services, which includes legal representation of the Cenpatico Integrated Care at administrative hearings; planning; program development; program evaluation; personnel management; staff development and training; provider auditing and monitoring; utilization review and quality assurance. Administrative costs do not include expenses incurred for the direct provision of health care services, including case management, or integrated health care services.

- **Adult Recovery Team ("ART")** means a defined group of individuals that includes, at a minimum, the member, his or her family, a behavioral health representative, and any individuals important in the member’s life that are identified and invited to participate by the member. This may include system partners such as extended family members, friends, family support partners, healthcare providers, community resource providers, representatives from churches, synagogues or mosques, agents from other service systems like the Department of Developmental Disabilities (DDD), Probation, or the Administrative Office of the Courts (AOC). The size, scope and intensity of involvement of the team members are determined by the objectives established for the adult, the needs of the family in providing for the adult, and by which individuals are needed to develop an effective service plan, and can therefore expand and contract as necessary to be successful on behalf of the adult should this be needed or required.

- **Affiliate** means a person or entity controlling, controlled by, or under common control with Cenpatico Integrated Care.

- **AHCCCS Health Plan** means an organization or entity that has a contract with AHCCCS to provide specified health-related goods and services in conformance with the stated requirements, Arizona statute and rules, and federal law and regulations.

- **AHCCCS Registered Provider** means a provider that enters into an agreement with AHCCCS under A.A.C. R9-22-703(A), and meets licensing or certification requirements to provide covered services.

- **Amendment** means a written document that is issued for the purpose of making changes to a document.

- **Arizona Department of Economic Security ("ADES")** means the State agency that has the powers and duties set forth in A.R.S. § 41-1951, et seq.

- **Assessment Intervention Center ("AIC")** means a time limited, intensive program serving children and families that delivers services in an ADHS-licensed BHRF (Provider Type B8). The program’s focus is on thorough psychiatric, psychological, and family systems evaluations, a comprehensive behavioral analysis; and development of targeted interventions individualized for each member and family. The program is designed for up to a thirty (30) day episode of care. The initial fourteen (14) days of service do not require prior authorization. Additional services require a concurrent authorization on or before the fourteenth (14th) day of service. The maximum length of stay is thirty (30) days. The goal of the program is to answer the question “What supports and interventions are needed for this member to live successfully in the community?”

- **Attachment** means any attachment, amendment, exhibit and/or schedule to a document.

- **Behavioral Health Disorder** means any behavioral, mental health, and/or substance use diagnoses found in the most current version of the Diagnostic and Statistical
Manual of International Classification of Disorders ("DSM") excluding those diagnoses such as mental retardation, learning disorders and dementia, which are not typically responsive to mental health or substance abuse treatment.

- **Behavioral Health Provider** means an individual or facility that delivers behavioral health services as a subcontractor in Cenpatico Integrated Care's provider network.

- **Best Practices** means evidence-based practices, promising practices, or emerging practices.

- **Board Eligible for Psychiatry** means a physician with documentation of completion of an accredited psychiatry residency program approved by the American College of Graduate Medical Education, or the American Osteopathic Association. Documentation would include either a certificate of residency training including exact dates, or a letter of verification of residency training from the training director including the exact dates of training.

- **Brief Intervention Program (BIP)** means a time-limited, intensive crisis intervention program that delivers services in an ADHS-licensed BHRF (Provider Type B8) to help persons live successfully in the community. The program includes crisis, supportive and treatment services. A CFT or ART meeting must be conducted within three (3) business days of a member's admission to the program. The maximum length of stay is a ten (10) day episode of care. No prior authorization is needed. Member cannot be readmitted within 72 hours of discharge from any Brief Intervention Program.

- **Cenpatico Integrated Care (Cenpatico IC) Provider Manual** means the Cenpatico IC Provider Manual including any amendments, appendices, modifications, supplements, bulletins, or notices related to the Cenpatico IC Provider Manual that may be made from time to time and available on Cenpatico IC of Arizona's website. Cenpatico IC shall use its reasonable efforts to give Subcontractor advance notice of any amendment or modification of the Cenpatico IC Provider Manual that materially affects Subcontractor's

- **Claim** means a service billed under a fee-for-service arrangement.

- **Community Service Agency ("CSA")** means an agency that is contracted directly by Cenpatico Integrated Care and registered with AHCCCS to provide rehabilitation and support services consistent with the staff qualifications and training. Refer to the AHCCCS Covered Behavioral Health Services Guide for details.

- **Complex Needs** means the presence of significant behavioral challenges that impact the safety of a member, facility personnel, and/or other members for which additional staff support is needed to address and successfully treat the member's behavioral challenges in the facility.

- **Conflict of Interest ("COI")** means any situation in which the Subcontractor or an individual employed or retained by the Subcontractor is in a position to exploit a contractual, professional, or official capacity in some way for personal or organizational benefit that otherwise would not exist.

- **Contract Year ("CY")** means the time period that corresponds to the federal fiscal year, October 1 through September 30 used for financial reporting purposes.

- **Credentialing** means the process of obtaining, verifying and evaluating information regarding applicable licensure, accreditation, certification, and educational and
practice requirements to determine whether a provider has the required credentials to deliver specific covered services to members.

- **Cultural Competence** means a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals which enables that system, agency, or those professionals to work effectively in cross-cultural situations. Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Competence implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors and needs presented by consumers and their communities.

- **Dedicated Health Care Coordinator** is the job title used by Cenpatico Integrated Care to describe the role Subcontractor employees perform related to assisting a High Needs Member and family in achieving recovery. These duties include all duties formerly assigned to the role of the Case Manager and include intensive case management services, management of care, coordination of services, employment support, health promotion, motivational interviewing, assisting with service planning and other similar services to support recovery.

- **Delegate** means the execution of a subcontract between Subcontractor and a qualified organization or person to perform one or more functions required to be provided by Subcontractor under the RBHA/Health Plan Attachment.

- **Deliverables** means the reports and other deliverables the Subcontractor is required to provide to Cenpatico Integrated Care (Cenpatico IC) pursuant to the Cenpatico IC Provider Manual.

- **Direct Care Staff** means, in the case where a Subcontractor is a health care entity, a person or entity who is employed by or otherwise engaged by Subcontractor to provide Covered Services to Members.

- **Disenrollment** means the discontinuance of a Member’s eligibility to receive Covered Services.

- **Exhibit** means any item labeled as an Exhibit to the RBHA/Health Plan Attachment or placed in the Exhibits section of the RBHA/Health Plan Attachment.

- **Federal CLAS Standards** means the US Office of Minority Health standards for Culturally and Linguistically Appropriate Services ("CLAS"), which may be amended or supplemented from time to time and is included as Exhibit F.

- **Fiscal Year ("FY")** means the State budget year: July 1 through June 30. This is to be distinguished from the Contract Year, as defined above.

- **Formulary** means a list of covered medications available for treatment of Members.

- **Freedom to Work** (also referred to as **Ticket to Work**) means an individual who becomes eligible under the Title XIX expansion program that extends eligibility to individuals sixteen (16) through sixty-four (64) years old who meet SSI disability criteria; whose earned income, after allowable deduction, is at or below 250% of the FPL; and who is not eligible for any other Medicaid program.

- **Geographic Service Area ("GSA")** means a specific region or regions in Arizona (defined by zip code) in which Cenpatico Integrated Care provides, directly or through subcontract, covered services to Members of that region.
• **Grievance** means a member’s expression of dissatisfaction with any aspect of his or her care, other than dissatisfaction with respect to an Action, which is managed as an appeal.

• **Health Care Coordinator**: Health Care Coordinator is the job title used by Cenpatico Integrated Care to describe the required duties performed by Subcontractor (Provider) employees related to coordinating physical health, behavioral health and social services in a member-focused manner with the goals of improving whole person health outcomes, and more effective and efficient use of resources. Health Care Coordinators, often referred to as Health Care Coordinators, Case Managers, Integrated Care Managers, or Care Coordinators; provide accessible, comprehensive, and continuous coordination of care based on effective working relationships with members and accumulated knowledge over time of members’ health care challenges and strengths. Health Care Coordinators build on members’ strengths to promote wellness, recovery, and resiliency.

• **High Need Case Management** is an intensive level of case management services provided to high need Members.

  **High Need Recovery Management ("HNRM")** means specially designed programs, care management services, treatment services and dedicated staff responsible to meet the care management and treatment needs of High Need Members. HNRM is required to be available 24/7/365 to monitor and facilitate the safety of High Need Members, the safety of communities, and assist High Need Members to live successfully in the community.

• **Health Home AKA Intake and Coordination of Care Agency or Intake Agency** means a contracted provider type requiring full execution of Intake Provider functions and requirements. Health Homes must accept all requests for services for eligible populations as identified in *Exhibit A* regardless of diagnosis, age, role in family, gender, type of support requested, disability or level of functioning. Intake agencies are required to manage Member care by performing the following roles: intake, assessment, service planning, clinical oversight of all services, service tracking and data reporting, enrollment and demographic submissions, education, engagement activities, psychiatric services, and ensure adequate treatment service availability to all enrolled Members as outlined in the Cenpatico Integrated Care Provider Manual and the AHCCCS Covered Behavioral Health Services Guide. An ADHS Division of Licensing Services outpatient license is required. Health Homes are required to accurately screen High Need Members for "High Needs" and refer High Need Members to High Need Recovery Centers.

• **Interagency Service Agreement ("ISA")** means an agreement between two or more agencies of the State wherein an agency is reimbursed for services provided to another agency or is advanced funds for services provided to another agency. (A.R.S. § 35-148(A))

• **Level I Behavioral Health Facility** means an inpatient treatment program or behavioral health treatment facility that is licensed under A.A.C. Title 9, Chapter 10 and includes a psychiatric acute hospital, a residential treatment center for individuals under the age of twenty-one (21), or a sub-acute facility.

• **Level IV Behavioral Health Facility** means a behavioral health agency as defined in A.A.C. Title 9, Chapter 10.
• **Low and Moderate Need Recovery Center** ("LMNR Centers") means a set of specially designed programs and services and designated staff responsible to meet the needs of Members with low to moderate needs. LMNR Centers are required to screen Members for "High Needs" and refer High Need Members to High Need Recovery Centers.

• **Material Gap** means a temporary change in a provider network that may reasonably be foreseen to jeopardize the delivery of covered health services to an identifiable segment of the Member population.

• **Material Omission** means facts, data or other information excluded from a report, contract, the absence of which could lead to erroneous conclusions following reasonable review of such report or contract.

• **May** means something is permissive.

• **Medical Expense Deduction** ("MED") means Title XIX waiver Member whose family income exceeds the limits of all other Title XIX categories (except ALTCS) and has family medical expenses that reduce income to or below 40% of the FPL. MED members may or may not have a categorical link to Title XIX.

• **Medical Institution** means an acute care hospital, psychiatric hospital—Non IMD, psychiatric hospital – IMD—, Residential Treatment Center—Non IMD, psychiatric hospital – IMD—, Skilled Nursing Facility, or Intermediate Care Facility for persons with intellectual disabilities.

• **Medicare Modernization Improvement Act of 2003** ("MMA") means the federal law that created a prescription drug benefit called Medicare Part D for individuals who are eligible for Medicare Part A and/or enrolled in Medicare Part B.

• **Medicare Part D Excluded Drugs** means the prescription drug coverage option available to Medicare beneficiaries, including Dual Eligible Members. Medications that are available under this benefit are not covered by AHCCCS for dual eligible Members. Certain drugs that are excluded from coverage by Medicare continue to be covered by AHCCCS. Those medications are barbiturates, benzodiazepines, and over the counter medication as defined in the AMPM. Prescription medications that are covered under Medicare, but are not on a Part D health plan’s formulary are not considered excluded drugs, and are not covered by AHCCCS.

• **Medications List** has the same meaning as "Formulary."

• **Member with High Needs** means Members identified by Cenpatico Integrated Care or Subcontractor who may benefit from receiving intensive services.

• **Mental Health Block Grant** ("MHBG") means an annual formula grant from The Substance Abuse and Mental Health Services Administration (SAMHSA) that provides funds to establish or expand an organized community-based system of care for providing non-Title XIX mental health services to children with serious emotional disturbances (SED) and adults with serious mental illness (SMI). These funds are used to: (1) carry out the State plan contained in the application; (2) evaluate programs and services, and; (3) conduct planning, administration, and educational activities related to the provision of services.

• **Must** denotes the imperative.

• **Non-Title XIX/XXI Funding** means fixed, non-capitated funds, including funds from MHBG and SABG, County, and other funds, and State appropriations (excluding
State appropriations for state match to support the Title XIX and Title XXI program), which are used for services to Non-Title XIX/XXI eligible persons and for medically necessary services not covered by Title XIX or Title XXI programs.

- **Non-Title XIX/XXI Member** or **Non-Title XIX/XXI Person** means an individual who needs or may be at risk of needing health-related services, but does not meet federal and state requirements for Title XIX or Title XXI eligibility.

- **Non-Title XIX/XXI SMI Member** means a Non-Title XIX/XXI Member who has met the criteria to be designated as Seriously Mentally Ill.

- **Office of Individual and Family Affairs (OIFA)** is an AHCCCS bureau that builds partnerships with individuals, families of choice, youth, communities, organizations to promote recovery, resiliency and wellness. OIFA collaborates with key leadership and community members in the decision making process at all levels of the behavioral health system. In partnership with the community, OIFA advocates for the development of culturally inclusive environments that are welcoming to individuals and families. establishes structures to promote diverse youth, family and individual voices in leadership positions throughout Arizona, delivers training, technical assistance and instructional materials for individuals and their families, ensure peers support and family support are available to all persons receiving services and their families, and monitors contractor performance and measure outcomes.

- **Outreach** means activities to identify and encourage Members or potential Members, who may be in need of, but not yet receiving physical or behavioral health services.

- **Payor** means Cenpatico Integrated Care or another entity that is responsible for funding Covered Services to Members.

- **Payor Contract** means Cenpatico Integrated Care's (Cenpatico IC's) contract with any Payor that governs provision of Covered Services to Members. When Cenpatico IC is the Payor, "Payor Contract" means Cenpatico IC's contract with the State or federal agency or other entity that has contracted with Cenpatico IC to arrange for the provision of Covered Services to eligible individuals of such agency or other entity.

- **Pharmacy Encounter Data** means a retail pharmacy encounter until such time AHCCCS expands Federal Drug Rebate processing to include all other pharmaceuticals reported on professional and outpatient facility encounters.

- **Potential Member** means a person that could be eligible for Medicaid funded or other services, but is not.

- **Privileging** means the process used to determine if credentialed clinicians are competent to perform certain treatment interventions, based on training, supervised practice, and/or competency testing.

- **Profit** means the excess of revenues over expenditures, in accordance with Generally Accepted Accounting Principles, regardless of whether Subcontractor is a for-profit or a not-for-profit entity.

- **Provider Network** means the agencies, facilities, professional groups, and professionals or other persons under subcontract to Cenpatico Integrated Care to
provide Covered Services to Members, including the Subcontractor to the extent the Subcontractor directly provides Covered Services to Members.

- **Psychiatrist** means a person who is a licensed physician as defined in A.R.S. Title 32, Chapter 13 or Chapter 17 and who holds psychiatric board certification from the American Board of Psychiatry and Neurology, the American College of Osteopathic Neurologists and Psychiatrists, or the American Osteopathic Board of Neurology and Psychiatry; or is board eligible.

- **Recovery Coach** see Health Care Coordinator.

- **Rehabilitation Services Administration ("RSA")** means the Division within ADES.

- **SAMHSA** means the Substance Abuse and Mental Health Services Administration, which is a part of the U.S. Public Health Service that provides funding through block grants for direct substance abuse and mental health services including substance abuse prevention and addiction treatment.

- **Shall** means something is mandatory.

- **Should** denotes a preference.

- **SMI Grievance Investigation** means a grievance or request for investigation that is filed by or on behalf of a person with Serious Mental Illness alleging a violation of the member’s rights or asserting that a condition requiring investigation exists.

- **SMI Member** means a person who meets the criteria for Serious Mental Illness.

- **SMI Member Receiving Physical Health Care Services** means a Title XIX eligible adult who is eligible to receive both behavioral and physical health care services through Cenpatico Integrated Care's provider network.

- **Specialty Assessment** means a specialized assessment written by a Specialty Provider to determine an eligible individual's level of functioning and medical necessity for the specialty services provided by the Specialty Provider. All persons being served in the public health system must have an assessment upon an initial request for services with updates occurring at least annually. The Specialty Assessment must be utilized to collect necessary information that will inform providers of how to plan for effective care and treatment of the individual for the medical condition being treated. Cenpatico Integrated Care does not have a mandated Specialty Assessment template but all Behavioral Health Assessments must include all elements outlined in Policy 105, Assessment and Service Planning and be in accordance to all state and federal regulations.

- **Specialty Provider** means a contracted provider type requiring full execution of specialty services as outlined in *Exhibit A*. Specialty Providers are required to deliver specialized programs and treatment services in treatment facilities, the community, Member homes, or specified offices to meet the unique needs of special populations. Required services hours, locations, populations serviced, and special treatment programs are outlined in *Exhibit A*. Specialty Providers include ADHS Division of Licensing Services licensed facilities, CSAs, MDs, DOs, Licensed Psychologists, NPs, LPCs, LISACs, and LCSWs.

- **Specialty Service Plan** means a written plan for services written by the Specialty Provider upon an eligible individual’s request for services. Specialty Service Plans require periodic updates to the plan to meet the changing health needs for persons who continue to meet medical necessity for requested services. Cenpatico
Integrated Care does not mandate a specific service plan template. All Specialty Service Plans must be written in accordance to all state and federal regulations.

- **State** means the State of Arizona and AHCCCS.
- **Substance Abuse Block Grant ("SABG")** an annual formula grant from The Substance Abuse and Mental Health Services Administration (SAMHSA) that supports primary prevention services and treatment services for persons 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.
- **Support Services** means Covered Services as defined in the AHCCCS Covered Behavioral Health Services Guide.
- **Temporary Assistance to Needy Families ("TANF")** means the federal cash assistance program under Title IV of the Social Security Act established by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193).
- **Third Party** means an individual, entity or program that is or may be liable to pay all or part of the medical cost of injury, disease, or disability of an AHCCCS applicant or Member as defined in R9-22-1001.
- **Ticket to Work** has the same meaning as "Freedom to Work."
- **Title XIX Covered Services** means the covered services identified in the AHCCCS Covered Behavioral Health Services Guide and the physical health care covered services described in Solicitation No. ADHS15-00004276, Scope of Work Section 4.7, Physical Health Care Covered Services.
- **Title XIX Waiver Group – AHCCCS Care (Non-MED)** means eligible individuals and couples whose income is at or below one hundred percent (100%) of the FPL and who are not categorically linked to another Title XIX program.
- **Title XXI Eligible Person** or **Title XXI Eligible Member**, means an individual who meets federal and state requirements for Title XXI eligibility.
- **Trauma-informed Care ("TIC")** means an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in the lives of people who receive services and people who provide services (SAMHSA Center for Trauma Informed Care).
- **Vital Materials** includes the Member Handbook; notices for denials, reductions, suspensions or terminations of services; consent forms; communications requiring a response from the Member; detailed description of Early Periodic Screening, Diagnostic and Treatment ("EPSDT") services; informed consent; and, all grievance, appeal and request for State fair hearing information in the AHCCCS Policy on Notice Requirements and Appeal Process for Title XIX/XXI Eligible Persons and Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI) (42 CFR 438.404(a) and 42 CFR 438.10(c)).
- **Young Adult Transitional Insurance ("YATI")** means individuals age 18 through age 25 who were enrolled in the foster care program under jurisdiction of the Department of Child Safety in Arizona on their 18th birthday.
19.2  AHCCCS Definitions
The definitions specified in Part 1 below refer to terms found in all AHCCCS contracts.

638 TRIBAL FACILITY  A facility that is owned and/or operated by a Federally recognized American Indian/Alaskan Native Tribe and that is authorized to provide services pursuant to Public Law 93-638, as amended. Also referred to as: tribally owned and/or operated 638 facility, tribally owned and/or operated facility, 638 tribal facility, and tribally-operated 638 health program.

ACUTE CARE CONTRACTOR  A contracted managed care organization (also known as a health plan) that provides acute care physical health services to AHCCCS members in the acute care program who are Title XIX or Title XXI eligible. The Acute Care Contractor is also responsible for providing behavioral health services for its enrolled members who are treated by a Primary Care Provider (PCP) for anxiety, depression, and Attention Deficit Hyperactivity Disorder (ADHD). Acute Care Contractors are also responsible for providing behavioral health services for dual eligible adult members with General Mental Health and/or Substance Abuse (GMH/SA) needs.

ACUTE CARE SERVICES  Medically necessary services that are covered for AHCCCS members and which are provided through contractual agreements with managed Care Contractors or on a Fee-For-Service (FFS) basis through AHCCCS.

ADJUDICATED CLAIM  A claim that has been received and processed by the Contractor which resulted in a payment or denial of payment.

ADMINISTRATIVE SERVICES SUBCONTRACTS  An agreement that delegates any of the requirements of the contract with AHCCCS, including, but not limited to the following:
   a. Claims processing, including pharmacy claims,
   b. Credentialing, including those for only primary source verification (i.e. Credential Verification Organization),
   c. Management Service Agreements,
   d. Service Level Agreements with any Division or Subsidiary of a corporate parent owner,
   e. DDD acute care subcontractors.
   Providers are not Administrative Services Subcontractors.

ADULT  A person 18 years of age or older, unless the term is given a different definition by statute, rule, or policies adopted by AHCCCS.

AGENT  Any person who has been delegated the authority to obligate or act on behalf of a provider [42 CFR 455.101].
AHCCCS CONTRACTOR OPERATIONS MANUAL (ACOM)

The ACOM provides information related to AHCCCS Contractor operations and is available on the AHCCCS website at www.azahcccs.gov.

AHCCCS ELIGIBILITY DETERMINATION

The process of determining, through an application and required verification, whether an applicant meets the criteria for Title XIX/XXI funded services.

AHCCCS MEDICAL POLICY MANUAL (AMPM)

The AMPM provides information regarding covered health care services and is available on the AHCCCS website at www.azahcccs.gov.

AHCCCS MEMBER

See “MEMBER.”

AHCCCS RULES

See “ARIZONA ADMINISTRATIVE CODE.”

AMBULATORY CARE

Preventive, diagnostic and treatment services provided on an outpatient basis by physicians, nurse practitioners, physician assistants and/or other health care providers.

AMERICAN INDIAN HEALTH PROGRAM (AIHP)

An acute care Fee-For-Service program administered by AHCCCS for eligible American Indians which reimburses for services provided by and through the Indian Health Service (IHS), tribal health programs operated under 638 or any other AHCCCS registered provider. AIHP was formerly known as AHCCCS IHS.

AMERICANS with DISABILITIES ACT (ADA)


APPEAL RESOLUTION

The written determination by the Contractor concerning an appeal.

ARIZONA ADMINISTRATIVE CODE (A.A.C.)

State regulations established pursuant to relevant statutes. Referred to in Contract as “Rules.” AHCCCS Rules are State regulations which have been promulgated by the AHCCCS Administration and published by the Arizona Secretary of State.

ARIZONA DEPARTMENT OF HEALTH SERVICES (ADHS)

The state agency that has the powers and duties set forth in A.R.S. §36-104 and A.R.S. Title 36, Chapters 5 and 34.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

Arizona’s Medicaid Program, approved by the Centers for Medicare and Medicaid Services as a Section 1115 Waiver Demonstration Program and described in A.R.S. Title 36, Chapter 29.
ARIZONA LONG TERM CARE SYSTEM (ALTCS)  
An AHCCCS program which delivers long-term, acute, behavioral health and case management services as authorized by A.R.S. §36-2931 et seq., to eligible members who are either elderly and/or have physical disabilities, and to members with developmental disabilities, through contractual agreements and other arrangements.

ARIZONA REVISED STATUTES (A.R.S.)  
Laws of the State of Arizona.

BALANCED BUDGET ACT (BBA)  
See “MEDICAID MANAGED CARE REGULATIONS.”

BEHAVIORAL HEALTH (BH)  
A mental health and substance use/abuse collectively.

BEHAVIORAL HEALTH DISORDER  
Any behavioral, mental health, and/or substance use diagnoses found in the most current version of the Diagnostic and Statistical Manual of International Classification of Disorders (DSM) excluding those diagnoses such as mental retardation, learning disorders and dementia, which are not typically responsive to mental health or substance abuse treatment.

BEHAVIORAL HEALTH PROFESSIONAL  
As specified in A.A.C. R9-10-101, an individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:
   a. Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251; or
   b. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. §32-3251 under direct supervision as defined in A.A.C. R4-6-101.;
   c. A psychiatrist as defined in A.R.S. §36-501;
   d. A psychologist as defined in A.R.S. §32-2061;
   e. A physician;
   f. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse; or
   g. A behavior analyst as defined in A.R.S. §32-2091; or
   h. A registered nurse.

BEHAVIORAL HEALTH SERVICES  
Physician or practitioner services, nursing services, health-related services, or ancillary services provided to an individual to address the individual’s behavioral health issue. See also “COVERED SERVICES.”

BOARD CERTIFIED  
An individual who has successfully completed all prerequisites of the respective specialty board and successfully passed the required examination for certification and when applicable, requirements for maintenance of certification.
BORDER COMMUNITIES  Cities, towns or municipalities located in Arizona and within a designated geographic service area whose residents typically receive primary or emergency care in adjacent Geographic Service Areas (GSA) or neighboring states, excluding neighboring countries, due to service availability or distance.

CAPITATION  Payment to a Contractor by AHCCCS of a fixed monthly payment per person in advance, for which the Contractor provides a full range of covered services as authorized under A.R.S. §36-2904 and §36-2907.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)  An organization within the United States Department of Health and Human Services, which administers the Medicare and Medicaid programs and the State Children’s Health Insurance Program.

CHILD  A person under the age of 18, unless the term is given a different definition by statute, rule or policies adopted by AHCCCS.

CHILD AND FAMILY TEAM (CFT)  A defined group of individuals that includes, at a minimum, the child and his or her family, a behavioral health representative, and any individuals important in the child’s life that are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches and community resource providers, representatives from churches, synagogues or mosques, agents from other service systems like (DCS) Department of Child Safety or the Division of Developmental Disabilities (DDD). The size, scope and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore expand and contract as necessary to be successful on behalf of the child.

CHILDREN with SPECIAL HEALTH CARE NEEDS (CSHCN)  Children under age 19 who are blind, children with disabilities, and related populations (eligible for SSI under Title XVI). Children eligible under section 1902(e)(3) of the Social Security Act (Katie Beckett); in foster care or other out-of-home placement; receiving foster care or adoption assistance; or receiving services through a family-centered, community-based coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V (CRS).

CLAIM DISPUTE  A dispute, filed by a provider or Contractor, whichever is applicable, involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLEAN CLAIM</td>
<td>A claim that may be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by A.R.S. §36-2904.</td>
</tr>
<tr>
<td>CLIENT INFORMATION SYSTEM (CIS)</td>
<td>The centralized processing system for files from each T/RBHA/Health Plan to AHCCCS as well as an informational repository for a variety of BH related reporting. The CIS system includes Member Enrollment and Eligibility, Encounter processing data, Demographics and SMI determination processes.</td>
</tr>
<tr>
<td>CONTRACT SERVICES</td>
<td>See “COVERED SERVICES.”</td>
</tr>
<tr>
<td>CONTRACTOR</td>
<td>An organization or entity that has a prepaid capitated contract with AHCCCS pursuant to A.R.S. §36-2904, §36-2940, or §36-2944 to provide goods and services to members either directly or through subcontracts with providers, in conformance with contractual requirements, AHCCCS Statute and Rules, and Federal law and regulations.</td>
</tr>
<tr>
<td>CONVICTED</td>
<td>A judgment of conviction has been entered by a Federal, State or local court, regardless of whether an appeal from that judgment is pending.</td>
</tr>
<tr>
<td>COPAYMENT</td>
<td>A monetary amount that the member pays directly to a provider at the time covered services are rendered, as defined in 9 A.A.C. 22, Article 7.</td>
</tr>
<tr>
<td>CORRECTIVE ACTION PLAN (CAP)</td>
<td>A written work plan that identifies the root cause(s) of a deficiency, includes goals and objectives, actions/ tasks to be taken to facilitate an expedient return to compliance, methodologies to be used to accomplish CAP goals and objectives, and staff responsible to carry out the CAP within established timelines. CAPs are generally used to improve performance of the Contractor and/or its providers, to enhance Quality Management/Process Improvement activities and the outcomes of the activities, or to resolve a deficiency.</td>
</tr>
<tr>
<td>COST AVOIDANCE</td>
<td>The process of identifying and utilizing all confirmed sources of first or third-party benefits before payment is made by the Contractor.</td>
</tr>
<tr>
<td>COVERED SERVICES</td>
<td>The health and medical services to be delivered by the Contractor as described in Section D, Program Requirements or the Scope of Work Section.</td>
</tr>
<tr>
<td>CREDENTIALING</td>
<td>The process of obtaining, verifying and evaluating information regarding applicable licensure, accreditation, certification, educational and practice requirements to determine whether a provider has the required credentials to deliver specific covered services to members.</td>
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<tr>
<td>DAY</td>
<td>A day means a calendar day unless otherwise specified.</td>
</tr>
<tr>
<td>DAY – BUSINESS/WORKING</td>
<td>A business day means a Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.</td>
</tr>
<tr>
<td>DELEGATED AGREEMENT</td>
<td>A type of subcontract agreement with a qualified organization or person to perform one or more functions required to be performed by the Contractor pursuant to this contract.</td>
</tr>
<tr>
<td>DIVISION OF BEHAVIORAL HEALTH SERVICES (DBHS)</td>
<td>The state agency that formerly had the duties set forth by the legislature to provide BH services within Arizona.</td>
</tr>
<tr>
<td>DEPARTMENT OF ECONOMIC SECURITY/DIVISION OF DEVELOPMENTAL DISABILITIES (DES/DDD)</td>
<td>The Division of a State agency, as defined in A.R.S. Title 36, Chapter 5.1, which is responsible for serving eligible Arizona residents with a developmental/intellectual disability. AHCCCS contracts with DES/DDD to serve Medicaid eligible individuals with a developmental/intellectual disability.</td>
</tr>
<tr>
<td>DISENROLLMENT</td>
<td>The discontinuance of a member’s eligibility to receive covered services through a Contractor.</td>
</tr>
<tr>
<td>DIVISION OF HEALTH CARE MANAGEMENT (DHCM)</td>
<td>The division responsible for Contractor oversight regarding AHCCCS Contractor operations, quality, maternal and child health, behavioral health, medical management, case management, rate setting, encounters, and financial/operational oversight.</td>
</tr>
<tr>
<td>DUAL ELIGIBLE</td>
<td>A member who is eligible for both Medicare and Medicaid.</td>
</tr>
<tr>
<td>DURABLE MEDICAL EQUIPMENT (DME)</td>
<td>Equipment that provides therapeutic benefits; is designed primarily for a medical purpose; is ordered by a physician/provider; is able to withstand repeated use; and is appropriate for use in the home.</td>
</tr>
</tbody>
</table>
EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT)

A comprehensive child health program of prevention, treatment, correction, and improvement of physical and mental health problems for AHCCCS members under the age of 21. The purpose of EPSDT is to ensure the availability and accessibility of health care resources as well as to assist Medicaid recipients in effectively utilizing these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health problems for AHCCCS members less than 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services listed in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

EMERGENCY MEDICAL CONDITION

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: a) placing the patient’s health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, b) serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part [42 CFR 438.114(a)].

EMERGENCY MEDICAL SERVICE

Covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These services must be furnished by a qualified provider, and must be necessary to evaluate or stabilize the emergency medical condition [42 CFR 438.114(a)].

ENCOUNTER

A record of a health care-related service rendered by a provider or providers registered with AHCCCS to a member who is enrolled with a Contractor on the date of service.

ENROLLEE

A Medicaid recipient who is currently enrolled with a Contractor [42 CFR 438.10(a)].

ENROLLMENT

The process by which an eligible person becomes a member of a Contractor’s plan.
<table>
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<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>EQUITY PARTNERS</td>
<td>The sponsoring organizations or parent companies of the managed care organization that share in the returns generated by the organization, both profits and liabilities.</td>
</tr>
<tr>
<td>EVIDENCE-BASED PRACTICE</td>
<td>An intervention that is recognized as effective in treating a specific health-related condition based on scientific research; the skill and judgment of care health professionals; and the unique needs, concerns and preferences of the person receiving services.</td>
</tr>
<tr>
<td>EXHIBITS</td>
<td>All items attached as part of the solicitation.</td>
</tr>
<tr>
<td>FEDERAL FINANCIAL PARTICIPATION (FFP)</td>
<td>FFP refers to the contribution that the Federal government makes to the Title XIX and Title XXI program portions of AHCCCS, as defined in 42 CFR 400.203.</td>
</tr>
<tr>
<td>FEE-FOR-SERVICE (FFS)</td>
<td>A method of payment to an AHCCCS registered provider on an amount-per-service basis for services reimbursed directly by AHCCCS for members not enrolled with a managed care Contractor.</td>
</tr>
<tr>
<td>FEE-FOR-SERVICE MEMBER</td>
<td>A Title XIX or Title XXI eligible individual who is not enrolled with an AHCCCS Contractor.</td>
</tr>
<tr>
<td>FISCAL AGENT</td>
<td>A Contractor that processes or pays vendor claims on behalf of the Medicaid agency, 42 CFR 455.101.</td>
</tr>
<tr>
<td>FRAUD</td>
<td>An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable State or Federal law, as defined in 42 CFR 455.2.</td>
</tr>
<tr>
<td>GENERAL MENTAL HEALTH/SUBSTANCE ABUSE (GMH/SA)</td>
<td>A classification of adult persons age 18 and older who have general behavioral health issues, have not been determined to have a serious mental illness, but are eligible to receive covered behavioral health services.</td>
</tr>
<tr>
<td>GEOGRAPHIC SERVICE AREA (GSA)</td>
<td>An area designated by AHCCCS within which a Contractor of record provides, directly or through subcontract, covered health care service to a member enrolled with that Contractor of record, as defined in 9 A.A.C. 22, Article 1.</td>
</tr>
<tr>
<td>GRIEVANCE SYSTEM</td>
<td>A system that includes a process for enrollee grievances, SMI grievances, enrollee appeals, provider claim disputes, and access to the state fair hearing system.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>HEALTH CARE PROFESSIONAL</td>
<td>A physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), licensed social worker, registered respiratory therapist, licensed marriage and family therapist and licensed professional counselor.</td>
</tr>
<tr>
<td>HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)</td>
<td>The Health Insurance Portability and Accountability Act; also known as the Kennedy-Kassebaum Act, signed August 21, 1996 as amended and as reflected in the implementing regulations at 45 CFR Parts 160, 162, and 164.</td>
</tr>
<tr>
<td>HEALTH PLAN</td>
<td>See “CONTRACTOR.”</td>
</tr>
<tr>
<td>INCURRED BUT NOT REPORTED LIABILITY (IBNR)</td>
<td>Incurred but not reported liability for services rendered for which claims have not been received.</td>
</tr>
<tr>
<td>INDIVIDUAL RECOVERY PLAN (FORMERLY KNOWN AS THE INDIVIDUAL SERVICE PLAN)</td>
<td>See “SERVICE PLAN”</td>
</tr>
<tr>
<td>INDIAN HEALTH SERVICES (IHS)</td>
<td>The operating division within the U.S. Department of Health and Human Services, responsible for providing medical and public health services to members of federally recognized Tribes and Alaska Natives as outlined in 25 U.S.C. 1661.</td>
</tr>
<tr>
<td>INFORMATION SYSTEMS</td>
<td>The component of the Offerors organization which supports the Information Systems, whether the systems themselves are internal to the organization (full spectrum of systems staffing), or externally contracted (internal oversight and support).</td>
</tr>
<tr>
<td>INTERGOVERNMENTAL AGREEMENT (IGA)</td>
<td>When authorized by legislative or other governing bodies, two or more public agencies or public procurement units by direct contract or agreement may contract for services or jointly exercise any powers common to the contracting parties and may enter into agreements with one another for joint or cooperative action or may form a separate legal entity, including a nonprofit corporation to contract for or perform some or all of the services specified in the contract or agreement or exercise those powers jointly held by the contracting parties. A.R.S. Title 11, Chapter 7, Article 3 (A.R.S. §11-952.A).</td>
</tr>
<tr>
<td>LIABLE PARTY</td>
<td>An individual, entity, or program that is or may be liable to pay all or part of the medical cost of injury, disease or disability of an AHCCCS applicant or member as defined in A.A.C. R9-22-1001.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>LIEN</td>
<td>A legal claim, filed with the County Recorder’s office in which a member resides and in the county an injury was sustained for the purpose of ensuring that AHCCCS receives reimbursement for medical services paid. The lien is attached to any settlement the member may receive as a result of an injury.</td>
</tr>
<tr>
<td>MAJOR UPGRADE</td>
<td>Any systems upgrade or changes that may result in a disruption to the following: loading of contracts, providers or members, issuing prior authorizations or the adjudication of claims.</td>
</tr>
<tr>
<td>MANAGED CARE</td>
<td>Systems that integrate the financing and delivery of health care services to covered individuals by means of arrangements with selected providers to furnish comprehensive services to members; establish explicit criteria for the selection of health care providers; have financial incentives for members to use providers and procedures associated with the plan; and have formal programs for quality, medical management and the coordination of care.</td>
</tr>
<tr>
<td>MANAGEMENT SERVICES AGREEMENT</td>
<td>A type of subcontract with an entity in which the owner of the Contractor delegates all or substantially all management and administrative services necessary for the operation of the Contractor.</td>
</tr>
<tr>
<td>MATERIAL CHANGE TO BUSINESS OPERATIONS</td>
<td>Any change in overall operations that affects, or can reasonably be foreseen to affect, the Contractor’s ability to meet the performance standards as required in contract including, but not limited to, any change that would impact or is likely to impact more than 5% of total membership and/or provider network in a specific GSA.</td>
</tr>
<tr>
<td>MANAGING EMPLOYEE</td>
<td>A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency [42 CFR 455.101].</td>
</tr>
<tr>
<td>MATERIAL OMISSION</td>
<td>A fact, data or other information excluded from a report, contract, etc., the absence of which could lead to erroneous conclusions following reasonable review of such report, contract, etc.</td>
</tr>
<tr>
<td>MEDICAID</td>
<td>A Federal/State program authorized by Title XIX of the Social Security Act, as amended.</td>
</tr>
<tr>
<td>MEDICAID MANAGED CARE REGULATIONS</td>
<td>The Federal law mandating, in part, that States ensure the accessibility and delivery of quality health care by their managed care Contractors. These regulations were promulgated pursuant to the Balanced Budget Act (BBA) of 1997.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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</tr>
<tr>
<td>MEDICARE</td>
<td>A Federal program authorized by Title XVIII of the Social Security Act, as amended.</td>
</tr>
<tr>
<td>MEDICAL MANAGEMENT (MM)</td>
<td>An integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve desired health outcomes, across the continuum of care (from prevention to end of life care).</td>
</tr>
<tr>
<td>MEDICAL RECORDS</td>
<td>A chronological written account of a patient’s examination and treatment that includes the patient’s medical history and complaints, the provider’s physical findings, behavioral health findings, the results of diagnostic tests and procedures, medications and therapeutic procedures, referrals and treatment plans.</td>
</tr>
<tr>
<td>MEDICAL SERVICES</td>
<td>Medical care and treatment provided by a Primary Care Provider (PCP), attending physician or dentist or by a nurse or other health related professional and technical personnel at the direction/order of a licensed physician or dentist.</td>
</tr>
<tr>
<td>MEDICALLY NECESSARY</td>
<td>As defined in 9 A.A.C. 22 Article 101. Medically necessary means a covered service provided by a physician or other licensed practitioner of the health arts within the scope of practice under State law to prevent disease, disability or other adverse conditions or their progression, or prolong life.</td>
</tr>
<tr>
<td>MEDICALLY NECESSARY SERVICES</td>
<td>Those covered services provided by qualified service providers within the scope of their practice to prevent disease, disability and other adverse health conditions or their progression or to prolong life.</td>
</tr>
<tr>
<td>MEMBER</td>
<td>An eligible person who is enrolled in AHCCCS, as defined in A.R.S. §36-2931, §36-2901, §36-2901.01 and A.R.S. §36-2981.</td>
</tr>
<tr>
<td>MEMBER INFORMATION MATERIALS</td>
<td>Any materials given to the Contractor’s membership. This includes, but is not limited to: member handbooks, member newsletters, surveys, on hold messages and health related brochures/reminders and videos, form letter templates, and website content. It also includes the use of other mass communication technology such as e-mail and voice recorded information messages delivered to a member’s phone.</td>
</tr>
<tr>
<td>NATIONAL PROVIDER IDENTIFIER (NPI)</td>
<td>A unique identification number for covered health care providers, assigned by the CMS contracted national enumerator.</td>
</tr>
<tr>
<td>NON-CONTRACTING PROVIDER</td>
<td>A person or entity that provides services as prescribed in A.R.S. §36-2901 who does not have a subcontract with an AHCCCS Contractor.</td>
</tr>
</tbody>
</table>
OFFEROR
An organization or other entity that submits a proposal to AHCCCS in response to a Request For Proposal as defined in 9 A.A.C. 22, Article 1.

PARENT
A biological, adoptive, or custodial mother or father of a child, or an individual who has been appointed as a legal guardian or custodian of a child by a court of competent jurisdiction.

PERFORMANCE IMPROVEMENT PROJECT (PIP)
A planned process of data gathering, evaluation and analysis to determine interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the quality of care and service delivery. Formerly referred to as Quality Improvement Projects (QIP).

PERFORMANCE STANDARDS
A set of standardized measures designed to assist AHCCCS in evaluating, comparing and improving the performance of its Contractors.

POST STABILIZATION CARE SERVICES
Medically necessary services, related to an emergency medical condition provided after the member’s condition is sufficiently stabilized in order to maintain, improve or resolve the member’s condition so that the member could alternatively be safely discharged or transferred to another location [42 CFR 438-114(a)].

POTENTIAL ENROLLEE
A Medicaid-eligible recipient who is not yet enrolled with a Contractor [42 CFR 438.10(a)].

PREPAID MEDICAL MANAGEMENT INFORMATION SYSTEM (PMMIS)
An integrated information infrastructure that supports AHCCCS operations, administrative activities and reporting requirements.

PREMIUM TAX
The premium tax is equal to the tax imposed pursuant to A.R.S. §36-2905 for all payments made to Contractors for the contract year.

PRIMARY CARE PROVIDER (PCP)
An individual who meets the requirements of A.R.S. §36-2901, and who is responsible for the management of the member’s health care. A PCP may be a physician defined as a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17, or a practitioner defined as a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15. The PCP must be an individual, not a group or association of persons, such as a clinic.
PRIMARY PREVENTION
The focus on methods to reduce, control, eliminate and prevent the
incidence or onset of physical or mental health disease through the
application of interventions before there is any evidence of disease
or injury.

PRIOR AUTHORIZATION
Prior authorization is a process used to determine in advance of
provision whether or not a prescribed procedure, service, or
medication will be covered. The process is intended to act as a safety
and cost savings measure.

PRIOR PERIOD
See “PRIOR PERIOD COVERAGE.”

PRIOR PERIOD COVERAGE (PPC)
The period of time prior to the member’s enrollment, during which
a member is eligible for covered services. The timeframe is from the
effective date of eligibility (usually the first day of the month of
application) until the date the member is enrolled with the
Contractor. Refer to 9 A.A.C. 22 Article 1. If a member made eligible
via the Hospital Presumptive Eligibility (HPE) program is
subsequently determined eligible for AHCCCS via the full application
process, prior period coverage for the member will be covered by
AHCCCS Fee-For-Service and the member will be enrolled with the
Contractor only on a prospective basis.

PRIOR QUARTER COVERAGE
The period of time prior to an individual’s month of application for
AHCCCS coverage, during which a member may be eligible for
covered services. Prior Quarter Coverage is limited to the three
month time period prior to the month of application. An applicant
may be eligible during any of the three months prior to application if
the applicant:

1. Received one or more covered services described in 9 A.A.C. 22,
   Article 2 and Article 12, and 9 A.A.C. 28, Article 2 during the
   month; and

2. Would have qualified for Medicaid at the time services were
   received if the person had applied regardless of whether the
   person is alive when the application is made. Refer to A.A.C. R9-
   22-303

AHCCCS Contractors are not responsible for payment for covered
services received during the prior quarter.

PROGRAM CONTRACTOR
See “CONTRACTOR”
**PROVIDER**
Any person or entity that contracts with AHCCCS or a Contractor for the provision of covered services to members according to the provisions A.R.S. §36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. §36-2901.

**PROVIDER GROUP**
Two or more health care professionals who practice their profession at a common location (whether or not they share facilities, supporting staff, or equipment).

**PRUDENT LAYPERSON**
A person without medical training who relies on the experience, knowledge and judgment of a reasonable person to make a decision regarding whether or not the absence of immediate medical attention will result in: 1) placing the health of the individual in serious jeopardy, 2) serious impairment to bodily functions, or 3) serious dysfunction of a bodily part or organ.

**QUALIFIED MEDICARE BENEFICIARY DUAL ELIGIBLE (QMB DUAL)**
A person determined eligible under A.A.C. R9-29-101 et seq. for Qualified Medicare Beneficiary (QMB) and eligible for acute care services provided for in A.A.C. R9-22-201 et seq. or ALTCS services provided for in A.A.C. R9-28-201 et seq. A QMB dual person receiving both Medicare and Medicaid services and cost sharing assistance.

**REFERRAL**
A verbal, written, telephonic, electronic or in-person request for health services.

**REGIONAL BEHAVIORAL HEALTH AUTHORITY (RBHA/Health Plan)**
A Managed Care Organization that has a contract with the administration, the primary purpose of which is to coordinate the delivery of comprehensive mental health services to all eligible persons assigned by the administration to the managed care organization. Additionally the Managed Care Organization shall coordinate the delivery of comprehensive physical health services to all eligible persons with a serious mental illness enrolled by the administration to the managed care organization.

**REINSURANCE**
A risk-sharing program provided by AHCCCS to Contractors for the reimbursement of certain contract service costs incurred for a member beyond a predetermined monetary threshold.

**RELATED PARTY**
A party that has, or may have, the ability to control or significantly influence a Contractor, or a party that is, or may be, controlled or significantly influenced by a Contractor. "Related parties" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the Offeror and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.
<table>
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<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>REQUEST FOR PROPOSAL (RFP)</td>
<td>A RFP includes all documents, whether attached or incorporated by references that are used by the Administration for soliciting a proposal under 9 A.A.C. 22 Article 6.</td>
</tr>
<tr>
<td>ROOM AND BOARD (or ROOM)</td>
<td>The amount paid for food and/or shelter. Medicaid funds can be expended for room and board when a person lives in an institutional setting (e.g. NF, ICF). Medicaid funds cannot be expended for room and board when a member resides in an alternative residential setting (e.g. Assisted Living Home, Behavioral Health Residential Facilities) or an apartment like setting that may provide meals.</td>
</tr>
<tr>
<td>SCOPE OF SERVICES</td>
<td>See “COVERED SERVICES.”</td>
</tr>
<tr>
<td>SERVICE LEVEL AGREEMENT</td>
<td>A type of subcontract with a corporate owner or any of its Divisions or Subsidiaries that requires specific levels of service for administrative functions or services for the Contractor specifically related to fulfilling the Contractor’s obligations to AHCCCS under the terms of this contract.</td>
</tr>
<tr>
<td>SERVICE PLAN</td>
<td>A complete written description of all covered health services and other informal supports which reflects applicable Evidence Based Practice Guidelines. The service plan includes individualized goals, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life.</td>
</tr>
<tr>
<td>SPECIAL HEALTH CARE NEEDS</td>
<td>Serious or chronic physical, developmental and/or behavioral health conditions. Members with special health care needs require medically necessary services of a type or amount beyond that generally required by members.</td>
</tr>
<tr>
<td>SPECIALTY PHYSICIAN</td>
<td>A physician who is specially trained in a certain branch of medicine related to specific services or procedures, certain age categories of patients, certain body systems, or certain types of diseases.</td>
</tr>
<tr>
<td>STATE</td>
<td>The State of Arizona.</td>
</tr>
<tr>
<td>STATEWIDE</td>
<td>Of sufficient scope and breadth to address the health care service needs of members throughout the State of Arizona.</td>
</tr>
<tr>
<td>STATE FISCAL YEAR</td>
<td>The budget year-State fiscal year: July 1 through June 30.</td>
</tr>
<tr>
<td>STATE PLAN</td>
<td>The written agreements between the State and CMS, which describes how the AHCCCS program meets CMS requirements for participation in the Medicaid program and the State Children’s Health Insurance Program.</td>
</tr>
<tr>
<td><strong>SUBCONTRACT</strong></td>
<td>An agreement entered into by the Contractor with any of the following: a provider of health care services who agrees to furnish covered services to member; or with any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor’s obligations to AHCCCS under the terms of this contract, as defined in 9 A.A.C. 22 Article 1.</td>
</tr>
</tbody>
</table>
| **SUBCONTRACTOR** | 1. A provider of health care who agrees to furnish covered services to members.  
2. A person, agency or organization with which the Contractor has contracted or delegated some of its management/administrative functions or responsibilities.  
3. A person, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies equipment or services provided under the AHCCCS agreement. |
| **SUBSIDIARY** | An entity owned or controlled by the Contractor. |
| **SUBSTANCE USE DISORDERS** | A range of conditions that vary in severity over time, from problematic, short-term use/abuse of substances to severe and chronic disorders requiring long-term and sustained treatment and recovery management. |
| **SUPPLEMENTAL SECURITY INCOME (SSI) AND SSI RELATED GROUPS** | Eligible individuals receiving income through Federal cash assistance programs under Title XVI of the Social Security Act who are aged, blind or have a disability and have household income levels at or below 100% of the FPL. |
| **THIRD PARTY LIABILITY (TPL)** | See “LIABLE PARTY.” |
| **TITLE XIX** | Known as Medicaid, Title XIX of the Social Security Act provides for Federal grants to the states for medical assistance programs. Title XIX enables states to furnish medical assistance to those who have insufficient income and resources to meet the costs of necessary medical services, rehabilitation and other services, to help those families and individuals become or remain independent and able to care for themselves. Title XIX members include but are not limited to those eligible under Section 1931 of the Social Security Act, Supplemental Security Income (SSI), SSI-related groups, Medicare cost sharing groups, Breast and Cervical Cancer Treatment Program and Freedom to Work Program. Which include those populations 42 U.S.C. 1396 a(a)(10)(A). |
| **TITLE XIX MEMBER** | Title XIX members include those eligible under 1931 provisions of the Social Security Act (previously AFDC), Sixth Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income (SSI) or SSI-related groups, Medicare Cost Sharing groups, Adult Group at or below 106% Federal Poverty Level (Adults <= 106%), Adult Group above 106% Federal Poverty Level (Adults > 106%), Breast and Cervical Cancer Treatment program, Title IV-E Foster Care and Adoption Subsidy, Young Adult Transitional Insurance, and Freedom to Work. |
| **TREATMENT** | A procedure or method to cure, improve, or palliate an individual’s medical condition or behavioral health issue. Refer to A.A.C. R9-10-101. |
| **TRIBAL REGIONAL BEHAVIORAL HEALTH AUTHORITY (TRBHA)** | An organization under contract with the State of Arizona that administers covered behavioral health services for Title XIX and XXI members. Tribal governments, through an agreement with the State, may operate a Tribal Regional Behavioral Health Authority for the provision of behavioral health services to American Indian members. Refer to A.R.S. §36-3401, §36-3407, and A.A.C. R9-22-1201. |

### 19.3 AHCCCS Definitions – Part 2

The definitions specified in Part 2 below refer to terms that exist in one or more contracts but do not appear in all contracts.

| 1931 (also referred to as TANF related) | Eligible individuals and families under Section 1931 of the Social Security Act, with household income levels at or below 100% of the Federal Poverty Level (FPL). See also “TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF).” |
| **ABUSE (OF MEMBER)** | Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault as defined by A.R.S. §46-451 and A.R.S. §13-3623. |
| **ABUSE (BY PROVIDER)** | Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the AHCCCS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the AHCCCS program as defined by 42 CFR 455.2. |
ACUTE CARE ONLY (ACO)  ACO refers to the enrollment status of a member who is otherwise financially and medically eligible for ALTCS but who either 1) refuses HCBS offered by the case manager; 2) has made an uncompensated transfer that makes him or her ineligible; 3) resides in a setting in which Long Term Care Services cannot be provided; or 4) has equity value in a home that exceeds $552,000. These ALTCS enrolled members are eligible to receive acute medical services but not eligible to receive LTC institutional, alternative residential or HCBS.

ADMINISTRATIVE OFFICE OF THE COURTS (AOC)  The Arizona Constitution authorizes an administrative director and staff to assist the Chief Justice with administrative duties. Under the direction of the Chief Justice, the administrative director and the staff of the Administrative Office of the Courts (AOC) provide the necessary support for the supervision and administration of all State courts.

ADULT GROUP ABOVE 106% FEDERAL POVERTY LEVEL (ADULTS > 106%)  Adults aged 19-64, without Medicare, with income above 106% through 133% of the Federal Poverty Level (FPL).

ADULT GROUP AT OR BELOW 106% FEDERAL POVERTY LEVEL (ADULTS <= 106%)  Adults aged 19-64, without Medicare, with income at or below 106% of the Federal Poverty Level (FPL).

AGENT  Any person who has been delegated the authority to obligate or act on behalf of another person or entity.

AID FOR FAMILIES WITH DEPENDENT CHILDREN (AFDC)  See “TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF).”

ANNIVERSARY DATE  The anniversary date is 12 months from the date the member enrolled with the Contractor and annually thereafter. In some cases, the anniversary date will change based on the last date the member changed Contractors or the last date the member was given an opportunity to change.

ANNUAL ENROLLMENT CHOICE (AEC)  The opportunity for a person to change Contractors every 12 months.
The department established pursuant to A.R.S. §8-451 to protect children and to perform the following:
1. Investigate reports of abuse and neglect.
2. Assess, promote and support the safety of a child in a safe and stable family or other appropriate placement in response to allegations of abuse or neglect.
3. Work cooperatively with law enforcement regarding reports that include criminal conduct allegations.
4. Without compromising child safety, coordinate services to achieve and maintain permanency on behalf of the child, strengthen the family and provide prevention, intervention and treatment services pursuant to this chapter.

The State agency responsible for all juveniles adjudicated as delinquent and committed to its jurisdiction by the county juvenile courts.

A 24 hour per day unit of service that is authorized by an ALTCS member’s case manager or the behavioral health case manager or a subcontractor for an acute care member, which may be billed despite the member’s absence from the facility for the purposes of short term hospitalization leave and therapeutic leave. Refer to the Arizona Medicaid State Plan, 42 CFR. §§447.40 and 483.12, and 9 A.A.C. 28 for more information on the bed hold service and AMPM Chapter 100.

As specified in A.A.C. R9-10-101, an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution’s policies and procedures that:
  a. If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; and
  b. Are provided under supervision by a behavioral health professional.

A health care institution that provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual to:
  a. Have a limited or reduced ability to meet the individual's basic physical needs;
  b. Suffer harm that significantly impairs the individual’s judgment, reason, behavior, or capacity to recognize reality;
  c. Be a danger to self;
  d. Be a danger to others;
  e. Be persistently or acutely disabled as defined in A.R.S. § 36-501; or
  f. Be gravely disabled.
| BEHAVIORAL HEALTH TECHNICIAN | As specified in A.A.C. R9-10-101, an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution’s policies and procedures that: a. If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; and b. are provided with clinical oversight by a behavioral health professional. |
| BREAST AND CERVICAL CANCER TREATMENT PROGRAM (BCCTP) | Eligible individuals under the Title XIX expansion program for women with income up to 250% of the FPL, who are diagnosed with and need treatment for breast and/or cervical cancer or cervical lesions and are not eligible for other Title XIX programs providing full Title XIX services. Qualifying individuals cannot have other creditable health insurance coverage, including Medicare. |
| CARE MANAGEMENT PROGRAM (CMP) | Activities to identify the top tier of high need/high cost Title XIX members receiving services within an AHCCCS contracted health plan; including the design of clinical interventions or alternative treatments to reduce risk, cost, and help members achieve better health care outcomes. Care management is an administrative function performed by the health plan. Distinct from case management, Integrated Care Managers should not perform the day-to-day duties of service delivery. |
| CASE MANAGEMENT | A collaborative process which assess, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual’s health needs through communication and available resources to promote quality, cost-effective outcomes. |
| CASH MANAGEMENT IMPROVEMENT ACT (CMIA) CHILDREN’S REHABILITATIVE SERVICES (CRS) | Cash Management Improvement Act of 1990 [31 CFR Part 205]. Provides guidelines for the drawdown and transfer of Federal funds. A program that provides medical treatment, rehabilitation, and related support services to Title XIX and Title XXI members who have completed the CRS application and have met the eligibility criteria to receive CRS-related services as specified in 9 A.A.C. 22. |
| CLIENT ASSESSMENT AND TRACKING SYSTEM (CATS) | A component of AHCCCS’ data management information system that supports ALTCS and that is designed to provide key information to, and receive key information from ALTCS Contractors. |
| COMPREHENSIVE MEDICAL AND DENTAL PROGRAM (CMDP) | A Contractor that is responsible for the provision of covered, medically necessary AHCCCS services for foster children in Arizona. Refer to A.R.S. §8-512. |
COMPETITIVE BID PROCESS  A state procurement system used to select Contractors to provide covered services on a geographic basis.

COUNTY OF FISCAL RESPONSIBILITY  The county of fiscal responsibility is the Arizona county that is responsible for paying the state's funding match for the member’s ALTCS Service Package. The county of physical presence (the county in which the member physically resides) and the county of fiscal responsibility may be the same county or different counties.

CRS-ELIGIBLE  An individual AHCCCS member who has completed the CRS application process, as delineated in the CRS Policy and Procedure Manual, and has met all applicable criteria to be eligible to receive CRS-related services as specified in 9 A.A.C. 22.

CRS RECIPIENT  An individual who has completed the CRS application process, and has met all applicable criteria to be eligible to receive CRS related covered Services.

DEVELOPMENTAL DISABILITY (DD)  As defined in A.R.S. §36-551, a strongly demonstrated potential that a child under six years of age has a developmental disability or will become a child with a developmental disability, as determined by a test performed pursuant to section 36-694 or by other appropriate tests, or a severe, chronic disability that:
   a. Is attributable to cognitive disability, cerebral palsy, epilepsy or autism.
   b. Is manifested before age eighteen.
   c. Is likely to continue indefinitely.
   d. Results in substantial functional limitations in three or more of the following areas of major life activity:
      (i) Self-care.
      (ii) Receptive and expressive language.
      (iii) Learning.
      (iv) Mobility.
      (v) Self-direction.
      (vi) Capacity for independent living.
      (vii) Economic self-sufficiency.
   e. Reflects the need for a combination and sequence of individually planned or coordinated special, interdisciplinary or generic care, treatment or other services that are of lifelong or extended duration.

EPISODE OF CARE  The period between the beginning of treatment and the ending of covered services for an individual. The beginning and end of an episodes of care is marked with a demographic file submission. Over time, an individual may have multiple episodes of care.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>FAMILY-CENTERED</td>
<td>Care that recognizes and respects the pivotal role of the family in the lives of members. It supports families in their natural care-giving roles, promotes normal patterns of living, and ensures family collaboration and choice in the provision of services to the member.</td>
</tr>
<tr>
<td>FAMILY OR FAMILY MEMBER</td>
<td>A biological, adoptive, or custodial mother or father of a child, or an individual who has been appointed as a legal guardian or custodian of a child by a court of competent jurisdiction, or other member representative responsible for making health care decisions on behalf of the member. Family members may also include siblings, grandparents, aunts and uncles.</td>
</tr>
<tr>
<td>FEDERAL EMERGENCY SERVICES (FES)</td>
<td>A program delineated in A.A.C. R9-22-217, to treat an emergency condition for a member who is determined eligible under A.R.S. §36-2903.03(D).</td>
</tr>
<tr>
<td>FEDERALLY QUALIFIED HEALTH CENTER (FQHC)</td>
<td>A public or private non-profit health care organization that has been identified by the HRSA and certified by CMS as meeting criteria under Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act.</td>
</tr>
<tr>
<td>FEDERALLY QUALIFIED HEALTH CENTER LOOK-ALIKE</td>
<td>A public or private non-profit health care organization that has been identified by the HRSA and certified by CMS as meeting the definition of “health center” under Section 330 of the Public Health Service Act, but does not receive grant funding under Section 330.</td>
</tr>
<tr>
<td>FIELD CLINIC</td>
<td>A “clinic” consisting of single specialty health care providers who travel to health care delivery settings closer to members and their families than the Multi-Specialty Interdisciplinary Clinics (MSICs) to provide a specific set of services including evaluation, monitoring, and treatment for CRS-related conditions on a periodic basis.</td>
</tr>
<tr>
<td>FREEDOM OF CHOICE (FC)</td>
<td>The opportunity given to each member who does not specify a Contractor preference at the time of enrollment to choose between the Contractors available within the Geographic Service Area (GSA) in which the member is enrolled.</td>
</tr>
<tr>
<td>HOME</td>
<td>A residential dwelling that is owned, rented, leased, or occupied at no cost to the member, including a house, a mobile home, an apartment or other similar shelter. A home is not a facility, a setting or an institution, or a portion and any of these, licensed or certified by a regulatory agency of the state as a defined in A.A.C. R9-28-101.</td>
</tr>
<tr>
<td>HOME AND COMMUNITY BASED SERVICES (HCBS)</td>
<td>Home and community-based services, as defined in A.R.S. §36-2931 and §36-2939.</td>
</tr>
</tbody>
</table>
INTEGRATED MEDICAL RECORD A single document in which all of the medical information listed in Chapter 900 of the AMPM is recorded to facilitate the coordination and quality of care delivered by multiple providers serving a single patient in multiple locations and at varying times.

INTERDISCIPLINARY CARE A meeting of the interdisciplinary team members or coordination of care among interdisciplinary treatment team members to address the totality of the treatment and service plans for the member based on the most current information available.

INTERMEDIATE CARE FACILITY FOR PERSONS WITH INTELLECTUAL DISABILITIES (ICF) A placement setting for persons with intellectual disabilities.

JUVENILE PROBATION OFFICE (JPO) An officer within the Arizona Department of Juvenile Corrections assigned to a juvenile upon release from a secure facility. Having close supervision and observation over juvenile’s who are ordered to participate in the intensive probation program including visual contact at least four times per week and weekly contact with the school, employer, community restitution agency or treatment program. (A.R.S. §38-353)

KIDSCARE Federal and State Children’s Health Insurance Program (Title XXI – CHIP) administered by AHCCCS. The KidsCare I program offers comprehensive medical, preventive, treatment services, and behavioral health care services statewide to eligible children under the age of 19, in households with income at or below 200% Federal Poverty Level (FPL). The KidsCare II program has the same benefits and premium requirements as KidsCare I, however household income limits cannot be greater than 175% FPL. The KidsCare II program is available May 1, 2012 through January 31, 2014.

MEDICAL PRACTITIONER A physician, physician assistant or registered nurse practitioner.

MEDICARE MANAGED CARE PLAN A managed care entity that has a Medicare contract with CMS to provide services to Medicare beneficiaries, including Medicare Advantage Plan (MAP), Medicare Advantage Prescription Drug Plan (MAPDP), MAPDP Special Needs Plan, or Medicare Prescription Drug Plan.

MULTI-SPECIALTY INTERDISCIPLINARY CLINIC (MSiC) An established facility where specialists from multiple specialties meet with members and their families for the purpose of providing interdisciplinary services to treat members.

PERSON WITH A DEVELOPMENTAL/ INTELLECTUAL DISABILITY An individual who meets the Arizona definition as outlined in A.R.S. §36-551 and is determined eligible for services through the DES Division of Developmental Disabilities (DDD). Services for AHCCCS-enrolled acute and long term care members with developmental/intellectual disabilities are managed through the DES Division of Developmental Disabilities.
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<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRE-ADMISSION SCREENING (PAS)</td>
<td>A process of determining an individual’s risk of institutionalization at a NF or ICF level of care as specified in 9 A.A.C. 28 Article 1.</td>
</tr>
<tr>
<td>RATE CODE</td>
<td>Eligibility classification for capitation payment purposes.</td>
</tr>
<tr>
<td>RISK GROUP</td>
<td>Grouping of rate codes that are paid at the same capitation rate.</td>
</tr>
<tr>
<td>ROSTER BILLING</td>
<td>Any claim that does not meet the standardized claim requirements of 9 A.A.C. 22, Article 7 is considered roster billing.</td>
</tr>
<tr>
<td>RURAL HEALTH CLINIC (RHC)</td>
<td>A clinic located in an area designated by the Bureau of Census as rural, and by the Secretary of the DHHS as medically underserved or having an insufficient number of physicians, which meets the requirements under 42 CFR 491.</td>
</tr>
<tr>
<td>SERIOUSLY MENTALLY ILL (SMI)</td>
<td>A person 18 years of age or older who has been determined to have a serious mental illness as defined in A.R.S. §36-550.</td>
</tr>
<tr>
<td>SIXTH OMNIBUS BUDGET AND RECONCILIATION ACT (SOBRA)</td>
<td>Eligible pregnant women under Section 9401 of the Sixth Omnibus Budget and Reconciliation Act of 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396(a)(10)(A)(ii)(IX), November 5, 1990, with individually budgeted incomes at or below 150% of the FPL, and children in families with individually budgeted incomes ranging from below 100% to 140% of the FPL, depending on the age of the child.</td>
</tr>
<tr>
<td>SMI ELIGIBILITY DETERMINATION</td>
<td>The process, after assessment and submission of required documentation to determine, whether a member meets the criteria for Serious Mental Illness.</td>
</tr>
<tr>
<td>STATE CHILDREN’S HEALTH INSURANCE PROGRAM (SCHIP)</td>
<td>State Children’s Health Insurance Program under Title XXI of the Social Security Act (Also known as CHIP). The Arizona version of CHIP is referred to as “KidsCare.” See also “KIDSCARE.”</td>
</tr>
<tr>
<td>STATE ONLY TRANSPLANT MEMBERS</td>
<td>Individuals who are eligible under one of the Title XIX eligibility categories and found eligible for a transplant, but subsequently lose Title XIX eligibility due to excess income become eligible for one of two extended eligibility options as specified in A.R.S. §36-2907.10 and A.R.S. §36-2907.11.</td>
</tr>
<tr>
<td>SUBSTANCE ABUSE</td>
<td>As specified in A.A.C. R9-10-101, an individual’s misuse of alcohol or other drug or chemical that: a. Alters the individual’s behavior or mental functioning; b. Has the potential to cause the individual to be psychologically or physiologically dependent on alcohol or other drug or chemical; and c. Impairs, reduces, or destroys the individual’s social or economic functioning.</td>
</tr>
<tr>
<td><strong>TELEMEDICINE</strong></td>
<td>The practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data through interactive audio, video or data communications that occur in the physical presence of the patient, including audio or video communications sent to a health care provider for diagnostic or treatment consultation. Refer to A.R.S. §36-3601.</td>
</tr>
<tr>
<td><strong>TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF)</strong></td>
<td>A Federal cash assistance program under Title IV of the Social Security Act established by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193). It replaced Aid To Families With Dependent Children (AFDC).</td>
</tr>
<tr>
<td><strong>Title XXI</strong></td>
<td>Title XXI of the Social Security Act provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low income children in an effective and efficient manner that is coordinated with other sources of child health benefits coverage.</td>
</tr>
<tr>
<td><strong>TITLE XXI MEMBER</strong></td>
<td>Member eligible for acute care services under Title XXI of the Social Security Act, referred to in Federal legislation as the “Children’s Health Insurance Program” (CHIP). The Arizona version of CHIP is referred to as “KidsCare.”</td>
</tr>
<tr>
<td><strong>TREATMENT PLAN</strong></td>
<td>A written plan of services and therapeutic interventions based on a complete assessment of a member's developmental and health status, strengths and needs that are designed and periodically updated by the multi-specialty, interdisciplinary team.</td>
</tr>
<tr>
<td><strong>VIRTUAL CLINICS</strong></td>
<td>Integrated services provided in community settings through the use of innovative strategies for care coordination such as Telemedicine, integrated medical records and virtual interdisciplinary treatment team meetings.</td>
</tr>
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</table>

### 19.4 Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>A.A.C.</td>
<td>Arizona Administrative Code</td>
</tr>
<tr>
<td>AAR</td>
<td>Arizona Administrative Register</td>
</tr>
<tr>
<td>ACOM</td>
<td>Arizona Healthcare Cost Containment System Contractor Operational Manual</td>
</tr>
<tr>
<td>ACORD</td>
<td>Association for Cooperative Operations Research and Development</td>
</tr>
<tr>
<td>ACT</td>
<td>Assertive Community Treatment</td>
</tr>
<tr>
<td>ADA</td>
<td>Americans with Disabilities Act</td>
</tr>
<tr>
<td>ADOE</td>
<td>Arizona Department of Education</td>
</tr>
<tr>
<td>ADES or DES</td>
<td>Arizona Department of Economic Security</td>
</tr>
<tr>
<td>ADES/DDD or DDD</td>
<td>Arizona Department of Economic Security, Division of Developmental Disabilities</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
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</tr>
<tr>
<td>ADES/RSA or RSA</td>
<td>Arizona Department of Economic Security, Rehabilitation Services Administration</td>
</tr>
<tr>
<td>ADHS</td>
<td>Arizona Department of Health Services</td>
</tr>
<tr>
<td>ADJC</td>
<td>Arizona Department of Juvenile Correction</td>
</tr>
<tr>
<td>ADOC</td>
<td>Arizona Department of Corrections</td>
</tr>
<tr>
<td>ADOH</td>
<td>Arizona Department of Housing</td>
</tr>
<tr>
<td>AHCCCS</td>
<td>Arizona Healthcare Cost Containment System</td>
</tr>
<tr>
<td>AIHP</td>
<td>American Indian Health Program</td>
</tr>
<tr>
<td>ALOS</td>
<td>Average Length of Stay</td>
</tr>
<tr>
<td>ALTCS</td>
<td>Arizona Long Term Care System</td>
</tr>
<tr>
<td>AOC</td>
<td>Administrative Office of the Courts of the Supreme Court</td>
</tr>
<tr>
<td>AR</td>
<td>Abandoned Rate</td>
</tr>
<tr>
<td>A.R.S.</td>
<td>Arizona Revised Statutes</td>
</tr>
<tr>
<td>ASAM</td>
<td>American Society of Addiction Medicine</td>
</tr>
<tr>
<td>ASAM PPC</td>
<td>American Society of Addiction Medicine Patient Placement Criteria</td>
</tr>
<tr>
<td>ASDB</td>
<td>Arizona State Schools for the Deaf and Blind</td>
</tr>
<tr>
<td>ASH</td>
<td>Arizona State Hospital</td>
</tr>
<tr>
<td>ASH LINE</td>
<td>Arizona’s Smokers Help Line</td>
</tr>
<tr>
<td>ASIIS</td>
<td>Arizona State Immunization Information System</td>
</tr>
<tr>
<td>ASIST</td>
<td>Applied Suicide Intervention Skills Training</td>
</tr>
<tr>
<td>AzeEIP</td>
<td>Arizona Early Intervention Program</td>
</tr>
<tr>
<td>BCC</td>
<td>Bureau of Corporate Compliance</td>
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<tr>
<td>BCCTP</td>
<td>Breast Cervical Cancer Treatment Program</td>
</tr>
<tr>
<td>BH</td>
<td>Behavioral Health</td>
</tr>
<tr>
<td>BHP</td>
<td>Behavioral Health Professional</td>
</tr>
<tr>
<td>CAP</td>
<td>Corrective Action Plan</td>
</tr>
<tr>
<td>CCO</td>
<td>Chief Clinical Officer</td>
</tr>
<tr>
<td>CCP</td>
<td>Cultural Competency Plan</td>
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<tr>
<td>CEO/COO</td>
<td>Chief Executive Officer/Chief Operating Officer</td>
</tr>
<tr>
<td>CFO</td>
<td>Chief Financial Officer</td>
</tr>
<tr>
<td>CFR</td>
<td>Code of Federal Regulations</td>
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<tr>
<td>CFT</td>
<td>Child and Family Team</td>
</tr>
<tr>
<td>CIS</td>
<td>Client Information System</td>
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<tr>
<td>CLAS</td>
<td>National Culturally Linguistically and Appropriate Service Standards</td>
</tr>
<tr>
<td>CLEAR</td>
<td>Council on Licensure, Enforcement and Regulation</td>
</tr>
<tr>
<td>CLIA</td>
<td>Clinical Laboratory Improvement Amendments</td>
</tr>
<tr>
<td>CMDP</td>
<td>Comprehensive Medical and Dental Plan</td>
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<tr>
<td>CMO</td>
<td>Chief Medical Officer</td>
</tr>
<tr>
<td>CMP</td>
<td>Care Management Program</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>--------------</td>
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</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
</tr>
<tr>
<td>CPHQ</td>
<td>Certified Professional in Healthcare Quality</td>
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<tr>
<td>CPR</td>
<td>Cardio Pulmonary Resuscitation Certification</td>
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<tr>
<td>CSA</td>
<td>Community Service Agency</td>
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<tr>
<td>CRS</td>
<td>Children’s Rehabilitative Services</td>
</tr>
<tr>
<td>CVO</td>
<td>Credential Verification Organization</td>
</tr>
<tr>
<td>CY</td>
<td>Contract Year</td>
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<tr>
<td>DASIS</td>
<td>Drug and Alcohol Services Information System</td>
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<tr>
<td>DBHS</td>
<td>Division of Behavioral Health Services</td>
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<tr>
<td>DCS</td>
<td>Department of Child Safety</td>
</tr>
<tr>
<td>DFSM</td>
<td>Division for Fee for Service Management</td>
</tr>
<tr>
<td>DHHS or HHS</td>
<td>U.S. Department of Health and Human Services</td>
</tr>
<tr>
<td>DIBR</td>
<td>Documents Incorporated by Reference</td>
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<tr>
<td>DIG</td>
<td>Data Infrastructure Grants</td>
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<tr>
<td>DME</td>
<td>Durable Medical Equipment</td>
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<tr>
<td>DMO</td>
<td>Deputy Medical Officer</td>
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<tr>
<td>DRA</td>
<td>Deficit Reduction Act of 2005</td>
</tr>
<tr>
<td>DSM</td>
<td>Diagnostic and Statistical Manual of International Classification of Disorders</td>
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<tr>
<td>D-SNP</td>
<td>Dual Eligible Special Needs Plan</td>
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<tr>
<td>DUI</td>
<td>Driving Under the Influence</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
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<tr>
<td>EHR</td>
<td>Electronic Health Records</td>
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<td>EMS</td>
<td>Emergency Medical Services</td>
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<td>EOC</td>
<td>Episode of Care</td>
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<td>EPLS</td>
<td>Excluded Provider List System</td>
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<tr>
<td>EPSDT</td>
<td>Early Periodic Screening Diagnostic and Treatment Service</td>
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<tr>
<td>EQRO</td>
<td>External Quality Review Organization</td>
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<td>FCCCR</td>
<td>First Contact Call Resolution Rate</td>
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<td>FES</td>
<td>Federal Emergency System</td>
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<tr>
<td>FFS</td>
<td>Fee for Service</td>
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<tr>
<td>F.I.R.S.T.</td>
<td>Families in Recovery Succeeding Together</td>
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<tr>
<td>FPL</td>
<td>Federal Poverty Level</td>
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<tr>
<td>FQHC</td>
<td>Federally Qualified Health Centers</td>
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<tr>
<td>FTP</td>
<td>File Transfer Protocol</td>
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<tr>
<td>GAAP</td>
<td>Generally Accepted Accounting Principles</td>
</tr>
<tr>
<td>GAAS</td>
<td>General Accepted Auditing Standards</td>
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<tr>
<td>GME</td>
<td>Graduate Medical Education</td>
</tr>
<tr>
<td>GMH</td>
<td>General Mental Health Adults</td>
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<tr>
<td>GSA</td>
<td>Geographical Service Area</td>
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</table>
HCAC  Health Care Acquired Condition
HCTC  Home Care Training to Home Care Client
HIE  Health Information Exchange
HIPAA  Health Insurance Portability and Accountability Act
HITECH  Health Information Technology for Economic and Clinical Health Act
HIV  Human Immunodeficiency Virus
HMIS  Homeless Management Information System
HRC  Human Rights Committee
HUD  Housing and Urban Development
IAD  Incident, Accident, and Death
ICF/MR  Intermediate Care Facility for People with Mental Retardation
ID  Identification
IDEA  Individuals with Disabilities Education Act
IEP  Individual Education Plan
IGA  Intergovernmental Agreement
IHS  Indian Health Services
IMD  Institution for Mental Disease
ISA  Interagency Service Agreement
ISP  Individual Service Plan
IVR  Interactive Voice Response
LEIE  List of Excluded Individuals/Entities
LEP  Limited English Proficiency
MAP  Medicare Advantage Plan
MAPDP  Medicare Advantage Prescription Drug Plan
MASL  Monthly Average Service Level
MCE  Medical Care Evaluation
MCO  Managed Care Organization
MED  Medical Expense Deduction
MEVS  Medicaid Eligibility Verification Service
MHBG  Mental Health Block Grant
MIPPA  Medicare Improvements for Patients and Providers Act
MIS  Management Information System
MM/UM  Medical Management/Utilization Management
MPS  Minimum Performance Standard
MRPDL  AHCCCS Minimum Required Prescription Drug List
MSBC  Medicaid School Based Claiming
NACHA  National Automated Clearing House Association
NOA  Notice of Action
NOMS  National Outcome Measures
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
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<tr>
<td>OHR</td>
<td>Office of Human Rights</td>
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<td>OIG</td>
<td>Office of Inspector General</td>
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<tr>
<td>OMB</td>
<td>Office of Management and Budget</td>
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<tr>
<td>OPI</td>
<td>Office Program Integrity</td>
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<tr>
<td>OPPC</td>
<td>Other Provider-Provider Condition</td>
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<tr>
<td>NON-MED</td>
<td>Non-Medical Expense Deduction Member</td>
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<td>PASRR</td>
<td>Pre-Admission Screening and Resident Review</td>
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<tr>
<td>PATH</td>
<td>Project for Assistance in Transition from Homelessness</td>
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<td>PCP</td>
<td>Primary Care Provider</td>
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<td>PDSA</td>
<td>Plan Do Study Act</td>
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<tr>
<td>PHA</td>
<td>Public Housing Authorities</td>
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<tr>
<td>PIP</td>
<td>Performance Improvement Plan, Process or Projects</td>
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<tr>
<td>PMMIS</td>
<td>AHCCCS Prepaid Medical Management Information System</td>
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<td>PPS</td>
<td>Prospective Payment System</td>
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<td>Quality Improvement Organizations</td>
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<td>Quality Management</td>
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<td>Quality of Care Concern</td>
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<td>RBHA/Health Plan</td>
<td>Regional Behavioral Health Authority/Health Plan</td>
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<td>RFP</td>
<td>Request for Proposal</td>
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<td>RHC</td>
<td>Rural Health Clinic</td>
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<td>RTC</td>
<td>Residential Treatment Center</td>
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<td>Substance Abuse</td>
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<tr>
<td>SAMHSA</td>
<td>Substance Abuse and Mental Health Services Administration</td>
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<tr>
<td>SABG</td>
<td>Substance Abuse Block Grant</td>
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<tr>
<td>SCHIP</td>
<td>State Children’s Health Insurance Program</td>
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<td>Serious Emotional Disturbance</td>
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<td>SMI</td>
<td>Serious Mental Illness</td>
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<td>SNF</td>
<td>Skilled Nursing Facility</td>
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<td>SOA</td>
<td>Speed of Answer</td>
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<td>SOBRA</td>
<td>Sixth Omnibus Budget and Reconciliation Act of 1986, amended by the Medicare Catastrophic Coverage Act of 1988</td>
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<td>Supplemental Security Income</td>
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<td>Social Security Income Management Administration Office</td>
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<td>SSL</td>
<td>Secure Sockets Layer</td>
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<td>TANF</td>
<td>Temporary Assistance to Needy Families</td>
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<td>TDD</td>
<td>Telecommunications Device for the Deaf</td>
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<td>TIC</td>
<td>Trauma Informed Care</td>
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<td>TRBHA</td>
<td>Tribal Regional Behavioral Health Authority</td>
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<tr>
<td>UR</td>
<td>Utilization Review</td>
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<tr>
<td>VFC</td>
<td>Vaccine for Children</td>
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<td>ZIP</td>
<td>Zone Improvement Plan</td>
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