Section 1.0 Scope

1.0.1 Introduction
1.0.2 References

1.0.1 Introduction

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) has developed a statewide Provider Manual template. Each Tribal and Regional Behavioral Health Authority (T/RBHA) has a T/RBHA specific Provider Manual, which includes content specific to their geographic service areas (GSAs) and communities. The Provider Manual describes public behavioral health system requirements for any entity that directly provides behavioral health services or provides monitoring and oversight of behavioral health services within Arizona's public behavioral health system. These entities may include:

- Behavioral health contracted and non-contracted providers, including those that provide emergency and post-stabilization services;
- Behavioral health prevention services providers;
- Regional Behavioral Health Authorities;
- Tribal Regional Behavioral Health Authorities; and
- State Behavioral Health Tribal Providers.

The ADHS/DBHS Provider Manual is applicable to defined populations that may access public behavioral health services. These populations include:

- Title XIX and Title XXI eligible behavioral health recipients;
- Title XIX and Title XXI enrolled behavioral health recipients;
- Behavioral health recipients receiving emergency/crisis services;
- Non-Title XIX persons determined to have a Serious Mental Illness;
- Special populations, including persons receiving services through the Substance Abuse Prevention and Treatment Performance Partnership (SAPT) block grant;
- Non-enrolled persons participating in ADHS/DBHS prevention sponsored activities;
- Non-enrolled persons participating in ADHS/DBHS HIV Early Intervention services;
- Other populations, based on the availability of funding and the prioritization of available funding.

1.0.2 References

The following citations can serve as additional resources for this content area:

A.R.S. Title 36, Chapter 5
9 A.A.C. 20
9 A.A.C. 21
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA Intergovernmental Agreements (IGAs)
Section 3.19 Special Populations
Policy Clarification Memorandums
ADHS/DBHS Covered Behavioral Health Services Guide

Section 2.0 Introduction

2.1 Foreword
2.2 References
2.3 Definitions
2.4 Overview of the Arizona Public Behavioral Health System
2.5 Partnering with Tribal and Regional Behavioral Health Authorities
2.6 Tribal and Regional Behavioral Health Authorities (T/RBHAs)
2.7 Overview of [T/RBHA]
2.8 Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) System Principles
2.9 Arizona Children's Principles
2.10 Principles for Persons determined to have a Serious Mental Illness (SMI)
2.11 What is the purpose of the Provider Manual?
2.12 Use of Terms
2.13 How is the Provider Manual Structured?
2.14 When did the Provider Manual go into effect?
2.15 Revisions to the Provider Manual

2.1 Foreword

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) develops, distributes and maintains the ADHS/DBHS Provider Manual. ADHS/DBHS has developed the statewide template Provider Manual to articulate the requirements of the Arizona public behavioral health system. The ADHS/DBHS Provider Manual contains requirements applicable to direct providers of Arizona's publicly funded behavioral health services. Each Tribal and Regional Behavioral Health Authority (T/RBHA) adds information specific to their geographic service areas (GSAs) and communities and creates a T/RBHA specific version of the document. For hyperlinks to T/RBHA specific versions of the Provider Manual, go to http://www.azdhs.gov/bhs/provider/index.htm.

2.2 References

The following citations can serve as additional resources for this content area:
9 A.A.C. 21
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA Intergovernmental Agreements (IGAs)
ADHS/DBHS Provider Manual
Substance Abuse Prevention & Treatment Block Grant
Community Mental Health Services Block Grant
12 Principles for Children's Health
Principles for Persons with a Serious Mental Illness

2.3 Definitions

Behavioral Health Recipient

Cultural Competence

Family

Natural Support

Serious Mental Illness

2.4 Overview of the Arizona Public Behavioral Health System

ADHS/DBHS administers behavioral health programs and services for children and adults and their families. ADHS/DBHS is responsible for administering behavioral health services for several populations funded through various sources.

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

Arizona state law requires ADHS/DBHS to administer community based treatment services for adults who have been determined to have a Serious Mental Illness (see 9 A.A.C. 21).

The Substance Abuse and Mental Health Services Administration (SAMHSA) provides funding to ADHS/DBHS through two block grants:

- The Substance Abuse Prevention and Treatment Block Grant (SAPT) supports a variety of substance abuse services in both specialized addiction treatment and more generalized behavioral health settings, and

- The Community Mental Health Services Block Grant (CMHS) supports Non-Title XIX services to children determined to have Serious Emotional Disturbance (SED) and adults determined to have Serious Mental Illness (SMI).

ADHS/DBHS administers other federal, state and locally funded behavioral health services.

2.5 Partnering with Tribal and Regional Behavioral Health Authorities (T/RBHAs)

ADHS/DBHS, in partnership with the Tribal and Regional Behavioral Health Authorities (T/RBHAs), promote collaboration and encourage family centered, personalized and culturally relevant behavioral health services that result in positive outcomes for persons. The expected outcomes include but are not limited to:

- Improved functioning;

- Reduced symptoms stemming from behavioral health problems; and

- Improved quality of life for families and individuals.

2.6 Tribal and Regional Behavioral Health Authorities (T/RBHAs)

ADHS/DBHS contracts with Regional Behavioral Health Authorities (RBHAs) to deliver behavioral health services to six Geographic Service Areas (GSAs). Each RBHA must have a network of providers to deliver all covered behavioral health services. RBHAs contract with behavioral health providers to provide the full array of covered behavioral health services.

ADHS also contracts with Tribal Regional Behavioral Health Authorities (TRBHAs). 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. ADHS/DBHS also has an intergovernmental agreement (IGA) with the Colorado River Indian Tribe (CRIT) to provide covered behavioral health 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 behavioral health services in accordance with the ADHS/DBHS Covered Behavioral Health Services Guide (see ADHS/CRIT IGA).

T/RBHAs by County and GSA

T/RBHA	Counties	GSA
Community Partnership of Southern Arizona (CPSA)	Greenlee, Graham, Cochise and Santa Cruz	3
Community Partnership of Southern Arizona (CPSA)	Pima	5
Cenpatico Behavioral Health of Arizona	Yuma and La Paz	2
Northern Arizona Regional Behavioral Health Authority (NARBHA)	Mohave, Coconino, Apache, Navajo and Yavapai	1
Cenpatico Behavioral Health of Arizona	Pinal and Gila	4
Magellan Health Services	Maricopa	6
Pascua Yaqui Tribe of Arizona		
Gila River Indian Community		
White Mountain Apache Tribe		

2.7 Overview of [T/RBHA]

[T/RBHA, enter overview of organization here]

2.8 ADHS/DBHS System Principles

All behavioral health services must be delivered in accordance with ADHS/DBHS system principles. ADHS/DBHS supports a behavioral health delivery system that includes:

- Easy access to care;
- Behavioral health recipient and family involvement;

- Collaboration with the Greater Community;
- Effective innovation;
- Expectation for improvement; and
- Cultural competency.

Easy Access to Care
Accurate information is readily available that informs behavioral health recipients, families and stakeholders how to access services;

The behavioral health network is organized in a manner that allows for easy access to behavioral health services; and

Services are delivered in a manner, location and timeframe that meet the needs of behavioral health recipients and their families.

Behavioral health recipient and family involvement
Behavioral health recipients and families are active participants in behavioral health delivery system design, prioritization of behavioral health resources and planning for and evaluating the services provided to them; and

Behavioral health recipients, families and other parties involved in the person and family's lives are central and active participants in the assessment, service planning and delivery of behavioral health services and connection to natural supports.

Collaboration with the Greater Community
Stakeholders including general medical, child welfare, criminal justice, education and other social service providers are actively engaged in the planning and delivery of integrated services to behavioral health recipients and their families;

Relationships are fostered with stakeholders to maximize access by behavioral health recipients and their families to needed resources such as housing, employment, medical and dental care, and other community services; and

Providers of behavioral health services collaborate with community stakeholders to assist behavioral health recipients and families in achieving their goals.

Effective Innovation
Behavioral health providers are continuously educated in and use best practices;

The services system recognizes that substance abuse and other mental health disorders are inextricably intertwined, and integrated substance abuse and mental health evaluation and treatment is the community standard; and

Behavioral health recipients and families (who want to) are provided training and supervision to become and be retained as providers of peer support services.

Expectation for Improvement
Services are delivered with the explicit goal of assisting people to achieve or maintain success, recovery, gainful employment, success in age-appropriate education, return to or preservation of adults, children and families in their own homes, avoidance of delinquency and criminality, self-sufficiency and meaningful community participation;

Services are continuously evaluated, and modified if they are ineffective in helping to meet these goals; and

Behavioral health providers instill hope that achievement of goals is possible even for the most disabled.

Cultural Competency
Cultural competence in health care demonstrates the ability of systems to provide care to persons with diverse values, beliefs and behaviors. As such, service delivery is tailored to meet the person's social, cultural, and linguistic needs, including the needs of the deaf and hard of hearing. As behavioral health care providers, the goal should be to create a behavioral health system of care that fits everyone's needs. To accomplish this goal, it is necessary to ensure that staff providing services have the skills to meet the person's unique family, culture, natural supports, traditions, strengths and sexual orientation or gender identity when developing a person's individual treatment plan. ADHS/DBHS endorses the following activities for ensuring a culturally competent behavioral health system:

- Behavioral health service providers are recruited, trained and evaluated based upon competency in linguistic and culturally appropriate skills in responding to the individual needs of each behavioral health recipient and family;

- T/RBHA management reflects cultural diversity in values and in policies; and

- T/RBHA management and behavioral health service providers strive to improve through periodic cultural self-assessment and modify individual services or the system as a whole when applicable.

2.9 Arizona Children's Principles

ADHS/DBHS requires that behavioral health services be delivered to all children according to the Arizona Children's Principles (See 12 Principles for Children's Health).

2.10 Principles for Persons determined to have a Serious Mental Illness (SMI)

The service delivery system shall operate in accordance with the following principles for persons who have been determined to have SMI and their families (See Principles for Persons with a Serious Mental Illness).

2.11 What is the purpose of the Provider Manual?

The purpose of the Provider Manual is to ensure that a consistent and reliable resource containing standards and requirements is readily available and easily accessible to all behavioral health service providers. The Provider Manual was designed to assist behavioral health service providers by serving as a reference for federal and state laws, other regulations and answers to many frequently asked questions.

2.12 Use of Terms

An attempt was made to use consistent terminology throughout the Provider Manual to the extent possible. Persons receiving behavioral health services are referred to as "behavioral health recipients" or simply as "persons". The use of the term "T/RBHA" conveys both Tribal Regional Behavioral Health Authorities and Regional Behavioral Health Authorities, though the manual also uses the term Tribal Regional Behavioral Health Authority when a clearer distinction is necessary. Some requirements only apply to RBHAs or Tribal RBHAs, and these terms should be interpreted as such when presented in this manner.

2.13 How is the Provider Manual Structured?

The Provider Manual contains 14 main sections. Eight sections (Sections 3-10) contain policies and procedures delineating standards and requirements that must be met when delivering public behavioral health services in the State of Arizona.

Main Sections
1.0 Scope
2.0 Introduction
3.0 Clinical Operations
4.0 Communication and Care Coordination
5.0 Member Rights and Provider Claims Disputes
6.0 Data and Billing Requirements
7.0 Reporting Requirements
8.0 Periodic Audits and Surveys
9.0 Training and Development
10.0 T/RBHA Specific Requirements
11.0 Definitions
12.0 Fact Sheets
13.0 Forms and Attachments
14.0 Index

Within each section of the Provider Manual, a standardized format was used to present and organize the information. Most sections contain the following topic headers:

Topic Headers within Main Sections and What You Will Find In Each

Topic Area	What You Will Find
Section	Identifies specific section numbers and titles. Each section number and title corresponds with the Table of Contents.
Introduction	Identifies the content area, provides an overview of the section and describes the reason for the requirement. The introduction section attempts to answer the following questions: Why is the standard important? and, What is the purpose of the requirement?
References	Identifies sources from where policy content was derived, including contracts, IGAs, U.S.C., C.F.R., A.R.S., A.A.C., etc.
Scope	Identifies to whom the standards and requirements in the section apply.
Did you know?	Offers additional information relevant to the topic area. Although presented in a user-friendly manner, the information described under this header may be either directive or suggestive based on how it is presented.
Definitions	A list of key words associated with the topic areas. All definitions presented in the manual are consolidated in Section 11.0, "Definitions".
Objective(s)	A concise statement that describes the intent of the topic area.
Procedures	Step by step instructions for implementing the topic area.

2.14 When did the Provider Manual go into effect?

The ADHS/DBHS Provider Manual became effective on January 1, 2004. Each T/RBHA has incorporated geographic and community specific information (e.g., crisis telephone numbers) and T/RBHA specific requirements into the Provider Manual.

2.15 Revisions to the Provider Manual

Policies established as medical policies are updated annually or more frequently, if changes are necessary. Other sections of the Provider Manual are updated on an ongoing basis, but at a minimum, sections will be reviewed every two years. For information or changes that must be communicated immediately, ADHS/DBHS issues Policy Clarification Memorandums and posts them to the ADHS/DBHS website at http://www.azdhs.gov/bhs/provider/policy_memos.htm. Upon review of Provider Manual sections referenced in ADHS/DBHS Policy Clarification Memorandums, changes are incorporated into the sections to memorialize the changes.

Behavioral health providers and others may provide comments and request for revisions to the Provider Manual. Behavioral health providers and other interested persons should contact the ADHS/DBHS Policy Office to be included on the distribution list for public comments. For information or questions regarding T/RBHA editions of the Provider Manual, providers and other stakeholders should contact **[T/RBHA insert language here for contact information].**

T/RBHAs must ensure that the ADHS/DBHS Policy Office is included in communication to providers when T/RBHA editions of the Provider Manual have been updated. In addition, current versions of T/RBHA Provider Manual policies must be posted to the T/RBHA website (including policies added to Section 10.0). T/RBHAs and T/RBHA providers must not remove ADHS/DBHS Provider Manual Template language without the prior approval of the ADHS/DBHS Policy Office. **[T/RBHA insert information here if providers are required to contact the T/RBHA if adding language to the T/RBHA edition of the Provider Manual]**

AHCCCS requires that ADHS/DBHS review and approve all policies pertaining to Title XIX and Title XXI eligible persons. As such, any policies developed by the T/RBHA that establishes requirements for the provision of behavioral health services must be submitted to the ADHS/DBHS Policy Office prior to implementation.

Arizona Department of Health Services
Division of Behavioral Health Services
PROVIDER MANUAL

Section 3.0 Clinical Operations

3.1 Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Limited Income Subsidy Program
3.2 Appointment Standards and Timeliness of Service
3.3 Referral and Intake Process
3.4 Co-payments
3.5 Third Party Liability and Coordination of Benefits
3.6 Member Handbooks

Section 3.1 Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Limited Income Subsidy Program

3.1.1 Introduction
3.1.2 References
3.1.3 Scope
3.1.4 Did you know…?
3.1.5 Objectives
3.1.6 Procedures
3.1.6-A. Title XIX/XXI screening and eligibility
3.1.6-B. Reporting requirements for Title XIX/XXI Eligibility Screening
3.1.6-C. Medicare Part D Prescription Drug coverage and Limited Income Subsidy eligibility
3.1.6-D. What if a person refuses to participate with the screening and/or application process for Title XIX/XXI or enrollment in a Part D plan?

3.1.1 Introduction

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

- Be eligible for Title XIX (Medicaid) or Title XXI (KidsCare) covered services,
- Not qualify for Title XIX/XXI entitlements, 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), 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 a Tribal/Regional Behavioral Health Authority (T/RBHA) or behavioral health provider does upon receiving a request for behavioral health services. For persons who are not Title XIX or Title XXI eligible, a financial screening and eligibility application must be filed with the appropriate eligibility agency (e.g., The Arizona Health Care Cost Containment System (AHCCCS), the Department of Economic Security (DES), KidsCare or the Social Security Income/Medical Assistance Only (SSI/MAO) program).

Beginning January 1, 2006, Medicare eligible behavioral health recipients, including persons who are dually eligible for Medicare (Title XVIII) and Medicaid (Title XIX/XXI), started receiving Medicare Part D prescription drug benefits through Medicare Prescription Drug Plans (PDPs) or Medicare Advantage Prescription Drug Plans (MA-PDs). **[T/RBHA insert information here indicating whether the T/RBHA is part of any Medicare Advantage plan network to provide the Medicare Part D benefit.]**

The following information will assist providers of behavioral health services in:

- Accessing and interpreting eligibility and enrollment information,
- Conducting financial screenings and assisting persons with applying for Title XIX/XXI benefits, and

- Assessing potential eligibility for Medicare Part D Prescription Drug coverage and the limited income subsidy (LIS) program.

3.1.2 References

The following citations can serve as additional resources for this content area:
42 CFR Part 400
42 CFR Part 403
42 CFR Part 411
42 CFR Part 417
42 CFR Part 422
42 CFR Part 423
A.R.S. § 36-3408
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA Intergovernmental Agreements (IGAs)
Section 3.4, Premiums and Co-payments
Section 3.5, Third Party Liability and Coordination of Benefits
Section 3.10, SMI Eligibility Determination
Section 3.21, Service Prioritization for Non-Title XIX/XXI Funding
Section 4.1, Disclosure of Behavioral Health Information
Section 4.2, Behavioral Health Medical Records Standards
Assisting Behavioral Health Recipients with AHCCCS Eligibility Manual

3.1.3 Scope

To whom does this apply?
This standard applies to all persons who are currently or potentially eligible for Title XIX or Title XXI behavioral health services and persons who are eligible for Medicare.

3.1.4 Did you know…?

- The Arizona Health Care Cost Containment System's (AHCCCS) Application for Health Insurance (see the Assisting Behavioral Health Recipients with AHCCCS Eligibility Manual) was designed to make the application process easier. Applicants can fill out the application and it will be routed to the correct eligibility determination office. The application also permits a person to apply for all AHCCCS programs for all family members on one application form. If the results of the eligibility screening indicate that a person may be eligible for the Medicare Part D prescription drug benefit, Title XIX or Title XXI, in order to continue to receive services, the applicant's application must be submitted within ten working days to the Social Security Administration (SSA), DES or AHCCCS, which shall determine the applicant's eligibility.

- In most cases, an eligibility determination is completed within 45 days after the date of application unless the person is pregnant (completed within 20 days) or in an inpatient hospital at the time of application (completed within 7 days).

- It is preferred and advantageous to use a person's AHCCCS identification number as opposed to the person's social security number when inquiring about a person's current eligibility status.

- Title XIX/XXI funding is not available to cover drugs available through Medicare Part D for persons dually eligible for Medicare and Medicaid.

- Medicare Part D Prescription Drug coverage is a voluntary benefit, but eligible persons who do not enroll in a Part D plan may not have access to prescription drug coverage through the T/RBHA.

3.1.5 Objectives

- To identify methods for accessing and interpreting Title XIX and Title XXI eligibility,
- For persons who are not Title XIX/XXI eligible, to describe the procedures to screen persons for Title XIX/XXI eligibility and, if indicated, apply for AHCCCS health insurance, and
- To identify and assist persons eligible for Medicare with enrolling in a Part D plan and with applying for the Limited Income Subsidy (LIS) program to pay the cost sharing of Medicare Part D.

3.1.6 Procedures

3.1.6-A. Title XIX/XXI screening and eligibility

What is the process?

- **First…**Verify the person's Title XIX or Title XXI eligibility,
- **Next…**for those persons **who are not** Title XIX or Title XXI eligible, screen for potential Title XIX and Title XXI eligibility, and
- **Finally…**as indicated by the screening tool, assist persons with applications for a Title XIX or Title XXI eligibility determination.

Step #1-Accessing Title XIX/XXI eligibility information

Behavioral health 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 and follow the prompts. Once the 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,
- **AHCCCS contracted Medical Electronic Verification Service (MEVS).** The AHCCCS member card can be "swiped" by providers to automatically access AHCCCS' PMMIS system 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' PMMIS system for up to date eligibility and enrollment. Maricopa County providers may also request a faxed copy of eligibility for their records. 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, and

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

If a person's Title XIX or Title XXI eligibility status still cannot be determined using one of the above methods, a behavioral health provider must:

- Call the contracted T/RBHA **[T/RBHA insert language here]** for assistance during normal business hours (8:00 am through 5:00 pm, 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 Years Day, Memorial Day, Independence Day, Thanksgiving Day and Christmas Day. Callers from outside Maricopa County can call 1-800-962-6690 or call (602) 417-7000 in Maricopa County and remain on the line for the next available representative. When calling the AHCCCS Verification Unit, the behavioral health provider must be prepared to provide the verification unit operator the following information:

    - The behavioral health provider's identification number,
    - The recipient's name, date of birth, AHCCCS identification number and social security number (if known), and
    - Dates of service(s).

Step #2-Interpreting eligibility information
A behavioral health provider will access two important pieces of information when using the eligibility verification methods described in Step #1: AHCCCS eligibility key codes and/or AHCCCS rate codes. Key codes and rate codes are assigned to AHCCCS eligibility categories and are important for determining:

- If a person is eligible for Title XIX/XXI covered behavioral health services and
- If ADHS/DBHS (behavioral health providers) is responsible for providing the person's Title XIX/XXI covered behavioral health services; or whether it is the AHCCCS Health Plan or Arizona Long Term Care System (ALTCS) Program Contractor's responsibility.

Available Resources for Interpreting Eligibility Information

- PM Attachment 3.1.1 is a behavioral health eligibility key code index and may be used by behavioral health providers to interpret key code information. The key code index will indicate if the ADHS/DBHS system (and T/RBHA contracted behavioral health provider) is responsible for the delivery of Title XIX/XXI covered behavioral health services.
- PM Attachment 3.1.2 is a listing of all AHCCCS rate codes and descriptions that include Title XIX/XXI behavioral health covered services that are provided by a T/RBHA and/or contracted behavioral health provider.
- PM Attachment 3.1.3 is a summary of AHCCCS rate codes for use by T/RBHA and/or contracted behavioral health providers in determining responsibility for providing behavioral health services.

If Title XIX or Title XXI eligibility status and behavioral health provider responsibility is confirmed, the behavioral health provider must provide any needed covered behavioral

health services in accordance with the ADHS/DBHS Provider Manual and the ADHS/DBHS Covered Behavioral Health Services Guide.

There are some circumstances whereby a person may be Title XIX eligible but the ADHS/DBHS behavioral health system is not responsible for providing covered behavioral health services. This includes persons enrolled as elderly or physically disabled (EPD) under the 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 eligible through ALTCS must be referred to his/her ALTCS case manager to arrange for provision of Title XIX behavioral health services. However, ALTCS-EPD individuals who are Seriously Mentally Ill may also receive Non-Title XIX SMI services from the T/RBHA. ALTCS-Division of Developmental Disabilities (DDD) persons' behavioral health services are provided through the ADHS/DBHS behavioral health system.

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

Step #3-Screening for Title XIX/XXI eligibility

When and who do I screen for Title XIX/XXI eligibility?

The T/RBHA or behavioral health provider must screen all Non-Title XIX/XXI persons using the Health-e Arizona online application:

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

How do I conduct a screening for Title XIX/XXI eligibility?

The T/RBHA or behavioral health provider meets with the person and completes AHCCCS eligibility screening through the Health-e Arizona web page 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 PM Section 4.2, Behavioral Health Medical Record Standards).

What's Next?

Once the screening tool is completed, the screening tool will indicate one of two options:

- That the person is potentially AHCCCS eligible.
  If the person is potentially eligible, then T/RBHAs or behavioral health providers must reference the Assisting Behavioral Health Recipients with AHCCCS Eligibility Manual and follow the appropriate steps.

  Pending the outcome of the Title XIX or Title XXI eligibility determination, the person may be provided services in accordance with Section 3.4, Premiums and Co-payments, and Section 3.21, Service Prioritization for Non-Title XIX/XXI Funding.

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 or Title XXI benefits, the person may be provided behavioral health services in accordance with Section 3.4, Premiums and Co-payments and Section 3.21, Service Prioritization for Non-Title XIX/XXI Funding.

- That the person does not appear Title XIX/XXI eligible.
  If the screening tool indicates that the person does not appear Title XIX or Title XXI eligible, the person may be provided behavioral health services in accordance with Section 3.4, Premiums and Co-payments and Section 3.21, Service Prioritization for Non-Title XIX/XXI Funding.

3.1.6-B. Reporting requirements for Title XIX/XXI Eligibility Screening

The number of screenings completed for Title XIX/XXI eligibility must be documented by providers and reported to the T/RBHA on a monthly basis. The reporting must include the following elements:

	SMI		NON-SMI		CHILD	
	New Applicant	**Currently Receiving Services**	**New Applicant**	**Currently receiving services**	**New Applicant**	**Currently receiving services**
Number Screened						

[T/RBHA enter specific information indicating where behavioral health providers should submit reports, the required format for reports, and how to access technical assistance.]

3.1.6-C. Medicare Part D Prescription Drug coverage and Limited Income Subsidy eligibility

Persons must report to the T/RBHA or provider if they are eligible or become eligible for Medicare as it is considered third party insurance. See Section 3.5, Third Party Liability and Coordination of Benefits, regarding how to coordinate benefits for persons with other insurance including Medicare. If a behavioral health recipient is unsure of Medicare eligibility, T/RBHAs or providers may verify Medicare eligibility by calling 1-800-MEDICARE (1-800-633-4227), with a behavioral health recipient's permission and personal information. Once a person is determined Medicare eligible, T/RBHAs or providers must offer assistance and provide assistance with Part D enrollment and the Limited Income Subsidy (LIS) application upon a behavioral health recipient's request. T/RBHAs and providers will be tracking behavioral health recipients' Part D enrollment and LIS application status and reporting tracking activities, when required by ADHS/DBHS.

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 or a Medicare Advantage Prescription Drug Plan (MA-PD), which is a managed care Medicare plan. Upon request, the T/RBHA or provider 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.

Applying for the Limited Income Subsidy (LIS)
The Limited Income Subsidy (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 T/RBHA or provider determines that a person may be eligible for the LIS (see www.ssa.gov for income and resource limits), the T/RBHA or provider must offer to assist the person in completing an application. Applications can be obtained and submitted through the following means:

- On-line at https://secure.ssa.gov/apps6z/i1020/main.html,
- By calling 1-800-772-1213,
- In person at a SSA local office, or
- By mailing a paper application to the SSA.

Reporting Part D enrollment and LIS applications
T/RBHAs and providers must track Medicare eligible behavioral health recipients' Part D enrollment and LIS application status. ADHS/DBHS has developed PM Form 3.1.1, Tracking of Medicare Part D Enrollment and PM Form 3.1.2, Tracking of Limited Income Subsidy (LIS) Status which can be used by the T/RBHA or behavioral health provider to track persons eligible for Medicare. **[T/RBHA insert and link to forms here, if requiring different tracking forms than ADHS/DBHS suggested forms]**. This will assist the T/RBHA to ensure that Medicare eligible persons are enrolled in a Part D plan and apply for the LIS program, if applicable. **[T/RBHA insert specific information indicating when and where behavioral health providers should submit tracking reports for Medicare eligibles.]** Periodically, ADHS/DBHS will request T/RBHAs to report tracking of Part D enrollment and LIS applications.

3.1.6-D. What if a person refuses to participate with the screening and/or application process for Title XIX/XXI 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 T/RBHA or behavioral health 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 stipulates 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 behavioral health services (see A.R.S. § 36-3408). As such, individuals who refuse to participate in the AHCCCS screening and eligibility application or enrollment in Medicare Part D, if eligible, will not be enrolled with a T/RBHA during his/her initial request for behavioral health services or will be disenrolled 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 (see the Assisting Behavioral Health Recipients with AHCCCS Eligibility Manual for information on obtaining required documentation) and
- A person is incapable of participating as a result of his/her mental illness and does not have a legal guardian.

If a person refuses to participate in the screening and/or application process for Title XIX or Title XXI eligibility or to enroll in a Part D plan, the T/RBHA or behavioral health provider must ask the person to sign the Decline to Participate in the Screening and/or Referral Process for AHCCCS (Title XIX/XXI) Health Insurance or Medicare Part D Plan Enrollment form (PM FORM ADHS AE-08 or PM FORM ADHS AE-08 Spanish). If the person refuses to sign the form, document his/her refusal to sign in the comprehensive clinical record (See Section 4.2, Behavioral Health Medical Records Standards).

Special considerations for persons determined to have a Serious Mental Illness
If a person is eligible for or requesting services as a person determined to have a Serious Mental Illness, 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 T/RBHA or behavioral health provider must request a clinical consultation by a behavioral health medical practitioner **[T/RBHA insert specific information here]**. If the person continues to refuse following a clinical consultation, the T/RBHA or behavioral health provider must request that the person sign the Decline to Participate in the Screening and/or Referral Process for AHCCCS (Title XIX/XXI) Health Insurance or Medicare Part D Plan Enrollment form (PM Form ADHS AE-08 or PM Form ADHS AE-08 Spanish). Prior to the termination of behavioral health services for persons determined to have a Serious Mental Illness who have been receiving behavioral health services and subsequently decline to participate in the screening/referral process, the T/RBHA must provide written notification of the intended termination using PM Form 5.5.1, Notice of Decision and Right to Appeal (see PM Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)).

For all persons who refuse to cooperate with the AHCCCS eligibility and/or application process or who do not enroll in a Part D plan
The T/RBHA or behavioral health provider representative 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. **[T/RBHA enter specific contact information here.]**

Arizona Department of Health Services
Division of Behavioral Health Services
PROVIDER MANUAL

Section 3.2 Appointment Standards and Timeliness of Service

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3.2.2 References
3.2.3 Scope
3.2.4 Did you know…?
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3.2.7-A. Type of response by a T/RBHA or a behavioral health provider (non-hospitalized persons)
3.2.7-B. 72-hour urgent behavioral health response for children taken into DES/CPS custody
3.2.7-C Appointments for psychotropic medications
3.2.7-D. Referrals for hospitalized persons not currently T/RBHA enrolled
3.2.7-E. Waiting times
3.2.7-F. Other requirements
3.2.7-G. Special populations

3.2.1 Introduction

It is vital that the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) system be responsive and accessible to all the persons it serves. It is the expectation of ADHS/DBHS 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 outcome 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. ADHS/DBHS has organized responses into three categories: immediate responses, urgent responses, and routine responses.

3.2.2 References

The following citations can serve as additional resources for this content area:
42 C.F.R. § 438.206
42 C.F.R. § 438.210
A.A.C. R9-20-503
A.A.C. R9-21-304
A.A.C. R9-22-210
A.A.C. R9-22-1205(H)
A.A.C. R9-22-502(B)
A.A.C. R9-31-1205(H)
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/Tribal IGAs
Section 3.3, Referral and Intake Process
Section 3.10, SMI Eligibility Determination
Section 7.5, Enrollment, Disenrollment, and other Data Submission
ADHS/DBHS Covered Behavioral Health Services Guide
DBHS Practice Protocol, Child and Family Team Practice

DBHS Practice Protocol, The Unique Behavioral Health Service Needs of Children, Youth, and Families Involved with CPS
Substance Abuse Performance Partnership Block Grant

3.2.3 Scope

To whom does this apply?

- All Title XIX and Title XXI eligible persons;
- Non Title XIX/XXI persons determined to have a Serious Mental Illness; and
- Persons presenting for crisis services. When a person presents for crisis services, providers must first deliver needed behavioral health services and then determine eligibility and T/RBHA enrollment status.

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. Behavioral health providers must respond to all persons in immediate need until the situation is clarified that the behavioral health provider is not financially responsible. Persons who are determined ineligible for covered services may be referred to applicable community resources.

Behavioral health providers must screen behavioral health recipients for Title XIX eligibility. Providers can utilize the Health-e Arizona web tool to verify potential eligibility and submit behavioral health recipient's information for formal eligibility determination and screening for other public assistance programs simultaneously. RBHAs must maintain a resource list of providers with a sliding fee scale and associated services, as well as other community resources, that may be available to individuals who do not qualify for coverage through the Arizona Health Care Cost Containment System (AHCCCS, Arizona's Medicaid program).

3.2.4 Did you know…?

- The first behavioral health service following the initial assessment may be another assessment service, if determined by the child and family team (CFT) or adult clinical team to be the most appropriate service.
- Persons being treated or determined to be in need of psychotropic medications may need an appointment with an individual qualified to prescribe psychotropic medications before an initial assessment is completed. An appointment will be made in these situations.
- Behavioral health recipients may be referred to a provider outside of a T/RBHA's network for services, if the services are not available in network (see Section 3.3, Referral and Intake Process). If a behavioral health recipient is referred for services out of network, he/she must receive services within timeframes described in this policy.

3.2.5 Definitions

Behavioral Health Medical Practitioner (BHMP)

Immediate Response

Routine Response

3.2.6 Objectives

To ensure the timely response and provision of needed covered behavioral health services to persons based on their individual clinical needs including urgent responses for children taken into the custody of the Arizona Department of Economic Security/Division of Children, Youth and Families/Child Protective Services (ADES/DCYF/CPS).

3.2.7 Procedures

3.2.7-A. Type of response by a Tribal/Regional Behavioral Health Authority (T/RBHA) or a behavioral health provider

	WHEN	WHAT	WHO
IMMEDIATE	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.	Services can be telephonic or face-to-face; the response may include any medically necessary covered behavioral health service.	▪ All persons requesting assistance unless determined not to be eligible. At the time of determination that an immediate response is needed, a person's eligibility and enrollment status may not be known. Behavioral health providers must respond to all persons in immediate need of behavioral health services until the situation is clarified that the behavioral health provider is not financially responsible.
URGENT ***DES/CPS child referral***	Behavioral Health services must be provided within a timeframe indicated by behavioral health condition but no later than 72 hours after notification by DES/CPS that a child has been or will be removed	Includes medically necessary covered behavioral health services. (See section 3.2.7-B for detailed information)	▪ Upon notification from ADES/DCYF/CPS that a child has been, or will imminently be, taken into the custody of ADES/DCYF/CPS, regardless of the child's Title XIX or Title XXI eligibility status;

	from their home.		
URGENT ***All other urgent responses***	Behavioral health services provided within a timeframe indicated by behavioral health condition but no later than 24 hours from identification of need.	Includes any medically necessary covered behavioral health service.	▪ Referrals for hospitalized persons not currently T/RBHA enrolled; ▪ All Title XIX/XXI eligible persons; ▪ All non-Title XIX persons determined to have a Serious Mental Illness ▪ All other non-Title XIX/XXI persons in need of crisis or emergency services.
ROUTINE	Appointment for initial assessment within 7 days of referral or request for behavioral health services.	Includes any allowable assessment service as identified in the ADHS/DBHS Covered Behavioral Health Services Guide.	▪ All Title XIX/XXI eligible persons; and ▪ All persons referred for determination as a person with a Serious Mental Illness
	The first behavioral health service following the initial assessment appointment within timeframes indicated by clinical need, but no later than 23 days of the initial assessment.	Includes any medically necessary covered behavioral health service including additional assessment services.	▪ All Title XIX/XXI persons; and ▪ All persons determined to have a Serious Mental Illness
	All subsequent behavioral health services within time frames	Includes any medically necessary covered behavioral health service.	▪ All Title XIX/XXI persons; and ▪ All persons determined to have a

	according to the needs of the person.		Serious Mental Illness

3.2.7-B. 72-hour urgent behavioral health response for children taken into DES/CPS custody

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

- Identify immediate safety needs and presenting problems of the child, to stabilize behavioral health crises and to be able to offer immediate services the child may need;
- Provide behavioral health services to each child with the intention of reducing the stress and anxiety that the child may be experiencing, and offering a coherent explanation to the child about what is happening and what can be expected to happen in the near-term;
- Provide needed behavioral health services to each child's new caregiver, including guidance about how to respond to the child's immediate needs in adjusting to foster care, behavioral health symptoms to watch for and report, assistance in responding to any behavioral health symptoms the child may exhibit, and identification of a contact within the behavioral health system;
- Initiate the development of the CFT for each child (see Child and Family Team Practice Protocol); and
- Provide the ADES/DCYF/CPS Case Manager with findings and recommendations for medically necessary covered behavioral health services for the initial Preliminary Protective Hearing, which occurs within 5 to 7 days of the child's removal. (See PM Attachment 4.4.1, DCYF Child Welfare Timelines, for more information).

3.2.7-C 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 ensure that the person does not experience a decline in his/her behavioral health condition.

Response for referrals or requests for psychotropic medications:

	WHEN	WHAT	WHO
Referral for psychotropic medications	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.	Screening, consultation, assessment, medication management, medications, and/or lab testing services as appropriate.	▪ All Title XIX/XXI eligible persons; ▪ All persons determined to have a Serious Mental Illness; and ▪ Any person in an emergency or crisis.
All initial assessments and treatment recommendations that indicate a need for psychotropic medications	The initial assessment and treatment recommendations must be reviewed by a BHMP within a timeframe based on clinical need.	Screening, consultation, assessment, medication management, medications, and/or lab testing services as appropriate.	▪ All Title XIX/XXI eligible persons; ▪ All persons determined to have a Serious Mental Illness; and ▪ Any person in an emergency or crisis.

3.2.7-D. Referrals for hospitalized persons

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

For referrals of Title XIX/XXI eligible persons:

- 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:

Persons referred for eligibility determination of Serious Mental Illness:

- 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 to Section 3.10, SMI Eligibility Determination; and
- Upon the determination that the person is eligible for services and the person is in need of continued behavioral health services, the person must be enrolled and the effective date of enrollment must be no later than the date of first contact.

3.2.7-E. Waiting times

ADHS/DBHS has established standards so that persons presenting for scheduled appointments do not have to wait unreasonable amounts of time. Unless a behavioral

health provider is unavailable due to an emergency, a person appearing for an established appointment must not wait for more than 45 minutes.

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

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

3.2.7-F. 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 subsection 3.2.7-C, Appointments for psychotropic medications.

Title XIX and Title XXI persons must never be placed on a "wait list" for any Title XIX/XXI covered behavioral health service. If the T/RBHA network is unable to provide medically necessary covered behavioral health services for Title XIX or Title XXI persons, it must ensure timely and adequate coverage of needed services through an alternative provider until a network provider is contracted. In this circumstance, the T/RBHA must ensure coordination with respect to authorization and payment issues. In the event that a covered behavioral health service is temporarily unavailable to a Title XIX/XXI eligible person, the behavioral health provider must adhere to the following procedure. **[T/RBHA insert language here. Consider that persons in an inpatient or residential facility may remain in that setting until the service is available or ensure intensive outpatient services/case manager/peer service while waiting for the desired service.]**

3.2.7-G. Special populations

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

SAPT Block Grant Populations

The following populations are prioritized and covered under the SAPT 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 SAPT Block Grant (Based on available funding):

WHEN	WHAT	WHO
Behavioral health services provided within a timeframe indicated by clinical need, but no later than 48 hours from the referral/initial request for services.	Any needed covered behavioral health service, including admission to a residential program if clinically indicated; If a residential program is temporarily unavailable, an attempt shall be made to place the person within another provider agency facility, including those in other geographic service areas. If capacity still does not exist, the person shall be placed on an actively managed wait list and interim services must be provided until the individual is admitted. Interim services include: counseling/education about HIV and Tuberculosis (include the risks of transmission), the risks of needle sharing and referral for HIV and TB treatment services if necessary, counseling on the effects of alcohol/drug use on the fetus and referral for prenatal care.	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)
Behavioral health services provided within a timeframe indicated by clinical need but no later than 14 days following the initial request for services/referral. All subsequent behavioral health services must be provided within timeframes according to the needs of the person.	Includes any needed covered behavioral health services; Admit to a clinically appropriate substance abuse treatment program (can be residential or outpatient based on the person's clinical needs); if unavailable, interim services must be offered to the person. Interim services shall minimally include education/interventions with regard to HIV and tuberculosis and the risks of needle sharing and must be offered within 48 hours of the request for treatment.	All other injection drug users

Behavioral health services provided within a timeframe indicated by clinical need but no later than 23 days following the initial assessment. All subsequent behavioral health services must be provided within timeframes according to the needs of the person.	Includes any needed covered behavioral health services.	All other persons in need of substance abuse treatment

Section 3.3 Referral and Intake Process

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3.3.7-A. Where to send referrals
3.3.7-B. Referral to a provider for a second opinion
3.3.7-C. Referrals initiated by DES/DCYF pending the removal of a child
3.3.7-D. Accepting referrals
3.3.7-E. Responding to referrals
3.3.7-F. Documenting and tracking referrals
3.3.7-G. Eligibility screening & supporting documentation
3.3.7-H Intake

3.3.1 Introduction

The referral process serves as the principal pathway by which persons are able to gain prompt access to publicly supported behavioral health services. The intake process serves to collect basic demographic information from persons in order to enroll them in the ADHS/DBHS system, screen for Title XIX/XXI AHCCCS eligibility and determine the need for any co-payments (See Section 3.4, Co-payments). 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 behavioral health services based on the urgency of the situation.

3.3.2 References

The following citations can serve as additional resources for this content area:

42 C.F.R. § 438.206(b)(3)
45 C.F.R. § 160.103
45 C.F.R. § 164.501
45 C.F.R. § 164.520 (c)(1)(B)
A.A.C. R9-20-101
A.A.C. R9-21-101
A.A.C. R9-22-711 (B)(2)
AHCCCS/ADHS Contract
ADHS/RBHA Contract
ADHS/TRBHA Intergovernmental Agreements (IGAs)
Section 3.1, Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescriptions Drug Coverage, and the Limited Income Subsidy Program
Section 3.2, Appointment Standards and Timeliness of Service
Section 3.4, Co-payments
Section 3.5, Third Party Liability and Coordination of Benefits
Section 3.6, Member Handbooks
Section 3.8, Outreach, Engagement, Re-engagement and Closure

Section 3.9, Assessment and Service Planning
Section 3.10, SMI Eligibility Determination
Section 3.19, Special Populations
Section 3.20, Credentialing and Recredentialing
Section 3.21, Service Package for Non-Title XIX/XXI Persons Determined to Have a Serious Mental Illness (SMI)
Section 4.1, Disclosure of Behavioral Health Information
Section 4.3, Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers
Child and Family Team Practice Protocol
The Unique Behavioral Health Service Needs of Children, Youth, and Families Involved with CPS Practice Protocol
ADHS/DBHS Covered Behavioral Health Services Guide
Substance Abuse Prevention and Treatment Block Grant
ADHS/DBHS Policy Clarification Memorandum: Proof of Citizenship Required Effective July 1, 2006 (May 8, 2006)

3.3.3 Scope

To whom does this apply?

- All Title XIX and Title XXI eligible persons;
- Non-Title XIX persons referred for an eligibility determination for Serious Mental Illness (SMI); and
- All other persons based on available funding and requirements described in Section 3.21, Service Package for Non-Title XIX/XXI Persons Determined to Have a Serious Mental Illness (SMI).

3.3.4 Did you know…?

The T/RBHA is responsible for managing referrals and wait lists for Non-Title XIX/XXI persons in accordance with the Substance Abuse Prevention and Treatment Block Grant for identified priority populations when behavioral health services are temporarily unavailable. If the T/RBHA network is unable to provide medically necessary services to Title XIX/XXI persons, it will ensure timely and adequate coverage of needed services through an out-of-network provider until a network provider is contracted (See PM Section 3.2, Appointment Standards and Timeliness of Service).

3.3.5 Definitions

Behavioral Health Professional

Health Care Professional

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Intake/Enrollment

Notice of Privacy Practices (NPP)

Referral for behavioral health services

3.3.6 Objectives

To facilitate a person's access to behavioral health services in a timely manner, the T/RBHAs and providers will maintain an effective process for the referral and intake for behavioral health services which includes:

- Communicating to potential referral sources the process for making referrals (e.g., centralized intake at T/RBHA, identification of providers accepting referrals); **[T/RBHA insert specific language here]**
- Collecting enough basic information about the person to determine the urgency of the situation and subsequently scheduling the initial assessment within the required timeframes and with an appropriate provider;
- Adopting a welcoming 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 recipient's cultural needs (see Section 3.23, 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 for enrollment into the system.

3.3.7 Procedures

3.3.7-A. Where to send referrals

In situations in which the T/RBHA does not have a single centralized intake process, provider directories will be developed and distributed by the T/RBHA to the AHCCCS Health Plans, Department of Economic Security /Division of Developmental Disabilities District Program Administrators (DES/DDD) and, upon request, to other referral sources. These directories will indicate which providers are accepting referrals and conducting initial assessments. It is important for providers to promptly notify the T/RBHA of any changes that would impact the accuracy of the provider directory (e.g., change in telephone or fax number, no longer accepting referrals). **[T/RBHA insert specific language here]**

3.3.7-B. Referral to a provider for a second opinion

Title XIX/XXI behavioral health recipients are entitled to a second opinion. Upon a Title XIX/XXI eligible behavioral health recipient's request or at the request of the T/RBHA treating physician, the T/RBHA must provide for a second opinion from a health care professional within the network, or arrange for the behavioral health recipient to obtain one outside the network, at no cost to the behavioral health recipient. **[T/RBHA insert specific language here]**

3.3.7-C. 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/Child Protective Services (CPS), behavioral health providers are expected to respond in an urgent manner (for additional information see Section 3.2, Appointment Standards and Timeliness of Service, Child and

Family Team Practice Protocol and The Unique Behavioral Health Service Needs of Children, Youth, and Families Involved with CPS Practice Protocol).

3.3.7-D. Accepting referrals

T/RBHAs or their providers are required to accept referrals for behavioral health services 24 hours a day, 7 days a week. The following information will be collected from referral sources:

- Date and time of referral;
- Information about the referral source including name, telephone number, fax number, affiliated agency, and relationship to the 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;
- Special needs for assistance due to impaired mobility, visual/hearing impairments or developmental or cognitive impairment;
- Accommodations due to cultural uniqueness and/or the need for interpreter services;
- Information regarding payment source (i.e., AHCCCS, private insurance, Medicare or self pay) including the name of the AHCCCS health plan or insurance company;
- Name, telephone number and fax number of AHCCCS primary care provider (PCP) or other PCP as applicable;
- Reason for referral including identification of any potential risk factors such as recent hospitalization, evidence of suicidal or homicidal thoughts, pregnancy, and current supply of prescribed psychotropic medications; and
- The names and telephone numbers of individuals the member, parent or guardian may wish to invite to the initial appointment with the referred person.

Don't Delay…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 person may need to see, timely triage and processing of referrals must not be delayed because of missing or incomplete information.

When psychotropic medications are a part of an enrolled person's treatment or have been identified as a need by the referral source, behavioral health 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) ADHS/DBHS has developed PM Form 3.3.1, ADHS/DBHS Referral for Behavioral Health Services. The T/RBHAs and providers must make this form available to their key referral sources. Referral sources, however, may use any other written format or they may contact the T/RBHAs and providers orally (e.g., telephone).

In situations in which the person seeking services or his/her family member, legal guardian or significant other contacts the T/RBHA or provider directly about accessing behavioral health services, the T/RBHA or provider will ensure that the protocol used to obtain the necessary information about the person seeking services is engaging and welcoming. **[T/RBHA insert additional language here if T/RBHA has specific protocol providers must use]**

When an SMI eligibility determination is being requested as part of the referral or by the person directly, the T/RBHAs and providers must conduct an eligibility determination for SMI in accordance with Section 3.10, SMI Eligibility Determination.

3.3.7-E. Responding to referrals

Follow-Up

When a request for behavioral health services is initiated but the person does not appear for the initial appointment, the T/RBHA or provider must attempt to contact the person and implement engagement activities consistent with Section 3.8, Outreach, Engagement, Re-engagement and Closure.

Final Dispositions

Within 30 days of receiving the initial assessment, or if the person declines behavioral health services, within 30 days of the initial request for behavioral health services, the T/RBHA or 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 (specifically Child Protective Services and adoption subsidy);
- Arizona Department of Economic Security/Division of Developmental Disabilities;
- Arizona Department of Corrections;
- Arizona Department of Juvenile Corrections;
- Administrative Offices of the Court;
- Arizona Department of Economic Security/Rehabilitation Services Administration; and
- Arizona Department of Education and affiliated school districts.

The final disposition must include 1) the date the person was seen for the initial assessment; and 2) the name and contact information of the provider who will assume primary responsibility for the person'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 4.1, Disclosure of Behavioral Health Information).

3.3.7-F. Documenting and tracking referrals

The T/RBHA level or subcontracted provider will document and track all referrals for behavioral health 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 ADHS/DBHS 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.

3.3.7-G. Eligibility screening & supporting documentation

Supporting Documentation

Persons who are not already AHCCCS eligible must be asked to bring supporting documentation to the screening interview to assist the behavioral health 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 behavioral health services. 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, see ADHS/DBHS Proof of Citizenship Policy Clarification Memorandum;
- For all applicants, documentation to prove United States citizenship or immigration status and identity, see ADHS/DBHS Proof of Citizenship Policy Clarification Memorandum;
- 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.

3.3.7-H Intake

Behavioral health providers must conduct intake interviews in an efficient and effective manner that is both “person friendly” and ensures the accurate collection of all the 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.

What happens during the intake?

During the intake, the behavioral health provider will collect, review and disseminate certain information to persons seeking behavioral health 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 services, consent forms in large font, etc.).

- The collection of required demographic information and completion of client demographic information sheet, including the behavioral health recipient's primary/preferred language (See Section 7.5, Enrollment, Disenrollment and other Data Submission);

- The completion of any applicable authorizations for the release of information to other parties (see Section 4.1, Disclosure of Behavioral Health Information);

- The dissemination of a Member Handbook to the person (see Section 3.6, Member Handbooks);

- The review and completion of a general consent to treatment (see Section 3.11, 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 3.5, Third Party Liability and Coordination of Benefits);

- Advising Non-Title XIX/XXI persons determined to have a Serious Mental Illness (SMI) that they may be assessed a co-payment (see Section 3.4, Co-payments).

- The review and dissemination of the T/RBHA Notice of Privacy Practices (NPP) and the ADHS/DBHS HIPAA Notice of Privacy Practices (NPP) located at www.azdhs.gov/bhs/hipaa/notice_0306.pdf in compliance with 45 CFR 164.520 (c)(1)(B); and

- The review of the person's rights and responsibilities as a recipient of behavioral health 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.

Who can complete an intake?

Behavioral health 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.

Section 3.4 Co-payments

3.4.1 Introduction
3.4.2 References
3.4.3 Scope
3.4.4 Did you know…?
3.4.5 Definitions
3.4.6 Objectives
3.4.7 Procedures
3.4.7-A. Co-payments for Non-Title XIX/XXI eligible persons determined to have a Serious Mental Illness (SMI)
3.4.7-B. Co-payments for Title XIX/XXI eligible persons

3.4.1 Introduction

Persons not covered by the Arizona Health Care Cost Containment System (AHCCCS) must contribute to the cost of behavioral health services, in accordance with state law (see A.R.S. 36-3409). A co-payment is a fixed amount, which does not exceed the actual cost of services that a person pays directly to a provider at the time covered services are rendered. For individuals who are Non-Title XIX/XXI eligible persons determined to have a Serious Mental Illness (SMI), the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) has established a co-payment to be charged to these members for covered services. Under limited circumstances, persons who are Title XIX/XXI eligible may be assessed a co-payment in accordance with A.A.C. R9-22-711.

3.4.2 References

The following citations can serve as additional resources for this content area:
A.R.S. 36-3409
A.A.C. R9-20-201(E)(1) and (2)
A.A.C. R9-21-202(A)(8)
A.A.C. R9-21-208
A.A.C. R9-21-401
A.A.C. R9-22-711
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA IGAs
AHCCCS Eligibility Policy Manual
ADHS/DBHS Covered Behavioral Health Services Guide
Section 3.3, Referral and Intake
Section 3.5, Third Party Liability and Coordination of Benefits
Section 3.10, SMI Eligibility Determination
Section 3.13, Covered Behavioral Health Services
Section 5.5, Notice and Appeal Requirements (SMI and Non SMI/Non-Title XIX/XXI)
Section 7.5, Enrollment, Disenrollment and Other Data Submission

3.4.3 Scope

To whom does this apply?

Non-Title XIX/XXI eligible persons determined to have a Serious Mental Illness (SMI) and Title XIX/XXI eligible persons who are referred to, or enrolled with, a behavioral health provider to receive publicly funded behavioral health services. Co-payment requirements in this policy are not applicable to services funded by the Substance Abuse Prevention and Treatment (SAPT), Community Mental Health Services (CMHS) or Project for Assistance in Transition from Homelessness (PATH) federal block grants.

3.4.4 Did you know…?

Persons determined to have a Serious Mental Illness 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.

Individuals and families with income exceeding 100% of the Federal Poverty Level (FPL) and who have medical expenses that reduce the countable income to 40% of the FPL may be eligible for the Arizona Health Care Cost Containment System (AHCCCS) Medical Expense Deduction (MED-Spend Down) Program (see the description of AHCCCS Health Insurance programs for additional information). When a provider discovers that a behavioral health recipient is unable to make his/her co-payment due to medical expenses, providers must screen those individuals for AHCCCS eligibility. Providers can utilize the Health-e Arizona web tool to verify potential eligibility and submit behavioral health recipient's information for formal eligibility determination and screening for other public assistance programs simultaneously.

When a person is accessing public behavioral health services, the person will be required to provide documentation to verify income and expenses (see section 3.3.7-G, Eligibility screening and supporting documentation, of PM Section 3.3, Referral and Intake).

Behavioral health providers must not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that services provided were not Title XIX/XXI covered services.

3.4.5 Definitions

Co-payment

In-network services

Out of network services

Serious Mental Illness

Third Party Liability

Transitional Medical Assistance (TMA)

Title XIX Waiver Group (TWG)

3.4.6 Objectives

Identify when and how providers must assess co-payments, address the collection of co-payments and address the actions to take for nonpayment of co-payments.

3.4.7 Procedures

Co-payments must be assessed and collected consistent with state law and Arizona Administrative Code requirements.

3.4.7-A. Co-payments for Non-Title XIX/XXI eligible persons determined to have a Serious Mental Illness (SMI)

Non-Title XIX/XXI eligible persons determined to have a Serious Mental Illness are eligible to receive a medication only benefit (see ADHS/DBHS Guidelines to RBHAs and Providers for Services to Non Title XIX Members with Serious Mental Illness). Co-payments assessed for non-Title XIX/XXI persons determined SMI are intended to be payments by the member for the service package (e.g., psychiatric assessments, medication management, medications), but co-payments are **only** collected at the time of the psychiatric assessment and psychiatric follow up appointments. Co-payments are not assessed for crisis services or collected at the time crisis services are provided. Co-payments are:

- A fixed dollar amount of $3[1];
- Applied to in network services; and
- Collected at the time services are rendered.

Collecting Co-payments

Providers will be responsible for collecting co-payments. Providers will:

- Assess the fixed dollar amount per service received, regardless of the number of units encountered;
- Collect the $3 co-payment at the time of the psychiatric assessment or the psychiatric follow up appointment; and
- **[T/RBHA, insert any additional instructions for collecting co-payments here.]**

[1] This co-payment covers the costs associated with the Service Package for Non-Title XIX/XXI Persons determined to have SMI, including medications, laboratory services, psychiatric assessments and psychiatric follow up visits.

Providers may take reasonable steps to collect on delinquent accounts. Behavioral health recipients who are having difficulties making co-payments must be screened for AHCCCS eligibility.

Any co-payments collected are retained by **[T/RBHA insert specific information regarding who retains co-payments collected, the T/RBHA or the provider]** and reported to ADHS/DBHS in the encounter.

[T/RBHA, insert any additional information here regarding the collection of co-payments, how co-payments are reported and how co-payments are tracked.]

Other Payment Sources
If a person has third party liability coverage, T/RBHAs or their providers must follow the requirements set forth in Section 3.5, Third Party Liability and Coordination of Benefits. Non-Title XIX/XXI persons determined to have SMI will pay the ADHS/DBHS co-payment or the costs required by a third party insurer, whichever amount is less, as described in PM Section 3.5, Third Party Liability and Coordination of Benefits.

Non-payment of Co-payments
Behavioral health providers may not refuse to provide or terminate services when behavioral health recipients are unable to pay co-payments. The following methods may be utilized to encourage a collaborative approach to resolve non-payment issues:

- Engage in informal discussions and avoid confrontational situations;
- Re-screen the person for AHCCCS eligibility;
- Present other payment options, such as payment plans or payment deferrals, and discuss additional payment options as requested by the person; and
- **[T/RBHA, insert other methods here, as deemed appropriate].**

The collection of co-payments is an administrative process, and as such, co-payments must not be collected in conjunction with a person's behavioral health treatment. All efforts to resolve non-payment issues, as they occur, must be clearly documented in the person's comprehensive clinical record.

3.4.7-B. Co-payments for Title XIX/XXI eligible persons

Under certain conditions, a behavioral health provider may collect a co-payment from a Title XIX/XXI eligible person.

Who is exempt from Title XIX/XXI co-payments?

- Children under the age of 19;
- Persons determined to have a Serious Mental Illness (SMI);Individuals up through age 20 eligible for the Children's Rehabilitative Services program;

- People who are in nursing homes, residential facilities such as an Assisted Living Home or who receive Home and Community Based Services such as attendant care or a visiting nurse; and
- Persons receiving hospice care.

Hospitalizations, emergency services and services paid on a fee-for-service basis are exempt from co-payments for all members.

Optional/nominal co-payments for Title XIX/XXI eligible persons

Behavioral health recipients in some AHCCCS programs will have co-payments for the following Title XIX/XXI covered behavioral health services:

- $2.30 per prescription drug; and
- $3.40 per doctor or other outpatient visit.

Behavioral health providers must ensure that persons subject to nominal co-payments are not denied services because of their inability to pay a co-payment.

Mandatory co-payments for Title XIX/XXI eligible persons

Behavioral health recipients in the Transitional Medical Assistance (TMA) and Title XIX Waiver Group (TWG) programs are subject to mandatory co-payments. Behavioral health providers may deny a service to a TMA or TWG member if the member does not pay the required co-payment.

Co-payments must be collected for TMA program members for the following Title XIX/XXI covered behavioral health services:

- $2.30 per prescription drug; and
- $4.00 per doctor or other outpatient visit.

Co-payments must be collected for TWG program members for the following Title XIX/XXI covered behavioral health services:

- $4.00 per generic prescription and brand name prescription when there is no generic available;
- $10.00 per brand name prescription when there is a generic available;
- $30.00 per visit for nonemergency use of the emergency room; and
- $5.00 per doctor office visit.

Other considerations for Title XIX and Title XXI eligible persons

T/RBHAs or their providers must follow the requirements set forth in Section 3.5, Third Party Liability and Coordination of Benefits, and collect third party payments for behavioral health services that are rendered to Medicaid (Title XIX)/Medicare (Title XVIII) dually eligible persons, as applicable.

Section 3.5 Third Party Liability and Coordination of Benefits

3.5.1 Introduction
3.5.2 References
3.5.3 Scope
3.5.4 Did you know…?
3.5.5 Definitions
3.5.6 Objectives
3.5.7 Procedures
3.5.7-A: How do behavioral health providers know if a person has other health insurance coverage?
3.5.7-B: How do behavioral health providers know what services the other health insurance party will cover?
3.5.7-C: Billing requirements
3.5.7-D: Discovery of third party liability after services were rendered or reimbursed
3.5.7-E: Co-payments, premiums, coinsurance and deductibles
3.5.7-F: Transportation
3.5.7-G: Medicaid eligible persons with Medicare Part A and Part B
3.5.7-H: Medicare Part D Prescription Drug Coverage

3.5.1 Introduction

Third party liability refers to situations in which persons enrolled in the public behavioral health system also have behavioral health service coverage through another health insurance plan, or "third party". The third party can be liable or responsible for covering some or all the behavioral health services a person receives, including medications. Behavioral health 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 behavioral health funds.

There are two methods used in the coordination of benefits; cost avoidance and post-payment recovery:

- Cost avoidance-Behavioral health providers must cost avoid all claims or services that are subject to third-party payment and may deny a service to a person if it is known that a third party (i.e., other insurer) will provide the service. RBHAs may deny payment to a provider if a provider is aware of third party liability and submits a claim or encounter to the RBHA. In emergencies, behavioral health providers must provide the necessary services and then coordinate payment with the third party payer.

- Post-payment recovery is necessary in cases where a behavioral health provider was not aware of third party coverage at the time services were rendered or paid for, or was unable to cost avoid.

The intent of this section is to describe the requirements for behavioral health 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 behavioral health services that were rendered to the enrolled person.

3.5.2 References

The following citations can serve as additional resources for this content area:

42 CFR Part 400
42 CFR Part 403
42 CFR Part 411
42 CFR Part 417
42 CFR Part 422
42 CFR Part 423
A.R.S. § 36-2903 (F)
A.R.S. § 36-3408
A.R.S. § 36-3409
A.A.C. R9-21-202(A)(8)
A.A.C. R9-22-1001
A.A.C. R9-22-1002
A.A.C. R9-22-1003
A.A.C. R9-22-1005
A.A.C. R9-22-1009
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA Intergovernmental Agreements (IGAs)
AHCCCS Contractor Operations Manual
AHCCCS Billing Manual for IHS/Tribal Providers
AHCCCS Fee-for-Service (FFS) Provider Manual
ADHS/DBHS Program Support Procedures Manual
Section 3.1, Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Limited Income Subsidy Program
Section 3.3, Referral and Intake
Section 3.4, Co-payments
Section 3.9, Assessment and Service Planning
Section 3.13, Covered Behavioral Health Services
Section 3.16, Medication Formularies

3.5.3 Scope

To whom does this apply?

All persons seeking services in the public behavioral health system.

3.5.4 Did you know…?

- If third party information becomes available to the provider at any time for Title XIX or Title XXI eligible persons, that information must be reported to the AHCCCS Administration within 10 days from the date of discovery. Providers report third party information via the following website: http://www.azahcccs.gov/commercial/ContractorResources/TPL.aspx.

ADHS/DBHS has also established a process for T/RBHAs to report third party information for Title XIX or Title XXI eligible persons daily to ADHS/DBHS on a Third Party Leads submission file. After submitting the file to AHCCCS for verification of the information, T/RBHAs will receive notification of updated information on the TPL files. The T/RBHA is responsible for making third party payer information available to all providers involved with the person receiving behavioral health 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/XXI, there is no cost sharing obligation if the T/RBHA has a contract with the Medicare provider and the provider's contracted 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 benefits. In addition, their families may also have private insurance. Simultaneous use of the private insurance and Title XIX coverage may occur through the coordination of benefits. Following an intake and assessment, behavioral health providers must determine the services and supports needed. Any necessary services that are not covered through the private insurance, including co-payments and deductibles, may be covered under Title XIX.

3.5.5 Definitions

Cost avoidance

Cost sharing

Dual eligible

Explanation of Benefits

In-network services

Non-QMB dual

Out of network services

QMB dual

Remittance Advice

3.5.6 Objectives

To establish guidelines for behavioral health providers to determine the existence of third party liability and to coordinate benefits for enrolled persons with third party liability.

3.5.7 Procedures

3.5.7-A: How do behavioral health providers know if a person has other health insurance coverage?

Behavioral health providers must inquire about a person's other health insurance coverage during the initial appointment or intake process (See Section 3.3, Referral and Intake). When behavioral health providers attempt to verify a person's Title XIX or Title XXI eligibility, information regarding the existence of any third party coverage is provided through the automated systems described in Section 3.1, Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage and the Limited Income Subsidy Program. If a person is not eligible for Title XIX or Title 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.

3.5.7-B: How do behavioral health providers know what services the other health insurance party will cover?

The third party health insurance coverage may cover all or a portion of the behavioral health services rendered to a person. Behavioral health providers must contact the third party directly to determine what coverage is available to the person. At times, T/RBHAs may incur the cost of co-payments or deductibles for a Title XIX/XXI eligible person or person determined to have a Serious Mental Illness, while the cost of the covered service is reimbursed through the third party payer. Title XIX/XXI funds cannot be used to pay for cost sharing of Medicare Part D Prescription Drug coverage.

3.5.7-C: Billing requirements

Upon determination that a person has third party coverage, a behavioral health provider must submit proper documentation to demonstrate that the third party has been assigned responsibility for the covered services provided to the person. For specific billing instructions, see the ADHS/DBHS Program Support Procedures Manual and AHCCCS Billing Manual for IHS/Tribal Providers. The following guidelines must be adhered to by behavioral health providers regarding third party payers:

- ADHS/DBHS and the T/RBHA must 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, ADHS/DBHS and the T/RBHA are not the payer of last resort.

- Benefits must be coordinated so that costs for services funded by ADHS/DBHS or the T/RBHA are cost avoided or recovered from a third party payer. 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 Remittance Advice or Explanation of Benefits from the third party payer. **[T/RBHA, if an alternative process is established for providers, insert a description of the process here.]** The only exceptions to this billing requirement are:

- When a response from the third party payer has not been received within the timeframe established by the T/RBHA for claims submission or, in the absence of a subcontract, within 120 days of submission;
- When it is determined that the person had relevant third party coverage after services were rendered or reimbursed; or
- When a behavioral health recipient eligible for both Medicaid and Medicare (dual eligible) receives services in a Level I Sub-acute facility that is not Medicare certified. Non-Medicare certified facilities should only be utilized for dual eligibles when a Medicare certified facility is not available.

In an emergency situation, the provider must first provide any medically necessary covered behavioral health services and then coordinate payment with any potential third party payers.

Providers must cost avoid all claims or services that are subject to third party payment and may deny a service to a person if providers know that the third party payer is financially responsible for providing the service. RBHAs may deny payment to a provider if a provider is aware of third party liability and submits a claim or encounter to the RBHA. However, if the provider knows that the third party payer will not pay for or provide a medically necessary covered service, then the provider must not deny the service nor require a written denial letter. 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 must refer to the formulary of the behavioral health recipients' Medicare Part D plan to determine if a specific drug will be covered under Medicare Part D. The Medicare Part D plan formularies are available at www.medicare.gov.

3.5.7-D: 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, behavioral health providers must identify all potentially liable third party payers and pursue reimbursement from them. In instances of post-payment recovery, the behavioral health provider must submit an adjustment to the original claim, including a copy of the Remittance Advice or the Explanation of Benefits. AHCCCS and/or ADHS/DBHS may refer cases to the T/RBHA for Title XIX and Title XXI persons in the following circumstances:

- Uninsured/under-insured motorist insurance
- Tortfeasors
- Special Treatment Trusts
- Adoptions
- Worker's compensation
- Estates

The behavioral health provider is responsible to report any cases involving the above circumstances to the T/RBHA. Behavioral health providers may be asked to cooperate with AHCCCS and/or ADHS/DBHS in third party collection efforts.

[T/RBHA enter specific language here]

3.5.7-E: Co-payments, premiums, coinsurance and deductibles

If a third-party insurer requires a person to pay a co-payment, coinsurance or deductible, the T/RBHA is responsible for covering those costs for Title XIX/XXI eligible persons (see PM Attachment 3.5.1, Third Party Liability and Coordination of Benefits, Title XIX/XXI Eligible Persons; see subsections 3.5.7-G and 3.5.7-H for specific cost sharing responsibilities for behavioral health recipients with Medicare Part A, B and D).

Non-Title XIX/XXI persons determined to have a Serious Mental Illness who have Third Party Liability

The ADHS/DBHS co-payment assessed for non-Title XIX/XXI persons determined SMI is intended to be payment by the member for services covered in the medication only benefit (e.g., psychiatric assessments, medication management, medications), but co-payments are **only** collected at the time of the psychiatric assessment and psychiatric follow up appointments. Non-Title XIX/XXI persons determined to have a Serious Mental Illness may be assessed the ADHS/DBHS co-payment in accordance with PM Section 3.4, Co-payments, or may be assessed co-payments, premiums, coinsurance and/or deductibles for services covered by the third party insurer. When a Non-Title XIX/XXI person determined to have SMI is assessed the ADHS/DBHS co-payment, he/she will pay the ADHS/DBHS co-payment or the co-payment required by the third party insurer, whichever is less (see PM Attachment 3.5.2, 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 determined to have SMI is assessed a co-payment for a generic medication that is also on the ADHS/DBHS Non-Title XIX/XXI Formulary, he/she will pay the ADHS/DBHS co-payment or the co-payment required by the third party insurer, whichever is less. T/RBHAs are responsible for covering the difference between the ADHS/DBHS co-payment and the third party co-payment when the third party co-payment is greater than the ADHS/DBHS co-payment. Behavioral health recipients are responsible for third party co-payments for services that are not services that ADHS/DBHS covers (see ADHS/DBHS Guidelines to the RBHAs and Providers for Services to Non-Title XIX Members with Serious Mental Illness) and third party premiums, coinsurance and deductibles, if applicable. When Non-Title XIX/XXI persons determined to have SMI have difficulty paying co-payments, the provider must re-screen the individual for Title XIX/XXI eligibility.

3.5.7-F: Transportation

Behavioral health providers must provide and retain fiscal responsibility for transportation for Title XIX and Title XXI persons in order for the person to receive a covered behavioral health service reimbursed by a third party, including Medicare.

3.5.7-G: Medicaid eligible persons with Medicare Part A and Part B

A Title XIX eligible person may receive coverage under both Medicaid (AHCCCS) and Medicare. These persons are sometimes referred to as “dual eligibles”. In most cases, behavioral health 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. In the event that a Title XIX eligible person also has coverage through Medicare, behavioral health providers must ensure adherence with the requirements described in this subsection.

Persons who are eligible for Medicare benefits can receive services through one of the following arrangements:

- Fee-for-service Medicare system; or
- Enroll in a Medicare Advantage Plan.

A Medicare Advantage Plan is a managed care entity that has a Medicare contract with the Centers for Medicare and Medicaid Services (CMS) to provide services to Medicare beneficiaries.

Medicare Part A and Part B cost sharing responsibilities for persons enrolled in a Medicare Advantage Plan

ADHS/DBHS is the payer of last resort. Therefore, if a behavioral health recipient is enrolled with a Medicare Advantage Plan, the behavioral health recipient must be directed to his/her Medicare Advantage Plan. However, if the Medicare Advantage Plan does not authorize a Title XIX covered behavioral health service, the **[T/RBHA or behavioral health provider]** must:

- Review the requested service;
- Determine if the service is a medically necessary covered service; and
- When determined, provide the Title XIX covered behavioral health service not covered by Medicare Part A or B.

[T/RBHA or behavioral health providers] have cost sharing responsibility for all Title XIX covered services provided to behavioral health recipients by a Medicare Advantage Plan. For those Medicare services that have benefit limits, the **[T/RBHA or behavioral health provider]** must reimburse all Title XIX and Medicare covered services when the behavioral health recipient reaches the Medicare Advantage Plan's benefit limits.

[T/RBHA or behavioral health providers] only have cost sharing responsibility for the amount of the behavioral health recipient's coinsurance, deductible or co-payment. **[T/RBHA or behavioral health providers]** have no cost sharing obligation if the Medicare payment exceeds the **[T/RBHA or behavioral health providers]** contracted rate for the services. The **[T/RBHA or behavioral health provider]** liability for cost sharing plus the amount of Medicare's payment must not exceed the **[T/RBHA's or behavioral health provider's]** contracted rate for the service. With respect to co-payments, the **[T/RBHA or behavioral health provider]** may pay the lesser of the co-payment or their contracted rate.

QMB duals enrolled in a Medicare Advantage Plan

QMB duals are entitled to:

- All Title XIX covered services;
- Medicare Part A covered services; and
- Medicare Part B covered services.

In addition to Title XIX covered services, QMB duals may receive Medicare services that are not covered under Title XIX, or differ in scope or duration. When a behavioral health recipient is enrolled in a Medicare Advantage Plan, the **[T/RBHA or behavioral health provider]** is

responsible for cost sharing for Medicare Part A and Part B services that are not covered under Title XIX, or differ in scope or duration. These Medicare services include:

- Inpatient psychiatric services (Medicare has a lifetime benefit maximum);
- Other behavioral health services such as partial care; and
- Any services covered by or added to the Medicare Program not covered under Title XIX.

Non-QMB duals enrolled in a Medicare Advantage Plan
[T/RBHA or behavioral health provider] is responsible for Part A and Part B cost sharing for Title XIX only covered services for Non-QMB duals.

Prior authorization for persons enrolled in a Medicare Advantage Plan
If the T/RBHA's contract with a behavioral health provider requires the behavioral health provider to obtain prior authorization before rendering services and the behavioral health provider does not obtain prior authorization, the T/RBHA is not obligated to pay the Medicare Part A or Part B cost sharing for Title XIX covered services, except for emergency services.

If the Medicare Advantage Plan determines that a service is medically necessary, the **[T/RBHA or behavioral health provider]** is responsible for Medicare Part A and Part B cost sharing, even if the **[T/RBHA or behavioral health provider]** determines otherwise. If the Medicare Advantage Plan denies a service requiring prior authorization for lack of medical necessity, the **[ADHS/DBHS, RBHA or behavioral health provider]** must apply its own authorization criteria and may not use the Medicare Advantage Plan's decision as the basis for denial.

Out of network services for persons enrolled in a Medicare Advantage Plan
If an out of network referral is made by a contracted behavioral health provider and the T/RBHA specifically prohibits out of network referrals in the provider contract, then the behavioral health provider may be considered to be in violation of the contract and the T/RBHA has no Part A or Part B cost sharing obligation. The behavioral health provider who referred the behavioral health recipient to an out of network provider is obligated to pay any Part A or Part B cost sharing. The behavioral health recipient must not be responsible for the Medicare Part A or Part B cost sharing, unless the behavioral health recipient has been advised of the T/RBHA's network and elects to go out of the network. In this case, the behavioral health recipient is responsible for paying the Medicare Part A and Part B cost sharing amount, unless the service is an emergency, pharmacy (not Medicare Part D) or other physician ordered service.

If the Medicare Advantage Plan and the T/RBHA have networks for the same service that have no overlapping providers and the T/RBHA chooses not to have the service performed in its own network, then the T/RBHA is responsible for Part A and Part B cost sharing for that service. If the overlapping providers have closed their panels and the behavioral health recipient goes to an out of network provider, then the T/RBHA is also responsible for Part A and Part B cost sharing.

Medicare Part A and Part B pharmacy and other physician ordered services for persons enrolled in a Medicare Advantage Plan
The requirements described under this heading are for information purposes only. Behavioral health providers may or may not have direct responsibilities related to these activities.

For purposes of this subsection, "in the T/RBHA network" refers to the provider who supplies the prescription, not the prescribing provider. T/RBHAs must cover pharmacy co-payments for medications prescribed by both contracted and non-contracted providers as long as the prescriptions are filled at a contracted pharmacy. However, if a provider prescribes a non-formulary medication, then the T/RBHA may opt to not reimburse for the prescription co-payment. If a T/RBHA requires prior authorization for formulary medications, then the T/RBHA may choose not to cover the co-payment if prior authorization was not obtained.

If a behavioral health recipient exceeds their pharmacy benefit limit, the T/RBHA must cover all prescription costs for the person. These prescriptions are subject to the T/RBHA's formulary, prior authorization and pharmacy network requirements.

If the Medicare Advantage Plan does not offer a pharmacy benefit, then the T/RBHA may require that the prescribing physician be in the T/RBHA's network for prescription benefit coverage. This requirement extends to all prescribed services (e.g., laboratory services).

Cost sharing responsibilities for persons under the Medicare fee-for-service program
A Medicare beneficiary may elect to receive Medicare services through providers authorized to deliver Medicare services. **[T/RBHAs or behavioral health providers]** have Part A and Part B cost sharing responsibility for Title XIX covered services provided to behavioral health recipients by fee-for-service behavioral health providers in the T/RBHA's network. **[T/RBHAs or behavioral health providers]** have no Part A and Part B cost sharing obligation if the Medicare payment exceeds the **[T/RBHA's or behavioral health provider's]** contracted rate for the services. The **[T/RBHA's or behavioral health provider's]** liability for Part A and Part B cost sharing plus the amount of Medicare's payment must not exceed the **[T/RBHA's or behavioral health provider's]** contracted rate for the service. For those Medicare services for which prior authorization is not required, but are also covered under Title XIX, there is no Part A or Part B cost sharing obligation if the T/RBHA has a contract with the provider and the provider's contracted rate includes Medicare Part A and Part B cost sharing as specified in the contract.

QMB duals receiving services under the Medicare fee-for-service program
QMB duals are entitled to:

- All Title XIX covered services;
- Medicare Part A covered services; and
- Medicare Part B covered services.

[T/RBHA or behavioral health provider] is responsible for the payment of the Medicare Part A and Part B deductible and coinsurance for Title XIX covered services. In addition to Title XIX covered services, QMB duals may receive Medicare services that are not covered under Title XIX, or differ in scope or duration. The services must be provided regardless of whether the behavioral health provider is in the T/RBHA's network. These Medicare services include:

- Inpatient psychiatric services (Medicare has a lifetime benefit maximum);
- Other behavioral health services such as partial care; and
- Any services covered by or added to the Medicare Program not covered under Title XIX.

Non-QMB duals receiving services under the Medicare fee-for-service program

[T/RBHA or behavioral health provider] is responsible for the payment of the Medicare Part A and Part B deductible and coinsurance for Title XIX covered services that are rendered on a fee-for-service basis by a Medicare behavioral health provider within the RBHA's network. **[T/RBHAs or behavioral health providers]** are not responsible for Medicare Part A and Part B services not covered under Title XIX.

Prior authorization for persons receiving services under the Medicare fee-for-service program

If the T/RBHA's contract with a behavioral health provider requires the behavioral health provider to obtain prior authorization before rendering services and the behavioral health provider does not obtain prior authorization, the T/RBHA is not obligated to pay the Medicare Part A and Part B cost sharing for Title XIX covered services, except for emergency services. The T/RBHA cannot require prior authorization for Medicare Part A and Part B only services.

If the Medicare provider determines that a service is medically necessary, the **[T/RBHA or behavioral health provider]** is responsible for Medicare Part A and Part B cost sharing, even if the **[T/RBHA or behavioral health provider]** determines otherwise. If Medicare denies a Part A or Part B service requiring prior authorization for lack of medical necessity, the **[ADHS/DBHS, RBHA or behavioral health provider]** must apply its own authorization criteria. If the criteria supports the provision of the Part A or Part B service, the **[T/RBHA or behavioral health provider]** must cover the cost of the service.

Out of network services for persons receiving services under the Medicare fee-for-service program

If an out of network referral is made by a contracted behavioral health provider and the T/RBHA specifically prohibits out of network in the provider contract, then the behavioral health provider may be considered to be in violation of the contract and the T/RBHA has no Part A or Part B cost sharing obligation. The behavioral health provider who referred the behavioral health recipient to an out of network provider is obligated to pay any Part A or Part B cost sharing. The behavioral health recipient must not be responsible for the Medicare Part A or Part B cost sharing, unless the behavioral health recipient has been advised of the T/RBHA's network and elects to go out of the network. In this case, the behavioral health recipient is responsible for paying the Medicare Part A and Part B cost sharing amount, unless the service is an emergency, pharmacy (not Medicare Part D) or other physician ordered service.

Medicare Part A and Part B pharmacy and other physician ordered services for persons receiving services under the Medicare fee-for-service program

The requirements described under this heading are for information purposes only. Behavioral health providers may or may not have direct responsibilities related to these activities.

T/RBHAs must cover prescriptions and other ordered services that are both prescribed and filled by in network providers. If a provider prescribes a non-formulary prescription, then the T/RBHA may opt to not reimburse for the prescription. The T/RBHA may also require prior authorization.

[T/RBHA insert specific language here]

3.5.7-H: Medicare Part D Prescription Drug Coverage

Beginning on January 1, 2006, all persons eligible for Medicare Part A or enrolled in Medicare Part B became eligible for Medicare Part D Prescription Drug coverage. Dual eligible persons (eligible for Medicaid and Medicare) no longer receive prescription drug coverage through Medicaid. To access Medicare Part D coverage, persons must enroll in either a Prescription Drug Plan (PDP – fee-for-service Medicare) or a Medicare Advantage-Prescription Drug Plan (MA-PD – managed care Medicare).

Cost sharing responsibilities for persons in a Medicare Part D PDP or MA-PD

The Medicare Part D Prescription Drug standard coverage includes substantial cost sharing requirements, which include monthly premiums, an annual deductible and co-insurance (see the Part D Voluntary Prescription Drug Benefit Program Benefits and Costs for People with Medicare).

Persons with limited income and resources may be eligible for the Limited Income Subsidy (LIS) or "extra help" program (see the Social Security Administration for income and resource requirements). With this "extra help", all or a portion of the persons' cost sharing requirements are paid for by the federal government. Dual eligibles and behavioral health recipients on a Medicare Savings Program through AHCCCS (QMB, SLMB, or QI-1) are automatically eligible for the LIS program. Other persons have to apply for the LIS program. Title XIX/XXI funds are not available to pay any cost sharing of Medicare Part D. T/RBHAs may utilize Non-Title XIX/XXI funds for cost sharing of Medicare Part D co-payments for Non-Title XIX/XXI persons determined to have SMI, as described in subsection 3.5.7-E.

Section 3.6 Member Handbooks

3.6.1 Introduction
3.6.2 References
3.6.3 Scope
3.6.4 Did you know…?
3.6.5 Definitions
3.6.6 Objectives
3.6.7 Procedures
3.6.7-A. Distribution

3.6.1 Introduction

Member Handbooks are intended to provide information to behavioral health recipients and potential enrollees regarding the availability of services in the public behavioral health system. The Member Handbook provides information regarding how to obtain services, what services are available, what service limitations exist for Title XIX/XXI and Non-Title XIX/XXI persons and behavioral health recipient rights and responsibilities, among other topics. This information is imperative in ensuring that behavioral health services are accessible.

3.6.2 References

The following citations can serve as additional resources for this content area:
42 CFR 438.10
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA IGAs
ADHS/DBHS Member Handbook Template
T/RBHA Specific Member Handbooks

3.6.3 Scope

To whom does this apply?
All persons receiving behavioral health services, potential enrollees and contracted providers.

3.6.4 Did you know…?

- Member Handbooks are reviewed annually, and if needed, updated by the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) and the Tribal and Regional Behavioral Health Authorities (T/RBHAs).

- The Member Handbook must be made available in identified prevalent non-English languages when the T/RBHAs are aware that another language is spoken by three thousand (3,000) or ten percent (10%), whichever is less, of the behavioral health recipients in a geographic region who also have Limited English Proficiency (LEP).

- The Member Handbook must be printed in a type-style and size which can easily be read by behavioral health recipients with varying degrees of visual impairment, such as large print and other alternative formats included but not limited to audio and/or Braille.

- Any approved revisions or updated versions of the Member Handbook must be posted to the T/RBHA website by the effective date of such revisions or updates.

- ADHS/DBHS templates for the T/RBHAs' use in developing T/RBHA versions of the member handbooks are available on the ADHS/DBHS website in both English and Spanish (see ADHS/DBHS and T/RBHA Member Handbooks).

- Member handbooks must include all information specified in 42 CFR 438.10.

- The content of the ADHS/DBHS Member Handbook Template must not be changed without prior written approval by ADHS/DBHS.

3.6.5 Definitions
Limited English Proficiency (LEP)

3.6.6 Objectives
To establish the responsibility of providers to distribute member handbooks to new enrollees and all persons receiving behavioral health services.

3.6.7 Procedures
3.6.7-A. Distribution
Member handbooks must be distributed to persons receiving behavioral health services within 10 days of their first service. Documentation of receipt of the member handbook within 10 days of first service must be filed in the persons' behavioral health record. (Please see PM Form 3.6.1 Member Handbook Receipt; this form includes minimum requirements for **all** member records and must include all indicated signatures; including when combined with other checklists.)

Member Handbooks must be available and easily accessible at all provider sites and each T/RBHA website. Upon request, copies must be made available to known consumer and family advocacy organizations and other human service organizations.

Persons receiving behavioral health services have the right to request and obtain a Member Handbook at least annually. T/RBHAs must notify persons of their right to request and obtain a Member Handbook at least annually by publishing this information using T/RBHA communications such as the T/RBHA webpage, newsletter, etc.

ADHS/DBHS may require the T/RBHAs to revise the Member Handbook and distribute it to all current enrollees if there is a significant program change. ADHS/DBHS determines if a change qualifies as significant.

[T/RBHA add specific language here]

Arizona Department of Health Services
Division of Behavioral Health Services
PROVIDER MANUAL

Section 3.0 Clinical Operations (Section 3.7. RESERVED to Section 3.20)

3.7 Reserved
3.8 Outreach Engagement, Re-Engagement and Closure
3.9 Assessment and Service Planning
3.10 SMI Eligibility Determination
3.11 General and Informed Consent to Treatment
3.12 Advance Directives
3.13 Covered Behavioral Health Services
3.14 Securing Services and Prior Authorization
3.15 Psychotropic Medication: Prescribing and Monitoring
3.16 Medication List
3.17 Transition of Persons
3.18 Pre-Petition Screening, Court-Ordered Evaluation and Court-Ordered Treatment
3.19 Special Populations
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Section 3.8 Outreach, Engagement, Re-Engagement and Closure

3.8.1 Introduction
3.8.2 References
3.8.3 Scope
3.8.4 Did you know…?
3.8.5 Definitions
3.8.6 Objectives
3.8.7 Procedures
3.8.7-A Outreach
3.8.7-B Engagement
3.8.7-C Re-engagement
3.8.7-D Ending an Episode of Care for a person in the behavioral health system
3.8.7-E Serving a person previously enrolled in the behavioral health system

3.8.1 Introduction

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 behavioral health providers must incorporate when delivering services within Arizona's public behavioral health system:

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

3.8.2 References

A.R.S. Title 36, Chapter 5
A.A.C.R9-21-302
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA IGAs
Section 3.4 Co-payments
Section 3.9 Intake, Assessment and Service Planning
Section 3.10 SMI Eligibility Determination
Section 3.11 General and Informed Consent to Treatment
Section 3.17 Transition of Persons

Section 3.18 Pre-Petition Screening, Court Ordered Evaluation and Court Ordered Treatment
Section 3.21, Service Package for Non-Title XIX/XXI Persons Determined to Have a Serious Mental Illness (SMI)
Section 3.22 Out-of-State Placements for Children and Young Adults
Section 3.23 Cultural Competence
Section 4.1 Disclosure of Behavioral Health Information
Section 4.3 Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers
Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons
Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)
Section 7.5 Enrollment, Disenrollment and Other Data Submission
Substance Abuse Prevention and Treatment Block Grant
ADHS/DBHS Demographic and Outcome Data Set User Guide
9 Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems
12 Principles for Children's Health

3.8.3 Scope

To Whom Does This Apply?

- All Title XIX and Title XXI eligible persons;
- All persons determined to have a Serious Mental Illness (SMI); and
- All other persons receiving services as part of the public behavioral health system according to Section 3.21, Service Package for Non-Title XIX/XI Persons Determined to Have a Serious Mental Illness (SMI) .

3.8.4 Did you know…?

Ongoing supportive services that strengthen resiliency, promote skill development, and encourage and maintain natural supports should be continued beyond the resolution of immediate symptoms. Premature disenrollment from the behavioral health system is neither efficient nor clinically sound. Arizona Department of Health Services/Division of Behavioral Health services (ADHS/DBHS) has principles which describe the department's philosophy on provisions of service in the adult and children's system (see 9 Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems and 12 Principles for Children's Health).

3.8.5 Definitions

Closure

Disenrollment

Engagement

Episode of Care

Outreach

Re-engagement

3.8.6 Objectives

This section describes requirements for behavioral health providers to:

- Actively engage all persons seeking or receiving behavioral health services to the maximum extent, to re-engage persons who withdraw from treatment prematurely, to appropriately end an episode of care for persons who are no longer receiving services, and to resume services for persons who have ended their episode of care less than six months prior when indicated; and
- Inform behavioral health providers about various outreach activities that are performed by Tribal/Regional Behavioral Health Authorities (T/RBHAs) and communicate information about the availability and accessibility of behavioral health services to individuals and the community at large.

3.8.7 Procedures

3.8.7-A Outreach

Overview of Outreach Activities

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

With what kinds of outreach activities are T/RBHAs typically involved?

Outreach activities conducted by the T/RBHAs may include, but are not limited to:

- Participation in local health fairs or health promotion activities;
- Involvement with local school districts;
- Routine contact with AHCCCS Health Plan behavioral health coordinators and/or primary care providers;
- Development of homeless outreach programs;
- Development of outreach programs to persons who are at risk, are identified as a group with high incidence or prevalence of behavioral health issues or are underserved;
- Publication and distribution of informational materials;
- Liaison activities with local and county jails, county detention facilities, and local and county CPS offices and programs;
- Routine interaction with agencies that have contact with substance abusing pregnant women/teenagers;
- Development and implementation of outreach programs that identify persons with co-morbid medical and behavioral health disorders and those who have been determined to have a Serious Mental Illness (SMI) within the T/RBHA'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 residing in Maricopa County.

[T/RBHA insert any additional language here]

3.8.7-B Engagement

- T/RBHAs or their subcontracted providers must actively engage the following in the treatment planning process:
  - The person and/or person's legal guardian;
  - The person's family/significant others, if applicable and amenable to the person;
  - Other agencies/providers as applicable; and
  - For persons with a Serious Mental Illness who are receiving Special Assistance (see Section 5.4, Special Assistance for Persons Determined to Have a Serious Mental Illness), the person (guardian, family member, advocate or other) designated to provide Special Assistance.

- Behavioral health providers must:
  - Provide a courteous, welcoming environment that provides persons with the opportunity to explore, identify and achieve their personal goals;
  - Engage persons in an empathic, hopeful and welcoming manner during all contacts;
  - Provide culturally relevant care that addresses and respects language, customs, and values and is responsive to the person's unique family, culture, traditions, strengths, age and gender;
  - Provide an environment that in which consumers from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices in the context of negotiating treatment options;
  - Provide care by communicating to members in their preferred language and ensuring that they understand all clinical and administrative information; (See Section 3.23 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.

[T/RBHA insert any additional language here]

3.8.7-C: Re-engagement

Behavioral health 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 behavioral health provider must attempt to re-engage the person by:

- Communicating in the person's preferred language;

- Contacting the person or the person's legal guardian by telephone, at times when the person may reasonably be expected to be available (e.g., after work or school);

- Whenever possible, contacting the person or the person's legal guardian face-to-face, if telephone contact is insufficient to locate the person or determine acuity and risk; and

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

- For persons determined to have a Serious Mental Illness who are receiving Special Assistance (see Section 5.4, 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 behavioral health provider must make further attempts to re-engage persons determined to have a Serious Mental Illness (SMI), children,

pregnant substance abusing women/teenagers, or any person determined to be at risk of relapse, decompensation, deterioration or a potential harm to self or others. Further attempts may include contacting the person or person's legal guardian face to face or contacting natural supports who the recipient has given permission to the provider to contact. If the person appears to meet clinical standards as a danger to self, danger to others, persistently and acutely disabled or gravely disabled the provider must determine whether it is appropriate, and make attempts as appropriate, to engage the person to seek inpatient care voluntarily. If this is not a viable option for the person and the clinical standard is met, initiate the pre-petition screening or petition for treatment process described in Section 3.18, Pre-petition Screening, Court Ordered Evaluation and Court Ordered Treatment.

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

[T/RBHA insert any additional language here]

Follow-up after significant and/or critical events
Behavioral health 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 within a timeframe based upon the person's clinical needs; ideally within 7 days, but no later than 30 days;
- Involved in a behavioral health crisis within timeframes based upon the person's clinical needs, but no later than 7 days;
- Refusing prescribed psychotropic medications within timeframes based upon the person's clinical needs and individual history; and
- Released from local and county jails and detention facilities within 72 hours.

Additionally, for persons to be released from Level I care, behavioral health providers must help establish priority prescribing clinician appointments within 7 days of the person's release to ensure client stabilization, medication adherence, and to avoid re-hospitalization.

[T/RBHA insert any additional language here]

3.8.7-D Ending an Episode of Care for a person in the behavioral health system

Under certain circumstances, it may be appropriate or necessary to disenroll a person from services after re-engagement efforts described in section 3.8.7-C have been expended. Ending the episode of care can occur due to clinical or administrative factors involving the enrolled person. The episode of care can be ended for both NTXIX and TXIX individuals, but TXIX eligible individuals no longer in an episode of care for behavioral health services remain enrolled with AHCCCS. When a person is disenrolled or has an episode of care ended, notice and appeal requirements may apply (see Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons and Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI.))

Clinical Factors

- Treatment Completed:

A person's episode of care must be ended upon completion of treatment. A NTXIX person would also be disenrolled at treatment completion. Prior to ending the episode of care or disenrolling a person following the completion of treatment, the behavioral health provider and the person or the person's legal guardian must mutually agree that behavioral health services are no longer needed.

- 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 behavioral health services. A NTXIX person would also be disenrolled from services. Prior to ending the episode of care or disenrolling a person for declining further treatment, the behavioral health provider must ensure the following:

- All applicable and required re-engagement activities described in subsection 3.8.7-C. 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 3.18, Pre-petition Screening, Court Ordered Evaluation and Court Ordered Treatment.
- Upon receiving a request from a CPS case manager or representative to discontinue services and/or disenroll a foster child, the behavioral health provider will conduct a Child Family Team (CFT) staffing to determine if this is clinically sound.

- Lack of Contact:

A person's episode of care may be ended if the T/RBHA or behavioral health provider is unable to locate or make contact with the person after ensuring that all applicable and required re-engagement activities described in subsection 3.8.7-C. have been conducted.
A NTXIX individual would also be disenrolled from services.

Administrative Factors

- Eligibility/Entitlement Information Changes Including:
  - Loss of Title XIX/XXI eligibility, if other funding is not available to continue services; and
  - Persons who become or are enrolled as elderly or physically disabled (EPD) under the Arizona Long Term Care System (ALTCS) must be disenrolled from the T/RBHA after ensuring appropriate coordination and continuity of care with the ALTCS program contractor. (Not applicable for developmentally delayed ALTCS members ALTCS/DD whose behavioral health treatment is provided through the T/RBHA system.) An ALTCS/EPD eligible person may remain enrolled with the T/RBHA as Non-Title XIX if the person has been determined to have a Serious Mental Illness (SMI) and will continue to receive Non-Title XIX covered SMI services through the T/RBHA.

- Behavioral health providers may disenroll Non-Title XIX/XXI eligible persons for non-payment of assessed co-payments per Section 3.4, Co-payments, under the following conditions:
  - The person is not eligible as a person determined to have a Serious Mental Illness (SMI) per Section 3.10, SMI Eligibility Determination; and
  - After attempting 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 3.4, Co-Payments.

- 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, as applicable. A NTXIX individual would also be disenrolled. This does not apply to persons placed out-of-state for purposes of providing behavioral health treatment (see Section 3.22, Out-of-State Placements for Children and Young Adults).

- Inter-T/RBHA Transfers

A person who relocates to another T/RBHA and requires ongoing behavioral health services must be closed from one T/RBHA and transferred to the new T/RBHA. Services must be transitioned per Section 3.17, Transition of Persons.

- Arizona Department of Corrections Confinements

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

- Children Held at County Detention Facilities

A child who was served by a T/RBHA 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. T/RBHAs and/or their subcontracted providers must check the AHCCCS Pre-paid Medical Management Information System (PMMIS) to ensure Title XIX/XXI eligibility prior to the delivery of each behavioral health service to a child who is held in a county detention facility.

- 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, T/RBHAs are 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, T/RBHAs and their subcontracted providers will need to notify AHCCCS via e-mail, when they become aware that an AHCCCS eligible member is incarcerated. AHCCCS has established email addresses for this purpose. Please note that there are two separate 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.

- 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 NTXIX individual would be disenrolled from the system.

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 behavioral health provider conducts all applicable and required re-engagement activities described in subsection 3.8.7-C. and such attempts are unsuccessful;
- The behavioral health provider and the person or the person's legal guardian mutually agree that ongoing behavioral health services are not needed; or
- A NTXIX individual would be disenrolled from the system.

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 behavioral health provider and the person or the person's legal guardian mutually agree that ongoing behavioral health services are not needed. The NTXIX individual would also be disenrolled.

Data Submission

Behavioral health providers must follow all applicable data submission procedures as described in Section 7.5, Enrollment, Disenrollment and Other Data Submission and the ADHS/DBHS Demographic and Outcome Data Set User Guide following a decision to end an episode of care or disenroll.

[T/RBHA insert any additional language here]

3.8.7-E Serving a person previously enrolled in the behavioral health system

Some persons who have ended their episode of care or were disenrolled may need to re-enter the behavioral health system. The process used is based on the length of time that a person has been out of the behavioral health system.

For persons not receiving services for less than 6 months	For persons not receiving services for 6 months or longer

For persons not receiving services for less than 6 months	For persons not receiving services for 6 months or longer
If the person has not received a behavioral health assessment in the past 6 months, conduct a new behavioral health assessment consistent with Section 3.9, Intake, Assessment and Service Planning, and revise the person's service plan as needed. If the person has received a behavioral health assessment in the last six months and there has not been a significant change in the person's behavioral health condition, T/RBHAs or behavioral health providers may utilize the most current assessment. Review the most recent service plan (developed within the last six months) with the person, and if needed, coordinate the development of a revised service plan with the person's clinical team (see Section 3.9, Intake, Assessment and Service Planning).	Conduct a new intake, behavioral health assessment and service plan consistent with Section 3.9, Intake, Assessment and Service Planning.
Continue the person's SMI status if the person was previously determined to have a Serious Mental Illness (SMI) (see Section 3.10, SMI Eligibility Determination).	Continue the person's SMI status if the person was previously determined to have a Serious Mental Illness (SMI) (see Section 3.10, SMI Eligibility Determination).
If the person presents at a different T/RBHA or provider, obtain new general and informed consent to treatment (see Section 3.11, General and Informed Consent to Treatment). **[T/RBHA insert additional information here]**	Obtain new general and informed consent to treatment, as applicable (see Section 3.11, General and Informed Consent to Treatment).
If the person presents at a different T/RBHA or provider, obtain new authorizations to disclose confidential information, as applicable (see Section 4.1, Disclosure of Behavioral Health Information.	Obtain new authorizations to disclose confidential information, as applicable (see Section 4.1, Disclosure of Behavioral Health Information.
Submit new demographic and enrollment data (see Section 7.5, Enrollment, Disenrollment and Other Data Submission).	Submit new demographic and enrollment data (see Section 7.5, Enrollment, Disenrollment and Other Data Submission).

Section 3.9 Assessment and Service Planning

3.9.1 Introduction
3.9.2 References
3.9.3 Scope
3.9.4 Did you know…?
3.9.5 Definitions
3.9.6 Procedures
3.9.6-A: Assessments
3.9.6-B: Service planning
3.9.6-C: Updates to the Assessment and Service Plan

3.9.1 Introduction

ADHS/DBHS supports a model for assessment, service planning, and service delivery that is strength-based, person-centered, family friendly, culturally sensitive, 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 individuals involved in the person's care who have integral relationships with the person;
- Development of a therapeutic alliance between the person and behavioral health 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 behavioral health services. For children, this team is the Child and Family Team (CFT) and for adults, this team is the Adult Recovery Team.

At a minimum, the functions of the Child and Family Team and Adult Recovery Team 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 performed to: (a) elicit information on the strengths, needs and goals of the individual person and his/her family, (b) identify the need for further or specialty evaluations, and (c) 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 Child and Family Team and Adult Recovery Team 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 behavioral health 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 behavioral health services.

3.9.2 References

The following citations can serve as additional resources for this content area:
9 A.A.C. 20
9 A.A.C. 21
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA Intergovernmental Agreements (IGAs)
Section 3.1, Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Limited Income Subsidy Program
Section 3.2, Appointment Standards and Timeliness of Service
Section 3.5, Third Party Liability and Coordination of Benefits
Section 3.6, Member Handbooks
Section 3.10, SMI Eligibility Determination
Section 3.11, General and Informed Consent to Treatment
Section 3.13, Covered Behavioral Health Services
Section 3.19, Special Populations
Section 3.20, Credentialing and Recredentialing
Section 3.23, Cultural Competence
Section 4.1, Disclosure of Behavioral Health Information
Section 4.2, Behavioral Health Medical Record Standards
Section 4.3, Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers
Section 5.4, Special Assistance for Persons Determined to have a Serious Mental Illness
Section 7.5, Enrollment, Disenrollment and Other Data Submission
ADHS/DBHS Covered Behavioral Health Services Guide
ADHS/DBHS Demographic and Outcome Data Set User Guide (DUG)
ADHS/DBHS Practice Protocol, Child and Family Team Practice
ADHS/DBHS Practice Protocol, Working with the Birth to Five Population
Arizona Vision and Principles
9 Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems

3.9.3 Scope

To whom does this apply?

This applies to all providers who are conducting assessments or involved in the service planning process in the ADHS/DBHS behavioral health system.

3.9.4 Did you know…?

There are seven basic principles on which this section is based. Behavioral health assessments and service plans:

1. Are developed with an unconditional commitment to persons enrolled in the behavioral health system and their families;

2. Begin with empathetic relationships that foster ongoing partnerships built through respect and equality throughout the service delivery system;

3. Build on a positive therapeutic alliance between the behavioral health provider and service recipient so that the service recipient feels comfortable with the provider and feels a sense of safety and trust in the treatment process;

4. Are developed collaboratively with families to engage and empower their unique strengths and resources;

5. Include other individuals important to the person;

6. Are individualized, strength-based, culturally appropriate and clinically sound; and

7. Are developed with the expectation that the person is capable of positive change, growth and leading a life of value.

While it may be feasible or even necessary to complete the assessment during one session, some individuals may benefit from and/or prefer that this process be conducted over the course of several clinical interviews and observations. For this reason, ADHS/DBHS encourages providers to utilize the 45 days for initial assessments to be completed to ensure a thorough and accurate evaluation (see Section 7.5, Enrollment, Disenrollment and Other Data Submission, for additional information on demographic data submission timeframes).

Behavioral health assessments must be completed by credentialed behavioral health medical practitioner (BHMPs), behavioral health professionals (BHPs) or behavioral health technicians (BHTs) who are trained on the minimum elements of the assessment and service plan contained in this policy (see Section 3.20, Credentialing and Recredentialing for credentialing requirements). BHPs and BHTs who conduct assessments must also receive clinical supervision.

3.9.5 Definitions

Adult Recovery Team

Annual Update

Assessment

Behavioral Health Medical Practitioner

Behavioral Health Technician

Child and Family Team

Clinical Teams

Credentialing

Family

Initial Assessment

Interim Service Plan

Individual Service Plan (ISP)

Special Assistance

3.9.6 Procedures

3.9.6-A: Assessments

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

ADHS/DBHS 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 ADHS/DBHS Demographic and Outcome Data Set User Guide (DUG) and Section 7.5, Enrollment, Disenrollment and Other Data Submission.

The initial and annual assessment must be completed by a behavioral health medical practitioner (BHMP), behavioral health professional (BHP) or behavioral health technician (BHT)) who is trained on the minimum elements of a behavioral health assessment and meets requirements in Section 3.20, Credentialing and Recredentialing. If an assessment is conducted and documented by a behavioral health technician, a behavioral health professional must review and sign the assessment information that was documented by the behavioral health technician.

Minimum elements of the behavioral health assessment

ADHS/DBHS 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 Section 4.2, Behavioral Health Medical Record Standards:

- Presenting issues/concerns;
- History of present illness, including review of major psychiatric symptoms (i.e., mood, depression, anxiety, psychosis, suicidal ideation, homicidal ideation, and other behavioral health symptoms) and frequency/duration of symptoms;
- Psychiatric history, including history of previous psychiatric hospitalization(s) and psychotropic medication trial(s);
- Medical history;
- Current medications, including over the counter (OTC) medications;
- Allergies and other adverse reactions;
- Developmental history for children/youth under the age of 18 and with other populations if clinically relevant;
- Family history;*
- Educational history/status;*
- Employment history/status;
- Housing status/living environment;
- Social history;*
- Legal history, including custody/guardianship status, pending litigation, Court Ordered Evaluation/Court Ordered Treatment (COE/COT) history, criminal justice history, and any history of sex offender adjudication;
- Substance abuse history including type of substance, duration, frequency, route of administration, longest period of sobriety, and previous treatment history;
- Standardized substance use screen for children age 11 to 18 and referral for comprehensive assessment when screened positive;
- Substance use screen for adults age 18 and older using the American Society of Addiction Medicine (ASAM) Second Edition – Revised of Patient Placement Criteria (ASAM PPC-2R);
- Labs/ Diagnostics, if applicable;
- Mental Status Examination;
- Risk Assessment: the potential risk of harm to self or others based on self-reports, clinical symptoms, personality factors, past history, substance abuse, criminogenic factors, etc.;
- Brief summary/Bio-Psycho-Social formulation;
- Axial Diagnoses I-V; and
- Date, begin, and end time of the assessment and printed name, signature, and professional credential of the provider completing the behavioral health assessment. If a privileged BHT completes the assessment, the assessment must also include a printed name, signature, professional credential, date and time of the privileged BHP who reviewed the assessment information.

* Additionally, confirm that sexual abuse/behavior information was documented as part of the person's Family, Educational, and Social History.

- REQUIRED FOR ALL TITLE XIX/XXI MEMBERS: Primary Care Provider (PCP) name and contact information.
- REQUIRED FOR ALL TITLE XIX/XXI MEMBERS: Involvement with other agencies (e.g., Child Protective Services, Probation, Division of Developmental Disabilities).
- ONLY REQUIRED FOR CHILDREN AGE 0 TO 5: Developmental screening for children age 0-5 with a referral for further evaluation by the child's Primary Care Provider (PCP), the Arizona Early Intervention Program (AzEIP) for children age birth to three, or the public school system for children age three to five when developmental concerns are identified.
- ONLY REQUIRED FOR CHILDREN AGE 6 TO 18: Child and Adolescent Service Intensity Instrument (CASII) Score and Date.
- ONLY REQUIRED FOR CHILDREN AGE 6 TO 18 WITH CASII SCORE OF 4 OR HIGHER: Strength, Needs and Culture Discovery Document.
- ONLY IF INDICATED: Seriously Mentally Ill Determination (for persons who request SMI determination or have an SMI qualifying diagnosis and GAF score of 50 or lower) in accordance with Section 3.10, SMI Eligibility Determination.
- ONLY REQUIRED FOR PERSONS DETERMINED SMI: Special Assistance assessment in accordance with Section 5.4, Special Assistance for Persons Determined to Have a Serious Mental Illness.

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.

[RBHA, insert additional information and/or links to RBHA forms here.]

3.9.6-B: Service planning

All individuals being served in the public behavioral health system must have a written plan for services upon an initial request for services and periodic updates to the plan to meet the changing behavioral health needs for individuals who continue to receive behavioral health services. ADHS/DBHS 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.

If a person is in immediate or urgent need of behavioral health 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.

The behavioral health recipient must be included in the development of the service plan. In addition, family members, designated representatives, agency representatives and other involved parties, as applicable, may be invited to participate in the development of the service

plan. Behavioral health providers must coordinate with the person's health plan, PCP or others involved in the care or treatment of the individual, as applicable, regarding service planning recommendations (see Section 4.3, Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers).

Minimum elements of the service plan for Title XIX/XXI Members and for non-Title XIX/XXI members determined to have SMI that have an assigned Case Manager

Service plans must be completed by behavioral health medical practitioners, behavioral health professionals or behavioral health technicians who are trained on the behavioral health service plan and meet requirements in Section 3.20, Credentialing and Recredentialing. In the event that a behavioral health technician completes the service plan, a behavioral health professional must review and sign the service plan.

The service plan must be documented in the comprehensive clinical record in accordance with Section 4.2, Behavioral Health Medical Record Standards, be based on the current assessment, and contain the following elements:

- The person/family vision that reflects the needs and goals of the person/family;
- Identification of the person's/family's strengths;
- Measurable objectives and timeframes to address the identified needs of the person/family;
- Identification of the specific services to be provided and the frequency with which the services will be provided;
- The signature of the person/guardian and the date it was signed;
- Documentation of whether or not the person/guardian is in agreement with the plan;
- The signature of a clinical team member and the date it was signed;
- The signature of the person providing Special Assistance, for persons determined to have Serious Mental Illness who are receiving Special Assistance (see Section 5.4, Special Assistance for Persons Determined to have a Serious Mental Illness); and
- The Service Plan Rights Acknowledgement (see Attachment 3.9.1, Service Plan Rights Acknowledgement Template), dated and signed by the person or guardian, the person who filled out the service plan, and a behavioral health professional if a behavioral health technician fills out the service plan.

The behavioral health recipient must be provided with a copy of his/her plan. **[T/RBHA, insert contact information here for customer/member services or other contact where a behavioral health recipient can be directed if he/she has questions about the service plan and his/her rights regarding the service plan.]**

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

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

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

These services should be incorporated into the peer-driven, self-developed proposed service plan as appropriate. It is recommended that a standardized process be used to develop peer-driven, self-developed proposed service plans.

Additionally, the peer-driven, self-developed proposed service plan must be reviewed with and approved by the behavioral health medical practitioner and maintained in the medical record. Progress and outcomes related to the approved peer-driven, self-developed service plan must be tracked and documented by the behavioral health medical practitioner.

[RBHA, insert additional information and/or links to RBHA forms here.]

What if the person and/or legal or designated representative disagree with the service plan?
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:

- A Notice of Action (PM Form 5.1.1) by the behavioral health representative on the team.

In cases that a person determined to have a Serious Mental Illness and/or legal or designated representative disagree with some or all of the Non-Title XIX/XXI covered services included in the service plan, the person and/or legal or designated representative **must** be given:

- PM Form 5.5.1, 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.

3.9.6-C: Updates to the Assessment and Service Plan

Behavioral health providers must complete an annual assessment update with input from the behavioral health recipient 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 behavioral health recipient and his/her family.

Section 3.10 SMI Eligibility Determination

3.10.1 Introduction
3.10.2 References
3.10.3 Scope
3.10.4 Definitions
3.10.5 Objectives
3.10.6 Procedures
3.10.6-A: General requirements
3.10.6-B: Criteria for SMI eligibility determination
3.10.6-C: Process for completion of SMI eligibility determination
3.10.6-D: Issues preventing timely completion of SMI eligibility determination
3.10.6-E: Notification of SMI eligibility determination
3.10.6-F: Review of SMI eligibility determination

3.10.1 Introduction

A critical focus of the ADHS/DBHS service delivery system is the effective and efficient delivery of behavioral health services to persons who have special needs due to the serious nature of their behavioral health disorder. One such group is persons with serious mental illness (SMI). Without receipt of appropriate care, these persons are at high risk for further deterioration of their physical and mental condition, increased hospitalizations and potential homelessness and incarceration.

In order to ensure that persons with serious mental illness are provided the necessary behavioral health services, ADHS/DBHS has developed a standardized process by which T/RBHAs and their providers may readily identify persons with serious mental illness and promptly enroll them into the ADHS/DBHS behavioral health system. The requirements associated with making an SMI determination are set forth in this section.

3.10.2 References

The following citations can serve as additional resources for this content area:
42 CFR 435.911
A.R.S. Title 36, Chapter 5
9 A.A.C. 21
AHCCCS/ADHS Contract
ADHS/RBHA Contract
ADHS/Gila River Health Care Corporation Intergovernmental Agreement
ADHS/Pascua Yaqui Behavioral Health Program Intergovernmental Agreement
Intake, Assessment and Service Planning Section
Disclosure of Behavioral Health Information Section
Credentialing and Privileging Section
Service Prioritization for Non-Title XIX/XXI Funding Section
Enrollment, Disenrollment, and Other Data Submission Section

Last Revised: 09/09/2004
Effective Date: 07/01/2005

Grievance and Requests for Investigation for Persons Determined to have a Serious Mental Illness Section
Member Complaints Section
Outreach, Engagement, Re-Engagement and Closure Section
Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons Section
Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI) Section
Co-occurring Psychiatric And Substance Disorders Practice Improvement Protocol

3.10.3 Scope

To whom does this apply?

- Persons who are referred for, request or have been determined to need an eligibility determination for serious mental illness; or

- Persons who have been determined to be seriously mentally ill and are enrolled in the ADHS/DBHS behavioral health system.

3.10.4 Definitions

Serious mental illness (SMI)

3.10.5 Objectives

The objective of this section is to ensure the prompt and accurate identification of persons with serious mental illness.

3.10.6 Procedures

3.10.6-A. General requirements

[Behavioral health providers are responsible versus T/RBHA- insert language here identifying who serves in this capacity] is responsible for identifying and conducting an SMI determination for persons who may have a serious mental illness. All persons must be evaluated by, or have their records reviewed by, a licensed psychiatrist, psychologist, or nurse practitioner designated by the T/RBHA for determination of SMI, if the person:

- Requests an SMI determination; or

- Has a score of 50 or lower on the Global Assessment of Functioning Scale (GAF) and has a qualifying SMI diagnosis (see PM Attachment 3.10.1 for a list of qualifying diagnoses).

Behavioral health providers must use the GAF as a screen for identifying persons (including enrolled children upon reaching 17 years of age) who may have functional impairments indicative of a serious mental illness. The GAF is completed as part of the assessment process (see Section 3.9, Intake, Assessment and Service Planning).

All Title XIX and Title XXI eligible persons must receive all necessary Title XIX or Title XXI covered services, including case management, throughout the SMI eligibility determination process.

3.10.6-B. Criteria for SMI eligibility determination

The determination of SMI requires both a qualifying SMI diagnosis and functional impairment as a result of the qualifying diagnosis (see PM Attachment 3.10.1 for a list of qualifying diagnoses).

Functional Criteria for SMI Determination

To meet the functional criteria for SMI, 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 months or for most of the past six months with an expected continued duration of at least six months:

- Inability to live in an independent or family setting without supervision – Neglect or disruption of ability to attend to basic needs. Needs assistance in caring for self. Unable to care for self in safe or sanitary manner. Housing, food and clothing, must be provided or arranged for by others. Unable to attend to the majority of basic needs of hygiene, grooming, nutrition, medical and dental care. Unwilling to seek prenatal care or necessary medical/dental care for serious medical or dental conditions. Refuses treatment for life threatening illnesses because of behavioral health disorder.

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

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

Person with Co-occurring Substance Abuse

For persons with co-occurring substance abuse without an established psychiatric diagnosis, the diagnostic assessment may be performed in accordance with the *Co-occurring Psychiatric And Substance Disorders Practice Improvement Protocol.*

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

- For psychotic diagnoses (bipolar I disorder with psychotic features, delusional disorder, major depression, recurrent, severe, with psychotic features, schizophrenia, schizoaffective disorder and psychotic disorder NOS) functional impairment is presumed to be due to the qualifying psychiatric diagnosis;

- For other major mental disorders (bipolar disorders, major depression and obsessive compulsive disorder), functional impairment is presumed to be due to the psychiatric diagnosis, unless:
  - The severity, frequency, duration or characteristics of symptoms contributing to the functional impairment cannot be attributed to the qualifying mental health diagnosis, or;

  - The assessor can demonstrate, based on a historical or prospective period of treatment, that the functional impairment is present only when the person is abusing substances or experiencing symptoms of withdrawal from substances.

- For all other mental disorders not covered above, functional impairment is presumed to be due to the co-occurring substance use unless:
  - The symptoms contributing to the functional impairment cannot be attributed to the substance abuse disorder (see PM Attachment 3.10.2, Substance Use/Psychiatric Symptomatology Table[1]); or

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

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

Re-enrollment or Transfer
If the person's status is SMI at disenrollment or upon transfer from another T/RBHA, the person's status shall continue as SMI upon re-enrollment or transfer.

3.10.6-C. Process for completion of SMI eligibility determination

Upon receipt of a referral for, a request, or identification of the need for an SMI determination, **[a behavioral health provider or T/RBHA insert language here identifying who is serving in this capacity]** shall schedule an appointment for an initial meeting with the person and a

[1] The psychiatric symptomatology table is a guideline only and is not to be used as a substitute for professional clinical judgment.

qualified assessor (see Section 3.20, Credentialing and Privileging). This shall occur no later than 7 days after receiving the request or referral.

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

- Make a clinical assessment whether the person is competent enough to participate in an assessment;
- Obtain general consent from the person or, if applicable, the person's guardian to conduct an assessment;
- Provide to the person and, if applicable, the person's guardian, the information required in R9-21-301(D)(2), a client rights brochure, and the appeal notice required by R9-21-401(B); and
- If, during the initial meeting with the person, the assessor is unable to obtain sufficient information to determine whether the applicant is SMI, the assessor must:
  - Request the additional information in order to make a determination of whether the person is SMI and obtain an authorization for the release of information, if applicable (see Section 4.1, Disclosure of Behavioral Health Information); and
  - Initiate an assessment including completion of the Serious Mentally Ill Determination Addendum (see PM Form 3.9.1) that is part of the standardized ADHS/DBHS assessment tool.

The licensed psychiatrist, psychologist, or nurse practitioner designated by the T/RBHA must make a final determination as to whether the person meets the eligibility requirements for SMI status based on:

- Conducting a face-to-face assessment or reviewing a face-to-face assessment by a qualified assessor (see Section 3.20, Credentialing and Privileging); 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.

If the designated reviewing psychiatrist, psychologist, or nurse practitioner has not conducted a face-to-face assessment and has a disagreement with:

- The current evaluating or treating qualified behavioral health professional or behavioral health technician regarding the diagnosis that cannot be resolved by oral or written communication, 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.
- The current evaluating or treating qualified behavioral health professional or behavioral health technician regarding functional impairment that will result in a determination that the

person does not meet eligibility requirements for SMI status that cannot be resolved by oral or written communications. 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 status, the person shall be provided written notice of the SMI eligibility determination within three business days of the initial meeting with the qualified assessor in accordance with Subsection 3.10.6-E. below.

3.10.6-D. 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 3.8, Outreach, Engagement, Re-Engagement and Closure);
- 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[2] to determine SMI eligibility within the required time periods.

The T/RBHA or their designee must:

- Document the reasons for the delay in the person's comprehensive clinical 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:

[2] Insufficient diagnostic information shall be understood to mean that the information available to the reviewer is suggestive of two or more equally likely working diagnoses, only one of which qualifies as 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).

- The T/RBHA or responsible provider 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 practitioner, 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 days of obtaining sufficient information.

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 subsection 3.10.6-E. below).

If the evaluation or information cannot be obtained within the required time period because of the need for a period of observation or abstinence from substance use in order to establish a qualifying mental health diagnosis, (in accordance with PM Attachment 3.10.2, Substance Use/Psychiatric Symptomatology Table), the person shall be notified that the determination may, with the agreement of the person, be extended for up to 90 (calendar) days. [3]

3.10.6-E. Notification of SMI eligibility determination

A determination of SMI status must be reported to the person in writing, including notice of his/her right to appeal the decision (see Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI).

If the eligibility determination results in a denial of SMI status, the T/RBHA shall notify the person in writing of:

- The reason for denial of SMI eligibility (see PM Form 3.10.1, SMI Determination);

- The right to appeal (see Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons, and Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)); 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 7.5, Enrollment, Disenrollment and Other Data Submission.

3.10.6-F. Review of SMI eligibility determination

The T/RBHA or a behavioral health provider may:

- Institute a periodic review of all persons determined to have a serious mental illness; and

[3] This extension may be considered a technical re-application to ensure 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.

- Re-evaluate in three to six months a person's SMI status if the person has a qualifying diagnosis and has met the functional criteria for risk of serious harm to self or others.

If as a result of such review, the person is determined to no longer meet the diagnosis and functional requirements for SMI status, the T/RBHA must ensure that:

- Services are continued depending on Title XIX/XXI eligibility, T/RBHA service priorities and any other requirements described in Section 3.21, Service Prioritization for Non-Title XIX/XXI Funding.

- Written notice of the reason for adverse determination and the right to appeal are provided to the affected person (see subsection 3.10.6-E above).

Section 3.11 General and Informed Consent to Treatment

3.11.1 Introduction
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3.11.7-D. Special requirements for children
3.11.7-E Informed Consent during Involuntary Treatment
3.11.7-F. Consent for behavioral health survey or evaluation for school-based prevention programs

3.11.1 Introduction

Each behavioral health recipient has the right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment. It is important for persons seeking behavioral health services to agree to those services and be made aware of the service options and alternatives available to them as well as specific risks and benefits associated with these services.

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) recognizes two primary types of consent: general consent and informed consent.

General consent is a one-time agreement to receive behavioral health 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 behavioral health services. General consent must be verified by a behavioral health recipient'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 determined to have a Serious Mental Illness);
- Procedures or services with known substantial risks or side effects; and
- Psychotherapy.

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.

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. (See subsection 3.11.7-E)

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 ADHS/DBHS school-based prevention program.

3.11.2 References

The following citations can serve as additional resources for this content area:
20 U.S.C. § 1232h (b)
42 C.F.R. § 438.100
42 C.F.R. § 438.102
A.R.S. § 8-514.05
A.R.S. § 14-5104
A.R.S. § 15-104
A.R.S. § 36-522
A.R.S. § 36-501.21
A.R.S. § 36-2272
A.R.S. § 44-132
R9-20-203
R9-20-208
R9-21-206
R9-21-503
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA IGAs
ADHS/DBHS Covered Behavioral Health Services Guide
ADHS/DBHS Policy and Procedure Manual CO 1.3, Use of Telemedicine,
Section 3.15, Psychotropic Medications: Prescribing and Monitoring
Section 3.18, Pre-Petition Screening, Court-Ordered Evaluation, and Court-Ordered Treatment
Section 4.1 Disclosure of Behavioral Health Information
Section 4.2, Behavioral Health Medical Record Standards
ADHS/DBHS Comprehensive assessment and treatment for substance use disorders in children and adolescents (Formerly known as Practice Improvement Protocol # 10)
The Arizona Medical Board's Guidelines for Physicians Who Incorporate or Use Complementary or Alternative Medicine in Their Practice

3.11.3 Scope

To whom does this apply?
All persons enrolled in the behavioral health system.

3.11.4 Did you know?

Behavioral health services delivered through telemedicine require informed consent from the person or their guardian prior to receiving the service(s). Appendix B-2 of the ADHS/DBHS Covered Behavioral Health Services Guide includes information regarding behavioral health service codes that can be encountered through the use of telemedicine.

3.11.5 Definitions

Behavioral Health Medical Practitioner

Complementary and Alternative Medicine (CAM)

General Consent

Informed Consent

Telemedicine

Voluntary Evaluation

3.11.6 Objectives

To describe requirements for behavioral health providers to:

- Ensure a behavioral health recipient's understanding of the risks and benefits of behavioral health services, including the risks associated with declining a specific service or procedure; and
- Document a person's agreement to the delivery of behavioral health treatment services and obtain a person's, or if applicable, a person's guardian, custodian or agent's signature to verify general and, when required, informed consent.

3.11.7 Procedures

3.11.7-A. General requirements

Any person, aged 18 years and older, in need of behavioral health 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 behavioral health 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 a lawfully authorized custodial agency representative's signature on a general consent form prior to the delivery of behavioral health 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 behavioral health 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 4.2, Behavioral Health Medical Record Standards. **[T/RBHAs insert specific information or forms here.]**

3.11.7-B: General consent

Administrative functions associated with a behavioral health recipient'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) behavioral health services. **[T/RBHA insert form used to obtain general consent to treatment here.]**

3.11.7-C: Informed consent

What Information must be provided to obtain informed consent?

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

- Behavioral health recipient'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.

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 if applicable, the person's guardian 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.

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 specific situations 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.

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 3.15, Psychotropic Medication Prescribing and Monitoring). The use of PM Form 3.15.1 is recommended as a tool to review and document informed consent for psychotropic medications; and
- Prior to the delivery of behavioral health services through telemedicine.

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 ADHS/DBHS Form MH-103 is required for persons determined to have a Serious Mental Illness and is recommended as a tool to review and document informed consent for voluntary evaluation of all other populations; and
- Prior to the delivery of any other procedure or service with known substantial risks or side effects.

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.

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.

3.11.7-D: Special requirements for children

In accordance with A.R.S. § 36-2272, except as otherwise provided by law or a court order, no person, corporation, association, organization or state-supported institution, or any individual employed by any of these entities, may procure, solicit to perform, arrange for the performance of or perform mental health screening in a nonclinical setting or mental health treatment on a minor without first obtaining the written or oral consent of a parent or a legal custodian of the minor child. If the parental consent is given through telemedicine, the health professional must verify the parent's identity at the site where the consent is given. This 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.

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/Child Protective Services (DES/CPS) 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:

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

For any child who has been removed from the home by CPS, 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 behavioral health services:

- Evaluation and treatment for emergency conditions that are not life threatening; and
- Routine medical and dental treatment and procedures, including early periodic screening, diagnosis and treatment services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (including behavioral health services and psychotropic medications).

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

Emergency Situations

In emergency situations involving a child in need of immediate hospitalization or medical attention, general and, when applicable, informed consent to treatment is not required.

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

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

3.11.7-E: 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.

3.11.7-F: 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 ADHS/DBHS.

Provider Manual Form 3.11.1, 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 ADHS/DBHS. The written consent must satisfy all of the following requirements:

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

Completion of PM Form 3.11.1 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.

Section 3.12 Advance Directives

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3.12.7 Procedures
3.12.7-A: What does a mental health care power of attorney do?
3.12.7-B: What are some of the powers and duties of the designee(s)?
3.12.7-C: What must be provided to an adult person at the time of enrollment?
3.12.7-D: How do I help an adult person develop an advance directive?
3.12.7-E: What else must health care providers do regarding advance directives?

3.12.1 Introduction

An advance directive is a written set of instructions developed by an adult person in the event the person becomes incapable of making decisions regarding his or her behavioral health treatment. An advance directive instructs others regarding the person's wishes, if he/she becomes incapacitated, and can include the appointment of a friend or relative to make behavioral health care decisions for the person. A person prepares an advance directive when capable, and the directive is followed when the person is incapable of making treatment decisions. This section outlines the requirements of behavioral health care providers with regard to advance directives.

3.12.2 References

The following citations can serve as additional resources for this content area:
42 C.F.R. § 422.128
42 C.F.R. § 438.6
42 C.F.R. § 438.10(g) (2)
42 C.F.R. § 489.100
42 C.F.R. § 489.102(a)
A.R.S. § 36-3221
A.R.S. § 36-3281
A.R.S. § 36-3283
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA IGAs
Section 3.6, Member Handbooks

Section 3.21, Service Package for Non-Title XIX/ XXI Persons Determined to Have a Serious Mental Illness (SMI)
Section 4.2, Behavioral Health Medical Record Standards
Section 4.3, Coordination of Care with AHCCCS Health Plans, Primary Care Providers, and Medicare Providers

3.12.3 Scope
All adult persons enrolled in the behavioral health system.

3.12.4 Did you know?
Advance directives not only identify services a person would desire if he or she becomes unable to make a decision, advance directives also:
- Promote individual treatment planning;
- Provide opportunities to create a team approach to treatment; and
- Foster recovery approaches.

The Arizona Secretary of State (www.azsos.gov) maintains a free registry called the "Arizona Advance Directive" where individuals can send advance directives for secure storage and can be accessible to individuals, loved ones and health care providers. This webpage also has other resources available on advanced directives.

If changes occur in State law regarding advance directives, adult persons receiving behavioral health services must be notified by their provider regarding the changes as soon as possible, but no later than 90 days after the effective date of the change.

3.12.5 Definitions
Advance Directive

Health Care Power of Attorney

Mental Health Care Power of Attorney

3.12.6 Objective
To ensure behavioral health care providers comply with Federal and State laws regarding advance directives for adult persons.

3.12.7 Procedures

3.12.7-A: What does a mental health care power of attorney do?
A mental health care power of attorney gives an adult person the right to designate another adult person to make behavioral health care treatment decisions on his or her behalf. The designee may make decisions on behalf of the adult person if/when she or he is found

incapable of making these types of decisions. The designee, however, must not be a provider directly involved with the behavioral health treatment of the adult person at the time the mental health care power of attorney is executed.

3.12.7-B: What are some of the powers and duties of the designee(s)?
The designee:

- May act in this capacity until his or her authority is revoked by the adult person or by court order;
- Has the same right as the adult person to receive information and to review the adult person's medical records regarding proposed behavioral health treatment and to receive, review, and consent to the disclosure of medical records relating to the adult person's treatment;
- Must act consistently with the wishes of the adult person as expressed in the mental health care power of attorney. If, however, the adult person's wishes are not expressed in a mental 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 she or he believes to be in the adult person's best interest; and
- May consent to admitting the adult person to a level 1 behavioral health 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.

3.12.7-C: What must be provided to an adult person at the time of enrollment?
At the time of enrollment, all adult persons, and when the individual is incapacitated or unable to receive information, the enrollee's family or surrogate, must receive information regarding (see 42 C.F.R. § 422.128):

- The person's rights, in writing, regarding advance directives under Arizona State law;
- A description of the applicable state law (summarized in 3.12.7-A and 3.12.7-B above); and information regarding the implementation of these rights;
- The behavioral health recipient's right to file complaints 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 conscience 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.

If an enrollee is incapacitated at the time of enrollment, behavioral health providers may give advance directive information to the enrollee's family or surrogate in accordance with state law.

Behavioral health providers must also follow up when the person is no longer incapacitated and ensure that the information is given to the person directly.

3.12.7-D: How do I help an adult person develop an advance directive?
Behavioral health providers must assist adult persons who are interested in developing and executing an advance directive. The T/RBHA can offer the following resources: **[T/RBHA insert specific language here.]**

3.12.7-E: What else must health care providers do regarding advance directives?
T/RBHAs or behavioral health care providers **[T/RBHAs indicate here who is responsible, T/RBHA or behavioral health provider]** must:

- Document in the adult person's clinical record whether or not the adult person was provided the information and whether an advance directive was executed;
- Not condition provision of care or discriminate against an adult person because of his or her decision to execute or not to execute an advance directive;
- Provide a copy of a person's executed advanced directive, or documentation of refusal, to the acute care primary care provider (PCP) for inclusion in the person'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 behavioral health recipients to whom they are assigned to provide services.

Section 3.13 Covered Behavioral Health Services

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3.13.7-A: Covered services matrix
3.13.7-B: Medicare Part D Prescription Drug Coverage
3.13.7-C: Flex funds

3.13.1 Introduction

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) system of care offers an assortment of covered behavioral health services to meet the individual needs of persons eligible for behavioral health services. Covered behavioral health services assist and encourage each person to achieve and maintain the highest possible level of health and self-sufficiency. The type of behavioral health service covered is contingent on each person's current eligibility status and, for some persons, is based on available funding.

3.13.2 References

The following citations can serve as additional resources for this content area:
42 CFR Part 400
42 CFR Part 403
42 CFR Part 411
42 CFR Part 417
42 CFR Part 422
42 CFR Part 423
9 A.A.C. 21
R9-22-1205
R9-31-1205
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA IGAs
Section 3.1, Eligibility for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Limited Income Subsidy Program
Section 3.4, Co-payments
Section 3.19, Special Populations
Section 3.25, Crisis Intervention Services
Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons
Section 5.4, Special Assistance for Persons Determined to Have a Serious Mental Illness
Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)
ADHS/DBHS Covered Behavioral Health Services Guide

3.13.3 Scope

To whom does this apply?

All Title XIX/XXI (Medicaid/SCHIP) and Title XVIII (Medicare) eligible persons; and all Non-Title XIX/XXI persons determined to have a Serious Mental Illness and all other persons receiving services as part of the behavioral health system, based on available funding.

3.13.4 Did you know…?

The ADHS/DBHS Covered Behavioral Health Services Guide contains information regarding each of the covered behavioral health services that are available through the publicly funded behavioral health 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 screen individuals for AHCCCS eligibility and, as applicable, assist individuals with applying for AHCCCS and/or enrolling in Medicare Part D (see Section 3.1, Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage and the Limited Income Subsidy Program). Medicare eligible behavioral health recipients, including persons who are dually eligible for Medicare (Title XVIII) and Medicaid (Title XIX/XXI), 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 behavioral health recipients enrolled in Part D is based on Part D plans' formularies. Individuals 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 behavioral health services. In addition, providers must obtain documentation from individuals during the screening process to verify lawful presence in the United States (see Section 3.27, Verification of U.S. Citizenship or Lawful Presence for Public Behavioral Health Benefits). Individuals unable to provide such documentation to verify citizenship or lawful presence are not eligible for state funded behavioral health services, other than crisis services. Crisis services are provided to any person presenting with a behavioral health crisis in the community, regardless of eligibility or enrollment status (see Section 3.25, Crisis Intervention Services).

Services for Non-Title XIX/XXI persons determined to have a Serious Mental Illness are subject to available funding, as appropriated by the Arizona Legislature. T/RBHAs must ensure that Non-Title XIX/XXI funding allocated by ADHS/DBHS 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 Notice and Appeal requirements (see Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons and Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI). Behavioral health services must be medically necessary, based upon the needs of the person, and providers must operate within their scope of practice.

Services must be provided in collaboration with other agencies to coordinate the culturally appropriate delivery of covered behavioral health services with other services and supports 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 to the extent that services are provided in support of the treatment goals of the identified eligible or enrolled person.

3.13.5 Definitions

Flex funds

Medically necessary covered services

3.13.6 Objectives

The intent of this section is to identify the covered services available to behavioral health recipients based upon their eligibility status.

3.13.7 Procedures

3.13.7-A: Covered services matrix

PM Attachment 3.13.1, Covered Services Matrix, lists the available covered behavioral health services for T/RBHA enrolled persons 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. PM Attachment 3.13.1, Covered Services Matrix is a condensed summary of available behavioral health services and related funding sources. Behavioral health providers may reference the ADHS/DBHS Covered Behavioral Health Services Guide for more detailed information.

3.13.7-B: 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.

3.13.7-C: Flex Funds

T/RBHAs and/or their subcontracted providers may provide flex funds based on available funding.

When can flex funds be used?

Flex funds may only be used for goods and/or services that are described in the person's service plan that cannot be purchased by any other funding source. The goods and/or services to be provided using flex 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.

When can flex funds not be used?
Flex 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); and
- The purchase of major medical equipment.

T/RBHAs and/or their subcontracted providers must use flex funds for the direct purchase of goods and/or services and may not provide flex funds as direct cash payments to behavioral health recipients or their families. See the ADHS/DBHS Covered Behavioral Health Services Guide for additional information regarding flex funds and applicable billing limitations.

How are flex funds accessed?
Each T/RBHA may approve flex fund services of up to $1,525 per individual/family per year. Clinical teams may access flex funds by: **[T/RBHA describe the process that clinical teams use to access flex funds. Include contact information for how to request flex funds.]**

[T/RBHA, insert process for approving flex fund expenditures. Is the T/RBHA responsible for approving flex fund expenditures or the clinical team?]

T/RBHAs must forward requests for approval of flex fund expenditures exceeding $1,525 per individual/family per fiscal year to **flexfunds@azdhs.gov**.
.

[T/RBHA, insert any additional information here.]

Section 3.14 Securing Services and Prior Authorization

3.14.1 Introduction
3.14.2 References
3.14.3 Scope
3.14.4 Did you know…?
3.14.5 Definitions
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3.14.7-A. Securing services that do not require prior authorization
3.14.7-B. Accessing services that require prior authorization
3.14.7-C. Prior authorization procedures for behavioral health providers contracted by a RBHA
3.14.7-D. Prior authorization procedures for behavioral health providers contracted by a Tribal RBHA
3.14.7-E. Prior authorizing medications
3.14.7-F. Coverage and payment of emergency behavioral health services

3.14.1 Introduction

It is important that persons receiving behavioral health services have timely access to the most appropriate services. It is also important that limited behavioral health resources are allocated in the most efficient and effective ways possible. Prior authorization processes are typically used to promote appropriate utilization of behavioral health services while effectively managing associated costs. Except during an emergency situation, ADHS/DBHS requires prior authorization before accessing inpatient services in a licensed (OBHL) Level I facility (a psychiatric acute hospital, a residential treatment center for persons under the age of 21 or a sub-acute facility). In addition, a Regional Behavioral Health Authority (RBHA) may require prior authorization of covered behavioral health services other than inpatient services with the prior written approval of ADHS/DBHS.

Behavioral health services can be accessed for a person by one of two ways:

<u>Securing Most Behavioral Health Services:</u>
Most behavioral health services do not require prior authorization. Based upon the recommendations and decisions of the clinical team (i.e., Child and Family Team or Adult clinical team), any and all covered services that address the needs of the person and family will be secured. During the treatment planning process, the clinical team may use established tools to guide clinical practice and to help determine the types of services and supports that will result in positive outcomes for the person. Clinical teams should make decisions based on a person's identified needs and should not use these tools as criteria to deny or limit services.

<u>Securing Services that Need Prior Authorization:</u>
Prior authorization is required for certain covered behavioral health services. Behavioral health services requiring prior authorization include:

- Non-emergency admissions to an OBHL Level I facility;
- Continued stay in an OBHL Level I facility;

- Admission to and continued stay in an OBHL Level II behavioral health residential facility for persons under the age of 21 (Tribal RBHAs); and

- **[RBHA add all other services that require prior authorization as approved by ADHS/DBHS]**

When it is determined that a person is in need of a behavioral health service requiring prior authorization, a behavioral health professional applies the designated authorization and continued stay criteria to approve the provision of the covered service. A decision to deny a prior authorization request must be made by the RBHA Medical Director or physician designee, or for TRBHAs, by the ADHS/DBHS Medical Director or physician designee.

This section is intended to:

- Present the distinctions between prior authorization of select behavioral health services and securing of all other behavioral health services;

- Describe federal requirements associated with authorization and denial of inpatient services;

- Identify the covered behavioral health services that must be prior authorized; and

- Identify how to access a covered behavioral health service that does not require prior authorization.

3.14.2 References

The following citations can serve as additional resources for this content area:

42 CFR 438.10 (a)
42 CFR 438.114
42 CFR 441
42 CFR 456
9 A.A.C. 20
9 A.A.C. 34
R9-22-210
R9-22-1204
R9-22-1205
R9-31-210
R9-31-1205
AHCCCS/ADHS Contract
ADHS/RBHA Contract
ADHS/T/RBHA IGAs
Section 3.9 Intake, Assessment and Service Planning
Section 3.16 Medication Formulary
Section 5.1 Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons
Section 5.2 Member Complaints
Section 5.3 Grievance and Request for Investigation for Persons Determined to have a Serious Mental Illness (SMI)
Section 5.5 Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)

Practice Improvement Protocol 8, The Adult Clinical Team
Practice Improvement Protocol 9, The Child and Family Team
Technical Assistance Document 3, The Child and Family Team Process
The Arizona Vision and Twelve Principles
ADHS/DBHS Policy Clarification Memorandum: Prior Authorization

3.14.3 Scope

To whom does this apply?
All persons who receive behavioral health services.

3.14.4 Did you know…?

- It is important for a behavioral health professional to document enough information in the comprehensive clinical record to validate that the prior authorization request meets all elements of the authorization criteria.

- The RBHA may require prior authorization of behavioral health services other than inpatient services only with the prior written approval of ADHS/DBHS.

- A Title XIX eligible person that is receiving services in a Level I residential treatment center who turns age 21 may continue to receive services until the point in time in which services are no longer required or the person turns age 22, whichever comes first.

- Prior authorization criteria may not include any one of the following as a sole criteria for denial of services:
  - Lack of family involvement;
  - Presence or absence of a particular mental health diagnosis; or
  - Presence of substance use, abuse or dependence.

3.14.5 Definitions

Adult Clinical Team

Behavioral Health Professional

Certification of Need (CON)

Child and Family Team

Clinical Teams

Denial

Emergency Behavioral Health Services

Inpatient Services

Level I Facility

Level II Facility

Medically Necessary Covered Services

Post Stabilization Services

Prior authorization

Prudent Layperson

Psychiatric Acute Hospital

Recertification of Need (RON)

Residential Treatment Center (RTC)

Sub-Acute Facility

3.14.6 Objectives

To ensure that behavioral health services are secured or prior authorized:

- Consistent with the Arizona Principles for persons receiving services through the public behavioral health system; and
- According to federal, state and T/RBHA requirements; and
- In a manner that allows timely access to care based on the person's clinical needs.

3.14.7 Procedures

3.14.7-A. Securing services that do not require prior authorization

Who can secure behavioral health services that do not require prior authorization?

The clinical team is responsible for identifying and securing the service needs of each behavioral health recipient through the assessment and service planning processes. In fulfilling this responsibility, the clinical team should focus on identifying the underlying needs of the behavioral health recipient, including the type, intensity and frequency of supports needed, rather than identifying pre-determined specific services.

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. This is done in conjunction with the clinical team, the behavioral health recipient, family, and natural supports. If the service is available through a contracted provider the person can access the service directly. If the requested service is only available through a non-contracted provider or if the clinical team requests services from a non-contracted provider, the clinical team is responsible for coordinating with **[T/RBHA insert with whom the clinical team is responsible for coordinating]** and obtaining the requested service as outlined below.

How can services with a non-contracted provider be secured?
Sometimes it may be necessary to secure services through a non-contracted provider in order to provide a needed covered behavioral health service or to fulfill a clinical team's request. The process for securing services through a non-contracted provider is as follows:
[T/RBHA please describe the following information here:

- **What is the process for securing services with a non-contracted provider (e.g., single case agreement, pursuing a contract, etc.)?**
- **What information must the clinical team submit to the T/RBHA to secure services through a non-contracted provider?**
- **Describe what happens if the process for securing services with a non-contracted provider does not work (e.g. unable to establish a single case agreement).**
- **How does the T/RBHA ensure payment to a non-contracted provider?**

In the event that a request to secure covered services through a non-contracted provider is denied, notice of the decision must be provided in accordance with Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons, and Section 5.5, Notice and Appeal Requirements (SMI and General).

What is the purpose of a utilization review process?
Behavioral health providers may choose to adopt tools, such as service planning guidelines, to retrospectively review the utilization of services. The goals of utilization review include:

- Detecting over and under utilization of services;
- Defining expected service utilization patterns;
- Facilitating the examination of clinicians and clinical teams that are effectively allocating services; and
- Identifying clinicians and behavioral health providers who could benefit from technical assistance.

[T/RBHA insert specific language here]

3.14.7-B. Accessing services that require prior authorization

What does prior authorization do?
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 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.

When is prior authorization available?

RBHAs or behavioral health providers must have staff available 24 hours a day, seven days a week to receive requests for any service that requires prior authorization.

What about emergencies?
Prior authorization must never be applied in an emergency situation. A retrospective review may be conducted after the person's immediate behavioral health needs have been met. If upon review of the circumstances, the behavioral health service did not meet admission authorization criteria, payment for the service 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.

What is Certification Of Need (CON)?
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 that requires prior authorization is determined through the application of admission and continued stay authorization criteria. 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 days of admission.

For a sample CON form, see PM Form 3.14.1.

What is Re-certification Of Need (RON)?
A RON is a re-certification made by a physician, nurse practitioner or physician assistant that inpatient services are still needed for a person. A RON must be completed at least every 60 days for a person who is receiving services in a Level I 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 a Level I 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. For a sample RON form, see PM Form 3.14.2.

What must be documented on a CON or RON?
The following documentation is needed on a CON and RON:

- Proper treatment of the person's behavioral 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; and

- CONs, a dated signature by a physician;

- RONs, a dated signature by a physician, nurse practitioner or physician assistant.

Additional CON requirements

- If a person becomes eligible for Title XIX or Title XXI services while receiving inpatient services, the CON must be completed and submitted to **[RBHA indicate here if this requirement is delegated to provider]** prior to the authorization of payment.

- For persons under the age of 21 receiving inpatient psychiatric services:

    - Federal rules set forth additional requirements for completing CONs when persons under the age of 21 are admitted to, or are receiving services in a Level I 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 or Title 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.

What criteria are used to determine whether to approve or deny a service that requires prior authorization?

For services in a psychiatric acute hospital or a sub-acute facility, ADHS/DBHS has developed the following criteria to be used by all T/RBHAs and behavioral health providers:

- ADHS/DBHS Admission to Psychiatric Acute Hospital or Sub-Acute Facility Authorization Criteria (see PM Attachment 3.14.1); and

- ADHS/DBHS Continued Psychiatric Acute Hospital or Sub-Acute Facility Authorization Criteria (see PM Attachment 3.14.2).

For services in a residential treatment center for persons under the age of 21, ADHS/DBHS has developed the following criteria to be used by all T/RBHAs and behavioral health providers:

Prior to denials for Residential Treatment Center (RTC) or sub-acute facility placement, T/RBHA Medical Directors or designees are expected to talk with the treating psychiatrist/psychiatric nurse practitioner most familiar with the child in order to gather any additional information that could be helpful in making the determination. If a psychiatrist or psychiatric nurse practitioner

has not yet been involved, an evaluation should be arranged in order for the T/RBHA Medical Director or designee to obtain the professional opinion of a behavioral health clinician.

In addition, if a denial is issued for admission to a RTC or sub-acute facility, the T/RBHA is expected to provide a clearly outlined alternative plan. This may require development of a CFT, if one has not already been established, or consultation with the CFT. It is expected that the alternative treatment plan will adequately address the behavioral health treatment needs of the child and will provide specific information detailing what services will be provided, where these services will be provided, and when these services will be available and what specific behaviors will be addressed by these services. It is also expected that the alternative treatment plan will include what crisis situations can be anticipated and how the crises will be addressed.

- ADHS/DBHS Admission to Residential Treatment Center Authorization Criteria (see PM Attachment 3.14.3); and

- ADHS/DBHS Continued Residential Treatment Center Authorization Criteria (see PM Attachment 3.14.4).

[RBHA insert specific references to and ability to access ADHS/DBHS approved authorization and continued authorization criteria for all other services subjected to prior authorization]

What happens if a person is ready to leave a Level I Facility but an alternative placement is not available?
If a person receiving inpatient services no longer requires services on an inpatient basis under the direction of a physician, but services suitable to meet the person's 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. All such instances shall be logged and provided to ADHS/DBHS upon request.

3.14.7-C. Prior authorization procedures for behavioral health providers contracted by a RBHA

What services must be prior authorized?
Services requiring prior authorization are:

- Non-emergency admission to and continued stay in an inpatient facility;

- **[RBHA add other services that require prior authorization by the RBHA]**

Who makes prior authorization decisions?
A behavioral health professional is required to prior authorize services unless it is a decision to deny. A decision to deny must be made by the RBHA Medical Director or physician designee.

How is prior authorization applied in an emergency admission?
Prior authorization must never be applied in an emergency situation.

What are the considerations for denials?
A denial of a request for admission to or continued stay in an inpatient facility can only be made by the RBHA's Medical Director or physician designee after verbal or written collaboration with the requesting clinician.

For Title XIX/XXI covered services requested by persons who are Title XIX/XXI eligible or who have been determined to have a serious mental illness, **[RBHA indicate here if this is a RBHA or provider responsibility]** must provide the person(s) requesting services with a Notice of Action (see PM Form 5.1.1) following:

- 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; and
- The denial in whole or in part, of payment for a service (this is the RBHA's responsibility).

Notice must be provided in accordance with Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons. Before a final decision to deny is made, the person's attending psychiatrist can ask for reconsideration and present additional information.

The RBHA or provider **[RBHA indicate here if this requirement is delegated to provider]** must ensure 24-hour access to a delegated psychiatrist or other physician designee for any denials of inpatient admission.

What documentation must be submitted to obtain a prior authorization and what are the timeframes for making a decision?
For requests for admission, **[RBHA insert required documentation here. Required documentation for each prior authorized service must be described]**.

Decisions to prior authorize inpatient admission must be made:

- Within one hour of the request for psychiatric acute hospital or sub-acute facility;
- Within 24 hours of the request for a residential treatment center for persons under the age of 21; and
- **[RBHA add timeframes for other ADHS/DBHS approved services that require prior authorization. Required timeframes for each prior authorized service must be described]**.

For requests for continued stay, **[RBHA insert required documentation here]**. Requests for continued stay must be submitted within the following timelines: **[RBHA insert timeframes for submitting required documentation here]**.

3.14.7-D. Prior authorization procedures for behavioral health providers contracted by a Tribal RBHA

What services must be prior authorized?
Services requiring prior authorization are:

- Non-emergency admission to and continued stay in an inpatient facility; and

- Admission and continued stay in a Level II behavioral health facility for persons under the age of 21.

Who makes prior authorization decisions?
A behavioral health professional is required to prior authorize services unless it is a decision to deny. A decision to deny must be made by the ADHS/DBHS Medical Director or physician designee.

How is prior authorization applied in emergency admission?
Prior authorization must never be applied in an emergency situation.

What are the considerations for denials?
A denial of a request for admission to or continued stay in an inpatient facility can only be made by the ADHS/DBHS Medical Director or physician designee after verbal or written collaboration with the requesting clinician.

For Title XIX/XXI covered services requested by persons who are Title XIX/XXI eligible or who have been determined to have a serious mental illness, ADHS/DBHS must provide the person(s) requesting services with a Notice of Action (see PM Form 5.1.1) following:

- 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; and

- The denial in whole or in part, of payment for a service.

Notice must be provided in accordance with Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons. Before a final decision to deny is made, the person's attending physician can ask for reconsideration and present additional information.

Upon denial of a service requiring prior authorization by the ADHS/DBHS Medical Director or physician designee, a letter is sent to providers notifying that the service was denied and the reason(s) for the denial.

What documentation must be submitted to obtain a prior authorization and what are the timeframes for making a decision?
Prior to admission (for requests made Monday through Friday 8:00 a.m. to 5:00 p.m.) or within 24 hours of an admission (for requests made after 5:00 pm Monday through Friday, on weekends or State holidays) the following must be submitted to the Arizona Department of Health Services/Division of Behavioral Health Services/ Bureau of Quality Management Operations (Facsimile number (602) 364-4749):

Level I:
- CON;
- TRBHA prior authorization request form (see PM Form 3.14.3); and

- The person's service plan (see Section 3.9, Intake, Assessment and Service Planning).

Level II (for persons under the age of 21):
- TRBHA prior authorization request form (see PM Form 3.14.3); and
- The person's service plan (See Section 3.9, Intake, Assessment and Service Planning).

Prior authorization decisions for non-emergency admissions to Level I facilities and Level II facilities for persons under the age of 21 will be made within 24 hours of receiving the request, or if the request is received on a weekend or State holiday, the decision will be made on the next business day.

Authorization cannot be provided without all the required documentation. For services provided after hours, on weekends or on State holidays, prior authorization must be obtained on the next business day.

A provider may also telephone the Bureau of Quality Management Operations at (602) 364-4648 or (602) 364-4642. After hours (after 5:00 pm Monday through Friday, on weekends or State holidays) a voice message can be left at the same number and the call will be returned the next business day.

Prior authorization is not required for Non-Title XIX/XXI individuals. If Title XIX or Title XXI eligibility is determined during the hospitalization, providers may request a retrospective authorization. For retrospective authorization to occur, a provider must submit a CON and the person's service plan to the Bureau of Quality Management Operations by the next business day following the person's Title XIX or Title XXI eligibility determination.

For requests for continued stay, the following documentation must be submitted to the Arizona Department of Health Services/ Division of Behavioral Health Services/ Bureau of Quality Management Operations (Facsimile number (602) 364-4697):

Level I:
- RON; and
- The person's service plan (RTC only) (see Section 3.9, Intake, Assessment and Service Planning).

Level II (for persons under the age of 21):
- TRBHA prior authorization request form (see PM Form 3.14.3); and
- The person's service plan (see Section 3.9, Intake, Assessment and Service Planning).

Requests for continued stay must be submitted within the following timelines:
- **Psychiatric acute hospital and sub-acute facility:** The initial authorization is valid for 72 hours. A request for continued stay authorization (see PM Form 3.14.3) must be submitted within the initial 72 hours or, if on a weekend or State holiday, the request for continued stay authorization must be submitted the next business day. All subsequent continued stay authorizations must be made prior to expiration of the last authorization;

- **Level I residential treatment centers:** The initial authorization is valid for 30 days. A request for continued stay authorization (see PM Form 3.14.3) must be submitted two weeks prior to the expiration of the current authorization; and

- **Level II facilities (for persons under the age of 21)**: The initial authorization is valid for 60 days. A request for continued stay authorization (see PM Form 3.14.3) must be submitted two weeks prior to the expiration of the current authorization.

3.14.7-E. Prior authorizing medications

RBHAs must obtain approval from the ADHS/DBHS Medical Director prior to establishing prior authorization for any medication, including dosage and dispensing restrictions. For specific information on medications requiring prior authorization, see Section 3.16, Medication Formulary. If a RBHA or behavioral health provider **[RBHA indicate here if this requirement is delegated to provider]** requires prior authorization for medications, the following requirements must be met:

- Adherence to all prior authorization requirements outlined in this section, including:
  - Prior authorization availability 24 hours a day, seven days a week;
  - Assurance that a person will not experience a gap in access to prescribed medications due to a change in prior authorization requirements. RBHAs and behavioral health providers must ensure continuity of care in cases in which a medication that previously did not require prior authorization must now be prior authorized; and
  - Incorporation of notice requirements when medication requiring prior authorization is denied, suspended or terminated.

3.14.7-F. Coverage and payment of emergency behavioral health services

The following conditions apply with respect to coverage and payment of emergency behavioral health services for persons who are Title XIX or Title XXI eligible:

- Emergency behavioral health services must be covered and reimbursement made to providers who furnish the services regardless of whether the provider has a contract with a T/RBHA;

- Payment must not be denied when:
  - A T/RBHA or behavioral health provider instructs a person to seek emergency behavioral health services;
  - A person has had an emergency behavioral health condition, including cases in which the absence of medical attention would have resulted in:
    - Placing the health of the person (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.

- Emergency behavioral health conditions must not be limited to a list of diagnoses or symptoms;

- A T/RBHA may not refuse to cover emergency behavioral health services based on the failure of a provider to notify the T/RBHA of a person's screening and treatment within 10 calendar days of presentation for emergency services.

- A person who has an emergency behavioral health condition must not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the person; and

- The attending emergency physician, or the provider actually treating the person, is responsible for determining when the person is sufficiently stabilized for transfer or discharge, and such determination is binding the T/RBHA.

The following conditions apply with respect to coverage and payment of post-stabilization care services for persons who are Title XIX or Title XXI eligible:

- The T/RBHA is responsible for ensuring adherence to the following requirements, even in situations when the function has been delegated to a subcontracted provider;

- Post-stabilization care services must be covered without authorization and reimbursement made to providers that furnish the services regardless of whether the provider has a contract with a T/RBHA for the following situations:
  - Post-stabilization care services that were pre-authorized by the T/RBHA;

  - Post-stabilization care services that were not pre-authorized by the T/RBHA or because the T/RBHA did not respond to the treating provider's request for pre-approval within one hour after being requested to approve such care or could not be contacted for pre-approval; or

  - The T/RBHA and the treating physician cannot reach agreement concerning the member's care and a T/RBHA physician is not available for consultation. In this situation, the T/RBHA must give the treating physician the opportunity to consult with a contracted physician and the treating physician may continue with care of the member until a contracted physician is reached or one of the following criteria is met:
    - A T/RBHA physician with privileges at the treating hospital assumes responsibility for the person's care;

    - A T/RBHA physician assumes responsibility for the person's care through transfer;

    - The T/RBHA and the treating physician reach an agreement concerning the person's care; or

    - The person is discharged.

Section 3.15 Psychotropic Medication: Prescribing and Monitoring

3.15.1 Introduction
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3.15.7-D. Psychotropic Medication Monitoring
3.15.7-E. Polypharmacy
3.15.7-F. Reporting requirements
3.15.7-G. Complementary and alternative medicine (CAM)

3.15.1 Introduction

The use of psychotropic medications is often an integral part of treatment for persons receiving care for behavioral health conditions. As such, the use of psychotropic medications must be monitored closely to help ensure that persons are treated safely and effectively. ADHS/DBHS developed guidelines and minimum requirements designed to:

- Ensure the safety of persons taking psychotropic medications;
- Reduce or prevent the occurrence of adverse side effects; and
- Help persons who are taking psychotropic medications restore and maintain optimal levels of functioning and achieve positive clinical outcomes.

3.15.2 References

The following citations can serve as additional resources for this content area:
42 C.F.R. § 438.100
A.R.S. § 32-1901
R9-20-101
R9-20-303
R9-21-206.01
R9-21-207
Section 3.2, Appointment Standards and Timeliness of Service
Section 3.11, General and Informed Consent to Treatment
Section 3.16, Medication Formulary
Section 3.20, Credentialing and Privileging
Section 4.2, Behavioral Health Medical Record Standards
Section 4.3, Coordination of Care With AHCCCS Health Plans, Primary Care Providers, and Medicare Providers
Section 7.4, Reporting of Incidents, Accidents and Deaths
Informed Consent for Psychotropic Medication Treatment Practice Protocol

Polypharmacy Use: Assessment of Appropriateness and Importance of Documentation Practice Protocol
Psychotropic Medication Use in Children, Adolescents, and Young Adults Clinical Practice Protocol
General and Informed Consent to Treatment for Persons Under the Age of 18 Policy Clarification Memorandum
The Arizona Medical Board's Guidelines For Physicians Who Incorporate Or Use Complementary Or Alternative Medicine In Their Practice
National Coordinating Council for Medication Error Reporting and Prevention

3.15.3 Scope

To whom does this apply?
All T/RBHA and subcontracted providers including the Arizona State Hospital utilizing behavioral health medical practitioners to prescribe psychotropic medications to the following populations:

- All Title XIX/XXI eligible persons;
- All non-Title XIX/XXI persons determined to have a Serious Mental Illness; and
- All other persons, based on available funding.

3.15.4 Did you know…?

- A person's target symptoms and clinical responses to treatment must be identified for each medication prescribed and documented in the person's comprehensive clinical record. Also, the use of psychotropic medication must always be referenced and incorporated into the person's individual treatment plan.

- Education regarding all prescribed medications must be routinely provided to persons, family members, guardians, or designated representatives in a culturally competent, language appropriate manner.

- Psychotropic medications that are not clinically effective after reasonable trials should be discontinued, unless the rationale for continuation can be supported and is documented in the person's comprehensive clinical record.

- Behavioral health medical practitioners must coordinate with primary care providers (PCPs) or other health care providers to minimize the potential for adverse clinical outcomes when prescribing psychotropic medications. See Section 4.3, Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers regarding expectations for coordination of care with PCPs and other health care providers.

3.15.5 Definitions

Adverse Drug Event (ADE)

Adverse Drug Reaction (ADR)

Behavioral Health Medical Practitioner.

Complementary and Alternative Medicine (CAM)

Cross-tapering

Medication Error

3.15.6 Objectives

To ensure that psychotropic medications prescribed for persons are prescribed and monitored in a manner that provides for safe and effective use.

To ensure that medication will not be used as punishment, for the convenience of the staff, or as a substitute for other behavioral health services and will 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).

3.15.7 Procedures

3.15.7-A. Basic requirements

Medications may only be prescribed by T/RBHA credentialed and licensed physicians, licensed physician assistants, or licensed nurse practitioners. See Section 3.20, Credentialing and Privileging for more information regarding credentialing requirements.

Psychotropic medication will be prescribed by a psychiatrist who is a licensed physician, or a licensed nurse practitioner, licensed physician assistant, or physician trained or experienced in the use of psychotropic medication, who has seen the client and is familiar with the client's medical history or, in an emergency, is at least familiar with the client's medical history.

When a client 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 client's record (See Section 4.2, Behavioral Health 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 client's record (See Section 4.2, Behavioral Health Medical Record Standards).

3.15.7-B. Assessments

Reasonable clinical judgment, supported by available assessment information, must guide the prescription of psychotropic medications. To the extent possible, candidates for psychotropic medications must be assessed prior to prescribing and providing psychotropic medications. Psychotropic medication assessments must be documented in the person's comprehensive clinical record per Section 4.2, Behavioral Health Medical Record Standards and must be scheduled in a timely manner consistent with Section 3.2, Appointment Standards and Timeliness of Service. Behavioral health medical practitioners 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 medications including any noted side effects and/or potential drug-drug interactions;
- For sexually active females of childbearing age, a review of reproductive status (pregnancy); and
- For post-partum females, a review of breastfeeding status.

Reassessments must ensure that the provider prescribing psychotropic medication notes in the client's record (See Section 4.2, Behavioral Health Medical Record Standards):

- The appropriateness of the current dosage;
- All medication being taken and the appropriateness of the mixture of the medications;
- Any side effects, abnormal and/or involuntary movements if treated with an anti-psychotic medication; and
- The reason for the use of the medication and the effectiveness of the medication.

3.15.7-C. Informed consent

Informed consent must be obtained from the person and/or legal guardian for each psychotropic medication prescribed. When obtaining informed consent, the behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience must communicate in a manner that the person and/or legal guardian can understand and comprehend. The comprehensive clinical record must include documentation of the essential elements for obtaining informed consent (See Section 4.2, Behavioral Health Medical Record Standards). Essential elements for obtaining informed consent for medication are contained within PM Form 3.15.1, Informed Consent for Psychotropic Medication Treatment. **It is preferred that the prescribing clinician provide information forming the basis of an informed consent decision. In specific situations in which this is not possible or practicable, information may be provided by another credentialed behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience.**

The use of PM Form 3.15.1 is recommended as a tool to document informed consent for psychotropic medications. If PM Form 3.15.1 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 4.2, Behavioral Health Medical Record Standards). **[T/RBHA, insert link here to T/RBHA specific informed consent]**

For more information regarding informed consent, please see Section 3.11, General and Informed Consent to Treatment.

3.15.7-D. Psychotropic Medication Monitoring

Psychotropic medications must be monitored. While T/RBHAs may establish additional guidelines or timelines beyond ADHS/DBHS minimum requirements, at a minimum, these must include:

- Heart Rate and Blood Pressure
  On initiation of any medication and at least every six months thereafter, or more frequently as clinically indicated. **[T/RBHAs Enter Specific Information Here]**

- Weight
  On initiation of any medication and at least every six months thereafter, or more frequently as clinically indicated. **[T/RBHAs Enter Specific Information Here]**

- Abdominal girth
  For individuals at least 18 years old, on initiation of any medication and at least every six months thereafter, or more frequently as clinically indicated. **[T/RBHAs Enter Specific Information Here]**

- Body Mass Index (BMI)
  On initiation of any medication and at least every six months thereafter, or more frequently as clinically indicated. **[T/RBHAs Enter Specific Information Here]**

- Abnormal Involuntary Movements (AIMS)
  On initiation of any antipsychotic medication and at least every six months thereafter, or more frequently as clinically indicated. **[T/RBHAs Enter Specific Information Here]**

- Fasting glucose
  On initiation of any medication affecting this parameter and at least annually thereafter or more frequently as clinically indicated. **[T/RBHAs Enter Specific Information Here]**

- Lipids
  On initiation of any medication affecting this parameter and at least annually thereafter or more frequently as clinically indicated. **[T/RBHAs Enter Specific Information Here]**

- Complete Blood Count (CBC)
  On initiation of any medication affecting this parameter and at least annually thereafter or more frequently as clinically indicated. **[T/RBHAs Enter Specific Information Here]**

- Liver function
  On initiation of any medication affecting this parameter and at least annually thereafter or more frequently as clinically indicated. **[T/RBHAs Enter Specific Information Here]**

- Lithium level
  Within one month of initiation of lithium or significant change in dose and at least annually thereafter or more frequently as clinically indicated. **[T/RBHAs Enter Specific Information Here]**

- Thyroid function
  Within one month of initiation of lithium and at least annually thereafter or more frequently as clinically indicated. **[T/RBHAs Enter Specific Information Here]**

- Renal function
  Within one month of initiation of lithium and at least annually thereafter or more frequently as clinically indicated. **[T/RBHAs Enter Specific Information Here]**

- Valproic acid level
  Within one month of initiation of valproic acid or divalproex or significant change in dose and at least annually thereafter or more frequently as clinically indicated. **[T/RBHAs Enter Specific Information Here]**

- Carbamazepine level
  Within one month of initiation of carbamazepine or significant change in dose and at least annually thereafter or more frequently as clinically indicated. **[T/RBHAs Enter Specific Information Here]**

[T/RBHAs Enter Specific Information Here for any additional monitoring parameters]

3.15.7-E. Polypharmacy

ADHS/DBHS recognizes two types of polypharmacy: intra-class polypharmacy and inter-class polypharmacy. (See Polypharmacy Use: Assessment of Appropriateness and Importance of Documentation Practice Protocol). Below are ADHS/DBHS expectations regarding prescribing multiple psychotropic medications to a person being treated for a behavioral health condition:

Intra-class Polypharmacy: Defined as more than two medications prescribed at the same time within the same class, other than for cross-tapering purposes. The person's medical record (See Section 4.2, Behavioral Health Medical Record Standards) must contain documentation specifically describing the rationale and justification for the combined use.

Inter-class Polypharmacy: Defined as more than three medications prescribed at the same time from different classes of medications for the overall treatment of behavioral health disorders. The medical record (See Section 4.2, Behavioral Health Medical Record Standards) must contain documentation specifically describing the rationale and justification for the combined use.

3.15.7-F. Reporting requirements

ADHS/DBHS requires that T/RBHAs establish a system for monitoring the following:

- Adverse drug reactions
- Adverse drug event
- Medication errors

The above referenced events must be identified, reported, tracked, reviewed and analyzed by the T/RBHA. **[T/RBHA fill in applicable info here]**

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 7.4, Reporting of Incidents, Accidents and Deaths for more information).

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

When a physician uses CAM, (See The 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 and/or legal guardian for each CAM prescribed (See PM 3.16, Medication Formulary). When obtaining informed consent, behavioral health medical practitioners must communicate in a manner that the person and/or legal guardian can understand and comprehend. The comprehensive clinical record must include documentation of the essential elements for obtaining informed consent (See Section 4.2, Behavioral Health Medical Record Standards). Essential elements for obtaining informed consent for medication are contained within PM Form 3.15.1, Informed Consent for Psychotropic Medication Treatment.

The use of PM Form 3.15.1 is recommended as a tool to document informed consent for CAM. If PM Form 3.15.1 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 (See Section 4.2, Behavioral Health Medical Record Standards) in an alternative fashion. **[T/RBHA, insert link here to T/RBHA specific informed consent]**

Section 3.16 Medication Formularies

3.16.1 Introduction
3.16.2 References
3.16.3 Scope
3.16.4 Did you know…?
3.16.5 Definitions
3.16.6 Objectives
3.16.7 Procedures
3.16.7-A. How are the formularies used to access medications?
3.16.7-B. Prior authorization
3.16.7-C. How can the Behavioral Health Providers have input?

3.16.1 Introduction

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) maintains two lists of medications, referred to as the Title XIX/XXI Medication Formulary and the Non-Title XIX/XXI Formulary. Tribal and Regional Behavioral Health Authorities (T/RBHAs) must use these medication formularies to ensure the availability of safe, cost-effective and efficacious medications, ADHS/DBHS may add or delete medications from the formularies based on factors such as obsolescence, toxicity, and substitution of superior products or newer treatment options.

Medicare eligible behavioral health recipients, including persons who are dually eligible for Medicare (Title XVIII) and Medicaid (Title XIX/XXI), receive Medicare Part D prescription drug benefits through Medicare Prescription Drug Plans (PDPs) or Medicare Advantage Prescription Drug Plans (MA-PDs). **[T/RBHA insert information here indicating whether the T/RBHA is part of any Medicare Advantage plans' networks to provide the Medicare Part D benefit.]** Prescription drug coverage for Medicare eligible behavioral health recipients enrolled in Part D is based on Part D plans' formularies. There may be an occasion when a behavioral health recipient's prescribed drug is not available through his/her Part D plan's formulary. This is considered a non-covered Part D drug. T/RBHAs and/or behavioral health 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.

3.16.2 References

The following citations can serve as additional resources for this content area:

42 CFR 400.202
42 CFR 422.2
42 CFR 422.106
42 CFR 423.100
42 CFR 423.120
42 CFR 423.4
42 CFR 423.34
42 CFR 423.272
42 CFR 423.462
42 CFR 423.464
42 CFR 423.505

A.R.S. 32-1901
R9-21-207
R9-22-209
R9-31-209
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/IGAs T/RBHA
ADHS/DBHS Covered Behavioral Health Services Guide
ADHS/DBHS Title XIX/XXI Medication Formulary
ADHS/DBHS Non-Title XIX/XXI Medication Formulary
T/RBHA Medication Formulary
Section 3.14, Securing Services and Prior Authorization
Section 3.15, Psychotropic Medications: Prescribing and Monitoring
Section 3.21, Service Package for Non-Title XIX/XXI Persons determined to have a Serious Mental Illness (SMI)
Medicare Modernization Act Final Guidelines - Formularies
Part D Voluntary Prescription Drug Benefit Program - Benefits and Costs for People With Medicare
Prescription Drug Benefit Manual - CMS

3.16.3 Scope

To whom does this apply?
This section is only applicable to behavioral health providers contracted with a Tribal or Regional Behavioral Health Authority (T/RBHA). ADHS/DBHS covers medications for the following:

- Title XIX and Title XXI eligible persons;
- Dual eligible persons who are prescribed medications covered through Medicaid (medications covered through Medicare Part D are billed to Medicare plans);
- Non-Title XIX/XXI persons determined to have Serious Mental Illness (SMI); and
- Non-Title XIX/XXI persons presenting with a behavioral health crisis in the community.

3.16.4 Did you know…?

- At a minimum, the T/RBHA's formulary for Title XIX/XXI eligible persons must include all medications on the ADHS/DBHS Title XIX/XXI Medication Formulary; however, T/RBHAs may choose to add to the comprehensive formulary, if desired.
- T/RBHAs must use the ADHS/DBHS Non-Title XIX/XXI Medication Formulary for Non-Title XIX/XXI persons when using Non-Title XIX/XXI funds.
- Updated versions of the ADHS/DBHS Title XIX/XXI Medication Formulary and ADHS/DBHS Non-Title XIX/XXI Medication Formulary are posted on the ADHS/DBHS website. Updated

information concerning covered medical testing services is also posted on the ADHS/DBHS website as part of the ADHS/DBHS Covered Behavioral Health Services Guide.

- Each Medicare Prescription Drug Plan (PDP) and Medicare Advantage plan (MA-PD or MA-PD/Special Needs Plan) establishes its own formulary. Formularies are based on the *Medicare Modernization Act Final Guidelines - Formularies* issued by the Centers for Medicare and Medicaid Services (CMS). Each Part D plan's formulary can be reviewed through http://www.medicare.gov/. Benzodiazepines and barbiturates are excluded under Medicare Part D and will continue to be covered through ADHS/DBHS.

3.16.5 Definitions

ADHS/DBHS Non-Title XIX/XXI Medication Formulary

ADHS/DBHS Title XIX/XXI Medication Formulary

Behavioral Health Medical Practitioner

Depo-medications

Dual eligible

Medicare Advantage Prescription Drug Plan (MA-PD)

Prescription Drug Plan (PDP)

Prior Authorization

Schizophrenic Spectrum Disorder

Third Party Liability

T/RBHA Formulary

3.16.6 Objectives

To provide persons access to safe, cost-effective and efficacious medications.

3.16.7 Procedures

3.16.7-A. How are the formularies used to access medications?

To ensure coverage of medications through the T/RBHA, providers must utilize the T/RBHA Formulary for Title XIX/XXI eligible persons and the ADHS/DBHS Non-Title XIX/XXI Medication Formulary for Non-Title XIX/XXI persons.

[T/RBHA insert specific information here (e.g. where providers can find the T/RBHA medication formulary – insert a direct link to the medication formulary.)]

Title XIX/XXI eligible persons receiving medication(s) have the right to appeal any decision that affects his/her coverage for medication(s) in accordance with PM Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons. Non-Title XXI/XXI persons determined SMI have the right to appeal decisions regarding coverage of their medications in accordance with PM Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI).

[T/RBHA insert information regarding how a person can file an appeal regarding a T/RBHA Formulary change or other decisions that affect coverage of medications.]

Behavioral health recipients 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. However, benzodiazepines and barbiturates are excluded under Medicare Part D and will continue to be covered through ADHS/DBHS. 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 must attempt to obtain an exception for the medication or assist the recipient in submitting an appeal with the health plan. T/RBHAs will cover medications for Non-Title XIX/XXI persons determined to have SMI when their third party insurer will not grant an exception for a medication that is a medication on the ADHS/DBHS Non-Title XIX/XXI Medication Formulary. When Non-Title XIX/XXI persons determined to have SMI, who have Medicare or private insurance, are assessed a co-payment for medications, providers must determine the applicable co-payment for the person in accordance with Provider Manual Section 3.4, Co-payments, and Provider Manual Section 3.5, Third Party Liability and Coordination of Benefits.

[T/RBHA insert specific information here.]

3.16.7-B. Prior authorization

T/RBHAs must obtain approval in writing from the ADHS/DBHS Chief Medical Officer or designee prior to implementing prior authorization protocols for any medication included on the ADHS/DBHS Title XIX/XXI Medication Formulary, including dosage and dispensing restrictions. T/RBHAs must also obtain approval in writing from the ADHS/DBHS Chief Medical Officer or designee prior to implementing prior authorization protocols for any medication included on the ADHS/DBHS Non-Title XIX/XXI Medication Formulary. If a T/RBHA or behavioral health provider requires prior authorization for medications, the requirements outlined in Section 3.14, Securing Services and Prior Authorization, Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons, and Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI, Non-TXIX/TXXI), must be met (see Section 3.14 Securing Services and Prior Authorization subsection 3.14.7-E).

Prior authorization criteria of medications prescribed for Non-Title XIX/XXI persons determined to have SMI

Non-Title XIX persons determined to have SMI are eligible to receive the medication-only benefit package (see Section 3.21, Service Package for Non-Title XIX/XXI Persons determined to have a Serious Mental Illness (SMI), which includes coverage of medications listed on the ADHS/DBHS Non-Title XIX/XXI Medication Formulary. After July 1, 2010, any non-TXTX/XXI enrolled persons determined to have SMI who are prescribed brand name atypical antipsychotic

medications which are not included on the ADHS/DBHS Non-Title XIX/XXI Medication Formulary must be transitioned to a generic alternative or an alternative funding source, RBHAs must use their established prior authorization processes to receive, review and respond to requests for time-limited coverage for atypical antipsychotic medication(s) including:

- Documentation by the prescribing medical professional of the clinical/safety concerns related to abrupt discontinuation of the medication;
- Documentation by the prescribing medical professional of a clear plan for how the member will be transitioned to an alternative generic antipsychotic medication(s) or alternative funding source;
- Issuance of required notices in the event of denying coverage of this limited benefit in accordance with Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI, Non-TXIX/TXXI); and
- Approval of such requests by the RBHA in 30 day increments, not to exceed 90 days of coverage within a 12 month period per individual per medication.

RBHAs must also utilize their established prior authorization processes for Non-Title XIX/XXI persons determined SMI who are prescribed Risperidal Consta, consistent with the following requirements:

- The member must have a diagnosis of schizophrenia or a schizophrenia spectrum disorder.
- The member must be at least 18 years old.
- The member must be able to tolerate at least 2mg/day of oral risperidone.
- The member must have a documented history of poor adherence to oral risperidone and documentation that patient education and other efforts to improve adherence have been tried (e.g. pill boxes).
- The prescribing medical professional must taper and discontinue oral risperidone within 60 days after Risperidal Consta is initiated.
- Target symptoms must be clearly documented and tracked over time in the psychiatric progress notes and assessments.

Prior authorization of Risperidal Consta may be approved for up to one year, but requires re-authorization annually and re-authorization must consider clinical indication and documented benefit. Authorization criteria for Risperidal Consta must minimally be approved for no less than 30 days.

If a T/RBHA wishes to establish any additional prior authorization criteria for medications on the ADHS/DBHS Non-Title XIX/XXI Medication Formulary, they must be for the purposes of ensuring clinical appropriateness of prescribing practices (e.g. intra-class polypharmacy and dosages above the FDA recommendation). All prior authorization policies and criteria must be approved by ADHS/DBHS in advance of implementation.

[T/RBHA insert the following information here: Identify all pharmacy practices subject to prior authorization, including any medications not on the T/RBHA formulary. Provide a detailed description of the process to get prior authorization for a medication.]

3.16.7-C. How can the Behavioral Health Providers have input?

Behavioral health providers can offer suggestions for adding or deleting medications to the ADHS/DBHS Title XIX/XXI Medication Formulary, ADHS/DBHS Non-Title XIX/XXI Formulary or their contracted T/RBHA's Medication Formulary.

Changes to the ADHS/DBHS Medication Formularies

To propose additions or deletions to the ADHS/DBHS Title XIX/XXI Medication Formulary or ADHS/DBHS Non-Title XIX/XXI Medication Formulary, a behavioral health medical practitioner shall submit a written request to the T/RBHA Chief Medical Officer or designee:

Chief Medical Officer
[T/RBHA, insert contact information here.]

Additions:
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.

Deletions:
A detailed summary of the reason for requesting the deletion.

The T/RBHA Chief Medical Officer or designee will present requests, as determined appropriate, to the ADHS/DBHS Chief Medical Officer or designee for a final determination.

[T/RBHA insert specific information here regarding requests and changes to the T/RBHA Medication Formulary.]

Section 3.16 Medication List

3.16.1 Introduction
3.16.2 References
3.16.3 Scope
3.16.4 Did you know…?
3.16.5 Definitions
3.16.6 Objectives
3.16.7 Procedures
3.16.7-A. How is the Medication List used to access medications?
3.16.7-B. Prior authorization
3.16.7-C. How can the Behavioral Health Providers have input?

3.16.1 Introduction

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) maintains an approved list of medications, referred to as the ADHS/DBHS Medication List, that must be included in the Tribal and Regional Behavioral Health Authorities' (T/RBHAs') formularies. The ADHS/DBHS Medication List ensures the availability of safe, cost-effective and efficacious medications for eligible service recipients. ADHS/DBHS 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 behavioral health recipients, including persons who are dually eligible for Medicare (Title XVIII) and Medicaid (Title XIX/XXI), receive Medicare Part D prescription drug benefits through Medicare Prescription Drug Plans (PDPs) or Medicare Advantage Prescription Drug Plans (MA-PDs). **[T/RBHA insert information here indicating whether the T/RBHA is part of any Medicare Advantage plans' networks to provide the Medicare Part D benefit.]** Prescription drug coverage for Medicare eligible behavioral health recipients enrolled in Part D is based on Part D plans' formularies. There may be an occasion when a behavioral health recipient's prescribed drug is not available through his/her Part D plan's formulary. This is considered a non-covered Part D drug. T/RBHAs and/or behavioral health 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.

3.16.2 References

The following citations can serve as additional resources for this content area:
42 CFR 400.202
42 CFR 422.2
42 CFR 422.106
42 CFR 423.100
42 CFR 423.120
42 CFR 423.4
42 CFR 423.34
42 CFR 423.272
42 CFR 423.462
42 CFR 423.464
42 CFR 423.505

A.R.S. 32-1901
R9-21-207
R9-22-209
R9-31-209
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/IGAs T/RBHA
ADHS/DBHS Covered Behavioral Health Services Guide
ADHS/DBHS Medication List
T/RBHA Medication Formulary
Section 3.14, Securing Services and Prior Authorization
Section 3.15, Psychotropic Medications: Prescribing and Monitoring
Section 3.25, Crisis Intervention Services
Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons
Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)
Medicare Modernization Act Final Guidelines - Formularies
Part D Voluntary Prescription Drug Benefit Program - Benefits and Costs for People With Medicare
Prescription Drug Benefit Manual - CMS

3.16.3 Scope

To whom does this apply?
This section is only applicable to behavioral health providers contracted with a Tribal or Regional Behavioral Health Authority (T/RBHA). ADHS/DBHS covers medications for the following:

- Title XIX and Title XXI eligible persons;
- Dual eligible persons who are prescribed medications covered through Medicaid (medications covered through Medicare Part D are billed to Medicare plans);
- Non-Title XIX/XXI persons determined to have Serious Mental Illness (SMI); and
- Non-Title XIX/XXI persons presenting with a behavioral health crisis in the community.

3.16.4 Did you know…?

- At a minimum, the T/RBHA's formulary must include all medications on the ADHS/DBHS Medication List; however, T/RBHAs may choose to add medications to their comprehensive formulary, if desired.
- Updated versions of the ADHS/DBHS Medication List are posted on the ADHS/DBHS website. Updated information concerning covered medical testing services is also posted on the ADHS/DBHS website as part of the ADHS/DBHS Covered Behavioral Health Services Guide.

- Each Medicare Prescription Drug Plan (PDP) and Medicare Advantage plan (MA-PD or MA-PD/Special Needs Plan) establishes its own formulary. Formularies are based on the *Medicare Modernization Act Final Guidelines - Formularies* issued by the Centers for Medicare and Medicaid Services (CMS). Each Part D plan's formulary can be reviewed through http://www.medicare.gov/. Benzodiazepines and barbiturates are excluded under Medicare Part D and will continue to be covered through ADHS/DBHS.

3.16.5 Definitions

ADHS/DBHS Medication List

Behavioral Health Medical Practitioner

Depo-medications

Dual eligible

Medicare Advantage Prescription Drug Plan (MA-PD)

Prescription Drug Plan (PDP)

Prior Authorization

Schizophrenic Spectrum Disorder

Third Party Liability

T/RBHA Formulary

3.16.6 Objectives

To provide persons access to safe, cost-effective and efficacious medications.

3.16.7 Procedures

3.16.7-A. How is the Medication List used to access medications?

To ensure coverage of medications through the T/RBHA, providers must utilize the ADHS/DBHS Medication List and T/RBHA Medication Formulary.

[T/RBHA insert specific information here (e.g. where providers can find the T/RBHA medication formulary – insert a direct link to the medication formulary.)]

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 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons. Non-Title XXI/XXI persons determined SMI have the right to notice and appeal when a decision affects medication coverage, in accordance with PM Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI).

[T/RBHA insert information regarding how a person can file an appeal regarding a T/RBHA Formulary change or other decisions that affect coverage of medications.]

Behavioral health recipients 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. However, benzodiazepines and barbiturates are excluded under Medicare Part D and will continue to be covered through ADHS/DBHS. 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 must attempt to obtain an exception for the medication or assist the recipient in submitting an appeal with the health plan. T/RBHAs will cover medications for persons determined to have 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 ADHS/DBHS Medication List.

Applicable co-payments must only be collected in accordance with Provider Manual Section 3.4, Co-payments. For persons with coverage from third party payors, co-payments are collected in accordance with Provider Manual Section 3.5, Third Party Liability and Coordination of Benefits.

[T/RBHA insert specific information here.]

3.16.7-B. Prior authorization

ADHS/DBHS requires the RBHAs to prior authorize coverage of Abilify (aripiprazole). See Provider Manual Attachment 3.16.1.

For all other medications on the ADHS/DBHS Medication List, RBHAs must obtain approval in writing from the ADHS/DBHS Chief Medical Officer or designee prior to implementing prior authorization protocols, including dosage and dispensing restrictions. If a RBHA or behavioral health provider requires prior authorization for medications, the requirements outlined in Section 3.14, Securing Services and Prior Authorization, Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons, and Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI, Non-TXIX/TXXI), must be met.

[RBHA insert the following information here: Identify all pharmacy practices subject to prior authorization, including any medications not on the RBHA formulary. Provide a detailed description of the process to get prior authorization for a medication.]

3.16.7-C. How can the Behavioral Health Providers have input?

Behavioral health providers can offer suggestions for adding or deleting medications to the ADHS/DBHS Medication List or their contracted T/RBHA's Medication Formulary.

Changes to the ADHS/DBHS Medication List

To propose additions or deletions to the ADHS/DBHS Medication List, a behavioral health medical practitioner shall submit a written request to the T/RBHA Chief Medical Officer or designee:

Chief Medical Officer
[T/RBHA, insert contact information here.]

Additions:
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.

Deletions:
A detailed summary of the reason for requesting the deletion.

The T/RBHA Chief Medical Officer or designee will present requests, as determined appropriate, to the ADHS/DBHS Chief Medical Officer or designee for a final determination.

[T/RBHA insert specific information here regarding requests and changes to the T/RBHA Medication Formulary.]

Section 3.17 Transition of Persons

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3.17.1 Introduction

Persons receiving behavioral health services in the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) 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), transitioning into adulthood, and moving out of the T/RBHA's geographic service area. During transitions of care, behavioral health providers must ensure that services are not interrupted and that the person continues to receive needed behavioral health services. Coordination and continuity of care during transitions are essential in maintaining a person's stability and avoiding relapse or decompensation in functioning.

The intent of this section is to:

- Identify the situations that require a transition of care;
- Describe expectations for providers when initiating or accepting a transition of care for an enrolled person; and
- Identify resources to assist behavioral health providers in supporting a person who is experiencing a transition of care.

3.17.2 References

The following citations can serve as additional resources for this content area:
A.R.S. § 36, Chapter 5
9 A.A.C. 21, Article 5
AHCCCS/ADHS Contract
ADHS/RBHA Contract
ADHS/TRBHA IGAs
Section 3.2, Appointment Standards and Timeliness of Services
Section 3.3, Intake and Referral Process
Section 3.4, Co-payments
Section 3.8, Outreach, Engagement, Re-Engagement and Closure

Section 3.10, SMI Eligibility Determination
Section 3.18, Pre-petition Screening, Court Ordered Evaluation and Treatment
Section 3.21, Service Prioritization for Non-Title XIX/XXI Funding
Section 4.1, Disclosure of Behavioral Health Information
Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)
Section 7.5, Enrollment, Disenrollment and other Data Submission
Practice Protocol, Transition to Adulthood

3.17.3 Scope

To whom does this apply?

All persons, regardless of funding source or behavioral health category, currently enrolled with a T/RBHA and experiencing a transition of care.

3.17.4 Did you know…?

Some persons may experience a transition of payers, but not actually change providers. This could happen for example, when a Title XIX behavioral health recipient moves from an Arizona Health Care Cost Containment System (AHCCCS) acute care Health Plan to the ALTCS program. Many ALTCS Program Contractors for the elderly and physically disabled (ALTCS/EPD) contract with the same behavioral health providers as the T/RBHAs. This kind of transition, where fiscal responsibility changes but not the provider, may be transparent to the person receiving services but could result in administrative changes for the provider (e.g., submitting claims or bills to the ALTCS Program Contractor versus submitting an encounter as a T/RBHA provider).

The ALTCS program is considered a "carve-in model," a service delivery model that assigns coverage of medical and behavioral health services through a single entity (i.e., Program Contractor). An exception to this "carve-in model" is the delivery of covered behavioral health services for persons eligible for ALTCS through the Division of Developmental Disabilities (DDD). ALTCS/DDD eligible persons receive covered behavioral health services through the T/RBHAs and their subcontracted behavioral health providers.

Accurate diagnosis of a co-occurring serious mental illness can be difficult when the person has been diagnosed with a developmental disability, which includes Autism and Cognitive Disability. Psychiatric symptoms are often inaccurately attributed to a person's developmental disability rather than a serious mental illness. All diagnoses that can be made of persons of normal intelligence can also be made in a person with a developmental disability. The Diagnostic Manual: Intellectual Disabilities (DM: ID), published in 2008, may be a useful resource in the diagnosis of mental illness in a person with a developmental disability

3.17.5 Definitions

Behavioral Health Category Assignment

Designated T/RBHA

Home T/RBHA

Independent Living Setting

Institution for Mental Disease (IMD)

Out-of-area service

Residence

Serious Mental Illness (SMI)

Transfer

3.17.6 Objectives

To ensure the coordination and continuity of care for all behavioral health recipients experiencing a transition in service providers.

3.17.7 Procedures

3.17.7-A. Transition from child to adult services

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

A transition plan that starts with an assessment of self-care and independent living skills, social skills, work and education plans, earning potential and psychiatric stability must be incorporated in the child's individual service plan (ISP).

What elements should be addressed as part of the child's transition plan?
Not all children transfer to the adult Serious Mental Illness (SMI) or General Mental Health/Substance Abuse (GMH/SA) system, but for children who do, providers must ensure a smooth transition. In order to accomplish a smooth transition, providers must develop a clear and explicit process and procedure that will ensure and support the delivery of children's and adult services during the transition period. Providers must ensure that adult system staff attend and are a part of the Child and Family Team (CFT) (during the four to six months prior to the child turning 18) in order to provide information and be part of the service planning, development and coordination effort that needs to take place so the individualized needs of that child can be met on the day they turn 18 years of age.

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

- Identifying the child's behavioral health needs into adulthood.
- Identifying personal strengths that will assist the child when he/she transitions to the adult system.
- Identifying staff that will coordinate services after the child reaches age 18, including any changes in the behavioral health provider, clinical team, guardian or family involvement.
- Identifying and collaborating with other involved state agencies and stakeholders to jointly establish a behavioral health service plan and prevent duplication of services.
- Establishing how the transition will be implemented.

- Planning for where the child will reside upon turning 18 and how he/she will support him/herself. If an SMI eligibility determination is made, consider initiating a referral for housing, if needed.

- Identifying the need for referrals to and assistance with applications for Supplemental Security Income (SSI), Rehabilitation Services Administration (RSA), SMI eligibility determination, Title XIX and Title XXI eligibility, housing, guardianship, training programs, etc. In addition, the team and/or behavioral health provider should assist in gathering necessary information to expedite these applications/determinations when the time comes to actually apply, including obtaining medical and school records to substantiate these needs. The team and/or behavioral health provider begin to develop a timeline and task list for when appointments are needed.

- Identifying the need for transportation to appointments and other necessary activities.

- Identifying special needs that the child may have and/or whether or not the child will require special assistance services.

- Identifying whether the child has appropriate life skills, social skills and employment or education plans.

- Taking necessary action if the child is not eligible for Title XIX or Title XXI benefits and/or Social Security Disability Income (SSDI) and is not determined to have a SMI. Identifying supports needed to be in place for a successful transition.

- Following guidelines established in ADHS/DBHS Clinical and Recovery Practice Protocol, Transition to Adulthood.

- Meeting the provisions of the JK Settlement Agreement[1] and the Arizona 12 Principles.

The services that have been planned, developed and provided for the child can continue to be provided after the child has turned 18 years of age, assuming that continuation of these services is the choice of the young person when he/she reached the age of majority. Providers shall properly encounter and receive payment for the provision of services of staff involved, including adult system staff, according to T/RBHA procedures included in Section 10.0, T/RBHA Specific Requirements (see http://www.azdhs.gov/bhs/provider/index.htm for a listing of T/RBHA provider manuals) **[T/RBHA, insert link(s) here to applicable policies]**.

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

[1] The JK Settlement Agreement defines its "Class members" as: all persons, under the age of twenty-one, who are eligible for Title XIX behavioral health services in the State of Arizona and have been identified as needing behavioral health services.

What needs to happen during the year before the child transitions to adult services?
When a child receiving behavioral health services reaches the age of 17, behavioral health providers must determine whether the child is potentially eligible for services as an adult with a Serious Mental Illness. If so, behavioral health providers must refer the child for an SMI eligibility determination pursuant to Section 3.10, SMI Eligibility Determination.

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

- Assist the child and/or family or guardian in applying for potential benefits (e.g., SSI, food stamps, etc.);
- Assist the child and/or family in applying for Title XIX or Title XXI benefits; if the child and/or family is already eligible, determine if eligibility will continue for the child once he/she turns 18;
- Address any new authorization requirements for sharing protected health information due to the child turning 18 (as described in Section 4.1, Disclosure of Behavioral Health Information) to ensure that the clinical team can continue to share information;
- Ensure that the child's behavioral health category assignment is changed consistent with Section 7.5, 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; and
- 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 or Title XXI services, behavioral health providers can continue to provide behavioral health services consistent with Section 3.21, Service Prioritization for Non-Title XIX/XXI Funding and Section 3.4, Co-payments.

3.17.7-B. Transition due to a change of the Behavioral Health Provider or the behavioral health category assignment

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

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

[T/RBHA insert specific information here]

3.17.7-C. 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 behavioral health services through T/RBHAs and their contracted providers.

Once a person is determined eligible and becomes enrolled with the Arizona Long Term Care Services/Elderly or Physically Disabled (ALTCS/EPD) Program, behavioral health providers must not submit claims or encounters for Title XIX covered services to the T/RBHA. To determine if a person is ALTCS/EPD eligible, **[RBHA insert contact information where providers call to find out if a person is ALTCS/EPD eligible]**. The behavioral health provider must, however, continue to provide and encounter needed non-Title XIX covered SMI services (e.g. housing) to persons determined to have a Serious Mental Illness.

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

When a person who has been receiving behavioral health services through the T/RBHA becomes enrolled in the ALTCS Program, the behavioral health provider must:

- 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 behavioral health services shifts to the ALTCS Program Contractor;
- Provide information to the ALTCS Program Contractor regarding the person's on-going needs for behavioral health services to 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 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 (July 1 – June 30);
  - For all persons, the number of hours of respite received in the contract year (July 1 – June 30); and
  - Whether there is a signed authorization for the release of information contained in the comprehensive behavioral health record pursuant to Section 4.1, Disclosure of Behavioral Health Information.

3.17.7-D Inter-T/RBHA Transfer

How is T/RBHA responsibility determined for adults?

For adults (persons 18 years and older), T/RBHA responsibility is determined by the adult person's current place of residence, except in the following situation:

- Persons who are unable to live independently must not be transferred to another T/RBHA with the exception of persons who are unable to live independently but are involved with DDD. However, T/RBHAs may agree to coordinate an Inter-T/RBHA transfer for individuals unable to live independently on a case-by-case basis. Persons involved with DDD who reside in a supervised setting are the responsibility of the T/RBHA in which the supervised setting is located. This is true regardless of where the adult guardian lives. When an ALTCS/DDD member is placed temporarily in a group home while a permanent placement is being developed in the home T/RBHA service area, covered services remain the responsibility of the home T/RBHA.

How is T/RBHA responsibility determined for children?

For children (ages 0-17 years), T/RBHA responsibility is determined by the current place of residence of the child's parent(s) or legal guardian; and

For children who have been adjudicated as dependent by a court, the location of the child's court of jurisdiction determines which T/RBHA has responsibility.

How is T/RBHA responsibility determined for persons who are temporarily residing in another T/RBHA's geographic service area (GSA)?

The home T/RBHA remains fiscally responsible for all services provided to an enrolled person who is visiting or otherwise temporarily residing in a different T/RBHA's geographic service area (GSA) as long as the person, or legal guardian for a child, maintains a place of residence in the home T/RBHA's GSA and intends to return. If the person, or legal guardian for a child, continues to reside in the new location after 3 months, the provider or T/RBHA may proceed with an Inter-T/RBHA transfer if the person, or legal guardian for a child, is consulted and agrees to the change. Only persons who are able to live independently, with the exception of persons who are unable to live independently but are involved with DDD, can be transferred.

Crisis services must be provided without regard to the person's enrollment status. When a person presents for crisis services, the T/RBHA or their contracted providers must:

- Provide needed crisis services;
- Ascertain the person's enrollment status with all T/RBHAs and determine whether the person's residence in the current area is temporary or permanent.
- If the person is enrolled with another T/RBHA, notify the home T/RBHA within 24 hours of the person's presentation. The home T/RBHA or their contracted providers is fiscally responsible for crisis services and must: Make arrangements with the T/RBHA at which the person presents to provide needed services, funded by the home T/RBHA;
- Arrange transportation to return the person to the home T/RBHA area; or
- Determine if the person intends to live in the new T/RBHA'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 T/RBHA must make arrangements for housing and consider this a temporary placement for three months. After three months, if the person continues to clearly express an intent/desire to remain in this new service area, the inter-T/RBHA transfer can proceed.

If the person is not enrolled with any T/RBHA and lives within the service area of the T/RBHA in which the person presented for services, behavioral health providers must notify the T/RBHA to initiate an enrollment. **[T/RBHA insert specific information here]**

If the person is not enrolled with any T/RBHA and lives outside of the service area of the T/RBHA at which the person presented for crisis services, the T/RBHA must enroll the person, provide needed crisis services and initiate the inter-T/RBHA transfer. If the person is not enrolled with a T/RBHA, 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 T/RBHA or their contracted providers must notify the designated T/RBHA associated with the person's residence within 24 hours of the person's presentation. The designated T/RBHA must proceed with the person's enrollment if the person is determined eligible for services. The designated T/RBHA is fiscally responsible for the provision of all medically necessary covered services, including transportation services, for eligible persons.

What if a T/RBHA or provider receives a referral for a hospitalized person?
In the event that a T/RBHA or provider receives a referral regarding a hospitalized person whose residence is located outside the T/RBHA's geographic service area, the T/RBHA or provider must immediately coordinate the referral with the person's designated T/RBHA.

When is an Inter-T/RBHA Transfer required?
An Inter-T/RBHA transfer must be completed under the following circumstances:

- An adult person voluntarily elects to change his/her place of residence to an independent living setting from one T/RBHA's area to another. Only adult persons who are able to live independently can be transferred to another T/RBHA, with the exception of persons who are unable to live independently but are involved with DDD. Adult persons involved with DDD who reside in a supervised setting are the responsibility of the T/RBHA in which the supervised setting is located;

- DDD transfers an adult person who is unable to live independently, but involved with DDD, to another placement;

- The parent(s) or legal guardian(s) of a child change their place of residence to another T/RBHA's area; or

- The court of jurisdiction of a dependent child changes to another T/RBHA's area.

Inter-T/RBHA transfers are not to be initiated when a person is under pre-petition screening or court ordered evaluation (see Section 3.18, Pre-petition Screening, Court Ordered Evaluation and Court Ordered Treatment).

What are the timeframes for initiating an Inter-T/RBHA transfer?
The home T/RBHA or its contracted 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.

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

- Schedule a meeting to establish a transition plan for the person. The meeting must include:
  - The person or the person's guardian or parent, if applicable;
  - Representatives from the home T/RBHA;
  - Representatives from the Arizona State Hospital (AzSH), when applicable
  - The behavioral health provider and representatives of the CFT/adult clinical team;
  - Other involved agencies; and
  - Any other relevant participant at the person's request or with the consent of the person's guardian.
- Establish a transition plan that includes at least the following:
  - The person's projected moving date and place of residence;
  - Treatment and support services needed by the person and the timeframe within which the services are needed;
  - A determination of the need to request a change of venue for court ordered treatment and who is responsible for making the request to the court, if applicable;
  - Information to be provided to the person regarding how to access services immediately upon relocation;
  - The enrollment date, time and place at the receiving T/RBHA and the formal date of transfer, if different from the enrollment date;
  - The date and location of the person's first service appointment in the receiving T/RBHA's GSA;
  - The individual responsible for coordinating any needed change of health plan enrollment, primary care provider assignment and medication coverage;
  - The person's behavioral health provider in the receiving T/RBHA's GSA, including information on how to contact the behavioral health provider;

- Identification of the person at the receiving T/RBHA who is responsible for coordination of the transfer, if other than the person's behavioral health provider;

- Identification of any special authorization required for any recommended service (e.g., non-formulary medications) and the individual who is responsible for obtaining needed authorizations; and,

- If the person is taking medications prescribed for 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.

Who is responsible for initiating an Inter-T/RBHA transfer?
[T/RBHA insert specific information here – who is responsible for this?]

What are the Behavioral Health Provider's responsibilities during an Inter-T/RBHA transfer?
As part of an Inter-T/RBHA transfer, the behavioral health provider must:

- 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 behavioral health services to 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 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 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 July 1 – June 30);

  - For all persons, the number of hours of respite received in the contract year July 1 - June 30); and

  - Any signed authorizations for the release of information contained in the person's comprehensive clinical record pursuant to Section 4.1, Disclosure of Behavioral Health Information.

What are the timeframes for completing an Inter-T/RBHA transfer?
When an Inter-T/RBHA transfer occurs, the person must be disenrolled from the home T/RBHA and enrolled in the receiving T/RBHA contingent upon the date the person expects to relocate to the receiving T/RBHA's geographic service area, but no later than 30 days of the referral by the home T/RBHA (see Section 7.5, Enrollment, Disenrollment and Other Data Submission). This timeframe allows sufficient time for the receiving T/RBHA to arrange for services and plan the

person's transition. If the person is not located or does not show up for his/her appointment on the date arranged by the T/RBHAs to transfer the person, the T/RBHAs must collaborate to ensure appropriate re-engagement activities occur (see Section 3.8, Outreach, Engagement, Re-Engagement and Closure) and proceed with the inter-T/RBHA transfer, if appropriate. **[T/RBHA, insert additional information here.]**

Who is responsible for care during an Inter-T/RBHA transfer?
In an Inter-T/RBHA transfer, the home T/RBHA and its contracted providers retain responsibility for service provision and coordination of care until such time as a person's record is closed for that T/RBHA (see Section 3.8, Outreach, Engagement, Re-engagement and Closure). The receiving T/RBHA must not delay the timely processing of an Inter-T/RBHA transfer because of missing or incomplete information.

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 or its contracted providers while the person is traveling outside of the home T/RBHA area. All incidents of provision of courtesy dosing shall be reported to the home T/RBHA. The home T/RBHA shall reimburse the behavioral health provider providing the courtesy doses upon receipt of properly submitted bills or encounters.

Appeals for Out-of-Area Service Provision
Persons determined to have a Serious Mental Illness who are the subject of a request for out-of-area service provision or Inter-T/RBHA transfer may file an appeal in accordance with Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI).

Inter-T/RBHA transfers after crisis enrollments
When a person presents for crisis services, providers must first deliver needed behavioral health services and then determine eligibility and T/RBHA enrollment status. Persons enrolled after a crisis event may not need or want ongoing behavioral health services through the T/RBHA. Providers must conduct re-engagement efforts as described in PM Section 3.8, Outreach, Engagement, Re-engagement and Closure, however; persons who no longer want or need ongoing behavioral health services must be disenrolled (i.e., closed in the Client Information System) 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 and an inter-T/RBHA transfer initiated, if the person presented for crisis services in a GSA other than where the person resides.

Inter-T/RBHA transfers when persons do not inform the home T/RBHA of a move to another geographic service area (GSA)
Timeframes specified in subsection 3.17.7-D cover circumstances when behavioral health recipients inform their provider or T/RBHA prior to moving to another service area. When behavioral health recipients inform their provider or T/RBHA less than 30 days prior to their move or do not inform their provider or T/RBHA of their move, the designated T/RBHA must not wait for all of the documentation from the previous T/RBHA before scheduling services for the behavioral health recipient. **[T/RBHA, insert additional information here.]**

3.17.7-E. Transitions of persons receiving court ordered services

This section pertains to court ordered treatment under A.R.S. § 36, Chapter 5 (see Section 3.18, Pre-petition Screening, Court Ordered Evaluation and Treatment). A person ordered by the court to undergo treatment and who is without a guardian may be transferred from one behavioral health provider to another behavioral health provider, as long as the medical director of the behavioral health provider initiating the transfer has established that:

- 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 behavioral health provider has accepted the person for transition.
- The medical director of the behavioral health 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 behavioral health provider as necessary.
- The medical director of the behavioral health provider requesting the transition must provide notification to the receiving behavioral health provider allowing sufficient time (but no less than 3 days) for the transition to be coordinated between the behavioral health 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 behavioral health 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; and
  - A written compilation of the person's treatment needs and suggestions for future treatment by the medical director of the transitioning behavioral health provider to the medical director of the receiving behavioral health provider. The medical director of the receiving behavioral health provider must accept this compilation before the transition can occur.
  - Transportation from the initiating behavioral health provider to the receiving behavioral health provider is the responsibility of the initiating behavioral health provider.

3.17.7-F. Transitions 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 behavioral health recipients being discharged from inpatient settings. Furthermore, re-engagement activities must occur for persons who are discharged from inpatient settings in accordance with Section 3.8, Outreach, Engagement, Re-engagement and Closure. If a behavioral health recipient will be moving to a GSA other than

where he/she has been receiving inpatient treatment services, coordination must occur between T/RBHAs, if applicable, to ensure appropriate services/placement and necessary re-engagement activities occur upon discharge. **[T/RBHA, insert additional information here for requirements for providers to establish appropriate treatment/placement for persons transitioning out of an inpatient level of care.]**

3.17.7-G. Transitions of persons receiving behavioral health services from Indian Health Services (IHS)

American Indian persons may choose to receive behavioral health services through a RBHA, TRBHA or at an IHS or 638 tribal provider. T/RBHA providers must respond to referrals in accordance with Section 3.3, Referral and Intake, and ensure necessary coordination of care occurs. **[T/RBHA, insert contact information here for the T/RBHA Tribal Liaison or other person who can address provider questions regarding services to American Indian persons.]**

Section 3.18 Pre-Petition Screening, Court-Ordered Evaluation, and Court-Ordered Treatment

3.18.1 Introduction
3.18.2 References
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3.18.7-A. Licensing Requirements
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3.18.7-E. Court-Ordered Treatment for persons charged with, or convicted of, a crime
3.18.7-F. Court-Ordered Treatment for American Indian Tribal Members in Arizona

3.18.1 Introduction

This policy is applicable to behavioral health providers under contract with a Regional Behavioral Health Authority (RBHA) and/or a Tribal Regional Behavioral Health Authority (TRBHA).

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 subsection 3.18.7-F.

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; 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 contracted agencies responsible for pre-petition screening and court-ordered evaluations must use the following forms prescribed in 9 A.A.C. 21, Article 5 for persons determined to have a Serious Mental Illness:

- ADHS/DBHS Form MH-100, Application for Involuntary Evaluation;
- ADHS/DBHS Form MH-103, Application for Voluntary Evaluation;
- ADHS/DBHS Form MH-104, Application for Emergency Admission for Evaluation;
- ADHS/DBHS Form MH-105, Petition for Court-Ordered Evaluation;
- ADHS/DBHS Form MH-110, Petition for Court-Ordered Treatment; and
- ADHS/DBHS Form MH-112, Affidavit, Addendum No. 1 and Addendum No. 2.

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." RBHAs and RBHA providers responsibilities for the provision and coverage of those services, is described in subsection 3.18.7-E.

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 behavioral health 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. RBHAs will provide explicit expectations for behavioral health providers regarding this content area within subsection 3.18.7.

3.18.2 References

The following citations can serve as additional resources for this content area:

A.R.S. § 12-136
A.R.S. § 13-3601.01
A.R.S. Title 14, Chapter 5
A.R.S. Title 36, Chapter 5
A.R.S. § 36-2005
A.R.S. § 36-2027
A.A.C. R9-20-802
A.A.C. R9-20-803
9 A.A.C. 21, Article 5
AHCCCS Contractor Operations Manual, Policy 423
ADHS/RBHA Contracts
Section 3.4, Co-payments
Section 3.9, Assessment and Service Planning
Section 3.10, SMI Eligibility Determination
Section 3.11, General and Informed Consent to Treatment
Section 3.17, Transition of Persons
Section 3.21, Service Package For Non-Title XIX/XXI Persons Determined to Have a Serious Mental Illness (SMI)
Section 4.2, Behavioral Health Medical Record Standards
TAD 5, Information Sharing with Family Members of Adult Behavioral Health Recipients
ADHS/DBHS Tribal Court Procedures for Involuntary Commitment webpage

3.18.3 Scope

To whom does this apply?

All persons who are unwilling or unable to seek behavioral health treatment, who may be DTS, DTO, PAD, or GD due to a mental disorder, and who may require pre-petition screening, court-ordered evaluation, and/or court-ordered treatment.

3.18.4 Did you know…?

- Arizona Counties are responsible for managing, providing, and paying for pre-petition screening and court-ordered evaluations and are required to coordinate provision of behavioral health services with the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) system. Some counties contract with RBHAs to process pre-petition screenings and petitions for court-ordered evaluations.

- Arizona law provides for the recognition and enforcement or "domestication" of tribal court orders for involuntary commitment to treatment, including admission to the Arizona State Hospital (AZSH) for American Indians residing on tribal reservations. The Arizona statute (see A.R.S. § 12-136) is necessary, as Tribal governments are sovereign and have sole jurisdiction over Tribal members on reservations. Legal, jurisdictional, and continuity of care issues exist related to the coordination of tribal and state courts ordering treatment for American Indians.

- American Indians living off of or experiencing a crisis off of the Tribal reservation are subject to county jurisdiction and can be court ordered under state law (see A.R.S. Title 36, Chapter 5).

- Arizona Health Care Cost Containment System/ Arizona Long Term Care Services (AHCCCS/ALTCS) Program Contractors are responsible for providing and funding services under court-ordered treatment of elderly and physically disabled (EPD) ALTCS-enrolled persons.

- Upon determination that a person is gravely disabled, the person must be recommended for appointment of a guardian and/or conservator if one is not already assigned to the person.

- A person found to be gravely disabled and who is undergoing court-ordered treatment receives an annual examination and review to determine whether the continuation of court-ordered treatment is appropriate.

- A person found to be persistently or acutely disabled and who is undergoing court-ordered treatment shall have an annual examination and review to determine whether the continuation of court-ordered treatment is appropriate.

- The medical director shall review the condition of a patient on conditional outpatient treatment at least once every thirty days and enter the findings in writing in the patient's medical record.

- The medical director of the agency providing court-ordered treatment must inform persons of their right to judicial review and their right to consult with counsel at least once each sixty days while undergoing court-ordered treatment. This notification must be recorded in the clinical record of the person by the individual who gave the notice.

  If the medical director rescinds an order for conditional outpatient treatment and the patient is returned to a mental health treatment agency for inpatient treatment, the patient shall be informed of the patient's right to judicial review and right to consult with counsel.

3.18.5 Definitions

American Indian Tribal Member

Court-Ordered Evaluation

Danger to Self (DTS)

Danger to Others (DTO)

Domestication or Recognition of Tribal Court Order

Gravely Disabled (GD)

Mental Disorder

Persistently or Acutely Disabled (PAD)

Pre-petition Screening

Tribal sovereignty in the United States

3.18.6 Objectives

To inform behavioral health providers of the pre-petitioning screening, court-ordered evaluation, and court-ordered treatment process for persons who are unable or unwilling to seek behavioral health treatment and, due to a mental disorder, may be DTS, DTO, PAD, or GD.

3.18.7 Procedures

3.18.7-A. Licensing Requirements

Behavioral health providers who are licensed by the Arizona Department of Health Services/Division of Assurance and Licensing Services/Office of Behavioral Health Licensing (OBHL) as a court-ordered evaluation or court-ordered treatment agency must adhere to OBHL requirements.

3.18.7-B. Pre-Petition Screening

Counties may contract with RBHAs for pre-petition screening services, or counties may provide their own pre-petition screening services. Procedures for pre-petition screening are outlined below.

The pre-petition screening includes an examination of the person's mental status and/or other relevant circumstances by a designated screening agency. The designated screening agency must follow these procedures:

- The pre-petition screening agency must offer assistance, if needed, to the applicant in the preparation of the application for court-ordered evaluation (see ADHS/DBHS Form MH-100, Application for Involuntary Evaluation).
- Any behavioral health provider that receives an application for court-ordered evaluation (see ADHS/DBHS Form MH-100, Application for Involuntary Evaluation)

must immediately refer the applicant for pre-petition screening and petitioning for court-ordered evaluation to the RBHA designated pre-petition screening agency or county facility.

[The following actions include requirements for RBHAs contracted to provide pre-petition screening and for RBHAs not contracted to provide pre-petition screening. Both sections may be applicable to RBHAs whose geographic service areas (GSAs) include multiple counties. In the event that only one section applies, please remove the section that does not apply.]

When the RBHA is contracted to provide pre-petition screening services
[RBHA, if applicable, indicate in which counties the RBHA is responsible for pre-petition screening services.]

When the county contracts with a RBHA for pre-petition screening and petitioning for court-ordered evaluation, the RBHA must refer the applicant to a designated pre-petition screening agency. The pre-petition screening agency must follow these procedures:

- Provide pre-petition screening within forty-eight hours excluding weekends and holidays;
- Prepare a report of opinions and conclusions. If pre-petition screening was not possible, the screening agency must report reasons why the screening was not possible, including opinions and conclusions of staff members who attempted to conduct the pre-petition screening;
- Have the medical director or designee of the RBHA review the report if it indicates that there is no reasonable cause to believe the allegations of the applicant for the court-ordered evaluation;
- Prepare a petition for court-ordered evaluation and file the petition if the RBHA determines that the person, due to a mental disorder, including a primary diagnosis of dementia and other cognitive disorders, is DTS, DTO, PAD, or GD. ADHS/DBHS Form MH-105, Petition for Court-Ordered Evaluation documents pertinent information for court-ordered evaluation;
- If the RBHA determines that there is reasonable cause to believe that the person, without immediate hospitalization, is likely to harm himself/herself or others, the RBHA must ensure completion of ADHS/DBHS Form MH-104, Application for Emergency Admission for Evaluation, and take all reasonable steps to procure hospitalization on an emergency basis;
- Contact the county attorney prior to filing a petition if it alleges that a person is DTO; and
- **[RBHA insert additional language here about what procedures the designated pre-petition screening agencies and all other providers must follow].**

When the RBHA is not contracted to provide pre-petition screening services
[RBHAs, if applicable, indicate in which counties the RBHA is not responsible for pre-petition screening services.]
When the county does not contract with a RBHA for pre-petition screening and petitioning for court-ordered evaluation; **[RBHA insert language here regarding specifically where a behavioral health provider would file pre-petition screens and**

court-ordered evaluations if other than the RBHAs contracted, designated pre-petition screening agency.]

3.18.7-C. 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:

[The following actions include requirements for RBHAs contracted to provide court-ordered evaluations and for RBHAs not contracted to provide court-ordered evaluations. Both sections may be applicable to RBHAs whose GSAs include multiple counties. In the event that only one section applies, please remove the section that does not apply.]

When the RBHA is contracted to provide court-ordered evaluations

[RBHA, if applicable, indicate in which counties the RBHA is responsible for court-ordered evaluation services.]

When the county contracts with the RBHA to perform court-ordered evaluations, the RBHA or its subcontracted behavioral health 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 medical director or designee; and
- Title XIX/XXI funds must not be used to reimburse court-ordered evaluation services.

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

[RBHA insert additional language here about what procedures the behavioral health provider must follow.]

Voluntary Evaluation

Any RBHA contracted behavioral health provider that receives an application for voluntary evaluation must immediately refer the person to the facility responsible for voluntary evaluations. **[RBHA insert language here regarding specifically where a behavioral health provider would refer a person for a voluntary evaluation.]**

The RBHA contracted behavioral health provider must follow these procedures:

- The evaluation agency must obtain the individual’s informed consent prior to the evaluation (see ADHS/DBHS Form MH-103, 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;

- For inpatient evaluations, the evaluation agency must complete evaluations in less than seventy-two hours of receiving notice that the person will voluntarily receive an evaluation; and
- **[RBHA insert additional information here].**

If a behavioral health provider conducts a voluntary evaluation service as described in this section, the comprehensive clinical record (see Section 4.2, Behavioral Health Medical Record Standards) must include:

- A copy of the application for voluntary evaluation, ADHS/DBHS Form MH-103, Application for Voluntary Evaluation;
- A completed informed consent form (see Section 3.11, General and Informed Consent to Treatment); and
- A written statement of the person's present medical condition.

When the county does not contract with the RBHA for court-ordered evaluations
[RBHAs, if applicable, indicate which counties the RBHA is not responsible for court-ordered evaluation services.]

[RBHA insert language here to indicate procedures followed when the county is responsible for court-ordered evaluations and voluntary evaluations.]

3.18.7-D. Court-Ordered Treatment following Civil Proceedings under A.R.S. Title 36

Based on the court-ordered evaluation, the evaluating agency may petition for court-ordered treatment. The behavioral health provider must follow these procedures:

- Upon determination that an individual is DTS, DTO, GD, or PAD, and if no alternatives to court-ordered treatment exist, the medical director of the agency that provided the court-ordered evaluation must file a petition for court-ordered treatment (see ADHS/DBHS Form MH-110, Petition for Court-Ordered Treatment);
- Any behavioral health provider filing a petition for court-ordered treatment must do so in consultation with the person's clinical team prior to filing the petition;
- The petition must be accompanied by the affidavits of the two physicians who conducted the examinations during the evaluation period and by the affidavit of the applicant for the evaluation (see ADHS/DBHS Form MH-112, Affidavit and attached addenda);
- 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.

Persons who are Title XIX/XXI eligible and/or determined to have a Serious Mental Illness (SMI).
When a person referred for court-ordered treatment is Title XIX/XXI eligible and/or determined or suspected to have a Serious Mental Illness, the RBHA must:

- Conduct an evaluation to determine if the person has a Serious Mental Illness in accordance with Section 3.10, 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 3.9, Assessment and Service Planning; and Section 3.21, Service Package For Non-Title XIX/XXI Persons Determined to Have a Serious Mental Illness (SMI); and
- Provide necessary court-ordered treatment and other covered behavioral health services in accordance with the person's needs, as determined by the person's clinical team, the behavioral health recipient, family members, and other involved parties(see Section 3.9, Assessment and Service Planning); and
- Perform, either directly or by contract, all treatment required by A.R.S. Title 36, Chapter 5, Article 5 and 9 A.A.C. 21, Article 5.

[RBHA insert specific language here]

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

- The person does not have a court appointed guardian;
- The medical director of the receiving behavioral health provider accepts the transfer; and
- The consent of the court for the transfer is obtained as necessary (see Section 3.17, Transition of Persons, for more details).

[RBHA insert specific language here]

3.18.7-E. Court-Ordered Treatment for persons charged with, or convicted of, a crime

T/RBHAs or T/RBHA providers may be responsible for providing evaluation and/or treatment services when an individual has been ordered by a court due to: 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."

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, the T/RBHA will cover DV services with Title XIX/XXI funds when the person is Title XIX/XXI eligible, the service is medically necessary, required prior authorization is obtained if necessary, and/or the service is provided by an in-network provider. For Non-TXIX/XXI eligible persons court ordered for DV treatment, the individual can be billed for the DV services.

Court ordered substance abuse evaluation and treatment
Substance abuse evaluation and/or treatment (i.e., DUI services) ordered by a court under A.R.S. § 36-2027 is the financial responsibility of the county, city, town or charter

city whose court issued the order for evaluation and/or treatment. Accordingly, if ADHS/DBHS or a T/RBHA receives a claim for such services, the claim will be denied with instructions to the provider to bill the responsible county, city or town.

3.18.7-F. Court-Ordered Treatment for American Indian Tribal Members in Arizona

Arizona tribes are sovereign nations, and tribal courts have jurisdiction over their members residing on reservation. Tribal court jurisdiction, however, does not extend to tribal members residing off the reservation or to state court ordered evaluation or treatment ordered because of a behavioral health crisis occurring off reservation.

Although some Arizona tribes have adopted procedures in their tribal codes, which are similar to Arizona law for court ordered evaluation and treatment, each tribe has its own laws which must be followed for the tribal court process. Tribal court ordered treatment for American Indian tribal members in Arizona is initiated by tribal behavioral health staff, the tribal prosecutor or other person authorized under tribal laws. In accordance with tribal codes, tribal members who may be a danger to themselves or others and in need of treatment due to a mental health disorder are evaluated and recommendations are provided to the tribal judge for a determination of whether court ordered treatment is necessary. Tribal court orders specify the type of treatment needed.

Additional information on the history of the tribal court process, legal documents and forms as well as contact information for the tribes, T/RBHA liaisons, and tribal court representatives can be found on the ADHS/DBHS web page titled, Tribal Court Procedures for Involuntary Commitment - Information Center.

[RBHA enter specific information for your GSA and/or tribes for this process]

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. Attachment 3.18.1, A.R.S. § 12-136 Domestication or Recognition of Tribal Court Order is a flow chart demonstrating the communication between tribal and state entities.

Regional Behavioral Health Authorities and RBHA providers must comply with state recognized tribal court orders for Title XIX/XXI and Non-Title XIX SMI persons. When tribal providers are also involved in the care and treatment of court ordered tribal members, RBHAs and RBHA providers must involve tribal providers to ensure the

coordination and continuity of care of the members for the duration of court ordered treatment and when members are transitioned to services on the reservation, as applicable. RBHAs are encouraged to enter into agreements with tribes to address behavioral health needs and improve the coordination of care for tribal members.

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. This clinical communication and coordination with the RBHA 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." RBHAs 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 behavioral health services.

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

Section 3.19 Special Populations

3.19.1 Introduction
3.19.2 References
3.19.3 Scope
3.19.4 Did you know…?
3.19.5 Definitions
3.19.6 Objectives
3.19.6 Overview
3.19.7 Procedures
3.19.7-A. SAPT Block Grant
3.19.7-B. CMHS Block Grant

3.19.1 Introduction

ADHS/DBHS receives Federal grants and State appropriations to deliver behavioral health services to special populations in addition to Federal Medicaid (Title XIX) and the State Children's Health Insurance Program (Title XXI) funding. The grants are awarded by a Federal agency and made available to ADHS/DBHS. ADHS/DBHS then disburses the funding throughout Arizona for the delivery of covered behavioral health 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 ADHS/DBHS and the public behavioral health system with funding to deliver services to persons who may otherwise not be eligible for covered behavioral health services. It is important for behavioral health providers to be aware of:

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

3.19.2 References

The following citations can serve as additional references for this content area:

42 CFR Part 54 Charitable Choice Provisions and Regulations
45 CFR Part 96 Block Grant Final Rules (SAPT and CMHS)
Centers for Medicare and Medicaid Services, Clinical Laboratory Improvement Amendments
A.R.S. §36-141
Public Health Service Act Part C PATH Final Rules
A.A.C. R9-21
ADHS/RBHA Contract
ADHS/TRBHA IGAs
ADHS/DBHS Covered Behavioral Health Services Guide
ADHS/DBHS Prevention Framework for Behavioral Health
Section 3.1, Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage and the Limited Income Subsidy Program (LIS)
Section 3.2, Appointment Standards and Timeliness of Service
Section 3.3, Referral and Intake Process
Section 3.4, Co-payments
Section 3.8, Outreach, Engagement, Re-engagement and Closure

Section 3.9, Assessment and Service Planning
Section 3.13, Covered Behavioral Health Services
Section 3.21, Service Package for Non-Title XIX/XXI Persons Determined to Have a Serious Mental Illness (SMI)
Section 4.4, Coordination of Care with Other Governmental Entities
Section 6.1, Submitting Tribal Fee-for-Service Claims to AHCCCS
Section 6.2, Submitting Claims and Encounters to the RBHA
Section 7.5, Enrollment, Disenrollment and Other Data Submission
SAPT Frequently Asked Questions Document

3.19.3 Scope

To whom does this apply?

Persons who are eligible to receive behavioral health services through the Substance Abuse Prevention and Treatment (SAPT) Block Grant, the Community Mental Health Services (CMHS) Block Grant, and the Projects for Assistance in Transition from Homelessness (PATH) Program.

3.19.4 Did you know…?

- ADHS/DBHS is the designated Single State Authority in Arizona to administer the SAPT Block Grant.
- SAPT funding may only be expended on individuals or services not covered by Title XIX or Title XXI.
- T/RBHAs receiving SAPT Block Grant funds are required to develop, expand and enhance a continuum of specialized care for pregnant females and females with dependent children up to the full annual grant award for substance abuse treatment services.
- A T/RBHA or provider may not deny any person SAPT Block Grant funded treatment services based on age.
- ADHS/DBHS maintains a SAPT Frequently Asked Questions (FAQs) document, on its website.
- CMHS Block Grant funds are allocated to provide services for Adult SMI and Child SED persons.
- Co-payments, or any other fee, are prohibited for the provision of services funded by the SAPT or CMHS Block Grants.
- The CMHS Block Grant requires the State to maintain a statewide planning council with representation by consumers, family members, State employees and providers.
- Another resource, 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 or co-occurring serious mental illness 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 DBHS based on a competitive request for proposals (RFP) process and direct provider contract. RBHAs and their subcontracted providers can contact the designated PATH provider in their area to obtain services for those individuals listed below. (See PM Attachment 3.19.2, Arizona PATH Program-Administrators Contact List for PATH information in your area)

3.19.5 Definitions

Block Grant

Serious Emotional Disturbance (SED)

3.19.6 Objectives

To ensure that RBHAs and providers are aware of:
Specific Federal grants awarded to the ADHS/DBHS public behavioral health system;
Special populations and prioritized populations covered under each Federal grant; and

- Responsibilities for delivering covered behavioral health services to the identified special populations

3.19.6 Overview

The SAPT Block Grant, CMHS Block Grant and PATH Grant 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.

Substance Abuse Prevention and Treatment (SAPT) Block Grant
The SAPT Block Grant 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.

Community Mental Health Services (CMHS) Block Grant
The CMHS Block Grant 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.

3.19.7 Procedures

3.19.7-A. SAPT Block Grant

Who is covered and what populations are prioritized?
SAPT Block Grant 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 SAPT Block Grant funded services.

Do behavioral health recipients have a choice of substance abuse providers?
Persons receiving substance abuse treatment services under the SAPT Block Grant have the right to receive services from a provider to whose religious character they do not object.

Behavioral health subcontractors providing substance abuse services under the SAPT Block Grant must notify persons of this right using PM Attachment 3.19.1. Providers must document that the person has received notice in the person's comprehensive clinical record.

If a person objects to the religious character of a behavioral health provider, the provider must refer the person to an alternative provider within 7 days, or earlier when clinically indicated, after the date of the objection. Upon making such a referral, providers must notify the T/RBHA of the referral and ensure that the person makes contact with the alternative provider.
T/RBHA insert who and how providers should notify you of these referrals.]

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

- Referral for primary medical care for pregnant females;
- Referral for primary pediatric care for children;
- Gender-specific substance abuse treatment; and
- Therapeutic interventions for dependent children

T/RBHAs must ensure the following issues do not pose barriers to access to obtaining substance abuse treatment:

- Child care;
- Case management; and
- Transportation

T/RBHAs must publicize the availability of gender-based substance abuse treatment services for females who are pregnant or have dependent children. Publicizing must include at a minimum the posting of fliers at each site notifying the right of pregnant females and females with dependent children to receive substance abuse treatment services.

[T/RBHA insert specific language for behavioral health providers with regards to providing the specialty program services for women and children.]

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). The minimum required interim services include:

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

SAPT Reporting Requirements:

The T/RBHA must, ensure that their providers 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 Level II Residential Treatment Center, to the ADHS/DBHS SAPT Waitlist System, or in a different format upon written approval by ADHS/DBHS.

- Title XIX/XXI persons may not be added to the wait list.
- Priority Population Members must be added to the wait list if the T/RBHA or its providers are not able to place the person in a Level II Residential Treatment Center within the timeframes prescribed in Section 3.2, Appointment Standards and Timeliness of Service
- Non-Title XIX/XXI persons may be added to the wait list if there are no available services.

Each T/RBHA must submit an annual plan regarding outreach activities and coordination efforts with local substance abuse coalitions.

Other SAPT Requirements:

Each T/RBHA must designate:

- A lead substance abuse treatment coordinator who will be responsible for ensuring T/RBHA compliance with all SAPT requirements;
- A women's treatment coordinator;
- An opiate treatment coordinator
- A prevention services administrator; and
- An HIV early intervention services coordinator

The lead substance abuse treatment coordinator must attend regular meetings with ADHS/DBHS to review services and comply with ADHS/DBHS policies.

HIV Early Intervention Services

Because persons with substance abuse disorders are considered at high risk for contracting HIV-related illness, the SAPT Block Grant requires HIV intervention services in order to reduce the risk of transmission of this disease.

[RBHA, and Tribal RBHAs that receive SAPT Block Grant funding, insert where/how to access HIV early intervention services.]

Who is eligible for HIV early intervention services?

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

Requirements for providers offering HIV early intervention services

- HIV early intervention service providers who accept funding under the SAPT grant must provide HIV testing services.
- Behavioral health providers must administer HIV testing services in accordance with the Clinical Laboratory Improvement Amendments (CLIA) requirements, which requires that any agency that performs HIV testing must register with CMS to obtain CLIA certification. However agencies may apply for a CLIA Certificate of Waiver which exempts them from regulatory oversight if they meet certain federal statutory requirements. Many of the Rapid HIV tests are waived. For a complete list of waived Rapid HIV tests please see (http://www.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 ensure any HIV testing will be performed accurately. (See http://www.cdc.gov/hiv/topics/testing/resources/guidelines/qa_guide.htm for Centers for Disease Control Quality Assurance Guidelines)
- The HIV Prevention Counseling training provided through ADHS must be completed by all T/RBHA HIV Coordinators, provider staff and provider supervisors who's 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.
- T/RBHA HIV Coordinators and provider staff delivering HIV Early Intervention Services for the SAPT Block Grant must attend an HIV Early Intervention Services Webinar issued by ADHS/DBHS on an annual basis, or as indicated by DBHS. The Webinar will be recorded and made available by DBHS. 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 SAPT Block Grant.
- 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.
- HIV early intervention service providers must actively participate in regional community planning groups to ensure coordination of HIV services.

Reporting requirements for HIV Early Intervention Services

For every occurrence in which an oral swab rapid test provides a reactive result, a confirmatory blood test must be conducted and the blood sample sent to the Arizona Sate 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 data base. 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
T/RBHAs must collect monthly progress reports from subcontracted providers and submit quarterly progress reports to ADHS/DBHS.

Site visits to provider offering HIV Early Intervention Services must be conducted bi-annually. The ADHS/DBHS HIV Coordinator, T/RBHA HIV Coordinator, provider staff and supervisors relevant to HIV services must be in attendance during staff visits.

- A budget review and description/justification for use of funding must be made available by the provider as part of the site visit.

Minimum performance expectations
T/RBHAs are expected to administer a minimum of 1 test per $600 in HIV funding.

Considerations when delivering services to SAPT Block Grant populations
SAPT Block Grant treatment services must be designed to support the long-term recovery needs of eligible persons. 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 for requirements). Behavioral health providers must also submit specific data elements to identify special populations and record limited clinical information (see Section 7.5, Enrollment, Disenrollment and Other Data Submission for requirements).

Restrictions on the use of SAPT Grant Funds
The State shall not expend SAPT Block Grant funds on the following activities:

- To provide inpatient hospital 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, or purchase major medical equipment;
- To satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds (Maintenance of Effort);
- To provide financial assistance to any entity other than a public or nonprofit private entity;
- To provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for AIDS;
- To pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of 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 (H0046 SE) services funded by the SAPT Block Grant 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).

3.19.7-B. CMHS Block Grant

Who is covered and what populations are prioritized?

The CMHS Block Grant provides non-Title XIX/XXI behavioral health services to adults with SMI and children with SED.

The CMHS Block Grant must be used:

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

Restrictions on the use of CMHS Block Grant Funds

The State shall not expend CMHS Block Grant funds on the following activities:

- To provide inpatient hospital 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, or purchase major medical equipment;
- To satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds (Maintenance of Effort);
- To provide financial assistance to any entity other than a public or nonprofit private entity;
- To provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for AIDS;
- To pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of 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 CMHS Block Grant are limited to children with SED.

Section 3.20 Credentialing and Recredentialing

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3.20.1 Introduction

The credentialing and recredentialing processes are integral components of the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) quality management program. The credentialing and recredentialing processes help to ensure that qualified behavioral health providers, who are capable of meeting the needs of the persons who are seeking and/or receiving behavioral health services, participate in the ADHS/DBHS provider network.

Credentialing and recredentialing 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 recredentialing requirements differ depending on the type of provider. Physicians, nurse practitioners, physician assistants, psychologists and all other behavioral health professionals who are registered to bill independently or provide behavioral health services for which they are licensed to perform must be credentialed prior to providing services in the ADHS/DBHS behavioral health system.

The specific requirements associated with the credentialing and recredentialing processes for each type of provider are discussed below.

3.20.2 References

The following citations can serve as additional resources for this content area:
42 CFR 438.214
A.R.S. Title 32, Chapter 33
A.R.S. § 36-551
4 A.A.C. 6
A.A.C. R9-20-101

A.A.C. R9-20-204
AHCCCS/ADHS Contract
ADHS/RBHA Contract
ADHS/TRBHA IGAs
AHCCCS Medical Policy Manual, Chapter 950
Section 3.9, Assessment and Service Planning
Section 3.10, SMI Eligibility Determination
ADHS/DBHS Covered Behavioral Health Services Guide

3.20.3 Scope

To whom does this apply?
This section applies to provider agencies and staff providing behavioral health services to persons enrolled in the ADHS/DBHS behavioral health system.

3.20.4 Did you know…?

If the Tribal/Regional Behavioral Health Authority (T/RBHA) delegates any of the credentialing/recredentialing or selection of provider responsibilities, the T/RBHA must retain the right to approve, suspend, or terminate any providers selected and may revoke the delegated function if the delegated performance is inadequate.

3.20.5 Definitions

Behavioral Health Professional

Behavioral Health Technician

Credentialing

Independent Licensed Practitioners

Primary Source Verification

Temporary/provisional credentialing

3.20.6 Objectives

The objectives of the credentialing and recredentialing processes are to:

- Maintain fair credentialing and recredentialing processes in which standards are applied consistently throughout the state;
- Obtain application information about a potential provider's background and work history;
- Verify credentials and other information (e.g., malpractice or sanction activity) with primary sources; and
- Provide flexibility in the process (i.e., expedited credentialing) so that any gaps in service within provider networks can be expeditiously addressed.

3.20.7 Procedures

3.20.7-A. General process for credentialing

Responsible Entity. Each T/RBHA or its designee must establish credentialing and recredentialing processes that are in compliance with the standards set forth in this section. **[T/RBHAs describe how the standards of this section will be implemented. Include the general requirements for providers to follow and identify whether the T/RBHA will be delegating functions of the credentialing process to another organization.]**

Accreditation by a nationally recognized accreditation organization. Accreditation by a nationally recognized accreditation organization will meet ADHS/DBHS credentialing and recredentialing standards. T/RBHAs must ensure, to the extent possible, that providers are not subjected to duplicative credentialing processes.

Fairness of Process. The T/RBHAs or their designee shall maintain fair credentialing and recredentialing processes which:

- Does 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;

- Affords 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;

- Notifies the provider when the information obtained through the primary source verification process varies substantially from what the provider provided;

- Ensures credentialing/recredentialing information is kept confidential; and

- States 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.

Provider File. The T/RBHAs must maintain an individual credentialing/recredentialing file for each credentialed provider. Each file must include:

- The initial credentialing and all subsequent recredentialing applications, including attestation by the applicant of the correctness and completeness of the application as demonstrated by signature on the application;

- Information gained through credentialing and recredentialing queries;

- Utilization data, quality of care concerns, performance measure rates, and level of member satisfaction; and

- Any other pertinent information used in determining whether or not the provider meets the T/RBHA's credentialing and recredentialing standards.

Notification Requirement. The T/RBHAs must 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 the T/RBHA's network. If the issue is determined to have criminal implications, a law enforcement agency must also be notified. The T/RBHA must:

- Maintain documentation of implementation of the procedure, as appropriate;

- Have an appeal process for instances in which the T/RBHA chooses to alter the provider's contract based on issues of quality of care and/or service; and

- Inform the provider of the appeal process.

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 ensure 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

- Behavioral health care providers who are part of the T/RBHA network are subject to an initial site visit as part of the initial credentialing process.

3.20.7-B. Temporary/Provisional Credentialing Process

The T/RBHA shall have 14 calendar days from receipt of a complete application to render a decision regarding temporary or provisional credentialing. Once provisional/temporary credentialing is approved, provider information must be entered into the T/RBHA's information system to allow payment to the provider effective the date the provisional credentialing is approved.

Providers working in a Federally Qualified Health Center (FQHC) and FQHC Look-alike Center, as well as hospital employed physicians (when appropriate), must be credentialed using the temporary or provisional credentialing process even if the provider does not specifically request their application be processed as temporary or provisional.

- If an expedited or temporary credentialing process is utilized, the following minimum requirements must be met:

A provider must complete a signed application that must include the following items:

- Reasons for any inability to perform essential functions of the position, with or without accommodation;
- Lack of present illegal drug use;
- History of loss of license and/or felony convictions;
- History of loss or limitation of privileges or disciplinary action;
- Current malpractice insurance coverage; and
- Attestation by the applicant of the correctness and completeness of the application.

In addition, the applicant must furnish the following information:

- Minimum five-year work history or total work history if less than five years; and
- Current Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate, as applicable.

The T/RBHA must conduct primary source verification of the following:

- Licensure or certification (A signed statement from the medical or nursing board of examiners stating they do primary verification of education and internship/residency as part of the licensing process is acceptable);
- Board certification, if applicable, or the highest level of credential attained; and
- National Practitioner Data Bank (NPDB) query; or
- In lieu of NPDB query, all of the following:
    - Minimum five-year history of professional liability claims resulting in a judgment or settlement;
    - Disciplinary status with regulatory board or agency; and
    - Medicare/Medicaid sanctions.

The T/RBHA's Medical Director must review the information obtained and determine whether to grant provisional credentials. Following approval of provisional credentials, the process of verification and committee review, as outlined in this Section, should be completed.

The T/RBHA must ensure compliance with all applicable credentialing requirements within six months following the granting of temporary credentials. If the provider has not been credentialed during this six month time period, then the T/RBHA may issue a second temporary credential. All credentialing must be completed by the end of the second six-month period.

[T/RBHAs add additional standards, including timelines for completion of the credentialing process and specific procedures for consideration of temporary credentialing]

3.20.7-C. Credentialing requirements

The following behavioral health professionals are subject to credentialing and recredentialing requirements outlined below:

- Physicians (MD and DO)
- Licensed Psychologists
- Nurse Practitioners
- 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)

The initial credentialing process for these providers must include the following components:

A written application to be completed signed and dated by the potential provider that attests to the following elements:

- Reasons for any inability to perform essential functions of the position, with or without accommodation;
- Lack of present illegal drug use;
- If applicable, history of loss of license and/or felony convictions;
- If applicable, history of loss or limitation of privileges or disciplinary action;
- Current malpractice insurance coverage; and
- Attestation by the applicant of the correctness and completeness of the application.

In addition, the applicant must furnish the following:

- Minimum five-year work history or total work history if less than five years; and
- DEA or CDS certification as applicable.

Primary source verification of:
- Licensure by the appropriate state licensing board;
- Board certification, if applicable, or highest level of credentials attained;
- Documentation of graduation from an accredited school and completion of any required internships/residency programs, or other postgraduate training(a signed statement from the medical or nursing board of examiners stating they do primary verification of education and internship/residency as part of the licensing process is acceptable);
- NPDB query; or
- In lieu of NPDB query, all of the following must be verified:
  - Minimum five-year history (or total history if less than five years) of professional liability claims resulting in judgment or settlement;
  - Disciplinary actions and licensure status with regulatory board or agency if applicable;
  - Medicare/Medicaid sanctions if applicable; and
  - State sanctions or limitations of licensure.

For credentialing of independent masters level behavioral health therapists who are registered by AHCCCS to bill independently, primary source verification of:

- Licensure by the Arizona Board of Behavioral Health Examiners (AzBBHE);
- A review of complaints received and disciplinary status through the AzBBHE;
- Minimum five-year history, or total history if less than five years, of professional liability claims resulting in a judgment or settlement; and
- Medicare/Medicaid sanctions, if applicable.

3.20.7-D. Credentialing requirements for individuals who are not licensed or certified
Individuals who are not licensed or certified must be included in the credentialing process and profiled as outlined in A.A.C. R9-20-204.

3.20.7-E. Recredentialing
The T/RBHAs or designee must ensure that all credentialed providers described in subsection 3.20.7-C are recredentialed. The recredentialing process must:

- Occur at least every three years; and
- Update information obtained during the initial credentialing process with the exception of:
  - History of loss of license and/or felony convictions;
  - Minimum five-year work history; and

- Board certification, if the provider is Board certified.

The recredentialing of individual providers must include a process for ongoing monitoring and intervention and if appropriate, provider sanctions, complaints and quality issues, which include, at a minimum, reviews of:

- Medicare/Medicaid sanctions;
- State sanctions or limitations on licensure;
- Member concerns including grievances (complaints) and appeals information;
- Utilization management information (such as: hospital length of stay, pharmacy utilization);
- Performance improvement and monitoring (such as performance measure rates);
- Results of any medical record review audits; and
- Quality of care issues (including trend data). If an adverse action is taken with a provider due to a quality of care concern, the T/RBHA must report the adverse action to the ADHS/DBHS Clinical Quality Management Unit.

[T/RBHAs add additional standards for the recredentialing process]

3.20.7-F. Additional credentialing standards for hospitals and behavioral health facilities
Hospitals and behavioral health facilities (Office of Behavioral Health Licensure (OBHL) licensed Level I, II, III, outpatient clinics and ADHS/DBHS Title XIX certified Community Service Agencies) must ensure the following:

- The provider is licensed/certified to operate in Arizona as applicable and is in compliance with any other applicable state or federal requirements; and
- The provider is reviewed and approved by an appropriate accrediting body, or if not accredited, Centers for Medicare and Medicaid Services (CMS) certification, ADHS/DBHS Title XIX certification or state licensure review may substitute for accreditation. In this case, the provider must provide a copy of the report to the contracted T/RBHA that verifies that a review was conducted and compliance was achieved.

Initial Assessment of Organizational Providers
As a prerequisite to contracting with the provider, the T/RBHA must ensure that the organizational provider has established policies and procedures that meet AHCCCS requirements. The requirements described in this section must be met for all providers included in the T/RBHA network (including, but not limited to, hospitals, home health agencies, attendant care agencies, group homes, nursing facilities, behavioral health facilities, dialysis center, transportation companies, dental and medical schools, and free standing surgi-centers; see AHCCCS Medical Policy Manual, Chapter 950).

Prior to contracting with the provider, the T/RBHA must:

- Confirm that the provider has met all the state and federal licensing and regulatory requirements (a copy of the license or letter from the regulatory agency will meet this requirement);

- Confirm that the provider is reviewed and approved by an appropriate accrediting body as specified by the Centers for Medicare and Medicaid Services (CMS) (a copy of the accreditation report or letter from the accrediting body will meet this requirement). The T/RBHA must state in policy which accrediting bodies it accepts;

- Conduct an onsite quality assessment if the provider is not accredited. The T/RBHA must develop a process and utilize assessment criteria for each type of unaccredited organizational provider for which it contracts which must include, but is not limited to, confirmation that the organizational provider has the following:
  - A process for ensuring that they credential their practitioners;

  - Liability insurance;

  - Business license; or

- CMS certification or state licensure review/audit may be substituted for the required site visit. In this circumstance, the T/RBHA must obtain the review/audit documentation from CMS or the state licensing agency and verify that the review/audit was conducted and that the provider meets the T/RBHA's standards. A letter from CMS that states the organizational provider was reviewed/audited and passed inspection is sufficient documentation when the T/RBHA has documented that they have reviewed and approved the CMS criteria and they meet the T/RBHA's standards.

- Review and approve the provider through the T/RBHA's credentialing committee.

<u>Reassessment of Organizational Providers</u>
T/RBHAs must reassess organizational providers at least every three years. The reassessment must include the following components and all information utilized by T/RBHAs must be current:

- Confirmation that the organizational providers remain in good standing with State and Federal bodies, and, if applicable, are reviewed and approved by an accrediting body. To meet this component, the T/RBHA must validate that the organizational provider meets the conditions listed below:
  - Federal requirements as applicable; and

  - Is licensed to operate in the State, and is in compliance with any other State requirements. If an organization provider is not accredited or surveyed or licensed by the State, an on-site review must be conducted, including minimally the components described above in subsection 3.20.7-F, 2nd bullet;

- Assess data available to the T/RBHA including:

- The most current review conducted by the ADHS Division of Licensing and/or summary of findings (please include date of review);

- Record of on-site inspection of non-licensed organizational providers to ensure compliance with service specifications.

- Evaluate organizational provider specific information including, but not limited to, the following:
  - Member concerns which include grievances (complaints);
  - Utilization management information (if applicable);
  - Performance improvement and monitoring (if applicable);
  - Results of medical records review audits (if applicable);
  - Quality of care issues and, if an adverse action is taken with a provider due to a quality of care concern, the T/RBHA must report the adverse action to the ADHS/DBHS Clinical Quality Management Unit; and
  - Onsite assessment.
- Review and approval by the T/RBHA's credentialing committee with formal documentation that includes any discussion, review of thresholds, and complaints or grievances.

Notice of Requirements (Limited to Providers)

The T/RBHA must have procedures for reporting (in writing) to appropriate authorities (ADHS/DBHS, 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 the T/RBHA's network, it must be reported. If the issue is determined to have criminal implications, a law enforcement agency must also be notified.

- The T/RBHAs must maintain documentation of implementation of the procedure, as appropriate;
- The T/RBHA must have an appeal process for instances in which the T/RBHA chooses to alter the provider's contract based on issues of quality of care and/or service; and
- The T/RBHA must inform the provider of the appeal process.

Section 3.21 Service Package for Non-Title XIX/XXI Persons Determined to Have a Serious Mental Illness (SMI)

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3.21.7-C: Psychiatric Assessments

3.21.1 Introduction

In Arizona's public behavioral health system, persons may be eligible for, or entitled to services as Title XIX (Medicaid), Title XXI (KidsCare) or as a person determined to have a Serious Mental Illness (SMI). Non-Title XIX/XXI funds are available but limited to the amount appropriated by the Arizona legislature. Additionally, it is incumbent upon the public behavioral health system to ensure that Non-Title XIX/XXI funding allocated by the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) for each geographic service area (GSA) is available for services throughout the fiscal year. As such, each Tribal and Regional Behavioral Health Authority (T/RBHA) must implement the following service package limitations for Non-Title XIX/XXI funded service delivery to persons determined to have SMI.

This section is intended to define standardized covered benefits for Non-Title XIX/XXI funded services for persons determined to have SMI to be applied consistently across the state. The covered benefits define ADHS/DBHS' expectations regarding the expenditure of Non-Title XIX/XXI funds for persons determined to have SMI.

3.21.2 References

The following citations can serve as additional resources for this content area:
A.R.S. § 1-502
A.R.S. § 36-502(D)
A.R.S. § 36-3408
A.A.C. R9-20-209
ADHS/RBHA Contracts
ADHS/TRBHA IGAs
Substance Abuse Performance Partnership Block Grant
Section 3.1, Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Limited Income Subsidy Program
Section 3.4, Co-payments
Section 3.5, Third Party Liability and Coordination of Benefits
Section 3.16, Medication Formularies
Section 5.3, Grievance and Requests for Investigations for Persons Determined to have a Serious Mental Illness
Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)

3.21.3 Scope

To whom does this apply?

To enrolled behavioral health recipients determined to have SMI receiving Non-Title XIX/XXI services and Non-Title XIX/XXI persons determined SMI undergoing court ordered evaluation (COE) and/or court ordered treatment (COT). This does not apply to individuals not eligible for public behavioral health services (see A.R.S. § 1-502 and A.R.S. § 36-3408).

3.21.4 Did you know…?

ADHS/DBHS receives limited Non-Title XIX/XXI service funds from a variety of sources. Non-Title XIX/XXI service fund sources include, but are not limited to:

- Center for Mental Health Services (CMHS) and Substance Abuse Prevention and Treatment (SAPT) Federal Block Grants;
- State appropriations for children, adults (including persons determined to have a Serious Mental Illness), substance abuse treatment and prevention;
- County and city funds;
- Other state agency funding agreements; and
- Other Non-Title XIX/XXI funds as made available periodically for targeted activities.

Non-Title XIX/XXI service funds do not include discretionary grant funds for specific grant projects.

State law does not permit the expenditure of state monies in excess of the amount that has been appropriated by the state legislature.

Behavioral health providers must screen behavioral health recipients for Title XIX eligibility. Providers can utilize the Health-e Arizona web tool to verify potential eligibility and submit behavioral health recipient's information for formal eligibility determination and screening for other public assistance programs simultaneously. RBHAs must maintain a resource list of providers with a sliding fee scale and associated services, as well as other community resources, that may be available to individuals who do not qualify for coverage through the Arizona Health Care Cost Containment System (AHCCCS, Arizona's Medicaid program).

Non-Title XIX/XXI persons determined to have SMI must be eligible for services and provide documentation of lawful presence in the United States, in accordance with A.R.S. § 1-502(A).

Crisis services are provided when a person presents with a sudden, unanticipated, or potentially dangerous behavioral health condition, episode or behavior. Crisis services are provided to any person presenting with a behavioral health crisis in the community, regardless of eligibility or enrollment status.

3.21.5 Definitions

ADHS/DBHS Non-Title XIX/XXI Medication Formulary

Medically Necessary Covered Services

Serious Mental Illness

3.21.6 Objectives

To communicate Non-Title XIX/XXI funded, covered behavioral health services for persons determined to have a Serious Mental Illness (SMI).

3.21.7 Procedures

3.21.7-A: General Requirements

ADHS/DBHS requires adherence to the following statewide covered service package for Non-Title XIX/XXI funded service delivery to persons determined to have a Serious Mental Illness:

- A Non-Title XIX/XXI medication formulary (see Section 3.16, Medication Formularies);
- Medically necessary laboratory services (see the ADHS/DBHS Covered Behavioral Health Services Guide);
- Psychiatric assessments;
- Psychiatric follow up appointments for medication management;
- Telephone contact by prescribing medical professionals (MD, DO, NP, PA) or nursing staff (RN, LPN);
- Nursing (RN, LPN) assistance for prescribing medical professionals and medication administration; and
- Oral interpretation and sign language services to ensure services are provided to persons in their preferred language.

Services identified for Non-Title XIX/XXI persons determined to have SMI are state-funded services, and as such, providers must ensure that individuals requesting these services are eligible to receive the services. Providers must screen individuals for AHCCCS eligibility and, as applicable, assist individuals with applying for AHCCCS and/or enrolling in Medicare Part D (see Section 3.1, Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage and the Limited Income Subsidy Program). Individuals 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 behavioral health services. In addition, providers must obtain documentation from individuals during the screening process to verify lawful presence in the United States. Individuals unable to provide such documentation to verify citizenship or lawful presence are not eligible for state funded behavioral health services.

3.21.7-B: Medications and Medication Management

Coverage of medications through the public behavioral health system is limited to the ADHS/DBHS Non-Title XIX/XXI Medication Formulary (see also Section 3.16, Medication Formularies) for Non-Title XIX/XXI persons determined to have SMI. However, Non-Title XIX/XXI persons determined to have SMI who have third party coverage, such as Medicare or private insurance, will continue to have access to medications on their health plan's formulary through their third party insurer (see Section 3.5, Third Party Liability and Coordination of Benefits for additional information regarding third party liability). For individuals without third party coverage, coverage of the cost of brand medications will be the responsibility of the

person. However, providers may contact **[T/RBHA insert T/RBHA name here]** for information on pharmaceutical assistance programs that offer no-cost or reduced-cost brand name medications: **[T/RBHA, insert contact information here and any other applicable information]**.

Laboratory services may be necessary in conjunction with prescribing medications and to ensure effective medication monitoring. As such, laboratory services listed within the ADHS/DBHS Covered Behavioral Health Services Guide are covered for Non-Title XIX/XXI persons determined to have SMI. In addition to laboratory services, prescribing medical professionals and/or nursing staff will provide medication management services to Non-Title XIX/XXI persons determined SMI as indicated in section II.C.3 of the ADHS/DBHS Covered Behavioral Health Services Guide. Telephone evaluation and management services are also covered and provided in accordance with section II.D.1.of the ADHS/DBHS Covered Behavioral Health Services Guide.

Non-Title XIX/XXI persons determined SMI may be assessed a co-payment at the time of their appointment for psychiatric follow up visits in accordance with Section 3.4, Co-payments.

[T/RBHA, insert any additional information here regarding expectations for medications and medication management.]

3.21.7-C: Psychiatric Assessments

Providers will complete psychiatric assessments with newly enrolled Non-Title XIX persons determined to have SMI and when the care of a Non-Title XIX/XXI person determined SMI is transferred to another behavioral health professional. Psychiatric assessments must also be reviewed and updated at least once every 12 months. Psychiatric assessments are provided in accordance with section II.C.3 of the ADHS/DBHS Covered Behavioral Health Services Guide and must be in compliance with A.A.C. R9-20-209.

Providers must additionally collect demographic information as required in the ADHS/DBHS Demographic Data Set User Guide when conducting a psychiatric assessment, when significant changes occur in a behavioral health recipient's status and at least annually.

Non-Title XIX/XXI persons determined SMI may be assessed a co-payment at the time of their appointment for psychiatric assessments in accordance with Section 3.4, Co-payments.

[T/RBHA, insert any additional information here regarding expectations for psychiatric assessments.]

Section 3.22 Out-of-State Placements for Children and Young Adults

3.22.1 Introduction
3.22.2 References
3.22.3 Scope
3.22.4 Did you know…?
3.22.5 Definitions
3.22.6 Objectives
3.22.7 Procedures
3.22.7-A. General requirements
3.22.7-B. Conditions to be met before a referral for out-of-state placement is made.
3.22.7-C. The Individual Service Plan (ISP)
3.22.7-D. Initial notification to ADHS/DBHS Office of Utilization Management
3.22.7-E. Periodic updates to ADHS/DBHS Office of Utilization Management

3.22.1 Introduction

At times, it may be necessary to consider an out-of-home placement for a child or young adult to meet the person's unique circumstances or clinical needs. The following factors may lead the person's Child and Family Team (CFT) or Adult Recovery Team (ART) to consider the temporary out-of-state placement of a child or young adult.

- A child or young adult needs specialized programming not currently available in Arizona to effectively treat a specified behavioral health condition;
- An out-of-state placement's approach to treatment incorporates and supports the child's or young adult's unique cultural heritage;
- A lack of current in-state bed capacity; and/or
- Geographical proximity encourages support and facilitates family involvement in the person's treatment.

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) expects that decisions to place children or young adults in out-of-state placements for behavioral health care and treatment are examined closely and made after the CFT or ART have reviewed all other in-state options. Other options may include single case agreements with in-state providers that would allow enhanced programming or staffing to meet the specific needs of the person or the development of an Individual Service Plan (ISP) that incorporates a combination of support services and clinical interventions and takes advantage of the full extent of all available covered services to meet the clinically identified needs of the child or young adult. In the event that an out-of-state placement is necessary and supported by the CFT orART, Tribal and Regional Behavioral Health Authorities (T/RBHAs) and their providers must follow the steps and procedures outlined in this section. In addition, services provided out-of-state must meet appointment standards and timelines specified in Section 3.2, Appointment Standards and Timeliness of Service.

3.22.2 References

The following citations can serve as additional resources for this content area:

R9-21-101 et seq.
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/Tribal IGAs
Section 3.2 Appointment Standards and Timeliness of Service
Section 3.9, Assessment and Service Planning
Section 3.14, Securing Services and Prior Authorization
ADHS/DBHS Practice Protocol Child and Family Team Practice
ADHS/DBHS Covered Behavioral Health Services Guide
Arizona Department of Education Academic Standards

3.22.3 Scope

To whom does this apply?

All persons under the age of 21 being considered for, or currently placed in, out-of-state placement.

3.22.4 Did you know…?

Coordination must occur with the person's Arizona Health Care Cost Containment System (AHCCCS) Health Plan Behavioral Health Coordinator or other health care provider for the provision of acute care services in the state in which the person will be placed. It is also required that coordination with the school system in the area occurs.

3.22.5 Definitions

Adult Recovery Team (ART)

Child and Family Team

Individual Service Plan (ISP)

Prior Authorization PM 3.22

Single Case Agreement

3.22.6 Objectives

To ensure that out-of-state placements for persons under the age of 21:

- Serve the individual needs of the person;
- Are determined to be more appropriate and beneficial than available in-state services;
- Facilitate family member involvement; and
- Promote the person's timely return to a community living environment.

3.22.7 Procedures

3.22.7-A. General requirements

When the T/RBHA is considering an out-of-state placement for a child or young adult, the following conditions apply:

- The CFT or ART will consider all applicable and available in-state services and determine that the services do not adequately meet the specific needs of the person and the person's family/guardian (not including those not under guardianship between 18 and under 21 years of age) is in agreement with the out-of-state placement;

- The out-of-state placement is registered as an AHCCCS provider;

- The out-of-state placement meets the Arizona Department of Education Academic Standards; and

- A plan for the provision of non-emergency medical care must be established.

3.22.7-B. Conditions to be met before a referral for out-of-state placement is made.
Documentation in the clinical record must indicate that the following conditions have been met before a referral for an out-of-state placement is made:

- All less restrictive clinically appropriate approaches have either been provided or considered by the CFT or ART and found not to meet the person's needs;

- The CFT or ART has been involved in the service planning process, and is in agreement with the out-of-state placement;

- The CFT or ART has determined how they will remain active and involved in service planning once the out-of-state placement has occurred;

- A proposed ISP that includes a discharge plan has been developed that addresses the needs and strengths of the person (see Section 3.9, Assessment and Service Planning);

- All applicable prior authorization requirements have been met (see Section 3.14, Securing Services and Prior Authorization);

- The Arizona Department of Education has been consulted to ensure that the educational program in the out-of-state placement meets the Arizona Department of Education Academic Standards and the specific educational needs of the person;

- Coordination has occurred with other state agencies involved with the person;

- The person's AHCCCS Health Plan Behavioral Health Coordinator or heath care provider has been contacted and a plan for the provision of any necessary non-emergency medical care has been established and is included in the comprehensive clinical record **[T/RBHA insert information here – clarify who is responsible for this activity]**; and

- Cultural considerations have been explored and incorporated into the ISP.

3.22.7-C. The Individual Service Plan
For a person placed out-of-state, the ISP developed by the CFT or ART must require that:

- Discharge planning is initiated at the time of referral, including:

- The measurable treatment goals being addressed by the out-of-state placement and the criteria necessary for discharge back to in-state services;

- The possible or proposed in-state residence where the person will be returning and the recommended services and supports required once the person returns from the out-of-state placement;

- What needs to be changed or arranged to accept the person for subsequent in-state placement that will meet the person's needs;

- How effective strategies implemented in the out-of-state placement will be transferred to the persons' subsequent in-stateplacement; and

- The actions necessary to integrate the person into family and community life upon discharge.

- The CFT or ART actively reviews the person's progress with clinical staffings occurring at least every 30 days. Clinical staffings must include the staff of the out-of-state facility;

- The person's family/guardian is involved throughout the duration of the placement; this may include family counseling in person or by teleconference or videoconference;

- The CFT or ART must ensure that essential and necessary health care services are provided; and

- Home passes are allowed as clinically appropriate and in accordance with the ADHS/DBHS Covered Behavioral Health Services Guide. For youth in Child Protective Services (CPS) custody, home passes must be determined only in close collaboration with CPS.

3.22.7-D. Initial notification to ADHS/DBHS Office of Utilization Management

T/RBHAs or subcontracted behavioral health providers are required to notify ADHS/DBHS Office of Utilization Management prior to a referral for out-of-state placement and upon discovering that a T/RBHA enrollee is in an out-of-state placement, using PM Form 3.22.1, Out-of-State Placement, Initial Notice. T/RBHAs may ask that providers assist with supplying the information required on the form and with providing copies of supporting clinical documentation. Prior authorization must be obtained prior to making a referral for out-of-state placement, in accordance with T/RBHA criteria (See Section 3.14, Securing Services and Prior Authorization).

What is the process for providing initial notification to ADHS/DBHS?

For behavioral health providers contracted with a RBHA, the provider notifies the RBHA of the intent to make a referral for out-of-state placement as follows: **[RBHAs describe how providers notify the RBHA to ensure that ADHS/DBHS Office of Utilization Management receives notification on PM Form 3.22.1 prior to a referral for out-of-state placement. What forms, if any, does the provider complete? Who at the RBHA (provide contact information) does the provider contact?]**. The **[RBHA insert "RBHA" or "Behavioral health provider"]** must complete PM Form 3.22.1, Out-of-State Placement, Initial Notice, and fax or email it to the ADHS/DBHS Office of Utilization Management (facsimile number (602)

364-4749) or DBHSMEDICALMANAGEMENT@azdhs.gov for approval of the Out-of-State placement request **prior** to placing the child or young adult.

For Tribal RBHAs (T/RBHAs), **[Tribal RBHAs describe specific internal process before submission to ADHS/DBHS Office of Utilization Management].** The TRBHA completes PM Form 3.22.1, Out-of-State Placement, Initial Notice, and a request for prior authorization, and compiles supporting clinical documentation in accordance with Section 3.14, Securing Services and Prior Authorization. PM Form 3.22.1 is then submitted via fax or e-mail to ADHS/DBHS Office of Utilization Management along with the request for prior authorization using the established prior authorization request process (facsimile number (602) 364-4749, e-mail address: DBHSMEDICALMANAGEMENT@azdhs.gov.)

3.22.7-E Periodic updates to ADHS/DBHS Office of Utilization Management
In addition to providing initial notification, every 90 days the T/RBHA is required to submit updates to ADHS/DBHS Office of Utilization Management regarding the person's progress in meeting the identified criteria for discharge from the out-of-state placement. T/RBHAs must use PM Form 3.22.2, Out-of-State Placement, 90-Day Update, to adhere to this requirement. T/RBHAs may ask that providers assist with providing the information required on the form.

T/RBHAs must complete PM Form 3.22.2 and submit the form via facsimile or e-mail to the ADHS/DBHS Office of Utilization Management (facsimile number (602) 364-4749, e-mail address: DBHSMEDICALMANAGEMENT@azdhs.gov.) every 90 days that the person continues to remain in out-of-state placement.

[T/RBHA enter additional information related to the 90-day update here]

Section 3.23 Cultural Competence

3.23.1 Introduction
3.23.2 References
3.23.3 Scope
3.23.4 Did you know…?
3.23.5 Definitions
3.23.6 Objective
3.23.7-A Required Cultural Competency Plan
3.23.7-B Overall ADHS/DBHS Cultural Competency Framework
3.23.7-C Language Access Services (LAS)
3.23.7-D Culturally Competent Care
3.23.7-E Organizational Supports for Cultural Competence
3.23.7-F Documenting Oral Interpretation Services and Translated Materials
3.23.8 Laws Addressing Discrimination and Respect for Diversity and Inclusion

3.23.1 Introduction

As Arizona's population becomes more diverse, the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS), continue to plan for these changes by developing ways to address needs of all individuals receiving services in the public behavioral health system. ADHS/DBHS, The Tribal and Regional Behavioral Health Authorities (T/RBHA) and behavioral health providers must have the ability to be responsive to the unique cultural, ethnic, or linguistic characteristics of the population it serves; therefore, ADHS/DBHS has based the Cultural Competency approach in a mixture of competency-based and evidence-based practice models.

In 1997, the U.S. Department of Health and Human Services - Office of Minority Health (OMH), developed the National Standards on Culturally and Linguistically Appropriate Services (CLAS), to support a more consistent and comprehensive approach to cultural and linguistic competence in health care. The CLAS standards have been integrated by ADHS/DBHS incorporating them in contracts, plans and policy language. Additionally the standards have served as the base for the ADHS/DBHS Cultural Competence framework and model.

Through ongoing data collection and community collaboration, ADHS/DBHS has determined that disparities and/or gaps exist with regard to access to effective, quality behavioral health services that are inclusive of all traditions, cultural beliefs, diverse cultures, and races and ethnicities. Therefore, ADHS/DBHS 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 Diversity Report, the T/RBHA Quarterly Diversity Episode of Care/Penetration Reports, the Annual Episode of Care/Penetration Reports, and the Language Services Reports are resources for determining areas of accomplishment and areas of improvement.

3.23.2 References

The following citations can serve as additional resources for this content area:

29 U.S.C § 102
29 U.S.C. § 206 (d)
29 U.S.C § 501
29 U.S.C. § 621
29 U.S.C. § 626 (e)
29 U.S.C § 791
42 U.S.C. § 2000d *et seq.*
42 U.S.C. § 2000e *et seq.*
42 U.S.C. § 1981
42 U.S.C. § 12101 *et seq.*
Balanced Budget Act of 1997
45 CFR Section 80.3
42 CFR § 438.10
42 CFR § 438.206
42.CFR § 422.2264(e)
Title VI of the Civil Rights Act
ADA Accessibility Guidelines
The Age Discrimination in Employment Act (ADEA)
Culturally and Linguistically Appropriate Services (CLAS) in Healthcare Standards
Mental Health: Culture, Race and Ethnicity- Supplemental Report of the Surgeon General
U.S. Department of Health & Human Services - Office for Civil Rights – LEP recipients
U.S. Department of Health & Human Services - Office of Minority Health
U.S. Equal Employment Opportunity Commission
Indian Health Care Improvement Act - Provisions in the Patient Protection and Affordable Care Act (P.L. 111-148)
President's Executive Order No.13166
A.R.S. § 23-341
A.R.S. § 36-1946
R9-21-202
AHCCCS/ADHS Contract
AHCCCS Contractor Operations Manual (ACOM)
ADHS/RBHA Contracts
ADHS/Tribal IGAs
ADHS Tribal Consultation Policy
Section 3.9 Intake, Assessment and Service Planning
Section 3.13 Covered Behavioral Health Services
Section 4.2 Behavioral Health Medical Record Standards
Section 5.1 Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons

Section 5.5 Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)
Section 9.1 Training Requirements
ADHS/DBHS Covered Behavioral Health Services Guide
ADHS/DBHS Cultural Competency Web page
The Adult Clinical Team Practice Protocol
The Child and Family Team Process Practice Protocol
The Prevention Framework for Behavioral Health, 2009 Revision
DiversityRx

3.23.3 Scope

To whom does this apply?
All behavioral health providers under contract with a T/RBHA or a T/RBHA network that deliver covered behavioral health services to eligible persons.

3.23.4 Did you know…?

- ADHS/DBHS follows the Nine Guiding Principles which were developed to provide a shared understanding of the key ingredients needed for an adult behavioral health system to promote recovery. System development efforts, programs, service provision, and stakeholder collaboration must be guided by these principles. These Guiding Principles correlated with and complement the 12 Principles for Children's Behavioral Health Care.

- According to data provided by the Joint Commission in their Web site publication titled About Hospitals, Language, and Culture: A Snapshot of the Nation *(October 27,2009);* the demographics of the United States have changed considerably over the last several decades. Currently, more than 37 million U.S. residents are foreign born, 54 million people speak a language other than English at home, and 24 million people speak English less than "very well" and are classified as LEP. Research has shown that a lack of sensitivity and responsiveness to cultural and language needs impacts quality, safety, and patient satisfaction. In addition, one-half of the U.S. population lacks the skills to function within the health care system.

- The Patient-Centered Communication standards were approved in December 2009 and released to the field in January 2010. The standards will be published in the *2011 Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC): The Official Handbook.* Joint Commission surveyors will evaluate compliance with the Patient-Centered Communication standards beginning January 1, 2011; however, findings will not affect the accreditation decision. The information collected by Joint Commission surveyors and staff during this implementation pilot phase will be used to prepare the field for common implementation questions and concerns. Compliance with the Patient-Centered Communication standards will be included in the accreditation decision no earlier than January 2012. View a pre-publication version of the standards.

- The President's Executive Order No.13166 issued in 2000, and enforced by the Department of Justice, titled "Improving Access to Services for Persons with Limited English Proficiency (LEP)," was created to "... improve access to federally conducted and federally assisted programs and activities for persons who, as a result of national origin, are limited in their English proficiency..."

- A Federal Web site (LEP.gov) was developed by the Federal Interagency Workgroup on LEP in support of the President's Executive Order 13166. The site was designed to provide guidance and technical assistance to health care recipients, federal agencies and communities.

- Healthy People 2010 is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats. One of the goals of Healthy People is to reduce health disparities. Additionally, Healthy People is the most comprehensive source of health data in the nation, according to the Healthy People 2010 and Steps to a Healthier US: Leading Prevention presentation.

- The State of Arizona is home of 22 federally recognized tribes on Indian reservations, which are considered sovereign nations. These tribal nations have jurisdiction over their tribal members residing on their tribal lands. Arizona recognizes the sovereignty of the tribes and practices government-to-government relationship with the tribes. The Arizona Governor enacted an Executive Order (2006-14) requiring consultation with the tribes prior to an enactment of legislation or policy impacting tribal members. This executive order is commensurate with federal Presidential executive orders requiring tribal consultation by federal agencies. ADHS has a Tribal Consultation Policy and works to incorporate government-to-government practices in its business relationships with tribes.

- Each RBHA has a Tribal Liaison. The Tribal Liaison works to enhance behavioral health services to American Indians both on and off reservation. The Tribal Liaison also works with tribal governments to facilitate the development of RBHA provider services on tribal lands.

- Beneficiary improvements, as described in the Medicare Improvements for Patients and Providers Act of 2008 mandates compliance with and enforcement of CLAS standards in Medicare. The Office of the Inspector General (OIG) must report, within two years, on the extent to which Medicare providers follow the rules regarding discrimination against beneficiaries with limited English proficiency and the Culturally and Linguistically Appropriate Services (CLAS) Standards, and requires the Secretary to correct any deficiencies (Department of Health & Human Services OIG, July 2010).

- Under Title VI of the Civil Rights Act, recipients of federal financial assistance must take reasonable steps to ensure meaningful access to their programs, services and activities by eligible limited English proficient (LEP) persons. In order to comply with

these Federal requirements, T/RBHA providers must provide language assistance services, such as interpreters and translated documents**.**

3.23.5 Definitions

CLAS Standards

Commonly Encountered LEP Groups

Cultural Competence

Culture

Disability

Interpretation

Health Disparities

Limited English Proficiency (LEP)

Linguistic Competence

Member Information Materials

Translation

3.23.6 Objective

To outline the frame work in which ADHS/DBHS has developed cultural competency specific activities based on Federal and State requirements and to effectively communicate the expectations for the delivery of culturally and linguistically appropriate behavioral health services.

3.23.7 Procedures

3.23.7-A. Required Cultural Competency Plan

The RBHAS are required to develop and implement an annual cultural competency plan according to ADHS/DBHS guidance to ensure compliance of State and Federal Rules and Regulations.

As the involvement of Indian Tribes in the development of ADHS/DBHS policies has increased and under the legal umbrella of the Intergovernmental Agreements (IGAs), ADHS/DBHS is committed to working with Indian Tribes to improve the quality, availability, accessibility and culturally responsive behavioral health care services for American Indians in Arizona. As part of those efforts the TRBHAS annually develop and

implement a cultural competency plan that addresses the unique needs of the population they serve. ADHS/DBHS provides guidance and technical assistance when needed to be in agreement with the most important goals of ADHS/DBHS cultural competency outlined in the annual plan.

3.23.7-B. Overall ADHS/DBHS Cultural Competency Framework

Required Culturally and Linguistically Appropriate Services (CLAS) Standards

The CLAS standards were established to correct inequities that currently exist in the provision of health and social services and to be more responsive to the individual needs of all patients/consumers. Ultimately, the aim of the standards is to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans.

The 14 standards are organized as follows:

- **Culturally Competent Care** (Standards 1-3), **Language Access Services** (Standards 4-7), and **Organizational Supports for Cultural Competence** (Standards 8-14). Within this framework, there are three levels of expectations for compliance:

- CLAS **mandates** are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7), and these mandates deal with linguistic competency

- CLAS **guidelines** are activities recommended by OMH for adoption as mandates by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).

- CLAS **recommendations** are suggested by OMH for voluntary adoption by health care organizations (Standard 14).

In accordance with all the standards, ADHS/RBHA contracts, ADHS/Tribal Intergovernmental Agreements and T/RBHA Annual Cultural Competency plans, require adherence to all three areas of the CLAS standards:

- Language Access Services (LAS);
- Culturally Competent Care; and
- Organizational Supports for Cultural Competence.

[T/RBHAs insert additional information here]

3.23.7-C Language Access Services (LAS)

To comply with the LAS requirements, T/RBHAS and subcontracted providers must:

- Provide language assistance services, including bilingual staff and interpreter services, at no cost to each behavioral health recipient with limited English proficiency at all points of contact, in a timely manner during all hours of operation;
- Provide to behavioral health recipients in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services;
- Ensure the competence of language assistance provided to limited English proficient behavioral health recipients, by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the behavioral health recipient); and
- Make available easily understood behavioral health-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

If the behavioral health recipient care requires the presence of a legal parent or guardian who does not speak English (e.g., when the patient/consumer is a minor or severely disabled), the T/RBHA and subcontracted providers must document the language not only of the recipient but also of the guardian or legal appointed representative. As a first preference, the availability of bilingual staff who can communicate directly with the recipient or guardian in their preferred language is desired. When such staff members are not available, face-to-face interpretation provided by trained staff, or contract or volunteer interpreters, is the next preference. Telephone interpreter services should be used as a supplemental system when an interpreter is needed instantly, or when services are needed in an unusual or infrequently encountered language. The competence and qualifications of individuals providing language services are discussed in Standard 6 of the CLAS standards final report.

Accessing Oral Interpretation Services
In accordance with Title VI of the Civil Rights Act, Prohibition against National Origin Discrimination, T/RBHAs and their subcontracted 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.

[T/RBHAs insert information, including contact information here for accessing language interpretation services.]

Accessing Interpretation Services for the Deaf and the Hard of Hearing
In accordance with A.R.S. § 36-1946, T/RBHAs and their subcontracted providers must provide auxiliary aids or licensed sign language interpreters that meet the needs of enrolled persons upon request, at no charge to AHCCCS eligible persons or person determined to have a Serious Mental Illness. 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 qualified and 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 http://www.acdhh.org or (602) 542-3323 (V/TTY)).

[T/RBHAs insert additional information here for accessing interpretation services for the deaf and hard of hearing.]

Translation of Written Material
T/RBHAs and their subcontracted providers must make written translated materials available, when the T/RBHA is aware that a language is spoken by 3,000 or 10% (whichever is less) of the provider behavioral health recipients, to the commonly encountered LEP groups who are AHCCCS eligible and to persons determined to have a Serious Mental Illness.

All vital materials shall be translated when the T/RBHA is aware that a language is spoken by 1,000 or 5% (whichever is less) of the T/RBHA´s behavioral health recipients who also have LEP. Vital materials must include at a minimum;

- Notice for denials, reductions, suspensions or termination of services;
- Service plans;
- Consent forms;
- Communications requiring a response from the behavioral health recipient; and
- Grievance notices.

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Members with LEP, whose languages are not considered commonly encountered, will be provided written notice in their primary or preferred language of the right to receive competent translation of written material.

Individual Service Plan (ISP) and Inpatient Treatment and Discharge Plan (ITDP)
The ADHS/DBHS 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 notification of the person's right to a Notice of Action (See PM Section 5.1 Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons) or Notice of Decision and Right to Appeal (See PM Section 5.5 Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)), if the person does not agree with the plan. ADHS/DBHS provides the service plan templates in both English and Spanish. The individual service plan is a vital document as defined in the AHCCCS/ADHS contract, ADHS/ RBHA Contracts and ADHS/ TRBHA IGAS.

As the service plans specifically incorporates 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 A.A.C. 21, Article 3.

In general, any document that requires the signature of the behavioral health recipient, and that contains vital information such as the treatment, medications or notices, or service plans must be translated into their preferred/primary language if requested by the behavioral health recipient or his/her guardian.

T/RBHAS and subcontracted providers must provide the service plans in the preferred/primary language expressed by the behavioral health recipient.

[T/RBHA insert additional information here for accessing translation of written materials]

3.23.7-D Culturally Competent Care

To comply with the Culturally Competent Care requirements, T/RBHAS and subcontracted providers must:

- Ensure that behavioral health recipients, receive from all provider staff members, effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language;
- Implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area; and
- Ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery. Providers with direct care responsibilities must complete mandated Cultural Competency training (see PM Section 9.1 Training Requirements and the Cultural Competence Plan), and ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery for the specific groups in the region.

3.23.7-E Organizational Supports for Cultural Competence

Under ADHS/DBHS guidance, and to comply with the Organizational Supports for Cultural Competence the T/RBHAs must:

- Develop, implement, and promote a written strategic plan following ADHS/DBHS standards and guidelines that outlines clear goals, policies, operational plans,

and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
- Conduct initial and ongoing organizational self-assessments of CLAS-related activities and integrate cultural and linguistic competence-related measures into internal audits, performance improvement programs, recipient satisfaction assessments, and outcomes-based evaluations, if required by ADHS/DBHS.
- Ensure that data on behavioral health recipients' race, ethnicity, and primary and/or preferred language is collected in the behavioral health medical record, integrated into management information systems, and periodically updated.
- Develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and recipient involvement in designing and implementing CLAS-related activities.

Subcontracted providers must:

- Maintain a current demographic profile of the service area as well as communicate existing needs to the T/RBHA in order to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
- Ensure that conflict and grievance resolution processes at the provider level are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by behavioral health recipients.
- Regularly make available to the T/RBHAS the information about progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

3.23.7-F Documenting Oral Interpretation Services and Translated Materials

Assessment and Service Planning

If the behavioral health recipient requests a copy of the assessment, those documents must be provided to the behavioral health recipient in his/her primary language. Documentation in the assessment must also be made in English; both versions must be maintained in the recipient's record. This will ensure that if any persons, who must review the recipient's record for purposes such as coordination of care, emergency services, auditing and data validation, have an English version available. If the primary/preferred language of the behavioral health recipient 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 behavioral health recipient's primary/preferred language for his/her signature.

Documentation of oral interpretation services provided in a language other than English must also be included in the recipient's record. Documentation must include date of service and interpreter name, each time a service requiring interpretation is provided.

3.23.8 Laws Addressing Discrimination and Respect for Diversity and Inclusion

T/RBHAs 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 Recipients Regarding Title VI Prohibition Against National Origin Discrimination affecting 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 LEP persons 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.

- The Americans with Disabilities Act prohibits discrimination against persons who have a disability. Providers are required to deliver services so that they are readily accessible to persons with a disability. T/RBHAs and their subcontracted 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. A T/RBHA or its subcontracted provider who employs fifteen or more persons is required to designate at least one person to coordinate its efforts to comply with federal regulations that govern anti-discrimination laws.

[T/RBHAs insert additional information here including list of local resources.]

Section 3.0 Clinical Operations (Section 3.21 RESERVED through Section 3.27)

3.21 Reserved
3.22 Out-of-State Placements for Children and Young Adults
3.23 Cultural Competence
3.24 Reserved
3.25 Crisis Intervention Services
3.26 Housing for Individuals determined to have a Serious Mental Illness (SMI)
3.27 Verification of U.S. Citzenship or Lawful Presence for Public Behavioral Health Benefits

Arizona Department of Health Services
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Section 3.25 Crisis Intervention Services

3.25.1 Introduction
3.25.2 References
3.25.3 Scope
3.25.4 Did you know…?
3.25.5 Definitions
3.25.6 Objectives
3.25.7 Procedures
3.25.7-A: General Requirements
3.25.7-B: Management of Crisis Services

3.25.1 Introduction

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

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.

3.25.2 References

The following citations can serve as additional resources for this content area:
ADHS/RBHA Contracts
ADHS/TRBHA IGAs
Section 3.16, Medication Formularies
Section 6.1, Submitting Tribal Fee-for-Service Claims to AHCCCS
Section 6.2, Submitting Claims and Encounters to the RBHA
ADHS/DBHS Covered Behavioral Health Services Guide

3.25.3 Scope

To whom does this apply?
Any person presenting with a behavioral health crisis in the community, regardless of Medicaid eligibility or enrollment status.

3.25.4 Did you know…?

- ADHS/DBHS has developed billing guidelines for crisis services (see PM Attachment 6.0.2, Billing Instructions Used to Identify Crisis Services). Guidelines for submitting claims for services, in general, are described in PM Attachment 6.0.1, Where Do I Submit My Claim?

- Collaboration agreements between RBHAs and local law enforcement/first responders address continuity of behavioral health services during a crisis, jail diversion and safety, and strengthening relationships between first responders and behavioral health providers.

3.25.5 Definitions

ADHS/DBHS Non-Title XIX/XXI Medication Formulary

Crisis

Crisis Intervention Services

Crisis Intervention Services (Inpatient Stabilization, Facility Based)

Crisis Intervention Services (Mobile, Community Based)

Crisis Intervention Services (Telephone)

Medically Necessary Covered Services

Serious Mental Illness

3.25.6 Objectives

To ensure that crisis services are readily available to individuals experiencing a behavioral health crisis.

3.25.7 Procedures

3.25.7-A: General Requirements

To meet the needs of individuals in communities throughout Arizona, T/RBHAs must ensure that the following crisis services are available:

- Telephone crisis intervention services, including a toll-free number, available 24 hours per day, seven days a week **[T/RBHA, insert numbers here]**;
- 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.
  - 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.
- 23-hour crisis observation/stabilization services, including detoxification services **[T/RBHA, insert additional information here]**; and
- Up to 72 hours of additional crisis stabilization as funding is available for mental health and substance abuse related services **[T/RBHA, insert additional information here]**.

[T/RBHA, insert additional information and/or any additional crisis services here.]

3.25.7-B: Management of Crisis Services

While T/RBHAs must provide a standard set of crisis services to ensure the availability of these services throughout the state, each T/RBHA must also be able to meet the specific needs of communities located within their service area. T/RBHAs must utilize the following in managing crisis services:

- T/RBHAs must allocate and manage funding to maintain the availability of required crisis services for the entire fiscal year;
- T/RBHAs must work collaboratively with local hospital-based emergency departments to determine whether a T/RBHA-funded crisis provider should be deployed to such locations for crisis intervention services;
- T/RBHAs must work collaboratively with local inpatient hospitals 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, T/RBHAs must use the generic medication formulary identified in the Non-Title XIX SMI benefit (see Section 3.16, Medication Formularies).

[T/RBHA, insert additional information here applicable to the T/RBHA crisis service system.]

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Section 3.26 Housing for Individuals determined to have a Serious Mental Illness (SMI)

3.26.1 Introduction
3.26.2 References
3.26.3 Scope
3.26.4 Did you know…?
3.26.5 Definitions
3.26.6 Objectives
3.26.7 Procedures
3.26.7-A: ADHS/DBHS Housing Requirements
3.26.7-B: T/RBHA Housing Programs and Requirements
3.26.7-C: Federal Programs and Assistance

3.26.1 Introduction

The Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) and Tribal and Regional Behavioral Health Authorities (T/RBHAs) have worked collaboratively to ensure a variety of housing options and support services are available to assist persons determined to have a Serious Mental Illness (SMI) live as independently as possible. Recovery often starts with safe, decent and affordable housing so that individuals are able to live, work, learn and participate fully in their communities. Safe, stable, and familiar living arrangements are critical to a person's ability to benefit from treatment and support services.

For persons determined to have SMI who are able to live independently, T/RBHAs have a number of programs to support independent living, such as rent subsidy programs, supported housing programs, bridge subsidy housing assistance while obtaining federal funding, and provider owned or leased homes and apartment complexes that combine housing services with other covered behavioral health services. Similarly, TRBHA housing programs include rent subsidy programs, owner occupied home repairs, move-in assistance and eviction prevention programs coupled with needed supported housing services to maintain independent living.

3.26.2 References

The following citations can serve as additional resources for this content area:
24 CFR Part 582
24 CFR 582.1
24 CFR Part 583
9 A.A.C. 20
9 A.A.C. 21
ADHS/RBHA Contracts
ADHS/TRBHA IGAs
Section 5.3, Grievance and Requests for Investigations for Persons Determined to have a Serious Mental Illness
Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)
ADHS/DBHS Covered Behavioral Health Services Guide
SAMHSA Permanent Supportive Housing Toolkit: http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510

3.26.3 Scope

To whom does this apply?

All persons determined to have Serious Mental Illness (SMI) who are enrolled in the public behavioral health system.

3.26.4 Did you know…?

- Medicaid (TXIX/XXI) does not cover supported housing services. However, ADHS/DBHS has limited funding allocated specifically for the provision of supported housing for Medicaid-eligible (Title XIX/XXI) individuals determined to have a SMI and for Non-Title XIX persons determined to have a SMI .

- In August 2000, ADHS/DBHS developed a permanent housing property acquisition program that allowed the RBHAs and their non-profit partners to purchase property for the first time in the history of Arizona, specifically for persons determined to have SMI. RBHAs used these funds to purchase homes and apartments through non-profit organizations that serve as contracted housing administrators/owners.

- ADHS/DBHS believes in permanent supportive housing and has adopted the SAMHSA model for permanent supportive housing programs. 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.

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

3.26.5 Definitions

Arizona Department of Housing (ADOH)

Homeless

Housing

Housing Administrator

Housing Referral

HB 2003 Permanent Housing Programs

Independent Community Housing

Permanent housing

Public Housing Authority (PHA)

Section 8

Serious Mental Illness

Shelter Plus Care

Sponsor-based Rental Assistance

Supported Housing Services

Supportive Housing

Tenant-Based Housing

Transitional Housing

U.S. Department of Housing and Urban Development (HUD)

3.26.6 Objectives

To communicate expectations for housing services and assistance provided for persons determined to have SMI who are receiving services within Arizona's public behavioral health system.

3.26.7 Procedures

3.26.7-A: ADHS/DBHS Housing Requirements

State Funded Supported Housing Programs

T/RBHAs must comply with the following requirements to effectively manage limited housing funds in providing supported housing services to eligible individuals (see the ADHS/DBHS Covered Behavioral Health Services Guide for additional information on Supported Housing):

- T/RBHAs must use supported housing allocations for individuals with a SMI and according to any restrictions pertaining to the funding source. For example, a particular allocation may require it be used for TXIX/XXI persons, while another allocation may require it be used for Non-TXIX persons.
- Housing must be safe, stable, 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.
- T/RBHAs and T/RBHA providers must not actively refer or place individuals determined to have SMI in a Homeless shelter, licensed Supervisory Care Homes, unlicensed board and care homes, or other similar facilities.[1]
- T/RBHAs 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, the T/RBHA must provide the tenant with a 30 day notice at the time of the tenant's annual recertification.
- T/RBHAs must not use supported housing allocations for room and board charges in residential treatment settings (Level II and Level III facilities). However, RBHAs may allow residential treatment settings to establish policies which require that persons earning income contribute to the cost of room and board.
- T/RBHAs may provide move-in assistance and eviction prevention services to those members in permanent housing. When move-in assistance is provided, T/RBHAs must prioritize assistance with deposits and payment for utilities over other methods of assistance, such as move-in kits or furnishings, consisting of pots and pans, dishes, sheets, etc. T/RBHAs are encouraged to seek donations for necessary move-in/home furnishing items whenever possible. T/RBHAs must not use supported housing allocations or other funding received from ADHS/DBHS (including block grant funds) to purchase furniture.

[1]When a behavioral health recipient chooses to reside in an unlicensed board and care home, T/RBHAs and/or behavioral health providers must report any observations of unsafe conditions or provision of services that require licensure to the local housing authority and the Office of Behavioral Health Licensing (OBHL) at (602) 364-2595.

- For appeals related to supported housing services, T/RBHAs and providers must follow requirements in Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI).
- Housing related grievances and requests for investigation for persons determined to have SMI must be addressed in accordance with Section 5.3, Grievance and Requests for Investigations for Persons Determined to have a Serious Mental Illness.

Other ADHS/DBHS Housing Requirements

T/RBHAs must additionally submit T/RBHA plans describing the T/RBHA housing programs and submit periodic reports on housing programs, as outlined in the ADHS/RBHA contracts and ADHS/TRBHA intergovernmental agreements.

3.26.7-B: T/RBHA Housing Programs and Requirements

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

- Housing for females with co-occurring disorders who are homeless,
- Apartment complexes for persons determined to have SMI with criminal backgrounds released from jail with a major biological disorder,
- Housing for persons determined to have SMI who are hearing impaired or deaf,
- Housing for persons determined to have SMI who have sexualized behaviors and are in need of on-site support,
- Gender based house model living for older females determined to have SMI,
- Apartment complex housing and services to 18-25 year old adults transitioning from the children's behavioral health system to the adult behavioral health system,
- Respite homes for persons with developmental disabilities who are determined to have SMI (joint ADHS/DBHS, DES/DD program),
- Specialized homes for polydipsia,
- Homes that specialize in dialectical behavioral therapy,
- Housing for persons determined to have SMI with limited English proficiency, and
- Housing suited to meet medical needs of persons determined to have SMI with diabetes and other chronic diseases.

[T/RBHA, insert information here covering T/RBHA specific housing programs/funding and related requirements.]

3.26.7-C: Federal Programs and Assistance

The US Department of Housing and Urban Development (HUD) provides funding for adults who are homeless and disabled. With these funds, HUD requires states to have active community-based forums during which local representatives identify regional homeless needs and gaps in each community. There are three HUD continuums of care programs in Arizona that provide funding for homeless individuals with disabilities. The programs are comprised of civic, faith-based, business, non-profit and government leaders who rate and rank programs applying for HUD funding. ADHS/DBHS and RBHAs are members of the continuum of care programs and provide the funding match required for the program to maintain existing housing and to create

new housing programs for RBHA enrolled members. ADHS/DBHS and RBHAs provide funding for the following HUD programs:

Shelter Plus Care rent subsidy for homeless people with disabilities and their families:
HUD requires a funding match to receive and maintain federal funds.The day-to-day operations are administered by RBHAs and other non-profit organizations.

Supportive Housing:
RBHA contracted housing providers serve as both grantee *and* administrator of various HUD housing programs.

Federal HUD Housing Choice Voucher Program:

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

[T/RBHA, insert contact information here for providers to call to receive additional information regarding these programs.]

Section 3.27 Verification of U.S. Citizenship or Lawful Presence for Public Behavioral Health Benefits

3.27.1 Introduction
3.27.2 References
3.27.3 Scope
3.27.4 Did you know…?
3.27.5 Definitions
3.27.6 Objectives
3.27.7 Procedures
3.27.7-A. Who is eligible to receive public behavioral health services with verification of U.S. citizenship/lawful presence?
3.27.7-B. Who is eligible to receive public behavioral health services without verification?
3.27.7-C. Completing an AHCCCS Eligibility Determination Screening as part of the verification process
3.27.7-D Documentation Requirements

3.27.1 Introduction

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 Service (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 (Medicaid) or Title XXI (KidsCare) covered services,
- Not qualify for Title XIX/XXI entitlements, but be eligible for services as a person determined to have a Serious Mental Illness (SMI) (See PM 3.21, Service Package for Non-Title XIX/XXI Persons Determined to Have a Serious Mental Illness); or
- Not qualify for Title XIX/XXI entitlements, but be eligible for services.

Tribal and Regional Behavioral Health Authorities (T/RBHAs) and T/RBHA providers must verify U.S. citizenship or lawful presence in the U.S. of all persons applying for publicly funded behavioral health services.

3.27.2 References

The following citations can serve as additional resources for this content area:
42 CFR Part 400
42 CFR Part 403
42 CFR Part 411

42 CFR Part 417
42 CFR Part 422
42 CFR Part 423
A.R.S. § 1-502
A.R.S. § 36-3408
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA Intergovernmental Agreements (IGAs)
Section 3.1, Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage and the Limited Income Subsidy Program
Section 3.4, Co-payments
Section 3.10, SMI Eligibility Determination
Section 3.19, Special Populations
Section 3.21, Service Package for Non-Title XIX/XXI Persons Determined to Have a Serious Mental Illness (SMI)
Section 4.1, Disclosure of Behavioral Health Information
Section 4.2, Behavioral Health Medical Record Standards
Assisting Behavioral Health Recipients with AHCCCS Eligibility Manual
Health-e-Arizona

3.27.3 Scope

To whom does this apply?

T/RBHA providers must obtain documentation to verify citizenship/lawful presence for persons who are:

- Potentially eligible for AHCCCS (Title XIX or Title XXI) behavioral health services; and
- Not eligible for AHCCCS, but who may be eligible for services as a person determined to have SMI (see Section 3.21, Service Package for Non-Title XIX/XXI Persons Determined to Have a Serious Mental Illness (SMI));
- 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.[1]
- Temporary documents include proof of income, expenses, assets or pregnancy.

3.27.4 Did you know…?

Persons who present for crisis services in the public behavioral health system are not required to verify U.S. Citizenship/Lawful Presence to receive needed services.

If a person is currently enrolled with AHCCCS and has been assigned to a T/RBHA, verification of citizenship/lawful presence has already been completed.

[1] If the persons who are applying have received AHCCCS Health Insurance since July 2006, AHCCCS and/or DES may already have this documentation on file.

The Arizona Health Care Cost Containment System's (AHCCCS) online application for Health Insurance titled Health-e-Arizona, (see the Assisting Behavioral Health Recipients with AHCCCS Eligibility Manual) was designed to simplify the application process. Applicants can complete an application and verify U.S. citizenship/lawful presence with the assistance of a provider using the subscriber version of the Health-e-Arizona online application. Once completed, the application will be routed to the correct eligibility determination agency. The application also permits a person to apply for all AHCCCS programs and other public benefits for all family members on one application form. As such, all family members will be required to verify citizenship/lawful presence and identification through the same application.

As part of the eligibility process, applicants must submit verification of documents requested by the Health-e-Arizona program based on their individual living and financial situations. The requested information is saved in the Health-e-Arizona system for future review.

Persons who are able but refuse to participate in the screening and/or application process using Health-e-Arizona are not eligible for behavioral health services (A.R.S. § 36-3408). See PM Section 3.1, Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Limited Income Subsidy Program, Subsection 3.1.6-D, for more information.

3.27.5 Definitions

Lawful Presence

U.S. Citizen

3.27.6 Objectives

- To describe the procedures to verify U.S. citizenship/lawful presence through Health-e-Arizona, and to assist behavioral health recipients with applying for AHCCCS health insurance, when indicated;
- To identify methods for determining if a person has previously verified U.S. citizenship/lawful presence and identification;
- To determine what documents are accepted as verification of citizenship/lawful presence and identification for AHCCCS eligibility; and
- To describe expectations for assisting persons in obtaining the necessary documents to verify citizenship/lawful presence and/or identity.

3.27.7 Procedures

3.27.7-A. Who is eligible to receive public behavioral health services with verification of U.S. citizenship/lawful presence?

The following individuals are eligible for public behavioral health services:

- Persons determined to be eligible for AHCCCS.

- Persons not eligible for AHCCCS but determined to have a Serious Mental Illness (SMI) **AND** can provide documentation of citizenship/lawful presence. (see Section 3.21, Service Package for Non-Title XIX/XXI Persons Determined to Have a Serious Mental Illness (SMI))

3.27.7-B. Who is eligible to receive public behavioral health services without verification?

Persons not eligible for AHCCCS and NOT determined as SMI but who qualify to receive behavioral health services funded through the Substance Abuse Prevention and Treatment (SAPT) Block Grant or the Projects for Assistance in Transition from Homelessness (PATH) Program are eligible to receive services in accordance with Provider Manual Section 3.19, Special Populations. However, persons receiving services funded by SAPT or PATH must still be screened for AHCCCS eligibility in accordance with Provider Manual 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.

3.27.7-C. Completing an AHCCCS Eligibility Determination Screening as part of the verification process

For an illustration on how the verification process works, see Attachment 3.27.4, Flowchart for the Citizenship/Lawful Presence Verification Process Through Health-e-Arizona,

For a list of those persons who are exempt from citizenship verification, see Attachment 3.27.3, 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 online application. An eligibility screening will be conducted:

- Upon initial request for behavioral health services,

- At least annually thereafter, if still receiving behavioral health services, and

- When significant changes occur in the person's financial status.

What is the process for completing the eligibility screening using Health-e-Arizona?
The T/RBHA or behavioral health provider meets with the person and completes the Health-e-Arizona online application. Once the online application screening has been completed, the Health-e-Arizona online application tool will indicate:

- If the person is potentially AHCCCS eligible the T/RBHA or behavioral health provider must obtain, from the applicant:
  - Documentation of identification and U.S. Citizenship needed if the person claims to be a U.S. citizen (see Attachment 3.27.1, Documents Accepted by AHCCCS To Verify Citizenship and Identity); or

  - 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 Attachment 3.27.2, Non-Citizen/Lawful Presence Verification Documents).

If the Health-e-Arizona 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

- Decide to not continue with the online application process, the provider will need to determine if the person is eligible for behavioral health services as described in Section 3.19, Special Populations and Section 3.21, Service Package for Non-Title XIX/XXI Persons Determined to Have a Serious Mental Illness (SMI). The provider must continue work with the person to obtain the required citizenship/lawful presence documents whenever possible for future eligibility status need.

What if a person is unable to provide the required identification or citizenship/lawful presence documents at the time of application?
To the extent that it is practicable, T/RBHAs or their contracted providers are expected to assist applicants in obtaining required documentation of identification and citizenship/lawful presence within the timeframes indicated by Health-e-Arizona (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 behavioral health services unless they meet the criteria outline in subsection 3.27.7-C. If the person obtains the required documentation at a later date he/she may reapply for AHCCCS eligibility using Health-e-Arizona (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 3.19, Special Populations.

3.27.7-D Documentation Requirements

Documentation of screening a behavioral health recipient through Health-e-Arizona must be included in the behavioral health medical record, including the Application Summary and final Determination of eligibility status notification printed from the Health-e-Arizona 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 Provider Manual Section 3.1, Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage and the Limited Income Subsidy Program.
[T/RBHA enter specific documentation information here.]

Section 4.0 Communication and Care Coordination

4.1 Disclosure of Behavioral Health Information
4.2 Behavioral Health Medical Record Standards
4.3 Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers
4.4 Coordiantion of Care with Other Governmental Entities
4.5 Partnerships with Familes and Family-Run Organizations in the Children's Behavioral Health

Section 4.1 Disclosure of Behavioral Health Information

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4.1.2 References
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4.1.1 Introduction

To improve the efficiency and effectiveness of the health care system, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 included provisions for national standards for electronic health care transactions. To safeguard the privacy of health care information, Congress incorporated provisions that mandated the adoption of federal privacy protections for individually identifiable health information. HIPAA specifies how a person's protected health information (PHI) will be used and disclosed. The U.S. Department of Health and Human Services has issued federal regulations (the Privacy Rule) that provide individuals with certain rights to control the use and disclosure of their protected health information. The Privacy Rule is applicable to any agency that has identified itself to be one of three types of "covered entities": health plan; health care provider; and/or health care clearinghouse. By the compliance date of April 14, 2003, covered entities must have implemented standards to protect and guard against the misuse of protected health information.

In 2009 Congress enacted the HITECH Act (Health Information Technology for Economic and Clinical Health Act) (Title XII, Subtitle D of the American Recovery and Reinvestment Act of 2009 (P. L. 111-005), which substantially expands the HIPAA Privacy and Security Rule. Tribal and Regional Behavioral Health Authorities (T/RBHAs) and their subcontracted providers are now required to comply with the HITECH Act regarding how they use and disclose protected health information. In the event a behavioral health recipient's unsecured PHI has been impermissibly used or disclosed, T/RBHAs and their subcontracted providers are responsible for notifying each affected individual in accordance with the HITECH Act Security Breach Notification requirement.

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS), the T/RBHAs and behavioral health providers must all comply with the Privacy Rule when providing health care services and/or paying for services with state and federal funds. Each organization is a separate "covered entity" and therefore must individually institute practices for complying with the Privacy Rule.

This section is intended to provide guidance as to whom information can be disclosed to and when authorization[1] is required prior to that disclosure. 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.

4.1.2 References

The following citations can serve as additional resources for this content area:
Title XIII, Subtitle D of the American Recovery and Reinvestment Act of 2009 (HITECH Act)
42 U.S.C. § 290-dd-2
42 U.S.C. § 10805
42 C.F.R. Part 2
45 C.F.R. Part 160, Subparts A and B
45 C.F.R. Part 164, Subparts A and E
A.R.S. § 12-2291, et seq.
A.R.S. § 13-3620
A.R.S. Title 14, Chapter 5, Article 2 or 3
A.R.S. § 14-3804
A.R.S. § 36-501
A.R.S. § 36-504
A.R.S. § 36-507
A.R.S. § 36-509
A.R.S. § 36-517.01
A.R.S. § 36-517.02
A.R.S. § 36-661, et seq.
A.R.S. § 36-664
A.R.S. Title 36, Chapter 32
A.R.S. § 36-3701, et seq.
A.R.S. § 41-3804
A.R.S. § 46-454
9 A.A.C. 20
9 A.A.C. 21
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA IGAs
ADHS/DDD-DES Interagency Service Agreement
Health Insurance Portability and Accountability Act Privacy Manual
Information Sharing with Family Members of Adult Behavioral Health Recipients Technical Assistance Document

4.1.3 Scope

To whom does this apply?
All persons receiving, or who have received, services through Arizona's public behavioral health system.

[1] For purposes of uniformity and clarity, the term "authorization" is used throughout this policy 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.

4.1.4 Did you know…?

- The "minimum necessary" standard ensures that only the minimum information necessary to accomplish an intended purpose is requested and disclosed.

- The United States Health and Human Services Department/Office of Civil Rights (OCR) has the authority for administering and enforcing compliance with the Privacy Rule. The OCR can assess significant penalties for failure to comply with HIPAA, including monetary fines and the loss of federal funds.

- Other components of HIPAA include the Transaction and Code Set Rules and the Security Rules.

- All covered entities must have a HIPAA Compliance Officer to hear complaints and address inquiries regarding the provider's practices.

4.1.5 Definitions

Alcohol and Drug Abuse Program

Clinical Teams

De-Identified Health Information

Designated Record Set

Health Care Decision-Maker

Health Care Provider

Health Insurance Portability and Accountability Act (HIPAA)

HITECH Act

HIV-Related Information

Individual

Individually Identifiable Health Information

Medical Records

Payment Records

Protected Health Information

Qualified Service Organization

Telemedicine

Unsecured Protected Health Information

4.1.6 Objectives

To give guidance to behavioral health providers on the obligations relating to the HIPAA laws and State laws and regulations related to the use, disclosure or when responding to requests for protected health information.

4.1.7 Procedures

4.1.7-A. Overview of confidentiality information

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

- Information obtained when providing behavioral health 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.

Behavioral Health Information Not Related to Alcohol and Drug Treatment

Information obtained when providing behavioral health 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, health care clearinghouse) to use or disclose protected health information with or without patient authorization in a variety of circumstances, some of which are required and others that are permissive. Many of the categories of disclosures contain specific words and phrases that are defined in the HIPAA Rule. Careful attention must be paid to the definitions of words and phrases in order to determine whether disclosure is allowed. In addition, the HIPAA Rule may contain exceptions or special rules that apply to a particular disclosure. State law may affect a disclosure. For example, the HIPAA Rule may preempt a state law or a state law may preempt the HIPAA Rule. In addition, a covered entity must, with certain exceptions, make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the disclosure.

Before disclosing protected health information, it is good practice to consult the specific citation to the HIPAA Rule, state law and consult with legal counsel before disclosing an individual's protected health information. See 4.1.7-C. for more detail regarding the disclosure of behavioral health information not related to alcohol or drug referral, diagnosis or treatment.

Drug and Alcohol Abuse Information

Information regarding treatment for alcohol or drug abuse is afforded special confidentiality by Federal statute and regulation. This includes any information concerning a person's diagnosis or treatment from a federally assisted alcohol or drug abuse program or referral to a federally assisted alcohol or drug abuse program. See subsection 4.1.7-D. for more detail regarding the disclosure of drug and alcohol abuse information.

4.1.7-B. General procedures for all disclosures

Unless otherwise excepted by state or federal law, all information obtained about a person related to the provision of behavioral health services to the person is confidential whether the information is in oral, written, or electronic format.

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

List of Persons Accessing Records

The T/RBHA must ensure 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.

Disclosure to Clinical Teams

Disclosure of information to members of a clinical team may or may not require an authorization depending upon the type of information to be disclosed and the status of the receiving party. Information concerning diagnosis, treatment or referral for drug or alcohol treatment may only be disclosed to members of a clinical team with patient authorization as prescribed in subsection 4.1.7-D. 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 subsection 4.1.7-C.

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.

4.1.7-C. 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. The latter part of subsection 4.1.7-C. contains a more detailed description of circumstances that are likely to involve the use or disclosure of behavioral health information.

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

- To the individual and the individual's health care decision maker;
- To health, mental health and social service providers for treatment, payment or health care operations;

- Incidental to a use or disclosure otherwise permitted or required by 45 C.F.R. Part 164, Subpart E;
- To a person or entity with a valid authorization;
- Provided the individual is informed in advance and has the opportunity to agree or prohibit the disclosure:
  - For use in facility directories;
  - To persons involved in the individual's care and for notification purposes;
- When required by law;
- For public health activities;
- About victims of child abuse, neglect or domestic violence;
- For health oversight activities;
- For judicial and administrative proceedings;
- For law enforcement purposes;
- About deceased persons;
- For cadaveric organ, eye or tissue donation purposes;
- For research purposes;
- To avert a serious threat to health or safety or to prevent harm threatened by patients;
- To a human rights committee;
- For purposes related to the Sexually Violent Persons program;
- With communicable disease information;
- To personal representatives including agents under a 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 payor 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 C.F.R. Part 2);
- To a person or entity to conduct utilization review, peer review and quality assurance pursuant to Section 36-441, 36-445, 36-2402 or 36-2917;
- To a person maintaining health statistics for public health purposes as authorized by law; and
- To a grand jury as directed by subpoena.

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

Disclosure to an individual

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 C.F.R. § 164.524; A covered entity should read and carefully apply the provisions in 45 C.F.R. §164.524 before disclosing protected health information in a designated record set to an individual.

An individual has a right of access to his or her designated record set, except for psychotherapy notes and information compiled for pending litigation. See 45 C.F.R. § 164.524(a)(1) and Section 13405(e) of the HITECH Act. Under certain conditions a covered entity may deny an individual access to the medical record without providing the individual an opportunity for review. See 45 C.F.R. § 164.524(a)(2). Under other conditions, a covered entity may deny an individual access to the medical record and must provide the individual with an opportunity for review. See 45 C.F.R. § 164.524(a)(3). A covered entity must follow certain requirements for a review when access to the medical record is denied. See 45 C.F.R. § 164.524(a)(4).

An individual must be permitted to request access or inspect or obtain a copy of his or her medical record. See 45 C.F.R. § 164.524(b)(1). A covered entity is required to act upon an individual's request in a timely manner. See 45 C.F.R. § 164.524(b)(2).

An individual may inspect and be provided with one free copy per year of his or her own medical record, unless access has been denied.

A covered entity must follow certain requirements for providing access, the form of access and the time and manner of access. See 45 C.F.R. § 164.524(c).

A covered entity is required to make other information available in the record when access is denied, must follow other requirements when making a denial of access, must inform an individual of where medical records are maintained and must follow certain procedures when an individual requests a review when access is denied. See 45 C.F.R. § 164.524(d).

A covered entity is required to maintain documentation related to an individual's access to the medical record. See 45 C.F.R. § 164.524(e).

Disclosure with an individual'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 C.F.R. §§ 164.502(a)(1)(iv); and 164.508. An authorization must contain all of the elements in 45 C.F.R. § 164.508.

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

- A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion;

- The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure;

- The name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested use or disclosure;

- A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose;

- An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. The statement "end of the research study," "none," or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research repository; and

- Signature of the individual and date. If the authorization is signed by a personal representative of the individual, a description of the representative's authority to act for the individual must also be provided.

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

- The individual's right to revoke the authorization in writing, and either:
  - The exceptions to the right to revoke and a description of how the individual may revoke the authorization; or

  - A reference to the covered entity's notice of privacy practices if the notice of privacy practices tells the individual how to revoke the authorization.

- The ability or inability to condition treatment, payment, enrollment or eligibility for benefits on the authorization, by stating either:
  - The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization when the prohibition on conditioning of authorizations in 45 C.F.R. § 164.508 (b)(4) applies; or

  - The consequences to the individual of a refusal to sign the authorization when, in accordance with 45 C.F.R. § 164.508 (b) (4), the covered entity can condition treatment, enrollment in the health plan or eligibility for benefits on failure to obtain such authorization.

- The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient.

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 C.F.R. § 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 C.F.R. § 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 C.F.R. § 164.506(c)(2). A covered entity may disclose to both covered and non-covered health care providers for payment activities. See 45 C.F.R. § 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 C.F.R. § 164.506(c)(4).

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

The HIPAA Rule does not modify a covered entity's obligation under A.R.S. § 13-3620 to report child abuse and neglect to Child Protective Services or disclose a child's medical records to Child Protective Services 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 C.F.R. § 164.512(c).

Disclosure to other persons including family members

A covered entity may disclose protected health information without authorization to other persons including family members actively participating in the patient's care, treatment or supervision. Prior to releasing information, an agency or non-agency treating professional or that person's designee must have a verbal discussion with the person to determine whether the person objects to the disclosure. If the person objects, the information cannot be disclosed. If the person does not object, or the person lacks capacity to object, the treating professional must perform an evaluation to determine whether disclosure is in that person's best interests. A decision to disclose or withhold information is subject to review pursuant to A.R.S. § 36-517.01.

An agency or non-agency treating professional may only release information relating to the person's diagnosis, prognosis, need for hospitalization, anticipated length of stay, discharge plan, medication, medication side effects and short-term and long-term treatment goals. 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 C.F.R. § 164.510(b).

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 C.F.R. § 164.502(g). Examples of agents appointed to act on an individual's behalf include an agent under a health care power of attorney, 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.

Disclosure to a personal representative, Unemancipated Minors

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

Similarly, if state law, including case law, prohibits a parent, guardian or other person acting *in loco parentis* from obtaining protected health information, then a covered entity may not disclose the protected health information. See 45 C.F.R. § 164.502(g)(3)(ii)(B).

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

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 C.F.R. § 164.502(g)(2). Simply stated, if there is a state law that permits the personal representative to obtain the adult or emancipated minor's protected health information, the covered entity may disclose it. A covered entity may withhold

protected health information if one or more of the exceptions in 45 C.F.R. § 164.502(g)(5) applies.

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

Disclosure for court ordered evaluation or treatment
An agency in which a person is receiving court ordered evaluation or treatment is required to immediately notify the person's guardian or agent or, if none, a member of the person's family that the person is being treated in the agency. 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 C.F.R. § 164.524(a)(3). If a family member makes the request for review, the reviewing official must apply the "best interest" standard in A.R.S. § 36-517.01.

The reviewer's decision may be appealed to the superior court. 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.

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 C.F.R. § 164.512(d).

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

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

Disclosure to prevent harm threatened by patients
Mental health providers have a duty to protect others against the harmful conduct of a patient. 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 C.F.R. §§ 164.512(j)(1)(ii); 164.512(f)(2) and (3) for rules that apply for disclosures made to law enforcement. See 45 C.F.R. § 164.512(j)(4) for what constitutes a good faith belief.

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 C.F.R. § 164.514(b) and not state law. If a human rights committee wants non-redacted identifiable health information for official purposes, it must first demonstrate to ADHS/DBHS that the information is necessary to perform a function that is related to the oversight of the behavioral health system, and in that case, a covered entity may disclose protected health information to the human rights committee in its capacity as a health oversight agency. See 45 C.F.R. § 164.512(d)(1).

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 C.F.R. § 164.512(k)(5).

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 C.F.R. § 164.512(f)(2)(i). In addition, a covered entity is permitted limited disclosure to governmental agencies to prevent or

lessen a serious and imminent threat to the health or safety of a person or the public. See 45 C.F.R. § 164.512(j).

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 persons statutes and sexual offender treatment programs. A competent professional is either statutorily required or may be ordered by the court to perform an examination of a person involved in the sexually violent persons program and must be given reasonable access to the person in order to conduct the examination and must share access to all relevant medical and psychological records, test data, test results and reports. 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 C.F.R. § 164.512(a) (disclosure permitted when required by law) and 45 C.F.R. § 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 C.F.R. § 164.506(c) to determine rules for disclosure for treatment, payment or health care operations.

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).

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).

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; and
- A private entity that accredits a health care facility or a health care provider.

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

Disclosures to the Department of Health Services or local health departments are also permissible under certain circumstances:

- Authorizations;
- Redisclosures;
- 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 C.F.R. § 164.508(c)(2)(ii), which requires the authorization to contain a statement to place the individual on notice of the potential for redisclosure by the recipient and thus, is no longer protected. Therefore, any authorization for protected health information that includes communicable disease information must contain the statement that redisclosure of that information is prohibited.

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

Disclosure to the Arizona Center for Disability Law, acting in its capacity as the State Protection and Advocacy Agency pursuant to 42 U.S.C. § 10805, is allowed when:

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

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

4.1.7-D. Disclosures of alcohol and drug information

T/RBHAs and their subcontracted 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.

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

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

T/RBHAs or their subcontracted providers may not acknowledge that a currently or previously enrolled person is receiving or has received alcohol or drug abuse services without the enrolled person's authorization as provided in section 4.1.7-D. of this policy.

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

The T/RBHA or subcontracted provider 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, 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.

<u>Redisclosure</u>
Authorization as provided above must be accompanied by the following written statement: "This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

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

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

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 C.F.R. § 2.52.

- Audit and Evaluation Activities – information may be disclosed for the purposes of audit and evaluation activities according to the provisions of 42 C.F.R. § 2.53.

- Qualified Service Organizations – information may be provided to a qualified service organization when needed by the qualified service organization to provide services to a currently or previously enrolled person.

- Internal Agency Communications - the staff of an agency providing alcohol and drug abuse services may disclose information regarding an enrolled person to other staff within the agency, or to the part of the organization having direct administrative control over the agency, when needed to perform duties related to the provision of alcohol or drug abuse diagnosis, treatment, or referral for treatment to a person. For example, an organization that provides several types of services might have an administrative office that has direct administrative control over each unit or agency that provides direct services.

Information concerning an enrolled person that does not include any information about the enrolled person's receipt of alcohol or drug abuse diagnosis, treatment or referral for treatment is not restricted under this 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 in section 4.1.7-C. of this policy.

Court-ordered disclosures

A state or federal court may issue an order that authorizes an agency to make a disclosure of identifying information that would otherwise be prohibited. A subpoena, search warrant or arrest warrant is not sufficient standing alone, to require or permit an agency to make a disclosure.

Crimes committed by a person on an agency's premises or against program personnel

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

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

A general medical release form or any authorization form that does not contain all of the elements listed in subsection 4.1.7-D. above is not acceptable.

[T/RBHA add information here]

4.1.7-E Security Breach Notification
T/RBHAs and their subcontracted providers, in the event of an impermissible use/disclosure of unsecured PHI, must provide notification to any and all persons affected by the breach in accordance with Section 13402 of the HITECH Act.

4.1.7-F. 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; and
- **[T/RBHA insert additional information here].**

Section 4.2 Behavioral Health Medical Record Standards

4.2.1 Introduction
4.2.2 References
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4.2.7-A Paper or electronic format
4.2.7-B. Disclosure of records
4.2.7-C. Comprehensive clinical record
4.2.7-D. Behavioral health provider records
4.2.7-E. Requirements for Community Service Agencies (CSA), Home Care Training to Home Care Client (HCTC) Providers and Habilitation Providers
4.2.7-F Adequacy and availability of documentation
4.2.7-G. Retention of records

4.2.1 Introduction

The behavioral health medical record contains clinical information pertaining to a behavioral health recipient. The information assists behavioral health providers in successfully treating and supporting recipients. Maintaining current, accurate, and comprehensive behavioral health medical records is important for many reasons. Documentation in the behavioral health medical record facilitates diagnoses and treatment, facilitates coordination of care, supports billing reimbursement information, provides evidence of compliance during periodic medical record reviews and can protect practitioners against potential litigation.

Medical record documentation must be legible, accurate and reflect a behavioral health recipient's behavioral health status, changes in behavioral health status, and reflect all behavioral health care needs and services provided.

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) recognizes the value of accurate and comprehensive behavioral health records. ADHS/DBHS, Arizona Health Care Cost Containment System (AHCCCS) and federal and state authorities establish the standards to guide behavioral health providers in ensuring the proper organization, content, maintenance and retention of behavioral health medical records.

4.2.2 References

The following citations can serve as additional resources for this content area:
45 C.F.R. § 164.502(b)
45 C.F.R. § 164.514(d)
A.R.S. § 12-2291 et. seq.
A.R.S. § 12-2294(C)

A.R.S. § 36-441
A.R.S. § 36-445
A.R.S, § 36-2402
A.R.S. § 36-2917
A.A.C. R9-20-211
A.A.C. R9-21-209
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA IGAs
AHCCCS Medical Policy Manual, Policy 940
Section 3.3 Referral and Intake Process
Section 3.4, Co-payments
Section 3.9, Assessment and Service Planning
Section 3.11, General and Informed Consent to Treatment
Section 3.12, Advance Directives
Section 3.14, Securing Services and Prior Authorization
Section 3.15, Psychotropic Medications: Prescribing and Monitoring
Section 3.17, Transition of Persons
Section 3.18, Pre-Petition Screening, Court Ordered Evaluation and Court Ordered Treatment
Section 3.19, Special Populations
Section 3.21, Service Package for Non-Title XIX/XXI Persons Determined to Have a Serious Mental Illness (SMI)
Section 4.3, Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers
Section 4.1, Disclosure of Behavioral Health Information
Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons
Section 5.4, Special Assistance for Persons Determined to have a Serious Mental Illness
Section 7.4, Reporting of Incidents, Accidents and Deaths
Section 7.5, Enrollment, Disenrollment and Other Data Submission
ADHS/DBHS Policy and Procedure Manual Section MI 5.2 Community Service Agencies-Title XIX Certification

4.2.3 Scope

To whom does this apply?

All providers contracting with a Tribal or Regional Behavioral Health Authority (T/RBHA) providing services in Arizona's public behavioral health system.

4.2.4 Did you know…?

- The behavioral health record is the property of the entity that generates the record.

- AHCCCS or its designee may inspect Title XIX and Title XXI behavioral health medical records at any time during regular business hours at the offices of ADHS/DBHS, the T/RBHAs, or behavioral health providers.

- The Department of Economic Security, Division of Developmental Disabilities (DES/DDD) or its designee may inspect the behavioral health medical records of their enrolled Title XIX, Title XXI, and DES/DDD Arizona Long Term Care Services (ATLCS) recipients at any time during regular business hours at the offices of ADHS/DBHS, the T/RBHAs, or behavioral health providers.

4.2.5 Definitions

Assessment

Behavioral Health Status

Certification of Need (CON)

Community Service Agency (CSA)

General Consent

Habilitation Provider

Home Care Training to Home Care Client (HCTC) Provider

Informed Consent

Medical Records

Recertification of Need (RON)

Telemedicine

Treatment

4.2.6 Objectives

To ensure that behavioral health records document the delivery of medically necessary services and that each behavioral health record is complete, accurate, legible, and current by establishing consistent standards for behavioral health providers.

4.2.7 Procedures

4.2.7-A Paper or electronic format

Records may be documented in paper or electronic format.

For paper documentation the record must be:

- Dated;

- Signed with an original signature and credential;
- Legible and either written in blue or black ink or typewritten;
- Corrected 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 (see A.A.C. R9-20-211(C), Client Records).

Providers that use 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 by the computer's internal clock;
- The record is recorded only by personnel authorized to make entries using T/RBHA or provider 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.

Transportation services

For providers that supply transportation services for recipients using provider employees (i.e. facility vans, drivers, etc.) the following requirements apply.

For providers that use contracted transportation services, for non-emergency transport of recipients, that are not direct employees of the provider (i.e. cab companies, shuttle services,

etc.) the original signature and credentials portion of these requirements is waived. Instead, documentation for the recipient record must include a summary log of the transportation event received from the transportation provider that includes all other elements listed as follows:

- Complete service provider's name and address;
- Name signature and credentials of the driver who provided the service;
- Vehicle identification (car, van, wheelchair van, etc.);
- Member's' AHCCCS ID 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.

4.2.7-B. Disclosure of records

Behavioral health records must be maintained as confidential and must only be disclosed according to the provisions in Section 4.1, Disclosure of Behavioral Health Information.

Section 4.1, Disclosure of Behavioral Health Information, contains information regarding the review of behavioral health medical records by behavioral health recipients.

When requested by a recipient's primary care provider or the recipients' DES/DDD/ALTCS support coordinator, the behavioral health record or copies of behavioral health record information must be forwarded within ten (10) days of the request. (See PM 4.3, Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers, for more information).

ADHS shall ensure that each recipient is guaranteed the right to request and receive a copy of his/her medical record and to request that they be amended or corrected, as specified in 45 C.F.R. Part 164.

4.2.7-C. Comprehensive clinical record

The designated behavioral health provider must ensure the development and maintenance of a comprehensive clinical record for each recipient. The comprehensive clinical record, whether electronic or hard copy, may contain information contributed by several other service providers involved with the care and treatment of a recipient.

The comprehensive clinical record must include the following:

- Identification information on each page of the record (i.e., recipient's name and AHCCCS /CIS identification number);
- Documentation of identifying demographics including 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;
- 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; and
- 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.

The comprehensive clinical record must also contain the following elements listed below. These elements are listed as follows using a system of topics/tabs for purposes of organization and maintenance of required documentation. ADHS/DBHS strongly recommends the use of this system.

[T/RBHA, insert statement here indicating whether the T/RBHA requires the comprehensive clinical record to be organized in a specific manner. T/RBHAs may modify this section to add categories and/or indicate a specific order for topics/ tabs/categories in the record.]

Intake Paperwork

- For recipients receiving substance abuse treatment services under the Substance Abuse Prevention & Treatment (SAPT) Block Grant, documentation that notice was provided

regarding the recipient's right to receive services from a provider to whose religious character the recipient does not object to.(See Section 3.19, Special Populations);

- Documentation of recipient's receipt of the Member Handbook and receipt of Notice of Privacy Practice; and

- Contact information for the recipient's primary care provider (PCP), if applicable.

Financial

- Documentation of the results of a completed initial Title XIX/XXI screening, annual screening and screening conducted when a significant change occurs using the Health-e-Arizona on-line module in a person's financial status**;** and

- Information regarding establishment of any co-payments assessed, if applicable (see Section 3.4, Co-payments).

Legal

- Documentation related to requests for release of information and subsequent releases;

- Copies of any advance directives or mental health care power of attorney as defined in Section 3.12, Advance Directives, if applicable including:

  - Documentation in the adult person's clinical record that the adult person 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 person 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 person if they are found to be incapable of making these decisions.

- Documentation of general and informed consent to treatment pursuant to Section 3.11, General and Informed Consent to Treatment, and Section 3.15, Psychotropic Medications: Prescribing and Monitoring;

- Authorization to disclose information pursuant to Section 4.1, Disclosure of Behavioral Health Information;

- 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 recipient and his/her legal

guardian or authorized representative if applicable (see Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons);

- For recipients undergoing a voluntary evaluation, as described in Section 3.18, Pre-Petition Screening, Court Ordered Evaluation and Court Ordered Treatment, a copy of the application for voluntary treatment; and

- Copies of any order for guardianship and letters of acceptance.

Assessments

- 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 3.9, Assessment and Service Planning, and Section 7.5, 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 PM Form 5.4.1, Notification of Person in Need of Special Assistance (see Section 5.4, Special Assistance for Persons Determined to have a Serious Mental Illness;

- An English version of the assessment and/or service plan if the documents are completed in Spanish; and

- For recipients receiving services via telemedicine, copies of electronically recorded information of direct, consultative or collateral clinical interviews.

Treatment and Service Plans

- The recipient's treatment and service plan;

- Child and Family Team (CFT) documentation; and

- Adult Recovery Team (ART) documentation.

Progress Notes that include the following:

- 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 person may be determined to have co-occurring diagnoses. Each provider that the person is referred to for treatment may be addressing a different

or new diagnosis. 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 DSM-IV code that applies) will help to ensure that diagnostic codes used for the documentation of delivery of services match the codes used on the billing/encounter claim submitted;

- 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 recipient's treatment plan;
- In the event that more than one provider simultaneously provides the same service to a recipient, 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 recipient's response to service; and
- For recipients receiving services via telemedicine, electronically recorded information of direct, consultative or collateral clinical interviews.

Medical

- Laboratory, x-ray, and other findings related to the recipient's behavioral health care;
- Medication record, when applicable; and
- Documentation of Certification of Need (CON) and Re-Certification of Need (RON), (see Section 3.14, Securing Services and Prior Authorization), when applicable.

Reports from other agencies

- Reports from providers of services, consultations, and specialists;
- Emergency/urgent care reports; and
- Hospital discharge summaries.

Correspondence

- Documentation of the provision of diagnostic, treatment, and disposition information (as allowed in Section 4.1, Disclosure of Behavioral Health Information) to the PCP and other providers to promote continuity of care and quality management of the recipient's health care;

- Letters;
- E-mails, printed out; and
- Documentation of any requests for and forwarding of behavioral health record information.

4.2.7-D. Behavioral health provider records

A recipient may receive behavioral health services from multiple behavioral health providers. Behavioral health providers who are licensed through the Office of Behavioral Health Licensure (OBHL) must maintain a behavioral health record that meets the requirements of A.A.C. R9-20-211). In addition, OBHL licensed behavioral health provider records must include:
[T/RBHA, insert requirements here, if any, regarding the organization of behavioral health provider records]:

- A periodic summary of the recipient's progress towards treatment goals;
- Physician and practitioner service orders;
- Applicable diagnostic or evaluation documentation;
- Signature/initials of the provider for each service;
- Documentation of adherence to reporting requirements;
- For OBHL licensed Level I facilities, documentation that any serious occurrence or death involving a behavioral health recipient (see Section 7.4, Reporting of Incidents, Accidents and Deaths):
  - Has been reported to AHCCCS and the Arizona Center for Disability Law (ACDL);
  - A copy of the information sent to AHCCCS and ACDL; and,
  - In the case of a behavioral health recipient's death that the aforementioned information has been reported to the Center for Medicare and Medicaid Services (CMS).
- Progress notes including:
  - 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;
  - The date the service was delivered;

- Duration of the service;
- A description of what occurred during the provision of the service related to the recipient's treatment plan; and
- The recipient's response to service.

- In the event that more than one provider simultaneously provides the same service to a behavioral health recipient:
  - Documentation of reasons for the involvement of multiple providers, including the names and roles of each provider involved in the service delivery; and
  - The number of units and start/stop time for each service provided, consistent with the encounter submission for the service(s).

What information must be forwarded to the recipient's comprehensive clinical record?
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. Subsection 4.2.7-D. describes the elements that must be maintained in the recipient's comprehensive clinical record.

Transition of medical records
Whether it becomes necessary to transfer the behavioral health recipient's medical records due to transitioning of the behavioral health recipient to a new T/RBHA (see PM 3.17 Transition of Persons, for additional information on Inter-T/RBHA transfers) and/or provider, or the T/RBHA has terminated the provider contract, it is important to ensure that there is minimal disruption to the behavioral health recipient's care and provision of services. The behavioral health medical record must be transferred in a timely manner that ensures continuity of care.

Is a written authorization required?
Federal and state law allow the transfer of behavioral health medical records from one provider to another, without obtaining the individual's written authorization if it is for treatment purposes (45 C.F.R. § 164.502(b), 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 4.1, Disclosure of Behavioral Health Information for other situations that may require written authorization).

What information must be sent to the new provider?
The original provider must send that portion of the medical record that is necessary to the continuing treatment of the behavioral health recipient. In most cases, this includes all communication that are recorded in any form or medium and that relate to patient examination, evaluation or behavioral or mental 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, 36-445, 36-2402 or 36-2917.

Who retains the original medical record?
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 in accordance with 4.2.7-B of this Section. The cost of copying and transmitting the medical record to the new provider shall be the responsibility of the transitioning provider (see the AHCCCS Contractors Operation Manual, Section 402).

[**T/RBHA insert specific information here**]

4.2.7-E. Requirements for Community Service Agencies (CSA), Home Care Training to Home Care Client (HCTC) Providers and Habilitation Providers
The T/RBHA must require that CSA, HCTC Provider and Habilitation Provider clinical records conform to the following standards. Each record entry must be:

- Dated and signed with credentials noted;
- Legible;
- Typed or written in blue or black ink; 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 recipient. The minimum written requirement for each behavioral health recipient'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 recipient's T/RBHA or CIS identification number and AHCCCS identification number;
- T/RBHAs must ensure that services provided by the agency/provider are reflected in the behavioral health recipient's service plan. CSAs, HCTC Providers and Habilitation

Providers must keep a copy of each behavioral health recipient's service plan in the recipient's record; and

- Daily documentation of the service(s) provided and monthly summary of progress toward treatment goals.

PM Form 4.2.1 is a recommended format that may be utilized to meet the 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 recipient's clinical team for inclusion in the comprehensive clinical record.

4.2.7-F 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 T/RBHA contracts, 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 ADHS/DBHS, 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 24 hours of the original request.

A provider's failure to prepare, retain and provide to ADHS/DBHS 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 their contracted T/RBHA.

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 contracted provider as the result of a change of ownership or any other circumstance.

4.2.7-G. Retention of records

A behavioral health provider must retain the original or copies of a recipient's medical records as follows:

- For an adult, for at least six (6) years after the last date the adult recipient received medical or health care services from the T/RBHA or behavioral health provider; and

- For a child, either for at least three (3) years after the child's eighteenth birthday or for at least six (6) years after the last date the child received medical or health care services from the T/RBHA or behavioral health provider, whichever occurs later.

Section 4.3 Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers

4.3.1 Introduction
4.3.2 References
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4.3.7-A. Coordinating care with AHCCCS Health Plans
4.3.7-B. The T/RBHA Acute Health Plan and Provider Coordinator
4.3.7-C. Sharing information with PCPs, AHCCCS Acute Health Plans, other treating professionals, and involved stakeholders
4.3.7-D. Responsibility for fee-for-service persons
4.3.7-E. Responsibility for persons enrolled in an AHCCCS Health Plan
4.3.7-F. PCPs prescribing psychotropic medications
4.3.7-G. Coordination of care with Medicare providers

4.3.1 Introduction

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 behavioral health services through behavioral health managed care organizations, also known as Tribal and Regional Behavioral Health Authorities (T/RBHAs). Because of this separation in responsibilities, communication and coordination between behavioral health 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 behavioral health recipients are Medicaid (Title XIX/XXI) and Medicare (Title XVIII) eligible and are referred to as "dual eligible" persons. Medicare covers limited inpatient behavioral health services, outpatient behavioral health services and prescription medication coverage. Medicare covered behavioral health 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 behavioral health recipients.

Holistic treatment requires integration of physical health with behavioral health to improve the overall health of an individual. Behavioral health recipients may be receiving care from multiple health care entities. Duplicative medication prescribing, contraindicated combinations of prescriptions and/or incompatible treatment approaches could be detrimental to a person. For this reason, communication and coordination of care between behavioral health providers, PCPs and Medicare providers must occur on a regular basis to ensure safety and positive

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

4.3.2 References

The following citations can serve as additional resources for this content area:

42 CFR 400.202
42 CFR 409.62
42 CFR 422.2
42 CFR 422.4
42 CFR 422.106
42 CFR 422.114
42 CFR 423.4
42 CFR 423.34
42 CFR 423.100
42 CFR 423.104
42 CFR 423.272
42 CFR 423.505
42 CFR 438.208
A.R.S. § 32-1901
A.R.S. § 36-545.04
9 A.A.C.20
9 A.A.C.21
A.A.C. R9-22-210.01
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/Tribal IGAs
CMS Medicare Benefit Policy Manual
AHCCCS Behavioral Health Services Guide
AHCCCS Medical Policy Manual
Section 3.2, Appointment Standards and Timeliness of Service
Section 3.3, Referral and Intake Process
Section 3.5, Third Party Liability and Coordination of Benefits
Section 3.17, Transition of Persons
Section 3.21, Service Package for Non-Title XIX/XXI Persons Determined to Have Serious Mental Illness (SMI)
Section 3.22, Out-of-State Placements for Children and Young Adults
Section 4.1, Disclosure of Behavioral Health Information
Section 6.1, Submitting Tribal Fee For Service Claims to AHCCCS
Section 6.2, Submitting Claims and Encounters to the RBHA
Section 7.5, Enrollment, Disenrollment and Other Data Submission
Section 9.1 Training Requirements
ADHS/DBHS Covered Behavioral Health Services Guide
ADHS/DBHS Practice Improvement Protocol, Pervasive Developmental Disorders and Developmental Disabilities

ADHS/DBHS Policy Clarification Memorandum: Coordination of Care Between AHCCCS Health Plan PCPs and Other PCPs in the Behavioral Health System
ADHS/DBHS Policy Clarification Memorandum: Coordination of Care with AHCCCS Health Plans and Primary Care Physicians

4.3.3 Scope

To whom does this apply?
All Title XIX and Title XXI eligible persons and all other T/RBHA enrolled persons receiving services from other health care providers.

4.3.4 Did you know…?

As of October 1, 2010, AHCCCS began automatically enrolling all Acute Care eligible members with a behavioral health benefit into a T/RBHA. Members are assigned based on the zip code in which they reside.

Each quarter, ADHS/DBHS is partnering with the T/RBHAs to introduce particular medical topics which impact individuals receiving behavioral health services.

Each AHCCCS Health Plan has a "Behavioral Health Coordinator." The Behavioral Health Coordinator can serve as a contact person and resource for behavioral health providers when problems arise concerning a person's medical care or any other health plan related issue. A Behavioral Health Coordinator may act on behalf of the PCP. See PM Attachment 4.3.1 for contact information for each AHCCCS Health Plan and Behavioral Health Coordinator.

T/RBHAs are required to identify at least one single point of contact within the T/RBHA to be named the Acute Health Plan and Provider Coordinator. 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 4.1, Disclosure of Behavioral Health Information.

In accordance with R9-22-210.01, hospitals, emergency room providers, or fiscal agents are required to notify T/RBHAs or their subcontracted providers no later than the 11th day from presentation of Title XIX/XXI eligible members for emergency inpatient behavioral health services.

AHCCCS eligible individuals who are automatically assigned to a T/RBHA may or may not access behavioral health services. When an AHCCCS eligible individual does receive behavioral health services through a T/RBHA, the T/RBHA must track an individual's "episode of care" in accordance with Section 7.5, Enrollment, Disenrollment and Other Data Submission.

As of January 1, 2006, AHCCCS no longer provides prescription drug coverage for dual eligible persons, except for certain excluded Medicare Part D drugs, in accordance with the Medicare Prescription Drug Modernization and Improvement Act of 2003. Medicare eligible persons must enroll in a Medicare Part D plan to receive prescription drug coverage through Medicare. Some

Medicare Advantage plans contract with the T/RBHAs to provide the Part A, Part B and/or Part D benefit.

4.35 Definitions

Acute Health Plan and Provider Coordinator

Behavioral Health Medical Practitioner

Medicare Advantage Prescription Drug Plan (MA-PD)

Prescription Drug Plan (PDP)

Prior Period Coverage

4.3.6 Objectives

To ensure that timely communication and coordination of care occurs between the T/RBHAs, subcontracted behavioral health providers, AHCCCS Health Plan PCPs, Medicare Providers or other health care provider(s), regarding a T/RBHA enrolled person's behavioral health and general medical care and treatment.

4.3.7 Procedures

4.3.7-A. Coordinating care with AHCCCS Health Plans

The following procedures will assist behavioral health providers in coordinating care with AHCCCS Health Plans:
If the identity of the person's primary care provider (PCP) is unknown, a behavioral health provider must contact the Acute Health Plan and Provider Coordinator(s) for the T/RBHA or the Behavioral Health Coordinator of the person's designated health plan to determine the name of the person's assigned PCP. See the AHCCCS Contracted Health Plans, PM Attachment 4.3.1 for contact information for the Behavioral Health Coordinators for each AHCCCS Health Plan.

T/RBHA 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. T/RBHA enrolled persons should also be prompted to visit their PCP for routine medical examinations annually or more frequently if necessary.

Behavioral health providers should request medical information from the person's assigned PCP. Examples include current diagnosis, medications, pertinent laboratory results, last PCP visit, Early Periodic Screening, Diagnosis and Treatment (EPSDT) screening results and last hospitalization. ADHS/DBHS has developed a sample request form that may be utilized for this purpose (see PM Form 4.3.2, Request for Information from PCP or Medicare Provider).
[T/RBHAs insert any standardized forms that have been developed for requesting information from PCP.] If the PCP does not respond to the request, contact the health plan's Behavioral Health Coordinator for assistance.

Behavioral health 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 **[T/RBHA insert language here regarding responsible person, i.e. Health Plan Liaison, or other]** at the T/RBHA.

4.3.7-B. The T/RBHA Acute Health Plan and Provider Coordinator

T/RBHAs are required to designate an Acute Health Plan and Provider Coordinator who must gather, review and communicate clinical information requested by PCPs, Acute Care Plan Behavioral Health Coordinators and other treating professionals or involved stakeholders (see PM Attachment 4.3.2, T/RBHA Acute Health Plan and Provider Coordinator Contact Information).

The T/RBHA must have a designated and published phone number for the Acute Health Plan and Provider Coordinator or a clearly recognized prompt on an existing phone number that facilitates prompt access to the Acute Health Plan and Provider Coordinator and that must be staffed during business hours.

T/RBHAs must ensure that T/RBHA Acute Health Plan and Provider Coordinator s receive training which includes, at a minimum, the following elements:

- Provider inquiry processing and tracking (including resolution timeframes);
- T/RBHA procedures for initiating provider contracts or AHCCCS provider registration;
- Claim submission methods and resources (see PM 6.2, Submitting Claims and Encounters to the RBHA);
- Claim dispute and appeal procedures (PM 5.6,Provider Claims Disputes); and
- Identifying and referring quality of care issues.

[T/RBHA identify other specific policies/resources where this information can be obtained as appropriate]

4.3.7-C. Sharing information with PCPs, AHCCCS Acute Health Plans, other treating professionals, and involved stakeholders

To support quality medical management and prevent duplication of services, behavioral health providers are required to disclose relevant behavioral health information pertaining to Title XIX and Title XXI eligible persons to the assigned PCP, AHCCCS 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.
- “Routine – Requests for intervention, information, or response within 10 days.

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

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

T/RBHAs and/or subcontracted providers must provide the required information annually, and/or when there is a significant change in the person's diagnosis and/or prescribed medications.

For all Title XIX/XXI enrolled persons, behavioral health 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, Intake and Referral Process);
- Coordinate the placement of persons in out-of-state treatment settings as described in Section 3.22, 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 behavioral health recipient'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 4.1, Disclosure of Behavioral Health Information.

When contacting or sending any of the above referenced information to the person's PCP, behavioral health providers must provide the PCP with an agency contact name and telephone number in the event the PCP needs further information.

ADHS/DBHS has developed a communications form (PM Form 4.3.1) 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.

PM Form 4.3.1 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 PM Form 4.3.1.
- The T/RBHA must track/log all the requests received from PCPs, AHCCCS Acute Health Plans, other treating professionals and other involved stakeholders, (see PM Form 4.3.3 T/RBHA Acute Health Plan and Provider Inquiry Monthly Log).
- Completed PM Form 4.3.3 T/RBHA Acute Health Plan and Provider Inquiry Monthly Log, must be submitted to ADHS/ DBHS by the 30th day after the end of the month.

Submission of the Acute Health Plan and Provider Inquiry Logs must be timely. The T/RBHA may be subject to corrective action if not compliant with this requirement.

ADHS/DBHS will communicate items of concern with T/RBHAs, if there are systemic issues evident in the information submitted on the T/RBHA Acute Health Plan and Provider Inquiry Monthly Log. T/RBHAs must resolve any such noted systemic issues.

4.3.7-D. Responsibility for fee-for-service persons

It is the responsibility of the T/RBHA to provide fee-for-service behavioral health services to Title XIX/XXI eligible persons not enrolled with an AHCCCS Health Plan.

The T/RBHA is responsible for providing all inpatient emergency behavioral health services for fee-for-service persons with psychiatric or substance abuse diagnoses.

The T/RBHA is responsible for behavioral health services to Native American Title XIX and Title XXI eligible persons referred by an Indian Health Services (IHS) or tribal facility for emergency services rendered at non-IHS facilities.

4.3.7-E. 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 the T/RBHA. This is limited to the behavioral health services only and after the individual has been medically cleared. The Health Plan Contractor is still obligated to provide all necessary medical services.

The following rules apply for other areas of coverage:
Pre-petition Screenings and Court Ordered Evaluations
Payment for pre-petition screenings and court ordered evaluations is the responsibility of the county. **[RBHA insert information here]**

Emergency Behavioral Health Services
When a Title XIX or Title 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.

The T/RBHA, 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 and Title XXI persons enrolled with a T/RBHA.

The T/RBHA is responsible for providing all non-inpatient emergency behavioral health services to Title XIX and Title XXI eligible persons. Examples of non-inpatient emergency services include assessment, psychiatric evaluation, mobile crisis, peer support and counseling. [1]

The T/RBHA is responsible for providing all inpatient emergency behavioral health services to persons with psychiatric or substance abuse diagnoses for all Title XIX and Title XXI eligible persons.

Emergency transportation of a Title XIX or Title XXI eligible person to the emergency room (ER) when the person has been directed by the T/RBHA or T/RBHA provider to present to this setting in order to resolve a behavioral health crisis is the responsibility of the T/RBHA. The T/RBHA or subcontracted provider directing the person to present to the ER must notify the emergency transportation provider of the T/RBHAs fiscal responsibility for the service.

Emergency transportation of a Title XIX or Title 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 3.25, Crisis Intervention Services

Non-emergency Behavioral Health Services
For Title XIX and Title XXI eligible persons, the T/RBHA is responsible for the provision of all non-emergency behavioral health services.

If a Title XIX or Title XXI eligible person is assessed as needing inpatient psychiatric services by the T/RBHA or subcontracted provider prior to admission to an inpatient psychiatric setting, the T/RBHA is responsible for authorization and payment for the full inpatient stay, as per PM Section 3.14, 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, the T/RBHA is responsible for the provision of this

[1] Note: in inpatient settings, these services would be included in the per diem rate.

service. Surgeries, procedures or therapies can include gastric bypass, interferon therapy or other procedures for which behavioral health support for a patient is indicated.

Non-emergency Transportation
Transportation of a Title XIX or Title XXI eligible person to an initial behavioral health intake appointment is the responsibility of the T/RBHA.

Medical Treatment for Persons in Behavioral Health Treatment Facilities
When a Title XIX or Title XXI eligible person is in a Level II or Level III residential treatment center and requires medical treatment, the AHCCCS Health Plan is responsible for the provision of covered medical services.

If a Title XIX or Title XXI eligible person is in a Level I psychiatric 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 Level I psychiatric 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 a T/RBHA.

4.3.7-F. 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.

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 and Title XXI eligible persons must not receive medications for psychiatric disorders from the health plan PCP and behavioral health provider simultaneously. If a person is identified to be simultaneously receiving medications from the health plan PCP and behavioral health provider, the behavioral health 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 T/RBHA behavioral health system must be filled by T/RBHA contracted pharmacies under the T/RBHA pharmacy benefit (see exceptions to this requirement for dual eligible persons in subsection 4.3.7-F, Coordination of care with Medicare providers). This is particularly important when the pharmacy filling the prescription is part of the contracted pharmacy network for both the prescribing T/RBHA and the person's AHCCCS Health Plan. The T/RBHA and contracted providers must take active

steps to ensure that prescriptions written by providers within the T/RBHA system are not charged to the person's AHCCCS Health Plan.

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. The T/RBHA is required to facilitate this process and to ensure that the following steps are taken:

- The T/RBHA 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, the T/RBHA 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 the T/RBHA 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.

- The T/RBHA will ensure that the member's transition to the PCP is seamless, and that the member does not go without medications during this transition period.

- Each month, the T/RBHA will complete Form 4.3.4 Recipient Transition from RBHA to PCP Tracking Log and submit it to ADHS/DBHS in order to monitor the transition process.

[T/RBHA, insert process for handling referral to the PCP from the T/RBHA for these members and coordination/communication process for ongoing care/treatment.]

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.

One-Time Face-to-Face Psychiatric Evaluations
Behavioral health 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 T/RBHA psychiatric consultation services **[T/RBHA insert contact information and/or additional information here]**. The T/RBHA 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.

4.3.7-G. Coordination of care with Medicare providers

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 (see PM Attachment 4.3.1). 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).

Some MA plans contract with the T/RBHA to provide some or all of the Medicare covered behavioral health services. In such cases, coordination of care should be simplified as the T/RBHA is providing Title XIX and state funded behavioral health services, as well as Medicare behavioral health services. Coordination with MA plans must be attempted by the T/RBHA and/or behavioral health provider when the Medicare behavioral health services are provided by the MA plan. ADHS/DBHS has developed sample forms for use when requesting or sharing information for purposes of coordinating care with Medicare providers (see PM Form 4.3.1, Communication Document, and PM Form 4.3.2, Request for Information from PCP or Medicare Plan/Provider).

[T/RBHA insert information here indicating which MA plans, if any, the T/RBHA contracts with to provide Medicare services.]

Medicare Fee-for-Service Program
Instead of enrolling in a Medicare Advantage plan, Medicare eligible behavioral health recipients may elect to receive all Medicare services (Parts A, B and/or D) through any provider authorized to deliver Medicare services. Therefore, behavioral health recipients in the Medicare Fee-for-Service program may receive services from Medicare registered providers in the T/RBHA provider network.

Inpatient Psychiatric Services
Medicare has a lifetime benefit maximum for inpatient psychiatric services. T/RBHA cost sharing responsibilities and billing for inpatient psychiatric services must be in accordance with Section 3.5, Third Party Liability and Coordination of Benefits, and Section 6.1, Submitting Tribal Fee for Service Claims to AHCCCS and Section 6.2, Submitting Claims and Encounters to the RBHA.

[T/RBHA insert information here specifying coordination of care of inpatient psychiatric services with Medicare providers].

Outpatient Behavioral Health Services
Medicare provides some outpatient behavioral health services that are also ADHS/DBHS covered behavioral health services. T/RBHA cost sharing responsibilities and billing for outpatient behavioral health services must be in accordance with Section 3.5, Third Party Liability and Coordination of Benefits, Section 6.1, Submitting Tribal Fee For Service Claims to AHCCCS and Section 6.2, Submitting Claims and Encounters to the RBHAs.
[T/RBHA insert information here specifying coordination of care of outpatient behavioral health services with Medicare providers.]

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

[T/RBHA insert information here specifying coordination of care of prescription medication services with MA plans].

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

with Section 3.5, Third Party Liability and Coordination of Benefits, and Section 3.21, Service Package for Non-Title XIX/XXI Persons Determined to Have a Serious Mental Illness (SMI).

Section 4.4 Coordination of Care with Other Governmental Entities

4.4.1 Introduction
4.4.2 References
4.4.3 Scope
4.4.4 Did you know…?
4.4.5 Definitions
4.4.6 Objectives
4.4.7 Procedures
4.4.7-A. General requirements
4.4.7-B. Arizona Department of Economic Security/Division of Children, Youth and Families (ADES/DCYF)
4.4.7-C. Arizona Department of Education (ADE), Schools, or Other Local Educational Authorities
4.4.7-D. Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD)
4.4.6-E. Department of Economic Security/Arizona Early Intervention Program (ADES/AzEIP)
4.4.7-F. Courts and Corrections
4.4.7-G. Arizona County Jails
4.4.7-H. Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA)
4.4.7-I. Arizona Department of Health Services/Office of Assisted Living Licensure

4.4.1 Introduction

Effective communication and coordination of services are fundamental objectives for behavioral health providers when serving persons involved with other government entities. When behavioral health providers and other public service 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 and accountability across service providers in meeting the needs of the person and family are established; and
- Limited resources are effectively utilized.

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) recognizes the importance of a responsive behavioral health system, especially when the needs of vulnerable persons have been identified by other government entities. For example, ADHS/DBHS 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 Economic Security/Child Protective Services (ADES/CPS) (see Section 3.2, Appointment Standards and Timeliness of Service). ADHS/DBHS expects all behavioral health providers to collaborate and provide any necessary assistance when CPS initiates requests for behavioral health services or supports.

The intent of this section is to communicate the ADHS/DBHS expectations fort behavioral health providers who must cooperate and actively work with other agencies serving behavioral health recipients.

4.4.2 References

A.R.S. § 8-881
A.R.S. § 15-825
A.R.S. §15-1181(12)
9 A.A.C 10-701
9 A.A.C.21
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA IGAs
Section 3.2, Appointment Standards and Timeliness of Service
Section 3.3, Referral and Intake Process
Section 3.8, Outreach, Engagement, Re-Engagement and Closure
Section 3.9, Assessment and Service Planning
Section 3.10, SMI Eligibility Determination
Section 4.1, Disclosure of Behavioral Health Information
Section 4.2, Behavioral Health Medical Record Standards
Section 4.3, Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers
ADHS/DBHS Covered Behavioral Health Services Guide
Practice Protocol 8, The Adult Clinical Team
Practice Protocol, Child and Family Team Practice
Practice Protocol, The Unique Behavioral Health Service Needs of Children, Youth, and Families Involved with CPS
Governor's Executive Order 2008-01

4.4.3 Scope

To whom does this apply?

All persons receiving behavioral health services who are involved with any other government entities.

4.4.4 Did you know…?

Persons receiving behavioral health services may be involved with other ADHS/DBHS Divisions or government entities, including the following:

Arizona Health Care Cost Containment System (AHCCCS);

Arizona Department of Economic Security/Division of Children, Youth and Families (ADES/DCYF);

Arizona Department of Juvenile Corrections (ADJC);

Administrative Office of the Arizona Supreme Court (AOC);

Arizona Department of Education (ADE);

ADES/Rehabilitation Services Administration (RSA);

ADHS/Children's Rehabilitative Services Administration (CRSA);

Tribal social services and Tribal courts;

Arizona Department of Corrections (ADOC):

ADES/Division of Developmental Disabilities (DDD);

AHCCCS/Arizona Long Term Care Services (ALTCS); and

ADES/Arizona Early Intervention Program (AzEIP).

ADHS/DBHS 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 persons involved with multiple systems.
[T/RBHA enter information on required protocols and agreements with State agencies and the location where these protocols and agreements are posted.]

ADHS/DBHS has developed a Practice Protocol, Child and Family Team Practice. The protocol includes suggested guidelines for developing and maintaining a collaborative relationship with other government entities that deliver services to children.

4.4.5 Definitions

Adult Clinical Team

Child and Family Team (CFT)

Individualized Education Program (IEP)

State Placing Agencies

4.4.6 Objectives

ADHS/DBHS endorses a collaborative process of assessment, service planning, service delivery, and support among multiple agencies to ensure that the care a person receives from a behavioral health service provider is effectively coordinated with other government entities.

4.4.7 Procedures

Behavioral health providers are responsible for actively coordinating the services a person receives with the services provided by other government entities. Behavioral health service providers, in cooperation with the contracting Tribal and Regional Behavioral Health Authorities (T/RBHAs), must coordinate efforts with other government entities and their service providers.

4.4.7-A. General requirements

The following information represents the ADHS/DBHS requirements for behavioral health providers when collaborating and coordinating care with other government entities that may be involved with persons receiving services in Arizona's public behavioral health system.

4.4.7-B. Arizona Department of Economic Security/Division of Children, Youth and Families (ADES/DCYF)

When a child receiving behavioral health services is also receiving services from ADES/DCYF, the behavioral health provider can work towards effective coordination of services with the CPS Specialist. Behavioral health providers are expected to:

- Coordinate the development of the behavioral health service plan with the child welfare case plan to avoid redundancies and/or inconsistencies.
- Ensure an urgent response to DCYF initiated referrals for children who have been removed from their homes (see Section 3.2, Appointment Standards and Timeliness of Service).
- Provide the CPS Specialist and the juvenile court with preliminary findings and recommendations on behavioral health risk factors, symptoms and service needs for hearing.
- Work collaboratively on child placement decisions if placement and funding are being sought for behavioral health treatment.
- Invite the CPS Specialist, CPS providers and resource parents to participate in the behavioral health assessment and service planning process as members of the Child and Family Team (CFT) (see Section 3.9, Assessment and Service Planning).
- Strive to be consistent with the service goals established by other agencies serving the child or family. Behavioral health service plans must be directed by the CFT toward the behavioral health needs of the child, and the team should seek the active participation of other involved agencies in the planning process.
- Attend team meetings such as Team Decision Making (TDM) and Family Group Decisions (as appropriate) for the purpose of providing input about the child and family's behavioral health needs. Where it is possible, TDM and CFT meetings should be combined.
- Coordinate, communicate and expedite necessary behavioral health services to stabilize in-home and out-of-home placements provided by DCYF.
- Provide behavioral health services during the reunification process and/or other permanency plan options facilitated by DCYF. Parent-child visitation arrangements and supervision are the responsibility of CPS. Therapeutic visitation is not a covered behavioral health service.
- Ensure responsive coordination activities and service delivery that supports DCYF planning and facilitates adherence to DCYF established timeframes (see Practice Protocol, The

Unique Behavioral Health Service Needs of Children, Youth, and Families Involved with CPS).

ADES/ADHS Arizona Families F.I.R.S.T. (Families in Recovery Succeeding Together) Program Behavioral health providers must ensure coordination for parents/families referred through the Arizona Families F.I.R.S.T (AFF) program (see Attachment 4.4.2, Overview of the Arizona Families F.I.R.S.T. (AFF) Program Model and Referral Process).

The AFF program provides expedited access to substance abuse treatment for parents and caregivers referred by ADES/DCYF/CPS and the ADES/FAA Jobs Program. ADHS/DBHS participates in statewide implementation of the program with ADES (see A.R.S. 8-881). T/RBHAs and providers must:

- Accept referrals for Title XIX and Title XXI eligible and enrolled persons 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 (see Section 3.19, Special Populations and Section 3.21, Service Package for Non-Title XIX/XXI Persons Determined to Have a Serious Mental Illness (SMI)).
- 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/CPS, the ADES/FAA JOBS Program and Substance Abuse Treatment providers to minimize duplication of assessments and achieve positive outcomes for families; and
- Develop procedures for collaboration in the referral process to ensure effective service delivery through the T/RBHA behavioral health system. Appropriate authorizations to release information must be obtained prior to releasing information.

[T/RBHA add specific language here]

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 DES/DCYF/CPS 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; 3.2.7-G, Special Populations).

4.4.7-C. Arizona Department of Education (ADE), Schools, or Other Local Educational Authorities

ADHS/DBHS has delegated the functions and responsibilities as a State Placing Agency to the T/RBHAs. As such it is the expectation of ADHS/DBHS that T/RBHAs work in collaboration with the ADE for the placement of children with behavioral health service providers.

Behavioral health 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. Behavioral health 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 4.1, Disclosure of Behavioral 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 3.9, Assessment and Service Planning);

- For children receiving special education services, ensuring that the behavioral health 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 Section 504 of the Rehabilitation Act of 1973 are provided adjustments in the academic requirements and expectations to accommodate their needs and enable them to participate in the general education program; and

- Ensuring that transitional planning occurs prior to and after discharge of an enrolled child from any out-of-home placement.

[T/RBHA add specific language here]

4.4.7-D. 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:

Type of DDD Eligibility	What behavioral health services are available?	Who is responsible for providing the behavioral health services?
Title XIX and eligible for ALTCS	All Title XIX covered services	T/RBHAs and contracted providers
Title XIX and not eligible for ALTCS	All Title XIX covered services	T/RBHAs and contracted providers
Non-Title XIX	Services provided based on eligibility for services*	T/RBHAs and contracted providers based on eligibility for services*

*See Section 3.19, Special Populations, and Section 3.21, Service Package for Non-Title XIX/XXI Persons Determined to Have a Serious Mental Illness (SMI).

Behavioral health providers can strive toward effective coordination of services with persons receiving services through DDD by:

- Working in collaboration with DDD staff and service providers involved with the person;
- Providing assistance to DDD providers in managing difficult behaviors;
- Inviting DDD staff to participate in the development of the behavioral health service plan and all subsequent planning meetings as members of the person's clinical team (see Section 3.9, Assessment and Service Planning);
- Incorporating information and recommendations in the Individual or Family Support Plan (ISP) developed by DDD staff, when appropriate, while developing the person's ISP;
- Ensuring that the goals of the ISP, of a person diagnosed with developmental disabilities who is receiving psychotropic medications, includes reducing behavioral health symptoms and achieving optimal functioning, not merely the management and control of challenging behavior;
- Actively participating in DDD team meetings; and
- For persons diagnosed with Pervasive Developmental Disorders and Developmental Disabilities, sharing all relevant information from the initial assessment and ISP with DDD to ensure coordination of services.

[T/RBA add information here on DDD specific protocols or agreements]

4.4.6-E. Department of Economic Security/Arizona Early Intervention Program (ADES/AzEIP)

Behavioral health service providers can strive 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 behavioral health 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 behavioral health provider will coordinate team functions so as to avoid duplicative processes between systems; and

- Coordinating enrollment in the T/RBHA children's system of care when a child transfers to the children's DDD system.

[T/RBHA add specific language here]

4.4.7-F. Courts and Corrections

Behavioral health providers are expected to collaborate and coordinate care for behavioral health recipients involved with:

- The Arizona Department of Corrections (ADC),

- Arizona Department of Juvenile Corrections (ADJC), or

- Administrative Offices of the Court (AOC).

When a person receiving behavioral health services is also involved with a court or correctional agency, behavioral health providers can work towards effective coordination of services by:

- Working in collaboration with the appropriate staff involved with the person;

- Inviting probation or parole personnel to participate in the development of the ISP and all subsequent planning meetings as members of the person's clinical team;

- Actively considering information and recommendations contained in probation or parole case plans when developing the ISP; and

- Ensuring that the behavioral health provider evaluates and participates in transition planning prior to the release of eligible persons and arranges and coordinates care upon the person's release (see Section 3.3, Referral and Intake Process).

[T/RBHA add specific language here]

4.4.7-G. Arizona County Jails

In Maricopa County, when a person receiving behavioral health services has been determined to have, or is perceived to have, a Serious Mental Illness (see Section 3.10, SMI Eligibility Determination) and is detained in a Maricopa County jail, the behavioral health provider must assist the person by:

- Working in collaboration with the appropriate staff involved with the person;

- Ensuring that screening and assessment services are provided to jailed persons upon request;

- Ensuring that the person has a viable discharge plan, that there is continuity of care if the person is discharged or incarcerated in another correctional institution, and that pertinent information is shared with all staff involved with the person's care or incarceration in accordance with Section 4.1, Disclosure of Behavioral Health Information; and

- Determining whether the person is eligible for the Jail Diversion Program.

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

[T/RBHA add specific language here]

4.4.7-H. 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 ADHS/DBHS system are distinct from vocational services available through RSA. Please refer to the ADHS/DBHS Covered Behavioral Health Services Guide for more details.

When a person determined to have a Serious Mental Illness is receiving behavioral health services and is concurrently receiving services from RSA, the behavioral health provider can ensure effective coordination of care by:

- Working in collaboration with the vocational rehabilitation (VR) counselors or employment specialists in the development and monitoring of the person's employment goals;

- Ensuring that all related vocational activities are documented in the comprehensive clinical record (see Section 4.2, Behavioral Health 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 persons who have been determined to have a Serious Mental Illness.

[T/RBHA add specific language here]

4.4.7-I. Arizona Department of Health Services/Office of Assisted Living Licensure
When a person receiving behavioral health services is residing in an assisted living facility, behavioral health providers must coordinate with the Office of Assisted Living Licensure to ensure that the facility is licensed and that there are no existing violations or legal orders. Behavioral health providers must also determine and ensure that the person living in an assisted living facility is at the appropriate level of care. The behavioral health provider can coordinate with the Office of Assisted Living Licensure to determine the level of care that a particular assisted living facility is licensed to provide.

[T/RBHA add specific language here]

Section 4.5 Partnerships with Families and Family-Run Organizations in the Children's Behavioral Health System

4.5.1 Background
4.5.2 References
4.5.3 Scope
4.5.4 Did you know…?
4.5.5 Definitions
4.5.6 Objectives
4.5.7 Procedures
4.5.7-A Effective family participation in service planning and service delivery
4.5.7-B Responsibilities of T/RBHAs and their behavioral health service providers
4.5.7-C Organizational commitment to employment of Family Members
4.5.7-D Provider commitment to the functions of family-run and parent support organizations
4.5.7-E. Training on family and youth Involvement in the Children's Behavioral Health System

4.5.1 Background

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. The following information addresses the types of roles available to families including parents/caregivers with children receiving services, when they are employed, volunteer or compensated in other ways, such as stipends or contracted work, and the elements that help families become effective in these roles.

This Section is organized around three categories of roles for families:

- Families are encouraged to participate and are supported as active and respected members of their child's Child and Family Team (CFT). In this capacity, families drive the development and implementation of a service plan that will respond to the unique strengths and needs of the child and family.
- Families participate in various activities that influence the local, regional and state service system. This type of activity is commonly called "Family Involvement". In Arizona, families have a range of opportunities to offer their unique insight and experience to the development and implementation of programs and policies. This includes various advisory activities on Boards, committees and policy making groups that work to improve children's behavioral health services.
- Family Members work in a professional capacity in the children's behavioral health system. In this capacity, Family Members offer a special type of support

(peer-delivered) to the families and children that they serve. Further, families who work in the service system influence the system by contributing the family perspective.

In addition, this section describes the role of family-run organizations in helping with the recruitment, training and support of Family Members.

Procedures outlined in this policy section are aimed at achieving the following outcomes:

- Increased adherence to statewide practice in accordance with the 12 Arizona Principles;
- Improved functional outcomes for children, youth and families;
- Improved engagement and collaboration in service planning between children, youth, families, community providers and other child serving agencies;
- Improved identification and incorporation of strengths and cultural preferences into planning processes;
- Coordinated planning for seamless transitions; and
- A stronger partnership with families in the process of supporting their child's/youth's behavioral health needs.

4.5.2 References

The following citations can serve as additional resources for this content area:

ADHS/RBHA Contracts
ADHS/Tribal IGAs
PM Section 3.23, Cultural Competency
Provider Manual Section 4.5, Partnerships with Families and Family-Run Organizations in the Children's Behavioral Health System
ADHS/DBHS Practice Protocol, Family and Youth Involvement in the Children's Behavioral Health System
Examining the Relationship Between Family-Run and Non Family-Run Organization Partners
Access, Voice and Ownership, Examining Service Effectiveness from the Family's Perspective
Learning from Colleagues: National technical assistance center for Children's Mental Health
Quick Guide for Self-Assessment of Family-Run Organizations in Systems of Care

4.5.3 Scope

To whom does this apply?

All families receiving services within the children's behavioral health system, Tribal and Regional Behavioral Health Authorities (T/RBHA) and T/RBHA providers.

4.5.4 Did you know…?

Family involvement is crucial to the success of the behavioral health system in Arizona, and includes having families involved at all levels of the system.

4.5.5 Definitions

Family Involvement

Family-Run Organizations

Family Member

Parent-Delivered Support or Service

Youth/Young Adult-Delivered Support

4.5.6 Objectives

To ensure the success of family involvement and family run organizations in Arizona by:

- Identifying family involvement as a necessary and effective component of Arizona's behavioral health system.
- Defining roles that are uniquely intended for parents/caregivers of children who receive or have received services.
- Defining roles that are uniquely intended for youth and young adults who receive or have received services.
- Describing the roles that family-run organizations play in optimizing family involvement and roles for parents/caregivers, youth and young adults who receive or have received services.

4.5.7 Procedures

4.5.7-A. Effective family participation in service planning and service delivery

Through the CFT process, parents/caregivers and youth are treated as full partners in the planning, delivery and evaluation of services and supports. Parents/caregivers and youth are an equal partner in the local, regional, tribal and state representing the family perspective as participants in systems transformation Behavioral health providers must:

- Ensure that families have access to information on the CFT process and have the opportunity to fully participate in all aspects of service planning and delivery.
- Approach services and view the enrolled child in the context of the family rather than isolated in the context of treatment.
- Recognize that families are the primary decision-makers in service planning and delivery.
- Provide culturally and linguistically relevant services that appropriately respond to a family's unique needs (see PM Section 3.23 Cultural Competency).
- Offer family peer to peer support to Families and make peer representation available to the CFT when requested.
- Provide information to families on how they can contact staff at all levels of the service system inclusive of the provider agency, T/RBHA and ADHS/DBHS at intake and throughout the CFT process.

- Work with the T/RBHAs to develop training in family engagement and participation, roles and partnerships for provider staff, parents/caregivers, youth and young adults (see DBHS Practice Protocol, Family and Youth Involvement in the Children's Behavioral Health System for more information on these roles).

4.5.7-B Responsibilities of T/RBHAs and their behavioral health service providers

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

- Support parents/caregivers, youth and young adults in roles that have influence and authority.
- Establish recruitment, hiring and retention practices for family, youth and young adults within the agency that reflect the cultures and languages of the communities served.
- Provide training for families, youth and young adults in cultural competency.
- Assign resources to promote family, youth and young adult involvement including committing money, space, time, personnel and supplies; and
- Demonstrate a commitment to shared decision making.

4.5.7-C Organizational commitment to employment of Family Members

Providers must demonstrate commitment to employment of parents/caregivers, and young adults by:

- Providing positions for parents/caregivers and young adults that value the first person experience.
- Providing compensation that values first-person experience commensurate with professional training.
- Establishing and maintaining a work environment that values the contribution of parents/caregivers, youth and young adults.
- Providing supervision and guidance to support and promote professional growth and development of parent/caregivers and young adults in these roles.
- Providing the flexibility needed to accommodate parents/Family Members and young adults employed in the system, without compromising expectations to fulfill assigned tasks/roles.

4.5.7-D Provider commitment to the functions of family-run and parent support organizations

Family-run and parent support organizations play a crucial role in supporting families, youth and young adults involved in the children's behavioral health system. They are key partners in transforming Arizona's behavioral health system and are vital to the process of identifying meaningful roles and opportunities for Family Members, youth and young adults to actively contribute to that transformation.

Family-run and parent support organizations not only support the current involvement and roles of Family Members, youth and young adults, but also work toward identifying and developing the next generation of community leaders. In order to demonstrate commitment to the importance and functions of family-run and parent support organizations, providers must:

- Establish partnerships with family-run and parent support organizations.
- Connect Family Members with family-run and parent support organizations as soon as the childe is enrolled in the behavioral health system to provide information and parent peer to peer support.
- Model an environment that encourages and promotes the ability of family-run and parent support organizations to provide coaching, mentoring and training to Family Members.

4.5.7-E. Training on family and youth Involvement in the Children's Behavioral Health System

In order to ensure understanding and implementation of the procedures described in this section, T/RBHAs and their service providers must provide training and deliver training services using the following process:

- Providers must establish partnerships with family-run organizations to co-facilitate trainings on family-professional partnerships. The T/RBHAs and their behavioral health service providers must identify Family Members actively involved in system transformation efforts and use family-run organizations to deliver family leadership trainings that have been designed and implemented in partnership with family leaders.
- The T/RBHAs and their behavioral health service providers must partner with family-run organizations in the delivery of trainings on peer-to-peer roles for Family Members employed in the system.

Section 5.0 Member Rights and Provider Claims Disputes

5.1 **Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons**
5.2 **Member Complaints**
5.3 **Grievance and Requests for Investigations for Persons Determined to have a Serious Mental Illness**
5.4 **Special Assistance for Persons Determined to have a Serious Mental Illness**
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Arizona Department of Health Services
Division of Behavioral Health Services
PROVIDER MANUAL

Section 5.1 Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons

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5.1.1 Introduction

All Title XIX and Title XXI eligible persons must be afforded the opportunity to appeal specified actions. The circumstances that constitute an action are defined in this section. When a provider or another entity takes certain actions as defined by this section, the Title XIX/XXI person must receive adequate and timely notice. Notice allows a Title XIX/XXI person to exercise their right to appeal a decision. Appeals of decisions for Title XIX/XXI persons not falling within the scope of this policy will be covered under Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI).

Title XIX/XXI eligible persons who have been adversely affected by a PASRR determination in the context of either a preadmission screening or a resident review shall be provided notice and the opportunity to appeal by Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS).

The intent of this section is to provide information to providers that describes the Title XIX and Title XXI member appeal process and describes procedures to ensure that Title XIX/XXI persons receive appropriate notification of decisions, including:

- The events that require notice to a Title XIX/XXI eligible person; and
- The timeframes and content associated with providing notice.

5.1.2 References

The following citations can serve as additional resources for this content area:

42 CFR 431.200 et seq.
42 CFR 438.210
42 CFR 438.400 et seq.
A.R.S. § 36-2903.01
ARS §36-2904
A.R.S. § 36-3413
A.R.S. Title 41, Chapter 6, Article 10
2 A.A.C. Chapter 19, Article 1

9 A.A.C. 21
9 A.A.C. 34, Article 2
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA IGAs
Section 3.6, Member Handbook
Section 3.9, Assessment and Service Planning
Section 3.14, Securing Services and Prior Authorization
Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)
Section 5.6, Provider Claims Disputes
Policy and Procedures GA 3.3, Title XIX/XXI Notice and Appeal Requirements
Policy and Procedures MI 5.3, Pre-admission Screening and Resident Review
ADHS/DBHS Covered Behavioral Health Services Guide

5.1.3 Scope

To whom does this apply?

This section applies to all Title XIX and Title XXI eligible persons who are seeking covered services through the ADHS/DBHS behavioral health system.

5.1.4 Did you know…?

- ADHS/DBHS must have systems in place for Title XIX and Title XXI eligible persons that include a complaint process, an appeal process and access to the State's Fair Hearing process.
- All Title XIX/XXI eligible persons must receive a Notice of Action and have the right to an appeal when a claim for service relates to the payment for a service that is not Title XIX/XXI covered and the decision is to deny the claim in whole or in part. This Notice of Action must be sent to the person along with the explanation of benefits (EOB) when the claim for payment has been denied (see Section 5.6, Provider Claims Disputes). A provider can file an appeal on behalf of a Title XIX/XXI eligible person with that person's written consent.

5.1.5 Definitions

Action

Appeal

Appeal Resolution

Complaint

Day

Denial

Health Care Professional

Limited Authorization

PASRR

Prior Authorization

Service Authorization Request

5.1.6 Objectives

The objectives of this section are to ensure that Title XIX and Title XXI eligible persons seeking or receiving covered services have access to an appeals process that fairly and efficiently resolves identified issues and that Title XIX/XXI eligible persons are provided required notices that:

- Are timely;
- Explain the action to be taken and the appeal process available to the person or their guardian, advocate and/or designated representative; and
- Are written in a manner that is clear and easily understood by the person.

5.1.7 Procedures

5.1.7-A: General Requirements

Language and Format Requirements

Entities responsible for sending notice to Title XIX/XXI eligible persons must ensure that:

- Notice and written documents related to the appeals process must be available in each prevalent, non-English language spoken within the Regional Behavioral Health Authority's (RBHA's) geographic service area (GSA);
- As applicable, providers must provide free oral interpretation services to explain information contained in the notice or as part of the appeal process for all non-English languages;
- Notice and written documents related to the appeals process must be available in alternative formats, such as Braille, large font or enhanced audio and take into consideration the special communication needs of the person; and
- Notice and written documents must be written using an easily understood language and format.

Computation of time

The following methodology must be used in computing any period of time described in this section:

- Computation of time for appeals begins the day after the act, event or decision and includes the final day of the period. For purposes of computing all timeframes with the exception of the standard service authorization time frames and extensions thereof, if the final day of the period is a weekend day (Saturday or Sunday) or legal holiday, the period is extended until the end of the next day that is not a weekend day(Saturday or Sunday) or a legal holiday.
- For a standard service authorization with or without an extension, if the final day of the period is a weekend day or legal holiday the period is shortened to the last working day immediately preceding the weekend day or legal holiday. (For more information see the AHCCCS Contractor Operation Manual (ACOM) Section 414, IV. Definitions).
- Computation of time in calendar days includes all calendar days.

- Computation of time in workdays includes all working days, i.e. non-weekend and non-legal holiday days.

Prohibition of punitive action
Providers must not take punitive action against a Title XIX/XXI eligible person who decides to exercise their right to appeal. RBHAs must ensure that punitive action is not taken against a provider who requests an expedited resolution to an appeal or who supports a Title XIX/XXI eligible person's appeal.

5.1.7-B: Notice of Action

For Title XIX/XXI covered services, notice must be provided following:

- 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 TXIX/XXI covered; and
- The denial of the Title XIX/XXI person's request to obtain services outside the network.

Who is responsible for sending the notice?
Following an action requiring notice to a Title XIX/XXI eligible person, **[T/RBHA insert language here regarding the entity responsible for providing notice to Title XIX/XXI persons]** must ensure the communication of a notice to the person.

ADHS/DBHS sends notices to Title XIX/XXI eligible persons enrolled with a Tribal RBHA (TRBHA) following:

- The denial or limited authorization of a requested service , including the type or level of service (see Section 3.14, Securing Services and Prior Authorization); and
- The reduction, suspension or termination of a previously authorized service.

ADHS/DBHS sends notices to Title XIX/XXI eligible persons who have been adversely affected by a PASRR determination in the context of either a preadmission screening or a resident review.

How is notice communicated to Title XIX/XXI eligible persons?
The use of PM Form 5.1.1 is required when providing notice regarding an action concerning a Title XIX/XXI person. (Please see the AHCCCS Contractors Operations Manual (ACOM) 414 for guidance in preparation of this form). PM Form 5.1.1 must be completed to include the following:

- The requested service;
- The reason/purpose of that request in layperson terms;
- The action taken or intended to be taken (denial, limited authorization, reduction, suspension or termination) with respect to the service request;
- The effective date of the action;
- The reason for the action, including member specific facts;
- The legal basis for the action;
- Where members can find copies of the legal basis;
- The right to and process for appealing the decision; and

- Legal resources for members for help with appeals, as prescribed by the Arizona Health Care Cost Containment System (AHCCCS) (See AHCCCS Contractors Operations Manual (ACOM) 414, Attachment C).

Delivery of Notices

The Notice of Action must be delivered to the Title XIX/XXI eligible person and, when applicable, their legal representative or designated representative (e.g., Department of Economic Security/Division of Children, Youth and Families/Child Protective Services Specialist and/or advocate for SMI persons requiring special assistance). For Title XIX/XXI eligible persons under the age of 18, the Notice of Action must be delivered to their legal or custodial parent or a government agency with legal custody of the Title XIX/XXI eligible person.

All notices must be personally delivered or mailed by certified mail to all parties at their last known residence or place of business. In the event that it may be unsafe to contact a person at his or her home address, or the person does not want to receive mail at home, alternate methods identified by the person for communicating notice must be used.

5.1.7-C. Notice of Action timeframes

For service authorization requests, the following timeframes for sending notice of action are in effect (See Section 3.14, Securing Services and Prior Authorization for required timeframes for decisions regarding prior authorization requests):

- For an authorization decision related to a service requested by or on behalf of a Title XIX/XXI eligible person, the responsible entity must send a notice of action within 14 days following the receipt of the person's request;
- For an authorization request in which the provider indicates, or the responsible entity determines, that the 14 calendar day timeframe could seriously jeopardize the person's life or health or ability to attain, maintain or regain maximum function, the responsible entity must make an expedited authorization decision and send the Notice of Action as expeditiously as the person's health condition requires, but no later than three working days after receipt of the request for service;
- If the Title XIX/XXI eligible person requests an extension of either timeframe above, the responsible entity must extend the timeframe up to an additional 14 days;
- If the responsible entity needs additional information and the extension is in the best interest of the person, the responsible entity shall extend the 14-calendar day or the three working day timeframe up to an additional 14 days. If the responsible entity extends the timeframe, the responsible entity must:
  - Give the Title XIX/XXI eligible person written notice of the reason for the decision to extend the timeframe using PM Form 5.1.2, Notice of Extension of Timeframe for Service Authorization Decision Regarding Title XIX/XXI Services, and inform the person of the right to file a complaint if the person disagrees with the decision; and
  - Issue and carry out the determination as expeditiously as the person's condition requires and no later than the date the extension expires.
- For service authorization decisions not reached within the maximum timeframes outlined above, the authorization shall be considered denied on the date that the timeframe expires.

- ADHS/DBHS, the Tribal/Regional Behavioral Health Authority (T/RBHA) or T/RBHA provider shall provide the requesting provider notification of a decision to deny a service authorization. The notification must be in writing.

For service terminations, suspensions or reductions, the following timeframes are in effect:

- The responsible entity must send the Notice of Action at least 10 days before the date of the action with the following exceptions:
  - The responsible entity may send the Notice of Action no later than the date of the action if:
    - The responsible entity has factual information confirming the death of a Title XIX/XXI person;
    - The responsible entity receives a clear written statement signed by the Title XIX/XXI person or their legal representative that the person no longer wants services or gives information to the responsible entity that requires termination or reduction of services and indicates that the person understands that this will be the result of supplying that information;
    - The Title XIX/XXI person is an inmate of a public institution that does not receive federal financial participation and the person becomes ineligible for TXIX/XXI;
    - The Title XIX/XXI person's whereabouts are unknown and the post office returns mail to the responsible entity indicating no forwarding address; or
- The responsible entity establishes the fact that the Title XIX/XXI person has been accepted for Medicaid by another state. The responsible entity may shorten the period of advance notice to five days before the date of action if the responsible entity has verified facts indicating probable fraud.

5.1.7-D. Title XIX and Title XXI appeal and State Fair Hearing process

Who is responsible?

Each RBHA is responsible for processing appeals and may not delegate this function to a provider. ADHS/DBHS processes appeals related to actions initiated by a Tribal RBHA or one of their subcontracted providers. Any responsibilities attributed to a RBHA in Subsections 5.1.7-D and 5.1.7-E of this section are the responsibility of ADHS/DBHS if the action relates to a Tribal RBHA or one of their subcontracted providers, or relates to an appeal concerning a PASRR determination.

The following information is provided to familiarize providers with the Title XIX/XXI appeal process.

Who can file an appeal or request a State Fair Hearing?

The following persons or representatives may file an appeal or request a State Fair Hearing 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/Child Protective Services Specialist and/or advocate for SMI persons requiring special assistance), including a provider, acting on behalf of the person, with the person's or legal representative's written consent.

- A Title XIX/XXI eligible person adversely affected by a PASRR determination in the context of either a preadmission screening or a resident review.

What is the 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.

How long does the RBHA have to resolve a standard appeal?
The RBHA must resolve standard appeals no later than 30 days from the date of receipt of the appeal, unless an extension is in effect.

Can the standard appeal resolution timeframe be extended?
If a Title XIX/XXI eligible person requests an extension of the 30-day timeframe, the RBHA must extend the timeframe up to an additional 14 days. If the RBHA needs additional information and the extension is in the best interest of the person, the RBHA may extend the 30-day timeframe up to an additional 14 days.

Under what circumstances must an appeal be expedited?
The RBHA must conduct an expedited appeal if:

- The RBHA receives a request for an appeal from a Title XIX/XXI eligible person and the RBHA determines that taking the time for a standard appeal resolution could seriously jeopardize the person's life or health, or ability to attain, maintain, or regain maximum function;
- The RBHA receives a request for an expedited appeal from a Title XIX/XXI eligible person supported with documentation from the provider that taking the time for a standard resolution could seriously jeopardize the person's life or health, or ability to attain, maintain or regain maximum function; or
- The RBHA receives a request for an expedited appeal directly from a provider, with the Title XIX/XXI eligible person's written consent, and the provider indicates that taking the time for a standard resolution could seriously jeopardize the person's life or health, or ability to attain, maintain or regain maximum function.

What if the request for an expedited appeal is denied?
If the RBHA denies a request for expedited resolution of an appeal from a Title XIX/XXI eligible person, the RBHA must resolve the appeal within the standard resolution timeframe and make reasonable efforts to give the person prompt oral notice of the denial. Within two calendar days, the RBHA must follow up with written notice of the denial.

How long does the RBHA have to resolve an expedited appeal?
The RBHA must resolve expedited appeals within three working days after the day the RBHA receives the appeal.

Can the expedited appeal resolution timeframe be extended?
If a Title XIX/XXI eligible person requests an extension of the three working day timeframe, the RBHA must extend the timeframe up to an additional 14 days. If the RBHA needs additional information and the extension is in the best interest of the person, the RBHA must extend the three working day timeframe up to an additional 14 days.

Requesting a State Fair Hearing
A Title XIX/XXI eligible person, legal or authorized representative may request a State Fair Hearing following the RBHA's resolution of an appeal. The request must be in writing and submitted to **[RBHA add contact information here].** The request must be received by the RBHA no later than 30 days after the date that the person received the Notice of the Appeal Resolution.

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. 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 the RBHA by contacting **[RBHA insert specific contact language here]** or, for Title XIX/XXI eligible persons enrolled with a Tribal RBHA, by contacting ADHS/DBHS Office of Grievance and Appeals at (602) 364-4575.

5.1.7-E: Continuation of services during the appeal or State Fair Hearing process
For the purposes of this subsection, if the following criteria are met, services shall be continued based on the authorization that was in place prior to the denial, termination, reduction or suspension of services that has been appealed. A Title XIX/XXI eligible person's services can continue during the appeal and State Fair Hearing process, unless continuation of services would jeopardize the health or safety of the person or another person, if:

- The person files the appeal timely*;
- 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.

*Timely filing means filing on or before the later of the following:

- Within 10 days after the date that the RBHA mails or delivers the Notice of Action; or
- The effective date of the action as indicated in the Notice of Action.

If a person wishes services to continue during appeal, they must request the continuation of services when the appeal is initially filed **and** at the time of requesting a State Fair Hearing.

At what point will a person's services no longer be continued during the appeal or State Fair Hearing process?
The RBHA must continue services until one 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 within10 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.

What happens if the person loses the appeal?
If the Director's decision upholds the RBHA's action, the RBHA may recover the cost of the services furnished to a Title XIX/XXI eligible person while the appeal is pending if the services were furnished solely because of the requirements of subsection 5.1.7-E.

What happens if a decision to deny authorization of services is reversed by ADHS/DBHS?
If the RBHA 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, the RBHA shall process a claim for payment from the provider in a manner consistent with the RBHA'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 decision to submit a clean claim to the RBHA for payment. For all claims submitted as a result of a reversed decision, the RBHA is prohibited from denying claims as untimely if they are submitted within the 90-day timeframe.

RBHAs are 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.

Section 5.2 Member Complaints

5.2.1 Introduction
5.2.2 References
5.2.3 Scope
5.2.4 Did you know…?
5.2.5 Definitions
5.2.6 Objectives
5.2.7 Procedures
5.2.7-A. Complaint process

5.2.1 Introduction

A complaint is defined as an expression of dissatisfaction with any aspect of member care, other than an action (see definition for "action"). Issues involving an action are subject to appeal, see Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons. For persons determined to have a Serious Mental Illness (SMI) appealing a decision regarding SMI eligibility, or Non-TXIX/XXI behavioral health recipients appealing the need for a covered service, see Section 5.5 Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI). Possible subjects for complaints include, but are not limited to; the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.

For allegations of rights violations involving persons determined to have a Serious Mental Illness see PM 5.3 Grievance and Requests for Investigation for Persons Determined to have a Serious Mental Illness. While any behavioral health recipient can file a complaint, the SMI grievance/request for investigation process is available only to persons determined to have a Serious Mental Illness.

All persons enrolled in, or seeking services from, the ADHS/DBHS behavioral health system have access to the same complaint process for expressions of dissatisfaction with any aspect of their care. Persons seeking or receiving behavioral health services are encouraged to resolve issues at the lowest possible level, but are not required to do so before utilizing the T/RBHA complaint, SMI grievance, or appeal processes. Issues that are handled through the complaint resolution process may still be managed through applicable grievance and appeal processes in the event they remain unresolved.

The intent of this section is to present information for behavioral health providers describing the member complaint process. Although the T/RBHAs are directly responsible for processing all member complaints, it is important for behavioral health providers to understand how a complaint can be filed, reviewed and resolved to the satisfaction of the behavioral health recipient. Behavioral health providers' responsibilities include educating persons about the complaint, appeal, and SMI grievance processes and assisting persons to negotiate the necessary steps to make a complaint.

5.2.2 References

The following citations can serve as additional resources for this content area:
42 CFR 431.200 et seq.
42 CFR 438.210
42 CFR 438.400 et seq.
A.R.S. 12-2297
9 A.A.C. 21
A.A.C. R9-21-402 (B)
A.A.C. R9-21-403 (C)
9 A.A.C. 34, Article 2
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA IGAs
Section 3.6, Member Handbooks
Section 3.14, Securing Services and Prior Authorization
Section 4.1, Disclosure of Behavioral Health Information
Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons
Section 5.3, Grievance and Requests for Investigation for Persons Determined to have a Serious Mental Illness (SMI)
Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)

5.2.3 Scope

To whom does this apply?

This applies to all persons who are:

- Seeking behavioral health services through the ADHS/DBHS behavioral health system; or
- Enrolled with the ADHS/DBHS behavioral health system.

5.2.4 Did you know…?

- All T/RBHAs are required to staff a customer services manager who is responsible for coordinating communications with eligible and enrolled persons and act as, or coordinate with, advocates, behavioral health providers, internal staff resources and others to resolve issues.
- The T/RBHA complaint process must:
  - Educate and notify persons about their rights and the process for filing complaints, appeals and SMI grievance/investigations in a manner that is understandable, including providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability;
  - Handle any complaints which involve potential fraud or abuse in accordance with applicable agency reporting requirements;

- Promptly identify and resolve complaints in the most expeditious and equitable manner with due regard for the dignity and rights of all persons;
- Maintain confidentiality and privacy of complaint matters and records at all times;
- Communicate, as appropriate, information on matters and decisions related to the complaint to affected parties, in a timely manner;
- Involve the active cooperation and participation, as deemed appropriate, of providers with a direct interest in the matter under review;
- Provide education and training to T/RBHA and provider staff regarding member rights and the complaint process, including the obligation to report suspected right's violations of persons determined to have a Serious Mental Illness pursuant to 9 A.A.C. 21-403(C);
- Track the types and volume of complaints, (regardless of whom within the organization receives the complaint or whether the complaint is received orally or in writing), in order to identify potential deficiencies in the delivery system for which corrective action plans can be developed; and
- Refrain from referring complainants to AHCCCS Administration for issues related to the behavioral health delivery system.

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5.2.5 Definitions

Action

Appeal

Behavioral Health Professional

Complaint

Grievance or Request for Investigation

Serious Mental Illness (SMI)

5.2.6 Objectives

To ensure that all persons seeking or receiving behavioral health services have access to a complaint process that fairly and efficiently resolves identified issues in a timely manner.

5.2.7 Procedures

5.2.7-A. Complaint process

Who can file a complaint?

- A complaint may be filed by persons enrolled in or seeking services through the ADHS/DBHS behavioral health system, a person's family member, legal guardian, or authorized representative, and/or a behavioral health provider.

- Complaints may be filed orally or in writing.

Where must complaints be directed?
Each T/RBHA is directly responsible for the complaint process and may not delegate this function to a behavioral health provider.

Complaints may be filed directly with the person's respective T/RBHA, as identified below, or initiated with the ADHS/DBHS Customer Service Unit at (602) 364-4558.

- For oral complaints: Call **[Name of T/RBHA]** at this toll free telephone number **[T/RBHA insert number].**

- To submit a written complaint: Mail the complaint to **[Name of T/RBHA]** at **[insert T/RBHA office and address].**

All complaints must be acknowledged. Complaints filed orally shall be considered acknowledged at the time of filing. Written complaints must be acknowledged to the complainant within 5 working days of receipt by the T/RBHA.

How long does the T/RBHA have to resolve a complaint?
T/RBHAs are required to dispose of each complaint and provide oral or written notice as expeditiously as the issue or behavioral health condition requires; however, within a timeframe that does not exceed 90 days from the day the T/RBHA receives the complaint.

Who makes decisions regarding a complaint?
The T/RBHA must ensure that the individuals who make decisions regarding complaints are not involved in any previous level of review or decision-making. Individuals must be behavioral health professionals (see definition) with the appropriate clinical expertise in treating the behavioral health recipient's behavioral health condition when making a decision regarding:

- A complaint related to the denial of expedited resolution of an appeal; or

- Complaints involving clinical issues.

What needs to be in the complaint record?

- At a minimum, the complaint record must include the following documentation:

    - The date the complaint was made;
    - The behavioral health recipient's first and last name;
    - Title XIX/XXI eligibility status;
    - The behavioral health enrollment category: SMI, GMH, Child/Adolescent, Substance Abuse treatment, not enrolled;

- The name of the person making the complaint;
- A description of the complaint;
- Any identified communication needs;
- That the complaint was acknowledged to the originator of the concern and when;
- All steps utilized during the investigation of the complaint and of the resolution;
- Steps taken to assist in ensuring immediate health care needs are met;
- That the resolution was communicated to affected parties, in accordance with confidentiality requirements, and when;
- Implemented corrective action plan(s) or action(s) taken to resolve the concern(s);
- Supporting evidence that the resolution was implemented; and
- Evidence that identified issues were referred, as indicated, to the appropriate committees, departments, and regulatory agencies.

Complaint records must be maintained for a minimum of six years from the date of resolution or disposition.

What if the complainant is not satisfied with the resolution to the complaint?
The T/RBHA will notify the complainant of further alternatives if they are dissatisfied with the complaint determination, including the option to contact AHDS/DBHS at 602-364-4558.

What is the role of behavioral health providers?
The T/RBHA and contracted providers must be available to assist a person in the filing of a complaint and must not retaliate against any persons who file such complaints. Behavioral health providers are also expected to cooperate and participate as requested by the T/RBHA in the resolution of the complaints. **[T/RBHA add any additional information here]**

Section 5.3 Grievance and Requests for Investigation for Persons Determined to have a Serious Mental Illness (SMI)

5.3.1 Introduction
5.3.2 References
5.3.3 Scope
5.3.4 Definitions
5.3.5 Objectives
5.3.6 Grievance and Requests for Investigation Principles
5.3.7 Procedures
5.3.7-A. Filing grievances and requests for investigations
5.3.7-B. Grievance and request for investigation resolution process

5.3.1 Introduction

A grievance and request for investigation process has been established for persons determined to have a Serious Mental Illness who are enrolled in the ADHS/DBHS behavioral health system. The grievance and request for investigation process for persons determined to have a Serious Mental Illness focuses on situations in which:

- The rights of a person determined to have a Serious Mental Illness have been violated;
- The person has been abused or mistreated;
- There is a death of a person that occurs in a mental health agency, or as a result of an action of a person employed by a mental health agency.

The intent of this section is to describe behavioral health provider responsibilities related to grievances and requests for investigations involving persons who have been determined to have a Serious Mental Illness.

5.3.2 References

The following citations can serve as additional resources for this content area:
A.R.S. §1-254
A.R.S.§36-502.D
A.R.S. 41, Chapter 6, Article 10
A.A.C. R9-21-101(B)
A.A.C. R9-21-103
9 A.A.C. 21, Article 4
ADHS/RBHA Contracts
ADHS/TRBHA IGA
Section 3.10 SMI Eligibility Determination
Section 5.4 Special Assistance for SMI Members
Section 5.2 Member Complaints
Section 7.3 Seclusion and Restraint Reporting
Section 7.4 Reporting of Incidents, Accidents and Deaths

5.3.3 Scope

To whom does this apply?

This applies to all persons who have been determined to have a Serious Mental Illness and are enrolled in the ADHS/DBHS behavioral health system. This section does not apply to grievances or requests for investigation asserted by, or on behalf of, persons with a Serious

Mental Illness to the extent the violation allegation asserts a violation relating to the right to receive state-funded services, supports and/or treatment that are no longer funded by the State due to limitations on legislative appropriation.

5.3.4 Definitions

Administrative Appeal

Abuse

Appeal

Condition Requiring Investigation

Dangerous

Grievance or Request for Investigation

Illegal

Inhumane

Mental Health Agency

Special Assistance

5.3.5 Objectives

To ensure that behavioral health providers allow persons determined to have a serious mental illness appropriate access to the grievance and request for investigation process.

5.3.6 Grievance and Requests for Investigation Principles

It is ADHS/DBHS' intent that the grievance and request for investigation process for persons determined to have a Serious Mental Illness must:

- Resolve in an expeditious and equitable manner any allegations that a rights violation or a condition requiring investigation has occurred with regard to persons determined to have a Serious Mental Illness;
- Maintain confidentiality and privacy of the grievance matters and records at all times;
- Take the necessary steps to protect the health, safety and security of any person determined to have a Serious Mental Illness, witness or individual filing the grievance;
- Communicate, as appropriate, timely information on matters and decisions related to the grievance and investigation to affected parties;
- Involve the active cooperation and participation as deemed appropriate of providers with a direct interest in the matter under review; and
- Serve as a means for identifying system deficiencies and developing corrective action plans to resolve any deficiencies identified.

5.3.7 Procedures

5.3.7-A. Filing grievances and requests for investigations

A grievance or request for investigation may be submitted orally or in writing by a person determined to have a Serious Mental Illness who is enrolled with a T/RBHA or by any other concerned person in situations in which it is alleged that:

- A violation of the person's rights may have occurred; or
- A condition requiring investigation currently exists or has occurred.

If asked, a behavioral health provider must assist a person in initiating an oral or written grievance or request for investigation.

If a behavioral health provider has reason to believe that a rights violation or condition requiring investigation has occurred, they must ensure that a grievance or request for investigation is filed. When requested, failure of an employee or individual under contract with a provider to file a grievance or request for investigation may be grounds for corrective action against the employee.

All grievances or requests for investigation must be:

- Submitted orally or in writing to **[Insert name of RBHA and place to send it]**
- Reduced to writing on the ADHS/DBHS grievance or request for investigation form (see PM Form 5.3.1) by either the person filing the grievance or request for investigation or by the provider to whom the grievance or request for investigation is made.
- Filed orally or in writing within one year of the alleged rights violation or condition for investigation occurred.

5.3.7-B. Grievance and request for investigation resolution process

The entity initially responsible for resolving grievances or requests for investigation differs depending on the nature of the grievance or request for investigation:

- Allegations of rights violations involving abuse or the death of a person determined to have a serious mental illness are investigated by ADHS/DBHS; and
- Allegations of rights violations other than abuse or death are investigated by:
  - The Arizona State Hospital if the violation occurred at the Hospital;
  - The RBHA if the violation occurred at the RBHA or at one of its providers; or
  - ADHS/DBHS if the violation occurred at the TRBHA or at one of its providers.

The process for resolving grievances or requests for investigation may also vary in length; ranging from:

- Immediate disposition without investigation;
- An investigation and final decision;
- An administrative appeal; or
- An administrative hearing.

How is time computed?

When computing any period of time associated with this process:

- The period begins the day after the act, event or decision occurs and includes all calendar days and the final day of the period. If the final day of the period is a weekend or legal

holiday, the period is extended until the end of the next day that is not a weekend or a legal holiday;
- If the period of time is not designated as calendar days and is less than 11 days, then intermediate Saturdays, Sundays and legal holidays must not be included in the computation.

What are the responsibilities of a behavioral health provider?

Behavioral health providers are not directly responsible for the resolution of the grievance or request for investigation, but are required to actively participate in the process as follows:

- Cooperate in the investigation by participating in any private face-to-face interviews the investigator requests. Failure to cooperate may lead to corrective action;
- Provide information requested by the RBHA or ADHS/DBHS designated investigator;
- Continue to cooperate and participate as necessary in any subsequent appeal proceedings relating to the grievance or request for investigation; and
- Implement any immediate, reasonable action required to protect the health and safety of any person determined to have a serious mental illness or involved staff.

Section 5.4 Special Assistance for Persons Determined to have a Serious Mental Illness

5.4.1 **Introduction**
5.4.2 **References**
5.4.3 **Scope**
5.4.4 **Did you know…?**
5.4.5 **Definitions**
5.4.6 **Objectives**
5.4.7 **General Requirements**
5.4.7-A **Criteria for Identifying the need for Special Assistance**
5.4.7-B **Persons Qualified to make a Special Assistance Determination**
5.4.7-C **When to assess for Special Assistance**
5.4.8 **Procedures**
5.4.8-A **Notifying the Office of Human Rights**
5.4.8-B **No longer in need of Special Assistance**
5.4.8-C **Requirements of the T/RBHA and subcontracted providers to help ensure provision of Special Assistance**
5.4.8-D **Confidentiality**
5.4.8-E **Other Requirements**

5.4.1 Introduction

Persons who have been determined to have a Serious Mental Illness (SMI) have specific rights, remedies and protections in accordance with Arizona law. These include the right to self-determination, freedom of choice, and the right to participate to the fullest extent possible in all phases of their treatment.

Individual service planning and inpatient treatment/discharge planning are fundamental aspects of an individual's comprehensive treatment. The appeal and grievance/investigation processes are the primary mechanisms which preserve and enforce the rights of individuals determined to have a SMI. In some instances, persons determined to have a SMI may have other conditions that can affect their ability to participate effectively in these processes. The Tribal or Regional Behavioral Health Authorities (T/RBHAs) and subcontracted providers are required to identify those in need of Special Assistance and facilitate the provision of Special Assistance. It is critically important that T/RBHAs and subcontracted providers regularly assess and identify persons who have been determined to have a SMI, who are unable to effectively participate in these services. T/RBHAs and providers must ensure that the person designated to provide Special Assistance is involved at key stages.

5.4.2 References

The following citations can serve as additional resources for this content area:
A.R.S. §§ 14-5303, 14-5304, 14-5305
A.R.S. §§ 36-107, A.R.S. §§ 36-501, 36-504, 36-509, 36-517.01
A.R.S. §§ 41-3803, 41-3804
9 A.A.C. 21
ADHS/RBHA Contracts
ADHS/TRBHA IGAs

Section 3.9, Assessment and Service Planning
Section 3.10, SMI Eligibility Determination
Section 4.1, Disclosure of Behavioral Health Information
ADHS/DBHS Policy and Procedures CO 1.4, Confidentiality
ADHS/DBHS Policy and Procedures GA 3.4, Special Assistance for Persons Determined to Have a Serious Mental Illness
ADHS/DBHS Policy and Procedures GA 3.8, Disclosure of Confidential Information to Human Rights Committees

5.4.3 Scope

To whom does this apply?
All persons determined to have a Serious Mental Illness who potentially may qualify for the provision of Special Assistance.

5.4.4 Did you know…?

A person determined to have a Serious Mental Illness who is also subject to a general guardianship automatically meets the criteria for Special Assistance.

The Office of Human Rights can designate a family member, friend, guardian or qualified advocate as the person meeting the needs of a person in need of Special Assistance.

Until the person designated to provide the person's Special Assistance needs is actively involved, the T/RBHA and behavioral health provider are required to postpone service and discharge planning, and/or the grievance, investigation and appeal processes.

"Special needs" are separate from the need for Special Assistance. Persons with special needs can include those who do not speak English, and may need an interpreter; persons who are deaf or hard of hearing and require auditory assistance; and persons who are blind or physically disabled, who may require visual or mobility assistance. T/RBHAs and providers are required to make the appropriate accommodations for special needs.

5.4.5 Definitions

ADHS/DBHS Office of Human Rights

Title XIX

Human Rights Committees

Qualified Clinician

Serious Mental Illness

Special Assistance

5.4.6 Objectives

To establish guidelines to ensure that persons determined to have a Serious Mental Illness (SMI) and are in need of Special Assistance are identified and provided the Special Assistance they require.

5.4.7 General Requirements

5.4.7-A Criteria for identifying the need for Special Assistance

A person who has been determined to have a SMI is in need of Special Assistance if he or she is unable to do any of the following:

- Communicate preferences for services;
- Participate effectively in individual service planning (ISP) or inpatient treatment discharge planning (ITDP); or
- Participate effectively in the appeal, grievance, or investigation processes;

And the person's limitations are due to any of the following:

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

A person who is subject to a general guardianship has been found to be incapacitated under A.R.S. § 14-5304 and therefore automatically satisfies the criteria for Special Assistance. Similarly, if a T/RBHA or subcontracted provider recommends a person with a SMI for a general guardianship (in accordance with R9-21-206 and A.R.S. § 14-5305), the person automatically satisfies the criteria for Special Assistance

The existence of any of the following circumstances for an individual should prompt the T/RBHA and subcontracted provider to more closely review the individual's need for Special Assistance:

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

5.4.7-B Persons qualified to make a Special Assistance Determination

The following may deem a person to be in need of Special Assistance:

- A qualified clinician providing treatment to the person;
- A case manager of a T/RBHA or subcontracted provider
- A clinical team of a T/RBHA or subcontracted provider;
- A T/RBHA;
- A program director of a subcontracted provider; including AzSH;
- The Deputy Director of ADHS/DBHS; or

- A hearing officer assigned to an appeal involving a person determined to have an SMI.

5.4.7-C When to Assess for Special Assistance

T/RBHAs and their subcontracted providers must on an ongoing basis assess whether persons determined to have a SMI are in need of Special Assistance. For persons who are also Title XIX-enrolled (on AHCCCS), minimally this assessment must occur at the following stages:

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

For persons with a SMI who are not Title XIX-enrolled, T/RBHAs, AzSH and subcontracted providers are required to assess whether the person is in need of Special Assistance:

- Upon admission to the AzSH and periodically during the person's stay;
- Initiation of the grievance or investigation processes; and
- Filing of an appeal.

T/RBHAs and their subcontracted providers shall document in the clinical record each time a person is assessed for Special Assistance, indicating what factors were considered and the conclusion reached. If it is determined that the person is in need of Special Assistance, they must notify the Office of Human Rights (OHR) by completing PM Form 5.4.1 Notification of Persons in Need of Special Assistance in accordance with the procedures outlined below.

5.4.8 Procedures

5.4.8-A Notifying the Office of Human Rights

The T/RBHAs and subcontracted providers must notify the Office of Human Rights (OHR) using PM Form 5.4.1 Notification of Person in Need of Special Assistance (Part A), within three working days of identifying a person in need of Special Assistance. If the person's Special Assistance needs require immediate assistance, the notification form must be submitted immediately, with a notation indicating the urgency**.**

The Office of Human Rights (OHR) will review the notification form to confirm that a complete description of the necessary criteria is included. In the event necessary information is not provided, OHR will contact the T/RBHA to obtain clarification. OHR will respond to the T/RBHA and subcontracted provider by completing Part B of PM Form 5.4.1, within three working days of receipt of notification from the T/RBHA. The notification process is complete only when OHR returns the form, with Part B completed, to the T/RBHAs and subcontracted providers. If Part B of PM Form 5.4.1 is not received within the required time period, the T/RBHAs and providers should follow up by contacting OHR at (602) 364-4585.

If the need for Special Assistance is urgent, OHR will respond as soon as possible, but generally within one working day of receipt of the notification form**.**

5.4.8-B No longer in need of Special Assistance

The T/RBHAs or subcontracted providers must notify the OHR within ten days of an event or a determination that an individual is no longer in need of Special Assistance using Part C of the original notification form, identifying:

- The reasons why Special Assistance is no longer required;
- The effective date;
- The name and title of the staff person completing the form; and
- The date the form is completed.

5.4.8-C Requirements of T/RBHAs and Subcontracted Providers to Help Ensure the Provision of Special Assistance

T/RBHAs and subcontracted providers must maintain open communication with the person (guardian, family member, friend, OHR advocate, etc.) assigned to meet the person's Special Assistance needs. For persons who are also Title XIX-enrolled, minimally, this involves providing timely notification to the person providing Special Assistance to ensure involvement in the following stages:

- ISP planning and review (including any instance when the person makes a decision about service options and/or modification/termination of services);
- ITDP planning (which includes any time when the person is admitted to a psychiatric inpatient facility); and
- Investigation, grievance or appeal process (including circumstances when initiating a request for investigation, grievance or appeal may be warranted).

T/RBHAs, AzSH and subcontracted providers must maintain open communication with the person assigned to meet the Special Assistance needs of a person who is not Title XIX-enrolled. This involves responding to general inquiries; additionally includes, providing timely and unsolicited notification to ensure involvement in the following:

- Inpatient treatment and discharge planning (ITDP) during the person's stay at the AzSH; and
- Investigation, grievance or appeals processes.

In the event that such procedures are delayed in order to ensure the participation of the person providing Special Assistance, the T/RBHAs and subcontracted providers must document the reason for the delay in the clinical record.

T/RBHAs and subcontracted providers shall provide relevant details and a copy of the original Special Assistance Notification form (both Parts A and B) to the receiving entity or case manager when a person in need of Special Assistance who is also Title XIX-enrolled (on AHCCCS) is admitted to an inpatient facility or is transferred to a different T/RBHA, case management provider site or case manager.

T/RBHAs and subcontracted providers shall provide relevant details and a copy of the original Special Assistance Notification form (both Parts A and B) to the receiving entity when a person in need of Special Assistance who is Non Title XIX-enrolled is admitted to AzSH or is transferred to a different T/RBHA or provider site.

T/RBHAs and subcontracted providers must periodically review whether the person's Special Assistance needs are being met by the person designated to meet those needs. If a concern arises, the T/RBHA and subcontracted provider should initially address the problem with the person providing Special Assistance. If the issue is not promptly resolved, they must take further action to address the issue, which may include contacting OHR for assistance.

5.4.8-D Confidentiality

T/RBHAs, AzSH and subcontracted providers shall grant access to clinical records of persons in need of Special Assistance to the Office of Human Rights in accordance with all federal and state confidentiality laws. (For further clarification see Section 4.1 Disclosure of Behavioral Health Information)

5.4.8-E Other Requirements

T/RBHAs and subcontracted providers must maintain a copy of the completed Notification of Special Assistance form (both Parts A and B) in the person's comprehensive clinical record.

The HRCs must make periodic visits to individuals in need of Special Assistance placed in residential settings to determine whether the services meet their needs, and their satisfaction with their residential environment.

T/RBHAs must ensure that all applicable T/RBHA and provider staff are trained on the requirements related to Special Assistance.

Section 5.5 Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)

5.5.1 Introduction
5.5.2 References
5.5.3 Scope
5.5.4 Did you know…?
5.5.5 Definitions
5.5.6 Objectives
5.5.7 Procedures
5.5.7-A. General requirements for notice and appeals
5.5.7-B. Notice requirements for persons applying for or who have been determined to have a Serious Mental Illness
5.5.7-C. Notice requirements for Non-Title XIX/XXI/Non-SMI populations
5.5.7-D. Filing an appeal
5.5.7-E. Appeal process for persons applying for or who have been determined to have a Serious Mental Illness
5.5.7-F. Appeals for Non-Title XIX/XXI/ Non-SMI populations
5.5.7-G. Behavioral health provider responsibilities

5.5.1 Introduction

This section applies to notice and appeal requirements for:

- Persons who have been determined to have a Serious Mental Illness (SMI);
- Persons who are evaluated for an SMI eligibility determination; and
- Behavioral health recipients who do not have a Serious Mental Illness and who are not Title XIX or Title XXI eligible.

The notice requirements and the appeal process for persons who are Title XIX/XXI eligible are described in Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons.

Persons who have been determined to have a Serious Mental Illness and who are receiving non-Title XIX/XXI (state funded) services must only receive notice of, and may only appeal, pursuant to this section, decisions regarding those services that are covered benefits established by the State. The notice and appeal requirements described within this section do not apply to actions or decisions that deny, suspend, reduce, or terminate a person's or persons' services benefits as a result of changes in state or federal law which require an automatic change, or in order to avoid exceeding the state funding legislatively appropriated for those services or benefits.

Persons who are evaluated for an eligibility determination or who have been determined to have a Serious Mental Illness must be provided notice under certain circumstances. Notice allows a

behavioral health recipient to exercise his/her right to appeal a decision. This section describes those circumstances when notice must be provided.
Persons who are evaluated for an eligibility determination or who have been determined to have a Serious Mental Illness can appeal certain decisions. These include, but are not limited to:

- Decisions regarding an SMI eligibility determination;
- Decisions regarding the need for, the timely provision of, or the continuation of covered behavioral health services; and
- Decisions regarding charges or co-payments for behavioral health services.

5.5.2 References

The following citations can serve as additional resources for this content area:
A.R.S. §1-254
A.R.S. §36-502.D
A.R.S. § 12-901 et.seq
A.R.S. § 36-111
A.R.S. § 36-3413
A.R.S. § 41-1061 et.seq
9 A.A.C. 1, Article 1
9 A.A.C. 21, Articles 2 and 4
ADHS/T/RBHA Contracts
ADHS/T/RBHA IGAs
ADHS/DBHS Covered Behavioral Health Services Guide
Section 5.3, Grievances and Request for Investigation for Persons Determined to have a Serious Mental Illness
Section 5.2, Member Complaints
Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons
Section 5.6, Provider Claims Disputes
Section 3.6, Member Handbook

5.5.3 Scope

To whom does this apply?
This section applies to:

- Persons who have been determined to have a Serious Mental Illness (SMI);
- Persons who are evaluated for an SMI eligibility determination; and
- Behavioral health recipients who do not have a Serious Mental Illness and who are not Title XIX or Title XXI eligible.

5.5.4 Did you know…?

- Each RBHA is responsible for processing appeals and may not delegate this responsibility to any other entity.
- Although the RBHAs and ADHS/DBHS are directly responsible for processing all member appeals, it is important for behavioral health providers to be aware of the fundamental

aspects of the appeal process and to offer behavioral health recipients assistance when requested or necessary.
- Persons determined to have a Serious Mental Illness, or others acting on their behalf, may also file grievances and requests for investigation under specified conditions (See Section 5.3, Grievance and Request for Investigation for Persons Determined to have a Serious Mental Illness.

5.5.5 Definitions

Action

Appeal

Complaint

Denial

Limited Authorization

PASRR

Qualified Clinician

Reduction of Service

Suspension of Service

Termination of Service

5.5.6 Objectives

The objectives of this section are to ensure:
Notices are provided as required by this policy which:
- Are timely;
- Explain the action to be taken and the appeal process available to the person or custodial/legal guardian; and
- Are written in a manner that is clear and easily understood by the person.

Persons evaluated for an eligibility determination or who have been determined to have a Serious Mental Illness, and persons who do not have a Serious Mental Illness and who are not Title XIX or Title XXI eligible, have access to an appeals process that fairly and efficiently resolves identified issues.

5.5.7 Procedures

5.5.7-A. General requirements for notice and appeals

Behavioral health providers must be aware of general requirements guiding notice and appeal rights for the populations covered in this section. Behavioral health providers may have direct responsibility for designated functions (i.e., sending notice) as determined by the RBHA and/or may be asked to provide assistance to persons who are exercising their right to appeal.

How is 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.

Language, format and comprehensive clinical record requirements

Notice and related forms must be available in each prevalent, non-English language spoken in the RBHA's geographic service area. As designated by the RBHA, behavioral health 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. **[RBHA indicate here if the provider will be responsible for providing free oral interpretation services. If no, then explicitly state that the RBHA is responsible for this function]**

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 behavioral health services. **[RBHA indicate here if the provider has any responsibility in this area. If no, then explicitly state that the RBHA is responsible for ensuring the availability of alternative formats]**

The provision of notice must be documented by placing a copy of the notice in the person's comprehensive clinical record.

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.

5.5.7-B. Notice requirements for persons applying for or who have been determined to have a Serious Mental Illness

Under what circumstances does a notice have to be provided?
For actions (see definition) related to Title XIX/XXI covered services, See Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons.

The following provisions apply to notice requirements for persons determined to have a Serious Mental Illness and for persons for which an SMI eligibility determination is being considered:

Persons who are evaluated for an SMI eligibility determination must receive PM Attachment 5.5.1, Notice of SMI Grievance and Appeal Procedure, at the time of application.

PM Form 5.5.1, Notice of Decision and Right to Appeal must be provided to persons determined to have a Serious Mental Illness or to persons applying for SMI services when:

- Initial eligibility for SMI services is determined. The notice must be sent within three 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 funds[1]. In this case, notice must be provided at least 30 days prior to the effective date unless the person consents to the change 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 PASRR determination in the context of either a preadmission screening or an annual resident review, which adversely affects the person.

Other notices that must be provided to persons determined to have a Serious Mental Illness
The following additional notices must be provided to persons determined to have a Serious Mental Illness or persons applying for SMI services:

- Notice of legal rights for persons with Serious Mental Illness (see ADHS Form MH-211) 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 behavioral health providers must post ADHS Form MH-211, "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;
- Notice of discrimination prohibited (ADHS Form MH-209), 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.

[1] Actions or decisions that deny, suspend, reduce, or terminate a person's or persons' services or benefits in order to avoid exceeding the state funding legislatively appropriated for those services or benefits do not require Notice.

Who is responsible for providing the notice?
Following a decision requiring notice to a behavioral health recipient, **[T/RBHA insert language here regarding the entity responsible for providing notice to behavioral health recipients]** must ensure the communication of a notice to the person.

ADHS/DBHS sends notices to persons determined to have a Serious Mental Illness who are enrolled with a Tribal RBHA when making a decision on behalf of the Tribal RBHA, and persons adversely affected by a PASRR determination.

5.5.7-C. Notice requirements for Non-Title XIX/XXI/Non-SMI populations

Behavioral health recipients who do not have a Serious Mental Illness and who are not Title XIX/XXI eligible are not required to receive notice under any circumstances.

5.5.7-D. Filing an appeal

Appeals that are related to a RBHA or one of their contracted behavioral health providers' decisions must be filed with the RBHA. Appeals that are related to a Tribal RBHA or one of their contracted behavioral health providers' decisions and appeals that relate to PASRR determinations must be filed with and processed by the ADHS/DBHS Office of Grievance and Appeals.

Title XIX/XXI eligible persons applying for or who have been determined to have a Serious Mental Illness and who are appealing an action (see definition) affecting Title XIX/XXI covered services may elect to use either the Title XIX/XXI appeal process (see Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons) or the appeal process for persons determined to have a Serious Mental Illness described within subsection 5.5.7-E.

What kinds of appeals exist?
There are two appeal processes applicable to this section:

- Appeals of persons applying for an eligibility determination or who have been determined to have a Serious Mental Illness; and
- Appeals for other covered service related issues.

Who can file an appeal?
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;
- 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 ISA/IGA with ADHS, 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 ADHS; and
- A provider, acting on the behavioral health recipient's behalf and with the written authorization of the person.

What are the timeframes for filing an appeal?
Appeals must be filed orally or in writing with the responsible RBHA, or ADHS/DBHS when required, within 60 days from the date of the decision being appealed. Late appeals must be accepted upon showing good cause.

Where must appeals be directed?

- For oral appeals to the RBHA: Call **[Name of RBHA]** at this toll free telephone number **[RBHA insert number]**.

- To submit a written appeal to the RBHA: Mail the appeal to **[Name of RBHA]** at **[insert RBHA office and address]**.

- For oral appeals to ADHS/DBHS: Call ADHS/DBHS at this toll free number-1-800-867-5808 or (602) 364-4575 within Maricopa County.

- To submit a written appeal to ADHS/DBHS: Mail the appeal to 150 North 18th Avenue, Suite 230, Phoenix, Arizona 85007.

5.5.7-E. Appeal process for persons applying for or who have been determined to have a Serious Mental Illness

An appeal may be filed concerning one or more of the following:

- Initial eligibility for SMI services;
- A decision regarding fees or waivers;
- The assessment report, and recommended services in the service plan or individual treatment and discharge plan;
- The denial, reduction, suspension or termination of any service that is a covered service funded through Non-Title XIX funds[2];
- 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;
- A decision is made that the person is no longer eligible for SMI services; and
- A PASRR determination in the context of either a preadmission screening or an annual resident review, which adversely affects the person.

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.

Continuation of services for appeals involving persons determined to have a Serious Mental Illness

[2] Actions or decisions that deny, suspend, reduce, or terminate a person's or persons' services or benefits in order to avoid exceeding the state funding legislatively appropriated for those services or benefits are not subject to appeal.

For persons determined to have a Serious Mental Illness, the person's behavioral health services will continue while an appeal of a modification to or termination of a covered behavioral health 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.

5.5.7-F. Appeals for Non-Title XIX/XXI/ Non-SMI populations

Based on available funding, a person who is Non-Title XXI/XXI and Non-SMI may file an appeal of a decision that is related to a determination of need for a covered service (e.g., modification to previously authorized services for a non-Title XIX/XXI eligible person).

In these circumstances, there is no continuation of services available during the appeal process.

5.5.7-G. Behavioral health provider responsibilities

While providers are not directly responsible for the resolution of appeals, they are required to actively participate in the process as follows:

- Provide information deemed to be necessary by the RBHA, ADHS/DBHS or the Office of Administrative Hearings (e.g., documents and other evidence); and
- Cooperate and participate as necessary throughout the appeal process.

Behavioral health providers must be available to assist a person in the filing of an appeal. For persons determined to have a Serious Mental Illness, the Office of Human Rights may be available to assist the person in filing as well as resolving the appeal.

Behavioral health providers must not retaliate against any person who files an appeal or interfere with a person's right to file an appeal. Additionally, no punitive action may be taken against a behavioral health provider who supports a person's appeal.

Section 5.6 Provider Claims Disputes

5.6.1 Introduction
5.6.2 References
5.6.3 Scope
5.6.4 Definitions
5.6.5 Did you know…?
5.6.6 Objectives
5.6.7 Procedures
5.6.7-A. Prior to filing an initial claim dispute
5.6.7-B. Process for initiating a claim dispute to the RBHA
5.6.7-C. Administrative hearing process for claim dispute decisions made by the RBHA
5.6.7-D. Process for initiating a claim dispute to ADHS/DBHS
5.6.7-E. Administrative hearing process for claim dispute decisions made by ADHS/DBHS

5.6.1 Introduction

The provider claim disputes process affords providers the opportunity to challenge a decision by the Tribal or Regional Behavioral Health Authority (T/RBHA) or Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) that impacts the provider for issues involving:

- A payment of a claim;
- The denial of a claim;
- The recoupment of payment of a claim; and
- The imposition of sanctions

Providers will initially file a claim dispute directly with either a Regional Behavioral Health Authority (RBHA) or ADHS/DBHS, depending upon:

- Which entity is responsible for the decision; and/or
- If a claim payment issue, if the dispute involves services to a person enrolled with a T/RBHA.

Providers initially submit a claim dispute to a RBHA when:

- Challenging a decision of the RBHA; or
- Disputing a claim payment issue for services provided to persons enrolled with a RBHA.

Providers initially submit a claim dispute to ADHS/DBHS when:

- Challenging a decision of ADHS/DBHS; or
- Disputing a claim payment issue for services provided to persons enrolled with a TRBHA.

Once the RBHA or ADHS/DBHS 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 the RBHA or ADHS/DBHS can be resolved through an informal process. Providers are encouraged to try and solve 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 the RBHA or ADHS/DBHS. The section is organized to delineate the process for filing a claim dispute:

- For providers disputing a decision of a RBHA;
- For providers disputing a decision of ADHS/DBHS; and
- The process for requesting an administrative hearing in the event a provider does not agree with the claim dispute decision of a RBHA or ADHS/DBHS.

5.6.2 References

The following citations can serve as additional resources for this content area:
A.R.S. § 36-2903.01.B.4
A.R.S. § 36-3413
A.R.S. Title 41, Chapter 6, Articles 1 and 10
2 A.A.C.19, Article 1
9 A.A.C. 34, Article 4
Balanced Budget Act of 1997
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA IGAs
AHCCCS Contractor Operations Manual, Section 206

5.6.3 Scope

To whom does this apply?
This applies to all providers with or without a contract with a T/RBHA who provide services to persons enrolled in the ADHS/DBHS behavioral health system.

5.6.4 Definitions

Claim Dispute

Clean Claim

Day

Filed

5.6.5 Did you know…?

- ADHS/DBHS and the RBHAs must ensure that when a claim for payment is denied in whole or in part, recouped, or a decision is made to impose a sanction, the affected provider is advised in writing of the right to file a claim dispute.

- ADHS/DBHS and the RBHAs review individual claim disputes and trend collective claims disputes for purposes of detecting fraud and abuse.

- The entire provider claim dispute process is outlined on PM Attachment 5.6.2.

5.6.6 Objectives

The objective of this policy is to ensure that providers understand the procedures for filing and resolving claim disputes.

5.6.7 Procedures

5.6.7-A. 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. PM Attachment 5.6.1 identifies contact persons at the RBHA and ADHS/DBHS that can assist with the informal resolution of a decision.

5.6.7-B. Process for initiating a claim dispute to the RBHA

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 a RBHA, the provider must file the claim dispute with the RBHA. See PM Attachment 5.6.1 for information regarding where to submit a claim dispute.

What does a written claim dispute include?

It is important for providers to ensure the claim dispute contains all required information and is filed within the required timeframes. Failure to do so will result in the denial of the claim dispute.

The claim dispute submitted must contain:

- A statement of the factual and legal basis for the dispute; and

- A statement of the relief requested.

What are the timeframes for initiating a 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 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, denial or recoupment of a timely claim submission.

How is time computed?
A written claim dispute is considered filed when it is received by the RBHA established by a date stamp or other record of the receipt. Providers must use the following methodology in computing any period of time described in this section:

- 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.

What happens after a provider files a claim dispute with the RBHA?
Within five days of receiving the claim dispute, the RBHA will notify the provider in writing that:

- The claim dispute has been received;
- The claim dispute will be reviewed; and
- A decision will be issued within 30 days of receipt of the claim dispute unless an extension has been agreed upon.

It is possible that a RBHA will determine that it is not the appropriate entity to process the claim dispute. This can happen when the RBHA determines that it is not responsible for the denial, non-payment or recoupment of the disputed claim or imposition of a sanction.

If the RBHA determines that it is not responsible for the decision, the claim dispute and all documentation will be sent immediately to the appropriate entity as well as a copy of the transmittal and all documentation to the provider that initiated the claim dispute.

How long does the RBHA have to make a decision, and how will a provider be informed of the decision?
The RBHA shall make a decision on the claim dispute, and mail a written Notice of Decision to all parties, within 30 days of receipt of the claim dispute, unless the RBHA and the provider both agree, in writing, to a longer period. To request an extension of the 30-day timeframe, the provider must submit to the RBHA, prior to the expiration of the original time limit, a written request including the reasons for the extension and a proposed new timeframe. A representative of the RBHA may also request an extension. In either case, the provider and the RBHA must agree to the extension and documentation of the extension of time must be maintained in the claim dispute case record.

What must the Notice of Decision include?
The Notice of Decision must include and describe in detail, the following:

- The nature of the claim dispute;

- The issues involved;
- The reasons supporting the RBHAs´ decision, including references to applicable statute, rule, applicable contractual provisions, policy and procedures;
- The Provider's right to request a hearing by filing a written request for hearing to ADHS/DBHS no later than 30 days after the date the Provider receives the RBHA´s decision; and
- If the decision is to overturn the original processing of the claim, it is required that the RBHA 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.

5.6.7-C. Administrative hearing process for claim dispute decisions made by the RBHA
If the provider is dissatisfied with the RBHA Notice of Decision, the provider may request an administrative hearing by filing, in writing, a request with the ADHS/DBHS Office of Grievance and Appeals. See PM Attachment 5.6.1 for contact information and where to submit a request for an administrative hearing.

What are the timeframes for requesting an administrative hearing?
The provider's request for a hearing must be filed in writing and received by ADHS/DBHS within 30 calendar days of the date of receipt of the RBHA claim dispute decision. A written request for hearing is considered filed when received by ADHS/DBHS Office of Grievance and Appeals established by a date stamp or other record of receipt.

What does a request for administrative hearing include?
In filing the request for an administrative hearing to ADHS/DBHS, the provider must include:
- Provider name, AHCCCS identification number, address and the ADHS/DBHS docket number;
- Member´s name and AHCCCS identification number;
- The issue to be determined at the administrative hearing; and
- The factual and legal basis for the request for administrative hearing.

What happens after a provider files a request for administrative hearing with ADHS/DBHS?
Upon receipt of a request for hearing, the ADHS/DBHS Office of Grievance and Appeals will schedule an administrative hearing at the State Office of Administrative Hearings. Statute requires an administrative law judge to conduct the administrative hearing within 60 days after the request is filed and issue a written recommended decision to the ADHS Director within 20 days after the hearing is completed. The ADHS Director will issue a final decision within 30 days after receiving the administrative law judge's recommended decision.

What options exist following the ADHS Director's decision?
The provider may appeal a final administrative decision as follows:

- For claim disputes involving Title XIX and XXI services, the provider has the option of filing a written notice of appeal of the ADHS Director's final decision to the Arizona Health Care Cost Containment System (AHCCCS). This appeal must be filed with the ADHS Office of Administrative Counsel within 30 calendar days after service of the ADHS Director's decision;

- File a motion for rehearing with the ADHS Director within 30 days after service of the ADHS Director's decision; or

- For final administrative decisions, file a petition for judicial review with the Arizona Superior Court within 35 days after service of the ADHS Director's decision.

5.6.7-D. Process for initiating a claim dispute to ADHS/DBHS

If an issue is unable to be resolved informally, providers may file a written claim dispute. For all claim disputes related to decisions of ADHS/DBHS, the provider must file the claim dispute with ADHS/DBHS. See PM Attachment 5.6.1 for information regarding where to submit a claim dispute.

What does a claim dispute include?

It is important for providers to ensure the claim dispute contains all required information and is filed within the required timeframes. Failure to do so will result in the denial of the claim dispute.

The claim dispute submitted must contain:

- A statement of the factual and legal basis for the claim dispute; and

- A statement of the relief requested.

What are the timeframes for initiating a claim dispute?

The claim dispute must be filed within the following established timeframes:

- Within 60 days of the notice advising that a sanction will be imposed, or

- For challenges 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, denial or recoupment of a timely claim submission.

How is time computed?

A written claim dispute is considered filed when it is received by the ADHS/DBHS 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 section:

- 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.

What happens after a provider files a claim dispute with ADHS/DBHS?
Within five days of receiving the claim dispute, ADHS/DBHS will notify the provider in writing that:

- The claim dispute has been received;
- The claim dispute will be reviewed; and
- A decision will be issued within 30 days of receipt of the claim dispute.

It is possible that ADHS/DBHS will determine that it is not the appropriate entity to process the claim dispute. This can happen when ADHS/DBHS determines that it is not responsible for the denial, non-payment or recoupment of the disputed claim or imposition of a sanction.

If ADHS/DBHS determines that it is not responsible for the claim dispute, the claim dispute and all documentation will be sent immediately to the appropriate entity as well as a copy of the transmittal and all documentation to the provider that initiated the claim dispute.

How long does ADHS/DBHS have to make a decision?
A final decision on the claim dispute will be made by ADHS/DBHS within 30 days of receipt of the claim dispute, unless ADHS/DBHS and the provider both agree, in writing, to a longer period. To request an extension of the 30-day timeframe, the provider must submit to ADHS/DBHS, prior to the expiration of the original time limit, a written request including the reasons for the extension and a proposed new timeframe that does not unreasonably postpone final resolution of the matter. A representative of ADHS/DBHS may also request an extension. In either case, the provider and ADHS/DBHS must agree to the extension in writing.

How will a provider be informed of the claim dispute decision?
A copy of the written Notice of Decision (referred to as decision) by ADHS/DBHS will be mailed to all parties no later than 30 days after the provider files a claim dispute with ADHS/DBHS, unless the provider and ADHS/DBHS agreed to a longer period. The Decision must include and describe in detail, the following:

- The nature of the claim dispute;
- The issues involved; the reasons supporting ADHS/DBHS' Decision, including references to applicable statute, rule, applicable contractual provisions, policy and procedures;
- The Provider's right to request a hearing by filing a written request for hearing to ADHS/DBHS no later than 30 days after the date the Provider receives the ADHS/DBHS´ decision; and
- If the claim dispute is overturned, the requirement that ADHS/DBHS shall reprocess and pay the claim(s) with interest, where applicable, in a manner consistent with the Decision within 15 business days of the date of the Decision.

5.6.7-E. Administrative hearing process for claim dispute decisions made by ADHS/DBHS

If the provider is dissatisfied with the ADHS/DBHS Notice of Decision, the provider may request an administrative hearing by filing, in writing, a request with the ADHS/DBHS Office of Grievance and Appeals. See PM Attachment 5.6.1 for contact information and where to submit a request for an administrative hearing.

What are the timeframes for requesting an administrative hearing?
The provider's request for a hearing must be filed in writing and received by ADHS/DBHS no later than 30 calendar days of the date of receipt of the ADHS/DBHS Notice of Decision. A written request for hearing is considered filed when received by ADHS/DBHS Office of Grievance and Appeals established by a date stamp or other record of receipt.

What does a request for administrative hearing include?
In filing the request for an administrative hearing to ADHS/DBHS, the provider must include:

- Provider name, AHCCCS identification Number, address, phone number and the ADHS/DBHS docket number;
- Member´s name and AHCCCS identification number;
- The issue to be determined at the administrative hearing; and
- The factual and legal basis for the request for administrative hearing.

What happens after a provider files a request for administrative hearing with ADHS/DBHS?
Upon receipt of a request for hearing, the ADHS/DBHS Office of Grievance and Appeals will schedule an administrative hearing at the State Office of Administrative Hearings. Statute requires an administrative law judge to conduct the administrative hearing within 60 days after the request is filed and issue a written recommended decision within 20 days after the hearing is completed. The ADHS Director will issue a final decision within 30 days after receiving the administrative law judge's recommended decision.

If ADHS/DBHS decision regarding a claim dispute is reversed through the claim dispute or hearing process, ADHS/DBHS shall reprocess and pay the claim(s) with interest, where applicable, in a manner consistent with the decision within 15 business days of the date of the decision unless a different timeframe is specified.

What options exist following the ADHS Director's decision?
The provider may appeal a final administrative decision as follows:

- For claims disputes involving Title XIX and XXI services, the provider has the option of filing a written notice of appeal of the ADHS Director's final decision to the Arizona Health Care Cost Containment System (AHCCCS). This appeal must be filed with the ADHS Office of Administrative Counsel within 30 calendar days after service of the ADHS Director's decision;

- File a motion for rehearing with the ADHS Director within 30 days after service of the ADHS Director's decision (see reference A.R.S. 41-1092.09); or

- For final administrative decisions, file a petition for judicial review with the Arizona Superior Court within 35 days after service of the ADHS Director's decision.

Section 6.0 Data and Billing Requirements

6.1 Submitting Tribal Fee-for-Service Claims to AHCCCS
6.2 Submitting Claims and Encounters to the RBHA

Section 6.1 Submitting Tribal Fee-for-Service Claims to AHCCCS

6.1.1 Introduction
6.1.2 References
6.1.3 Scope
6.1.4 Did you know…?
6.1.5 Definitions
6.1.6 Objectives
6.1.7 Procedures
6.1.7-A. What general requirements apply to Tribal Fee-for-Service providers when submitting claims ?
6.1.7-B What requirements apply to Tribal Fee-for-Service providers when submitting claims?

6.1.1 Introduction

Upon rendering a covered behavioral health service, billing information is submitted by behavioral health providers as a "claim" or as an "encounter." Some behavioral health providers are reimbursed on a fee-for-service basis (these providers submit "claims") and others are paid on a capitated basis or contract under a block purchase arrangement (these providers submit "encounters").

The intent of this section is to:

- Identify general requirements for submitting claims data to AHCCCS;
- Identify procedures and standardized forms for submitting claims data to AHCCCS;
- Articulate the timelines for submitting billing information.

For information on procedures for submitting claim/encounter data to the RBHA, see Provider Manual Section 6.2, Submitting Claims and Encounters to the RBHA.

6.1.2 References

The following citations can serve as additional resources for this content area:
45 CFR 162.1101
45 CFR 162.1102
A.R.S. §36-2904
9 A.A.C. 34
AHCCCS/ADHS Contract
ADHS/TRBHA IGAs
Section 3.4, Co-Payments
Section 3.5, Third Party Liability and Coordination of Benefits
ICD-9-CM Manual
First DataBank
Physicians' Current Procedural Terminology (CPT) Manual
Health Care Procedure Coding System (HCPCS) Manual
Medicare Claims Processing Manual
CMS 1500
UB 04

Client Information System (CIS) File Layout and Specifications Manual
ADHS/DBHS Office of Program Support Procedures Manual
AHCCCS Billing Manual for IHS/Tribal Providers

6.1.3 Scope

To whom does this apply?
All behavioral health providers contracted with a Tribal RBHA that submit claims to AHCCCS.

6.1.4 Did you know…?

Submission of legible and accurate billing data facilitates timely reimbursement for fee-for-service providers.

- Paper claims are not considered legible if they contain highlighter or color marks, copy overexposure marks or dark edges.
- Behavioral health providers must not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that services provided were not Title XIX/XXI covered services.
- When crisis services are billed, these services must be identified as such see PM Attachment 6.0.2, Billing Instructions Used to Identify Crisis Services).

6.1.5 Definitions

Claim

Clean Claim

Fee-for-Service

Retro-eligibility Claim

6.1.6 Objectives

To ensure behavioral health providers submit timely, accurate and complete claims to AHCCCS.

6.1.7 Procedures

6.1.7-A. What general requirements apply to Tribal Fee-for-Service providers when submitting claims?

All paper claims must be submitted using the CMS 1500, UB-04 or the Universal Pharmacy Form**.** For specific billing instructions, see AHCCCS Billing Manual for IHS/Tribal Providers.

Providers must use the following forms to submit paper claims:

- The CMS 1500 (formerly HCFA 1500) Claim Form is used to bill non-facility services, including professional services, transportation and independent laboratories.

- The UB 04 (formerly HCFA 1450) Claim Form is used to bill all hospital inpatient, outpatient, emergency room, hospital-based clinic and residential treatment center services.
- The Universal Pharmacy Claim Form is used by pharmacists to bill pharmacy services using NDC codes.

All claims or copies of paper claims:
- Must be legible and submitted on the correct form.
- May be returned to the provider without processing if they are illegible, incomplete, or not submitted on the correct form.

HIPAA regulations specify the format for the submission of all electronic claims submitted to AHCCCS.
- HIPAA Format 837P is used to bill non-facility services, including professional services, transportation and independent laboratories.
- HIPAA Format 837I is used to bill hospital inpatient, outpatient, emergency room, hospital-based clinic and residential treatment center services.
- HIPAA Format NCPDC is used by pharmacists to bill pharmacy services using NDC codes.

If more information is needed regarding electronic submission of claims to **AHCCCS**, please contact AHCCCS Electronic Claims Submission Unit at (602) 417-7670 #4.

What happens after a claim is submitted?
Submitted claims for services delivered to a Title XIX or Title XXI eligible person will result in one of the following dispositions:
- Denied;
- Pended; or
- Approved.

Denied claims: Claims are typically denied because of a discrepancy between form field(s) and AHCCCS' edit tables. A denied claim may be resubmitted as long as the claim is submitted within **12 months of the date of service.** Tribal RBHA claims will be denied in the event the claim is untimely, illegible or incomplete.

Pended Claims: A claim may stop processing and "pend" for internal review when the error detected concerns data or procedures that may be resolved by AHCCCS. Internally pended claims are generally processed without further information from the provider.
Approved claims: Approved claims have passed the timeliness, accuracy and completeness standards and have been successfully processed by AHCCCS.

6.1.7-B. What requirements apply to Tribal Fee-for-Service providers when submitting claims?

Behavioral health providers must submit accurate, timely and complete claims data to AHCCCS for all covered behavioral health services, either on paper or electronically.

All paper claims must be mailed to: AHCCCS Claims

P.O. Box 1700
Phoenix, Arizona 85002-1700

For submitting electronic claims: Contact the AHCCCS Electronic Claims Submission Unit at (602) 417-7670 #4

Claim submission timeframes

All initial claims must be received by AHCCCS no later than six months from the date of service, unless the behavioral health recipient has retro-eligibility. For hospital inpatient claims, "date of service" means the date of discharge of the behavioral health recipient. Claims initially received beyond the six-month timeframe, except retro-eligibility claims, will be denied. If a claim is originally received within the six-month timeframe, the provider has up to 12 months from the date of service to resubmit the claim in order to achieve clean claim status or to correct a previously processed claim, unless the claim is a retro-eligibility claim. If a claim does not achieve clean claim status or is not corrected within 12 months, AHCCCS is not liable for payment.

What is a retro-eligibility claim?

A retro-eligibility claim is a claim where no eligibility was entered in the AHCCCS system on the date(s) of service but, at a later date, eligibility was posted retroactively to cover the date(s) of service. Retro-eligibility fee-for-service claims are considered timely submissions if the initial claim is received by AHCCCS no later than six months from the AHCCCS date of eligibility posting. Retro-eligibility claims must attain clean claim status no later than 12 months from the AHCCCS date of eligibility posting. Corrections to paid retro-eligibility claims must be received by AHCCCS no later than 12 months from the AHCCCS date of eligibility posting.

Can a denied claim be resubmitted?

AHCCCS will deny claims with errors that are identified during the editing process. These errors will be reported to the provider in the AHCCCS remittance advice. Providers must correct claim errors and resubmit claims to AHCCCS for processing within the 12-month clean claim timeframe.

When resubmitting a denied claim, the provider must submit a new claim form containing all previously submitted lines. The original AHCCCS claim reference number (CRN) must be included on the claim to enable the AHCCCS 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 timeframe. For additional information related to claim submission, see PM Attachment 6.0.1, Where Do I Submit My Claim?

Requirements for Medicare Part A and B, and Medicare Part D Prescription Drug Plan

Coordination of Benefits for persons eligible for Medicare Part A, Part B or Part D must follow the procedures established in Provider Manual Section 3.5, Third Party Liability and Coordination of Benefits.

For specific billing instructions on Medicare Part A and B, and Medicare Part D Prescription Drug Plan, see the Client Information System (CIS) File Layout and Specifications Manual and ADHS/DBHS Office of Program Support Procedures Manual.

Section 6.2 Submitting Claims and Encounters to the RBHA

6.2.1 Introduction
6.2.2 References
6.2.3 Scope
6.2.4 Did you know…?
6.2.5 Definitions
6.2.6 Objectives
6.2.7 Procedures
6.2.7-A. What general requirements apply to RBHA providers when submitting encounters?
6.2.7-B. What requirements apply to RBHA contracted providers when submitting encounters?
6.2.7-C What requirements apply to RBHA providers when submitting claims?

6.2.1 Introduction

Upon rendering a covered behavioral health service, billing information is submitted by behavioral health providers as a "claim" or as an "encounter". Some behavioral health providers are reimbursed on a fee-for-service basis (these providers submit "claims") and others are paid on a capitated basis or contract under a block purchase arrangement (these providers submit "encounters"). Although the providers submitting claims data utilize standardized forms, submission of claim and encounter data follow the procedure required by each Regional Behavioral Health Authority (RBHA).

The intent of this section is to:

- Identify general requirements for submitting encounter data;
- Identify procedures for submitting encounter data;
- Identify procedures for submitting claims; and
- Articulate the timelines for submitting billing information.

Procedures for submission of claims to the RBHA vary significantly among providers. RBHA specific requirements concerning claims submission by the providers shall be articulated by each RBHA(see subsection 6.2.7-C for RBHA specific requirements for claims submission).

For information on procedures for submitting Tribal claims data, see Section 6.1, Submitting Tribal Fee-For Service Claims to AHCCCS.

6.2.2 References

The following citations can serve as additional resources for this content area:

45 CFR 162.1101
45 CFR 162.1102
9 A.A.C. 34
AHCCCS/ADHS Contract
ADHS/RBHA Contract

Section 3.4, Co-Payments
Section 3.5, Third Party Liability and Coordination of Benefits
Section 6.1, Submitting Tribal Fee-for-Service Claims to AHCCCS
Section 8.1, Encounter Validation Studies
CMS 1500
UB 04
ICD-9-CM Manual
First Data Bank
Physicians' Current Procedural Terminology (CPT) Manual
Health Care Procedure Coding System (HCPCS) Manual
ADHS/DBHS Office of Program Support Procedures Manual
Client Information System (CIS) File Layout and Specifications Manual

6.2.3 Scope

To whom does this apply?
All behavioral health providers contracted with a RBHA that submit claim or encounter data.

6.2.4 Did you know…?

- The RBHA must submit all encounters including resubmissions or corrections to ADHS/DBHS within 210 days from the end date of service.
- The RBHA may be assessed sanctions for non-compliance with encounter submission requirements.
- The Arizona Health Care Cost Containment System Administration (AHCCCSA) conducts data validation studies of Title XIX and Title XXI encounter submissions. A data validation study examines a sample of medical records to ensure that the encountered service has actually been provided. The RBHA will also perform data validation studies.
- A Trading Partner Agreement for Electronic Data Interchange (EDI) transactions must be in place between a RBHA and provider before a provider can submit electronic claim or encounter data to a RBHA.
- Behavioral health providers must not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that services provided were not Title XIX/XXI covered services.
- When crisis services are encountered, these services must be identified as such (see PM Attachment 6.0.2, Billing Instructions Used to Identify Crisis Services for guidance).

6.2.5 Definitions

Clean Claim

Encounter

Sanction

6.2.6 Objectives

To ensure behavioral health providers submit timely, accurate and complete claims or encounter data.

6.2.7 Procedures

6.2.7-A. What general requirements apply to RBHA providers when submitting encounters?

All encounters or copies of paper encounters:

- Must be legible and submitted on the correct form.
- May be returned to the provider without processing if they are illegible, incomplete, or not submitted on the correct form.

HIPAA regulations specify the format for the submission of all electronic claims and encounters submitted to **[Insert Name of RBHA]**.

- HIPAA Format 837P is used to bill or encounter non-facility services, including professional services, transportation and independent laboratories.
- HIPAA Format 837I is used to bill or encounter hospital inpatient, outpatient, emergency room, hospital-based clinic and residential treatment center services.
- HIPAA Format NCPDP is used by pharmacies to bill or encounter pharmacy services using NDC codes.

If more information is needed regarding electronic submission of claims and encounters to **[Name of RBHA]**, please contact **[Enter RBHA contact name and contact information]**.

What happens after an encounter is submitted?
Submitted encounters for services delivered to eligible persons will result in one of the following dispositions:

- Rejected;
- Pended; or
- Adjudicated.

Rejected encounters: Encounters are typically rejected because of a discrepancy between submitted form field(s) and the RBHA's, ADHS/DBHS' or AHCCCS' edit tables. A rejected encounter may be resubmitted as long as the encounter is submitted within the RBHA's established timeframe. **[RBHA enter specific requirement.]**

Pended encounters: Encounters may pend at AHCCCS. The RBHA must resolve all pended encounters within 120 days of the original processing date. The RBHA must not delete pended

encounters as a means to avoid sanctions for failure to correct encounters within the specified number of days. **[RBHA enter any provider expectations.]**

Adjudicated encounters: Adjudicated encounters have passed the timeliness, accuracy and completeness standards and have been successfully processed by ADHS/DBHS (and AHCCCS for Title XIX/XXI eligible persons).

What about submissions for Non-Title XIX/XXI eligible persons?
Submitted encounters for services delivered to Non-Title XIX/XXI enrolled persons must be submitted in the same manner and timeframes as described in this subsection. These encounters are not submitted to AHCCCS, but must be sent to CIS within 210 days from the end date of service.

Encounters for services delivered to Non-Title XIX/XXI enrolled persons will result in one of the following dispositions: Rejected or accepted.

Rejected encounters for services delivered to Non-Title XIX/XXI enrolled persons will be returned to the RBHA with an explanation of the disallowance. A RBHA may resubmit the encounter within 210 days from the end date of service.

6.2.7-B. What requirements apply to RBHA contracted providers when submitting encounters?

Where are encounters submitted?

Paper encounters are mailed to:	**[RBHA billing contact and address]**
Electronic encounters are sent to:	**[Add RBHA process for submitting electronic encounter forms]**

Encounter Submission Timeframes
All encounters must be submitted to **[RBHA]** within **[Enter RBHA specific requirement]** from the date of service. Encounters received beyond the **[Enter RBHA specific requirement**], may be subject to timeliness sanctions.

Dates of service must not span a contract year. Contract years begin on July 1 and end on June 30. If a service spans a contract year, the claim must be split and submitted in two different date segments, with the appropriate number of units for each segment so the dates of service do not span a contract year. For additional information related to encounter submission, see PM Attachment 6.0.1, Where Do I Submit My Claim?

Pseudo identification numbers for Non-Title XIX/XXI eligible persons
Pseudo identification numbers are only applicable to behavioral health providers under contract with a RBHA.

On very rare occasions, usually following a crisis episode, basic information about a behavioral health recipient may not be available. When the identity of a behavioral health recipient is unknown, a behavioral health provider may use a pseudo identification number to register an unidentified person. This allows an encounter to be submitted to ADHS/DBHS, allowing the RBHA 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. For a list of available pseudo identification numbers, see Attachment 6.2.1, Pseudo Identification Numbers.

6.2.7-C. What requirements apply to RBHA providers when submitting claims?

[RBHA enter specific provider requirements for claims submission.]

Requirements for Medicare Part A and B, and Medicare Part D Prescription Drug Plan
Coordination of Benefits for persons eligible for Medicare Part A, Part B or Part D must follow the procedures established in Provider Manual Section 3.5, Third Party Liability and Coordination of Benefits.

For specific billing instructions on Medicare Part A and B, and Medicare Part D Prescription Drug Plan, see the Client Information System (CIS) File Layout and Specifications Manual and the ADHS/DBHS Office of Program Support Procedures Manual.

Section 7.0 Reporting Requirements

7.1 Fraud and Program Abuse Reporting
7.2 Medical Institution Reporting for Medicare Part D
7.3 Seclusion and Restraint Reporting
7.4 Reporting of Incidents Accidents and Deaths
7.5 Enrollment Disenrollment and Other Data Submission
7.6 Duty to Report Abuse Neglect or Explotation
7.7 Duty to Warn
7.8 Reporting Discovered Violations of Immigration Status

Section 7.1 Fraud and Program Abuse Reporting

7.1.1 Introduction
7.1.2 References
7.1.3 Scope
7.1.4 Did you know…?
7.1.5 Definitions
7.1.6 Objectives
7.1.7 Procedures
7.1.7-A Reporting of fraud and program abuse involving Title XIX/XXI funds or AHCCCS registered for providers and recipients
7.1.7-B Reporting of fraud and program abuse involving Non-Title XIX/XXI funds or ADHS/DBHS registered providers or other providers and recipients
7.1.7-C Reporting of fraud and program abuse to the T/RBHA

7.1.1 Introduction

The reporting of suspected fraud and program abuse is intended to avoid the misappropriation of Federal, State and Local funds. In the context of this section of the Provider Manual, "fraud" is considered an act of purposeful deception committed by a person or behavioral health provider to gain an unauthorized benefit. "Abuse" committed by a behavioral health provider (for purposes of this section of the Provider Manual) means activities that are inconsistent with standard fiscal business or medical practices and that result in unnecessary costs to the Arizona Health Care Cost Containment System (AHCCCS) and/or the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) programs. Persons receiving care in the behavioral health system can also commit acts of program abuse (e.g., by loaning or selling their AHCCCS identification card).

Behavioral health providers must be cognizant of the potential for fraud and program abuse within the public behavioral health system. Fraud and program abuse can result in the misuse of Federal and State funds, can jeopardize the care and treatment of persons receiving behavioral health services and can result in monetary fines, criminal prosecution, the termination of providers and prohibition from participation in Medicare/Medicaid Programs. This section outlines the procedures for behavioral health providers to report suspected incidents of fraud and/or program abuse.

7.1.2 References

The following citations can serve as additional resources for this content area:

42 CFR 438.608
A.R.S. § 13-2310
A.R.S. § 36-2918.01
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA IGAs
AHCCCS Contractor Operations Manual, Chapter 100, Section III. A

Office of Program Integrity Operations and Procedure Manual
Section 7.4, Reporting of Incidents, Accidents and Deaths

7.1.3 Scope

To whom does this apply?

- All Tribal/Regional Behavioral Health Authority (T/RBHA) enrolled persons receiving behavioral health services; and
- All behavioral health providers.

7.1.4 Did you know…?

- This section does not include reporting of physical and sexual abuse regarding persons who have been diagnosed with a Serious Mental Illness (SMI). Section 7.4, Reporting of Incidents, Accidents and Deaths, contains information for reporting abuse of persons determined to have a SMI.

- T/RBHAs are responsible for ensuring that mechanisms are in place for the prevention, detection and reporting of fraud or program abuse.

- All employees of behavioral health providers must be familiar with the types of fraud and program abuse that could occur during their normal daily activities.

- ADHS/DBHS and each T/RBHA have designated a compliance officer and compliance committee designed to prevent and detect suspected fraud or program abuse.

- Any person who knowingly obtains any benefit by means of false or fraudulent pretenses, representations, promises or material omissions is guilty of a Class 2 Felony.

7.1.5 Definitions

Abuse

Fraud

7.1.6 Objectives

To identify requirements for behavioral health providers to report suspected cases of fraud or abuse.

7.1.7 Procedures

7.1.7.-A Reporting of fraud and program abuse involving Title XIX/XXI funds or AHCCCS registered providers and recipients

Upon becoming aware of a suspected incident of fraud or program abuse, including a suspected incident committed by the T/RBHA, a T/RBHA or provider has 10 working days to inform the

AHCCCS Office of Inspector General of the suspected fraud or program abuse in writing to the address below or by submitting an online form accessible at the link below.

AHCCCS Office of Inspector General
MD4500
801 E. Jefferson Street
Phoenix, Arizona 85034
http://www.azahcccs.gov/fraud/reporting/reporting.aspx

Phone: (602) 417-4193 or (602) 417-4045
Fax: (602) 417-4102
Toll Free: 1-888-487-6686 or 1-800-654-8713 ext. 4045

In addition, T/RBHAs or providers should advise the ADHS/DBHS Corporate Compliance Officer of the report to AHCCCS by calling or writing to the contact information below.

ADHS/DBHS
Office of Program Integrity
1740 West Adams, #409
Phoenix, Arizona 85007
(602) 364-3758 or 1-866-569-4927
Fax number: (602) 542-3940
Email: reportfraud@azdhs.gov

7.1.7-B Reporting of fraud and program abuse involving Non-Title XIX/XXI funds or ADHS/DBHS registered providers or other providers and recipients

Upon becoming aware of a suspected incident of fraud or program abuse, including a suspected incident committed by the T/RBHA, a T/RBHA or provider has 10 working days to inform the ADHS/DBHS Corporate Compliance Officer by completing the Suspected Fraud and Program Abuse Report and faxing, mailing or emailing it to the ADHS/DBHS at the address listed above. Reports of fraud or program abuse may also be taken over the phone at (602) 364-3758 or 1-866-569-4927.

7.1.7-C Reporting of fraud and program abuse to the T/RBHA

In addition to notifying ADHS or AHCCCS, behavioral health providers may need to notify their contracted T/RBHA of all suspected incidents of fraud or program abuse. **[T/RBHAs may insert specific instructions and include any forms providers must submit here.]**

Section 7.2 Medical Institution Reporting for Medicare Part D

7.2.1 Introduction
7.2.2 References
7.2.3 Scope
7.2.4 Did you know…?
7.2.5 Definitions
7.2.6 Objectives
7.2.7 Procedures
7.2.7-A: Reporting requirements

7.2.1 Introduction

Medicare eligible behavioral health recipients, including persons who are dually eligible for Medicare (Title XVIII) and Medicaid (Title XIX/XXI) 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 co-payment requirements of all persons. However, Medicare Part D co-payments are waived when a dual eligible person enters a Medicaid funded medical institution for at least a full calendar month. Medical institutions 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 ensure co-payments for Part D are waived. The waiver of co-payments 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 co-pay costs, it is imperative that these individuals are identified as soon as possible.

7.2.2 References

The following citations can serve as additional resources for this content area:
42 CFR 400.202
42 CFR 409.62
42 CFR 422.2
42 CFR 422.4
42 CFR 423.4
42 CFR 423.104
9 A.A.C. 20
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA IGAs
ADHS/DBHS Covered Behavioral Health Services Guide

7.2.3 Scope

To whom does this apply?
This section applies to all facilities designated as a medical institution (provider types 02, 71, 78, B1, B2, and B3).

7.2.4 Did you know…?

Enrollees with Medicare Part D prescription drug coverage and AHCCCS (health insurance and Medicare Savings Programs), dual eligibles, have minimal prescription drug co-payments. Part D co-payments will be waived when dual eligible persons enter an institution with the intent to remain for at least a full calendar month.

7.2.5 Definitions

Dual Eligible

Institutionalized individual

Medicare Advantage Prescription Drug Plan (MA-PD)

Medical Institution

Prescription Drug Plan (PDP)

7.2.6 Objectives

To inform behavioral health providers designated as medical institutions of reporting and tracking requirements for dual eligible persons to ensure Medicare Part D co-pays are waived.

7.2.7 Procedures

7.2.7-A: Reporting requirements

To ensure that dual eligible persons' Medicare Part D co-payments 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, AHCCCS must be notified immediately upon admittance. Reporting must be done using PM Form 7.2.1, AHCCCS Notification To Waive Medicare Part D Co-Payments 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 "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

Medical institutions include the following behavioral health providers:

- Acute Hospital (PT 02)
- Psychiatric Hospital – IMD (PT 71)
- Residential Treatment Center – IMD (PT B1, B3)
- Residential Treatment Center – Non IMD (PT 78, B2)

[T/RBHA, insert additional language here]

Arizona Department of Health Services
Division of Behavioral Health Services
PROVIDER MANUAL

Section 7.3 Seclusion and Restraint Reporting

7.3.1 Introduction
7.3.2 References
7.3.3 Scope
7.3.4 Did you know…?
7.3.5 Definitions
7.3.6 Objectives
7.3.7 Procedures
7.3.7-A. Reporting to the T/RBHA
7.3.7-B. Reporting to the Office of Human Rights
7.3.7-C. Reporting to Human Rights Committees
7.3.7-D. Reporting a Serious Occurrence or Death
7.3.7-E. Reporting to the Office of Behavioral Health Licensure (OBHL)
7.3.7-F. Reporting a Death to Centers for Medicare and Medicaid Services (CMS)

7.3.1 Introduction

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 behavioral health recipients, 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 licensed Level I psychiatric acute hospital programs (42 CFR § 482.13) residential treatment centers serving persons under the age of 21 (42 CFR § 483 Subpart G) and sub-acute agencies (9 A.A.C. 20).

7.3.2 References

The following citations can serve as additional resources for this content area:
42 USC § 290ii
42 USC § 290ii-1
42 CFR § 482.13
42 C.F.R. § 483 Subpart G
42 C.F.R. § 483.374
A.R.S. § 36-513
A.R.S. § 36-528
A.A.C. R9-20-101
A.A.C. R9-20-202
A.A.C. R9-20-203
A.A.C. R9-20-216
A.A.C. R9-20-601
A.A.C. R9-20-602
A.A.C. R9-21-101
A.A.C. R9-21-204
AHCCCS/ADHS Contract

ADHS/RBHA Contracts
ADHS/TRBHA IGAs
ADHS/DBHS Quality Management Utilization Management Plan and Work Plan
ADHS/DBHS Performance Improvement Specifications Manual
Section 7.4, Reporting of Incidents, Accidents and Deaths
ADHS/DBHS Policy and Procedure QM 2.4, Reporting and Monitoring the Use of Seclusion and Restraint
ADHS/DBHS Policy and Procedure GA 3.8, Disclosure of Confidential Information to Human Rights Committees
National Association of State Mental Health Program Directors Position Statement on Seclusion and Restraint

7.3.3 Scope

To whom does this apply?

To all Tribal and Regional Behavioral Health Authority (T/RBHA) contracted Office of Behavioral Health Licensure (OBHL) licensed Level I behavioral health inpatient treatment programs. The policy is applicable to all enrolled individuals.

7.3.4 Did you know…?

- 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.
- R9-20-602(Q) and 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 behavioral health recipients, the training is a resource for mental health service direct care staff, administrators, and recipients 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.
- 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 behavioral health recipient'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).

- Each T/RBHA is also required to collect certain aggregate data that compiles total seclusion and restraints for the reporting period, and forward that data to the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS).

7.3.5 Definitions

ADHS/DBHS Office of Human Rights

Drug used as a Restraint, Sub-Acute Agency

Emergency Safety Situation

Human Rights Committees

Level I Inpatient Treatment Program

Mechanical Restraint

Mechanical Restraint, Sub-Acute Agency

Personal Restraint- Level I Psychiatric Acute Hospital Programs

Personal Restraint- Residential Treatment Centers Providing Services to Persons under the Age of 21

Personal Restraint, Sub-Acute Agency

Residential Treatment Center (RTC)

Restraint

Seclusion- Individuals Determined to have a Serious Mental Illness

Seclusion- Level I Programs

Seclusion, Sub-Acute Agency

Serious Occurrence

Serious Mental Illness (SMI)

Sub-Acute Agency

7.3.6 Objectives

To establish reporting requirements regarding the use of seclusion and restraint, for all enrolled persons, including persons determined to have a Serious Mental Illness (SMI) and children.

7.3.7 Procedures

7.3.7-A. Reporting to the T/RBHA

Licensed Level I behavioral health programs authorized to use seclusion and restraint must report each occurrence of seclusion and restraint and information on the debriefing subsequent to the occurrence of seclusion or restraint to the T/RBHA within five days of the occurrence. The individual reports must be submitted on PM Form 7.3.1, Seclusion and Restraint Reporting-Level I Facilities.

In the event that a use of seclusion or restraint requires face-to-face monitoring, a report detailing face-to-face monitoring must be attached to Form 7.3.1, Seclusion and Restraint Reporting, Level I Programs. The face-to-face monitoring form must include the requirements as per 42 CFR 482.13, 42 CFR § 483 Subpart G, R9-20-602 and R9-21-204, outlined in Attachment 7.3.1 Face-to-Face Monitoring Requirements.

Licensed Level I behavioral health programs must submit the total number of occurrences of the use of seclusion and restraint that occurred in the prior month to the T/RBHA by the 5th calendar day of the month. If there were no occurrences of seclusion and/or restraint during the reporting period, the report should so indicate.

[T/RBHA insert specific language here, including where to send the total number of occurrences report and what form, if any has been developed to meet this requirement]

7.3.7-B. Reporting to the Office of Human Rights

The T/RBHA must submit individual reports received from providers involving enrolled children and individuals determined to have a Serious Mental Illness to the Office of Human Rights. This must be done on a weekly or monthly basis, as arranged with the Office of Human Rights.

The Arizona State Hospital (AzSH) must submit individual reports involving individuals determined to have a Serious Mental Illness and children to the Office of Human Rights. This must be done on a weekly or monthly basis, as arranged with the Office of Human Rights.

The T/RBHA and AzSH must also submit monthly summary reports, as required by Policy and Procedure Manual Section QM 2.4, F. Procedures, to the Office of Human Rights by the 10th day of each month.

7.3.7-C. Reporting to Human Rights Committees

The RBHAs and AzSH must submit redacted individual reports received from providers involving all enrolled persons to the appropriate Human Rights Committee for the region. The reports must be submitted on a weekly or monthly basis, as arranged with the appropriate Human Rights Committee.

The RBHAs and AzSH must also submit monthly summary reports to the appropriate Human Rights Committee by the 10th day of each month. Monthly summary reports must be redacted.

7.3.7-D. 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. For more information regarding this subject, follow the guidelines in Section 7.4, Reporting of Incidents, Accidents and Deaths.

7.3.7-E. Reporting to the Office of Behavioral Health Licensure (OBHL)

An OBHL licensed Level I behavioral health program must notify OBHL 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 incident report within five days of initial notification. For more information regarding this subject, follow the guidelines in Section 7.4, Reporting of Incidents, Accidents and Deaths.

Reporting to Arizona Health Care Cost Containment System (AHCCCS) and Arizona Center for Disability Law (ACDL)

OBHL licensed Level I behavioral health facilities are required to report a serious occurrence, including a death or occurrence following a seclusion and/or restraint event, to AHCCCS and 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 AHCCCS and ACDL, 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

The Arizona Center for Disability Law
FAX Number (602) 274-6779-Attention Mental Health Team

7.3.7-F. Reporting a Death to 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. Staff must document the death in the program's incident/accident log. Staff must document in the patient'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) 744-3679

Section 7.4 Reporting of Incidents, Accidents and Deaths

7.4.1 Introduction
7.4.2 References
7.4.3 Scope
7.4.4 Did you know…?
7.4.5 Definitions
7.4.6 Objectives
7.4.7 Procedures
7.4.7-A. Reporting incidents, accidents and deaths to the T/RBHA
7.4.7-D. Reporting allegations of abuse towards persons determined to have a Serious Mental Illness
7.4.7-E. Reporting incidents, accidents and deaths to the Office of Behavioral Health Licensure
7.4.7-F. Reporting deaths and serious occurrences in OBHL Level I Facilities

7.4.1 Introduction

Significant events, such as accidents, injuries, allegations of abuse, human rights violations, and deaths require careful examination and review to ensure the protection of behavioral health recipients. Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS), as well as other federal and state agencies, requires the prompt reporting of significant events involving persons receiving services within the public behavioral health system. The reporting of significant events to ADHS/DBHS, 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/Office of Behavioral Health Licensure (OBHL) 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 behavioral health providers following an incident, accident, or death involving a behavioral health recipient. In addition, T/RBHAs may require subcontracted providers to submit a written summary of their review of deaths of adult Non-Seriously Mentally Ill (SMI) behavioral health recipients.

Behavioral health providers must be aware of what constitutes an event that requires reporting (by either the T/RBHA or behavioral health providers) to:

- CMS;
- AHCCCS;
- ADHS/DBHS;
- The Arizona Center for Disability Law.
- ADHS/OBHL;

Behavioral health 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.

7.4.2 References

The following citations can serve as additional resources for this content area:
42 CFR § 483.352
42 CFR § 483.374
42 CFR § 51.2
A.R.S. § 46-454
A.A.C. R9-6-206 (A) and (B)
A.A.C. R9-20-202
A.A.C. R9-20-203
A.A.C. R9-21-203
AHCCCS/ADHS Contract
ADHS/RBHA Contract
ADHS/TRBHA IGAs
Section 4.1, Disclosure of Behavioral Health Information
Section 4.2, Behavioral Health Medical Record Standards
Section 7.3, Seclusion and Restraint Reporting
Section 7.6, Duty to Report Abuse, Neglect or Exploitation
Policy and Procedure GA 3.7, Review of Deaths of All Behavioral Health Recipients
Policy and Procedure QM 2.5, Reports of Incidents, Accidents and Deaths
ADHS/DBHS Covered Behavioral Health Services Guide
ADHS/DBHS Performance Improvement Specification Manual, Section XVII
ADHS/DBHS Framework for Prevention in Behavioral Health

7.4.3 Scope

To whom does this apply?
All persons receiving behavioral health services.

7.4.4 Did you know…?

- All deaths, regardless of whether the enrolled recipient is a child, adult with Serious Mental Illness or adult without a Serious Mental Illness, are reviewed by ADHS/DBHS' Medical Director or designee, and selected cases are referred to the ADHS/DBHS Mortality and Morbidity Committee for further review and potential action, in accordance with ADHS/DBHS' established quality assurance process.

- OBHL licensed Level I behavioral health facilities are required to report any serious occurrence that occurs as a result of a seclusion and restraint event, in accordance with Section 7.3, Seclusion and Restraint Reporting**.**

- Upon recognition of abuse, neglect or exploitation of an incapacitated person, behavioral health 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 report

must be followed up by a written report within 48 hours. See Section 7.6, Duty to Report Abuse, Neglect or Exploitation.

- 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.

7.4.5 Definitions

Abuse

Behavioral Health Recipient

Enrolled Person

Exploitation

Incapacity

Incident or Accident

Level I Facility

Neglect

Prevention Activity

Serious Injury

Serious Occurrence

7.4.6 Objectives

To identify reporting requirements for behavioral health providers following:

- An incident, accident, or death of an enrolled behavioral health recipient;
- An incident, accident or death of any behavioral health recipient during a prevention activity, regardless of his or her enrollment status; and
- An allegation of abuse of any behavioral health recipient determined to have a Serious Mental Illness.

To identify procedures for behavioral health providers in submitting a summary of their review of deaths of adult, Non-SMI behavioral health recipients.

7.4.7 Procedures

7.4.7-A. Reporting incidents, accidents and deaths to the T/RBHA

Behavioral health providers must report any incident, accident or death as defined by this section, of an *enrolled* behavioral health recipient to the T/RBHA within 48 hours.

7.4.7-B Reporting incidents, accidents and deaths during prevention activities

Behavioral health providers are required to report to the T/RBHA any incident, accident or death of a behavioral health recipient participating in a T/RBHA or provider sponsored prevention activity, as defined in this section, regardless of his or her enrollment status with the T/RBHA, within 48 hours.

PM Form 7.4.1, Incident/Accident/Death Report Form must be used for reporting incidents, accidents and deaths of enrolled behavioral health recipients; and incidents, accidents and deaths occurring during prevention activities.

[T/RBHA insert contact information and specific instructions here]

7.4.7-C Review of Deaths to the T/RBHA

T/RBHAs may require behavioral health providers prepare and submit a written summary of their review of deaths *only* for adult, Non-SMI behavioral health recipients using the ADHS/DBHS Mortality Review Form, contained in the Performance Improvement Specification Manual Section XVII. **[T/RBHA Insert information regarding timeframes for submitting report]**

7.4.7-D. Reporting allegations of abuse towards persons determined to have a Serious Mental Illness

Allegations of abuse concerning persons determined to have a Serious Mental Illness must be reported within 48 hours to the T/RBHA. PM Form 7.4.1 Incident/Accident/Deaths Report Form must be used to report occurrences of abuse to the T/RBHA.

7.4.7-E. Reporting incidents, accidents and deaths to the Office of Behavioral Health Licensure

Behavioral health providers licensed by OBHL must provide notification to OBHL involving any incident or accident as defined on PM Form 7.4.1.

Behavioral health providers must orally report the above referenced events to ADHS/OBHL within one working day of knowledge of the event (contact OBHL at 602-364-2595). The oral report must be followed up with a written incident report within 5 working days. Behavioral health 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.

Community Service Agencies (CSAs) which are not licensed with OBHL, are not required to report any incidents, accidents or deaths to ADHS/OBHL that occur during a T/RBHA or provider sponsored prevention activity.

7.4.7-F. Reporting deaths and serious occurrences in OBHL Level I Facilities

This subsection is applicable to Title XIX certified/OBHL licensed Level I behavioral health facilities that provide inpatient psychiatric services to persons under the age of 21.

Reporting serious occurrences of behavioral health recipients:
Title XIX certified/OBHL licensed Level I behavioral health facilities that provide inpatient psychiatric services to persons under the age of 21 are required to report any serious occurrences (see definition) involving a behavioral health recipient to:

- AHCCCS;
- The Arizona Center for Disability Law; and
- CMS Regional Office (for deaths only).

What are the timeframes?
Any serious occurrence involving a behavioral health recipient in a Level I 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.

Where must the report be sent?
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
- CMS Regional Office (to report a death only)
  FAX Number (415) 744-2692-Attention Survey & Certification Coordinator

Other considerations
Specific documentation requirements apply to ADHS/OBHL licensed behavioral health provider records. Please see Section 4.2, Behavioral Health Medical Record Standards.

In the case of a minor (person under the age of 18), the Level I 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.
[T/RBHA insert specific instructions here]

Section 7.5 Enrollment, Disenrollment and Other Data Submission

7.5.1 Introduction
7.5.2 References
7.5.3 Scope
7.5.4 Did you know…?
7.5.5 Definitions
7.5.6 Objectives
7.5.7 Procedures
7.5.7-A: Enrollment and disenrollment transactions
7.5.7-B: Demographic and clinical data

7.5.1 Introduction

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 Arizona Department of Health Services / Division of Behavioral Health Services (ADHS/DBHS) behavioral health service delivery system. It is necessary for behavioral health providers to submit specific data on each person who is actively receiving services from the behavioral health system. As such, it is important for behavioral health 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 data in turn is used by ADHS/DBHS to:

- Monitor and report on outcomes of individuals in an episode of care (e.g., changes in diagnosis or GAF, employment/educational status, place of residence, substance use, number of arrests),
- 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 behavioral health providers to submit the following data in a timely, complete, and accurate manner:

- Episode of Care transactions, and
- Demographic and clinical data, including changes in a person's behavioral health status,

7.5.2 References

The following citations can serve as additional resources for this content area:

AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA IGAs
Section 3.8, Outreach, Engagement, Re-Engagement and Closure
Section 3.9, Intake, Assessment and Service Planning
Section 3.10, SMI Eligibility Determination
Section 3.17, Transition of Persons
ADHS/DBHS Demographic Data Set User Guide
ADHS/DBHS Covered Behavioral Health Services Guide

7.5.3 Scope

To whom does this apply?

This applies to all behavioral health providers who are delivering behavioral health services to persons who are enrolled in the ADHS/DBHS behavioral health system. It has particular relevance for those behavioral health providers that conduct assessments, ongoing service planning, and annual updates.

7.5.4 Did you know…?

- Arizona Health Care Cost Containment System (AHCCCS) enrolled individuals are considered enrolled with the Tribal/Regional Behavioral Health Authority (T/RBHA) at the onset of their eligibility. They are provided an AHCCCS identification card with the assigned T/RBHA. This assignment is sent daily from ADHS/DBHS to the T/RBHA.

- When the individual contacts a provider for services, the provider opens an episode of care. The episode of care will remain in effect until the person completes treatment. No separate T/RBHA enrollment is required for AHCCCS enrolled individuals.

- For Non-Title XIX/XXI eligible individuals, a HIPAA 834-enrollment transaction must be submitted by T/RBHAs to ADHS/DBHS within 14 days of first contact with a behavioral health recipient. Behavioral health providers may be required to submit 834 transactions to the T/RBHA within a shorter timeframe (see subsection 7.5.7-A. for required timeframe).

- Behavioral health providers are permitted to submit and change single data fields when necessary, without being required to re-submit every data field contained in a demographic record transaction.

- Behavioral health providers delivering services to a Non-Title XIX/XXI eligible person are not required to submit fund source changes if the person posts retroactive Title XIX/XXI eligibility. The ADHS/DBHS system will be notified by AHCCCS to change the person's fund source from Non-Title XIX/XXI eligible to Title XIX/XXI eligible and requires no action from the behavioral health provider.

- ADHS/DBHS has developed a flow chart that includes the timeframes for all data submissions. See PM Attachment 7.5.1.

7.5.5 Definitions

834 Transaction Enrollment/Disenrollment

.

Annual Update

Assessment

Behavioral Health Category Assignment

Change

Client Information System (CIS)

Closure

Crisis Episode

Day

Demographics

Edit

Episode of Care

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Intake / Enrollment

Outcome Measures

7.5.6 Objectives

To ensure that data elements specified by ADHS/DBHS and the T/RBHAs are collected and submitted in a timely, complete and accurate manner for each person in the public behavioral health system.

7.5.7 Procedures

7.5.7-A: Enrollment and disenrollment transactions

General requirements

- For a Non-Title XIX/XXI eligible person to be enrolled, behavioral health providers must submit an 834 enrollment transaction to the T/RBHA. All AHCCCS enrolled individuals with a mental health benefit are considered enrolled with the T/RBHA at the time of their AHCCCS eligibility.

- For a Non-Title XIX/XXI eligible person who receives a covered behavioral health service, he/she must be enrolled effective the date of first contact by a behavioral health provider.

- All persons who are served through the ADHS/DBHS 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.

When is enrollment information collected?

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 3.9, Intake, Assessment and Service Planning). PM Attachment 7.5.2, 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 the T/RBHA by ADHS/DBHS daily for the providers to access.

What kind of data is included in an 834?

The data fields that are included in the 834 transmittals are dictated by HIPAA and consist 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.

For a specific list of data elements necessary to create an 834 enrollment and disenrollment, for Non-Title XIX/XXI eligible individuals, see PM Attachment 7.5.2.

What happens if there is not enough information to complete an enrollment?

Behavioral health 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 the T/RBHA if required data elements are missing. For Title XIX/XXI eligible individuals, the 834 information will be provided to the T/RBHA by ADHS/DBHS.

What are the 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 **[T/RBHA add name here]** within **[T/RBHA insert number of days]** days of the first contact with a behavioral health recipient; The 834 disenrollment transaction must be submitted to **[T/RBHA add name here]** within **[T/RBHA insert number of days]** days of the person being disenrolled from the system; and any changes to the enrollment/disenrollment transaction data fields (e.g., change in address, insurance coverage) must be submitted **[T/RBHA insert number of days]** days from the date of identifying the need for the change.

What other events require 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.

Other considerations for both Non-Title XIX/XXI eligible and AHCCCS enrolled individuals

- For an AHCCCS enrolled individual, AHCCCS will notify ADHS/DBHS of changes to the above information. That information will be provided from ADHS/DBHS to the T/RBHA on a daily file.
- When a person in an episode of care permanently re-locates from one T/RBHA's geographic area to another T/RBHA's geographic area, an inter-T/RBHA transfer must occur (see Section 3.17, Transition of Persons). The steps that are necessary to facilitate an inter-T/RBHA transfer include the following data submission requirements:
  - The home T/RBHA must submit an 834 plan change transaction on the date of transfer; and end the episode of care, and

  - The receiving T/RBHA must submit an 834 plan change transaction on the date of accepting the person for services and start an episode of care.

- AHCCCS will notify ADHS/DBHS when a T/RBHA 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 the T/RBHA on a daily file.

What technical assistance is 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 behavioral health provider to the receiving T/RBHA. If a behavioral health provider requires assistance for technical related problems or issues, please contact **[T/RBHA enter contact name and telephone numbers for IT technical assistance]**.

7.5.7-B: Demographic and clinical data

When is demographic and clinical data 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 within 45 days of the first service and submitted to ADHS/DBHS within 55 days. Additional clinical data may be collected at subsequent assessment and service planning meetings with the person (e.g., education, vocation) as well as during periodic and annual updates. Demographic and clinical data recorded in the person's behavioral health medical record must match the demographic file on record with ADHS/DBHS.

What are the specific data elements?
The ADHS/DBHS Demographic Data Set User Guide describes the data elements that comprise the demographic data set and the timeframe requirements for submitting the demographic data set. T/RBHAs must ensure that providers collect required demographic data set elements in accordance with the ADHS/DBHS Demographic Data Set User Guide. **[T/RBHA, insert reference to required form(s) and hyperlink to form(s) here that providers must use to collect the demographic data set.]** When ADHS/DBHS issues updates to the demographic data set, T/RBHAs are responsible for communicating changes to their providers.

What are the timeframes for submitting demographic and clinical data?
The following timeframes apply to demographic and clinical data submissions (see the ADHS/DBHS Demographic Data Set User Guide):

- All required demographic data submitted to **[T/RBHA insert name here]** within **[T/RBHA insert number of days]** of the initial intake for all enrolled persons.

- Outcome measures, for children birth through age 17, submitted to **[T/RBHA insert name here]** within **[T/RBHA insert number of days]** of the 6 month anniversary date of the last demographic submission (see Section 3.9, Intake, Assessment and Service Planning). For outcome measures submission dates that do not coincide with the annual update, the

reason for submission will be indicated as a "change" (see specific instructions in the ADHS/DBHS Demographic Data Set User Guide).

- All required demographic data submitted to **[T/RBHA insert name here]** within **[T/RBHA insert number of days]** of the annual update (see Section 3.9, Intake, Assessment and Service Planning).

- All required demographic data submitted to **[T/RBHA insert name here]** within **[T/RBHA insert number of days]** of a recorded change in the person's demographic data record. Behavioral health providers must ensure that the person's behavioral health medical record matches the demographic data set on file with ADHS/DBHS.

- All required data elements submitted to **[T/RBHA insert name here]** within **[T/RBHA insert number of days]** of the end of the episode of care. The required data elements include the reason for the person's disenrollment. See the ADHS/DBHS Demographic Data Set User Guide to determine the specific data elements that must accompany a demographic disenrollment transaction.

Determining a behavioral health recipient's behavioral health category assignment
Behavioral health 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 Attachment 7.5.3, SMI and SED Qualifying Diagnoses Table),

- Adult with SMI,

- Adult, non-SMI with general mental health need, and

- Adult, non-SMI with substance abuse (see Attachment 7.5.4, Substance Abuse Disorders Qualifying Diagnoses Table).

Behavioral health providers must initially assign and update, as necessary, behavioral health category assignments as follows (see the ADHS/DBHS 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 determined to have a Serious Mental Illness in accordance with Section 3.10, 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”.

How can demographic and clinical data be used?
Behavioral health providers are encouraged to utilize demographic and clinical data to improve operational efficiency and gain information about the persons who receive behavioral health services. Behavioral health providers may consider:

- Utilizing and integrating collected demographic data into the person’s assessments,

- Monitoring the nature of the provider’s behavioral health recipient population, and

- Evaluating the effectiveness of the provider’s behavioral health services towards improving the clinical outcomes of persons enrolled in the ADHS/DBHS system.

What technical assistance is 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 behavioral health provider to the receiving T/RBHA. If a behavioral health provider requires assistance for technical related problems or issues, please contact **[T/RBHA enter contact name and telephone numbers for IT technical assistance]**.

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Section 7.6 Duty to Report Abuse, Neglect or Exploitation

7.6.1 Introduction
7.6.2 References
7.6.3 Scope
7.6.4 Did you know…?
7.6.5 Definitions
7.6.6 Objectives
7.6.7 Procedures
7.6.7-A Duty to report abuse, neglect and exploitation of incapacitated or vulnerable adults
7.6.7-B. Duty to report abuse, physical injury, neglect and denial or deprivation of medical or surgical care or nourishment of minors

7.6.1 Introduction

Any employee of the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) contracted Tribal and Regional Behavioral Health Authorities (T/RBHAs) and/or its contracted providers who has been informed of or has a reasonable basis to believe that abuse, neglect or exploitation 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/Child Protective Services (DES/DCYF/CPS) worker as appropriate.

7.6.2 References

The following citations can serve as additional resources for this content area:
A.R.S. § 13-3620
A.R.S. § 36-501
A.R.S. § 46-451, *et seq.*
A.A.C. R9-21-409(C) (1)
Section 4.1, Disclosure of Behavioral Health Information
Section 7.4, Reporting of Incidents, Accidents and Deaths
Arizona Adult Protective Services (APS) Central Intake Unit
Arizona Child Abuse Hotline

7.6.3 Scope

To whom does this apply?

This Provider Manual section applies to all employees of and providers contracting with a T/RBHA to provide services in Arizona's public behavioral health system, as well as all persons receiving, or who have received, services through Arizona's public behavioral health system.

7.6.4 Did you know…?

- A person who violates any provision of A.R.S. § 13-3620, and who fails to report that they have a reasonable belief that abuse, physical injury, neglect and denial or deprivation of medical care or nourishment of a minor has occurred is guilty of a class 1 misdemeanor; except if the failure to report involves a reportable offense, the person is guilty of a class 6 felony.

- A person who intentionally or knowingly engages in emotional abuse of a vulnerable adult who is a patient or resident in any setting in which health care, health-related services or assistance with one or more of the activities of daily living is provided or, has the care and custody of a vulnerable adult, and intentionally or knowingly subjects or permits the vulnerable adult to be subjected to emotional abuse is guilty of a class 1 misdemeanor per A.R.S. § 46-454 .

- A person who furnishes a report, information or records required or authorized under A.R.S. § 46-454 or A.R.S. §13-3620, or a person who participates in a judicial or administrative proceeding or investigation resulting from a report, information, or records required or authorized by law, is immune from any civil or criminal liability.

- Reporting of incidents, accidents or deaths of behavioral health recipients to the Center for Medicaid and Medicare Services (CMS) , Arizona Health Care Cost Containment System (AHCCCS), ADHS/DBHS, Arizona Center for Disability Law and ADHS/Office of Behavioral Health Licensing (OBHL) is described in PM Section 7.4, Reporting of Incidents, Accidents and Deaths.

7.6.5 Definitions

Abuse

Abuse (of child/minor)

Child

Emotional abuse

Exploitation (of incapacitated or vulnerable adult)

Neglect

Patient

Peace officers

Physical injury

Serious physical injury

Vulnerable adult

7.6.6 Objectives

To establish procedures regarding the duty to report abuse, neglect and exploitation of incapacitated or vulnerable individuals to a peace officer, DES/APS employee or a DES/DCYF/CPS employee by calling the Arizona Child Abuse Hotline or the Adult Protective Services (APS) Central Intake Unit.

Additionally, to establish procedures regarding the duty to report the suspected or alleged abuse, physical injury, neglect and denial or deprivation of medical or surgical care or nourishment of minors who receive services through the T/RBHA and its contracted providers.

7.6.7 Procedures

7.6.7-A Duty to report abuse, neglect and exploitation of incapacitated or vulnerable adults

Behavioral health providers responsible for the care of an incapacitated or vulnerable adult 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 DES/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.
- 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 DES/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 PM Section 4.1, Disclosure of Behavioral 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.
- 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 DES/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.

[T/RBHA, insert additional procedures here for behavioral health providers to meet reporting requirements.]

7.6.7-B. Duty to report abuse, physical injury, neglect and denial or deprivation of medical or surgical care or nourishment of minors

Any behavioral health provider who reasonably believes that any of the following incidents has occurred shall immediately report this information to a peace officer and to a DES/DCYF/CPS worker by calling the Arizona Child Abuse Hotline:

- 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 written report within seventy-two hours. 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.
- 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 DES/DCYF/CPS 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 PM Section 4.1, Disclosure of Behavioral 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.

- 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 DES/DCYF/CPS 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.

[T/RBHA, insert additional procedures here for behavioral health providers to meet reporting requirements including any special protocols that may exist with other agencies.]

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Section 7.7 Duty to Warn

7.7.1 Introduction
7.7.2 References
7.7.3 Scope
7.7.4 Definitions
7.7.5 Objectives
7.7.6 Procedures
7.7.6-A Duty to protect potential victims of physical harm

7.7.1 Introduction

Any Tribal/Regional Behavioral Health Authority (T/RBHA), mental health provider employed or contracted by a T/RBHA or a subcontracted provider of a mental health provider, having 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.

7.7.2 References

The following citations can serve as additional resources for this content area:
A.R.S. § 36-501
A.R.S. § 36-517.02
Tarasoff v. Regents of the University of California, 551 P2d. 334 (Cal. 1976)
Little v. All Phoenix South Community Mental Health Center, Inc., 186 Ariz. 97, 919 P.2d 1368 (Ct. App. 1995)
Hamman v. County of Maricopa, 161 Ariz. 58, 775 P.2d 1122 (1989)
Section 3.18, Pre-Petition Screening, Court Ordered Evaluation and Court Ordered Treatment
Section 4.1, Disclosure of Behavioral Health Information

7.7.3 Scope

To whom does this apply?
This applies to all T/RBHAs, their subcontracted providers, and any subcontracted provider of a mental health provider in Arizona's public behavioral health system.

7.7.4 Definitions

Mental Health Provider

Patient

7.7.5 Objectives

The objective of this section is to identify situations in which a T/RBHA, a T/RBHA mental health provider employed or contracted by a T/RBHA or a subcontracted provider of a mental health provider may have a duty to protect potential victims of physical harm when a patient poses a serious danger of violence to others.

7.7.6 Procedures

7.7.6-A Duty to Protect Potential Victims of Physical Harm

All T/RBHA mental health providers employed or contracted by a T/RBHA, or subcontracted providers of mental health providers have a duty to protect others against the violent conduct of a patient. When a T/RBHA mental health provider employed or contracted by a T/RBHA or a subcontracted 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, the T/RBHA mental health providers employed or contracted by a T/RBHA or a subcontracted 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 T/RBHA mental health provider employed or contracted by a T/RBHA or a subcontracted 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 PM Section 3.18, 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.

[T/RBHA, insert additional procedures here for behavioral health providers when providers have reason to believe that they have a duty to warn potential victims of harm.]

Section 7.8 Reporting Discovered Violations of Immigration Status

7.8.1 Introduction
7.8.2 References
7.8.3 Scope
7.8.4 Did you know…?
7.8.5 Definitions
7.8.6 Objectives
7.8.7 Procedures
7.8.7-A Identification of Violations
7.8.7-B Reporting process
7.8.7-C Documentation Expectations

7.8.1 Introduction

Employees of Regional Behavioral Health Authorities (RBHAs) and employees of RBHA contracted providers are considered agents of ADHS/DBHS, and therefore, must report discovered violations of immigration status to Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS). ADHS/DBHS 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.

7.8.2 References

The following citations can serve as additional resources for this content area:
42 CFR Part 400
42 CFR Part 403
42 CFR Part 411
42 CFR Part 417
42 CFR Part 422
42 CFR Part 423
A.R.S. § 1-502
A.R.S. § 36-3408
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA Intergovernmental Agreements (IGAs)
Section 3.27, Verification of U.S. Citizenship or Lawful Presence for Public Behavioral Health Benefits

7.8.3 Scope

To whom does this apply?

Reporting requirements described in this policy apply to all ADHS/DBHS, RBHAs and RBHA providers.

7.8.4 Did you know…?

In Arizona, A.R.S. § 1-502 requires all RBHAs and RBHA providers to obtain documentation to verify U.S. citizenship/lawful presence for all persons who apply for public behavioral health services.

Arizona law requires all employees and "agents" of the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) to report discovered violations of immigration status as set forth in A.R.S. § 1-502.

7.8.5 Definitions

Lawful Presence

U.S. Citizen

7.8.6 Objectives

- To describe the expectations and procedures that RBHAs and RBHA providers must follow in identifying and reporting discovered violations of Immigration laws; and
- To identify methods that must not be used in the process of identifying and reporting discovered violations of Immigration laws.

7.8.7 Procedures

7.8.7-A Identification of Violations

RBHAs and RBHA providers mustl refrain from conduct or actions that could be considered discriminatory behavior. It is unlawful and discriminatory to deny persons behavioral health services, exclude persons from participation in those services, or otherwise discriminate against any person based on grounds of race, color or national origin.

RBHA and RBHA providers mustl not use any information obtained about a person's citizenship or lawful presence for any purpose other than to provide a person with behavioral health 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 behavioral health services, in the course of completing the application process or while conducting business with the RBHA/RBHA provider, **voluntarily reveals** that he or she is not lawfully present in the United States then and only then may the RBHA/RBHA provider consider it to be a reportable violation.

RHBAs/RBHA providers must not require documentation of citizenship or lawful presence from persons who are not personally applying for behavioral health 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 the RBHA to verify 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 (see Section 3.27, Verification of U.S. Citizenship or Lawful Presence for Public Behavioral Health Benefits).

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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 3.27, Verification of U.S. Citizenship or Lawful Presence for Public Behavioral Health Benefits).

RBHAs and RBHA 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 ADHS/DBHS Corporate Compliance Officer at ARS1502@azdhs.gov

7.8.7-B Reporting process

The RBHA or RBHA provider who identifies a violation must submit a report to ADHS/DBHS via secure email to ADHS/DBHS Corporate Compliance at ARS1502@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.

7.8.7-C Documentation Expectations

The RBHA/RBHA provider must document in the person's behavioral health medical record (if a provider) or in the Corporate Compliance Office (if a RBHA) 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 ADHS/DBHS;

- Any actions taken as a result of the report; and
- A copy of the email to ADHS/DBHS that contains the report.

Section 8.0 Periodic Audits and Surveys

8.1 Encounter Validation Studies
8.2 Reserved
8.3 Behavioral Health Recipient Satisfaction Survey
8.4 Performance Improvement Projects
8.5 Medical Care Evaluation Studies

Section 8.1 Encounter Validation Studies

8.1.1 Introduction
8.1.2 References
8.1.3 Scope
8.1.4 Did you know…?
8.1.5 Objectives
8.1.6 Procedures
8.1.6-A. Criteria used in encounter validation studies
8.1.6-B. Behavioral health provider responsibilities
8.1.6-C. Encounter validation study findings
8.1.6-D. AHCCCS Encounter Data Validation

8.1.1 Introduction

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. The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) requires the Regional Behavioral Health Authorities (RBHAs) to conduct encounter validation studies of their providers. For guidelines on the RBHA data validation process, see the Office of Program Support Operations and Procedures Manual.

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 behavioral health providers that encounter validation studies may be performed by AHCCCS, RBHAs and/or ADHS/DBHS staff; and

- Convey ADHS/DBHS' expectation that behavioral health providers cooperate fully with any encounter validation review that AHCCCS, the RBHAs and/or ADHS/DBHS may conduct.

8.1.2 References

The following citations can serve as additional resources for this content area:
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
Section 3.9, Assessment and Service Planning
Section 3.13, Covered Behavioral Health Services
Section 4.2, Behavioral Health Medical Record Standards
Section 6.1, Submitting Tribal Fee-for-Service Claims to AHCCCS
Section 6.2, Submitting Claims and Encounters to the RBHA
ADHS/DBHS Covered Behavioral Health Services Guide
Office of Program Support Operations and Procedures Manual

8.1.3 Scope

To whom does this apply?

All behavioral health providers under contract with a RBHA or a RBHA network that deliver covered behavioral health services to eligible persons.

8.1.4 Did you know…?

- The majority of correctness errors found are caused by invalid procedure or revenue codes and by not coding the diagnosis to the correct level of specificity. Coding from the ICD-9 is required on all encounter submissions.

- RBHAs are required to conduct encounter validation studies of their providers on a quarterly basis.

- If determined appropriate, ADHS/DBHS and the RBHAs can pass down sanctions for non-compliance with encounter submission requirements to behavioral health providers.

8.1.5 Objectives

To communicate an overview of data validation studies and the expectation for behavioral health providers to cooperate with all activities associated with AHCCCS' or ADHS/DBHS' data validation review.

8.1.6 Procedures

8.1.6-A. Criteria used in encounter validation studies

The criteria include timeliness, correctness and omission of encounters. These criteria are defined as follows:

- Timeliness-The time elapsed between the date of service and the date that the encounter is received; **[RBHA insert RBHA specific language here]**

- 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-9 diagnoses not reported to the correct level of specificity; and

- Omission- Provider documentation shows a service was provided, however, an encounter was not submitted.

In addition, assessment compliance must be monitored by the RBHA in accordance with Section 3.9, Assessment and Service Planning.

[RBHA insert language here]

8.1.6-B. Behavioral health provider responsibilities

Behavioral health providers must deliver covered services in accordance with the ADHS/DBHS Covered Behavioral Health Services Guide. Behavioral health providers must document adequate information in the clinical record and submit encounters in accordance with Section 6.2, Submitting Claims and Encounters to the RBHA.

8.1.6-C. Encounter validation study findings

RBHAs are required to report the data validation findings to the provider. **[RBHA insert RBHA specific language here]**

8.1.6.-D AHCCCS Encounter Data Validation

AHCCCS performs yearly data validation studies. All AHCCCS contractors and subcontractors are contractually required to participate in this process. In addition, the data validation studies enable AHCCCS to monitor and improve the quality of encounter data. Information regarding AHCCCS Encounter Data Validation Study procedures can be found in the Office of Program Support Operations and Procedures Manual.

Section 8.2 Reserved

8.2.1 Reserved

Section 8.3 Behavioral Health Recipient Satisfaction Survey

8.3.1 Introduction
8.3.2 References
8.3.3 Scope
8.3.4 Did you know…?
8.3.5 Objectives
8.3.6 Procedures
8.3.6-A Statewide Behavioral Health Recipient Satisfaction Survey

8.3.1 Introduction

The purpose of the annual Behavioral Health Recipient Satisfaction Survey is to solicit independent or individual feedback from behavioral health recipients regarding the quality of services received and the expected outcomes associated with those services. The information collected from surveys is used to improve the public behavioral health system. The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) currently administers a statewide behavioral health recipient satisfaction survey primarily based on the Mental Health Statistics Improvement Program (MHSIP) surveys (the Adult Consumer Survey and the Youth Services Survey for Families (YSS-F)). These surveys are administered annually statewide to a statistically significant sample of enrolled TXIX/XXI behavioral health recipients.

8.3.2 References

The following citations can serve as additional resources for this content area:

42 C.F.R. § 438.10 (b)(c)(d)
42 C.F.R. § 438.206
42 C.F.R. § 438.240
A.A.C. R9-22-522 (B)(1) and (5)
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA IGAs
Policy and Procedures Manual QM 2.3, Behavioral Health Recipient Satisfaction Survey
ADHS/DBHS Annual Consumer Survey Report
ADHS/DBHS Quality Management (QM) Plan
ADHS/DBHS Medical Management/Utilization Management (MM/UM) Plan
Mental Health Statistics Improvement Program (MHSIP)

8.3.3 Scope

To whom does this apply?

T/RBHAS and behavioral health providers that deliver covered behavioral health services to Title XIX or Title XXI eligible persons receiving services in the public behavioral health system.

8.3.4 Did you know…?

- All Tribal and Regional Behavioral Health Authorities (T/RBHAs) and T/RBHA contracted providers are required to participate in and collaborate with ADHS/DBHS in planning, implementation, data analysis and results reporting for the annual statewide behavioral health recipient surveys.

- ADHS/DBHS utilizes survey data submitted by the T/RBHAs to complete a statewide report of findings. The results of the statewide Behavioral Health Recipient Satisfaction Survey are public information and are available on the ADHS/DBHS Web site: ADHS/DBHS Annual Consumer Survey Report.

- Each T/RBHA conducts an in-depth analysis of the survey data, and copies of the report may be obtained from the respective T/RBHA. The results of the survey are used to initiate performance improvement efforts and activities statewide.

- Two MHSIP survey instruments are administered by ADHS/DBHS: the Adult Consumer Survey and the Youth Services Survey for Families (YSS-F).

- The adult survey is administered to adult behavioral health recipients. If the individual requests assistance, a guardian may complete the questionnaire on the behavioral health recipient's behalf. The YSS-F is administered to the parent/guardian of the child receiving services.

8.3.5 Objectives

To describe behavioral health providers' obligations regarding the Annual Behavioral Health Recipient Satisfaction Survey. The survey allows ADHS/DBHS and T/RBHAs to receive feedback from behavioral health recipients and families to improve services, protect their rights, and enhance access to quality care. Results from the survey provide comprehensive data to make systemic program improvements.

The survey gives TXIX/XXI enrolled behavioral health recipients aged 18 and over and family members of persons under age 18 receiving behavioral health services, an opportunity to provide direct feedback about their experiences while receiving services in the public behavioral health system.

8.3.6 Procedures

8.3.6-A Statewide Behavioral Health Recipient Satisfaction Survey

Annually, ADHS/DBHS and the T/RBHAs jointly conduct a statewide Behavioral Health Recipient Satisfaction Survey with the participation of T/RBHA providers. The purpose of the survey is to assess behavioral health recipients' perception of (1) access to services, (2) the quality and appropriateness of services, (3) the outcomes of services, (4) participation in treatment planning, (5) cultural sensitivity (6) general satisfaction with services received, (7) social connectedness and (8) improvement in functioning. The results of the survey are used to initiate performance improvement efforts statewide.

Section 8.4 Performance Improvement Projects

8.4.1 Introduction
8.4.2 References
8.4.3 Scope
8.4.4 Did You Know …?
8.4.5 Definitions
8.4.6 Objectives
8.4.7 Procedures

8.4.1 Introduction

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) is committed to establishing high quality behavioral health services. One method for achieving this is through adherence to the standards and guidelines set by the Centers for Medicare and Medicaid Services (CMS). ADHS/DBHS adheres to CMS standards and guidelines and, in turn, promotes improvement in the quality of the behavioral health care provided to behavioral health recipients through the development and implementation of Performance Improvement Projects (PIPs). Performance Improvement Projects consist of utilizing a comprehensive protocol endorsed by CMS, as described in the AHCCCS Medical Policy Manual (AMPM), Chapter 900 and 42 CFR 438.240. The protocol standards and guidelines help to ensure that Medicaid managed care organizations meet these quality assurance requirements when conducting Medicaid External Quality Review Activities.

What are Performance Improvement Projects (PIPs)?

A PIP is a systematic process designed to:

- Identify, plan and implement system interventions to improve the quality of care and services provided to behavioral health recipients;
- Evaluate and monitor the effectiveness of system interventions and data on an ongoing basis; and
- Result in significant performance improvement sustained over time through the use of measures and interventions.

PIPs are designed to:

- Demonstrate achievement and sustainment of improvement for significant aspects of clinical care and non-clinical services;
  - A clinical study topic would be one for which outcome indicators measure a change in behavioral health status or functional status; and,
  - A non-clinical or administrative study topic would be one for which indicators measure changes in member satisfaction or processes of care.

- Correct significant systemic issues that come to the attention of ADHS/DBHS in part through:
  - Data from ADHS/DBHS functional areas (e.g.: network, medical director's office);
  - Statewide contractor performance data and contract monitoring activities;
  - Tracking and trending of complaints, 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/Utilization Management data analysis and reporting; and
  - Member and/or provider satisfaction surveys and feedback.

What PIPs are currently included in the Quality Management Utilization Management Annual Plan and Work Plan?
Specific information concerning current PIPs can be found in the ADHS/DBHS Quality Management Plan.

8.4.2 References

42 CFR 438.240
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA IGAs
AHCCCS Medical Policy Manual, Chapter 900
ADHS/DBHS Annual Quality Management Plan

8.4.3 Scope

To Whom Does this Apply?
T/RBHAs and T/RBHA contracted behavioral health providers.

8.4.4 Did You Know …?

The PIP protocol is based on a guidebook produced by the National Committee for Quality Assurance (NCQA) under a contract with CMS. The guidebook is entitled *"Health Care Quality Improvement Studies Managed Care Settings: A Guide for State Medicaid Agencies."*

8.4.5 Definitions

Interventions

Sound Methodology

Statistical Significance

Study Indicator

8.4.6 Objectives

To ensure that T/RBHAs and their subcontracted providers understand and actively participate in the implementation of the PIPs.

The purpose of a health care quality PIP is to assess and improve processes and outcomes. In order for such projects to achieve real improvements in care, and for interested parties to have confidence in the reported improvements, PIPs must be designed, conducted, and reported in a manner that utilizes sound methodology.

8.4.7 Procedures

T/RBHA contracted providers play an integral role in the implementation of the ADHS/DBHS PIPs. Behavioral health providers shall participate with any or all aspects of the PIP implementation process.

There are ten (10) steps to be undertaken when conducting PIPs:

- Select the study topic(s). In general, a clinical or non-clinical issue selected for study should affect a significant number of behavioral health recipients and have a potentially significant impact on health, functional status or satisfaction.

- Define the study question(s). It is important to clearly state, in writing, the question(s) the study is designed to answer. Stating the question(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.

- Select the study indicator(s). A study indicator is a quantitative or qualitative characteristic reflecting a discrete event (e.g., a behavioral health recipient has stopped taking medication and has experienced a crisis which resulted in hospitalization), or a status (e.g., a behavioral health recipient has/has not experienced a crisis that resulted in hospitalization) that is to be measured. Each project should have one or more quality indicators for use in tracking performance and improvement over time.

- Use a representative and generalizable study population. Once a topic has been selected, measurement and improvement efforts must be system-wide. A decision needs to be made as to whether to review data for the entire population or use a sample of the population.

- Use sound sampling techniques (if sampling is used). If a sample is to be used to select members of the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. When conducting a study designed to estimate the rates at which certain events occur, the sample size has a large impact on the level of statistical confidence in the study estimates.

- Reliably collect data. Procedures used to collect data for a given PIP must ensure that the data collected on the PIP indicators are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. Potential sources of data include administrative data (e.g., enrollment, claims, and encounters), medical records, tracking logs, results of any provider interviews and results of any recipient interviews and surveys. Data can be collected from either automated data systems or by a manual review of records.

- Implement intervention and improvement strategies. Real, sustained improvements in care result from a continuous cycle of measuring and analyzing performance, and developing and implementing system-wide improvements in care. Actual improvements in care depend on thorough analysis and implementation of appropriate solutions.

- Analyze data and interpret study results. Data analysis begins with examining the performance on the selected clinical or non-clinical indicators. The analysis of the study data should include an interpretation of the extent to which the PIP was successful and what follow-up activities are planned as a result.

- Plan for "real" improvement. When a change in performance is found, it is important to know whether the change represents "real" change or random chance. This can be assessed in several ways, but is most confidently done by calculating the degree to which an intervention is statistically significant.

- Achieve sustained improvement. Real change results from changes in the fundamental processes of health care delivery. Such changes should result in sustained improvements. In contrast, a one-time improvement can result from unplanned accidental occurrences or random chance. If real change has occurred, the project should be able to achieve sustained improvement.

[T/RBHAs insert specific information here]

Section 8.5 Medical Care Evaluation Studies

8.5.1 Introduction
8.5.2 References
8.5.3 Scope
8.5.4 Did you know…?
8.5.5 Objectives
8.5.6 Procedures
8.5.6-A. Participating providers
8.5.6-B. Participating provider responsibilities and requirements

8.5.1 Introduction

Medical Care Evaluation (MCE) Studies are an established method to promote the most effective and efficient use of available services consistent with behavioral health recipient needs and professionally recognized standards of care for persons receiving treatment in an Arizona Department of Health Services/Division of Behavioral Health/Office of Behavioral Health Licensing licensed Level I facility. ADHS/DBHS has established guidelines for the development and reporting of MCE studies and ensures that each Tribal/Regional Behavioral Health Authority (T/RBHA) has a review process in place to confirm that required MCE Studies are undertaken, completed, analyzed, and utilized to improve behavioral health recipient care. This section outlines the provider's role in this process.

8.5.2 References

42 CFR 456.141 through 145
42 CFR 456.241 through 245
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA IGAs
The Joint Commission
ADHS/DBHS Covered Behavioral Health Services Guide

8.5.3 Scope

To whom does this apply?
All OBHL licensed Level I subcontracted providers.

8.5.4 Did you know…?

T/RBHAs must ensure that all OBHL licensed Level I subcontracted providers (See Participating providers) adhere to the MCE study requirements.

ADHS/DBHS will ensure the systematic application of MCE study topics and methodologies across T/RBHAs via review of statewide utilization data trends. T/RBHA proposed MCE study proposals, study methodologies and supporting data will be reviewed via the ADHS/DBHS MM/UM Committee. Final approval of ADHS/DBHS systemic MCE studies will occur at the ADHS/DBHS MM/UM Committee.

8.5.5 Objectives

To establish a method to promote the most effective and efficient use of available behavioral health facilities and services consistent with behavioral health recipient needs and professionally recognized standards of health care.

8.5.6 Procedures

8.5.6-A. Participating providers

Who participates?

The following provider types must conduct MCE studies:

- Level I hospital;
- Level I Psychiatric hospital;
- Level I Residential treatment centers (RTC) secure (non-IMD)
- Level I Residential treatment centers (RTC) secure (IMD)
- Level I Residential treatment centers (RTC) Non secure (non-IMD)
- Level I Residential treatment centers (RTC) Non secure (IMD)
- Level I Sub-acute facilities (IMD and Non-IMD) accredited by the Joint Commission, the Council on Accreditation (COA) or the Commission on Accreditation of Rehabilitation Facilities (CARF).

8.5.6-B. Participating provider responsibilities and requirements

Request for Registration

By May 31st of each year, each participating subcontracted Level I provider as described in section 8.5.6-A. must submit PM Form 8.5.1, MCE Study Request for Registration and Evaluation Methodology to the T/RBHA for the upcoming state fiscal year.

Timeframe

The standard study period for MCE studies starts on July 1st of each year through June 30th of the succeeding year. Deviations from this study period and all longitudinal studies must be pre-approved by the ADHS/DBHS Bureau of Quality Management Operations prior to initiation. Any request for exemption shall be made in writing and received by ADHS/DBHS within two (2) weeks from the date the T/RBHA received the PM Form 8.5.1, MCE Study Request for Registration and Evaluation Methodology.

Methodology

For T/RBHA subcontracted providers that provide Title XIX certified inpatient hospital, mental hospital, residential treatment center or sub-acute services, the subcontracted provider's Quality Management or Utilization Review Committee proposes the methods to be used in selecting and conducting medical care evaluation studies in the subcontracted provider facility. The conduction of the MCE study is the responsibility of the facility that provides the service. PM Form 8.5.1, MCE Study Request for Registration and Evaluation Methodology must be used to describe the proposed methodology.

Each MCE Study must:

- Identify and analyze medical or administrative factors related to the subcontracted provider facility's behavioral health recipient care;

- Include analysis of at least the following:
  - Admissions;
  - Length of stay;
  - Ancillary services provided including drugs and biologicals; and
  - Professional services performed;

- Include recommendations for improvements beneficial to behavioral health recipients, staff, the facility and the community; and

- Use data obtained from one or more of the following sources: dependent upon the scope of the MCE study; medical records or other appropriate subcontracted provider facility data; profiles and other comparative data; and/or secondary data sources, such as external organizations that compile utilization statistics.

Documenting, Analyzing and Reporting Study Findings

- Each Level I subcontracted provider facility will document the results of each study as well as how the results have been used to make changes to improve the quality of care to behavioral health recipients and promote more effective and efficient use of facilities and services.

- Each Level I subcontracted provider facility will analyze its findings for each study and take action as needed to correct or investigate any deficiencies or problems in the review process for admissions or continued stay cases.

- Each Level I subcontracted provider facility shall recommend, as appropriate, more effective and efficient facility care procedures based on the study findings.

Each Level I subcontracted provider must submit a final MCE study report to the home T/RBHA by July 31st of each year. This report will include an in-depth analysis and narrative of how the subcontracted provider facility plans to use the information to improve care. To provide the final study report, please see PM Form 8.5.2 Medical Care Evaluation – Provider and T/RBHA Review of Final Results. If the MCE study results and analysis are not approved by the home T/RBHA, the home T/RBHA must conduct follow up activities with the provider to finalize the study.

[T/RBHA insert additional information here]

Section 9.0 Training and Development

9.1 Training Requirements

Section 9.1 Training Requirements

9.1.1 Introduction
9.1.2 References
9.1.3 Scope
9.1.4 Did you know…?
9.1.5 Objectives
9.1.6 Procedures
9.1.6-A. Required training for behavioral health providers
9.1.6-B Office of Behavioral Health Licensure (OBHL) required training
9.1.6-C. Required training specific to Professional Foster Homes Providing HCTC Services
9.1.6-D. Required training specific to Community Service Agencies
9.1.6-E. Other situations that may prompt additional behavioral health provider training
9.1.6-F Training Expectations for ADHS/DBHS Clinical and Recovery Practice Protocols
9.1.6-G. Training Requests

9.1.1 Introduction

Behavioral health agency staff must participate in appropriate training, education, and technical assistance in order to effectively meet the requirements of the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) public behavioral health system. ADHS/DBHS requires that behavioral health providers receive certain training with the intended purpose of meeting the following goals:

- To promote a consistent practice philosophy;
- To assist behavioral health providers in developing a qualified, knowledgeable and culturally competent workforce;
- To provide timely information regarding new initiatives and best practices that impact the delivery of behavioral health services; and
- To ensure that services are delivered in a manner that results in achievement of the Arizona System Principles, including the Arizona Children's Vision and Principles and Principles for Persons Determined to have a Serious Mental Illness (SMI).

The intent of this section is to provide information to behavioral health providers regarding the scope of required training topics, how training needs are identified for behavioral health providers and how behavioral health providers may request specific technical assistance from contracted T/RBHAs.

9.1.2 References

The following citations can serve as additional resources for this content area:
A.A.C. R6-5-5850
A.A.C. R9-20-203
A.A.C. R9-20-204(F)
A.A.C. R9-20-206
A.A.C. R9-20-602(Q)
A.A.C. R9-20-1502
A.A.C. R9-21-(301-314)

AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA IGAs
Section 3.20, Credentialing and Recredentialing
Section 3.23, Cultural Competence
Section 4.3, Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers
Section 4.4, Coordination of Care with other Governmental Entities
Section 5.4, Special Assistance for Persons Determined to Have a Serious Mental Illness
Section 8.4, Performance Improvement Projects
Policy and Procedure Manual MI 5.2, Community Service Agencies-Title XIX Certification
Arizona Vision and 12 Principles
9 Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems

9.1.3 Scope

To whom does this apply?

This section applies to all behavioral health providers delivering services within the ADHS/DBHS public behavioral health system.

9.1.4 Did you know…?

- ADHS/DBHS monitors the T/RBHAs to ensure that behavioral health providers receive all required training.
- ADHS/DBHS requires T/RBHAs 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 T/RBHA and provider trainers is determined by each T/RBHA. **[T/RBHA insert link here to qualifications or T/RBHA identify how providers can access trainer requirements].**
- In addition to the required training content areas, T/RBHAs must ensure that appropriate training/technical assistance is available to behavioral health 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 in accordance with R9-20-602(Q).
- 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).

9.1.5 Objectives

To ensure that behavioral health providers have the necessary knowledge and skills to successfully provide high quality services to persons receiving services in the public behavioral health system.

9.1.6 Procedures

9.1.6-A. Required training for behavioral health providers (This section does not apply to Home Care Training to Home Care Client (HCTC) providers [see subsection 9.1.6-C] and Community Service Agency providers [see subsection 9.1.6-D])

The following is required training content that behavioral health providers should receive before providing services, but must receive within 90 days of the staff person's hire date, as relevant to each staff person's job duties and responsibilities:

- Screening for eligibility, enrollment for covered behavioral health services (when eligible), and referral when indicated;
- Use of assessment and other screening tools (e.g., substance-related, crisis/risk, developmental, etc.), including the Birth-to-Five Assessment depending upon population(s) served;
- Application of diagnostic classification systems and methods depending upon population(s) served;
- Use of effective interview and observational techniques that support engagement and are strengths-based, recovery-oriented, and culturally sensitive;
- Behavioral health service planning that addresses the client's/family's needs as identified through initial and ongoing assessment practices;
- Behavioral health record documentation requirements;
- Confidentiality/HIPAA;
- Coordination of care requirements with Primary Care Providers (PCPs) (see PM Section 4.3, Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers) and other involved agencies and government entities (see PM Section 4.4, Coordination of Care with other Governmental Entities);
- Sharing of treatment/medical information;
- Management of difficult cases, including high-risk persons and persons that are court ordered for treatment;
- Covered behavioral health services (including information on how to assist persons in accessing all medically necessary covered behavioral health services regardless of a person's behavioral health category assignment or involvement with any one type of service provider);
- Overview of Substance Abuse Prevention and Treatment Block Grant: Priority placement criteria, interim service provision, consumer wait list reporting, and expenditure restrictions of the Substance Abuse Prevention and Treatment Block Grant in accordance with requirements in PM Section 3.19, Special Populations; PM Section 3.2 Appointment Standards and Timeliness of Service; PM Section 3.21 Service Prioritization for Non-Title XIX/XXI Funding, and; 45 CFR Part 96);
- Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) Program;
- Rights and responsibilities of eligible and enrolled behavioral health recipients, including rights for persons determined to have Serious Mental Illness;
- Appeals, grievances and requests for investigations;
- Complaint Process;
- Customer service;
- Fraud and abuse requirements and protocols;

- Managed care concepts, including information on the T/RBHA and the public behavioral health system;
- Overview of Arizona behavioral health system policies and procedures, including the ADHS/DBHS system principles:
  - Arizona Vision and 12 Principles in the children's system,
  - 9 Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems in the adult system,
- Best practices in the treatment and prevention of behavioral health disorders;
- Clinical training as it relates to specialty populations and/or conditions;
- Information regarding the appropriate clinical approaches when delivering services to children in the care and custody of ADES/DCYF;
- Overview of partnership with Department of Economic Services/Rehabilitative Services Administration (DES/RSA);
- Cultural competency;
- Child and Family Team (CFT) practice, depending on the population(s) served;
- Third party liability and coordination of benefits;
- Claims/encounters submission process;
- Advance Directives;
- Interpretation and Translation services;
- Identification and reporting of persons in need of Special Assistance for individuals who have been determined to have a Serious Mental Illness (SMI) and ensuring involvement of persons providing Special Assistance;
- ADHS/DBHS Demographic Data Set, including required timeframes for data submission and valid values; and
- Medicare Prescription Drug Modernization and Improvement Act of 2003 (MMA), including the following (as required by the Balanced Budget Amendment):
  - Assisting persons in choosing a Medicare Part D plan;
  - Accessing relevant resources (e.g., plan formularies); and
  - Answering questions and obtaining informational materials

[T/RBHA insert additional training information here]

Continuing Training Requirements

In addition to training required within the first 90 days of hire, all providers are required to undergo ongoing training for the following content areas:

- Each RBHA must provide evidence to the Office of Program Support (OPS) Encounter Unit, on a monthly basis, of ongoing provider training concerning procedures for submission of encounters. In addition, the RBHA must provide training to any provider with a data validation review rate greater than ten percent;
- ADHS/DBHS Demographic Data Set, including required timeframes for data submission and valid values; and
- Providers must ensure that staff at all levels and across all disciplines receives ongoing education and training in culturally and linguistically appropriate service delivery.

ADHS/DBHS also recognizes that there may be ongoing training requirements, specific to each T/RBHA. **[T/RBHA insert information here identifying ongoing training**

requirements.]

9.1.6-B Office of Behavioral Health Licensure (OBHL) required training (This section does not apply to Home Care Training to Home Care Client (HCTC) providers [see subsection 9.1.6-C] and Community Service Agency providers [see subsection 9.1.6-D)
The following is required training content where a licensee shall ensure that a behavioral health technician or behavioral health paraprofessional has the skills and knowledge necessary to perform the duties consistent with the job description of the behavioral health technician or behavioral health paraprofessional and the services the agency is authorized to provide including, if applicable, the skills and knowledge necessary to:

- Protect client rights in R9-20-203;
- Provide treatment that promotes client dignity, independence, individuality, strengths, privacy and choice;
- Recognize obvious symptoms of a mental disorder, personality disorder, or substance abuse;
- Provide the behavioral health services that the agency is authorized to provide and that the staff member is qualified to provide;
- Meet the unique needs of the client populations served by the agency or the staff member, such as children, adults age 65 or older, individuals who have substance abuse problems, individuals who are seriously mentally ill, or individuals who have co-occurring disorders;
- Protect and maintain the confidentiality of client records and information;
- Recognize and respect cultural differences;
- Recognize, prevent, and respond to a situation in which a client:
  - 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;
- Read and implement a client's treatment plan;
- Assist a client in accessing community services and resources;
- Record and document client information;
- Demonstrate ethical behavior, such as by respecting staff member and client boundaries and recognizing the inappropriateness of receiving gratuities from a client;
- Identify types of medications commonly prescribed for mental disorders, personality disorders, and substance abuse and the common side effects and adverse reactions of the medications;
- Recognize and respond to a fire, disaster, hazard, and medical emergency; and
- Provide the activities or behavioral health services identified in the staff member's job description or the agency's policy and procedure.

Training must be completed and documented in accordance with OBHL requirements (see R9-20-204(F) and R9-20-206).

9.1.6-C. Required training specific to Professional Foster Homes Providing HCTC Services
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, which must comply with training requirements as listed in 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;
- 30 hours of pre-service training utilizing Partnering for Safety and Permanence: the Model Approach to Partnerships in Parenting (PS-MAPP);
- 18 hours of pre-service training utilizing the Arizona Home Care Training to Client Service Curriculum;
- Behavioral health management of crisis situations including:
  - Prevention of violent behaviors,
  - Behavior management skills, and
  - De-escalation techniques
- Medical/health care issues, procedures, and techniques, including the purpose/use/administration of medications, medication interactions, and potential medication reactions.

The provider delivering HCTC services must complete the above training prior to providing services. In addition, the provider delivering HCTC services for children must complete and credibly document annual training as outlined in R6-5-5850, Special Provisions for a Professional Foster Home.

Adults

Medicaid reimbursable HCTC services for adults are provided in Adult Therapeutic Foster Homes licensed by the Arizona Department of Health, which must comply with training requirements as listed in R9-20-1502:

- Protecting the person's rights;
- Providing behavioral health services that the adult therapeutic foster 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 R9-20-1502.

9.1.6-D. 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 behavioral health recipients. For a

complete description of all required training specific to CSAs, see Policy and Procedure Manual MI 5.2, Community Service Agencies-Title XIX Certification.

9.1.6-E. Other situations that may prompt additional behavioral health provider training
Additional training is necessary for behavioral health providers serving in specific roles and functions including:

- Assessors conducting the behavioral health assessment and children age birth to five assessment;
- Providers responsible for service plan development and implementation;
- Child and Family Team facilitators;
- Child and Family Team coaches and supervisors of CFT facilitators (See ADHS/DBHS Practice Protocol Child and Family Team Practice) including the use of PM Form 9.1.1 Arizona Child and Family Teams Proficiency Measurement Tool for Facilitation and PM Attachment 9.1.1 Arizona Child and Family Teams Proficiency Measurement Tool for Facilitation User's Guide);
- Providers delivering services through distinct programs (e.g., Assertive Community Treatment teams);
- Providers offering specialized therapeutic approaches (e.g., Dialectical Behavioral Therapy, Multi-Systemic Therapy);
- Providers offering expertise in specialized areas (e.g., developmental disabilities, trauma, substance abuse, children age birth to five);
- Providers involved in Level I facilities; and
- Behavioral health providers providing services to children and families involved with Child Protective Services (CPS) will be required to attend "Unique Needs of Children Involved with CPS" training that is offered by each T/RBHA on a regular basis. (See Unique Needs of Children, Youth and Families Involved with Child Protective Services).

In addition, specific situations may necessitate the need for additional training. For example, quality improvement initiatives may require focused training efforts. New regulations that impact the public behavioral health system may also require concerted training strategies (e.g., the Balanced Budget Act (BBA), Medicaid Modernization Act (MMA) and Deficit Reduction Act (DRA)).

9.1.6-F Training Expectations for ADHS/DBHS Clinical and Recovery Practice Protocols
Under the direction of the ADHS/DBHS Chief Medical Officer, the Department publishes ADHS/DBHS Practice Protocols and identifies national clinical best practices to assist behavioral health providers. National guidelines and Practice Protocols without required elements can be accessed at http://www.azdhs.gov/bhs/guidance/guidance.htm.

Selected Practice Protocols have required elements. Behavioral health providers should receive training on Practice Protocols 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). As Practice Protocols with required elements are revised or added, training expectations will be identified. Practice Protocols with required elements can be accessed at http://www.azdhs.gov/bhs/guidance/guidance.htm.

9.1.6-G. Training Requests

Please contact the T/RBHA to find out where and when training is available or to request technical assistance or trainings that are mentioned in this section. **[T/RBHA identify how providers can access these types of trainings and specific contact information.]**

Arizona Department of Health Services
Division of Behavioral Health Services
PROVIDER MANUAL

Section 9.2 **Peer Support/Recovery Support Training, Certification and Supervision Requirements**

9.2.1 Introduction
9.2.2 References
9.2.3 Scope
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9.2.7 Procedures
9.2.7-A. Peer Support Specialist/Recovery Support Specialist Qualifications
9.2.7-B. Peer Support Employment Training Program Approval Process
9.2.7-C. Competency Exam
9.2.7-D. Peer Support Employment Training Curriculum Standards
9.2.7-E. Supervision of the Certified Peer Support Specialist / Recovery Support Specialist
9.2.7-F. Process for Submitting Evidence of Certification

9.2.1 Introduction

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) has developed training requirements and certification standards for Peer Support Specialists/Recovery Support Specialists providing Peer Support Services, as described in the ADHS/DBHS Covered Behavioral Health Services Guide. Peers serve an important role as behavioral health providers, and ADHS/DBHS expects consistency and quality in peer-delivered behavioral health services and support for peer-delivered behavioral health services statewide.

9.2.2 References

A.A.C. R6-5-5850
A.A.C. R9-20-1502
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/DBHS Covered Behavioral Health Services Guide
Section 3.13, Covered Behavioral Health Services
Section 4.5, Partnerships with Families and Family-Run Organizations in the Children's Behavioral Health System
Section 9.1, Training Requirements
The Centers for Medicare and Medicaid Services (CMS) State Medicaid Director Letter (SMDL #07-011)

9.2.3 Scope

To whom does this apply?
All behavioral health providers delivering training services for certification[1] of individuals as Peer Support Specialists/Recovery Support Specialists within the ADHS/DBHS public behavioral health system.

[1] Peer Support Services are also billed by family members who provide services in the public behavioral health system (see PM 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.

9.2.4 Did you know…?

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 (CMHS) 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).

9.2.5 Definitions

Covered Behavioral Health Services Guide

Behavioral Health Paraprofessional

Behavioral Health Professional

Behavioral Health Technician

Peer

Peer-run Organization

Peer Support Services

Peer Support Specialist / Recovery Support Specialist

Recovery

9.2.6 Objectives

To ensure that behavioral health providers and peers have the necessary knowledge and skills to successfully provide quality behavioral health services in the public behavioral health system.

To ensure that Peer Support Employment Training Certification Programs offer training and education that effectively prepares individuals for delivering behavioral health services, including Peer Support Services, as a peer.

To ensure that Peer Support Specialists/Recovery Support Specialists are certified to provide Peer Support Services, as described in the ADHS/DBHS Covered Behavioral Health Services Guide.

9.2.7 Procedures

9.2.7-A. Peer Support Specialist/Recovery Support Specialist Qualifications

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

- be self-disclosed as a "peer"; and
- meet the requirements to function as a behavioral health paraprofessional, behavioral health technician, or behavioral health professional.

Individuals meeting the above criteria may be certified as a Peer Support Specialist/Recovery Support Specialist by completing training and passing a competency test through an ADHS/DBHS approved Peer Support Employment Training Program. ADHS/DBHS will oversee the approval of all certification materials including curriculum and testing tools. Individuals are certified by the agency in which he/she completed the Peer Support Employment Training Program; however, certification through an ADHS/DBHS approved Peer Support Employment Training Program is applicable statewide, regardless of which program a person has gone through for certification.

Some agencies may wish to employ individuals prior to the completion of certification through a Peer Support Employment Training Program. However, certain trainings must be completed prior to delivering behavioral health services (see subsection 9.2.7-D.). An individual must be certified as a Peer Support Specialist/Recovery Support Specialist or currently enrolled in a ADHS/DBHS-approved Peer Support training program under the supervision of a certified Peer prior to billing Peer Support Services.

9.2.7-B. 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 ADHS/DBHS, and ADHS/DBHS will issue feedback or approval of the curriculum, competency exam and exam scoring methodology in accordance with subsection 9.2.7-D.

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 subsection 9.2.7-C.) during this three year period, the program must submit the updated curriculum to ADHS/DBHS for review and approval.

ADHS/DBHS will base approval of the curriculum, competency exam and exam scoring methodology only on the elements included in this policy. 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.

9.2.7-C. Competency Exam

Participants must complete and pass a competency exam with a minimum score of 80% upon completion of required training. Each Peer Support Employment Training Program has the authority to develop a unique competency exam. However, all exams must include at least one question related to each of the curriculum core elements listed in subsection 9.2.7-D. For peers who have been providing Peer Support Services prior to the implementation of this policy or peers who have training or work history from another state, certification may be obtained after passing the competency exam. If a peer does not pass the competency exam, the Peer Support Employment Training Program may require that the peer repeat or complete additional training prior to taking the competency exam again.

9.2.7-D. 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 recovery 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; 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 and its purpose.

- Advocacy and Systems Perspective
  - Brief overview of behavioral health system infrastructure;
  - Stigma and effective stigma reduction strategies;
  - 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;
  - Brief overview of advocacy and effective strategies; and
  - Familiarization of the Americans with Disabilities Act

- Psychiatric Rehabilitation Skills
  - Strengths based approach; identifying one's own strengths and helping others identify theirs;
  - Distinguishing between sympathy and empathy;
  - Learned helplessness; what it is and how to assist others in overcoming its effects;
  - Overview of motivational interviewing; communication skills and active listening;
  - Healing relationships and creating mutual responsibility;
  - Combating negative self-talk; noticing patterns and replacing negative statements about one's self, using one's mind to boost self-esteem and relieve stress;
  - Group facilitation; and
  - Creating a safe and supportive environment; building trust.

- Professional Responsibilities of the Peer Support Employee and Self Care in the Workplace. Qualified peers must receive training on the following elements prior to delivering any covered behavioral health services:

- Professional boundaries & ethics- the varied roles of the helping professional;
- Confidentiality;
- Mandatory reporting requirements;
- Understanding common symptoms of mental illness and substance use and orientation to commonly used medications;
- Service documentation/billing and using recovery language throughout documentation; and
- Self-care and the use of ongoing supports; dealing with stress in the workplace.

Some curriculum elements include concepts included in required training, as described in PM Section 9.1, Training Requirements. Peer support employment training programs must not duplicate training required of peers for employment with a licensed agency or Community Service Agency (CSA)[2]. Training elements in this section must be specific to the peer role in the public behavioral health system and instructional for peer interactions.

For a list of references to assist in developing a curriculum that addresses the topics listed in the Curriculum Standards, see PM Attachment 9.2.1, Suggested Curriculum Development References.

[T/RBHA, insert any additional resources available here for development of curriculum, including contact at the T/RBHA for questions or assistance.]

9.2.7-E. Supervision of the Certified Peer Support Specialist / Recovery Support Specialist

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

Agencies employing Peer Support Specialists/Recovery Support Specialists must have a qualified individual (behavioral health professional (BHP) or behavioral health technician (BHT)) level individual designated to provide Peer Support Specialist/Recovery Support Specialist supervision. Supervision must be documented and inclusive of both clinical and administrative supervision.

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

[T/RBHA, insert additional information here regarding resources available to agencies for establishing supervision requirements. Also indicate here any expectations for agencies regarding T/RBHA monitoring/oversight activities for this requirement.]

[2] 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.

9.2.7-F. 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. T/RBHAs must ensure that Peer Support Specialists/Recovery Support Specialists meet qualifications and have certification, as described in this policy.

[T/RBHA, insert additional information here regarding monitoring and any established auditing/oversight activities where personnel files of Peer Support Specialists/Recovery Support Specialists are reviewed.]

Section 11.0 Definitions

11.1 Definitions

DIVISION OF BEHALVIORAL HEALTH SERVICES DEFINITIONS
(Revised 11/01/11)

Abuse
The infliction of, or allowing another person to inflict or cause physical pain or injury, impairment of bodily function, disfigurement or serious emotional damage which may be evidenced by severe anxiety, depression, withdrawal or untoward aggressive behavior. Such abuse may be caused by acts or omissions of an individual having responsibility for the care, custody or control of a client receiving behavioral health services or community services. Abuse shall also include sexual misconduct, assault, molestation, incest, or prostitution of, or with, a client under the care of personnel of a mental health agency, which may occur under circumstances outside of a licensed sponsored activity.

Abuse (of child/minor)
The infliction or allowing of physical injury, impairment of bodily function or disfigurement or the infliction of or allowing another person to cause serious emotional damage as evidenced by severe anxiety, depression, withdrawal or untoward aggressive behavior and which emotional damage is diagnosed by a medical doctor or psychologist pursuant to section A.R.S. § 8-821 and is caused by the acts or omissions of an individual having care, custody and control of a child. Abuse includes:
(a) Inflicting or allowing sexual abuse pursuant to section A.R.S. § 13-1404, sexual conduct with a minor pursuant to section A.R.S. § 13-1405, sexual assault pursuant to section A.R.S. § 13-1406, molestation of a child pursuant to section A.R.S. § 13-1410, commercial sexual exploitation of a minor pursuant to section A.R.S. § 13-3552, sexual exploitation of a minor pursuant to section A.R.S. § 13-3553, incest pursuant to section A.R.S. § 13-3608 or child prostitution pursuant to section A.R.S. § 13-3212.
(b) Physical injury to a child that results from abuse as described in section A.R.S. § 13-3623, subsection C.

Abuse (of incapacitated or vulnerable adult)
(a) Intentional infliction of physical harm.
(b) Injury caused by negligent acts or omissions.
(c) Unreasonable confinement.
(d) Sexual abuse or sexual assault.

Abuse Section 5.3
For purposes of this section 5.3, includes both physical and sexual abuse

Abuse Section 7.1
Provider practices that are inconsistent with sound fiscal business, or medical practices, and result in an unnecessary cost to the AHCCCS program, the State of Arizona or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes behavioral health recipient practices that result in unnecessary costs to the AHCCCS program and/or the State of Arizona.

Abuse Section 7.4
The infliction of, or allowing another person to inflict or cause physical pain or injury, impairment of bodily function, disfigurement or serious emotional damage which may be evidenced by severe anxiety, depression, withdrawal or untoward aggressive behavior. Such abuse may be caused by acts or omissions of an individual having responsibility for the care, custody or control of a client receiving behavioral health services or community services. Abuse shall also

include sexual misconduct, assault, molestation, incest, or prostitution of, or with, a client under the care of personnel of a mental health agency, which may occur under circumstances outside of a licensed sponsored activity.

Action
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 of service;
- The failure to provide services in a timely manner;
- The failure to act within established timeframes for resolving an appeal or complaint and providing notice to affected parties; and
- The denial of the Title XIX/XXI eligible person's request to obtain services outside the network.

Acute Health Plan and Provider Coordinator
A person or persons identified by the T/RBHA to act as a single point of contact to respond to coordination of care inquiries from AHCCCS Health Plans, PCP's and other involved clinicians. This coordinator will be supervised by and have direct priority access to a Behavioral Health Professional (BHP) as described in R9-20-204 and performs the functions as described in the ADHS/RBHA Contracts and ADHS/Tribal IGA's.

ADHS/DBHS Documents
Include contracts, policies, plans, manuals, and clinical guidance documents that collectively describe all behavioral health system requirements and expectations.

ADHS/DBHS Medical Policies
Describe required clinical and medical functions pertaining to the direct provision of behavioral health services. The ADHS/DBHS Medical Director designates and signs all policies contained in DBHS Policy and Procedures Manual.

ADHS/DBHS Non-Title XIX/XXI Medication Formulary
The ADHS/DBHS formulary for Non-Title XIX/XXI persons.

ADHS/ DBHS Office of Grievance and Appeals
The Office of Grievance and Appeals is responsible for the administration and oversight of the administrative grievance and appeal processes. In addition, the Office of Grievance and Appeals investigates allegations of sexual abuse, physical abuse or the death of individuals determined to have a Serious Mental Illness (SMI). The purpose of the grievance and appeal processes is to resolve case specific issues and to remedy any systematic concerns that are identified.

ADHS/DBHS Office of Human Rights
The Office of Human Rights (OHR), established within ADHS/DBHS, is responsible for assisting individuals who have been determined to have a Serious Mental Illness (SMI) with understanding, exercising and protecting their rights through outreach and education, addressing systemic issues and direct advocacy assistance. OHR advocates assist individuals, primarily individuals in need of Special Assistance, with individual service planning and inpatient treatment/discharge planning and the grievance/investigation and appeal processes. The Office of Human Rights is also responsible for providing general oversight, addressing systemic issues and maintaining a list of all individuals in need of Special Assistance to help ensure that their needs are met.

ADHS/DBHS Policy Committee
Is the body responsible for the review and development of ADHS/DBHS policy. The ADHS/DBHS Policy Committee includes, at a minimum, ADHS/DBHS division and office representatives, family members, peers and other representatives as necessary.

ADHS/DBHS Public Comment
Means a stage of draft (ADHS/DBHS) documents whereby suggestions for revisions are elicited from providers, behavioral health recipients, family members, state agencies and other stakeholders. ADHS/DBHS considers suggested revisions collected during the public comment stage when finalizing ADHS/DBHS documents.

ADHS/DBHS Title XIX/XXI Medication Formulary
A list of minimum medications covered for Title XIX/XXI eligible persons that must be included on each T/RBHA formulary.

Addiction
Compulsion and craving to use alcohol or other drugs regardless of negative or adverse consequences.

Adjudication Hearing
In juvenile proceedings – during a fact finding session, the court determines whether or not there is sufficient evidence to sustain the allegations found in a petition. An adjudication hearing is the juvenile counterpart to an adult trial.

Administrative Appeal
An appeal to the ADHS/DBHS of a decision made by the Arizona State Hospital or a T/RBHA as the result of a grievance.

Administrative Hearing
A hearing conducted by the Office of Administrative Hearings under A.R.S. Title 41, Chapter 6, Article 10.

Administrative Review
The portion of the appeal process beginning with the initial filing of a formal written appeal by the provider with the TRBHA or ADHS/DBHS and concluding with the issuance of a final decision by a RBHA or ADHS/DBHS that advises of formal hearing rights under A.R.S 41-1092 et seq.

Adult Clinical Team
A group of individuals working in collaboration who are actively involved in a person's assessment, service planning and service delivery. At a minimum, the team consists of the person, their guardian (if applicable) and a qualified behavioral health representative. The team may also include members of the enrolled person's family, physical health, mental health or social service providers, representatives or other agencies serving the person, professionals representing disciplines related to the person's needs, or other persons identified by the enrolled person. For persons determined to have a serious mental illness, the clinical team consists of a team leader, a psychiatrist, case manager, vocational specialist, psychiatric nurse, and other professionals or paraprofessionals, such as a psychologist, social worker, consumer case management aide, or rehabilitation specialist, as needed, based on the client's needs.

Advance Directive
Federal regulations define an advance directive as a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as

recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

Adverse Action or Decision
For purposes of this section means an action or decision taken by a T/RBHA or ADHS/DBHS for which a provider may file an appeal. This does not include disputes between a prospective service provider and a T/RBHA in connection to the T/RBHA's contract process.

Adverse Drug Event (ADE)
Any incident in which the use of a medication (drug or biologic) at any dose, a medical device, or a special nutritional product (for example, dietary supplement, infant formula, medical food) may have resulted in an adverse outcome in a consumer.

Adverse Drug Reaction (ADR)
An undesirable response associated with use of a drug that either compromises therapeutic efficacy, enhances toxicity, or both.

Age Groups The following age groups have been defined to provide consistency to data field requirements.			
0thru4	Birth through age 4 but not equal to age 5.	**5thru17**	Age 5 thru age 17 but not equal to age 18.
0thru17	Birth through age 17 but not equal to age18.	**5&Older** **18&Older**	Age 5 and older. Age 18 and older.

Alcohol and Drug Abuse Program
(42 CFR Part 2) An individual or entity (other than a general medical care facility) who holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment;

An identified unit within a general medical facility, which holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral to treatment;

Medical personnel or other staff in a general medical care facility whose primary function is the provision of alcohol or drug abuse diagnosis, treatment or referral for treatment and who are identified as such providers.

Alcohol and/or Drug Services, Intensive Outpatient Program (IOP)
Treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan, including assessment, counseling, crisis intervention and activity therapies or education.

American Indian Tribal Member
Any individual defined in 25UC16039(c)[IHCIA, Sec 4(13)], 1603(f) [IHCIA Sec. 4(28)] or 1679(b) [IHCIA Sec. 809(a)], or who has been determined eligible as an Indian pursuant to Section 136.12 of this part. This means the individual is:

(i) A member of a Federally-recognized Indian tribe;
(ii) Resides in an urban center and meets one or more of the following four criteria:
(A) Is a member of a tribe, band or organized group of Indians, including those tribes, bands or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, the first or second degree, of any such member;

(B) Is an Eskimo of Aleut or other Alaska Native;
(C)Is considered by the Secretary of the Interior to be an Indian for any purpose; or
(D) Is determined to be an Indian under regulations promulgated by the Secretary;
(iii) Is considered by the Secretary of the Interior to be an Indian for any purpose; or;
(iv) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian Health care services, including as a California Indian, Eskimo, Aleut or other Alaska Native.

Annual Update
An annual review and documented update of a person's behavioral health assessment, treatment and progress toward meeting defined service goals over the past year. In addition to meeting with the person and other team members this involves a review of the person's behavioral health record including previous assessments, progress notes, medications, service plans and reviews, demographic and clinical data elements for the past 12 months.

Appeal AzSH
A request for review of an action. For purposes of this section, a request for review of a decision made by ADHS/DBHS, AzSH, a T/RBHA or a T/RBHA provider

Appeal Resolution
For purposes of this policy is the written determination by the RBHA or ADHS/DBHS, or AzSH concerning an appeal.

Appeal Section 5.2/GA 3.1
A request for review of an action, and for a person determined to have a serious mental illness, an adverse decision by a T/RBHA or ADHS/DBHS.

Appeal Section 5.1/GA 3.3
A request for review of an action.

Appeal Section 5.5/GA 3.5
For purposes of this section, a request for review of a decision made by ADHS/DBHS, a T/RBHA or a T/RBHA provider.

Appealable Agency Action
An action that determines the legal rights, duties, or privileges of a party.

Applicant
For purposes of this policy, includes an agency that has submitted an application for Title XIX Certification as a Community Service Agency.

Approval
The process by which ADHS/DBHS allows the use of a new technology or change in use of an existing technology or psychotherapeutic.

Arizona Department of Housing (ADOH)
A department established for state government in Arizona to assist in addressing needs for homes for working families. In an effort to allow for greater coordination and innovation of housing related services at the state level, the Legislature passed and Governor Jane Dee Hull signed HB2615 during the 2001 legislative session, establishing the Arizona Department of Housing (ADOH). The functions of this department were previously performed by the Arizona Department of Commerce.

Assessment
The ongoing collection and analysis of a person's medical, psychological, psychiatric and social conditions in order to initially determine if a behavioral health disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensure that the person's service plan is designed to meet the person's (and family's) current needs and long term goals.

Attachment (relationship)
An enduring emotional connection between a caregiver and an infant/young child. Attachment is characterized by the child's tendency, when under stress, to seek contact, comfort and proximity to a specific individual ("attachment figure") who is perceived to be bigger, stronger, wiser, and more competent. If that person is available to the child for comfort or protection, s/he will be preferred over any other individual. Conditions which typically activate children's behavior for seeking comfort and security are fatigue, illness, fear, and other experiences of vulnerability. Infants are not born attached to anyone and early on respond to the various people they encounter in very similar (though not identical) ways. Over the course of the first year of life however, infants become increasingly selective about whom they regard as competent to protect and comfort them. The emergence of a discriminate attachment figure, an attachment to a specific other, typically occurs in the 7-9 month period of development, cross-culturally. Given the opportunity, infants typically form attachments to more than one person.

Attachment Behavior
Any form of behavior that results in a person attaining or retaining proximity to a specific and preferred individual for the purpose of achieving protection, comfort, and/or the feeling of security. A young child's attachment behaviors include crying, smiling,
calling, reaching, following, clinging, and protesting separations from attachment figures, the condition of being alone, or placement with a stranger. Attachment behaviors are designed to activate the caregiver's corresponding inclination to meet the child's need for protection, comfort, and/or the feeling of security.

Behavioral Health Category Assignment
One of five possible designations (i.e., child non-SED, child with SED, adult with SMI, adult non-SMI with general mental health need and adult non-SMI with substance abuse) that is assigned to each person enrolled in the ADHS/DBHS behavioral health system.

Behavioral Health Medical Practitioner
An individual licensed and authorized by law to use and prescribe medication and devices, as defined in A.R.S. § 32-1901, and who is one of the following with at least one year of full-time behavioral health work experience: a. A physician; b. A physician assistant; or c. A nurse practitioner.

Behavioral Health Paraprofessional
An individual who meets the applicable requirements in R9-20-204 and has:
a. An associate's degree;
b. A high school diploma; or
c. A high school equivalency diploma.

Behavioral Health Professional
An individual who meets the applicable requirements in A.A.C. R9-20-204 and is a licensed:
a. Psychiatrist,
b. Behavioral health medical practitioner,
c. Psychologist,
d. Social worker,

e. Counselor,
f. Marriage and family therapist,
g. Substance abuse counselor, or
h. Registered nurse with at least one year of full-time behavioral health work experience.

Behavioral Health Recipient
Any adult or child that receives services through ADHS/DBHS funded programs (including prevention activities for non-enrolled persons).

Behavioral Health Related Field
Includes psychology, sociology/social work, counseling (including chemical dependency), nursing, and social/human services-related fields with focus on behavioral health (for a list of behavioral health classes, see PM Attachment 3.20.1, Examples of College Classes Relevant to Behavioral Health).

Behavioral Health Representative
A behavioral health professional, a behavioral health technician or a paraprofessional who is responsible for assisting the team in treatment planning, securing behavioral health services, and any other processes requiring involvement or facilitation from the behavioral health system. The behavioral health representative can also be the Clinical Liaison or work under their clinical direction.

Behavioral Health Status
A person's overall emotional and psychological condition including the use of a person's cognitive and emotional capabilities, the ability to function in society, and other skills needed to meet the ordinary demands of everyday life

Behavioral Health Technician
An individual who meets the applicable requirements in A.A.C. R9-20-204 and:
a. Has a master's degree or bachelor's degree in a field related to behavioral health;
b. Is a registered nurse;
c. Is a physician assistant who is not working as a medical practitioner;
d. Has a bachelor's degree and at least one year of full-time behavioral health work experience;
e. Has an associate's degree and at least two years of full-time behavioral health work experience;
f. Has a high school diploma or high school equivalency diploma and:
i. 18 credit hours of post-high school education in a field related to behavioral health completed no more than four years before the date the individual begins providing behavioral health services and two years of full-time behavioral health work experience; or ii. Four years of full-time behavioral health work experience; or
g. Is licensed as a practical nurse, according to A.R.S. Title 32, Chapter 15, with at least two years of full-time behavioral health work experience.

Behavioral Health Work Experience
For the purposes of this policy, behavioral health work experience includes paid work and volunteer work in the behavioral health field that is directly related to the services the direct service staff member intends to provide.

Best practices
Strategies, activities and approaches that have been shown to be effective, through research and evaluation at preventing and/or or delaying substance abuse, violence, or other problem behaviors.

Block Grant
Federal money allocated to states, cities, or counties for distribution to community groups, charities, and other social service providers, most often administered under the allocated agency's rules and regulations (also known as "formula" grant). URL: http://answers.hhs.gov/questions/3208

Bonding
The affectional tie and warm, loving commitment of the caregiver to the infant. Although, colloquially, the term "bonding" tends to be used interchangeably with the word "attachment" or the general concept of emotional connectedness, the literature tends to reserve this term for the caregiver's side of the attachment relationship.

Caregiver
An individual who has the principal responsibility for caring for a child or dependant adult.

Certification of Need (CON)
Certification by a physician that inpatient services, including treatment in inpatient hospitals (42 CFR 456.60); inpatient psychiatric facilities (inclusive of residential treatment centers and sub-acute facilities, 42 CFR 441.152); and mental hospitals (42 CFR 456.160) are or were needed at the time of the person's admission.

Certification of Need (CON) (42 CFR 441.152, 456.30, 456.160) QM 2.9/QM 3.0
A CON is a certification made by a physician that inpatient services are or were needed at the time of the person's admission to a Level I facility. 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 that requires prior authorization is determined through the application of admission and continued stay authorization criteria. 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 days of admission.

Change
Any modification to a client's status on any demographic record field that occurs after the Demographic has been accepted by ADHS/DBHS.

Child
An individual who is under eighteen years of age.

Child and Adolescent Service Intensity Instrument (CASII)
The CASII is a tool to determine the appropriate service intensity for a child or adolescent. The CASII assessment method consists of quantifying the clinical severity and service needs on six dimensions (eight ratings) that are standardized using anchor points. The ratings are quantified in order to convey information easily, but also provide a rating spectrum along which a child/adolescent may score on any given dimension. This can be done for any child/adolescent ages 6-18 in any setting regardless of diagnosis or the system with which the child is involved. The instrument also considers three distinct types of disorders: psychiatric disorders, substance use disorders, or developmental disorders (including autism and mental retardation), and has the ability to integrate these as overlapping clinical issues. Once the dimensional ratings are

done, the scores are combined to generate a service intensity recommendation.

Child and Family Team
The Child and Family Team (CFT) is a defined group of people that includes, at a minimum, the child and his/her family, a behavioral health representative, and any individuals important in the child's life and who are identified and i invited to participate by the child and family . This may include, for example, teachers, extended family, members, friends, family support partners, healthcare providers, coaches, community resource providers, representatives from churches, synagogues or mosques, agent from other service systems like CPS or DDD. etc. 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 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 child.

Child and Family Team (CFT) Facilitator
Although, individuals other than the behavioral health service provider may lead a CFT meeting, ultimately the behavioral health service provider is responsible for facilitating the CFT practice. If designated by the CFT, a team member may assume responsibility for leading team meetings and moderating discussions to facilitate consensus in the development of Service Plan goals and interventions. Individuals other than behavioral health service providers (i.e. family members, Child Protective Services' case managers, and natural supports) can learn to lead effective Child and Family Team meetings.

Children with Complex Needs
Children who are identified as being at level 3, 4, 5, or 6 using the CASII.

Children with Standard Needs
Children who are identified as being at level 0, 1, or 2 using the CASII.

Claim
A service billed under a fee-for-service arrangement.

Claim Dispute
A dispute involving a payment of a claim, denial of a claim or imposition of a sanction.

CLAS Standards
The collective set of culturally and linguistically appropriate services (CLAS) mandates, guidelines, and recommendations issued by the United States Department of Health and Human Services Office of Minority Health intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services (National Standards for Culturally and Linguistically Appropriate Services in Health Care Final Report, OMH, 2001).

Clean Claim
A claim that may be processed without obtaining additional data from the provider of service or from a third party but does not include claims under investigation for fraud and abuse or claims under the review for medical necessity.

Client Information System (CIS)
The data system used by ADHS/DBHS

Clinical Liaison

A behavioral health professional or a behavioral health technician who has been credentialed and privileged by the T/RBHA or their designee in accordance with ADHS/DBHS requirements to perform this function. The clinical liaison:
• Assumes the primary responsibility of clinical oversight of the person's care
• Ensures the clinical soundness of the assessment/treatment process
• Serves as the point of contact, coordination and a communication with the person's team and other systems where clinical knowledge is important.

Clinical Teams
A team of individuals whose primary function is to develop a comprehensive and unified service or treatment plan for an enrolled person. The team may include an enrolled person, members of the enrolled person's family, health, mental health or social service providers including professionals representing disciplines related to the person's needs, or other persons that are not health, mental health or social service providers identified by the person or family. Clinical teams include Child and Family Teams and Adult Clinical Teams.

Closure
The HIPAA compliant transmission of information to terminate a client's enrollment in the ADHS/DBHS behavioral health service delivery system. For TXIX/XXI individuals, this information is provided from AHCCCS to ADHS/DBHS, and from ADHS/DBHS to the T/RBHAs. For NTXIX/XXI individuals, this information is provided to ADHS/DBHS from the T/RBHAs

Commonly Encountered LEP Groups
A significant number or percentage of the population eligible to receive services, or likely to be directly affected by the covered entity's (ADHS) programs who need services or information in a language other than English to communicate effectively. All vital materials shall be translated when a language is spoken by 1,000 or 5% (whichever is less) of members who have LEP in that language. Vital materials include, at a minimum, notices for denials, reductions, suspensions or terminations of services, and consent forms. All materials shall be translated when a language is spoken by 3,000 or 10% (whichever is less) of members who have LEP.

Community-Based Services
Services that are provided in the home and community rather than in offices or institutions. In addition, to fully be considered community-based services, they must be provided in partnership with the family and preserve the child's cultural and ethnic ties. Source: "Everything is normal until proven otherwise – a book about wraparound services" Dennis, K. & Lourie, I. (2006)

Community Service Agency (CSA)
A provider (provider type A3) of non-licensed behavioral health services. Agencies or organizations must be certified by ADHS/DBHS and registered with AHCCCS to provide services for Title XIX and Title XXI members.

CSA Contractor
An independent entity contracting with a Community Service Agency to provide services. CSA Contractors must exclude T/RBHAs and Office of Behavioral Health Licensure (OBHL) licensed facilities.

Complaint
An expression of dissatisfaction with any aspect of care other than the appeal of an action for Title XIX/XXI behavioral health recipients. Complaints include, but are not limited to; concerns about the quality of care or services provided, aspects of interpersonal relationships with behavioral health service providers, and lack of respect for behavioral health recipients' rights.

Complementary and Alternative Medicine (CAM)
A broad range of healing philosophies (schools of thought), approaches and therapies that mainstream Western (conventional) medicine does not commonly use, accept, study, understand, or make available. A few of the many CAM practices include the use of acupuncture, ayurveda, herbs, homeopathy, naturopathy, therapeutic massage, and traditional Oriental medicine to promote well-being or treat health conditions.

Condition Requiring Investigation
An incident or condition that appears to be dangerous, illegal or inhumane, including the death of a person with Serious Mental Illness.

Confidential HIV Information
Information concerning whether a person has had an HIV-related test or has HIV infection, HIV related illness or acquired immune deficiency syndrome and includes information which identifies or reasonably permits identification of that person or the person's contacts.

Co-payment
A fixed monetary amount that a member pays directly to a contractor or provider at the time covered services are rendered.

Corrective Action
An action taken to improve the performance of the T/RBHA and/or its contracted provider to enhance quality management/performance improvement activities and the outcomes of the activities; or to correct a deficiency.

Corrective Action Plan (CAP)
A written work plan that includes goals and objectives, steps to be taken, and methodologies to be used to accomplish CAP goals and objectives, as well as the staff responsible to carry out the CAP within established timelines. CAPs are generally used to improve the performance of the RBHAs and/or their contracted providers, to enhance QM/PI activities and the outcomes of the activities, and/or to correct a deficiency.

Cost avoidance
Avoiding payment of claims when third party payment sources are available.

Cost sharing
T/RBHA payment on behalf of behavioral health recipients for Medicare and private insurer costs, including premiums, deductibles and coinsurance.

Court Ordered Evaluation
A professional multidisciplinary analysis based on data describing the person's identity, biography and medical, psychological and social conditions carried out by a group of persons consisting of not less than the following:

(a) Two licensed physicians, who shall be qualified psychiatrists, if possible, or at least experienced in psychiatric matters, and who shall examine and report their findings independently. The person against whom a petition has been filed shall be notified that he may select one of the physicians. A psychiatric resident in a training program approved by the American Medical Association or by the American Osteopathic Association may examine the person in place of one of the psychiatrists if he is supervised in the examination and preparation of the affidavit and testimony in court by a qualified psychiatrist appointed to assist in his training, and if the supervising psychiatrist is available for discussion with the attorneys for all

parties and for court appearance and testimony if requested by the court or any of the attorneys.

(b) Two other individuals, one of whom, if available, shall be a psychologist and in any event a social worker familiar with mental health and human services which may be available placement alternatives appropriate for treatment. An evaluation may be conducted on an inpatient basis, an outpatient basis or a combination of both and every reasonable attempt shall be made to conduct the evaluation in any language preferred by the person.

COT Court Ordered Treatment
In accordance with the A.A.C. R9-21-101 and A.R.S. § 36-533 In Arizona, an individual can be ordered by the court to undergo mental health treatment if found to fit one of the following categories due to a mental disorder:

- A Danger to Self;
- A Danger to Others;
- Gravely Disabled, which means that the individual is unable to take care of his/her basic physical needs; or
- Persistently or Acutely Disabled, which means that the individual is more likely to suffer severe mental or physical harm that impairs his/her judgment such that the person is not able to make treatment decisions for himself.

Credentialing
Is the process of obtaining, verifying and assessing information (e.g., validity of the license, certification, training and/or work experience) to determine whether a behavioral health professional or a behavioral health technician has the required credentials to provide behavioral health services to persons enrolled in the ADHS/DBHS behavioral health system. It also includes the review and primary source verification of applicable licensure, accreditation and certification of behavioral health providers.

Crisis
An acute, unanticipated, or potentially dangerous behavioral health condition, episode or behavior.

Crisis Episode
A short enrollment is allowed for crisis only individuals who are not transferred to on-going care. Only a minimum data set needs to be collected. See the Demographic Data Set User Guide for fields. These fields must be gathered within 45 days after the start of the episode of care and submitted to ADHS/DBHS within 55 days.

Crisis Intervention Services
Services provided to a person for the purpose of stabilizing an acute, unanticipated, or potentially dangerous behavioral health condition, episode or behavior.

Crisis Intervention Services (Inpatient Stabilization, Facility Based)
Crisis intervention services provided at a Level 1 psychiatric acute hospital or a Level 1 sub-acute agency (see AAC R9-20-101(37)). Persons may walk-in or may be referred/transported to these settings.

Crisis Intervention Services (Mobile, Community Based)
Crisis intervention services provided by a mobile team or individual who travels to the place where the person is experiencing the crisis (e.g., person's place of residence, emergency room, jail, community setting) to:

- Stabilize acute psychiatric or behavioral symptoms;
- Evaluate treatment needs; and
- Develop plans to meet the needs of the persons served.

Depending on the situation, the person may be transported to a more appropriate facility for further care (e.g., a crisis services center).

Crisis Intervention Services (Telephone)
Crisis intervention (telephone) services provided by qualified service providers within the scope of their practice to triage, refer and provide telephone-based support to persons in crisis. This is often the first place of access to the behavioral health system. This service may also include a follow-up call to ensure the person is stabilized.

Cross-tapering
A process by which one medication is added to a person's medication regime, and its dosage gradually increased, while the dosage of another medication that has been prescribed for the same clinical purpose is gradually reduced and discontinued. This provides a safe and cautious way to substitute one medication for another.

Cultural Competence
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 behavioral health recipients and their communities.

Culture
Are the thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Culture defines:

- How health care information is received;
- How rights and protections are exercised;
- What is considered to be a health problem;
- How symptoms and concerns about the problem are expressed;
- Who should provide treatment for the problem; and
- What type of treatment should be given.

In sum, because health care is a cultural construct, arising from beliefs about the nature of disease and the human body, cultural issues are actually central in the delivery of health services treatment and preventive interventions. By understanding, valuing, and incorporating the cultural differences of America's diverse population and examining one's own health-related values and beliefs, health care organizations, practitioners, and others can support a health care system that responds appropriately to, and directly serves the unique needs of populations whose cultures may be different from the prevailing culture (Katz, Michael. Personal communication, November 1998).

Culture
The shared values, norms, traditions, customs, arts, history, folklore, music, religion, and institutions of a group of people.

Culturally based
Developed in collaboration with or by the targeted population.

Culturally Competent Agencies and Individuals
Culturally competent agencies and individuals are characterized by their understanding of and respect for the differences between and among diverse groups (i.e., acknowledging and incorporating acceptance of customs, values, and beliefs of different groups); continuing self-

assessment regarding culture; careful attention to the dynamics of difference; continuous expansion of cultural knowledge and available resources; and appropriate adaptations of service models to better meet the needs of diverse populations. Culturally competent agencies strive to hire culturally competent employees and individuals; seek advice and consultation from diverse communities; and actively assess their capability of providing responsive services to diverse clients. Culturally competent agencies are committed to strategies and practices that enhance services to diverse individuals, families, and communities.

Culturally Competent Care
Children and their families receive services from all staff members that are effective, understandable, and respectful and are provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Culturally relevant
A prevention program, message, or strategy development that is meaningful to the identified population.

Curriculum
A written document which details the workshops, lessons, and/or presentations used in life skills education, parent/family education, public information& marketing, alternative activities, community education, and/or training services.

Danger to Others (DTO)
The judgment of a person who has a mental disorder is so impaired that he is unable to understand his need for treatment and as a result of his mental disorder his continued behavior can reasonably be expected, on the basis of competent medical opinion, to result in serious physical harm to others.

Danger to Self (DTS)
(a) Behavior which, as a result of a mental disorder, constitutes a danger of inflicting serious physical harm upon oneself, including attempted suicide or the serious threat thereof, if the threat is such that, when considered in the light of its context and in light of the individual's previous acts, it is substantially supportive of an expectation that the threat will be carried out.
(b) Behavior which, as a result of a mental disorder, will, without hospitalization, result in serious physical harm or serious illness to the person, except that this definition shall not include behavior which establishes only the condition of gravely disabled

Dangerous
A condition that poses or posed a danger or the potential of danger to the health or safety of a person with Serious Mental Illness.

Day
A calendar day unless otherwise specified.

De-Identified Health Information
Health information that neither identifies nor provides a reasonable basis to identify an individual.

Demographics
The data set captured in the Demographic Data Set User Guide.

Denial
The decision to deny an initial request made by, or on behalf of, a behavioral health

recipient for the authorization of a covered service.

Dependent Adult
A person eighteen years of age or older who is unable to protect the person's own interests or unable to adequately perform or obtain services necessary to meet essential human needs, as a result of a physical or mental condition which requires assistance from another, or as defined by department rule. (definition from Iowa Human Services Dept)

Depo-medications
Medications which require intramuscular administration.

Descriptive Characteristics
Information used to profile clients at intake and during treatment in the behavioral health system and includes the following areas:
- Socio-demographic profile;
- Treatment characteristics;
- Participation status;
- Medical condition;
- Other agency involvement;
- Special fund source identifier; and
- Served by CFT.

Designated Child Psychiatric Provider
T/RBHA Child Medical Director or assigned licensed child and adolescent psychiatrist who is responsible for approving medication requests and maintaining clinical documentation for children birth to five years of age for a designated clinic(s) or geographic service area within the T/RBHA. The T/RBHA holds this individual responsible for compliance monitoring related to birth to five prescribing practices.

Designated T/RBHA
The T/RBHA responsible for the geographic service area where an eligible person has established his/her residence.

Designated Record Set
(45 C.F.R. § 164.501) A group of records maintained by or for a covered entity that is: the medical and billing records about individuals maintained by or for a covered healthcare provider; the enrollment, payment claims adjudication, and case or medical management record systems maintained by or for a health plan; or used, in whole or in part, by or for the covered entity to make decisions about individuals. For purposes of this definition, record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used or disseminated by or for a covered entity.

Detention
The temporary confinement of a juvenile who requires secure care in a physically restricting facility that is completely surrounded by a locked and physically secure barrier with restricted ingress and egress for the protection of the juvenile or the community pending court disposition or as a condition of probation (A.R.S. 8-201).

Direct service staff member
For purposes of this policy, includes a qualified Community Service Agency employee, contractor or volunteer providing behavioral health rehabilitation and/or support services to eligible and enrolled persons.

Disability

A physical or mental impairment which substantially limits one or more major life activities, or an individual who has a record of such impairment or is regarded as having an impairment (U.S.C. Title 42 Chapter 126 Section 12102 (2)).

Discharge Pending List
Is the list maintained by AzSH, with the individual's name that meet the criteria specified at the Transition to Community Placement Setting section from the Policy and Procedures M.I 5.5 Arizona State Hospital.

Disenrollment
Applies only to NTXIX individuals. The HIPAA-compliant transmission, by a behavioral health provider to a T/RBHA and by a T/RBHA to ADHS, of information to terminate a client's enrollment in the ADHS/DBHS behavioral health service delivery.

Disposition Hearing
A hearing conducted after a juvenile is adjudicated or admits to the delinquent/incorrigible act, to determine the most appropriate placement of the juvenile. Other consequences may also be assigned at a disposition hearing. A disposition hearing is the juvenile counterpart to sentencing in an adult trial.

Disposition Report
A report developed by a Juvenile Probation Officer with insights from other involved parties (e.g., behavioral health system representatives) that includes recommendations for placement and ongoing behavioral health services subsequent to the Dispositional Hearing. The Disposition Report is presented to the judge at the Disposition Hearing.

Domestication or Recognition of Tribal Court Order
The process in which the judicial orders and judgments of tribal courts within the state of Arizona, are recognized and have the same effect and are subject to the same procedures, defenses, and proceedings as judgments of any court of record in the state as indicated in A.R.S. 12-136.

Drug used as a Restraint, Sub-Acute Agency
(A.A.C. R9-20-101) A pharmacological restraint as used in A.R.S. § 36-513 that is not standard treatment for a behavioral health recipient's medical condition or behavioral health issue and is administered:

a. To manage a behavioral health recipient's behavior in a way that reduces the safety risk to the person or others; and
b. To temporarily restrict the behavioral health recipient's freedom of movement.

Dual eligible
Refers to a behavioral health recipient who is eligible for both Title XIX and Medicare services. There are two types of dual eligible behavioral health recipients: those eligible for Qualified Medicare Beneficiary (QMB) benefits (QMB dual), and Medicare beneficiaries that are not eligible for QMB benefits (Non-QMB dual).

Early Intervention
Identification of individuals with suspected behavioral health problems for the purpose of addressing the problems before they get worse. It may involve referring individuals for assessment and treatment for example, and routine evaluations done by health care providers.

Edit
A check to ensure that data in a field is valid and complete.

Emergency Behavioral Health Services
Covered inpatient and outpatient services provided after the sudden onset of an emergency behavioral health condition. These services must be furnished by a qualified provider, and must be necessary to evaluate or stabilize the emergency behavioral health condition.

Emergency Safety Situation
(42 CFR 483.352) Unanticipated resident behavior that places the resident or others at serious threat of violence or injury if no intervention occurs and that calls for the use of restraint or seclusion as an immediate response.

Emerging Family Leaders
A diverse cadre of family leaders who have been actively involved in the planning of their own children's care and is interested in making a positive impact in the quality of services and supports delivered to all children and families in their community. These emerging leaders are supported, coached and mentored, and trained by family members who are further in their journey. For diversely identified communities, the term "Emerging Family Spokesperson" may be more appropriate than Emerging Family Leader. Explore the appropriateness of terminology and definition with the individual and the community.

Emotional abuse
A pattern of ridiculing or demeaning a vulnerable adult, making derogatory remarks to a vulnerable adult, verbally harassing a vulnerable adult or threatening to inflict physical or emotional harm on a vulnerable adult.

Empowerment
An intentional, dynamic, ongoing process involving mutual respect, critical reflection, caring and group participation, through which people lacking an equal share of valued resources gain greater access to and control over those resources.

Encounter
A record of a covered service rendered by a provider to a person enrolled with a capitated RBHA on the date of service.

Engagement
The establishment of a trusting relationship, rapport and therapeutic alliance based on personal attributes, including empathy, respect, genuineness and warmth.

Enrolled Person
A Title XIX/XXI or Non-Title XIX/XXI eligible person recorded in the ADHS/DBHS Information System as specified by ADHS/DBHS**.**

Enrollment
The process by which a person is enrolled into the Contractor and ADHS/DBHS data system.

Episode of Care
The period between the beginning of treatment and the ending of behavioral health services for an individual. Within an episode of care, a person may transfer to a different service, facility, program or location. The beginning and end of an episode of care is marked with a demographic file submission. Over time, an individual may have multiple Episodes of Care.

Evidence Based
Programs or practices which have several of the characteristics listed below: replication, sustained effects, published in a peer reviewed journal, a control group study, cost benefit analysis, adequately prepared and trained staff, appropriate supervision, include assessment

and quality assurance processes, consumer and family involvement, cultural, gender, and age appropriateness, and coordination of care.

Evidence Based Practice
Practices, based on research findings and expert or consensus opinion in regard to available evidence, that are expected to produce a specific clinical outcome.

Experimental or investigational therapies
Treatments which are not generally considered standard of care within the psychiatric medical community. In addition, these therapies are not usually considered a covered benefit by the state and federal statute.

Explanation of Benefits
Forms that are sent by payors to both enrollees and providers. Explanation of Benefits (EOBs) provide necessary information about claim payment information and patient responsibility amounts. Patient responsibility amounts are needed for accurate patient balance billing.

Exploitation
The illegal use of a client's resources for another individual's profit or advantage according to A.R.S. Title 46, Chapter 4 or Title 13, Chapter 18, 19, 20, or 21.

Exploitation (of incapacitated or vulnerable adult)
The illegal or improper use of an incapacitated or vulnerable adult or his/her resources for another's profit or advantage.

Family
The primary care-giving unit, inclusive of the wide diversity of primary care-giving units in our culture. Family therefore is a biological, adoptive or self-created unit of people residing together and consisting of adult(s) and children, with adult(s) performing duties of parenthood for the children. Persons within this unit share bonds, culture, practices and significant relationships. Biological parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family.

Family-Driven Care
Family-driven care means families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes choosing culturally and linguistically competent supports, services and providers; setting goals; designing, implementing and evaluation programs; monitoring outcomes; and partnering in funding decisions.

Family-focused Therapy
Involves all members of the family unit and provides psychoeducation about the nature of the mental illness and therapeutic interventions that address the family dynamics and relationships that may be contributing to conflicts within the family.

Family Involvement
Meaningful family involvement occurs when positive outcomes are linked with system characteristics. Successful outcomes are directly linked with strategies that provide families with a cluster of three attributes: access, voice and ownership.

- **Access** occurs when youth and family members are offered valid opportunities for inclusion in the process of deciding what sort of services will be provided and how they will be delivered, In other words, family members have a seat at the table when the real work of planning is taking place.

- **Voice** is present when youth and family members not only have a seat at the planning table but actually have an opportunity to present their perspectives and to be heard during the planning process.
- **Ownership** exists when youth and family members feel a sense of commitment to the course of action which has been developed through the planning process, identify with it, and believe it to be worthwhile.

(From *Access, Voice and Ownership: Examining Service Effectiveness from the Family's Perspective* by Patricia Miles and John Franz http://paperboat.com/images/stories/ArticleArchive/Access%20Voice%20&%20Ownership.pdf)

Family Leaders
A diverse cadre of family members who consistently and effectively are the collective voice of families in shaping community response to children with emotional behavioral, mental health and substance abuse challenges. For diversely identified communities, the term "Family Spokesperson" may be more appropriate than Family Leader. Explore the appropriateness of terminology and definition with the individual and the community.

Family Member
(A.R.S. § 36-501) A spouse, parent, adult child, adult sibling, or other blood relative of a person undergoing treatment, evaluation, or receiving community services.

Family Member Section 5.4
A parent or caregiver who has raised or is currently raising a child with emotional, behavioral or mental health challenges and has experience navigating the children's behavioral health system. This is inclusive of youth and adolescents diagnosed with serious emotional disturbance up to age 22 if the adolescent is being served by an Individual Education Program (IEP) or up to age 26 if the young adult is being served by an Individual Service Plan (ISP) in transition to the adult mental health system.

Family-Professional Partnerships
In this collaborative partnership, professionals and family members are equal partners. " 'Equal partners' does not mean that parents and professionals assume each others' roles, but rather that they respect each others' roles and contributions. While professionals bring technical knowledge and expertise to this relationship, parents offer the most intimate knowledge of their children, and often special skills." (Allen & Petr, 1998)

Family-Run Organizations
A family-run organization is an organization that has a board of directors made up of more than 50% family members, who have primary responsibility for the raising of a child, youth, adolescent or young adult with a serious emotional disturbance up to age 18 or 21 if the adolescent is being served by an Individual Education Plan (IEP) or up to 26 if the young adult is being served by an Individual Service Plan in transition to the adult mental health system.

Fee-for-Service
A fee paid for each service based on actual utilization of services, using payment rates set for units of care provided.

Filed
The date on which the claim dispute is received by the RBHA or ADHS/DBHS.

Flex funds
Funds utilized to purchase any of a variety of one-time or occasional goods and/or services needed for enrolled persons (children or adults) and their families, when the goods and/or

services cannot be purchased by any other funding source, and the service or good is directly related to the enrolled person's service plan.

Fraud
An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the person or some other person. It includes any act that constitutes fraud under applicable Federal or State Law.

Gatekeeper
An individual who has access to a group of people.

General Consent
A voluntary written agreement to receive behavioral health services

Geographic Service Area (GSA)
Is a specific county or defined grouping of counties that are available for contract award. The Contractor is responsible to provide covered services to eligible residents of their contracted GSA (s) except as otherwise stated in the ADHS/RBHA contracts and ADHS/TRBHA IGAs.

Gravely Disabled (GD)
A condition evidenced by behavior in which a person, as a result of a mental disorder, is likely to come to serious physical harm or serious illness because he/she is unable to provide for his/her basic physical needs.

Grievance or Request for Investigation
For purposes of this section means a complaint that is filed by a person with SMI or other concerned person's regarding a violation of the person with SMI's rights or a condition requiring an investigation.

Guardian
An individual or entity appointed to be responsible for the treatment or care of an individual according to A.R.S. Title 14, Chapter 5.

Guilty Except Insane (GEI)
(After 1996) means that at the time of the commission of the criminal act the person was afflicted with a mental disease or defect of such severity that the person did not know the criminal act was wrong. Mental disease or defect does not include disorders that result from acute voluntary intoxication or withdrawal from alcohol or drugs, character defects, psychosexual disorders, or impulse control disorders. (Persons designated GEI are placed under the authority of the Psychiatric Security Review Board (PSRB) for a term of commitment equivalent to their sentence had they been convicted and sent to prison.)

Habilitation Provider
A home and community based service provider certified through the Department of Economic Security/Division of Developmental Disabilities (DES/DDD) and registered with the AHCCCS Administration.

HB 2003 Permanent Housing Programs
The HB 2003 permanent housing program is a legislative appropriation for housing and housing related services. ADHS/DBHS used these funds to purchase homes and apartments through non-profit organizations who serve as contracted housing administrators. Each tenant pays a percentage of his/her adjusted income towards rent and sign and abide by the Arizona Residential Landlord Tenants Act and property lease agreements.

Health Care Decision-Maker
An individual who is authorized to make health care treatment decisions for a person, including the parent of a minor or an individual who is authorized pursuant to A.R.S., Title 14, Chapter 5, Article 2 or 3, or A.R.S. §§ 36-3221, 36-3231

Health Care Power of Attorney
A person who is an adult may designate another adult individual or other adult individuals to make health care decisions on that person's behalf by executing a written health care power of attorney that meets all the following requirements:

- Contains language that clearly indicates that the person intends to create a health care power of attorney;
- Is dated and signed or marked by the person who is the subject of the health care power of attorney [except as provided under A.R.S.§ 36-3221 (B)]; and
- Is notarized or is witnessed in writing by at least one adult who affirms the notary or witness was present when the person dated and signed or marked the health care power of attorney [except as provided under A.R.S.§ 36-3221 (B)] and that the person appeared to be of sound mind and free from duress at the time the of execution of the health care power of attorney.

Health Care Professional
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.

Health Care Provider
Any person or organization that furnishes, bills or is paid for health care.

Health Disparities
According to The Office of Minority Health, is the significant difference between one population and another. The Minority Health and Health Disparities Research and Education Act of 2000, describe these disparities as differences in "the overall rate of disease incidence, prevalence, morbidity, mortality or survival rates".

HIPAA
(Health Insurance Portability and Accountability Act of 1996) (45 C.F.R. §§ 160.103 and 164.501) A federal law that includes a section on administrative simplification requiring standardization of electronic date interchanges and greater protection of confidentiality and security of health data. The HIPAA Rule contains a number of words and phrases that have specific meaning as applied to the HIPAA Rule. Examples of such words and phrases include, but are not limited to, "treatment," "payment," "health care operations," "designated record set" and "protected health information."

HITECH Act
Health Information Technology for Economic and Clinical Health Act (Title XIII, Subsection D of the American Recovery and Reinvestment Act of 2009 (ARRA). Expands the HIPAA Privacy and Security Rules and increases the penalties for HIPAA violations.

HIV-Related Information (A.R.S. § 36-661)
Information concerning whether a person has had an HIV-related test or has HIV infection, HIV related illness or acquired immune deficiency syndrome and includes information which identifies or reasonably permits identification of that person or the person's contacts.

Home Care Training to Home Care Client (HCTC) Provider
Home Care Training to Home Care Client services are delivered by a Department of Economic Security (DES)-licensed professional foster home to a child residing in the professional foster home. HCTC services assist and support a child in achieving his/her behavioral health service plan goals and objectives. HCTC services include supervision and the provision of covered behavioral health support and rehabilitation services, including personal care, psychosocial rehabilitation, skills training and development, behavioral interventions and transportation to behavioral health appointments and services including counseling and to facilitate participation in treatment and discharge planning. The Covered Behavioral Health Services Guide allows for exceptions to billing limitations, if additional supports are needed for the HCTC provider. The clinical rationale for providing these additional services must be specifically documented in the Service Plan and Progress Note.

Home T/RBHA
The T/RBHA with which the person is currently enrolled.

Homeless
As defined in 42 U.S.C. § 11302, the term "homeless" or "homeless individual or homeless person" includes-
1. An individual who lacks a fixed, regular, and adequate nighttime residence; and
2. An individual who has a primary nighttime residence that is –
    A. A supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
    B. An institution that provides a temporary residence for individuals intended to be institutionalized; or
    C. A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

Housing
ADHS/DBHS and T/RBHA funded or partially funded independent housing; Supported Housing (H0043) as defined in the ADHS/DBHS Covered Behavioral Health Services Guide; and/or federally funded or mixed federal/state funded housing.

Housing Administrator
Non-profit organization contracted by the RBHA or a non-profit RBHA that administers housing grants and programs.

Housing Referral
A written authorization from the RBHA for the provision of covered services to an eligible member. The Housing Referral will constitute the agreement of the provider to provide services identified in the tenant's ISP. Housing Referrals will be in such form and format determined by the RBHA.

Office of Human Rights (OHR)
The Office of Human Rights is established within ADHS and is responsible for the hiring, training, supervision, and coordination of human rights advocates. Human rights advocates assist and advocate on behalf of persons determined to have a serious mental illness in resolving appeals and grievances. Advocates coordinate and assist Human Rights Committees in performing their duties.

Human Rights Committees
Human Rights Committees are established by state statute to provide independent oversight

and to ensure the rights of enrolled persons are protected. There is one Human Rights Committee established for each region and the Arizona State Hospital, with each committee providing independent oversight and review within its respective jurisdiction.

Illegal
An incident or occurrence that is or was likely to constitute a violation of a state or federal statute, regulation, court decision or other law.

Immediate Response
An expedited and instant response to a person who may be in need of medically necessary covered behavioral health services. An immediate response should be initiated without delay, within a timeframe indicated by the person's clinical needs, but no later than two hours from the initial identification of need.

In-network services
Services provided by Tribal and Regional Behavioral Health Authority (T/RBHA) contracted providers.

Incapacitated Person
Any person who is impaired by reason of a mental illness, mental deficiency, mental disorder, physical illness or disability, chronic use of drugs, chronic intoxication, or other cause, except minority, to the extent that he lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person.

Incident or Accident
Include the following:

a) Deaths;
b) Medication error(s) requiring medical services;
c) Adverse reaction to medications requiring medical services;
d) Suicide attempt requiring medical services;
e) Self-inflicted injury requiring medical services;
f) Suspected or alleged abuse;
g) Suspected or alleged neglect;
h) Suspected or alleged exploitation of client;
i) Physical injury occurring on premises or during a licensee-sponsored activity requiring medical services;
j) Food poisoning requiring medical services;
k) Unauthorized absence from a residential agency, inpatient treatment program, Level IV transitional agency providing services to clients under the age of 18, or an adult in a therapeutic foster home;
l) Physical injury that occurs as the result of a personal or mechanical restraint;
m) Suspected or alleged criminal activity that occurs on the premises or during a licensee-sponsored activity off the premises;
n) Incidents or allegations of violations of the rights contained in A.A.C. R9-20-203 for all enrolled persons or in 9 A.A.C. 21, Article 2 for persons determined to have a Serious Mental Illness; and
o) Discovery that a client, staff member, or employee has a communicable disease listed in A.A.C. R9-6-202 (A) or (B)

Independent Community Housing
A setting where a person can live either alone or with a roommate in a home or apartment without on-going daily supervision from behavioral health providers. Options include: HUD Section 8 programs through local Public Housing Authorities; Low-income subsidized housing through local non-profit organizations; Shelter Plus Care and Supportive Housing Programs funded with federal grants and administered by RBHA contracted housing providers; State

subsidized rental units; and Permanent Houses and apartments purchased with HB 2003 funding.

Independent Licensed Practitioners
Behavioral health professionals who are Physicians (MD and DO), Licensed Psychologists, Nurse Practitioners, or Physician Assistants and the following behavioral health professionals who are licensed by the Arizona Board of Behavioral Health Examiners and authorized to practice without direct supervision: Licensed Clinical Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, and Licensed Independent Substance Abuse Counselors.

Independent Living Setting
A setting in which a person lives without supervision or in-home services provided by a T/RBHA or subcontracted provider agency.

Individual
Any person currently or previously enrolled in a T/RBHA.

Individually Identifiable Health Information
(45 C.F.R. § 160.103) Information, including demographic data, that relates to the individual's past, present or future physical or mental health or condition, the provision of health care to the individual, or the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual.

Infant and Early Childhood Mental Health
The ability of children from birth to age five to grow, develop and learn in a way that enhances their psychological, physical, social and emotional health both as an individual and in relationship to their caregivers, environment and culture with respect for each child's uniqueness.

Informed Consent
A Voluntary agreement, oral or written, except when explicitly required to be written, following presentation of all facts necessary to form the basis of an intelligent consent by the person or guardian prior to the provision of specified behavioral health services.

Inhumane
An incident, condition or occurrence that is demeaning to a person with Serious Mental Illness or which is inconsistent with the proper regard for the right of the person to humane treatment.

Inpatient Services
A behavioral health service provided in a psychiatric acute hospital (including a psychiatric unit in a general hospital), a residential treatment center for persons under the age of 21, or a sub-acute facility.

Inpatient treatment and discharge plan or "ITDP"
Is the written plan for services to a client prepared and implemented by an inpatient facility in accordance with the R9-21-101, *et seq.*

Institution for Mental Disease (IMD)
A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. An institution is an IMD if its overall character is that of a facility established and maintained primarily for the

care and treatment of individuals with mental diseases.

Institutionalized individual
An institutionalized individual means a full-benefit dual eligible individual who is an inpatient in a medical institution or nursing facility for which payment is made under Medicaid throughout a month, as defined under section 1902(q)(1)(B) of the Act.

Intake
The collection by appropriately trained T/RBHA/provider staff of basic demographic information about a person in order to enroll him/her in the ADHS/DBHS system, to screen for Title XIX/XXI AHCCCS eligibility and to determine the need for any copayments

Intake / Enrollment
The collection by appropriately trained T/RBHA/provider staff of basic information about a Non-Title XIX/XXI eligible person in order to enroll him/her in the ADHS/DBHS system, to screen for Title XIX/XXI AHCCCS eligibility and to determine the need for any copayments.

Inter-class Polypharmacy
Defined as more than three medications prescribed at the same time from different classes of medications for the overall treatment of behavioral health disorders. The medical record must contain documentation specifically describing the rationale and justification for the combined use.

Interim and Ongoing Individual Service Plans
A written description of the behavioral health services and other informal supports that have been identified through the assessment and treatment planning process that address immediate needs and assist the person to meet his/her specified goals.

Interpretation
The transfer of oral speech from a source language into a target language while maintaining the speaker's intent.

Interventions
A service, practice, treatment or variable that can create change.

Intra-class Polypharmacy
Defined as more than two medications prescribed at the same time within the same class, other than for cross-tapering purposes. The person's medical record must contain documentation specifically describing the rationale and justification for the combined use.

Lawful Presence
The designation given to a non-U.S. citizen who is living in the United States with permission as granted by the Department of Homeland Security, U.S. Citizenship and Immigration Service (USCIS), or at the approval of the Attorney General of the United States

Letter of Authorization (LOA)
A correspondence from the T/RBHA to AzSH approving continued stay in AzSH.

Level I Inpatient Treatment Program
A program licensed per 9 A.A.C. 20 and includes a psychiatric acute hospital (including a psychiatric unit in a general hospital), a residential treatment center for persons under the age of 21, or a sub-acute facility.

Level II Facility
A facility licensed per 9 A.A.C. 20.

Level III Residential Setting
These facilities provide continuous 24-hour supervision and intermittent treatment in a group residential setting to persons who are determined to be capable of independent functioning but still need some protective oversight to insure they receive needed services.

Limited Authorization
A service authorization that falls short of the original request, with respect to either the duration, frequency, or type of service requested.

Limited English Proficiency (LEP)
Persons who have difficulty speaking, reading, writing or understanding the English language due to many reasons such as:

- Were not born in the United States or whose native language is a language other than English; or
- Come from environments where a language other than English is dominant; or
- Come from environments where a language other than English has had a significant impact on their level of English language proficiency.

Linguistic Competence
The capacity of an organization and its personnel to effectively communicate in a manner that is easily understood by diverse audiences including persons of Limited English Proficiency, those who are illiterate or have low literacy skills, and individuals with disabilities. This may include, but is not limited to, bilingual/bicultural staff and other organizational capacity such as telecommunication systems, sign or foreign language interpretation services, alternative formats, and translation of legally binding documents (e.g. consent forms, confidentiality and recipient rights statements, release of information, member handbooks and health education materials).

Mechanical Restraint
(42 CFR 482.13(1)(i)) A physical or mechanical device, material, or equipment attached or adjacent to a behavioral health recipient's body that the person cannot easily remove that restricts the freedom of movement or normal access to one's body, but does not include a device, material or equipment:
a. Used for surgical or orthopedic l reasons; or
b. Necessary to allow a person to heal from a medical condition or to participate in a treatment program for a medical condition.

Mechanical Restraint, Sub-Acute Agency
(A.A.C. R9 20-101) Any device, article, or garment attached or adjacent to a behavioral health recipient's body that the person cannot easily remove and that restricts the behavioral health recipient's freedom of movement or normal access to the behavioral health recipient's body but does not include a device, article, or garment:
a. Used for surgical or orthopedic purposes, or
b. Necessary to allow a behavioral health recipient to heal from a medical condition or to participate in a treatment program for a medical condition.

Medical Behavioral Health Practitioner
An individual licensed and authorized by law to use and prescribe medication and

devices, as defined in A.R.S. § 32-1901, and who is one of the following with at least one year of full-time behavioral health work experience: a. A physician; b. A physician assistant; or c. A nurse practitioner.

Medical Institution
Acute care hospital, psychiatric hospital (non-Institution for Mental Disease), Residential Treatment Center (non-IMD), Intermediate Care Facility for People with Mental Retardation (ICF/MR), psychiatric hospital – IMD, Residential Treatment Center – IMD or Skilled Nursing Facility (SNF).

Medical Records
(A.R.S. § 12-2291) All communications related to a patient's physical or mental health or condition that are recorded in any form or medium and that are maintained for purposes of evaluation or treatment, including records that are prepared by a health care provider or by other providers. Medical records do not include materials that are prepared in connection with utilization review, peer review or quality assurance activities.

Medically Necessary Covered Services
Behavioral health 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 that are aimed at achieving the following:
• The prevention, diagnosis, and treatment of behavioral health impairments;
• The ability to achieve age-appropriate growth and development; and
• The ability to attain, maintain, or regain functional capacity.

Medicare Advantage Prescription Drug Plan (MA-PD)
A Medicare Advantage plan that provides qualified prescription drug coverage.

Medication Error
Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.

Member Information Materials
Any materials given to a behavioral health recipient. This includes, but is not limited to; member handbooks, member newsletters, surveys, and health related brochures and videos. It also includes templates of form letters and Web site content as well.

Mental Disorder
A substantial disorder of the person's emotional processes, thought, cognition or memory. Mental disorder is distinguished from:
(a) Conditions that are primarily those of drug abuse, alcoholism or mental retardation, unless, in addition to one or more of these conditions, the person has a mental disorder;

(b) The declining mental abilities that directly accompany impending death; and

(c) Character and personality disorders characterized by lifelong and deeply ingrained antisocial behavior patterns, including sexual behaviors that are abnormal and prohibited by statute unless the behavior results from a mental disorder.

Mental Health Agency

"Mental health agency" includes a regional authority, service provider, inpatient facility, or an agency licensed to conduct screening, evaluation and treatment under this Chapter.

Mental Health Care Power of Attorney
A designated agent who may make decisions about mental health treatment on behalf of a person if the person is found incapable. These decisions shall be consistent with any wishes the person has expressed in the mental health care directive, mental health care power of attorney, health care power of attorney or other advance directive.

Mental Health Provider
Any physician or provider of mental health or behavioral health services involved in evaluating, caring for, treating or rehabilitating a patient.

Mental Retardation (MR) [1]
For purposes of this policy, and as defined by the American Association on Mental Retardation. Mental retardation is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. Per Federal guidelines, the impairment must be manifested before age 22. The impairment must be likely to continue indefinitely and result in substantial functional impairments in major life activities.

[1] Please note that the American Association on Mental Retardation is currently the American Association on Intellectual and Developmental Disabilities (AAIDD) and Mental Retardation is currently referred to as "Intellectual disability". This policy reflects terminology in accordance with the 42 C.F.R. 483.103(3)(i).

Mistreatment
An intentional, reckless or negligent action or omission that exposes a behavioral health recipient to a serious risk of physical or emotional harm. Mistreatment includes but is not limited to:

- Abuse, neglect or exploitation;
- Corporal punishment;
- Any unreasonable use or degree of force or threat of force not necessary to protect the person or another person from bodily harm;
- Infliction of mental or verbal abuse, such as screaming, ridicule, or name calling;
- Incitement or encouragement of others to mistreat a behavioral health recipient;
- Transfer or the threat of transfer of a behavioral health recipient for punitive reasons;
- Restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- Use of medication as punishment;
- Any act in retaliation against a behavioral health recipient for reporting an incident of mistreatment; and
- Commercial exploitation including but not limited to requiring work with no pay, use of photographs for commercial purposes without consent, spending funds belonging to enrolled persons without consent.

Natural Support
Refers collectively to support commonly identified as:

- "Informal Support " (support provided by those individuals who know or are related to the individual/family, but do not provide a paid service, such as a grandparent or neighbor who is connected to the individual/family) and
- "Community Support" (those supports that are part of the individuals/family's community, such as faith community, neighborhood or community organizations).

Neglect
With respect to an adult, “neglect” is a pattern of conduct without the person’s informed consent resulting in deprivation of food, water, medication, medical services, shelter, cooling, heating or other services necessary to maintain minimum physical or behavioral health. With respect to a child/minor, “neglect” is the inability or unwillingness of a parent, guardian or custodian of a child to provide that child with supervision, food, clothing, shelter or medical care if that inability or unwillingness causes substantial risk of harm to the child’s health or welfare, except if the inability of a parent or guardian to provide services to meet the needs of a child with a disability or chronic illness is solely the result of the unavailability of reasonable services.

Neglect
With respect to an adult, “neglect” is a pattern of conduct without the person’s informed consent resulting in deprivation of food, water, medication, medical services, shelter, cooling, heating or other services necessary to maintain minimum physical or mental health. With respect to a child, “neglect” is the inability or unwillingness of a parent, guardian or custodian of a child to provide that child with supervision, food, clothing, shelter or medical care if that inability or unwillingness causes substantial risk of harm to the child’s health or welfare.

Non-QMB dual
A person who is eligible for Title XIX services and has Medicare coverage, but who is not eligible for QMB benefits.

Not Guilty by Reason of Insanity (NGRI) (prior to 1996)
Means that at the time of commission of the criminal act the person was afflicted with a mental disease or defect of such severity that the person did not know the criminal act was wrong and is therefore not responsible for his criminal conduct. (Persons designated as NGRI remain under the authority of the original Court of commitment indefinitely.)

Notice of Privacy Practices (NPP)
A notice that describes how the behavioral health recipient’s medical information may be used and disclosed and how they can get access to this information as required under federal HIPAA regulations.

Nursing Facility (NF)
Is a health care facility that is licensed and Medicare/Medicaid certified by ADHS in accordance with 42 CFR 483 to provide inpatient room, board and nursing services to members who require these services on a continuous basis but who do not require hospital care or direct daily care from a physician.

Older adult
A person who is age 55 or older.

Opiate Dependency
A cluster of cognitive, behavioral, and physiological symptoms related to opiate usage. There is a pattern of repeated self-administration than can result in tolerance, withdrawal, and compulsive drug-taking behavior. (DSM-IV-TR)

Opiate Withdrawal
1. Spontaneous Withdrawal: A physiological/psychological state resulting from a cessation of an opiate drug or a reduction in dosage ; and

2. Precipitated Withdrawal: A physiological/psychological state resulting from administration of an opioid antagonist.

Outcome
The immediate desired change in attitudes, values, behaviors, or conditions. Stated in the following format: "By a specified date, there will be a change (increase or decrease) in the target behavior, among the target population."

Outcome Measures
Information that allows measurement of behavioral health outcomes for Adults and Children. At a minimum, outcome measures for adults and children include the following:

- For all clients, a complete Demographic Data Set must be completed and submitted at the start of the episode of care, upon any major change is status, at least once every 365 days, and at the end of the episode of care.
- For children, the CASII field must also be submitted at least every 6 months.

Outreach
Activities designed to inform persons in a culturally and linguistically appropriate manner of behavioral health services availability and engage or refer those persons in need of services.

Out-of-Area Service
The provision of a behavioral health service to a person in a geographic area other than that of the person's home T/RBHA. Out-of-area service provision includes services provided to a person who is discharged from an inpatient or residential setting to a different T/RBHA's area, but who does not live in an independent living setting.

Out of network services
Services provided by providers that are not contracted with a Tribal or Regional Behavioral Health Authority (T/RBHA).

PASRR
Pre-Admission Screening and Resident Review.

Parent-Delivered Support or Service
Emotional and informational support provided by a parent or caregiver who has similar personal life expertise and has navigated two child serving systems.

Patient
Any person undergoing examination, evaluation or behavioral health treatment.

Payment Records
All communications related to payment for a patient's health care that contain individually identifiable information

Peace officers
Sheriffs of counties, constables, marshals and/or policemen of cities and towns

Peer (QM 2.6)
For purposes of this policy; a health care professional/provider from the same discipline or with similar or essentially equal qualifications.

Peer-Delivered Services
Peer-delivered services reflect a continuum of programs and supports provided by individuals who identify themselves as having behavioral health challenges and are receiving or have received behavioral health care. Peer services can include programs that are peer-operated (planned, delivered and administered by people with lived experience), peer partnerships

(shared governance between peer and non-peer organizations or staff) and peer employees – the unique discipline of providing peer services as a member of the target population.

Peer/Recovery Support
Social and emotional support, generally coupled with specific, skill-based training, coaching or assistance, that is provided to bring about a targeted social or personal change at the symptom, individual, family or community level. Targets for peer support services can include a variety of individualized and personal goals, including living preferences, employment or educational goals and development of social networks and interests.

Peer Review:
The evaluation of the necessity, quality or utilization of care/service provided by a health care professional/provider. Peer review is conducted by other health care professionals/providers from the same discipline or with similar or essentially equal qualifications who are not in direct economic competition with the health care professional under review. The process compares the health care professional/provider's performance with that of peers or with community standards of care/service.

Peer Review
An in-depth review specifically intended to investigate the clinical soundness of treatment provided for an individual consumer by a clinician (e.g. medical doctor, nurse practitioner, physician assistant), typically conducted through a committee structure inclusive of same-specialty peers. The peer review process is confidential and is not disclosed as public record or produced in response to a subpoena or other legal order unless otherwise required by law.

Peer Reviewed Literature
Scientific studies critically assessed by scholars in the author's field or specialty and deemed eligible for publication. The review process is used to ensure studies are sound and findings are valid.

Peer Worker
Peer Worker refers to an individual who is, or has been, a recipient of behavioral services and who currently provides behavioral health services to individuals enrolled in the public behavioral health system. The peer worker may be either an employee or volunteer/unpaid. Services that may be provided by a peer worker vary depending on the peer worker's education and experience. For example, a peer worker who is also behavioral health professional can provide all of the treatment and support services that the agency is able to provide under the agency's OBHL license or the agency's ADHS/DBHS Community Services Agencies Title XIX certification. Peer Workers may have job titles such as Peer Support Specialists, Recovery Guides, Recovery Specialists, etc.

Pending Admission List
A list of individuals who have been appointed for admission by the Chief Medical Officer, but not yet admitted to the AzSH.

Permanent housing
Community-based housing available to low-income individuals with disabilities and provides long-term housing and supportive services for not more than: 8 such persons in a single structure or contiguous structures; 16 such persons, but only if not more than 20 percent of the units in a structure are designated for such persons; or more than 16 persons if the applicant demonstrates that local market conditions dictate the development of a large project and such development will achieve the neighborhood integration objectives of the program within the context of the affected community.

Persistently or Acutely Disabled (PAD)
Means a severe mental disorder that meets all of the following criteria:

1. If not treated has a substantial probability of causing the person to suffer or continue to suffer severe and abnormal mental, emotional, or physical harm that significantly impairs judgment, reason, behavior, or capacity to recognize reality.
2. Substantially impairs the person's capacity to make an informed decision regarding treatment and this impairment causes the person to be incapable of understanding and expressing an understanding of the advantages and disadvantages of accepting treatment and understanding and expressing an understanding of the alternatives to the particular treatment offered after the advantages, disadvantages, and alternatives are explained to that person.
3. Has a reasonable prospect of being treatable by outpatient, inpatient, or combined inpatient and outpatient treatment.

Person Centered Planning
Person-centered planning is a process-oriented approach to empowering people with disability labels. It focuses on the people and their needs by putting them in charge of defining the direction for their lives, not on the systems that may or may not be available to serve them. This ultimately leads to greater inclusion as valued members of both community and society

Personal Restraint
The application of physical force without the use of any device, for the purpose of restricting the free movement of a behavioral health recipient's body, but for a behavioral health agency licensed as an OBHL Level I RTC or a Level I subacute facility, does not include:

- Holding a person for no longer than five minutes, without undue force, in order to calm or comfort the person; or
- Holding a person's hand to escort the person from one area to another.

Personal Restraint- Level I Psychiatric Acute Hospital Programs
((42 CFR 482.13(1)(ii)) The application of physical force without the use of any device, for the purpose of restricting the free movement of a behavioral health recipient's body. Personal restraint does not include the temporary touching or holding of the hand, wrist, arm, shoulder or back for the purpose of inducing a resident to walk to a safe location.

Personal Restraint- Residential Treatment Centers Providing Services to Persons under the Age of 21
(42 CFR 483.352) The application of physical force without the use of any device, for the purpose of restricting the free movement of a behavioral health recipient's body. Personal restraint does not include briefly holding without undue force a resident in order to calm or comfort him or her, or holding a resident's hand to safely escort a resident from one area to another.

Personal Restraint, Sub-Acute Agency
(A.A.C. R9 20-101) The application of physical force without the use of any device, for the purpose of restricting the free movement of a behavioral health recipient's body, but:
a. For a Level 1 RTC or a Level 1 sub acute agency, does not include:
i. Holding a behavioral health recipient for no longer than five minutes, without undue force, in order to calm or comfort the behavioral health recipient, or
ii. Holding a behavioral health recipient's hand to safely escort the behavioral health recipient from one area to another; and
b. For a correctional facility, does not include physically holding a person by a security officer for purposes not related to a behavioral health recipient's behavioral health issue.

Physical injury
The impairment or physical condition that includes any skin bruising, pressure sores, bleeding, failure to thrive, malnutrition, dehydration, burns, fracture of any bone, subdural hematoma, soft tissue swelling, injury to any internal organ or any physical condition that imperils health or welfare.

Post Stabilization Services
Medically necessary services, related to an emergency medical condition, provided after the person's condition is sufficiently stabilized in order to maintain, improve or resolve the person's condition so that the person could alternatively be safely discharged or transferred to another location.

Pre-petition Screening
The review of each application requesting court-ordered evaluation, including an investigation of facts alleged in such application, an interview with each applicant and an interview, if possible, with the proposed patient. The purpose of the interview with the proposed patient is to assess the problem, explain the application and, when indicated, attempt to persuade the proposed patient to receive, on a voluntary basis, evaluation or other services.

Preliminary Protective Hearing (PPH)
A Hearing held within 5-7 days of when a dependency petition is filed. At the PPH, the court will make orders about the child's placement, visitation and tasks and services to be provided.

Preponderance of Evidence
A standard of proof that it is more likely than not that an alleged event occurred.

Prescriber
For the purposes of this section, a prescriber is a behavioral health medical practitioner licensed to prescribe medications and includes a. A physician; b. A physician assistant; or c. A nurse practitioner.

Prescription Drug Plan (PDP)
Prescription drug coverage that is offered under a policy, contract, or plan that has been approved as specified in 42 CFR 423.272 and that is offered by a Prescription Drug Plan (PDP) sponsor that has a contract with CMS that meets the contract requirements under 42 CFR 423.505. This includes fallback prescription drug plans.

Prevention
The creation of conditions, opportunities, and experiences that encourage and develop healthy, self sufficient children and that occur before the onset of problems (Arizona Revised Statutes). Prevention is an active process that creates and rewards conditions that lead to healthy behaviors and life styles (Center for Substance Abuse Prevention, (CSAP)).

Prevention Activity
Any activity provided in accordance with ADHS/DBHS Framework for Prevention in Behavioral Health.

Primary Source Verification
Verification is a direct contact with the sources of credentials. For example, this may include residency programs, licensing agencies, and specialty boards to guarantee that statements about training, experience and other qualifications are legitimate, unchallenged and appropriate.

Prior Authorization

The process by which ADHS/DBHS, a RBHA or subcontracted provider authorizes, in advance, the delivery of covered services contingent upon the medical necessity of the services.

Prior Period Coverage

AHCCCS provides prior period coverage for the period of time prior to the Title XIX member's enrollment during which the member is eligible for covered services. The time frame is from the effective date of eligibility (or 10/1 if the effective date of eligibility is prior to 10/1) to the day the member is enrolled with an acute health plan. ADHS receives notification from the Administration of the member's enrollment. ADHS is responsible for payment of all claims for medically necessary behavioral health services, provided to members during prior period coverage.

Privileging

Is the process used to determine if credentialed clinicians are competent to perform their assigned responsibilities, based on training, supervised practice and/or competency testing.

Privileging

The process by which a health organization reviews training, clinical competency and the scope of practice of its health providers.

Program Director

The Community Service Agency staff person who is directly responsible for the program, direct service staff or contractor and services provided by the CSA.

Protected Health Information

(45 C.F.R. § 160.103) The Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper or oral.

Protective factor

An attribute, situation, condition, or environmental context that develops resiliency in individuals and prevents the likelihood of Alcohol Tobacco and Other Drug (ATOD) use.

Provider

A person or entity that contracts with a T/RBHA to provide covered services directly to members.

Provider Appeal

A formal written disagreement with a decision made by a T/RBHA or ADHS/DBHS

Prudent Layperson

A person without medical training who exercises those qualities of attention, knowledge, intelligence and judgment which society requires of its members for the protection of their own interest and the interests of others.

Public Housing Authority (PHA)

HUD funded unit of local government that provides independent housing for low-income individuals and families. Program includes Section 8 Housing Choice Vouchers and low rent units.

Psychiatric Acute Hospital

A hospital that provides inpatient services licensed per 9 A.A.C. 20 and includes a general hospital with a psychiatric unit and a specialty psychiatric hospital (including the Arizona State Hospital).

QMB dual
A person who is eligible for QMB benefits as well as Title XIX services. QMB duals are entitled to Title XIX services and Medicare Part A and Part B services.

Qualified Clinician
Means a behavioral health professional who is licensed or certified under A.R.S. Title 32, or a behavioral health technician who is supervised by a licensed or certified behavioral health professional.

Qualified Interpreter/Translator
A T/RBHA or provider employee who has received a spoken and/or written language evaluation from a language testing agency recommended by ADHS/DBHS. If a language evaluation is not available for a particular tribal language, the evaluation must be conducted by the TRBHA using a process approved by ADHS/DBHS. Sign language interpreters must be licensed according to A.R.S. § 36-1946 and A.A.C. R9 Chapter 26, Article 5. T/RBHAs are responsible for determining what level of written or oral language competency is required to perform clinical or administrative functions. Sign language, oral interpretation and translation services must be provided by a T/RBHA or provider employee who is proficient and skilled in translating and interpreting language(s).

Qualified Service Organization
(42 CFR Part 2) A person or organization that provides services to a program, such as data processing, bill collecting, dosage preparation, laboratory analyses, or legal, medical, accounting, or other professional services, or services to prevent or treat child abuse or neglect, including training on nutrition and child care and individual and group therapy. The person or organization has entered into a written agreement with a program providing drug or alcohol referral, diagnosis or treatment under which the person or organization acknowledges that in receiving, storing, processing or otherwise dealing with any records concerning enrolled persons, it is fully bound by these regulations and, if necessary, will resist in judicial proceedings any efforts to obtain access to records of enrolled persons except as permitted by these regulations.

Quality of Care Concern (QOC)
An allegation that any aspect of care, or treatment, or utilization of behavioral health services caused or could have caused an acute medical/psychiatric condition or an exacerbation of a chronic medical/psychiatric condition and may ultimately cause the risk of harm to the behavioral health recipient.

Recertification of Need (RON)
A certification by a physician, physician assistant or nurse practitioner that inpatient services continue to be needed for a person.

Recertification of Need (RON) (42 CFR 441.152, 456.30, 456.160) QM 2.9/QM 3.0
A RON is a re-certification made by a physician, nurse practitioner or physician assistant that inpatient services are still needed for a person. A RON must be completed at least every 60 days for a person who is receiving services in a Level I 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) and RON for persons under the age of 21 in a Level I facility must be completed and reviewed every 30 days.

Recovery
Recovery is a deeply personal process and no single, universally accepted definition of recovery currently exists. In the simplest sense, recovery is a *lived experience* of moving through and beyond the limits of one's disorder. In the process, individuals develop a positive and meaningful sense of identity separate from their condition, disability or its consequences in their life.1 Key characteristics of recovery include:

- Recovery is personal and individualized (not defined by a treatment agency)
- Recovery moves beyond symptom reduction and relief (e.g. meaningful connections in the community, overcoming specific skill deficits, establishing a sense of quality and well-being)
- Recovery is both a process of healing (regaining) and a process of discovery (moving beyond)
- Recovery encompasses the possibility for individuals to test, make mistakes and try again.

Recovery can occur within or outside the context of professionally directed treatment, and where professional treatment is involved, it may, depending on its orientation and methods, play a facilitative, insignificant or inhibiting role in the recovery process.2 A small yet exciting body of research suggests that peer-delivered services produce outcomes superior to professional treatment alone in several key domains, including increased social networks, lower levels of worry and improved satisfaction with life.

Recovery Goal
Describes where the person wants to be and how they will know when a service is no longer needed. Provides a vision of how the person would like their life, family and environment.

Reduction of Service
Reduction of service occurs when a decision is made to reduce the frequency or duration of an ongoing service. A reduction of service does not include a planned change in service frequency or duration that is initially identified in the person's service plan and agreed to in writing by the person receiving services or his/her legal guardian.

Re-engagement
Required activities by providers designed to encourage the consumer to remain enrolled and continue receiving services

Referral for Behavioral Health Services
Any oral, written, faxed, or electronic request for behavioral health services made by any person, or person's legal guardian, family member, an AHCCCS health plan, primary care provider, hospital, jail, court, probation and parole officer, tribal government, Indian Health Services, school, or other governmental or community agency.

Region
Geographical region designated by ADHS in its contract with the Regional Behavioral Health Authority.

Regional Behavioral Health Authority (RBHA)
An organization under contract with ADHS that administers covered behavioral health services in a geographically specific area of the state.

Regulatory Agency
A governmental organization that ensures laws and regulations in a particular industry are enforced (e.g., Child Protective Services, Adult Protective Services, Attorney General's Office, Medical Board, Board of Nursing, Board of Behavioral Health Examiners, Office of Behavioral

Health Licensing, AHCCCS).

Remittance Advice
An electronic or paper document submitted to a provider to explain the disposition of a claim.

Residence
For purposes of this policy means living in a particular locality, in this case the State of Arizona, on permanent basis.

Resident Review
Evaluation of a vulnerable individual who may currently be placed in a nursing facility or may be in need of nursing facility placement, to ensure appropriateness of nursing facility placement and provision of adequate behavioral health services.

Residential Services
Behavioral health services provided in a facility licensed pursuant to Arizona Administrative Code, Title 9, Chapter 20, as a level II or level III facility.

Residential Treatment Center (RTC)
A facility that provides Level I services licensed per 9 A.A.C. 20 to provide services to persons under the age of 21.

Resilience
The personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, and other stresses and to go on with life with a sense of mastery, competence, and hope (New Freedom Commission on Mental Health, 2003).

Restraint
Means personal restraint, mechanical restraint or drug used as a restraint and is the following in accordance with 42 CFR 482.13(e)(1):
(A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a behavioral health recipient to move his or her arms, legs, body, or head freely; or
(B) A drug or medication when it is used as a restriction to manage the behavioral health recipient's behavior or restrict the behavioral health recipient's freedom of movement and is not a standard treatment or dosage for the behavioral health recipient's condition.
(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a behavioral health recipient for the purpose of conducting routine physical examinations or tests, or to protect the behavioral health recipient from falling out of bed, or to permit the behavioral health recipient to participate in activities without the risk of physical harm (this does not include a physical escort).

Retro-eligibility Claim
A claim where no eligibility was entered in the AHCCCSA system for the date(s) of service but at a later date, eligibility was posted retroactively to cover the date(s) of service.

Risk factors
Conditions that increase the risk of a particular problem from developing.

Routine Response
A response that is within timeframes indicated by the person's clinical needs, but does not require an immediate or urgent response.

Sanction
The portion of a capitation or allocation funding payment that is held back (permanent) from the RBHA by ADHS/DBHS because the RBHA failed to submit a sufficient amount (see Table 2) of CIS "clean" encounters. This should be recorded by the RBHA as an administrative expense.

Schizophrenic Spectrum Disorder
For the purpose of PM Section 3.16, Medication Formularies, Schizophrenic Spectrum Disorder includes Schizophreniform Disorder, Schizophrenia, and Schizoaffective Disorder in addition to the subtypes of Schizophrenia. DSM-IV-TR Cluster A personality disorders and other psychotic disorders are excluded from this definition.

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

Seclusion – Individuals Determined to have a Serious Mental Illness
The restriction of a behavioral health recipient to a room or area through the use of locked doors or any other device or method which precludes a person from freely exiting the room or area or which a person reasonably believes precludes his/her unrestricted exit. In the case of an inpatient facility, confining a behavioral health recipient to the facility, the grounds of the facility, or a ward of the facility does not constitute seclusion. In the case of a community residence, restricting a behavioral health recipient to the residential site, according to specific provisions of an individual service plan or court order, does not constitute seclusion.

Seclusion- Level I Programs
(42 CFR 482.13(1)(ii)) The involuntary confinement of a person in a room or an area where the person is physically prevented from leaving.

Seclusion, Sub-Acute Agency
(A.A.C. R9-21-101) The involuntary confinement of a behavioral health recipient in a room or an area from which the behavioral health recipient cannot leave, but does not include the confinement of a behavioral health recipient in a correctional facility.

Section 8
Section 8 is the more common name for the Housing Choice Voucher Program which is sponsored by the Department of Housing and Urban Development (HUD). Qualified applicants receive vouchers which are used to subsidize the cost of housing. These vouchers are awarded to individuals who meet certain income and earned income requirements. The goal of these programs is to provide affordable low cost housing to low income occupants.

Serious Emotional Disturbance (SED)
1. Children from birth up to age 18;
2. Child currently or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified in the Diagnostic and Statistical Manual, Fourth Edition, Text Revision (**DSM-IV-TR**). Qualifying SED diagnoses are listed as ICD-9 codes in ADHS/DBHS Provider Manual Attachment 7.5.3, SMI and SED Qualifying Diagnoses Table; and
3. The mental, behavioral or emotional disorder has resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities. Such roles or functioning include achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills.

Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment.

Serious Injury
Any significant impairment of the physical condition of the person as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma and injuries to internal organs, whether self-inflicted or inflicted by someone else.

Serious Mental Illness (SMI)
A condition of persons who are eighteen years of age or older and who, as a result of a mental disorder as defined in A.R.S. 36-501, exhibit emotional or behavioral functioning which is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long -term or indefinite duration. In these persons mental disability is severe and persistent, resulting in a long-term limitation of their functional capacities for primary activities of daily living such as interpersonal relationships, homemaking, self-care, employment and recreation.

Serious Mental Illness MI 5.3
For purposes of this policy, an individual is considered to have a serious mental illness if the individual meets the requirement for a serious mental illness diagnosis, which is identified by using Provider Manual Attachment 3.10.1, Serious Mental Illness (SMI) Qualifying Diagnosis to establish a qualifying diagnosis for this program. This is not the same as the "Serious Mental Illness Determination" process according to the Department of Health Services, Behavioral Health Services for Persons with Serious Mental Illness (A.A.C. R9-21) Rules. For a person to be covered under the PASRR program, a "Serious Mental Illness Determination" is not required.

Serious Occurrence
(A.A.C. R9-20-601 and R9-20-202) Any of the following that occurred on the premises or during a licensee sponsored activity off the premises that required medical services or immediate intervention by an emergency response team or a medical practitioner:
a. A serious injury, or any significant impairment of the physical condition of the behavioral health recipient as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else;
b. A medication error or an adverse reaction to a medication;
c. Suspected or alleged abuse, neglect, or exploitation of the behavioral health recipient or a violation of the behavioral health recipient's rights under R9-20-203(B) or (C);
d. Food poisoning possibly resulting from food provided at the agency or during a licensee-sponsored activity off the premises;
e. An unauthorized absence from a residential agency or an inpatient treatment program;
f. A physical injury that occurred as the result of a personal or mechanical restraint;
g. A behavioral health recipient's death; or
h. A behavioral health recipient's suicide attempt.

Serious Occurrence Section 7.4
A behavioral health recipient's death, a serious injury to a behavioral health recipient or a suicide attempt by a behavioral health recipient.

Serious physical injury
Physical injury that creates a reasonable risk of death or that causes serious or permanent disfigurement, serious impairment of health or loss or protracted impairment of the function of any bodily organ or limb.

Service Authorization Request
A behavioral health recipient's request, through a behavioral health provider, for the provision of a covered service that requires prior authorization

Service Plan
A written description of the covered behavioral health services and other informal supports that have been identified through the assessment process that will assist the person to meet his/her specified goals.

Sexual Abuse
Sexual misconduct caused by acts or omissions of an employee or contracted staff of the Arizona State Hospital or the T/RBHA or subcontracted provider. Sexual abuse includes molestation, sexual assault, incest, or prostitution of, or with, a person receiving services.

Shelter Plus Care
The Shelter Plus Care program (S+C) is authorized by title IV, subtitle F, of the Stewart B. McKinney Homeless Assistance Act (the McKinney Act) (42 U.S.C. 11403– 11407b). S+C is designed to link rental assistance to supportive services for hard-to-serve homeless persons with disabilities (primarily those who are seriously mentally ill; have chronic problems with alcohol, drugs, or both; or have acquired immunodeficiency syndrome (AIDS) and related diseases) and their families. The program provides grants to be used for rental assistance for permanent housing for homeless persons with disabilities. Rental assistance grants must be matched in the aggregate by supportive services that are equal in value to the amount of rental assistance and appropriate to the needs of the population to be served.

Single Case Agreement
If the services to meet an identified clinical need are not available within the contracted network, necessary services are provided in a timely manner through an out-of-network provider. A single case agreement is a contractual agreement developed for an enrolled person based on that person's behavioral health needs and for a predetermined period of time.

Sound Methodology
Systematic approaches to gathering information that rely on established processes and procedures drawn from scientific research techniques.

Special Assistance
The support provided to a person determined to have a Serious Mental Illness who is unable to articulate treatment preferences and/or participate effectively in the development of the Individual Service Plan (ISP), Inpatient Treatment and Discharge Plan (ITDP), grievance and/or appeal processes due to cognitive or intellectual impairment and/or medical condition.

Special Assistance
Assistance provided to a person who has been determined to need additional assistance to fully understand and participate in the Service Plan (SP) or the Inpatient Treatment and Discharge Plan (ITDP) process, the appeal process, or the grievance or request for investigation process.

Specialized Services (pertaining to a Serious Mental Illness)
Specialized services are those services specified by the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) that, when combined with services provided by the NF, result in continuous and aggressive implementation of an individualized plan of care. The plan of care:

a. Is developed and supervised by an interdisciplinary team which includes a physician, qualified mental health professionals, and, as appropriate, other professionals;

b. Prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of Serious Mental Illness which requires intervention by trained behavioral health personnel, and
c. Is directed toward:
(1) Diagnosing and reducing the person's behavioral symptoms that necessitate institutionalization;
(2) Improving his/her level of independent functioning; and
(3) Achieving a functioning level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time.

Sponsor-based Rental Assistance
Sponsor-based rental assistance provides a subsidy for rental assistance through contracts between the grantee and contracted sponsor organization. A sponsor may be a private nonprofit organization or a community mental health agency established as a public nonprofit organization. Participants reside in housing owned or leased by the sponsor.

State Placing Agencies
This term refers to the department of juvenile corrections, the department of economic security, the department of health services or the administrative office of the court. (A,R.S. §15-1181(12))

Statistical Significance
Results of a study are not likely to have occurred by chance alone. By convention, a difference between two groups is usually considered statistically significant if chance could explain it only 5% of the time or less.

Stigma
A cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses. Stigma leads to low self-esteem, isolation, and hopelessness in individuals, and deters the public from seeking and wanting to pay for care. Responding to stigma, people with mental health problems often internalize public attitudes and become so embarrassed or ashamed that they conceal symptoms and fail to seek treatment.

Study Indicator
A tool used to measure or gauge, over time, the performance of functions or goals of an individual, organization or service.

Sub-Acute Facility
A facility that provides inpatient services licensed per 9 A.A.C. 20.

Subcontracted Provider
A Community Service Agency that has been Title XIX Certified by the Department, has registered with AHCCCS, and holds a contract with a RBHA or Tribal RBHA or designee.

Substance abuse
The continued use of alcohol or other drugs in spite of negative consequences.

Substance Use
The ingestion of alcohol or other drugs without the experience of any negative consequences.

Support and Rehabilitation Services
Support and Rehabilitation Services are two categories of Medicaid covered services that behavioral health providers in Arizona may provide to enrolled children and their families. These services are sometimes known by other names, such as Direct Support

Services, In-Home and Community-Based Support Services, Peer and Family-Delivered In-Home and Community –Based Support Services, or Wraparound Services. Because there are potential differences between each of these terms, this protocol uses the name Support and Rehabilitation Services.

Support and Rehabilitation Services Provider
A behavioral health provider agency that delivers Support and Rehabilitation Services as defined above. There are two main types of Support and Rehabilitation Services providers:

Generalist Support and Rehabilitation Services Providers -- configure their program operations to the needs of the Child and Family Team without arbitrary limits on frequency, duration, type of service, age, gender, population or other factors associated with the delivery of Support and Rehabilitation Services.

Specialist Support and Rehabilitation Services Providers – provide either a limited scope of Support and Rehabilitation Services (such as primarily specializing in respite services or skills training services) and/or services that may be designed for a specific population, age, gender, frequency, duration or some other factor (such as a service specializing in working with teenagers or those with a history of displaying harmful sexual behaviors).

Supported Housing Services
Services, as defined in the ADHS/DBHS Covered Behavioral Health Services Guide (see service code H0043), that are provided to assist individuals or families to obtain and maintain housing in an independent community setting including the person's own home or apartments and homes that are owned or leased by a subcontracted provider. These services may include rent and utility subsidies, and relocation services to a person or family for the purpose of securing and maintaining housing.

Supportive Housing
Housing, as defined in 24 CFR Part 583, in conjunction with which supportive services are provided for tenants if the housing is safe and sanitary and meets any applicable State and local housing codes and licensing requirements in the jurisdiction in which the housing is located and the requirements of this part; and the housing is transitional housing; safe haven; permanent housing for homeless persons with disabilities; or is a part of, a particularly innovative project for, or alternative method of, meeting the immediate and long-term needs of homeless persons and families.

Suspension of Service
A decision to temporarily stop providing a service.

T/RBHA Formulary
A list of medications that are made available by individual T/RBHAs for Title XIX/XXI eligible persons. The list must encompass all medications included on the ADHS/DBHS Title XIX/XXI Medication Formulary.

Team
A group of individuals working in collaboration who are actively involved in a person's assessment, service planning and service delivery. At a minimum, the team consists of the person, family members as appropriate in the case of children and a qualified behavioral health clinician. As applicable, the team would also include representatives from other state agencies, clergy, other relevant practitioners involved with the person and any other individuals requested by the person.

Team Decision Making (TDM)

A CPS meeting process that includes family members, their extended family or other support persons, foster parents (if the child is in placement), child (12 years of age or older) service providers, other community representatives, the caseworker of record, the supervisor and, often, resource staff from CPS. The meeting is a sharing of all information about the family which relates to the protection of the children and functioning of the family. The goal is to reach consensus on a decision regarding placement and to make a plan which protects the children and preserves or reunifies the family. TDM meetings should be held for ALL placement related decisions, for all families served by CPS.

Technology
Any device or apparatus which is designed or manufactured to reduce the severity of behavioral health diagnoses symptoms recognized by DSM-IV-TR and/or the ICD 9. Technology for the purposes of this policy does not include medications which are reviewed within the purview of the Pharmacy and Therapeutics committee.

Telemedicine
The practice of healthcare delivery, diagnosis, consultation, treatment and 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.

Tenant-Based Housing
A scattered-site program in which the tenant holds the lease and is directly responsible to the owner of the property. This program is comparable to the HUD Section 8 Housing Choice Voucher Program, but with modifications to meet the needs of adults determined to have a Serious Mental Illness.

Termination of Service
A decision to stop providing a covered behavioral health service.

Third Party Liability
Payment sources available to pay all or a portion of the cost of services incurred by a person.

Tier I Rehabilitation and Support Services
Services provided by direct service staff members meeting the qualifications of a behavioral health paraprofessional, behavioral health technician or behavioral health professional, including the following: Unskilled Respite, Personal Care, Self-help/Peer Services/Comprehensive Community Support Services (Peer Support), Psychoeducational Services and Support to Maintain Employment services.

Tier II Rehabilitation and Support Services
Services provided by direct service staff members meeting the qualifications of a behavioral health technician or behavioral health professional, including the following: Behavioral Health Prevention/Promotion Education, Skills Training, Home Care Training Family, Comprehensive Community Support Services (Supervised Day Program) and Supervised Behavioral Health Day Treatment services.

Title 14 Guardian
Any person or agency who has been appointed by a Court to have specific powers, rights, and duties with respect to matters involving the “incapacitated person.”

Title 14 Guardian with Mental Health Powers (T-14+)
Any person or agency who has been appointed by a Court to have specific additional mental health powers with respect to matters involving the “incapacitated person” when the ward has

been determined to be incapacitated due to a mental disorder.

Title 14 Guardian with Mental Health Powers (T-14+)
Any person who has been appointed by a Court to have specific additional mental health powers with respect to matters involving the "incapacitated person" when the ward has been determined to be incapacitated due to a mental disorder.

Title XIX
Means Title XIX of the Social Security Act, as amended. Is an entitlement program under which the federal government makes matching funds available to states for health and long term care services for eligible low-income individual. This is the Federal statute authorizing Medicaid which is administered by AHCCCS.

Title XIX Covered Services
Means those covered services identified in the ADHS/DBHS Covered Behavioral Health Services Guide as being Title XIX reimbursable.

Title XIX Eligible Person
Means an individual who meets Federal and State requirements for Title XIX eligibility.

Title XIX Member
Means an AHCCCS member eligible for federally funded Medicaid programs under Title XIX of the Social Security Act including those eligible under Section 1931 provisions of the Social Security Act (previously AFDC), Sixth Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income (SSI), SSI-related groups, and Title XIX Waiver Groups, Medicare Cost Sharing groups, Breast and Cervical Cancer Treatment program and Freedom to Work

Title XIX Waiver Member
Means all AHCCCS Medical Expense Deduction (MED) members, and adults or childless couples at or below 100% of the Federal Poverty Level who are not categorically linked to another Title XIX program. This would also include Title XIX linked individuals whose income exceeds the limits of the categorical program and are eligible for MED.

Title XIX Waiver Group (TWG)
Referred to as the "AHCCCS Expansion Population," this group consists of individuals in the AHCCCS Care Program (childless adults) and individuals who qualify for the Medical Expense Deduction (MED) program.

Title XXI Member
Means a person eligible for acute care services under Title XXI known as the "State Children's Health Insurance Program" (SCHIP), 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, The Arizona version of the SCHIP is referred to as Kids Care.

Transfer
The closure of a person's record by the home T/RBHA and simultaneous enrollment of the person by a different T/RBHA.

Transitional Housing
Housing services that facilitate the movement of homeless individuals and families to permanent housing. A homeless individual may stay in transitional housing for a period not to exceed 24

months.

Transitional Medical Assistance (TMA)
An AHCCCS program for Families with Children participants who become ineligible due to excess earned income. Families may be eligible to receive Transitional Medical Assistance (TMA) for up to twelve months.

Translation
The conversion of written text from a source language into the target language while maintaining the author's intent.

Treatment
The provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another. (45 C.F.R. 164.501)

Treatment MI 5.5
Means the range of behavioral health care received by a behavioral health recipient that is consistent with the therapeutic goals defined in their ISP.

T/RBHA
Means a reference to both RBHAs and Tribal RBHAs.

Tribal RBHA
Means a Native American Indian tribe under Contract with ADHS to coordinate the delivery of behavioral health services to eligible and enrolled persons who are residents of the Federally recognized Tribal Nation that is the party to the Contract

Tribal sovereignty in the United States
The inherent authority of indigenous tribes to govern themselves within the borders of the United States of America. The US federal government recognizes tribal nations as "domestic dependent nations" and has established a number of laws attempting to clarify the relationship between the United States federal and state governments and the tribal nations. The Constitution and later federal laws grant to tribal nations more sovereignty than is granted to states or other local jurisdictions, yet do not grant full sovereignty equivalent to foreign nations, hence the term "domestic dependent nations".

Unsecured Protected Health Information

Protected Health Information that is not secured through the use of encryption or destruction that will render PHI unusable, unreadable or indecipherable to unauthorized individuals.

Urgent Response
A rapid and prompt response to a person who may be in need of medically necessary covered behavioral health services. An urgent response should be initiated in a punctual manner, within a timeframe indicated by the person's clinical needs, but no later than twenty-four hours from the initial identification of need.

Urgent responses must be initiated within 72 hours of notification by DES/CPS that a child has been, or will be, removed from their home.

U.S. Citizen

An individual may be a U.S. citizen based on where they were born, having a U.S. citizen parent, by marriage or by naturalization as described below:

- **Citizen by Birth**

A person is a U.S. citizen if the person was born in the United States (including those born in current states before statehood) or in a U.S. territory. Territories are:

- Guam;
- Puerto Rico based on date of birth;
- The Virgin Islands based on date of birth;
- The Northern Mariana Islands based on date of birth;
- American Samoa;
- Swain's Island; and
- Panama Canal Zone based on date of birth.

EXCEPTION: This does not include a person who was born to foreign diplomats residing on one of the preceding jurisdictions.

- **Citizenship Through U.S. Citizen Parent**

A person born to U.S. citizen parents can meet the criteria for U.S. citizenship. The regulation used to evaluate U.S. citizenship through a parent is based on the age of the person on February 27, 2001, when the Children's Citizenship Act (CCA) became effective.

If the person was born…	THEN the person…
After February 27, 1983 (under age 18 on February 27, 2001)	Automatically acquires U.S. citizenship under the CCA when all of the following requirements are met: • At least one biological or adoptive parent is a U.S. citizen by birth or naturalization. • The child is under age of 18. • The child is admitted to the U.S. as an immigrant. Immigrant means the child entered the U.S. on an immigrant visa and/or was admitted as a lawful permanent resident. • The child lives in the legal and physical custody of the U.S. citizen parent(s). • An adopted child acquires U.S citizen status effective the date the child meets all the previously listed CCA requirements, and the full and final adoption is completed. U. S. Citizenship and Immigration Services (USCIS) documentation is not required to prove U.S. citizenship for a person who meets the above requirements and permanently lives in the U.S. However, the person can obtain documentation by applying to the USCIS for a Certificate of Citizenship or to a passport acceptance facility for a U.S. passport.
On or before February 27, 1983 (18 years of age or older on February 27, 2001)	Acquires citizenship if the person's parents meet one of the following criteria: • Both parents are U.S. citizens and at least one parent lived in the U.S or its territories before

	the person's birth. • One parent is a U.S. citizen and the other is a non-citizen. The parent who is a citizen must have lived in the U.S., its possessions, or its territories for a total of five years before the person's birth. At least two of the five years must be after the parent reached age 14. **NOTE**: Consider the parent to have had U.S. residence for any period of time that the parent lived outside of the U.S as one of the following: • A U.S. government employee • Serving in the U.S Armed Forces • Working for an international organization.

- **Citizenship Through Marriage**

A woman who married a U.S. citizen before September 22, 1922 established U.S. citizenship. This does not apply to a man who married a U.S. citizen.

- **Citizenship by Naturalization**

Individuals who are not U.S. citizens by birth or adoption may apply for and go through the naturalization process to become U.S. citizens.

A person born outside the U.S can derive U.S citizenship from parents who were naturalized as U.S. citizens if both parents (or sole custodial parent) were naturalized before:

- The person's 21st birthday if naturalization was before October 14, 1940; or
- The person's18th birthday if naturalization was on or after October 14, 1940.

- **Dual citizenship**

An individual may be a U.S. citizen and a citizen of another country. A person claiming dual citizenship can lose U.S. citizenship only if the person voluntarily abandons it. Dual citizenship status does not affect the individual's U.S. citizenship.

U.S. Department of Housing and Urban Development (HUD)
The department of the federal government that provides funding for housing and support programs.

Violation of Rights
For all enrolled persons, a violation of those rights contained in A.A.C. R9-20-203 and, for persons enrolled as seriously mentally ill, rights contained in A.A.C. Title 9, Chapter 21, Article 2.

Voluntary Evaluation
An inpatient or outpatient evaluation service that is provided after a determination that a person will voluntarily receive an evaluation and is unlikely to present a danger to self or others until the voluntary evaluation is completed. A voluntary evaluation is invoked after the filing of a pre-petition screening but before the filing of a court ordered evaluation and requires the informed consent of the person.

Volunteer

An individual who meets the requirements to provide services in a Community Service Agency and is not a paid staff member.

Vulnerable adult
An individual who is eighteen years of age or older who is unable to protect himself from abuse, neglect or exploitation by others because of a physical or mental impairment.

Waived physician prescriber
Drug Addiction Drug Treatment Act of 2000 (DATA 2000) allows physicians to prescribe narcotic drugs in schedules III, IV, V or a combination of such drugs for the treatment of opioid dependence. The physician must meet training standards described under the training and supervision recommendation section of this document.

Working Day
A Monday, Tuesday, Wednesday, Thursday or Friday unless:
a. A legal holiday falls on Monday, Tuesday, Wednesday, Thursday or Friday; or
b. A legal holiday falls on Saturday or Sunday and a contractor is closed for business the prior Friday or following Monday.

Young Child
Children birth to five years of age.

Youth/Young Adult-Delivered Support
A young adult who has been a recipient of services or sibling that provides support guidance, training and coaching of the youth with the goal of enhancing the youth's life skills.

834 Transaction Enrollment/Disenrollment
The HIPAA-compliant transmission of an individual's information. For Title XIX/XXI eligible individuals, the 834 is provided to ADHS/DBHS from AHCCCS, then from ADHS/DBHS to the T/RBHAs on a daily file. For a Non-Title XIX/XXI eligible individual, the information is used to establish or terminate a person's enrollment in the ADHS/DBHS behavioral health service delivery.

Arizona Department of Health Services
Division of Behavioral Health Services
PROVIDER MANUAL

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Division of Behavioral Health Services (DBHS)
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ADHS/DBHS FINANCIAL REPORTING GUIDE

Effective Date: July 1, 201~~1~~3

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ACRONYMS

I. ACRONYMS

ADHS	Arizona Department of Health Services
ACOM	AHCCCS Contractor Operations Manual
AHCCCS	Arizona Health Care Cost Containment System
AICPA	American Institute of Certified Public Accountants
A. R. S.	Arizona Revised Statues
BFO	Bureau of Financial Operations /Division of Behavioral Health Services
CD	Certificate of Deposit
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CMHS	Center for Mental Health Services
COE	Court Ordered Evaluation
DBHS	Division of Behavioral Health Services
E-Statements	Electronic Financial Statement Formats
FASB	Financial Accounting Standards Board
FFCB	Federal Farm Credit Banks
FFS	Fee-For-Service
FHLB	Federal Home Loan Banks
FHLMC	Federal Home Loan Mortgage Corporation
FNMA	Federal National Mortgage Association
GAAP	Generally Accepted Accounting Principles
GNMA	Governmental National Mortgage Association
GSA	Geographical Service Area

IBNR	Incurred But Not Reported
LOC	Letter of Credit
OFR	Office of Financial Review
OMB	Office of Management and Budget
OPS	Office of Program Support
PPS	Pre-Petition Screening
PL	Public Law
RBHA	Regional Behavioral Health Authority
RBUC	Reported But Unpaid Claim
SA	Substance Abuse
SAPT	Substance Abuse Prevention and Treatment
SED	Serious Emotional Disturbance
SFAS	FASB Statement of Financial Accounting Standards
SIG	State Infrastructure Grant
SMI	Seriously Mental Ill
SOP	Statement of Position
TRBHA	Tribal Regional Behavioral Health Authority
T/RBHA	Tribal/Regional Behavioral Health Authorities

OVERVIEW

II. OVERVIEW

The purpose of this reporting guide is to set the periodic financial reporting requirements for contracted T/RBHAs. The primary objectives of the reporting guide are to establish consistency and uniformity in financial reporting among the T/RBHAs and to provide guidelines to assist the T/RBHAs in meeting contractual reporting requirements. This reporting guide is neither intended to limit the scope of audit procedures to be performed during the T/RBHA's annual certified audit nor to replace the independent certified public accountants judgment as to the work to be performed. It is merely a supplement to the contract.

Financial statements must be prepared and presented on an accrual basis and in accordance with GAAP and all other applicable authoritative literature. If there are any inconsistencies between this reporting guide and any contract provision, the contract provision shall prevail. This guide is not intended nor should it be construed as an all-inclusive manual. The format and content of the required reports are subject to change. Questions regarding the content or format of a report are to be directed to the DBHS Chief Financial Officer (CFO).

FISCAL MONITORING AND FINANCIAL VIABILITY

III. FISCAL MONITORING AND FINANCIAL VIABILITY

A. CRITERIA FOR MONITORING FINANCIAL VIABILITY

The RBHA shall, on a monthly basis, meet certain financial viability criteria as outlined in this reporting guide. ADHS utilizes certain ratios and standards to assist in the monitoring of the RBHA's financial performance and viability. These ratios and standards will be used for evaluation purposes; however, they are not necessarily the only factors considered when evaluating RBHA financial viability. Should a RBHA fail to meet a ratio or standard, corrective action may be required and sanctions may be imposed. The financial ratios and standards are summarized in this reporting guide.

B. FINANCIAL RATIOS AND STANDARDS TABLE

Ratio	Description	Standard
LIQUIDITY RATIOS		
Current Ratio: Current Assets Current Liabilities	Provides an indication of the organization's ability to pay its short-term liabilities.	≥ 1.0
Defensive Interval: (Cash +Current Investments) ((Operating Expenses - Non Cash Expense Items)/[Period Being Measured (days)])	Measures the organization's ability to meet short-term obligations.	≥ 30 DAYS
PERFORMANCE RATIOS		
Total Title XIX/XXI Administrative Expenses (Total Title XIX Revenue ~~less Interpretive Services~~)	Indicates the proportion of Title XIX administrative expenses to Title XIX revenue.	≤ ~~7.5~~8.0%
~~Title XXI Administrative Expenses~~ ~~(Title XXI Revenue less Interpretive Services)~~	~~Indicates the proportion of Title XXI administrative expenses to Title XXI revenue.~~	~~≤ 7.5%~~
Total Non-Title XIX/XXI Administrative Exp. (Total Non-Title XIX/XXI Revenue ~~less Interpretive Services~~)	Indicates the proportion of Non-Title XIX/XXI administrative expenses to Non-Title XIX/XXI revenue.	≤ ~~7.5~~8.0%
Total Title XIX/XXI Service Expenses (Total Title XIX Revenue ~~less Interpretive Services~~)	Indicates the proportion of Title XIX services expenses to Title XIX revenue.	No less than 89.7%
~~Title XXI Service Expenses~~ ~~(Title XXI Revenue less Interpretive Services)~~	~~Indicates the proportion of Title XXI services expenses to Title XXI revenue.~~	~~No less than 89.7%~~
Total Non-Title XIX/XXI Service Expenses (Total Non-Title XIX/XXI Revenue ~~less Interpretive Services~~)	Indicates the proportion of Non-Title XIX/XXI services expenses to Non-Title XIX/XXI revenue.	No less than 89.7%
MINIMUM CAPITALIZATION, PERFORMANCE BOND AND EQUITY PER ENROLLED MEMBER		
Maintenance of Minimum Capitalization	**GSA 1 through GSA 6** Net assets (not including the value of the Performance Bond) shall be greater than or equal to ninety percent (90%) of the monthly capitation and Non-Title XIX/XXI payment to the RBHA. ~~This amount shall never fall below the initial minimum capitalization requirement for each GSA.~~	~~GSA 1 $ 3,400,000~~ ~~GSA 2 $ 1,100,000~~ ~~GSA 3 $ 1,000,000~~ ~~GSA 4 $ 1,600,000~~ ~~GSA 5 $ 5,800,000~~ ~~GSA 6 $15,000,000~~ As Established by ADHS
Performance Bond	GSA 1 through GSA 5 shall be 110% of monthly capitation and Non-Title XIX/XXI payment to RBHA. GSA 6 shall be 80% of the monthly capitation and Non-Title XIX/XXI payment to RBHA.	As Established by ADHS
Equity per Enrolled Member	Unrestricted Net Assets less Performance Bond reported on Statement of Financial Position divided by the # of Title XIX, Title XIX DD and Title XXI enrollees in an episode of care as of the 1st day of each month	$300/Enrolled Member

C. FINANCIAL STANDARDS

1. CURRENT RATIO

Current Assets divided by Current Liabilities shall be equal to or greater than 1:1. If current assets include a receivable from a parent company, the parent company must have liquid assets that support the amount of the intercompany loan.

2. DEFENSIVE INTERVAL

Cash and Current Investments divided by the average daily operating expense less Non Cash expenses shall be equal to or greater than 30 days.

3. ADMINISTRATIVE AND SERVICE EXPENSE PERCENTAGES

Each expense percentage shall be calculated separately by program for Title XIX~~, Title~~ /XXI and Non-Title XIX/XXI.

Service Expense Percentage Standard:	
Title XIX/~~ and Title~~ XXI	No less than 89.7%
Non-Title XIX/XXI	No less than 89.7%
Administrative Expense Percentage Standard:	
Title XIX/~~ and Title~~ XXI	≤ 8.0~~7.5~~%
Non-Title XIX/XXI	≤ 8.0~~7.5~~%

4. INITIAL CAPITALIZATION

~~4~~5. MAINTENANCE OF MINIMUM CAPITALIZATION

Net Assets/Equity (not including the value of the Performance Bond) shall be greater than or equal to ninety percent (90%) of the monthly capitation and Non-Title XIX/XXI payments to the RBHA. ~~This amount should never fall below the initial minimum capitalization requirement for each GSA.~~

~~5~~6. EQUITY PER ENROLLED MEMBER

The equity per enrolled member shall be greater than or equal to $300 per enrolled member. This calculation shall be based on Unrestricted Net Assets ~~(~~less Performance Bond~~)~~ reported on Statement of Financial Position divided by the number of Title XIX, Title XIX DD and Title XXI enrollees ~~enrolled~~ in an episode of care~~members~~ as of the first day of each month.

6. PERFORMANCE BOND

****See SECTION VII. PERFORMANCE BOND for more information and instructions.**

The RBHAs are required to post a Performance Bond to guarantee the payment of the RBHA's obligations to providers, non-contracting providers, and non-providers, and to guarantee the performance by the RBHA of obligations under their respective RBHA contracts. For GSAs 1 through 5, the Performance Bond requirement is equal to 110% of the expected monthly capitation and Non-Title XIX/XXI payment or as determined by ADHS. For GSA 6, the Performance Bond requirement is equal to eighty percent (80%) of the expected monthly capitation and Non-Title XIX/XXI payment or as determined by ADHS. The Performance Bond shall be adjusted when the total of monthly payments change by ten percent (+/-10%). The Performance Bond shall be of standard commercial scope issued by a surety company doing business in the State of Arizona, an irrevocable stand-by letter of credit, or a cash deposit. Performance Bond substitutes shall be in a form acceptable to ADHS and shall be payable to ADHS. Upon notification, a RBHA shall make changes to the amount required by ADHS.
RBHAs shall maintain a Performance Bond that during the final contract year has an expiration date of at least fifteen (15) months after the contract expiration date. If the Contractor has additional liabilities outstanding fifteen (15) months after the termination of the contract, the Contractor may request a reduction in the Performance Bond sufficient to cover all outstanding liabilities, subject to ADHS' approval, until all liabilities have been paid.

Deliverables to satisfy Performance Bond requirements shall be sent to the Office of Financial Review at the following address:

~~The mailing address for performance bond deliverables sent via U.S. Mail is as follows:~~

ADHS/DBHS/BFO
Attention: Manager, Office of Financial Review
150 North 18th Avenue, Suite #2470
Phoenix, Arizona 85007

7. RECONCILIATIONS

Where does incentives go?????

8. PROFIT LIMIT ~~/RISK CORRIDOR~~ CALCULATIONS

Based on individual RBHA contracts, ADHS limits the service profit ~~or loss on Title XIX and Title XXI programs, and the service profit~~ on Non-Title XIX/XXI programs. The RBHA shall record by GSA, and adjust monthly, as necessary, any excess profit ~~or loss~~ resulting from the profit limit ~~/risk corridor~~ calculations. ADHS requires that these entries be reflected in the program(s) where the profit ~~or loss~~ in excess of the limit ~~corridor~~ occurs. An ~~separate~~ analysis of the profit ~~or loss~~ for ~~the Title XIX, Title XXI and~~ Non-title XIX/XXI programs shall be performed on a monthly basis.

Monthly, throughout the fiscal year the RBHA shall accrue a ~~receivable/~~payable for any estimated excess ~~loss/~~profit.

~~Prior period revenue adjustments, if applicable, must be recorded in the Profit/Risk Corridor Analysis and Profit Limit Analysis Reports for the appropriate program. Record the amount as an adjustment under the revenue section. Be sure to disclose the details on the bottom of the report.~~

~~Sanctions, if applicable, must be reported on the "Less Sanction" line. This does not include data validation sanctions.~~

After the RBHA's final audit is received, and no later than twelve (12) months after the end of the fiscal year, any profits on service revenue in excess of the ~~profit/risk corridor for Title XIX and Title XXI and any excess profit above the~~ profit limit as determined by the RBHA contract for Non-Title XIX/XXI, will be returned to ADHS. Service revenue is defined as total revenue less actual administrative costs not to exceed eight percent (8%). Excess profit is defined as "service revenue minus service expenses minus profit limit". ~~ADHS will reimburse the RBHA for excess losses in the Title XIX and Title XXI programs, subject to available funding.~~

~~The qualifying incentive revenue and administrative costs are excluded from the profit/risk corridor calculations.~~

9.~~8.~~ NON-TITLE XIX/XXI CRISIS, MEDICATIONS AND SUPPORTED HOUSING

No profit is allowed on Non-Title XIX/XXI Crisis, Medications and Supported Housing funds. The RBHA is under no obligation to deliver or pay for services beyond the amount paid to them for these programs. The RBHA's responsibility for providing services to Non-Title XIX/XXI Crisis, Medications and Supported Housing eligible persons shall be limited to the amount of funding that has been paid to the RBHA by ADHS. The RBHA shall manage allocated funds for services for Non-Title XIX/XXI Crisis, Medications and Supported Housing eligible persons in a manner sufficient to enable it to deliver services throughout the entire year. The RBHA may expend ~~7.5~~8.0% of the total amount of Non-Title XIX/XXI Crisis, Medications and Supported Housing for administrative expenses. The RBHA shall return to ADHS all Non-Title XIX/XXI Crisis, Medications and Supported Housing funds not expended on services and administration for Non-Title XIX/XXI Crisis, Medications and Supported Housing persons.

Supported Housing funds must be spent in accordance with approved housing plans. Pre-approval must be obtained from the ADHS Housing Coordinator prior to deviating from the approved housing plan. Encounter relief for Supported Housing will be provided for housing purchases and renovations outlined in the approved housing plans. Other housing expenses are expected to be encountered.

109. ENCOUNTER REPORTING REQUIREMENTS

All RBHAs are required to submit encounters or claims for every service rendered to a client in accordance with encounter and claims submission requirements outlined in the ADHS/DBHS Guides and Manuals.

Medicaid funds cannot be used for pre-petition screenings and court-ordered evaluations.

Upon request of the RBHA, additional information on capacity based crisis expenses may be submitted to ADHS to be added to the encounters in order to give the RBHA credit for the cost of the capacity based crisis services incurred. Additional required information shall include all encounterable crisis services and documentation of actual amounts paid for capacity based crisis services. Capacity based service credit is defined as the difference between the paid amount for capacity based crisis services and the encounterable crisis services value. Credit will not be given for crisis services that could have been encountered but were not. Reports may be requested of the RBHAs to substantiate services that could and could not be encountered. ADHS may, at its discretion, reduce the total credit allowed for capacity based services beginning with FY2012.

All crisis services that are billed/encountered must be identified by entering the emergency indicators as indicated in the billing instructions beginning July 1, 2010. Crisis encounters will only be identified via emergency indicators. Stabilization services provided using codes S9484 and S9485 should be reported on line 505b, Crisis Intervention – Stabilization, under the appropriate column, except for SAPT and CMHS. These service codes are usually utilized within a hospital/subacute facility but due to the federal block grant regulations, SAPT and CMHS funds cannot be used for hospital inpatient services. On the other hand, stabilization services provided using codes other than S9484 and S9485, including crisis services provided at a Rural Substance Abuse Transitional Center (A6), should be reported under the appropriate column on the applicable line of service.

Accurate encounter data shall be submitted timely to assist ADHS in evaluating each RBHA's performance and for establishing capitation rates. For a complete list of service codes by provider type refer to the ADHS/DBHS Covered Services Guide, Appendix B-2. Encounter reporting analysis shall be performed by ADHS four (4) months after each quarter-end and eight (8) months after the fiscal year-end.

The value used by RBHA subcontractors to encounter services shall be determined by the contracted rate established at the beginning of the contract period. All rates should use the AHCCCS fee-for-service rate schedule as the baseline. All rates are subject to review and

approval by ADHS. RBHAs must develop statistically sound encounter rates that are based on actual costs.

Any retrospective changes, to contracted rates that may result in the adjustment or voiding and replacement of encounters must be pre-approved through the Office of Program Support (OPS). When doing so, provide justification for why this process is necessary for the batch being submitted.

Recoupments: This Section is for Fee-For-Service Arrangements

In accordance with AHCCCS Contractor Operations Manual (ACOM) Recoupment Policy 412, recoupments are actions initiated by the Contractor to recover all or part of a previously paid claim. Recoupments include Contractor initiated/requested repayments as well as overpayments identified by the Provider where the Contractor seeks to actively withdraw funds to correct the overpayment from the Provider.

RBHAs' claims payment systems, as well as its prior authorization and concurrent review process, must minimize the likelihood of having to recoup already-paid claims. Any individual recoupment in excess of $50,000 within a contract year must be approved in advance by AHCCCS, Division of Health Care Management. Pre-approval should be requested in writing per the requirements of ACOM Policy 412 and submitted to the OPS mailbox at OPS@azdhs.gov. ADHS will forward the request to AHCCCS. If AHCCCS does not respond to ADHS within thirty (30) days, the recoupment request is deemed approved. ADHS will notify the requestor accordingly.

RBHAs must notify ADHS of any cumulative recoupment greater than $50,000 per provider Tax Identification Number per contract year. This written request should also include the requirements as set forth per ACOM Policy 412 and submitted to the OPS mailbox at OPS@azdhs.gov.

RBHAs shall not recoup monies from a provider later than 12 months after the date of original payment on a clean claim without prior approval of AHCCCS as further described in the ACOM *Recoupment Request Policy*. Pre-approval should be requested in writing and submitted to the OPS mailbox at OPS@azdhs.gov.

RBHAs are required to reimburse providers for previously recouped monies if the provider was subsequently denied payment by the primary insurer based on timely filing limits or lack of prior authorization and the member failed to disclose additional insurance coverage other than AHCCCS.

The provider shall have 90 days from the date they become aware that payment will not be made to submit a new claim with documentation from the primary insurer that payment will not be made. Documentation includes but is not limited to any of the following items establishing that the primary insurer has or would deny payment based on timely filing limits or lack of prior authorization; an Explanation of Benefit, policy or procedure, Provider Manual excerpt, etc.

RBHAs must void encounters that are recouped in full. For recoupment's that result in a reduced claim value or adjustments that result in an increased claim value, replacement encounters must be submitted. Notify OPS in writing prior to voiding or replacing recoup

claims. AHCCCS will validate the submission of applicable voids and replacement encounters upon completion of any approved recoupment that meets the qualifications of this section. All replaced or voided encounters must reach adjudicated status within 120 days of the approval of the recoupment. Refer to the ACOM *Recoupment Request Policy* and the AHCCCS *Encounter Reporting User Manual* for further guidance.

Encounter Reporting:

ADHS shall, on a quarterly basis, retroactively calculate the Contract Year-to-Date (CYTD) value of encounters (based on dates of service) submitted by each RBHA. The calculation will be performed in order to measure timeliness and completeness of encounter submissions. Encounter reporting may be considered complete when the RBHA's encounter values reported to ADHS reach the minimum percentage levels specified in the table below as compared to the service (non-administrative) revenue (92.5% of total ADHS revenue) for each calendar quarter. Revenue not required by ADHS to be encountered will be excluded from the encounter reporting calculation (also known as "encounter relief"). Prior period adjustments, if applicable, will be excluded from current period revenue. This includes any ADHS qualifying incentives earned by the RBHA per individual contracts.

MINIMUM PERCENTAGE OF ENCOUNTERS TABLE – MARICOPA

QTR 1 (Jul – Sep)	QTR 2 (Jul - Dec)	QTR 3 (Jul - Mar)	QTR 4 (Jul - June)	YTD (Jul – June)
35%	45%	65%	75%	95%

MINIMUM PERCENTAGE OF ENCOUNTERS TABLE – GREATER ARIZONA

QTR 1 (Jul – Sep)	QTR 2 (Jul - Dec)	QTR 3 (Jul - Mar)	QTR 4 (Jul - June)	YTD (Jul– June)
35%	45%	55%	65%	85%

The completion percentages in the table above were selected to account for utilization fluctuation among quarters, and to recognize encounter submission lags. The objective is to ensure a steady inflow of submitted encounters.

The RBHAs will have eight (8) months following the fiscal year end to submit the required percentages of encounters (refer to the table above) for the final evaluation. ~~A sanction may be assessed if~~ If the RBHA fails to submit the required encounter~~s~~ percentage at the end of each of the five evaluation periods~~,~~. a permanent withhold will be assessed by ADHS calculated as an amount equal to the lesser of the amount of the indicated encounter deficit or 2% of the value of service revenue (92.0% of total ADHS revenue) for the period being evaluated.

For all encounter withholds (accrued by RBHA or assessed by ADHS), the entire withhold amount shall be reported on the Statement of Activities, line 650, Encounter Withhold Expenses under the program(s) applicable to the withhold.

Encounter withhold expenses will not be treated as a service expense when performing reconciliations.

Sanction for Not Submitting the Minimum Percentage of Encounters:

ADHS may sanction the RBHA and/or pass through any sanctions assessed by AHCCCS (To ADHS) when the RBHA fails to submit the required minimum percentage of encounters. The full amount of the sanction will be withheld from the RBHA's monthly payment. The sanction shall be reported as an administrative expense in "All Other Operating" (Line 607). The sanction should be allocated to the appropriate program(s) then further disclosed on Schedule A of the Statement of Activities. Refer to **Section IV. Reporting Issues, D. Sanctions** of this guide for more information.

Provider Encounter Monitoring

On an ad hoc basis, ADHS will request evidence that a RBHA regularly monitors the volume of encounters submitted by their providers. The report will list the Total Revenue paid to the provider by major program and the Total Encounters submitted by the provider by major program. The report will show the percentage of Encounters submitted to Revenue Received, along with an explanation for under/over production of encounters.

11~~0~~. OTHER REQUIREMENTS

In addition to any other remedies available to ADHS, if the RBHA fails to meet any of the criteria in the reporting guide, ADHS may require the RBHA to submit an action plan for review and approval delineating how and when the RBHA will come into compliance with all criteria.

REPORTING ISSUES

IV. REPORTING ISSUES

A. GENERAL

Financial data shall be reported in the format prescribed by ADHS. Generally Accepted Accounting Principles (GAAP) should be observed in the preparation of each report. Examples and general guidelines for each report follow. Separate instructions and template formats will be provided by ADHS in Microsoft Excel format (E-Statements). All amounts are to be rounded and reported in whole dollars. An explanation of adjustments made for prior periods and adjustments to prior months in the current fiscal year are to be disclosed on "Schedule A Disclosures". Predefined classifications are to be utilized prior to reporting in the "Other" column or "Other" line item categories. Items included in the "Other" categories are to be itemized on a supporting schedule. If there are insufficient instructions for a specific category, the RBHA shall request direction from the DBHS Chief Financial Officer. A perceived lack of instruction is not sufficient grounds for failure to report accurately. ADHS has provided the required reporting formats to ensure consistent reporting among all RBHAs. It is the RBHA's responsibility to ensure that all reports submitted are accurate, complete and timely. Adherence to GAAP is the overriding responsibility of the RBHA. If there is a conflict between GAAP and these instructions, the RBHA should advise the DBHS Chief Financial Officer of such conflict.

ADHS recognizes that interim financial statements are based on information available at the end of the reporting period, which may be incomplete. Revisions to a prior period will invalidate the previously submitted report. If material revisions are submitted after the ADHS due date, then sanctions may be imposed for untimely or inaccurate reporting.

The ADHS/DBHS Financial Reporting Guide, RBHA audited financial statements, quarterly Statement of Activities, Statement of Financial Position, Statement of Cash Flows and related Schedule A Disclosures will be posted on ADHS/DBHS' web site. The address is http://www.azdhs.gov. ADHS will refer requests for copies of the above documents to the RBHA. It is the RBHA's responsibility to provide copies to the requesting entity and may charge a reasonable fee.

B. ADHS BLOCK GRANTS

The practices, procedures and standards specified in and required by the Accounting and Auditing Procedures Manual for Contractors of Arizona Department of Health Services Funded Programs and any Uniform Financial Reporting Requirements shall be used by the RBHA in the management, recording and reporting of Federal Block Grant funds.

The RBHA shall comply with all terms, conditions and requirements of the CMHS and SAPT Performance Partnership Block Grants. Financial, performance and program data subject to audit shall be retained by the RBHA as documentation of compliance with federal requirements.

The RBHA shall establish fiscal controls to ensure that funds are accounted for in a manner that permits separate reporting of mental health and substance abuse grant funds and services. SAPT grant funds should be allocated by category (General Services, Pregnant/Parenting Women, Crisis, Meth Initiative, Flex Funds, Prevention, HIV and Children) in accordance with the ADHS Allocation Schedule. CMHS grant funds should be allocated by category (Children with SED, Adults with SMI, Flex Funds and Coaching and Training). Prior written approval must be obtained from ADHS for any deviations from the ADHS Allocation Schedule. Funds paid to RBHAs for a fiscal year shall be available for obligation and expenditures until the end of the fiscal year for which the funds were paid.

The RBHA shall, at the close of a fiscal year, defer all Federal Block Grant funds received but unexpended. The deferred revenue shall be recognized as earned in the first period of the following fiscal year. The recognized revenue shall be reported in the same program as ADHS originally remitted. Any revenue requiring deferral in the second year following its original remittance shall be returned to ADHS for reversion to the Authorizing Federal Agency. RBHAs shall maintain all necessary financial, contractual, budget and program data to ensure appropriate expenditure of grant funds.

The RBHAs are required to notify all non-profit providers that expend $500,000 or more a year in Federal Awards such as the SAPT and CMHS Block Grants to have a Single Audit conducted in accordance with the provisions of OMB Circular A-133. Refer to Exhibits B and C for additional information and for a Sample Letter to Providers.

The RBHAs shall submit an annual SAPT Distribution Report in the format provided by ADHS by October 15 ~~July 30~~ of each year. Similarly, the RBHAs shall submit an annual CMHS Distribution Report in the format provided by ADHS by October 15 ~~July 30~~ of each year.

SAPT Block Grant

Category	**Financial Guide Reporting Requirement**
SA General Services	RBHAs report expenditures for General Services, including Intravenous Drug Users and Medication Assisted Treatment (MAT) as follows: • SAPT Column • By appropriate expenditure line (501-511, excluding inpatient hospital services) footnote MAT expenses on Statement of Activities, Schedule A monthly
Specialty Programs for Pregnant/Parenting Women	RBHAs report expenditures for Specialty Programs for Pregnant/Parenting Women as follows: • SAPT Column • By appropriate expenditure line (501 – 511, excluding inpatient hospital services)
Crisis Services	RBHAs report expenditures for Crisis Services as follows: • SAPT Column • By appropriate expenditure line (501 – 511, excluding inpatient hospital services)

SAPT Block Grant Continued

Category	Financial Guide Reporting Requirement
Meth Initiative	RBHAs report expenditures for Meth as follows: • SAPT Column • Line 503a, Medication Services
Flex Funds	RBHAs report expenditures for Flex Funds as follows: • SAPT Column • Line 504h, Flex Funds
Prevention	These services are non-encounterable. RBHAs report expenditures for prevention services as follows: • SAPT Column • Line 509a, Prevention
HIV/AIDS Early Intervention Services	These services are non-encounterable. RBHAs report expenditures for HIV/AIDS as follows: • SAPT Column • Line 509b, HIV
Children	RBHAs report expenditures for Children Services as follows: • SAPT Column • By appropriate expenditure line (501 – 511, excluding inpatient hospital services) footnote amount expended on Statement of Activities, Schedule A monthly

CMHS Block Grant

Category	Financial Guide Reporting Requirement
Children with SED	RBHAs should report expenditures as follows: • CMHS SED Column • By appropriate expenditure line (501 – 511, excluding inpatient hospital services)
Adults with SMI	RBHAs report expenditures as follows: • CMHS SMI Column • By appropriate expenditure line (501 – 511, excluding inpatient hospital services)
Flex Funds	RBHAs report expenditures as follows: • CMHS SED or SMI Column, in accordance with ADHS Allocation Schedule • Line 504h, Flex Funds
Coaching & Training	RBHAs report expenditures as follows: • ~~CMHS SED Column~~ Other Federal • Line 511, Other ADHS Service Expense Not Reported Above. Disclose on Schedule A

C. COST ALLOCATION PLAN

Each RBHA shall prepare an indirect cost allocation plan in conformance with appropriate federal regulations such as OMB Circular A-122 "Cost Principles of Non-Profit Organizations." The Cost Principles described in OMB Circular A-122 will be the standard applied to Cost Allocation Plans submitted by all RBHAs including for-profit entities. A list of individual costs to be allocated, along with the applicable base should be included in all Cost Allocation Plans. As per the OMB Circular A-122, actual conditions shall be taken into account in selecting the base to be used in allocating the expenses in each grouping to benefiting functions. The essential consideration in selecting a method or a base is that it is the one best suited for assigning the pool of costs to cost objectives in accordance with benefits derived; a traceable cause and effect relationship; or logic and reason. When an allocation can be made by assignment of a cost grouping directly to the function benefited, the allocation shall be made in that manner. In accordance with OMB Circular A-122, "Cost Principles of Non-Profit Organizations", expenses should be recorded directly to the applicable program(s), if identifiable. If the program(s) cannot be readily identified, pro-rate the expense using the percentage of ADHS service expense for each program. The use of revenue as the base for the allocation of all allowable general and administrative cost including corporate overhead is not acceptable. Revenue is not an equitable base for allocation because it has no relationship to cost nor does it have a relationship to the provision of services. This plan shall be submitted to ADHS for approval by May 2 of each fiscal year and should identify items of cost and its allocation base. The Statement of Activities shall be reviewed for adherence to the RBHA's cost allocation plan and shall be an integral part of each RBHA's annual certified audit. Any issues of non-compliance with federal guidelines must be included in the certified audit report. All instances of questioned costs or procedural deficiencies related to Indirect Cost Plans, as identified in the certified audit reports, will be investigated by ADHS, and are subject to repayment to ADHS.

D. SANCTIONS

ADHS may impose sanctions on the RBHAs for failure to perform certain contractual obligations, and financial reporting guide requirements. The amount of the sanction will be determined by the sanction committee guided by the Sanction Protocol.

The full amount of the sanction will be withheld from the RBHA's monthly payment. Revenue from specific programs will be reduced by the amount of the sanction. The RBHA should ensure that they report the full amount of the program's revenue then report the sanction in the same program as an administrative expense, on Line 607, All Other Operating, then further disclose on Schedule A of the Statement of Activities. In addition, sanctions must be reported on the "Less Sanctions" line of the Profit Corridor Report.

E. PHARMACY REBATES

Pharmacy rebates received shall be reported on the Statement of Activities line 510b "Pharmacy Rebates Received" and should be allocated to programs in conformance with OMB Circular A-122, "Cost Principles of Non-Profit Organizations."

Pharmacy rebate related expenses shall be reported on line 510c "Pharmacy Rebate Related Expense" and allocated to programs in conformance with OMB Circular A-122, "Cost Principles of Non-Profit Organizations."

F. QUALIFYING INCENTIVE PAYMENTS

Based on each RBHA's contract, qualifying incentive payments may be earned and should be reported as ADHS Revenue – Qualifying Incentive Payments on line 401b in the Program/Adm & Mgmt/Gen Column of the Statement of Activities in the period earned ~~or paid~~. Qualifying incentive payments will not be included in the profit/risk corridor calculation.

If a RBHA decides to pass on qualifying incentives to a provider, the pass-thru money may be treated as a service or administrative expense and should be recorded on line 511 or line 607 of the Statement of Activities under the Program/Adm & Mgmt/Gen Column and disclosed on Schedule A.

Returned incentive payments (non-qualifying) will be treated as ADHS Revenue and reported on Line 401a under the applicable program that it was previously withheld. These payments will be included in the ratio and profit/risk corridor calculations.

Qualifying incentives will be paid to the RBHAs after ADHS makes its determination upon review of the documentation received from the RBHAs.

G. COMMUNITY REINVESTMENT

The amount of Community Reinvestment should be reported on the Statement of Activities Line 701, Unrelated Business Expenses, under the Program Admin & Mgt/Gen Column and further disclosed on the Statement of Activities, Schedule A.

H. REPORTING ADHS/NON ADHS REVENUE AND EXPENSES

1) All revenue received from ADHS should be reported on Line 401a, ADHS Revenue (unless otherwise directed by ADHS). This is the base for calculating the following:
    a) Performance ratios such as Service and Administrative Expense Ratios
    b) Profit Corridor
    c) Encounter Reporting Requirements

    Only ADHS related service expenses should be reported on lines 501 through 511. ADHS Service Expenses are totaled on line 513. ADHS Administrative Expenses should be reported on lines 601 through 607 with a total on line 608. These amounts are used in calculating ADHS Performance Ratios. ADHS Service Expenses are used to calculate excesses on the Profit Corridor.

    Interpretive Services should be reported on line 620 under the applicable programs. RBHAs must maintain an internal tracking mechanism to ensure these expenses are being recorded properly. Interpretive expenses must be paid for using Administrative Capitation Funds; and therefore, are not included in the Performance Ratios and Profit Corridor calculations. Use the Adjustment line under the Revenue Section of the Profit Corridor Analysis to exclude Interpretive Services from Revenue. Disclose details of the adjustment on the bottom of the Profit Corridor Analysis, under the Adjustment Section.

2) Grants and Other Revenue received from other sources should be reported on Line 402, Specialty and Other Grants. The related service expenses for this revenue source should be reported on Line 520, Service Expenses from Non ADHS Sources. The detailed/specific expenses should be reported on the Statement of Activities, Schedule A disclosure. The related administrative expenses should be reported on Line 651, Non ADHS and/or Unrelated Admin Expense.

    However, Non ADHS Revenue that is directly related to providing behavioral health services should be reported on Line 406, Other Behavioral Health Funding Sources – Non ADHS. The related service expenses for this revenue source should be reported on Line 520, Service Expenses from Non ADHS Sources. The detailed/specific expenses should be reported on the Statement of Activities, Schedule A Disclosure. The related administrative expenses should be reported on Line 651, Non ADHS and/or Unrelated Admin Expense.

Revenue and expenses received from Non ADHS sources may be reported in any of the various program columns, if the funds are spent on activities closely related to that program. If not related to any of the pre-determined programs, it should be reported in the NTXIX/XXI Other Column. These amounts are not figured in the Performance Ratios and Profit Corridor.

Examples of Non ADHS Revenue that should be reported on Line 402:
Revenue from the Arizona Department of Housing
Revenue from City or County
Revenue from the Department of Economic Security

Examples of Non ADHS Revenue that should be reported on Line 406:

Revenue from Training Fees
Revenue from Inter-RBHA Pharmacy Arrangements
RBHA assessed Sanctions

3) Revenue earned or received that is unrelated to providing Behavioral Health services should be reported on Line 407, Unrelated Business Revenue. The related expenses should be reported on Line 701, Unrelated Business Expenses. The basis for using this line should be based on how the revenue was earned. The detailed/specific expenses should be reported on the Statement of Activities, Schedule A disclosure. Generally, these unrelated amounts should be reported under the Program Adm Mgt/Gen Column. These amounts are not figured into the Performance Ratios and Profit Corridor.

   Examples of Unrelated Revenue and Expenses that should be reported on Line 407 and Line 701:
   Revenue from Provider Support
   Revenue from Rental Income
   Revenue from Photocopying Fees

I. REQUESTS FOR OTHER INFORMATION

Upon ADHS' request, the RBHA shall submit additional data or reports to supplement other financial information. The RBHA shall provide complete and accurate information no later than thirty (30) days after receipt of the request unless otherwise specified by ADHS.

J. FINANCIAL REPORTING TIMELINE

Report due dates that fall on a weekend or State recognized holiday will be due the next business day. All reports are due to the Office of Financial Review and the Compliance Mailbox (email address BHSCompliance@azdhs.gov) by 5:00 p.m. on the due date. Financial reports are considered timely when received by ADHS in the required format (refer to **Periodic Reporting Requirements, Section V. A - C**).

Extensions may be granted, but must be requested in writing and addressed to the Manager, Office of Financial Review. Requests must be received at least five (5) business days prior to ADHS' filing date and must include the reason for the extension and the revised filing date. Requests for filing extensions will be reviewed on a case to case basis.

PERIODIC REPORTING REQUIREMENTS

V. PERIODIC REPORTING REQUIREMENTS

A. MONTHLY FINANCIAL STATEMENTS

Monthly Financial Statements are ***due to ADHS 30 days after month-end*** and must include the following reports:

1. Statement of Financial Position
    a. Schedule A Disclosures
2. Statement of Changes in Net Assets/Equity
3. Statement of Activities
    a. Schedule A Disclosures
4. Statement of Cash Flows
    a. Schedule A Disclosures
5. Profit/Risk Corridor Calculation Reports
6. Financial Ratio Analysis Comparison Report
7. Certification Statement

B. QUARTERLY FINANCIAL STATEMENTS

Quarterly Financial Statements are ***due to ADHS 30 days after quarter-end and 40 days after the 4th quarter-end*** and must include the following reports: (No monthly financial statement is due for the quarter end months)

1. Statement of Financial Position
    a. Schedule A Disclosures
2. Statement of Changes in Net Assets/Equity
3. Statement of Activities
    a. Schedule A Disclosures
4. Statement of Cash Flows
    a. Schedule A Disclosures
5. Profit/Risk Corridor Calculation Reports
6. LAG (IBNR) Report - Summary
    a. LAG Report by Program
7. Financial Ratio Analysis Comparison Report
8. Certification Statement

The required monthly, quarterly and annual supplemental reports shall be submitted electronically (E-statements) in the Microsoft Excel format provided by ADHS to ensure consistent reporting for each GSA. The Certification Statement must be signed by the CFO and scanned to OFR within three business days of report submittal. Draft and Annual Financial Reporting Packages must be sent electronically, with the exception of the bound Auditor's Report. Refer to **Section VI. Financial Reporting Formats and Instructions** for report examples and instructions.

C. ANNUAL FINANCIAL STATEMENTS

1. DRAFT CONSOLIDATED AUDIT REPORTS

Due to ADHS 75 days after fiscal year-end and must include the following reports:

a. Statement of Financial Position
b. Statement of Functional Expenses
c. Supplemental Schedule of Title XIX, Title XXI and Non-Title XIX/XXI revenue and expenses, included as supplemental information under the auditor's report, all disclosures etc., and all applicable opinion letters.
d. OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations. (Also applies to For-Profit Entities) Title XIX, Title XXI, SAPT and CMHS must be audited as major programs
e. Annual Certification Statement signed by RBHA CFO
f. Annual Supplemental Reports as outlined in C. 3., excluding the RBHA Financial Disclosure Statement and Related Party Transactions/Certification

2. FINAL CONSOLIDATED AUDIT REPORTS

The final audit reporting package ***is due to ADHS 100 days after the fiscal year-end*** and includes the following:

a. Annual Certification Statement signed by RBHA CFO
b. Statement of Financial Position
c. Statement of Functional Expenses
d. Supplemental Schedule of Title XIX, Title XXI and Non-Title XIX/XXI revenue and expenses, included as supplemental information under the auditor's report, all disclosures etc., and all applicable opinion letters.
e. OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations. (Also applies to For-Profit Entities) Title XIX, Title XXI, SAPT and CMHS must be audited as major programs
f. Bound Auditor's Report
g. Annual Supplemental Reports as outlined in C. 3.

3. ANNUAL SUPPLEMENTAL REPORTS

a. Statement of Financial Position Reconciliation from 4th Quarter Submission to Audited Consolidated Financial Statements
b. Schedule A Disclosure for Statement of Financial Position Reconciliation from 4th Quarter Submission to Audited Consolidated Financial Statements
c. Statement of Change in Net Assets/Equity
d. Reconciliation of Change in Net Assets/Equity from 4th Quarter Submission to Audited Consolidated Financial Statements
e. Disclosure Statement/Related Party Transactions Certification
f. RBHA Financial Disclosure Statement and Related Party Transactions
g. Cash Flow
h. Cash Flow Schedule A Disclosure
i. Annual Statement of Activities (audited by program and Indirect Expenses allocated in accordance with the Cost Allocation Plan)
j. Annual Statement of Activities Schedule A Disclosures
k. Financial Ratios and Standards Report
l. Draft Profit/Risk Corridor Analysis
m. Lag Report including methodology used to calculate IBNR

D. RELATED PARTY FINANCIAL STATEMENTS

The RBHAs shall submit electronically to ADHS the Annual Audited Financial Statements of Related Parties and Certification with whom the RBHA conducted business transactions. The related parties' Annual Audited Financial Statements are due 120 days after their fiscal year end.

RBHAs that contract with Related Parties to perform functions on behalf of the RBHA will provide an Annual Income Statement (reporting RBHA activities only) and accompanying documentation as agreed upon or other documentation deemed acceptable to ADHS. The after-tax profit/(loss) greater than 3% from these statements will be combined with the RBHAs profit/(loss) on an allocated basis. Refer to Exhibit A, Agreed Upon Procedures For RBHAs With Related Parties Performing On Their Behalf, for additional information.

E. TOP 20 PROVIDERS FINANCIAL STATEMENTS

The RBHAs shall submit electronically and hard copies in a binder, the most recent Annual Audited Financial Statements of their Top 20 Providers by February 28 following the end of the state fiscal year. Use ADHS Revenue to determine the Top 20 Providers.

FINANCIAL REPORTING FORMATS AND INSTRUCTIONS

VI. FINANCIAL REPORTING FORMATS AND INSTRUCTIONS

A. CERTIFICATION STATEMENT

All Financial Reporting Packages, including the Draft and Final, must include a Certification Statement, signed and dated by the Chief Financial Officer. Unsigned or unlabeled reports will not be accepted. The signature of the Chief Financial Officer is confirmation that the reports have been reviewed by the RBHA for accuracy and completeness. The certification statement must be an exact copy as the sample below:

CERTIFICATION STATEMENT OF
(Entity Name)
FOR THE PERIOD ENDED:_____

Name of Preparer: _____

Title: _____

Telephone Number: _____

I hereby attest that the information submitted in the reports herein is current, complete and accurate to the best of my knowledge. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation with the reports may be prosecuted under applicable state and/or federal laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested might result in denial of a request to participate, or where the entity already participates, a termination of a RBHA's agreement with the Arizona Department of Health Services.

_____ _____
Date Chief Financial Officer

B. STATEMENT OF FINANCIAL POSITION

The Statement of Financial Position illustrates the financial position of the RBHA as of the reporting date. It is the primary source of information about the RBHA's liquidity and financial stability.

C. INSTRUCTIONS FOR THE STATEMENT OF FINANCIAL POSITION

LINE #	ACCOUNT	DESCRIPTION
101	Cash	Cash and cash equivalents available for use. Cash equivalents are investments maturing 90 days or less from the date of purchase.
102	Current Investments	Readily saleable investments maturing one year or less from the date of purchase and expected to be redeemed or sold within one year of the statement date.
103	Accounts Receivable (net)	Report Accounts Receivable net of allowance for doubtful accounts. Amount should include any amount receivable from ADHS. (Disclose on Schedule A)
104	Notes Receivable (current portion)	Principal amounts on notes receivable due to the RBHA within one year of the statement date.
105	Prepaid Expenses	All prepaid expenses.
106	Other Current Assets	All other current assets not reported elsewhere on the Statement of Financial Position. (Disclose on Schedule A)
107	Total Current Assets	Total of the above accounts.
108	Land	Land.
109	Building	Buildings, capital leases, and other improvements.
110	Leasehold Improvements	Capital improvements to facilities leased.
111	Furniture and Equipment	Office equipment, data processing hardware and software (where permitted), and furniture, as well as similar assets held under capital leases.
112	Vehicles	Vehicles owned or leased.
113	Total Property and Equipment	The total of lines 108 through 112.
114	**Less**: Accumulated Depreciation	The total of all depreciation and amortization accounts relating to the various asset accounts, as set forth above.
115	Net Property and Equipment	Line 113 minus line 114.
116	Notes Receivable (net of current portion)	Loans payable to the RBHA over a period exceeding one year from the statement date.
117	Performance Bond	Disclose on Schedule A the method by which the RBHA satisfied this requirement. Indicate whether or not the amounts are included in the financial statements and if over or under funded and reasons therefore.
118	Long Term Investments	Investments with a maturity date of more than one year from the statement date.
119	Deposits	Refundable deposits.
120	Other Non-Current Assets	All other non-current assets not reported elsewhere on the Statement of Financial Position. (Disclose on Schedule A)
121	Total Non-Current Assets	Total of Lines 116 through 120.
122	**TOTAL ASSETS**	Line 107 plus 121.
201	Incurred But Not Reported Claims	Methodology for IBNR calculation is described in the section pertaining to the IBNR Lag Report. (Disclose on Schedule A)
202	Reported But Unpaid Claims	Claims that have been reported but remain unpaid at the statement date.
203	Payable to ADHS	Accruals for profit in excess of the contract profit/risk corridor. (Disclose on Schedule A)

C. STATEMENT OF FINANCIAL POSITION INSTRUCTIONS (CONTINUED)

LINE #	ACCOUNT	DESCRIPTION
204	Payable to Providers	Amounts owed to providers for block purchase, sub-capitation or other agreements.
205	Trade Accounts Payable	Amounts owed to creditors for the acquisition of goods and services, other than behavioral health services.
206	Accrued Salaries and Benefits	Amounts owed to employees for wages and benefits earned but not paid.
207	Long-term Debt (current portion)	Principal amounts on loans, notes, and capital lease obligations due within one year of the statement date.
208	Deferred Revenue	Accruals for deferred revenue/unearned revenue, as prescribed by GAAP. (Disclose on Schedule A)
209	Risk Pool Payable	Amounts accrued for risk pools established by the RBHA.
210	Other Current Liabilities	All other current liabilities not reported elsewhere on the Statement of Financial Position. (Disclose on Schedule A)
211	Total Current Liabilities	Total of lines 201 through 210.
212	Long-term debt (net of current portion)	The long-term portion of principal on loans, notes, and capital lease obligations.
213	Loss Contingencies	Loss Contingency accruals, which are non-current in nature, as prescribed by GAAP. (Disclose on Schedule A)
214	Other Non-current Liabilities	All other non-current liabilities not reported elsewhere on the Statement of Financial Position. (Disclose on Schedule A)
215	Total Non-current Liabilities	Total of lines 212 through 214.
216	**Total Liabilities**	Line 211 plus line 215.
217	**Net Assets/Equity**	Line 122 – 216. (Disclose Restricted Net Assets on Schedule A).
218	**TOTAL LIABILITIES AND NET ASSETS/EQUITY**	Line 216 plus line 217.

STATEMENT OF FINANCIAL POSITION
AS OF: [ ]

ASSETS

CURRENT ASSETS

101 Cash (Disclose on Schedule A)
102 Current Investments
103 Accounts Receivable (net) (Disclose on Schedule A)
104 Notes Receivable (current portion)
105 Prepaid Expenses
106 Other Current Assets (Disclose on Schedule A)
107 Total Current Assets

NON-CURRENT ASSETS

108 Land
109 Building
110 Leasehold Improvements
111 Furniture and Equipment
112 Vehicles
113 Total Property and Equipment
114 **Less:** Accumulated Depreciation
115 Net Property and Equipment
116 Notes Receivable (net of current portion)
117 Performance Bond (Disclose on Schedule A)
118 Long Term Investments
119 Deposits
120 Other Non-current Assets (Disclose on Schedule A)
121 Total Non-current Assets

122 TOTAL ASSETS

LIABILITIES AND NET ASSETS/EQUITY

CURRENT LIABILITIES

201 Incurred But Not Reported Claims (Disclose on Schedule A)
202 Reported But Unpaid Claims
203 Payable to ADHS (Disclose on Schedule A)
204 Payable to Providers
205 Trade Accounts Payable
206 Accrued Salaries and Benefits
207 Long-term Debt (current portion)
208 Deferred Revenue (Disclose on Schedule A)
209 Risk Pool Payable
210 Other Current Liabilities (Disclose on Schedule A)
211 Total Current Liabilities

NON-CURRENT LIABILITIES

212 Long-term debt (net of current portion)
213 Loss Contingencies (Disclose~~d~~ on Schedule A)
214 Other Non-current Liabilities (Disclose on Schedule A)
215 Total Non-current Liabilities

216 TOTAL LIABILITIES
217 NET ASSETS/EQUITY
Unrestricted Net Assets
Restricted Net Assets (Disclose on Schedule A)

218 TOTAL LIABILITIES AND NET ASSETS/EQUITY

STATEMENT OF FINANCIAL POSITION
AS OF:
Schedule A Disclosures

ASSETS:

Cash
Restricted

Unrestricted

Total Cash

Accounts Receivable
ADHS

Program ID	Category ID
Current Year	
Select Program	Identify Category
Prior Year	
Select Program	Identify Category

Non-ADHS &/or Unrelated Business
Current Year
Prior Year

Allowance for Doubtful Accounts

Total Accounts Receivable

Other Current Assets (Detail of Line 106)
Identify Current Assets

Total Other Current Assets

Other Non-Current Assets (Detail of Line 120)
Identify Other Non-Current Assets

Total Other Non-Current Assets

PERFORMANCE BOND:
List type of Security and Amount

Adjustments:
Disclose and describe any adjustments made to previously submitted financial statements, including those that affect the current period financial statements

Payable to ADHS – Other Category
Disclose items recorded as "Other" in the category for Payable to ADHS Section

Explain ≥10% fluctuation in account from prior period
Describe fluctuation in each account greater than 10%

LIABILITIES:

IBNR Claims Estimate
Current Year
Current Year IBNR
Prior Year (s)
Prior Year IBNR
Total IBNR

Payable to ADHS (Detail of Line 203)

Program ID	Category ID
Current Year	
Select Program	Select Category
Prior Year	
Select Program	Select Category

Total Payable - ADHS

Deferred Revenue from: (Detail of Line 208)

Program ID	Category ID
ADHS	
Current Year	
Select Program	Identify Category
Prior Year	
Select Program	Identify Category

Non-ADHS &/or Unrelated Business
Current Year
Select Program Identify Category
Prior Year
Select Program Identify Category

Total Deferred Revenue

Other Current Liabilities (Detail of Line 210)
Identify Other Current Liabilities

Total Other Current Liabilities

Loss Contingencies (Detail of Line 213)
Identify Loss Contingencies

Total Loss Contingencies

Other Non-Current Liabilities (Detail of Line 214)
Identify Other Non-current Liabilities

Total Other Non-Current Liabilities

Restricted Net Assets (Detail of Line 217)
Itemized Restricted Net Assets
Total Restricted Net Assets

D. STATEMENT OF CHANGES IN NET ASSETS/EQUITY

The Statement of Changes in Net Assets/Equity includes changes due to Title XIX, Title XXI and Non-Title XIX/XXI activities and reflects the current impact of revenue and expenses on the RBHA's financial position.

E. INSTRUCTIONS FOR THE STATEMENT OF CHANGES IN NET ASSETS/EQUITY

Beginning Balance	Prior Year's Ending Balance
Net Surplus (Net of Dividends Paid) Net Earning for the period ended	YTD Inc (Dec) in Net Assets Net Assets/Equity from Statement of Activities
Dividends Paid	Total Dividends Paid
Prior Period Adjustments	Total of Cumulative Adjustments from Prior Period
Ending Balance	Total Ending Net Assets Net Assets/Equity from Statement of Activities

RBHA

STATEMENT OF CHANGES IN NET ASSETS /EQUITY

AS OF : (Current Month)

	Initial Capital	Additional Capital	Net Assets/ Retained Earnings	Total
Beginning Balance:	$	$	$	$
Increase/(Decrease) of Net Surplus / Net Earnings for the period ended: **(Current Month)**				
Less Dividends Paid				
**Prior Period Adjustments				
Ending Balance: **(Current Month)**	$	$	$	$

**Disclosure of Prior Period Adjustments

F. STATEMENT OF ACTIVITIES

The Statement of Activities encompasses year-to-date revenue and expenses for Title XIX, Title XXI, Non-Title XIX/XXI, Federal and County programs. All items are to be reported using the accrual method of accounting based on funding categories. The intent of the statement is to capture, on an accrual basis, the revenue of the RBHA and to match that revenue with related expenses by each funding program. Any expense allocation shall be made in a consistent manner and shall be in compliance with the cost allocation plan.

G. INSTRUCTIONS FOR THE STATEMENT OF ACTIVITIES

Revenue and expense shall be accrued according to GAAP. Revenue and expense shall be reported under the applicable funding program column in the line indicated in these instructions.

Revenue is to be calculated and accrued as follows:

a. Title XIX and Title XXI revenue should be accrued using the projected number of eligible clients provided by AHCCCS multiplied by the approved capitation rates currently being paid, unless the most recent proposed capitation rates were already approved and are awaiting payment. Any deviations from the above must be pre-approved in writing.

b. Non-Title XIX/XXI revenue is to be accrued using $1/12^{th}$ of the annual allocation as reported on the ADHS Allocation Schedule. Revisions to the allocation may occur throughout the year, but until the RBHAs are notified in writing of any changes, the amount reported on the Allocation Schedule (or Payment Schedule if appropriate) is the best and most probable estimate of what ADHS will pay out. Prior written approval must be obtained from ADHS for any deviations from the ADHS Allocation Schedule.

c. Other revenue sources should be accrued in accordance with GAAP (i.e. CERs and revenue sources other than ADHS).

Service expenses are to be calculated as part of the IBNR calculation and allocated on a consistent basis in accordance with GAAP within each funding program. Refer to **Section VI. Financial Reporting Formats and Instructions, L. and M. Lag Report** for more information.

Service expenses should be allocated to service line items and to each funding program based on current year service utilization/encounter data. ADHS may request the service allocation methodologies, as needed. Any other reasonable and consistent method used to allocate expense should be disclosed in Schedule A of the Statement of Activities.

Service expenses are to be reported in accordance with contractual requirements, ADHS Guides and Manuals and the ADHS/DBHS Financial Reporting Guide, Exhibit D.

Administrative expenses shall be reported in conformance with the RBHA's cost allocation plan. Refer to **Section IV. Reporting Issues, C. Cost Allocation Plan** for more information**.**

All Non ADHS revenue and expenses shall be reported and disclosed separately.

Line item instructions are on the following page.

LINE ITEM INSTRUCTIONS FOR THE STATEMENT OF ACTIVITIES

LINE		ACCOUNT	DESCRIPTION
Revenue:			**Revenue**
401		Revenue Under ADHS Contract	Revenue Under ADHS Contract
a		ADHS Revenue	Accrued Revenue for Title XIX, Title XXI, Non-Title XIX/XXI, Federal and County
b		ADHS Revenue - Qualifying Incentive Payments	Earned revenue for qualifying incentives from ADHS
402		Specialty & Other Grants	Other Revenue earned from specialty grants. (Disclose on Schedule A)
403		Client Fees (Co-pays)	Co-payments billed for client services
404		Third Party Recoveries	Third-party liability insurance recovered from third party insurances as described in the ADHS/DBHS Provider Manual section 3.5
a		Medicare	Medicare eligible client amounts due from Medicare
b		Other Insurance	Any other third party Insurer liable for claim payment
405		Interest Income	Interest income earned on performance bond or other investments should be reported in the Management & General Column
406		Other Behavioral Health Funding - Non ADHS	Any other behavioral health funding source that is not received from ADHS, allocate to programs (Disclose on Schedule A)
407		Unrelated Business Revenue	Any other business activity not related to providing behavioral health services. (Disclose on Schedule A)
408		**TOTAL REVENUE**	Sum of line 401 through line 407
Service Expenses:			**Service Expenses**
501		Treatment Services	Treatment Services
a		Counseling	Counseling
	1	Counseling, Individual	Refer to Exhibit D Crosswalk to Covered Services Guide
	2	Counseling, Family	Refer to Exhibit D Crosswalk to Covered Services Guide
	3	Counseling, Group	Refer to Exhibit D Crosswalk to Covered Services Guide
b		Assessment, Evaluation and Screening	Refer to Exhibit D Crosswalk to Covered Services Guide
c		Other Professional	Refer to Exhibit D Crosswalk to Covered Services Guide
d		*Total Treatment Services*	The total of lines 501 a through c
502		Rehabilitation Services	Rehabilitation Services
a		Living Skills Training	Refer to Exhibit D Crosswalk to Covered Services Guide
b		Cognitive Rehabilitation	Refer to Exhibit D Crosswalk to Covered Services Guide
c		Health Promotion	Refer to Exhibit D Crosswalk to Covered Services Guide
d		Supported Employment Services	Refer to Exhibit D Crosswalk to Covered Services Guide
e		*Total Rehabilitation Services*	The total of lines 502 a through d
503		Medical Services	Medical Services
a		Medication Services	Refer to Exhibit D Crosswalk to Covered Services Guide
b		Medical Management	Refer to Exhibit D Crosswalk to Covered Services Guide
c		Laboratory, Radiology & Medical Imaging	Refer to Exhibit D Crosswalk to Covered Services Guide
d		Electro-Convulsive Therapy	Refer to Exhibit D Crosswalk to Covered Services Guide
e		*Total Medical Services*	The total of lines 503 a through d
504		Support Services	Support Services
a		Case Management	Refer to Exhibit D Crosswalk to Covered Services Guide
b		Personal Care Services	Refer to Exhibit D Crosswalk to Covered Services Guide
c		Family Support	Refer to Exhibit D Crosswalk to Covered Services Guide
d		Peer Support	Refer to Exhibit D Crosswalk to Covered Services Guide
e		Home Care Training to Home Care Client	Refer to Exhibit D Crosswalk to Covered Services Guide
f		Unskilled Respite Care	Refer to Exhibit D Crosswalk to Covered Services Guide
g		Supported Housing	Refer to Exhibit D Crosswalk to Covered Services Guide
h		Flex Fund Services	Refer to Exhibit D Crosswalk to Covered Services Guide
i		Transportation	Refer to Exhibit D Crosswalk to Covered Services Guide

LINE		ACCOUNT	DESCRIPTION
j		*Total Support Services*	The total of lines 504 a through i
505		Crisis Intervention Services	Crisis Intervention Services
A		Crisis Intervention - Mobile	Refer to Exhibit D Crosswalk to Covered Services Guide
B		Crisis Intervention - Stabilization	Refer to Exhibit D Crosswalk to Covered Services Guide
C		Crisis Intervention - Telephone	Refer to Exhibit D Crosswalk to Covered Services Guide
D		*Total Crisis Intervention Services*	The total of lines 505 a through c
506		Inpatient Services	Inpatient Services
a		Hospital	Hospital
	1	Psychiatric (Provider Types 02 & 71)	Refer to Exhibit D Crosswalk to Covered Services Guide
	2	Detoxification (Provider Types 02 & 71)	Refer to Exhibit D Crosswalk to Covered Services Guide
b		Sub-acute Facility	Sub-acute Facility
	1	Psychiatric (Provider Types B5 & B6)	Refer to Exhibit D Crosswalk to Covered Services Guide
	2	Detoxification (Provider Types B5 & B6)	Refer to Exhibit D Crosswalk to Covered Services Guide
c		Residential Treatment Center (RTC)	Residential Treatment Center (RTC)
	1	Psychiatric - Secure & Non-Secure Provider Types (78, B1, B2, B3)	Refer to Exhibit D Crosswalk to Covered Services Guide
	2	Detoxification - Secure & Non-Secure Provider Types (78, B1, B2, B3)	Refer to Exhibit D Crosswalk to Covered Services Guide
d		Inpatient Services, Professional	Refer to Exhibit D Crosswalk to Covered Services Guide
e		*Total Inpatient Services*	The total of lines 506 a through d
507		Residential Services	Residential Services
a		Level II Behavioral Health Residential Facilities	Refer to Exhibit D Crosswalk to Covered Services Guide
b		Level III Behavioral Health Residential Facilities	Refer to Exhibit D Crosswalk to Covered Services Guide
c		Room and Board	Refer to Exhibit D Crosswalk to Covered Services Guide
d		*Total Residential Services*	The total of lines 507 a through c
508		Behavioral Health Day Program	Behavioral Health Day Program
a		Supervised Day Program	Refer to Exhibit D Crosswalk to Covered Services Guide
b		Therapeutic Day Program	Refer to Exhibit D Crosswalk to Covered Services Guide
c		Medical Day Program	Refer to Exhibit D Crosswalk to Covered Services Guide
d		*Total Behavioral Health Day Program*	The total of lines 508 a through c
509		Prevention Services	Prevention Services
a		Prevention	Non-Title XIX/XXI Prevention Services
b		HIV	Non-Title XIX/XXI HIV Prevention
c		*Total Prevention Services*	The total of lines 509 a through b
510		Medication	Medication
a		Medication Expense	Medication expense – cost of drugs only
b		Pharmacy Rebate Received	Rebate Received, allocated by program
c		Pharmacy Rebate Related Expense	Rebate related expense, allocate by program – expense related to collection of rebate
d		Total Medication	The total of lines 510 a through c
511		Other ADHS Service Expenses Not Reported Above	Other ADHS service expenses that are not indicated above. (Disclose on Schedule A)
513		**Subtotal ADHS Service Expenses**	The total of lines 501 through 512
520		Service Expenses from Non ADHS Sources	Service expense not related to ADHS revenue; allocate to programs (Disclose on Schedule A)
525		**Total Service Expense**	The total of line 513 and 520
Administrative Expenses:			**Administrative Expenses**
601		Salaries	Accrued salary expense
602		Employee Benefits	Accrued employee benefit expense
603		Professional & Outside Services	Professional and outside services expense
604		Travel	Travel expense
605		Occupancy	Building rent or other occupancy expense
606		Depreciation	Depreciation and amortization expense of building, leasehold improvements, furniture, and equipment
607		All Other Operating	Other ADHS administrative expense, including Translation Services, not classified above. (Disclose on Schedule A)
608		**Subtotal ADHS Administrative Expenses**	The total of lines 601 through 607
620		Interpretive Services	Sign Language or Interpretive Services

LINE		ACCOUNT	DESCRIPTION
650		Encounter Withhold Expense	
651		Non ADHS and/or Unrelated Admin. Expense	Administrative expense for Non ADHS or Unrelated Business activities. (Disclose separately on Schedule A)
652		**Sub-total Administrative Expense**	The total of lines 608 through line 651
701		Unrelated Business Expenses	Any other business expense for activities not related to providing behavioral health services. (Disclose on Schedule A)
790		Income Tax Provisions	For-profit entity income tax expense
	a	ADHS Income Tax Provision	Income tax expense related to net gain from ADHS operations
	b	Non ADHS Income Tax Provision	Income tax expense related to net gain from Non ADHS operations
799		**Subtotal Income Tax Provision**	Line 790a plus 790b
800		**TOTAL EXPENSES**	Line 525 plus line 608 plus line 652 plus line 701 plus line 799
801		**INC/(DEC) IN NET ASSETS/EQUITY**	Line 408 minus line 800

1. STATEMENT OF ACTIVITIES

STATEMENT OF ACTIVITIES
YEAR TO DATE AS OF:

		TXIX CHILD	TXIX CMDP	TXIX DD CHILD	TXIX SMI	TXIX DD ADULT	TXIX GMH/SA	TXXI CHILD	TXXI ADULT	NTXIX/XXI CRISIS	NTXIX/XXI MEDICATIONS	NTXIX/XXI SUPPORTED HOUSING	NTXIX/XXI OTHER
REVENUE													
401	Revenue Under ADHS Contract												
a	ADHS Revenue												
b	ADHS Revenue – Qualifying Incentive Payments												
402	Specialty & Other Grants*												
403	Client Fees (Co-pays)												
404	Third Part Recoveries												
a	Medicare												
b	Other Insurance												
405	Interest Income												
406	Other Behavioral Health Funding Sources - Non ADHS*												
407	Unrelated Business Revenue*												
408	**TOTAL REVENUE**												
EXPENSES													
Service Expenses:													
501	Treatment Services												
a	Counseling												
1	Counseling, Individual												
2	Counseling, Family												
3	Counseling, Group												
b	Assessment Evaluation and Screening												
c	Other Professional												
d	*Total Treatment Services*												
502	Rehabilitation Services												
a	Living Skills Training												
b	Cognitive Rehabilitation												
c	Health Promotion												
d	Supported Employment Services												
e	*Total Rehabilitation Services*												
503	Medical Services												
a	Medication Services												
b	Medical Management												
c	Laboratory, Radiology & Medical Imaging												
d	Electro-Convulsive Therapy												
e	*Total Medical Services*												
504	Support Services												
a	Case Management												
b	Personal Care Services												
c	Family Support												
d	Peer Support												
e	Home Care Training to Home Care Client												
f	Unskilled Respite Care												
g	Supported Housing*												
h	Flex Fund Services												
i	Transportation												
j	*Total Support Services*												
505	Crisis Intervention Services												
a	Crisis Intervention Mobile												
b	Crisis Intervention Stabilization												
c	Crisis Intervention Telephone												
d	*Total Crisis Intervention Services*												
506	Inpatient Services												
a	Hospital												
1	Psychiatric (Provider Types 02 & 71)												
2	Detoxification (Provider Types 02 & 71)												
b	Sub-acute Facility												
1	Psychiatric (Provider Types B5 & B6)												
2	Detoxification (Provider Types B5 & B6)												
c	Residential Treatment Center (RTC)												
1	Psychiatric – Secure & Non-secure (Provider Types 78,B1,B2,B3)												
2	Detoxification – Secure & Non- Secure (Provider Types 78,B1,B2,B3)												
d	Inpatient Services, Professional												
e	*Total Inpatient Services*												
507	Residential Services												
a	Level II Behavioral Health Residential Facilities												
b	Level III Behavioral Health Residential Facilities												
c	Room and Board												
d	*Total Residential Services*												
508	Behavioral Health Day Program												
a	Supervised Day Program												
b	Therapeutic Day Program												
c	Medical Day Program												
d	*Total Behavioral Health Day Program*												
509	Prevention Services												
a	Prevention												
b	HIV												
c	*Total Prevention Services*												
510	Medication												
a	Medication Expense												
b	Pharmacy Rebate Received												
c	Pharmacy Rebate Related Expense												
d	Total Medication Expense												
511	Other ADHS Service Expenses Not Rpt'd Above*												
513	**Subtotal ADHS Service Expenses**												
520	Service Expenses from Non ADHS Sources*												
525	**Total Service Expense**												
Administrative Expenses:													
601	Salaries												
602	Employee Benefits												
603	Professional & Outside Services												
604	Travel												
605	Occupancy												
606	Depreciation												
607	All Other Operating*												
608	**Subtotal ADHS Administrative Expenses**												
620	Interpretive Services												
651	Non ADHS and/or Unrelated Admin. Expense*												
652	**Subtotal Administrative Expense**												
701	Unrelated Business Expenses*												
790	Income Tax Provision												
a	ADHS Income Tax Provision												
b	Non ADHS Income Tax Provision												
799	**Subtotal Income Tax Provision**												
800	**TOTAL EXPENSES**												
801	**INC/(DEC) IN NET ASSETS/EQUITY**												

***Disclose on Schedule A**

CMHS SED BLOCK GRANT	CMHS SMI BLOCK GRANT	SAPT BLOCK GRANT	OTHER FEDERAL	COUNTY	PASRR/ADOH	PATH	SUBTOTAL	PROGRAM ADMIN & MGMT/GEN	TOTAL

2. SCHEDULE A DISCLOSURE

RBHA
STATEMENT OF ACTIVITIES
SCHEDULE A DISCLOSURE
YEAR TO DATE AS OF:

TXIX CHILD	TXIX CMDP	TXIX DD CHILD	TXIX SMI	TXIX DD ADULT	TXIX GMH/SA	TXXI CHILD	TXXI ADULT	NTXIX/XXI CRISIS	NTXIX/XXI MEDICATIONS	NTXIX/XXI SUPPORTED HOUSING	NTXIX/XXI OTHER

DISCLOSURE OF NTXIX/XXI OTHER and OTHER FEDERAL ADHS REVENUE
Itemization of Items Reported In Other Columns
Total Other – NTXIX/XXI OTHER and OTHER FEDERAL

DISCLOSURE OF OTHER GRANTS REPORTED ON LINE 402
Total Other Grants

DISCLOSURE OF OTHER BEHAVIORAL HEALTH SOURCES RE
LINE 406
Itemization of Items Reported on Line 406
Total Other Behavioral Health Revenue

UNRELATED BUSINESS REVENUE REPORTED ON L INE 407
Itemization of Items Reported on Line 407
Total Unrelated Business Revenue

DISCLOSURE OF SUPPORTED HOUSING ON LINE 504g (Choose a category)
Rent Subsidy
Property Acquisition
Move-in/Start-up Kits
Assistance with Deposits
Utility Payments
Eviction/Prevention Efforts
Housing Provider (Property Manager)
Damages to the Unit
Other ADHS Approved Housing Expense s
(Itemize accordingly)

DISCLOSURE OF ALL OTHER BEHAVIORAL HEALTH SERVICE
ON LINE 511
Itemization of Items Reported on Line 511
Total All Other Behavioral Health Services

DISCLOSURE OF SERVICE EXPENSES FROM NON ADHS SOURC
Itemization of Items Reported on Line 520
Total Service Expense Non ADHS Sources

DISCLOSURE OF ALL OTHER OPERATING ON LINE 607
Itemization of Items Reported on Line 607
Total All Other Operating

DISCLOSURE OF NON ADHS and/or UNRELATED ADMINISTRAT
Itemization of Items Reported on Line 651
Total Non ADHS and/or Unrelated Administrative Expenses

DISCLOSURE OF UNRELATED BUSINESS EXPENSES ON LINE 7
Itemization of Items Reported on Line 701
Total Unrelated Business Expenses

ADJUSTMENTS

(Disclose and describe any adjustments to previously submitted financ affect the current financial statements.)

Notes:

Amount Expended for SAPT Children
Amount Expended for SAPT MAT

CMHS SED BLOCK GRANT	CMHS SMI BLOCK GRANT	SAPT BLOCK GRANT	FEDERAL OTHER	COUNTY	PASRR/ADOH	PATH	SUB TOTAL	PROGRAM ADMIN & MGMT/ GEN	TOTAL

H. STATEMENT OF CASH FLOWS

The primary purpose of the Statement of Cash Flows is to provide information about an entity's cash inflows and cash outflows during an accounting period. Cash flows are classified in terms of operating, investing and financing activities. Significant non-cash investing and financing activities not affecting cash must also be disclosed in the Statement of Cash Flows. The indirect method is used for financial reporting. For further guidance, the RBHA should refer to SFAS 117.

I. INSTRUCTIONS FOR THE STATEMENT OF CASH FLOWS

Segment Description	Instructions (Indirect Method)
CASH FLOWS FROM OPERATING ACTIVITIES: Changes in Net Assets/Equity Adjustments to Reconcile Excess of Revenue Over/(Under) Expenses to Net Cash Provided (used) by Operating Activities: Depreciation and Amortization Changes in Operating Assets and Liabilities: **(Increases)/Decreases in Assets:** Current Investments Receivables Interest Receivable Inventory and Prepaid Expenses Deposits Other **Increases/(Decreases) in Liabilities:** IBNR RBUC Accounts Payable to ADHS Accounts Payable to Providers Interest Payable Trade Accounts Payable Accrued Salaries and Benefits Other Liabilities **NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES**	Begin with the Revenue Over/(Under) Expenses for the period, as reported on the Statement of Activities. Each Statement of Financial Position account should be analyzed to calculate any difference in accounts from the prior period. The effects of all deferrals of prior operating cash receipts and payments, accruals of expected future operating cash receipts and payments pertaining to the entity's operating activities should be reported, each as a line item, in this segment of the statement.
CASH FLOWS FROM INVESTING ACTIVITIES: Proceeds from Sale of Property and Equipment Purchase of Property and Equipment (Describe on Schedule A) Proceeds from Sales of Investments Purchase of Investments **NET CASH PROVIDED (USED) BY INVESTING ACTIVITIES**	Cash flows from investing activities include the results of analyses of the Statement of Financial Position accounts pertaining to the entity's investing activities. Purchases and sales of investments, furniture, equipment, and other related assets are reflected in this segment of the statement.
CASH FLOWS FROM FINANCING ACTIVITIES: Contributions from Parent Dividends Paid Acquisition of Debt (Describe on Schedule A) Payment of Lease Obligations Payment of Other Debts (Describe on Schedule A) **NET CASH PROVIDED (USED) BY FINANCING ACTIVITIES**	Cash flows from financing activities include the results of analyses of Statement of Financial Position accounts pertaining to financing activities, such as contributions from parent, dividends paid, acquisition and repayment of debts, long-term leases, etc.
NET INCREASE/(DECREASE) IN CASH	This is the net increase/decrease in cash during the period.
BEGINNING CASH	The cash balance at the beginning of the period.
ENDING CASH BALANCE** ****Must agree with Cash Balance reported on the Balance Sheet**	The sum of net increase/decrease and beginning cash balance.

STATEMENT OF CASH FLOWS
YEAR TO DATE FOR PERIOD ENDED:

CASH FLOWS FROM OPERATING ACTIVITIES:

Changes in Net Assets/Equity
Adjustments to Reconcile Excess of Revenue Over/(Under) Expenses
to Net Cash Provided (Used) by Operating Activities:
Depreciation and Amortization
Changes in Operating Assets and Liabilities

(Increases)/Decreases in Assets:

- Current Investments
- Receivables
- Inventory & Prepaid Expenses
- Interest Receivable
- Deposits
- Other

Increases/(Decreases) in Liabilities:

- IBNR
- RBUC
- Accounts Payable to ADHS
- Accounts Payable to Providers
- Interest Payable
- Trade Accounts Payable
- Accrued Salaries & Benefits
- Other Liabilities

NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES

CASH FLOWS FROM INVESTING ACTIVITIES

- Proceeds from Sale of Property & Equipment
- Purchase of Property & Equipment (Describe on Schedule A)
- Proceeds from Sales of Investments
- Purchase of Investments

NET CASH PROVIDED (USED) BY INVESTING ACTIVITIES

CASH FLOWS FROM FINANCING ACTIVITIES:

- Contributions from Parent
- Dividends Paid
- Acquisition of Debt (Describe on Schedule A)
- Payment of Lease Obligations
- Payment of Other Debts (Describe on Schedule A)

NET CASH PROVIDED (USED) BY FINANCING ACTIVITIES

NET INCREASE/(DECREASE) IN CASH
BEGINNING CASH
ENDING CASH BALANCE *

***NOTE: ENDING CASH BALANCE MUST AGREE WITH TOTAL CASH BALANCE ON BALANCE SHEET**

STATEMENT OF CASH FLOWS
YEAR TO DATE FOR PERIOD ENDED:
Schedule A Disclosure

Describe:

1. Sources and amounts of cash received for other grants.

2. Underlying transactions for acquisition of debt.
   (Debtor, amount, purpose of loan, term, interest rate and term of debt acquired during the quarter.)

3. Underlying transactions for retirement of debt.
   (Debtor, amount paid off.)

4. Cash Flows from financing activities – Payment of Other Debt

5. Supplemental data or non-cash investing and financing activities, gifts, etc.

6. Purchase of Property and Equipment.

J. PROFIT~~/RISK CORRIDOR~~ LIMIT CALCULATIONS

See **Section III. C. #7** for information on Profit~~/Risk Corridor Analysis~~ Limit Calculations.

K. INSTRUCTIONS FOR THE PROFIT LIMIT CALCULATIONS ~~/RISK CORRIDOR ANALYSIS~~

An ~~separate~~ analysis should be prepared for ~~Title XIX, Title XXI and~~ Non-Title XIX/XXI programs. Enter the profit limit ~~/risk receivable,~~ payable~~,~~ or adjustment amount(s) if applicable. The details of any adjustment must be disclosed. Also, disclose factors contributing to the excess profit ~~or loss~~.

Accrue a Payable to ADHS and adjust the revenue in the appropriate program. No more than 3% profit should be earned in ~~each program: Title XIX, Title XXI and~~ SAPT Block, CMHS Block Grant and Non-Title XIX/XXI (Non-Title XIX/XXI Other and County). Revenue and Expenses, as reported in the Profit Limit Calculations ~~Corridor Analysis~~, must match the Revenue and Expenses as reported in the Statement of Activities.

RBHAs shall not earn a profit in Non-Title XIX/XXI SMI Medications, Supported Housing and Crisis. These programs are treated separately for profit purposes. Unexpended funds in these programs must be returned to ADHS upon request. Losses incurred in these programs will not be reimbursed.

For-Profit Entities:

The provision for income tax will not be added to service expense. In the event of excess profit in any program, the excess profit amount must be used to reduce revenue in the Statement of Activities. When revenue is reduced, revise the amount on line 401a.

The required steps are as follows:

1) Calculate Profit Limit ~~/Risk~~; and
2) Enter the amount of excess profit on the ~~Profit Risk Corridor~~ Amount Payable Reported by RBHA line on the Profit ~~Risk Corridor~~ Limit Analysis Report. Accrue this amount as a Payable to ADHS.
3) Reduce the ADHS Revenue on the Profit ~~Risk Corridor~~ Limit Analysis Report. The Total Revenue should remain the same after adjusting for steps 2 and 3. If there is an excess profit, reduce revenue on the Statement of Activities accordingly. This is the amount that must be returned to ADHS.
~~4) A reduction in revenue will have the effect of lowering taxes originally reported. Add the difference between the original tax amount and the new reduced tax amount to the original Payable to ADHS.~~
~~5) Reduce revenue again by the change in the Payable to ADHS (tax difference). In total, revenue should be reduced by the same amount as the second iteration, and the Profit/Risk Corridor Payable should equal the amount of the second iteration. The Total Revenue should remain the same after adjusting for steps 4 and 5. The total revenue reduction should equal the total Payable to ADHS. This is the amount that must be returned to ADHS.~~
~~6) Increase the original accrual by this additional amount.~~

7) Reduce revenue on the Statement of Activities by the amount of the total Payable to ADHS.
8) It is not necessary to continue the iteration after the first reduction in taxes is completed.

RBHA
Profit/Risk Corridor Analysis - TXIX
Per the RBHA Un-audited Financial Statements
FOR MONTH ENDED: July 31, 20XX

TXIX	**TXIX Child**	**TXIX CMDP**	**TXIX DD Child**	**Total TXIX Child**
ADHS Revenue	$0	$0	$0	$0
Profit/Risk Corridor Amount (Receivable) reported by RBHA				$0
Profit/Risk Corridor Amount Payable reported by RBHA				$0
Adjustments*	-	-	-	$0
Total Revenue	**$0**	**$0**	**$0**	**$0**
ADHS Service Expense	$0	$0	$0	$0
ADHS Administrative Expense	$0	$0	$0	$0
Adjustments				$0
Service & Administrative Expense	**$0**	**$0**	**$0**	**$0**
EBIT	**$0**	**$0**	**$0**	**$0**
ADHS Income Tax provision	$0	$0	$0	$0
Net Profit/(Loss)	**$0**	**$0**	**$0**	**$0**
Contractual Profit Margin	0.00%	0.00%	0.00%	0.00%

	TXIX Child	**TXIX CMDP**	**TXIX DD Child**	**Total TXIX Child**
Service Revenue (92.5% of Total Revenue)	-	-	-	-
ADHS Service Expense & Income Tax	$0	$0	$0	$0
Service Profit/(Loss)	-	-	-	-
Profit Corridor (+/-3% of Service Revenue)	-	-	-	-
Less Sanctions				-
Revised Profit Corridor				-
Excess Service Profit/(Loss)	-	-	-	-
Contractual Profit/Risk Corridor %	0.00%	0.00%	0.00%	0.00%

***Adjustments:**
Disclose details of adjustments recorded
Disclosure:

Identify factors contributing to non-compliance of profit/risk corridors

TXIX SMI	TXIX DD ADULT	Total TXIX SMI	TXIX GMH/SA	Total TXIX
$0	$0	$0	$0	$0
			$0	$0
			$0	$0
			$0	$0
$0	$0	$0	$0	$0
$0	$0	$0	$0	$0
$0	$0	$0	$0	$0
			$0	$0
$0	$0	$0	$0	$0
$0	$0	$0	$0	$0
$0	$0	$0	$0	$0
$0	$0	$0	$0	$0
0.00%	0.00%	0.00%	0.00%	0.00%

TXIX SMI	TXIX DD ADULT	Total TXIX SMI	TXIX GMH/SA	Total TXIX
$0	$0	$0	$0	$0
0.00%	0.00%	0.00%	0.00%	0.00%

RBHA

Profit~~/Risk Corridor~~ Limit Analysis –~~TXXI and~~ NTXIX/XXI
Per the RBHA Un-audited Financial Statements
FOR MONTH ENDED:

	~~TXXI~~		
	~~TXXI Child~~	~~TXXI Adult~~	~~Total TXXI~~
ADHS Revenue	~~$0~~	~~$0~~	~~$0~~
~~Profit/Risk Corridor Amount (Receivable) reported by RBHA~~	-	-	-
Profit~~/Risk Corridor~~ Limit Amount Payable reported by RBHA	-	-	-
Adjustments*	-	-	-
Total Revenue	**~~$0~~**	**~~$0~~**	**~~$0~~**
ADHS Service Expense	~~$0~~	~~$0~~	~~$0~~
ADHS Administrative Expense	~~$0~~	~~$0~~	~~$0~~
Adjustments*	-	-	-
Service & Administrative Expense	**~~$0~~**	**~~$0~~**	**~~$0~~**
EBIT	**~~$0~~**	**~~$0~~**	**~~$0~~**
ADHS Income Tax provision	~~$0~~	~~$0~~	~~$0~~
Net Profit/(Loss)	**~~$0~~**	**~~$0~~**	**~~$0~~**
	-	-	-
Contractual Profit Margin	~~0.00%~~	~~0.00%~~	~~0.00%~~
	-	-	
	-	-	

	~~TXXI Child~~	~~TXXI Adult~~	~~Total TXXI~~
	-	-	
Service Revenue (92.~~5~~% of Total Revenue)	-	-	-
ADHS Service Expense ~~& Income Tax~~	~~$0~~	~~$0~~	~~$0~~
Service Profit/(Loss)	-	-	-
Profit Limit ~~Corridor~~ (+/-3% of Service Revenue)	-	-	-
~~Less Sanctions~~	-	-	-
~~Revised Profit Corridor~~	-	-	-
Excess Service Profit/(Loss)	-	-	-
Contractual Profit/Risk Corridor %	~~0.00%~~	~~0.00%~~	~~0.00%~~

***Adjustments:**
Disclose details of adjustments recorded

Disclosure:
Identify factors contributing to non-compliance of profit/risk corridors

NTXIX/XXI

SAPT Block Grant	CMHS SED Block Grant	CMHS SMI Block Grant	Total CMHS	NTXIX/XXI OTHER	COUNTY	Total NTXIX/XXI
$0	$0	$0	$0	$0	$0	$0
$0	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
$0	$0	$0	$0	$0	$0	$0
$0	$0	$0	$0	$0	$0	$0
$0	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
$0	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
$0	$0	$0	$0	$0	$0	$0
$0	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

SAPT Block Grant	CMHS SED Block Grant	CMHS SMI Block Grant	Total CMHS	NTXIX/XXI OTHER	COUNTY	Total NTXIX/XXI
-	-	-	-	-	-	-
$0	$0	$0	$0	$0	$0	$0
-	-	-	-	-	-	-
-	-	-	-	-	-	-
-	-	-	-	-	-	-
-	-	-	-	-	-	-
-	-	-	-	-	-	-
-	-	-	-	-	-	-
0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

L. LAG REPORT

AICPA Statement of Position (SOP) 89-5 defines IBNR as costs associated with health care services incurred during a financial reporting period but not reported to the prepaid health care provider until after the reporting date. GAAP requires costs to be accrued as services are rendered. This requirement is met through accrual of a liability, i.e., IBNR. In conjunction with the IBNR process, SOP 89-5 further states that premiums (equivalent to capitation) are reported as revenue in the month members are entitled to service; premiums collected in advance are deferred revenue. SOP 89-5 concludes: "Health care costs should be accrued as the services are rendered, including estimates of the costs of services rendered but not yet reported. Furthermore, if a provider of prepaid health care services is obligated to render services to specific members beyond the premium period due to provisions in the contract or regulatory requirements, the costs to be incurred for such services should also be accrued currently." (AICPA SOP 89-9, paragraph 30)

There are three primary components of claims expense:

- Paid Claims
- Received but unpaid claims (RBUCs). A claim should be classified as an RBUC immediately upon its receipt and is to be tracked as such. The processing status of a RBUC is either pended, in process, or payable.
- Incurred But Not Reported claims (IBNRs)

Paid claims and RBUC expenses are identifiable as part of the basic accounting systems of the RBHAs. Since these components, along with a well-established prior authorization and referral system, form the basis for IBNR estimation, it is imperative that the RBHA has an adequate claims accrual and payment system. The system must be capable of reporting claims on a date-of-service basis, have the capacity to highlight large outlier cases, possess sufficient internal controls to prevent and detect payment errors, and conform to regular payment patterns. Once IBNR estimates have been established, continuous monitoring of reported and paid claims is essential.

Claim expense evaluation requires consideration of current trends and conditions. The following claims environment factors should be considered:

- Changes in various policies, practices, or coverage;
- Trends in inflation;
- Trends in claims lag time;
- Trends in length of hospital inpatient stay;
- Changes in contractual agreements.

IBNRs are difficult to estimate because the total units of service and the exact service costs are not always known prior to claims receipt. Since inpatient and residential treatment center claims are the major expenses incurred by the RBHAs, it is important to accurately identify costs of outstanding unbilled services. Selection of an appropriate system for estimating IBNR claims expense is based on RBHA circumstances, characteristics, and the availability of reliable information.

Elements of an IBNR system are:

1. The IBNR system must function as an integral part of the overall financial management and claims system. These systems join to collect, analyze, and share claims data. They require effective referral, prior authorization, utilization review and discharge planning functions. The RBHA must, in addition, have a full accrual accounting system to properly identify and record the expense, together with the related liabilities for all unpaid and unbilled services provided to clients.

2. An effective IBNR system requires the development of reliable lag reports that identify the length of time between the dates of service, receipt of claims, and processing/payment of claims by major provider type (hospital, outpatient, etc.). Reliable claims/cash disbursement systems generally produce much of the necessary data. Lag Reports and projections are most useful when there is a sufficient, accurate claims history, with stable lag patterns. If this is not the case, the reports will require modification, on a pro-forma basis, to reflect corrections for known errors or skewed payment patterns. The data included in the Lag Reports should include all information received to date.

3. Whenever practical, claims data collection and analysis should begin before the service is provided (i.e., prior authorization records). This prospective claims data, together with claims data collected as the services are provided (i.e., prior authorization records), should be used to identify claims liabilities.

4. Claims data may be segregated to permit analysis by: county, major provider, or category of service.

5. Subcontract agreements should clearly state each party's responsibility for claims/encounter submission, prior notification, authorization, and reimbursement rates. These agreements should be in writing, clearly understood, and followed consistently by each party.

6. Individual IBNR amounts, once established, should be monitored for adequacy and adjusted, as needed. If IBNR estimates are subsequently found to be significantly high or inaccurate, analysis should be performed to determine the reasons therefore. This analysis should be incorporated into a RBHA's IBNR methodology, if applicable.

   Several different methods can be used to determine the total IBNR amount. The RBHAs should employ a method that best meets their needs and accurately estimates their IBNRs. If a RBHA is considering a method different from that previously described, a written description of the process must be submitted to ADHS for approval prior to its use. The IBNR methodology used by the RBHA must also be evaluated by the RBHAs Independent Certified Public Accountant for reasonableness. If the RBHA employs an alternate method to estimate its IBNR, the RBHA must submit documentation to back-up the amount of IBNR reported. Documentation is required only on the quarterly, draft and final audited reports. Documentation may be sent electronically and is due on the same day the financial reports are due. The quarterly and final reports will be considered incomplete if the documentation for the IBNR estimate is not submitted by the report's due date.

Lag Reports are used to track historical payment patterns. When a sufficient history exists and a regular claims submission pattern has been established, this methodology can be employed. If the Lag Report is not the primary methodology, the RBHA should use lag information as a validation test for accruals calculated using other methods. Typically, the information on the schedules is organized according to the month services are rendered on the horizontal axis and the month claims for those services are paid on the vertical axis. Population and category of service should track specifically, as each population may have different characteristics. A Lag Report - Summary should be prepared for each GSA.

M. INSTRUCTIONS FOR THE LAG REPORT

Once a number of months (typically eighteen) becomes fully reported and paid, the information can be used to estimate IBNRs. IBNR can be estimated by computing the average period over which claims are submitted and applying the completion factor months, which are not yet fully developed. The following example demonstrates the lag table:

Fully Developed Table

Month of Service

Month of Payment	Current	1st Prior	2nd Prior	Total	Percent of Total	Cumulative Percent
Current	2,000	800	1,400	4,200	10.0%	10.0%
1st Prior	8,500	8,750	8,200	25,450	60.6%	70.6%
2nd Prior	3,750	2,800	3,700	10,250	24.4%	95.5%
3rd Prior	750	650	700	2,100	5.0%	100.0%
Total	15,000	13,000	14,000	42,000	100.0%	

This table indicates that 10.0 percent of all claims are reported and paid in the month services are rendered, 60.6 percent are paid in the second month, etc. In this example, within four months from the date of service all claims are paid (i.e., fully developed). The information in this example can be used to calculate IBNRs by examining claims payment experience for the three months prior to the balance sheet date.

By dividing the claims paid to date, by the decimal form of the cumulative percent developed from the fully developed table for the applicable month, an estimate can be made of each month's total claims to be experienced for the period. Subtracting the total claims paid to date from this estimate yields the estimated claims expense accrual for the IBNR.

The following steps must be taken in order to estimate the total claims expense as of the end of June:

1. For each month not yet fully developed, the cumulative percentage (obtained from the fully developed table) should be divided into the total amount of claims paid to date for each month. The result will be estimated total claims expense for each month.
2. Subtract all claims paid or received (RBUCs) for that month from the estimated total claims expense for each month. The remainder represents the IBNR estimate.

An example of a completed Lag Report is shown below:

LAG REPORT EXAMPLE

	Month of Service				% of Total	Cumulative
Month of Payment	Current	1st Prior	2nd Prior	Total	Dollars	Percent
Current	$ 1,600	$ 1,900	$ 1,600	$ 5,100	17.47%	17.47%
1st Prior	$ 0	$10,600	$ 9,700	$20,300	69.52%	86.99%
2nd Prior	$ 0	$ 0	$ 3,800	$ 3,800	13.01%	100.00%
3rd Prior	$ 0	$ 0	$ 0	$ 0		
Total	$ 1,600	$12,500	$15,100	$29,200		
Divided by Cumulative Percent	17.47%	86.99%	100%	N/A		
Calculated Total FFS Claim Expense	$ 9,159	$14,369	$15,100	$38,631		
Adjustments*	0	0	0	0		
Total FFS Claim Expense	$ 9,159	$14,369	$15,100	$38,628		
Less: Amount Paid to Date				$29,200		
Less RBUCs				$ 1,400		
Total IBNR				$ 8,028		

* Disclose adjustments at management's discretion. Provide a detailed explanation and show calculations.

Estimates developed by this lag methodology should be monitored for reasonableness. This is particularly true for the most recent months where the information is less developed. If the calculation is producing an unusually low or high total claims expense for any particular month, it should be investigated for validity.

The IBNR liabilities should tie to the Statement of Financial Position. A RBHA may submit a Lag Report with less than the required information and in a format different from the illustrated report, if prior approval has been obtained from DBHS Chief Financial Officer.

RBHA
LAG REPORT – SUMMARY
AS OF:

	Month of Service								
Month of Payment	**Current**	**1st Prior**	**2nd Prior**	**3rd Prior**	**4th Prior**	**5th Prior**	**6th Prior**	**7th Prior**	**8th Prior**
Current									
1st Prior									
2nd Prior									
3rd Prior									
4th Prior									
5th Prior									
6th Prior									
7th Prior									
8th Prior									
9th Prior									
10th Prior									
11th Prior									
12th Prior									
13th Prior									
14th Prior									
15th Prior									
16th Prior									
17th Prior									
18th Prior									
Total Claims Paid									
Title XIX									
Title XXI									
Non-Title XIX/XXI									

Total FFS Expense Reported									
Title XIX									
Title XXI									
Non-Title XIX/XXI									

Total Block/Sub Cap Exp Rprtd									
Title XIX									
Title XXI									
Non-Title XIX/XXI									

Total RBUCs Reported									
Title XIX									
Title XXI									
Non-Title XIX/XXI									

Total IBNR Reported									
Title XIX									
Title XXI									
Non-Title XIX/XXI									

Month of Service										
9th Prior	10th Prior	11th Prior	12th Prior	13th Prior	14th Prior	15th Prior	16th Prior	17th Prior	18th Prior	Total

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N. FINANCIAL RATIO ANALYSIS COMPARISON REPORT

This is a report generated from the E-statements for analysis purposes.

O. INSTRUCTIONS FOR THE FINANCIAL RATIO ANALYSIS COMPARISON REPORT

The majority of the amounts are linked from other statements. The following fields require input:

- Monthly Capitation and Non-Title XIX/XXI Payment under the Maintenance of Minimum Capitalization Section

- The Number of Enrollees under the Equity Per Enrolled Member Section

RBHA
Financial Ratio Analysis Comparison
As of: July 31, 20XX

Liquidity Ratio

Current Ratio: (Standard ≥ 1.0)

Current Assets/Current Liabilities

Month Ending	Current Assets	Current Liabilities	Ratio
Jul-XX	-	-	-

Equity per Enrolled Member (Standard ≥ $300 per enrolled member)

Net Assets / (Number of Enrolled Members * $300)

Month Ending			Total
Jul-XX	Net Assets/Equity	$	-
	Less Performance Bond reported on Financial Statements	$	-
	Subtotal	$	-
	Divided by the No. of Enrollees		-
	$300 per enrolled member	$	300
Compliance/*(Out of Compliance)		$	(300)

* Out of Compliance provide plan of correction.

Performance Ratios

Title XIX/XXI Administrative Ratio: (Standard ≤ 8.0~~7.5~~%)

Title XIX/XXI Admin. Exp./(Total Title XIX/XXI Rev.~~ less Interpretive Services~~)

Month Ending	Title XIX/XXI Administrative Expense	(Title XIX/XXI Revenue ~~less interpretive Services~~)	Percent
Jul-XX	-	-	-%

~~**Title XXI Administrative Ratio: (Standard ≤ 7.5%)**~~

~~Title XXI Admin. Exp./(Total Title XXI Rev. less Interpretive Services)~~

~~Month Ending~~	~~Title XXI Administrative Expense~~	~~(Title XXI Revenue less Interpretive Services)~~	~~Percent~~
~~Jul-XX~~	~~-~~	~~-~~	~~-%~~

Non-Title XIX/XXI Administrative Ratio: (Standard ≤ 8.0~~7.5~~%)

Non-Title XIX/XXI Admin. Exp./(Total Non-Title XIX/XXI Rev.~~ less Interpretive Services~~)

Month Ending	Non-Title XIX/XXI Administrative Expense	(Non-Title XIX/XXI Revenue ~~less Interpretive Services~~)	Percent
Jul-XX	-	-	-%

Defensive Interval (in days): (Standard ≥ 30 days)

(Cash + Current Investments)/

((Total Expense - Non-cash Expense)/days)

Month Ending	Cash & Current Investments	Total Expenses – Non-cash Expenses	Current Days	Defensive Days
Jul-XX	-	-	-	-

Maintenance of Minimum Capitalization

(Net Assets - Performance Bond reported on Financial Statements) ≥ ((Monthly Capitation Payment + Non-Title XIX/XXI Payment)*90%)

Month Ending	Net Assets/Equity	Performance Bond		Total
Jul-XX	-	-		-
	Monthly Capitation Payment	**Non-Title XIX/XXI Payment**	***90%**	
				-
Compliance/*(Out of Compliance)				-

* Out of Compliance provide plan of correction.

Title XIX/XXI Service Ratio: (Standard: No less than 89.7%)

Title XIX/XXI Service Exp./(Total Title XIX/XXI Rev. ~~less Interpretive Services~~)

Month Ending	Title XIX/XXI Service Expense	(Title XIX/XXI Revenue ~~less Interpretive Services~~)	Percent
Jul-XX	-	-	-%

~~**Title XXI Service Ratio: (Standard: No less than 89.7%)**~~

~~Title XXI Service Exp./(Total Title XXI Rev. less Interpretive Services)~~

~~Month Ending~~	~~Title XXI Service Expense~~	~~(Title XXI Revenue less Interpretive Services)~~	~~Percent~~
~~Jul-XX~~	~~-~~	~~-~~	~~-%~~

Non-Title XIX/XXI Service Ratio: (Standard No less than 89.7%)

Non-Title XIX/XXI Service Exp./(Total Non-Title XIX/XXI Rev. ~~less Interpretive Services~~)

Month Ending	Non-Title XIX/XXI Service Expense	(Non-Title XIX/XXI Revenue ~~less Interpretive Services~~)	Percent
Jul-XX	-	-	-%

P. FORMATS FOR ANNUAL REPORTS

ANNUAL
STATEMENT OF FINANCIAL POSITION
AS OF:
Reconciliation from 4th Quarter Submission to Audited Consolidated Financial Statements

	As Submitted	Audit Adjustments		Restated	
ASSETS	**4th Quarter**	**Debits**	**Credits**	**Balance**	**Notes***
Current Assets					
101 Cash (Disclose on Schedule A)					
102 Current Investments					
103 Accounts Receivable (net) (Disclose on Schedule A)					
104 Notes Receivable (current portion)					
105 Prepaid Expenses					
106 Other Current Assets (Disclose on Schedule A)					
107 Total Current Assets					
Non-Current Assets					
108 Land					
109 Building					
110 Leasehold Improvements					
111 Furniture and Equipment					
112 Vehicles					
113 Total Property and Equipment					
114 Less: Accumulated Depreciation					
115 Net Property and Equipment					
116 Notes Receivable (net of current portion)					
117 Performance Bond (Disclose on Schedule A)					
118 Long Term Investments					
119 Deposits					
120 Other Noncurrent Assets (Disclose on Schedule A)					
121 Total Noncurrent Assets					
122 TOTAL ASSETS					

LIABILITIES AND NET ASSETS/EQUITY

		As Submitted	Audit Adjustments		Restated	
	Current Liabilities	**4th Quarter**	**Debits**	**Credits**	**Balance**	**Notes***
201	Incurred But Not Reported Claims					
202	Reported But Unpaid Claims					
203	Payable to ADHS					
204	Payable to Providers					
205	Trade Accounts Payable					
206	Accrued Salaries and Benefits					
207	Long-term Debt (current portion)					
208	Deferred Revenue (Disclose on Schedule A)					
209	Risk Pool Payable					
210	Other Current Liabilities					
211	Total Current Liabilities					
	Non-Current Liabilities					
212	Long-term debt (net of current portion)					
213	Loss Contingencies (Disclose on Schedule A)					
214	Other Noncurrent Liabilities					
215	Total Noncurrent Liabilities					
216	**TOTAL LIABILITIES**					
217	**NET ASSETS/EQUITY**					
	Unrestricted Net Assets					
	Restricted Net Assets					
218	**TOTAL LIABILITIES AND NET ASSETS/EQUITY**					

*** LIST THE BASIS OF AUDIT ADJUSTMENTS**

ANNUAL
STATEMENT OF FINANCIAL POSITION
AS OF:

Schedule A Disclosures

ASSETS:

Cash

Restricted

Unrestricted

Total Cash

Accounts Receivable

ADHS

Program ID	Category ID
Current Year	
Prior Year	

Non-ADHS &/or Unrelated Business

Current Year

Prior Year

Allowance for Doubtful Accounts

Total Accounts Receivable

Other Current Assets (Detail of Line 106)

Total Other Current Assets

Other Noncurrent Assets (Detail of Line 120)

Identify Other Noncurrent Assets

Total Other Noncurrent Assets

PERFORMANCE BOND:

List type of Security and Amount

Adjustments:

Disclose and describe any adjustments made to previously submitted financial statements, including those that affect the current period financial statements

Payables to ADHS – Other Category

Disclose items recorded as "Other" in the category for Payable to ADHS Section

Explain ≥10% fluctuation in account from prior period

Describe fluctuation in each account greater than 10%

LIABILITIES:

IBNR Claims Estimate

Current Year

Current Year IBNR

Prior Year

Prior Year IBNR

Total IBNR

Payable to ADHS (Detail of Line 203)

Program ID	Category ID
Current Year	
Select Program	Select Category
Prior Year	

Total Payable - ADHS

Deferred Revenue from: (Detail of Line 208)

Program ID	Category ID
ADHS	
Current Year	
Prior Year	
Non-ADHS &/or Unrelated Business	
Current Year	
Prior Year	

Total Deferred Revenue

Other Current Liabilities (Detail of Line 210)

Identify Other Current Liabilities

Total Other Current Liabilities

Loss Contingencies (Detail of Line 213)

Identify Loss Contingencies

Total Loss Contingencies

Other Noncurrent Liabilities (Detail of Line 214)

Identify Other Noncurrent Liabilities

Total Other Noncurrent Liabilities

Restricted Assets (Detail of Line 217)

Itemized Restricted Assets

Total Restricted Assets

ANNUAL
CHANGES IN NET ASSETS/EQUITY
AS OF:
Reconciliation from 4th Quarter Submission to Audited Consolidated Financial Statements

Unrestricted:
Beginning Net Assets/EQUITY
Revenue Over/(Under) Expenses from 4th Quarter
Audit Adjustments (Disclose Basis Below)
Ending Net Assets/EQUITY

Temporarily Restricted:
Beginning Net Assets/EQUITY
Revenue Over/(Under) Expenses from 4th Quarter
Audit Adjustments (Disclose Basis Below)
Ending Net Assets/EQUITY

Permanently Restricted:
Beginning Net Assets/EQUITY
Revenue Over/(Under) Expenses from 4th Quarter
Audit Adjustments (Disclose Basis Below)
Ending Net Assets/EQUITY

Total Ending Net Assets/EQUITY (Line 217 Statement of Financial Position)

LIST THE BASIS OF AUDIT ADJUSTMENTS

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RBHA NAME
DISCLOSURE STATEMENT/RELATED PARTY TRANSACTIONS CERTIFICATON

RBHA NAME: _____
DISCLOSURE STATEMENT/RELATED PARTY TRANSACTIONS FOR THE YEAR ENDED: _____
CONTRACT NUMBER: _____

I hereby attest that the information contained in the Disclosure Statement/Related Party Transactions is current, complete and accurate to the best of my knowledge. I also attest that these reported transactions are reasonable, will not impact on the fiscal soundness of the RBHA, and are without conflict of interest. I understand that whoever knowingly and willfully makes or causes be made a false statement on the statement may be prosecuted under applicable federal and/or state laws. In addition, knowing and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the RBHA already participates in the agreement may terminate the agreement or contract with ADHS.

_____ _____
Date Signed Chief Financial Officer

RBHA NAME
FINANCIAL DISCLOSURE STATEMENT

The RBHA must provide the following information as required by 42 CFR 455 Subpart B.

1. Ownership: List the name and address of each person with ownership or controlling interest as defined by 42 CFR 455.101, in the disclosing entity.

Name	Address	Percent of Ownership or Control

2. RBHA Ownership: List the name and the address of each person with an ownership or control interest in any RBHA in which the disclosing entity has direct or indirect ownership of 5% or more:

Name	Business Name	Address	Percent of Ownership or Control

Name of above persons who are related to one another as spouse, parent, child or sibling:

3. Ownership in Other Entities: List the name of any other entity in which a person with ownership or controlling interest in the RBHA also has an ownership or controlling interest:

4. Business Transactions: List the Ownership of any subcontractor with whom the RBHA has had business transactions totaling more than $ 25,000 during the 12-month period ending on the date of the request:

Subcontractor	Describe Ownership of Subcontractors	Type of Business Transaction with Provider	Dollar Amount of Transaction

5. Long –Term Business Transactions: List any significant business transactions, as defined in 42CFR 455.101, between the RBHA and any wholly-owned supplier or between the RBHA and any subcontractor during the five-year period ending on the date of the request:

Subcontractor	Describe Ownership of Subcontractors	Type of Business Transaction with Provider	Dollar Amount of Transaction

6. Criminal Offenses: List the name of any person who has ownership or controlling interest in the RBHA, or is an agent or managing employee of the RBHA and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XXI services program since the inception of those programs:

Name	Address	Title

7. Creditors: List the name and address of each creditor whose loans or mortgages exceed 5% of the total RBHA equity and are secured by assets of the RBHA.

Name	Address	Description Of Debt	Amount of Security

RBHA RELATED PARTY TRANSACTIONS

1. **Board of Directors:** List the Names/Titles and Addresses of the Board of Directors of the RBHA:

Name/Title Address

_____
_____
_____
_____
_____
_____

2. **Related Party Transactions:** Describe transactions between the RBHA and any related party in which a transaction or series of transactions during any one fiscal year exceeds the lesser of $10,000 or 2% of the total operating expenses of the disclosing entity. List property, goods, services and facilities in detail noting the dollar amounts or other consideration for each transaction and the date thereof. Include a justification as to (1) the reasonableness of the transaction, (2) its potential adverse impact on the fiscal soundness of the disclosing entity, and (3) that the transaction is without conflict of interest:

a) The sale, exchange or leasing of any property:

Description of Transaction	Name of Related Party And Relationship	Dollar Amount for Reporting Period

Justification:

_____
_____
_____
_____
_____
_____

b) The furnishing of goods, services or facilities for consideration:

Description of Transaction	Name of Related Party And Relationship	Dollar Amount for Reporting Period

Justification:

c) Describe all transactions between the RBHA and any related party which includes the lending of money, extensions of credit or any investment in a related party. This type of transaction requires review and approval in advance by the ADHS Director:

Description of Transaction	Name of Related Party And Relationship	Dollar Amount for Reporting Period

Justification:

d) List the Name and Address of any individual who owns or controls more than 10% of stock or that has a controlling interest (i.e. formulates, determines or vetoes business policy decisions):

Name	Address	Owner or Controller	Has Controlling Interest? Yes/No

PERFORMANCE BOND INSTRUCTIONS

VII. PERFORMANCE BOND

A. PERFORMANCE BOND DESCRIPTION

ADHS allows several specific ways to satisfy the performance bond, as follows:

- Cash Deposits
- Irrevocable Stand-by Letter of credit issued by any of the below named institutions:
  1. A bank insured by the Federal Deposit Insurance Corporation.
  2. A Savings and Loan association insured by the Federal Savings and Loan Insurance Corporation.
  3. A credit union insured by the National Credit Union Administration.
- Surety Bonds issued by a surety company approved by ADHS.
- Substitute security, as agreed to by ADHS.

On or before June 15 of each year, the RBHA shall establish and maintain a performance bond rated at least A by A.M. Best Company of a standard scope issued by a surety company or companies holding a certificate of authority to transact surety business in the State of Arizona issued by the Director of the Department of Insurance pursuant to Title 20, Chapter 2, Article 1, and in a form prescribed by R2-7-505.

A full listing of acceptable substitute securities is described below. The acceptable list is complete; no others can be substituted. The listing of unacceptable securities is not comprehensive; it is designed only to give an idea of common securities that have already been considered and rejected. ADHS will periodically review the acceptable substitutes and consider other options as needed.

Certificate of Deposit (CD). CDs must be issued by a financial institution and insured by the appropriate Federal Agency. The CD must be assigned to ADHS and forwarded to the State Treasurer for safekeeping.

United States Treasury Bills (T-Bills). Similar to the Treasury Notes and Bonds, except they are much shorter in term, three, six and twelve months, and are sold at a discount. This means that less than the face amount is paid for the original purchase price and the face amount is recovered at maturity. The interest earned is the difference between the amount paid and the par value of the T-Bill.

United States Treasury Notes and Bonds. This type of security is backed by the full faith and credit of the United States Government. These are notes, with maturities ranging from two to thirty years. Interest is paid semi-annually on the anniversary of the issued date and six months later. They are considered coupon securities even though they are now mostly in book entry form. Ownership is simply entered in the computers of the Federal Reserve. Interest is paid by the Federal Reserve by issuing credits to members that the notes are recorded through and the banks credit the customer's account. These notes and bonds shall be held by the custodian of the State Treasurer (U.S. Bank). They may not be released or substituted without ADHS approval.

Federal Farm Credit Banks (FFCB). The FFCB is 37 banks that issue two types of securities that can be substitutes for the performance bond, Consolidated System wide bonds and Consolidated System wide notes. The securities are the joint and several obligations of all 37 member banks of the FFCB.

Federal Home Loan Banks (FHLB). The FHLB serves the same function for the Savings and Loan industry as the Federal Reserve does for the banking industry. It is owned by the member Savings and Loan and issues coupon interest bonds much like the Federal Reserve.

Federal National Mortgage Association (FNMA). FNMA issues two types of securities, coupon interest bonds and mortgage bonds. The coupon interest bonds are acceptable for the Performance Bonds. The Mortgage bonds are not acceptable because of the repayment of the principal over the life of the bonds.

Securities NOT acceptable to ADHS:

- Federal Home Loan Mortgage Corporation (FHLMC).
- Governmental National Mortgage Association (GNMA).
- Municipal Bonds.
- Corporate Bonds.
- Commercial Paper.
- Stocks.
- Letter of credit from other than a Bank, Savings and Loan or Credit Union.
- Banker's acceptance.
- Mutual Funds.
- Letter of Credit (guarantee) from any parent organization.

The Performance Bond shall remain in the safekeeping of the State of Arizona Treasurer's Office, or the State Treasurer's appointed custodian.

RBHA PROCEDURES:

Depending on the type of Performance Bond posted, the RBHA shall have funds deposited with the State Treasurer, Certificates of Deposit assigned to the State Treasurer, or substitute securities deposited with the State Treasurer's appointed custodian. The Original Letter of Credit or Surety bond must be sent to ADHS and will be forwarded to the State Treasurer for safekeeping.

The Performance Bond shall have an immediate redemption value equal to or greater than the Performance Bond required at the time of purchase.

The Performance Bond shall have a termination date of either the date in which the RBHA has liabilities relating to the performance of the contract of less than $50,000 or twelve months following the termination date of the contract, whichever is later.

The State of Arizona Contract Number shall be noted on the performance bond. The RBHA must submit a written request to ADHS to withdraw or release its Performance Bond.

B. PERFORMANCE BOND INSTRUCTIONS

1. CASH DEPOSITS

a. Deposit of Funds

i. The RBHA shall send ADHS a check in an amount that meets or exceeds the Performance Bond requirement. The check shall be accompanied by a letter describing:

- The application of funds as a Performance Bond for the ADHS contract.
- The name and phone number of a primary contact.
- Instructions for the disposition of the interest from the deposit. Interest can be reinvested or disbursed monthly.
- Directions of where to send any disbursed interest.

ii. ADHS will complete and send the Securities Safekeeping Form with the RBHA's check to the State Treasurer for processing and deposit.

iii. Subject to the instructions provided, the State Treasurer may issue warrants each month for the interest in the account.

iv. The State Treasurer will furnish statements of the account only upon written request. This request may be made at any time.

b. Withdrawal of Funds

i. The RBHA must send a letter to ADHS requesting the withdrawal of any or all principal funds. The letter must include:

- The amount of the withdrawal.
- The date the funds should be withdrawn, (allow a minimum of ten working days).
- The manner in which the warrant from the State Treasurer's Office should be handled: Mailed by the US Postal Service, or Courier (please include name and phone number of primary contact).

2. IRREVOCABLE LETTER OF CREDIT

a. Establishment of Bond

i. The RBHA should secure approval from ADHS prior to posting an irrevocable Letter of Credit (LOC) as a Performance Bond. Only stand-by LOCs are acceptable. The request for approval must include:

- General requirements of the proposed LOC.
- An amount that meets or exceeds the Performance Bond requirement.
- A time period that meets or exceeds ADHS' contract term.
- ADHS must receive a signed extension of the LOC at least 60 days prior to the expiration of the LOC or upon ADHS demand.

ii. The RBHA must send the LOC to ADHS ten working days prior to the execution date. ADHS will review the LOC for elements necessary for the Performance Bond and advise the RBHA of the acceptance of, or required changes to, the LOC. Upon acceptance of the LOC by ADHS, the RBHA must submit the original LOC to ADHS. The original will be held with the State Treasurer for safekeeping until the agreement ends or is terminated by the parties.

b. Return of original Letter of credit

Original Letter of credit will be returned to the maker upon:

- Termination of the LOC.
- Satisfying the Performance Bond requirement with another acceptable form.

3. SURETY BONDS

a. Establishment of a Surety Bond

The RBHA shall secure approval from ADHS prior to posting a Surety Bond as a Performance Bond.

The general requirements of a Surety Bond are as follows:

- An amount that meets or exceeds the Performance Bond requirement.
- A time period that meets or exceeds ADHS' contract term.
- ADHS must receive a signed extension of the bond 60 days prior to the bond expiration date or upon ADHS demand.

The RBHA must send the original Surety Bond to ADHS. ADHS will notify the RBHA in writing of the acceptance of the Surety Bond or of any necessary changes within five days of receipt of agreement. The original will be forwarded to the State Treasurer for safekeeping until the agreement ends or is terminated by the parties.

b. Return of Surety Bond original

The original Surety Bond will be returned to the makers upon:

- Termination of the Surety Bond, or
- Satisfying the Performance Bond requirement with another acceptable form.

4. CERTIFICATE OF DEPOSIT

a. Assignment to Arizona State Treasurer

The completion of the Assignment to Arizona State Treasurer form is the RBHA's responsibility. Only Certificates of Deposit (CD) from banks, savings and loans, or credit unions, insured by the appropriate federal institution, are acceptable for the Performance Bond. The face amount of the CD must be equal to or greater than the Performance Bond requirement.

b. Deposit of the Certificate of Deposit

The RBHA shall deliver to ADHS the original CD (or receipts for the CD if certificate is not issued), the Assignment to Arizona State Treasurer, and a letter detailing the reason for the deposit and the name of a contact person.

ADHS will complete and send a Securities Safekeeping form with the CD and the Assignment to Arizona State Treasurer to the State Treasurer. It is the RBHA's responsibility to monitor the maturity date of the CD. No notifications will be made from the State Treasurer's Office or ADHS.

c. Withdrawal of a Certificate of Deposit

The RBHA must send a letter to ADHS requesting the release of a specific CD. The letter must include:

- The name of the institution issuing the CD.
- The certificate number.
- The amount of the CD.
- The manner in which the CD is to be returned to the RBHA.
- The name of a contact person.

5. UNITED STATES TREASURY BILLS

a. Establishment of custodial account

i. The RBHA shall open a custodial account by providing the following information to US Bank (Forms and the US Bank contact information are available from ADHS upon request):

- Request for Taxpayer Identification Number and Certification (Form W-9)
- State of Arizona Client Data Form completed with specimen signatures
- Arizona Department of Health Security Deposit Form (Form E125)
- Shareholder Communication Act Form Authorization by an Institutional Shareholder
- Money Market Fund Disclosure Form
- State Treasurer Custody Agreement & Appendix A. (mutually agreed upon)
- Articles of Incorporation
- List of Principals and Directors

ii. After US Bank has opened the custodial account, the RBHA should execute the Arizona Department of Health Security Deposit Form (Form E125) to transfer the funds to US Bank (Funds for Treasury Bills can not be transferred in less than $1,000 increments). Funds will be electronically transferred to US Bank based on the instructions per the E125 Deposit Form.

iii. After the funds have been deposited, US Bank will send a copy of the executed custody agreement to ADHS, the State Treasurer and the RBHA.

US Bank shall not permit the RBHA to make any withdrawal, disbursement, exchange, or transfer of Eligible Securities or other property from the Account if the Account Value, after giving effect to such transaction, would be less than the Minimum Account Balance (MAB). In addition, upon receipt of a MAB change notice, US Bank shall, by facsimile or electronic mail, confirm to ADHS that the RBHA's Account Value is at least equal to the new Minimum Account Balance.

iv. The RBHA can set up an on line access account to retrieve quarterly statements from US Bank. US Bank will send annual statements to the RBHA.

b. Withdrawal of Funds

i. To withdraw funds, the RBHA must send a letter to ADHS requesting the withdrawal. The letter must include:

- The amount of the withdrawal
- The date that the funds should be withdrawn (allow a minimum of ten working days)
- E-126 Security Release Form

ii. Upon approval, ADHS will forward the E-126 form to US Bank to release the funds.

TRIBAL GENERAL ACCOUNTING ISSUES AND REPORTING REQUIREMENTS

VIII. TRIBAL GENERAL ACCOUNTING ISSUES AND REPORTING REQUIREMENTS

A. GENERAL ACCOUNTING ISSUES

The TRBHA shall ensure that it has a system to produce complete, timely, reliable and accurate financial records in accordance with Government Auditing Standards, and if applicable OMB A-133, "Audits of States, Local Governments and Non-Profit Organizations".

Reports should be submitted electronically to the Office of Financial Review and the compliance mailbox at BHSCompliance@azdhs.gov. Report due dates that fall on a weekend or State recognized holiday are due the next business day. All reports are due by 5:00 p.m. on the due date. Extensions may be granted, but must be requested in writing and addressed to the Manager, Office of Financial Review. Requests must be received at least five (5) business days prior to ADHS' filing date and must include the reason for the extension and the revised filing date. Requests for filing extensions will be reviewed on a case to case basis.

Reports should be submitted electronically, whenever possible. If deliverables must be mailed, submit to the following address:

ADHS/DBHS/BFO
Attention: Manager, Office of Financial Review
150 N. 18th Avenue, Suite # 270
Phoenix, Arizona 85007

B. REPORTING REQUIREMENTS

1. Revenue and Expense Report

Based on individual Intergovernmental Agreements (IGA), the Revenue and Expense Report is either due 45 days after quarter-end or semi-annually by February 15 and August 15.

Quarterly or semi-annually, the TRBHA shall submit a year-to-date report detailing revenue and expenses separately for Supported Housing, Crisis Services, Medications, Title XIX/XXI Reimbursement, Grants (if applicable) and Title XIX Administration. Any reclassifications or adjustments should be footnoted on the report under disclosures.

Unexpended funds must be returned to ADHS upon request.

Annual Revenue and Expense Report with Annual Certification Statement is due by November 15 of each year.

TRBHA
Revenue and Expense Summary
For the (#) Months Ended (Date):

Revenue
- 401 ADHS/DBHS
- 406 Other Revenue
- **Total Revenue**

Service Expenses
- 501 Treatment Services
- 502 Rehabilitation Services
- 503 Medical Services
- 504 Support Services
- 505 Crisis Intervention Services
- 506 Inpatient Services
- 507 Residential Services
- 508 Behavioral Health Day Program
- 509 Reserved for Future Use
- 510 Medications
- 511 Flex Funds
- 512 Housing
  - a. Rent Subsidy
  - b. Property Acquisition
  - c. Move-In/Start-up Kits
  - d, Assistance with Deposits
  - e. Housing Provider (Property Manager)
  - f. Utility Payments
  - g. Eviction/Prevention Efforts
  - h. Damages to Unit
  - i. Other ADHS Approved Housing Expense (Disclose accordingly)
- 513 Coaching/Training
- 514 SAPT
  - a. SA General Services
  - b. Pregnant/Parenting Women
  - c. HIV
  - d. Prevention
  - e. Meth
  - f. Children

Administrative Expense
- 601 Salaries
- 602 Employee Benefits
- 603 Professional & Outside Services
- 604 Travel
- 605 Occupancy
- 606 Depreciation
- 607 All Other Operating*
  - Legal
  - Human Resources
  - Purchasing
  - Advertising
  - Utilities
  - Telephones
  - Translation Services
  - Staff Education
  - Mileage, Fuel, Lease
  - Supplies
  - Maintenance
  - Travel
  - Capital Outlay
- 620 Interpretive Services
- **Administrative Expense Sub-total**

Indirect Costs XX%
- **Total Expenses**
- **Net Revenue/(Loss)**

Adjustments:

Notes:

2. CERTIFICATION STATEMENT

The Revenue and Expense Reports must include a Certification Statement, signed and dated by the Chief Financial Officer. Scanned or mailed Certifications are due to ADHS within three business days of report submittal. Unsigned or unlabeled reports will not be accepted. The signature of the Chief Financial Officer is confirmation that the reports have been reviewed by the RBHA for accuracy and completeness. The certification statement must be an exact copy as the sample below:

CERTIFICATION STATEMENT OF (ENTITY NAME)
FOR THE PERIOD ENDED: _____, 20XX

Name of Preparer:_____

Title:_____

Phone No._____

I hereby attest that the information submitted in the reports herein is current, complete and accurate to the best of my knowledge. I understand that whoever knowing and willfully makes or caused to be made a false statement or representation with this report may be prosecuted under applicable state and /or federal laws. In addition, knowing and willfully failing to fully and accurately disclose the information requested might result in denial of a request to participate, or where the entity already participates, a termination of a T/RBHA's agreement or contact with the Arizona Department of Health Services.

Date Chief Financial Officer

3. Audited Financial Statements

Audited Financial Statements are due to ADHS nine (9) months after the Tribe's fiscal year-end. If the TRBHA expends $500,000 or more a year in Federal Awards, an Audit conducted in accordance with OMB Circular A-133 is required. SAPT and CMHS Block Grants must be audited as major programs. These reports must be prepared by an Independent Auditor and include supplemental schedules and audit opinions.

C. GENERAL REPORTING GUIDELINES

Financial data shall be reported in the format prescribed by ADHS. Generally Accepted Accounting Principles (GAAP) should be observed in the preparation of each report. Examples and general guidelines for each report follow. Separate instructions and template formats will be provided by ADHS in Microsoft Excel format (E-Statements). All amounts are to be rounded and reported in whole dollars. An explanation of adjustments made for prior periods and adjustments to prior months in the current fiscal year are to be disclosed. If there are insufficient instructions for a specific category, the TRBHA shall request direction from the DBHS Chief Financial Officer. A perceived lack of instruction is not sufficient grounds for failure to report accurately. ADHS has provided the required reporting formats to ensure consistent reporting among the TRBHAs. It is the TRBHA's responsibility to ensure that all reports submitted are accurate, complete and timely. Adherence to GAAP is the overriding responsibility of the TRBHA. If there is a conflict between GAAP and these instructions, the TRBHA should advise the DBHS Chief Financial Officer of such conflict.

ADHS recognizes that interim financial statements are based on information available at the end of the reporting period, which may be incomplete. Revisions to a prior period will invalidate the previously submitted report. If material revisions are submitted after the ADHS due date, then sanctions may be imposed for untimely or inaccurate reporting.

D. ADHS BLOCK GRANTS

The practices, procedures and standards specified in and required by the Accounting and Auditing Procedures manual for Contractors of Arizona Department of Health Services Funded Programs and any Uniform Financial Reporting Requirements shall be used by the TRBHA in the management, recording and reporting Federal Block Grant funds.

The TRBHA shall comply with all terms, conditions and requirements of the CMHS and SAPT Performance Partnership Block Grants. Financial, performance and program data subject to audit shall be retained by the TRBHA as documentation of compliance with federal requirements.

The TRBHA shall establish fiscal controls to ensure that funds are accounted for in a manner that permits separate reporting of mental health and substance abuse grant funds and services. SAPT Grant funds should be allocated by category (Flex Funds, General Services, Pregnant/Parenting Women, HIV, Prevention, Meth Initiative and Children) in accordance with the ADHS Allocation Schedule. CMHS grant funds should be allocated by category (Children with SED, Children with SMI, Flex Funds and Coaching and Training) in accordance with the ADHS Allocation Schedule. Prior written approval must be obtained from ADHS for any deviations from the ADHS Allocation Schedule. Funds paid to TRBHAs for a fiscal year shall be available for obligation and expenditures until the end of the fiscal year for which the funds were paid.

The TRBHA shall, at the close of a fiscal year, defer all Federal Block Grant funds received but unexpended. The deferred revenue shall be recognized as earned in the first period of the following fiscal year. The recognized revenue shall be reported in the same program as ADHS originally remitted. Any revenue requiring deferral in the second year following its original remittance shall be returned to ADHS for reversion to the Authorizing Federal Agency.

TRBHAs shall maintain all necessary financial, contractual, budget and program data to ensure appropriate expenditure of grant funds.

The TRBHAs are required to notify all non-profit providers that expend $500,000 or more a year in Federal Awards such as the SAPT and CMHS Block Grants to have a Single Audit conducted in accordance with the provisions of OMB Circular A-133. Refer to Exhibits B and C for additional information and for a Sample Letter to Providers.

The TRBHAs shall submit an annual SAPT Distribution Report in the format provided by ADHS by July 30 of each year. Similarly, the TRBHAs shall submit an annual CMHS Distribution Report in the format provided by ADHS by July 30 of each year.

SAPT Block Grant

Category	Financial Guide Reporting Requirement
Flex Funds	TRBHAs report expenditures for flex funds as follows: • SAPT Column • Line 51l, Flex Funds
SA General Services	TRBHAs report expenditures for General Services and Intravenous Drug Users as follows: • SAPT Column • Line 514a, excluding inpatient hospital services
Specialty Programs for Pregnant/Parenting Women	TRBHAs report expenditures for Specialty Programs for Pregnant/Parenting Women as follows: • SAPT Column • Line 514b, excluding inpatient hospital services
HIV/AIDS Early Intervention Services	TRBHAs report expenditures for HIV/AIDS as follows: • SAPT Column • Line 514c, HIV
Prevention	TRBHAs report expenditures for prevention services as follows: • SAPT Column • Line 514d, Prevention
Meth Initiative	TRBHAs report expenditures for Meth Initiative as follows: • SAPT Column • Line 514e, Meth
Children	RBHAs report expenditures for Children Services as follows: • SAPT Column • By appropriate expenditure line (501 – 511, excluding inpatient hospital services) footnote amount expended on Statement of Activities, Schedule A quarterly

CMHS Block Grant

Category	Financial Guide Reporting Requirement
Children with SED	TRBHAs report expenditures for these services as follows: • CMHS SED Column • By appropriate expenditure line, excluding inpatient hospital services
Adults with SMI	TRBHAs report expenditures as follows: • CMHS SMI Column • By appropriate expenditure line, excluding inpatient hospital services
Flex Funds	TRBHAs report expenditures as follows: • CMHS SED Column • Line 511, Flex Funds
Coaching & Training	TRBHAs report expenditures as follows: • CMHS SED Column • Line 513

E. SANCTIONS

Per the contractual agreement with the TRBHA, ADHS may impose sanctions on the TRBHAs for failure to perform certain contractual obligations and financial reporting guide requirements. The amount of the sanction will be determined by the sanction committee guided by the Sanction Protocol. The full amount of the sanction will be withheld from the TRBHAs monthly payment. TRBHAs should ensure that they report the full amount of the program's revenue, and then report the sanction in the same program as an administrative expense under "Other Operating".

F. INDIRECT COST AGREEMENT

If applicable, the TRBHA shall provide ADHS with a copy of their most recent Indirect Cost Agreement by October 1 of each year.

EXHIBIT A
AGREED UPON PROCEDURES FOR RBHAs WITH RELATED PARTIES PERFORMING ON THEIR BEHALF

1) The RBHA will provide separate Annual Income Statements for each Related Party starting with the report for the period ended June 30, 2010 and each year thereafter. These reports will be the basis for determining the after-tax profit/(loss) greater than 3% that will be combined with each GSA's profit/(loss) when calculating the profit/risk corridor.

2) These annual profit/(loss) statements will be accompanied by "back-up" documentation from each corresponding entity. "Back-up" documentation will include but is not limited to, copies of General Ledger/Sub-Ledger entries, Prescription Medication Expense Reports, allocation worksheets showing how allocation rates were derived, worksheets showing how direct and/or indirect costs were allocated, etc.

3) "Back-up" documentation may not be identical for each entity. The documentation submitted should be customized to suit each entity's circumstances.

4) The RBHA will coordinate the preparation of these reports along the timelines of the Annual Audit for the year ended June 30, 20XX.

5) ADHS and the RBHA agree to cooperate in complying with this reporting process should there be issues not previously addressed or that were not clear.

The final profit corridor amount will be determined after ADHS' final verification of the documents submitted for review.

The Annual Income Statements and supporting documentation are due to ADHS by September 30 of each fiscal year.

EXHIBIT B
A-133 AUDIT REQUIREMENT AND PROVIDER NOTIFICATION

Division of Behavioral Health Services
Bureau of Financial Operations

150 N. 18th Avenue, Suite 280
Phoenix, Arizona 85007-3241
(602) 364-4558
(602) 364-4736 FAX
Internet: www.azdhs.gov

JANICE K. BREWER, GOVERNOR
WILL HUMBLE, DIRECTOR

May 13, 2010

DESIGNATED T/RBHA

Re: A-133 Audit Requirement and Provider Notification

Dear:

This letter serves as guidance regarding the A-133 Audit Requirement and required notification process to your providers. Under the Federal Single Audit Act and Federal OMB Circular A-133, organizations receiving federal funding of $500,000 or more during their fiscal year must comply with OMB Circular A-133 reporting requirements and the terms specified in contract with ADHS/BHS. The information can be found at http://www.whitehouse.gov/omb/circulars/ .

This requirement also transfers to the T/RBHA providers and compliance with the Federal OMB Circular A-133 shall be incorporated into their contracts. I have attached a copy of a sample template that can be used to implement the notification process to the provider. The template lists the minimum requirements of the Single Audit Report Package. In addition to implementing a notification process, please incorporate a procedure at the T/RBHA level for monitoring, tracking, and reporting the A-133 requirement for the providers.

Please be advised that if you have a process in place that includes provider notification, monitoring, and tracking, it is not necessary to change the process as long as it meets the A-133 requirements. If you have questions or require additional information, please contact me at (602) 364-4699.

Sincerely,

Chief Financial Officer
ADHS/DBHS

EXHIBIT C
SAMPLE FEDERAL FUNDING LETTER TO PROVIDERS

(*Date*)

(*First Name, Last*)
*(1*Title*)*
(Name of Company)
(Address)
(,*City, State, Zipcode)*

(*Mr or Ms, Last Name*)

(Name of Subrecipient) is a subrecipient with the (Name of TRBHA) Regional Behavioral Health Authority and as such receives funding through one or more federally funded programs. Under the Federal Single Audit Act and OMB Circular A-133, organizations receiving federal funding of **$500,000 or more** during their fiscal year must comply with OMB Circular A-133 reporting requirements and the terms specified by your contract. If your organization has received funding that falls within these guidelines, please submit your completed Single Audit Report Package for your fiscal year ending xxxx. Please include our office on your distribution list for all components shown in **bold** below. The TRBHA single audit package includes:

1. **Financial Statement** and **Single Audit** including your **Schedule of Expenditures of Federal Awards** (**SEFA**). Per the OMB Circular A-133, please include identifiers and contract numbers for pass-through funds. (See §310 (2))
2. Copy of the "Data Collection Form" (SF-SAC)
3. Schedule of Findings and Questioned Costs
4. Any **Financial Statement Findings**
5. Any **Federal Award Findings and Questioned Costs**
6. **Prior Audit Findings** (if any)
7. **Corrective Action Plan** (CAP)
8. **Management Letter** (if applicable)

If your organization's **total** Federal funding during the (**year**) fiscal year was **less than** $500,000 and you do not fall within the Federal or contract requirements for the above reporting, please **mark this letter** accordingly, and **return a copy** to our office.

☐ We are required by Federal Regulation and contract to submit a Single Audit and will do so by (date) ___/___/___.

☐ We have already sent our **(year)** Single Audit Package to xxxx (date) ___/___/___.

☐ We **do not** fall within the requirements and will not be submitting a **(year)** Single Audit (Explain below):

Explain:_____

Name (print) _____ **Title:** _____

Signature: _____ **Phone #**: _____

EXHIBIT D - Crosswalk to Covered Services Guide

Arizona Health Care Cost Containment System

AHCCCS Contractor Operations Manual

ACOM

MANUAL OVERVIEW

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OVERVIEW

Effective Date: 07/01/05
Revision Date: 10/25/06

Staff responsible for overview: Division of Health Care Management Administration

I. Purpose

The purpose of the AHCCCS Contractor Operations Manual is to consolidate and provide ease of access to the administrative, claims, financial, and operational policies and requirements of the AHCCCS Administration.

The Manual applies to all Acute Care and Long Term Care Contractors, Arizona Department of Health Services/Behavioral Health Services, Arizona Department of Health Services/Children's Rehabilitation Services, and other entities that have a contract or intergovernmental agreement with AHCCCS to provide covered services (hereinafter referred to as Contractors). This manual also applies to subcontractors who are delegated responsibilities under a contract. As necessary, the policies within the manual specify as necessary the applicability to specific Contractors. This Manual does not replace existing manuals or documents such as those listed in Section IV.

II. Definitions

The words and phrases contained in the AHCCCS Contractor Operations Manual have the following meanings, unless a chapter or policy contains another meaning.

Acute Care Contractor: A contracted managed care organization (also known as a health plan) that provides acute care medical services to AHCCCS members who are Title XIX or Title XXI eligible, and who do not qualify for another AHCCCS program. Most behavioral health services are carved out and provided through the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS).

Arizona Department of Health Services, Division of Behavioral Health (ADHS/BHS): A **Prepaid** Inpatient Health Plan mandated to provide behavioral health services to Title XIX acute care and Title XXI members who are eligible for behavioral health services. Services are provided through the ADHS Division of Behavioral Health and its Contractors.

Arizona Health Care Cost Containment System (AHCCCS): The Administration, Contractor, and other arrangements through which health care services are provided to an eligible person, as defined by A.R.S. § 36-2902, et seq.

AHCCCSA: The Arizona Health Care Cost Containment System Administration.

AHCCCS Division of Health Care Management (AHCCCS/DHCM): The division responsible for Contractor oversight regarding AHCCCS medical program operations, quality and utilization management, financial and operational oversight.

Arizona Administrative Code (A.A.C.): Administrative Code, commonly known as rules, is promulgated by State agencies and other entities that prescribe the implementation of statutory intent and requirements.

Arizona Department of Economic Security, Comprehensive Medical and Dental Plan: A department within the Arizona Department of Economic Security that is responsible for managing the medical needs of foster children in Arizona under A.R.S. §8-512.

Arizona Department of Economic Security, Division of Developmental Disabilities (ADES/DDD): The State agency division responsible for providing services to eligible Arizona residents with developmental disabilities, as defined in A.R.S. Title 36, Chapter 5.1.

Arizona Department of Health Services (ADHS): The state agency mandated to serve the public health needs of all Arizona citizens.

Arizona Department of Health Services, Children's Rehabilitative Services: A prepaid Inpatient Health Plan administered by the Arizona Department of Health Services. CRS provides 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 defined in 9 A.A.C. 7.

Arizona Long Term Care System (ALTCS) Contractor: A contracted managed care organization, that provides long term care, acute care, behavioral health, and case management services to Title XIX eligible elderly, physically or developmentally disabled individuals who are determined to be at risk of an institutional level of care.

Arizona Revised Statutes (A.R.S.): The Laws of the State of Arizona.

Centers for Medicare and Medicaid Services (CMS): The organization within the U.S. Department of Health and Human Services that administers the Medicare and Medicaid programs and the State Children's Health Insurance Program (known as KidsCare in Arizona).

Code of Federal Regulations (CFR): The codification of the general and permanent rules established by the executive departments and agencies of the federal government.

Contractor: A Managed Care Organization providing health care services to acute or long term care members and/or a Prepaid Inpatient Health Plan providing behavioral health services to eligible acute care members and/or CRS related services to eligible acute or long term care members.

III. Policy

The Division of Health Care Management (DHCM), in conjunction with other divisions within AHCCCS, is responsible for the formulation of policy for the AHCCCS Contractor Operations Manual. Stakeholder input is sought as appropriate. Policy changes may stem from several sources, including but not limited to recently promulgated or revised federal and state regulations, program contract changes, changes in accepted business standards of practice, and internal or external discussions.

IV. References

As appropriate, this Manual provides reference to other AHCCCS manuals, legal references or documents, which provide more detailed information. These include, but are not limited to:

1. 1115 Waiver
2. AHCCCS State Plan
3. Code of Federal Regulations (CFR)
4. Arizona Revised Statutes (ARS)
5. Arizona Administrative Code (Rules)
6. AHCCCS Contracts
    a. Acute Care
    b. Arizona Long Term Care System (ALTCS)
    c. Behavioral Health Services
    d. Children's Rehabilitation Services
    e. Arizona Department of Economic Security Children's Medical and Dental Program
7. AHCCCS Medical Policy Manual (AMPM)
8. Encounter Reporting User Manual
9. Reinsurance Claims Processing Manual
10. Provider Affiliation Transmission Manual
11. Claims Reporting Guide

V. Contact

Revisions to the Manual are published on the AHCCCS web site, which can be accessed at http://www.azahcccs.gov/commercial/ContractorResources/manuals/manuals.aspx. Updates for the web site occur on a monthly or as-needed basis.
Any questions concerning the **content** of the AHCCCS Contractor Operations Manual should be addressed to:

AHCCCS Division of Health Care Management
701 E. Jefferson, Mail Drop 6100
Phoenix, AZ 85034

Attention to:

Content Area	Contact	Telephone No.	E-mail
Acute Care	Elizabeth Stackfleth	602-417-4796	Elizabeth.Stackfleth@azahcccs.gov
ALTCS	Jami Snyder	602-417-4614	Jami.Snyder@azahcccs.gov
Finance	Kathy Rodham	602-417-4568	Kathy.Rodham@azahcccs.gov

Any questions concerning the **technical aspects** of the AHCCCS Contractor Operations Manual should be addressed to:

P. J. Schoenstene - Contracts and Policy Administrator
AHCCCS Division of Health Care Management
701 E. Jefferson, Mail Drop 6100
Phoenix, AZ 85034
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CHAPTER 100 – ADMINISTRATION

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101 – MARKETING, OUTREACH AND RETENTION

Original Date: 10/10/1993
Effective Date 10/01/2010; 01/19/2012
Revision Date: 11/08/2010; 01/19/2012

Staff responsible for policy: DHCM Operations

I. Purpose

This policy establishes guidelines and restrictions for all AHCCCS Contractors, awarded a contract or under contract with AHCCCS to deliver health care services, for marketing and outreach activities referencing the AHCCCS program.

II. Definitions

Financial Sponsor: Any monies or in kind contributions provided to an organization, other than attendance fees or table fees, to help offset the cost of an event.

Health education: Programs, services or promotions that are designed or intended to advise or inform the Contractor's enrolled members about issues related to healthy lifestyles, situations that affect or influence health status, behaviors that affect or influence health status or methods or modes of medical treatment.

Health education materials: Materials that are designed, intended, or used for health education or outreach to the Contractor's actual members. Health education materials include, but are not limited to, condition specific brochures, member newsletters, posters, and member handbooks. Materials previously approved under the Member Information Policy should be listed in all requests as defined in Section A of this policy.

Incentives: Items that are used to encourage behavior changes in the Contractor's enrolled members or Health promotion incentives to motivate members to adopt a healthy life style and/or obtain health care services. These may include:

- infant car seats;
- discounts for merchandise or services; and
- manufacturer or store coupons for savings on products; or
- services or any other objects that are designed or intended to be used in health education or outreach.

Incentives may not be used in conjunction with the distribution of alcohol or tobacco products.

Marketing: Any medium of communication that is written, oral, personal, or electronic, including any promotional activities, intended to increase a Contractor's membership or to "Brand" a Contractor's Name or organization.

Marketing materials: General audience materials such as general circulation brochures, Contractor's Web site and other materials that are designed, intended, or used for increasing Contractor membership or establishing a brand. Such marketing materials may include, but are not limited to: scripts or outlines for member services representatives, provider directories, brochures or leaflets that are distributed or circulated by any third party (including providers), and posters. All Marketing materials must include a health message.

Outreach: Any means of educating or informing the Contractor's enrolled members about health issues. See also "health education" and "retention".

Outreach materials: Materials that are designed, intended, or used for health education or outreach to the Contractor's enrolled members. See "Health education materials".

Promotion: Any activity in which marketing materials are given away or displayed where the intent is to increase the Contractor's membership.

Promotional materials: See "marketing materials".

Provider: A hospital and hospital staff, a physician and physician office staff, a pharmacy and a pharmacist, and/or ancillary service providers and their staff.

Retention: Outreach activities specifically designed to target and maintain current membership.

III. Policy

Contractors are limited to marketing through health related events including events that have a health educational component and sponsorships.

Marketing is information intended for the general public about the existence of the Contractor and the availability of the Contractor as an enrollment option for people upon being deemed eligible for AHCCCS.

Outreach is communication with enrolled members for the purpose of retaining the member as an enrollee, and improving the health status of enrolled members via the adoption of healthy lifestyles and/or improved management of chronic illness.

Retention activities are designed to prevent members from losing their AHCCCS enrollment. Retention efforts must be directed to members currently enrolled with the Contractor who are determined to be at risk for attrition through Annual Enrollment Choice (AEC), expressed intent (member initiated contact including survey response), or analysis of membership trends such as decreased utilization of preventive services. Assisting one's own members with the

redetermination process is permissible, but only to the extent that the member allows the assistance.

For Marketing, Outreach and Retention, Contractors may only utilize approved materials and mediums for disseminating information as identified in this policy and comports with the Member Information Policy. See restrictions below.

AHCCCS must approve all marketing, outreach and retention activities and materials. In addition to approval of advertising copy, approval of the publication in which the ad will be placed is also required.

Medicare Advantage marketing that is targeted to AHCCCS dual members requires Marketing Committee approval only when CMS does not approve, such as a document marketed under the Medicare Advantage File & Use marketing rules. This applies only to marketing as defined by this policy.

IV. Procedure

A. Contractor Submissions

1. Materials

The use of materials, including those pertaining to health education, incentives, marketing, outreach, and promotions, must be prior approved by the AHCCCS Marketing Committee. Member materials that have been previously approved under the Member Information Policy may be used during marketing activities only if included in a specific activity request submitted to AHCCCS.

Contractors shall review all their materials on a regular basis in order to revise materials, if necessary, to reflect current practices. Any changes or amendments to previously approved marketing materials (e.g., prior leaflet approved, but subsequently modified) must also be submitted in advance to AHCCCS for approval.

2. Events

Contractors may participate in health-related marketing and outreach events that are listed in Figure 1 in the "PRE-Approved" column. Events that are listed in the "PRE-Approved" column must either be health related or have a health education component (events where health education is a component, i.e., celebration events – Angeles Del Barrio, etc.). Contractor's participation in events must be substantive; an unmanned booth with handouts is not acceptable.

Contractors may not attend events that are listed in the "Not-Approved" column in Figure 1, or any event determined by AHCCCS to not be in the best interest of the State of Arizona.

If the Contractor is not certain if an event would qualify in the "PRE-Approved" column, the Contractor must submit to the AHCCCS Marketing Committee a request for

approval prior to the event. The request shall include the Name of the Event, the location and the address.

Example:

Roosevelt Shot Clinic (Name of Event)
Phoenix Ranch Market (Location)
1602 E Roosevelt St (Address)
Phoenix, AZ 85006
9AM-1PM (Start and End Time)
Flu Shots (Service)

We will distribute the following:
Tooth Brush Approved 12/10/08

We will be handing out the tooth brush kits as the Roosevelt Clinic has been stressing dental hygiene this month.

Figure 1

PRE-Approved Events (Must Be Health Related)	**Not-Approved**
Back to School Events (not on K-12 school grounds)	Events that are not health related or do not have a health education component
College/University Events	Events on K-12 grounds
DES Health and/or Resource Events – if open to all AHCCCS plans	DES offices (except those listed on the approval list)
WIC Health and/or Resource Events – if open to all AHCCCS plans	WIC Offices (except those listed on the approval list)
Events where health education is a component (i.e. celebration events – Angeles Del Barrio, etc.)	Job Fairs
Community Center/Recreational Events (i.e. Golden Gate, Boys and Girls Club, YMCA, parks and senior center)	County/State Fairs
Community/Family Resource Events (i.e. food banks, food distribution locations, homeless and/or women's shelters)	Bi-national Health Events (i.e. Mexican consulate on their premises)
Provider Events (i.e. doctors, hospitals, and/or specialist) that the Contractor is contracted with	Political Events
Faith Based Events	Pharmacy Events not open to all contractors
Farmers Market Events	KidsCare Specific Events
Health Educational Forum (community sponsored) (i.e. nutritional, health benefits, and prevention topics)	Swap Meets
Safety Events (i.e. sun safety, water safety, and fire safety)	
Immunization Clinics	
Senior Events	
Shopping Mall Events	
AHCCCS Contractor's Event that is created and sponsored on its own for its own members only	

The Contractor shall submit to the AHCCCS Marketing Committee all marketing outreach events that the Contractor was a participant. Participation includes but is not limited to having a booth at the event, financially contributing to the event and/or having a presence at the event.

The Contractor shall submit on the 10th of every month a report of the previous months activities; using the excel format in Attachment B. The report will include; the Name of the Event, the location, the address, the date, the start and end time of the event and any services provided by the Contractor in chronological order. Contractors may only distribute materials previously approved within the prior two years.

Monthly reports must be submitted electronically to:

Chairman, Marketing Committee
Division of Health Care Management
Email: MarketingCommittee@azahcccs.gov

The AHCCCS Marketing Committee will review the Contractor's monthly submission to determine if the Contractor's participation in any events were in violation of this policy. If AHCCCS determines the Contractor was in violation of this policy, the Contractor may be subject to sanctions. Failure to disclose an event attended may also result in Administrative Action.

3. **Sponsorships**
   Contractors may participate as financial sponsors of health-related marketing and outreach events that are listed in Figure 1 in the "PRE-Approved" column. In addition to the information required to be submitted for events, the request must include the dollar amount of the participation, and either a copy or description of any materials (including websites) on which the contractors name or logo will appear prior to production. If there is a potential for television advertising of the event, the use of the contractor's name or logo is prohibited.

4. Sponsorship requests shall be submitted, separately by type, for approval 30 days prior to dissemination or the event. If 30 day notice is not possible, the request must indicate the reason for the shortened timeframe. Requests must be submitted electronically to:

   Chairman, Marketing Committee
   Division of Health Care Management
   Email: MarketingCommittee@azahcccs.gov

5. **Health Plan Logos and Health Plan Name Inclusion**
   Health Plan logos can be included on event flyers or websites that are produced by hosting organizations without prior approval (Contractors must monitor and police logo use to prevent misuse). Flyers or websites will require prior approval by AHCCCS if the Contractor is providing financial support for the event.

B. AHCCCS Approval

AHCCCS will attempt to approve or deny the request within 15 working days of receipt of the complete request. Approval shall only apply to the form of communication or specific date described with the initial submission. Modifications of any type would need to be resubmitted.

If a Contractor wishes to contest AHCCCS' decision, it may do so by filing a grievance in accordance with Title 9, Chapter 34 of the Arizona Administrative Code (9 A.A.C. 34).

C. Restrictions

The following restrictions apply to all marketing, outreach and retention activities.

1. The following shall *not* be allowed:
    a. Incentive items such as t-shirts, buttons, balloons, key chains, etc. unless the intent of such a give-away is outreach in nature (i.e., for educating members about the benefits of safety, immunizations, or well-care). All incentive items must be prior approved by the AHCCCS Marketing Committee.
    b. Solicitation of any individual face-to-face, door-to-door, or over the telephone;
    c. References to competing plans;
    d. Promotional materials, incentives, or any other activity to influence enrollment in conjunction with the sale or offering of any private insurance;
    e. Television advertising;
    f. Direct mail advertising;
    g. Marketing of non-mandated services. Medicare Advantage marketing that is targeted to AHCCCS dual members requires Marketing Committee approval only when CMS does not approve, such as a document marketed under the Medicare Advantage File & Use marketing rules. This applies only to marketing as defined by this policy.
    h. Utilization of the word "free" in reference to covered services;
    i. Listing of providers in marketing and open enrollment materials who do not have signed contracts with the Contractor;
    j. Use of the AHCCCS logo;
    k. Inaccurate, misleading, confusing or negative information about AHCCCS or the Contractor; and any information that may defraud members or the public;
    l. Discriminatory marketing practices as specified in the Arizona Administrative Code 9 A.A.C. 22, Article 5, 9 A.A.C. 28, Article 5, 9 A.A.C. 31, Article 5.
2. AHCCCS reserves the right to impose additional restrictions.
3. The Contractor shall ensure that:
    a. Any outreach or incentive item given away by the Contractor to its members shall not exceed $50.00. Any marketing item given away to the general public by the Contractor shall not exceed $10.00. (The total cost of all marketing and outreach/incentive items given to each member household, at each event, may not exceed $50.00.)

b. All materials identify the Contractor as an AHCCCS provider and are consistent with the requirements for information to members described in the contract and AHCCCS policies.
c. All materials that have been produced by the Contractor and refer to contract services shall specify: "Contract services are funded in part under contract with the State of Arizona".
d. Marketing materials that are distributed by the Contractor shall be distributed to its entire contracted geographic service area. Exclusion of any particular group or class of members would be considered to be a discriminatory marketing practice and subject to sanction.
e. Outreach materials cannot include the words such as "join", "enroll", "sign up" or similar verbiage unless approved through the Committee. If the Contractor intends to use such language in the materials or script, the request for approval must explain how the message is related to an Outreach goal.
f. Contractors may not encourage or induce the member to select a particular Contractor when completing the application and may not complete any portion of the application on behalf of the potential enrollee. This prohibition covers all situations, whether sponsored by the Contractor, their parent company, or any other entity.
g. Subcontractors are advised that they must comply with this policy. Failure of a subcontracted provider to adhere to this policy may result in sanctions/penalties to the Contractor contracted with such a provider.

D. Temporary Restrictions

Any activities, materials, or mediums in violation of this policy will be subject to sanction regardless of previous approval or terms of privately held contractual agreements. AHCCCS will review the ban of the following activities on an annual basis.

1. The following shall *not* be allowed:
    a. Radio advertising;
    b. Billboards;
    c. Bus Advertisements (including bus stops and city and school busses);
    d. School based events;
    e. KidsCare Marketing.

E. Contractor Responsibilities

1. All Contractors will be required to report their marketing, outreach and retention costs on a quarterly basis as a separate line item in the quarterly financial statements. This requirement also applies to any marketing costs included in an allocation from a parent or other related corporation.

   All marketing costs allocated and otherwise will be excluded in the determination of capitation rate ranges. Additionally, any Contractor not in compliance with the AHCCCS viability criteria indicators, as defined in the contract, may be restricted from further marketing until the Contractor is in compliance with the viability criteria indicators.

2. The Contractor CEO (or designee) shall sign the Marketing Attestation Statement within 45 days of the beginning contract year. See Attachment A.

3. Marketing materials that have received approval from AHCCCS must be resubmitted to DHCM for re-approval every two years.

F. Sanctions/ Penalties

Any violation of this policy may result in the sanctions as described in ACOM Sanction Policy.

IV. References

- 42 CFR 438.104, 42 CFR 438.10, 42 CFR 431.12, 42 CFR 431.307
- Arizona Revised Statute §36-2988.I
- Arizona Administrative Code 9 A.A.C. 22, Article 5, 9 A.A.C. 28, Article 5
- AHCCCS contract

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OUR FIRST CARE IS YOUR HEALTH CARE
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

ATTACHMENT A

MARKETING ATTESTATION STATEMENT

The oral and written information given to potential members by the Contractor is accurate in order for members to make an informed decision on whether to enroll with a specific Contractor.

All information potential members are given has been approved by the AHCCCS Marketing Committee and is in compliance with the AHCCCS Division of Health Care Management Marketing, Outreach, and Retention Policy.

_____
Signature of Authorized Representative

_____
Title

_____
CONTRACTOR

_____
Date

Please sign, date, and then return to:

Michael Veit, MD 5700
AHCCCS Contracts and Purchasing
701 E. Jefferson St.
Phoenix AZ 85034

ATTACHMENT B – Monthly Marketing Report. Click on “Attachment B” or the title below to go to the Excel Monthly Marketing Report.

ACOM 101 Attachment B: Monthly Marketing Outreach Activities Report

Contractor Name: _____

Reporting Month: _____

Date of Submission: _____

Name of Event	Type of Event (must correspond to list on figure 1 of the policy)	Location	Address of Event	Date/Time of Event	Services Provided by Contractor

Reviewed 1-19-2012

102 - DISTRIBUTION OF GRADUATE MEDICAL EDUCATION MONIES AFTER 1997

Effective Date: 07/21/97
Revision Date: 11/29/02

Staff responsible for policy: DHCM Finance

I. Purpose

Scope

This policy describes the methodology for distributing graduate medical education (GME) monies for hospital services after September 30, 1997.

This policy does not provide for additional funding due to the development of new programs initiated after April 1, 1997 or changes in the size of existing GME programs, and is in effect until the legislature provides an alternate distribution methodology for GME.

Applicability

This policy applies to AHCCCS registered hospitals with GME programs that were approved by the AHCCCS Administration (AHCCCSA) as of October 1, 1999.

Background

This distribution methodology is established pursuant to A.R.S. §36-2903.01, which states:

"Beginning September 30, 1997, the Administration shall establish a separate graduate medical education program to reimburse hospitals that had graduate medical education programs that were approved by AHCCCSA as of October 1, 1999. The Administration shall separately account for monies for the graduate medical education program based on the total reimbursement for graduate medical education reimbursed to hospitals by the system in Federal Fiscal Year (FFY) 1995-1996 pursuant to the tiered per diem methodology specified in this section. The graduate medical education program reimbursement shall be adjusted annually by the increase or decrease in the index published by the Data Resources Incorporated Hospital Market Basket Index for Prospective Hospital Reimbursement. Subject to legislative appropriation, on an annual basis, each qualified hospital shall receive a single payment from the graduate medical education program that is equal to the same percentage of graduate medical education reimbursement that was paid by the system in FFY 1995-1996. Any reimbursement for graduate medical education made by the Administration shall not be subject to future settlements or appeals by the hospitals to the Administration."

II. Definitions

Graduate Medical Education (GME): Accredited M.D. and D.O. programs provided in conjunction with hospitals participating in the AHCCCS program.

III. Policy

To determine the total GME fund for FFY98, the total amount of GME payments made by the AHCCCS Administration to hospitals in FFY96 shall be inflated by the Data Resources Incorporated (DRI) market basket for prospective payment hospitals for FFY97 and for FFY98. Each year thereafter, the total GME fund shall be adjusted as defined by legislation.

For FFY98, and each year thereafter, the GME fund distribution shall consist of two calculations based on the status of the GME program, i.e., hospitals with established GME programs receiving a GME payment in FFY96, and hospitals with "new" GME programs that did not receive GME payments in FFY96, but for which legislation allowed them to enter the GME fund distribution.

GME Fund distribution will be as follows:

1. Hospitals with GME programs receiving AHCCCS payments in FFY96 shall receive a GME payment directly from AHCCCS each year. The total of this payment shall be based on the percentage of the total FFY96 GME fund that their FFY96 GME payment represented.

   For example: If Hospital “A” received 10% of the total GME fund in FFY96, then Hospital “A” will receive approximately 10% of the total GME fund in each of the subsequent years. The amount is approximate because payments made to hospitals with "new" GME programs will slightly impact the GME payments received by hospitals with existing programs.

2. Hospitals with "new" GME programs shall also receive a GME payment directly from AHCCCS each year. The total of that payment shall be based on the percentage of the total FFY96 GME fund that their initial GME payment represented.

   For example: If Hospital “C” received their initial GME payment in FFY97, and that payment represented 2% of the total GME fund in FFY96, then Hospital “C” will receive 2% of the total GME fund in each of the subsequent years.

The same method applies to "new" programs that receive initial GME payments in FFY98 or thereafter.

As such, until new legislation is passed, "new" GME programs shall take away from the GME funds available to existing GME programs.

IV. References

- Arizona Revised Statute §36-2903.01

This policy supports the guidelines presented by the Office of Intergovernmental Relations. Revisions to this policy are under the authority of the Assistant Director of the Division of Health Care Management/Finance.

103 - FRAUD AND ABUSE POLICY

Effective Date: 10/01/94
Revision Date: 10/01/03

Staff responsible for policy: DHCM Administration

I. Purpose

This policy applies to all Acute Care and Long Term Care Contractors, Arizona Department of Health Services/Behavioral Health Services. Arizona Department of Health Services/Children's Rehabilitation Services, and other entities that have a contract or Intergovernmental Agreement with AHCCCS to provide covered services (hereafter referred to as Contractors). This manual also applies to subcontractors who are delegated responsibilities under a contract. Its purpose is to prevent the occurrence of abuse of members and member and provider fraud and abuse within the AHCCCS program. The AHCCCS Office of Program Integrity is the office of primary responsibility for conducting investigations and inquiries relating to fraud, waste and abuse as it pertains to providers and members.

The objectives of this policy are to:

A. facilitate the reporting of potential fraud and abuse cases to AHCCCSA for investigation; and
B. require Contractors to work with AHCCCSA (i.e., via workgroup) to further develop prevention and detection mechanisms (i.e., best practices) for Medicaid managed care.

It is anticipated that this policy will be updated as Federal and State requirements are more specifically defined for fraud and abuse in a managed care setting, and as AHCCCSA and Contractors are better able to identify and scrutinize prevention and detection of managed care fraud and abuse. The AHCCCSA will work with Contractors in a joint effort to better define Medicaid managed care fraud and abuse, the applicability of federal requirements, and how best to prevent and/or detect fraud and abuse.

II. Definitions

Abuse of a member: Intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual or emotional abuse or sexual assault. (A.R.S. § 46-451 and 13-3623)

Abuse by a 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. (42 CFR 455.2)

Fraud by a member or provider: Intentional deception or misrepresentation made by a person or persons with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR 455.2)

Compliance Officer: The on-site official designated by each Contractor to implement, oversee and administer the Contractors' compliance program including fraud and abuse control. The Compliance Officer shall be an on-site management official, available to all employees, with designated and recognized authority to access and provide records and make independent referrals to the AHCCCSA Office of Program Integrity.

Provider: Any entity or individual providing health care or other services.

III. Policy

A. Prevention/Detection

Contractors shall have in place, internal controls, policies and procedures that are capable of preventing, detecting, and reporting fraud and abuse activities. For example, operational policies and controls such as claims edits, prior authorization, utilization and quality review, provider profiling, provider education, post-processing review of claims, adequate staffing and resources to investigate unusual incidents, and corrective action plans can assist Contractors in preventing and detecting potential fraud and abuse activities.

More detailed descriptions of the controls that Contractors should consider are contained in the document AHCCCS Contractors Fraud and Abuse Prevention/Detection Summary (Attachment A).

B. Reporting

If a Contractor discovers, or is made aware, that an incident of potential/suspected fraud and abuse has occurred, the Contractor shall report, within 10 business days of the discovery, the incident to AHCCCSA by completing the confidential AHCCCS Referral For Preliminary Investigation form (Attachment B). Timely reporting of fraud and abuse improves the likelihood of a successful investigation and prosecution.

The same form shall be used for abuse of members referrals as well as referrals for provider and member fraud and abuse.

1. Abuse of Member Referrals

   The form and its attachments shall be submitted to:

   AHCCCS, Division of Health Care Management
   Clinical Quality Management Unit
   701 E. Jefferson, Mail Drop 6500
   Phoenix, AZ 85034
   FAX (602) 417-4162

2. Fraud and Abuse by Providers or Members

   The form and its attachments shall be submitted to:

   AHCCCS, Office of Program Integrity
   801 E. Jefferson, Mail Drop 4500
   Phoenix, AZ 85034
   FAX (602) 417-4102

All pertinent documentation and/or investigative reports that would assist AHCCCSA in its investigation shall be attached to the forms.

C. Compliance Officer Responsibilities Related to Fraud and Abuse

1. Oversee, monitor and be the focal point for the Contractor's compliance program, with the authority to review all documents and functions as they relate to fraud and abuse prevention, detection and reporting such as provider registration, prior authorization and contracts

2. Maintain and monitor a tracking system of fraud and abuse

3. Have the authority to independently refer potential member and provider fraud and abuse cases to AHCCCSA

4. Be an on-site management official who reports directly to the organization's CEO, COO or equivalent, on a regular periodic basis, regarding all fraud and abuse issues including policy matters, cases and training

5. Have direct access to the CEO and/or the governing body, senior management and legal counsel

6. Ensure all employees, providers and members receive adequate training/information by overseeing a comprehensive training program, which addresses fraud and abuse prevention, recognition and reporting, and encourages employees, providers, and members to report fraud and abuse without fear of retaliation

7. Ensure an internal reporting procedure that is well defined and made known to all employees

8. Periodically review and revise the fraud and abuse policies to meet changing regulations or trends, and

9. Regularly attend and participate in AHCCCS, Office of Program Integrity work group meetings

D. Other State and Federal Regulations

In addition to the specific requirements stated above, it is required that Contractors be in compliance with all State and Federal regulations related to fraud and abuse not directly detailed in this policy.

IV. References

- Section 1903(q) of the Social Security Act
- Title 42 of the Code of Federal Regulations (42 CFR) 1007.1 through 1007.21
- 42 CFR 455.1 through 455.23
- Arizona Revised Statutes (A.R.S.) § 46-451
- A.R.S. § 13-3623
- Arizona Administrative Code R9-22, Article 5

ATTACHMENT A

AHCCCS CONTRACTORS FRAUD & ABUSE PREVENTION/DETECTION ACTIVITIES SUMMARY

PREVENTION / DETECTION / CONTROL	PURPOSE
AHCCCS CONTRACTORS: ◈ Each Contractor should have a corporate culture, which encourages its employees to detect and report fraud and abuse. ◈ Contractors should establish procedures for the prevention, detection and reporting of fraud and abuse. ◈ Should a Contractor be made aware of any activities that may involve member or provider fraud, the fraud section shall immediately notify AHCCCS as described in AHCCCS policy. ◈ Contractors should assist governmental agencies as practical in providing information and other resources during the course of investigations of possible fraud and abuse.	◈ Create an environment conducive to preventing and detecting fraud and abuse.
CONTRACTOR EMPLOYEES: ◈ Contractors should implement lines of reporting for possible fraud and abuse that are well defined and made known to all employees through new employee orientation. ◈ Employees that interact with providers and members should be trained in fraud and abuse detection and reporting. These employees must be familiar with the types of fraud and abuse which could be encountered and the steps to report any such noted fraud or abuse. ◈ Those employees that interact with providers and members shall watch for signs of potential fraud and abuse such as the abuse, neglect or exploitation of an eligible person and/or the loss, theft, misappropriation, or overpayment of AHCCCS and/or Contractor funds.	◈ Increase employees' awareness of what fraud is, how to find it, their responsibilities, and how to report it.

MEMBER SERVICES: ◈ Through the member handbooks, Contractors can encourage members to report providers that may be providing unnecessary or inappropriate services. Include directions of how to report information to the Contractor. ◈ Establish a member complaint system, which logs and documents all complaints. All complaints should be reviewed timely and resolved. Any complaints, which involve fraud or abuse, should be handled in accordance with the Contractors' reporting structure. ◈ Member handbooks should include a definition of member fraud and abuse with reference to penalty for fraud and abuse under law.	◈ Identify possible fraud from member reporting and member complaints. ◈ Discourage member fraud by informing members of penalties associated with fraud and abuse.
PROVIDER SERVICES: ◈ The credentialing/certification process (including re-credentialing) must ensure a careful review of all participating providers. Providers considering participation in the contract must complete a pre-application, which is reviewed by Contractor personnel. ◈ Credentialing criteria include, but are not limited to (1) a complete, accurate and verified application, (2) a current Arizona professional license, (3) proof of completion of education and training commensurate with the provider's field of practice, (4) a review of any history of limitations, suspensions or restrictions of privileges, and (5) a review of any felony convictions, substance abuse, and suspensions or terminations from the Medicaid or Medicare programs and/or debarment from the Department of Health and Human Services. ◈ Contractors shall monitor providers for non-compliance with Contractors' and/or AHCCCS rules, policies and procedures.	◈ Prevent fraudulent use of the Medicaid system by disbarred, unlicensed, unqualified, and otherwise inappropriate providers. ◈ Avoid possible fraud by monitoring providers for compliance with Contractor and AHCCCS rules, policies & procedures.

GRIEVANCE AND APPEALS: Grievances are tracked by type and referred to appropriate personnel.	◈ **Detect possible abuse of members, by a provider, or patterns of inappropriate utilization, referrals, etc.**
CONTRACTING WITH PROVIDERS: ◈ Provider contracts there must include specific sections describing the provider's responsibilities to (1) comply with all applicable Federal, State and local laws, rules and regulations, (2) notify the Contractor of any credentialing/licensure change, (3) maintain professional standards, (4) maintain and furnish records and documents as required by law, rule and regulation, and (5) abide by applicable laws, rules, regulations and contract provisions to avoid termination of the contract, and (6) other AHCCCS subcontract provisions, as appropriate. ◈ By educating providers to bill correctly, Contractors can discourage the submission of claims for non-covered or unnecessary services. ◈ Provider manuals should include a section about fraud and abuse, which includes references to provider fraud and abuse and member fraud, and abuse. The manual should describe how providers can report potential cases of fraud and abuse to the Contractor. ◈ Contracts should also include anti-kickback language and reference to self-referrals in each of its standard contract forms.	◈ Reduce possibility of provider fraud by making provider aware of applicable rules, regulations, etc. during contract process. ◈ **Avoid possible fraud by educating providers about how to bill appropriately**
PRIOR AUTHORIZATION: ◈ The Prior Authorization Department should be the beginning of a continuous series of review for medical services. These responsibilities include, but are not limited to, verifying (1) member eligibility, (2) medical necessity, (3) appropriateness of service being authorized, (4) the service being requested is a covered service, and (5) appropriate provider referral. ◈ Any portion of the prior authorization request, which is deemed an "unusual incident", should immediately be written up and referred to the appropriate personnel.	◈ To avoid possibility of member or provider abuse, such as over or under utilization.

CLAIMS SYSTEM: ◈ Claims Edits: During the initial processing of a claim, the claim should be reviewed for items such as member eligibility, covered services, excessive or unusual services for sex or age, duplication of services, prior authorization, invalid procedure codes, and duplicate claim. Any unusual items should cause the claim to pend for review. Also, claims over a certain amount should automatically be pended for review. ◈ Post Processing Review of Claims: After claims are paid, retrospective review of a sample of claims is done to determine the following: (1) reasonable charges were made for services provided, (2) the appropriateness of inpatient and outpatient care, (3) the appropriate level of care, (4) excessive diagnostic testing or ancillary referrals. ◈ Contractors should also conduct audits of claims payments to attain a reasonable assurance that payments are being prepared correctly for claims submitted from authorized providers for eligible AHCCCS members.	◈ Prevent/detect payments to providers for services not performed, not authorized, or otherwise inappropriate. ◈ Test for validity of the original claims process for detecting fraud and misuse.
UTILIZATION/QUALITY MANAGEMENT: Utilization/Quality Management controls include (1) prior authorization and/or pre-admission review, (2) admission review, (3) concurrent review, (4) discharge review, and (5) retrospective review. Utilization reports (provider and member profiling) should be monitored to determine if a specific provider or member shows unusually high or low levels of service utilization. If at any time during the utilization/quality management process an "unusual incident" should be suspected or discovered, the matter would be immediately referred to the appropriate personnel. Regularly scheduled medical record audits and site reviews are conducted.	◈ To reduce possibility of provider and member abuse, such as over or under utilization.

REVISED: 06/12/00

C O N F I D E N T I A L

OPI Case #_____

AHCCCS REFERRAL FOR PRELIMINARY INVESTIGATION

Suspected Program Fraud or Abuse and Member Fraud: Refer to: Director, Office of Program Integrity, 801 E. Jefferson, Mail Drop 4500 Phoenix, AZ 85034 (602) 417-4045 / **FAX** (602) 417-4102, **or Toll Free** 1-800-654-8713 ext. 7-4045

SEE DEFINITIONS AND EXAMPLES OF FRAUD & ABUSE ON THE REVERSE SIDE

Referral Source

Name & Title of Individual Referring:_____

_____

Date of Referral _____

Phone Number _____ Return Call Needed to Referring Individual __YES __NO

Referring Individual is Affiliated With: NAME_____

- ❑ AHCCCS Contractor
- ❑ Government Agency
- ❑ Health Care Provider
- ❑ Recipient/Recipient Family
- ❑ Other (Anonymous, Citizen, etc.) _____

Name of Individual actually reporting the incident, (if different that of the referring individual above):

_____**Phone Number**_____

Provider/Caregiver ~ Recipient ~ AHCCCS Contractor *allegedly involved* in the Issue:

Provider/Caregiver or AHCCCS Contractor Information:

NAME_____ **AHCCCS Provider ID #** _____

Address and Phone # _____

Recipient/Member Information (if applicable and available):

NAME_____ **AHCCCS ID or Social Sec. #** _____

Date of Birth_____ **Address and Phone #** _____

NARRATIVE DESCRIPTION OF ISSUE: *(Please include the **Who, What, Where**, and **When** of the issue).*
PLEASE DO NOT USE ABBREVIATIONS
*Dollar Loss to the program (if known) $*_____

(Narrative may be continued on the reverse side.)

Narrative continued:

_____

_____

_____

_____

AGENCIES NOTIFIED: ❑ APS ❑ CPS ❑ ADHS LICENSURE ❑ POLICE ❑ Other _____

Comments:_____

DEFINITIONS

AHCCCS CONTRACTOR **means an AHCCCS Health Plan, Program Contractor, Arizona Department of Health Services/ Behavioral Health Services, Regional Behavioral Health Authorities, Arizona Department of Health Services/Children's Rehabilitation Services and any other entity that has a contract or Intergovernmental Agreement with AHCCCS to provide covered services.**

FRAUD **means 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 Federal or State law.** ***[42 CFR § 455.2]***

ABUSE **means provider practices that are inconsistent with sound fiscal, business, or medical practice, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.** ***[42 CFR § 455.2]***

ABUSE OF A MEMBER **means any intentional, knowing or reckless infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, emotional or sexual abuse, or sexual assault.** ***[ARS § § 46-451;13-3623]*** *REPORT MEMBER ABUSE TO: AHCCCS/DHCM-CQM, 701 E. JEFFERSON, MD-6500, Phoenix, AZ 85034*

EXAMPLES OF FRAUD AND ABUSE

FALSIFYING CLAIMS/ENCOUNTERS

Alteration of a Claim
Upcoding
Incorrect Coding
Double Billing
Unbundling
Billing for Services/Supplies Not Provided
Misrepresentation of Services/Supplies
Substitution of Services
Submission of Any False Documents

ADMINISTRATIVE / FINANCIAL

Kickbacks/Stark Violations
Fraudulent Credentials
Fraudulent Enrollment Practices
Fraudulent Recoupment Practices
Embezzlement

Delivery of Services

Denying Access to Services/Benefits
Limiting Access to Services/Benefits
Failure to Refer to a Needed Specialist
Underutilization
Overutilization

ABUSE OF A MEMBER

Physical Abuse
Neglect
Mental Abuse
Emotional Abuse
Sexual Abuse
Discrimination
Providing Substandard Care
Financial Exploitation

Member Fraud

Eligibility Determination Issues:
Resource Misrepresentation (Transfer/Hiding)
Residency
Household Composition
Income
Citizenship Status
Misrepresentation of Medical Condition

Please note, the above lists only a *few* examples of potential fraud and abuse scenarios.

Revised: 10/10/03

104 – BUSINESS CONTINUITY AND RECOVERY PLAN

Effective Date: 10/01/04
Revision Date: 01/01/11

Staff responsible for policy: DHCM Administration

I. Purpose

This policy applies to all Acute Care and Long Term Care (ALTCS) Contractors, Arizona Department of Health Services/Behavioral Health Services (ADHS/BHS), Children's Rehabilitation Services (CRS), and any other entity that has a contract or Intergovernmental Agreement with AHCCCS to provide covered services (hereinafter referred to as Contractors).

AHCCCS requires in contract that each of its Contractors have a Business Continuity Plan. The purpose of this policy is to outline the required components of the Plan and also suggested checklists and plan testing methods.

AHCCCS is mandated to provide health care benefits to its enrollees. It does so through contracts with Acute and ALTCS Contractors, the CRS Contractor, and ADHS/BHS, through a network of providers for fee-for-service enrollees, but also recover from the disruption as quickly as possible. This recovery can be accomplished by the development of a Business Continuity Plan that contains strategies for recovery.

II. Definition

Contractor: Refers to Acute Care and Long Term Care (ALTCS) Contractors, Arizona Department of Health Services/Behavioral Health Services (ADHS/BHS), Children's Rehabilitation Services (CRS), and any other entity that has a contract or Intergovernmental Agreement with AHCCCS to provide covered services (hereinafter referred to as Contractors).

III. Policy

A. Each Contractor shall have a Business Continuity and Recovery Plan.

B. The Business Continuity and Recovery Plan shall be reviewed at least annually and updated as needed by the Contractor.

C. The Contractor shall ensure that its staff is trained and familiar with the Plan.

D. The Plan should be specific to the Contractor's operations in Arizona and reference local resources. Generic Plans which do not reference operations in Arizona and the Contractor's relationship to AHCCCS are not appropriate.

E. The Plan shall contain a listing of key customer priorities, key factors that could cause disruption, and what timelines Contractors will be able to resume critical customer services. Examples of these priorities are: Providers receipt of prior authorization approvals and denials, members receiving transportation, timely claims payments, etc.

F. The Plan shall contain specific provisions for recovery of key customer priorities.

The CRS Contractor shall include in key customer priorities the following critical processes:

1. Eligibility and Enrollment,
2. Scheduling,
3. Clinic Visits,
4. Prior-Authorization,
5. Surgeries,
6. Utilization Review/Concurrent Review,
7. Claims/Provider Payments, and
8. Grievance/Appeals and Quality of Care Concerns.

G. The Plan shall contain specific timelines for resumption of services. The timelines should note the percentage of recovery at certain hours, and key actions required to meet those timelines. An example of this would be: Telephone service restored to prior authorization unit within 4 hours, to Member Services within 24 hours, to all phones in 24 hours, etc.

H. The Plan shall contain, at a minimum, planning and training for:

- Electronic/telephonic failure at the Contractor's main place of business.
- Complete loss of use of the main site and any satellite sites.
- Loss of primary computer system/records, or networks.
- How the Contractor will communicate with AHCCCS during a business disruption. The name and phone number of a specific contact in the Division of Health Care Management is preferred. The plan should direct the contractor staff to contact AHCCCS Security at 602-417-4888 in the event of a disruption outside of normal business hours.

I. The Plan should include provisions for periodic testing, at least annually. Results of the tests shall be documented.

J. All Contractor Plans shall be subject to review and approval by AHCCCS Administration. A summary of the plan, with emphasis on the components from Paragraph H of this section, shall be submitted to the Division of Health Care Management 15 days after the start of the contract year and annually thereafter. The summary shall be no longer than 5 pages and include timelines for recovery.

K. Each Contractor shall designate a staff person as Business Continuity Planning Coordinator and furnish AHCCCS with that contact information.

IV. References

The Federal Emergency Management Agency (FEMA) has a website which contains additional information on Business Continuity Planning, including a checklist for reviewing a Plan. AHCCCS encourages the Contractor to use relevant parts of this checklist in the evaluation and testing of its own Business Continuity Plan. The website is located at http://www.fema.gov/ofm

V. Authority

AHCCCS Acute Care, ALTCS, and ADHS/BHS Contracts require Contractors to have a Business Continuity Plan.

105 – GRADUATE MEDICAL EDUCATION LOANS

Effective Date: 03/01/2007
Revision/Review Date: 04/12/2012

Staff responsible for policy: DHCM Reimbursement

I. Purpose

This policy establishes guidelines for the approval, issuance and repayment of interest-free loans as authorized by A.R.S. § 36-2921 for establishment of graduate medical education (GME) programs.

II. Definitions

AHCCCS Inpatient Hospital Days of Care: Has the meaning given at A.A.C. R9-22-701.

Graduate Medical Education Program: Has the meaning given at A.R.S. § 36-2903.01(H)(9)(e).

Hospital: Has the meaning given at A.A.C. R9-22-101(B).

Primary Care Area: A geographic area of the state defined under the Arizona Department of Health Services, Primary Care Area Program.

Primary Care Discipline: Any of the fields of medicine described by A.R.S. § 36-2901(12).

Population-to-Primary-Care-Provider Ratio: A statistic determined under the Arizona Department of Health Services, Primary Care Area Program and published by the ADHS for all counties and Primary Care Areas in the state.

III. Policy

A. General

Subject to available funds, the Administration may issue interest-free loans of not more than five hundred thousand dollars to one hospital per county per fiscal year to fund costs for the establishment of a GME program in that county and reasonable costs for the first two years of its operation.

B. Eligible Hospitals

To be eligible to receive a loan under this policy, a hospital must:

1. Be physically located in Arizona;

2. Be affiliated with an accredited allopathic or osteopathic medical school having a physical presence in Arizona and licensed by the state of Arizona to grant degrees; and

3. Establish a new GME program that meets the requirements of paragraph C.

C. Eligible Programs

To be eligible for loan funding under this section, a GME program must:

1. Be structured to accommodate at least six resident positions at a hospital not currently operating a GME program, or at least four resident positions at a hospital currently operating one or more GME programs in medical disciplines different from the newly established program; and

2. Be accredited by a nationally recognized accrediting body, or

3. Have applied for accreditation and can reasonably expect to receive accreditation within one year of the loan issuance.

D. Application

The Administration will accept applications on an annual basis. A hospital wishing to be considered for a loan must submit to the Administration by September 1st of each year all of the following:

1. A completed loan application on a form provided by the Administration.

2. Evidence of program accreditation or evidence of application for program accreditation.

3. A copy of the medical school affiliation agreement or the letter of understanding which documents the duties and responsibilities of both the medical school and the program.

4. A pro forma budget detailing expected program costs for the first five years of the program's operation.

For state fiscal year 2007 only, applications must be received by May 1st, 2007.

E. Determination of Application Approval or Denial

The Administration will determine approval or denial of a loan application in the following manner:

1. Where more than one application is received from the same county, the Administration will apply the following preferences in the following order of priority until one application per county remains:

   a. Preference will be given to hospitals in the Primary Care Area having the highest Population-to-Primary-Care-Provider Ratio.

   b. If more than one application remains within a county, preference will be given to programs that are accredited as of the date of application for a loan.

   c. If more than one application remains within a county, preference will be given to programs in the primary care disciplines.

   d. If more than one application remains within a county, preference will be given to applicants who have not previously received a loan from the Administration.

   e. If more than one application remains within a county, preference will be given to the hospital having the higher Medicaid utilization ratio, determined as follows:

      Using the hospital's most recent Medicare Cost Report information on file with the Administration as of the date of application and the Administration's inpatient hospital claims and encounter data for the time period corresponding to the hospital's Medicare Cost Report information, the total AHCCCS inpatient hospital days of care will be divided by the total Medicare Cost Report inpatient hospital days.

2. The Administration will rank the remaining applications according to the following order of priority:

   a. Preference will be given to hospitals in counties with a population of less than five hundred thousand persons according to the most recent federal decennial census.

   b. Thereafter, the applications will be ranked in descending order according to the Population-to-Primary-Care-Provider Ratio for each hospital's Primary Care Area.

3. Subject to available funds, the Administration will offer loans in descending order beginning with the highest ranked application. The Administration will deny applications when no funds remain for the fiscal year. An applicant whose application is denied due to unavailability of funds for the current fiscal year may reapply for the following fiscal year.

F. Determination of Loan Amount

The Administration will offer loan amounts based on the number of resident positions reasonably expected to be filled in the first two years of the program's operation, which expectation must be supported by the pro forma budget and the program plan submitted for purposes of accreditation. The loan amount offered will be the lesser of one hundred thousand dollars per resident or five hundred thousand dollars, but in no case less than two hundred thousand dollars.

G. Loan Approval and Issuance

By November 1st of each year, the Administration will notify each loan applicant of approval or denial of the loan application and, for approved applications, the approved amount of the loan. The Administration will issue a warrant for the approved amount of the loan following execution of a promissory note for the full amount of the loan.

For state fiscal year 2007 only, the Administration will notify each loan applicant by June 30th, 2007.

H. Loan Repayment

Repayment of the loan must begin within 90 days following receipt of the first federal payment for direct GME or five years after the date of loan issuance, whichever is earlier. Repayment will be in annual installments and must be completed no more than ten years after the date of loan issuance. Each installment will be equal to the loan amount divided by the number of years remaining of the ten-year time limit for full repayment.

A hospital may elect to begin repayment prior to the required date and may elect to repay the loan in full at any time prior to the date that repayment in full is required.

IV. References

- A.R.S. § 36-2921
- A.R.S. § 36-2903.01(H)(9)(e)
- A.R.S. § 36-2901(12)
- A.A.C. R9-22-101(B)
- A.A.C. R9-22-701
- Arizona Department of Health Services, Primary Care Area Program

106– AHCCCS CONTRACTOR DELIVERABLE TEMPLATES POLICY

UNDER DEVELOPMENT

107 CONTRACTING WITH MEDICARE SPECIAL NEEDS PLANS

Effective Date: April 1, 2012
Revision Date:

Staff responsible for policy: DHCM Administration

I. Purpose

This Policy applies to organizations, whether or not they are existing Acute Care or ALTCS Contractors, that currently have contracts, or will be pursuing contracts, with the Centers for Medicare and Medicaid (CMS) to operate as a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) in calendar year 2013. Beginning January 1, 2013, federal regulations require that all D-SNPs have a contract in place with the State Medicaid Agency which outlines for CMS and the State the specific dual eligible population the D-SNP will serve as well as care coordination and cost sharing obligations. D-SNPs are a type of Medicare Advantage plan which limits enrollment to Medicare beneficiaries who are also receiving Medicaid benefits. The purpose of this Policy is to maximize care coordination for AHCCCS acute care and ALTCS members who are dual eligibles.

To further align care coordination of dual eligibles, the AHCCCS Administration also intends to submit a Dual Demonstration Project Proposal to CMS which outlines additional proposals for integration and care coordination of dual eligible members for the time period of January 2014 through December 2016.

II. Definitions

Acute Care Duals: AHCCCS beneficiaries who are determined eligible for AHCCCS acute care benefits, including but not limited to AHCCCS members eligible under 1931, SSI MAO, and AHCCCS Care, who are enrolled in Medicare Part A and/or Part B.

ALTCS Duals: Persons who have been determined eligible for the ALTCS EPD or DD Program because they require an institutional level of care and meet financial and other eligibility criteria for Title XIX eligibility and who are also enrolled in Medicare Part A and/or Part B.

III. Policy

A. AHCCCS Acute Care Duals

In spring 2013 AHCCCS will award acute care contracts to successful bidders of the Request for Proposal (RFP) process for provision of acute care services beginning October 1, 2013. To maximize care coordination of AHCCCS dual eligible members in anticipation

of the upcoming RFP process, AHCCCS will sign contracts for the time period of January 1, 2013 through December 31, 2013 with:

1) 2012 Medicare approved D-SNPs, which are NOT current Acute Care Contractors, to continue operation of D-SNPs in those counties in which they currently operate 2012 Medicare approved D-SNPs. The AHCCCS contracts will be effective from January 1, 2013 through December 31, 2013 only. AND
2) Current Acute Care Contractors which operate 2012 Medicare approved D-SNPs to continue operation of D-SNPs in all such counties, regardless of whether or not the D-SNP operates in a county in which it also has an acute care contract. AHCCCS contracts with current Acute Care Contractors operating D-SNPS will be effective only from January 1, 2013 through December 31, 2013.

Beginning January 1, 2014, AHCCCS will align care of dual eligibles and will not contract with any D-SNPs operating in counties in which they do not *also* have an acute care contract. Alignment of dual eligible members in the same plan for both Medicare and Medicaid services provides members with one entity that coordinates all aspects of care, thus decreasing fragmentation of care and reducing confusion for members, providers, and contractors related to service delivery.

B. ALTCS-EPD Duals

In May 2011 AHCCCS awarded new contracts for the ALTCS-EPD Program covering the time period of October 1, 2011 through September 30, 2014, with the possibility for two 1-year contract extensions. As a condition of receiving an award in Maricopa and Pima counties, bidders were required to have an aligned Medicare Advantage Plan or a D-SNP in those counties. To further enhance care coordination of ALTCS dual eligible members, AHCCCS will sign contracts for the time period of January 1, 2013 through December 31, 2013 with:

1) 1) 2012 Medicare approved D-SNPs, which are NOT current ALTCS Contractors, to continue operation of D-SNPs in those counties in which they currently operate 2012 Medicare approved D-SNPs. The AHCCCS contracts will be effective from January 1, 2013 through December 31, 2013 only. AND

2) Current ALTCS Contractors which operate 2012 Medicare approved D-SNPs to continue operation of D-SNP plans in all such counties, regardless of whether or not the D-SNP operates in a county in which it also has an ALTCS contract. AHCCCS contracts for current ALTCS Contractors operating D-SNPS will be effective only from January 1, 2013 through December 31, 2013 only.

Beginning January 1, 2014, AHCCCS will align care of dual eligibles and will not contract with any D-SNPs operating in counties in which they do not *also* have an ALTCS contract. Alignment of dual eligible members in the same plan for both Medicare and Medicaid services provides members with one entity that coordinates all aspects of care, thus decreasing fragmentation of care and reducing confusion for members, providers, and contractors related to service delivery.

C. ALTCS-DD Duals

ALTCS services for persons who are Developmentally Disabled (DD) are provided by the Department of Economic Security (DES), Division of Developmental Disabilities (DDD) as specified in State Law. Therefore, D-SNPs do not have contracts directly with the State Medicaid Agency for serving DD members. If CMS recommends D-SNP contracting for DD ALTCS members, AHCCCS will explore whether alignment of Medicare and Medicaid services can be achieved and pursue contracting when feasible.

IV. Data Sharing

Claims data for Medicare beneficiaries enrolled in Medicare Advantage plans is not currently available to states. Therefore, AHCCCS may require that all current AHCCCS Contractors operating D-SNPs submit Medicare claims to AHCCCS. This data will be used by AHCCCS for care coordination and other operational activities related to dual eligible members.

V. Care Coordination

All D-SNPs must ensure timely coordination of care with the member's Acute Care or ALTCS Contractor.

VI. Process

AHCCCS has developed a contract template for use by each D-SNP. All contracts must describe the following:

1. The MA organization's responsibility, including financial obligations, to provide or arrange for Medicaid benefits;
2. The category(ies) of eligibility for dual-eligible beneficiaries to be enrolled under the SNP, as described under by the Social Security Act at sections 1902(a), 1902(f), 1902(p), and 1905;
3. The Medicaid benefits covered under the SNP;
4. The cost-sharing protections covered under the SNP;
5. The identification and sharing of information on Medicaid provider participation;
6. The verification of enrollee's eligibility for both Medicare and Medicaid;
7. The service area covered by the SNP; and
8. The contract period for the SNP.

D-SNPs may review the contract template and submit their proposed agreement with tracked changes to Katrina Cope at Katrina.Cope@azahcccs.gov. D-SNPs are required to submit a contract with the State Medicaid Agency to CMS by July 1, 2012. To ensure that AHCCCS has adequate time to review the D-SNP contracts, all contracts must be received no later than April 30, 2012.

Questions concerning this Policy may be directed to Katrina Cope at (602) 417-4173.

VII. References

- Section 1859(f) of the Social Security Act
- Section 164 of the Medicare Improvement for Patients and Providers Act
- Section 3205 of the Affordable Care Act
- 42 Code of Federal Regulations 422.107
- Medicare Managed Care Manual Chapter 16-B: Special Needs Plans

CHAPTER 200 – CLAIMS PAGE

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201 - MEDICARE COST SHARING FOR MEMBERS IN MEDICARE FFS

Effective Date: 10/01/97
Revision Date: 06/01/01, 03/11/10

Staff responsible for policy: DHCM Finance

I. Purpose

This policy applies to AHCCCS acute care Contractors, Arizona Long Term Care System (ALTCS) Contractor and the Arizona Department of Health Services (ADHS) for Title XIX behavioral health services, hereafter known as Contractors.

The purpose of this policy is limited to and defines cost sharing responsibilities of AHCCCS Contractors for their members that are enrolled in Medicare FFS. Refer to the "Medicare cost sharing for members in Medicare HMO" policy for Managed Care members.

This reimbursement policy will maximize cost avoidance efforts by Contractors and provide a reimbursement methodology that provides continuity of care for AHCCCS members.

II. Definitions

Cost Sharing: Refers to AHCCCS Contractors' obligation for payment of applicable Medicare FFS coinsurance and deductibles, and copayments.

Dual Eligible: Refers to an AHCCCS member who is eligible for both Medicaid and Medicare services. There are two types of dual eligible members: those eligible for Qualified Medicare Beneficiary (QMB) benefits (QMB Dual), and Medicare beneficiaries not eligible for QMB benefits (Non-QMB Dual).

QMB Dual: An individual who is eligible for QMB benefits as well as Medicaid benefits. QMB duals are entitled to AHCCCS and Medicare Part A and B services.

Non-QMB Dual: An individual who is eligible for Medicaid and has Medicare coverage, but who is not eligible for QMB.

In-Network Provider: A provider that is contracted with the Contractor to provide services. However, at its discretion, a Contractor may authorize services to be provided by a non-contracted provider, such as a hospital.

Out of Network Provider: An out of network provider is a provider that is neither contracted with nor authorized by the Contractor to provide services to AHCCCS members.

Medicare Risk HMO: A managed care entity that has a Medicare contract with CMS to provide services to Medicare beneficiaries.

III. Policy

A. Covered Services

1. QMB Duals

QMB Duals are entitled to all AHCCCS and Medicare part A and B covered services. The Contractor is responsible for the payment of the Medicare deductible and coinsurance for AHCCCS covered services. In addition to AHCCCS covered services, QMB Duals may receive Medicare services that are not covered by AHCCCS, or differ in scope or duration. The services must be provided regardless of whether the provider is in the Contractor's network. These services include:

- Chiropractic services for adults
- Inpatient and outpatient occupational therapy coverage for adults
- Inpatient psychiatric services (Medicare has a lifetime benefit maximum)
- Other behavioral health services such as partial hospitalization
- Any services covered by or added to the Medicare program not covered by AHCCCS

Please refer to the AHCCCS Medical Policy Manual (AMPM) for Medicare only covered services that are specific to the acute care and ALTCS programs.

2. Non- QMB Duals

The Contractor is responsible for the payment of the Medicare deductible and coinsurance for AHCCCS covered services that are rendered on a FFS basis by a Medicare provider within the Contractor's network. Contractors are not responsible for the services listed in III. A. 1.

3. Cost Sharing Matrix

Covered Services	Contractor Responsibility	In Network	Out of Network*	Prior Authorization Required
Medicare Only—not covered by AHCCCS	Cost sharing responsibility only for QMB Duals	YES	YES	NO
AHCCCS Only—not covered by Medicare, including pharmacy and other prescribed services	Reimbursement for all medically necessary services	YES	NO	YES
AHCCCS and Medicare covered Service (except for emergent)	Cost sharing responsibility only	YES	NO	YES
Emergency Services	Cost sharing responsibility only	YES	YES	NO

*Unless authorized by the AHCCCS Contractor

B. Limits on Cost Sharing

Contractors have cost sharing responsibility for AHCCCS covered services provided to members by an in-network FFS Medicare provider. Contractors shall have no cost sharing obligation if the Medicare payment exceeds the Contractor's contracted rate for the services. The Contractor's liability for cost sharing plus the amount of Medicare's payment shall not exceed the Contractor's contracted rate for the service.

For those Medicare services for which prior authorization is not required, but are also covered by AHCCCS, there is no cost sharing obligation if the Contractor has a contract with the provider, and the provider's contracted rate includes Medicare cost sharing as specified in the contract.

The exception to these limits on payments as noted above is that the Contractor shall pay 100% of the member copayment amount for any Medicare Part A Skilled Nursing Facility (SNF) days (21 through 100) even if the Contractor has a Medicaid Nursing Facility rate less than the amount paid by Medicare for a Part A SNF day.

C. Prior Authorization

If the Contractor's contract with a provider requires the provider to obtain prior authorization before rendering services, and the provider does not obtain prior authorization, the Contractor is not obligated to pay the Medicare cost sharing for AHCCCS covered services, except for emergent care. The Contractor cannot require prior authorization for Medicare only services.

If the Medicare provider determines that a service is medically necessary, the Contractor is responsible for Medicare cost sharing, even if the Contractor determines otherwise. If Medicare denies a service for lack of medical necessity, the Contractor must apply its own criteria to determine medical necessity. If criteria support medical necessity, then the Contractor shall cover the cost of the service.

D. Out of Network Services

1. Provider

If an out of network referral is made by a contracted provider, and the Contractor specifically prohibits out of network referrals in the provider contract, then the provider may be considered to be in violation of the contract. In this instance, the Contractor has no cost sharing obligation. The provider who referred the member to an out of network provider would be obligated to pay any cost sharing. The member shall not be responsible for the Medicare cost sharing except as stipulated in D.2. of this policy.

2. Member

If a member has been advised of the Contractor's network, and the member's responsibility is delineated in the member handbook, and the member elects to go out of network, the member is responsible for paying the Medicare cost sharing amount. (Emergent care, pharmacy, and other prescribed services are the exceptions.) This member responsibility must be explained in the Contractor's member handbook.

E. Pharmacy and Other Physician Ordered Services

Contractors shall cover prescriptions and other ordered services that are both prescribed and filled by in-network providers. If a provider prescribes a non-formulary prescription, then the Contractor may opt to not reimburse for the prescription. The Contractor may also require prior authorization.

IV. References

- Social Security Act, 1905(p)(3)
- AHCCCS State Plan Amendment 96-13 - Medicare Cost Sharing
- Arizona Revised Statutes §36-2946 A and §36-2972 C
- Arizona Administrative Code R9-29, Articles 3 and 4

202 - MEDICARE COST SHARING FOR MEMBERS IN MEDICARE HMO

Effective Date: 10/01/97
Revision Date: 07/01/03, 03/11/10

Staff responsible for policy: DHCM Finance

I. Purpose

This policy applies to AHCCCS acute care Contractors, Arizona Long Term Care System (ALTCS) Contractors and the Arizona Department of Health Services (ADHS) for Title XIX behavioral health services, hereafter known as Contractors. The purpose of this policy is limited to and defines cost sharing responsibilities of AHCCCS Contractors for their members who are enrolled in Medicare Risk HMO's. Refer to the "Medicare cost sharing for members in Medicare FFS" policy for fee for service members.

This reimbursement policy will maximize cost avoidance efforts by Contractors and provide a reimbursement methodology that provides continuity of care for AHCCCS members.

II. Definitions

Cost Sharing: Refers to AHCCCS Contractors' obligation for payment of applicable Medicare FFS coinsurance and deductibles, and copayments.

Dual Eligible: Refers to an AHCCCS member who is eligible for both Medicaid and Medicare services. There are two types of dual eligible members: those eligible for Qualified Medicare Beneficiary (QMB) benefits (QMB Dual), and Medicare beneficiaries not eligible for QMB benefits (Non-QMB Dual).

QMB Dual: An individual who is eligible for QMB benefits as well as Medicaid benefits. QMB duals are entitled to AHCCCS and Medicare Part A and B services.

Non-QMB Dual: An individual who is eligible for Medicaid and has Medicare coverage, but who is not eligible for QMB.

In-Network Provider: A provider that is contracted with the Contractor to provide services. However, at its discretion, a Contractor may authorize services to be provided by a non-contracted provider, such as a hospital.

Out of Network Provider: An out of network provider is a provider that is neither contracted with nor authorized by the Contractor to provide services to AHCCCS members.

Medicare Risk HMO: A managed care entity that has a Medicare contract with CMS to provide services to Medicare beneficiaries.

III. Policy

A. Payor of Last Resort

AHCCCS is the payor of last resort. Therefore, if a member is enrolled with a Medicare Risk HMO, the member shall be directed to their Medicare Risk HMO for services. However, if the Medicare Risk HMO does not authorize a Medicaid covered service, the Contractor shall review the requested service for medical necessity, and elect to authorize it.

B. Covered Services

1. QMB Dual

QMB Duals are entitled to all AHCCCS and Medicare part A and B covered services. In addition to AHCCCS covered services, QMB Duals may receive Medicare services that are not covered by AHCCCS, or differ in scope or duration. When a member is enrolled in a Medicare Risk HMO, the Contractor is responsible for cost sharing for Medicare services that are not covered by AHCCCS, or differ in scope or duration. These services include:

- Chiropractic services for adults
- Inpatient and outpatient occupational therapy coverage for adults
- Inpatient psychiatric services (Medicare has a lifetime benefit maximum)
- Other behavioral health services such as partial hospitalization
- Any services covered by or added to the Medicare program not covered by AHCCCS

Please refer to the AHCCCS Medical Policy Manual (AMPM) for Medicare only covered services that are specific to the acute care and ALTCS programs.

2. Non- QMB Dual

Contractors are responsible for cost sharing for AHCCCS-only covered services for Non-QMBs. Contractors are not responsible for the services listed in III. B. 1.

3. Cost Sharing Matrix

Covered Services—	Contractor Responsibility	In Network	Out of Network*	Prior Authorization Required
Medicare Only Covered Services**	Cost Sharing responsibility for QMB Duals Only.	N/A	N/A	NO
AHCCCS Only—not covered by Medicare	Reimbursement for all medically necessary services	YES	NO	YES
AHCCCS and Medicare covered Service (except for emergent and pharmacy services)	Cost sharing responsibility only	YES	NO	YES
Emergency Services	Cost sharing responsibility only	YES	YES	NO
Pharmacy and Other Physician Ordered Services (see E. for more details)	Cost sharing responsibility until member reaches HMO cap, then full reimbursement	YES	NO	YES/NO (See E. for more details.)

*Unless prior authorized. Also, see section E.
** AHCCCS Contractors are not responsible for cost sharing for Medicare Only Services for Non-QMBs.

C. Limits on Cost Sharing

Contractors have cost sharing responsibility for all AHCCCS covered services provided to members by a Medicare Risk HMO. For those services that have benefit limits, the Contractor shall reimburse providers for all AHCCCS and Medicare covered services when the member reaches the Medicare Risk HMO's benefit limits.

Contractors only have cost sharing responsibility for the amount of the *member's* coinsurance, deductible or copayment. Total payments to a provider shall not exceed the Medicare allowable amount which includes Medicare's liability and the member's liability. *For* those Medicare services which are also covered by AHCCCS, there is no cost sharing obligation if the Contractor has a contract with the Medicare provider, and the provider's contracted rate includes Medicare cost sharing as specified in the contract.

Contractors shall have no cost sharing obligation if the Medicare payment exceeds the Contractor's contracted rate for the services. The Contractor's liability for cost sharing plus the amount of Medicare's payment shall not exceed the Contractor's contracted rate for the service. With respect to copayments, the Contractor may pay the lesser of the copayment, or their contracted rate.

The exception to these limits on payments as noted above is that the Contractor shall pay 100% of the member copayment amount for any Medicare Part A Skilled Nursing Facility (SNF) days (21 through 100) even if the Contractor has a Medicaid Nursing Facility rate less than the amount paid by Medicare for a Part A SNF day.

D. Prior Authorization

If the Contractor's contract with a provider requires the provider to obtain prior authorization before rendering services, and the provider does not obtain prior authorization, the Contractor is not obligated to pay the Medicare cost sharing for AHCCCS covered services, except for emergent care. See F for exceptions for pharmacy and other physician ordered services.

If the Medicare Risk HMO determines that a service is medically necessary, the Contractor is responsible for Medicare cost sharing, even if the Contractor determines otherwise. If the Medicare Risk HMO denies a service for lack of medical necessity, the Contractor must apply its own criteria to determine medical necessity, and may not use the Medicare Risk HMO's decision as the basis for denial.

E. Out of Network Services

1. Provider

If an out of network referral is made by a contracted provider, and the Contractor specifically prohibits out of network referrals in the provider contract, then the provider may be considered to be in violation of the contract. In this instance, the Contractor has no cost sharing obligation. The provider who referred the member to an out of network provider is obligated to pay any cost sharing. The member shall not be responsible for the Medicare cost sharing except as stipulated in E.2. of this policy.

However, if the Medicare HMO and the Contractor have networks for the same service that have no overlapping providers, and the Contractor chooses not to have the service performed in its own network, then the Contractor is responsible for cost sharing for that service. If the overlapping providers have closed their panels and the member goes to an out of network provider, then the Contractor is responsible for cost sharing.

2. Member

If a member has been advised of the Contractor's network, and the member's responsibility is delineated in the member handbook, and the member elects to go out of network, the member is responsible for paying the Medicare cost sharing amount. (Emergent care, pharmacy, and other prescribed services are the exceptions.) This member responsibility must be explained in the Contractor's member handbook.

F. PHARMACY AND OTHER PHYSICIAN ORDERED SERVICES

Contractors shall cover pharmacy copayments for prescriptions prescribed by both contracted and non-contracted providers as long as the prescriptions are filled at a contracted pharmacy. For purposes of this section, "in network" refers to the provider who supplies the prescription, not the prescribing provider. However, if a provider prescribes a non-formulary prescription, then the Contractor may opt to not reimburse for the prescription copayment. If a Contractor requires prior authorization for formulary medications, then the Contractor may choose not to cover the copayment if prior authorization is not obtained.

If a member exceeds their pharmacy benefit limit, the Contractor shall cover all prescription costs for the member. These prescriptions are subject to the Contractor's formulary, prior authorization and pharmacy network requirements.

If the Medicare Risk HMO does not offer a pharmacy benefit, then the Contractor may require that the prescribing physician be in the Contractor's network for prescription benefit coverage.

This requirement extends to all "prescribed services" such as laboratory and DME.

IV. References

- Social Security Act, 1905(p)(3)
- AHCCCS State Plan Amendment 96-13 - Medicare Cost Sharing
- Arizona Revised Statutes §36-2946 A and §36-2972 C
- Arizona Administrative Code R9-29, Articles 3 and 4

203 – CONTRACTOR CLAIMS PROCESSING BY SUBCONTRACTED PROVIDERS

Effective Date: 02/01/97; 04/13/2012
Revision Date: 11/01/02, 6/15/05, 04/13/12

Staff responsible for policy: DHCM

I. Purpose

This policy applies to all Contractors with subcontracts that require claims and encounters to be adjudicated and paid by or under the direction of a subcontracted provider group.

Per the AHCCCS contract Section D, Subcontracts, "No subcontract shall operate to terminate the legal responsibility of the Contractor to assure that all activities carried out by the subcontractor conform to the provisions of this contract". Accordingly, AHCCCS holds its Contractors responsible for the complete, accurate, and timely payment of all valid provider claims arising from the provision of medically necessary covered services to its enrolled members regardless of subcontract arrangements.

II. Definitions

ACOM: AHCCCS Contractor Operation Manual

Subcontracted Provider Group: Any health plan subcontracted provider, provider group, or provider management company responsible for the coordination of health care service delivery to AHCCCS members.

III. Policy

A. Contractors shall obtain prior approval from AHCCCS of all subcontracts that call for claims processing to be performed by or under the direction of a subcontracted provider group. The subcontract shall be submitted to AHCCCS Division of Health Care Management for prior approval at least 60 days prior to the beginning date of the subcontract.

B. The Contractor shall ensure they have a mechanism in place to inform providers of the appropriate place to send claims at the time of notification or prior authorization if the provider has not otherwise been informed of such information via subcontract and/or a provider manual.

C. Date of Receipt: The receipt date of the claim is the date stamp on the claim or the date electronically received. The receipt date is the day the claim is received at the Contractor's specified mailing address. The Contractor shall forward all claims received to the subcontracted provider group responsible for claims adjudication.

D. Timeliness of Claim Submission and Payment: Unless a subcontract specifies otherwise, Contractors with 50,000 or more members shall ensure that 95% of all clean claims are

paid within 30 days of receipt of the clean claim and 99% are paid within 60 days of receipt of the clean claim. Unless a subcontract specifies otherwise, Contractors with fewer than 50,000 members shall ensure that 90% of all clean claims are paid within 30 days of receipt of the clean claim and 99% are paid within 60 days of receipt of the clean claim. Additionally, unless a shorter time period is specified in contract, the Contractor shall not pay a claim initially submitted more than 6 months after date of service or pay a clean claim submitted more than 12 months after date of service. Claim payment requirements pertain to both contracted and non-contracted providers.

E. Interest Payments: Effective for all non-hospital clean claims with dates of service October 1, 2004 and thereafter, in the absence of a contract specifying other late payment terms, a Contractor is required to pay interest on late payments. Late claims payments are those that are paid after 45 days of receipt of the clean claim (as defined in this contract). In grievance situations, interest shall be paid back to the date interest would have started to accrue beyond the applicable 45 day requirement. Interest shall be at the rate of ten per cent per annum, unless a different rate is stated in a written contract. In the absence of interest payment terms in a subcontract, interest shall accrue starting on the first day after a clean claim is contracted to be paid. For hospital clean claims, a slow payment penalty shall be paid in accordance with A.R.S. 293.01. When interest is paid, the Contractor must report the interest as directed in the AHCCCS Encounter Reporting Manual.

F. Electronic Processing Requirements: Contractors are required to accept and generate required HIPAA compliant electronic transactions from to/any provider interested and capable of electronic submission or electronic remittance receipt; and must be able to make claims payments via electronic funds transfer. (See Section D, Paragraph 38 for requirements)

G. The Contractor shall require the subcontracted provider group to submit a monthly claims aging summary to the Contractor to ensure compliance with claims payment timeliness standards. The Contractor may consider requiring such reports to be consistent in format with the AHCCCS required reports.

H. The Contractor shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule. The schedule for review shall be submitted to AHCCCS, Division of Health Care Management for prior approval. As a result of the performance review, any deficiencies must be communicated to the subcontractor in order to establish a corrective action plan. The results of the performance review and the correction plan shall be communicated to AHCCCS upon completion.

I. The Contractor shall monitor the volume of encounters received from the subcontracted provider group so that encounters are forwarded in accordance with AHCCCS' standards and thresholds.

J. The Contractor shall ensure the subcontracted provider group's remittance advice meets the requirements in the AHCCCS RFP including, but not limited to:

1. The remittance advice shall contain sufficient detail to explain the payment including the composition of the net amount of the payment. In addition, if payment is being denied, there must be sufficient detail to explain the reasons for denial.

2. Provider claims dispute rights shall be referenced.

K. The Subcontractor shall adhere to the Coordination of Benefits/Third Party Liability requirements per the RFP, Section D. The Subcontractor shall adhere to all requirements per the ACOM *Member Notice for Non-Covered Services Policy.*

L. The Subcontractor shall adhere to all Health Insurance, Portability and Accountability Act (HIPAA) requirements according to Public Law 107-191, 110 Statutes 1936.

IV. References

- Acute Care Contract, Section D, Subcontracts, Claims Payment/Health Information System, Coordination of Benefits/Third Party Liability

- ALTCS Contract, Section D, Subcontracts, Claims Payment/Health Information System, Coordination of Benefits/Third Party Liability

- Arizona Administrative Code R9-22, Article 7: Payments by Contractors

204 – TEACHING PHYSICIAN AND DENTIST REIMBURSEMENT OPTION

Original Date: 01/01/2005
Effective Date: 10/01/2010
Revision Date: 08/12/2010

Staff responsible for policy: DHCM Administration

I. Purpose

This policy applies to AHCCCS Acute and Long Term Care Contractors. This policy describes permissible claiming scenarios for teaching physicians in situations where medical residents perform specific low level evaluation and management services without the presence of a teaching physician. Contractors may exercise their own judgment in determining whether they will choose this option for their contracted residency programs. When Contractors do utilize this option, documentation of the arrangement must be included in the contract files.

This policy also describes permissible claiming scenarios for dental services provided by third and fourth year dental students and dental residents under the supervision of a teaching dentist.

II. Definitions

For purposes of this policy the following definitions apply:

Resident: An individual who participates in an approved Graduate Medical Education (GME) program or a recognized dental resident program.

Dental Student: An individual enrolled in an approved dental school or university. Dental students must be in the third or fourth year of their training or otherwise be qualified for clinical privileges under the direct supervision of qualified dental faculty.

Teaching Physician: A physician (other than another resident) who involves residents in the care of his or her patients.

Teaching Dentist: A dentist (other than another resident or dental student) who oversees patient treatment provided by a resident or a dental student.

III. Policy

A. Hospital outpatient department or other ambulatory entity

1. Consistent with Medicare, AHCCCS permits an exception to the direct supervision rule for certain primary care residency programs. The exception rule allows specific low

level evaluation and management CPT codes to be billed by the teaching physician for services rendered by the residents without the presence of the teaching physician. The permitted codes are:

New Member	Established Member
99201	99211
99202	99212
99203	99213

Additionally, AHCCCSA allows for the reimbursement of Preventive Medicine CPT codes for members under 21 years of age. All the codes should be used with a "GE" modifier to designate the claim as a teaching physician billing exception claim.

2. For the above exceptions to apply, the residency program must attest to the Contractor in writing that the following conditions are met:

   a. Services must be furnished in an outpatient department of a hospital or other ambulatory entity included in determining GME payments to a teaching hospital.
   b. Residents furnishing service without the presence of a teaching physician must have completed more than **six months** (post graduate) of an approved residency program.
   c. The teaching physician in whose name payment is sought may not supervise more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability.
   d. The members seen must be an identifiable group of individuals who consider the setting and residency program to be the continuing source of their health care. The residents must generally follow the same group of members through the course of their residency program.
   e. The range of services furnished by the residents includes all of the following: acute and chronic care, care coordination, and comprehensive care not limited by organ system or diagnosis.
   f. The types of residency programs most likely to qualify for the primary care exception rule include: family practice, general internal medicine, geriatric medicine, pediatrics and obstetrics/gynecology.

Note: This is an abbreviated summary. Refer to Medicare Part B News, Issue #192 October 22, 2001, "Supervising Physicians in Teaching Settings" for the complete details.

3. Contractors should instruct the teaching physicians to follow the documentation guidelines as outlined by Noridian, the Medicare intermediary in Arizona, in Transmittal 1780, CR 2290, effective November 22, 2002 which describes clarification to "Supervising Physicians in Teaching Settings - Documentation."

B. Nursing Facility Setting

1. AHCCCSA permits the billing of the following low level evaluation and management nursing facility CPT codes by the teaching physician for services rendered by the residents without the presence of the teaching physician:

New Member	Established Member
99301	99311

All the codes should be used with a "GE" modifier to designate the claim as a teaching physician billing exception claim.

2. For the above to apply, the residency program must attest to the Contractor in writing that the following conditions are met:

   a. Services must be furnished in a nursing facility.
   b. Residents furnishing service without the presence of a teaching physician must have completed more than **twelve months** (post graduate) of an approved residency program.
   c. The teaching physician in whose name payment is sought may not supervise more than four residents at any given time and must be immediately available via telephone.
   d. The members seen must be an identifiable group of individuals who consider the setting and residency program to be the continuing source of their health care. The residents must generally follow the same group of members through the course of their residency program.
   e. The range of services furnished by the residents includes all of the following: acute and chronic, care coordination, and comprehensive care not limited by organ system or diagnosis.
   f. The types of residency programs most likely to qualify include: family practice, general internal medicine, geriatric medicine, pediatrics and obstetrics/gynecology.

3. Contractors should instruct the teaching physicians to follow the documentation guidelines as outlined by Noridian, the Medicare intermediary in Arizona, in Transmittal 1780, CR 2290, effective November 22, 2002 which describes clarification to "Supervising Physicians in Teaching Settings - Documentation."

C. Services Provided by Dental Students/Dental Residents

1. AHCCCS permits billing for dental services provided by dental students or dental residents when the following conditions are met:

   a. Services must be furnished at the dental school clinic or other dental treatment facility identified by the dental school and permitted by the Dental Practice Act.

b. All dental services must be provided under the direct supervision of a teaching dentist certified as either faculty or adjunct faculty by the dental school.

2. The teaching dentist must be an AHCCCS registered provider in order to bill for services.

3. The teaching dentist must be credentialed by the AHCCCS Contractor that is being billed for services.

4. All treatment notes written by dental students or residents must be counter-signed by a teaching dentist.

IV. References

- Title 42 of the Code of Federal Regulations (42 CFR) 415.152 (Definitions)
- 42 CFR 415.170, 172, 174 (Conditions for Payment for Ambulatory Care)
- Medicare Part B News, Issue #192 October 22, 2001, "Supervising Physicians in Teaching Settings"
- Documentation clarification via Noridian: Transmittal 1780; CR 2290, November 22, 2002, Medicare Part B: "Supervising Physicians in Teaching Settings - Documentation"
- Arizona Board of Dental Examiners, Title 32 (The Dental Practice Act) Article 2. Licensing, 32-1231, Persons not required to be licensed, 2.

205 – GROUND AMBULANCE TRANSPORTATION REIMBURSEMENT GUIDELINES FOR NON-CONTRACTED PROVIDERS

Effective Date: 05/01/2006
Revision Date:

Staff responsible for policy: DHCM Administration

I. Purpose

This policy applies to AHCCCS Acute and Long Term Care Contractors (hereafter referred to as Contractors). The purpose of this policy is to provide ground ambulance transportation reimbursement guidelines. It is limited to AHCCCS Contractors and ambulance or emergent care transportation providers when a contract does **not** exist between these entities.

Note: A contract agreement between parties would **not** be subject to this policy.

Refer to the AHCCCS Medical Policy Manual Chapter 300, policy 310, "Transportation" for a general description of the transportation policy.

II. Definitions

For purposes of this policy the following definitions apply:

Advanced Life Support (ALS): 42 CFR 414.605, describes ALS as **either** transportation by ground ambulance vehicle, that has medically necessary supplies and services, and that the treatment includes administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); **or** transportation, medically necessary supplies and services, and the provision of at least one ALS procedure.

Ambulance: Under AR.S. §36-2201, ambulance means **"**Any publicly or privately owned surface (ground), water or air vehicle that contains a stretcher and necessary medical equipment and supplies pursuant to section §36-2202 and that is especially designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded or who require medical monitoring or aid. "Ambulance" does not include a surface vehicle that is owned and operated by a sole proprietor, partnership, private corporation or municipal corporation for the emergency transportation and in–transit care of its employees or a vehicle to accommodate an incapacitated or disabled person who does not require medical monitoring, care or treatment during transport and that is not advertised as having medical equipment and supplies or qualified ambulance attendants as defined in A.R.S. §36-2201."

Basic life support (BLS): Under 42 CFR 414.605, BLS is transportation by ground ambulance vehicle and medically necessary supplies and services, plus the provision of BLS ambulance services. The ambulance must be staffed by an individual who is qualified in accordance with State and local laws as an emergency medical technician-basic (EMT–Basic).

Emergency Ambulance Services: Emergency ambulance services are as described in 9 A.A.C. 22, Article 2, 9 A.A.C. 25, and in 42 CFR 410.40 and 414.605.

Emergency Ambulance Transportation: Emergency ground and air ambulance services required to manage an emergency medical condition of an AHCCCS member at an emergency scene and transport to the nearest appropriate facility.

Emergency Medical Condition: Emergency medical condition is defined as the treatment for a medical condition, including emergency labor and delivery which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possess an average knowledge of health and medicine, could reasonably expect that in the absence of immediate medial attention to result in:
1. Placing the member's health in serious jeopardy
2. Serious impairment to bodily functions or
3. Serious dysfunction of any bodily organ or part.

Emergency Medical Services: Emergency medical services means services provided for the treatment of an emergency medical condition.

EMT-Basic (EMT-B): The EMT-B provides basic life support without providing invasive procedures or cardiac monitoring or ALS procedures.

Under A.R.S. §36-2201 and 9 A.A.C. 25 and as administered by the Arizona Department of Health Services (ADHS), bureau of emergency medical services, the EMT-basic is certified to perform or provide all of the medical treatments, procedures, medication and techniques included in the U.S. Department of Transportation, National Highway Safety Administration EMT-B curriculum. In addition to the examples of BLS services/procedures in Section III(A)(2)(a), the following are examples of member conditions requiring the basic skill level of the EMT-B:
1. Labor and delivery in route to medical care (no history of complications)
2. ETOH (intoxication) and passed out due to intoxication.

EMT-Paramedic (EMT-P): The EMT-P is educated and capable to perform invasive procedures, heart monitoring and administer a wide variety of drugs and other ALS procedures. Under A.R.S. §36-2201 and 9 A.A.C. 25 and as administered by the Arizona Department of Health Services (ADHS), Bureau of Emergency Medical Services, the EMT-P is certified to perform or provide all of the medical treatments, procedures, medication and techniques included in the U.S. Department of Transportation, National Highway Safety Administration EMT-P curriculum. In addition to the examples of ALS services/procedures noted in Section

III(A)(1)(a)(4)(a) of this policy, the following are examples of member conditions requiring the advanced skill level of the paramedic:

1. Gun shot/stab wounds/major trauma
2. Impending birth/complications of pregnancy
3. Chest pain /heart attack
4. Hemorrhage/shock/profuse bleeding
5. Unconscious/coma/uncontrolled seizures/severe head injury
6. Unresponsive/"found down"
7. Diabetic coma
8. Stroke
9. Respiratory distress (respiratory arrest/asthma).

III. Policy

A. Ground Emergency Ambulance Transportation

Ambulance providers that have fees established by the Arizona Department of Health Services (ADHS), are reimbursed by AHCCCS Contractors at 80% of the ambulance provider's ADHS-approved fees for covered services. For ambulance providers whose fees are not established by ADHS, the AHCCCS Fee for Service (FFS) schedule will be used, which pays 80% of billed charges or the established capped-fee-for-service amount for covered services, whichever is less.

Criteria and reimbursement processes for Advanced Life Support (ALS) and Basic Life Support (BLS) are as follows.

1. Advanced Life Support (ALS) level

    a. In order for ambulance services to be reimbursable at the ALS level, all of the following criteria must be satisfied**:**
        1) The ambulance must be ALS licensed and certified in accordance with A.R.S. §36-2212 and 9 A.A.C.13**,** Articles 10 and 11
        2) ALS certified personnel such as the EMT-P described in Section II are present
        3) ALS services/procedures are medically necessary, based upon the member's symptoms and medical condition (refer to examples in Section II under EMT-P) at the time of the transport and
        4) ALS services/procedures and authorized treatment activities were provided.
            a) ALS services/procedures performed by an EMT-P include but are not limited to:
                i. Manual defibrillation/ cardioversion
                ii. Endotracheal intubation
                iii. Esophageal obdurate airway

iv. Monitor central venous line
v. Cardiac pacing
vi. Chest decompression
vii. Surgical airway
viii. Intraosseous line
ix. Gastric suction
x. Parenteral fluid, as a directed medical therapy and not for the purpose of maintaining an intravenous line
xi. Medication administration excluding oxygen
xii. Required, medically necessary pre-hospital phlebotomy
xiii. Placement/establishment of a peripheral venous catheter
xiv. Basic cardiac monitoring

b) Services/procedures that do not qualify as ALS include, but are not limited to:
i. Parenteral fluid, for the purpose of maintaining an open line or other non-therapeutic rate of fluid administration
ii. Oxygen delivery (by any means)
iii. Pulse oximetry
iv. Blood glucose testing
v. Assisting a member in the administration of their own home medications

b. Emergency ground ambulance claims are subject to medical review. Claims must be submitted with documentation of medical necessity and a copy of the trip report evidencing:
1) Medical condition, signs and symptoms, procedures, treatment
2) Transportation origin, destination, and mileage (statute miles)
3) Supplies and
4) Necessity of attendant, if applicable.

Claims submitted without such documentation are subject to denial.

Contractors must process the claims within the timeframes established in 9 A.A.C. 22, Article 7. Emergency transportation ordered by the Contractor cannot be denied upon receipt. This claim is not subject to further medical review.

2. Basic Life Support (BLS) level

a. In order for ambulance services to be reimbursable at the BLS level, all of the following criteria must be satisfied**:**
1) The ambulance must be BLS licensed and certified in accordance, A.R.S. §36-2212 and 9 A.A.C.13**,** Articles 10 and 11

2) BLS certified personnel, for example, the EMT-B described in Section II are present
3) BLS services/procedures, are medically necessary, based upon the member's symptoms and medical condition at the time of the transport and
4) BLS services/procedures and authorized treatment activities were provided.
   BLS services/procedures performed by an EMT-B include but are not limited to:
   a) Monitoring intravenous lines during interfacility transfers
   b) Blood glucose monitoring
   c) Utilizing the automatic external defibrillator (AED)
   d) Assisting a patient to take the following prescribed medications (must be the patient's prescription)
      i. Nitroglycerin
      ii. Auto injectable epinephrine
      iii. Bronchodilating inhalers

b. Emergency ground ambulance claims are subject to medical review. Claims must be submitted with documentation of medical necessity and a copy of the trip report evidencing:
   1) Medical condition, signs and symptoms, procedures, treatment
   2) Transportation origin, destination, and mileage
   3) Supplies and
   4) Necessity of attendant, if applicable.

   Claims submitted without such documentation are subject to denial.

   Contractors must process the claims within the timeframes established in 9 A.A.C. 22, Article 7. Emergency transportation ordered by the Contractor cannot be denied upon receipt. This claim is not subject to further medical review.

B. Nonemergent Ground Ambulance Transportation-Payment Guidelines

1. All Hospital-to-Hospital transfers for the Contractor will be paid, minimally**,** at the BLS rate, unless the transfer requires ALS level of service. This includes transportation between general and specialty hospitals.

2. At the Contractor's discretion, nonemergent ambulance transportation, other than the scenario described in #1 above, may not require prior authorization or notification, but is subject to review for medical necessity by the Contractor. Medical necessity criteria is based upon the medical condition of the member and includes ground ambulance services provided because the member's medical condition was contradictory to any other means of transportation. This may include after hour calls. An example would be as follows: an ambulance company receives a call from the emergency room to transport a nursing facility member back to the facility and the Contractor can not be reached.

3. Transportation reimbursement will be reduced to the level of the appropriate alternative transportation when services provided do not qualify as ALS or BLS (Refer to Section II, Definitions), or the ALS/BLS services rendered at the time of transport are deemed not medically necessary. If the transportation vendor does not have established non-ALS or non-BLS levels, claims will be paid at the AHCCCS established capped-fee-for-service amount for the appropriate alternative transportation service for example: taxi, or van (ambulatory, wheelchair or stretcher).

4. Nonemergent transportation by ambulance is appropriate if:
   a. Documentation that other methods of transportation are contraindicated and
   b. The member's medical condition, regardless of bed confinement, requires the medical treatment provided by the qualified staff in an ambulance.

5. Nonemergent transportation ordered by the Contractor cannot be denied upon receipt. This claim is not subject to further medical review.

IV. References

- Title 42 of the Code of Federal Regulations (42 CFR) 410.40 (Coverage of Ambulance Services)
- 42 CFR 414.605 (Definitions)
- A.R.S. §36 Chapter 21.1 Articles 1, 2 (Emergency Medical Services)
- Arizona Administrative Code (A.A.C.) 9 A.A.C. 22, Article 2 (Transportation Services)
- 9 A.A.C. 13, Article 10 (Ambulance Service Licensure)
- 9 A.A.C 13 Article 11 (Ambulance Registration Certificate)
- 9 A.A.C. 25 ((Department of Health Services Emergency Medical Services)
- AHCCCS Medical Policy Manual, Chapter 300, Policy 310, Transportation

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301 – PROSPECTIVE TITLE XIX WAIVER GROUP (TWG) MEDICAL EXPENSE DEDUCTION (MED) RECONCILIATION POLICY

Effective Date: 10/01/10
Revision Date: 3/24/08, 12/17/09, 8/27/10, 4/17/12

Staff responsible for policy: DHCM Finance

I. Purpose

This policy applies to the Title XIX Waiver Group (TWG) Medical Expense Deduction (MED) prospective population reconciliation for those AHCCCS Acute Care Contractors (hereafter referred to as Contractors) contracted to provide medical services for the TWG MED population. This reconciliation applies to CYE '11. This reconciliation will not occur after CYE '11 as the program terminated effective 9/30/11

The TWG MED reconciliation is based upon prospective net revenue as described in this policy. AHCCCS will reimburse/recoup 100% of a Contractor's reasonable costs in excess of a 3% profit or loss, as determined by fully adjudicated encounter data, subcapitated expenses, and paid reinsurance amounts.

II. Definitions

Net TWG MED Capitation: MED Prospective Capitation plus Delivery Supplement payments less the administrative % and the premium tax %.

III. Policy

A. General

1. The TWG MED reconciliation shall relate to medical expenses during the prospective period of enrollment (including subcapitated expenses) net of reinsurance for the TWG MED population. The amount of the reimbursement to be reconciled against will be net of the administrative percentage and premium tax components included in the capitation rate (see Attachment A for calculation).

2. The reconciliation will limit the Contractor's profits and losses to 3% of the Contractor's net TWG MED capitation. Any losses in excess of 3% will be reimbursed to the Contractor, and likewise, profits in excess of 3% will be recouped.

B. AHCCCS Responsibilities

1. No sooner than six months after the contract year to be reconciled, AHCCCS shall perform an initial reconciliation of actual medical cost experience to capitation and reinsurance paid:

   Prospective Capitation + Delivery Supplement payment - administration % - premium tax % (see Attachment A for calculation)

   Less: Total medical expenses (net of reinsurance)

   Equals: Profit/Loss to be reconciled

2. AHCCCS will utilize fully adjudicated encounters and subcapitated expenses reported by the Contractor to determine the actual medical cost experience.

3. AHCCCS will compare adjudicated encounter and subcapitated expense information to financial statements and other Contractor submitted files for reasonableness. AHCCCS may perform an audit of self-reported subcapitated expenses included in the reconciliation.

4. AHCCCS will provide to the Contractor the data used for the initial reconciliation and provide a set time period for review and comment by the Contractor. Upon completion of the review period, AHCCCS will evaluate Contractor comments and make any adjustments to the data or reconciliation as warranted. AHCCCS may then process partial distributions/recoupments through a future monthly capitation payment.

5. A second and final reconciliation will be done no sooner than 15 months after the end of the contract year to be reconciled. This will allow for completion of the claims lag, encounter reporting and reinsurance payments. AHCCCS will provide to the Contractor the data used for the final reconciliation and provide a set time period for review and comment by the Contractor. Upon completion of the review period, AHCCCS will evaluate Contractor comments and make any adjustments to the data or reconciliation as warranted.

6. Any amount over or underpaid as a result of the final reconciliation will be paid or recouped through a future monthly capitation payment.

C. Contractor Responsibilities

1. Contractor shall maintain financial statements that separately identify Title XIX Waiver Group MED transactions, and shall submit such statements as required by contract and in the format specified in the Reporting Guide.

2. Contractor shall monitor the estimated TWG MED reconciliation receivable/payable and record appropriate accruals on financial statements submitted to AHCCCS on a quarterly basis.

3. It is the Contractor's responsibility to identify to AHCCCS any encounter data issues or necessary adjustments via the initial reconciliation by the due date specified with the initial reconciliation. It is also the responsibility of the Contractor to have any identified encounter data issues corrected and adjudicated no later than 15 months from the end of the contract year being reconciled. Any encounter data issues identified that are the result of an error by AHCCCS will be corrected prior to the final reconciliation.

4. Submit data as requested by AHCCCS for reconciliation purposes (e.g. encounter detail file, reinsurance payments, etc.).

5. Contractor shall report all subcapitated expenses in a format requested by AHCCCS. Subcapitated encounters should have a subcap code of 01 and a CN 1 code of 05 and a paid amount of $0. All subcapitated encounters that do not conform to this format and have a health plan paid amount greater than $0 will be excluded from the reconciliation expenditures.

6. For all current and past reconciliations, if the Contractor performs recoupments on the related claims, the related encounters must be adjusted (voided or void/replaced) and adjudicated no later than 120 days from the date of the recoupment. AHCCCS reserves the right to adjust any previously issued reconciliation results for the impact of the revised encounters and recoup any amounts due AHCCCS. If the Contractor does not submit the revised encounters within the required timeframe, AHCCCS may recoup the estimated impact on the reconciliation and reserves the right to sanction the Contractor.

IV. References

- Acute Care Contract, Section D, Compensation

V. Note

Administration percentage by contract year:

- CYE '11 – 8.0%

Premium tax – 2%

Attachment A – Sample TWG Reconciliation

Health Plan
Prospective Title XIX Waiver Group MED Reconciliation - EXAMPLE
For Contract Year Ended X/XX/XX

		MED
Gross TWG MED Revenue [1]	$	30,000,000.00
Premium Tax [7]	$	(600,000.00)
Admin %	$	(2,177,777.78)
TWG MED Revenue Net of Admin and Premium Tax*	$	27,222,222.22
HP Paid Encounters [2]	$	(26,800,000.00)
HP Reported Subcapitated Expenditures [3]	$	(105,000.00)
Exclusion of Subcap Code 01 Encounters [6]	$	548,000.00
Reinsurance Paid [4]	$	3,225,000.00
Net Profit/(Loss)	$	4,090,222.22
% of Rev Net of Admin		15.03%
MM [5]		60,000

Net Capitation	$	27,222,222.22
Total Profit/(Loss)	$	4,090,222.22
Risk Band Corridor - 3% or (3%)	$	816,666.67
TWG MED Amount Due To (From) Health Plan	$	(3,273,555.56)

Assumptions:

(1) Gross TWG MED revenue includes prospective capitation and delivery supplement paid for the period 10/1/xx - 9/30/xx.

(2) Health Plan Encounters includes all prospective TWG MED adjudicated encounters for the period 10/1/xx - 9/30/xx.

(3) Subcapitated Expenditures is data submitted by the Health Plans for the prospective TWG MED time period.

(4) Reinsurance Paid includes all payments to the Health Plan for the period of 10/1/xx - 9/30/xx.

(5) Member Months are actual TWG MED prospective member months paid for the period of 10/1/xx-9/30/xx.

(6) Subcap Code 01 Encounters have been excluded from the data because the health plans are required to self report sub-capitated expenses as noted in #3 above. Subcap Code 01 and CN 05 Encounters are for the period of 10/1/xx - 9/30/xx.

7) The Health Plan is responsible for a premium tax to the Department of Insurance of 2% on all payments received by the HP from AHCCCS.

*** Building the Gross Capitation Rate**		
Cap Rate before Admin and Prem Tax		$100.00
Add Admin Amount per Policy	+$100 * 8%	$8.00
Subtotal	+$100 + $8.00	$108.00
Add Premium Tax (PT) of 2.0% [7]	+$108/.98 - $108	$2.20
Gross Capitation Rate	+$108.00 + $2.20	$110.20

*** Calculating the Net Revenue**	
Gross Capitation Rate	$110.20
Deduct Premium Tax (Gross x 2%) [7]	$2.20
Deduct Admin Amount per Policy ((Gross-PT) - ((Gross-PT)/1.08))	$8.00
Net Capitation Revenue (Gross-PT-Admin)	$100.00

Source: TWG Cap and MM Paid - DOS, ReportAHAHG296
TWG Medical Expenses - DOS, Report AHAHG294
Health Plan Self Reported Subcapitated Expenses
TWG Reinsurance Paid from DBF

301A – PROSPECTIVE TITLE XIX WAIVER GROUP (TWG) NON-MED RECONCILIATION POLICY

Effective Date: 10/01/2011
Revision Date: 8/27/2010, 4/17/12

Staff responsible for policy: DHCM Finance

I. Purpose

This policy applies to the Title XIX Waiver Group (TWG) non-Medical Expense Deduction (non-MED) prospective population reconciliation (TWG non-MED Reconciliation) for those AHCCCS Acute Care Contractors (hereafter referred to as Contractors) contracted to provide medical services for the non-MED population.

The TWG non-MED reconciliation is based upon prospective net capitation and prospective expenses as described in this policy. AHCCCS will recoup/reimburse 100% of a Contractor's costs in excess of a 2% profit or loss, as determined by fully adjudicated encounter data, self reported subcapitated expenses, and paid reinsurance amounts.

II. Definitions

Net TWG non-MED Capitation: Non-MED Prospective Risk Adjusted Capitation plus Delivery Supplement payments, less the administrative and the premium tax components. The administrative component will be equivalent to the percentage listed in section V. This PMPM is multiplied by the actual prospective TWG non-MED member months for the period being reconciled to arrive at the administrative component amount used in the reconciliation calculation.

Reinsurance: Reinsurance will be based on the actual reinsurance revenue received by the Contractor for the dates of being reconciled.

III. Policy

A. General

1. The prospective TWG non-MED reconciliation shall relate to medical expenses during the prospective period being reconciled (including subcapitated expenses) net of reinsurance. The amount of the reimbursement to be reconciled against will be net of the administrative and premium tax components included in the capitation rate (see Definitions and Attachment A for calculation).

2. The reconciliation will limit the Contractor's profits and losses to 2% of the Contractor's net prospective TWG non-MED capitation. Any losses in excess of 2% will be reimbursed to the Contractor, and profits in excess of 2% will be recouped.

B. AHCCCS Responsibilities

1. No sooner than six months after the end of the period to be reconciled, AHCCCS shall perform an initial reconciliation of actual medical cost experience to capitation and reinsurance:

   Prospective Risk Adjusted Capitation + Delivery Supplement payment - administration - premium tax (see Definitions and Attachment A for calculation)

   Less: Total medical expenses (net of reinsurance – see Definitions)

   Equals: Profit/Loss to be reconciled

2. AHCCCS will utilize fully adjudicated encounters and subcapitated expenses reported by the Contractor to determine the actual medical cost experience.

3. AHCCCS will compare fully adjudicated encounter and subcapitated expense information to financial statements and other Contractor submitted files for reasonableness. AHCCCS may perform an audit of self-reported subcapitated expenses included in the reconciliation.

4. AHCCCS will provide to the Contractor the data used for the initial reconciliation and provide a set time period for review and comment by the Contractor. Upon completion of the review period, AHCCCS will evaluate Contractor comments and make any adjustments to the data or reconciliation as warranted. AHCCCS may then process partial distributions/recoupments through a future monthly capitation payment.

5. A second and final reconciliation will be done no sooner than 15 months after the end of the period to be reconciled. This will allow for completion of the claims lag, encounter reporting and reinsurance payments. AHCCCS will provide to the Contractor the data used for the final reconciliation and provide a set time period for review and comment by the Contractor. Upon completion of the review period, AHCCCS will evaluate Contractor comments and make any adjustments to the data or reconciliation as warranted.

6. Any amount over or underpaid as a result of the final reconciliation will be paid or recouped through a future monthly capitation payment.

C. Contractor Responsibilities

1. Contractor shall maintain financial statements that separately identify prospective TWG non-MED transactions, and shall submit such statements as required by contract and in the format specified in the Reporting Guide.

2. Contractor shall monitor the estimated prospective TWG non-MED reconciliation receivable/payable and record appropriate accruals on financial statements submitted to AHCCCS on a quarterly basis.

3. It is the Contractor's responsibility to identify to AHCCCS any encounter data issues or necessary adjustments via the initial reconciliation by the due date specified with the initial reconciliation. It is also the responsibility of the Contractor to have any identified encounter data issues corrected and adjudicated no later than 15 months from the end of the period being reconciled. Any encounter data issues identified that are the result of an error by AHCCCS will be corrected prior to the final reconciliation.

4. Submit data as requested by AHCCCS for reconciliation purposes (e.g. encounter detail file, reinsurance payments, etc.).

5. Contractor shall report all subcapitated expenses in a format requested by AHCCCS. Subcapitated encounters should have a subcap code of 01 and a CN 1 code of 05 and a paid amount of $0. All subcapitated encounters that do not conform to this format and have a health plan paid amount greater than $0 will be excluded from the reconciliation expenditures.

6. For all current and past reconciliations, if the Contractor performs recoupments on the related claims, the related encounters must be adjusted (voided or void/replaced) and adjudicated no later than 120 days from the date of the recoupment. AHCCCS reserves the right to adjust any previously issued reconciliation results for the impact of the revised encounters and recoup any amounts due AHCCCS. If the Contractor does not submit the revised encounters within the required timeframe, AHCCCS may recoup the estimated impact on the reconciliation and reserves the right to sanction the Contractor.

IV. References

- Acute Care Contract, Section D, Compensation

V. Note

Administration:

- CYE ’11 – Contractor CYE ’09 Bid Administration PMPM less 5.88%
- CYE ’12 – Contractor CYE ’09 Bid Administration PMPM less 5.88%

Premium tax – 2%

Attachment A – Sample TWG non-MED Reconciliation

Health Plan
Prospective Title XIX Waiver Group non-MED Reconciliation - EXAMPLE
For Contract Year Ended 9/30/XX

				non-MED
TWG non-MED Risk Adjusted Capitation Revenue [1]			$	30,000,000.00
Premium Tax [7]			$	(600,000.00)
Admin %			$	(2,049,933.60)
TWG non-MED Revenue Net of Admin and Premium Tax*			$	27,350,066.40
HP Paid Encounters [2]			$	(26,800,000.00)
HP Reported Subcapitated Expenditures [3]			$	(105,000.00)
Exclusion of Subcap Code 01 Encounters [6]			$	548,000.00
Reinsurance Paid [4]			$	3,225,000.00
Net Profit/(Loss)			$	4,218,066.40
% of Rev Net of Admin				15.42%
MM [5]				60,000
Net Capitation	$	27,350,066.40		
Total Profit/(Loss)	$	4,218,066.40		
Risk Band Corridor - 2% or (2%)	$	547,001.33		
TWG Non-MED Amount Due To (From) Health Plan	$	(3,671,065.07)		
Premium Tax	$	(74,889.73)		
Net TWG Non-MED Amount Due To (From) Health Plan	$	(3,745,954.80)		

Assumptions:

(1) TWG non-MED revenue includes prospective risk adjusted capitation and delivery supplement paid for the period being reconciled.

(2) Health Plan Encounters includes all prospective TWG non-MED adjudicated encounters for the period being reconciled.

(3) Subcapitated Expenditures is data submitted by the Health Plans for the prospective TWG non-MED time period.

(4) Reinsurance Paid includes all payments to the Health Plan for the period being reconciled.

(5) Member Months are actual TWG non-MED prospective member months paid for the period being reconciled.

(6) Subcap Code 01 Encounters have been excluded from the data because the health plans are required to self report sub-capitated expenses as noted in #3 above. Subcap Code 01 and CN 05 Encounters are for the period being reconciled.

7) The Health Plan is responsible for a premium tax to the Department of Insurance of 2% on all payments received by the HP from AHCCCS.

*** Building the Gross Capitation Rate**		
Cap Rate before Admin and Prem Tax		$100.00
Add CYE09 Bid Admin PMPM less 5.88%	+$100+8.75-(8.75*.0588)	$8.24
Subtotal		$108.24
Add Premium Tax (PT) of 2.0% [7]	+$108.24/.98-$108.24	$2.21
Gross Capitation Rate		$110.44

*** Calculating the Net Revenue**	
Gross Capitation Rate	$110.44
Deduct Premium Tax (Gross x 2.0%)) [7]	$2.21
Deduct Admin	$8.24
Net Capitation Revenue (Gross-PT-Admin)	$100.00

Source: TWG Cap and MM Paid - DOS, ReportAHAHG296
TWG Medical Expenses - DOS, Report AHAHG294
Health Plan Self Reported Subcapitated Expenses
TWG Reinsurance Paid from DBF

302 - PRIOR PERIOD COVERAGE RECONCILIATION: ACUTE CARE CONTRACTORS

Effective Date: 10/01/10
Revision Date: 03/15/08, 12/09/09, 8/25/10, 4/17/12

Staff responsible for policy: DHCM Finance

I. Purpose

This policy applies to PPC reconciliations for CYE '11 and forward for all AHCCCS Acute Care Contractors.

Due to the uncertainty regarding actual utilization and medical cost experience during the PPC period, AHCCCS intends to limit the financial risk to its Contractors. For CYE '11 and forward, AHCCCS will reconcile the PPC period for all risk groups, except the Title XXI members, SOBRA Family Planning, and State Only Transplants. Effective 10/01/11 and forward, the Title XIX Waiver Group MED population will no longer be reconciled, as the program terminated 9/30/11.

II. Definitions

PPC Capitation: Capitation payment for the period of time from the 1st day of the month of application or the 1st eligible month, whichever is later, to the day a member is enrolled with the Contractor. Also, the period of time between the date a MED member was approved and the date the member met spenddown, or 1st day of the month the member reduced resources whichever is later.

PPC Period: The period from the effective date of eligibility to the day a member is enrolled with a Contractor.

PPC Medical Expense: Total expenses covered under the Acute Care Contract for services provided during the PPC time period.

Title XIX Waiver Group Member (TWG): All Medical Expense Deduction (MED) and Non-MED (AHCCCS Care) members who do not meet the requirements of a categorically linked Medicaid program. The Title XIX MED program terminated 9/30/11.

III. Policy

A. General

1. For CYE '11 the reconciliation shall relate solely to aggregate adjudicated PPC medical expenses for the following capitation risk groups: TANF, SOBRA, SSI w/Med, SSI w/o Med, and the Title XIX Waiver Group (MED and non-MED). For CYE 12 and forward the reconciliation shall relate solely to aggregate adjudicated PPC medical expenses for the following capitation risk groups: TANF, SOBRA, SSI w/Med, SSI w/o Med, and Title XIX Waiver Group Non-MED. The reconciliation will exclude Title XXI, SOBRA Family Planning, and State Only transplant members for all contract years.

2. For all contract years, administrative, premium tax and non-operating expenses shall be excluded.

3. The reconciliation will limit the Contractor's profits and losses to 2% of the Contractor's net PPC capitation for all covered risk groups combined (See Attachment A for calculation). Any losses in excess of 2% will be reimbursed to the Contractor, and likewise, profits in excess of 2% will be recouped. The full PPC period is eligible for this reconciliation.

B. AHCCCS Responsibilities

1. No less than six months after the contract year to be reconciled, AHCCCS shall perform an initial reconciliation.

2. AHCCCS will compare fully adjudicated encounter information to financial statements and other Contractor submitted files for reasonableness.

3. AHCCCS will provide to the Contractor the data used for the initial reconciliation and provide a set time period for review and comment by the Contractor. Upon completion of the review period, AHCCCS will evaluate Contractor comments and make any adjustments to the data or reconciliation as warranted. AHCCCS may then process partial distributions/recoupments through a future monthly capitation payment.

4. A second and final reconciliation will be done no less than 12 months after the end of the contract year to be reconciled. This will allow for completion of the claims lag and encounter reporting. AHCCCS will provide to the Contractor the data used for the final reconciliation and provide a set time period for review and comment by the Contractor. Upon completion of the review period, AHCCCS will evaluate Contractor comments and make any adjustments to the data or reconciliation as warranted.

5. Any amount over or underpaid as a result of the final reconciliation will be paid or recouped with a future monthly capitation payment.

C. Contractor Responsibilities

1. Contractors shall submit encounters for PPC medical expenses and those encounters must reach fully adjudicated status by the required due dates. AHCCCS will only utilize fully adjudicated encounters reported by the Contractor to determine the medical expenses used in the reconciliation.

2. The Contractor shall maintain financial statements that separately identify all PPC transactions, and shall submit such statements as required by contract and in the format specified in the Reporting Guide.

3. The Contractor shall monitor the estimated PPC reconciliation receivable/payable and record appropriate accruals on financials statements submitted to AHCCCS on a quarterly basis.

4. It is the Contractor's responsibility to identify to AHCCCS any encounter data issues or necessary adjustments via the initial reconciliation by the due date provided. It is also the responsibility of the Contractor to correct (including adjudication of corrected encounters) any identified encounter data issues no later than 12 months after the end of the contract year being reconciled. Reconciliation data issues identified that are the result of an error by AHCCCS will be corrected prior to the final reconciliation.

5. Submit data as requested by AHCCCS for reconciliation purposes. (e.g. encounter detail file, etc.)

6. For all reconciliations, if the Contractor performs recoupments on the related claims, the related encounters must be corrected (voided or void/replaced) and adjudicated no later than 120 days after the date of the recoupment. AHCCCS reserves the right to adjust any previously issued reconciliation results for the impact of the revised encounters and recoup any amounts due AHCCCS. If the Contractor does not submit the revised encounters within the required timeframe, AHCCCS may recoup the estimated impact on the reconciliation and reserves the right to sanction the Contractor.

D. Reconciliation Calculation for All Covered Risk Groups

PPC Capitation – Administration% (See Section V) – Premium Tax %

Less: Total Medical Expense

Equals: Profit/Loss to be reconciled
See Attachment A for calculation

1. AHCCCS will utilize fully adjudicated encounters reported by the Contractor to determine the actual medical cost expense. AHCCCS may incorporate completion factors in the initial reconciliation based on internal data available at the time of the reconciliation.

2. PPC Capitation and Medical expense to be included in the reconciliation are based on the **DATE OF SERVICE** for the contract year being reconciled.

IV. References

Acute Care Request for Proposal, Section D

V. Note

Administration percentage by contract year:
- CYE '11 – 8.0%
- CYE '12 – 8.0%

Premium tax – 2%

Attachment A – Sample PPC Reconciliation

CONFIDENTIAL

Attachement A

HEALTH PLAN
PRIOR PERIOD COVERAGE RECONCILIATION - EXAMPLE
FOR CONTRACT YEAR ENDED XX/XX/XX

PPC	TANF <1	TANF 1-13	TANF 14-44F	TANF 14-44M	TANF 45+	SSI/W	SSI W/O	SOBRA MOTHERS	MED (CYE '11 Only)	Non-MED	TOTAL
PPC Revenue	$ 315,000.00	$ 100,000.00	$ 308,000.00	$ 80,000.00	$ 40,000.00	$ 4,000.00	$ 15,000.00	$ 75,000.00	$ 80,000.00	$ 500,000.00	$ 1,517,000.00
Less: Premium Tax [3]	$ 6,300.00	$ 2,000.00	$ 6,160.00	$ 1,600.00	$ 800.00	$ 80.00	$ 300.00	$ 1,500.00	$ 1,600.00	$ 10,000.00	$ 30,340.00
Less: Admin %	$ 22,866.67	$ 7,259.26	$ 22,358.52	$ 5,807.41	$ 2,903.70	$ 290.37	$ 1,088.89	$ 5,444.44	$ 5,807.41	$ 36,296.30	$ 110,122.96
PPC Revenue Net of Admin and Premium Tax *	$ 285,833.33	$ 90,740.74	$ 279,481.48	$ 72,592.59	$ 36,296.30	$ 3,629.63	$ 13,611.11	$ 68,055.56	$ 72,592.59	$ 453,703.70	$ 1,376,537.04
Less: Expenditures HP Paid	$ 275,000.00	$ 90,000.00	$ 280,000.00	$ 74,000.00	$ 37,000.00	$ 4,500.00	$ 16,000.00	$ 65,000.00	$ 70,000.00	$ 200,000.00	$ 1,111,500.00
Net Profit/(Loss)	$ 10,833.33	$ 740.74	$ (518.52)	$ (1,407.41)	$ (703.70)	$ (870.37)	$ (2,388.89)	$ 3,055.56	$ 2,592.59	$ 253,703.70	$ 265,037.04
% of Rev Net of Admin	3.79%	0.82%	-0.19%	-1.94%	-1.94%	-23.98%	-17.55%	4.49%	3.57%	55.92%	19.25%

Net Capitation	$ 1,376,537.04
Total Profit/(Loss)	$ 265,037.04
Risk Band Corridor - 2% or (2%)	$ 27,530.74
PPC Amount Due To (From) Health Plan	$ (237,506.30)
Premium Tax	$ (4,845.13)
Net PPC Amount Due To (From) Health Plan	$ (242,351.42)

For all Covered PPC Risk Groups:
Assumptions:

1) PPC Revenue includes applicable PPC Capitation with dates of service in the contract year to be reconciled.
2) PPC Expenditures include applicable adjudicated encounters based on the date of service for the contract year being reconciled.
3) The Health Plan is responsible for a premium tax to the Department of Insurance of 2% on all payments received by the HP from AHCCCS.

*** Building the Gross Capitation Rate All PPC Covered Risk Groups**

Cap Rate before Admin and Prem Tax		$100.00
Add Admin Amount Per Policy	+$100 * 8.0%	$8.00
Subtotal	+$100 + $8.00	$108.00
Add Premium Tax (PT) of 2%	+$108.00/.98	$2.20
Gross Capitation Rate	+$108+$2.20	$110.20

*** Calculating the Net Revenue**

Gross Capitation Rate	$110.20
Deduct Premium Tax (Gross x .02))	$2.20
Deduct Admin ((Gross-PT) - ((Gross-PT)/1.08))	$8.00
Net Capitation Revenue (Gross-PT-Admin)	$100.00

302A - PRIOR PERIOD COVERAGE (PPC) RECONCILIATION - ALTCS CONTRACTORS

Effective Date: 10/01/06
Revision Date: 08/15/09, 8/18/10
Staff responsible for policy: ALTCS Finance

I. Purpose

This policy applies to all AHCCCS ALTCS EPD Program Contractors for CYE 07 forward.

The Program Contractors are paid capitation for all PPC member months, including partial member months. This capitation includes the cost of providing medically necessary covered services to members during the PPC period.

Annually, AHCCCS will prepare a reconciliation of Net PPC Revenue paid to the Program Contractors to the actual PPC Medical Expenses as determined by adjudicated encounter data. For Program Contractors whose total encounter reported PPC Medical Expenses as determined by adjudicated encounter data are more than 10% higher than the Net PPC Revenue, AHCCCS will reimburse 100% of the excess. For Program Contractors whose Net PPC Revenue is more than 10% higher than the total PPC medical expenses as determined by adjudicated encounter data, AHCCCS will recoup 100% of the excess.

II. Definitions

PPC Period: The period from the effective date of eligibility to the day a member is enrolled with a Program Contractor.

PPC Medical Expense: Total Covered Medical Expenses for services provided during the PPC time period.

PPC Revenue: PPC Capitation and, through CYE06, PPC Reinsurance payments. Effective 10/1/06, there is no longer Reinsurance for PPC expenses; therefore no Reinsurance Revenue is included.

Net PPC Revenue: Through CYE 09 PPC revenue paid to the Program Contractor less an 8% administrative add on and 2% premium tax (PPC Revenue X (.98/1.08)). Effective 10/01/09 PPC revenue paid to the Program Contractor less a 7.5% administrative add on and 2% premium tax (PPC Revenue X (.98/1.075)).

III. Policy

A. General

1. The reconciliation shall relate solely to aggregate PPC Covered Medical Expenses as determined by adjudicated Encounter data.

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2. The reconciliation will limit the Program Contractor's profits and losses to 10% of the Contractor's Net PPC Revenue. Any losses in excess of 10% will be reimbursed to the Contractor, and likewise, any profits in excess of 10% will be recouped.

3. Prior to Contract Year Ended (CYE) 2007 AHCCCS provided PPC Reinsurance for expenses that met the deductible limits. To the extent that PPC reinsurance payments are made on claims for dates of service prior to October 1, 2006, the reinsurance payments will be included in the PPC Revenue for the purposes of this reconciliation.

B. AHCCCS Responsibilities

1. Approximately 15 months after the contract year to be reconciled, AHCCCS shall perform an initial reconciliation of actual medical cost experience to Net PPC Revenue in order to monitor the status of the risk sharing arrangement.

2. The reconciliation for the PPC period shall be based on adjudicated encounters submitted by the Program Contractor for PPC medical expenses, compared to the Net PPC Revenue paid to the Program Contractor during the reconciliation year (see Attachment A for calculation).

3. AHCCCS will compare encounter information to financial statements for reasonableness.

4. A final reconciliation will be performed approximately 18 months after the end of the contract year to be reconciled. This will allow for completion of claims lag and encounter reporting.

5. A reconciliation spreadsheet and supporting documentation will be forwarded to the Program Contractors for review.

6. Distributions will be made to the Program Contractor after the Program Contractor has agreed to the reconciliation amount by the AHCCCS stated deadline.

7. In the event a Program Contractor is required to reimburse AHCCCS, such reimbursement will be collected by AHCCCS through a reduction to the Program Contractor's prospective capitation payments after the Program Contractor has agreed to the reconciliation amount by the AHCCCS stated deadline.

C. Program Contractor Responsibilities

1. Program Contractor shall maintain financial statements that separately identify all PPC Revenue and Expense as outlined in the ALTCS Financial Reporting guide, and shall submit such statements as required by contract.

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2. It is the Program Contractor's responsibility to identify to AHCCCS any encounter data issues or necessary adjustments via the interim reconciliation by the specified due date. It is also the responsibility of the Program Contractor to have any encounter data issues identified, corrected and adjudicated within the 18 months of the end of the contract year being reconciled.

IV. References
ALTCS Request for Proposal, Section D, Compensation

V. Note
Administration percentage by contract year
- CYE 08 – 8.0%
- CYE 09 – 8.0%
- CYE 10 – 7.5%
- CYE 11 – 7.5%

Premium tax – 2%
Attachment A – Sample PPC Reconciliation for CYE 08 and CYE 09
Attachment B – Sample PPC Reconciliation for CYE 10 and CYE 11

ATTACHMENT A - SAMPLE PPC RECONCILIATION CYE08 AND CYE09

Prior Period Coverage Reconciliation CYEXX

		PROGRAM CONTRACTOR
PPC REVENUE		
PPC CAPITATION	$	214,090
Reinsurance Paid*		-
TOTAL PPC REVENUE		214,090
LESS: 8% ADMIN ADD-ON & 2% Premium Tax (Subtotal-(subtotal*(.98/1.08)))		19,823
NET PPC REVENUE	**$**	**194,267**
PPC MEDICAL EXPENSE	$	134,268
OVER/(UNDER) PAYMENT	$	59,999
10% ALLOWANCE OF NET PPC REVENUE		19,427
PAYMENT/(RECOUPMENT)	**$**	**(40,572)**
PREMIUM TAX 2%		**(828)**
TOTAL PAYMENT/(RECOUPMENT)	**$**	**(41,400)**

***** Through 9/30/06, PPC expenses were eligible for Reinsurance, thus any Reinsurance paid to a Contractor for PPC expenses would be included as additional revenue. Effective 10/1/06, there is no longer Reinsurance for PPC expenses.

ATTACHMENT B - SAMPLE PPC RECONCILIATION CYE10 and CYE11

Prior Period Coverage Reconciliation CYEXX

		PROGRAM CONTRACTOR
PPC REVENUE		
PPC CAPITATION	$	214,090
Reinsurance Paid*		-
TOTAL PPC REVENUE		214,090
LESS: 7.5% ADMIN ADD-ON & 2% Premium Tax (Subtotal-(subtotal*(.98/1.075)))		18,920
NET PPC REVENUE	**$**	**195,170**
PPC MEDICAL EXPENSE	$	134,268
OVER/(UNDER) PAYMENT	$	60,902
10% ALLOWANCE OF NET PPC REVENUE		19,517
PAYMENT/(RECOUPMENT)	**$**	**(41,385)**
PREMIUM TAX 2%		**(828)**
TOTAL PAYMENT/(RECOUPMENT)	**$**	**(42,213)**

***** Through 9/30/06, PPC expenses were eligible for Reinsurance, thus any Reinsurance paid to a Contractor for PPC expenses would be included as additional revenue. Effective 10/1/06, there is no longer Reinsurance for PPC expenses.

303 - Home and Community Based Services (HCBS) Reconciliation - ALTCS

Effective Date: 10/01/11
Revision Date:

Staff responsible for policy: ALTCS Finance

I. Purpose

Reconcile the assumed HCBS member months used for capitation rate development against actual HCBS placement. This policy applies to all AHCCCS ALTCS EPD Contractors for CYE 12 (Oct. 1, 2011 – Sept. 30, 2012) and forward.

HCBS Assumed Mix and Recoupment: The Contractor's capitation rate is based in part on the assumed ratio ("mix") of HCBS member months to the total number of member months (i.e. HCBS + institutional). At the end of the contract year, AHCCCS will compare the *actual percent of* HCBS member months to the *assumed* HCBS percentage that was used to calculate the full long term care capitation rate for that year. Member months for those members who received acute care services only are not included in this reconciliation. If the Contractor's actual HCBS percentage is different than the assumed percentage, AHCCCS may recoup (or reimburse) the difference between the institutional capitation rate and the HCBS capitation rate for the number of member months which exceeded (or was less than) the assumed percentage. This reconciliation will be made in accordance with the following schedule:

Percent over/under assumed percentage:	**Amount to be recouped/reimbursed:**
The First 0 - 1.0 percentage points	0% of capitation over/under payment
>1 percentage point	50% of capitation over/under payment

II. Definitions

HCBS Placement types:

- Home
- Adult Foster Care
- Assisted Living Centers
- Assisted Living Home
- Adult Therapeutic Foster Care
- Adult Development Home
- Behavioral Health Therapeutic Home
- Behavioral Health Level II
- Behavioral Health Level III
- Child Developmental Foster Home
- Behavioral Health Services Center
- Group Home for Developmentally Disabled

- Traumatic Brain Injury Treatment Facility
- Rural Substance Abuse Transitional Agency

Institutional Placement types:

- Institution
- Level I Behavioral Health Center
- Psychiatric Hospital

III. Policy

A. General

1. The reconciliation shall relate solely to HCBS assumed member months and actual placement data as determined by monthly placement reports.

2. The reconciliation will limit Contractor's profit and losses to the schedule as detailed above.

B. AHCCCS Responsibilities

1. AHCCCS shall, at the end of the contract year, run placement reports by member by month to be used for the development of the schedule of HCBS and Institutional placement mix. The placement report will provide for the most up to date placement information, including any retroactive changes as reported by Contractors.

2. Approximately four (4) months after the contract year to be reconciled, AHCCCS shall perform the HCBS reconciliation.

3. The reconciliation for the HCBS mix shall be based on the schedule of HCBS and Institutional placement mix, capitation rates developed for the contract year and the actual member months.

4. A reconciliation spreadsheet will be forwarded to the Contractors for review.

5. Distributions will be made to the Contractor after the Contractor has agreed to the reconciliation amount by the AHCCCS stated deadline.

6. In the event a Contractor is required to reimburse AHCCCS, such reimbursement will be collected by AHCCCS through a reduction to the Contractor's prospective capitation payments after the Contractor has agreed to the reconciliation amount by the AHCCCS stated deadline.

C. Contractor's Responsibilities

1. Contractors shall review monthly placement information and make corrections to placement during the contract year.

2. It is the Contractor's responsibility to identify to AHCCCS any placement data issues or necessary adjustments via electronic Member Change Report (EMCR) with the appropriate contract type changes to the Division of Health Care Management (DHCM).

3. It is the Contractor's responsibility to review and approve via signature the HCBS reconciliation and return the approval to AHCCCS per instructions provided with the reconciliation spreadsheet.

IV. References

ALTCS Request for Proposal, Section D, Compensation**.**

304 - PREMIUM TAX REPORTING POLICY

Effective Date: 10/01/11
Revision Date: 10/01/08, 10/01/10, 4/25/12

Staff responsible for policy: DHCM Finance

I. PURPOSE

This policy outlines the procedures necessary for AHCCCS Contractors to report and pay Premium Tax to the Arizona Department of Insurance (DOI) on a quarterly basis.

Under A.R.S. §36-2905 and §36-2944.01, each AHCCCS Contractor is required to pay to the DOI a tax equal to 2% of the total capitation, including reinsurance, and any other reimbursement **paid** to the Contractor by AHCCCS from and after October 1, 2003.

Each Contractor will report and pay premium tax to the DOI for all payments received from AHCCCS during the quarter. The tax is based on date of payment, not date of service. AHCCCS administration will report to the DOI the total payments to each Contractor for the calendar year by February 15th of the following year.

II. DEFINITIONS

ACH – Automated Clearing House

AHCCCS - Arizona Health Care Cost Containment System

AHCCCS Contractors - Acute Care Health Plans, Arizona Long Term Care System Program Contractors, Department of Economic Security/Division of Developmental Disabilities, Children's Rehabilitative Services, Comprehensive Medical Dental Program, and Arizona Department of Health Services – Division of Behavioral Health

BHS – Behavioral Health Services within the Department of Health Services

CMDP – Comprehensive Medical Dental Program within the Department of Economic Security

Contractor – Under the definitions in 36-2901, "Contractor" means an entity paid by AHCCCS on a prepaid, capitated basis, which means the entity receives payment notwithstanding the amount of services provided to a member.

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.

CRS – Children's Rehabilitative Services

CYE – Contract year ending/ended

DBF - Division of Business and Finance within AHCCCS

DDD – Division for the Developmentally Disabled within the Department of Economic Security

DHCM – Division of Health Care Management within AHCCCS

DOI – Arizona Department of Insurance

EPD – Elderly and physically disabled

FFS – Fee for service

HCBS – Home and Community-based Services

IGA (Inter Governmental Agreement) – An agreement between two state agencies whereby one state agency provides goods and/or services to another.

Payment – a payment that is made to the Contractor

PPC – Prior-Period Coverage

Recoupment – A payment that has been refunded by the Contractor to AHCCCS

SOC – Share of Costs

TWG – Title XIX Waiver Group

VD – Ventilator Dependent

III. POLICY

A. Quarterly Submission of Premium Tax to DOI

Each AHCCCS Contractor is required to file a quarterly tax report (http://www.id.state.az.us/taxunit/e-qtr.pdf) and pay estimated premium taxes based on estimated payments received for the current quarter. See Attachment A for information on how payments will be handled. The premium tax is based on date of payment, not date of service. The tax payments are due on or before March 15, June 15, September 15 and December 15 of each year. The amount of the payments shall be an estimate of the tax due for the quarter that ends in the month that payment is due. If a Contractor has no tax to report, the Contractor must file a form stating $0 tax due.

Contractors are required to periodically monitor the DOI website for updated forms and instructions.

B. Payments include:

- capitation revenue
- delivery supplemental payments
- reinsurance
- Reconciliation payments/recoupments (PPC, TWG, HCBS, SOC, Revenue, etc.)
- Monies withheld due to sanctions or other liens shall not reduce the taxable amount due. These amounts will be added back into the total payments.

C. Payments to Contractors; Inclusion/Exclusion of Premium Tax:

- Any capitation payments/recoupments related to dates of service prior to October 1, 2003, will not have the premium tax included. The Contractor will not be reimbursed for the premium tax associated with these payments. However, the Contractor will be responsible for reporting and paying premium taxes associated with payments/recoupments made after October 1, 2003 (regardless of the dates of service). All capitation rates effective October 1, 2003 and forward, include the premium tax in the rate.
- Reconciling payments and supplemental payments will have the premium tax included in the payment.
- Reinsurance payments include the premium tax for all payments/recoupments made after October 1, 2003, regardless of the dates of service. For recoupment of payments made prior to October 1, 2003, the premium tax will not be recouped.

D. Payments Excluded from Premium Tax:

- *Tribal Case Management* – Tribal Contractors only receive payment for case management services, and payments are paid on a fee-for-service basis. Additionally, Tribal Case Management only receives payments on behalf of a member for a month in which some case management service is provided to the member. In other words, if no services are provided to a member for a month, they do not receive the monthly case rate for that member. Thus, this is not capitation as defined, and payments are therefore not subject to premium tax.
- *Federally Qualified Health Centers (FQHC)* – Contract with AHCCCS Contractors to provide services to members, and is not itself considered a direct Contractor with AHCCCS that receives capitation from AHCCCS.
- *Health Care Group (HCG)* – HCG is eligible under §36-2901, paragraph 6, subdivision (b), (c), (d) or (e), which is not included within the scope of the legislation.
- *Fee for Service (FFS)* – ADHS, DES – Payments are based on services provided to FFS members

- *Third Party Liability* – If a Contractor pays a claim and finds that there is another party that is responsible for paying the claim, the Contractor or AHCCCS (via the AHCCCS contracted TPL administrator) will subrogate the claim to the third party and will recover the amount that had been paid from the third party. The recovery of the expense is not subject to premium tax.
- *Fraud and Abuse* – Recovery of overpayment made by a Contractor to a provider. This is considered a contra-expense and is not subject to premium tax.
- *Indian Health Services* – Payments are paid on a fee-for-service basis.
- *Breast & Cervical Cancer Administration Payment* – Payments to contractors are in response to billings from the entity for administration services rendered and are not based on member capitation. Therefore, this entity is not considered a Contractor.
- *State Only Transplant Payments* – Any payments made for Individuals who are eligible under one of the Title XIX eligibility categories, are found eligible for a transplant, and 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

E. Quarterly Reporting to AHCCCS

In addition to filing the original Form E-QTR, AHCCCS Contractor Quarterly Premium Tax Report, and tax payment with the DOI, each Contractor will submit a copy of the premium tax report(s) filed with the DOI to:

Finance Manager, DHCM
AHCCCS
701 E. Jefferson, M/D 6100
Phoenix, AZ 85034

The copy of the quarterly premium tax report(s) shall be due to DHCM on the same date the original quarterly premium tax report is due to the DOI. On a semi-annual basis DHCM will compare the copy of the report to AHCCCS Contractor payment records. AHCCCS will work with the Contractor to research and resolve any discrepancies.

F. Annual Reporting to DOI by Division of Health Care Management

No later than January 31 of each year, the Division of Business and Finance (DBF) shall provide a report to DHCM listing all payments AHCCCS made to Contractors for the preceding calendar year. By February 15 succeeding the end of a calendar (tax) year, DHCM will report the total amount AHCCCS paid to Contractors, by health plan to:

Compliance Section Manager, Financial Affairs Division
Arizona Department of Insurance
2910 N. 44th St., Suite 210
Phoenix, AZ 85018-7256

The DOI will compare this information to the quarterly reports submitted by the contractors. The DOI will issue an assessment of additional tax and may impose penalties and interest to a Contractor that underpaid the tax during the preceding calendar year. The penalty may be as much as 5% of the amount of tax paid late, with a minimum penalty of $25. Interest is 1% of the tax paid late per month. The DOI will issue refunds to any Contractor that overpaid the tax for the calendar year period.

IV. PAYMENT OPTIONS

A. Payment by check can be mailed, delivered by overnight courier or hand delivered. The DOI accepts U.S. Postal Service postmark as evidence of filing. Postage meter stamps do not apply. Filings received by overnight courier must include an airbill or receipt bearing the date that the item was picked up by the courier from the originating sender. Hand deliveries must be received before 5:00 P.M. on the due date.

B. To electronically pay taxes, fees or related penalty or interest, please use the NAIC OPTins system. Please use the following for all instructions on electronic payments: HTTP://WWW.ID.STATE.AZ.US/FORMS/TAX_FORMS/E-ACH.INSTRUCTION.PDF .

C. Payment is due on or before the due date for filing. When a due date falls on a weekend or a state holiday, it is extended to the following business day.

V. TIMELINESS

The submission of late reports shall constitute failure to report subject to the Civil Penalty and Interest for Late Tax Payment provisions described in the premium tax reporting instructions. (http://www.id.state.az.us/forms/tax_forms/E-QTR.INSTRUCTION.pdf)

VI. ADJUSTMENTS TO QUARTERLY PREMIUM TAX PAYMENTS

The tax form includes a line to make overpayment or underpayment adjustments to the previous quarter for the first three quarters of the calendar year. Adjustments to the December 15 payment will not be reported on the March 15 tax report.

The DOI will reconcile all tax payments received to the data provided by AHCCCS before April 1 of the following calendar year and will issue an assessment with a Notice of Right of Appeal if the Contractor has underpaid the tax for the calendar year period.

If a Contractor receives a significant payment from AHCCCS after a tax report is filed but before the end of the tax period, the contractor should promptly file an amended tax report for that period along with documentation supporting the amended filing and additional tax payment.

VII. REFERENCE

- A.R.S. §§ 36-2905 and §36-2944.01
- Quarterly Tax form: http://www.id.state.az.us/taxunit/e-qtr.pdf
- Instructions: http://www.id.state.az.us/forms/tax_forms/E-QTR.INSTRUCTION.pdf
- Attachment A – Matrix of Reimbursement for Premium Tax Collection
- Electronic Payments/E-ACH: http://www.id.state.az.us/forms/tax_forms/E-ACH.INSTRUCTION.pdf

Attachment A

Matrix of Managed Care Contracting and Reimbursement
Premium Tax Collection
Effective 10/01/11

Reimbursement	Acute Care	ALTCS EPD/VD	ALTCS DES/DDD	CMDP	CRS	ADHS/BHS	Handling of P.T.
Prospective Capitation	Yes	Yes	Yes	Yes	Yes	Yes	1
PPC Capitation	Yes	Yes	No	Yes	No	No	1
Delivery Supplement	Yes	No	No	No	No	No	1
DDD/BHS Capitation	No	No	Yes	No	No	No	5
Regular Reinsurance	Yes	Yes	Yes	Yes	Yes	No	4
Catastrophic Reinsurance	Yes	Yes	Yes	Yes	Yes	No	4
Transplant Reinsurance	Yes	Yes	Yes	Yes	No	No	4
BH Reinsurance	No	Yes	No	No	No	No	4
PPC Reconciliation	Yes	Yes	No	Yes	No	No	2
HCBS Reconciliation	No	Yes	No	No	No	No	2
SOC Reconciliation	No	Yes	No	No	No	No	2
Miscellaneous Reconciliations, as applicable	Yes	Yes	Yes	Yes	Yes	Yes	2
Acute Program Tiered Prospective Reconciliation	Yes	No	No	No	Yes	Yes	2
Targeted Case Management	No	No	Yes	No	No	No	1
Rural Hospital Payments	Yes	No	No	No	No	No	2

Attachment A

Status of how premium tax will be handled:

1. All rates effective 10/1/03 and thereafter have the 2% premium tax included in rate.

2. Premium tax will be added to the payment manually.

3. ALTCS performs the reconciliation and develops a rate that is used for a mass adjustment. The 2% premium tax will be included in the rate.

4. Reinsurance will have 2% premium tax directly included in all payments/recoupments made after 10/1/03. Tribal and FFS payments will be excluded from Premium Tax.

5. Rate is set for DDD which includes 2% premium tax. The component for BHS is paid to BHS, of which the 2% is not included. DDD receives the tax that is related to the BHS payment and will be responsible for payment.

Payments Not liable for Premium Tax

- Tribal Case Management - ALTCS
- Federally Qualified Health Centers (FQHC)
- Health Care Group (HCG) – no federal participation
- Fee for Service (FFS) – AHCCCS and DDD
- Third Party Liability
- Fraud and Abuse
- Indian Health Services
- State Only Transplant capitation payments

305 – PERFORMANCE BOND AND EQUITY PER MEMBER REQUIREMENTS

Effective Date: 10/01/08
Revision Date: 10/01/08

Staff responsible for policy: DHCM Finance

I. Purpose

This policy applies to all AHCCCS contractors that are required to both maintain a performance bond and meet a minimum equity requirement. The purpose of this policy is to establish standards for Contractors to meet the performance bonding and equity requirements. These standards will continue to ensure a Contractor's ability to meet its claims payment obligations, while addressing the individual differences among Contractors and enrollment growth.

II. Definitions

Equity: Net Assets that are not designated or restricted for specific purposes.

Member: For purposes of this policy, a member is defined as any acute care member enrolled at the end of the period, excluding SOBRA Family Planning members.

Performance Bond: In general, a performance bond is an instrument that provides a financial guarantee in the amount of one month's capitation. Refer to the *AHCCCS Performance Bond Policy* for definitions of acceptable instruments

III. Policy

A. Performance bonding requirements:

The initial amount of the Performance Bond shall be equal to 80% of the total capitation payment expected to be paid to the Contractor in the first month of the contract year, or as determined by AHCCCS. The total capitation amount shall include delivery supplemental payments, less premium tax. This applies to all AHCCCS lines of business except Department of Developmental Disabilities, Children's Rehabilitative Services (CRS), Comprehensive Medical and Dental Program (CMDP), Arizona Department of Health Services Division of Behavioral Health (BHS), and Medicare Advantage Plans. This requirement must be satisfied by the Contractor no later than 30 days after notification by AHCCCS of the amount required. Thereafter, AHCCCS shall evaluate the enrollment statistics of the Contractor on a monthly basis to determine if the Performance Bond must be increased. When the amount of the performance bond falls below 70% of one month's capitation, then the amount of the instrument must be increased to at least 80% of one month's capitation. Contractors must increase the amount of the performance bond within 30 days of notice from AHCCCS.

B. Equity per member requirements:

Formula:
Unrestricted equity, less on-balance sheet performance bond, divided by the number of non-SOBRA Family Planning Extension Services members enrolled at the end of the period.

Acute Requirement:

Contractors with 0-99,999 members:	$150
Contractors with 100,000+ members:	$100

Long Term Care Requirement:

All contractors	$2,000

C. Remediation when a Contractor fails to meet the equity per member requirement:

If a contractor's equity per member falls below the requirement, then AHCCCS will review the causes for the lack of compliance. AHCCCS may require the Contractor to comply with the following measures:

- ✓ Submission of corrective action plan to increase equity
- ✓ Monthly financial reporting, if not already required
- ✓ Increase the amount of the performance bond
- ✓ Capital infusion to bring equity into compliance
- ✓ Enrollment Cap

In addition, if the contractor fails to comply with the above requirements, AHCCCS may apply sanctions as delineated in the *Sanctions Policy.*

D. Restrictions on equity:

The following asset types will constitute restricted assets, and therefore will be subtracted from a contractor's equity when calculating the equity per member ratio:

1. Assets recorded as "due from affiliates" which are resulting from transactions other than cash/bank account sweep arrangements

2. Goodwill and adjustments to other assets resulting from a purchase, including those resulting from purchases and revaluations recorded in accordance with SFAS No. 141, *Business Combinations* and EITF 88-16, *Basis in Leverage Buyout Transactions*

3. Guarantees of debt

4. On balance sheet performance bonds

5. Other assets determined to be restricted by AHCCCS

E. Requirements for Contractors with restricted equity:

If a Contractor's equity is not supported by unrestricted cash or investments, and the Contractor does not meet the equity per member requirements, then the contractor may be required to maintain a performance bond in an amount greater than 80% of one month's capitation to cover the amount of the equity necessary to meet the requirements.

IV. Division of Health Care Management (DHCM) Monitoring Responsibilities

1. DHCM financial consultants will be responsible for monitoring compliance with equity per member requirements on a quarterly basis. Analyses will be performed to determine the equity per member sufficiency. Deficiencies and requests for remediation will be communicated in writing to the contractor. The contractor will be required to submit a plan to increase the equity within 30 days.

2. The financial consultant responsible for performance bonds will monitor compliance with performance bond requirements on a monthly basis. AHCCCS will notify the contractor of required changes to the amount of the performance bond. Contractors will have 30 days to comply with new requirements.

V. References

Acute Care contract, Section D
ALTCS contract, Section D

306 – PERFORMANCE BOND

Effective Date: 10/01/08
Revision Date: 10/01/08

Staff responsible for policy: DHCM Finance

I. Purpose

This policy applies to all Health Plans and Program Contractors that require a Performance Bond.

The AHCCCS Request for Proposal (RFP) requires the posting of a Performance Bond (PB), Section D, as long as the Contractor has AHCCCS-related liabilities of $50,000 or more outstanding, or 15 months following the effective date of their contract, whichever is later, to guarantee (1) payment of the Contractor's obligations to providers and non-contracting providers and (2) performance by the Contractor of its obligations under this Contract.

II. Definitions

1. United States Treasury Notes & Bonds
   This type of security is backed by the full faith and credit of the United States Government. These are notes with maturities ranging from two to thirty years. Interest is paid semiannually on the anniversary of the issue date and six months later. They are considered coupon securities even though they are now mostly issued in book entry form. Ownership is simply entered in the computers of the Federal Reserve. Interest is paid by the Federal Reserve issuing credits to the member banks that the notes are recorded through, and the banks credit the customer's account.

2. United States Treasury Bill (T-Bills)
   This type of security is backed by the full faith and credit of the United States Government, just like the Notes and Bonds. The only differences are that T-Bills are much shorter in term, three and six months, and they are sold at a discount. This means that less than the face amount is paid at original purchase and the face amount is recovered at maturity. The interest earned is part of the face amount and is earned on the amount paid for the T-Bill.

3. Federal Farm Credit Banks Funding Corporation (FFCB)
   The FFCB is 37 banks that issue two types of securities that can be substituted for the PB, Consolidated Systemwide Bonds and Consolidated Systemwide Notes. The securities are the joint and several obligations of all 37 member banks of the FFCB. It is felt that Congress will not allow this alliance to fail because of the farming community's dependence for funds.

4. Federal Home Loan Banks (FHLB)
The FHLB serves the same function for the Savings and Loan industry as the Federal Reserve for the banking industry. It is owned by the member Savings and Loan and issues coupon bonds much like the Federal Reserve.

5. Federal National Mortgage Association (FNMA)
The securities issued by FNMA are often called "Fannie Mae's". FNMA issues two types of securities, bonds and mortgage bonds. The coupon interest bonds are the securities acceptable for the PB. The mortgage bonds are not acceptable because of the repayment of the principal over the life of the bonds.

6. Federal Home Loan Mortgage Corporation (FHLMC)
The securities issued by FHLMC are often called "Freddie Mac's". Bonds issued by FHLMC are mortgage type bonds that are repaid to principal and interest over the life of the bond, and the mortgages that secure the bond. This causes the principal to draw down over the life of the bond, and the life of the PB.

7. Government National Mortgage Association (GNMA)
The securities issued by GNMA are often called "Ginnie Mae's". Bonds issued by GNMA are mortgage type bonds that are repaid to principal and interest over the life of the bond, and the mortgages that secure the bond. This causes the principal to draw down over the life of the bond, and the life of the PB.

8. Municipal Bonds
Bonds issued by a municipality. The two types are General Obligation Bonds, backed by the full faith and credit of the issuer, and Revenue Bonds, repaid by the revenue generated by the project the bonds fund. Recent bankruptcies of some cities and the fact that most of these bonds are not insured makes repayment of principal somewhat endangered.

9. Corporate Bonds
The most common form of bonds this category represents is debentures. Debentures are bonds drawn on the general credit and good name, of the issuing company. Rating services, Moody and S&P, and reporting companies, Dun and Bradstreet, try to continually assess the bonds value, and their issuing companies, but are limited to historic data. In the case of D&B the rating of America West Airlines was rated as good up to two months before the company filed for bankruptcy protection. This causes most users of the services to become aware of critical situations only after it is too late to do anything. This is another category of securities that is considered a good investment but does not meet the much higher standards that need to be applied in meeting the PB.

10. Commercial Paper
Short-term notes issued by corporations that are much like corporate bonds. The major difference is that commercial paper must be issued for less than 270 days; this allows the corporation to avoid registration of the security. Being like corporate bonds, commercial paper holds the same drawbacks but with no advantages as a PB for AHCCCS. Also, because these notes are short-term they do not lend themselves to the 15 month time frame required by the PB.

11. Stocks (Equity Investments)
Stocks, even in the most stable credit worthy companies, vary in value every day. This would require a considerable cushion above the required PB amount to compensate for market fluctuations. Also it would require AHCCCS to monitor the value of each stock posted as a PB. This would require the resources normally found only with large investors or brokers. This monitoring is well beyond the intent of the PB.

12. Banker's Acceptance (BA)
Bankers' Acceptance are notes from other than a bank that are guaranteed by the issuing bank. They are short-term in nature, less than 270 days to elude regulation.

13. Mutual Funds
Mutual Funds are an equity ownership in the fund rather than ownership in any of the securities held by the fund. The principal may be in jeopardy of loss through the mutual fund's investment losses or administration expenses. Even when the fund is dominated by or wholly made up of treasury securities the fund's owner does not own the securities.

III. Policy

Per Contract with AHCCCS, Section D, the initial amount of the Performance Bond to be equal to 80% of the total capitation payment expected to be paid in the first month of the new contract, or as determined by AHCCCS. Thereafter, AHCCCS shall evaluate the enrollment statistics of the contractor on a monthly basis and determine if adjustments are necessary in accordance with the *Performance Bond and Equity Per Member Policy*.

The following are general requirements for all PB's:

1. The amount, duration or scope of the PB may not be changed or discontinued without prior approval of AHCCCS Division of Health Care Management (DHCM).
2. A contact person must be listed and their phone number.
3. Any security agreement must be disclosed.
4. AHCCCS will confirm the PB with the appropriate institution at least annually.

Listed are several specific ways to satisfy the PB:

1. Cash Deposits, or
2. An Irrevocable Letter of Credit issued by:
   A. A bank insured by the Federal Deposit Insurance Corporation, or
   B. A savings and loan association insured by the Federal Savings and Loan Insurance Corporation, or
   C. A credit union insured by the National Credit Union Administration, or
3 Surety Bond of standard commercial scope issued by a surety or insurance company doing business in Arizona, or
4. Certificate of Deposit, or
5. County resolution, or
6. An acceptable substitute in lieu of one of the above agreed to by AHCCCS.

Cash Deposit

I. Deposit of Funds

A. Any funds to be deposited with the State Treasurer shall be sent to the AHCCCS Division of Health Care Management (DHCM) in the form of a check. Along with the check should be a letter describing:
   1. The application of funds (Acute, ALTCS or any combination of both),
   2. A primary contact and phone number, for any issues concerning the deposit, and
   3. Instructions for the interest from the deposit: interest to be disbursed must also include directions of where the interest is to be sent.

B. After the funds have been deposited, AHCCCS DHCM will send a copy of the State Treasurer's "Securities Safekeeping" form that records the deposit.

C. Based on instructions with the deposit, a warrant will be issued each month for the interest on the account.

D. The State Treasurer will furnish statements of the account only upon written request. This request may be made at any time.

II. Withdrawal of Funds

A. To withdraw principal funds, send a letter to AHCCCS DHCM requesting the withdrawal. The letter must include:
   1. The amount of the withdrawal
   2. The program that the funds are being withdrawn from (Acute or ALTCS)
   3. The date that the funds should be withdrawn, (allow a minimum of ten working days)
   4 The manner the warrant from the State Treasurer's office is to be handled:

a. Mailed by the US Postal Service, or
b. Courier pick-up (please include a phone number of the primary contact so prompt notice can be given), or
c. Wiring instructions.

B. AHCCCS DHCM will forward the warrant in the manner requested in the withdrawal letter.

Letter of Credit

I. Establishment of Letter of Credit

A. Before a Letter of Credit can be accepted as a PB it must be approved by AHCCCS for form and amount. Requirements include:

1. Be of standard commercial scope and issued by a bank, credit union or savings and loans doing business in the State of Arizona and insured by the appropriate Federal Institution;
2. For an amount that meets or exceeds the PB dollar requirement;
3. For a time period that meets or exceeds the AHCCCS contract term plus three months;
4. AHCCCS DHCM must receive a signed extension 30 days prior to the expiration date;
5. A statement that the PB cannot be changed in the amount, duration or scope, or discontinued without the authorization of AHCCCS DHCM.

B. Send a copy of the agreement to be executed to AHCCCS DHCM thirty working days prior to the execution date. AHCCCS will review the agreement and advise of acceptance or that changes are necessary. The AHCCCS review will only be for issues that are necessary for the AHCCCS PB; it will not include review for any other matters.

C. AHCCCS DHCM will forward the letter of credit to our outside counsel for review.

D. AHCCCS DHCM will respond in writing that the PB is acceptable or changes need to be made for acceptance.

E. After the agreement is executed, send a statutory notice of deposit form and the original to AHCCCS DHCM. The original will be held in safe keeping until the agreement ends or is terminated by the parties. Make copies for your file prior to sending the original to AHCCCS DHCM.

II. Return of Letter of Credit original

The original Letter of Credit will be returned to the makers upon:

1. Termination of the Letter of Credit, or
2. Termination of the AHCCCS contract, or
3. Satisfying the PB requirement with another acceptable form as outlined by AHCCCS,
4. Statutory Notice of Release form

Surety Bond

I. Establishment of Bond

A. Before a Surety Bond can be accepted as a PB it must be approved by AHCCCS for form and amount. Requirements include:

1. Be of standard commercial scope and issued by a bank, credit union, savings and loans, or insurance company authorized to do business in the State of Arizona and insured by the appropriate Federal Institution;
2. For an amount that meets or exceeds the PB dollar requirement;
3. For a time period that meets or exceeds the AHCCCS contract term plus three months;
4. AHCCCS Division of Health Care Management (DHCM) must receive a signed extension 30 days prior to the expiration date;
5. A statement that the PB cannot be changed in the amount, duration or scope or discontinued without the authorization of AHCCCS DHCM.

B. Send a copy of the agreement to be executed to AHCCCS DHCM thirty working days prior to the execution date. AHCCCS will review the agreement and advise of acceptance or that changes are necessary. The AHCCCS review will only be for issues necessary for the AHCCCS PB; it will not include review for any other matters.

C. AHCCCS DHCM will forward the surety bond to our outside counsel for review.

D. AHCCCS DHCM will respond in writing whether the PB is acceptable or changes need to be made for acceptance.

E. After the agreement is executed, send a Statutory Notice of Deposit form and the original to AHCCCS DHCM. The original will be held in safe keeping until the agreement ends or is terminated by the parities. Make copies for your file prior to sending the original to AHCCCS DHCM.

II. Return of Surety Bond original

The original Surety Bond will be returned to the makers upon:

1. Termination of the Surety bond, or
2. Termination of the AHCCCS contract, or
3. Satisfying the PB requirement with another acceptable form as outlined by AHCCCS, or
4. Statutory Notice of Release

Certificate of Deposits

I. Types of Certificate of Deposits

Only Certificates of Deposit from banks, savings and loans, or credit unions and insured by the appropriate Federal institution, are applicable for the PB.

II. Assignment to Arizona State Treasurer

All Certificate of Deposit must be assigned to the Arizona State Treasurer in compliance with Arizona Revised Statute Section 35-155. This can be accomplished with the "Assignment to Arizona State Treasurer" form.

III. Deposit of the Certificate of Deposit

A. Send or deliver the original Certificate of Deposit (or receipt for the Certificate of Deposit if a certificate is not issued) and the Assignment form to AHCCCS DHCM. A letter should accompany the Certificate of Deposit describing the form of PB the Certificate of Deposit is satisfying (Acute or ALTCS) and a contact person. Also, a Statutory Notice of Deposit form should accompany the Certificate of Deposit.

B. After the Certificate of Deposit has been sent to the State Treasurer, AHCCCS DHCM will send copy of the State Treasurer's "Securities Safekeeping" form to record the deposit of the Certificate of Deposit.

C. After the Certificate of Deposit has been deposited with the State Treasurer it is the Health Plan's responsibility to monitor the maturity date. No notification should be expected from the State Treasurer's office or AHCCCS DHCM. Evidence of the renewal of each CD must be sent to AHCCCS DHCM within 5 days of the renewal date.

IV. Withdrawal of a Certificate

Send a letter to AHCCCS DHCM requesting the release of a specific Certificate of Deposit giving:

1. The institution of the Certificate of Deposit,
2. The certificate number,
3. The amount of the Certificate of Deposit,
4. The program the Certificate of Deposit is being withdrawn from,
5. The manner the Certificate of Deposit is to be returned to the Plan,
6. A contact person, and
7. Statutory Notice of Release form.

Securities

I. Acceptable Securities

The following list is an outline of the acceptable and unacceptable securities that may be posted as a PB. The listing is not comprehensive but it includes the most common securities.

Acceptable:

A. United States Treasury Bills
B. United States Treasury Notes
C. United States Treasury Bonds
D. Federal Farm Credit Banks Funding Corporation Bonds
E. Federal Home Loan Bank Bonds
F. Federal National Mortgage Association (Fannie Mae) Coupon Interest Bonds

Unacceptable:

A. Federal Home Loan Mortgage Corporation
B. Government National Mortgage Association
C. Municipal Bonds
D. Corporate Bonds
E. Commercial Paper
F. Stocks
G. Letter of Credit from other than a bank, savings and loan or credit union
H. Bankers Acceptance
I. Mutual Funds

II. Deposit of Security as Performance Bond

A. Execute a "Statutory Deposit Custody Agreement" with the State Treasurer's appointed custodian.

B. The face amount of the security or principal amount of the purchase price, whichever is lower, must be equal to or greater than the PB requirement. On an ongoing basis, the lower of cost or market must be equal to or greater than the PB requirement.

C. After deciding on one of the securities to be used as a PB, fill out a "Notice of Statutory Deposit Delivery" form and submit the form and security if not in Book Entry form, to AHCCCS DHCM. Include a letter that details the reason for the deposit of the security and a contact person.

D. AHCCCS DHCM will forward the Notice of Statutory Deposit Delivery form (and security if applicable) to the State Treasurer's appointed custodian who will then,

1. Effect the transfer from the purchasing agent, or
2. Make the purchase as directed

E. The security will remain in the safekeeping of the State Treasurer's appointed custodian. Any interest distributions will be accomplished through instructions to the appointed custodian and require no intervention by AHCCCS DHCM. (Only interest on Coupon Interest Bonds is available for distribution, interest on Discount Interest Bonds must remain in the account to satisfy the maturity amount).

F. Confirmation statement to be received by DHCM from State Treasurer's appointed custodian acknowledging transaction completed.

III. Release of Security as a Performance Bond

A. Fill out a "Notice of Statutory Deposit Release" form and send it along with a letter of explanation to AHCCCS DHCM.

B. AHCCCS DHCM will forward the Notice of Statutory Deposit Release form to the State Treasurer's appointed custodian. The custodian will then release the security in the manner instructed in the Notice of Statutory Deposit Release form.

IV. References

Acute Care Contract, Section D

307 - SETTING AND ADJUSTING RATES FOR HOME AND COMMUNITY BASED SERVICES

Effective Date: 8-1-06
Revision Date:

Staff responsible for policy: DHCM Reimbursement Administrator

I. Purpose

This policy establishes the standard procedures for rebasing and updating reimbursement rates for Home and Community Based Services (HCBS) provided to members enrolled in Fee-for-Service programs under the Arizona Long Term Care System consistent with ARS 36-2959 (B).

This policy applies to all HCBS fee-for-service rates whose establishment and maintenance are within the authority of the Director under A.R.S. Title 36, Chapter 29.

II. Definitions

All terms used in this policy have the meanings prescribed by A.A.C. Title 9, Chapters 22 and 28.

III. Policy

The Arizona Health Care Cost Containment System (AHCCCS) rebases and updates rates for Home and Community Based Services (HCBS) as needed to recognize changes in the cost of providing such services.

The rates must be rebased at least once every five years per Arizona Revised Statute §36-2959. AHCCCS is committed to reimbursing services at rates that are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

Rates will be analyzed for their reasonableness and applicability to the AHCCCS population, for their consistency with rates for similar services, and for their practicability with respect to available budget, and a written recommendation of new rates will be submitted to Executive Management. Information used for the analysis may include but not be limited to the following:

A. Published Medicare rates;
B. Feedback from the AHCCCS Medical/Dental Directors;
C. Feedback from contracted health plans;
D. Feedback from AHCCCS providers;
E. Rates in use in other states;
F. Costs associated with the delivery of services, including programmatic, administrative and indirect costs in providing services in rural and urban Arizona;
G. Any economic factors unique to Arizona;

H. Current levels of supply and demand, including gaps in the delivery of critical services;
I. Consultant rebase study on the adequacy and appropriateness of Title XIX reimbursement rates to service providers for the elderly and physically disabled program of the Arizona Long Term Care System;
J. Survey information on wages paid and benefits offered to home care workers;
K. Reimbursement rates paid by other agencies in Arizona for similar services; and
L. Information from national cost and wage indices such as Global Insights and the Bureau of Labor Statistics.

Fiscal impact analysis

Wherever practicable, the fiscal impact of proposed rate updates will be estimated by the Reimbursement Unit and presented together with the recommended rates for Executive Management consideration.

Executive Management approval

All rate updates will be approved in writing by the Director or the Deputy Director prior to implementation.

Documentation

All final documents (both internally and externally created) used in rates analysis and determination will be kept on file for a period of five years within the Division of Health Care Management for purposes of facilitating future analyses and audits.

Responsibility

The Manager of the Reimbursement Unit is responsible for ensuring that all rate updates are performed in compliance with this policy.

IV. References

A.R.S. § 36-2903.01(B)(6)
A.R.S. § 36-2903.01(H)
A.R.S. § 36-2904(A)
A.R.S. § 36-2904(B)
A.R.S. § 36-2959(B)
A.A.C. R9-22-710
A.A.C. R9-22-712
A.A.C. R9-28-708

308 – PAYMENTS TO FQHCS (Federally Qualified Health Care Centers) / RHCS (Rural Health Clinics)

Policy moved to FQHC / RHC Section of the website.

http://www.azahcccs.gov/commercial/FQHC-RHC.aspx

309 – RESERVED

310 - DELIVERY SUPPLEMENT PAYMENT: ACUTE CARE CONTRACTORS

Effective Date: 10/01/2008
Revision Date: 11/16/2009

Staff responsible for policy: DHCM Finance

I. Purpose

This policy applies to the payment of the delivery supplemental payment for all acute contractors.

II. Definitions

PPC Period: The period from the effective date of eligibility to the day a member is enrolled with a Contractor.

III. Policy

A. General

1. A supplemental payment was implemented for Contractors to cover the cost of delivery services. When the Contractor has an enrolled woman who delivers during a prospective enrollment period, the Contractor will be entitled to a supplemental payment. Supplemental payments will not apply to women who deliver in a prior period coverage time period. This payment covers the cost of the inpatient hospitalization and some prenatal care.

2. All newborns must be reported within six months of birth to receive a delivery supplemental payment.

3. All births must be reported by the woman's health plan. All births reported by any other State Agency will not be eligible for a delivery supplemental payment.

4. All newborns must be reported by the enrolled woman's health plan through the AHCCCS website or telephone call to AHCCCS. Capitation for all newborns will be paid from the date of notification by the enrolled woman's health plan.

5. Only those eligible for the delivery supplement by contract are subject to this policy. State Only Transplants and PPC members are not eligible for the delivery supplemental payment.

IV. References

Acute Care Contract, Section D

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401 - CHANGE OF PLAN: ACUTE CARE CONTRACTORS (HEALTH PLANS)

Effective Date: 08/01/94
Revision Date: 02/01/03

Staff responsible for policy: DHCM Operations

I. Purpose

This policy applies to Acute Care Contractors (hereafter referred to as Contractors). This policy establishes guidelines, criteria and timeframes for how, when and by whom change requests will be processed for Title XIX and Title XXI members. This policy delineates the rights, obligations and responsibilities of:

- The member
- The member's current Contractor
- The requested Contractor, and
- The AHCCCSA,

in facilitating continuity of care, quality of care and efficient and effective program operations and in responding to administrative issues regarding member notification and errors in assignment.

II. Definitions

Day: A calendar day, unless otherwise specified

III. Policy

A. Criteria For Change Of Plan Approval

Plan change requests will be granted for members if certain conditions are met. These conditions are:

1. Administrative Actions Resulting in a Request for a Health Plan Change

a. A member was entitled to freedom of choice, but was not given a pre-enrollment notice or sent an auto-assignment/freedom of choice notice. Title XXI members must choose a health plan prior to eligibility being effective. If a Title XXI member is transferred from Title XIX to Title XXI, and the Title XXI member has not made a health plan choice, the Title XXI member will continue to be enrolled in the health plan they were enrolled in at the time of transfer. They will then be sent and enrollment choice notice giving them all Title XXI enrollment choices and an opportunity to select a health plan.

b. A member was entitled to participate in an Annual Enrollment Choice but:
   1) was not sent an Annual Enrollment Choice or
   2) was sent and Annual Enrollment Choice notice but was unable to participate in the Annual Enrollment Choice due to circumstances beyond the member's control.

c. Family members were inadvertently enrolled in different health plans (this paragraph does not apply to Title XXI members). A member who is enrolled in a health plan through the auto-assignment process may inadvertently be enrolled in a different health plan than other family members. In this case, the member who was inadvertently enrolled will be disenrolled from the health plan of assignment and enrolled in the health plan where the other family members are enrolled when AHCCCS is notified of the problem. Other family members will not be permitted to change to the health plan to which the new member was auto-assigned. However, the condition set forth in the paragraph shall not apply if a member was afforded an enrollment choice during their Annual Enrollment Choice period.

d. A member of a special group is not enrolled in the same health plan as the group, in accordance with the AHCCCSA's list of special group agreements (this paragraph does not apply to Title XXI members). If a member who is part of such a special group is inadvertently enrolled in the wrong health plan, AHCCCS, upon notification, will disenroll the member from the health plan and enroll the member in the special group health plan.

e. A member who was enrolled in a health plan, lost eligibility and was disenrolled, then was subsequently redetermined eligible and reenrolled in a different health plan within 90 days from the date of disenrollment. In this case the member should be reenrolled in the health plan that the member was enrolled in the prior to the loss of eligibility. If this does not occur, AHCCCS, upon notification, will enroll the member in the correct health plan. Title XXI members who loose eligibility and subsequently re-apply must choose a health plan prior to being made eligible regardless of the length of time between eligibility periods.

f. A Title XIX applicant who made a pre-enrollment choice and was denied Title XIX, but determined Title XXI eligible will be granted their Title XIX pre-enrollment choice. The person will be advised of their approval for Title XXI. The member will have 16 days to make a Title XXI choice. If the member does not change their choice within this timeframe the member will remain with their Title XIX choice. If the Title XIX applicant did not pre-enroll and was subsequently approved for Title XXI, the member will be contacted to obtain a Title XXI choice.

g. Newborns will automatically be assigned to the mother's health plan. If the mother is Title XIX or Title XXI eligible she will be given 16 days from notification to select another health plan for the newborn. Newborns of Federal Emergency Services (FES) mothers will be auto assigned and the mother will be given 16 days from notification to select another health plan.

h. Adoption subsidy children will be auto-assigned and the guardian will be given 16 days from notification to select another health plan.

i. A Title XIX eligible member who is entitled to freedom of choice but becomes eligible and is auto-assigned prior to having the full choice period of 16 days. The member will be given an opportunity to request a plan change following auto-assignment, however, the member must request a plan change within 16 days from the interview date (application record receipt date) or receipt of the choice letter. A member who does not make a selection within 16 days will remain with the auto-assigned health plan.

j. A member whose eligibility category changed from SOBRA to the SOBRA Family Planning Extension Program may change their health plan if their current PCP will not be providing Family Planning Extension Program services.

2. Medical Continuity Of Prenatal Care

a. A pregnant member who is enrolled in a health plan through auto-assignment or freedom of choice, but who is receiving or has received prenatal care from a provider who is affiliated with another health plan, may be granted a medical continuity plan change if the medical directors of both health plans concur.

b. If there are other individuals in the pregnant member's family who are also AHCCCS eligible and enrolled, they have the option to remain with the current plan or go to the new plan if the medical continuity plan change is granted. The member may not return to the original health plan or change to another health plan after the medical continuity plan change has been granted except during the annual enrollment choice period.

c. The member must be transitioned within the requirements and protocols in the AHCCCS Member Transition for Annual Enrollment Choice, Open Enrollment and Other Plan Changes Policy and in the AHCCCS Medical Policy Manual, Chapter 500.

3. Medical Continuity Of Care

a. AHCCCS has standards for network composition that result in uniform availability and accessibility of services from all health plans serving a specific geographic area. It is impossible for the standards to cover and respond to the array of circumstances that may occur in actual delivery of, medical/health care services. In unique situations, special plan changes may be approved on a case-by-case basis if necessary to ensure the member access to medical /health care.

b. A plan change for medical continuity is not an automatic process. The member's PCP, or other medical provider, must provide documentation to both health plans that supports the need for a health plan change. The health plan(s) must be reasonable in the request for documentation. However, the burden of proof that a plan change is necessary rests with the member's medical provider. The Plan change must be approved by both health plan Medical Directors.

c. When the Medical Directors of both the receiving and relinquishing health plans have discussed the request and have not been able to come to an agreement, the relinquishing health plan shall submit the request to the AHCCCS Chief Medical Officer (CMO) or designee. The AHCCCS Acute Care Change of Plan Form (ATTACHMENT A) and the supporting documentation must be sent to the AHCCCS DHCM/CQM Manager within 14 business days from the date of the original request.

   The results of the review will be shared with both Medical Directors. The relinquishing health plan will be responsible for issuing a final decision to the member. If the member request is denied, the relinquishing health plan will send the member a notice of action.

d. The member must be transitioned within the requirements and protocols in the AHCCCS Member Transition for Annual Enrollment Choice, Open Enrollment and Other Plan Changes Policy and in the AHCCCS Medical Policy Manual, Chapter 500.

B. Responsibility For Processing, Evaluation And Approval

1. Current Health Plan Responsibilities When A Plan Change Is Not Warranted

a. The current health plan has the responsibility to promptly address the member's concerns regarding availability and accessibility of service and quality of medical care delivery issues that may have caused a plan change request These issues include, but are not limited to:

1) Quality of medical care delivery

2) Transportation convenience

3) Transportation service availability

4) Physician or provider preference

5) Physician or provider recommendation

6) Physician or provider office hours

7) Timing of appointments and services

8) Office waiting time

b. Additionally, the health plan must explore all options available to the member, such as resolving transportation problems, provider availability issues, allowing the member to choose another PCP, or to see another medical provider, if appropriate.

c. Quality of care and delivery of medical services issues raised by the member must be referred to the current health plan's quality management staff and/or the health plan's Medical Director for review within one day of the health plan's receipt/notification of the problem.

d. The delivery of covered services remains the responsibility of the current health plan if a plan change for medical continuity of prenatal or other medical care is not approved.

e. The current health plan must notify the member, in writing, that a plan change is not warranted. If the plan change request was the result of a member concern, as defined in section B(1)(a) of this policy, the notice must include the health plan's resolution of this concern. The notice must also advise the member of the AHCCCS and health plan grievance policy and include timeframes for filing a grievance.

f. Health plans may reach an agreement with an out-of-network provider, to care for the member on a temporary basis, for the members' period of illness and/or pregnancy in order to provide continuity of care.

2. Current (Sending) Health Plan Responsibilities When A Plan Change Is Warranted

a. If a member contacts the current health plan, verbally or in writing, and states that the reason for the plan change request is due to situations defined in Section A(1) of this policy, the sending/current health plan shall advise the member to telephone the AHCCCS Verification Unit at 417-7000 or 1-800-962-6690 in order for AHCCCS to process the change.

b. If the member contacts the sending/current health plan, verbally or in writing, to request a plan change for medical continuity of care as defined in A(2) or A(3) of this policy, the following steps must be taken:

1) The sending/current health plan will contact the receiving health plan to discuss the request. If a plan change is indicated for medical continuity of care, the AHCCCS Plan Change Request form (Attachment A) must be completed. All the members to be affected are added to the form and the form signed by the medical directors or physician designees of both health plans. When the AHCCCS Plan Change Request form is signed it is to be submitted to the AHCCCS Division of Member Services (DMS) Enrollment Unit.

2) To facilitate continuity of prenatal care for the member, health plans shall sign off and forward the AHCCCS Plan Change Request form to the AHCCCS DMS Enrollment Unit Manager within 2 working days of the member's plan change request. The timeframe for other continuity of care issues is 10 business days.

3) The Enrollment Unit Manager will review the plan change documentation and forward to the Enrollment Unit for processing.

4) The enrollment Unit will consider these plan changes as an administrative plan change.

c. The member must be transitioned within the requirements and protocols in the AHCCCS Member Transition for Annual enrollment Choice, Open Enrollment and Other Plan Changes Policy and in the AHCCCS Medical Policy Manual, Chapter 500.

3. Notification Requirements

The health plan will provide notification to its physicians and members of this policy. Information regarding this policy must be included in the provider manual and in the member handbook.

4. Receiving Health Plan Responsibilities

The member must be transitioned within the requirements and protocols in the AHCCCS Member Transition for Annual Enrollment Choice, Open Enrollment and Other Plan Changes Policy and in the AHCCCS Medical Policy Manual, Chapter 500.

5. Member responsibilities

a. The member shall request a change of plan directly from AHCCCS only for situations defined in Section A(1) of this policy. The member shall direct all other plan change requests to the member's current health plan.

b. A member who has questions or concerns about the Plan Change Policy should be first advised about the options available to the member and the steps the health plan is required to take to accommodate medically necessary services. If the member continues to present questions or concerns, the member should be advised of the AHCCCS/Health Plan Grievance Policy, including timeframes for filing a grievance.

C. AHCCCS Administration Responsibilities

1. The AHCCCSA shall process change of plan requests that are listed in Section A(1) and shall send notification of the change via the daily recipient roster to the sending and receiving health plans. It is the health plan's responsibility to identify members from the daily recipient roster who are leaving the health plan.

   Additionally, AHCCCSA will send the relinquishing health plan's transition coordinator a Prior Plan letter. The Prior Plan letter is system generated and mailed on a daily basis. The letter includes the transitioning member's name, AHCCCS ID, date of birth, and the name of the receiving health plan.

   If the AHCCCSA denies a Section A(1) change of plan request, AHCCCSA will send the member a denial letter. The member will be given 60 days to file a grievance.

2. If AHCCCSA receives a letter or verbal request from a member wanting a plan change, for reasons defined in Section A(1) of this policy, that also references other problems (i.e., transportation, accessibility or availability of services), that information will be sent to the current health plan.

3. If AHCCCSA receives a letter or verbal request from a member wanting a plan change for reasons listed in Section A(2) or A(3) the information will be forwarded to the current health plan.

IV. References

- 9 A.A.C. 22, Article 5 and 9 A.A.C. 31, Articles 3 and 5
- Acute Care Contract, Section D
- ALTCS Contract, Section D
- AHCCCS Medical Policy Manual, Chapter 500
- Attachment A

Attachment A

MEMBER REQUEST FOR PLAN CHANGE

CHANGE REASON: ☐**Medical Continuity of Prenatal Care** ☐**Medical Continuity of Care**

MEMBER INFORMATION

Member Name:		Member ID:		Phone#:	- -
Address:		Apt/Space#:		DOB:	- - Sex:
City:		State:		ZIP:	
Member's PCP:		AHCCCS ID#:		Phone#:	- -

CURRENT (Sending) Health Plan:		**Receiving Health Plan**:	
Health Plan Name:		Health Plan Name:	
Health Plan ID#:		Health Plan ID#:	
Contact Name:		Contact Name:	
Contact Phone:		Contact Phone:	
Contact Fax:		Contact Fax:	

PROVIDER REQUESTED FOR CONTINUITY

Provider Name:		AHCCCS ID#:		Phone#	- -

DOCUMENTATION OF MEDICAL CONTINUITY

(include all information supporting the need for the change)

Member requests change of plan to:

Member's effective date is: - - Rate Codes:

☐ Approved ☐ Denied ☐ Approved ☐ Denied

Medical Directo5r's Signature/Sending Plan

Medical Director's Signature/Receiving Plan

Reason stated for denial by Receiving Plan:

PLEASE ATTACH ANY RELEVANT DOCUMENTATION

☐ Documentation Attached ☐ Additional family members listed on attached page

After review by AHCCCSA this plan change has been: ☐ Approved ☐ Denied

AHCCCS Medical Director (for Designee)

Date

Any plan change request processed by the health plans must involve continuity of care issues. If a plan change is requested for any other reason, the request should be managed according to the AHCCCS Change of Plan Policy.

402 - MEMBER TRANSITION FOR ANNUAL ENROLLMENT CHOICE, OPEN ENROLLMENT AND OTHER PLAN CHANGES: ACUTE CARE AND ARIZONA LONG TERM CARE SYSTEM (ALTCS) CONTRACTORS

Effective Date: 08/01/95
Revision Date: 02/01/03

Staff responsible for policy: DHCM Operations

I. Purpose

This policy applies to all Acute Care and Arizona Long Term Care System (ALTCS) Contractors (hereafter referred to as Contractors). This policy establishes guidelines, criteria and timeframes for how members are to be transitioned between AHCCCS Contractors. This policy delineates the rights, obligations and responsibilities of, the member's current Contractor and the requested (receiving) Contractor.

The Contractors and AHCCCS work together to ensure the smooth transition of members as they change from one Contractor to another. While administrative and financial considerations are involved, the overriding consideration should be a smooth transition for all members and ensuring that continuity and quality of care are maintained.

This policy applies to members transitioning in the following circumstances.

A. Annual Enrollment Choice

Annual enrollment choice provides AHCCCS members with the opportunity to change Acute Care Contractors once per year, subject to the availability of other contracted Acute Care Contractors in their area.

Members must notify AHCCCS of their wish to change Acute Care Contractors during the annual enrollment choice period. If the member does not participate in annual enrollment choice, and their eligibility is maintained, he/she will remain with their current Acute Care Contractor.

B. Open Enrollment

AHCCCS may also conduct an open enrollment on a limited basis as deemed necessary by the AHCCCS Administration. Members must notify AHCCCS of their wish to change Acute Care Contractors during open enrollment.

If the member does not participate in open enrollment and their eligibility is maintained, he/she will remain with their current Acute Care Contractor unless the Acute Care Contractor is no longer available in that Geographic Service Area (GSA).

C. Contractor Changes Permitted by Policy

Members who have been granted a plan change pursuant to the AHCCCS Change of Plan Policy.

D. Eligibility Changes

Members who have changed eligibility from Acute to the ALTCS or from ALTCS to Acute.

Members who have become eligible and have enrolled into the Children's Rehabilitative Services (CRS) program while maintaining enrollment with an Acute or ALTCS Contractor, or members who have lost eligibility for CRS, but remained eligible for either the Acute or ALTCS program.

Each AHCCCS Contractor will participate in the transition of members. Contractors must have in place the necessary policies and procedures for the acceptance and transfer of members.

Transition coordination activities must include, but are not limited to, compliance with AHCCCS standards and policies found in the AHCCCS Medical Policy Manual, Chapter 500. The cost of reproducing and forwarding member records will be the responsibility of the relinquishing Acute Care Contractor and its providers.

This policy does not apply to members transitioning between Indian Health Service (IHS) and a Contractor.

II. Definitions

Annual enrollment choice: The annual opportunity for a member to change his/her Acute Care Contractor. The member is given their annual enrollment choice in the 10th month following their anniversary date. If an individual member makes a timely (within the period stated on the annual choice letter) annual enrollment choice, the change in Acute Care Contractors will occur on the first of the month in which their anniversary date occurs.

Anniversary date: The first day of the month in which a case (Members who share the same household identification number or a single person household) has Acute eligibility updated. Those Title XIX members within the case who had a break in eligibility and were reenrolled within 90 days will cause the entire case to have the break in eligibility ignored when calculating the anniversary month.

Case: Members who share the same household identification number.

Children's Rehabilitative Service (CRS): serves individuals under 21 years of age who meet the criteria established by Arizona Department of Health Services. CRS has a contract with AHCCCS for the provision of care for specific conditions. Members may be concurrently enrolled with CRS and with a Contractor.

Enrollment Transition Information Form (ETI): The form the Relinquishing Contractor must complete and transmit to the Receiving Contractor for those members requiring coordination of services as a result of transitioning to another Contractor. (See AHCCCS Medical Policy Manual, Chapter 500).

Indian Health Service (IHS): Indian Health Service is a division of the U. S. Public Health Service. It administers a system of hospitals and health care centers providing health services to Native Americans and Native Alaskans.

Member Transition: The process during which members change from one Acute Care Contractor to another, change from the Acute to the ALTCS program, change from ALTCS to the Acute program, change from one ALTCS Contractor to another, or enroll or disenroll from CRS.

Open enrollment: The period of time when selected enrolled members in an affected GSA or Acute Care Contractor may select membership with another AHCCCS Acute Care Contractor if one is available in their service area.

Plan change: The process where a member changes Acute Care Contractors whether during Annual Enrollment Choice, Open Enrollment or Pursuant to the AHCCCS "Change of Plan Policy".

Receiving Contractor: The Contractor with which the member will become enrolled as a result of annual enrollment choice, open enrollment, a plan change or a change in eligibility.

Regional Behavioral Health Authority (RBHA): The Regional Behavioral Health Authority is an organization under contract with the Arizona Department of Health Services to coordinate the delivery of behavioral health services in a geographically specific service area of the state.

Relinquishing Contractor: The Contractor in which the member is currently enrolled. This is the Contractor that the member will be leaving as a result of annual enrollment choice, open enrollment, a plan change or a change in eligibility.

Transition coordinator: A designated Contractor health care professional who is responsible for the oversight of transition activities.

Transition plan: A documented plan (policy) which details the Contractor's protocols, standards and procedures for performing transition activities for members joining and leaving the Contractor. The Contractor's transition plan must be approved in writing by AHCCCSA prior to implementation.

III. Policy

A. Contractor Responsibilities During Annual Enrollment Choice, Open Enrollment And Other Contractor Changes

1. Relinquishing and receiving Contractors must comply with all transition policies specified in the AHCCCS Medical Policy Manual Chapter 500.

2. Relinquishing Contractors who fail to notify receiving Contractors about members that meet the AHCCCS transition notification requirements, as indicated in the AHCCCS Medical Policy Manual Chapter 500, may be responsible for the cost of the member's care for medically necessary services for up to 30 days after the transition. The scope and responsibility for such cases will be reviewed and determined by the AHCCCS Administration. In cases where AHCCCS determines that the relinquishing Contractor has a period of responsibility following the transition date, AHCCCS will require the receiving Contractor to provide AHCCCS with information about all cost incurred by the member during the period determined by AHCCCS. Failure to provide the information to AHCCCS as specified by AHCCCS and by the date specified by AHCCCS will negate the receiving Contractor's claim to reimbursement in that case.

3. Each Contractor must develop and submit a transition plan and designate a transition coordinator who meets the requirements addressed in this policy. Contractors are also encouraged to designate an information system staff member or representative to work with transition coordinators to assist with the technical requirements necessary for member transition.

4. Contractor representatives must be accessible for members participating in annual enrollment choice or open enrollment. These representatives must have the authority to respond to member and provider concerns and facilitate problem resolution.

B. Relinquishing Contractor Responsibilities

1. Relinquishing Contractors must complete and transmit an Enrollment Transition Information (ETI) form for each member with special circumstances, as described in the AHCCCS Medical Policy Manual, Chapter 500, and must comply with the notification requirements specified in this policy. If there is no pertinent information to transmit concerning a member who is transitioning, no action is required.

2. Relinquishing Contractors that fail to notify receiving Contractors of members that meet the AHCCCS transition notification requirements as indicated in the AHCCCS Medical Policy Manual, Chapter 500, may be responsible for the cost of the member's care for medically necessary services for up to 30 days after the transition. The scope and responsibility for such cases will be reviewed and determined by AHCCCS Administration.

3. Relinquishing Contractors with transitioning members who are hospitalized at the time of transition must notify the hospital prior to transitioning the member and must comply with the requirements of the AHCCCS Medical Policy Manual, Chapter 500. For those hospitalized transitioning members in intensive care units, critical care units, and neonatal intensive care units, close consultation between attending physicians, current primary care provider (PCP) and the member's receiving Contractor and PCP is required.

4. The Relinquishing Contractor is responsible for ensuring that a transitioning member's medical records are copied and mailed when requested by the receiving Contractor's transition coordinator, the member's new PCP, or his/her designated office staff. In cases where additional information is medically necessary but is exceptionally lengthy, the relinquishing Contractor is responsible for the cost of copying and postage. Under no circumstances is the member required to pay fees or costs associated with the copying and/or transfer of medical records to the receiving Contractor.

5. For members changing Contractors or changing to or from ALTCS, all AHCCCS Contractors must cover and deliver medically necessary services to their assigned members through the date of transition. Under no circumstances may a Contractor cancel, postpone, or deny a service based on the fact that a member will be transitioning to another Contractor except as discussed in AMPM, Chapter 500.

   Additionally, Contractors are responsible for ensuring that all staff involved with the coordination and/or authorization of services between members and providers are aware of the Acute Care Contractor's duties and obligations to deliver medically necessary services to transitioning members through the date of transition.

6. The relinquishing Contractor will remain responsible for adjudicating any pending member grievances that are filed prior to the member's transition.

7. If an ALTCS member is no longer ALTCS eligible but is eligible for acute care the relinquishing Contractor is responsible for obtaining the member's choice of acute care Acute Care Contractor and notifying AHCCCS, as a part of the ALTCS disenrollment process, when the member is transitioning from ALTCS to Acute.

8. If a member enrolled in a Contractor becomes eligible and enrolls in CRS, the member's Contractor and CRSA, or its subcontractor, must cooperate in the coordination of care for the member.

9. If a member enrolled in CRS is no longer eligible for CRS, but remains eligible for the Acute or ALTCS programs, CRSA, or its subcontractor, is responsible for contacting the member's Contractor to coordinate care for the transitioning member's CRS condition.

C. Receiving Contractor Responsibilities

Receiving Contractors that fail to act upon enrollment transition information communicated by the relinquishing Contractor for members that meet the AHCCCS notification requirements, or fail to coordinate or provide the necessary covered services to transitioning members after being properly notified in a timely manner, will be subject to possible sanctions.

1. Within 10 business days for Acute Care members and 12 days for ALTCS members (allows for case management on-site visit) of the effective date of transition, the receiving Contractor must provide new members with member information as specified in the AHCCCS Member Information Policy.

2. Receiving Contractors are responsible for ensuring that:

   a) Transitioning members are assigned to a PCP in accordance with AHCCCS requirements.

   b) Transitioning members can obtain routine, urgent, and emergent medical care in accordance with AHCCCS standards.

3. When a pregnant woman who is considered high-risk and is in her third trimester or a member who is anticipated to deliver within 30 days of transition, elects to remain with her current physician through delivery, the receiving Contractor is responsible for the payment of obstetrical and delivery services. If the member's current physician and/or facility selected as her delivery site are not within the receiving Contractor's provider network, the receiving Contractor must negotiate for continued care with the member's provider of choice for payment of obstetrical services even if delivery is scheduled to occur outside of the receiving Contractor's contracted network.

4. For members receiving behavioral health services through an ADHS Contractor, the receiving Contractor is responsible for notification about the enrollment changes (if known), coordination of behavioral health services, and case management with the member's assigned Regional Behavioral Health Authority.

5. The receiving Contractor is responsible for maintaining ongoing communication with the transition coordinator of the relinquishing Contractor and ensuring all appropriate documents (i.e., medical records if requested, treatment plans, etc.) are received in a timely manner or as specified by both Contractors.

D. Member Responsibilities During Annual Enrollment Choice

1. Members are encouraged to thoroughly review all AHCCCS and Acute Care Contractor annual enrollment choice material, call the prospective Acute Care Contractors, and ask questions prior to making a decision.

   Members must maintain eligibility to stay enrolled with AHCCCS. If a Title XIX member loses eligibility after making an annual enrollment choice and regains eligibility prior to the 90-day reenrollment period, the member's annual enrollment choice will be honored. If the member regains eligibility after the 90-day re-enrollment period, he/she will lose their annual enrollment choice. If a Title XIX member regains eligibility after the 90-day period and did not make a pre-enrollment choice, he/she will be auto-assigned to an available Acute Care Contractor. If a Title XXI member loses eligibility after making an annual enrollment choice and regains eligibility within the 90-day period the annual enrollment choice will not be honored. The member must make another enrollment choice.

2. Members who change Acute Care Contractors during their annual enrollment choice will not receive services from their new Acute Care Contractor (receiving Acute Care Contractor) until the first day of the month in which their anniversary date occurs. Members will continue to receive their medical care from their current AHCCCS Acute Care Contractor (relinquishing Acute Care Contractor) through the end of the month previous to the anniversary date. If the member does not make a choice before the last day of the month the member will not receive services from their new Acute Care Contractor (receiving Acute Care Contractor) until the first day of the month following their anniversary month. Members will continue to receive their medical care from their current AHCCCS Acute Care Contractor (relinquishing Acute Care Contractor) through the end of the month of the anniversary date.

3. Members who elect to change their Acute Care Contractor during their annual enrollment choice must notify AHCCCS of their choice. If members are satisfied with their current Acute Care Contractor and do not wish to change, no action on the part of the member is required unless their Acute Care Contractor is no longer available in the member's GSA. Members will receive instruction on how to change Acute Care Contractors or remain with their current Acute Care Contractor in the annual enrollment choice packet.

E. Transition Plan

1. Contractors must submit a transition plan to AHCCCS within the time lines set by AHCCCS. The transition coordinators will be notified, in writing, of the date the transition plan is due to AHCCCS. The transition plan must be approved by AHCCCS prior to implementation. The scope of the transition plan must address the transition of new and existing members. Contractors should refer to the authority references listed on page 10 of this policy when developing their transition plans.

2. At a minimum, transition plans must address the following areas:

   a) Transition notification requirements as indicated in the AHCCCS Medical Policy Manual

   b) Timely notification to receiving Contractors of transitioning members no later that 10 business days from the date of the potential transition listing (for annual enrollment choice and open enrollment) or the daily roster (for all other Contractor changes)

   c) PCP assignment procedures

   d) Case management assignment for Contractors

   e) General communication and coordination of member transition activities

   f) Procedures for transfer of medical records and coordination of services between PCPs

   g) Procedures for recording the number of behavioral health and nursing facility services for transitioning members

F. Transition Coordinator

Contractors must identify a representative to serve as transition coordinator. The individual appointed to this position must be a health care professional who possesses the appropriate education and experience to effectively coordinate and oversee all transition issues, responsibilities, and activities. The role of the transition coordinator includes:

1. Coordinating plan change transition activities

2. Ensuring that transition activities are accomplished in accordance with AHCCCS and Contractor policies and procedures

3. Acting as an advocate for members leaving and joining the Contractor

4. Facilitating communication between Contractors and AHCCCS

5. Assisting PCPs, internal Contractor departments, and other contracted providers with the coordination of care for transitioning members

6. Ensuring that continuity and quality of care of transitioning members is maintained during Contractor transitions

7. Participating in AHCCCS Acute Care Contractor transition coordinator's planning meetings

8. Assisting AHCCCS Administration with developing transition policy, procedures, and standards

G. Potential Transition Listing

To assist with the identification of members who have made an annual enrollment choice and will be transitioning between Acute Care Contractors as a result of the annual enrollment choice, AHCCCS will provide Acute Care Contractors with a Potential Transition Listing. This listing will be transmitted to the Acute Care Contractor via the File Transfer Protocol (FTP) server approximately two weeks before the member's enrollment effective date.

The Potential Transition Listing will include the following member information:

1. AHCCCS ID Number

2. Name and address

3. Date of birth

4. Rate code

5. Relinquishing Acute Care Contractor

6. Receiving Acute Care Contractor

7. New PCP choice by name (if identified by the member at the time of annual enrollment choice)

IV. References

- Arizona Administrative Code R9-22, Articles 5 and 7
- Acute Care Contract, Section D
- ALTCS Contract, Section D
- AHCCCS Medical Policy Manual, Chapter 500

403 - ENROLLMENT CHOICE IN A CHOICE COUNTY AND CHANGE OF CONTRACTOR POLICY: ARIZONA LONG TERM CARE SYSTEM (ALTCS), ELDERLY/ PHYSICALLY DISABLED (EPD) CONTRACTORS

Effective Date: 10/01/00
Revision Date: 08/01/01

Staff responsible for policy: DHCM Operations

I. Purpose

This policy applies to ALTCS/EPD Contractors. This policy establishes guidelines, criteria and timeframes for how, when and by whom enrollment choice in a choice county and Contractor change requests will be processed for ALTCS members. This policy applies to Arizona Long Term Care (ALTCS) Contractors only (hereafter referred to as Contractors).

This policy delineates the rights, obligations and responsibilities of:

- The member
- The member's current Contractor
- The receiving Contractor, and
- The AHCCCS Administration,

in facilitating continuity of care, quality of care and efficient and effective program operations and in responding to administrative issues regarding member notification and errors in assignment.

II. Definitions

ALTCS Local Office: The ALTCS local office currently responsible for the member's financial eligibility case record.

Anniversary Date: The month for which the member is entitled to make an annual enrollment choice. The anniversary date is 12 months from the date enrolled with the Contractor and annually thereafter.

Choice County or Geographic Service Area (GSA): A county or GSA with more than one ALTCS Contractor.

County of Fiscal Responsibility: The county that is financially responsible for the State's share of ALTCS funding.

Current Contractor: The Contractor with whom the member is enrolled at the time the change request is generated.

Day: Day means a calendar day unless otherwise specified.

Receiving Contractor: The Contractor to whom the member is being changed.

Requested Contractor: The Contractor to whom the member wants to change.

III. Policy

Some, but not all, ALTCS applicants and members who reside in a choice county or who are planning to move to a choice county must be offered an opportunity to choose a Contractor.

A. Enrollment Choice in a Choice County

1. Individual Entitled to Enrollment Choice

An individual is entitled to enrollment choice when:

a. An applicant resides in a choice county and a choice county is the county of fiscal responsibility.

b. A member moves from another county to his or her own home in a choice county, unless the member's current Contractor is available in the choice county.

c. A member moves from another county to a nursing facility or alternative residential setting in a choice county and the current Contractor has chosen to negotiate an enrollment change.

d. A member is currently enrolled with a Contractor serving a choice county, but a valid condition exists (see Section B) for requesting an enrollment change to another Contractor serving a choice county.

e. A former member resides in a choice county and reestablishes eligibility that results in reenrollment more than 90 days after disenrollment.

f. A member attains the annual anniversary date.

2. Individual Who Does Not Have Enrollment Choice

This policy does not apply to the following individuals:

a. A member who is developmentally disabled

b. A member who is a Native American with on-reservation status

c. A choice county resident whose county of fiscal responsibility is not a choice county (unless the current Contractor chooses to negotiate a change to that choice county)

d. A member who was disenrolled from a Contractor in a choice county, but subsequently reestablishes ALTCS eligibility that results in reenrollment within 90 days from disenrollment.

e. Residents of counties other than a choice county, unless a choice county is the county of fiscal responsibility.

f. A member who moves to a choice county and his or her current Contractor is available in that choice county.

3. Initial Enrollment Process

The initial enrollment process is used to obtain enrollment choice from an ALTCS/EPD applicant whose county of fiscal responsibility is a choice county.

Stage	Description
1	ALTCS staff provides the applicant with: • An explanation of enrollment choice • Marketing materials from the Contractors serving the choice county. • Assistance in choosing a Contractor
2	ALTCS Staff obtains an enrollment choice before the application is approved.
3	Ongoing enrollment is prospective, effective the date the application is approved. Prior period coverage is effective retroactive to the first day of the first eligible month, unless the member is being transferred from an acute Contractor to an ALTCS Contractor.

4. Re-enrollment After Disenrollment

When a member, whose county of fiscal responsibility is a choice county, is disenrolled due to loss of ALTCS eligibility, but is subsequently determined eligible within 90 days from the date of disenrollment, the member will be reenrolled with the former Contractor, if that Contractor is still available. If that Contractor is not available, the member will be given the opportunity to choose a Contractor.

When reenrollment occurs more than 90 days after the disenrollment, or another valid reason for change exists, the member will be given the opportunity to choose a Contractor.

When a member is reenrolled within 90 days, the anniversary date is determined by the previous enrollment date. The member may choose to enroll with a different Contractor on his/her anniversary date, which is established by the initial enrollment with that Contractor.

5. Enrollment Choice Process For Fiscal County Changes

An enrollment choice must be obtained before a member's enrollment can be changed to a Contractor serving a choice county. The enrollment choice process applies to an ALTCS member who moves to a choice county to:

a. His or her own home

b. A nursing facility or alternative residential setting and the current Contractor requests an enrollment choice in order to negotiate an enrollment change with a Contractor in a choice county.

The enrollment choice process consists of the following steps:

Step	Action
1	The ALTCS local office provides the member with: • an explanation of enrollment choice • marketing materials from each of the Contractors serving a choice county The member is asked to provide a choice prior to actually moving or within 10 days of our request.
2	The ALTCS local office provides the member with assistance in making the decision throughout the process.
3	When the member does not make a choice within 10 days, the ALTCS local office sends an Enrollment Choice Reminder Notice asking the member to provide a choice within the next 10 days.

B. Identifying & Processing Requests for Contractor Changes Within a Choice County

Generally, once enrollment occurs a member cannot change enrollment until their anniversary date. This is called Annual Enrollment. However, an enrollment change from one choice county Contractor to another choice county Contractor can be made for certain reasons.

1. Medical Continuity of Care Requests

In unusual situations, special Contractor changes may be approved on a case-by-case basis to ensure the member's access to care. These situations generally involve existing conditions at the time of enrollment as opposed to new conditions that develop after enrollment.

The following special process is required:

Step	Action
1	The member's PCP must provide documentation to the Medical Directors of both Contractors that support the need for a Contractor change. Both Contractors must be reasonable in the request for documentation.
2	The Medical Directors of both Contractors must approve the change. • In order to provide continuity of care on a temporary basis for the member's period of illness, the current Contractor may agree to reimburse the member's provider for service rather than approve a Contractor change. • If one of the Contractors denies the request, the change request is forwarded to the AHCCCS Medical Director for a final decision.
3	When both Contractors approve the change the receiving Contractor sends the completed Program Contractor Change Request Form (DE-621) to the Program Contractor Change Request Coordinator at AHCCCS Central Office Field Operations. When the requested Contractor denies the request, the DE-621 is returned to the current Contractor who may forward the DE-621 to the AHCCCS Medical Director.

Step	Action
4	If the AHCCCS Medical Director approves the change, the DE-621 is returned to the current Contractor to negotiate the effective date of the change. The current Contractor sends the DE-621 to the Program Contractor Change Request Coordinator at AHCCCS Central Office Field Operations.
5	The Program Contractor Change Request Coordinator processes the change.
6	If the change request is denied by the AHCCCS Medical Director, the Division of Health Care Management/ALTCS Unit will provide written notice of the denial including notice of appeal rights to the member and to both the current and receiving/requested Contractors.

2. Valid Conditions (Excluding Medical Continuity of Care)

When any of the following conditions exist, an ALTCS local office may authorize a change of Contractors within a choice county.

a. Erroneous network information or agency error: The applicant or representative made an enrollment choice based on erroneous information regarding facility, residential setting, PCP or other provider contracting with the chosen Contractor based on information supplied by the network database, marketing materials, or agency error. Erroneous information includes omissions or failure to divulge network limitations and restrictions in the Contractor's marketing material or database submissions.

b. Lack of initial enrollment choice: An ALTCS applicant residing in a choice county is, for any reason, not offered a choice of Contractors during the application process.

c. Lack of annual enrollment choice: The member was entitled to participate in an Annual Enrollment Choice but was not sent an Annual Enrollment Choice notice or the notice was not received, or was sent an Annual Enrollment Choice notice but was unable to participate in the Annual Enrollment Choice due to circumstances beyond the member's control (i.e., member or representative was hospitalized, anniversary date fell within a 90 day disenroll/reenroll period).

d. Family continuity of care: The member, either through auto-assignment or the choice process, is not enrolled with the same Contractor as the other family members. To promote continuity of care, family members, such as married couples, may choose to be enrolled with the same Contractor.

e. Continuity of institutional or residential setting: The member's Contractor terminates their contract with the institutional or residential setting in which the member resides, and the member or the member's representative requests to change to a Contractor who contracts with their institutional or residential setting. The member must be enrolled and living in the facility at the time of the contract termination.

f. If the provider (nursing facility or alternative residential setting) terminates the contract, the Local Office will request instructions from the Division of Health Care Management/ALTCS Unit before making any changes.

g. Failure to correctly apply the 90-day reenrollment policy: The member lost ALTCS eligiblity and was disenrolled, was subsequently reapproved for ALTCS within 90 days of the disenrollment date, but was enrolled with a different Contractor.

3. Processing Enrollment Change Requests

The following procedures apply when a member requests a change of Contractors within a choice county

When…	Then…
The member makes the request for a change to the Contractor and claims a valid condition exists (see pages 7 and 9).	The Contractor will report the request to the Local ALTCS Office using the ALTCS Member Change Report Form (DE-701).
The ALTCS local office receives a change request from a Contractor or a member	The ALTCS local office will investigate the request to determine if a valid condition exists.
The ALTCS local office determines that a valid change condition exists	The ALTCS local office will change the member's enrollment to the Contractor the member chooses. The enrollment change is effective the day the change is processed by the ALTCS local office.
The ALTCS local offices determines that the nursing facility or alternative residential setting terminated the contract	The ALTCS local office will send written request to the DHCM ALTCS Unit Manager and may change the enrollment only if approved in the response.

When…	Then…
The ALTCS local office determines that a valid situation does not exist	The ALTCS local office will: • Send the member a Denial of Program Contractor Change Request (DE-548) denying the request and giving the member the right to appeal the decision. • Refer the member to his or her current Contractor for resolution of existing issues.

C. Fiscal County and Enrollment Change Policies

1. Placements by a Contractor

When a Contractor places a member in a nursing facility or alternative residential setting in a different county (either to receive specialized treatment or because of lack of beds in the Contractor's county), the county of fiscal responsibility and enrollment do not change.

2. Moves initiated by the member or the member's family

When a member moves from one county to another county, the county of fiscal responsibility and enrollment are determined according to the following policies:

If the member moves to…	Then…
His or her own home	<u>County of Fiscal Responsibility</u> • The county of fiscal responsibility changes to the (new county) county in which the home is located. <u>Enrollment</u> • Enrollment remains unchanged if the same Contractor serves both counties • Enrollment changes if the member moves to a county served by a different Contractor. • The Enrollment Choice process must be completed prior to enrollment and fiscal county changes if the home is located in a choice county and the current Contractor is not available in that choice county.

If the member moves to…	Then…
A nursing facility or an alternative residential setting	• The county of fiscal responsibility and enrollment will remain unchanged unless the current Contractor successfully negotiates a change with a Contractor serving the new county. • The Enrollment Choice process must be completed prior to the negotiation process when the member moves to a choice county.

3. Uncoordinated Moves by the Member

The Contractor is responsible for explaining the service limitations and exclusions to members who move out of the Contractor's service area.

The current Contractor is liable only for those services authorized by an ALTCS member's case manager.

D. Member Moves to Own Home in Another County

When a member resides in his or her own home the following policies apply:

- The county of fiscal responsibility is the county where the member's or child's parents home is located.
- Enrollment is with a Contractor serving the geographic service area (or fiscal county) where the home is located.
- When the member moves to his or her own home in a choice county, and is not already enrolled with a Contractor serving that choice county, the member must be given an opportunity to choose a Contractor. The member will be enrolled with the Contractor selected through the enrollment choice process.
- The enrollment change and the change in county of fiscal responsibility cannot occur until the enrollment choice process is completed.

1. Member's Responsibilities

The member is responsible for reporting the move or anticipated move to the current Contractor and the ALTCS local office.

2. Contractor Responsibilities

The current Contractor is responsible for:

a. Notifying the ALTCS local office that the member moved by sending a Member Change Report (DE-701),

b. Explaining service limitations and exclusions to a member who moves out of the Contractor's service area, and

c. Transitioning the member to the new Contractor, which includes forwarding medical records and other materials to the receiving Contractor.

3. ALTCS Local Office Responsibilities

The ALTCS local office is responsible for:

a. Completing the enrollment choice process for members changing to a choice county,

b. Changing the member's living arrangement (if appropriate) and address when the move occurs,

c. Making necessary changes in the county of fiscal responsibility and enrollment, and

d. Making changes to eligibility and share of cost arising from the change in the member's living arrangement.

4. Enrollment Change Procedures

The ALTCS local office will complete the following steps:

Step	Action
1	Determine if the county of fiscal responsibility and enrollment need to be changed. (The county of fiscal responsibility and enrollment may already be correct.) • If a change is required, proceed to Step 2. • If no change is needed, update the address and living arrangement, and share of cost, if necessary.

Step	Action
2	Complete the Enrollment Choice Process if enrollment needs to be changed to a Contractor serving a choice county. When the member is unable or unwilling to make a choice the current ALTCS local office will either select a Contractor for the member or permit auto assignment to a Contractor by PMMIS in accordance with the criteria in the Eligibility Policy Manual.
3	Process fiscal county and enrollment changes.
4	Determine if the eligibility case record should be transferred according to the criteria in Eligibility Policy Manual.

E. Member Moves to a Nursing Facility or Alternative Residential Setting in Another County

When the current Contractor provides services to the county where the member is moving, the enrollment and county of fiscal responsibility do not change.

When the current Contractor chooses to contract with the nursing facility or alternative residential setting, the enrollment and county of fiscal responsibility do not change.

When the current Contractor requests an enrollment change, the approval of both the current and the requested/receiving Contractor is required.

When the member moves to a choice county, the enrollment choice process must be completed before the current Contractor can initiate negotiations with a requested Contractor.

When the receiving/requested Contractor does not agree to the change, the current Contractor may request a decision from the AHCCCS Medical Director.

1. Member's Responsibilities

The member is responsible for reporting the move or anticipated move to the current Contractor and the ALTCS local office.

2. Current Contractor Responsibilities

a. When the current Contractor is notified that a member has moved to another county or plans to move to another county, and the member resides or plans to reside in a nursing facility or alternative residential setting, and the current Contractor does not serve the other county, the current Contractor has the following options:

- Retain the member and contract with an out of county provider,
- Negotiate an enrollment change, or
- Pay facility expenses for a limited number of days while plans are being made to move the member to a contracted facility. If the member refuses to move to a contracted facility, follow the non-user procedures in the AHCCCS Eligibility Policy Manual.

b. When enrollment change is the preferred option, the current Contractor is responsible for:

- Calling the ALTCS local office and requesting an enrollment choice when the move is to a choice county
- Completing a Program Contractor Change Request (DE-621) and sending it to the Contractor serving the GSA or the requested choice county Contractor, and
- Transitioning the member when a change is approved.

3. ALTCS Local Office Responsibilities

a. General Responsibilities

The ALTCS local office is responsible for:

- Assuring that the current Contractor is aware of the move or the member's plan to move, by contacting the current Contractor and advising the member to contact the current Contractor
- Informing the member that the current Contractor:
  - Must be involved in the placement change
  - Is only liable for services authorized by the case manager
- Changing the member's address when the move is verified, and
- Determining whether to retain or transfer the eligibility case file based on the case file transfer policy in the Eligibility Policy Manual.

b. Enrollment Choice for Transfers to a Choice County

When enrollment choice is requested by the current Contractor, the ALTCS local office is also responsible for:

- Informing the member about enrollment choice
- Providing marketing materials to the member
- Providing assistance to the member as necessary, and
- Obtaining an enrollment choice from the member and notifying the current Contractor.

4. Requested Contractor's Responsibilities

When a Program Contractor Change Request (DE-621) is received the requested Contractor is responsible for:

a. Approving or denying the change request by completing the DE-621, and

b. Transitioning the member when the change request is approved or the AHCCCS Medical Director directs the change.

5. AHCCCS Medical Director's Responsibilities

The AHCCCS Medical Director determines whether an enrollment change is appropriate when the receiving/requested Contractor denies the enrollment change and the current Contractor requests review by the AHCCCS Medical Director.

If approved, a written decision is issued to the current Contractor. If denied, a written notice of the denial including notice of appeal rights is issued to the current Contractor, the receiving/requested Contractor and the member.

6. AHCCCS Central Office Field Operations Responsibilities

The AHCCCS Central Office Field Operations is responsible for:

a. Processing enrollment and county of fiscal responsibility changes, and

b. Sending the ALTCS local office a copy of the DE-621.

F. Enrollment Change Process

The following steps are involved in the enrollment change process:

Step	Action
1	The member moves or indicates a desire or plan to move to a nursing facility or alternative residential setting in another county.
2	When advised of the move the ALTCS office: • notifies the current Contractor, • advises the member to contact the current Contractor, and • warns the member about limitations on services received from out-of-network providers.
3	When the move has been verified, the ALTCS local office changes only the member's address/living arrangement, not the county of fiscal responsibility.
4	When the move is to a choice county: • The current Contractor asks the ALTCS local office to complete the Enrollment Choice Process. • The ALTCS local office obtains an enrollment choice and informs the current Contractor.
5	The current Contractor completes a Program Contractor Change Request (DE-621) and sends it to the Contractor serving the new county of residence. In a choice county this will be the requested Contractor. If the Contractor serving the new county of residence denies the request, the current Contractor may forward to the AHCCCS Medical Director for a final decision.
6	When the Contractors or the AHCCCS Medical Director approves a change, the Program Contractor Change Request Coordinator at AHCCCS Central Office processes the enrollment and county of fiscal responsibility changes and notifies the ALTCS local office. The current Contractor will forward medical records and other materials to the receiving Contractor.

Step	Action
7	If the change request is denied by the AHCCCS Medical Director, the Division of Health Care Management/ALTCS Unit will provide written notice of the denial including notice of appeal rights to the member and to both the current and receiving/requested Contractors. When the change is denied, the current Contractor continues to provide services to the member.
8	The ALTCS local office determines if the eligibility case record should be transferred according to the criteria in Eligibility Policy Manual.

G. The Contractor's Responsibilities

1. Provide Contractor change policy

Contractors are responsible for providing information on the Contractor change policy in:

a. The Member Handbook for new and existing members, and

b. The Provider Manual for providers

2. Address members' concerns

The current Contractor is responsible for promptly addressing members' concerns regarding availability and accessibility of services and quality of medical care. These issues include but are not limited to:

a. Quality of care

b. Case management responsiveness

c. Transportation service availability

d. Institutional care issues

e. Physician or provider office hours

f. Office waiting time, and

g. Network limitations and restrictions.

3. Refer unresolved issues

When quality of care and delivery of medical service issues raised by the member cannot be solved through the normal case management process, the current Contractor must refer the issue for review by:

a. The current Contractor's Quality Management Department and/or

b. The AHCCCS Medical Director

4. Transitioning Between Contractors

The current Contractor is responsible for:

a. Reporting the member's address and living arrangement changes to AHCCCS

b. Encouraging members to report anticipated moves to another county or geographic service area to them (current Contractor) and to the ALTCS local office prior to moving. Advance notice will facilitate continuity of service delivery.

c. Advising members to contact the ALTCS local office to request an enrollment change between Contractors serving a choice county if a valid reason other than medical continuity of care is claimed.

d. Accepting a member's request for an enrollment change to another county. The request may be verbal or in writing and may be addressed to the member's case manager.

e. Forwarding medical records and other materials to the receiving Contractor

Both the current Contractor and the receiving Contractor are responsible for assuring a safe transition for the member when an enrollment change occurs. The Contractors will transition within the requirements and protocols in the AHCCCS Medical Policy Manual, Chapter 500.

5. Process Members' Enrollment Change Requests

The Contractor will process enrollment change requests from members as follows:

When the member requests a Contractor change	Then the current Contractor
Within a choice county and the member claims a valid condition exists	Refers the issue to the ALTCS local office for review using the ALTCS Member Change Report (DE-701).
That requires the approval of both the current and the receiving Contractors	Notifies the ALTCS local office if the member lives in a choice county or is moving to a choice county to initiate the Enrollment Choice Process. Negotiates the change with the requested Contractor. Completes a DE-621 and forwards it to the requested Contractor. Notifies the member if the change is approved. May forward the DE-621 to the AHCCCS Medical Director if the requested Contractor denies the change. Notifies the member in writing if the enrollment change is denied at the Contractor level. The denial notice must include • the AHCCCS Program Contractor Grievance Policy, and • timeframes for filing a grievance.

6. Notify hospitals of certain enrollment changes

When an enrollment change occurs while the member is hospitalized, the current Contractor must notify the hospital of the member's disenrollment prior to the enrollment with the receiving Contractor.

If the current Contractor fails to provide such notice to the hospital, the current Contractor will continue to be responsible for payment of hospital services provided to the member until the date notice is provided to the hospital as required in the AHCCCS Medical Policy Manual, Chapter 500.

7. Process Grievances

When an enrollment change requested by the member is denied by the Contractor (not the AHCCCS Medical Director), the current Contractor is responsible for processing any resulting grievances.

H. AHCCCS Administration's Responsibilities

1. Enrollment change requests received from members

Except for valid changes within a choice county or a change due to the member moving to his or her own home, the AHCCCS Administration or the ALTCS local office will refer a member's request for an enrollment change to the current Contractor.

2. Process enrollment change requests

The AHCCCSA will process enrollment change requests within 5 days after the request is received, or all conditions for processing an enrollment change have been met, whichever is later.

3. Issue decisions

The AHCCCSA will notify Contractors of enrollment change approvals via the daily recipient roster. AHCCCSA will mail a new AHCCCS ID card to the member.

AHCCCSA will send notification to both the current and receiving Contractors and the member when an enrollment change is denied by the AHCCCS Medical Director. When approved by the AHCCCS Medical Director, notification will be sent to the current Contractor.

4. Process Grievances

When an enrollment change is denied by the AHCCCS Medical Director, AHCCCSA is responsible for processing all resulting member grievance.

The Division of Health Care Management, ALTCS Unit sends the member a denial notice, which explains the Grievance System under 9 A.A.C. 34.

5. Monitor policy compliance

The AHCCCS Division of Health Care Management (DHCM) will monitor Contractor compliance with this policy. Any violations of this policy, especially attempts to deny care or steer high cost or difficult members to another Contractor, will be considered contract violations and will be subject to sanctions up to and including contract termination.

IV. References

- Arizona Administrative Code R9-28, Article 7
- ALTCS Contract, Section D
- AHCCCS Medical Policy Manual Chapter 500

404 – MEMBER INFORMATION POLICY

Original Date: 11/17/97
Effective Date: 06/01/2012
Revision Date: 06/09/09, 01/28/10, 08/12/10, 08/11/11, 05/18/2012

Staff responsible for policy: DHCM Operations

I. Purpose

This policy applies to Acute, Children's Rehabilitative Services (CRS), Behavioral Health Services (BHS), and Arizona Long Term Care System (ALTCS) Contractors (including the Division of Developmental Disabilities). This policy establishes guidelines for AHCCCS Contractors (and those who have been awarded contracts) regarding member information requirements and the approval process for member information materials developed by or used by the Contractor. This policy pertains to oral communication to members and written materials, including outreach materials that are disseminated to a Contractor's own members. It also pertains to the content of a Contractor's website. It does NOT pertain to marketing outreach or incentive materials, which are disseminated to potential members, as described in Policy 101, AHCCCS Marketing, Outreach and Incentives, in chapter 100 of this manual, unless the materials meet the description in III.A.2 below. The exception is the written and oral information specifically mentioned in this policy.

All member information materials developed by the Contractor that may also be disseminated to non-members must also meet the requirements of ACOM 101 and shall specify: "Contract services are funded in part under contract with the State of Arizona."

II. Definitions

Member/Recipient information materials: 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.

III. Policy

A. Oral Information

1. The Contractor must make oral interpretation services available to its members free of charge. Services for all non-English languages and the hearing impaired must be available.

2. The Contractor must make oral interpretation services available to potential members, free of charge, when oral information is requested for use in choosing among Contractors. Services for all non-English languages and the hearing impaired must be available.

B. Printed Information

1. Materials Requiring Approval by the Administration

All member/recipient information materials developed by the Contractor and disseminated to its own members must be submitted to the AHCCCS Administration for approval, prior to dissemination, unless otherwise specified in Contract. This includes member material that is located on the Contractor's website, e-mail messages and voice recorded phone messages delivered to a member's phone. Once member materials are approved by the Administration, the Contractor must ensure that the information contained within the material item is updated regularly and appropriately based on such changes as benefit, contractual, policy or other relevant updates. .

2. Materials Not Requiring Approval by the Administration

Customized letters for individual members need not be submitted for approval. Health related brochures developed by a nationally recognized organization (see Attachment A) do not require submission to the AHCCCS Administration for approval. Attachment A is not an all inclusive list. Contractors may submit names of other organizations to AHCCCS to determine if they should be added to the list. Contractors will receive an updated copy of this Attachment, as necessary.

The Contractor will be held accountable for the content of materials developed by the organizations listed in Attachment A. AHCCCS suggests that the Contractor review the materials to ensure that: 1) the services are covered under the AHCCCS program; 2) the information is accurate; and 3) the information is culturally sensitive.

It is important to note that in all instances where the Contractor is required by its contract with AHCCCS to educate its members, brochures developed by outside entities must be supplemented with informational materials developed by the Contractor which are customized for the Medicaid population.

3. Reading Level and Language Requirements

All materials shall be translated when the Contractor is aware that a language is spoken by 3,000 or 10% (whichever is less) of the Contractor's members who also have limited English proficiency (LEP) in that language.

All vital materials shall be translated when the Contractor is aware that a language is spoken by 1,000 or 5% (whichever is less) of the Contractor's members who also have LEP in that language. Vital materials must include, at a minimum, 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 and request for hearing information as described in the "Enrollee Grievance System Standards" section of the applicable Contract.

All written notices informing members of their right to interpretation and translation services in a language, shall be translated when the Contractor is aware that 1,000 or 5% (whichever is less) of the Contractor's members speak that language and have LEP.

The Contractor is not required to submit to the AHCCCS Administration the member material translated into a language other than English, however, it is the Contractor's sole responsibility to ensure the translation is accurate and culturally appropriate.

The Contractor shall make every effort to ensure that all information prepared for distribution is written in an easily understood language and format. The reading level and methodology used to measure it should be included with the submission.

The materials shall be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.

4. Review of Materials

All proposed Contractor member materials will be reviewed by the Division of Health Care Management. Information shall be submitted via electronic mail (unless the material is not available in an electronic format). Proposed materials shall be submitted to:

Acute, ALTCS, CRS, BHS & DDD Contractor Materials

Operations Compliance Officer (or her/his designee)
AHCCCS, Division of Health Care Management
701 E. Jefferson, Mail Drop 6100
Phoenix, AZ 85034

Unless otherwise indicated, proposed materials must be submitted 30 days before the intended publication date. AHCCCS will notify the Contractor in writing within fifteen (15) working days of receipt of the complete materials packet whether or not the materials have been approved, denied or require modification.

5. New Member Information

All Contractor(s) shall produce and provide the following information to each member/representative or household within twelve (12) business days of receipt of notification of the enrollment date. Acute Care Contractors have the option of providing the Member Handbook and Network Description/Provider Directory with the new member packet, or providing written notification that the information is available on the Contractor's website, by electronic mail or by postal mailing. Should the Acute Contractor elect to provide notification that the information available using the latter approach, refer to the requirements listed under subsections A and B.

ALTCS Contractors must continue to provide a printed copy of the Member Handbook and Network Description/Provider Directory. ALTCS Case Managers must also review the Handbook with the member annually.

A. Member Handbook

The Acute, ALTCS, DDD, BHS, and CRS member handbooks shall contain the information provided in Attachment C.

Acute Contractors who elect to provide notification that the information is available on their website, by electronic mail or by postal mailing must submit the request along with a comprehensive list of all changes to the Member Handbook to AHCCCS for review and approval a minimum of sixty (60) days in advance of the effective date of the changes. The Contractor must also ensure that:

1) The Handbook is available electronically and may be printed from the Contractor's website, if the enrollee elects to do so;

2) The enrollee is provided the option of obtaining a printed version of the Handbook upon request;

3) Enrollees receive written notice of changes, considered to be significant by AHCCCS (see 42 C.F.R. §438.10), at least thirty (30) days in advance of the intended effective date and annually thereafter. Examples include but are not limited to:

- Contractor service hours and availability
- Changes to the Provider network
- Benefit changes

B. Network Description/Provider Directory

Acute/ ALTCS/ DDD Network Description

The description shall, at a minimum, contain information about primary care providers, specialists, hospitals and pharmacies. ALTCS Program Contractors shall also include skilled nursing facilities and alternative residential settings. The description will include:

1) Provider name

2) Provider address

3) Provider telephone number

4) Non-English languages spoken

5) Whether or not the provider is accepting new patients

The information will also include any restrictions on the member's freedom of choice among network providers. This information must be current and can be in the same form as typical correspondence to members.

Acute Care Contractors who elect to provide notification that the information is available for the Network Description/Provider Directory information on their website, by electronic mail or by postal mailing must follow the same submission requirements as delineated for the Member Handbook under subsection A.

CRS Network Description

The description shall, at a minimum, contain information about CRS providers, specialists, hospitals and pharmacies. The description will include:

1) Specialty Provider and Clinic names

2) Specialty Clinic address

3) Specialty Clinic telephone number

4) Clinic Provider telephone number

5) Non-English languages spoken by clinic providers

6) Whether or not the specialty provider is accepting new patients

The information will also include any restrictions or an explanation of the recipient's freedom of choice among clinic providers. The materials can be in the same form as typical correspondence to members.

BHS Network Description

ADHS shall provide a description of the provider network ensuring the following information is provided to all behavioral health recipients:

1) Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the behavioral health recipient's service area, including identification of providers that are not accepting new referrals.

2) The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post stabilization services covered under the contract.

3) The fact that the behavioral health recipient has a right to use any hospital or other setting for emergency care.

4) The names and locations of the pharmacies to be used for filling prescriptions for psychotropic medications.

6. Website Content
Acute, CRS, DDD, and ALTCS

The Contractor must include the following member related information on its website. All of the information must be located on the Contractor's website in a manner that members can easily find and navigate (e.g. "Consumer Page" from the Contractor's home page).

A. A current member handbook.
B. The current and past three member newsletters.
C. AHCCCS member and provider survey results via link to AHCCCS website.
D. Performance measure results via link to AHCCCS website.
E. Contractor member and provider survey results, as available.
F. Formulary, which must be updated within 30 days of a change being made. The following shall be available in a user friendly format:
   - A medication formulary listing by the Brand name and/or Generic name of the medication, including notations for all medications that require a prior authorization.
   - A medication formulary listing by drug class.
   - A specific (individual) drug look-up capability.
G. Tobacco Cessation Information, as described in the member handbook. A link to the Tobacco Education and Prevention Program (TEPP) website should be included.

H. A user friendly, searchable provider directory. The directory must include the following search functions and be updated at least monthly, if necessary:
   - Name
   - Specialty/Service
   - Languages spoken by Practitioner
   - Office Locations (e.g. county, city or zip code)

I. Information on community resources that is applicable to the Contractor's population and geographic service area. Examples of acute care resources are WIC, Head Start and AzEIP. ALTCS resources may include Area Agency on Aging and the Alzheimer's Association. The following links should be provided: www.MyAHCCCS.com and www.azlinks.gov.

J. Services for which prior authorization is required and prior authorization criteria.

K. Best practice guidelines.

In addition, any information that is not listed above, that is directly related to members or potential members must be prior approved by the Division of Heath Care Management.

The Contractor will submit annually and within forty-five (45) days after the beginning of the Contract Year, the Contractor's Annual Website Certification form (see Attachment B) verifying that all required information is available and current on the Contractor's website.

The Division of Health Care Management will review the content of the Contractor's website to ensure the Contractor is in compliance with this policy and the AHCCCS contract.

BHS and its subcontractors must have a website with links to the following information:

a. Formulary

b. Provider manual

c. Member handbook

d. Provider listing

ADHS must ensure that its subcontractors' websites have a fully operational claims inquiry function.

IV. References

- Title 42 of the Code of Federal Regulations (42 CFR) Part 438
- Arizona Administrative Code R9-22, Article 5
- Acute Care Contract, Section D
- APIPA/CRS Contract, Attachment J
- ALTCS Contract, Section D
- ADHS/DBHS Contract, Section D
- DDD Contract, Section D

Attachment A

NATIONAL ORGANIZATIONS RECOGNIZED BY AHCCCS

Ambulatory Pediatric Association
American Academy of Allergy, Asthma, and Immunology
American Academy of Child and Adolescent Psychiatry
American Academy of Ophthalmology
American Academy of Pediatrics
American Association of Cancer Education
American Association of Psychiatric Services for Children
American Association of Public Health Physicians
American Cancer Society, Inc.
American College of Allergy & Immunology
American College of Cardiology
American College of Emergency Physicians
American College Health Association
American College Medical Quality
American College of Nutrition
American College Obstetricians and Gynecologists
American College of Physicians
American College of Preventative Medicine
American Dental Association
American Diabetes Association
American Dietetic Association
American Gynecological and Obstetrical Society
American Heart Association
American Hospital Association
American Institute of Ultrasound in Medicine
American In Vitro Allergy/Immunology Society
American Lung Association
American Medical Association
American Medical Directors Association
American Medical Women's Association
American Pediatric Society
American Public Health Association
American Red Cross
American Society for Adolescent Psychiatry
American Society of Anesthesiologists
American for Clinical Nutrition
American Society for Reproductive Medicine
American Venereal Disease Association
Arizona Department of Health Services

Bright Futures
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys
Centers for Disease Control and Prevention
Channing Bete Company
Health Wise
La Leche League USA
March of Dimes
Maricopa County Department of Health Services
National Perinatal Association
Pima County Department of Health Services
Produce for Better Health Foundation
Susan G. Komen for the Cure
United States Department of Agriculture
U.S. Department of Health & Human Services
U.S. State Health Departments World Medical Association

CONTRACTOR ANNUAL WEBSITE CERTIFICATION **Attachment B**

Contractor:_____ Date Submitted:_____

#	Requirement	URL of Page Where Information Is Found	Contractor Notes/Comments	AHCCCS Comments
MEMBER INFORMATION – ACOM 404, Member Information Policy				
	A Program member specific link from the Contractor's home page			
A	**A current member handbook**			
B	**Current and past 3 member newsletters**			
C-1	**AHCCCS member survey results via link to AHCCCS website**			
C-2	**AHCCCS Provider survey results via link to AHCCCS website**			
D	**Performance measure results via link to AHCCCS member website.**			
E-1	**Contractor member survey results, as available.**			
E-2	**Contractor provider survey results, as available.**			

#	Requirement	URL of Page Where Information Is Found	Contractor Notes/Comments	AHCCCS Comments
MEMBER INFORMATION – ACOM 404, Member Information Policy continued				
F	**Formulary, which must be updated within 30 days of a change being made. The following shall be available in a user friendly format:** • **A medication formulary listing by the Brand name and/or Generic name of the medication, including notations for all medications that require a prior Authorization.** • **A medication formulary listing by drug class** • **A specific (individual) drug look-up capability**			
G	**Tobacco Cessation Information, as described in the member handbook. A link to the Tobacco Education and Prevention Program (TEPP) website should be included**			
H	**A user friendly, searchable provider directory (including specialists for referrals). The directory must include the following search functions and be updated at least monthly, if necessary:** • **Name** • **Specialty/Service** • **Languages spoken by Practitioner** **Office Locations (e.g. county, city or**			

#	Requirement	URL of Page Where Information Is Found	Contractor Notes/Comments	AHCCCS Comments
MEMBER INFORMATION – ACOM 404, Member Information Policy continued				
I	**Information on community resources that is applicable to the Contractor's population and geographic service area. Examples of acute care resources are WIC, Head Start, AzEIP. ALTCS resources may include Area Agency on Aging, Alzheimer's Association. The following links should be provided:** ❑ **www.MyAHCCCS.com** ❑ **www.azlinks.gov**			
J	**Services for which prior authorization is required and prior authorization criteria.**			
K	**Best Practice Guideline**			

Additional Member Information that Has been Approved by AHCCCS

#	Additional Member Information	URL of Page Where Information Is Found	Contractor Notes/Comments	AHCCCS Comments

#	Requirement	URL of Page Where Information Is Found	Contractor Notes/Comments	AHCCCS Comments
PROVIDER INFORMATION – ACOM 416, PROVIDER NETWORK INFORMATION POLICY				
A	**Formulary (both Searchable and Comprehensive Listings**			
B	**Provider Manual**			
C	**Provider Directory (including specialists for referral)**			
D-1	**Performance measure results -Contractor Specific**			
D-2	**Performance measure results via link to AHCCCS member website (AHCCCS Program)**			
E	**Medical Determination Criteria and Practice Guidelines**			
F	**Contractor provider survey results, as available.**			
The following functionality is available to providers (Indicate compliance by typing "Yes" under Contractor notes/comments column)				
A	**Enrollment Verification**			
B	**Claims Inquiry (adjustments requests; information on denial reasons)**			
C	**Accept HIPAA compliant electronical claims transactions**			
D	**Display Reimbursement Information**			

❑ **Explain (describe) what actions have been taken to determine that members who access your website can easily find and navigate the required member website content.**

Contact Person:_____ Phone #: _____ E-mail Address:_____

Approved By:_____ Title:_____ Phone #:_____

ATTACHMENT C: MEMBER HANDBOOK REQUIREMENTS

Member Handbook Requirements	ACUTE	ALTCS-DDD	CRS	BHS
Table of Contents	X	X	X	X
A general description about how managed care works, particularly in regards to member responsibilities, appropriate utilization of services and the PCP's roll as gatekeeper of services.	X	X	X	
A description of all available covered services and an explanation of any service limitations or exclusions from coverage. The description should include a brief explanation of the Contractor's approval and denial process.	X	X	X	X
How to obtain and change a PCP	X	X		
The handbook revision date	X	X	X	X
How to make , change and cancel appointments with a PCP/Provider	X	X		X
How to make, change and cancel appointments with a CRS Clinic Provider/Provider			X	
List of applicable co-payments, what to do if a member is billed, and under what circumstances a member may be billed for non-covered services.	X	X	X	X
Dual eligibility (Medicare and Medicaid) services received in and out of the Contractor's network and coinsurance and deductibles. See Section D, "Medicare Services and Cost Sharing" in the Contract	X	X	X	X
The process of referral and self-referral to specialists and other providers, including access to behavioral health services.	X	X	X	
How to file a compliant with the contractor. This must include the member's right to file a complaint to the Contractor regarding the adequacy of Contractor's Notice of Action letters. Further, it must include the member's right to contact AHCCCS if the Contractor does not resolve the member's concern of adequacy with the Notice	X	X	X	X

Member Handbook Requirements	ACUTE	ALTCS-DDD	CRS	BHS
of Action letter.				
What to do in case of an emergency and instructions for receiving advice on getting care in case of an emergency. In a life-threatening situation, the member handbook should instruct members to use the emergency medical services (EMS) available and /or activate EMS by dialing 9-1-1. The handbook should contain information on proper emergency service utilization. It must also state that a member has a right to obtain emergency services at any hospital or other emergency room facility (in or out of network).	X	X	X	X
How to obtain emergency transportation and medically necessary transportation.	X	X	X	X
The handbook must state the following verbatim: Early Periodic Screening, Diagnostic and Treatment (EPSDT) is a comprehensive child health program of prevention and treatment, correction, and improvement (amelioration) 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 USC 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	X	X		

Member Handbook Requirements	ACUTE	ALTCS-DDD	CRS	BHS
not apply to EPSDT services. A well child visit is synonymous with an EPSDT visit and includes all screenings and services described in the AHCCCS EPSDT and dental periodicity schedules. <u>Amount, Duration and Scope:</u> The Medicaid Act defines EPSDT services to include screening services, vision services, dental services, hearing services and "such other necessary health care, diagnostic services, treatment and other measures described in federal law subsection 42 USC 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the (AHCCCS) state plan." This means that EPSDT covered services include services that correct or ameliorate physical and mental defects, conditions, and illnesses discovered by the screening process when those services fall within one of the 28 optional and mandatory categories of "medical assistance" as defined in the Medicaid Act. Services covered under EPSDT include all 28 categories of services in the federal law even when they are not listed as covered services in the AHCCCS state plan, AHCCCS statutes, rules, or policies as long as the services are medically necessary and cost effective. 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				

Member Handbook Requirements	ACUTE	ALTCS-DDD	CRS	BHS
services that are solely for cosmetic purposes, or that are not cost effective when compared to other interventions.				
Maternity and family planning services. This must include information on the importance of making, keeping, and the availability of postpartum services, and an explanation regarding choosing a Primary Care Obstetrician. The ability to change Contractors for Continuity of Care reasons should be included (This is not applicable if there is only one Contractor in a GSA).	X	X		
Description of all covered behavioral health services and how to access these services.	X	X		X
Out of Country/ out of state/ out of geographic service area moves.	X	X		X
All grievance and request for hearing information included in the Contractor's Enrollee Grievance System Policy as described in the "Grievance System" section of the Contract	X	X	X	X
Contributions the member can make towards his/her own health, member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the Contractor. This shall include a statement that the member is responsible for protecting his or her ID card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the member's eligibility and /or legal action. A sentence shall be included that stresses the importance of members keeping, not discarding, the ID card.	X	X	X	X
Advance Directives	X	X	X	X
Use of other sources of insurance. See Section D, "Coordination of Benefits/Third Party Liability" in the contract	X	X	X	X
A description of fraud and abuse, including instructions on how to report suspected fraud or abuse.	X	X	X	X
A statement that informs the member of their right to request	X	X	X	X

Member Handbook Requirements	ACUTE	ALTCS-DDD	CRS	BHS
information on whether or not the Contractor has physician incentive plans (PIP) that affect the use of referral services, the right to know the types of compensation arrangements the Contractor uses, the right to know whether stop-loss insurance is required and the right to a summary of member survey results, in accordance with PIP regulation.				
The right to be treated fairly regardless of race, religion, gender, age, ability to pay.	X	X	X	X
Instructions for obtaining culturally competent materials and/or services, including translated member materials.	X	X	X	X
The availability of printed materials in alternative formats and how to access such materials.	X	X	X	X
The availability interpretation services for oral information at no cost to the member and how to obtain these services.	X	X	X	X
Information regarding prenatal HIV testing counseling services.	X	X	X	
The right to know about providers who speak languages other than English.	X	X	X	X
How to obtain, at no charge, a directory of providers.	X	X	X	
The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand the information.	X	X	X	X
Female members, under the age of 21, may have direct access to preventative and routine services from gynecology providers within the Contractor's network without a referral from a primary care provider.	X	X		
The right to a second opinion from a qualified health care professional within the network, or have a second opinion arranged outside the network, only if there is not adequate in-network coverage, at no cost to the enrollee.	X	X	X	X

Member Handbook Requirements	ACUTE	ALTCS-DDD	CRS	BHS
The right to request a copy of his/her medical record and /or inspect medical records at no cost.	X	X	X	X
The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.	X	X	X	X
The right to participate in decisions regarding his or her health care, including the right to refuse treatment.	X	X	X	X
Tobacco Cessation information. This should include, but is not limited to, information regarding the availability/accessibility of community support groups, information regarding the Arizona Smokers Helpline, and how members can seek tobacco cessation treatment, care and services.	X	X		
Information on community resources that is applicable to the Contractor's population and geographic service area. Examples of acute care resources are WIC, Head Start and AzEIP. ALTCS resources may include Area Agency on Aging and the Alzheimer's Association. The following link must be provided: www.MyAHCCCS.com	X	X	X	
Information on what to do when family size or other demographic information change.	X			
How to contact Member Services and a description of its function.	X		X	X
Description of all covered dental services and how to access these services, including the process form making dental appointments.	X			
How to access after hours care (urgent care).	X	X		X
How to change Contractors.	X	X		
Information on where no cost/ low cost family planning benefit and primary care coverage for members losing AHCCCS/Family Planning Services eligibility are available.	X			

ALTCS				
How to contact the case manager		X		
Member's share of cost		X		
Explanation of the Transition Program and services available.		X		
Detailed descriptions of all current residential placement options.		X		
Explanation of when Program Contractor changes may occur.		X		
CRS				
How to contact the CRS Contractor			X	
A description of CRS/Parent Advisory Council			X	
Advocacy Information			X	
A description of each clinic's specialties.			X	
Information to facilitate family members as decision-makers in the treatment planning process.			X	
Information regarding the unique needs of children with CRS Conditions and the CRS program for public/private health care insurers, health care insurers, health care providers, and students, regional and national health organizations, community groups and organizations and public health and school personnel.			X	
DBHS				
Confidentiality and confidentiality limitations.				X
Information that coordination of care with schools and state agencies may occur, within the limits of applicable regulations. [42 CFR 438.10(e)(2)(i)(c)]				X

Statement of the Arizona Vision and information regarding the J.K. Principles				X
A statement that TXIX and Title XXI covered services are funded under contract with AHCCCS				X
Member's right to request information on the structure and operation of ADHS or subcontractors [42 CFR 438.10 (g)(3)(i)]				X

405 - CULTURAL COMPETENCY AND FAMILY/PATIENT CENTERED CARE

Original Date: 03/02/00
Effective Date: 03/02/00
Revision Date: 11/16/10, 01/01/11

Staff responsible for policy: DHCM Operations

I. Purpose

This policy applies to Acute Care, Arizona Long Term Care System (ALTCS), and CRS Contractors. This policy describes the requirement that Contractors offer accessible and high quality services in a culturally competent manner.

II. Definitions

CLAS Standards: The collective set of culturally and linguistically appropriate services (CLAS) mandates, guidelines, and recommendations issued by the United States Department of Health and Human Services Office of Minority Health intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services.

Competent: Properly or well qualified and capable.

Cultural competency: An awareness and appreciation of customs, values, and beliefs and the ability to incorporate them into the assessment, treatment and interaction with any individual.

Culture: The integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. Culture defines the preferred ways for meeting needs, and may be influenced by factors such as geographic location, lifestyle and age.

Limited English proficiency (LEP): Not being able to speak, read, or write or understand the English language at a level that permits one to interact effectively with health care providers or the Contractor.

Member: A person eligible for AHCCCS, who is enrolled with a Contractor.

Provider: A person or entity who is registered with AHCCCS and/or subcontracts with an AHCCCS Contractor to provide AHCCCS covered services to members.

Subcontractor:

1. A person, agency or organization to which a Contractor has contracted or delegated some of its management functions or responsibilities to provide covered services to its members; or

2. A person, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or leased of real property) to obtain space, supplies, equipment or services provided under the AHCCCS agreement.

III. Policy

A. Cultural Competency Plan

Each Contractor must have a comprehensive cultural competency program, which is described in a written plan. The Cultural Competency Plan (CCP) must describe how care and services will be delivered in a culturally competent manner.

The Contractor must identify a staff member responsible for the CCP. If there is a change in the staff member responsible for the CCP, the Contractor must notify the Division of Health Care Management (DHCM).

The CCP must contain a description of:

1. Education and Training

a. The training program consists of the methods the Contractor will use to train its staff so that services are provided effectively to members of all cultures. Training must be customized to fit the needs of staff based on the nature of the contacts they have with providers and/or members.

b. The education program consists of methods the Contractor will use for providers and other subcontractors with direct member contact. The education program will be designed to make providers and subcontractors aware of the importance of providing services in a culturally competent manner. The contactor must also make additional efforts to train or assist providers and subcontractors in receiving training in how to provide culturally competent services.

2. Culturally Competent Services and Translation/Interpretation Services

The Contractor describes the method for evaluating the cultural diversity of its membership to assess needs and priorities in order to provide culturally competent care to its membership. Culturally competent care requires that the Contractor evaluate its network, outreach services and other programs to improve accessibility and quality of care for its membership. It must also describe the provision and coordination needed for linguistic and disability-related services. The availability and accessibility of translation services should not be predicated upon the non-availability of a friend or family member who is bilingual. Members may elect to use a friend or relative for this purpose, but they should not be encouraged to substitute a friend or relative for a translation service. A Contractor, at the point of contact, must make members aware that translation services are available. The services that are offered must be provided by someone who is proficient and skilled in translating language(s).

The Contractor must provide translations in the following manner:

a. All materials shall be translated when the Contractor is aware that a language is spoken by 3,000 or 10% (whichever is less) of the Contractor's members who also have limited English proficiency (LEP) in that language.

b. All vital materials shall be translated when the Contractor is aware that a language is spoken by 1,000 or 5% (whichever is less) of the Contractor's members who also have LEP in that language. Vital materials must include, at a minimum, notices for denial, reduction, suspension or termination of services, vital information from the member handbook and consent forms.

c. All written notices informing members of their right to interpretation and translation services in a language shall be translated when the Contractor is aware that 1,000 or 5% (whichever is less) of the Contractor's members speak that language and have LEP.

B. Evaluation and Assessment of CCP

The Contractor must evaluate the CCP for effectiveness. Evaluations are to be made on an annual basis and a copy of the evaluation sent to DHCM. The evaluation may, for example, focus on comparative member satisfaction surveys, outcomes for certain cultural groups, member complaints, grievances, provider feedback and/or Contractor employee surveys. If issues are identified, they should be tracked and trended, and actions should be taken to resolve the issue(s).

C. CRS Family Centered and Culturally Competent Care

The CRS Contractor will provide family-centered care in all aspects of the service delivery system. The responsibilities of the CRS Contractors in support of family-centered care include:

1. Recognizing the family as the primary source of support for the recipients' health care decision-making process. Service systems and personnel should be made available to support the family's role as decision makers.
2. Facilitating collaboration among recipients, families, health care providers, and policymakers at all levels for the:
    a. Care of the member;
    b. Development, implementation, and evaluation of programs; and
    c. Policy development.
3. Promoting a complete exchange of unbiased information between recipients, families, and health care professionals in a supportive manner at all times.
4. Recognizing cultural, racial, ethnic, geographic, social, spiritual, and economic diversity and individuality within and across all families.

5. Implementing practices and policies that support the needs of recipients and families, including medical, developmental, educational, emotional, cultural, environmental, and financial needs.
6. Participating in Family-Centered Cultural Competence Trainings.
7. Facilitating family-to-family support and networking.
8. Promoting available, accessible, and comprehensive community, home, and hospital support systems to meet diverse, unique needs of the family.
9. Acknowledging that families are essential to the members' health and wellbeing and are crucial allies for quality within the service delivery system.
10. Appreciate and recognize the unique nature of each recipient and their family.

Culturally and Linguistically Appropriate Services CLAS

The CRS Contractor is expected to incorporate CLAS standards into its care model at all levels.

IV. References

- Balanced Budget Act of 1997 (BBA)
- BBA Regulations: Title 42 of the Code of Federal Regulations (42 C.F.R.) 438.306(e), 63 Fed. at 52021
- Title VI of the Civil Rights Act: Title 42 of the United States Code (42 U.S.C.) 2000d (see 45 C.F.R. 80, app. A (1994)
- Americans with Disabilities Act: 42 U.S.C., Chapter 126
- National Standards of Culturally and Linguistically Appropriate Health Care, Volume 65 of the Federal Register (65 Fed. Reg.) 80865-80897 (December 22, 2000)
- Title VI Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency, 68 Fed. Reg. 47311, (August 8, 2003)

V. Web Addresses

http://erc.msh.org - Under Quick Links choose "Providers Guide to Quality and Culture"
www.ahrqpub@ahrq.gov - Choose "Minority Health
www.ahrq.gov/about/cods/cultcomp.htm - Oral, Linguistic, and Culturally Competent Services Guides for Managed Care Plans
www.ahrq.gov/consumer/espanoix.htm - Has information in both Spanish and English
www.diversityrx.org/BEST/ - Diversity Rx
www.hrsa.gov/OMH/ - Office of Minority Health
www.georgetown.edu/research/gucdc/nccc/nccc8.html - National Center for Cultural Competence
www.ahrq.gov/data/hcup/factbk3/factbk3.htm - Agency for Healthcare Research and Quality
www.lep.gov - Federal Governmental Web Address
www.usdoj.gov/crt/cor - Choose LEP Page
www.cms.gov/healthplans/quality/project03.asp - Centers for Medicare and Medicaid Services
www.languageline.com - Translation Service
www.cyracom.net - Translation Service
www.xculture.org - Cross Cultural Health Care Program (CCHCP)
www.omhrc.gov/cultural - Center for Linguistics and Cultural Competence in Health Care (CLCCHC)
www.mentalhealth.org/publications/allpubs/Ca-0015/default.asp - Substance Abuse and Mental Health Services Administration (Children's Issues)
www.ama-assn.org/ama/pub/category/4849.html - Links to Cultural Competency Issues
www.cdcnpin.org/scripts/population/culture.asp - Centers for Disease Control
http://cecp.air.org/cultural/Q_howdifferent.htm - Center for Effective Collaboration and Practice
www.ems-c.org/cfusion/culture.cfm - Emergency Medical Services for Children (good resource page)

406 – RESERVED

407 - MEMBER NOTICE FOR NON-COVERED SERVICES

Effective Date: 10/01/03
Revision Date:

Staff responsible for policy: DHCM Operations

I. Purpose

This policy applies to Acute Care and Arizona Long Term Care System (ALTCS) Contractors. This policy applies to Acute Care and ALTCS members whenever payment is denied for services not covered under the State Plan.

II. Definitions

Not applicable

III. Policy

Notice of action shall be sent to the member whenever payment is denied for services not covered under the State Plan. These services are detailed in the Arizona Administrative Code as noted below.

For the Acute Care and long term care programs, Title XIX non-covered services found in the following citations apply:

- R9-22-201 (B)(10), (11)
- R9-22-205 (B)(2), (3), (4)(a), (b), (e)
- R9-22-207 (D)(1)
- R9-22-212 (E)(7), (8)
- R9-22-215(C)(3), (4)
- R9-22-215(C)(1)--[Acute Care only]

For the Acute Care (Title XXI) program, non-covered services found in the following citations apply:

- R9-31-201 (D)(8), (9)
- R9-31-205(C)(2), (3)(a)(b)(d)(f)

The member notice shall meet the standards as described in contract under the enrollee grievance standards and policies.

IV. References

- Title 42 of the Code of Federal Regulations (42 CFR) 438.404(c)(2)

408 - SANCTIONS POLICY

Effective Date: 10/01/03
Revision Date:

Staff responsible for policy: DHCM Administration

I. Purpose

This policy specifies the sanctions which may be imposed by the AHCCCS Division of Health Care Management (DHCM) in accordance with federal and state laws, regulations and the AHCCCS contract. This policy applies to all AHCCCS Contractors who are either Managed Care Organizations (MCO) or Prepaid Inpatient Health Plans (PIHP).

II. Definitions

Act: The Social Security Act.

Acute Care Contractor: A contracted managed care organization that provides acute care medical services to AHCCCS members who are Title XIX or Title XXI eligible, and who do not qualify for another AHCCCS program. Behavioral health services are carved out and provided through the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS).

Arizona Department of Health Services, Division of Behavioral Health (ADHS/BHS): A Prepaid Inpatient Health Plan mandated to provide behavioral health services to Title XIX acute care and Title XXI members who are eligible for behavioral health services. Services are provided through the ADHS Division of Behavioral Health and its Contractors, the Regional Behavioral Health Authorities.

Arizona Long Term Care System (ALTCS) Contractor: A contracted managed care organization, that provides long term care, acute care, behavioral health, and case management services to Title XIX eligible elderly, physically or developmentally disabled individuals who are determined to be at risk of an institutional level of care.

Balanced Budget Act of 1997 (BBA): The federal law mandating, in part, that States ensure the delivery of quality health care by their managed care Contractors. CMS finalized the BBA Medicaid regulations which implement the corresponding provisions of the BBA June 14, 2002. Included in these regulations is 42 CFR 438.700 et seq. regarding sanctions.

Children's Rehabilitative Services (CRS): A Prepaid Inpatient Health Plan administered by the Arizona Department of Health Services. CRS provides 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.

Contractor: For the purpose of this policy, Contractor means, a Managed Care Organization providing health care services to acute or long term care members and / or a Prepaid Inpatient Health Plan providing behavioral health services to eligible acute care members and/or CRS related services to eligible acute or long term care members.

III. Policy

A. General

AHCCCSA may impose sanctions, including, but not limited to, temporary management of the Contractor, monetary penalties, suspension of enrollment, withholding of payments, suspension, refusal to renew, or termination of the contract or any related subcontracts in accordance with applicable Federal and States laws and regulations, and the AHCCCS contract. Prior to the imposition of a sanction, AHCCCSA may provide a written cure notice to the Contractor regarding the details of the non-compliance. The cure notice will specify the period of time during which the Contractor must bring its performance back into compliance with contract requirements. If, at the end of the specified time period, the Contractor has complied with the cure notice requirements, AHCCCSA will take no further action. If, however, the Contractor has not complied with the cure notice requirements, AHCCCSA will proceed with the imposition of sanctions.

Written notice will be provided to the Contractor specifying the sanction to be imposed, the grounds for such sanction and either the length of suspension or the amount of capitation prepayment to be withheld, when applicable. The Contractor may appeal the decision to impose a sanction in accordance with Arizona Administrative Code (A.A.C.) R9-34-401 et seq.

B. Basis for Imposition of Sanctions

AHCCCSA may impose sanctions for any of the following:

1. Substantial failure to provide medically necessary services that the Contractor is required to provide under law or the terms of its contract to its enrolled members

2. Discrimination among enrollees on the basis of their health status or need for health care services

3. Misrepresentation or falsification of information furnished to CMS or AHCCCSA

4. Misrepresentation or falsification of information furnished to an enrollee, potential enrollee, or provider

5. Imposition of premiums or charges in excess of the 1115 Waiver

6. Failure to comply with the requirements for physician incentive plan

7. Distribution directly, or indirectly through any agent or independent Contractor, of marketing or outreach materials that have not been approved by AHCCCSA or that contain false or materially misleading information

8. Failure to meet AHCCCS Financial Viability Standards

9. Material deficiencies in the Contractor's provider network

10. Failure to meet quality of care and quality management requirements

11. Failure to meet AHCCCS encounter standards

12. Failure to fund accumulated deficit in a timely manner

13. Failure to increase the Performance Bond in a timely manner

14. Failure to comply with any provisions contained in the contract, and/or

15. Failure to comply with applicable State or Federal laws or regulations.

C. Types of Sanctions

AHCCCSA may impose the following types of intermediate sanctions:

1. Monetary penalties The amount of the monetary penalty may vary depending on the nature of the Contractor's action or failure to act. Examples are as follows:

a. The maximum of $25,000 may be imposed per occurrence for the following actions:

1) Substantial failure to provide medically necessary services that the Contractor is required to provide under the terms of this contract to its enrolled members

2) Misrepresentation or falsification of information furnished to an enrollee, potential enrollee, or provider

3) Failure to comply with physician incentive plan requirements, and

4) Distribution directly, or indirectly through any agent or independent Contractor, of marketing or outreach materials that have not been approved by AHCCCSA or that contain false or materially misleading information.

b. The maximum of $100,000 may be imposed per occurrence for the following types of actions:

1) Discrimination among enrollees on the basis of their health status or need for health care services, and

2) Misrepresentation or falsification of information furnished to CMS or AHCCCSA.

2. Temporary Management Appointment of temporary management for a Contractor may be optional or required.

a. Optional Imposition. Optional imposition of temporary management may occur when AHCCCSA determines that:

1) There is continued egregious behavior by the Contractor, including but not limited to the bases described in III(B) or behavior which is contrary to any requirements in Sections 1903 (m) and 1932 of the Social Security Act

2) Substantial risk to enrollees' health due to non-compliance of the Contractor

3) Temporary management is necessary to insure the health of its members while:

a) The Contractor corrects the non-compliance in III.C.2.a.1), or

b) The Contractor reorganizes, or

c) AHCCCSA completes termination of the contract, or

4) The Contractor has violated a term of its contract, and temporary management is authorized by contract.

b. Required Imposition. Required imposition of temporary management will occur when AHCCCSA determines that a Contractor has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Social Security Act or 42 CFR 438.700 et seq. AHCCCSA will:

1) Allow the Contractor's members the option to disenroll from the Contractor without cause, and

2) Notify the affected members of their right to disenrollment.

c. Hearing. For temporary management imposed pursuant to the BBA provisions, AHCCCSA may not delay the imposition of temporary management to provide a hearing before imposing the sanction. For temporary management imposed pursuant to State Law, AHCCCS will provide an opportunity for hearing prior to imposing this sanction unless public health, safety, or welfare requires emergency action .

d. Duration. AHCCCSA will not terminate the temporary management until it determines that the Contractor can ensure that the sanctioned behavior will not recur.

3. Member enrollment related sanctions AHCCCSA may sanction a Contractor by:

a. Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll

b. Suspending all new enrollment, including auto-assignments, after the effective date of the sanction, and

c. Suspending payment for members enrolled after the effective date of the sanction until CMS or AHCCCSA is satisfied that the reason for the sanction no longer exists and is not likely to recur.

4. Additional sanctions AHCCCSA may impose additional sanctions as provided under State Laws, regulations, or contract to address areas of non-compliance.

D. General Notification of Sanction to Contractor

Written Notification. AHCCCSA will notify the Contractor by certified letter of the specific basis for the sanction and applicable sanction as follows:

1. If the Contactor continues non-compliance, the notification will include the type and amount (if applicable) of the sanction.

2. If the sanction involves a monetary penalty, the notification will state the amount which will be deducted from the Contractor's next monthly capitation payment.

3. The notification will include timelines for the imposition of the sanction.

4. If the sanction involves termination, the notification will include the information in E.2. below.

E. Termination of the Contract

1. Cause for termination. AHCCCSA retains the right to terminate a contract when a Contractor fails to:

   a. Carry out the substantive terms of its contract, or

   b. Meet applicable requirements in Sections 1932, 1903(m**),** or 1905(t) of the Social Security Act.

2. Termination of contract. AHCCCSA will:

   a. Send the Contractor the pre-termination notice by certified mail. The notice will specify AHCCCSA's intent to terminate the contract, the reason for termination, and the time and place of the pre-termination hearing.

   b. After the hearing, AHCCCSA will give the Contractor written notice of the decision affirming or reversing the proposed termination of the contract. If the decision affirms the proposed termination, the effective date of the termination will be provided.

   c. In cases where termination is upheld as a result of the hearing, AHCCCSA will notify the affected members of the Contractor's termination and provide them with information regarding available Contractors in their Geographic Service Area.

F. Notification to CMS

For sanctions imposed or lifted pursuant to the BBA (42 CFR 438.700 et seq.), AHCCCSA will provide CMS with written notice:

1. Whenever it imposes or lifts a sanction for any of the sanctionable items listed in III.B. The notice will specify the Contractor, the type of sanction, and the reason for the imposition or lifting of the sanction; and

2. The notice will be given no later than 30 days after it imposes or lifts a sanction.

IV. References

- Balanced Budget Act of 1997
- Title 42 of the United States Code (42 USC) 1396b(m) [Section 1903 (m) of the Social Security Act]
- 42 USC 1396 u-2 (e) [Section 1932(e) of the Social Security Act]
- Title 42 of the Code of Federal Regulations (42 CFR) 438.700 et seq.
- Arizona Revised Statutes (A.R.S.) 36-2903M
- AAC. R-9-22, Article 6
- AAC R9-34-401 et seq.
- AHCCCS Contract

409 – Intra-Agency Care Coordination for Services

Original Date: 04/01/05
Effective Date: 04/01/05
Revision Date: 05/01/06; 03/01/10; 6/01/10, 1/1/11

Staff responsible for policy: DHCM Administration

I. Purpose

This policy applies to all Acute Care Contractors, Arizona Long Term Care System (ALTCS) Contractors, and the CRS Contractor. This policy provides guidance to the Contractors about the procedures to follow when a request for service potentially covered by another Medicaid (AHCCCS) payer is received by a Contractor who is not responsible for the service. This includes the care coordination responsibilities between Acute Care / ALTCS Contractors and CRS.

II. Definitions

Continuity of Care: The coordination of care received by a patient over time and across multiple healthcare providers.

Contractor: Acute Care Contractors, ALTCS Contractors, and/or the CRS Contractor.

CRS: CRS refers to the AHCCCS CRS subcontractor.

CRS Coverage Criteria: For a service to be considered covered by CRS, the service must be medically necessary and related to the member's CRS condition.

Days: Means a calendar day unless otherwise specified.

Filed: Means the date that the Contractor or AHCCCS, whichever is applicable, receives the request as established by a date stamp on the request or other record of receipt.

Materials for Forwarding: Materials will include a cover letter with the original date the service request was received and a copy of the NOE if applicable.

Receipt Date: The date of receipt is the date the request is filed with the original AHCCCS Contractor.

Recipient Status Check: The process utilized by a Contractor to determine whether an AHCCCS enrolled member has been previously accepted into the CRS program for a condition which can be covered under Arizona Administrative Code (AAC) R9-7.

Recipient Status Review: The process, outlined in ACOM Policy 426, Eligibility Review for CRS Applicants and Referrals, utilized by CRS and/or its subcontractor to determine whether an applicant has a condition that can be covered under AAC R9-7.

Working Days: Shall be a "Working Day" as defined in AAC R9-34-202. Monday, Tuesday, Wednesday, Thursday, or Friday unless: a) a legal holiday falls on one of these days; or b) a legal holiday falls on Saturday or Sunday and a Contractor is closed for business the prior Friday or following Monday.

III. Policy

To ensure the AHCCCS member receives medically necessary covered services in a timely coordinated manner. When any Contractor refers a member to another Contractor for eligibility determination or for services, the sending Contractor shall assist or direct the member in making initial contact with the receiving Contractor.

A. Service requests received by an Acute/ALTCS Contractor from a provider for a potentially CRS covered service:

1. EXPEDITED REQUEST
   a. The Contractor will review the service request to determine if the service is an AHCCCS covered service.
      i. If confirmed, the Contractor will proceed to A.1.b.
      ii. If not confirmed, the Contractor will follow ACOM Policy 414 (within 3 Working Days of receipt date).
   b. The Contractor will determine whether the service requested is potentially covered by CRS.
      i. If confirmed, the Contractor will proceed to A.1.c.
      ii. If not confirmed, the Contractor will follow ACOM Policy 414 (within 3 Working Days of receipt date).
   c. The Contractor will perform a CRS recipient status check.
      i. If confirmed, the Contractor will prepare materials for forwarding to CRS (within 1 Working Day of receipt date).
      ii. If not confirmed, the Contractor will follow ACOM Policy 414 (within 3 Working Days of receipt date); and the Contractor will assist in the completion of an application for CRS. (CRS will process the application under the normal application review process.) The Contractor cannot deny the service for being CRS covered under Policy 414 in this circumstance.

2. STANDARD REQUEST
   a. The Contractor will review the service request to determine if the service is an AHCCCS covered service.
      i. If confirmed, the Contractor will proceed to A.2.b.
      ii. If not confirmed, the Contractor will follow ACOM Policy 414 (within 14 Days of receipt date).
   b. The Contractor will determine whether the service requested is potentially covered by CRS.
      i. If confirmed, the Contractor will proceed to A.2.c.
      ii. If not confirmed, the Contractor will follow ACOM Policy 414 (within 14 Days of receipt date).
   c. The Contractor will perform a CRS recipient status check.
      i. If confirmed, the Contractor will prepare materials for forwarding to CRS (within 3 Days of receipt date).
      ii. If not confirmed, the Contractor will assist in the completion of an application for CRS and prepare materials for forwarding to CRS (within 5 Days of receipt date if information is available to complete an application). If the Contractor does not have enough information for a complete application, it will follow ACOM 414 (within 14 Days of receipt date).

B. Service requests received by an Acute/ALTCS Contractor from CRS:

1. EXPEDITED REQUEST
   a. The Contractor will follow ACOM Policy 414 (within 3 Working Days of receipt date).
   b. In the event the Contractor disagrees with the CRS coverage determination, the Contractor will follow ACOM Policy 414, and the Contractor shall follow the process identified in Section III.G of this policy.

2. STANDARD REQUEST
   a. The Contractor will follow ACOM Policy 414 (within 14 Days of receipt date).
   b. In the event the Contractor disagrees with the CRS coverage determination, the Contractor will follow ACOM Policy 414, and the Contractor shall follow the process identified in Section III.G of this policy.

C. Service requests received by CRS from a provider for a potentially CRS covered service:

1. EXPEDITED REQUEST
   a. CRS will review the service request to determine if the service is an AHCCCS covered service.
      i. If confirmed, CRS will proceed to C.1.b.

ii. If not confirmed, CRS will prepare materials for forwarding to the Acute/ALTCS Contractor as an Expedited request (within 1 Working Day of receipt date).

b. CRS will determine whether the service requested is potentially covered by CRS.
   i. If confirmed, CRS will proceed to C.1.c.
   ii. If not confirmed, CRS will prepare materials for forwarding to the Acute/ALTCS Contractor as an Expedited request (within 1 Working Day of receipt date).

c. CRS will perform a CRS recipient status check.
   i. If confirmed, CRS will follow ACOM Policy 414 (within 3 Working Days of receipt date).
   ii. If not confirmed, CRS will prepare materials for forwarding to the Acute/ALTCS Contractor as an Expedited request (within 1 Working Day of receipt date).

2. STANDARD REQUEST

a. CRS will review the service request to determine if the service is an AHCCCS covered service.
   i. If confirmed, CRS will proceed to C.2.b.
   ii. If not confirmed, CRS will prepare materials for forwarding to the Acute/ALTCS Contractor (within 3 Days of receipt date).

b. CRS will determine whether the service requested is potentially covered by CRS.
   i. If confirmed, CRS will proceed to C.2.c.
   ii. If not confirmed, CRS will prepare materials for forwarding to the Acute/ALTCS Contractor (within 3 Days of receipt date).

c. CRS will perform a CRS recipient status check.
   i. If confirmed, CRS will follow ACOM Policy 414 (within 14 Days of receipt date).
   ii. If not confirmed CRS will perform a recipient status review.
      a) If enrolled as a recipient, CRS will proceed to C.2.d.
      b) If not enrolled as a recipient, CRS will prepare materials for forwarding to the Acute/ALTCS Contractor and issue a Notice of Extension (using a form letter developed by AHCCCS that indicates the name of the Acute/ALTCS Contractor performing the review [see Exhibit A]) to the member, provider and other AHCCCS Contractor (within 14 Days of receipt date).

d. CRS will perform a service coverage review.
   i. If service meets CRS coverage criteria, CRS will follow ACOM Policy 414 (within 14 Days of receipt).
   ii. If service does not meet CRS coverage criteria, CRS will prepare materials for forwarding to the Acute/ALTCS Contractor and issue a Notice of Extension (using a form letter developed by AHCCCS that

indicates the name of the Acute/ALTCS Contractor performing the review [see Exhibit A]) to the member, provider and other AHCCCS Contractor (within 14 Days of receipt date).

D. Service requests received by CRS from an Acute/ALTCS Contractor for a potentially CRS covered service for a CRS recipient:

1. EXPEDITED REQUEST
   a. CRS will determine whether the service requested is potentially covered by CRS.
      i. If confirmed, CRS will proceed to D.1.b.
      ii. If not confirmed, CRS will initiate CRS Medical Director to AHCCCS Contractor Medical Director Contact. (within 2 Working Days of receipt date).
   b. CRS will perform a coverage review.
      i. If service meets CRS coverage criteria, CRS will follow ACOM Policy 414.
      ii. If service does not meet CRS coverage criteria, CRS will prepare materials for forwarding to the Acute/ALTCS Contractor and issue a Notice of Extension (using a form letter developed by AHCCCS that indicates the name of the Acute/ALTCS Contractor performing the review [see Exhibit A]) to the member, provider and other AHCCCS Contractor (within 3 Working Days of receipt date).

2. STANDARD REQUEST
   a. CRS will determine whether the service requested is potentially covered by CRS.
      i. If confirmed, CRS will proceed to D.2.b.
      ii. If not confirmed, CRS will prepare materials for forwarding to the Acute/ALTCS Contractor and issue a Notice of Extension (using a form letter developed by AHCCCS that indicates the name of the Acute/ALTCS Contractor performing the review [see Exhibit A]) to the member, provider and other AHCCCS Contractor (within 14 Days of the receipt date).
   b. CRS will perform a coverage review.
      i. If service meets CRS coverage criteria, CRS will follow ACOM Policy 414 (within 14 Days of receipt date).
      ii. If service does not meet CRS coverage criteria, CRS will prepare materials for forwarding to the Acute/ALTCS Contractor and issue a Notice of Extension (using a form letter developed by AHCCCS that indicates the name of the Acute/ALTCS Contractor performing the review [see Exhibit A]) to the member, provider and other AHCCCS Contractor (within 14 Days of the receipt date).

E. Service requests received by CRS from an Acute/ALTCS Contractor for a potentially CRS covered service for a non CRS recipient:

1. EXPEDITED REQUEST
   a. CRS Medical Director to AHCCCS Contractor Medical Director contact reminding the Acute/ALTCS Contractor of its responsibility to act on these requests under A(1).

2. STANDARD REQUEST
   a. CRS will perform a CRS recipient status check.
      i. If confirmed, CRS will follow ACOM Policy 414 (within 14 Days of receipt date).
      ii. If not confirmed CRS will perform a recipient status review.
         a) If enrolled as a recipient, CRS will proceed to E.2.b.
         b) If not enrolled as a recipient, CRS will prepare materials for forwarding to the Acute/ALTCS Contractor and issue a Notice of Extension (using a form letter developed by AHCCCS that indicates the name of the Acute/ALTCS Contractor performing the review [see Exhibit A]) to the member, provider and other AHCCCS Contractor (within 14 Days of receipt date).
   b. CRS will perform a service coverage review.
      i. If service meets CRS coverage criteria, CRS will follow ACOM Policy 414 (within 14 Days of receipt).
      ii. If service does not meet CRS coverage criteria, CRS will prepare materials for forwarding to the Acute/ALTCS Contractor and issue a Notice of Extension (using a form letter developed by AHCCCS that indicates the name of the Acute/ALTCS Contractor performing the review [see Exhibit A]) to the member, provider and other AHCCCS Contractor (within 14 Days of receipt date).

F. Inpatient Care Coordination for ALTCS/Acute and CRS members and recipients:

1. For members who are also CRS recipients, CRS will be responsible for:
   a. Coverage and payment of all inpatient stays that are initiated by CRS and strictly related to the CRS condition being treated.
   b. Documenting the notification of the facility, the treating physician and the Acute/ALTCS Contractor if CRS determines that the inpatient stay no longer meets CRS coverage criteria and the date that CRS will no longer cover the inpatient stay.
   c. Providing care coordination in the concurrent review process with the Acute/ALTCS Contractor.

G. Request for Review Process (dispute):

1. If the Acute/ALTCS Contractor disagrees with a CRS coverage decision, the Contractor shall provide the medically necessary service and initiate a "Request for Review" to the CRS Contractor or designee. The following shall be the process for resolving the Request for Review:
   a. The Contractor shall submit the service request and all accompanying/relevant documentation to the CRS Chief Medical Officer or designee with a request for secondary review and determination if the coverage decision was appropriate; within 30 Days of the receipt of the CRS coverage decision.
   b. The CRS Chief Medical Officer or designee shall issue a written decision to the Contractor no later than ten (10) Working Days from the date of the receipt of the Request for Review.
   c. All CRS decisions shall advise the Contractor that the Contractor may file a request for review with the Office of Administrative Legal Services (OALS) at AHCCCS within thirty (30) Days of receipt of the CRS decision in the event that the Contractor continues to disagree with the CRS decision.
   d. If AHCCCS determines that the service should have been provided by CRS, the CRS Contractor shall be financially responsible for the costs incurred by the Contractor in providing the service.

IV. References

- 42 CFR §438.210
- 42 CFR Part 438 Subpart F, Grievance System
- AAC R9-7-201 et seq.
- AHCCCS Contracts

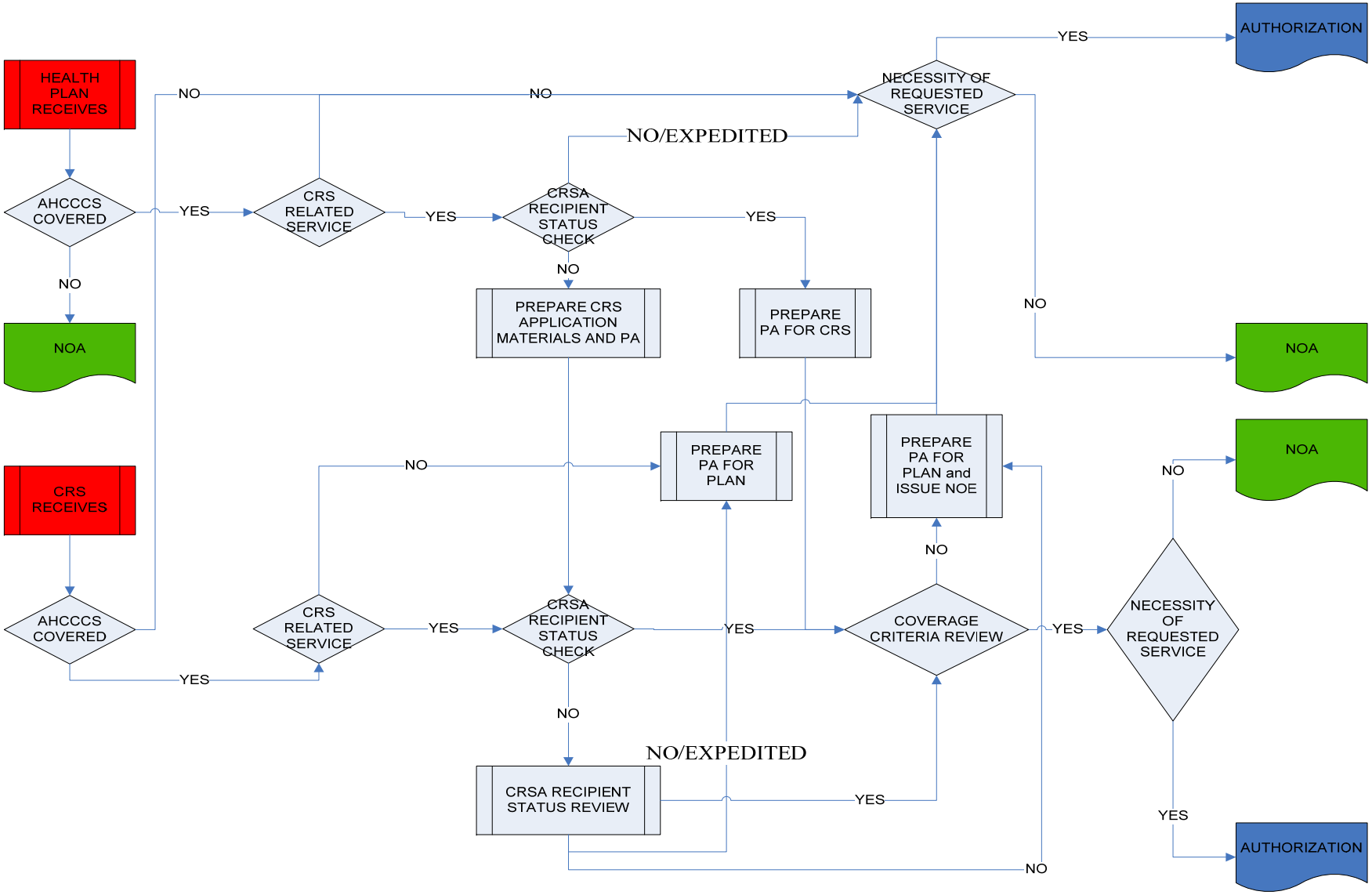

HEALTH PLAN RECEIVES
AHCCCS COVERED
NO
NOA
YES
CRS RELATED SERVICE
YES
CRSA RECIPIENT STATUS CHECK
NO
PREPARE CRS APPLICATION MATERIALS AND PA
YES
PREPARE PA FOR CRS
NO/EXPEDITED
NECESSITY OF REQUESTED SERVICE
YES
AUTHORIZATION
NO
NOA
CRS RECEIVES
AHCCCS COVERED
YES
CRS RELATED SERVICE
YES
CRSA RECIPIENT STATUS CHECK
NO
PREPARE PA FOR PLAN
NO
YES
PREPARE PA FOR PLAN and ISSUE NOE
NO
COVERAGE CRITERIA REVIEW
YES
NECESSITY OF REQUESTED SERVICE
NO
NOA
YES
AUTHORIZATION
NO/EXPEDITED
CRSA RECIPIENT STATUS REVIEW
YES
NO

Exhibit A ACOM Policy # 409, Revised / Approved 10/1/09

Insert CRSA Logo

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will help you. If this notice does not tell you what you asked for, what we decided and why, please call us at XXX-XXX-XXXX. This notice is available in other languages and formats if you need it.

Si usted no entienda esta carta o usted tiene alguna pregunta por favor de llamar al XXX-XXX-XXXX o (800) XXX-XXXX. Esta carta esta disponible en otras idiomas y formato si es que lo necesita.)

NOTICE OF EXTENSION

TO: Date

FROM:

(Your doctor OR name of provider- as appropriate) have asked that Children's Rehabilitative Services (CRS) pay for your child's (*describe services requested and the reason for the services in easily understood language*).

The information sent by your (*doctor OR name of provider- as appropriate)* shows that you would not be able to get services from Children's Rehabilitative Services (CRS) at this time for this problem. AHCCCS requires children with special health problems to get their services for that health problem from CRS. We are sending the request to your health plan, *(insert the name of the AHCCCS Contractor the request is being forwarded to)* so they can decide if they will pay for *(insert what the service request is)*.

(*Insert the name of the AHCCCS Contractor the request is being forwarded to)* may take fourteen (14) more days to make a decision. (*Insert the name of the AHCCCS Contractor the request is being forwarded to)* will make this decision by *(insert date the extension expires; this cannot exceed 14 days from the date of the extension letter and cannot exceed 28 days from the date of request. For example, if you issue/mail the Notice of Extension on Day 6 of the standard request timeframe, and you give fourteen (14) additional days, the decision must be made by the twentieth (20th) day of the request. The timeframe is counted from the date on the letter which represents the mail date).*

If *(Insert name of AHCCCS Contractor)* cannot make a decision because they need more medical information that they do not get from (*requesting provider)* then they will have to deny this request.

If you do not agree with us taking this extra time to make a decision you can file a grievance (complaint). You can do this by contacting *(insert grievance phone number and insert the address for grievances for CRS).*

Sincerely,

Children's Rehabilitative Services

410 – RESERVED

411 - PRE-PAID MEDICAL MANAGEMENT INFORMATION SYSTEMS (PMMIS) INTERFACE

Effective Date: 05/01/05; 05/01/2012
Revision Date: 05/01/2012

Staff responsible for policy: DHCM/ALTCS Unit/Case Management

I. Purpose

This policy applies to Arizona Long Term Care System (ALTCS) Contractors. This policy provides a tutorial on access to and data entry into the Client Assessment and Tracking System (CATS) sub-system of the AHCCCS mainframe computer system, Pre-Paid Medical Management Information Systems (PMMIS).

II. Overview/General Information

PMMIS is made up of several sub-systems, each with a distinct function. The sub-systems however are interrelated and share common data and many rules of processing.

ALTCS eligibility information is recorded in a separate system from PMMIS, called AHCCCS Customer Eligibility (ACE). ACE transmits eligibility and enrollment data to PMMIS via an interface.

ALTCS Program and Tribal contractors have primary access to the CATS sub-system in PMMIS for purposes of recording and storing case management related data about ALTCS members.

Contractors are required to either directly input data or transmit the information via electronic interface. Comments must be directly entered on the CATS comment screens; they can not be transmitted electronically. If the contractor does not do direct data input, they are not required to enter comments in CATS. Tribal contractors are required to do direct data input, including comments.

III. UserID and Security Access Requests

All individuals needing access to PMMIS must complete and submit the following 2 forms to AHCCCS in order to obtain a UserID#:

- User Access Request Form
- User Affirmation Statement

These forms are available on the AHCCCS website in the "AHCCCS Data Access Forms" section at: http://www.azahcccs.gov/commercial/ISD/DataAccessForms.aspx. The completed forms for ALTCS case management staff should be faxed to the AHCCCS Division of Health Care Management (DHCM) ALTCS Unit at (602) 417 – 4855.

AHCCCS will provide each approved user with a permanent 7 digit UserID and a temporary password following completion of these forms. The first time the user signs on, s/he will be prompted to change the password before continuing with the sign-on. Passwords must be 6-8 digits and contain a combination of alpha and numeric characters, ending with a number. Passwords must then be changed approximately every 30 days thereafter. Users are prompted when the password needs to be changed.

Even if ALTCS case managers will not be directly accessing PMMIS for data entry, they will need a 6-digit Case Manager ID# for use in assigning members to their caseloads. This process requires the case manager to be affiliated, in PMMIS, to an ALTCS Contractor. The instructions for Case Manager Affiliation can be found in Appendix A at the end of this policy.

IV. Signing-on/off

```
                        A D O A   D A T A   C E N T E R
                        INFORMATION  SERVICES  DIVISION
*************************************************************************
*                              WARNING NOTICE                           *
* THIS SYSTEM IS RESTRICTED SOLELY TO STATE OF ARIZONA AUTHORIZED USERS FOR *
* LEGITIMATE STATE BUSINESS PURPOSES ONLY.  STATE OF ARIZONA STRICTLY      *
* PROHIBITS THE ACTUAL OR ATTEMPTED UNAUTHORIZED ACCESS, USE OR MODIFICATION*
* OF THIS SYSTEM.  UNAUTHORIZED USAGE AND/OR USERS ARE SUBJECT TO          *
* DISCIPLINARY PROCEEDINGS AND/OR CRIMINAL AND CIVIL PENALTIES UNDER STATE, *
* FEDERAL, OR OTHER APPLICABLE DOMESTIC AND FOREIGN LAWS.  THE USE OF THIS  *
* SYSTEM MAY BE MONITORED AND RECORDED FOR ADMINISTRATIVE AND SECURITY      *
* REASONS.  ANYONE ACCESSING THIS SYSTEM EXPRESSLY CONSENTS TO SUCH        *
* MONITORING AND IS ADVISED THAT IF MONITORING REVEALS POSSIBLE EVIDENCE OF *
* CRIMINAL ACTIVITY, STATE OF ARIZONA MAY PROVIDE THE EVIDENCE OF SUCH      *
* ACTIVITY TO LAW ENFORCEMENT OFFICIALS.  ALL USERS MUST COMPLY WITH STATE  *
* OF ARIZONA SECURITY POLICIES REGARDING THE PROTECTION OF STATE OF ARIZONA *
* INFORMATION ASSETS.                                                      *
*************************************************************************
PLEASE ENTER APPLICATION REQUEST: cicsacp

               IP ADDRESS = 170.68.17.115   - IP PORT = 01839
               ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
                     DATE = 05/19/06 - TIME = 10:53:53
                     THE HELP DESK TEL. (602) 364-4444
```

On the ADOA Data Center screen shown above, the user must type "**cicsacp**" in the Application Request field and press <Enter>. The screen pictured below will then be displayed.

```
                              Signon to CICS                          APPLID
  CICSACPR

   WELCOME TO CICS/TS


   Type your userid and password, then press ENTER:

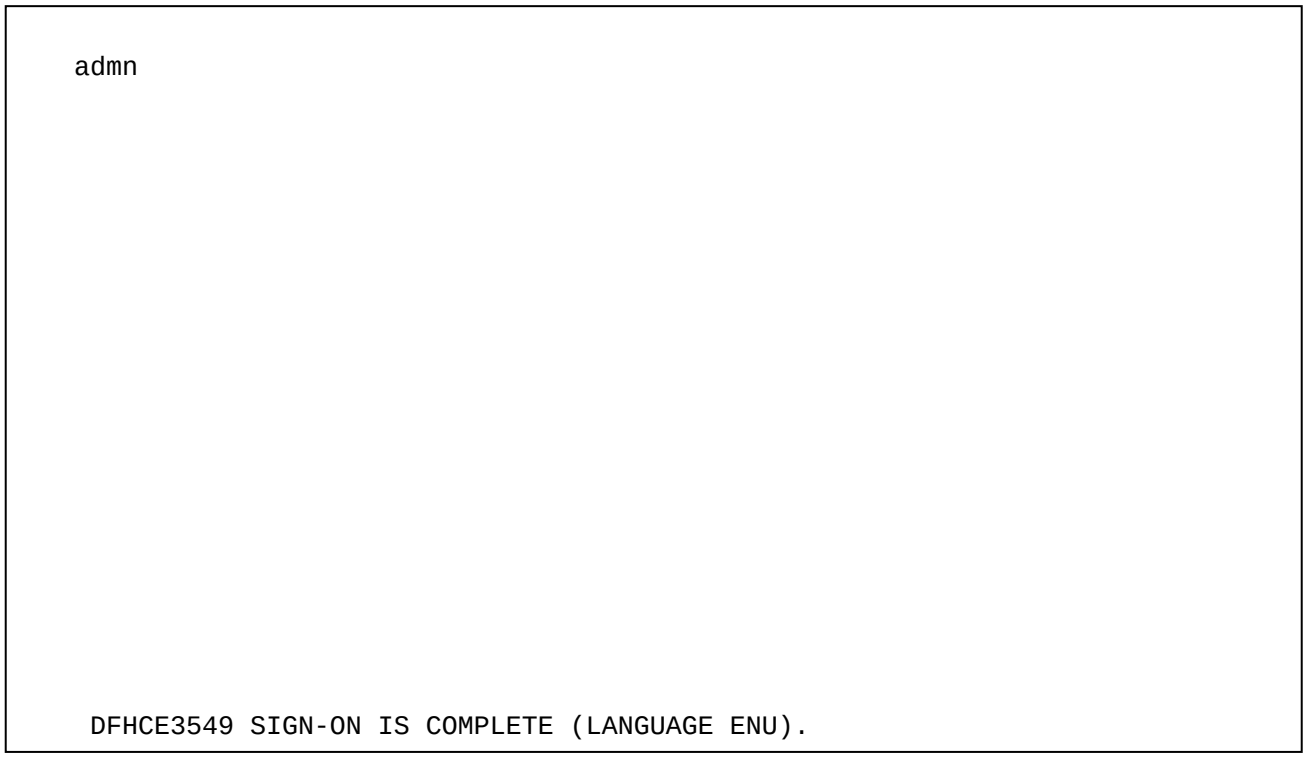
            Userid . . . . abcde12
            Password . . . *******
            Language . . .

         New Password . . .



   DFHCE3520 PLEASE TYPE YOUR USERID.
   F3=Exit
```

On the screen shown above, the user must type the 7 digit UserID and their Password and then press <Enter> to proceed with the sign-on. The screen shown on the next page will be displayed.



The user must then type “admn” on the screen shown above and press <Enter> to complete the sign-on process. The PMMIS Main Menu (shown on next page) will be displayed.

Signing-off
Users sign-off PMMIS by pressing the F12 key until the ADOA Data Center screen shown on page 411-3 of this policy is displayed again.

V. PMMIS Main Menu

```
TR: AH000                      AHCCCS - PMMIS                          05/19/06
NTR: _____________________        MAIN MENU                            09:13:07
                                                                       AH00M000

       1. CASE MANAGEMENT                  11. ALTCS MEDICAL ELIGIBILITY(CATS)
       2. ENCOUNTERS                       12. ALTCS FINANCIAL ELIGIBILITY(LEDS)
       3. SYSTEM SERVICE REQUEST           13. ALTCS GENERAL INQUIRY/MAINTENANCE
       4. HEALTH PLAN                      14. ELIGIBILITY QUALITY CONTROL/FRAUD
       5. INFORMATION MANAGEMENT           15. REINSURANCE
       6. PROVIDER                         16. (AVAILABLE)
       7. RECIPIENT                        17. FINANCE
       8. REFERENCES                       18. CLAIMS
       9. UR/QA                            19. SVES - WTPY REQUEST/RESPONSE
      10. SECURITY                         20. KIDS CARE (KEDS)



                          ENTER SELECTION: 11


PF: 1=HLP       3=CLR 4=MSG                                          12=ESC
```

Pictured above is the first screen users will see after completing the sign-on procedure for the AHCCCS system. From this screen users may access a variety of subsystems, including the Client Assessment and Tracking System (CATS) which is the focus of this policy.

Users may either enter “11” in the Selection field as shown above, or type the screen name of the specific screen the user wishes to access, in the NTR field at the top right of the screen and press Enter. Entering “11” will take the user to the CATS main menu which is shown in the next section.

VI. Client Assessment and Tracking System (CATS) Screens

Each of the screens described in this section share common features for access and movement within them. The following provides information about some of those common features:

The top of all PMMIS screens will look similar to this:

```
TR: SCREEN # HERE              AHCCCS - LONG TERM CARE                DATE HERE
 NTR: _____ I _______________    SCREEN NAME HERE                      TIME HERE
```

- "**TR**" – this field displays the 2-digit Alpha and 3-digit Numeric "name" of the screen or "Transaction" the user is currently accessing. For example: CA160.
- "**NTR**" – the 2-digit Alpha and 3-digit Numeric "name" of the screen that the user wishes to access next may be entered in the 1st position of this field as the "Next Transaction".
  The user may access any of the screens described in this section directly by entering the screen name here or s/he may use the Transaction Keys described below to "transaction travel" through them in sequential order.
- **Function Codes**: these single digit codes, entered in the 2nd position of the "NTR" field, indicate the action the user will take on the screen.

  - **I** - Used to inquire into a record, no changes will be made to the data
  - **C** - Used to change a record. Users may not have "Change" security access to all the screens described in this section.

See the Cost Effectiveness Study (CA160) section of this policy for information regarding 2 additional Function Codes that apply to that screen only.

- **AHCCCS ID#**: Most of the member data screens described in this policy are accessed by entering the member's 9-digit AHCCCS ID# in the 3rd position of the "NTR" field, to the right of the Function Code described above.

- **Transaction Keys**: these keys (described on the next page) allow the user to maneuver between the screens and within the system. As the user "transaction travels" with these keys, the data for the member whose AHCCCS ID# was last entered will be displayed until the user changes the AHCCCS ID# in the NTR field as noted above.

Transaction Keys

F2	From any CATS screen described in this chapter, returns the user to the CATS main menu (CA000) OR from a Comments screen, returns the user to the CATS screen from which they entered the Comments screen.
F3	Takes the user to a Comments screen from those CATS screens that have a Comments feature.
F5	Takes the user to the screen that immediately **precedes** the current one (for example, F5 from CA161 will take the user to CA160).
F6	Takes the user to the screen that immediately **follows** the current one (for example, F6 from CA160 will take the user to CA161).
F7	Takes the user backward, on the same screen, to information from previous dates (e.g., prior CES dates)
F8	Takes the user forward, on the same screen, to information from later dates (e.g., more CES dates)
F9	Scrolls the user back to lines of data (e.g., more placement lines on CA161) or Comments that precede those which are visible on the current screen.
F10	Scrolls the user forward to additional lines of data or comments on the current screen.
F11	Clears data entry errors so the user may proceed without having to resolve the edits first. Changes will not be saved until the edits are resolved.
F12	From any screen except Comments, begins to back the user out of PMMIS by either first returning to the sub-system main menu or going directly to the PMMIS main menu. Pressing F12 from the PMMIS main menu returns the user to the ADOA Data Center sign-on screen.

There are some exceptions to the above Transaction Keys. The user should note the directional information specific to each screen listed at the bottom of each screen.

The following screens that the contractors have access to for inquiry and/or direct data input of member information will be covered in this policy:

A. CATS Main Menu (CA000)
B. Case Management Name Search (CA105)
C. Cost Effectiveness (CA160)
D. Placement History (CA161)
E. Case Management Service Plan (CA165)
F. ACE Critical Data (CA166)
G. Member Income (CA167)
H. Case Management Review Tracking List (CA225)
I. Inquire Part D Drug Plan (RP214)
J. Inquire FYI Data (RP215)

K. Inquire Eligibility and Enrollment (RP285)

All contractors will use this system to record the Cost Effectiveness Study and Placement History for all enrolled members. Tribal Contractors must also enter service plan authorization data for ALTCS Fee for Service members. The remaining screens in this policy provide inquiry access to other member or case management related data.

A. CATS MAIN MENU (CA000)

```
 TR: CA000                  AHCCCS - LONG TERM CARE                    05/19/06
NTR: _____ _ _______________ MEDICAL ELIGIBILITY MENU                  09:16:59
ASSESS DATE: ___________                          WORKER ID: 605636    LT03L820


 A  PAS ADD SCREEN           (CA005)     L  PAS ASSIGNMENT TRACKING  (CA220)
 B  PAS INTAKE SCREEN        (CA010)     M  CASE MGMT NAME SEARCH    (CA105)
 C  OLD PAS MENU             (CA100)     N  COST EFFECTIVENESS STUDY (CA160)
 D  EPD PAS MENU             (CA500)     O  PLACEMENT MAINTENACE     (CA161)
 E  DD PAS MENU              (CA700)     P  SERVICE PLAN             (CA165)
 F  ASSESSMENT SUMMARY       (CA070)     Q  ACE CRITICAL DATA        (CA166)
 G  PAS REOPEN/DELETE        (CA075)
 H  TRANSITIONAL PGM MAINT.  (CA080)     R  SHARE OF COST            (CA175)
 I  PAS SIMULATED SCORE MENU (CA600)     S  CASE MANAGER REVIEW      (CA225)

 J  PAS REFERRAL TRACKING    (CA210)     T  AMADC ERROR MESSAGES     (CA230)
 K  REASSESSMENT TRACKING    (CA215)


                    SELECT LETTER:  _  AND PRESS ENTER


             ENTER=PROCESS       1=HELP       12=SECURITY DRIVER
```

To access the CATS screens used by ALTCS case managers (bolded above), users may either enter the letter code indicated for the screen (M, N, O, P, Q or S) in the space at the middle bottom of this screen (Select Letter) or type the screen name of the specific screen the user wishes to access in the NTR field at the top right of the screen and press Enter.

CA167/Member Income can not be accessed directly from this menu because the user needs to have designated the AHCCCS ID# of the desired member prior to entering CA167. See detailed instructions about CA167 beginning on page 411-38 of this policy for more information.

An example and description of each of the bolded screens follows in this section.

B. CASE MANAGEMENT NAME SEARCH (CA105)

```
TR: CA105                      AHCCCS - LONG TERM CARE                  01/10/03
 NTR: _____ I _________________   CASE MGMT NAME SEARCH                    09:13:24
 WORKER ID: 605636                                                       LT02L105

 NAME: CAMPBELL               ___________   DOB: ___________   SEX: _

 SEL                NAME                  AHCCCS ID   CASE ID   BIRTHDATE   SEX
 ---  ---------------------------------  ---------  ---------  ----------  ---
  S   CAMPBELL              ED            A12345678  100043562  01/01/1949   M
  _   CAMPBELL              SUE           A98765432  110430905  02/01/1925   F




 PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN 9=CNF                12=ESC
```

This screen allows the user to search for an ALTCS member by name and/or date of birth.

When searching by name, the system will seek to match the exact spelling of the last name, so the user must either enter the last name in its entirety or an asterisk after as many letters as the user is sure of. For example, if the user entered "CAMPB*", the system would bring up all names beginning with "CAMPB" but if the user had just entered "CAMP", the name CAMPBELL would not have appeared.

Both a name or date of birth search may be narrowed by entering an "M" or "F" to indicate the sex of the member sought.

From the list of names provided in the search, the user may enter an "S" to the left of the name and press **F9** to bring up the same demographic screen as shown on page **411- 31 of this policy**.

C. COST EFFECTIVENESS STUDY (CA160)

The purpose of the Cost Effectiveness Study (CES) is to compare the cost of Home and Community Based Services (HCBS) to the cost of institutionalization for each ALTCS member. AHCCCS considers HCBS to be cost effective if the cost is at or below 100% of the cost of institutionalization. The CES must be completed prior to the initiation of HCBS services in order to determine if those services will be cost effective and can be provided.

The CES is a projection of HCBS costs so it should be completed based on the services and amounts that the member **needs**, including any services which are expected to be authorized but may not be authorized currently. In order to determine the ongoing cost effectiveness of services the member needs, the units in each of the 3 months should reflect the units the member would receive for the entire month, not just the amount from the CES date until the end of the month.

```
TR: CA160                        AHCCCS - LONG TERM CARE                  09/01/04
NTR: _____ 1 ___2_________ CMP - COST-EFFECTIVENESS STUDY                15:28:25
                                                                          LT02L110

CES DATE:____3______  ASSESS DATE: ___________
NAME: _____________________ ___________ _     AHCCCS ID: __________
WORKER ID: 605636    CURR CSMGR: _______    LATEST ACN: _________

 LOC: A INST GRS COST: $ ____4______ SOC: $ ___B______ NET COST: $ ____C______
        HCBS GRS COST: $ ____D______ SOC: $ __E_______ NET COST: $ _____F_____
SERVICE    UNIT          MONTH 1        MONTH 2        MONTH 3      AVG COST
 CODE MOD  COST    UNITS  COST    UNITS  COST    UNITS  COST       PER MONTH
__5__ _6 __7______ _8__ __G______ __9_ __G_____ _10__ ___G_____    ___H_____
______ __ _________ ____ _________ ____ _________ ____ ___________ ___________
______ __ _________ ____ _________ ____ _________ ____ ___________ ___________
______ __ _________ ____ _________ ____ _________ ____ ___________ ___________
______ __ _________ ____ _________ ____ _________ ____ ___________ ___________
______ __ _________ ____ _________ ____ _________ ____ ___________ ___________

                      COMMENTS: I  CUR PLACEMENT: _ DATE: ___J______ REASON: __
HCBS PRCNT : __K___   SSI PRCNT: ____

                                                      Z037 NO APPLICATION FOUND
1=HLP 2=CA000 3=COM 4=EDSUM 5=CA070 6=CA161 7=SBK 8=SFD 9=SUP 10=SDN 11=CLR/ADD
```

The **Numbered** fields shown on the screen above are for data entry. The **Lettered** fields above are information-only and the data can not be changed from these fields.

Instructions for completion of the **Numbered** fields are as follows:

(1) Function Code - enter the appropriate function code from the options below:

- **A** - used to add a new CES date. This function code is unique to CA160.
- **C** - used to change an existing CES. All data except the date can be changed.
- **I** - used to inquire into a record. No changes can be made to the screen in this function.
- **D** - used to delete an entire CES record, including the date. This function code is unique to CA160.

Hint: If a CES already exists for a member and the case manager wants to create a new one, with a new date, s/he can either:

1. Change the function code to an **"A"**, add a new CES date and type over the existing service/cost data with the desired changes OR
2. Press F11 which will bring up a blank CES screen for the member and automatically change the function code to an **"A"** so that a new CES date can then be added

Do **NOT** use a function code **"C"** if a new CES needs to be created. An **"A"** function must be used to add a new CES date. The Change function should be used to make changes to an existing CES only. If the user uses a **"C"** and types over the existing data with current information, all the historical CES data will be lost. This is not the appropriate method for making a new CES.

(2) AHCCCS ID – this unlabeled line is where the user enters the AHCCCS ID# of the member whose CES information the user wishes to access. CES information is saved by AHCCCS ID# so data from any prior ALTCS enrollments will be available for each member.

(3) CES DATE - the date of the most recent CES will appear, if one already exists for the member. If there is no previously established CES, the message "NO CES RECORDS EXIST" will appear at the bottom right of the screen.

If there are prior CES dates, press F7 to scroll backward to view these. Press F8 to scroll forward again.

Enter the date in this field, along with an "A" Function code to add a new CES. The format is MM/DD/YYYY.

(4) INST GRS COST - the anticipated monthly institutional gross cost should be entered here.

(5) SERVICE CODE - enter the appropriate 5 character service codes for the services that the member needs. If more services will be entered than there are lines on the screen, pressing F10 (after the 1st screen is entered) will provide additional lines. F9 will return the user to the 1st screen after additional line data is entered or viewed.

The word "NONE" may be typed on the 1st service line under the following circumstances:

- members residing in a Nursing Facility who have no potential for HCBS placement
- members who are receiving only Hospice services
- members residing in a Nursing Facility because HCBS would not be cost effective
- members with Acute Care Only status

(6) MOD - enter the 2 character modifier for the service, as needed. A list of all available modifiers can be found on RF114 and the valid modifiers for a specific procedure code can be found via RF122. The following are the most common modifiers:

- U2 – used to designate Attendant Care provided as Self-Directed Attendant Care
- U3 - used to designate Attendant Care provided by the member's spouse
- U4 – used to designate Attendant Care provided by a family member who does NOT live with the member
- U5 - used to designate Attendant Care provided by a family member who DOES live with the member
- U6 – used to designate Self Directed Attendant Care when skilled services are being provided by the caregiver

(7) UNIT COST - enter the cost per unit of the service. This is entered as dollars and cents, with a maximum of 6 digits ($9999.99).

(8) (9) and (10) UNITS - enter the units of service that are needed per month for each of the 3 months. The units should reflect the units the member would receive for a whole month, not just the amount from the CES date until the end of the month. The units may vary from month to month if the member's service needs are expected to change over time. The number entered in this field can not exceed 4 digits (9999). **A zero must be entered in the field if no units of service are expected for one or more months.**

Below is an explanation of the **Lettered, information-only** fields:

(A) LOC – this field will generally be blank but it may show a Level of Care code from the last PAS. Since no LOC is assessed from the PAS process anymore, this information might be very old and most likely will be irrelevant to the member's current status. If a code does appear, the following explains the codes used:

CODE	DESCRIPTION
I	Class 1
P	Class 2
S	Class 3
T	ALTCS Transitional

(B) SOC - the member's anticipated monthly Share of Cost, if s/he were to be placed in a Nursing Facility, will be displayed here, based on the date of the CES. The member's monthly SOC history may be found via the CA166 screen (see information on this screen beginning on page 411-28 of this chapter). The SOC amount will change over time with the member's income and deductions. If the member is not currently known, by ALTCS eligibility staff, to be in a NF, the amount shown in the "CES SOC AMT" field on CA166 is the SOC amount that the member would be expected to pay if s/he were in a NF.

(C) NET COST - the system will display the net institutional cost (gross cost minus SOC) after the CES is entered by the user.

(D) HCBS GRS COST - the system will display the total average cost of the HCB services. This is the sum of the 3 month average for each service entered on the CES.

(E) HCBS SOC – if the member will have a Share of Cost in an HCBS setting (usually due to an Income-Only Trust), the amount, based on the date of the CES, will be displayed here. The SOC amount will change over time with the member's income and deductions.

(F) NET COST - the system will display the net HCBS cost (gross cost minus SOC) after the CES is entered by the user.

(G) COST - the system will display the total monthly cost (unit cost X units) for each service.

(H) AVG COST - the system will calculate and display the average monthly cost of each service (total cost divided by 3).

(I) COMMENTS - a "Y" or "N" is displayed here to indicate if comments are present or not. F3 will bring up the comments screen for CA160 so that the user may review or enter comments. The user must be in a "C" (Change) function on CA160 prior to moving to the Comments screen in order to be able to enter comments on that screen. F2 will return the user to the CA160 screen.

HINT: The beginning of the comments is usually brought up when you first go to this screen. Pressing the **Shift key and F10** together will immediately bring up the end of the file so new comments can be added.

(J) CUR PLACEMENT/DATE/REASON - this information is read from the most recent line on CA161/Placement Maintenance.

(K) HCBS PRCNT - the system calculates the HCBS percentage based on the services entered above compared to the cost of an institutional placement. The figure is the HCBS net cost (F) divided by the institutional net cost (C).

NOTE – the "SSI PRCNT" field is no longer used and no data/information will appear in this field.

NOTE - Errors can be cleared from this screen by pressing F11. This allows the user to either move out of the screen or start over again without having to resolve the errors created first.

D. PLACEMENT MAINTENANCE (CA161)

```
TR: CA161                  AHCCCS - LONG TERM CARE                    10/14/03
NTR: _____ 1 ___2_______     PLACEMENT MAINTENANCE                    11:29:47
                                                  WORKER ID:           LT02L115
NAME: _____________________ __________ _          AHCCCS ID: __________
LAST CES DATE: ___A_______  CURR CSMGR: ___3___   LATEST ACN: _________
LAST REVIEW DATE:  ____4______  NEXT REVIEW DATE:  ____B______
LATEST PC: __C___          ENROLL DATE: ___D_______  DISENROLL DATE: ____E____
CTRT TYPE:  F                                     BEHAVIORAL HEALTH CODE:  5
 PLACEMENT  RES   PLACEMENT    PLACEMENT     PLACEMENT    WORKER    DATE LAST
    CDE     CDE    REASON      BEG DATE      END DATE       ID       MODIFIED
     6       7       8        ___9______    ___10_____   __G___    ____H_____
     _       _       __       __________    __________   ______    __________
     _       _       __       __________    __________   ______    __________
     _       _       __       __________    __________   ______    __________
     _       _       __       __________    __________   ______    __________
     _       _       __       __________    __________   ______    __________
     _       _       __       __________    __________   ______    __________
     _       _       __       __________    __________   ______    __________

                                COMMENTS: I

                                                   Z037 NO APPLICATION FOUND
 1=HELP 2=CA000 3=COM 4=EDSUM 5=CA160 6=CA165 9=SUP 10=SDN 11=CLR 21=TOP 22=BOT
```

The **Numbered** fields shown on the screen above are for data entry. The **Lettered** fields above are information-only and the data can not be changed from these fields.

Instructions for completion of the **Numbered** fields are as follows:

(1) Function Code - enter the appropriate function code from the options below:

- **C** - used to change placement information, including adding new placement data.
- **I** - used to inquire into a record. No changes can be made to the screen in this function.

The Function Code must be a "C" in order to enter or change any data on this screen.

(2) AHCCCS ID – this unlabeled line is where the user enters the AHCCCS ID# of the member whose placement history the user wishes to access. Placement information is saved by AHCCCS ID# so data from any prior ALTCS enrollments will be displayed for each member.

(3) CURR CSMGR - enter the 6-digit ID# of the Case Manager currently assigned to the case. This field **must** be changed when a new case manager is assigned to a case. It is this field that is read by the system as the current case manager for all reports generated by AHCCCS. This field is also used by the system to generate the information on CA225/CM Review Tracking List.

(4) LAST REVIEW DATE – the date of the last on-site service review with the member should be entered here.

(5) BEHAVIORAL HEALTH CODE – the Behavioral Health code that describes the member's current BH status should be entered here. The code entered must correspond to the member's current Placement and Residence code (see matrix of appropriate combinations shown on the next page). This field must be reviewed and updated, as needed, at the time of each service review to ensure it reflects the member's current BH status, even if the member's Placement has not changed. **This field may not be left blank.**

The following provides a description of the Behavioral Health codes to be used:

CODE	DESCRIPTION
A	**Psychotropic Medications only.** Includes only medications used to modify behavioral health symptoms. Does not include Sedative-Hypnotics when used to treat insomnia or on a PRN basis prior to a procedure, Anti-anxiety medications used for muscle spasms or Anticonvulsants used to treat a seizure disorder. Medication monitoring by the prescribing physician is not considered a separate service so if the member receives no other BH "services", s/he would be included in this category.
B	**Behavioral Health services only**. This category would apply to members who receive any Behavioral Health services but who take no psychotropic medications. Does not include members who have only received a Behavioral Health evaluation but do not receive on-going BH services.
C	**Behavioral Health services and Psychotropic medications**. See A and B above. Includes members receiving psychotropic medication monitoring by a nurse.
D	**Behavioral Health Placement without Psychotropic medications**. Includes RTC, Level II or III Behavioral Health facilities and Alternative Residential Settings that specialize in Behavioral Health. Also includes Behavioral Health units within nursing facilities but excludes Wandering/Dementia units in nursing facilities.
E	**Behavioral Health Placement with Psychotropic medications**. See A and D above.
F	**No Behavioral Health Needs**.

The table below shows appropriate combinations of Placement, Residence and Behavioral health codes. Descriptions of the available Placement and Residence codes can be found following this table.

PLACEMENT	RESIDENCE	BEHAVIORAL HEALTH
H	8, F, K, L, R	D or E
H	5, 6, 9, B, E, G	A – F
H	1, P	A – C, F
Q	2, 4	A – F
Q	W	A – C, F
Q	7, C, J	D or E
D	1, 2	A – C, F
Z	1	F

(6) PLACEMENT CODE - enter the code for the placement that corresponds to services authorized by the Case Manager. These codes are shown below.

CODE	DESCRIPTION	
Z	Not Placed – a member must not remain in this placement for more than 30 consecutive days following ALTCS enrollment. No active services can be approved on the service plan during any "not placed" period.	
H	HCBS – members residing in their own home or an approved alternative residential setting. Members residing in their own home must receive at least one of the following LTC services to qualify for an HCBS placement:	
	• Adult Day Health • Attendant Care • Behavior Management • Emergency Alert System • Habilitation • Home Delivered Meals • Home Health Services	• Homemaker • Home Modifications • Partial Care • Personal Care • Psychosocial Rehabilitation • Respite
Q	Institutionalized – members residing in an AHCCCS registered Nursing Facility, ICF-MR, Institution for Mental Disease (IMD) or inpatient psychiatric facilities for individuals under age 21 (RTCs).	
D	Acute Care Only - members who reside in their own homes but receive no LTC services, members who reside in an uncertified facility, members who reside in alternative residential settings not registered with AHCCCS and/or members who have been disqualified from LTC benefits due to an uncompensated transfer of resources. Acute care services include: physician services, medical equipment and supplies, prescription drugs, medically necessary transportation, rehabilitative therapies (physical, speech, occupational and/or respiratory) and behavioral health services.	

(7) RESIDENCE CODE – enter the code that best describes the type of placement setting the member resides in. The Residence code must correspond with both the current Placement and Behavioral Health codes (see matrix of appropriate combinations on preceding page). A new Placement line must be started if the Residence code changes, even if the Placement code has not changed. Residence codes are shown below.

CODE	DESCRIPTION
1	Home
2	Nursing Facility
4	ICF/MR
5	Adult Foster Care
6	Group home for DD
7	Residential Treatment Center
8	Traumatically Brain Injured
9	Assisted Living Centers
B	Assisted Living Home
C	Institute for Mental Disease
E	Adult Developmental Home
F	Adult Therapeutic Foster Home
G	Child Developmental Foster Home
J	Level I Behavioral Health Center
K	Level II Behavioral Health Center
L	Level III Behavioral Health Center
R	Rural Substance Abuse Transitional Center
W	Wandering Dementia Unit in NF

(8) PLACEMENT REASON - enter the 2-digit code for the reason the placement was authorized by the case manager. Reason codes are shown below – the most commonly used codes are bolded..

CODE	DESCRIPTION
01	HCBS not appropriate or cost effective
02	HCBS not available in member's community
03	**Member/rep desires nursing facility placement**
04	Member voluntarily withdraws/awaiting disenroll
05	**Member in NF with no discharge potential**
06	HCBS recommended, cost expected to decrease
07	HCBS - Ventilator Dependent
08	Member hospitalized prior to initial placement
10	**Hospice – used with HCBS and NF placement codes**
11	Other (**Comments required**)
12	**Acute Care only**
13	**HCBS is available and cost effective**

Placement Reason code "**23**" may be used to delete a placement line if entered in error. This code will remove the entire placement line from the screen.

Reason code "11" should only be used if none of the other reason codes adequately describes the member's circumstances. When Reason code "11" is used, comments to describe those special circumstances are required (there will be a system error if comments are not entered).

(9) PLACEMENT BEG DATE - enter the start date of the placement. Format is MM/DD/YYYY.

(10) PLACEMENT END DATE - enter the end date of the placement, if applicable. Format is MM/DD/YYYY. The end date will be left blank for the member's current placement. This field must be completed before a new placement can be entered. There can not be an overlap between the end date and a subsequent placement start date.

Below is an explanation of the **Lettered, information-only** fields:

(A) LAST CES DATE - the date of the most recent CES from CA160 is displayed.

(B) NEXT REVIEW DATE – The system will calculate the date the member's next on-site service review is due based on the "Last Review Date" entered and the member's current placement. Members in "H" and "D" placement will be due in 90 days and members "Q" placement will be due in 180 days. Members still in "Z" placement when a "Last Review Date" is entered will show a Next Review Date in 30 days.

(C) LATEST PC - the 6-digit ID# of the ALTCS Contractor the member was last, or is currently, enrolled with, is displayed here. A list of ALTCS Contractor IDs can be found in Appendix B at the end of this chapter.

(D) ENROLL DATE - the date the member was enrolled with the ALTCS Contractor shown in "Latest PC" field is displayed. The current Placement begin date can not precede this date.

(E) DISENROLL DATE - if the member is not currently enrolled with an ALTCS Contractor, the date the member was last disenrolled is displayed. The last Placement End date must match this date.

(F) CTRT TYPE – The member's current Contract Type will be displayed here. The following shows the applicable Contract types for ALTCS Program and Tribal Contractors:

CODE	DESCRIPTION
Program Contractors	
J	LTC, Capitated
L	LTC, Capitated, Acute Care Only
M	LTC, Prior Period Coverage
O	LTC, Prior Period Coverage, Acute Care Only
Tribal Contractors	
P	LTC, Partially Capitated
T	LTC, Fee For Service, Acute Care Only

(G) WORKER ID# - the ID# of the worker who last updated the line is displayed.

(H) DATE LAST MODIFIED - the date the line was last updated is displayed.

(I) COMMENTS - a "Y" or "N" is displayed here to indicate if comments are present or not. F3 will bring up the comments screen for CA161 so that the user may review or enter comments. The user must be in a "C" (Change) function on CA161 prior to moving to the Comments screen in order to be able to enter comments on that screen. F2 will return the user to the CA161 screen.

System comments should be used to explain special circumstances or miscellaneous codes that the data on the corresponding screen does not explain adequately.

HINT: The beginning of the comments is usually brought up when you first go to this screen. Pressing the **Shift key and F10** together will immediately bring up the end of the file so new comments can be added.

NOTE - Errors can be cleared from this screen by pressing F11. This allows the user to either move out of the screen or start over again without having to resolve the errors created first.

CA161 Provider Search Instructions

On CA161/Placement Maintenance, users can do a "provider" search to determine who the "CURR CSMGR" (Field 3) or "WORKER ID" (Field G) indicated on this screen belong to. The user may place the curser in either Field 3 or Field G (bolded in the screen example below) and press F1.

```
TR: CA161                  AHCCCS - LONG TERM CARE                      07/17/06
NTR: _____ C _______________ PLACEMENT MAINTENANCE                       11:39:54
                                                  WORKER ID: 605636     LT02L115
NAME: SMITH                  RICHARD              AHCCCS ID: A12345678
LAST CES DATE: 01/26/2006  CURR CSMGR: 605636   LATEST ACN:
LAST REVIEW DATE:  04/27/2006  NEXT REVIEW DATE:  07/26/2006
LATEST PC: 999999          ENROLL DATE: 07/28/2003  DISENROLL DATE: __________
CTRT TYPE:  J                                    BEHAVIORAL HEALTH CODE:  F
PLACEMENT  RES   PLACEMENT    PLACEMENT     PLACEMENT    WORKER    DATE LAST
   CDE     CDE    REASON      BEG DATE      END DATE       ID       MODIFIED
    H       1       13       07/28/2003    __________    605636    07/17/2006
    _       _       __       __________    __________    ______    __________
    _       _       __       __________    __________    ______    __________
    _       _       __       __________    __________    ______    __________
    _       _       __       __________    __________    ______    __________
    _       _       __       __________    __________    ______    __________
    _       _       __       __________    __________    ______    __________
    _       _       __       __________    __________    ______    __________

                                  COMMENTS: N

                            Z171 ACTIVE IN ACE        Z011 END OF FILE
1=HELP 2=CA000 3=COM 4=EDSUM 5=CA160 6=CA165 9=SUP 10=SDN 11=CLR 21=TOP 22=BOT
```

A screen such as the one shown below will be displayed. The provider information from the ID chosen on the screen will be at the top of the list shown. Pressing F2 will return the user to CA161.

```
  TR: CA161 ACT: C      AHCCCS - INFORMATION REFERENCING                 07/17/06
                                PROVIDER ID/NAME                        12:54:45
                                                                        AH05L012
 S  SORTED BY PROVIDER ID
 E
 L PR ID  NPI         PROVIDER NAME              -----PROVIDER TYPE-------------
   ______ __________ _________________________
 _ 605636             SANDERS, CAROL             98 CASE MANAGER
 _ 605644             SURBER/SANDRA              98 CASE MANAGER
 _ 605652             GONZALES DOLORES           98 CASE MANAGER
 _ 605660             SALM, JANICE               98 CASE MANAGER
 _ 605678             SULLIVAN MARIE             98 CASE MANAGER
 _ 605686             HUMPHRIES FRED             98 CASE MANAGER
 _ 605694             HEGLUND/MARILYN            98 CASE MANAGER
 _ 605701             HERREID SUSAN              98 CASE MANAGER
 _ 605719             LANGLEY SHEVA              98 CASE MANAGER
 _ 605727             NORRIS/SUSAN               98 CASE MANAGER
 _ 605735             PHILLIPS/WANDALEE          98 CASE MANAGER
 _ 605743             SKERTICH/OLIVE             98 CASE MANAGER
 _ 605751             WINOGRAD ROCHELLE          98 CASE MANAGER
 _ 605769             YANNO/RICHARD              98 CASE MANAGER
PF:       2=RTN                        7=UP  8=DWN       10=TOP 11=BOT
```

E. SERVICE PLAN (CA165) – Used by Tribal Contractors to authorize ALTCS services.

```
TR: CA165                  AHCCCS - LONG TERM CARE                    11/04/03
NTR: _____ 1 ___2_______      CMP - SERVICE PLAN                       14:57:18
KEY DATE: ____3______                                  WORKER ID:      LT02L120
NAME: ____________________ __________ _                AHCCCS ID: _________
LAST CES DATE: ___A_______  CURR CSMGR: ___B___   LATEST ACN: _________
LAST PC: ___C___ ENR DT: ____D_____ DISEN DT: ___E______ LST RVW DT: ____F____
CUR: LOC: G_   PLACEMENT: _H   DATE: __________   RSN __  NXT RVW DT: ___I____
PAS DIAG CDS:  ______ __J____ ______   DIAG 1:  ____________________________
DIAG 2: ____________________________ DIAG 3:  ____________________________
A SER  MOD RES EFF DT    END DT    UNITS UNIT COST TOT COST TOT USED  PROV RSN
4 __5__ 6_ _ ____7_____ ____8_____ __9__ __10_ __ ___K_____ ___L____ _11___ 12
_ _____ __ _ __________ __________ _____ ________ _________ ________ ______ __
_ _____ __ _ __________ __________ _____ ________ _________ ________ ______ __
_ _____ __ _ __________ __________ _____ ________ _________ ________ ______ __
_ _____ __ _ __________ __________ _____ ________ _________ ________ ______ __

                                COMMENTS: M

1=HELP 2=CA000 3=COM 4=EDSUM 5=CA161 6=CA175 9=SUP 10=SDN 11=CLR 21=TOP 22=BOT
```

The **Numbered** fields shown on the screen above are for data entry. The **Lettered** fields above are information-only and the data can not be changed from these fields.

Instructions for completion of the **Numbered** fields are as follows:

(1) Function Code - enter the appropriate function code from the options below:

- **C** - used to change service information, including adding service authorizations.
- **I** - used to inquire into a record. No changes can be made to the screen in this function.

The Function Code must be a "C" in order to enter or change any data on this screen.

(2) AHCCCS ID – this unlabeled line is where the user enters the AHCCCS ID# of the member whose service plan history the user wishes to access. Service authorizations are saved by AHCCCS ID# so data from any prior ALTCS enrollments will be displayed for each member.

(3) KEY DATE – This **optional** field may be used to quickly display previous service plan entries beginning with a specific date by entering that date in this field. Format is MM/DD/YYYY. Services with that begin date or later will be displayed. This avoids having to scroll through screens of entries to find a specific service or time period. This field may be left blank if the user does not wish to review previous entries.

HINT: Usually, the end of the file (last authorized services) is brought up when you first go to this screen. F9 will scroll backward to previous authorizations and F10 scrolls forward again.

Pressing the **Shift key and F9** together will immediately bring up the beginning of the file (first screen of authorized services) and the **Shift key and F10** together will immediately bring up the end of the file.

(4) ACT - enter the appropriate action code from the options below:

- **I** - used to initiate a new service authorization
- **C** - used to make changes to an existing service authorization
- **T** - used to terminate an existing service authorization that has unclaimed units. This Action code requires a Reason code at the end of the service line (see table of Termination Reason codes beginning on the next page).

(5) SERV - enter the appropriate procedure 5-digit HCPCS or 4-digit Revenue code for the service being authorized.

(6) MOD - enter the 2 character modifier for applicable services. Durable Medical Equipment and medical supplies must have a modifier to be authorized. Fee-For-Service (FFS) Transportation intended as "Rural" will need a modifier entered in order for AHCCCS to pay the rural rate. The following are the most common modifiers:

- U2 – used to designate Attendant Care provided as Self-Directed Attendant Care
- U3 - used to designate Attendant Care provided by the member's spouse
- U4 – used to designate Attendant Care provided by a family member who does NOT live with the member
- U5 - used to designate Attendant Care provided by a family member who DOES live with the member
- U6 – used to designate Self Directed Attendant Care when skilled services are being provided by the caregiver
- NU - used for a DME or medical supply purchase
- RR - used for a DME rental
- RA - Replacement of a DME item.
- RB - Replacement of a part of DME furnished as part of a repair.
- TN – used for rural transportation

All valid modifiers for a specific procedure code may be found in the PMMIS Reference subsystem, on RF122.

(7) EFF DT - enter the start date for the service authorization. Format is DD/MM/YYYY.

(8) END DT - enter the end date for the service authorization. The end date of an authorization must not exceed 90 days for an HCBS service or 180 days for an institutional service.

Service authorization begin and end dates must not overlap Placement begin and end dates on CA161/Placement Maintenance.

(9) UNITS - enter the number of units being authorized for the dates of service indicated. Information about maximum units allowed for a specific procedure code can be found in the PMMIS Reference subsystem, on RF113.

(10) UNIT COST - enter the unit cost of the service being authorized. The system will not allow this cost to exceed the AHCCCS FFS rate (if one has been set) for ALTCS FFS members. The maximum allowable charge for a specific procedure code can be found in the PMMIS Reference subsystem, on RF112.

(11) PROV - enter the 6-digit ID# of the Provider authorized to render the service. The provider must be eligible to provide the specific type of service authorized. Refer to PR035, in the PMMIS Provider subsystem, for the Categories of Service a specific provider is registered to provide.

NOTE: The following "dummy" Provider codes should be used to show that ALTCS covered services are provided but they are <u>not</u> paid for with AHCCCS funds:

<u>029108</u> - Signifies any service paid completely by another payer source, for example Tribal or private pay. In these cases, the appropriate service code would be used (for example, G0154 for Home Health Nursing), however, 029108 would be used as the provider number and the unit cost would be $0.00 to indicate the service will not be paid by AHCCCS.

<u>042490</u> - Signifies services provided in an uncertified facility.

(12) RSN – when a service line is being <u>terminated</u>, a Reason Code must be entered in this field. The termination of a service authorization should be rare. Changes in service code, begin or end dates, units and unit cost should be made using the (C)hange action code instead and no Reason Code is needed for these types of changes. Terminations Reason Codes are listed below.

Code	Description
01	Member does not meet medical/functional PAS criteria of AHCCCS
02	Member becomes financially ineligible
03	Member becomes financially and medically ineligible
04	Member's needs have been met and service is no longer required
05	Member's request for suspension or termination of service
06	Member moved out of provider's service area
07	Member died
08	Member moved out of state
09	Contact with member has been lost
10	Provider has been changed
11	No service is available

12	Another source is available
13	Member's caregiver/family is able to take over care
14	Member discharged to home
15	Member left against medical advice
16	Member discharged to other
17	Member needs a higher level of care
18	Member needs a lower level of care
19	Hospitalization
20	Covered by Medicare
21	Member refused services
22	Assessment only – completed
23	Delete - This code may be used to delete a service line if entered in error. The entire service line will be removed from the screen as long as AHCCCS has not paid any claims from that authorization.

Below is an explanation of the **Lettered, information-only** fields:

(A) LAST CES DATE - the most recent CES date from CA160 will be displayed here.

(B) CURR CSMGR - the 6-digit ID# of the case manager currently assigned to the case on CA161 will be displayed here.

(C) LAST PC - the 6-digit ID# of the Contractor the member was last or is currently enrolled with is displayed. A list of ALTCS Contractor IDs can be found in Appendix B at the end of this chapter.

(D) ENR DAT - the date the member was enrolled with the Contractor shown in "LAST PC" field is displayed.

(E) DISEN DAT - if the member is not currently enrolled with an ALTCS Contractor, the date the member was last disenrolled is displayed. **If a date appears in this field, the member is not currently enrolled and no service can be authorized beyond the date shown.**

(F) LST RVW DT - the last date the case manager has entered in "LAST REVIEW DATE" field on CA161/Placement Maintenance will be displayed here. The field will be blank if no reviews or placement data has been entered.

(G) LOC – this field is currently not used. It used to show either the member's Level of Care from the most recent PAS or the Level of Care, for members in a nursing facility, based on the Nursing Facility service/revenue code authorized by the case manager on this screen.

(H) PLACEMENT/DATE/RSN - the Placement/Reason codes and begin date from the current placement on CA161 will be displayed here.

(I) NXT RVW DT - the date the next service review is due, as calculated based on the date entered in the "LAST REVIEW DATE" field on CA161/Placment Maintenance, is displayed here. Members in "H" and "D" placement will be due in 90 days and members "Q" placement will be due in 180 days. Members still in "Z" placement when a "Last Review Date" is entered will show a Next Review Date in 30 days.

(J) PAS DIAG CDS - up to 3 diagnostic (ICD-9) codes from the last PAS will be displayed. The three lines next to and below this, labeled "DIAG 1/2/3", will display the definition of those codes.

(K) TOTL COST - the total cost of the service authorized on the line (units X unit cost).

(L) TOT USED - The total number of units AHCCCS has paid to the provider to date will be displayed. The number in this field will not exceed the number of units authorized but may be less.

(M) COMMENTS - a "Y" or "N" is displayed here to indicate if comments are present or not. F3 will bring up the comments screen for CA165. The user must be in a "C" (Change) function on CA165 prior to moving to the Comments screen in order to be able to enter comments on that screen. The oldest comments saved for the member are displayed when the screen is first accessed. F9 will scroll backward to prior comments and F10 will scroll forward. Pressing the **Shift key and F9** together will take you immediately to the beginning of the comments and the **Shift key and F10** together will take you immediately to the end of the comments. F2 will return the user to the CA165 screen.

System comments should be used to explain special circumstances or miscellaneous codes that the data on the corresponding screen does not explain adequately.

CA165 Provider Search Instructions

On CA165/Service Plan, users can do a provider search to determine who the Provider ID# on any service authorization line and/or who the Case Manager ID# on this screen belong to. The user may place the curser on either the Provider ID# (one at a time) or the Current Case Manager ID# (examples shown bolded in the screen example below) and press F1.

```
TR: CA165                  AHCCCS - LONG TERM CARE                    05/30/06
NTR: _____ I _______________  CMP - SERVICE PLAN                       07:41:43
KEY DATE: __________                                WORKER ID: 605636    LT02L120
NAME: BROWN                SAMUEL                   AHCCCS ID: A23456789
LAST CES DATE: 04/13/2006  CURR CSMGR: 124412   LATEST ACN:
LAST PC: 999999 ENR DT: 11/01/2005 DISEN DT:            LST RVW DT: 05/16/2006
CUR: LOC: _   PLACEMENT: H   DATE: 11/01/2005   RSN 13  NXT RVW DT: 08/14/2006
PAS DIAG CDS:  3449                    DIAG 1:  PARALYSIS, UNSPECIFIED
DIAG 2: _____________________          DIAG 3:  ____________________________
A SER  MOD RES EFF DT    END DT    UNITS UNIT COST TOT COST TOT USED  PROV RSN
_ 97113 __ _ 04/20/2006 06/22/2006    28    31.74    888.72     0.00 020876 __
_ 97535 __ _ 04/20/2006 06/22/2006    28    29.87    836.36     0.00 020876 __
_ S5125 __ _ 05/08/2006 06/30/2006   960     3.88   3724.80   312.00 076433 __

                                  COMMENTS: Y

                           Z171 ACTIVE IN ACE        Z022 MORE DATA AVAILABLE
1=HELP 2=CA000 3=COM 4=EDSUM 5=CA161 6=CA166 9=SUP 10=SDN 11=CLR 21=TOP 22=BOT
```

A screen such as the one shown below will be displayed. The provider information from the ID chosen on the screen will be at the top of the list shown. Pressing F2 will return the user to CA165.

F. AHCCCS Customer Eligibility (ACE) Critical Data (CA166)

Information available about a member through the ACE Critical Data screen is accessed in the same way as the previously described CATS screens, via member AHCCCS ID# entered in the field labeled **(A)** below. This screen is inquiry only; no information can be changed on this screen.

1. Main screen:

```
TR: CA166                  AHCCCS - LONG TERM CARE                    09/07/04
NTR: _____ I ___A_________  ACE CRITICAL DATA                         07:54:48
WORKER ID: 605636                                                      LT02L130
NAME: CAMPBELL                    ED        STATUS: A  EFF TERM DAT: __________
AHCCCS-ID: A12345678  ACE ID: 900000000 TRIBE CD: 07  RES CD: 07  NET TEST: F
CASE MANAGER: 123456 MANAGER, CASEY                   OFFICE: 12A  PAS LOC: I
FIN REDE DUE DATE: 07/13/2005    MED REASS DUE DATE: NONE        DD STATUS: 4

LIVING ARRANGEMENT(LAR): HS   LAR PROVIDER: ______   LAR BEG DATE: 07/23/2004
MOST RECENT TRANSITIONAL PERIOD BEGIN DATE: 12/01/1999   END DATE: 05/31/2001
 MAJOR DIAG 1: 03B(7169 )  MAJOR DIAG 2: 06G(3109 )  MAJOR DIAG 3: 12C(     )

  AUTH REP: CAMPBELL             MARY        _          RELATION: SP
         STREET ADDRESS: 1234 E NORTHVIEW AVE          _________________________
     CITY: PHOENIX             ST: AZ  ZIP: 85034 ____  RES PHO: 602 555 5555
                                                        BUS PHO: ___ ___ ____
 LEGAL REP: _____________________ __________ _          RELATION: __
         STREET ADDRESS: _____________________          _________________________
     CITY: ____________________  ST: __  ZIP: _____ ____  RES PHO: ___ ___ ____
                                                        BUS PHO: ___ ___ ____
                          Z171 ACTIVE IN ACE        Z008 RECORD FOUND
1=HLP 2=CA000 3=ADD 4=ERR 5=CA165 6=CA225 (7=DEM 8=SOC 9=VER 10=MHS) 11=CLEAR
```

The following tables provide information regarding codes that appear on the CA166:

ALTCS Eligibility Site Codes	
12	Valley ALTCS
15	Freedom to Work
21	Tucson
22	Sierra Vista
31	Flagstaff
32	Prescott
33	Show Low
34	Chinle
35	Cottonwood
41	Yuma
42	Lake Havasu City
43	Kingman
51	Casa Grande
52	Globe

DD Status Codes	
1	Potential DD member
2	DD member In ICF/MR or Home/Group Home
3	DD member in Nursing Facility
4	EPD member

Status Codes	
A	Active enrollment
I	Inactive enrollment

Tribe/Reservation Codes					
01	Ak Chin	**08**	Havasupai	**15**	Salt River Pima-Maricopa
02	Camp Verde Yavapai	**09**	Hopi	**16**	San Carlos Apache
03	Cocopah	**10**	Hualapai	**17**	Yavapai-Apache
04	Colorado River	**11**	Kaibab Paiute	**18**	Fort Mohave
05	White Mountain Apache	**12**	Navajo	**19**	Quechan
06	Fort McDowell	**13**	Tohono O'Odham	**20**	Pascua Yaqui
07	Gila River	**14**	Tonto Apache	**21**	San Juan Southern Paiute

More Codes from CA166 Main Screen

Living Arrangement Codes	
AH	CLIENT IS IN ACUTE HOSPITAL BED
HA	CLIENT IS IN AN ASSISTED LIVING HOME
HB	MH LEVEL I OR II BEHAVIORAL HEALTH CTR
HC	DD CHILD IN DD CHILD DEVELOPMENT FOSTER HOME
HD	MH LEVEL III BEHAVIORAL HEALTH CTR
HF	LIVES IN AN ADULT FOSTER HOME
HG	LIVES IN A GROUP HOME
HI	LIVES AT HOME AND INTENDS TO RECEIVE SERVICES
HL	CLIENT IS IN AN ASSISTED LIVING CENTER
HN	LIVES AT HOME AND DOESN'T RECEIVE IN-HOME SERVICES
HO	QMB-ONLY LIVING ARRANGEMENT (SERVICES N/A)
HR	RURAL SUBSTANCE ABUSE TRANSITIONAL AGENCY
HS	LIVES AT HOME AND RECEIVES IN-HOME SERVICES
HT	LIVES IN A THERAPEUTIC ADULT FOSTER HOME
HZ	ALZHEIMER ASSISTED LIVING FACILITIES
LH	A/R IN LTC HOSPITAL BED OR ACUTE PSYCHIATRIC HOSPI
LT	CLIENT IS IN LTC FACILITY OR RTC
OS	CLIENT IN OUT-OF-STATE FACILITY (HOSPITAL OR LTC)
RH	CLIENT REFUSING LTC SERVICES
SC	ALTERNATE ACUTE LIVING ARRANGEMENT

Relationship Codes (for authorized and/or legal representative)			
AU	AUNT	**NB**	NEIGHBOR
BR	BROTHER	**NO**	NONE
CH	CHILD	**NR**	NOT RELATED
CO	COUSIN	**OT**	OTHER
DA	DAUGHTER	**PA**	PARENT
FA	FATHER	**PO**	PARENT OF ADULT
FF	FOSTER FATHER	**PS**	STEP PARENT
FM	FOSTER MOTHER	**NO**	NONE
GD	GRANDDAUGHTER	**SI**	SISTER
GF	GRANDFATHER	**SO**	SON
GM	GRANDMOTHER	**SP**	SPOUSE
GS	GRANDSON	**UN**	UNCLE
MO	MOTHER		

2. Pressing **F7** will bring up the Demographic screen shown below. **F2** will return the user to CA166.

```
 TR: CA166 ACT: I              AHCCCS - RECIPIENT    USER-ID: 57N    10/27/11
                              DEMOGRAPHIC INQUIRE                   15:19:32
                                                                    RP01L035
A12345678 CAMPBELL ED                     SEX F DOB 12/04/1966 DOD

      HOME ADDRESS           RES CTY: MARICOPA             HEAD OF HOUSE?: N
SOUTH MOUNTAIN CARE          FIS CTY: MARICOPA           ON RESERVATION?: N
6420 S. 22ND ST                   SSN: 555-55-5555
PHOENIX                      CASE ID: 555555555              OTHER RECORDS?
AZ 85040                        RACE: CAUCASIAN/WHITE         SPECIAL PGMS:
                            TRIBE ID:                            MEDICARE: Y
     MAILING ADDRESS         MAR STA: SINGLE                THIRD PTY CHG: Y
SOUTH MOUNTAIN CARE          LANG: ENGLISH                   ALTERNATE ID: Y
6420 S. 22ND ST               LANG SRC: ON-LINE, DMS
PHOENIX                      CITIZEN: US US CITIZEN           MEDICAL COND:
AZ 85040                CITIZEN SRC: AZ                    CORRESPONDENCE: Y
                            CARE LVL:
                            FACILITY:                                CO-PAY: N
HOME PH: (602) 555-0000  ATTN:
 EMG PH: (   )    -        EMAIL SRC: WB
E-MAIL: MYNAME@NETZERO.NET
PF: 1=HLP 2=RTN                  6=NXT                                12=ESC
          14=MDC 15=TPL 16=ALT       18=COR
```

NOTE - The F14, F15 and F16 options above will only appear on the screen if there is data to report (i.e. F14 will not appear on this screen if the member does not have Medicare).

3. If "F14=MDC" is shown as an option on the demographic screen (#2), pressing **Shift and F2** will bring up the Medicare Coverage screen shown below. **F2** will return the user to the demographic screen.

```
 TR: CA166 ACT: I              AHCCCS - RECIPIENT    USER-ID: 57N    05/19/06
                          INQUIRE MEDICARE COVERAGE                  13:21:30
                                                                     RP01L050
A12345678 CAMPBELL ED                        SEX M DOB 01/01/1949 DOD __________

      MEDICARE   PAYER  BEGIN      END           CHG    DATE       LAST MOD
PART  CLAIM NO.   ID    DATE       DATE      SRC RSN  REC ADDED  DATE       USR
 A  123456789A   FREE 05/01/1995             AS       01/13/1995 09/07/2005 BAT
 B  123456789A   030  05/01/1995             SI       01/13/1995 01/12/2001 BAT
 C  123456789A        07/01/2005             AS       06/14/2005 06/14/2005 BAT
 D  123456789A        01/01/2006             MS       12/15/2005 12/15/2005 BAT


PF: 1=HLP 2=RTN                          7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

If this screen indicates the member has "Part C" as shown in the example above, this means the member is eligible for the Qualified Medicare Beneficiaries (QMB) program.

If the screen indicates that the member has "Part D' as shown in the example on the preceding page, refer to the RP214 screen (instructions on page 411-42 of this chapter) to determine which Part D drug plan the member is enrolled with.

4. If "F15=TPL" is shown as an option on the demographic screen (#2), pressing **Shift and F3** will bring up the Third Party Coverage Summary screen shown below. **F2** will return the user to the demographic screen.

```
 TR: CA166 ACT: I                AHCCCS - RECIPIENT   USER-ID: 57N  01/13/03
                           INQUIRE THIRD PARTY COVERAGE SUMMARY      10:48:56
                                                                     RP01L055
A12345678 CAMPBELL ED                      SEX M DOB 01/01/1949 DOD __________

       CARRIER                                                       COV CHG
  SRC NUM   NAME                 POLICY NUMBER  BEGIN DATE  END DATE TYP RSN
 S OA       BCBS                 1234-5678      07/10/2002

 PF: 1=HLP 2=RTN                        7=UP  8=DWN                   12=ESC
```

For more information on any TPL listed in the screen above, put an **"S"** in the selection field to the left of the policy and press Enter. The Third Party Coverage Detail screen shown in #5 below will be displayed.

5. Pressing **F2** from this Third Party Coverage Detail screen will return the user to the TPL screen shown in #4.

```
TR: RP155 ACT: I                  AHCCCS - RECIPIENT  USER-ID: 57N   01/13/03
                             INQUIRE THIRD PARTY COVERAGE DETAIL       10:49:17
                                                                       RP02L055
A12345678 CAMPBELL ED                        SEX M DOB 01/01/1949 DOD __________
            SOURCE: OA
      CARRIER NUMBER:           CARRIER NAME: BCBS
    STREET ADDRESS-1: 123.W EAST ST
    STREET ADDRESS-2:
              CITY: PHX                  STATE: AZ    ZIP: 85223
       CARRIER PHONE: (     )     -
        GROUP NUMBER:
       POLICY NUMBER: 1234-5678            COVERAGE TYPE:
   POLICY BEGIN DATE: 07/10/2002           DATE VERIFIED:
     POLICY END DATE:
       CHANGE REASON:
POLICY HOLDER'S NAME: CAMPBELL ED
 POLICY HOLDER'S SSN: 555-55-5555
            EMPLOYER:
RELATIONSHIP OF POLICY HOLDER TO RECIPIENT: SELF
DATE RECORD ADDED: 07/10/2002  LAST MOD. DATE: 07/10/2002 LAST MOD. USER: 067

PF: 1=HLP 2=RTN                                                      12=ESC
```

6. If "F16=ALT" is shown as an option on the demographic screen (#2), pressing **Shift and F4** will bring up the Alternate ID screen shown below. **F2** will return the user to the demographic screen.

```
TR: CA166 ACT: I             AHCCCS - RECIPIENT     USER-ID: 57N     01/13/03
NTR: _____________________  INQUIRE ALTERNATE ID                       10:49:51
                                                                       RP01L085
A12345678 CAMPBELL ED                        SEX M DOB 01/01/1949 DOD __________

    ALTERNATE ID  ID   ID DESCRIPTION   BEGIN         LAST MOD       DAT REC
                 TYPE                    DATE   SRC  DATE      USR   ADDED

  90014760        AC APPLICATION CONT 06/19/2002 OA 06/19/2002 0A1 06/19/2002
  100555555       AS ACE SYSTEM ID NU 07/23/2002 OA 07/23/2002 0A1 07/23/2002
  123456780A      MC MEDICARE CLAIM I 01/01/2002 OA 07/10/2002 067 07/10/2002
  555-55-5555     SN UNVERIFIED SSN/P 06/19/2002 OA 06/19/2002 0A1 06/19/2002



PF: 1=HLP 2=RTN 3=CLR 4=MSG            7=UP  8=DWN                    12=ESC
```

7. From CA166 (#1), pressing **F8** will bring up the Share of Cost screen shown below. **F2** will return the user to CA166. The "CES SOC AMT" field indicates the SOC amount an HCBS member would have to pay if s/he were admitted to an institutional placement.

```
TR: CA166 ACT: I          AHCCCS - RECIPIENT          USER-ID: 57N   04/23/04
NTR: ____________________  INQUIRE SHARE OF COST                        09:42:15
                                                                        RP03L075
A12345678 CAMPBELL ED                      SEX   DOB 19490101   DOD

                                                  T  ORIGINAL    DATE    USER
    SOC      SOC        SOC       SOC       CES   Y  POSTING     LAST    LAST
    DATE    AMOUNT    ADJ AMT   USED AMT  SOC AMT P    DATE       MOD     MOD

  04/2004       .00                 .00    963.69 I 03/29/2004 03/29/2004 BAT
  03/2004       .00                 .00    963.69 I 02/27/2004 02/27/2004 BAT
  02/2004       .00                 .00    963.69 I 01/26/2004 01/26/2004 LC*
  01/2004       .00                 .00    946.49 I 12/26/2003 12/26/2003 LC*
  12/2003       .00                 .00    946.53 I 11/28/2003 11/28/2003 BAT
  11/2003       .00                 .00    946.53 I 10/29/2003 10/29/2003 BAT
  10/2003       .00                 .00    946.53 I 09/28/2003 09/28/2003 BAT
  09/2003       .00                 .00    946.53 I 08/29/2003 08/29/2003 BAT
  08/2003       .00                 .00    946.53 I 07/29/2003 07/29/2003 BAT
  07/2003       .00                 .00    946.53 I 06/28/2003 06/28/2003 BAT
  06/2003       .00                 .00    946.53 I 05/29/2003 05/29/2003 BAT
  05/2003       .00                 .00    946.53 I 04/28/2003 04/28/2003 BAT

PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN                     12=ESC
```

8. From CA166 (#1), pressing **F9** will bring up the Verification screen shown below. The user must enter a date in "DOS FROM DATE" field in order for eligibility/enrollment data to appear. This date can be the specific date for which eligibility or enrollment information is sought or the current date.

```
TR: CA166 ACT: I             AHCCCS - RECIPIENT     USER-ID: 57N     01/13/03
 NTR:                             VERIFICATION                        11:38:29
                                                                      RP07L050
 A12345678 CAMPBELL ED                       SEX M DOB 01/01/1949 DOD

 AS OF DATE 01/13/2003 DOS FROM DATE __________ DOS THRU DATE __________ FYI
 THE RECIPIENT'S ELIGIBILITY IS:                                   ADDED ON
                           BEGIN ON:            ENDED ON
                           BEGIN ON:            ENDED ON

 THE RECIPIENT'S  ENROLLMENT IS:        BEGIN      END      RATE
      HEALTH PLAN          CTRT TYP     DATE       DATE     CODE CSA  ADDED ON

 PART A BEGINS:            AND ENDS:            MEDICARE CLAIM #:
 PART B BEGINS:            AND ENDS:
 THE RECIPIENT HAS THIRD PARTY COVERAGE WITH:
 THE POLICY NO IS                BEGINNING ON            ENDING ON

 PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN                    12=ESC
```

9. Entering a "DOS FROM DATE" brings up information as shown below. **F2** will return the user to CA166.

```
TR: CA166 ACT: I             AHCCCS - RECIPIENT     USER-ID: 57N     01/13/03
 NTR:                             VERIFICATION                        10:39:17
                                                                      RP07L050
 A12345678 CAMPBELL ED                       SEX M DOB 01/01/1949 DOD

 AS OF DATE 01/13/2003 DOS FROM DATE 11/01/2002 DOS THRU DATE __________ FYI N
 THE RECIPIENT'S ELIGIBILITY IS:                                   ADDED ON
 L SD MAO                  BEGIN ON: 11/01/2000 ENDED ON           06/19/2002
                           BEGIN ON:            ENDED ON

 THE RECIPIENT'S  ENROLLMENT IS:        BEGIN      END      RATE
      HEALTH PLAN          CTRT TYP     DATE       DATE     CODE CSA  ADDED ON
 ANY LTC PLAN           LTC/CAP      08/01/2002              2200 13 07/24/2002
 ANY LTC PLAN           LTC/CAP      06/19/2002 07/31/2002 2210 13 06/19/2002
 ANY LTC PLAN           LTC/PPC      10/01/2000 06/18/2002 221Z 13 06/19/2002

 PART A BEGINS: 01/01/2002 AND ENDS:            MEDICARE CLAIM #: 555555555A
 PART B BEGINS:            AND ENDS:
 THE RECIPIENT HAS THIRD PARTY COVERAGE WITH: BCBS
 THE POLICY NO IS 1234-5678       BEGINNING ON 07/10/2002 ENDING ON

 PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN                    12=ESC
               15=TPL
```

10. From CA166 (#1), pressing **F10** will bring up the BHS/FYI Data screen shown below. Pressing **F2** from this screen will generate an error. **F12 must be used to return the user to CA166 from the BHS/FYI Data screen.**

```
 TR: CA166 ACT: I              AHCCCS - RECIPIENT    USER-ID: 57N    06/04/04
NTR: _____________________    INQUIRE BHS/FYI DATA                  07:36:10
                                                                    RP04L016
A12345678 CAMPBELL             ED       SEX  M  DOB 19490101   DOD __________

            BHMIS ID: XXXXXXXXXX
    TYPE                                  CHG                          LAST MOD
     ID   BEGIN DATE END DATE   STA  RSN SITE CAT   DATE ADDED   DATE    USER

   079999 09/01/1994 06/20/2002  A   CH   23   S    09/24/2003 09/24/2003 CNV
   079999 06/01/1994 07/31/1994  A   RO   23   S    09/24/2003 09/24/2003 CNV
   079999 04/19/1994 04/30/1994  A   RO   23   S    09/24/2003 09/24/2003 CNV



 PF: 1=HLP 2=RTN 3=CLR 4=MSG       6=DSP 7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

"BHMIS ID" is an identification number assigned by ADHS/BHS for their tracking purposes only.
"TYPE ID" should be 079999 which indicates enrollment with ADHS/BHS.
"CHG RSN" (Change Reason) codes may be found on RF525 in PMMIS.

SITE CODES	
02	CENPATICO 2
03	YUMA BEHAVIORAL HEALTH SERVICE
05	COMCARE
07	MAGELLAN
08	VALUE OPTIONS
11	GILA RIVER INDIAN TRIBE
14	NAVAJO NATION
15	NORTHERN AZ REG BEHAVIORAL SER
17	SALT RIVER PIMA-MARICOPA IND
18	SOUTHEAST AZ BEHAVIORAL SERV
22	CENPATICO 4
23	PINAL/GILA BEHAVIORAL SERVICES
24	AZ CENTER FOR CLINICAL MGMT
25	PASCUA YAQUI TRIBE
26	COMM PARTNER SO AZ SVC AREA 5
27	COMM PARTNER SO AZ SVC AREA 3
MENTAL HEALTH CATEGORIES	
C	CHILDREN SERVICES
D	SUBSTANCE/ALCOHOL ABUSE MENTAL HEALTH SERVICES
G	GENERAL MENTAL HEALTH SERVICES
S	SMI
Z	SED CHILDREN

CA166 Provider Search Instructions

On CA166/ACE Critical Data, users can do a provider search to determine who the Provider ID# in the "LAR Provider" (Living Arrangement) field belongs to, if applicable. The Provider ID# that appears in this field will reflect only the Nursing Facility or Assisted Living Facility provider that AHCCCS eligibility has recorded as the member's current living arrangement in ACE.

```
TR: CA166                  AHCCCS - LONG TERM CARE                      05/30/06
NTR: _____ I _______________  ACE CRITICAL DATA                          07:53:31
WORKER ID: 605636                                                        LT02L130
NAME: JONES                ALICE           STATUS: A  EFF TERM DAT: __________
AHCCCS-ID: A87654321  ACE ID: 100000000 TRIBE CD: 15  RES CD: __  NET TEST: P
CASE MANAGER: 123456 MANAGER, CASEY                   OFFICE: 13A  PAS LOC: I
FIN REDE DUE DATE: 10/31/2006    MED REASS DUE DATE: NONE        DD STATUS: 4

LIVING ARRANGEMENT(LAR): LT   LAR PROVIDER: 355752   LAR BEG DATE: 07/22/2000
MOST RECENT TRANSITIONAL PERIOD BEGIN DATE: __________   END DATE: __________
 MAJOR DIAG 1: 3109        MAJOR DIAG 2: 582         MAJOR DIAG 3: __________

  AUTH REP: JONES                PHYLLIS    _          RELATION: OT
         STREET ADDRESS: 12345 E THOMAS
     CITY: ANYWHERE            ST: AZ  ZIP: 85256 ____  RES PHO: ___ ___ ____
                                                        BUS PHO: 555 555 5555
 LEGAL REP: _____________________ __________ _          RELATION: __
         STREET ADDRESS: _____________________    ____________________
     CITY: ____________________  ST: __  ZIP: _____ ____  RES PHO: ___ ___ ____
                                                        BUS PHO: ___ ___ ____

                                                   Z026 RETURN FROM HELP
1=HLP 2=CA000 3=ADD 4=ERR 5=CA165 6=CA167 (7=DEM 8=SOC 9=VER 10=MHS) 11=CLEAR
```

The user should place the curser on the Provider ID# in the LAR Provider field (bolded in the screen example above) and press F1. A screen such as the one shown below will be displayed. The provider information from the ID chosen on the screen will be at the top of the list shown. Pressing F2 will return the user to CA166.

```
TR: CA166 ACT: I      AHCCCS - INFORMATION REFERENCING                  05/30/06
                               PROVIDER ID/NAME                         07:54:14
                                                                        AH05L012
S  SORTED BY PROVIDER ID
E
L PR ID  NPI        PROVIDER NAME                -----PROVIDER TYPE------------
  ______ __________ ____________________________
_ 355752             PLAZA HEALTHCARE            22 NURSING HOME
_ 355760             DUNKIN/MARTHA(BETH)         50 ADULT FOSTER CARE
_ 355778             JOHNSON/LEONILA(MILA)       50 ADULT FOSTER CARE
_ 355786             WHITE MNTN REG MED CENTER   22 NURSING HOME
_ 355794             LEAR/LISA A.                07 DENTIST
_ 355801             CARDOZA/MARTY               50 ADULT FOSTER CARE
_ 355819             THE WILLOWS                 50 ADULT FOSTER CARE

PF:       2=RTN                          7=UP  8=DWN       10=TOP 11=BOT
```

G. MEMBER INCOME (CA167)

Monthly income data for a member is displayed on this screen. Data is available by the Budget Months recorded in the AHCCCS Customer Eligibility (ACE) system, not necessarily for every calendar month. This data is made available to case managers for purposes of determining Room & Board charges if/when the member is admitted to an Assisted Living Facility.

Users may not designate or switch between members on the CA167 screen. Users can only access CA167 from any of the other member data screens (CA160, CA161, CA165 or CA166) as long as the member's AHCCCS ID# has already been entered on that previous screen. For example, if the user is viewing John Smith's CA160/CES, s/he may type "CA167" in the NTR field and bring up CA167 for John Smith but could not travel to CA167 from John Smith's CA160 and plan to view Mary Jones' Income data. To switch between members for income data, the user may press F5 to return to CA166, enter another member's AHCCCS ID and then return to CA167 for that member's income data by either pressing F6 or by typing "CA167" in the NTR field.

Upon entering CA167 for a specific member, the current month will appear in the Budget Month field (e.g. March 2006 = Budget Month 200603) but the user must press the Enter key in order for any income data available for that month to be displayed. As eligibility does not record income data for every month, if the member's income has not changed since it was last recorded, income data may not appear for the current month. The F7 key will scroll the user backward, month by month, to view data for prior months. If there is no data recorded for a particular month, the message "NOT FOUND IN ACE" will appear at the top of the screen. Users may continue to scroll until income data is displayed or a specific Budget Month can be entered to bring the user directly to that month.

```
2519 NOT FOUND IN ACE
TR: CA167                    AHCCCS - LONG TERM CARE                  04/12/06
NTR:       I                      MEMBER INCOME                       09:38:21
BUDGET MONTH: 200604                                                  LT02L135

NAME: BUNNY               BUGS             ACN:          AHCCCS ID: A12345678

 TYPE OF INCOME            SOURCE OF INCOME            REPORTED AMOUNT




1=HLP 2=CA000       5=CA166 6=CA225                              12=AH000
```

In the example below, the last Budget Month for which income was recorded in ACE is March 2006. All Earned and Unearned income for the member will be displayed, including the Type, Source and Amount. Up to 14 income types/sources may be displayed for a member as applicable.

```
TR: CA167                      AHCCCS - LONG TERM CARE                    03/09/06
NTR:       I                        MEMBER INCOME                         08:41:32
BUDGET MONTH: 200603                                                      LT02L135

NAME: BUNNY                 BUGS            ACN:          AHCCCS ID: A12345678

 TYPE OF INCOME             SOURCE OF INCOME            REPORTED AMOUNT
 SOCIAL SECURITY            SOCIAL SECURITY ADMINISTR       227.00
 NO EARNED INCOME                                             0.00




1=HLP 2=CA000       5=CA166 6=CA225                              12=AH000
```

H. CASE MANAGER REVIEWS TRACKING LIST (CA225)

```
TR: CA225                  AHCCCS - LONG TERM CARE                        10/01/03
 NTR: _____ I _____________ CASE MANAGER REVIEWS TRACKING LIST            08:01:59
                   FROM MONTH: ____1____ THRU MONTH: ____2_____           LT02L170
 CASE MANAGER: ___3__   ________________________________   WORKER ID: 605636
                                                          CURRENT
  DUE DATE                 CLIENT NAME       AHCCCS ID PLC LOC   FACILITY
 ____A_____ ___________B________ __________ _____C__  D_ E ___F__ ____________
 __________ ____________________ __________ __________  __ _ _______ ____________
 __________ ____________________ __________ __________  __ _ _______ ____________
 __________ ____________________ __________ __________  __ _ _______ ____________
 __________ ____________________ __________ __________  __ _ _______ ____________
 __________ ____________________ __________ __________  __ _ _______ ____________
 __________ ____________________ __________ __________  __ _ _______ ____________
 __________ ____________________ __________ __________  __ _ _______ ____________
 __________ ____________________ __________ __________  __ _ _______ ____________

  ENT=PROCESS   1=HELP   2=CA000   6=CA165   9=SUP  10=SDN  11=CLEAR  12=CA000
```

This screen is designed to provide the user with a list of member service assessment/review due dates within a specified time period for a specific case manager. This information is obtained from the "CURR CSMGR" (current case manager) and "Next Review Date" fields on CA161. This screen is one of only 2 CATS screens that is not accessed with a member's AHCCCS ID# (CA105 is the other).

The **Numbered** fields shown on the screen above are for data entry. The **Lettered** fields above are information-only and the data can not be changed from these fields.

Instructions for completion of the **Numbered** fields are as follows:

(1) FROM MONTH - this field will contain the current month/year when the user enters this screen. If the user wants to view an earlier time period, that month/year should be entered (for example if, in April 2006, the user wants to see if there are any overdue cases back to January 2006, 01/2006 would be entered in this field). The format is MM/YYYY.

(2) THRU MONTH - this field will contain the current month/year when the user enters this screen. If the user wants to view a later time period, that month/year should be entered. The format is MM/YYYY.

(3) CASE MANAGER - enter the 6-digit ID# of the case manager for whom case review information is sought. Only review information about enrolled members who are currently assigned to this case manager on CA161 will appear when this ID# is entered.

Below is an explanation of the **Lettered, information-only** fields:

(A) DUE DATE - the date from the "NEXT REVIEW DATE" field on CA161 will be displayed here. The system calculates the date the member's next on-site service review is due based on the

"Last Review Date" entered on CA161 and the member's current placement. Members in "H" and "D" placement will be due in 90 days and members "Q" placement will be due in 180 days. Members still in "Z" placement when a "Last Review Date" is entered will show a Next Review Date in 30 days.

(B) CLIENT NAME - the member's name (last, first) will be displayed here.

(C) AHCCCS ID - the member's AHCCCS ID# will be displayed here.

(D) CURRENT PLC - the member's current placement code will be displayed here. This information is read from CA161.

(E) CURRENT LOC - the information in this field is inconsistent and should not be relied on. This field used to display the Level of Care from either the most recent PAS or as updated by the case manager on CA165.

(F) FACILITY - the provider ID# and name of the nursing facility the member resides in, if applicable, will be displayed here. This information is read from CA165/Service Plan. If there is no open service authorization for the facility on CA165, this field will be blank.

I. INQUIRE PART D DRUG PLAN (RP214)

```
 TR: RP214 ACT: I              AHCCCS - RECIPIENT    USER-ID: MA3    10/25/10
NTR: _____________________  INQUIRE PART D DRUG PLAN                 16:35:40
   (A)          (B)                      (C)         (D)    (E)     RP01L014
A12345678  BEET VICTORY H                SEX F DOB 01/01/1900  DOD
     (F)
ALTERNATE DOB:
  (F)                                                      (L)
  S  (G)   (H)          (I)             (J)     (K)      DATE         (M)
  T EN   DRUG                          BEGIN    END      REC       LAST MOD
  A TP   PLAN ID     PLAN NAME         DATE     DATE     ADDED     DATE   USER

  A EC   S5678001  HEALTH NE/HEALTH N 01/01/09          12/27/08 12/27/08 BAT
  A EC   S5884086  HUMANA IN/HUMANA S 01/01/07 12/31/08 11/27/07 12/27/08 BAT
  A AA   S5960028  UNICARE L/MEDICARE 01/01/06 12/31/06 03/24/06 09/25/08 CV*









PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

The RP214/Inquire Part D Drug Plan screen may be used to determine which Medicare Part D drug plan the member is enrolled with and whether this was an enrollment choice or an auto-assignment by CMS. This information may be used by Contractors to determine if the member has Medicare Part D coverage so that this can be coordinated with the member's other AHCCCS benefits. AHCCCS does not cover prescriptions or the copayments when a member has Medicare Part D drug coverage.

Below is an explanation of the **Lettered** fields. This is an **information-only** screen for Contractors – no data can be added or changed on this screen by users.

(A) This is the member's AHCCCS ID number. If you scroll to this screen on a case you are already looking at, the information displayed will be for the same member. If you want to look at a different case, enter the appropriate AHCCCS ID and press ENTER. This is the only field on this screen that allows entry.

(B) This is the member's last name, first name and middle initial.

(C) This is the member's gender.

(D) This is the member's date of birth.

(E) This is the member's date of death, as applicable.

(F) This is the status of the line. This is almost always (A)ctive. It will only be (I)nactive if the enrollment segment was totally inactivated.

(G) This is the enrollment type. "EC" is enrollment choice by the member. "AA" is auto-assignment to the plan by CMS (Centers for Medicare and Medicaid Services).

(H) This is the drug plan ID# for the Medicare Part D plan the member is assigned to. RF568 provides a reference table of plan IDs . This reference table will show you the full name of the Part D plan and the effective dates of the plan availability.

(I) This is the abbreviated name of the Medicare Part D drug plan.

(J) This is the begin date of the member's coverage with the specific Medicare Part D drug plan. In the example on the screen, you can see the begin and end dates of three different Medicare Part D drug plans.

(K) This is the end date of the member's coverage with the specific Medicare Part D drug plan.

(L) This is the date the record was added to the system.

(M) This is the date the particular record was last modified and how it was modified. If there is a "*CV", this record is a result of conversion. If there is a "BAT", this is record is a result of the batch process.

J. INQUIRE FYI DATA (RP215)

```
 TR: RP215 ACT: I              AHCCCS - RECIPIENT    USER-ID: MA3    10/26/10
NTR: _____________________      INQUIRE FYI DATA                     16:52:29
(PRIMARY)                                                            RP02L015
   (A)        (B)                              (C)        (D)            (E)
A12345678 BALDMAN GERM                      SEX M DOB 06/01/1982 DOD

           CRS CLIENT ID:   (F)                 TSC CLIENT ID:  (G)
         AZEIP CLIENT ID:    (H)
     (I)      (J)         (K)    (L)  (M)              (N)           (O)
    TYPE                            CHG                          LAST MOD
     ID   BEGIN DATE  END DATE   STA RSN SITE CAT  DATE ADDED     DATE    USR

   H7352  03/01/2008              A                 06/09/2010  06/09/2010 BAT
   999222 01/01/2008              A                 01/04/2008  10/03/2010 BAT
   999222 07/01/1999 12/31/2007   A                 12/22/2004  12/03/2007 BAT
```

The RP215/Inquire FYI Data screen is used to show special enrollments.. This information is used by Contractors to determine if the member is enrolled with a Medicare HMO, Children's Rehabilitative Services (CRS), AzEIP (Arizona Early Intervention Program) or TSC (Targeted Support Coordination).

Below is an explanation of the **Lettered** fields. This is an **information-only** screen for Contractors – no data can be added or changed on this screen by users.

(A) This is the member's AHCCCS ID number. If you scroll to this screen on a case you are already looking at, the information displayed will be for the same member. If you want to look at a different case, enter the appropriate AHCCCS ID and press ENTER. This is the only field on this screen that allows entry.

(B) This is the member's last name, first name and middle initial.

(C) This is the member's gender.

(D) This is the member's date of birth.

(E) This is the member's date of death, as applicable.

(F) This is the member's Children's Rehabilitative Services client ID number, if applicable.

(G) This field was created to display the member's Targeted Support Coordination client ID number, as applicable. Since the Department of Economic Security (DES) uses the member's AHCCCS ID number instead, this field will be blank.

(H) This is the member's Arizona Early Intervention Program (AzEIP) client ID number, as applicable. Since the Department of Economic Security (DES) uses the member's AHCCCS ID number instead, this field will be blank.

(I) The type ID will show the member's special enrollment as follows.

Medicare HMO enrollment show a Type ID starting with an "H". The reference table to look up the Medicare HMO plan names is RF517.

999111 = CRS

999555 = AzEIP

999222 = TSC

(J) This is the begin date of the member's special enrollment.

(K) This is the end date of the member's special enrollment. If there is no end date, the member's enrollment in that special category continues. Members can have more than one special enrollment active at one time. In the example on the screen, the member has a Medicare HMO enrollment and TSC enrollment active.

(L) This is the status of the line. This is almost always (A)ctive. It will only be (I)nactive if the special enrollment segment was totally inactivated.

(M) If there is a change to the Medicare HMO enrollment, there will be a change reason in this field. Refer to RF525 for a list of change reasons.

The "Site" and "CAT" fields on this screen are no longer used.

(N) This is the date the record was added to the system.

(O) This is the date the particular record was last modified and how it was modified. This information is updated by daily/monthly electronic matches between DES and PMMIS so this field will usually show "BAT". This means that the record was updated in that the batch process.

K. INQUIRE ELIGIBILTIY AND ENROLLMENT (RP285)

```
TR: RP285 ACT: I                    AHCCCS - RECIPIENT  USER-ID: MA3 11/12/10
 NTR: _____________________  INQUIRE ELIGIBILITY AND ENROLLMENT       15:12:58
                                                                      RP02L085
 A12345678 JOHNS WILBUR                    SEX M DOB 07/18/1929 DOD
                     (A)
                    ELG          COMB BEG          COMB END
                    KEY            DATE              DATE
                    140         02/01/2009
                    587         07/01/2008        01/31/2009
                    587         10/01/2005        08/31/2007




       (B)  (C)                                        (E)      (F)
      HEALTH PLAN/     ENROLLMENT    ENROLLMENT      RATE     ENRL
      CSA/CTRT TYP (D) BEGIN DATE      END DATE      CODE     TYP     STA
      110015 19 J      10/28/2010                     2210      MA      A
      110306 13 J      07/01/2010    10/27/2010       2210      EC      A
      110088 13 J      03/16/2009    06/30/2010       2210      EC      A
      110088 13 M      03/01/2009    03/15/2009       221Z      RA      A
      010497 05 A      12/11/2008    02/28/2009       3618      RE      A
 PF: 1=HLP 2=RTN 3=CLR 4=MSG              7=UP  8=DWN       10=UP  11=DWN 12=ESC
```

The Inquire Eligibility and Enrollment (RP-285) screen is used to review the combined eligibility and enrollment history for a specific member. The top half of the screen contains eligibility data and the bottom half of the screen contains enrollment information. This screen is useful to quickly reference which AHCCCS program a member is eligible for, the dates of that enrollment and their health plan.

The only entry field on this screen is the member's AHCCCS ID number. Enter the number for the member you wish to inquire about and press ENTER. The member's information will appear on the screen.

Below is an explanation of the **Lettered** fields. This is an **information-only** screen for Contractors – no data can be added or changed on this screen by users.

(A) Eligibility Key: Use RF534 to determine what each eligibility key code means. Enter the code you are looking for on RF534 and press ENTER. A full description of the code will be displayed.

(B) Health Plan: The following table lists current AHCCCS Health Plans and ALTCS Contractors:

Code	Name		Code	Name
Acute AHCCCS Health Plans			**ALTCS Contractors**	
010088	Bridgeway Health Solutions		110007	DES/Division of Developmental Disabilities
010158	AP/IPA		110049	Evercare Select
010166	DES CMDP		110088	Bridgeway Health Solutions
010254	Care 1st		110306	Mercy Care Plan LTC
010299	PHP/Community Connection		190000	Native American Community Health
010306	Mercy Care Plan		190009	White Mountain Apache Tribe
010314	University Family Care		190017	Navajo Nation
010383	Maricopa Health Plan		190025	Gila River Indian Community
010497	Health Choice Arizona		190033	Tohono O'Odham Nation
999998	American Indian Health Plan		190075	Pasqua Yaqui Tribe
000850	Federal Emergency Services		190083	San Carlos Apache Tribe
002220	AHCCCS Non-Pay		190091	Hopi Tribe
003335	FFS Regular			
008040	SLMB - Part B Buy-In Only			
008050	QI1 - Part B Buy-In Only			
008690	FFS Temporary			
008715	AHCCCS QMB Only			
888886	FFS LTC (Residual)			

(C) County: Use the following table for Arizona County codes:

CODE	COUNTY
01	APACHE
03	COCHISE
05	COCONINO
07	GILA
09	GRAHAM
11	GREENLEE
13	MARICOPA
15	MOHAVE
17	NAVAJO
19	PIMA
21	PINAL
23	SANTA CRUZ
25	YAVAPAI
27	YUMA
29	LA PAZ

(D) Contract Type: RF410 displays a list of contract types. The most common contract types for Long Term Care are:

J	Long Term Care Capitated
L	Long Term Capitated Acute Care Only
P	Long Term Care Partially Capitated (for FFS members)
T	Long Term Care FFS Acute Care Only

(E) Rate Code: RF401 displays a list of rate codes.

(F) Enrollment Type: RF513 displays a list of enrollment types.

V. References

- AHCCCS Medical Policy Manual, Chapter 1200
- AHCCCS Medical Policy Manual, Chapter 1600

Appendix A
ALTCS CONTRACTOR
CASE MANAGER AFFILIATION

Purpose: The purpose of the following information is to provide the procedures to follow regarding the affiliation of case managers with ALTCS Contractors. These procedures are necessary to assign case managers their 6-digit Case Manager ID#.

- Procedure One includes the steps to follow to affiliate a case manager who has never before been affiliated with an ALTCS Contractor.
- Procedure Two includes the steps to follow to affiliate a case manager who was affiliated previously with another Contractor and that affiliation is still active. The prior affiliation must be terminated before a new one can be initiated.
- Procedure Three includes the steps to follow to affiliate a case manager who was affiliated previously with a Contractor and that affiliation has been terminated.
- Procedure Four includes the steps to follow to terminate a case manager's affiliation when s/he no longer works for the Contractor.
- Procedure Five includes the steps to follow to change a case manager's name.

Procedure One
New Case Manager, Never Affiliated

1. Go to the PR800A AHCCCS - PROVIDER CASE MANAGER SEARCH screen.

```
7337 ENTER SEARCH CRITERIA - OR - PRESS PF6 TO ADD NEW CASE MANAGER
  TR: PR800 ACT: A             AHCCCS - PROVIDER                    05/17/11
 NTR: _____________________   CASE MANAGER SEARCH                    07:54:18
                                                                     PR01L091

    CASE MANAGERS ARE HIGHLIGHTED WHEN THEIR SSNS MATCH NON-CASE MANAGER SSNS

 CASE MANAGER NAME: _____________________________          SSN: ____________
     PROVIDER TYPE:

 SEL             NAME                          ID    STATUS     SSN       PR TYPE




 PF: 1=HLP 2=RTN 3=CLR 4=MSG      6=NXT  7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

2. Search for the case manager by last name.

```
7337 ENTER SEARCH CRITERIA - OR - PRESS PF6 TO ADD NEW CASE MANAGER
 TR: PR800 ACT: A             AHCCCS - PROVIDER                        05/17/11
NTR: _____________________  CASE MANAGER SEARCH                        07:54:18
                                                                       PR01L091

   CASE MANAGERS ARE HIGHLIGHTED WHEN THEIR SSNS MATCH NON-CASE MANAGER SSNS

CASE MANAGER NAME: doe_____________________           SSN: ___________
    PROVIDER TYPE:

SEL             NAME                          ID    STATUS     SSN       PR TYPE









PF: 1=HLP 2=RTN 3=CLR 4=MSG      6=NXT  7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

3. If the search by last name does not find a listing for the case manager, then search for the case manager by Social Security Number (SSN).

```
7338 NO MATCH FOUND FOR SEARCH CRITERIA
 TR: PR800 ACT: A             AHCCCS - PROVIDER                        05/17/11
NTR: _____________________  CASE MANAGER SEARCH                        07:58:48
                                                                       PR01L091

   CASE MANAGERS ARE HIGHLIGHTED WHEN THEIR SSNS MATCH NON-CASE MANAGER SSNS

CASE MANAGER NAME: _____________________           SSN: 234-23-2345
    PROVIDER TYPE:

SEL             NAME                          ID    STATUS     SSN       PR TYPE









PF: 1=HLP 2=RTN 3=CLR 4=MSG      6=NXT  7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

4. If the above name search does not result in a listing for the case manager and with the SSN number displayed, press the <F6> key to go to the PR800A AHCCCS - PROVIDER CASE MANAGER DEMOGRAPHICS screen.

```
TR: PR800 ACT: A                AHCCCS - PROVIDER                      05/17/11
NTR: _____________________   CASE MANAGER DEMOGRAPHICS                  08:00:10
                                                                        PR01L193
      CASE MANAGER  ID:         NAME: _____________________________ SSN: 234-23-2345



 ENROLLMENT BEGIN DATE: ___________


CORRESPONDENCE ADDRESS:
         STREET LINE 1: _____________________________
         STREET LINE 2: _____________________________
        CITY/STATE/ZIP: _____________________________ __ _____
           COUNTY CODE: __                    COUNTRY CODE: __
        BUSINESS PHONE:( ___ ) ___ - ____ EMERGENCY PHONE:( ___ ) ___ - ____
          ATTENTION TO: _____________________________




PF: 1=HLP 2=RTN 3=CLR 4=MSG 5=PRI                                       12=ESC
```

5. The case manager's Social Security Number will be transferred from the previous screen. Complete the screen as follows. For "Name", enter the case manager's last name (comma) (space) case manager's first name. For Enrollment Begin Date, enter the employment begin date with the new program contractor. For Street Line 1, enter the new program contractor name. For Street Line 2, enter the program contractor office address where the case manager is located. For City/State/Zip, enter the program contractor office information. For County Code, enter "01". For Business Phone, enter the case manager's phone number. Optional entries can be entered for both "Emergency Phone" and "Attention To".

```
TR: PR800 ACT: A                AHCCCS - PROVIDER                      05/17/11
NTR: _____________________   CASE MANAGER DEMOGRAPHICS                  14:37:44
                                                                        PR01L193
      CASE MANAGER  ID:         NAME: doe, john___________________ SSN: 234-23-2345


 ENROLLMENT BEGIN DATE: 03/01/2008


CORRESPONDENCE ADDRESS:
         STREET LINE 1: any program contractor_
         STREET LINE 2: 1111 w. elm st___________
        CITY/STATE/ZIP: phoenix__________          az  85034
           COUNTY CODE: 13                  COUNTRY CODE: 01
        BUSINESS PHONE:( 602 ) 555 - 5555 EMERGENCY PHONE:( 602 ) 555 - 5556
          ATTENTION TO: _____________________________




PF: 1=HLP 2=RTN 3=CLR 4=MSG 5=PRI                                       12=ESC
```

6. Press the <ENTER> key. In the upper left portion of the screen, the following message will be displayed: "RECORD(S) SUCCESSFULLY ADDED". The ID assigned to the case manager will be displayed on the screen.

```
9200 RECORD(S) SUCCESSFULLY ADDED
 TR: PR800 ACT: A              AHCCCS - PROVIDER                      05/17/1
NTR: _______________________  CASE MANAGER DEMOGRAPHICS                14:41:0
                                                                      PR01L19
      CASE MANAGER  ID: 606962 NAME: DOE, JOHN                 SSN: 234-23-234
         PROVIDER TYPE: 98  CASE MANAGER
 CURRENT ENRLMT STATUS: 16  PENDING-AFFILIATION MISSING


 ENROLLMENT BEGIN DATE: 03/01/2008
   ENROLLMENT END DATE: 99/99/9999

CORRESPONDENCE ADDRESS:
         STREET LINE 1: ANY PROGRAM CONTRACTOR
         STREET LINE 2: 1111 W. ELM ST
        CITY/STATE/ZIP: PHOENIX                    AZ  85034
           COUNTY CODE: 13 MARICOPA        COUNTRY CODE: 01 UNITED STATES OF
        BUSINESS PHONE:( 602 ) 555 - 5555 EMERGENCY PHONE:( 602 ) 555 - 5556
          ATTENTION TO:




PF: 1=HLP 2=RTN 3=CLR 4=MSG 5=PRI 6=NXT                                12=ESC
```

7. Press the <F6> key to go to the PR800A AHCCCS - HEALTH PLAN CASE MANAGER AFFILIATIONS screen. For Program Contractor, enter the program contractor ID. For County, enter the appropriate county code. For Affiliation Start Date, enter the employment begin date.

```
TR: PR800 ACT: A                AHCCCS - HEALTH PLAN                 05/17/11
NTR: _______________________     CASE MANAGER AFFILIATIONS             14:56:21
                                                                      HP07L690

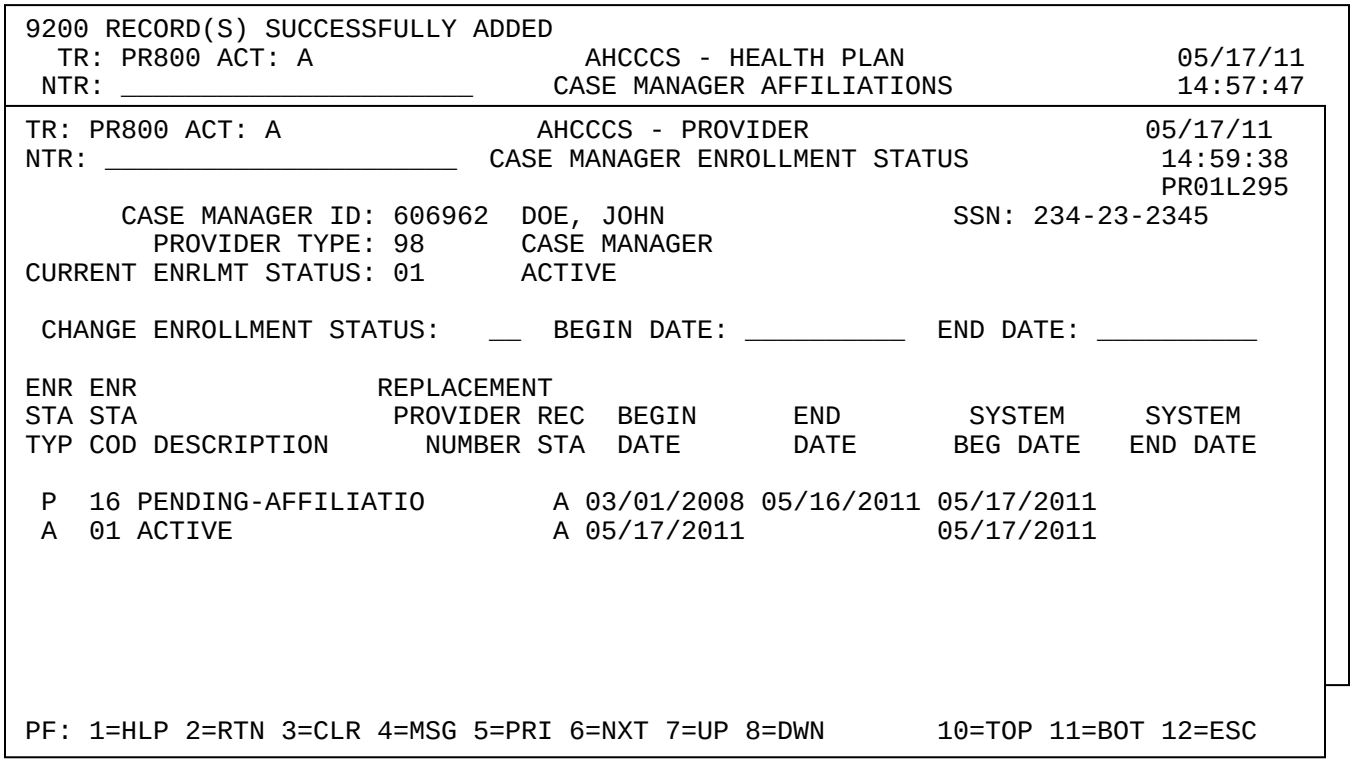
   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 16 PENDING-AFFILIATION MISSING

PROGRAM                                                    AFFILIATION
CONTRACTOR                        COUNTY               START DATE   END DATE

110007                            13                    03 01 08    __ __ __
______                            __                    __ __ __    __ __ __
______                            __                    __ __ __    __ __ __
______                            __                    __ __ __    __ __ __
______                            __                    __ __ __    __ __ __
______                            __                    __ __ __    __ __ __
______                            __                    __ __ __    __ __ __
______                            __                    __ __ __    __ __ __
______                            __                    __ __ __    __ __ __

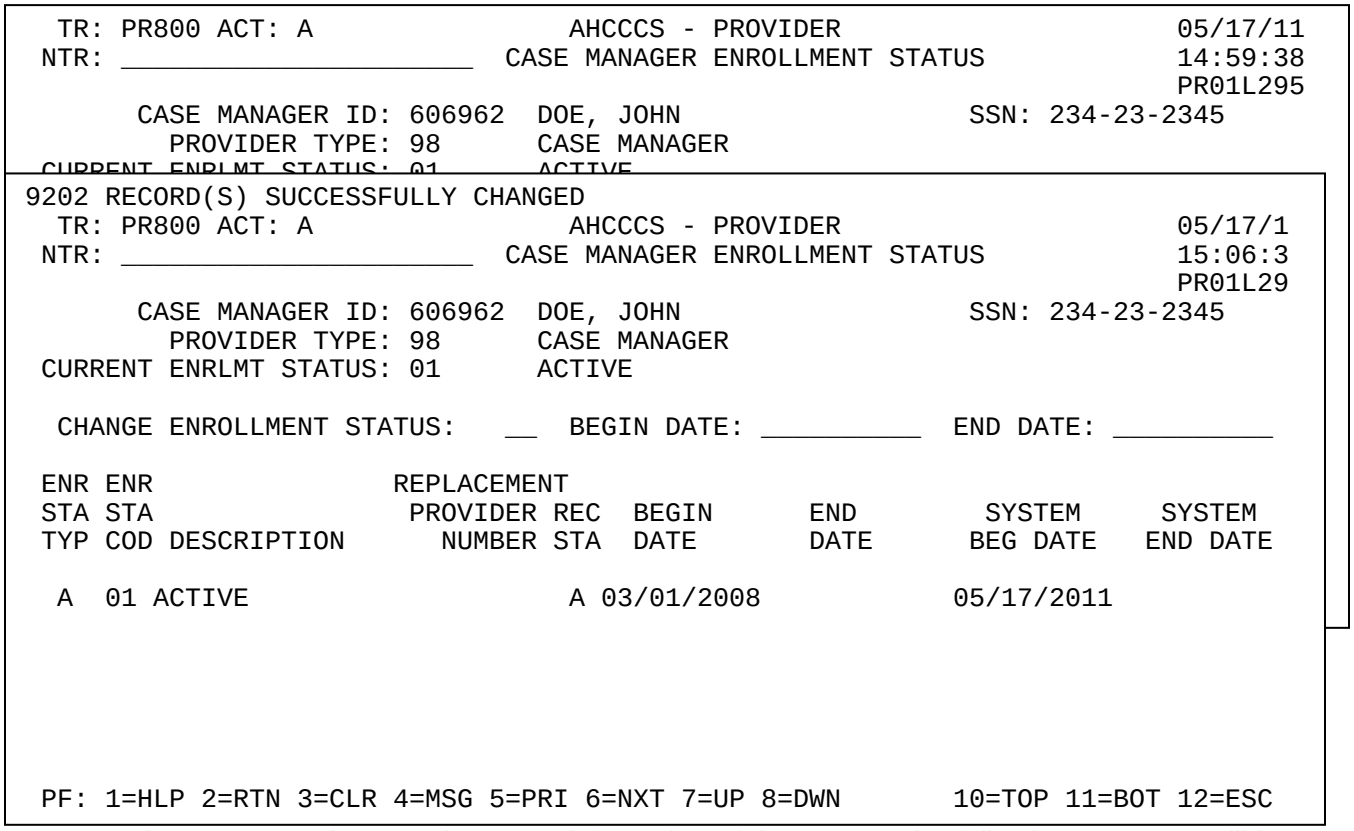
PF: 1=HLP 2=RTN 3=CLR 4=MSG 5=PRI 6=NXT       8=DWN                    12=ESC
```

8. Press the <ENTER> key. In the upper left portion of the screen, the following message will be displayed: “RECORD(S) SUCCESSFULLY ADDED”.



9. Press the <F6> key to go to the PR800A AHCCCS – PROVIDER CASE MANAGER ENROLLMENT STATUS screen.

10. For “Change Enrollment Status”, enter “01”. For “Begin Date”, enter employment begin date. For “End Date”, enter 99/99/9999.



11. Press the <ENTER> key. In the upper left portion of the screen, the following message will be displayed: “RECORD(S) SUCCESSFULLY CHANGED”. The screen will display “Enr Sta Type/Enr Sta Cod/Description” of “A 01 ACTIVE” and for “Begin Date” the employment begin date.

12. To confirm case manager affiliation with the new program contractor, go to the HP014I AHCCCS - HEALTH PLAN INQUIRE CASE MANAGER AFFILIATIONS screen.

```
TR: HP014 ACT: I                  AHCCCS - HEALTH PLAN                  05/17/11
NTR: _____________________ INQUIRE CASE MANAGER AFFILIATIONS            15:08:33
                                                                        HP07L190
```

```
TR: HP014 ACT: I                  AHCCCS - HEALTH PLAN                  05/17/11
NTR: _____________________ INQUIRE CASE MANAGER AFFILIATIONS            15:12:16
                                                                        HP07L190

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 01 ACTIVE

DISPLAY:  S CURRENT AFFILIATIONS    _ OLD AFFILIATIONS    _ ALL AFFILIATIONS

PROGRAM                                                        AFFILIATION
CONTRACTOR                          COUNTY              START DATE   END DATE

110007 LTC DD DES                   13 MARICOPA         03/01/2008




PF: 1=HLP 2=RTN 3=CLR 4=MSG              7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

13. Enter the case manager ID and press the <ENTER> key. The screen will display the “Program Contractor”, “County” and “Affiliation Start Date”.

Procedure Two

Transferred Case Manager, Prior Affiliation still Active

1. Go to the PR800A AHCCCS - PROVIDER CASE MANAGER SEARCH screen. Search for the case manager first by last name. If the search by last name does not find a listing for the case manager, then search for the case manager by Social Security Number (SSN).

2. If the above name search provides a listing for the case manager, place an “S” in the “SEL” field at the beginning of this line.

```
7342 PLACE 'S' BESIDE DESIRED NAME AND PRESS ENTER
 TR: PR800 ACT: A              AHCCCS - PROVIDER                    05/23/11
NTR: _____________________  CASE MANAGER SEARCH                    15:29:15
                                                                    PR01L091

   CASE MANAGERS ARE HIGHLIGHTED WHEN THEIR SSNS MATCH NON-CASE MANAGER SSNS

CASE MANAGER NAME: DOE                                  SSN: ____________
    PROVIDER TYPE:

SEL             NAME                          ID     STATUS     SSN        PR TYPE

 S   DOE, JOHN                               606962    A 01   234-23-2345     98
 _   DOHANYOS, MEREDITH                      123456    A 01   000-00-0000     98
 _   DOHERTY TOM                             456789    T 30   111-22-3333     98
 _   DOLLEY, SYLVIE                          987654    T 30   222-33-4444     98
 _   DOLORES JOSSE                           654321    T 30   333-44-5555     98

PF: 1=HLP 2=RTN 3=CLR 4=MSG      6=NXT  7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

3. Press the <ENTER> key. This action will bring up the PR810C AHCCCS - PROVIDER CASE MANAGER DEMOGRAPHICS screen.

```
 TR: PR810 ACT: C                AHCCCS - PROVIDER                      05/17/11
NTR: _____________________  CASE MANAGER DEMOGRAPHICS                   15:29:06
                                                                        PR01L293
      CASE MANAGER  ID: 606962 NAME: DOE, JOHN                SSN: 234-23-2345
      PROVIDER TYPE: 08  CASE MANAGER
```

```
TR: HP014 ACT: C                AHCCCS - HEALTH PLAN                   05/17/11
NTR: _____________________ CHANGE CASE MANAGER AFFILIATIONS             15:31:36
                                                                        HP07L490

   ENTER CASE MANAGER ID: 606962 OR SSN: ___ __ ____
     CASE MANAGER'S NAME:
   CURRENT ENRLMT STATUS:

DISPLAY:  S CURRENT AFFILIATIONS    _ OLD AFFILIATIONS    _ ALL AFFILIATIONS

PROGRAM                                                      AFFILIATION
CONTRACTOR                          COUNTY                START DATE   END DATE




PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

4. If the PR810C screen displays a former program contractor with a current enrollment status of ***01 Active***, go to the HP014C AHCCCS - HEALTH PLAN CHANGE CASE MANAGER AFFILIATIONS screen.

5. Enter the case manager ID and press the <ENTER> key.

```
TR: HP014 ACT: C                AHCCCS - HEALTH PLAN                   05/17/1
NTR: _____________________ CHANGE CASE MANAGER AFFILIATIONS             15:32:4
                                                                        HP07L49
```

```
 TR: HP014 ACT: C                AHCCCS - HEALTH PLAN                   05/23/11
NTR: _____________________ CHANGE CASE MANAGER AFFILIATIONS             14:37:40
                                                                        HP07L490

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 01 ACTIVE

 DISPLAY:  S CURRENT AFFILIATIONS    _ OLD AFFILIATIONS    _ ALL AFFILIATIONS

 PROGRAM                                                     AFFILIATION
 CONTRACTOR                          COUNTY                START DATE   END DATE

 110007 LTC DD DES                   13 MARICOPA            03 01 08    04 30 11




 PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

6. Enter the Affiliation End Date one day prior to the employment begin date with the new program contractor.

7. Press the <ENTER> key. In the upper left of the screen the following message will be displayed: “RECORD(S) SUCCESSFULLY CHANGED”.

```
9202 RECORD(S) SUCCESSFULLY CHANGED
 TR: HP014 ACT: C                AHCCCS - HEALTH PLAN                  05/23/11
NTR: _____________________ CHANGE CASE MANAGER AFFILIATIONS            14:39:31

  TR: PR815 ACT: C               AHCCCS - PROVIDER                     05/23/11
 NTR: _____________________  CASE MANAGER ENROLLMENT STATUS            14:40:44
                                                                       PR01L295
       CASE MANAGER ID: 606962                              SSN:
         PROVIDER TYPE:
 CURRENT ENRLMT STATUS:

  CHANGE ENROLLMENT STATUS:       BEGIN DATE:             END DATE:

 ENR ENR               REPLACEMENT
 STA STA                PROVIDER REC  BEGIN      END        SYSTEM     SYSTEM
 TYP COD DESCRIPTION      NUMBER STA  DATE       DATE      BEG DATE   END DATE




 PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP 8=DWN       10=TOP 11=BOT 12=ESC
```

8. Go to the PR815C AHCCCS – PROVIDER CASE MANAGER ENROLLMENT STATUS screen. Enter the case manager ID and press the <ENTER> key.

9. For Current Enrollment Status, enter “30”. For Begin Date, enter the date following the enrollment end date indicated on the HP014C screen. For End Date, enter 99/99/9999.

```
TR: PR815 ACT: C                AHCCCS - PROVIDER                     05/23/11
NTR: _____________________  CASE MANAGER ENROLLMENT STATUS            14:42:02
                                                                       PR01L295
      CASE MANAGER ID: 606962  DOE, JOHN                SSN: 234-23-2345
        PROVIDER TYPE: 98      CASE MANAGER
CURRENT ENRLMT STATUS: 16      PENDING-AFFILIATION MISSING
9202 RECORD(S) SUCCESSFULLY CHANGED
  TR: PR815 ACT: C              AHCCCS - PROVIDER                      05/23/11
 NTR: _____________________  CASE MANAGER ENROLLMENT STATUS            14:44:00
                                                                       PR01L295
       CASE MANAGER ID: 606962  DOE, JOHN                SSN: 234-23-2345
         PROVIDER TYPE: 98      CASE MANAGER
 CURRENT ENRLMT STATUS: 30      TERMINATION-OTHER

  CHANGE ENROLLMENT STATUS:   __  BEGIN DATE: __________  END DATE: __________

 ENR ENR               REPLACEMENT
 STA STA                PROVIDER REC  BEGIN      END        SYSTEM     SYSTEM
 TYP COD DESCRIPTION      NUMBER STA  DATE       DATE      BEG DATE   END DATE

  A  01 ACTIVE                  A 03/01/2008 04/30/2011 05/17/2011
  T  30 TERMINATION-OTHER       A 05/01/2011            05/23/2011




 PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP 8=DWN       10=TOP 11=BOT 12=ESC
```

11. Go to the PR810C AHCCCS - PROVIDER CASE MANAGER DEMOGRAPHICS screen.

```
 TR: PR810 ACT: C               AHCCCS - PROVIDER                        05/23/11
NTR: _____________________  CASE MANAGER DEMOGRAPHICS                    15:10:50
                                                                         PR01L293
      CASE MANAGER  ID: 606962 NAME: DOE, JOHN                 SSN: 234-23-2345
         PROVIDER TYPE: 98  CASE MANAGER
 CURRENT ENRLMT STATUS: 30  TERMINATION-OTHER
     STATUS BEGIN DATE: 05/01/2011  STATUS END DATE: 99/99/9999

 ENROLLMENT BEGIN DATE: 03/01/2008
```

```
TR: PR810 ACT: C               AHCCCS - PROVIDER                        05/23/1
NTR: _____________________  CASE MANAGER DEMOGRAPHICS                    15:10:5
                                                                         PR01L29
      CASE MANAGER  ID: 606962 NAME: DOE, JOHN                 SSN: 234-23-234
         PROVIDER TYPE: 98  CASE MANAGER
 CURRENT ENRLMT STATUS: 30  TERMINATION-OTHER
     STATUS BEGIN DATE: 05/01/2011  STATUS END DATE: 99/99/9999

 ENROLLMENT BEGIN DATE: 03/01/2008
   ENROLLMENT END DATE: 99/99/9999

CORRESPONDENCE ADDRESS:
         STREET LINE 1: new PROGRAM CONTRACTOR
         STREET LINE 2: 5555 E. oak ST
        CITY/STATE/ZIP: PHOENIX                  AZ  85034
           COUNTY CODE: 13 MARICOPA        COUNTRY CODE: 01 UNITED STATES OF
        BUSINESS PHONE:( 602 ) 555 - 1111 EMERGENCY PHONE:( 602 ) 555 - 1112
          ATTENTION TO: _____________________________



PF: 1=HLP 2=RTN 3=CLR 4=MSG                                          12=ESC
```

12. For Enrollment Begin Date, enter the employment begin date with the new program contractor. For Street Line 1, enter the new program contractor name. For Street Line 2, enter the program contractor office address where the case manager is located. For City/State/Zip, enter the program contractor office information. For County Code, enter the program contractor office county location (must agree with zip code). For Country Code, enter "01". For Business Phone, enter the case manager's phone number. Optional entries can be entered for both "Emergency Phone" and "Attention To".

```
9202 RECORD(S) SUCCESSFULLY CHANGED
 TR: PR810 ACT: C               AHCCCS - PROVIDER                        05/23/11
NTR: _____________________  CASE MANAGER DEMOGRAPHICS                    15:14:29
                                                                         PR01L293
      CASE MANAGER  ID: 606962 NAME: DOE, JOHN                 SSN: 234-23-2345
         PROVIDER TYPE: 98  CASE MANAGER
 CURRENT ENRLMT STATUS: 30  TERMINATION-OTHER
     STATUS BEGIN DATE: 05/01/2011  STATUS END DATE: 99/99/9999

 ENROLLMENT BEGIN DATE: 03/01/2008
   ENROLLMENT END DATE: 99/99/9999

CORRESPONDENCE ADDRESS:
         STREET LINE 1: NEW PROGRAM CONTRACTOR
         STREET LINE 2: 5555 E. OAK ST
        CITY/STATE/ZIP: PHOENIX                  AZ  85034
           COUNTY CODE: 13 MARICOPA        COUNTRY CODE: 01 UNITED STATES OF
        BUSINESS PHONE:( 602 ) 555 - 1111 EMERGENCY PHONE:( 602 ) 555 - 1112
          ATTENTION TO: _____________________________



PF: 1=HLP 2=RTN 3=CLR 4=MSG                                          12=ESC
```

14. Go to the HP014A AHCCCS - HEALTH PLAN ADD CASE MANAGER AFFILIATIONS screen. Enter the case manager ID and press the <ENTER> key.

```
 TR: HP014 ACT: A                AHCCCS - HEALTH PLAN                 05/23/11
NTR: _____________________  ADD CASE MANAGER AFFILIATIONS             15:16:20
                                                                     HP07L690

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 30 TERMINATION-OTHER

PROGRAM                                                    AFFILIATION
CONTRACTOR                          COUNTY            START DATE   END DATE

_______                             __                __ __ __     __ __ __
_______                             __                __ __ __     __ __ __
_______                             __                __ __ __     __ __ __
_______                             __                __ __ __     __ __ __
_______                             __                __ __ __     __ __ __
_______                             __                __ __ __     __ __ __
_______                             __                __ __ __     __ __ __

PF: 1=HLP 2=RTN 3=CLR 4=MSG                  8=DWN                  12=ESC
```

15. For Program Contractor, enter the new program contractor ID. For County, enter the appropriate county code. For Affiliation Start Date, enter the employment begin date.

```
 TR: HP014 ACT: A                AHCCCS - HEALTH PLAN                 05/23/11
NTR: _____________________  ADD CASE MANAGER AFFILIATIONS             15:17:28
                                                                      HP07L690

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 30 TERMINATION-OTHER

PROGRAM                                                  AFFILIATION
CONTRACTOR                        COUNTY              START DATE   END DATE

110065 PINAL/GILA LTC             21                   05 01 11       __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __

PF: 1=HLP 2=RTN 3=CLR 4=MSG                 8=DWN                  12=ESC
```

16. Press the <ENTER> key. In the upper left portion of the screen, the following message will be displayed: “RECORD(S) SUCCESSFULLY ADDED”.

```
9200 RECORD(S) SUCCESSFULLY ADDED
 TR: HP014 ACT: A                AHCCCS - HEALTH PLAN                 05/23/11
NTR: _____________________  ADD CASE MANAGER AFFILIATIONS             15:20:11
                                                                      HP07L690

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 30 TERMINATION-OTHER

PROGRAM                                                  AFFILIATION
CONTRACTOR                        COUNTY              START DATE   END DATE

110065 PINAL/GILA LTC             21 PINAL             05 01 11
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __

PF: 1=HLP 2=RTN 3=CLR 4=MSG                 8=DWN                  12=ESC
```

17. Go to the PR815C AHCCCS – PROVIDER CASE MANAGER ENROLLMENT STATUS screen. Enter the case manager ID and press the <ENTER> key.

```
TR: PR815 ACT: C                AHCCCS - PROVIDER                      05/23/1
NTR: _____________________  CASE MANAGER ENROLLMENT STATUS               15:21:2
                                                                         PR01L29
```

```
 TR: PR815 ACT: C                AHCCCS - PROVIDER                      05/23/11
NTR: _____________________  CASE MANAGER ENROLLMENT STATUS               15:21:21
                                                                         PR01L295
      CASE MANAGER ID: 606962  DOE, JOHN                 SSN: 234-23-2345
        PROVIDER TYPE: 98      CASE MANAGER
CURRENT ENRLMT STATUS: 30      TERMINATION-OTHER

 CHANGE ENROLLMENT STATUS:   01  BEGIN DATE: 05/01/2011  END DATE: 99/99/9999

ENR ENR               REPLACEMENT
STA STA                PROVIDER REC  BEGIN      END        SYSTEM     SYSTEM
TYP COD DESCRIPTION      NUMBER STA  DATE       DATE      BEG DATE   END DATE

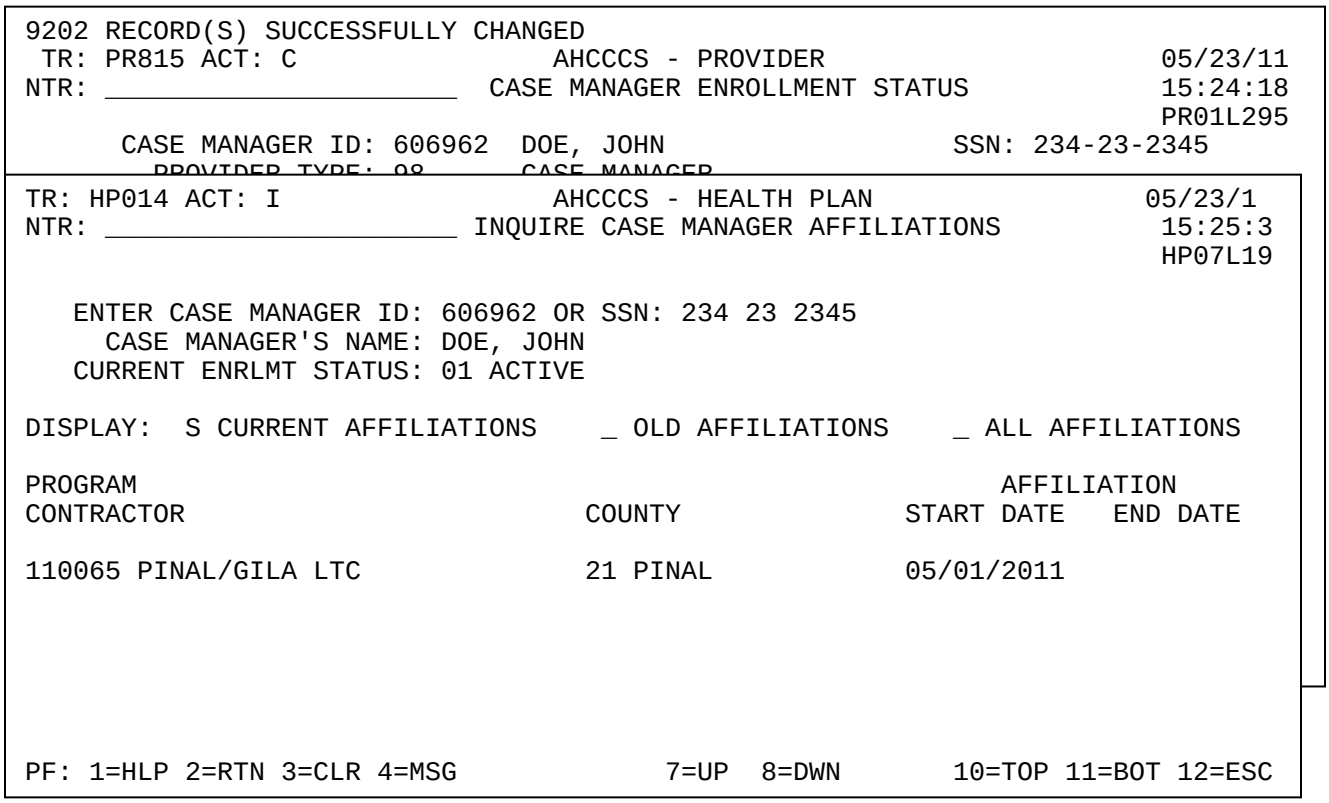
 A  01 ACTIVE                   A 03/01/2008 04/30/2011 05/17/2011
 T  30 TERMINATION-OTHER        A 05/01/2011            05/23/2011




PF: 1=HLP 2=RTN 3=CLR 4=MSG            7=UP 8=DWN       10=TOP 11=BOT 12=ESC
```

18. For “Change Enrollment Status”, enter “01”. For “Begin Date”, enter employment begin date. For “End Date”, enter 99/99/9999.

19. Press the <ENTER> key. In the upper left portion of the screen, the following message will be displayed: "RECORD(S) SUCCESSFULLY CHANGED". The screen will display "Enr Sta Type/Enr Sta Cod/Description" of "A 01 ACTIVE" and for "Begin Date" the employment begin date.



20. To confirm case manager affiliation with the new program contractor, go to the HP014I AHCCCS - HEALTH PLAN INQUIRE CASE MANAGER AFFILIATIONS screen. Enter the case manager ID and press the <ENTER> key. The screen will display the "Program Contractor", "County" and "Affiliation Start Date".

Procedure Three

Reinstated Case Manager

1. Go to the PR800A AHCCCS - PROVIDER CASE MANAGER SEARCH screen. Search for the case manager first by last name. If the search by last name does not find a listing for the case manager, then search for the case manager by Social Security Number (SSN).

2. If the above name search provides a listing for the case manager, place an “S” in the “SEL” field at the beginning of this line.

```
7342 PLACE 'S' BESIDE DESIRED NAME AND PRESS ENTER
  TR: PR800 ACT: A             AHCCCS - PROVIDER                      08/22/11
 NTR: _____________________  CASE MANAGER SEARCH                      14:44:35
                                                                      PR01L091

    CASE MANAGERS ARE HIGHLIGHTED WHEN THEIR SSNS MATCH NON-CASE MANAGER SSNS

 CASE MANAGER NAME: DOE                                 SSN: ___________
     PROVIDER TYPE:

 SEL             NAME                          ID    STATUS     SSN       PR TYPE

 S   DOE, JOHN                               606962   A 01   234-23-2345    98
 _   DOHANYOS, MEREDITH                      123456   A 01   000-00-0000    98
 _   DOHERTY TOM                             456789   T 30   111-22-3333    98
 _   DOLLEY, SYLVIE                          987654   T 30   222-33-4444    98
 _   DOLORES JOSSE                           654321   T 30   333-44-5555    98


 PF: 1=HLP 2=RTN 3=CLR 4=MSG      6=NXT  7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

3. Press the <ENTER> key. This action will bring up the PR810C AHCCCS - PROVIDER CASE MANAGER DEMOGRAPHICS screen.

```
  TR: PR810 ACT: C               AHCCCS - PROVIDER                     08/22/11
 NTR: _____________________  CASE MANAGER DEMOGRAPHICS                 14:43:12
                                                                       PR01L093
       CASE MANAGER  ID: 606962 NAME: DOE, JOHN              SSN: 234-23-2345
          PROVIDER TYPE: 98  CASE MANAGER
  CURRENT ENRLMT STATUS: 30  TERMINATION-OTHER
      STATUS BEGIN DATE: 10/26/2007  STATUS END DATE: 99/99/9999

  ENROLLMENT BEGIN DATE: 10/25/2006
    ENROLLMENT END DATE: 99/99/9999

 CORRESPONDENCE ADDRESS:
           STREET LINE 1: EVERCARE SELECT
           STREET LINE 2: 3141 N. 3RD AVE STE100
          CITY/STATE/ZIP: PHOENIX                    AZ  85013
             COUNTY CODE: 13 MARICOPA        COUNTRY CODE: 01 UNITED STATES OF
          BUSINESS PHONE:( 602 ) 331 - 5100 EMERGENCY PHONE:( 602 ) 745 - 7992
            ATTENTION TO:


 PF: 1=HLP 2=RTN 3=CLR 4=MSG                                          12=ESC
```

4. If the PR810C screen displays a former program contractor with a current enrollment status of ***30 TERMINATION-OTHER***, do the following. For Enrollment Begin Date, enter the employment begin date with the new program contractor. For Street Line 1, enter the new program contractor name. For Street Line 2, enter the program contractor office address where the case manager is now located. For City/State/Zip, enter the program contractor office information. For County Code, enter the program contractor office county location (must agree with zip code). For Country Code, enter “01”. For Business Phone, enter the

case manager's phone number. Optional entries can be entered for both "Emergency Phone" and "Attention To".

5. Press the <ENTER> key. In the upper left portion of the screen, the following message will be displayed: "RECORD(S) SUCCESSFULLY CHANGED".

```
9202 RECORD(S) SUCCESSFULLY CHANGED
  TR: PR810 ACT: C              AHCCCS - PROVIDER                      08/22/11
 NTR: _____________________  CASE MANAGER DEMOGRAPHICS                 15:01:29
                                                                       PR01L293
       CASE MANAGER  ID: 606962 NAME: DOE, JOHN               SSN: 234-23-2345
          PROVIDER TYPE: 98  CASE MANAGER
  CURRENT ENRLMT STATUS: 30  TERMINATION-OTHER
      STATUS BEGIN DATE: 10/26/2007  STATUS END DATE: 99/99/9999

  ENROLLMENT BEGIN DATE: 10/01/2011
    ENROLLMENT END DATE: 99/99/9999

 CORRESPONDENCE ADDRESS:
          STREET LINE 1: NEW PROGRAM CONTRACTOR
          STREET LINE 2: 5555 E. OAK ST.
         CITY/STATE/ZIP: PHOENIX                   AZ  85034
            COUNTY CODE: 13 MARICOPA        COUNTRY CODE: 01 UNITED STATES OF
         BUSINESS PHONE:( 602 ) 555 - 1111 EMERGENCY PHONE:( 602 ) 555 - 1112
           ATTENTION TO: _____________________________


PF: 1=HLP 2=RTN 3=CLR 4=MSG 5=PRI 6=NXT                                12=ESC
```

6. Press the <F6> key to go to the HP014A AHCCCS - HEALTH PLAN CASE MANAGER AFFILIATIONS screen.

```
 TR: HP014 ACT: A                AHCCCS - HEALTH PLAN                 08/22/1
NTR: _____________________  ADD CASE MANAGER AFFILIATIONS             15:05:5
                                                                     HP07L69

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 30 TERMINATION-OTHER

PROGRAM                                                  AFFILIATION
CONTRACTOR                        COUNTY              START DATE   END DATE

_______                           __                  __ __ __     __ __ __
_______                           __                  __ __ __     __ __ __
_______                           __                  __ __ __     __ __ __
_______                           __                  __ __ __     __ __ __
_______                           __                  __ __ __     __ __ __
_______                           __                  __ __ __     __ __ __

PF: 1=HLP 2=RTN 3=CLR 4=MSG                 8=DWN                  12=ESC
```

7. For Program Contractor, enter the program contractor ID. For County, enter the appropriate county code. For Affiliation Start Date, enter the employment begin date.

8. Press the <ENTER> key. In the upper left portion of the screen, the following message will be displayed: “RECORD(S) SUCCESSFULLY ADDED”.

```
9200 RECORD(S) SUCCESSFULLY ADDED
 TR: HP014 ACT: A                AHCCCS - HEALTH PLAN                 08/22/11
NTR: _____________________  ADD CASE MANAGER AFFILIATIONS             15:10:58
                                                                     HP07L690

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 30 TERMINATION-OTHER

PROGRAM                                                  AFFILIATION
CONTRACTOR                        COUNTY              START DATE   END DATE

110044 NEW PROGRAM CONTRACTOR     13 MARICOPA          10 01 11     __ __ __
_______                           __                  __ __ __     __ __ __
_______                           __                  __ __ __     __ __ __
_______                           __                  __ __ __     __ __ __
_______                           __                  __ __ __     __ __ __
_______                           __                  __ __ __     __ __ __
_______                           __                  __ __ __     __ __ __
_______                           __                  __ __ __     __ __ __
_______                           __                  __ __ __     __ __ __

PF: 1=HLP 2=RTN 3=CLR 4=MSG                 8=DWN                  12=ESC
```

9. Press the <F6> key to go to the PR815C AHCCCS – PROVIDER CASE MANAGER ENROLLMENT STATUS screen.

10. For “Change Enrollment Status”, enter “01”. For “Begin Date”, enter employment begin date. For “End Date”, enter 99/99/9999.

```
TR: PR815 ACT: C                AHCCCS - PROVIDER                      08/22/11
NTR: _____________________  CASE MANAGER ENROLLMENT STATUS              15:15:42
                                                                       PR01L295
      CASE MANAGER ID: 606962  DOE, JOHN                  SSN: 234-23-2345
        PROVIDER TYPE: 98      CASE MANAGER
CURRENT ENRLMT STATUS: 30      TERMINATION-OTHER
```

```
9200 RECORD(S) SUCCESSFULLY ADDED
 TR: PR815 ACT: C                AHCCCS - PROVIDER                      08/22/11
NTR: _____________________  CASE MANAGER ENROLLMENT STATUS              15:19:19
                                                                       PR01L295
      CASE MANAGER ID: 606962  DOE, JOHN                  SSN: 234-23-2345
        PROVIDER TYPE: 98      CASE MANAGER
CURRENT ENRLMT STATUS: 01      ACTIVE

 CHANGE ENROLLMENT STATUS:   __  BEGIN DATE: __________  END DATE: __________

ENR ENR               REPLACEMENT
STA STA                PROVIDER REC  BEGIN      END        SYSTEM     SYSTEM
TYP COD DESCRIPTION      NUMBER STA  DATE       DATE      BEG DATE   END DATE

 T  30 TERMINATION-OTHER         A 10/26/2007 09/30/2011 10/25/2007
 A  01 ACTIVE                    A 10/01/2011            08/22/2011




PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP 8=DWN       10=TOP 11=BOT 12=ESC
```

11. Press the <ENTER> key. In the upper left portion of the screen, the following message will be displayed: “RECORD(S) SUCCESSFULLY CHANGED”. The screen will display “Enr Sta Type/Enr Sta Cod/Description” of “A 01 ACTIVE” and for “Begin Date” the employment begin date.

12. To confirm case manager affiliation with the new program contractor, go to the HP014I AHCCCS - HEALTH PLAN INQUIRE CASE MANAGER AFFILIATIONS screen.

13. Enter the case manager ID and press the <ENTER> key. The screen will display the "Program Contractor", "County" and "Affiliation Start Date".

```
TR: HP014 ACT: I                  AHCCCS - HEALTH PLAN                  08/22/1
NTR: _____________________ INQUIRE CASE MANAGER AFFILIATIONS            15:25:1
                                                                        HP07L19

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 01 ACTIVE

DISPLAY:  S CURRENT AFFILIATIONS    _ OLD AFFILIATIONS    _ ALL AFFILIATIONS

PROGRAM                                                    AFFILIATION
CONTRACTOR                          COUNTY              START DATE   END DATE

110044 NEW PROGRAM CONTRACTOR       13 MARICOPA         10/01/2011




PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

Procedure Four

Terminating a Case Manager

1. If the case manager's current CM ID is not known, go to the PR800A AHCCCS - PROVIDER CASE MANAGER SEARCH screen to search for the individual by last name. As shown below, the ID is displayed on this screen once the case manager is found.

```
7342 PLACE 'S' BESIDE DESIRED NAME AND PRESS ENTER
  TR: PR800 ACT: A             AHCCCS - PROVIDER                        08/22/11
 NTR: _____________________  CASE MANAGER SEARCH                        14:44:35
                                                                        PR01L091

    CASE MANAGERS ARE HIGHLIGHTED WHEN THEIR SSNS MATCH NON-CASE MANAGER SSNS

 CASE MANAGER NAME: DOE                                  SSN: ___________
     PROVIDER TYPE:

 SEL             NAME                          ID     STATUS     SSN       PR TYPE

 S   DOE, JOHN                                606962   A 01   234-23-2345    98
 _   DOHANYOS, MEREDITH                      123456   A 01   000-00-0000    98
 _   DOHERTY TOM                             456789   T 30   111-22-3333    98
 _   DOLLEY, SYLVIE                          987654   T 30   222-33-4444    98
 _   DOLORES JOSSE                           654321   T 30   333-44-5555    98


 PF: 1=HLP 2=RTN 3=CLR 4=MSG      6=NXT  7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

2. If the case manager's CM ID is known, go to the HP014C AHCCCS - HEALTH PLAN CHANGE CASE MANAGER AFFILIATIONS screen. Enter the case manager ID and press the <ENTER> key.

```
TR: HP014 ACT: I                AHCCCS - HEALTH PLAN                  05/23/1
NTR: _____________________ INQUIRE CASE MANAGER AFFILIATIONS           15:25:3
                                                                       HP07L19

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 01 ACTIVE

DISPLAY:  S CURRENT AFFILIATIONS    _ OLD AFFILIATIONS    _ ALL AFFILIATIONS

PROGRAM                                                    AFFILIATION
CONTRACTOR                        COUNTY              START DATE   END DATE

110065 PINAL/GILA LTC             21 PINAL            05 01 09




PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

3. Enter the Affiliation End Date as the day the individual's employment with the program contractor ended.

```
 TR: HP014 ACT: C                AHCCCS - HEALTH PLAN                  05/23/11
NTR: _____________________ CHANGE CASE MANAGER AFFILIATIONS           12:22:03
                                                                      HP07L490
```

```
9202 RECORD(S) SUCCESSFULLY CHANGED
 TR: HP014 ACT: C                AHCCCS - HEALTH PLAN                  09/06/1
NTR: _____________________ CHANGE CASE MANAGER AFFILIATIONS           12:30:1
                                                                      HP07L49

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 16 PENDING-AFFILIATION MISSING

 DISPLAY:  S CURRENT AFFILIATIONS    _ OLD AFFILIATIONS    _ ALL AFFILIATIONS

 PROGRAM                                                    AFFILIATION
 CONTRACTOR                        COUNTY                START DATE   END DATE

 110065 PINAL                      21 PINAL               05 01 09    08 31 11




 PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

4. Press the <ENTER> key. In the upper left of the screen the following message will be displayed: "RECORD(S) SUCCESSFULLY CHANGED".

5. Go to the PR815C AHCCCS – PROVIDER CASE MANAGER ENROLLMENT STATUS screen. Enter the case manager ID and press the <ENTER> key.

6. For Current Enrollment Status, enter “30”. For Begin Date, enter the date following the enrollment end date indicated on the HP014C screen. For End Date, enter 99/99/9999.

```
TR: PR815 ACT: C                AHCCCS - PROVIDER                       09/06/11
NTR: _____________________  CASE MANAGER ENROLLMENT STATUS               12:33:48
                                                                        PR01L295
      CASE MANAGER ID: 606962  DOE, JOHN                 SSN: 234-23-2345
        PROVIDER TYPE: 98      CASE MANAGER
CURRENT ENRLMT STATUS: 16      PENDING-AFFILIATION MISSING

 CHANGE ENROLLMENT STATUS:   30  BEGIN DATE: 09/01/2011  END DATE: 99/99/9999

ENR ENR               REPLACEMENT
STA STA                PROVIDER REC  BEGIN      END        SYSTEM     SYSTEM
TYP COD DESCRIPTION      NUMBER STA  DATE       DATE      BEG DATE   END DATE

 A  01 ACTIVE                    A 12/13/1999 08/31/2011 12/22/1999
 P  16 PENDING-AFFILIATIO        A 09/01/2011            09/06/2011




PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP 8=DWN       10=TOP 11=BOT 12=ESC
```

7. Press the <ENTER> key. In the upper left of the screen the following message will be displayed: “RECORD(S) SUCCESSFULLY CHANGED”. The screen will display “Enr Sta Type/Enr Sta Cod/Description” of “T 30 TERMINATION-OTHER” and for “Begin Date” the date previously entered.

```
9202 RECORD(S) SUCCESSFULLY CHANGED
  TR: PR815 ACT: C                AHCCCS - PROVIDER                       09/06/
 NTR: _____________________  CASE MANAGER ENROLLMENT STATUS               12:44:
                                                                        PR01L2
      CASE MANAGER ID: 606962  DOE, JOHN                 SSN: 234-23-2345
        PROVIDER TYPE: 98      CASE MANAGER
 CURRENT ENRLMT STATUS: 30     TERMINATION-OTHER

  CHANGE ENROLLMENT STATUS:   __  BEGIN DATE: __________  END DATE: __________

 ENR ENR               REPLACEMENT
 STA STA                PROVIDER REC  BEGIN      END        SYSTEM     SYSTEM
 TYP COD DESCRIPTION      NUMBER STA  DATE       DATE      BEG DATE   END DATE

  A  01 ACTIVE                    A 12/13/1999 08/31/2011 12/22/1999
  T  30 TERMINATION-OTHER         A 09/01/2011            09/06/2011




 PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP 8=DWN       10=TOP 11=BOT 12=ESC
```

Procedure Five

Changing a Case Manager's Name

1. Go to the PR810C AHCCCS - PROVIDER CASE MANAGER DEMOGRAPHICS screen using the case manager's ID. Type over the existing name with the changed name.

```
TR: PR810 ACT: C                AHCCCS - PROVIDER                        10/14/1
NTR: _____________________  CASE MANAGER DEMOGRAPHICS                     11:11:5
                                                                         PR01L29
      CASE MANAGER  ID: 123456 NAME: BROWN, MARY            SSN: 123-45-6789
         PROVIDER TYPE: 98  CASE MANAGER
 CURRENT ENRLMT STATUS: 01  ACTIVE
     STATUS BEGIN DATE: 08/27/2010  STATUS END DATE: 99/99/9999

 ENROLLMENT BEGIN DATE: 08/27/2010
   ENROLLMENT END DATE: 99/99/9999

CORRESPONDENCE ADDRESS:
         STREET LINE 1: MERCY CARE PLAN
         STREET LINE 2: 4350 E COTTON CTR BLVD #4
        CITY/STATE/ZIP: PHOENIX                    AZ  85040
           COUNTY CODE: 13 MARICOPA        COUNTRY CODE: 01 UNITED STATES OF
        BUSINESS PHONE:( 602 ) 555 - 0000 EMERGENCY PHONE:( 602 ) 263 - 3000
          ATTENTION TO: MARY BROWN



PF: 1=HLP 2=RTN 3=CLR 4=MSG                                          12=ESC
```

2. Press the <ENTER> key. In the upper left of the screen the following message will be displayed: "RECORD(S) SUCCESSFULLY CHANGED".

```
9202 RECORD(S) SUCCESSFULLY CHANGED
 TR: PR810 ACT: C                AHCCCS - PROVIDER                       10/14/11
NTR: _____________________  CASE MANAGER DEMOGRAPHICS                    11:02:15
                                                                        PR01L293
      CASE MANAGER  ID: 123456 NAME: SMITH, MARY            SSN: 123-45-6789
         PROVIDER TYPE: 98  CASE MANAGER
 CURRENT ENRLMT STATUS: 01  ACTIVE
     STATUS BEGIN DATE: 08/27/2010  STATUS END DATE: 99/99/9999

 ENROLLMENT BEGIN DATE: 08/27/2010
   ENROLLMENT END DATE: 99/99/9999

CORRESPONDENCE ADDRESS:
         STREET LINE 1: MERCY CARE PLAN
         STREET LINE 2: 4350 E COTTON CTR BLVD #4
        CITY/STATE/ZIP: PHOENIX                    AZ  85040
           COUNTY CODE: 13 MARICOPA        COUNTRY CODE: 01 UNITED STATES OF
        BUSINESS PHONE:( 602 ) 555 - 0000 EMERGENCY PHONE:( 602 ) 263 - 3000
          ATTENTION TO: MARY SMITH



PF: 1=HLP 2=RTN 3=CLR 4=MSG 5=PRI 6=NXT                              12=ESC
```

APPENDIX B
ALTCS Contractor ID Numbers

ID	Contractor Name
Program Contractors	
110007	DES/Division of Developmental Disabilities
110049	Evercare Select
110306	Mercy Care Plan
110088	Bridgeway Health Solutions
Tribal Contractors	
190000	Native American Community Health Center
190009	White Mountain Apache Tribe
190017	Navajo Nation
190025	Gila River Indian Community
190033	Tohono O'Odham Nation
190075	Pascua Yaqui Tribe
190083	San Carlos Apache Tribe
190091	Hopi Tribe

412 - Claims Reprocessing Policy

Original Date: 1/12/2008
Effective Date: 10/01/2008
Revision Date: 09/01/09, 11/1/11

Staff responsible for policy: DHCM Acute Operations and ALTCS

I. Purpose

This policy establishes requirements to be followed by all Contractors (Acute Care, Long Term Care, CRS and BHS) for recoupment, refund, and recovery activities.

II. Definitions

Day: Calendar day unless otherwise specified.

Provider: Any person or entity who submits a claim and receives payment for the provision of covered services to members pursuant to the provisions A.R.S. § 36-2901 et seq. or any subcontractor of a Provider delivering such services. For the purposes of this policy, a Provider shall be further defined as all individuals associated by the same Tax Identification Number utilized for claiming purposes.

Recoupment: An action initiated by the Contractor to recover all or part of a previously paid claim. Recoupments include Contractor initiated/requested repayments as well as overpayments identified by the Provider where the Contractor seeks to actively withdraw funds to correct the overpayment from the Provider.

Refunds: An action initiated by a Provider to return an overpayment to a Contractor. In these instances the Provider writes a check or transfers money to the Contractor directly.

Retroactive Third Party Recovery: An action initiated by the Contractor to recover all or part of a previously paid claim resulting from the discovery of a liable party not known at the time of payment. Retroactive Third Party Recoveries only include overpayments identified by the Contractor where the Contractor seeks to actively recover funds from a liable party without the involvement of the provider.

III. Policy

A. Single Recoupments in Excess of $50,000

The Contractor must obtain advance approval from the AHCCCS Division of Health Care Management (DHCM) prior to initiating any single recoupment in excess of $50,000 per Provider Tax Identification Number (TIN). To obtain advance approval, the Contractor must submit a written request for approval of the recoupment to the assigned AHCCCS Acute or ALTCS Operations and Compliance Officer in the format detailed below:

1. A detailed letter of explanation must be submitted that describes:
    - How the need for recoupment was identified
    - The systemic causes resulting in the need for a recoupment
    - The process that will be utilized to recover the funds
    - Methods to notify the affected Provider(s) prior to recoupment
    - The anticipated timeline for the project
    - The corrective actions that will be implemented to avoid future occurrences
    - Total recoupment amount, total number of claims, range of dates for the claims being recouped, and total number of Providers impacted
    - Other recoupment action specific to this Provider within the contract year

2. An electronic file containing the following:
    - AHCCCS Member ID
    - Date of Service
    - Original Claim Number
    - Date of Payment
    - Amount Paid
    - Amount to be Recouped

3. A copy of the written communication that will serve as prior notification to the affected Provider(s).

B. Recoupment of Payments Initiated More than 12 Months from the Date of Original Payment

The Contractor is prohibited from initiating recoupment of monies from a Provider TIN more than 12 months from the date of original payment of a clean claim unless prior approval is obtained from AHCCCS. Retroactive Third Party Recoveries (as outlined in Section G) are not typically included in this section. Dependent on the size and/or volume of the recoupment request, AHCCCS reserves the right to follow the process defined in Section G.

To request prior approval from AHCCCS, the Contractor must submit a request in writing to the assigned AHCCCS Acute or ALTCS Operations and Compliance Officer with all of the following information:

1. A detailed letter of explanation must be submitted that describes:
    - How the need for recoupment was identified
    - The systemic causes resulting in the need for a recoupment
    - The process that will be utilized to recover the funds
    - Methods to notify the affected Provider(s) prior to recoupment
    - The anticipated timeline for the project
    - The corrective actions that will be implemented to avoid future occurrences
    - Total recoupment amount, total number of claims, range of dates for the claims being recouped, and total number of Providers impacted

2. An Electronic file containing the following:
    - AHCCCS Member ID
    - Date of Service
    - Original Claim Number
    - Date of Payment
    - Amount Paid
    - Amount to be Recouped

3. A copy of the written communication that will serve as prior notification to the affected Provider(s).

C. Cumulative Recoupments in Excess of $50,000 per Provider per Contract Year

Contractors must continuously track recoupment efforts per Provider TIN. When recoupment amounts for a Provider TIN have or are forecasted to cumulatively exceed $50,000 during a contract year, the Contractor must notify the assigned AHCCCS Acute or ALTCS Operations and Compliance Officer at the time total recoupments are anticipated to exceed $50,000 with all of the following information:

1. A detailed letter of explanation that describes:
    - How the need for recoupment was identified
    - The process that will be utilized to recover the funds
    - Methods to notify the affected Provider(s)
    - Cumulative recoupment amount, total number of claims and range of dates for the claims being recouped

D. AHCCCS Responsibility and Authority

AHCCCS reserves the right to evaluate and to present the proposed recoupment action to the affected Providers as part of the approval and or notification process. Communication will be at the timing and discretion of the Agency.

The AHCCCS Division of Health Care Management (DHCM) will review all requests for recoupment, evaluating such factors as validity, accuracy, and efficiency of Contractor processes. DHCM will also evaluate the proposed recoupment for the purposes of minimizing provider hardship or inconvenience. DHCM will acknowledge all requests in writing through electronic mail upon receipt of the completed file. A written determination will be sent to the Contractor by electronic mail no later than 30 days from the date of receipt of all required information from the Contractor. Any request to which no response is sent within the 30 day timeframe above will be deemed approved by DHCM.

E. Data Processes for Recoupment

Upon receipt of approval for recoupment from AHCCCS, the Contractor shall have no more than 120 days to complete the project and submit the following to the assigned AHCCCS Operations and Compliance (Acute Care) or Financial Compliance Officer (ALTCS):

1. Voided or replacement encounters (which must reach adjudicated status) and the appropriate associated information for all impacted encounters for recouped claims;
2. Upon completion of the recoupment project, an electronic file containing all of the following information for all recouped claims:

    a. AHCCCS Member Identification number
    b. Date of Service
    c. Original AHCCCS CRN
    d. New AHCCCS CRN
    e. AHCCCS Allowed amount
    f. Health Plan Allowed amount
    g. Health Plan Paid amount
    h. Provider Identification Number

The Contractor must submit the above information for each adjudicated encounter. AHCCCS will validate the submission of applicable voided and replacement encounters upon completion of this project. As a result of the adjudicated encounter data, AHCCCS may adjust related reinsurance payments, Title XIX or Prior Period Coverage reconciliation payments or any other amounts paid to the Contractor that are impacted by the recoupment.

F. Data Processes for Refunds

Upon receipt of refund from a Provider, the Contractor shall have 120 days to void or replace encounters (which must reach adjudicated status) and submit the appropriate associated information for all impacted encounters for refunded claims. All voided or replaced encounters must reach adjudicated status no later than 120 days from the date of the refund.

The contractor must also be able to identify the following for all refunds received and provide this information to AHCCCS upon request:

- The systemic causes resulting in the need for the refund
- The corrective actions that will be implemented to avoid future occurrences

G. Retroactive Third Party Recovery

Contractors may engage in Retroactive Third Party Recoveries for members for which a claim was paid, *for dates of service in the current and/or prior contract years,* to determine if there are other payor sources that were not known at the time of payment. This recovery period is limited to three years after the date of service as defined in A.R.S. §36-2923 and the Deficit Reduction Act of 2005 (Public Law 109-171). *The Contractor is prohibited from recouping related payments from providers, requiring providers to take action or requiring the involvement of providers in any way.*

Although all encounters related to these recoveries must be adjusted, these adjustments cannot be completed through the normal encounter adjustment process as the Contractor may not request adjustments from, nor adjust related payment to, providers. Instead, the Contractor must submit an external replacement (adjustment) file (via an approved AHCCCS vendor with a prescribed AHCCCS file format) in order to directly update impacted encounters. This external replacement file must be submitted within 120 days from completion of the recovery project. The Contractor must contact the AHCCCS Encounter Unit at the completion of the recovery project for a list of approved AHCCCS vendors as well as the acceptable external replacement file format, and to coordinate submission of these files.

Based upon the submitted replacement (adjustment) file data, AHCCCS will adjust prior and current payment reconciliations and reinsurance payments if appropriate.

The Contractor must submit quarterly updates regarding retroactive third party recoveries to their assigned AHCCCS Operations & Compliance Officer. The notification must include information regarding recovery time period, associated project timeline, and covered lines of business.

H. Attestation

All documentation and data submitted by the Contractor for purposes of recoupment and refund activities must be certified by the Contractor as specified in the Balanced Budget Act of 1997 42 CFR 438.600 et seq.. If it is determined after the recoupment or refund action that information provided to AHCCCS is inaccurate, invalid, or incomplete, or that the Contractor failed to comply with any provision of this Policy, the Contractor may be subject to corrective action, up to and including sanction under the Acute Care Contract, Paragraph 72 or the ALTCS Contract, Paragraph 80.

IV. References

- Title 42 of the Code of Federal Regulations Part 438 Subpart H, 42 CFR 438.600 et seq.
- Title 9 of the Arizona Administrative Code, Chapter 22, Articles 6 and 7 (A.A.C. R9-22-601 et seq. and A.A.C. R9-22-701 et seq.)
- Title 9 of the Arizona Administrative Code, Chapter 28, Articles 6 and 7 (A.A.C. R9-28-601 et seq. and A.A.C. R9-28-701 et seq.)
- Acute Care Contract Section D, ALTCS Contract Section D, CMDP Intergovernmental Agreement Section D, BHS Contract Section D.
- Arizona Revised Statute §36-2923
- Deficit Reduction Act of 2005 (Public Law 109-171)

413 - GAP-IN-SERVICES POLICY

Effective Date: April 1, 2007
Revision Date: July 1, 2010

Staff responsible for policy: DHCM Operations

I. Purpose

This policy applies to all Arizona Long Term Care System (ALTCS) Contractors. This policy establishes guidelines, criteria and timeframes for the responding to and reporting of gaps in critical services for ALTCS Home and Community Based (HCBS) members. This policy is based in part by the Ball vs. Betlach (Biedess) Court decision made in Federal District Court.

II. Definitions

AHCCCSA: means the Arizona Health Care Cost Containment System Administration

Arizona Long Term Care System (ALTCS) Contractor is a contracted managed care organization, that provides long term care, acute care, behavioral health, and case management services to Title XIX eligible elderly, physically or developmentally disabled individuals who are determined to be at risk of an institutional level of care.

Ball vs. Betlach (Biedess) is a Federal class action lawsuit brought against the State of Arizona and AHCCCS in 2000 alleging violations of Federal laws. The Federal District Court has ordered that AHCCCS (via its Contractors) establish a network of contracted provider agencies adequate to ensure that critical services are provided without gaps. Furthermore, the order states that unforeseeable gaps in critical services be resolved within two hours of the gap being reported. This matter is currently under appeal by AHCCCS.

Contractor means a Managed Care Organization providing health care services to acute or long term care members and / or a Prepaid Inpatient Health Plan providing behavioral health services to eligible acute care members and / or CRS related services to eligible acute or long term care members.

Critical Services are Attendant Care, Personal Care, Homemaking and Respite care.

Contingency Plan or Back-up Plan includes information about actions that the member/representative should take to report any gaps in critical services.

Gap in Service is the difference between the number of hours of home care worker critical service scheduled in each individual's HCBS care plan and the hours of the scheduled type of critical service that are actually delivered to the qualified individual.

Gap in Services Log is the form Contractors must complete on a monthly basis which records gaps in services.

Member Service Preference Level indicates how quickly the member chooses to have a service gap filled if the scheduled caregiver of that critical service is not available.

Non-Provision of Service is any time that the number of hours of home care worker critical services are not provided as scheduled**.**

Non-Provision of Service Log is the form contracted provider agencies must complete monthly on which all non provisions of services must be recorded.

Telephone Survey is a survey conducted by Contractors to all providers agencies contracted to provide services deemed as "Critical Services" verifying each contracted provider agency has availability after normal business hours, including weekends.

III. Policy

A. Non-Provision of Services Log

1. The Non Provision of Service Log (NPS Log) should be completed by the provider agency and/or Contractor:
    a) when the authorized services are not provided as scheduled
    b) when scheduled services are no longer available because a replacement caregiver cannot be found
    c) when a request for DDD nonscheduled respite is made and not met

2. Contractors will determine what fields should be completed by the provider agency and any additional instructions for the completion of the form. Contractors will need to complete any fields that the provider agency does not complete.

3. Reporting timelines will be set by the Contractor.

4. Contractors will review each NPS Log submitted by each provider agency to determine which non-provision of services meet the definition of gap in services as defined in AMPM, Chapter 1600, Case Management, Policy 1620.

5. Contractors will compile all NPS Logs submitted by each provider agency into one complete NPS Log. The complete NPS Log will be submitted to AHCCCS, ALTCS Operations by the 10th business day of the month.

6. See Attachment A for NPS Log Instructions and Form.

B. Gap In Services Log

1. Contractors must submit a completed Gap in Service Log (Gap Log) and Hours Authorized report to AHCCCS, ALTCS Operations for all gaps in critical services as defined by the AMPM Chapter 1600, Policy 1620.

2. Completed reports are to be submitted to ALTCS Operations by close-of-business on the 10th business day of the month following the reporting month – e.g., if report is for critical gaps in service for January, the report must be received by COB on the 10th business day of February.

3. See Attachment B for Gap In Service Log and Authorized Hours Log Instructions and Form.

C. Telephone Survey

1. Each Contractor must conduct Telephone Surveys verifying that each of their contracted provider agencies of critical services has availability after normal business hours, including weekends. A provider agency is determined to be available to address a member's potential gap in critical services if they immediately answer the phone call or return the phone call within 15 minutes.

2. Surveys must be conducted at a minimum of quarterly. A Contractor may request from AHCCCS to conduct Surveys a minimum of semi-annually if they can demonstrate 100% compliance for two consecutive quarters. AHCCCS may at anytime direct a Contractor to conduct Telephone Surveys more frequently than quarterly.

3. Completed Surveys are to be submitted to ALTCS Operations by close of business on the 10th business day of the month following the end of the quarter – e.g., for quarter ending March 31, 2010 Surveys would be due April 14, 2010.

4. See Attachment C for Telephone Survey form and instructions.

IV. References

- Ball vs. Biedess Court Order
- AHCCCS ALTCS Contract, ¶16, Case Management; ¶28, Network Development
- AMPM Chapter 1600, Case Management

I. INSTRUCTIONS FOR COMPLETING THE NPS LOG

The Non-Provision of Services (NPS) Log form should be completed by the Provider/Agency and/or Program Contractor. An NPS takes place anytime a service that has an open authorization does not occur at the time authorized and for the amount of hours authorized. Examples of NPS are

- when the authorized services are not provided at the time scheduled
- when scheduled services are no longer available because a replacement cannot be found
- when a request for DDD nonscheduled respite is made and not met
- When a member is not home due to a hospitalization

Note: Non-Provision of Services are not limited to the examples above.

Program Contractors will determine what fields should be completed by the Provider/Agency and any additional instructions for the completion of the form. Program Contractors will need to complete any fields that the Provider/Agency does not complete. Reporting timelines will be provided by the Program Contractors.

If you have any questions please call your respective ALTCS Program Contractor.

II. NPS

Column # Instruction/Explanation

0. **Program Contractor ID #** - Program Contractor fills in column with identification number 110306, 110049, etc.
1. **Provider Registration Number** - Provider's AHCCCS Identification numbers. Column to be filled in by Provider or Program Contractor. Please ensure that this Column is completed.
2. **Date Called In** - The date the Agency was notified of the NPS. Use the following format 02/01/05.
3. **Time Called In** - The time the Agency was notified. **Use military time** i.e., 08:00, 13:30, etc. Please round to the nearest 15-minute increment.
4. **NPS Date** - The date the NPS occurs. This date may be the same as the date in column 1 or the consumer may have waited to call. Use the following format 11/01/04.
5. **Time Service Scheduled to Begin** - Insert the time the service was regularly scheduled to begin. **Use military time** i.e., 08:00, 13:30, etc. Please round to the nearest 15-minute increment.
6. **County Code** - The County of **residence** code from the following chart:

County	Code
Apache	01
Cochise	03
Coconino	05
Gila	07
Graham	09
Greenlee	11
La Paz	29
Maricopa	13
Mohave	15
Navajo	17
Pima	19
Pinal	21
Santa Cruz	23
Yavapai	25
Yuma	27

7. **Member's Name** - List consumer's name, last name, first name and middle initial – Jones, Mary J.

8. **Member's Zip Code** - Member's Zip Code – this column can be filled in either by the Program Contractor or the Provider.

9. **Member's AHCCCS ID** - List consumer's AHCCCS Identification Number – A12345678.

10. **Select from the following authorized service type** - Select what service the consumer was to receive and list the corresponding alphabetical bullet in Column 10. A consumer may be receiving more than one service i.e., personal care and homemaker. Please list member's name twice and use a separate line to record the second service.

Service type	
Attendant Care	A
Homemaker	B
Personal Care	C
Respite	D

11. **Member Service Preference Level at the time of notice** – Agencies shall obtain from the member/representative the Member Service Preference Level at time the Provider/Agency either receives a call from consumer advising of a NPS or the Provider/Agency contacts the member/representative. The Member Service Preference Level is a designation of how quickly the member chooses to have a service gap filled if the scheduled caregiver of that critical service is not available. The member may have indicated a lower preference level previously but immediate circumstances indicate a higher preference level now.

    Insert the Member Service Preference Level as indicated by the member/representative at the time the Provider/Agency makes contact with the member. Column to be filled in by Agency/Provider.

Member Service Preference Level	___
Needs services within 2 hours	1
Needs services today	2
Needs services within 48 hours	3
Can wait until next scheduled day	4

12. **Member Service Preference Level** at time of last Case Manager's visit - Insert the Member Service Preference Level indicated by the member/representative during the initial or reassessment interviews. Column to be filled in by Program Contractors.

Member Service Preference Level	
Needs services within 2 hours	1
Needs services today	2
Needs services within 48 hours	3
Can wait until next scheduled day	4

13. **Reason for the NPS** - List the reason the non-provision of services occurred. Use the corresponding numerical bullet only. Use #8, only when a non-scheduled respite service has been requested and the Agency does not have a caregiver available. Provide a brief explanation in Column 22, "Comments", if "Other" is used.

Reason for non-provision of service	
Caregiver Cancelled	1
Caregiver Did Not Show	2
Caregiver Left Early	3
Caregiver refuses to go or return to an unsafe or threatening environment at the member's residence	4
Caregiver quit	5
Member not available to receive services when caregiver arrives at the scheduled time	6
Replacement caregiver not available	7
Non scheduled respite service request	8
Member refuses services	9
Member called to cancel/reschedule services	10
Other	11

III. RESOLUTION

14. **Explain how NPS was resolved** - List how the NPS was met on the day of the NPS. Use the corresponding alphabetical bullet only. Unpaid Community Organization could be the consumer's church or civic organization. Unpaid Caregiver could be an unpaid family member, neighbor, friend, etc. who has been designated by the member/representative to assist in an emergency. If an unpaid caregiver is willing to stay with the member until the Agency can get another caregiver to the home use "H".

Explain how NPS was resolved	
Attendant Care	A
Homemaker	B
Personal Care	C
Respite	D
Unpaid Caregiver	E
Unpaid Community Organization	F
Other	G
Unpaid/Paid Caregivers	H

Note: 1) If an "E", "F" or "H" is recorded in Column 14, then Column 21 must be completed.
2) If "G" is used then an explanation must be included. Begin explanation(s) of "Other" in column 22, "Comments". A "G" should not be used to indicate that no services were provided. If no services are provided leave the column blank.

15. **Original Hours Authorized** - The amount of hours authorized by the Case Manager for the date of the NPS being reported.

16. **Hours provided to resolve NPS on the day of the NPS**- Number of hours provided by all entries in Column 14 above to meet member's needs. For example, Case Manager authorized 8 hours for attendant care services; Agency was able to get a replacement caregiver to provide 6 hours and Unpaid Caregiver

provided 2 hours until replacement arrived so a total of 8 hours should be recorded. Note: If Column 16 is less than the number of hours authorized in Column 15, then Column 20 must be completed.

17. **Length of time before services replaced** - Time to resolve NPS in service hours – i.e., the time between the Agency/Contractor notification and the delivery of service. Please record time to resolve NPS in hours– a half day as 12 hours; 1 day as 24 hours; the next once a week scheduled visit as 168 hours.

    For example:

    A. the Agency was notified at 8:30 AM that the caregiver cancelled the 8:00 AM scheduled service. The Member Service Preference Level indicated by the member/representative at the time of the call was "1" – Within 2 hours. The Agency was able to get a substitute caregiver to the member's home by 9:30 AM. Column 17 should record the length of time to resolve the NPS as 1 hour.
    B. the Agency was notified at 8:30 AM that the caregiver cancelled the 8:00 AM regularly scheduled Tuesday services. The Member Service Preference Level indicated by the member/representative at the time of the call was 3 – Within 48 hours. The Agency is able to have a substitute caregiver there at 8:00 AM Wednesday morning. Column 17 should record the length of time to resolve the NPS as 23.5 hours.
    C. the Agency was notified at 8:30 AM that the caregiver cancelled the 8:00 AM once a week Tuesday services. The Member Service Preference Level indicated by the member/representative at the time of the call was 4 – Next Scheduled Visit. Column 17 should record the length of time to resolve the NPS as 167.5 hours.

18. **Was Member Service Preference Level Timeline Met** - Place a Y (Yes) or N (No) to indicate if the NPS was met within the timeline indicated by the Member Service Preference Level at the time of the notice in Column 11. **The clock on the NPS begins when the provider is notified by the member/representative or caregiver that the caregiver either will not or has not arrived to provide services. NOTE: if an "N" is recorded in Column 18, then Column 19 must be filled out.**

19. **If Member Service Preference Level Timeline Not Met** - List the reason the Member Service Preference Level timeline was not met. Use the corresponding numerical bullet. Provide a brief explanation if "Other" is used in column 22, "Comments".

If Member Service Preference Timelines not met explain why	
Reserved (Do Not Use)	1
Consumer Choice	2
Unable to find replacement	3
Not alerted of NPS	4
Other	5

20. **If total Authorized Hours not replaced explain why -** List the reason the total authorized units not replaced. Use the corresponding numerical bullet. Provide a brief explanation if "Other" is used in column 22, "Comments".

If total hours were not replaced explain why	
Full replacement hours not needed	1
Consumer Choice	2
Unable to find replacement	3
Not alerted of NPS	4
Other	5

21. If Unpaid Caregiver used, explain why – Use corresponding number to indicate the reason an unpaid caregiver was used. Note if there is an "E", "F" or "H" used in Column 14 then Column 21 must be completed. For example, the Agency is notified that the caregiver cancelled, the Agency calls the member/representative to determine the Member Service Preference Level and discusses getting another caregiver out to the member. The member refuses and states they wish to use an unpaid caregiver. A number 1 would be recorded in Column 21. Provide a brief explanation if "Other" is used in column 22, "Comments".

If Unpaid Caregiver used, explain why	
Consumer Choice	1
No Agency Staff Available	2
Other	3

Attachment A-1 NON-PROVISION OF SERVICE GAP LOG (Revised 4/1/2007)

														RESOLUTION								
Provider Name:																						
Program Contractor:										***(10)***	***(11)***	***(12)***	***(13)***	***(14)***					***(19)***	***(20)***	***(21)***	***(22)***
0		***(2)***	***(3)***	***(4)***	***(5)***	***(6)***	***(7)***	***(8)***	***(9)***	**Select from the following authorized service type**	**Member Service Preference Level at Time of Notice (Agency)**	**Member Service Preference Level (Program Contractor)**	**Reason for the NPS**	**Explain How NPS was Resolved**	***(15)***	***(16)***	***(17)***	***(18)***	**If Member Service Preference Timeline not met explain why:**	**If total Authorized Hours not replaced explain why:**	**If unpaid Caregiver used explain why:**	**To be completed when an explanation is required.**
Program Contractor ID #	**Provider Registration Number**	**Date Called In**	**Time Called In**	**NPS Date**	**Time Services Scheduled to Begin**	**County Code**	**Member's Name**	**Member's Zip Code**	**Member's AHCCCS ID**	**A. Attendant Care B. Homemaker C. Personal Care D. Respite**	**1 - Within 2 hrs 2 - Services today 3 - Within 48 hrs 4. Next scheduled visit**	**1 - Within 2 hrs 2 - Services today 3 - Within 48 hrs 4. Next scheduled visit**	**1. Caregiver cancelled 2. Caregiver did not show 3. Caregiver left early 4. Caregiver refuses to go or return to an unsafe or threatening environment 5. Caregiver quit 6. Member not available to receive services when caregiver arrives at scheduled time 7 Replacement caregiver not available 8. Non-scheduled respite services not available 9. Member refuses service 10. Member called to cancel/reschedule services 11. Other**	**A. Attendant Care B. Homemaker C. Personal Care D. Respite E. Unpaid Caregiver F. Unpaid Community Organization G. Other (explain) H. Unpaid/Paid Caregivers**	**Original Hours Authorized**	**Hours Provided to Resolve NPS**	**Length of Time Before Services Provided**	**Was Member Service Preference Level Timeline Met - Y/N**	**1. Reserved 2. Consumer Choice 3. Unable to find replacement 4. Not alerted of NPS 5. Other (explain)**	**1. Full replacement hours not needed 2. Consumer Choice 3. Unable to find replacement 4. Not alerted of NPS 5. Other (explain)**	**1. Consumer Choice 2. No Agency staff available 3. Other**	**Comments**

I. INSTRUCTIONS

Program Contractors must submit a completed Gap in Service Log (Gap Log) and Hours Authorized report to AHCCCS, ALTCS Operations for all gaps in critical services as defined by the AMPM Chapter 1600, Policy 1620. Completed reports are to be submitted to AHCCCS, ALTCS Operations by the 10th business day of the month following the reporting month.

II. GAP

Column # Instruction/Explanation

0. **Program Contractor ID #** - Program Contractor fills in column with identification number 110306, 110049, etc.
1. **Provider Registration Number** - Provider's AHCCCS Identification numbers. Column to be filled in by Provider or Program Contractor. Please ensure that this Column is completed.
2. **Date Called In** - The date the Agency was notified of the gap in service. Use the following format 02/01/05.
3. **Time Called In** - The time the Agency was notified. **Use military time** i.e., 08:00, 13:30, etc. Please round to the nearest 15-minute increment.
4. **Gap Date** - The date the gap in service occurs. This date may be the same as the date in column 1 or the consumer may have waited to call. Use the following format 11/01/04.
5. **Time Service Scheduled to Begin** - Insert the time the service was regularly scheduled to begin. **Use military time** i.e., 08:00, 13:30, etc. Please round to the nearest 15-minute increment.
6. **County Code** - The County of **residence** code from the following chart:

County	Code
Apache	01
Cochise	03
Coconino	05
Gila	07
Graham	09
Greenlee	11
La Paz	29
Maricopa	13
Mohave	15
Navajo	17
Pima	19
Pinal	21
Santa Cruz	23
Yavapai	25
Yuma	27

7. **Member's Name** - List consumer's name, last name, first name and middle initial – Jones, Mary J.

8. **Member's Zip Code** - Member's Zip Code – this column can be filled in either by the Program Contractor or the Provider.

9. **Member's AHCCCS ID** - List consumer's AHCCCS Identification Number – A12345678.

10. **Select from the following authorized service type** - Select what service the consumer was to receive and list the corresponding alphabetical bullet in Column 10. A consumer may be receiving more than one service i.e., personal care and homemaker. Please list member's name twice and use a separate line to record the second service.

Service type	
Attendant Care	A
Homemaker	B
Personal Care	C
Respite	D

11. **Member Service Preference Level at the time of notice** - Insert the Member Service Preference Level as indicated by the member/representative at the time the Provider/Agency either receives a call from consumer advising of a gap in service or the Provider/Agency contacts the member/representative to discuss the member's current needs. Agencies shall obtain from the member/representative the Member Service Preference Level at time of service gap notification as a member may have indicated a lower preference level previously but immediate circumstances indicate a higher preference level now. Column to be filled in by Agency/Provider.

Member Service Preference Level	
Needs services within 2 hours	1
Needs services today	2
Needs services within 48 hours	3
Can wait until next scheduled day	4

12. **Member Service Preference Level** at time of last Case Manager's visit - Insert the Member Service Preference Level indicated by the member/representative during the initial or reassessment interviews. Column to be filled in by Program Contractors.

Member Service Preference Level	
Needs services within 2 hours	1
Needs services today	2
Needs services within 48 hours	3
Can wait until next scheduled day	4

13. **Reason for Service Gap** - List the reason the gap in service hours occurred. Use the corresponding numerical bullet only. **#4 should be used only when there is an ongoing NPS/gap in service**. Provide a brief explanation in Column 22 if "Other" is used.

Reason for service gap	
Caregiver Cancelled	1
Caregiver Did Not Show	2
Care Giver Left Early	3
Replacement Caregiver Not Available	4
Reserved	5
Other	6

III. RESOLUTION

14. **Explain how gap was resolved** - List how the gap was met on the day of the gap. If services are not provided on the day of the gap regardless of the reason (i.e., member chose next scheduled visit) the column will be blank. Use the corresponding alphabetical bullet only. Unpaid Community Organization could be the consumer's church or civic organization. Unpaid Caregiver could be an unpaid family member, neighbor, friend, etc. who has been designated by the member/representative to assist in an emergency. If an unpaid caregiver is willing to stay with the member until the Agency can get another caregiver to the home use "H". See scenario #2.

Explain how gap was resolved	
Attendant Care	A
Homemaker	B
Personal Care	C
Respite	D
Unpaid Caregiver	E
Unpaid Community Organization	F
Other	G
Unpaid/Paid Caregivers	H

Note: 1) If an "E", "F" or "H" is recorded in Column 14, then Column 21 must be completed.
2) If "G" is used then an explanation must be included. Provide an explanation of "Other" in Column 22. A "G" should not be used to indicate that no services were provided. **If no services are provided leave the column blank.**

15. **Original Hours Authorized** - The amount of hours authorized by the Case Manager for the date of the gap.

16. **Hours provided to resolve gap on the day of the gap** - Number of hours provided by all entries in Column 14 above to meet member's needs. For example, Case Manager authorized 8 hours for attendant care services; Agency was able to get a replacement caregiver to provide 6 hours and Unpaid Caregiver provided 2 hours until replacement arrived so a total of 8 hours should be recorded. Note: If Column 16 is less than the number of hours authorized in Column 15, then Column 20 must be completed.

17. **Length of time before services provided** - Time to resolve gap in service hours – i.e., the time between the Agency/Contractor notification and the delivery of service. Please record time to resolve gaps in hours – a half day as 12 hours; 1 day as 24 hours; next once a week scheduled visit as 168 hours.

For example:

A. the Agency was notified at 8:30 AM that the caregiver cancelled the 8:00 AM scheduled service. The Member Service Preference Level indicated by the member/representative at the time of the call was 1 – Within 2 hours. The Agency was able to get a substitute caregiver to the member's home by 9:30 AM. Column 17 should record the length of time to resolve the gap in service as 1 hour.
B. the Agency was notified at 8:30 AM that the caregiver cancelled the 8:00 AM regularly scheduled Tuesday services. The Member Service Preference Level indicated by the member/representative at the time of the call was 3 – Within 48 hours. The Agency is able to have a substitute caregiver there at 8:00 AM Wednesday morning. Column 17 should record the length of time to resolve the gap in service as 23.5 hours.
C. the Agency was notified at 8:30 AM that the caregiver cancelled the 8:00 AM once a week Tuesday services. The Member Service Preference Level indicated by the member/representative at the time of the call was 4 – Next Scheduled Visit. Column 17 should record the length of time to resolve the gap in service as 167.5 hours.

18. Was Member Service Preference Level Timeline Met - Place a Y (Yes) or N (No) to indicate if the service gap was met within the timeline indicated by the Member Service Preference Level at the time of the notice in Column 11. **The clock on the service gap begins when the provider is notified by the member/representative or caregiver that the caregiver either will not or has not arrived to provide services. NOTE: if an "N" is recorded in Column 18, then Column 19 must be filled out.**

19. If Member Service Preference Level Timeline Not Met - List the reason the Member Service Preference Level timeline was not met. Use the corresponding numerical bullet. Provide a brief explanation in Column 22 if "Other" is used.

If Member Service Preference Timelines not met explain why	
Reserved	1
Consumer Choice	2
Unable to find replacement	3
Not alerted of service gap	4
Other	5

20. If total Authorized Hours not replaced explain why - List the reason the total authorized units not replaced on the day of the gap. Use the corresponding numerical bullet. Provide a brief explanation if "Other" is used in Column 22.

If total hours were not replaced explain why	
Full replacement hours not needed	1
Consumer Choice	2
Unable to find replacement	3
Not alerted of service gap	4
Other	5

21. If Unpaid Caregiver used, explain why – Use corresponding number to indicate the reason an unpaid caregiver was used. Note if there is an "E", "F" or "H" used in Column 14 then Column 21 must be completed. For example, the Agency is notified that the caregiver cancelled, the Agency calls the member/representative to determine the Member Service Preference Level and discusses getting another caregiver out to the member. The member refuses and states they wish to use an unpaid caregiver. A number 1 would be recorded in Column 21. Provide a brief explanation if "Other" is used in Column 22.

If Unpaid Caregiver used, explain why	
Consumer Choice	1
No Agency Staff Available	2
Other	3

22. **Explanation Column –** Complete this column when an explanation is required**.**

Authorized Hours Worksheet – (See tab at bottom of Excel page) The Program Contractor must report monthly the total hours of authorized services by service provided on the second sheet of the Service Gap Log. Please do not modify the worksheet as any modifications interfere with the analysis.

(a) Month	*(b) Program Contractor ID Number*	*(c) Attendant Care*	*(d) Personal Care*	*(e) Homemaking*	*(f) Respite*	*(g) TOTAL*
Insert Previous Month (Jan.)	123456	65,266	585	1,579	0	67,430
Insert Current Month (Feb.)	123456	67,422	531	1,804	0	69,757

(h) Month	*(i) # of HCBS In-Home Members as of the last day of the month*	*(j) # of Gap Hours Reported*	*(k) Hours Provided to Resolve Gap*	*(l) Average Gap Hours Per Member*	*(m) Total Authorized Hours*	*(n) % of Gap Hours to Authorized Hours*
Previous Month (Jan.)	500	125	87	25	67,430	.19%
Current Month (Feb.)	490	91	69	19	69,757	.13%
(o) % of Variance to Current	<2%>	< 37%>	<26%>	<32%>	3.34%	<46%>

(a) Previous Month: This row should contain the name of the previous month's data. i.e., January.
Current Month: This row should contain the name of the current month's data, i.e., February.

(b) Program Contractor ID Number: List Program Contractor identification number from Column 0 on the Gap in Service Log.

(c) Attendant Care: List the total number of attendant care hours authorized for the previous and current months.

(d) Personal Care: List the total number of personal care hours authorized for the previous and current months.

(e) Homemaker: List the total number of homemaker hours authorized for the previous and current months.

(f) Respite: List the total number of respite hours authorized for the previous and current months.

(g) Total: List the totals of Columns (c), (d), (e) and (f).

(h) Previous Month: This row should contain the name of the previous month's data. i.e., January.
Current Month: This row should contain the name of the current month's data, i.e., February.

(i) # of HCBS In-Home Members as of the Last Day of the Month: List the total number of in-home HCBS members for the month you are reporting on the appropriate line; i.e., January and February

(j) # of Gap Hours reported: List the total hours reported in column 15 (Original Hours Authorized) of the Gap in Service Log.

(k) Hours Provided to Resolve Gap: List the total of hours reported in column 16 (Hours Provided to Resolve Gap) of the Gap in Service Log.

(l) Average GAP Hours Per Member: The total number of gap hours (j) divided by the # of HCBS in-home members (i).

(m) Total Authorized Hours: List the totals from column g above.

(n) % of Gap Hours to Authorized Hours: The total of gap hours reported (j) divided by the total hours authorized (m).

(o) % of Variance to Current: The difference between the previous month's information and the current month's information divided by the current month's data. **Provide comments/explanations of variances that may need clarification at the bottom of the Excel sheet.**

NOTE: Please bracket all negative numbers as shown in the example.

Authorized Hours Worksheet - (See tab at bottom of Excel page) The Program Contractor must indicate on the line on the second page of the Service Gap Log that it has received from each contracted provider a report or acknowledgement that they have had no gaps in service for the reporting month. If no report or acknowledgement is received, the Program Contractor must send, under separate cover, an explanation of why no report or acknowledgement was received.

_____Yes/No - All Contracted Providers Reporting; If No, Provide Explanation Under Separate Documentation

Service Gap Scenarios **See Service Gap Tracking Log for recording of scenarios.**

Scenario 1:

History: J. Smith, with quadriplegia lives at home alone and requires services in the morning and evening. Consumer has limited to minimal informal support systems.

Assessment/
Authorized: Case Manager has assessed and authorized a total of 6 hours of attendant care to be split 3 hours in the morning and 3 hours at night, to begin at 8:00 AM and 7:00 PM, seven days a week. Member Service Preference Level indicated by the member/representative was a Level 1 and the Agency has been notified.

Situation: At 8:00 AM the caregiver calls the Consumer and then calls the Agency letting both know that they will be unable to work today. Agency calls Consumer to discuss situation and member indicates immediate priority needs. (Agencies shall obtain from the member/representative the Member Service Preference Level at time of service gap notification as a member may have indicated a lower preference level previously but immediate circumstances indicate a higher preference level now.)

Resolution: Agency is able to obtain another caregiver and has them at the Consumer's home at 10:00 AM and will provide 2 hours of personal care services. The replacement morning caregiver will also be able to cover the 3 hour evening shift therefore; a gap is not recorded for the evening shift because it was resolved before the scheduled time service was to begin.

Scenario 2:

History: T. Jones is an older person with dementia who tends to wander and cannot be left alone. Consumer lives with his son. The son works outside of the home.

Assessment/
Authorized: Case Manager has assessed and authorized a total of 9 hours of attendant care six days a week. Caregiver is scheduled to begin at 7:00 AM. Member Service Preference Level indicated by the member/representative was a Level 1 and the Agency has been notified.

Situation: At 7:30 AM the caregiver calls to say they will be unable to work today. The Agency calls the Consumer's son to discuss the situation and the son indicates immediate priority needs. The son is not part of the Contingency Plan due to his employment outside of the home.

Resolution: The Agency makes several calls to try and find another caregiver. At 8:30 the Primary Agency calls the Program Contractor and informs them they can not find a replacement caregiver. The Program Contractor contacts another contracted provider within their network and makes arrangements for a replacement caregiver to be at the member's home at noon. The son then stays with his father until the replacement caregiver arrives. Total number of service hours received from both paid and unpaid are 9 (5 unpaid caregiver and 4 by paid caregiver) therefore, an "H" is recorded under column 14.

Scenario 3:

History: M. Brown is married and lives with his elderly spouse. The spouse is unable to assist with most personal care however is able to assist with simple meals and the urinal. The Browns are a Spanish speaking family who live 30 miles from town. The Browns would prefer Spanish speaking caregivers.

Assessment /Authorized: Case Manager has assessed and authorized 2 hours of personal care 7 days a week and 2 hours of homemaker services Monday, Wednesday and Friday. Personal care hours are to begin at 7:30 AM and homemaker hours at 11:00 AM. Member Service Preference Level indicated by the member/representative was a Level 2 because of the Personal Care service. The spouse can get the member simple meals and is able to assist with the urinal. The member has indicated that when a Homemaker is not available the service can be delayed until the next scheduled visit.

Situation: Personal Care Worker called the Agency at 7:30 AM on Wednesday and lets the Agency know they won't be in to work. The Agency calls the Consumer to discuss the situation pertaining to Personal Care services and member confirms his Service Preference Level as a Level 2. The Homemaker calls the Agency at 11:00 AM on Wednesday to let the Agency know they wouldn't be in to work. The Agency calls the member and discusses the Homemaker needs. The Member Service Preference Level is indicated by the member to be a Level 4 – Next Scheduled Visit.

Resolution: The Agency only has a non-Spanish speaking Personal Care worker available. That worker is sent to the member's home at 10:30 AM for 2 hours of care. The family refuses the caregiver because of the language issue and calls the Primary Agency. The Agency calls the Program Contractor and informs them they can not find a Spanish speaking replacement caregiver. The Program Contractor contacts another contracted provider within their network and makes arrangements for a replacement caregiver to be at the member's home at 1:00 PM. The time recorded in column 17 to resolve the gap in Personal Care services is 5.5 hours. On a separate line the hours recorded in Column 17 for the resolution of Homemaker services is 48 hours.

NOTE: **As no Homemaker services were provided until the next scheduled visit Column 14 is blank. Column 20 now shows a "2" as member chose not to receive Homemaker services until the next scheduled visit.**

Scenario 4:

History: S. White is married and lives with her elderly spouse. The spouse is unable to do housework, shopping, laundry, etc.

Assessment/ Authorized: Case Manager has assessed and authorized 2 hours of Homemaker services Monday, Wednesday and Friday beginning at 11:00 AM. Member Service Preference Level indicated by the member/representative was a Level 4 for Homemaker.

Situation: At 11:30 on Wednesday the member calls the Agency to report the homemaker has not shown up. While on the phone, the Agency and the Whites discuss the situation. The Whites explain that the homemaker always goes grocery shopping for them on Wednesdays and they can't wait until Friday for the service. The Member Service Preference Level is currently indicated as Level 2.

Resolution: The Agency is able to have a homemaker out to the Whites at 4:30 PM the same day. The time recorded in Column 17 is 5 hours.

Scenario #5:

Situation: The member is to receive attendant care services 3 times a week for 6 hours a day. Caregiver shows up at the regularly scheduled time and the member did not answer the door. The caregiver made a reasonable attempt to verify that the member was not home (i.e. looked in windows, checked with a neighbor, called the member's telephone number, etc.) The caregiver notified their agency who instructed them to wait 15 minutes before leaving.

Resolution: The provider agency records this on the Non-Provision of Service Log and would indicate 6 (Member not available to receive services when caregiver arrives at scheduled time) in column 13. Because this is not a gap in services, Program Contractors would not record this on the Gap In Service Log submitted to AHCCCS.

Scenario 6:

History: J. Johnson lives with her son who works outside the home. The son performs her morning and evening care. All the member requires is assistance with housekeeping.

Assessment/
Authorized: Case Manager has assessed and authorized 2 hours of homemaker services twice a week. Services are scheduled Tuesdays and Thursdays beginning at 10:00 AM. Member Service Preference Level indicated by the member/representative was a Level 4.

Situation: At 10:15 AM on Tuesday the member calls the Agency and states that the homemaker did not show up. The Agency discusses the situation with the member who indicates the Member Service Preference Level is Level 4. The Agency calls the homemaker and finds out the homemaker has been in an accident and is no longer available and they do not have another homemaker available today or in the foreseeable future. The Agency calls the Program Contractor and advises them of the situation.

Resolution

The Program Contractor contacts other contracted providers in their network and is unable to find a replacement caregiver for today from any of them. All agencies will continue to look for a replacement caregiver for as soon as possible. On Friday, a provider agency (not the original agency) contacts the Program Contractor to report having found a replacement caregiver for this member to begin at 10:00 AM that day. This caregiver will only be available for one week while the member she usually takes care of is out of town. The Program Contractor contacts the original provider agency to advise them the non-provision of services has been temporarily resolved so this does not continue to be recorded on the log. At the end of the week when the replacement caregiver is no longer available for the member neither the original nor any of the Program Contractor's other provider agencies are able to find another replacement caregiver. One month later a replacement caregiver has still not been found. Program Contractor, Agencies continue to look for a caregiver. The Case Manager continues to discuss with the member alternative service/placement options to meet her needs. Member chooses to remain in her son's home. The Case Manager and the member develop a Managed Risk Agreement.

Scenario 7:

History: Ms. Brown is a 48 year old member with MS who lives alone but has friends in her home frequently. Member has had numerous caregivers and agencies providing her care over the last several months. The current agency is the last of the Program Contractor's contracted providers who is willing to serve this member.

Assessment/
Authorized: Case Manager has assessed and authorized 5 hours per day of Attendant Care, 7 days/week. Member Service Preference Level is 2

Situation: Member's current caregiver arrives at member's home at scheduled time and finds member and a few friends actively using illegal drugs. This is not the first time this has occurred. The caregiver does not feel the situation is safe for her so she advises the member that she can not stay to provide care. One of member's friends becomes verbally aggressive towards caregiver so she immediately leaves the home. She drives away from the home and calls her employer agency to inform them of the situation. The provider contacts the Program Contractor to inform them that they are no longer willing to send a caregiver into this unsafe setting.

Resolution: The case manager contacts the member to inform her that as a result of the drug activity in her home, they are unable to find a caregiver for the member today and it is not known when another caregiver will be found. The next day the case manager and her supervisor visit the member in her home to update her Managed Risk Agreement which outlines what the barriers to care are and the potential consequences if the member's behaviors/choices continue. This is recorded on the Non-provision of service log until a replacement caregiver is found. It is not a gap in service and therefore not recorded on the Gap In Service Log.

Attachment B-1 SERVICE GAP LOG (Revised 02/12/2007)

Provider Name:

Program Contractor:

0	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)
										Select from the following	Member Service Preference Level at	Member Service Preference Level	Reason for Service Gap	Explain How Gap was Resolved					If Member Service Preference Timeline not met explain why:	If total Authorized Hours not replaced explain why:	If unpaid Caregiver used explain why:	
Program Contractor ID #	Provider Registration Number	Date Called In	Time Called In	Gap Date	Time Services Scheduled to Begin	County Code	Member's Name	Member's Zip Code	Member's AHCCCS ID	A. Attendant Care B. Homemaker C. Personal Care D. Respite	1 - Within 2 hrs 2 - Services today 3 - Within 48 hrs 4. Next scheduled visit	1 - Within 2 hrs 2 - Services today 3 - Within 48 hrs 4. Next scheduled visit	1. Caregiver cancelled 2. Caregiver did not show 3. Care Giver Left Early 4. Replacement caregiver not available 5. Reserved 6. Other	A. Attendant Care B. Homemaker C. Personal Care D. Respite E. Unpaid Caregiver F. Unpaid Community Organization G. Other (explain) H. Unpaid/Paid Caregivers	Original Hours Authorized	Hours Provided to Resolve Gap	Length of Time Before Services Provided	Was Member Service Preference Level Timeline Met - Y/N	1. Reserved 2. Consumer Choice 3. Unable to find replacement 4. Not alerted of service gap 5. Other (explain)	1. Full replacement hours not needed 2. Consumer Choice 3. Unable to find replacement 4. Not alerted of service gap 5. Other (explain)	1. Consumer Choice 2. No Agency staff available 3. Other	To be completed when an explaination is required
XXXXXX	111111	12/10/04	8:00	12/10/04	8:00	13	Smith, J	XXXXX	A11111111	A	1	1	1	A	3	2	2	Y		1		
XXXXXX	222222	12/15/04	7:30	12/15/04	7:00	19	Jones, T	XXXXX	A22222222	A	1	1	1	H	9	9	0	N	3		2	
XXXXXX	333333	12/20/04	7:30	12/20/04	7:30	3	Brown, M	XXXXX	A33333333	C	2	2	1	C	2	2	5.5	Y				
XXXXXX	333333	12/20/04	7:30	12/20/04	7:30	3	Brown, M	XXXXX	A33333333	B	4	2	1		2	0	48	Y		2		
XXXXXX	333333	12/30/04	11:30	12/30/04	11:00	27	White, S	XXXXX	A44444444	B	2	4	2	B	2	2	5	Y				
XXXXXX	6666666	02/13/07	10:15	02/13/07	10:00	17	Johnson, J	XXXXX	A6666666	B	4	4	2		2		96	N	3	3		
XXXXXX	6666666	02/13/07	10:15	02/15/07	10:00	17	Johnson, J	XXXXX	A6666666	B	4	4	2	B	2	2	24	Y				
XXXXXX	6666666	02/27/07	10:00	02/27/07	10:00	17	Johnson, J	XXXXX	A6666666	B	2	4	2		2		48	N	3	3		
XXXXXX	6666666	03/01/07	10:00	03/31/07	10:00	17	Johnson, J	XXXXX	A6666666	B	2	4	2		2		744	N	3	3		

RESOLUTION

Attachment B-2

AUTHORIZED HOURS WORKSHEET:

Program Contractor:

(a)	(b)	©	(d)	(e)	(f)	(g)
Month	**Program Contractor ID Number**	**Attendant Care**	**Personal Care**	**Homemaker**	**Respite**	**Total**
Insert Previous Month (Jan)	123456	65,266	585	1,579	0	67,430
Insert Current Month (Feb)	123456	67,422	531	1,804	0	69,757

(h)	(i)	(j)	(k)	(l)	(m)	(n)
Month	**# of HCBS Members as of the last day of the month**	**# of Gap Hours Reported**	**Hours Provided to Resolve Gap**	**Average Gap Hours Per Member**	**Total Authroized Hours**	**% of Gap Hours to Authorized Hours**
Insert Previous Month (Jan)	500	125	87	25	67,430	0.19%
Insert Current Month (Feb)	490	91	69	19	69,757	0.13%
(o) %of Variance to Current	<2%>	<37%>	<26%>	<32%>	3.34%	<46%>

_____ Yes/No - Did all providers submit a NPS Report? If no, provide an explanation under separate documentation.

TELEPHONE SURVEY INSTRUCTIONS

Purpose: To determine if a Contractor's provider agencies of critcal services are available to address a member's potential gap in critical services.

Survey Instructions: Contractors are to call **all** provider agencies contracted to provide services deemed as "Critical Services". All calls conducted Monday through Friday are to be made between the hours of 8 pm and 5 am. Calls can be made on the weekends regardless of time. The calls should be split approximately 50/50 between weekdays and weekends. A provider agency is determined to be available to address a member's potential gap in critical services if they immediately answer the phone call or return the phone call within 15 minutes.

Summarize Survey Results: Contractors are to summarize results from the survey and describe any provider specific or overall corrective action plans (if any) that the Contractor may take as a response to Survey results.

Timeframe for Survey: Completed Surveys are to be submitted to ALTCS Operations by close of business on the 10th business day of the month following the end of the quarter – e.g., for quarter ending March 31, 2010 Surveys would have been due April 14, 2010.

Notes: 1) Use military time to record time called and time of response.

2) Do not modify the template

TELEPHONE SURVEY

Contractor Name: ***Date Submitted: xx/xx/xxxx***

Program Contractor ID No.	County Code	Provider Name	Provider ID No.	Phone No. 24/7 hrs/day	Date Called	Time Called	Time Call Returned	Person Returning Call	Explanation If More Than 15 Minutes to Return Call	Corrective Action Taken (if any)
110306	7	XYZ Home Care	xxxxxxxx	602-555-6787	xx/xx/xx	4:45	5:00	Jane Smith		
110003	3	ABC Home Care	xxxxxx	520-555-0845	xx/xx/xx	21:30	21:33	John Doe		
110049	15	YME Home Care	xxxxxxx	928-555-6767	xx/xx/xx	22:00	22:30	Mary Jane	Mary Jane was calling caregivers regarding another case	None

414 – CONTENT OF NOTICES OF ACTION FOR SERVICE AUTHORIZATION

Effective Date: 08/01/2007
Revision Date: 08/01/2008, 10/01/2009, 01/01/2011

Staff responsible for policy: DHCM Medical Management Unit

I. Purpose

This policy applies to all Acute Care Contractors, Arizona Long Term Care System (ALTCS) Contractors, Arizona Department of Health Services/Department of Behavioral Health Services (ADHS/DBHS) and the CRS Contractor, hence forth "Contractor".

This policy provides clarification to the Contractor's contract regarding required content of a notice of action relates to coverage and authorization of services. Contractors must follow all other requirements regarding Notice of Action set forth in the AHCCCS Contract.

II. Policy

When a Contractor makes a decision to deny, issue a limited authorization of a service authorization request, reduce suspend or terminate a previously authorized service, the Contractor shall provide a written Notice of Action (NOA) letter to the member. When a Contractor requires more information to make a decision and it is in the member's best interest the Contractor shall provide a written Notice of Extension (NOE) letter to the member.

The Notice of Action letter must contain, in easily understood language, the information necessary for the member to understand what decision and action the Contractor has made, and how to appeal that decision. Members must be able to understand from the NOA the reason for the action to help them decide if they want to appeal the decision, and how to best argue their case if they decide to appeal. Additionally, if the reason for the denial is a lack of necessary information, the member must be informed so that they can provide the necessary information.

The Notice of Extension letter must contain, in easily understood language, the information that the contractor requires to make the service determination and how to grieve the NOE decision. The member must be able to understand what information is required to make the service determination so they can provide necessary information in the event they have access to the information.

Contractors must use the Notice of Action template incorporated in this policy. The template can not be altered except for the areas designated in the letter.

Contractors must ensure that the Member Handbooks inform the members that they can complain to the Contractor about inadequate Notices of Action. Additionally, the

Contractor must inform the member that if the Contractor does not resolve the complaints about the Notice of Action letter to the member's satisfaction the member may complain to the AHCCCS Division of Health Care Management, Medical Management Unit.

III. Right to be Represented

Contractors must acknowledge the member's right to be assisted by a representative, including an attorney. The Contractor's appeals process must register the existence of the third party and the Contractor must ensure that the required communications related to the appeals process occur between the Contractor and the representative. The member's representatives, upon request, must be provided timely access to documentation relating to the decision under appeal. Consistent with federal privacy regulations, Contractors must make reasonable efforts to verify the identity of the third party and the authority of the third party to act on behalf of the member. This verification may include requiring that the representative provide a written authorization signed by the member; however, if the Contractor questions the authority of the representative or the sufficiency of a written authorization, it must promptly communicate that to the representative.

IV. Definitions

Action: The denial or limited authorization of a service request, or the reduction, suspension or termination of a previously approved service.

Appeal: A request for review of an action.

Appeal Computation of Time: Computation of time for appeals is in calendar days and begins the day after the act, event, or decision and includes all calendar days and the final day of the period. For purposes of computing member appeal dates, 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 (Saturday or Sunday) or a legal holiday. The first day of the "count" always begins on the day after the event. The due date for the appeal is the working day immediately *after* the last day of the "count" if the last day falls on a weekend or legal holiday. If the last day of the "count" falls on a weekday, then that weekday is the due date. **Example 1:** A Notice of Appeal Resolution (NAR) received Friday 9/4. The Request for Hearing (RFH) must be filed 30 days from the date the member receive the NAR. The first (1st) day is Saturday 9/5 and the thirtieth (30th) day is Sunday 10/4. Therefore, the due date is Monday 10/5. **Example 2:** The Notice of Appeal Resolution is received Thursday 9/3. The RFH must be filed thirty (30) days from the date the member receives the NAR. Therefore, the first (1st) day is Friday 9/4 and the thirtieth (30th) day is Saturday 10/3. Therefore, the due date is Monday 10/5. **Example 3:** The Notice of Appeal Resolution is received Wednesday 9/2. The RFH must be filed thirty (30) days from the date the member receives the NAR. The first (1st) day is Thursday 9/3 and the thirtieth (30th) day is Friday 10/2. Therefore, the due date is Friday 10/2.

Expedited Authorization Request: A request for services in which the requesting provider indicates or the Contractor determines that following the standard timeframes for authorization could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. The decision must be made within three (3) working days.

Legal Holidays: Legal holidays as defined by the State of Arizona are: New Year's Day – January 1; Martin Luther King Jr./Civil Rights Day – 3rd Monday in January; Lincoln/Washington Presidents' Day – 3rd Monday in February; Memorial Day – Last Monday in May; Independence Day – July 4; Labor Day – 1st Monday in September; Columbus Day – 2nd Monday in October; Veterans Day – November 11; Thanksgiving Day – 4th Thursday in November; Christmas Day – December 25. When a holiday falls on a Saturday, it is recognized on the Friday preceding the holiday and when a holiday falls on a Sunday, it is recognized on the Monday following the holiday. Legal holiday dates for the current year are posted at: http://www.azlibrary.gov/links/holidays.cfm

Notice of Action letter: The written notice to the effected member regarding an action by the Contractor.

Notice of Extension letter: The written notice to a member to extend the timeframe for making either an urgent or standard authorization decision by up to fourteen days if criteria for a service authorization extension are met.

(Date of) Receipt of a Service Authorization Request Date: The date of receipt of the service request is the date the Contractor receives the service request from the requesting provider. The Contractor may use electronic date stamps or manual stamping for logging the receipt. If the Contractor sub-contracts prior authorization to a delegated entity, the date the delegated entity receives the request is the date of the request. The receipt of request date is the qualifying event in the computation of time and the count begins the day after the event, act or decision. Refer to the computation of time definition.

Service Authorization Request: A request from the member, their representative, or a provider for a service for the member.

Service Request Computation of Time: Computation of time for standard authorization requests (both with and without extensions of time) is in **calendar** days, and begins the day after the act, event (the receipt of request), or decision and includes all calendar days and the final day of the period. The first day of the "count" always begins on the day after the event. However, if the due date for a decision falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona, the decision must be made on the day preceding the weekend or holiday. The due date for a decision is the working day immediately *prior* to the last day of the "count" if the last day falls on a weekend or legal holiday. If the last day of the "count" falls on a weekday, then that weekday is the due date. Computation of time for expedited requests is computed in **working days** and begins the day after the act, event or decision and includes all working days as defined by this Policy. **Example 1:** A

standard service authorization request is filed Monday 8/24. The Contractor has fourteen (14) days to issue the decision or a Notice of Action (NOA) letter. The first (1st) day is Tuesday, 8/25 and the fourteenth (14th) day falls on Labor Day, Monday 9/7. Therefore, the due date for the NOA is Friday, 9/4, providing there is no Notice of Extension issued. **Example 2:** A standard service authorization request is filed Tuesday 8/25. The Contractor has fourteen (14) days to issue a decision or a NOA. The first (1st) day is Wednesday, 8/26 and the fourteenth (14th) day falls on Tuesday 9/8. Therefore, the due date for the decision or NOA is Tuesday 9/8.

Working Days: "Working Day" as defined in R9-34-202. Monday, Tuesday, Wednesday, Thursday, or Friday unless: a) a legal holiday falls on one of these days; or b) a legal holiday falls on Saturday or Sunday and a Contractor is closed for business the prior Friday or following Monday.

V. Notice of Action Content Requirements

A. The Notice of Action must contain and clearly explain in easily understood language the following information:

1. The requested service;
2. the reason/purpose of that request;
3. the action taken by the Contractor (denial, limited authorization, reduction, suspension or termination) with respect to the service request;
4. the reason for the action, including factual findings about the member's condition that were the basis for the Contractor's action;
5. the legal basis for the action; citations to general provisions in the AHCCCS statute or regulations or to the Contractor's internal policy manual are not sufficient.
6. where members can find copies of the legal basis: the local public library and the web page with links to legal authorities; when a legal authority or an internal reference to the Contractor's policy manual is available on-line, the Contractor shall provide the accurate URL site to enable the member to find the reference on-line.
7. the right to and process for appealing the decision;
8. legal resources for members for help with appeals, as prescribed by AHCCCS.

B. **A general statement that a requested service is not medically necessary, without explanation of why a service is not medically necessary, is unacceptable as a reason for the action.** Use of this or similar language as a reason for an action will result in regulatory action by AHCCCS, including but not limited to civil monetary penalties per event (letter) and/or capping of enrollment. If a Contractor determines that a service is not medically necessary, it is appropriate to cite the relevant regulation, e.g. R9-22-101.B, R9-22-201 B.1., R9-28-201., as the legal basis for the action and to state the regulation in easy to understand terms. Additionally, the Contractor must also explain why a denied/reduced service is not medically necessary in language which is easily understood by the member. Refer to Section II of the Guide for examples where medical necessity is appropriately used in denying/limiting services.

C. Contractors must cite the AHCCCS Early Periodic Screening, Diagnosis and Treatment (EPSDT) Rule R9-22-213 and federal law 42 USC 1396d(r)(5) when denying, reducing or terminating a service for a Title XIX member who is younger than twenty-one (21) years of age when these provisions are applicable. When the Contractor denies, reduces, or terminates services that have been requested for Title XIX members under the age of 21, the Contractor must explain why the requested services do not meet the conditions as described in this policy and the AMPM Chapter 400, Section 430. The Contractor must specify why the requested services do not meet the EPSDT criteria and are not covered and must also specify that EPSDT services include coverage of screening services, vision services, dental services, hearing services and such other necessary health care, diagnostic services, treatment and other measures described in federal law subsection 42 USC 1396(d) (a) to correct or ameliorate (make better) defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the AHCCCS State Plan.

D. A Notice that does not explain why the service has been denied/ reduced and merely refers the member to a third person for more information is unacceptable. The NOA must state the reasons supporting the denial/reduction. The Contractor may also include a statement referring a member to a third person for more help when the third person can explain treatment alternative in more detail.

VI. Member Complaints regarding the Adequacy and/or Understandability of NOA

If a member complains about the adequacy of a Notice of Action Letter, the Contractor shall review the initial notice against the content requirements of this policy. If the Contractor determines that the original notice is inadequate or deficient, the Contractor must issue an amended Notice of Action consistent with the requirements of this policy. Should an amended notice be required, the timeframe for the member to appeal and continuation of services starts from the date of the amended notice.

If the member complains to the Contractor regarding the adequacy of the amended Notice of Action, the Contractor must promptly inform AHCCCS, the Division of Health Care Management, Medical Management Unit of the complaint. Additionally, the Contractor must inform the member of their right to contact AHCCCS, Division of Health Care Management, Medical Management Unit, if the issue is not resolved to the member's satisfaction.

VII. Timeframes for Decisions and the Notice of Action Letter

Each Contractor must meet the following timeframes for issuing a decision:

A. **Standard Authorization Decision Timeframe:** For standard authorization decisions, the Contractor must provide a decision as expeditiously as the member's condition warrants but no later than fourteen days from receipt of the request. The Contractor may issue a Notice of Extension of up to fourteen additional calendar days, if the criteria for a

service authorization extension are met. Refer to Service Request Computation of Time under "Definitions" for further information when the end date falls on a weekend or legal holiday. **Example**, A request is received on a Tuesday, the second (2nd) day of the month and the first day of the count begins Wednesday the day after the receipt of the request, the third (3rd) day of the month. Therefore the decision must be made by Tuesday, the sixteenth (16th) of the month. [42 CFR 438.210 (d) (1)]

B. **Expedited Authorization Decision Timeframe:** For expedited authorization decisions, the Contractor must provide a decision as expeditiously as the member's health condition requires but no later than three **working** days from the receipt of the request, with a possible extension of up to fourteen additional calendar days, if the criteria for an extension are met. Refer to Service Request Computation of Time under "Definitions" for further information when the end date falls on a weekend or legal holiday. **Example:** A request is received on Thursday, the tenth (10th) of the month, and a decision must be rendered by Tuesday, the third (3rd) **working** day or the fifteenth (15th) day of the month. [42 CFR 438.210 (d) (2)]

C. For **service authorization decisions not reached within the timeframes** outlined for standard or expedited requests, this constitutes a denial and is thus an adverse decision on the date that the timeframe expires. The Contractor must issue a Notice of Action letter denying the request on the date that the timeframes expire. Refer to Service Request Computation of Time under "Definitions" for further information when the end date falls on a weekend or legal holiday. [42 CFR 404.(c) (5)]

D. When a **Notice of Extension is issued**, and a decision is not reached by the timeframe noted in the Notice of Extension letter, not to exceed the twenty eighth (28th) day from the service request date for standard authorization requests, or three (3) working days plus fourteen (14) calendar days from the date of the expedited (urgent) request, this constitutes a denial and is thus an adverse decision on the date that the timeframe expires. The Contractor must issue a Notice of Action letter denying the request on the date that the timeframe expires. Refer to Service Request Computation of Time under "Definitions" for further information when the end date falls on a weekend or legal holiday. [42 CFR 438.210 (d) (1 and 2)]

E. The Contractor must mail the notice within the following timeframes:
   i. For termination, suspension, or reduction of a previously authorized service, the notice must be mailed at least ten (10) days before the date of the proposed termination, suspension, or reduction except for situations in 42 CFR 4321.213 and 214 providing exceptions to advance notice. [42 CFR 438.404 (c) (1)]
   ii. For standard service authorization decisions that deny or limit services, the Contractor must provide notice no later than fourteen (14) days from the receipt of the request, unless there is Notice of Extension (refer to Notice of Extension in this Policy). [42 CFR 438.404 (c) (3)]
   iii. For decisions where Notices of Extension have been sent, the Contractor must mail the notice by the end date of the Notice of Extension, not to exceed fourteen

additional calendar days from the end of the standard or urgent decision timeframe, and may never exceed twenty-eight calendar days.

VIII. **Notice of Extension**

A. The Contractor may extend the timeframe to make a service authorization outlined for both the standard and urgent request when the member or provider requests an extension, or when the Contractor can justify that the need for additional information is in the member's best interest. [42 CFR 438.404]

B. The Contractor may extend the timeframe to make a decision regarding an expedited or standard authorization request by up to fourteen (14) additional days. **Exampls 1:** A request is received on a Tuesday, the second (2nd) day of the month and the first day of the count begins Wednesday, the third day of the month. Therefore the decision must be made by Tuesday, the sixteenth (16th) of the month, but on day nine (9) of the request (the eleventh (11th) a Notice of Extension for a fourteen (14) day period is issued. The count begins on the day after the Notice of Extension, or the twelfth (12th) of the month, and the end date for making the decision is on the twenty fifth (25th) of the month, or fourteen days from the date of issuance of the Notice of Extension. **Example 2:** A request is received on a Thursday, the tenth (10th) of the month and a decision must be rendered by Tuesday, the third (3rd) **working** day or the fifteenth (15th) day of the month. If on Tuesday, the fifteenth (15th) of the month a Notice of Extension is issued for fourteen (14) additional **calendar** days, the count begins the day after the event and therefore the decision must be made by the twenty-ninth (29th) day of the month.

C. If the Contractor extends the timeframe in order to make a decision, the Contractor must:
   i. Give the member written notice of the reason for the decision to extend the timeframe;
   ii. Inform the member of the right to file a grievance (complaint) if her or she disagrees with the decision to extend the timeframe;
   iii. Make the decision as expeditiously as the member's condition and no later than the date the extension expires.

IX. Attachments

A. The required Notice of Action template is included in this policy as Attachment A.
B. The Notice of Action Guide to Language is included in this policy as Attachment B.
C. A list of legal resources for members is included in this policy as Attachment C.
D. The Notice of Extension letter template is included in this policy as Attachment D.

X. References

- 42 CFR §438.210
- 42 CFR §438.404
- 42 CFR Part 438 Subpart F, Grievance System
- Arizona Administrative Code, Title 9, Chapter34
- AHCCCS/Contractor Contract

Attachment A ACOM Policy # 414, Revised / Approved 8/1/08

Insert Logo Here

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will help you. If this notice does not tell you what you asked for, what we decided and why, please call us at XXX-XXX-XXXX. This notice is available in other languages and formats if you need it.

Si usted no entienda esta carta o usted tiene alguna pregunta por favor de llamar al XXX-XXX-XXXX or (800) XXX-XXXX. Esta carta esta disponible en otras idiomas y formato si es que lo necesita.)

NOTICE OF ACTION

TO: Date:

FROM:

(You or your doctor- as appropriate) have asked that (*Health Plan Name)* pay for (*describe services requested and the reason for the services in easily understood language*).

Our Decision

(*Insert action being taken here and date effective if terminating or reducing a current service*).

The Reasons For Our Decision

Facts About Your Condition or Situation that Support Our Decision

(*Insert the reason for the action, which must be complete and in commonly understood language. The explanation must be both member and fact specific, describing the member's condition and the reasons supporting the Contractor decision. If the reason for the denial is a lack of information, the missing info must be identified so the member has an opportunity to provide it)*

Legal Basis for Our Decision

We based our decision on (*insert correct legal citation here*).

Copies of Legal Citations can be found at the local library or at http://www.azahcccs.gov/Regulations/LawsRegulations/.

Your Rights if You Disagree with This Decision

If you are not happy with this decision, you can ask us to look at the decision again. This is called an appeal. You can appeal by telling us over the phone or in writing. You must call us at (***Insert grievance phone number***) or write us by (***insert date, 60 calendar days after the date of this Notice. If the 60th day falls on a weekend or holiday the contractor must use the next business day*****).**

If you are writing your appeal, please send it to (*insert Contractor mailing address here*).

You can also see your medical records and get other information about your appeal. Before we make our decision, you can give us any information that you think will be helpful. You can ask us to set up a meeting so that you can give us the information in person, or you can give it to us in writing.

After we review your appeal, we will send you our decision in writing within 30 days of the date we received your appeal request.

If You Need a Faster Decision on Your Appeal

If you or your doctor believes that your health or ability to function will be harmed unless a decision is made in the next three days, you or your doctor can ask us for a fast review by calling us and asking for an expedited appeal. If we agree, we will decide your appeal in 3 working days. If we do not agree a fast review is needed, we will write you within 2 days, and we will also try to call you. Then, we will decide your appeal within 30 days.

Getting Help If You Want to Appeal This Decision

You can have someone help you appeal. Your doctor or other health care provider can appeal for you if you write to us giving them permission.

If you would like legal help with this decision, please contact the legal aid program in your county listed on the attached sheet.

Taking More Than 30 Days to Decide Your Appeal

For all appeals, up to 14 more days may be taken to make a decision on your case. This is called an extension. If we want an extension, we will write you and tell you why it is needed and how it is helpful to you. If you want an extension, you can ask for it by writing or calling us. If an extension is given, a decision in your appeal will be made in 44 days, rather than 30 days.

Continuing Services While We Make a Decision on Your Appeal ***(Insert: "This paragraph does not apply to you" if the member has not been receiving the requested service)***

If the services you write about in your appeal are already being given to you, but are going to be cut back or stopped, you can ask that the services continue while we make a decision. If you want those services to continue, you must say so when you appeal. Your services will only be continued if you appeal by (***insert date, the later of 10 calendar days from the date of the Notice OR the intended date of the action***). If you do not win your appeal, you may be responsible for paying for these services provided during the appeal.

If you have any questions about filing an appeal or if you need help, you can call us at (*insert Contractor phone number here*).

Sincerely,

(Insert name of Decision Maker)

ACOM Policy Attachment B: Legal Services Programs that May Be Able to Help You With This Decision

APACHE COUNTY White Mountain Legal Aid a division of Southern Arizona Legal Aid 5658 Highway 260, Ste. 15, Lakeside, AZ 85929 Phone: (928) 537-8383 / 1-800-658-7958	COCHISE COUNTY Southern Arizona Legal Aid 2 Copper Queen Plaza, Upstairs PO Box AL, Bisbee, AZ 85603 Phone: (520) 432-1639 / 1-800-231-7106	COCONINO COUNTY DNA People's Legal Services 201 E Birch Street Flagstaff, AZ 86001 Phone: (928) 774-0653 / 1-800-789-5781
GILA COUNTY White Mountain Legal Aid a division of Southern Arizona Legal Aid 5658 Highway 260, Ste.15 Lakeside, AZ 85929 Phone: (928) 537-8383 / 1-800-658-7958	GRAHAM COUNTY / GREENLEE COUNTY Southern Arizona Legal Aid 2 Copper Queen Plaza, Upstairs PO Box AL, Bisbee, AZ 85603 Phone: (520) 432-1639 / 1-800-231-7106	LA PAZ COUNTY Community Legal Services 201 S. 1st Ave.Yuma, AZ 85364-2250 Phone: (928) 782-7511/ 1-800-424-7962
MARICOPA COUNTY Community Legal Services P.O. Box 21538 Phoenix, AZ 85036-1538 Phone: (602) 258-3434 / 1-800-852-9075 Community Legal Services East Side Office 20 W. First St. Suite 101, Mesa, AZ 85201 Phone: (480) 833-1442 / 1-800-896-3631	MOHAVE COUNTY Community Legal Services 1720 Beverly, Ste. A Kingman, AZ 86409 Phone: 928-681-1177 / 1-800-255-9031	NAVAJO NATION DNA – Chinle Agency Office PO Box 767, Chinle, AZ 86503 Phone: (928) 674-5242 / 1-800-789-7598 DNA – Fort Defiance Agency Office PO Box 306, Window Rock, AZ 86515 Phone: (928) 871-4151 1-800-789-7287 DNA – Hopi Legal Services PO Box 558, Keams Canyon, AZ 86034 Phone: (928) 738-2251 / 1-800-789-9586 DNA – Tuba City Agency Office PO Box 765, Tuba City, AZ 86045 Phone: (928) 283-5265 / 1-800-789-8919 Fax: (928) 283-5460 Native American Disability Law Center Farmington Office 3535 E. 30th St., Ste. 201 Farmington, NM 87410 Phone: 505-566-5880 / 1-800-862-7271 Gallup Office 207 S. Second St., Gallup, NM 87301 Phone: 505-863-7455 / 877-283-3208
PINAL COUNTY Southern Arizona Legal Aid 766 North Park Ave. Casa Grande, AZ 85222 Phone: (520) 316-8076 / 1-877-718- 8086	NAVAJO COUNTY White Mountain Legal Aid a division of Southern Arizona Legal Aid 5658 Highway 260, Ste. 15 Lakeside, AZ 85929 Phone: (928) 537-8383 / 1-800-658-7958 Native American Disability Law Center Farmington Office 3535 E. 30th St., Ste. 201 Farmington, NM 87402 Phone: 505-566-5880 / 1-800-862-7271 Gallup Office 207 S. Second St., Gallup, NM 87301 Phone: 505-863-7455 / 877-283-3208	
PIMA COUNTY Southern Arizona Legal Aid (SALA) Southern Arizona Legal Aid, Inc. Continental Building 2343 E. Broadway Blvd., Ste. 200 Tucson, AZ 85719-6007 Phone: (520) 623-9465 / 1-800-640-9465 Tohono O'odham Legal Services a division of Southern Arizona Legal Aid P.O. Box 597, Sells, AZ 85634-0597 Phone: (520) 383-2420 / 1-800-398-0772		
SANTA CRUZ COUNTY Southern Arizona Legal Aid 1071 N. Grand Ave., Suite 110 Nogales, AZ 85621 Phone: (520) 287-9441	WHITE MOUNTAIN APACHE TRIBE White Mountain Apache Legal Aid a division of Southern Arizona Legal Aid 116 East Oak St. or PO Box 1030 Whiteriver, AZ 85941 Phone: (928) 338-4845 / 1-866-312-2291	

ACOM Policy Attachment B (continued)

YUMA COUNTY Community Legal Services 201 S. 1st Ave.Yuma, AZ 85364-2250 Phone: (928) 782-7511 / 1-800-424-7962	YAVAPAI COUNTY Community Legal Services 401 N. Mt. Vernon Prescott, AZ 86301 Phone: (928) 445-9240 / 1-800-233-5114	STATEWIDE Arizona Center for Disability Law 3839 N 3rd Street, Suite 209, Phoenix, AZ 85012 Phone: (602) 274-6287/ 1-800-927-2260

General Legal Information about Your Rights & Website for Each Legal Aid Office: www.azlawhelp.org 11.01.08

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415 - PROVIDER NETWORK DEVELOPMENT AND MANAGEMENT PLAN POLICY

Original Date: 12/13/07
Effective Date: 06/01/2010; 10/01/2011, 12/01/2011
Revision Date: 09/28/09, 01/28/10, 05/10/10, 08/26/10, 01/24/2011, 12/01/2011

Staff responsible for policy: DHCM Operations

I. Purpose

This policy provides guidance to Acute Care, Arizona Long Term Care System (ALTCS) and Behavioral Health Contractors to develop Provider Network Development and Management Plans. It is critical for Contractors to develop provider networks that are diverse and flexible to meet a variety of member issues both immediate as well as long range. Provider networks must be a foundation that supports an individual's needs as well as the membership in general.

II. Definitions

Contractor	An organization or entity agreeing through a direct contracting relationship with AHCCCS to provide the goods and services specified by the contract in conformance with the stated contract requirements, AHCCCS statute and rules and Federal law and regulations.
GSA	Geographic Service Area: A specific county or defined grouping of counties designated by AHCCCS within which a Contractor provides, directly or through subcontract, covered health care to members enrolled with that Contractor.
Provider	Any person or entity (including Tribal/Regional Behavioral Health Authorities) who 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.

III. Policy

The Contractor shall develop and maintain a provider network development and management plan, which assures the Administration that the provision of covered services will occur as stated in the Contract [42 CFR 438.207(b)]. The Network Development and Management Plan

must be evaluated; updated and submitted to AHCCCS, Division of Health Care Management, within 45 days from the start of each contract year.

The Contractor shall immediately notify AHCCCS in writing when there has been a significant change in operations that would affect adequate capacity and services. The changes include, but are not limited to, changes in services, covered benefits, geographic service areas, payments or eligibility of a new population.

Contractors must submit the Network Attestation form (Attachment A) in conjunction with the annual submission of the Network Development and Management Plan. See Attachment A-1 for instructions on completing the form.

Contractors will submit the Plan to their assigned Operations and Compliance Officer at one of the following addresses:

Acute Care Contractors:

[Compliance Officer Name]
AHCCCS Division of Health Care Management
MD 6500
701 E. Jefferson St.
Phoenix, AZ 85034

Long Term Care Contractors:

[Compliance Officer Name]
AHCCCS Division of Health Care Management
MD 6100
701 E. Jefferson St.
Phoenix, AZ 85034

IV. Procedure

The Network Development and Management Plan shall include the Contractors process to develop maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract (items that apply to specific Contractors (ALTCS, Acute, or Behavioral Health) are identified in **bolded** parenthetical notation).

The Plan must include the process the Contractor utilizes to ensure:

1. **(Acute and ALTCS)** That covered services are accessible to AHCCCS members in terms of timeliness, amount, duration and scope as those are to non-AHCCCS persons within the same service area.
2. That covered services are provided promptly and are reasonably accessible in terms of location and hours of operation.

3. That there shall be sufficient personnel for the provision of all covered services, including emergency care on a 24 hour a day, 7 day a week basis.
4. (**ALTCS and Behavioral Health**): A priority shall be placed on allowing members, when appropriate, to reside or return to their own home versus having to reside in an institution or alternative residential setting. To that end the development of home and community based services shall include provisions for the availability of services on a 7 day a week basis, and for extended hours, as dictated by member needs.

The plan must also include a description or explanation of the following:

1. Evaluation of the prior year's Plan including reference to the success of proposed interventions and/or the need for re-evaluation;
2. Current status of the network by service type (Hospital, Nursing Facility, HCBS, Primary Care OB/GYN, Specialist, Oral Health, Non Emergent Transportation, Ancillary Services, etc.) at all levels including:
    a. how members access the system;
    b. relationships between the various levels (focus on provider to provider contact and facilitation of such by the Contractor; e.g. PCP, Specialists, Hospitals, RBHAs).
3. Current network gaps and the methodology used to identify them;
4. Immediate short-term interventions when a gap occurs, including expedited or temporary credentialing;
5. Interventions to fill network gaps and barriers to those interventions;
6. Outcome measures/evaluation of interventions;
7. Ongoing activities for network development based on identified gaps and future needs projection;
8. Coordination between internal departments; including a comprehensive listing of all committees and committee membership where this coordination occurs. Identification of members should include the department/area (i.e., QM, MM/UM, GRV, FIN, CLAIMS) that they represent on the committee.
9. Coordination with outside organizations; (**ALTCS** Contractors shall address member/provider council activities)
10. A description of network design by GSA for the general population, including details regarding special populations. [**Acute and Behavioral Health** contractors shall understand these populations to include the developmentally delayed (Arizona Early Intervention Program (AzEIP)), the homeless and those in border communities; among others. **ALTCS** Program Contractors shall understand these populations to include behavioral health; young adults and children; among others.] The description shall cover:
    i. how members access the system,
    ii. relationships between various levels of the system,
    iii. (**Acute and Behavioral Health)** a listing/description of the available alternatives to Nursing Facility placement such as Assisted Living Facilities, alternative residential settings, or home and community based services (minimum one listed per GSA) as required by contract. A similar requirement exists on a larger scale under number 17 of the ALTCS Only listing. If the contractor requires additional information on procuring such

services, they shall contact the ALTCS program contractor in the GSA for assistance in identifying available alternatives.

iv. *(***Acute Only***)* the plan for incorporating the medical home for members and the progress in its implementation,

v. (**ALTCS Only**) the description shall include a list of these providers along with a description of services provided by the program and projected utilization.

11. **(Acute and ALTCS)** A description of the adequacy of the geographic access to tertiary hospital services for the Contractor's membership;
12. (**Acute Only***)* The assistance provided to PCPs when they refer members to specialists. The methods used to communicate the availability of this assistance to the providers;
13. (**Acute Only**) An analysis of the Contractors Appointment Availability Report statistics as set forth in ACOM Policy 417;
14. The methodology(ies) the Contractor uses to collect and analyze member, provider and staff feedback about the network designs and performance. When specific issues are identified, the protocols for handling them.
15. (**Acute Only**) If the Contractor does not have contracts with hospitals but contracts with physicians with hospital admitting and treatment privileges, Attachment B (Non-Contracted Hospital and Physician Admitting and Treatment Privileges) of this policy must be submitted annually.

(For **ALTCS Contractors Only**)

16. Listing of non-Medicare Certified Home Health Agencies the Contractor is using. The listing is to be provided on the form distributed by AHCCCS and attached to the Plan. (AMPM Policy 1240) (See Attachment A)
17. The strategies the Program Contractor has for Work Force Development. Program Contractors make up the largest payer group for paraprofessionals in the long term care market and must leverage this to ensure adequate resources in the future. Successful efforts to recruit, retain and maintain a long-term care workforce are necessary to meet the needs of the anticipated growth in the ALTCS membership. The Program Contractor must have as part of their network development plan a component regarding paraprofessional work force development in nursing facilities, alternative residential facilities and in-home (attendant care, personal care and homemaker). Work Force Development is defined as all activities that increase the number of individuals participating in the long-term health care workforce. It includes actions related to the active recruitment and pre-employment training of new caregivers and opportunities for the continued training of current caregivers (i.e. Program Contractor supported/sponsored training). Work Force Development also includes efforts to review compensation and benefit incentives, while providing a plan for the expansion of the paraprofessional network at all levels of client care.
18. Strategies the Contractor will take to provide members with “in-home” HCBS versus placing members in Assisted Living Facilities and Nursing Facilities. A priority shall be placed on allowing members, when appropriate, to reside or return to their own home versus having to reside in an institutional or alternative residential setting.

19. A Contractor who has greater than 25% of their members residing in an Alternative Residential Setting (ARS) per GSA shall develop an action plan that identifies approaches to make placements in in-home settings rather than ARS. The plan must be continuously evaluated for effectiveness and revised as needed. A comprehensive report must be submitted to AHCCCS 15 days after the end of each quarter until the Contractor has less than 25% of their members in ARS for four consecutive quarters. A plan must be developed if a Contractor has two consecutive quarters of 25% of their members in a GSA residing in ARS.
20. A listing of Assisted Living Facilities for which the Contractor has already obtained a waiver from the Single Choice Occupancy requirement. Listing must include the name of the facility and the date of the waiver approval. (See Attachment C)
21. A listing of nursing facilities that have withdrawn from the Medicaid Program but are still being utilized by the Contractor. The listing must include the name of the facility and the number of residents the Contractor has in each facility. (See Attachment C)
22. Description of how the Contractor will handle the loss (closure, contract termination) of a major healthcare provider (hospital, nursing facility, large provider group).
23. A description of the methods the Contractor will use to ensure that ALTCS members receive needed services in the event of a natural disaster.

The plan must include answers to the following questions:

a. (**Acute Only**) How does the Contractor assess the medical and social needs of new members to determine how the Contractor may assist the member in navigating the network more efficiently?
b. (**Acute Only**) What assistance is provided to members with a high severity of illness or higher utilization to better navigate the provider network?
c. (**Acute Only**) How does the Contractor support the Graduate Medical Education (GME) programs within its contracted GSA(s) and pursue contracting opportunities with graduates and providers that are opening new practices in, or relocating to, Arizona, especially in rural or underserved areas?
d. (**Acute Only**) Describe the Contractor's process to increase provider participation in Baby Arizona.
e. What interventions has the Contractor implemented to reduce avoidable/preventable ER utilization? What was the outcome of those interventions?
f. **(Acute and ALTCS)** Are members with special health care needs assigned to specialists for their primary care needs? If so, what general criteria are used to determine if a member should be assigned in this manner?
g. What are the most significant barriers to efficient network deployment within the Contractor's service area? How can AHCCCS best support the Contractor's efforts to improve its network and the quality of care delivered to its membership?
h. **(Acute and ALTCS)** What interventions has the Contractor implemented to address and reduce no-show rates and how is information collected to assess the efficacy of these measures?

i. **(Behavioral Health only)** How are members with chronic medical conditions identified within the RBHA system record keeping mechanism and how are placement options coordinated with/communicated to Acute Care Contractors?

V. Provider Terminations Due to Rates (Quarterly Submission)

The Contractor will submit to their AHCCCS Compliance Officer a report of providers who have terminated their contract due to rates 15 days following the end of each quarter using the report template attached (Attachment D) to this policy.

The report will consist of the following information regarding all providers who terminate their contracts for rate related reasons during the reporting period by GSA:

Provider Name	The name of the provider leaving the network. If a provider group has terminated their contract, each provider in the group should be listed separately.
Provider ID Number	The 6-digit AHCCCS legacy identification number. Do not use a provider's NPI.
Provider Type	The Provider Type code as utilized in PMMIS.
PCP	'Y' yes or 'N' no (Is defined as a 08-MD, 31-DO, 19-NP, 18-PA; responsible for the management of a member's health care)
Provider Capacity	This column should be populated with the number of members assigned to, residing in, or regularly receiving services from the provider. In the case of hospitals, outpatient facilities, labs, etc. indicate the number members (unduplicated) that on average utilize the providers during a three month time period. In the case of nursing facilities and alternative residential settings indicate the number of members residing in the facility at the time of termination notice by the provider.
Reason for Termination	Insert one of the following reasons: • Increased rate requested (provider initiated) • AHCCCS FFS rate reduction (pass-through) • Contractor rate reduction (not associated with an AHCCCS reduction) • Other (must describe)
Attestation	Include a statement if the loss of the provider will result in a network gap. If there will be a gap, indicate how the Contractor will meet member needs after the provider leaves the network.

VI. Providers that Diminish their Scope of Service and/or Close their Panel (Quarterly Submission)

The Contractor will submit to their AHCCCS Compliance Officer a report of providers that have diminished their scope of service and/or closed their panel, 15 days following the end of each quarter using the report template attached (Attachment E) to this policy.

The report will consist of the following information regarding all providers who have diminished their scope of service and/or that closed their panel during the reporting period by GSA:

Provider Name	The name of the provider.	
Provider ID Number	The 6-digit AHCCCS legacy identification number. Do not use a provider's NPI.	
Provider Type	The Provider Type code as utilized in PMMIS.	
Scope of Service Diminished	Type of Service N/A if not applicable	
Panel Closed	'Y' yes N/A if not applicable	A) Medicaid B) Non-Medicaid
Provider Capacity	This column should be populated with the number of members assigned to, residing in, or regularly receiving services from the provider. In the case of hospitals, outpatient facilities, labs, etc. indicate the number members (unduplicated) that on average utilize the providers during a three month time period. In the case of nursing facilities and alternative residential settings indicate the number of members residing in the facility.	
Reason	Insert one of the following reasons: • Increased rate requested (provider initiated) • AHCCCS FFS rate reduction (pass-through) • Contractor rate reduction (not associated with an AHCCCS reduction) • Other (must describe)	
Attestation	Include a statement if the change will result in a network gap. If there will be a gap, indicate how the Contractor will meet member needs after the provider leaves the network.	

VI. References

- Title 42 of the Code of Federal Regulations (42 CFR) Part 438.200
- Acute Care Contract, Section D
- ALTCS Contract, Section D

Attachment A

NETWORK ATTESTATION STATEMENT

This Attestation Statement is to accompany the Network Development and Management Plan which is due within 45 days from the start of each contract year. Each Contractor will be required to submit this Attestation Statement for each GSA in which they operate.

Network Attestation Statement

From

Contractor's Name

To The

Arizona Health Care Cost Containment System
Division of Health Care Management, Operations

☐ I hereby attest that the Network Development and Management Plan submitted does not meet the Network Standards (Acute Contract Section D, ¶28 and ¶29; ALTCS Contract Section D, ¶28 and ¶29; ACOM Policy 415 Provider Network Development and Management Plan and ACOM Policy 419 ALTCS Network Standards) for the following GSA(s) and/or county (ies):

☐ I hereby attest that the Network Development and Management Plan submitted meets all other Network Standards other than those listed above (Acute Contract Section D, ¶28 and ¶29; ALTCS Contract Section D, ¶28 and ¶29; ACOM Policy 415 Provider Network Development and Management Plan and ACOM Policy 419 ALTCS Network Standards) for the following GSA(s) and/or county (ies):

(Network Administrator Signature) Date

Attachment A-1 Instructions for the

NETWORK ATTESTATION STATEMENT

This Attestation Statement is to accompany the Network Development and Management Plan which is due within 45 days from the start of each contract year. Each Contractor will be required to submit this Attestation Statement for each GSA in which they operate.

Network Attestation Statement

From

❶ Contractor's Name

To The

Arizona Health Care Cost Containment System
Division of Health Care Management, Operations

❷☐ I hereby attest that the Network Development and Management Plan submitted does not meet the Network Standards (Acute Contract Section D, ¶28 and ¶29; ALTCS Contract Section D, ¶28 and ¶29; ACOM Policy 415 Provider Network Development and Management Plan and ACOM Policy 419 ALTCS Network Standards) for the following GSA(s) and/or county (ies):

❸☐ I hereby attest that the Network Development and Management Plan submitted meets all other Network Standards other than those listed above (Acute Contract Section D, ¶28 and ¶29; ALTCS Contract Section D, ¶28 and ¶29; ACOM Policy 415 Provider Network Development and Management Plan and ACOM Policy 419 ALTCS Network Standards) for the following GSA(s) and county (ies):

❹(Network Administrator Signature) ❺Date

Contractors must submit a separate Attestation for each Line of Business (LOB)

❶ Insert Contactor's name: Mercy Care Plan
Mercy Care LTC

❷ Check this box if the GSA and county you are reporting does not meet required Network Standards. Insert the Settings/Service types, GSA(s) and/or county (ies) where Network Standards are not met.

Example:

Acute LOB: GSA 4 – Apache, Mohave, Navajo: Speech/hearing Therapist

ALTCS LOB: GSA 44 - Apache County: Assisted Living Centers; Adult Day Health; Speech Therapy

❸ Check this box if the GSA and county you are reporting meets all required Network Standards. Insert the GSA number and the county (ies) meeting the Standards.

Example:

Acute LOB: GSA 4 – Coconino
GSA 12 - Maricopa

ALTCS LOB: GSA 44 - Coconino, Mohave, Navajo
GSA 52 - Maricopa

NOTE: It is possible to have both Bullet 2 and Bullet 3 boxes checked at the same time. One or more counties in a multiple GSA could be in full compliance with the Network Standards while one or more could be out of compliance.

❹ Have the appropriate Network Administrator sign the Attestation Statement

❺ Include the date the Attestation was signed

Attachment B: **Non-Contracted Hospital and Physician Admitting & Treatment Privileges Attestation Statement**

I_____ affirm that _____ has contracts with physician(s) with admitting and treatment privileges at the hospitals within the communities identified below as required in Section J, List of Attachments, Attachment B of the AHCCCS Acute Care Contract.

Signature: _____ Date: _____

GSA 2
- ☐ Blythe, CA
- ☐ Lake Havasu City
- ☐ Parker
- ☐ Yuma
- ☐ GSA Not Applicable

GSA 4
- ☐ Bullhead City
- ☐ Page
- ☐ Flagstaff
- ☐ Payson
- ☐ Gallup, NM
- ☐ Show Low
- ☐ Kanab, UT
- ☐ Springerville
- ☐ Kingman
- ☐ Lake Havasu City
- ☐ Winslow
- ☐ Needles, CA
- ☐ GSA Not Applicable

GSA 6
- ☐ Cottonwood
- ☐ Flagstaff
- ☐ Maricopa County
- ☐ Prescott
- ☐ GSA Not Applicable

GSA 8
- ☐ Casa Grande
- ☐ Globe
- ☐ Maricopa County Dist. 4
- ☐ Payson
- ☐ GSA Not Applicable

GSA 10
- ☐ Contracts are required
- ☐ Nogales
- ☐ GSA Not Applicable

GSA 12
- ☐ Contracts are required
- ☐ GSA Not Applicable

GSA 14
- ☐ Benson
- ☐ Bisbee
- ☐ Douglas
- ☐ Safford
- ☐ Sierra Vista
- ☐ Tucson
- ☐ Willcox
- ☐ GSA Not Applicable

Attachment C
NETWORK DEVELOPMENT AND MANAGEMENT REPORT

PROGRAM CONTRACTOR:_____**DATE:** _____

ALTCS Contract, Paragraph 28, Network Management and Development Plan require the following items to be listed:

Non-Medicare Certified Home Health Agencies (HHA):

	Non-Medicare Certified HHA Name	AHCCCS ID#	Type of Services Provide	Geographic Area Served
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9				
10				

Use of a non-Medicare Home Health Agency(ies) is in compliance with AMPM Chapter 1200, Section 1240, ALTCS Services/Settings, Home Health Services.

List of Assisted Living Facilities for which the Contractor has already obtained a waiver from the Single Choice Occupancy requirement. Listing must include the name of the facility and the date of the waiver approval:

	Assisted Living Center	AHCCCS ID#	City / Area Served	Exception Period (10-07 to 9/08)
1.				
2.				
3.				
4.				
5.				

List of nursing facilities who have withdrawn from the Medicaid Program but are still being utilized by the Contractor. The listing must include the name of the facility and the number of residents the Contractor has in each facility:

	Nursing Facility	AHCCCS ID#	City / Area Served	Number of Residents
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Attachment D
Provider Terminations Due to Rates

Contractor Name: Date:

GSA # (Complete one table per GSA)

Provider Name	Provider ID	Provider Type	PCP	Provider Capacity	Reason for Termination	Attestation

GSA # (Complete one table per GSA)

Provider Name	Provider ID	Provider Type	PCP	Provider Capacity	Reason for Termination	Attestation

Attachment E
Providers that Diminished their Scope of Service and/or Closed their Panel

Contractor Name: Date:

GSA # (Complete one table per GSA)

Provider Name	Provider ID	Provider Type	Scope of Service Diminished	Panel Closed		Provider Capacity	Reason	Attestation

GSA # (Complete one table per GSA)

Provider Name	Provider ID	Provider Type	Scope of Service Diminished	Panel Closed		Provider Capacity	Reason	Attestation

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

GUIDE TO LANGUAGE IN NOTICES OF ACTION

OCTOBER 1, 2009

ATTACHMENT C, ACOM POLICY #414

This document is only a guide and is intended to provide examples of easily understood language. Contractors are required to use language specific to the members' situation and service request. See the AHCCCS Contract and Polices for all requirements regarding Notice of Action letter requirements. This document is not to be relied upon for Legal citations. Legal citations change regularly. The Contractor is responsible for citing the correct legal source when changes to the legal basis occur.

AHCCCS GUIDE TO NOTICE OF ACTION LETTERS
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AHCCCS GUIDE TO NOTICE OF ACTION LETTERS

Background

When an AHCCCS Contractor makes a decision to not pay for a requested service, the Contractor must notice the member, in writing, of that decision. That written notice is called a Notice of Action (NOA) letter. This guide is intended to provide examples of language for use in NOA letters, and is not intended to be a complete reference for Federal, State, and Contractual requirements regarding Notices of Action letters.

The point of the NOA letters is to notify members of adverse decisions and provide them with the factual basis or reason for that decision, and how to appeal that decision. NOA letters must be written such that they are easy for the member to understand. Members need to understand the reason for action so that they can decide if they want to appeal the decision, and how to best argue their case if they do decide to appeal. The better the member understands the reason for the action, the more able the member will be to participate in their health care decisions.

In the case where additional medical information is needed to make a decision, the NOA letter must be clear enough to allow the member the opportunity to provide any additional supportive information that may assist the member in receiving the requested service. The Contractor and member do not need to rely solely on the member's physician or provider to supply any additional information. If the member has information that would help in the decision process, the member should be made aware that they can supply this to the Contractor to aid in the decision. For example, if the member has some test results or therapy notes that support their need for the requested services the Contractor must accept these as additional medical documentation.

If the member files an appeal, the issues to be decided at the hearing will be based on the specific reasons given in the NOA letter. Therefore, it is critical that the NOA letter fully and clearly explain the Contractors justification for the action. NOA letters must include the following:

a. the requested service;
b. the reason/purpose of that request in layperson terms;
c. the action taken by the Contractor (denial, limited authorization, reduction, suspension or termination) with respect to the service request;
d. the reason for the action, including member specific facts;
e. the legal basis for the action; **citations to general provisions in the AHCCCS statute or regulations or to the Contractor's internal policy manual are not sufficient.**
f. where members can find copies of the legal basis; when a legal authority including an internal Contractor's policy manual is available on-line, the Contractor shall provide the accurate URL site to enable the member to find the legal authority on-line.
g. the right to appeal the decision and the process for appealing the decision;
h. legal resources for members for help with appeals, as prescribed by AHCCCS.

Contractors, via the NOA letter, must help members understand the decisions made by the Contractor. **A general statement that a requested service is not medically necessary, without explanation of why a service is not medically necessary, is unacceptable as a reason for the action.** Use of this or similar language as a reason for an action will result in regulatory action by AHCCCS, including but not limited to civil monetary penalties up to $25,000 per event (letter) and/or capping of enrollment. If a Contractor determines that a service is not going to be paid for by the Contractor due to any of the main categories cited below, it is appropriate to cite the relevant regulation, e.g. R9-22-201 B.1. , R9-28-201., as the legal basis for the action. Citations must be accurate and specify the particular section of the law that is applied. However, the Contractor must also explain why a denied/ reduced service is not going to be paid for by the Contractor in language which is easily understood by the member. Refer to specific sections of the Guide for examples where the Contractor is appropriately denying or limiting services.

The NOA letter may not merely refer the member to a third party (e.g., the member's physician or case worker) in lieu of adequately citing in the letter the complete and accurate factual and legal bases for the denial / reduction or termination of a service. For example, simply telling the member to call their physician because a service is denied without providing the member specific reason for the denial is unacceptable.

Contractors must cite the AHCCCS Early Periodic Screening, Diagnosis and Treatment (EPSDT) Rule R9-22-213 and federal law 42 USC 1396(d)(r)(5) when denying, reducing or terminating a service for a Title XIX member who is younger than twenty-one (21) years of age when these provisions are applicable. When the Contractor denies, reduces, or terminates services that have been requested for Title XIX members under the age of 21, the Contractor must explain why the requested services do not meet the conditions as described in this policy and the AMPM Chapter 400, Section 430. The Contractor must specify why the requested services do not meet the EPSDT criteria and are not covered and must also specify that EPSDT services include coverage of screening services, vision services, dental services, hearing services and such other necessary health care, diagnostic services, treatment and other measures described in federal law subsection 42 USC 1396(d) (a) to correct or ameliorate (make better) defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the AHCCCS State Plan.

As explained more fully in the Guide, reasons for the denial, termination or reduction of requested medical services generally fall into one of several main categories:

I. Not a paid benefit, exhausted benefits;
II. Not medically necessary;
III. Out of network provider;
IV. Not enough information to make a decision in the legally required time frame; or
V. System issues, including coverage by another entity.

In the event that more than one reason actually applies to a particular request by an individual or a provider, all applicable reasons should be given and explained in language that would be understood by a member.

Due to the ongoing evolution of AHCCCS rules, Contractors must constantly review and update the rules references in this Guide to ensure accuracy. It is incumbent upon Contractors to ensure that the rule references in the actual Notice of Action letters are accurate.

I. Not a Covered Benefit or Exhausted Benefit

This should only be cited as the reason in the NOA letter when the service is not available to anyone in the AHCCCS program or to anyone in the particular demographic group to which the member belongs, such as a member over the age of 21. Additionally, in general, AHCCCS benefits are driven by medical necessity and not by an absolute limit. However, there are some services that do have a limited benefit that may be exhausted.

A. Examples of ACCEPTABLE language regarding benefit not covered or exhausted include:

1. **Eyeglasses for Member After their 21st birthday:**
   Your doctor asked that we pay for eye glasses for you to help you see better.

   Our decision:

   We have reviewed the request and will not pay for the eye glasses.

   The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: AHCCCS does not pay for eye glasses for members after their 21st birthday and if their only problem is seeing clearly. To get glasses, you must have problems seeing due to surgery for cataracts, a film that can grow on your eyes. Cataracts cause a blurring or cloudiness over the lens in your eye. The notes from your doctor do not say you have this. There may be places that can help you to get glasses. Please call us at *XXX-XXX-XXXX* and we will give you the names of some places that might help you get glasses.

   Acute Legal Basis: See Legal Basis Table A, basis number 1.
   Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 1 and 2

2. **Experimental Device:**
   Your doctor asked us to pay for a surgery to put a device *(insert name)* that *(purpose of device and medical condition/reason for request here*).

   Our decision: We have reviewed the request and will not pay for the surgery.

   The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: We can not pay for it because there is no medical proof that it will help you. That means it is experimental. We have called your doctor to tell *him/her* that we cannot pay for this. Your doctor will be able to help you with a different treatment. Make sure you call *him/her* within the next few days.

   Acute Legal Basis: See Legal Basis Table A, basis number 3.
   Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2 and 3.

3. **Request for Drug Not Approved for the Treatment of Underlying Condition:**

Your doctor has asked us to pay for a drug called *(insert Drug Name)*, a drug commonly used for (*therapeutic class information).*

Our decision: We are not going to pay for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: This drug has not been okayed by the Government (Federal Drug Administration) to treat your problem. We have also told your doctor about this decision and the names of the drugs that might be helpful, should your doctor agree. Your doctor can order one of these different drugs for your problem that we can pay for. Please ask your doctor for another drug to help your problem.

Acute Legal Basis: See Legal Basis Table A, basis numbers 3.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2 and 3.

4. Cosmetic Surgery:

Your doctor asked us to pay for a surgery to fix a bump on your nose.

Our Decision: We can not pay for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: The bump on your nose does not hurt your health. That means it is cosmetic surgery, and AHCCCS can not pay for cosmetic surgery.

Acute Legal Basis: **See Legal Basis Table A, basis number 4.**

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2 and 4.

5. Dental Services for Member 21 Years of Age or Older- Acute:

Your doctor asked us to pay for cleaning of your teeth.

Our Decision: We can not pay for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: AHCCCS only pays for emergency treatment of painful or infected teeth for members who are age 21 years and older. The notes from your dentist do not say that your tooth is causing pain. The notes from your dentist do not say that your tooth is infected. Please talk to your dentist about low cost dental clinics such as St. Vincent de Paul or the Arizona Dental School.

Acute Legal Basis: See Legal Basis Table A, basis number 5

6. **Root Canal for Member 21 Years of Age or Older:**
   Your dentist asked us to pay for root canal surgery on your back tooth to fix a root canal that was done before.

   Our Decision: We can not pay for this.

   The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: The notes from your dentist do not say that you have infection or pain in the tooth. Routine root canal surgery on back teeth is not a paid for service for members who are 21 years of age or older unless there is pain or infection.

   Acute Legal Basis: See Legal Basis Table A, basis number 5.

   Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2 and 5.

7. **Fertility Clinic:**
   Your doctor has asked us to pay for visits to a fertility clinic to help you get pregnant.

   Our Decision: We have reviewed the request and decided we cannot pay for this.

   The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: AHCCCS does not pay for care to help you get pregnant. These services are called "infertility services." Please ask your doctor if there is something else he can recommend to help you have a baby.

   Acute Legal Basis: See Legal Basis Table A, basis number 6.
   Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2 and 6.

8. **Hearing Aid for Member 21 Years of Age or Older:**
   You asked us to pay for a hearing aid to help you hear well.

   Our Decision: We can not pay for this.

   The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: AHCCCS does not pay for hearing aids for members who are 21 years of age or older. Please ask your doctor if there is something else that can be done for your hearing problem.

   Acute Legal Basis: See Legal Basis Table A, basis number 7.

   Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2 and 7.

9. Compression Stockings:
You have asked us to pay for special stockings called support hose for your (*insert reason*).

Our Decision: We have reviewed your request and we are not paying for the stockings.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: These special stockings can help with swelling, pain in your legs, or to prevent blood clots. Your medical records do not show that you have any of these problems. The stockings would be personal care items if you do not have a medical need. We can not pay for these because personal care items are not paid by AHCCCS.

Acute Legal Basis: See Legal Basis Table A, basis number 8.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2 and 8.

10. Request Exceeding 240 Diapers per Month:
You asked for 300 diapers a month for your child.

Our Decision: We have reviewed this request and we cannot pay for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: We can only pay for 240 diapers a month unless your child has a spastic bowel or chronic diarrhea. The records we have don't show that your child has these problems. We are approving 240 diapers a month. *(If this request is for someone 21 years of age or older and they have no medical need for the diapers, then add the age limitations to the legal basis: Diapers are covered for members who are at least 3 years old and only until the member's 21st birthday).*

Acute/Long Term Care Legal Basis: See Legal Basis Table A, basis number 9.

11. Your dentist asked us to pay for dentures.
Your dentist asked us to pay for dentures.

Our Decision: We are not going to pay for these.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: AHCCCS does not pay for dentures. Please ask your doctor if there is something else that can be done for your problem. You may be able to get dentures through the dental school or a program that helps people get dentures at a cheaper price. You can talk with your dentist about these programs. *(The Health Plan may choose to attach a list of the programs that offer reduced cost dental services to adults or insert the name and numbers/ addresses of the clinics in the member's area. The list is available in English or Spanish*

http://www.azahcccs.gov/shared/Downloads/News/2008Session/ClinicList_English.pdf

http://www.azahcccs.gov/shared/Downloads/News/2008Session/ClinicList_Spanish.pdf)

Acute Legal Basis: See Legal Basis Table A, basis number 17.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2 and 17.

B. Examples of UNACCEPTABLE explanations to use when denying services because they are not covered or exhausted include:

1. AHCCCS does not cover services or medications for cosmetic purposes.

2. AHCCCS does not cover dental services for persons over 21 except for emergency conditions.

3. Treatment for infertility is not a covered benefit under the AHCCCS program.

4. Effectiveness of this treatment has not been established (experimental).

5. This treatment is a phase II clinical trial.

II. Not Medically Necessary

Medical necessity is the most common reason for denying, limiting or terminating an authorization request. All decisions regarding medical necessity MUST be made by a Medical Director or other qualified medical professional. It is important that up to date information be reviewed and evaluated when taking an action relative to medical necessity. Criteria for making medical necessity decisions must be available to members and providers. Contractors must notify the members regarding what information is missing that is necessary to make a determination of medical necessity, e.g. for a sleep study that requires that a member meet the Contractor's criteria such as documented fatigue, snoring, falling asleep during the day, etc., but the member's physician only documents complaints of fatigue, the NOA letter would say that the notes from your doctor do not say you snore or fall asleep during the day as the reason/ basis for the denial.. The member must be allowed the ability to provide needed information that may help in the determination or in the member's appeal. Lack of medical necessity may be cited in several situations, including:

1. The requested service has not been shown to be effective for the member's condition;
2. The amount, duration or scope of services requested is not necessary to treat the member's condition;
3. Other less expensive, less intrusive yet equally effective services have not been tried and failed and these are required to be tried before approving this particular service; (more conservative, less invasive or less risky procedures, plain X-rays before MRIs);
4. Step therapy is required before approving requested drug therapy, including generic drugs or less expensive brand name drugs; or
5. The requested service is considered personal care, not medically necessary treatment.

A. Examples of ACCEPTABLE language regarding medical necessity include:

1. Therapy: Extraordinary Number of Visits (approving less than requested):

Your doctor asked that we pay for three hours of physical therapy every day for twelve weeks to help you (*insert reason here, e.g. walk)*.

Our Decision: We reviewed your medical record, and we will pay for one hour of physical therapy three days a week for six weeks.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: The notes from your therapist say you are now walking by yourself down your entire street. You can get out of bed by yourself. You have been given exercises to do every day. Your therapist can help with the exercise program by seeing you just once a week and making changes then. This amount of therapy should help you get better. If you need more therapy after this, you or your doctor can ask us to pay for that at a later time.

Acute Legal Basis: See Legal Basis Table A, basis number 10.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2 and 10.

2. Physical Therapy; Request to Extend Therapy (continuation of Therapy):

Your doctor asked that we pay for more physical therapy to help you with (*insert medical condition and reason for therapy*).

Our Decision: We will not pay for this. Your therapy will end on *(10 days from date of letter).*

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: The Physical Therapist was ordered by your doctor to teach you how to walk with a walker and to give you exercises that would help you get in and out of bed, go to the bathroom alone and walk around your house. The notes from your physical therapist state you can now do all of these things. Your medical record shows that you can do these exercises at home without help. You must need a new exercise program or be unable to do your exercises for a physical therapist to be needed. We can look at a request for therapy in the future if your health changes.

Acute Legal Basis: See Legal Basis Table A, basis number 10.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2 and 10.

3. Speech Therapy; Request to Extend Therapy (continuation of Therapy) for a Title XIX member under 21 years of age:

Your doctor has asked that *(XYZ)* Health Plan pay for your speech therapy (someone who helps with your talking or communication skills) to continue. You have been having a speech therapist come to your home to help you learn to use your new "talking board" (the tool you have which talks by pressing the buttons).

Our Decision: We are not going to pay for this starting on *(10 days from date of letter).*

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: The speech therapy notes say that your child can use the taking board without any help. The notes say that your child uses the board to talk to your family and teachers. The notes also say your child has learned all the uses of the talking board and the speech therapist was only reinforcing the teaching with you and your child. If something changes with your child we can look at any future needs of your child at that time.

Acute Legal Basis: See Legal Basis Table A, basis numbers 10 and 11.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2, 10 and 11.

4. Gastric Surgery to Reduce Secretion:
Your doctor asked us to pay for a surgery to reduce the amount of acid in your stomach.

Our Decision: We are not going to pay for the surgery.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: This surgery is only paid for when other treatments have been tried and did not work. (*XYZ Health Plan*) requires that you and your doctor try medicines to reduce the amount of acid in your stomach first such as *(Insert the Contractors required drug treatment protocol for the member)*. The notes from your doctor do not say that you have tried these medicines and that they did not work.

Acute Legal Basis: See Legal Basis Table A, basis number 10.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2 and 10.

5. MRI; Shoulder:

Your doctor has asked us to pay for Magnetic Resonance Imaging or MRI (a special kind of picture) of your shoulder (*insert reason for test here*) for the pain you are having.

Our Decision: We are not going to pay for the MRI.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: (*XYZ Health Plan)* requires that you have a regular X-ray of your shoulder before getting an MRI. Your medical records do not show that you have had an X-ray. We also want you to try some physical therapy to see if this will help you. A physical therapist is trained to help you with special exercises.

Acute Legal Basis: See Legal Basis Table A, basis number 10.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2 and 10.

6. MRI; Lower Back:
You asked us to pay for Magnetic Resonance Imaging or MRI (a special kind of picture) of your back (*insert reason test ordered*).

Our Decision: We are not going to pay for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: You must try physical therapy or a visit to a pain specialist first to help you. The notes we have from your doctor do not show that you have tried these yet. Please talk to your doctor for help with this.

Acute Legal Basis: See Legal Basis Table A, basis number 10 for medically necessary and cost effective, or use basis 12 if explanation is based on Standard of Care criteria for that particular diagnosis.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, use 2 AND basis number 10 for medically necessary and cost effective, or use basis 12 if explanation is based on Standard of Care criteria for that particular diagnosis.

7. Podiatrist for Flat Feet:
You asked us to pay for a visit a podiatrist (foot doctor) to treat your flat feet.

Our Decision: We are not going to pay for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: Care by a foot doctor has not been shown to help flat feet. *Contractor may choose to recommend insoles or some over the counter remedy in* ***accordance with the Contractor's criteria used as a basis for the decision).***

Acute Legal Basis: See Legal Basis Table A, basis number 10.
Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, use numbers 2 and 10.

8. Podiatrist for Routine Foot Care:
You asked us to pay for a podiatrist (a foot doctor) to trim your toe nails.

Our Decision: We are not going to pay for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: XYZ Health Plan does not pay for trimming of nails or other foot care unless you have a disease like diabetes or bad blood flow. These diseases make it unsafe to do this yourself. The notes we have from your doctor do not say you have any of these diseases.

Acute Legal Basis: See Legal Basis Table A, basis number 10.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, use numbers 2 and 10.

9. Hysterectomy/Endometrial Ablation:

You asked us to pay for a hysterectomy *(surgery to remove your womb)/endometrial ablation (surgery on the inside of your womb)*, to help with (*insert reason*).

Our Decision: We are not paying for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: This surgery is only approved when other treatments have been tried and did not work. We require you and your doctor to try other treatments such as *(insert examples of less invasive/less expensive treatment that are part of the Contractor's specific criteria that the member must try and fail before a surgical option would be considered.)* before we pay for this treatment.

Acute Legal Basis: See Legal Basis Table A, basis number 10.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, use numbers 2 and 10.

10. Electric Wheelchair or Power Operated Vehicle:

You asked us to pay for a power wheelchair, a special wheelchair that uses a battery and controls to use. This was asked for in order to help you (insert need or reason for the request).

Our Decision: We are not paying for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: The notes from your doctor say you can walk around your house and safely use a regular (manual) wheelchair. (*The Contractor should substitute their criteria for the examples of options outlined in the previous sentence.)*

Acute Legal Basis: See Legal Basis Table A, basis number 10.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, use numbers 2 and 10.

11. Durable Medical Equipment for a Title XIX member under 21 years old:

You asked that *(XYZ)* Health Plan pay for a combination stroller and car seat for your child so you can travel easier and only have one piece of equipment.

Our Decision: We are not going to pay for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: You have a custom light weight wheelchair you use for your child. You

also have a car seat in your car. You have a wheelchair carrier on your car. You can use the wheelchair when you travel. You use the car seat that is in your car. Your car seat meets all the safety needs when it is put in properly. These already meet your child's needs and will worked for your child until your child is 60 pounds. The device that is both a car seat and a stroller only work till your child is 45 pounds and can be less safe as a car seat if you do not put it in correctly after each use.

cute Legal Basis: See Legal Basis Table A, basis numbers 10 and 11.
Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2, 10 and 11.

12. Durable Medical Equipment:

a. Your doctor asked us to pay for a shower bench for you to sit on during your bath.

Our Decision: We are not paying for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: The notes from your doctor say it is not safe for you to get in the shower, and you get bed baths. The notes from your case manager say you are not able to stand or transfer to the shower even with your attendant's help. We are paying for an attendant to give you bed baths daily.

b. You asked us to pay for a cane to help you walk.

Our Decision: We are not paying for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: Our records show that you have a walker. The walker is safer for you. *(The Contractor may need to support this decision as to why the member's condition is not improved enough to use a cane, or describe the criteria for a cane.)*

c. You asked us to pay for a bed side commode so you do not have to walk to the bathroom at night.

Our Decision: We are not paying for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: The notes from your *(doctor/ or case manager)* show that you can walk to the bathroom safely on your own.

d. You asked us to pay for a hand held grabber to help you reach things on high shelves.

Our Decision: We are not paying for this at this time.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: We require that you first get an evaluation from an occupational therapist to see if this would help or if other care is better for you. An occupational therapist is trained to see how to help you safely do things in your home. We have asked if your doctor would write an order for an occupational therapist. Your doctor said this was ok. An occupational therapist will be calling you for an appointment. We will look at your request again after the therapist sees you and tells us what is best for you.

Acute Legal Basis: See Legal Basis Table A, basis numbers 10 and 12.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2, 10 and 12.

13. Request for Brand Name Device/DME; Substitution of Equivalent Device:
You asked us to pay for a specific brand name device (*insert specific brand name device/DME here*, *e.g., Clinitron Bed*).

Our Decision: We are not paying for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: We do not pay for this device, but do pay for (*insert name*), which is an equal device and does the same thing. According to the notes from your doctor this device will meet all of your medical needs. We have asked your doctor to order this equipment. We are waiting for your doctor to tell us if you can have *(insert the name of the alternative device. If the timeframe for making a decision has expired use additional language from Section IV in the guide and add the appropriate legal basis below).*

Acute Legal Basis: See Legal Basis Table A, basis numbers 10 if using medically necessary or use number 13 if time has expired.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2 AND 10 if using medically necessary or use number 13 if time has expired.

14. Request for a Specific piece of equipment/ DME for a Title XIX member who is under 21 years old.
You have asked that (XYZ) Health Plan pay for a second pair of "sports" eye glasses for your child. These sport eye glasses have a band around them so they have less chance of falling off. The glasses are bendable plastic and have less chance of breaking than hard plastic glasses.

Our Decision: We are not going to pay for these.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: We paid for glasses for your child in April of this year. Your child was given light weight plastic glasses that have less chance of breaking if they fall off. You can buy a band of elastic for holding eyeglasses around your child's head. This will allow your child to play sports with the other children. Your child should not be prevented from playing any games or sports with her current glasses.

Acute Legal Basis: See Legal Basis Table A, basis numbers 11.

Elderly/Physically Disabled Long Term Care Legal Basis See Legal Basis Table A, basis numbers 2 and 11.

15. Request for Brand Name Device/DME- Member Request; Not the Appropriate Device/DME for Member:

You asked us to pay for a specific brand name device, (*insert name of specific device/DME here e.g., Clinitron Bed)* to help you (*insert need here*).

Our Decision: We are not paying for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: The notes we have from your doctor say that this is not the best device for you because (*insert reason in understandable language what the decision is based upon.)*. We will pay for (*insert name of product or device that will be provided when your doctor orders it)*, which will better meet your needs and is safer for you.

Acute Legal Basis: See Legal Basis Table A, basis number 10.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2 and 10.

16. Request for Device with Unnecessary Features:

a. You asked us to pay for *(insert device, i.e. walker)* that also has *(insert name of feature)* to help you *(insert reason for device*).

Our Decision: We will pay for the *(insert name of device).* We will not pay for (*insert features that are being denied*). The notes we have from your doctor do not show that (*insert feature*) will help you because (*insert reason that the decision is based upon, in understandable language)*.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: SAMPLE: The notes from your doctor say that you do not walk safely unless you have a walker that does not scoot. If there were wheels on your walker you might slide and lose your balance. The wheels may make you fall. Only people you have good balance should have wheels on their walker. You have

had a stroke that left you weak on your right side and you fall towards that side. The notes from your doctor say you are not safe without something or someone to keep you steady. A walker without wheels is steadier.

b. You asked us to pay for a walker with a seat to help you walk.

Our Decision: We will pay for the walker. We will not pay for the seat. The notes we have from your doctor do not show that seat will help because (*insert reason in understandable language that the decision is based upon).*

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: SAMPLE: The seat on the walker would help you if you walked for long distances. You have a scooter to help you with long distances. The notes from your physical therapist say that you can no longer walk more than 40 feet. Your doctor and therapist state that this is the best you will be able to do after your stroke. The stroke left you weak and you have muscular dystrophy which will make your muscles weaker over time. You only use your walker to help you in the bathroom because your scooter does not fit. You have a physical therapist visiting with you twice a week for the next two weeks. You should ask the therapist to help you set up your bathroom so you can rest by using a small chair or sturdy stool. Your therapist can help you with this.

Acute Legal Basis: See Legal Basis Table A, basis number 10.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2 and 10.

17. Gastric Bypass:

Your doctor has asked us to pay for gastric bypass surgery, a surgery to help you lose weight.

Our Decision: We are not paying for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: This surgery is only paid for when other treatments have been tried and did not work. You must try other treatments first, *like medication or a weight loss plan (The Contractor may expand on this explanation so it is reflective of the Contractor's criteria for this service).* These treatments are less risky and may help you without surgery.

Acute Legal Basis: See Legal Basis Table A, basis numbers 10 and 12.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2, 10 and 12.

18. Breast Reduction Surgery:

You have asked us to pay for a surgery to make your breasts smaller (a breast reduction) to help with back pain.

Our Decision: We are not paying for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: The notes from your doctor do not show that you have tried other treatments that did not work. These other treatments have less risk. We pay for breast reduction when you are at the right weight for your height, you have tried and failed physical therapy, and failed the use of drugs that might help your pain. We have shared this information with your doctor. Please talk to your doctor about these other treatments.

Acute Legal Basis: See Legal Basis Table A, basis numbers 10 and 12.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2, 10 and 12.

19. Genetics Testing and Counseling:

Your doctor has asked us to pay for genetic testing to see if you have a chance of getting breast cancer.

Our Decision: We are not paying for this test.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: The findings of the test can not tell if you will get breast cancer. *XYZ Health Plan* will pay for annual mammograms (special x-rays to see if you have a lump in your breast) and this is the best way known to find a lump early. You can also ask your doctor to teach you how to check your breasts every month to see if you can find a lump.

Acute Legal Basis: See Legal Basis Table A, basis numbers 10 and 12.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2, 10 and 12.

20. Orthotics, custom:

You have asked that we pay for specially made shoe inserts to help with *(Contractor must insert member specific information).*

Our Decision: We are not going to pay for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: You must try other treatments that can work just as well like *store bought shoe inserts, supportive shoes, physical therapy or pain medicine before trying specially made shoe inserts.* **(***The Contractor should substitute their criteria for the examples of*

options outlined in the previous sentence.) The notes from your doctor do not show that you have tried these other treatments. Please talk to your doctor about these other treatments.

Acute Legal Basis: See Legal Basis Table A, basis number 10. *(continued)*
Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2 and 10.

21. Specialty Referral:

We have reviewed your request for a visit to an allergist, a doctor to test you for things that might make you sick.

Our Decision: We are not paying for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: You must first try drugs called anti-histamines (a drug that decreases your allergies) such as *(insert the Contractor preferred drug therapy)* that may help for at least 6 weeks before we will pay for the special doctor visit. These medicines can help you feel better and you may not need to go to a special doctor. We have shared this information with your doctor to see if the medicines would be okay for you. We have not heard back from your doctor yet. *(Contractor should use the language from Section IV if the timeframe has expired legal basis if appropriate).* Please talk to your doctor about what medicines you can try.

Acute Legal Basis: See Legal Basis Table A, basis number 10 for medically necessary and number 12 if standard of care is cited; also use number 13 if time has expired and a decision could not be made.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis number 2 AND 10 for medically necessary and number 12 if standard of care is cited; also use number 13 if time has expired and a decision could not be made.

22. Request for Sleep Studies:

Your doctor has asked that we pay for a sleep study, a test to see if you are getting restful sleep.

Our Decision: We are not going to pay for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: We only pay for these if you have these problems: (*insert specific plan criteria here*). The notes from your doctor do not say you have these problems.

Acute Legal Basis: See Legal Basis Table A, basis number 10.

Elderly/Physically Disabled Long Term Care Legal Basis See Legal Basis Table A, basis numbers 2 and 10.

23. Dental: Partial Denial Members 21 years of age or older:
Your dentist has asked us to pay for (*insert all requested service and reason for request here)*.

Our Decision: We will pay for some of these services, but not all of them. The care we will pay for is (*insert here*). The care we will not pay for is (*insert here*).

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: We are not paying for (*insert here*) because the notes sent by your doctor do not show that you need this to get better because (*insert reason in understandable language that the decision is based upon)*. Please talk to your dentist about other treatments. You must also call your dentist to set up an appointment for the dental care we will pay for.

Acute Legal Basis: See Legal Basis Table A, basis number 10 for and the appropriate AMPM policy reference in Chapter 300, Policy 310.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2, 10 and the appropriate AMPM policy reference in Chapter 300, Policy 310.

24. Dental: Deep Cleaning- All Ages based on Medical Need:
Your dentist asked us to pay for deep cleaning of your teeth to help with gum bleeding.

Our Decision: We are not paying for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: The notes and/or x-rays from your dentist do not tell us why you need this instead of a regular cleaning. *(Insert the Contractor's criteria that would need to be met for this service to be paid for)* Please talk to your doctor or dentist.

Acute Legal Basis: See Legal Basis Table A, basis number 10 for and the appropriate AMPM policy reference in Chapter 300, Policy 310.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2, 10 and the appropriate AMPM policy reference in Chapter 300, Policy 310.

25. Dental; Referral to Pedodontist- Members younger than 21 years of age:
Your dentist has asked that we pay for (*insert specific care and reason here*).

Our Decision: We are not paying for this care at this time because (*insert reason in understandable language that the decision is based upon).*

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: At *XYZ Health Plan* we only have contracts for children's dental care with special dentists called Pedodontists. These dentists are specially trained to take care of children and are the best at this care. You must see a children's dentist to help us decide what care you need. You can call (*insert provider name and number or you can attach a list of the pedodontists and state this)* to set up a visit, or call us for help at phone number *(insert Contractor phone number).*

Acute Legal Basis: See Legal Basis Table A, basis number 10.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2 and 10.

26. Dental: Sedation- All Ages based on Medical Need:
You have asked us to pay for putting you to sleep (general anesthesia) during your dental care.

Our Decision: We are only going to pay for one relaxing drug, and it will not make you totally fall asleep. This is called conscious sedation or twilight sleep.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: You do not need to be completely asleep to get this care. Your dentist has agreed that this is ok for you. Your dentist thinks this one drug will be enough to help you relax and get the dental work done. Please call your dentist to set up your care.

Acute Legal Basis: See Legal Basis Table A, basis number 10 for and the appropriate AMPM policy reference in Chapter 300, Policy 310.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2, 10 for and the appropriate AMPM policy reference in Chapter 300, Policy 310.

27. Pharmacy; Request for Brand Name Drug-Dispense as Written Request; Lack of Step Therapy:
Your doctor has asked us to pay for a drug called *(insert Drug Name)*, a drug commonly used for (*therapeutic class information or the reason for drug as stated on the service request).*

Our Decision: We are not paying for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: This is a brand name drug. Before we will pay for a brand name drug, you must first try the generic drug. A generic drug is the same as the brand, but costs less

The generic drug you must try first is (*insert drug name*). Our records do not show that you have tried this drug. We have asked your doctor if it is ok for you to use the generic drug. We have told your doctor that we would pay for the generic drug but your doctor has not said this is ok. Your doctor must tell us why you cannot take the generic drug

OR Your doctor must tell us why you must have the brand name drug. *(If you have attempted to contact the doctor you may list the times/ dates you have called their doctor:)* We did not get the notes from your doctor that would tell us why you need the brand name drug. *(Use the timeframe expired language here and in the legal basis if appropriate from Section IV of the guide).* You can call your doctor's office to see if they have said this is ok. You will then be able to get this from the pharmacy.

Acute Legal Basis: See Legal Basis Table A, basis number 10 with added statement that, " There are other medications that cost less and work as well. This means that when more than one service will help you, we pay for the one that costs less."
Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2 and 10 with added statement that, "There are other medications that cost less and work as well. This means that when more than one service will help you, we pay for the one that costs less.**"**

28. Pharmacy; Request for Drug Not on Formulary; Attempt Formulary Med First:
Your care provider (insert the type or name of person requesting the service/ drug) has asked us to pay for a drug called *(insert Drug Name)*, a drug commonly used for (*therapeutic class information or the reason for drug as stated on the service request).*

Our Decision: We are not paying for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: You must try other drugs used for *(insert therapeutic class information)* that work as well and cost less. Drugs such as*: (insert name(s) of the preferred formulary drug(s) that meet the formulary equivalent criteria AND that the member has not tried)*. These drugs are as good as the drug your care provider asked for. We are waiting for your care provider to agree to this drug or let us know why you must take *(insert Drug Name). (Use the timeframe expired language here and in the legal basis if appropriate).* Please talk to your doctor for help.

Acute Legal Basis: See Legal Basis Table A, basis number 10 with added statement that, "There are other medications that cost less and work as well. This means that when more than one service will help you, we pay for the one that costs less.**"**
Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2 and 10 with added statement that, "There are other medications that cost less and work as well. This means that when more than one service will help you, we pay for the one that costs less."

29. Pharmacy; Request without Following Step Therapy Criteria:
Your doctor asked us to pay for a drug called *(insert Drug Name),* a drug commonly used for (*therapeutic class information or the reason for drug as stated on the service request).*

Our Decision: We are not paying for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: There is another drug treatment you must try first, such as *(Insert the Contractor's criteria that should be met in order to approve this drug, or the drug names that should have been tried in an easily understood format, do not include the names of drugs the member has tried).*If this other drug treatment does not work, then you can try *(insert drug name from first sentence).* These drugs are as good as the drug your care provider asked for. . The notes we have from your care provider do not show that you have tried the other drug treatment.

We have called your care provider and told him/her this. We have not heard back if this is ok (*Insert language regarding expired timeframe here and in the legal basis if appropriate).*Please talk to your doctor.

Acute Legal Basis: See Legal Basis Table A, basis numbers 10 and 12.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2, 10 and 12.

30. Pharmacy Request; Noncompliance with Required Step Therapy:
Your (*care provider or doctor*) has asked that we pay for a drug called *(insert drug Name),* a drug commonly used for (*therapeutic class information or the reason for drug as stated on the service request).*

Our Decision: We are not paying for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: The notes we have do not show that you have used (*insert drug name as stated in the provider notes or order*) the way your doctor told you to take it. Our records from the pharmacy show you have only picked up your (*Insert name of drug*) on (*Insert dates*)You must first use *(insert drug Name)* the way your (*care provider or doctor*) told you to before we can pay for (*insert drug name*). Please talk to your doctor about the drug you already have and how to take it the way it will work best. (If member is new you would not be able to mention pharmacy records but can rely on provider's notes)

Acute Legal Basis: See Legal Basis Table A, basis numbers 10 and 12.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2, 10 and 12.

31. Pharmacy Request; Noncompliance with Medical Regime:

Your care provider has asked that we pay for a drug called *(insert drug Name),* a drug commonly used for (*therapeutic class information or the reason for drug as stated on the service request).*

Our Decision: We are not paying for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: The notes we have from your care provider show that *(list what in is the providers notes say have been ordered)* and you have not picked them up from your pharmacy. Your care provider's notes say that you have been taking these drugs, but we do not have any notes from the pharmacy that show you are getting them. You should talk to your care provider about what problems you have been having taking this drug so that you can be helped to feel better. **Acute Legal Basis: See Legal Basis Table A, basis numbers 10 and 12.**

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2, 10 and 12.

This document is only a guide and is intended to provide examples of easily understood language. See the AHCCCS Contract and Polices for all requirements regarding Notice of Action. Additionally, this document is not to be relied upon for Legal citations. These change regularly and Contractors must verify that the specific regulations are correctly cited in their NOA letters.

32. Attendant Care – Initial request:

On (*insert date of case management assessment*), you asked your case manager to have someone (an attendant caregiver) help you 24 hours every week. Attendant Care is a paid caregiver service that helps you with making meals, doing the laundry, shopping, cleaning your house, bathing, dressing, getting around your home, and moving from your bed and chair. You can get a copy of the notes from that visit from your case manager.

Our Decision: We are going to pay an attendant care giver to help you 3 hours per day, everyday. You will get 21 hours every week. We are not paying for the other three (3) hours you asked for.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: You told the case the case manager that you need help with bathing, doing your laundry, cleaning your house, grocery shopping and making your lunches and dinners. You are able to dress yourself and get your own breakfast. The case manager notes show that the things you need could be done in 21 hours per week. You can get a copy the notes (assessment) from that visit from your case manager.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2, 10 and 15.

33. Attendant Care – Reduction (Change in Situation):

Your case manager met with you on (*insert date of case management assessment*), to go over your home care needs and attendant care needs. You have been getting 40 hours per week of Attendant Care (8 hours each day, Monday - Friday). Attendant Care is a paid caregiver service that helps you with making meals, doing the laundry, shopping, cleaning your house, bathing, dressing, getting around your home, and moving from your bed and chair. You can get a copy of the notes from that visit from your case manage.

Our Decision: We are reducing your attendant care from 40 hours each week to 38 hours weekly. This is a 2 hour reduction in your hours every week. This will start on (*ten days from DATE of letter*.)

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: Your care giver spends two hours each week grocery shopping. You daughter asked us to stop having the attendant shop for you. Your daughter said she would rather do your shopping herself. We will now being paying for 38 hours of Attendant Care each week. You can get a copy of the notes from that visit from your case manager.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2, 10 and 15.

34. Reduction in hours due to a change in condition (Improved Condition):

On (*insert date of case management assessment*), you met with your case manager to go over your home care needs. You started getting more Attendant Care services (56 hours per week, 8 hours per day, 7 days per week) when you hurt your hip and leg 6 months ago. Attendant Care is a paid caregiver service that helps you with making meals, doing the laundry, cleaning your house, bathing, dressing, getting around your home, and moving from your bed and chair. You can get a copy the notes from that visit from your case manager.

Our Decision: We are changing your Attendant Care hours back to 28 hours each week. This is the same number of hours you were getting before you got hurt. This is a reduction of 28 hours weekly. This will start on (*at least ten days from DATE of letter)*.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: You are done with therapy and your hip and leg are better. You are now able to bathe and dress yourself without help. You can get a copy the notes from that visit from your case manager. If at any time you feel that your care needs have changed and you need more help you can speak with your case manager.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2, 10 and 15.

35. Attendant Care – Substitution:

On (*insert date of case management assessment*) you met with your case manager to go over your home care needs. You told your case manager that you would like to go to Adult Day Health 2 days each week (Wednesday and Friday) for 5 hours each time.

Our Decision: We will approve Adult Day Health services for you 2 days per week for 5 hours each time. Your Attendant Care hours however, will be reduced from 40 hours per week to 29 hours per week starting *(Ten Days from DATE of letter*). Your Attendant Care worker will continue to give you care for 8 hours on Tuesdays, Thursdays and Saturdays but on Wednesdays and Fridays, the worker will only help you in the morning (8am-10:30am) until you are picked up to go to the Adult Day Health center.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: You have been getting 40 hours each week of Attendant Care (8 hours per day, Tuesday – Saturday) to help with bathing, dressing, fixing your lunch and to be with you so you are safe in your home. You will be going to Adult Day Health from 11am to 4 pm on Wednesdays and Fridays starting (*insert start date, tens days or greater from the date of letter*). You will need 2 ½ hours on those days to get ready for Adult Day Health. If at any time you feel that your care needs have changed and you need more help you can speak with your case manager.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2, 10 and 15.

36. Denial – Emergency Alert System:

On (*insert date of case management assessment*), you met with your case managers to review your home care needs. You asked your case manager to pay for an Emergency Alert System. This is an alarm system in your home that sends an alert if you are not safe or have fallen and cannot get up by yourself. You can get a copy of the notes from that visit from your case manager.

Our Decision: We are not going to pay for an Emergency Alert System for you.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: We will not pay for the alarm system for you since you have an Attendant Care worker with you for 40 hours each week and your family has told the case manager that they are with you at all other times. They have said you are rarely left alone but if you were alone that you are able to use the telephone to call for help in an emergency. There are also things you can do at home to let your family or Attendant know if you need help when they are out of the room, such as using a bell or monitor. You can speak with your case manager for some ideas to make you feel safe. If at any time you feel that your care needs have changed and you need more help you can speak with your case manager.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2, 10 and 15.

37. Home Modification: Other Alternatives to Home Modification:

On (*insert date of case management assessment*) you met with your case manager to review your home care needs. You asked your case manager to pay for a Home Modification to remodel your bathroom. This includes removing your tub and replacing it with a roll in shower. You also asked for a raised toilet (higher than normal) with handrails. You asked us to widen your door so you can wheel in with a mobile shower chair you have been given.

Our Decision: We are not going to pay for the removal of your tub to change it to a roll in shower. We will pay to have your shower doors removed. We are not paying for a raised toilet with handrails. We are going to pay to widen your door.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: The notes from your case manager and the Occupational Therapist (a person trained to look at how to best change your home to meet your needs) do not tell us that these changes to your bathroom are needed. You have a bedside commode with armrests that is raised. This will fit over your toilet so you can use the toilet in your bathroom. Widening the door will let you go into the bathroom with your walker. This is a safe way to use your toilet and the Occupational Therapist that visited your home will show you how to do this once your door is widened. We are not going to pay to remove your tub so you can have a roll in shower. The bathroom is too small to make this

possible. The Occupational Therapist that visited you said you can use your tub with a shower bench once the doors are taken off. The Occupational Therapist will visit you once the doors are taken off to show you and your attendant how to do this. You have a shower bench that you have not been using. The Occupational Therapist says this will be safe and work well for you.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2, 10 and 15. Also, AHCCCS Medical Policy Manual, Chapter 1200, Policy 1240(J) that states AHCCCS will pay for one ramp so a member can get into and out of their home.

38. Home Modification: More than one Ramp:

On (*insert date of case management assessment*) you met with your case manager to review your home care needs. You asked your case manager to pay for a Home Modification to put in a ramp at the back door of your home so you can go into your backyard.

Our Decision: We are not going to pay for a ramp at your back door.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: You use a wheelchair to get around both inside and outside your home. Your home has a wheelchair ramp built at the side entrance near your driveway that you use to get into and out of your house. You told the case manager that you have no problems using this ramp. AHCCCS will pay for a ramp for a member when the member does not already have a way to safely get into or out of their home and a ramp would help them to do that.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2, 10 and 15. Also, AHCCCS Medical Policy Manual, Chapter 1200, Policy 1240(J) that states AHCCCS will pay for one ramp so a member can get into and out of their home.

39. CES Above 100%:

On (insert date of case management assessment) you met with your case manager to go over your home care needs. You asked for 40 hours per week of Attendant Care and Home Health Nursing visits 3 times per week. Attendant Care is a paid caregiver service that helps you with making meals, laundry, cleaning your house, bathing, dressing, getting around your home, and moving from your bed and chair. Home Health Nursing is a nurse who would visit you for bowel care (help emptying your bowels). You can get a copy of the notes from that visit from your case manager.

Our Decision: You have been approved for 40 hours per week of Attendant Care and 2 visits every week by a Home Health Nurse.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: You have been approved for 40 hours every week of Attendant Care. AHCCCS policy/rules do not allow Health Plans to spend more for a member's home care than we would spend for their care in a nursing home (unless the extra costs are expected to last less than 6 months). We compare the costs between a nursing home and home services as follows:

1. We start with what a nursing home would cost for you. That amount is $4920.10 per month. Then we subtract the amount that you would have to pay **IF** you were in a nursing home. This amount is called the "Alternate Share of Cost" or "Cost Effectiveness Study (CES) Share of Cost". It is based on the income and expenses that you have reported to AHCCCS. In your case, AHCCCS has told us this amount is $726.90 per month. If you have questions about how that amount is calculated, you can ask your case manager to talk to the AHCCCS office that did your eligibility about this.
2. The difference between the cost of your care in the nursing home and the Alternate Share of Cost is called the "Net Institutional Cost". This is the amount we would have to pay for your care in a nursing home. Your Net Institution Cost would be $4393.20 per month.
3. The total cost per month of the Home Health Nursing ($1341.60) and Attendant Care services ($2924.00) that you have asked for is $4265.60. This total amount is called the "Net Home and Community Based Services (HCBS) Cost". ****** *Contractors will have to add similar language to #1 above here to cover the situations where a member has an HCBS SOC that is part of the CES calculation.*
4. If the Net HCBS Cost is more than the Net Institutional Cost, the home care services are not "cost effective" so we can not give you all of those services. Your Net HCBS cost ($4265.60) is more than your Net Institutional Cost ($4193.20). We can only give you services that cost $4193.20 or less per month.

Total Nursing Home Cost	$4920.10
CES Share of Cost	- $726.90
Net Institutional Cost	= **$4193.20**
Services you asked for	
40 hours of Attendant Care	$2924.00
3 Nursing visits per week	+ $1341.60
Net Home Services Cost	= **$4265.60**

You told your case manager that you must have the 40 hours per week of Attendant Care. The case manager has determined that the cost of 2 Home Health Nurse visits a week along with the 40 hours per week of Attendant Care would cost $3818.40 per month. Since this amount is less than your Net Institutional Cost, it is "cost effective" and can be authorized.

Total Nursing Home Cost	$4920.10
CES Share of Cost	- $726.90

Net Institutional Cost	**= $4193.20**
Services we **can** provide	
40 hours of Attendant Care	$2924.00
2 Nursing visits per week	+ $ 894.40
Net Home Services Cost	**= $3818.40**

Legal Basis for Our Decision: Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2, 10 and 15.

40. Adult Day Health for member in an Assisted Living Facility:

On (*insert date of case management assessment*) you met with your case manager to go over your care needs. You and the Assisted Living Facility where you live asked for you attend an Adult Day Health center twice a week. Adult Day Health is a service that gives members a chance to do activities and spend time with people their own age.

Our Decision: We are denying your request for Adult Day Health services twice a week.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: The type of facility that you live in is required, under their Arizona Department of Health Services license, to offer daily activities that are planned for the people that live there. Your case manager will talk to the Assisted Living Facility manager about the activities your facility has and will ask them to talk with you about what kinds of activities you would be interested in.

Legal Basis for Our Decision: We based our decision on Arizona Administrative Code (AAC) Section R9-10-712 that says Assisted Living Facilities have to have activities for the people who live there.

B. Examples of UNACCEPTABLE explanations to use when denying services due to lack of medical necessity include:

1. The medication prescribed for you to treat your diabetes is not on our formulary. Our records do not show your health need qualifies you to use this drug.

2. The medical information supplied does not indicate or document as sufficient need for this service.

3. We have reviewed the records from your doctor. Based on those records, the care your doctor ordered does not meet the AHCCCS standard.

4. This item is not medical in nature and therefore not needed in your medical care.

5. Medical services for incarcerated people are paid by the incarcerating facility.

6. The information submitted by your doctor does not show you meet guidelines for approval of this request.

7. The information received from your dentists does not explain the need for your treatment.

8. Dentures are not a paid benefit of (*XYZ health plan*), unless they are shown to be medically needed. The information sent by your dentist and primary care doctor does not support the medical need for dentures at this time.

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III. Out of Network Provider

AHCCCS Contractors may restrict members to services provided by in-network providers for the provision of non emergency services. Requests for services from out-of-network providers may be denied if the services are reasonably available in the Contractor's network.

A. Example of ACCEPTABLE regarding out of network language includes:

1. **Request to See Out of Network Physician:**
   You have asked to see (*insert doctor name here*) to treat your (*fill in the medical condition).*

   Our Decision: We are not paying for this because (*insert doctor name here)* does not contract with this health plan.

   The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: We have other doctors who treat your problem who do contract (have an agreement to work with) with us. We will help you in getting an appointment to see *him/her*. Please call us at (*insert phone number*) for help making the appointment.

   Acute Legal Basis: See Legal Basis Table A, basis number 16.

   Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2 and 16.

2. **Request to Use Out of Network Facility:**
   Your doctor has asked that you get (*insert service*) at (*insert facility name*) for your (*insert problem*).

   Our Decision: We are not paying for (*insert service*) because we do not contract with (*insert facility name*).

   The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: There are many other places you can get the care you need that do contract with us. Your doctor will know which of our contracted *(hospitals, etc as ordered*) *she/ he)* wants to use. We have told your doctor which of these *(hospitals, etc as ordered)* we are contracted with. Please ask your doctor for help picking a contracted facility and we will pay for (*insert service*).

   Acute Legal Basis: See Legal Basis Table A, basis number 16.

   Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2 and 16.

B. Examples of UNACCEPTABLE language regarding out of network services:

1. This doctor is not on our provider list. Please talk to your doctor about getting a referral to a doctor on the list.

2. We have reviewed your request for care at ABC facility. We have decided that this request will not be approved at this time. We have looked at your medical file, and decided based on medical standards that your care can be done at EFG facility.

IV. Not Enough Information Received within the Legally Required Time Frame to make a Decision

In some cases Contractors do not have sufficient information to make a coverage determination within the required timeframes. The required timeframes are 3 days for expedited requests, 14 days for standard requests, or up to an additional 14 days when an extension is given. The expiration of a timeframe must result in a Notice of Action Letter.

A. Examples of Acceptable Language regarding non-receipt of necessary information:

1. Referral to Specialist:
Dr. *X* has asked us to pay for a visit to see Dr. *Y* for the pain in your legs.

Our Decision: We are not going to pay for you to see Dr. *Y*.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: We need more medical information to help us decide. We asked Dr. *X* to give us more information. We had to get this information by *(insert date)* or we have to deny the request. We could not make a decision to pay for the visit to Dr. *Y* without this information. The information we need is: *(The Contractor must insert an explanation of the information that they were seeking. The member must be given the opportunity to provide this information to the Contractor, or at the minimum know what to ask the provider for so the member can assist in the process)* We have asked your doctor for this information and did not hear back. We needed to get an answer by now. If your doctor gets us this information we can look at this request again.

Acute Legal Basis: See Legal Basis Table A, basis numbers 10 and 13.
Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2, 10 and 13.

B. Examples of Unacceptable Language regarding non-receipt of necessary information

1. Your doctor did not submit requested medical information to document the need for these services. We must deny any request on day 28 in accordance with federal law.

2. We did not receive the information we needed to make the decision.

V. System Issues—Coverage by Another Entity

Members or physicians may submit requests to a Contractor for paid services that are actually provided by other entities, such as the Behavioral Health System (BHS), Children's Rehabilitative Services (CRS), or private insurance.

A. Examples of ACCEPTABLE language regarding coverage by another entity:

1. Requested Drug Must Be Obtained Through the Behavioral Health System:
Your doctor asked us to pay for a drug called *(insert Drug Name),* a drug used to treat (*insert therapeutic class info)*).

Our Decision: We are not paying for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: This drug has been ordered by your psychiatrist, a doctor who helps with mental problems. This drug must be paid for by (*insert RBHA name here*). We have sent this request over to your mental health clinic for review. You can contact us at (xxx) xxx-xxxx for help getting an appointment with the mental health clinic if you would like.

Acute Basis: See Legal Basis Table A, basis number 18.

2. Drug Must Be Ordered By a Psychiatrist or Mental Health Provider:
Your doctor asked us to pay for a drug called *(insert Drug Name),* a drug used to treat *(insert therapeutic class info here*).

Our Decision: We are not paying for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: State law requires that you get these types of drugs from (*insert RBHA name here*). Please call us at (*insert phone number*) so we can help you get care from (*insert RBHA name*).

Acute Legal Basis: See Legal Basis Table A, basis number 18.

3. Coverage by Another Insurer:
You have asked that we pay for (*insert item/service here*) for your (*insert medical condition here*).

Our Decision: We are not paying for this because this may be paid for by your *(Medicare Part D or primary (first) insurance company).*

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: Our records show this is (*insert name of other insurer including just stating "Medicare Part D" while member is waiting for Medicare to confirm provider*). Please call your other insurance company to help you get these services. *(If this is a Medicare Part D medication problem, please assist the member with WellPoint enrollment at point of sale and then issue this letter outlining what has been done)* **(For**

non Part D Medicare members) If your other insurance company denies payment for the (insert item/service here), please tell us and we will see if we can pay for it.

Acute Legal Basis: See Legal Basis Table A, basis number 20.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2 and 20.

4. Member receives or orders service and then requests reimbursement:

You have asked *XYZ Health Care* to pay you back for your electric scooter.

Our Decision: We are not going to pay you back for this.

The Reasons For Our Decision. Facts About Your Condition or Situation that Support Our Decision: *XYZ Health Care* needs your doctor to order the scooter and then ask for the scooter to be paid for by *XYZ Health Care* before it is delivered to your house. This is called prior authorization. Your doctor did not order the scooter. You bought the scooter from a local store. *XYZ Health Care* will not pay you back for this. Your member handbook tells you about prior authorization and how to get services. If you do not understand this please call us at *XXX-XXX-XXXX* so we can explain this to you.

Acute Legal Basis: See Legal Basis Table A, basis number 21.

Elderly/Physically Disabled Long Term Care Legal Basis: See Legal Basis Table A, basis numbers 2 and 21.

B. Examples of UNACCEPTBLE language regarding coverage by another entity

1. Your symptoms and diagnosis as documented by your primary care physician require management and monitoring by a behavioral health specialist. You must enroll with (*insert RBHA name*). Please contact them for assistance in obtaining your medication.

REFERENCES

42 CFR 438 et seq

AAC R9-22 et seq

AAC R9-28 et seq

Ekloff v Rodgers Settlement Agreement AAC R9-22-212

AHCCCS Medical Policy Manual

This document is only a guide and is intended to provide examples of easily understood language. See the AHCCCS Contract and Polices for all requirements regarding Notice of Action. Additionally, this document is not to be relied upon for Legal citations. These change regularly and Contractors must verify that the specific regulations are correctly cited in their NOA letters.

Number	Description	Arizona Revised Statute (ARS); Arizona Administrative Code (AAC), or AHCCCS Policy	**TABLE A: Legal Basis or Policy in Layman's terms- ENGLISH**
	Legal web address for all Arizona Administrative Codes		Copies of Legal Citations can be found at the local library or at http://www.azahcccs.gov/reporting/LawsRegulations/state/state.aspx
	AHCCCS Medical Policy Manual web link		http://www.azahcccs.gov/shared/MedicalPolicyManual/MedicalPolicyManual.aspx?ID=contractormanuals
1	Not covered: Eye Glasses Member over 21	R9-22-212E.9	We based our decision on Arizona Administrative Code Section R9-22-212E.9. that says AHCCCS only pays for eyeglasses for members until a member has their 21st birthday, unless they have had eye surgery for cataracts.
2	EPD/ LTC covers same services as Acute	R9-28-202	We based our decision on Arizona Administrative Code (AAC) Section R9-28-202 that says the Long Term Care Program pays the same services as the Acute Program.

Number	Description	Arizona Revised Statute (ARS); Arizona Administrative Code (AAC), or AHCCCS Policy	**TABLE A: Legal Basis or Policy in Layman's terms- ENGLISH**
3	Not covered: Experimental/ Clinical Research	R9-22-202B10.a & R-9-22-101B.	We based our decision on Arizona Administrative Code (AAC) Section R9-22-202B.10.a says AHCCCS does not pay for experimental services. The definition of experimental services can be found at Arizona Administrative Code (AAC) R9-22-101B. If you would like help understanding the definition please call us at *XXX-XXX-XXXX*.
4	Not Covered: Cosmetic Services	R9-22-215C.4	We based our decision on Arizona Administrative Code (AAC) Section R9-22-215C.4. that says AHCCCS does not pay for cosmetic procedures.
5-Acute Only	Not Covered: Dental Services for members 21 and older- Emergent care only	R9-22-207B. & AMPM Chapter 300 - dental coverage	We based our decision on Arizona Administrative Code (AAC) Section R9-22-207 B. that says AHCCCS only pays for dental emergencies for members 21 years of age or older. There is a list of paid for services for emergency dental care in the AHCCCS Medical Policy Manual Chapter 300, Policy 310.
6	Not Covered: Infertility Treatment	R9-22-205.B.4.a	We based our decision on Arizona Administrative Code (AAC) Section R9-22-205.B.4.a. says AHCCCS does not pay for infertility services.
7	Not Covered: Hearing Aids member 21 and older	R9-22-212.E.8 and AMPM Chapter 300, Policy 310	We based our decision on Arizona Administrative Code (AAC) Section R9-22-212.E.8 that says hearing aids are not paid for members who are 21 years of age or older. There is a list of paid for services for hearing aids in the AHCCCS Medical Policy Manual Chapter 300, Policy 310.
8	Not Covered: Personal Care items	R9-22-202B.10.c	We based our decision on Arizona Administrative Code (AAC) Section R9-22-202.B.10.c, which says AHCCCS does not pay for personal care items.

Number	Description	Arizona Revised Statute (ARS); Arizona Administrative Code (AAC), or AHCCCS Policy	**TABLE A: Legal Basis or Policy in Layman's terms- ENGLISH**
9-Acute Only	Not Covered: Diapers for member 21 and older or for an amount greater than 240 for members 3 and older unless medical condition	R9-22-212E.6.d	We based this decision on the Arizona Administrative Code (AAC) Section R9-22-212E.6.d which lets us pay for no more than 240 diapers a month for you. More diapers can be paid for only when a member has spastic bowel or chronic diarrhea. (*Diapers are covered for members who are at least 3 years old and only until the member's 21st birthday.)*
10	Medical Necessary and Cost Effective	R9-22-202B.1	We based this decision Arizona Administrative Code (AAC) Section R9-22-202.B.1 that says AHCCCS only pays for services that are medically necessary, or will help you get better. Also, services must be the least costly service that will give you the same result (cost effective).
11	EPSDT Guideline	R9-22-213 & 42 USC 1396 (d)(r)(5)	We based our decision on Arizona Administrative Code (AAC) section R9-22-213 and federal law 42 USC 1396d(r)(5) that says AHCCCS pays for services listed in federal law 42 USC 1396d (a) that help or make better an injury, illness, condition or defect whether or not the service is in the AHCCCS State Plan.
12	Medical Standard of Care no met	R9-22-202.B7	We also used Arizona Administrative Code (AAC) Section R9-22-202.B7 that says an AHCCCS plan should make sure that care that meets medical standards be given. This means that treatment accepted and agreed to by providers should be used to treat your problem before other care is tried.

Number	Description	Arizona Revised Statute (ARS); Arizona Administrative Code (AAC), or AHCCCS Policy	**TABLE A: Legal Basis or Policy in Layman's terms- ENGLISH**
13	Decision not made within timeframes and therefore considered denied	R9-34-206.E.	We based this decision on Arizona Administrative Code (AAC) R9-34-206.E. that states that when authorization decisions are not reached within the timeframe allowed by rules, the health plan must deny the request.
14	Not Covered: Dental services for cosmetic purposes	R9-22-207D & AHCCCS Chapter 300, Policy 310	We also used Arizona Administrative Code (AAC) Section R9-22-207D that says AHCCCS does not pay for dentures if they are just to make you look better, you must have a medical need. There is a list of paid for services for dental care in the AHCCCS Medical Policy Manual Chapter 300, Policy 310.
15	Definition of medically necessary	R9-22-101B	Arizona Administrative Code (AAC) Section R9-22-101B states that to be medically necessary a service must 1.) prevent disease or disability 2.) help avoid bad problems that may occur due to your disease process 3.) stop your disease or condition from getting worse 4.) or will help you live longer or keep you in your home.
16	Out of Network	R9-22-705.A	We based our decision on Arizona Administrative Code (AAC) Section R9-22-705.A that states that AHCCCS health plans may only pay for services to providers they are contracted with.
17	Dentures- not a covered benefit	SB 1145 and HB 2641-491R	We based our decision on Senate Bill SB 1145 and House Bill 2641-491R ***[Arizona Administrative Code (AAC) Section XXX this will need to be updated once the legislative rule is assigned inserted into the AAC]*** that says AHCCCS does not pay for dentures. Effective 10/1/09.

Number	Description	Arizona Revised Statute (ARS); Arizona Administrative Code (AAC), or AHCCCS Policy	**TABLE A: Legal Basis or Policy in Layman's terms- ENGLISH**
18	Acute Care Only - services covered by the Division of Behavioral Health	R9-22-1202C.4	We based our decision on Arizona Administrative Code (AAC) Section R9-22-1202C.4 that requires that the behavioral health system provide your behavioral drugs and the medical care related to those drugs.
19	Services covered under the Children's Rehabilitation Services benefit	R9-7	We based this decision on the Arizona Administrative Code (AAC) Section R9-7 that requires primary care providers and other practitioners to refer a child with special health care needs to CRS.
20	AHCCCS is the payor of last resort	R9-22-1003(A)	We based this decision on the Arizona Administrative Code (AAC) Section R9-22-1003(A) that says that AHCCCS must not pay for services if other insurance companies will pay for them.
21	AHCCCS is not obligated to pay for services that require prior authorization, when prior authorization is required.	R9-22-212A	We based our decision on Arizona Administrative Code (A.A.C.) Section R9-22-212A that says a health plan does not have to pay or pay equipment that is requires prior authorization when that prior authorization is not received.

Number	Description	Arizona Revised Statute (ARS); Arizona Administrative Code (AAC), or AHCCCS Policy	**TABLE A: Legal Basis or Policy in Layman's terms- ENGLISH**
Other commonly used references	Incontinence Briefs	R9-22-212 E.5 and 6	*We based on decision on Arizona Administrative Code (A.A.C.) Section R9-22-212 E. 5 or 6 etc. Reword and insert the appropriate citation from below:* 5. Except for incontinence briefs for persons over 3 years old and under 21 years old as provided in subsection (6), personal care items including items for personal cleanliness, body hygiene, and grooming are not covered unless needed to treat a medical condition. Personal care items are not covered services if used solely for preventive purposes. 13. Incontinence briefs, including pull-ups are covered to prevent skin breakdown and enable participation in social, community, therapeutic and educational activities under the following circumstances: a. The member is over 3 years old and under 21 years old; b. The member is incontinent due to a documented disability that causes incontinence of bowel or bladder, or both; c. The PCP or attending physician has issued a prescription ordering the incontinence briefs; d. 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; e. The member obtains incontinence briefs from providers in the contractor's network; f. Prior authorization has been obtained as required by the Administration, contractor, or contractor's designee. Contractors may require a new prior authorization to be issued no more frequently than every 12 months. Prior authorization for a renewal of an existing prescription may be provided by the physician through telephone contact with the member rather than an in-person physician visit. Prior authorization will be permitted to ascertain that: i. The member is over age 3 and under age 21; ii. The member has a disability that causes incontinence of bladder or bowel, or both; iii. A physician has prescribed incontinence briefs as medically necessary. A physician prescription supporting medical necessity may be required for specialty briefs or for briefs

Number	Description	Arizona Revised Statute (ARS); Arizona Administrative Code (AAC), or AHCCCS Policy	**TABLE A: Legal Basis or Policy in Layman's terms- ENGLISH**
			different from the standard briefs supplied by the contractor; and iv. The prescription is for 240 briefs or fewer per month, unless evidence of medical necessity for over 240 briefs is provided.
Other commonly used citations	Hearing Aids	R9-22-212 E.8	*We based on decision on Arizona Administrative Code (A.A.C.) Section R9-22-212 E.8. Reword and insert the appropriate citation from below:* 8. Hearing aids are not covered for a member who is age 21 or older.

Attachment D ACOM Policy # 414, Revised / Approved 10/1/09

Insert Contractor Logo

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will help you. If this notice does not tell you what you asked for, what we decided and why, please call us at XXX-XXX-XXXX. This notice is available in other languages and formats if you need it.

Si usted no entienda esta carta o usted tiene alguna pregunta por favor de llamar al XXX-XXX-XXXX o (800) XXX-XXXX. Esta carta esta disponible en otras idiomas y formato si es que lo necesita.)

NOTICE OF EXTENSION

TO: Date

FROM:

(Your doctor OR name of provider- as appropriate) have asked that (*Health Plan Name)* pay for (*describe services requested and the reason for the services in easily understood language*). (*You or the name of requesting provider – if the member or requesting provider has requested the extension OR Health Plan name)* feels that it is in your best interest to try to take fourteen (14) more days to make a decision. We need this time so we can get more information from (*insert name of requesting provider*). We need (*insert what additional information is needed, e.g. notes from your doctor that tell us if you have tried Drug X before , or notes from your doctor that tell us if you have had a chest x-ray. Be as specific as possible in what information is needed in order to assist the member in getting the service or provides the member with an idea of what information is missing that the member may be able to supply).*

We will make this decision by *(insert date the extension expires; this cannot exceed 14 days from the date of the extension letter and cannot exceed 28 days from the date of request. For example, if you issue/mail the Notice of Extension on Day 6 of the request timeframe, and you give fourteen (14) additional days, the decision must be made by the twentieth (20th) day of the request. The timeframe is counted from the date on the letter which represents the mail date)* If we do not get the information from *(insert name of requesting provider)* then we will have to deny this request.

If you do not agree with us taking this extra time to make a decision you can file a grievance (complaint). You can do this by contacting *(insert the Contractor's grievance phone number and insert the address for grievances).*

As your health plan, we can decide to take this extra time if we feel it will be of help to you. We felt this extra time would help us to get the extra (notes or tests) that would help us make this decision.

Sincerely,

(Insert name of Health Plan)

415 - PROVIDER NETWORK DEVELOPMENT AND MANAGEMENT PLAN POLICY

Original Date: 12/13/07
Effective Date: 06/01/2010; 10/01/2011, 12/01/2011
Revision Date: 09/28/09, 01/28/10, 05/10/10, 08/26/10, 01/24/2011, 12/01/2011

Staff responsible for policy: DHCM Operations

I. Purpose

This policy provides guidance to Acute Care, Arizona Long Term Care System (ALTCS) and Behavioral Health Contractors to develop Provider Network Development and Management Plans. It is critical for Contractors to develop provider networks that are diverse and flexible to meet a variety of member issues both immediate as well as long range. Provider networks must be a foundation that supports an individual's needs as well as the membership in general.

II. Definitions

Contractor	An organization or entity agreeing through a direct contracting relationship with AHCCCS to provide the goods and services specified by the contract in conformance with the stated contract requirements, AHCCCS statute and rules and Federal law and regulations.
GSA	Geographic Service Area: A specific county or defined grouping of counties designated by AHCCCS within which a Contractor provides, directly or through subcontract, covered health care to members enrolled with that Contractor.
Provider	Any person or entity (including Tribal/Regional Behavioral Health Authorities) who 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.

III. Policy

The Contractor shall develop and maintain a provider network development and management plan, which assures the Administration that the provision of covered services will occur as stated in the Contract [42 CFR 438.207(b)]. The Network Development and Management Plan

must be evaluated; updated and submitted to AHCCCS, Division of Health Care Management, within 45 days from the start of each contract year.

The Contractor shall immediately notify AHCCCS in writing when there has been a significant change in operations that would affect adequate capacity and services. The changes include, but are not limited to, changes in services, covered benefits, geographic service areas, payments or eligibility of a new population.

Contractors must submit the Network Attestation form (Attachment A) in conjunction with the annual submission of the Network Development and Management Plan. See Attachment A-1 for instructions on completing the form.

Contractors will submit the Plan to their assigned Operations and Compliance Officer at one of the following addresses:

Acute Care Contractors:

[Compliance Officer Name]
AHCCCS Division of Health Care Management
MD 6500
701 E. Jefferson St.
Phoenix, AZ 85034

Long Term Care Contractors:

[Compliance Officer Name]
AHCCCS Division of Health Care Management
MD 6100
701 E. Jefferson St.
Phoenix, AZ 85034

IV. Procedure

The Network Development and Management Plan shall include the Contractors process to develop maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract (items that apply to specific Contractors (ALTCS, Acute, or Behavioral Health) are identified in **bolded** parenthetical notation).

The Plan must include the process the Contractor utilizes to ensure:

1. **(Acute and ALTCS)** That covered services are accessible to AHCCCS members in terms of timeliness, amount, duration and scope as those are to non-AHCCCS persons within the same service area.
2. That covered services are provided promptly and are reasonably accessible in terms of location and hours of operation.

3. That there shall be sufficient personnel for the provision of all covered services, including emergency care on a 24 hour a day, 7 day a week basis.
4. (**ALTCS and Behavioral Health**): A priority shall be placed on allowing members, when appropriate, to reside or return to their own home versus having to reside in an institution or alternative residential setting. To that end the development of home and community based services shall include provisions for the availability of services on a 7 day a week basis, and for extended hours, as dictated by member needs.

The plan must also include a description or explanation of the following:

1. Evaluation of the prior year's Plan including reference to the success of proposed interventions and/or the need for re-evaluation;
2. Current status of the network by service type (Hospital, Nursing Facility, HCBS, Primary Care OB/GYN, Specialist, Oral Health, Non Emergent Transportation, Ancillary Services, etc.) at all levels including:
    a. how members access the system;
    b. relationships between the various levels (focus on provider to provider contact and facilitation of such by the Contractor; e.g. PCP, Specialists, Hospitals, RBHAs).
3. Current network gaps and the methodology used to identify them;
4. Immediate short-term interventions when a gap occurs, including expedited or temporary credentialing;
5. Interventions to fill network gaps and barriers to those interventions;
6. Outcome measures/evaluation of interventions;
7. Ongoing activities for network development based on identified gaps and future needs projection;
8. Coordination between internal departments; including a comprehensive listing of all committees and committee membership where this coordination occurs. Identification of members should include the department/area (i.e., QM, MM/UM, GRV, FIN, CLAIMS) that they represent on the committee.
9. Coordination with outside organizations; (**ALTCS** Contractors shall address member/provider council activities)
10. A description of network design by GSA for the general population, including details regarding special populations. [**Acute and Behavioral Health** contractors shall understand these populations to include the developmentally delayed (Arizona Early Intervention Program (AzEIP)), the homeless and those in border communities; among others. **ALTCS** Program Contractors shall understand these populations to include behavioral health; young adults and children; among others.] The description shall cover:
    i. how members access the system,
    ii. relationships between various levels of the system,
    iii. (**Acute and Behavioral Health)** a listing/description of the available alternatives to Nursing Facility placement such as Assisted Living Facilities, alternative residential settings, or home and community based services (minimum one listed per GSA) as required by contract. A similar requirement exists on a larger scale under number 17 of the ALTCS Only listing. If the contractor requires additional information on procuring such

services, they shall contact the ALTCS program contractor in the GSA for assistance in identifying available alternatives.

iv. *(***Acute Only***)* the plan for incorporating the medical home for members and the progress in its implementation,

v. (**ALTCS Only**) the description shall include a list of these providers along with a description of services provided by the program and projected utilization.

11. **(Acute and ALTCS)** A description of the adequacy of the geographic access to tertiary hospital services for the Contractor's membership;
12. (**Acute Only***)* The assistance provided to PCPs when they refer members to specialists. The methods used to communicate the availability of this assistance to the providers;
13. (**Acute Only**) An analysis of the Contractors Appointment Availability Report statistics as set forth in ACOM Policy 417;
14. The methodology(ies) the Contractor uses to collect and analyze member, provider and staff feedback about the network designs and performance. When specific issues are identified, the protocols for handling them.
15. (**Acute Only**) If the Contractor does not have contracts with hospitals but contracts with physicians with hospital admitting and treatment privileges, Attachment B (Non-Contracted Hospital and Physician Admitting and Treatment Privileges) of this policy must be submitted annually.

(For **ALTCS Contractors Only**)

16. Listing of non-Medicare Certified Home Health Agencies the Contractor is using. The listing is to be provided on the form distributed by AHCCCS and attached to the Plan. (AMPM Policy 1240) (See Attachment A)
17. The strategies the Program Contractor has for Work Force Development. Program Contractors make up the largest payer group for paraprofessionals in the long term care market and must leverage this to ensure adequate resources in the future. Successful efforts to recruit, retain and maintain a long-term care workforce are necessary to meet the needs of the anticipated growth in the ALTCS membership. The Program Contractor must have as part of their network development plan a component regarding paraprofessional work force development in nursing facilities, alternative residential facilities and in-home (attendant care, personal care and homemaker). Work Force Development is defined as all activities that increase the number of individuals participating in the long-term health care workforce. It includes actions related to the active recruitment and pre-employment training of new caregivers and opportunities for the continued training of current caregivers (i.e. Program Contractor supported/sponsored training). Work Force Development also includes efforts to review compensation and benefit incentives, while providing a plan for the expansion of the paraprofessional network at all levels of client care.
18. Strategies the Contractor will take to provide members with “in-home” HCBS versus placing members in Assisted Living Facilities and Nursing Facilities. A priority shall be placed on allowing members, when appropriate, to reside or return to their own home versus having to reside in an institutional or alternative residential setting.

19. A Contractor who has greater than 25% of their members residing in an Alternative Residential Setting (ARS) per GSA shall develop an action plan that identifies approaches to make placements in in-home settings rather than ARS. The plan must be continuously evaluated for effectiveness and revised as needed. A comprehensive report must be submitted to AHCCCS 15 days after the end of each quarter until the Contractor has less than 25% of their members in ARS for four consecutive quarters. A plan must be developed if a Contractor has two consecutive quarters of 25% of their members in a GSA residing in ARS.
20. A listing of Assisted Living Facilities for which the Contractor has already obtained a waiver from the Single Choice Occupancy requirement. Listing must include the name of the facility and the date of the waiver approval. (See Attachment C)
21. A listing of nursing facilities that have withdrawn from the Medicaid Program but are still being utilized by the Contractor. The listing must include the name of the facility and the number of residents the Contractor has in each facility. (See Attachment C)
22. Description of how the Contractor will handle the loss (closure, contract termination) of a major healthcare provider (hospital, nursing facility, large provider group).
23. A description of the methods the Contractor will use to ensure that ALTCS members receive needed services in the event of a natural disaster.

The plan must include answers to the following questions:

a. (**Acute Only**) How does the Contractor assess the medical and social needs of new members to determine how the Contractor may assist the member in navigating the network more efficiently?
b. (**Acute Only**) What assistance is provided to members with a high severity of illness or higher utilization to better navigate the provider network?
c. (**Acute Only**) How does the Contractor support the Graduate Medical Education (GME) programs within its contracted GSA(s) and pursue contracting opportunities with graduates and providers that are opening new practices in, or relocating to, Arizona, especially in rural or underserved areas?
d. (**Acute Only**) Describe the Contractor's process to increase provider participation in Baby Arizona.
e. What interventions has the Contractor implemented to reduce avoidable/preventable ER utilization? What was the outcome of those interventions?
f. **(Acute and ALTCS)** Are members with special health care needs assigned to specialists for their primary care needs? If so, what general criteria are used to determine if a member should be assigned in this manner?
g. What are the most significant barriers to efficient network deployment within the Contractor's service area? How can AHCCCS best support the Contractor's efforts to improve its network and the quality of care delivered to its membership?
h. **(Acute and ALTCS)** What interventions has the Contractor implemented to address and reduce no-show rates and how is information collected to assess the efficacy of these measures?

i. **(Behavioral Health only)** How are members with chronic medical conditions identified within the RBHA system record keeping mechanism and how are placement options coordinated with/communicated to Acute Care Contractors?

V. Provider Terminations Due to Rates (Quarterly Submission)

The Contractor will submit to their AHCCCS Compliance Officer a report of providers who have terminated their contract due to rates 15 days following the end of each quarter using the report template attached (Attachment D) to this policy.

The report will consist of the following information regarding all providers who terminate their contracts for rate related reasons during the reporting period by GSA:

Provider Name	The name of the provider leaving the network. If a provider group has terminated their contract, each provider in the group should be listed separately.
Provider ID Number	The 6-digit AHCCCS legacy identification number. Do not use a provider's NPI.
Provider Type	The Provider Type code as utilized in PMMIS.
PCP	'Y' yes or 'N' no (Is defined as a 08-MD, 31-DO, 19-NP, 18-PA; responsible for the management of a member's health care)
Provider Capacity	This column should be populated with the number of members assigned to, residing in, or regularly receiving services from the provider. In the case of hospitals, outpatient facilities, labs, etc. indicate the number members (unduplicated) that on average utilize the providers during a three month time period. In the case of nursing facilities and alternative residential settings indicate the number of members residing in the facility at the time of termination notice by the provider.
Reason for Termination	Insert one of the following reasons: • Increased rate requested (provider initiated) • AHCCCS FFS rate reduction (pass-through) • Contractor rate reduction (not associated with an AHCCCS reduction) • Other (must describe)
Attestation	Include a statement if the loss of the provider will result in a network gap. If there will be a gap, indicate how the Contractor will meet member needs after the provider leaves the network.

VI. Providers that Diminish their Scope of Service and/or Close their Panel (Quarterly Submission)

The Contractor will submit to their AHCCCS Compliance Officer a report of providers that have diminished their scope of service and/or closed their panel, 15 days following the end of each quarter using the report template attached (Attachment E) to this policy.

The report will consist of the following information regarding all providers who have diminished their scope of service and/or that closed their panel during the reporting period by GSA:

Provider Name	The name of the provider.	
Provider ID Number	The 6-digit AHCCCS legacy identification number. Do not use a provider's NPI.	
Provider Type	The Provider Type code as utilized in PMMIS.	
Scope of Service Diminished	Type of Service N/A if not applicable	
Panel Closed	'Y' yes N/A if not applicable	A) Medicaid B) Non-Medicaid
Provider Capacity	This column should be populated with the number of members assigned to, residing in, or regularly receiving services from the provider. In the case of hospitals, outpatient facilities, labs, etc. indicate the number members (unduplicated) that on average utilize the providers during a three month time period. In the case of nursing facilities and alternative residential settings indicate the number of members residing in the facility.	
Reason	Insert one of the following reasons: • Increased rate requested (provider initiated) • AHCCCS FFS rate reduction (pass-through) • Contractor rate reduction (not associated with an AHCCCS reduction) • Other (must describe)	
Attestation	Include a statement if the change will result in a network gap. If there will be a gap, indicate how the Contractor will meet member needs after the provider leaves the network.	

VI. References

- Title 42 of the Code of Federal Regulations (42 CFR) Part 438.200
- Acute Care Contract, Section D
- ALTCS Contract, Section D

Attachment A

NETWORK ATTESTATION STATEMENT

This Attestation Statement is to accompany the Network Development and Management Plan which is due within 45 days from the start of each contract year. Each Contractor will be required to submit this Attestation Statement for each GSA in which they operate.

Network Attestation Statement

From

Contractor's Name

To The

Arizona Health Care Cost Containment System
Division of Health Care Management, Operations

☐ I hereby attest that the Network Development and Management Plan submitted does not meet the Network Standards (Acute Contract Section D, ¶28 and ¶29; ALTCS Contract Section D, ¶28 and ¶29; ACOM Policy 415 Provider Network Development and Management Plan and ACOM Policy 419 ALTCS Network Standards) for the following GSA(s) and/or county (ies):

☐ I hereby attest that the Network Development and Management Plan submitted meets all other Network Standards other than those listed above (Acute Contract Section D, ¶28 and ¶29; ALTCS Contract Section D, ¶28 and ¶29; ACOM Policy 415 Provider Network Development and Management Plan and ACOM Policy 419 ALTCS Network Standards) for the following GSA(s) and/or county (ies):

(Network Administrator Signature) Date

Attachment A-1 Instructions for the

NETWORK ATTESTATION STATEMENT

This Attestation Statement is to accompany the Network Development and Management Plan which is due within 45 days from the start of each contract year. Each Contractor will be required to submit this Attestation Statement for each GSA in which they operate.

Network Attestation Statement

From

❶ Contractor's Name

To The

Arizona Health Care Cost Containment System
Division of Health Care Management, Operations

❷☐ I hereby attest that the Network Development and Management Plan submitted does not meet the Network Standards (Acute Contract Section D, ¶28 and ¶29; ALTCS Contract Section D, ¶28 and ¶29; ACOM Policy 415 Provider Network Development and Management Plan and ACOM Policy 419 ALTCS Network Standards) for the following GSA(s) and/or county (ies):

❸☐ I hereby attest that the Network Development and Management Plan submitted meets all other Network Standards other than those listed above (Acute Contract Section D, ¶28 and ¶29; ALTCS Contract Section D, ¶28 and ¶29; ACOM Policy 415 Provider Network Development and Management Plan and ACOM Policy 419 ALTCS Network Standards) for the following GSA(s) and county (ies):

❹(Network Administrator Signature) ❺Date

Contractors must submit a separate Attestation for each Line of Business (LOB)

❶ Insert Contactor's name: Mercy Care Plan
Mercy Care LTC

❷ Check this box if the GSA and county you are reporting does not meet required Network Standards. Insert the Settings/Service types, GSA(s) and/or county (ies) where Network Standards are not met.

Example:

Acute LOB: GSA 4 – Apache, Mohave, Navajo: Speech/hearing Therapist

ALTCS LOB: GSA 44 - Apache County: Assisted Living Centers; Adult Day Health; Speech Therapy

❸ Check this box if the GSA and county you are reporting meets all required Network Standards. Insert the GSA number and the county (ies) meeting the Standards.

Example:

Acute LOB: GSA 4 – Coconino
GSA 12 - Maricopa

ALTCS LOB: GSA 44 - Coconino, Mohave, Navajo
GSA 52 - Maricopa

NOTE: It is possible to have both Bullet 2 and Bullet 3 boxes checked at the same time. One or more counties in a multiple GSA could be in full compliance with the Network Standards while one or more could be out of compliance.

❹ Have the appropriate Network Administrator sign the Attestation Statement

❺ Include the date the Attestation was signed

Attachment B: **Non-Contracted Hospital and Physician Admitting & Treatment Privileges Attestation Statement**

I_____ affirm that _____ has contracts with physician(s) with admitting and treatment privileges at the hospitals within the communities identified below as required in Section J, List of Attachments, Attachment B of the AHCCCS Acute Care Contract.

Signature: _____ Date: _____

GSA 2
- ☐ Blythe, CA
- ☐ Lake Havasu City
- ☐ Parker
- ☐ Yuma
- ☐ GSA Not Applicable

GSA 4
- ☐ Bullhead City
- ☐ Page
- ☐ Flagstaff
- ☐ Payson
- ☐ Gallup, NM
- ☐ Show Low
- ☐ Kanab, UT
- ☐ Springerville
- ☐ Kingman
- ☐ Lake Havasu City
- ☐ Winslow
- ☐ Needles, CA
- ☐ GSA Not Applicable

GSA 6
- ☐ Cottonwood
- ☐ Flagstaff
- ☐ Maricopa County
- ☐ Prescott
- ☐ GSA Not Applicable

GSA 8
- ☐ Casa Grande
- ☐ Globe
- ☐ Maricopa County Dist. 4
- ☐ Payson
- ☐ GSA Not Applicable

GSA 10
- ☐ Contracts are required
- ☐ Nogales
- ☐ GSA Not Applicable

GSA 12
- ☐ Contracts are required
- ☐ GSA Not Applicable

GSA 14
- ☐ Benson
- ☐ Bisbee
- ☐ Douglas
- ☐ Safford
- ☐ Sierra Vista
- ☐ Tucson
- ☐ Willcox
- ☐ GSA Not Applicable

Attachment C
NETWORK DEVELOPMENT AND MANAGEMENT REPORT

PROGRAM CONTRACTOR:_____**DATE:** _____

ALTCS Contract, Paragraph 28, Network Management and Development Plan require the following items to be listed:

Non-Medicare Certified Home Health Agencies (HHA):

	Non-Medicare Certified HHA Name	AHCCCS ID#	Type of Services Provide	Geographic Area Served
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9				
10				

Use of a non-Medicare Home Health Agency(ies) is in compliance with AMPM Chapter 1200, Section 1240, ALTCS Services/Settings, Home Health Services.

List of Assisted Living Facilities for which the Contractor has already obtained a waiver from the Single Choice Occupancy requirement. Listing must include the name of the facility and the date of the waiver approval:

	Assisted Living Center	AHCCCS ID#	City / Area Served	Exception Period (10-07 to 9/08)
1.				
2.				
3.				
4.				
5.				

List of nursing facilities who have withdrawn from the Medicaid Program but are still being utilized by the Contractor. The listing must include the name of the facility and the number of residents the Contractor has in each facility:

	Nursing Facility	AHCCCS ID#	City / Area Served	Number of Residents
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Attachment D
Provider Terminations Due to Rates

Contractor Name: Date:

GSA # (Complete one table per GSA)

Provider Name	Provider ID	Provider Type	PCP	Provider Capacity	Reason for Termination	Attestation

GSA # (Complete one table per GSA)

Provider Name	Provider ID	Provider Type	PCP	Provider Capacity	Reason for Termination	Attestation

Attachment E
Providers that Diminished their Scope of Service and/or Closed their Panel

Contractor Name: Date:

GSA # (Complete one table per GSA)

Provider Name	Provider ID	Provider Type	Scope of Service Diminished	Panel Closed		Provider Capacity	Reason	Attestation

GSA # (Complete one table per GSA)

Provider Name	Provider ID	Provider Type	Scope of Service Diminished	Panel Closed		Provider Capacity	Reason	Attestation

416- PROVIDER NETWORK INFORMATION POLICY

Original Date: 12/13/07
Effective Date: 10/01/08
Revision Date: 08/12/10

Staff responsible for policy: DHCM Operations

I. Purpose

This policy applies to Acute Care and Arizona Long Term Care System (ALTCS) Contractors. This policy establishes guidelines for AHCCCS Acute and ALTCS Contractors regarding provider information requirements and it also pertains to the content of a Contractor's website.

II. Definitions

Material Change	A change which affects, or can reasonably be foreseen to affect, the Contractor's ability to meet the performance and network standards as described in the contract.
Provider	Any person or entity who contracts with AHCCCSA 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.

III. Policy

The Contract contains multiple requirements for communications between Contractors and their provider network. The list below instructs the Contractor on content and timing of these communications. The list does not supersede any additional requirements that may be outlined in the Contract.

A) Provider Manual

The Contractor shall develop, distribute and maintain a provider manual. The Contractor shall ensure that each contracted provider is made aware of a website provider manual or, if requested, issued a hard copy of the provider manual and is encouraged to distribute a provider manual to any individual or group that submits claim and encounter data. The Contractor remains liable for ensuring that all providers, whether contracted or not, meet the applicable AHCCCS requirements with regard to covered services, billing, etc. At a minimum, the

Contractor's provider manual must contain information on the following (items that apply to only ALTCS or Acute Contractors are identified in **bolded** parenthetical notation):

a. Introduction to the Contractor which explains the Contractor's organization and administrative structure
b. Provider responsibility and the Contractor's expectation of the provider
c. Overview of the Contractor's Provider Service department and function
d. Listing and description of covered and non-covered services, requirements and limitations including behavioral health services
e. Emergency room utilization (appropriate and non-appropriate use of the emergency room)
f. EPSDT Services - screenings include a comprehensive history, developmental/behavioral health screening, comprehensive unclothed physical examination, appropriate vision testing, hearing testing, laboratory tests, dental screenings and immunizations. EPSDT providers must document immunizations into ASIIS and enroll every year in the Vaccine for Children program.
g. Description of Dental services coverage and limitations
h. Description of Maternity/Family Planning services
i. The Contractor's policy regarding PCP assignments
j. Referrals to specialists and other providers, including access to behavioral health services. (as provided to Acute Care enrollees by the ADHS/RBHA system)
k. Grievance system process and procedures for providers and enrollees
l. Billing and encounter submission information
m. Information about policies and procedures relevant to the providers including, but not limited to, utilization management and claims submission
n. Reimbursement, including reimbursement for dual eligible members (i.e. Medicare and Medicaid) or members with other insurance
o. Cost sharing responsibility
p. Explanation of remittance advice
q. Prior authorization and notification requirements
r. Claims medical review
s. Concurrent review
t. Fraud and Abuse
u. Information on the False Claims Act provisions of the Deficit Reduction Act as required in the *Corporate Compliance* paragraph of the Contract.
v. Formulary information, including updates when changes occur, must be provided in advance to providers, including pharmacies. The Contractor is not required to send a hard copy, unless requested, of the formulary each time it is updated. A memo may be used to notify providers of updates and changes, and refer providers to view the updated formulary on the Contractor’s website.
w. AHCCCS appointment standards
x. Americans with Disabilities Act (ADA) requirements and Title VI, as applicable
y. Eligibility verification

z. Cultural competency information, including notification about Title VI of the Civil Rights Act of 1964. Providers should also be informed of how to access interpretation services to assist members who speak a language other the English or who use sign language.
aa. Peer review and appeal process.
bb. (**Acute Only**) Medication management services as described in the Acute Contract Section D, Paragraph 12.
cc. Information about a member's right to be treated with dignity and respect as specified in 42 CFR 438.100.
dd. Notification that the contractor has no policies which prevent the provider from advocating on behalf of the member as specified in 42 CFR 438.102.
ee. Information on how to access or obtain Practice Guidelines and coverage criteria for authorization decisions.
ff. (**ALTCS** Only) Description of the ALTCS Change of Program Contractor policy.

B) Website

The Contractor must develop and maintain a website capable of the following, provider focused, information and functionality [Section D, Technological Advancement]:

The website must have links to the items listed below:

a) Formulary (both Searchable and Comprehensive Listing)
b) Provider Manual (Must Contain Services Requiring Prior Authorization)
c) Provider Directory (including specialists for referral)
d) Performance Measure Results (Contractor-Specific and AHCCCS Program)
e) Medical Determination Criteria and Practice Guidelines

The Contractor must also provide the following electronic functionality:

a) Enrollment Verification
b) Claims Inquiry (adjustment requests; information on denial reasons)
c) Accept HIPAA compliant electronic claims transactions
d) Display Reimbursement Information

The Contractor will submit annually by November 15th the Contractor's Annual Website Certification form (ACOM 404, Attachment B) verifying that all required information is available and current on the Contractor's website.

C) Required Notifications

The Contractor is expected to provide written or electronic communication to contracted providers in the following instances:

a) **Exclusion from Network** – Under Federal Regulation [42 CFR 438.12] the Contractor is required to provide written notice of the reason for declining any written request for inclusion in the network.

b) **Policy/Procedure Change** – The Contractor is required to notify affected providers 30 days in advance of any material change, as defined in this policy, in Contractor policy or procedure. This requirement includes notification to providers in the event of a material change to network composition that may affect the ability to refer or place members for specialty care (e.g. termination of Orthopaedic group; SNF). Such notice must also be provided to the AHCCCS Division of Health Care Management Operations and Compliance Officer to which the Contractor is assigned 60 days in advance of the proposed change.
c) **Subcontract Updates** – Periodically, AHCCCS may make changes to the required Minimum Subcontract provisions. In the event of such a change, Contractors are required to amend all subcontracts on their regular renewal schedule or within 6 calendar months of the update, whichever comes first.
d) **Termination of Contract** – The Contractor must provide written notice to hospitals and/or provider groups at least 90 days prior to any contract termination without cause. Contracts between Contractors and individual practitioners are exempted.
e) **Chronic Care and Disease Management Information** – The Contractor must disseminate information as required by the AHCCCS Medical Policy Manual Policy 1020(H), MM/UM Program Scope and Requirements.

In addition to the updates required above, AHCCCS may require Contractors to disseminate information on behalf of the administration as stipulated in Section D Paragraph 29 of the Contract. In these instances, AHCCCS will provide prior notification as is deemed reasonable or prudent.

IV. References

- Title 42 of the Code of Federal Regulations (42 CFR) Part 438
- Arizona Administrative Code R9-22, Article 5
- Acute Care Contract, Section D
- ALTCS Contract, Section D

417 - APPOINTMENT AVAILABILITY MONITORING AND REPORTING POLICY

Original Date: 1/8/08
Effective Date: 10/1/08
Revision Date: 1/8/08

Staff responsible for policy: DHCM Operations

I. Purpose

This policy applies to Acute Care Contractors. This policy establishes a common process for AHCCCS Contractors to monitor and report the appointment availability and wait time100 of contracted Primary Care, Specialist, Dental and Maternity providers to ensure compliance with AHCCCS standards as set forth in Section D, Paragraph 33 of the contract.

II. Definitions

Established Patient: A Member that has received professional services from the physician or any other physician of the same specialty who belongs to the same group or practice, within the past three years.

New Patient: A Member that has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

Wait time: The time a patient has to wait in the provider's office beyond their scheduled appointment time.

III. Policy

A. Monitoring of Appointment Standards

1. Provider Appointment Availability Review: Contractors are required on a quarterly basis to review the availability of Routine, Urgent and Emergent appointments for Primary Care, Specialist and Dental providers. Contractors must also review these standards for Maternity Care providers relating to the first, second, and third trimesters and high risk pregnancies. Additionally, contractors must review the amount of time members must wait to be seen during a scheduled appointment by contracted providers. Contractors can utilize various methodologies to conduct this review including but not limited to: Appointment schedule review, secret shopper phone calls, etc. Contractors must conduct Provider Appointment Availability Reviews in sufficient quantity to ensure that results can be determined statistically significant.

2. Member Appointment Availability Review: Contractors must conduct Member Appointment Availability Reviews in sufficient quantity to ensure that results can be determined statistically significant regarding their experience with the availability of Primary Care, Specialist, Dental and Maternity Care appointments. This review must include the availability of Routine, Urgent and Emergent appointments as well as first, second, and third trimesters and high risk pregnancies. Contractors can utilize various methodologies to conduct this review including but not limited to: phone calls, monitoring of member complaints, etc.

B. Tracking and Reporting

1. Contractors must track the appointment availability on a quarterly basis for both New and Established Patients by Provider Type.

2. AHCCCS will review Contractor monitoring and corrective actions plans implemented as a result of provider non compliance of appointment standards, during annual Operational and Financial Reviews.

3. Contractors will submit the Appointment Availability Report, found in sections C and D, as a component of the Network Development and Management Plan along with an attestation of the validity of the methodologies utilized, including the statistical significance of the results, and a cover letter that summarizes the data; explains significant trending in either direction (positive or negative) and any interventions applied to areas of concern.

C. Instructions For Completing the Appointment Availability Provider Report: PCPs, Specialist, and Dentist

Section

Surveys: Enter the total number of provider surveys conducted for both New and Established patients for each provider type.

Pass: Enter total number of providers that were in compliance with the AHCCCS appointment standards.

Fail: Enter total number of providers that were not in compliance with the AHCCCS appointment standards.

Compliance Percentage: This column automatically calculates the percentage of providers that are compliant with the AHCCCS appointment standards.

Maternity Care

Section

Surveys: Enter the total number of provider surveys conducted with Maternity care providers related to compliance with the AHCCCS standards for initial prenatal care appointments.

Pass: Enter total number of providers that were in compliance with the AHCCCS appointment standards for maternity care.

Fail: Enter total number of providers that were not in compliance with the AHCCCS appointment standards for maternity care.

Compliance Percentage: This column automatically calculates the percentage of providers that are compliant with the AHCCCS appointment standards for maternity care.

Wait Times

Section

Surveys: Enter the total number of surveys conducted related to compliance with the AHCCCS wait time standards.

Pass: Enter total number of providers that were in compliance with the AHCCCS wait time standards.

Fail: Enter total number of providers that were not in compliance with the AHCCCS wait time standards.

Compliance Percentage: This column automatically calculates the percentage of providers that are compliant with the AHCCCS wait time standards.

D. Instructions For Completing the Appointment Availability Member Report: PCPs, Specialist, and Dentist

Section

Surveys: Enter the total number of member surveys conducted for both New and Established patients for each provider type.

Pass: Enter total number of providers that were in compliance with the AHCCCS appointment standards.

Fail: Enter total number of providers that were not in compliance with the AHCCCS appointment standards.

Compliance Percentage: This column automatically calculates the percentage of providers that are compliant with the AHCCCS appointment standards.

Maternity Care

Section

Surveys: Enter the total number of member surveys conducted with Maternity care providers related to compliance with the AHCCCS standards for initial prenatal care appointments.

Pass: Enter total number of providers that were in compliance with the AHCCCS appointment standards for maternity care.

Fail: Enter total number of providers that were not in compliance with the AHCCCS appointment standards for maternity care.

Compliance Percentage: This column automatically calculates the percentage of providers that are compliant with the AHCCCS appointment standards for maternity care.

Wait Times

Section

Surveys: Enter the total number of surveys conducted related to compliance with the AHCCCS wait time standards.

Pass: Enter total number of providers that were in compliance with the AHCCCS wait time standards.

Fail: Enter total number of providers that were not in compliance with the AHCCCS wait time standards.

Compliance Percentage: This column automatically calculates the percentage of providers that are compliant with the AHCCCS wait time standards.

IV. References

1. Title 42, Code of Federal Regulations (42CFR) 438.206 (c)(1)(i) [Availability of Services]
2. Title 42, Code of Federal Regulations (42CFR) 438.206 (c)(1)(iv), (v) and (vi) [Availability of Services]
3. AHCCCS Acute Care Contract, Section D

Appointment Availability Provider Report: PCPs, Specialist, and Dentist		Routine				Urgent				Emergent			
Provider Type		Surveys	Pass	Fail	Compliance Percentage	Surveys	Pass	Fail	Compliance Percentage	Surveys	Pass	Fail	Compliance Percentage
PCP	New												
	Established												
Specialist	New												
	Established												
Dentist	New												
	Established												
Total													

Maternity Care	Request	Surveys	Pass	Fail	Compliance Percentage
1st trimester	14 days				
2nd trimester	7 days				
3rd trimester	3 days				
High risk pregnancy	3 days*				
Total					

*within 3 days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists

Wait Times	Surveys	Pass	Fail	Compliance Percentage
PCP				
Specialist				
Total				

Member Appointment Availability Report PCPs, Specialist, and Dentist		Routine				Urgent				Emergent			
Provider Type		Surveys	Pass	Fail	Compliance Percentage	Surveys	Pass	Fail	Compliance Percentage	Surveys	Pass	Fail	Compliance Percentage
PCP	New												
	Established												
Specialist	New												
	Established												
Dentist	New												
	Established												
Total													

Maternity Care	Request	Surveys	Pass	Fail	Compliance Percentage
1st trimester	14 days				
2nd trimester	7 days				
3rd trimester	3 days				
High risk pregnancy	3 days*				
Total					

*within 3 days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists

Wait Times	Surveys	Pass	Fail	Compliance Percentage
PCP				
Specialist				
Total				

418 - PROVIDER AND AFFILIATE ADVANCE REQUEST POLICY

Original Date: 01/31/08
Effective Date: 10/01/08
Revision Date: 01/31/08

Staff responsible for policy: DHCM Operations (Acute Care and ALTCS)

I. Purpose

This policy applies to the Acute Care and ALTCS Contractors. The policy establishes the procedure for Contractor approval or notification to AHCCCS of provider and affiliate advances as required by Section D, Paragraph 49 of the Acute Care Contract and Section D, Paragraph 50 of the Arizona Long Term Care System (ALTCS) Contract.

II. For purposes of this policy definitions are as follows:

Affiliate (Related Party Transactions): Transactions with 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 the Contractor. Control, for purposes of this definition, means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of an enterprise through ownership, by contract, or otherwise. "Related parties" or "Affiliates" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, 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.

Advance: Includes but is not limited to payment to a provider by a Contractor which is based on an estimate of received but unpaid claims (RBUCS), an estimate of the value of erroneous claim denials (including underpayments), or as otherwise defined by the Contractor.

Day: Calendar day unless otherwise specified.

Provider: Any person or entity who submits a claim and receives payment for the provision of covered services to members according to the provisions of A.R.S. § 36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. § 36-2901. For the purposes of this policy, a Provider shall be further defined as all individuals associated by the same Tax Identification Number, utilized for claiming purposes.

III. Policy

A. Provider Advances

The Contractor shall submit written notification of any cumulative advance equal to or in excess of $50,000 per provider Tax Identification Number (TIN) within a contract year. For any individual advance equal to or in excess of $50,000 per provider Tax Identification Number (TIN) within a contract year, the Contractor must request approval from AHCCCS at least 10 days prior to disbursement of the funds. In exigent circumstances, AHCCCS may waive the 10 day notification requirement. All requests for approval must be submitted in writing to the Acute Care or ALTCS Operations and Compliance Officer in the format detailed below:

1. A detailed letter of explanation must be submitted that delineates:
    - A copy of the written communication that will serve as notification to the affected provider(s).
    - The provider(s) name(s) and AHCCCS Identification Number(s).
    - The date the provider and contractor initiated discussions relating to the need for an advance;
    - The systemic organizational causes resulting in the need for an advance;
    - The process that will be utilized to reconcile the funds against claims payments;
    - The anticipated timeline for the project ;
    - The corrective action(s) that will be implemented to avoid future occurrences; and
    - Total advance amount, and if applicable, the percentage that the advance amount is of total estimated amount that should have been paid, and range of dates (month / year) for the impacted claims.

2. Upon completion of the advance(s), AHCCCS may request that the Contractor make available within three working days a listing of the payments to be advanced, organized by provider Tax Identification Number if multiple providers are affected, that should include the following:
    - AHCCCS Member ID
    - Date of Service
    - Original Claim Number
    - Date of Payment
    - Amount Paid
    - Amount Advanced
    - Balance due to/from the provider

B. Routine/Scheduled Advances to Provider and Any Advances to Affiliates

Routine/scheduled advances to providers as a result of contractual arrangements or **any** advance to an affiliate must be submitted to AHCCCSA for prior approval. The request for approval must be submitted 30 days in advance of the effective date of the contractual arrangement or advance and 30 days prior to any amendments to contractual arrangements.

All contractual arrangements regarding routine/scheduled advances in existence at the start of new contract award resulting from a Request for Proposal must be reported to AHCCCS 15 days prior to the start of the new contract cycle.

AHCCCS may request additional information or periodic reconciliations related to these advances.

C. AHCCCS Responsibilities

All requests submitted will be reviewed by the Division of Health Care Management to evaluate the appropriateness of the Contractors plan to advance payment and resolve any future occurrences with accurate and timely claims payment. AHCCCS reserves the right to discuss any advance with the provider community to such extent as it is appropriate to determine the appropriate communication and approval action. Communication will be at the timing and discretion of AHCCCS.

DHCM will acknowledge all requests in writing through electronic mail upon receipt of the completed file. A written determination will be sent to the Contractor by electronic mail no later than 30 days from the date of receipt of all required information from the Contractor. Any request for which no response is sent within the 30 day timeframe above will be deemed approved by DHCM.

IV. References

Acute Care Contract Section D
ALTCS Contract, Section D

419 – ALTCS NETWORK STANDARDS

Effective Date: 10/01/2010; 10/01/2011; 01/25/2012
Revision Date: 01/18/2011; 01/25/2012

Staff responsible for policy: DHCM Operations

I. Purpose

This policy applies to ALTCS Program Contractors, (hereafter referred to as Contractors). Contractors shall develop and maintain a provider network that is supported by written agreements which is sufficient to provide all covered services to ALTCS members [42 CFR 438.206]. This policy establishes network standards for all levels (institutional, HCBS, acute, alternative residential, non-emergency transportation, etc.) by county and GSA. If established network standards are not met, it must be explained in the Network Development and Management Plan.

II. Definitions

Facility Location	The location of the provider within the county
GSA	Geographic Service Area, an area designated by the Administration 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. 28, Article 1.
LOI	Letter of Intent to contract with a provider
Services & Settings	Refer to ALTCS Contract for services and settings, Section D, Paragraph 10.

III. Policy

A. General Requirement

Program Contractors shall have contracted providers that represent the minimum providers for a county/GSA. The standard (either an "X" or a number of facilities/providers required in the tables below) will indicate the number of providers by a specific city, zone, facility location or countywide coverage.

Example:

- For Apache County, due to the limited availability of providers in rural areas, nursing facilities and HCBS Community settings have been set at the location of available providers. HCBS Home, Behavioral Health and Acute Services must be provided countywide.

- For Cochise County, the Program Contractor must have signed contracts with one nursing facility in Benson, one in Douglas, two in Sierra Vista and one in Willcox. HCBS Community settings have been established by the location of available providers. HCBS Home, Behavioral Health and most Acute Services must be provided county wide. Inpatient hospital standards have been set in Benson, Bisbee, Douglas, Sierra Vista and Willcox.

B. Geographic Service Areas (GSA)

Counties have been assigned to GSAs; Minimum Network Standards have been set by GSA.

County	GSA
Apache	44
Cochise	46
Coconino	44
Gila	40
Graham	46
Greenlee	46
La Paz	42
Maricopa	52
Mohave	44
Navajo	44
Pima	50
Pinal	40
Santa Cruz	50
Yavapai	48
Yuma	42

Apache County - GSA 44

	Springerville	St. Johns	Countywide Coverage	Facility Location
Long Term Care				
Nursing Facility				X
HCBS Community	**Must have 1 or more Assisted Living Facilities**			
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)				X
Behavioral Health Facilities (Level II, Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)				X
DD Group Home				X
HCBS Home				
Adult Day Health			X	
Attendant Care			X	
Emergency Alert			X	
Home Modifications			X	
Habilitation			X	
Home Health Care			X	
Home-Delivered Meals			X	
Homemaker			X	
Hospice			X	
Personal Care			X	
Respite Care			X	
Behavioral Health				
Inpatient Services			X	
Emergency Care			X	
Evaluation			X	
Individual, Group, Family Counseling			X	
Medication Monitoring			X	
Behavioral Health Day Program/Partial Care			X	
Psychosocial Rehabilitation			X	

Apache County - GSA 44

	Springerville	St. Johns	Countywide Coverage	Facility Location
Acute Services				
Dentist			X	
Durable Medical Equipment & Supplies			X	
Inpatient Hospital	X			
Laboratory			X	
Medical Imaging			X	
PCP	X	X		
Pharmacy	X	X		
Podiatrist			X	
Physician Specialists			X	
Therapies			X	
Transportation			X	

Cochise County - GSA 46

	Benson	Bisbee	Douglas	Sierra Vista	Willcox	Countywide Coverage	Facility Location
Long Term Care							
Nursing Facility	1		1	2	1		
HCBS Community	**Must have 10 or more Assisted Living Facilities**						
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)							X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)							X
DD Group Home							X
HCBS Home							
Adult Day Health						X	
Attendant Care						X	
Emergency Alert						X	
Home Modifications						X	
Habilitation						X	
Home Health Care						X	
Home-Delivered Meals						X	
Homemaker						X	
Hospice						X	
Personal Care						X	
Respite Care						X	
Behavioral Health							
Inpatient Services						X	
Emergency Care						X	
Evaluation						X	
Individual, Group, Family Counseling						X	
Medication Monitoring						X	
Behavioral Health Day Program/Partial Care						X	
Psychosocial Rehabilitation						X	

Cochise County - GSA 46 Continued

	Benson	Bisbee	Douglas	Sierra Vista	Willcox	Countywide Coverage	Facility Location
Acute Services							
Dentist						X	
Durable Medical Equipment & Supplies						X	
Inpatient Hospital	X	X	X	X	X		
Laboratory						X	
Medical Imaging						X	
PCP	X	X	X	X	X		
Pharmacy	X	X	X	X	X		
Podiatrist						X	
Physician Specialist						X	
Therapies						X	
Transportation						X	

Coconino County - GSA 44

	Flagstaff	Fredonia	Page	Sedona	Williams	Countywide Coverage	Facility Location
Long Term Care							
Nursing Facility	2			1			
HCBS Community	**Must have 6 or more Assisted Living Facilities**						
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)							X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)							X
DD Group Home							X
HCBS Home							
Adult Day Health						X	
Attendant Care						X	
Emergency Alert						X	
Home Modifications						X	
Habilitation						X	
Home Health Care						X	
Home-Delivered Meals						X	
Homemaker						X	
Hospice						X	
Personal Care						X	
Respite Care						X	
Behavioral Health							
Inpatient Services						X	
Emergency Care						X	
Evaluation						X	
Individual, Group, Family Counseling						X	
Medication Monitoring						X	
Behavioral Health Day Program/Partial Care						X	
Psychosocial Rehabilitation						X	

Coconino County - GSA 44 Continued

	Flagstaff	Fredonia	Page	Sedona	Williams	Countywide Coverage	Facility Location
Acute Services							
Dentist						X	
Durable Medical Equipment & Supplies						X	
Inpatient Hospital	X		X				
Laboratory						X	
Medical Imaging						X	
PCP	X	X	X	X	X		
Pharmacy	X		X	X	X		
Podiatrist						X	
Physician Specialists						X	
Therapies						X	
Transportation						X	

Gila County - GSA 40

	Globe/Miami/ Claypool	Payson	Hayden/ Winkelman	Countywide Coverage	Facility Location
Long Term Care					
Nursing Facility	2	2			
HCBS Community	**Must have 3 or more Assisted Living Facilities**				
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)					X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)					X
DD Group Home					X
HCBS Home					
Adult Day Health				X	
Attendant Care				X	
Emergency Alert				X	
Home Modifications				X	
Habilitation				X	
Home Health Care				X	
Home-Delivered Meals				X	
Homemaker				X	
Hospice				X	
Personal Care				X	
Respite Care				X	
Behavioral Health					
Inpatient Services				X	
Emergency Care				X	
Evaluation				X	
Individual, Group, Family Counseling				X	
Medication Monitoring				X	
Behavioral Health Day Program/Partial Care				X	
Psychosocial Rehabilitation				X	

Gila County - GSA 40 Continued

	Globe/Miami/ Claypool	Payson	Hayden/ Winkelman	Countywide Coverage	Facility Location
Acute Services					
Dentist				X	
Durable Medical Equipment & Supplies				X	
Inpatient Hospital	X	X			
Laboratory				X	
Medical Imaging				X	
PCP	X	X			
Pharmacy	X	X	X		
Podiatrist				X	
Physician Specialists				X	
Therapies				X	
Transportation				X	

Graham County - GSA 46

	Safford	Countywide Coverage	Facility Location
Long Term Care			
Nursing Facility	1		
HCBS Community	**Must have 3 or more Assisted Living Facilities**		
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)			X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)			X
DD Group Home			X
HCBS Home			
Adult Day Health		X	
Attendant Care		X	
Emergency Alert		X	
Home Modifications		X	
Habilitation		X	
Home Health Care		X	
Home-Delivered Meals		X	
Homemaker		X	
Hospice		X	
Personal Care		X	
Respite Care		X	
Behavioral Health			
Inpatient Services		X	
Emergency Care		X	
Evaluation		X	
Individual, Group, Family Counseling		X	
Medication Monitoring		X	
Behavioral Health Day Program/Partial Care		X	
Psychosocial Rehabilitation		X	

Graham County - GSA 46 Continued

	Safford	Countywide Coverage	Facility Location
Acute Services			
Dentist		X	
Durable Medical Equipment & Supplies		X	
Inpatient Hospital	X		
Laboratory		X	
Medical Imaging		X	
PCP	X		
Pharmacy	X		
Podiatrist		X	
Physician Specialists		X	
Therapies		X	
Transportation		X	

Greenlee County - GSA 46

	Clifton/Morenci	Countywide Coverage	Facility Location
Long Term Care			
Nursing Facility	Within 1 hour drive of Morenci		
HCBS Community			
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)			X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)			X
DD Group Home			X
HCBS Home			
Adult Day Health		X	
Attendant Care		X	
Emergency Alert		X	
Home Modifications		X	
Habilitation		X	
Home Health Care		X	
Home-Delivered Meals		X	
Homemaker		X	
Hospice		X	
Personal Care		X	
Respite Care		X	
Behavioral Health			
Inpatient Services		X	
Emergency Care		X	
Evaluation		X	
Individual, Group, Family Counseling		X	
Medication Monitoring		X	
Behavioral Health Day Program/Partial Care		X	
Psychosocial Rehabilitation		X	

Greenlee County - GSA 46 Continued

	Clifton/Morenci	Countywide Coverage	Facility Location
Acute Services			
Dentist		X	
Durable Medical Equipment & Supplies		X	
Inpatient Hospital	Within 1 hour drive of Morenci		
Laboratory		X	
Medical Imaging		X	
PCP	X		
Pharmacy	X		
Podiatrist		X	
Physician Specialists		X	
Therapies		X	
Transportation		X	

La Paz County - GSA 42

	Parker	Countywide Coverage	Facility Location
LONG TERM CARE			
Nursing Facility	Within 1 hour drive of Parker		
HCBS Community			
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)			X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)			X
DD Group Home			X
HCBS Home			
Adult Day Health		X	
Attendant Care		X	
Emergency Alert		X	
Home Modifications		X	
Habilitation		X	
Home Health Care		X	
Home-Delivered Meals		X	
Homemaker		X	
Hospice		X	
Personal Care		X	
Respite Care		X	
Behavioral Health			
Inpatient Services		X	
Emergency Care		X	
Evaluation		X	
Individual, Group, Family Counseling		X	
Medication Monitoring		X	
Behavioral Health Day Program/Partial Care		X	
Psychosocial Rehabilitation		X	

La Paz County - GSA 42 Continued

	Parker	Countywide Coverage	Facility Location
Acute Services			
Dentist		X	
Durable Medical Equipment & Supplies		X	
Inpatient Hospital	X		
Laboratory		X	
Medical Imaging		X	
PCP	X		
Pharmacy	X		
Podiatrist		X	
Physician Specialists		X	
Therapies		X	
Transportation		X	

Maricopa County – GSA 52

Part I – Institutional and Alternative Residential Settings

AHCCCS has divided Maricopa County into 9 zones (defined by zip code boundaries). The following tables list the required number of contracts for 4 key provider settings.

Zone 1 – Phoenix

Zone 1 is comprised of the following zip codes:

85022, 85023, 85024, 85027, 85029, 85032, 85046, 85054, 85050, 85053, 85085, 85086, 85087, 85254, 85324, 85331,85377

Setting	Standard	Facility Location Within Zone
Nursing Facility	4	X
Adult Foster Care	20	X
Assisted Living Center	4	X
Assisted Living Home	20	X

Zone 2 – Phoenix

Zone 2 is comprised of the following zip codes:

85012, 85013, 85014, 85015, 85016, 85017, 85018, 85019, 85020, 85021, 85028, , 85051, 85253, 85274

Setting	Standard	Facility Location Within Zone
Nursing Facility	8	X
Adult Foster Care	10	X
Assisted Living Center	6	X
Assisted Living Home	14	X

Zone 3 – Buckeye, Goodyear, Phoenix & Tolleson

Zone 3 is comprised of the following zip codes:

85031, 85033, 85035, 85037, 85043, 85320, 85322, 85323, 85326, 85338, 85339, 85353

Setting	Standard	Facility Location Within Zone
Nursing Facility	2	X
Adult Foster Care	2	X
Assisted Living Center	0	X
Assisted Living Home	10	X

Zone 4 – Phoenix

Zone 4 is comprised of the following zip codes:

85001, 85002, 85003, 85004, 85006, 85007, 85008, 85009, 85010, 85025, 85034, 85036, 85040, 85041, 85042, 85044, 85045, 85048, 85055, 85056, 85271

Setting	Standard	Facility Location Within Zone
Nursing Facility	5	X
Adult Foster Care	0	X
Assisted Living Center	2	X
Assisted Living Home	7	X

Zone 5 – Gila Bend, Glendale & Wickenburg

Zone 5 is comprised of the following zip codes:

85301, 85302, 85303, 85304, 85305, 85306, 85308, 85310, 85311, 85313, 85337, 85342, 85358, 85361, 85390

Setting	Standard	Facility Location Within Zone
Nursing Facility	3	X
Adult Foster Care	24	X
Assisted Living Center	4	X
Assisted Living Home	20	X

Zone 6 – El Mirage, Peoria, Sun City, Sun City West. & Surprise

Zone 6 is comprised of the following zip codes:

85275, 85307, 85309, 85335, 85340, 85345, 85351, 85355, 85361, 85363, 85372, 85373, 85374, 85375, 85376, 85379, 85380, 85381, 85382, 85383, 85387,85388,85396

Setting	Standard	Facility Location Within Zone
Nursing Facility	8	X
Adult Foster Care	4	X
Assisted Living Center	10	X
Assisted Living Home	16	X

Zone 7 – Carefree, Cave Creek, Fountain Hills & Scottsdale

Zone 7 is comprised of the following zip codes:

85250, 85251, 85255, 85256, 85257, 85258, 85259, 85260, 85262, 85263, 85264, 85268

Setting	Standard	Facility Location Within Zone
Nursing Facility	6	X
Adult Foster Care	4	X
Assisted Living Center	2	X
Assisted Living Home	2	X

Zone 8 – Mesa, Tempe

Zone 8 is comprised of the following zip codes:

85201, 85202, 85203, 85204, 85205, 85206, 85207, 85208, 85209, 85210, 85212, 85213, 85215, 85218, 85219, 85220, 85256, 85281, 85282

Setting	Standard	Facility Location Within Zone
Nursing Facility	8	X
Adult Foster Care	5	X
Assisted Living Center	8	X
Assisted Living Home	20	X

Zone 9 – Chandler, Tempe, Gilbert, Queen Creek & Sunlakes

Zone 9 is comprised of the following zip codes:

85222, 85224, 85225, 85226, 85227, 85233, 85234, 85236, 85242, 85243, 85246, 85248, 85249, 85283, 85284, 85296, 85297

Setting	Standard	Facility Location Within Zone
Nursing Facility	4	X
Adult Foster Care	2	X
Assisted Living Center	4	X
Assisted Living Home	20	X

TOTAL FOR ZONES 1 THROUGH 9

Setting	Standard
Nursing Facility	48
Adult Foster Care	71
Assisted Living Center	40
Assisted Living Home	129

Maricopa County – GSA 52

Part II – Acute Care, Behavioral Health and Home and Community Based Services

In addition to the standards for the 4 settings covered in Part I, Part II delineates the standards for coverage of acute care, behavioral health and home and community based services. Inpatient Hospitals, PCP Services and Pharmacy Services have city-specific requirements. Countywide coverage is required for all other covered services. Also see Section D, Paragraph 28, Network Development for further requirements.

ACUTE CARE SERVICES CITIES

Inpatient Hospitals
- Metropolitan Phoenix **
- Wickenburg

PCP
- Avondale/Goodyear/Laveen
- Litchfield Park/Tolleson
- Buckeye
- Gila Bend
- Metropolitan Phoenix **
- Queen Creek
- Wickenburg

Pharmacy
- Avondale/Goodyear/Laveen
- Litchfield Park/Tolleson
- Buckeye
- Metropolitan Phoenix **
- Wickenburg

**For purposes of the RFP/Contract, Metropolitan Phoenix encompasses the following:
Phoenix, Paradise Valley, Cave Creek/Carefree, Fountain Hills, Scottsdale, Glendale, Sun City/Sun City West, Tempe, Mesa, Gilbert, Chandler, Apache Junction, Peoria, El Mirage, Surprise and Youngtown. Offerors/Program Contractors are expected to contract with at least one PCP and one pharmacy in each of these cities. Additionally, within this area, standards must be met as specified in Section D: Program Requirements, Paragraph 28. Network Development.

For inpatient hospital services, Offerors/Program Contractors are expected to contract with at least one hospital in the Central District (Zones 1, 2 &4), at least one in the Northwest District (Zones 3, 5, 6 & 7) and at least one in the Southeast District (Zones 8 & 9).

County-wide Coverage*
Services include but are not limited to the following:

Acute Care Services
- Dentist
- Durable Medical Equipment & Supplies
- Laboratory
- Medical Imaging
- Podiatrist
- Physician Specialists
- Therapies
- Transportation

HCBS Services
- Adult Day Health Care
- Attendant Care
- Emergency Alert
- Home Modifications
- Habilitation
- Home Health Care
- Home-Delivered Meals
- Homemaker
- Hospice
- Personal Care
- Respite Care

Maricopa County – GSA 52

Part II – Acute Care, Behavioral Health and Home and Community Based Services

County-wide Coverage*

Behavioral Health Facilities
- Level II, Behavioral Health
- Level III, Behavioral Health
- Rural Substance Abuse Transitional Agency

Behavioral Health
- Emergency Care
- Evaluation
- Individual, Group, family Counseling
- Partial Care
- Medication Monitoring
- Behavioral Health Day program/Partial care
- Psychosocial Rehabilitation

County-wide Coverage

- DDD Group Home

* See Section D. Program Requirements, Paragraph 10. Covered Services, for a complete listing of services to be provided

Mohave County - GSA 44

	Bullhead City	Kingman	Lake Havasu City	Countywide Coverage	Facility Location
Long Term Care					
Nursing Facility	1	2	2		
HCBS Community	**Must have LOI* with 28 or more Assisted Living Facilities**				
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)					X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)					X
DD Group Home					X
HCBS Home					
Adult Day Health				X	
Attendant Care				X	
Emergency Alert				X	
Home Modifications				X	
Habilitation				X	
Home Health Care				X	
Home-Delivered Meals				X	
Homemaker				X	
Hospice				X	
Personal Care				X	
Respite Care				X	
Behavioral Health					
Inpatient Services				X	
Emergency Care				X	
Evaluation				X	
Individual, Group, Family Counseling				X	
Medication Monitoring				X	
Behavioral Health Day Program/Partial Care				X	
Psychosocial Rehabilitation				X	

Mohave County - GSA 44 Continued

	Bullhead City	Kingman	Lake Havasu City	Countywide Coverage	Facility Location
Acute Services					
Dentist				X	
Durable Medical Equipment & Supplies				X	
Inpatient Hospital	X	X	X		
Laboratory				X	
Medical Imaging				X	
PCP	X	X	X		
Pharmacy	X	X	X		
Podiatrist				X	
Physician Specialists				X	
Therapies				X	
Transportation				X	

Navajo County - GSA 44

	Winslow	Show Low/ Pinetop/ Lakeside	Snowflake/ Taylor	Holbrook	Countywide Coverage	Facility Location
LONG TERM CARE						
Nursing Facility	1	1				
HCBS Community	**Must have LOI* with 5 or more Assisted Living Facilities**					
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)						X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)						X
DD Group Home						X
HCBS Home						
Adult Day Health					X	
Attendant Care					X	
Emergency Alert					X	
Home Modifications					X	
Durable Medical Equipment					X	
Home Health Care					X	
Home-Delivered Meals					X	
Homemaker					X	
Hospice					X	
Personal Care					X	
Respite Care					X	
Behavioral Health						
Inpatient Services					X	
Emergency Care					X	
Evaluation					X	
Individual, Group, Family Counseling					X	
Medication Monitoring					X	
Behavioral Health Day Program/Partial Care					X	
Psychosocial Rehabilitation					X	

Navajo County - GSA 44 Continued

	Winslow	Show Low/ Pinetop/ Lakeside	Snowflake/ Taylor	Holbrook	Countywide Coverage	Facility Location
Acute Services						
Dentist					X	
Durable Medical Equipment & Supplies					X	
Inpatient Hospital	X	X				
Laboratory					X	
Medical Imaging					X	
PCP	X	X	X	X		
Pharmacy	X	X	X	X		
Podiatrist					X	
Physician Specialists					X	
Therapies					X	
Transportation					X	

Pima County – GSA 50

AHCCCS has divided Tucson in Pima County into 4 zones (defined by zip code boundaries). The following tables list the standard Number of Nursing Facilities and Assisted Living Facility LOI/contracts within each zone.

Tucson - Northwest Zone

The Northwest Zone is comprised of the following zip codes:
85321, 85653, 85654, 85701, 85704, 85705, 85737, 85738, 85741, 85742, 85743, 85745

Long Term Care	Northwest Zone	Facility Location Within the Zone
Nursing Facility	3	X
HCBS Community	**Must have 16 or more Assisted Living Facilities**	
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)		X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)		X
DD Group Home		X

Tucson - Southwest Zone

The Southwest Zone is comprised of the following zip codes: (Includes Green Valley)
85601, 85614, 85713, 85714, 85723, 85724, 85735, 85736, 85746

Long Term Care	Southwest Zone	Facility Location Within the Zone
Nursing Facility	2	X
HCBS Community	**Must have 10 or more Assisted Living Facilities**	
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)		**X**
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)		X
DD Group Home		X

Pima County – GSA 50 Continued

Tucson - Northeast Zone

The Northeast Zone is comprised of the following zip codes:
85619, 85702, 85712, 85715, 85716, 85717, 85718, 85719, 85731, 85739, 85749

Long Term Care	Northeast Zone	Facility Location Within the Zone
Nursing Facility	8	X

HCBS COMMUNITY	**Must have 14 or more Assisted Living Facilities of which 2 must be Assisted Living Centers**
Assisted Living Facilities (Adult Foster Care, Assisted Living Home)	**X**
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)	X
DD group Home	X

Tucson - Southeast Zone

The Southeast Zone is comprised of the following zip codes: (Includes Sahuarita)
85601, 85629, 85641, 85706, 85708, 85710, 85711, 85730, 85732, 85734, 85747, 85748 85757,

Long Term Care	Southeast Zone	Facility Location Within the Zone
Nursing Facility	1	X

HCBS COMMUNITY	**Must have 37 or more Assisted Living Facilities of which 2 must be Assisted Living Centers**
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)	**X**
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)	X
DD Group Home	X

Pima County - GSA 50 Continued

HCBS HOME	Tucson	Green Valley	Countywide Coverage	Facility Location
Adult Day Health			X	
Attendant Care			X	
Emergency Alert			X	
Home Modifications			X	
Habilitation			X	
Home Health Care			X	
Home-Delivered Meals			X	
Homemaker			X	
Hospice			X	
Personal Care			X	
Respite Care			X	

Behavioral Health				
Inpatient Services			X	
Emergency Care			X	
Evaluation			X	
Individual, Group, Family Counseling			X	
Medication Monitoring			X	
Behavioral Health Day Program/Partial Care			X	
Psychosocial rehabilitation			X	

Acute Services				
Dentist			X	
Durable Medical Equipment & Supplies			X	
Inpatient Hospital	X			
Laboratory			X	
Medical Imaging			X	
PCP	X	X		
Pharmacy	X	X		
Podiatrist			X	
Physician Specialists			X	
Therapies			X	
Transportation			X	

Pinal County - GSA 40

	Apache Junction	Casa Grande	Coolidge	Eloy	Florence	Kearney	Mammoth/ San Man./ Oracle	County-wide Coverage	Facility Location
Long Term Care									
Nursing Facility	*1 – A.J. **5 – E. V.	1					3 - Tucson		
HCBS Community	**Must have 17 or more Assisted Living Facilities**								
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)									X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)									X
DD Group Home									X
HCBS Home									
Adult Day Health								X	
Attendant Care								X	
Emergency Alert								X	
Home Modifications								X	
Habilitation								X	
Home Health Care								X	
Home-Delivered Meals								X	
Homemaker								X	
Hospice								X	
Personal Care								X	
Respite Care								X	
Behavioral Health									
Inpatient Services								X	
Emergency Care								X	
Evaluation								X	
Individual, Group, Family Counseling								X	
Medication Monitoring								X	
Behavioral Health Day Program/Partial Care								X	
Psychosocial Rehabilitation								X	

Pinal County - GSA 40 Continued

	Apache Junction	Casa Grande	Coolidge	Eloy	Florence	Kearney	Mammoth/ San Man./ Oracle	County-wide Coverage	Facility Location
Acute Services									
Dentist								X	
DME & Supplies								X	
Inpatient Hospital		X							
Laboratory								X	
Medical Imaging								X	
PCP	X	X	X	X	X	X	X		
Pharmacy	X	X	X		X	X	X		
Podiatrist								X	
Physician Specialist								X	
Therapies								X	
Transportation								X	

*1 – Apache Junction; **5– East Valley, Maricopa County

Santa Cruz County - 50

	Nogales	Countywide Coverage	Facility Location
Long Term Care			
Nursing Facility	1		
HCBS Community	**Must have LOI* with 3 or more Assisted Living Facilities**		
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)			X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)			X
DD Group Home			X
HCBS Home			
Adult Day Health		X	
Attendant Care		X	
Emergency Alert		X	
Home Modifications		X	
Habilitation		X	
Home Health Care		X	
Home-Delivered Meals		X	
Homemaker		X	
Hospice		X	
Personal Care		X	
Respite Care		X	
Behavioral Health			
Inpatient Services		X	
Emergency Care		X	
Evaluation		X	
Individual, Group, Family Counseling		X	
Medication Monitoring		X	
Behavioral Health Day Program/Partial Care		X	
Psychosocial Rehabilitation		X	

Santa Cruz County – 50 Continued

	Nogales	Countywide Coverage	Facility Location
Acute Services			
Dentist		X	
Durable Medical Equipment & Supplies		X	
Inpatient Hospital	X		
Laboratory		X	
Medical Imaging		X	
PCP	X		
Pharmacy	X		
Podiatrist		X	
Physician Specialist		X	
Therapies		X	
Transportation		X	

Yavapai County - GSA 48

	Cottonwood	Prescott	Camp Verde	Sedona	Prescott Valley	Countywide Coverage	Facility Location
Long Term Care							
Nursing Facility	1	3	1	1	1		
HCBS Community	**Must have 20 or more Assisted Living Facilities**						
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)							X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)							X
DD Group Home							X
HCBS Home							
Adult Day Health						X	
Attendant Care						X	
Emergency Alert						X	
Home Modifications						X	
Habilitation						X	
Home Health Care						X	
Home-Delivered Meals						X	
Homemaker						X	
Hospice						X	
Personal Care						X	
Respite Care						X	
Behavioral Health							
Inpatient Services						X	
Emergency Care						X	
Evaluation						X	
Individual, Group, Family Counseling						X	
Medication Monitoring						X	
Behavioral Health Day Program/Partial Care						X	
Psychosocial Rehabilitation						X	

Yavapai County - GSA 48

	Cottonwood	Prescott	Camp Verde	Sedona	Prescott Valley	Countywide Coverage	Facility Location
Acute Services							
Dentist						X	
Durable Medical Equipment & Supplies						X	
Inpatient Hospital	X	X					
Laboratory						X	
Medical Imaging						X	
PCP	X	X	X	X	X		
Pharmacy	X	X	X	X	X		
Podiatrist						X	
Physician Specialists						X	
Therapies						X	
Transportation						X	

Yuma County - GSA 42

	Yuma	Countywide Coverage	Facility Location
Long Term Care			
Nursing Facility	4		
HCBS Community	**Must have 11 or more Assisted Living Facilities**		
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)			X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)			X
DD Group Home			X
HCBS Home			
Adult Day Health		X	
Attendant Care		X	
Emergency Alert		X	
Environmental Modifications		X	
Habilitation		X	
Home Health Care		X	
Home-Delivered Meals		X	
Homemaker		X	
Hospice		X	
Personal Care		X	
Respite Care		X	
Behavioral Health			
Inpatient Services		X	
Emergency Care		X	
Evaluation		X	
Individual, Group, Family Counseling		X	
Medication Monitoring		X	
Behavioral Health Day Program/Partial Care		X	
Psychosocial Rehabilitation		X	

Yuma County - GSA 42 Continued

	Yuma	Countywide Coverage	Facility Location
Acute Services			
Dentist		X	
Durable Medical Equipment & Supplies		X	
Inpatient Hospital	X		
Laboratory		X	
Medical Imaging		X	
PCP	X		
Pharmacy	X		
Podiatrist		X	
Physician Specialist		X	
Therapies		X	
Transportation		X	

IV. References

- ALTCS Contract, Section D, Paragraph 28, Network Development
- ALTCS Contract Section D, Paragraph 29, Network Management
- ACOM Network Management and Development Policy
- ACOM Network Summary Policy

420 – ALTCS NETWORK SUMMARY

Effective Date: 05/01/2012
Revision Date: 01/28/2011, 10/1/2011, 2/09/2012, 4/12/2012

Staff responsible for policy: DHCM Operations

I. Purpose

To establish a Contractor reporting requirement and format regarding the Contractor's contracted network in order for AHCCCS to monitor network adequacy and compliance with contractual requirements. The Network Summary is an integral part of this monitoring process.

II. Definitions

DES/DDD	The Department of Economic Security's Division of Developmental Disabilities.
District	A DES/DDD service district.
Facility Location:	The location of the provider within the county
GSA:	Geographic Service Area, an area designated by the Administration 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. 28, Article 1.
ICF	Intermediate Care Facility for persons with intellectual disabilities.
Services & Settings**:**	Refer to ALTCS Contract for services and settings, Section D, Paragraph 10.
Zones:	Maricopa and Pima Counties have been divided into zones by zip codes for the nursing facilities and HCBS Community. Maricopa County zones are numbered 1 through 9. Pima County has been divided into 4 zones: Northeast, Northwest, Southeast and Southwest. Network Standards have been set for each zone as outlined in the ACOM ALTCS Network Standards Policy.

III. Policy

A. General Requirement

On October 15 and April 15 all Contractors must submit information about each individual provider within their network. Each contractor will be responsible for submitting true and valid information. Submission of false or erroneous information may result in sanctions imposed upon the Contractor.

The Network Summary listing of the provider network must be submitted in an Excel spreadsheet in the format listed below and must be sent by e-mail or uploaded to the SFTP server. The format for the provider listing must not deviate from the authorized format including the column and row titles and the data to be listed.

The Network Rosters have been set up by GSA/District. Each GSA/District file contains worksheets for Nursing Facilities, HCBS Community, HCBS Home, Behavioral Health and Acute Care Providers. The worksheets have been set up to enter provider information by county and by service and/or setting. Individual providers (i.e., PCPs, Specialists, etc.) should be listed last name (,) first name when applicable. Examples of the GSA/District Network Rosters are found below in this Policy. For Network Roster Templates by GSA/District contact a Division of Health Care Management ALTCS Operational and Compliance Officer.

B. Geographic Service Areas (GSA) – E/PD Contractors only.

Counties have been assigned to GSAs; Minimum Network Standards have been set by GSA.

County Code	County	GSA
01	Apache	44
03	Cochise	46
05	Coconino	44
07	Gila	40
09	Graham	46
11	Greenlee	46
29	La Paz	42
13	Maricopa	52
15	Mohave	44
17	Navajo	44
19	Pima	50
21	Pinal	40
23	Santa Cruz	50
25	Yavapai	48
27	Yuma	42

C. Districts

DES/DDD has assigned districts. DES/DDD will use the following codes for district reporting.

District Code	District
31	Central
32	East
33	South
34	North
35	West

D. Contractor Identification Numbers (PC ID #)

	Contractor	*Contractor Identification Number (PC ID #)*
1	Bridgeway Health Solutions	110088
2	DES/DDD	110007
3	Evercare Select	110049
4	Mercy Care Plan – LTC	110306
5	SCAN Long Term Care	110097

E. ATTACHMENT A – Network Summary Template
Click on "Attachment A" to go to the Excel Network Summary Template

ICF/NURSING FACILITIES NETWORK ROSTER

(1) No.	(2) PC ID #	(3) County Code	(4) Zone	(5) Provider Type	(6) AHCCCS Provider No.	(7) Name	(8) Address	(9) City	(10) State	(11) Zip Code	(12) Telephone	(13) Contact Person	(14) Limitations/Restrictions

ICF/Nursing Facilities Network Roster

Name: Insert name of Contractor or Offeror.

GSA/District: Geographic Service Area or DES/DDD districts. For E/PD contractors counties have been assigned to GSAs: See Section III (B) for GSA numbers. Insert appropriate GSA Number where indicated on the Network Summary. See ACOM ALTCS Network Standards Policy for the appropriate County/GSA standards. DES/DDD designates service areas into districts. See Section III (C) for District Codes. Insert the appropriate District Code where indicated on the Network summary.

(1) No: The row number for each provider is listed. If you require additional rows insert the rows and number accordingly.

(2) PC ID #: See above listing for Contractor and Identification Number (ID#) affiliation.

(3) County Code: See above listing for County Code.

(4) Zone: Insert the Zone number in which the facility resides. See ACOM ALTCS Network Standards Policy for the appropriate Zone number.

(5) Provider Type: If the provider is an AHCCCS registered provider insert the Provider Type (See AMPM 610-01 or the Bidder's Library for a list of provider types). If the Provider is not registered with AHCCCS at this time, place "XX" in the Column.

NOTE: in the event of a Contract Award, the Contractor must ensure the Provider has registered with AHCCCS prior to providing services to members.

(6) AHCCCS Provider Identification No: Insert the AHCCCS assigned number identifying the provider. If the Provider does not have a number leave the row blank.

(7) Name: The actual name of the facility. Do not use the corporation name.

(8) Address: The address where the facility is located. Do not use the billing address if different from where the member will receive the service.

(9) City: The city where the facility is located.

(10) State: State where the facility is located.

(11) Zip Code: Zip Code for the facility's location.

(12) Telephone: The telephone number of the contact person.

(13) Contact Person: The name of the person to contact.

(14) Limitations or Restrictions: List any limitations or restrictions the Contractor has with the provider. Listed below are examples of restrictions and limitations. These examples are not meant to be an inclusive list; any limitations or restrictions should be noted.

a) Contractor has a Long Term Care setting which will only allow current members to continue in the facility.

b) Contractor has a Long Term Care setting which will allow only sub-acute/specialty admission.

NOTE: ICF/Nursing Facilities must be listed sequentially by zone as follows:

Maricopa County zones - 1 through 9

Pima County zones – NE, NW, SE, SW

See ACOM ALTCS Network Standards Policy for zone definitions by zip code

HCBS COMMUNITY NETWORK ROSTER

(1) No.	(2) PC ID #	(3) County Code	(4) Zone	(5) Provider Type	(6) AHCCCS Provider No.	(7) Name	(8) Address	(9) City	(10) State	(11) Zip Code	(12) Telephone	(13) Contact Person	(14) Limitations/Restrictions

HCBS Community Roster. (DES/DDD - Do not report independent contractors here.)

Name: Insert name of Contractor or Offeror.

GSA/District: Geographic Service Area or DES/DDD districts. For E/PD contractors counties have been assigned to GSAs: See Section III (B) for GSA numbers. Insert appropriate GSA Number where indicated on the Network Summary. See ACOM ALTCS Network Standards Policy for the appropriate County/GSA standards. DES/DDD designates service areas into districts. See Section III (C) for District Codes. Insert the appropriate District Code where indicated on the Network summary.

(1) No: The row number for each provider is listed. If you require additional rows insert the rows and number accordingly.

(2) PC ID #: See above listing for Contractor and Identification Number (ID#) affiliation.

(3) County Code: See above listing.

(4) Zone: Insert the Zone number in which the facility resides. See ACOM ALTCS Network Standards Policy for the appropriate Zone number.

(5) Provider Type: If the provider is an AHCCCS registered provider insert the Provider Type (See AMPM 610-01.). If the Provider is not registered with AHCCCS at this time, place "XX" in the Column.

NOTE: in the event of a Contract Award, the Contractor must ensure the Provider has registered with AHCCCS prior to providing services to members.

(6) AHCCCS Provider Identification No: Insert the AHCCCS assigned number identifying the provider. If the Provider does not have an identification leave row blank.

(7) Name: The actual name of the provider. Do not use the corporation name.

(8) Address: The address where the Provider's office is located. Do not use the billing address if different from where the member will receive the service.

(9) City: The city where the community setting/facility is.

(10) State: State where the community setting/facility is.

(11) Zip Code: Zip Code for the community setting/facility address.

(12) Telephone: The telephone number of the contact person

(13) Contact Person: The name of the person to contact.

(14) Limitations or Restrictions: List any limitations or restrictions the Contractor has with the provider. Listed below are examples of restrictions and limitations. These examples are not meant to be an inclusive list; any limitations or restrictions should be noted.

(a) Contractor has an Assisted Living Facility setting which will only allow current residents who become eligible for the ALTCS program to continue in the facility.

(b) Contractor has an Assisted Living Home that only admits head injury members with behavior management issues.

NOTE: HCBS Settings must be listed sequentially by zone as follows:

Maricopa County zones - 1 through 9

Pima County zones – NE, NW, SE, SW

See ACOM ALTCS Network Standards Policy for zone definitions by zip code

												(13) SERVICES PROVIDED											
(1) No.	(2) PC ID #	(3) Cty. Code	(4) Prov. Type	(5) AHCCCS Provider No.	(6) Name	(7) Address	(8) City	(9) State	(10) Zip Code	(11) Tel.	(12) Cont. Person	Adult Day Hlth. Y/N	Attend. Care Y/N	Emer. Alert Y/N	Envir. Mod. Y/N	Hab. Y/N	Home Hlth. Care Y/N	HDM Y/N	Home-Maker Y/N	Hosp. Y/N	Persn. Care Y/N	Resp. Y/N	(1 DI Pl
1.																							
2.																							
3.																							
4.																							
5.																							

HCBS HOME NETWORK ROSTER

HCBS Home Roster. (DES/DDD - Do not report independent contractors here).

Name: Insert name of Contractor or Offeror.

GSA/District: Geographic Service Area or DES/DDD districts. For E/PD contractors counties have been assigned to GSAs: See Section III (B) for GSA numbers. Insert appropriate GSA Number where indicated on the Network Summary. See ACOM ALTCS Network Standards Policy for the appropriate County/GSA standards. DES/DDD designates service areas into districts. See Section III (C) for District Codes. Insert the appropriate District Code where indicated on the Network summary.

(1) No: The row number for each provider is listed. If you require additional rows insert the rows and number accordingly.

(2) PC ID #: See above listing for Program Contractor and Identification Number (ID#) affiliation.

(3) County Code: See above listing.

(4) Provider Type: If the provider is an AHCCCS registered provider insert the Provider Type (See AMPM 610-01 or the Bidder's Library for a list of provider types). If the Provider is not registered with AHCCCS at this time, place "XX" in the Column.

NOTE: in the event of a Contract Award, the Contractor must ensure the Provider has registered with AHCCCS prior to providing services to members.

(5) AHCCCS Provider Identification No: Insert the AHCCCS assigned number identifying the provider. If the Provider does not have an identification leave row blank.

(6) Name: The actual name of the provider. Do not use the corporation name.

(7) Address: The address where the Provider is located.

(8) City: The city where the Provider is located.

(9) State: State where the Provider is located.

(10) Zip Code: Zip Code for the Provider's address.

(11) Telephone: The telephone number of the contact person.

(12) Contact Person: The name of the person to contact.

(13) Services Provided: For each provider listed, place a "Y" in the column to indicate what services are contracted to be provided. A provider may have several "Y"s.

(14) DCW Plan: The Provider's plan for complying with the Direct Care Worker Training and Testing program requirements beginning October 1, 2012. Place "AP" in the column for Providers that plan to or have already become an Approved Training Program to train their direct care workers. Place a "C" in the column for Providers that plan to or have already contracted with an Approved Training Program to train their direct care workers.

NOTE: The requirement is only applicable to Providers that provide Attendant Care, Personal Care and Homemaker services. Use line 16 "Limitations and Restrictions" to note Providers to whom the requirement is not applicable (e.g. Providers of Respite or Habilitation services only).

(15) DCW Plan Effective Date: The date the Provider's plan will be in effect to comply with the Direct Care Worker Training and Testing program requirements beginning October 1, 2012. Provide the date (XX-XX-XX) the plan noted in column 14 will be in effect.

(16) Limitations or Restrictions: List any limitations or restrictions the Contractor has with the provider. Listed below are examples of restrictions and limitations. These examples are not meant to be an inclusive list; any limitations or restrictions should be noted.

(a) The Provider provides services within the Prescott city limits only.

BEHAVIORAL HEALTH NETWORK ROSTER

												(13) SERVICES PROVIDED									
(1) No.	(2) PC ID #	(3) Cty Code	(4) Prov Type	(5) AHCCCS Provider No.	(6) Name	(7) Address	(8) City	(9) State	(10) Zip Code	(11) Tel.	(12) Contact Person	Inpat Ser Y/N	Emer. Care Y/N	Eval. Y/N	Ind Grp Fmly Coun. Y/N	Med Monit Y/N	Psych Rehab Y/N	BH Day/ Partial Care Y/N	(14) Serv In Setting Y/N	(15) Limit Restrict

Behavioral Health Roster (Only ALTCS E/PD Contractors)

Name: Insert name of Contractor or Offeror.

GSA: Geographic Service Area, counties have been assigned to GSAs: See Section III (B) for GSA numbers. Insert appropriate GSA Number where indicated on the Network Summary. See ACOM ALTCS Network Standards Policy for the appropriate County/GSA standards.

(1) No: The row number for each provider is listed. If you require additional rows insert the rows and number accordingly.

(2) PC ID #: See above listing for Contractor and Identification Number (ID#) affiliation.

(3) County Code: See above listing.

(4) Provider Type: If the provider is an AHCCCS registered provider insert the Provider Type (See AMPM 610-01 or the Bidder's Library for a list of provider types). If the Provider is not registered with AHCCCS at this time, place "XX" in the Column.

NOTE: in the event of a Contract Award, the Contractor must ensure the Provider has registered with AHCCCS prior to providing services to members.

(5) AHCCCS Provider Identification No: Insert the AHCCCS assigned number identifying the provider. If the Provider does not have an identification leave row blank.

(6) Name: The actual name of the provider. Do not use the corporation name.

(7) Address: The address where the Provider is located.

(8) City: The city where the Provider is located.

(9) State: State where the Provider is located.

(10) Zip Code: Zip Code for the service address.

(11) Telephone: The telephone number of the contact person.

(12) Contact Person: The name of the person to contact.

(13) Services Provided: For each provider listed, place a "Y" in the column to indicate what services are contracted to be provided. A provider may have several "Y"s.

(14) Services Provided in the Member's Residence: Place a "Y" in the column to indicate when a service is provided in the Member's residence (i.e., Nursing Facility, HCBS Community, HCBS Home, etc.)

(15) Limitations or Restrictions: List any limitations or restrictions the Contractor has with the provider. Listed below are examples of restrictions and limitations. These examples are not meant to be an inclusive list; any limitations or restrictions should be noted.

a) Contractor has services available for children and young adults only.

b) The Provider has services only within the city limits of Prescott.

ACUTE SERVICES NETWORK ROSTER

(1) No.	(2) PC ID #	(3) County Code	(4) Provider Type	(5) AHCCCS Provider No.	(6) Name	(7) Address	(8) City	(9) State	(10) Zip Code	(11) Telephone	(12) Contact Person	(13) Limitations/ Restrictions

Acute Care Services Roster

Name: Insert name of Contractor or Offeror. (Only ALTCS E/PD Contractors)

GSA: Geographic Service Area, counties have been assigned to GSAs: See Section III (B) for GSA numbers. Insert appropriate GSA Number where indicated on the Network Summary. See ACOM ALTCS Network Standards Policy for the appropriate County/GSA standards.

(1) No: The row number for each provider is listed. If you require additional rows insert the rows and number accordingly.

(2) PC ID #: See above listing for Contractor and Identification Number (ID#) affiliation.

(3) County Code: See above listing.

(4) Provider Type: If the provider is an AHCCCS registered provider insert the Provider Type (See AMPM 610-01 or the Bidder's Library for a list of provider types). If the Provider is not registered with AHCCCS at this time, place "XX" in the Column.

NOTE 1: In the event of a Contract Award, the Contractor must ensure the Provider has registered with AHCCCS prior to providing services to members.

NOTE 2: Providers listed under PCP services should meet the definition of a PCP in RFP Section D, Paragraph 10. Physician specialists, i.e., cardiologists, should be listed on the Acute Care Services – Physician Specialists Only worksheet.

(5) AHCCCS Provider Identification No: Insert the AHCCCS assigned number identifying that provider. If the Provider does not have an identification leave row blank. In the event of a Contract Award, the Contractor must ensure the Provider has registered with AHCCCS prior to providing services to members.

(6) Name: The actual name of the provider. Do not use the corporation name. Provider names should be listed last name (,) first name when appropriate.

(7) Address: The address where the Provider is located. Do not use the billing address if different from where the member will receive the service.

(8) City: The city where the Provider is located.

(9) State: State where the Provider is located.

(10) Zip Code: Zip Code for the Provider's location.

(11) Telephone: The telephone number of the contact person.

(12) Contact Person: The name of the person to contact.

(13) Limitations or Restrictions: List any limitations or restrictions the Contractor has with the provider. Listed below are examples of restrictions and limitations. These examples are not meant to be an inclusive list; any limitations or restrictions should be noted.

(a) Contractor has a signed agreement with a PCP; however, the provider is not accepting new members.

(b) Contractor has a number of hospitals listed on their roster however; members are admitted to one primary hospital for stays longer than two days.

ACUTE SERVICES PHYSICIAN SPECIALISTS ONLY NETWORK ROSTER

(1) No.	(2) PC ID #	(3) County Code	(4) Provider Type	(5) AHCCCS Provider No.	(6) Name	(7) Address	(8) City	(9) State	(10) Zip Code	(11) Telephone	(12) Contact Person	(13) Specialty	(14) Limitations/ Restrictions

Acute Care Services –Other Roster

NOTE: List providers not covered under Acute Care Services. For example: Physician Specialists, Cardiologists, Pulmonologists, etc. DES/DDD should not report independent contractors here.

Name: Insert name of Contractor or Offeror.

GSA/District: Geographic Service Area or DES/DDD districts. For E/PD contractors counties have been assigned to GSAs: See Section III (B) for GSA numbers. Insert appropriate GSA Number where indicated on the Network Summary. See ACOM ALTCS Network Standards Policy for the appropriate County/GSA standards. DES/DDD designates service areas into districts. See Section III (C) for District Codes. Insert the appropriate District Code where indicated on the Network summary.

DES/DDD shall submit this roster for Physical Therapists, Occupational Therapists, Speech Therapists and Respiratory Therapists only.

(1) No: The row number for each provider is listed. If you require additional rows insert the rows and number accordingly.

(2) PC ID #: See above listing for Contractor and Identification Number (ID#) affiliation.

(3) County Code: See above listing.

(4) Provider Type: If the provider is an AHCCCS registered provider insert the Provider Type (See AMPM 610-01). If the Provider is not registered with AHCCCS at this time, place "XX" in the Column.

NOTE: in the event of a Contract Award, the Contractor must ensure the Provider has register with AHCCCS prior to providing services to members.

(5) AHCCCS Provider Identification No: Insert the AHCCCS assigned number identifying that provider. If the Provider does not have an identification leave row blank.

(6) Name: The actual name of the provider. Do not use the corporation name. Provider names should be listed last name (,) first name when appropriate.

(7) Address: The address where the Provider is located. Do not use the billing address if different from where the member will receive the service.

(8) City: The city where the Provider is located.

(9) State: State where the Provider is located.

(10) Zip Code: Zip Code for the Provider's location.

(11) Telephone: The telephone number of the contact person.

(12) Contact Person: The name of the person to contact.

(13) Specialty: For provider listed, indicate, the specialty/service provided.

(14) Limitations or Restrictions: List any limitations or restrictions the Contractor has with the provider. Listed below are examples of restrictions and limitations. These examples are not meant to be an inclusive list; any limitations or restrictions should be noted.

(a) Contractor has a signed agreement with a specialist; however, the provider is not accepting new members.

DES/DDD ALTCS INDEPENDENT CONTRACTOR NETWORK ROSTER

(1) Service Offered	**(2)** County Code	**(3)** # Contractors

District: DES/DDD district. See Section III (C) for District Codes, inserting the appropriate District Code where indicated on the Network summary. Only DES/DDD is required to complete this portion of the Network Summary.

(1) Service Offered: The service offered – see AMPM Chapter 1200 for the category of ALTCS services and descriptions. Insert any additional rows needed.

(2) County Code: See Section III (B) for the county codes.

(3) # Contractors: Number of independent contractors offering the listed service in the district and listed county.

DES/DDD ALTCS THERAPUETIC SERVICES WAIT LIST

(1) Therapy	**(2)** County Code	**(3)** # Members

District: DES/DDD district. See Section III (C) for District Codes, inserting the appropriate District Code where indicated on the Network summary. Only DES/DDD is required to complete this portion of the Network Summary.

(1) Therapy: The therapeutic service offered. Services to be reported are Physical Therapy, Occupational Therapy, Speech Therapy and Respiratory Therapy. Insert any additional rows needed.

(2) County Code: See Section III (B) for the county codes.

(3) Number of members served for the listed therapy in the district and listed county.

DES/DDD ALTCS HCBS SERVICES WAIT LIST

(1) Service	**(2)** County Code	**(3)** # Members

District: DES/DDD district. See Section III (C) for District Codes, inserting the appropriate District Code where indicated on the Network summary. Only DES/DDD is required to complete this portion of the Network Summary.

(1) Service: The HCBS service experiencing a wait time. If there are no wait times for any HCBS service, put 'None' in the table. Insert any additional rows needed.

(2) County Code: See Section III (B) for the county codes.

(3) # Members: Number of members served for the listed service in the district and listed county.

IV. References

ACOM ALTCS Network Standards Policy
ACOM Provider Network Development and Management Plan PolicyALTCS Contract Section D, Paragraph 10
ALTCS Contract Section D, Paragraph 28
ALTCS Contract Section D, Paragraph 29
ALTCS Contract Section D, Paragraph 32
ALTCS/DDD Contract Section D, Paragraph 10
ALTCS/DDD Contract Section D, Paragraph 28
ALTCS/DDD Contract Section D, Paragraph 29
ALTCS/DDD Contract Section D, Paragraph 32
AMPM ALTCS Services and Settings for Members Who Are Elderly and/or Have Physical Disabilities and/or Have Developmental Disabilities

421 – CONTRACT TERMINATION: NURSING FACILITIES AND ALTERNATIVE RESIDENTIAL SETTINGS

Effective Date: 04/08/09
Revision Date:

Staff responsible for policy: DHCM ALTCS Unit

I. Purpose

This policy applies to the Arizona Long Term Care System (ALTCS) Contractors in a Geographic Service Area (GSA) with more than one Contractor for Title XIX covered services, hereafter known as Contractors, AHCCCS registered Nursing Facilities (NF) and Alternative Residential Settings (ARS).

This policy is limited to and defines the relationship between a NF and/or an ARS and a Contractor following the termination of a contract between these entities, regardless of which entity terminates the contract or the reason for contract termination. This policy delineates how the Contractor, NF and ARS will collaborate to provide for the needs of the members residing in the facility at the time of contract termination.

II. Definitions

A. **Add-on**: Generally refers to contract standards that a Contractor may have with a NF to establish criteria for additional payment to the Class 1, 2 or 3 levels determined by the UAT.

B. **Alternative Residential Setting (ARS):** Under the Home and Community Based Services (HCBS) program, members may receive certain services while they are living in an alternative HCBS setting. HCBS settings as defined in 9 A.A.C. 28 Article 1 and AMPM Chapter 1200, section 1230. Alternative residential settings include but are not limited to Assisted Living Centers (ALC), Assisted Living Homes (ALH) and Adult Foster Care (AFC) Homes.

C. **Anniversary Date:** The month the member is able to make an annual enrollment choice. The Anniversary Date is in most situations 12 months from the date the member was enrolled with the Contractor and annually thereafter. Only members in a GSA w/ more than one Contractor have a choice of Contractors.

D. **Nursing Facility (NF):** A health care facility that is licensed and Medicare/Medicaid certified by the Arizona Department of Health Services in accordance with 42 CFR 483 to provide inpatient room, board and nursing services to members who require these services on a continuous basis but who do not require hospital care or direct daily care from a physician. Contracted NFs are those facilities that have a contract with a Program

Contractor. Non-contracted NFs are those facilities that do not have a contract with a Program Contractor.

E. **Room and Board (R & B):** 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/MR). 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 Level 2) or an apartment like setting that may provide meals.

F. **Subacute or Specialty Care**: Generally refers to contract standards that a Contractor may have with a NF to establish criteria for paying a rate higher than the Class 1, 2 and 3 levels determined by the UAT.

G. **Share of Cost (SOC):** The amount an ALTCS member is required to pay toward the cost of long term care services is called the share of cost.

H. **Universal Assessment Tool (UAT):** A standardized tool that is used by Contractors to assess the acuity of NF residents and commonly used for ARS residents residing in ALC, ALH and AFC settings. The use of the UAT is not intended to impact how Contractors determine authorizations for specialty levels of care (e.g., wandering dementia, medical sub-acute and behavioral management).

III. Policy

A. **Member / Resident Options When Contract is Terminated**

Affected members residing in a NF and/or ARS at the time of a contract termination may continue to reside in that facility until their open enrollment period, at which time they must either choose a Program Contractor that is contracted with the facility, or move to a setting that is contracted with their current Program Contractor.

A meeting between the Contractor, NF and/or ARS and AHCCCS will be held prior to the effective date of the contract termination to plan all aspects related to the change in contract status and impact on members and representatives.

The Contractor in collaboration with the NF and/or ARS and AHCCCS must develop a member / representative communication plan. The purpose of the communication plan is to provide affected or impacted members and/or their representatives with consistent information regarding the contract termination. The Contractor must receive approval of their member / representative communication plan from the AHCCCS, Division of Health Care Management.

B. **Level of Care/Medical Necessity Determination**

The Contractor will apply the UAT to determine the appropriate level of care assignment for the member in the NF or ARS. If the facility disputes the level of care determination, it will request a second review by the Contractor. If the Contractor and facility disagree on the level of care assignment after the second review by the Contractor, then the facility shall use the claims dispute process.

If the Contractor had in place a provision for subacute or specialty care rates or an "add-on" at the time of the contract termination, then the Contractor shall apply those criteria to the residents that would have met those criteria.

C. **Reimbursement**

1. Nursing Facilities
   The Contractor shall reimburse the NF at the previously contracted rates or the AHCCCS fee for service schedule rates, whichever are greater. Should AHCCCS increase its fee schedule, the Contractor shall reimburse the NF at the greater of the AHCCCS fee for service schedule rates or the Contractor's previously contracted rates. Should AHCCCS reduce its fee schedule, the Contractor shall reduce its previously contracted rates by the same percentage, and pay the greater of the adjusted rates.

   If the Contractor had in place a provision for subacute, specialty care or add-on rates at the time of the contract termination, then the Contractor shall apply those rates. Should AHCCCS adjust its fee schedule, then the Contractor will adjust its subacute or add-on rate(s) by the average adjustment to the NF fee schedule rates.

2. Alternative Residential Settings
   The Contractor shall reimburse the ARS at the previously contracted rate. Should AHCCCS adjust its HCBS Fee Schedule rates, the Contractor will adjust its ARS rates by the average percentage that the HCBS Fee Schedule rates are adjusted.

D. **Share of Cost**

AHCCCS shall determine the member's SOC and inform the Contractor. The Contractor shall inform the NF of the share of cost amount to be collected from the member.

E. **Room and Board**

Contractors shall determine the member's room and board amount and inform the member and the ARS of the amount to be collected from the member.

F. **Claims Disputes**

Contractors, NFs and ARSs will use the claims dispute process as delineated in 9 Arizona Administrative Code 34, Article 401 et seq. These are the claims dispute processes required in the contract between AHCCCS and the Contractor.

G. **Contractor Operations**

In the event that a Contractor's general operations (i.e., case management, claims payment) are impairing the efficient operation of a NF or ARS, the facility shall identify those issues to the Contractor for resolution. Should the Contractor fail to resolve the operational issues within 30 days, the facility shall bring the issue(s) to the attention of AHCCCS. AHCCCS shall determine if the Contractor is out of compliance with AHCCCS contract and policy requirements. If so, AHCCCS will require a Corrective Action Plan from the Contractor and monitor compliance. If the Contractor is not out of compliance, there are no additional administrative remedies available to the NF or ARS.

H. **Quality of Care**

In the event that a Contractor or other entity, such as Arizona Department of Health Services (ADHS) Licensure, identifies instances where the overall quality of care delivered by a NF or ARS places residents in immediate jeopardy, the Contractors will inform residents of the problems and offer the residents alternative placement. Members may choose to continue to reside in the NF or ARS. In the event that a Contractor identifies a member specific quality of care concern, the Contractor shall identify that to the NF or ARS for resolution. The Contractor shall also report to external entities, and to AHCCCS as required by Chapter 900 of the AMPM.

I. **Admissions / Discharges / Readmissions**

1. NFs or ARSs are not required to accept new admissions of members who are enrolled with a noncontracted Contractor.
2. NFs are required to otherwise follow admission, readmission, transfer and discharge rights as per 42 CFR 438.12.
3. The Contractor shall authorize Bedhold days up to the allowed limit (Short Term Hospitalization Leave – 12 days and Therapeutic – 9 days) as per Chapter 100 of the AMPM.

IV. References

- 42 CFR 483, Subpart B.
- A.A.C. 9-34
- AHCCCS/ALTCS Contract
- AHCCCS Medical Policy Manual, Chapter 900
- AHCCC Medical Policy Manual, Chapter 1200

422 – AZSH COORDINATION POLICY

Original Date: 1/15/2009
Effective Date: 1/15/2009
Revision Date: 1/15/2009

Staff responsible for policy: DHCM

I. Purpose

This policy establishes requirements for Acute Care, ALTCS and CMDP Contractors to provide payment for services provided at the Maricopa Integrated Health Systems Clinics and or Medical Center to AHCCCS members residing in the Arizona State Hospital (AzSH).

II. Definitions

III. Policy

AzSH Coordination

All medical services for enrolled members residing in the AzSH who require medical services that are not provided by AzSH during their stay will be provided by Maricopa Integrated Health Systems Clinics and or Medical Center. The Contractor will provide reimbursement for medically necessary services under one of the following arrangements:

- The Contractor will develop a contractual agreement with Maricopa Integrated Health Systems including Maricopa Medical Center, Clinics and MIHS physicians to provide all medically necessary services. The Contractor will assign MIHS PCPs to all members residing in AzSH.

OR

- In the absence of a contractual agreement, the Contractor will designate two staff members responsible for coordination of care, prior authorization processes, claims payments, provider and member issues for all services delivered by Maricopa Integrated Health Systems. These staff members will have knowledge of the Health Plans responsibility to arrange care for AzSH residents and provide a seamless and obstacle free process for the provision of services and payment and be available to AzSH and MIHS 24 hours a day.

Emergency medical services for AzSH residents will be provided by the MIHS Maricopa Medical Center and reimbursed by the Contractor regardless of prior authorization or notification.

Non-behavioral health related pharmacy services for AzSH residents will be provided by AzSH in consultation with the Contractor and the Contractor is responsible for payment.

IV. References

- AHCCCS Acute Care Contract Section D, ALTCS Contract Section D, CMDP Intergovernmental Agreement Section D.

423 – Court Ordered Evaluation/Treatment Policy for DUI/Domestic Violence Offenses

Original Date: 07/01/2009
Effective Date: 07/01/2009
Revision Date: 08/17/2009

Staff responsible for policy: DHCM Acute and ALTCS Operations

I. Purpose

The purpose of this policy is to provide clarification regarding the financial responsibility of ALTCS and ADHS for the provision of specific mental health treatment/care when such treatment is ordered as a result of a judicial ruling. Sections III. A. and B. apply to both ALTCS and ADHS.

II. Definitions

None

III. Policy

A. Driving Under the Influence (DUI)

When an evaluation is conducted and/or treatment is ordered by the court for a person impaired by alcohol and charged with a crime pursuant to ARS 36-2027, the cost of the evaluation and/or treatment is a charge against the county, city, or town whose court ordered the evaluation and/or treatment. See ARS 36-2027 (E). As such, the county, city or town is a source of third party liability for any evaluation and/or treatment services that are also AHCCCS covered services. Upon receipt of the claim, the contractor should deny the claim and return it to the provider with directions to bill the responsible county, city or town.

ARS 36-2028 addresses person receiving alcohol evaluation and/or treatment services other than pursuant to a court order. A member is not a source of first or third party liability as those terms are defined in AAC R9-22-1001. Therefore, the contractor will not deny the claim due to cost-avoidance.

B. Domestic Violence (DV) Offender Treatment

Although a judge may determine that court ordered domestic violence offender treatment is the financial responsibility of the offender under A.R.S. 36-3601.01, an AHCCCS member cannot be considered a legally responsible third party with respect to themselves. As a result, it is AHCCCS' expectation that ADHS/DBHS ensure that the T/RBHAs provide

domestic violence offender treatment when the service is medically necessary. When required prior authorization is obtained and/or the service is provided by an in-network provider, the member is not a source of first or third party liability as those terms are defined in AAC R9-22-1001. The contractor will not deny the claim.

IV. References

- Arizona Revised Statute 13-3601.01
- Arizona Revised Statute 36-2027
- Arizona Revised Statute 36-2028
- Arizona Administrative Code R9-22-1001

424 - VERIFICATION OF RECEIPT OF PAID SERVICES

Original Date: 01/01/10
Effective Date: 04/01/10
Revision Date: 07/01/10, 10/28/10

Staff responsible for policy: DHCM Finance

I. Policy

All Acute, ALTCS (EPD and DD), CRS, and ADHS/DBHS Contractors will be responsible for verifying member receipt of paid services according to Federal and contractual requirements to identify potential service / claim fraud. The Contractor will be expected to perform periodic audits through member contact and report the results of these audits to AHCCCS DHCM.

II. Definitions

Validation: Receipt of affirmative confirmation from the member (written or verbal).

III. Procedure

A. General Requirements

1. Contractors shall perform, at a minimum, quarterly audits to determine member receipt of paid services.

2. A Quarterly Verification of Services Audit Report, shall be due on January 15th; April 15th; July 15th; and October 15th; using the format in Attachment A.

B. Sampling

1. Shall be from claims with dates of services (DOS) from the reporting quarter. The report is due the 15th day after the end of the quarter that follows the reporting quarter. For example, the July 15th report would be for paid claims with DOS for January through March. Surveys can be performed at any point after claims have been paid.

2. Members who are surveyed shall have been enrolled with the Contractor during the period under review.

3. Shall consist of claims that resulted in payment.

4. Shall be proportionally selected from the entire range of services available under the contract (e.g. inpatient, outpatient, nursing facility, assisted living facility and in-home services).

5. Sample size shall be at least 100 claims randomly selected based on the qualifications above. The minimum sampling size for an ALTCS Contractor with less than 2,000 members shall be 50 claims. (The minimum sample size refers to completed surveys.)

C. Methodology

1. The audit can be performed by mail, telephonically or in person (e.g., ALTCS case management on-site visits). Concurrent review will be allowed, however, if used it must be recorded and tied back to a successfully adjudicated claim.

2. Survey language should be in an easily understood language, including the description of services (e.g., x-ray; surgery; blood tests; counseling) when validating the receipt of paid services.

3. Individual survey results indicating that paid services may not have been received shall be referred to the Contractor's fraud and abuse (F&A) department for review and on to the AHCCCS OIG department as appropriate.

D. Reporting

1. Shall include total number of surveys sent out, total number of surveys completed, total services requested for validation, number of services validated, and number of services referred to AHCCCS OIG department for further review (Attachment A).

2. A cover letter should accompany the report that discusses the number of surveys that resulted in a referral to the Contractor's F&A department and analysis and interventions where appropriate.

IV. References

- Acute Care Contract, Section D, Surveys
- Acute Care Contract/CRS, Attachment J, Surveys
- ALTCS Contract, Section D, Surveys
- ALTCS/DDD, Section D, Surveys
- CMDP Contract, Section D, Surveys

Attachment A: Quarterly Verification of Services Audit Report

Contractor Name:
Reporting Quarter:
Date of Submission:

Type of Service Reviewed	Total Surveys Sent Out	Number of Surveys Completed	Survey Percentage	Total Services Requested for Validation	Number of Services Validated	% of Services Validated	Number of Services Referred to AHCCCS OIG Department	Notes
Assisted Living Facilities			0.0%			0.0%		
Dental			0.0%			0.0%		
DME			0.0%			0.0%		
Emergency Facility Services (ER and Urgent Care)			0.0%			0.0%		
Evaluation & Management (PCP, Physician, and Specialists), Referral, and Other			0.0%			0.0%		
Home Health Services and HCBS			0.0%			0.0%		
Inpatient			0.0%			0.0%		
Lab. X-ray (Medical Imaging and X-ray			0.0%			0.0%		
NF/			0.0%			0.0%		
Outpatient (All other outpatient)			0.0%			0.0%		
Pharmacy			0.0%			0.0%		
Physical Therapy, Occupational Therapy, Speech Therapy			0.0%			0.0%		
Transportation			0.0%			0.0%		
Vision			0.0%			0.0%		
Total	**0**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	

425 - SOCIAL NETWORKING

Original Date: 02/01/2010
Effective Date: 02/01/2010
Revision Date: 02/25/2010, 01/01/2011

Staff responsible for policy: DHCM Operations

I. Purpose

The purpose of this policy is to provide requirements for policy development, permitted uses of applications, and acceptable content for Social Networking. This policy shall also apply to all communications included in Policy 404, Member Information; Policy 416, Provider Network Information; and all future Website Requirements policy, when conducted through Social Networking applications.

II. Scope

This policy applies to all AHCCCS Medical and Behavioral Health Contractors (Acute, Long Term Care, CMDP, the CRS Contractor, and ADHS/DBHS) if/when the Contractor chooses to use Social Networking applications/tools for a Medicaid line of business.

III. Definitions

Broadcast: Video, Audio, or text messages transmitted through an internet, cellular or wireless network for display on any device.

Friends/Followers: Persons that choose to interact through online social networks by creating accounts or pages and proactively connecting with others.

Interactions: Conversational exchange of messages.

Intermediary: Steps that allow review and approval prior to publication.

Social Networking Applications: Web based services (excluding the Contractor's State mandated website content, member portal, and provider portal) that provide a variety of ways for users to interact, such as e-mail, comment posting, image sharing, invitation and instant messaging services.

Static Content: Copy written by the Contractor or taken from an outside authoritative source for web posting, for any period of time, shall be defined as Static Content and

considered member materials under Policy 404 of the AHCCCS Contractors Operations Manual. Static Content does not include individualized e-mails or "status" messages.

Tags/Tagging: Placing personal identification information within a picture or video. Tags generally are presented as hovering links to additional information about the individual identified.

Username: An identifying pseudonym associating the author to messages or content generated.

Web Blog (Weblog): A type of website, usually maintained by an individual with regular entries of commentary, descriptions of events, or other material such as graphics or video. Entries are commonly displayed in reverse-chronological order.

IV. Policy

A. General Requirements:

1. Contractors must establish a Social Networking Administrator; who can hold another position, but is ultimately responsible for policy development, implementation and oversight of all activities.

2. Contractors shall develop an internal company policy, based on the content of this policy, for the use of Social Networking to interact with its membership and/or providers with regard to the AHCCCS lines of business. The policy must include a statement of purpose/general information stating how the Contractor uses Social Networking (i.e., customer service, community outreach, notifications; members and/or providers). This policy must be evaluated and submitted on an annual basis no later than 45 days after the beginning of the contract year, or 45 days prior to initiation of a new policy, to AHCCCS DHCM for approval.

3. Intended uses and initial content must be submitted to DHCM for approval 30 days prior to launch of any new Social Networking capability.

4. Contractor employees shall receive instruction and/or training on the AHCCCS and Contractor's policy before using Social Networking applications on behalf of the Contractor.

5. The policy must include the requirement that, when using Social Networking applications, the protection of Personal Health Information (PHI) and all HIPAA Privacy Rules related information must be maintained and monitored. This includes the maintenance of records under federal regulation, state law and Contract, for the purposes of monitoring compliance with this requirement.

6. Contractors shall develop and maintain a Social Networking Matrix that identifies personnel and subcontractors participating in social networking activities on behalf of the Contractor which shall include the Social Networking application name (i.e., MySpace, Twitter, Facebook, Nixle.com, etc.), first and last name of the individual, username (if applicable), e-mail address, and password.

7. The Social Networking Plan shall also identify management resources, internal teams, external management resources (subcontractors) and human resource needs to monitor usage, analyze information trends and prepare responses for the public or private individuals/organizations. (Such information and trends can be an invaluable tool for gathering public and private information, identifying future training requirements or focus group information, or outreach programs and to improve public awareness).

8. All web blogs shall be clear, direct, professional, honest, ethical, and written in the first person.

9. Contractors shall comply with copyright and intellectual property law. They shall also reference or cite sources appropriately.

10. AHCCCS reserves the right to monitor, or review the Contractor's monitoring of, all web blog and blogging activity without notice.

B. Social Networking Applications:

If the site or medium is not listed in this section, you may submit the URL of a page describing the requested media to AHCCCS for review/approval. However, unless separately approved or listed below, the Contractor can assume the site or medium is prohibited.

Permitted:

Communication

- **Blogs**: Blogger, LiveJournal, Open Diary, TypePad, WordPress, Vox, ExpressionEngine, Xanga
- **Micro-blogging / Presence applications**: Twitter, Plurk, Tumblr, Jaiku, fmylife
- **Social networking**: Bebo, Facebook, LinkedIn, MySpace, Orkut, Skyrock, Hi5, Ning, Elgg
- **Social network aggregation**: NutshellMail, FriendFeed

- **Events**: Upcoming, Eventful, Meetup.com

Prohibited (includes but is not limited to):

Collaboration

- **Wikis**: Wikipedia, PBwiki, wetpaint
- **Social bookmarking** (or social tagging)[3]: Delicious, StumbleUpon, Google Reader, CiteULike
- **Social news**: Digg, Mixx, Reddit, NowPublic
- **Opinion sites**: epinions, Yelp

Multimedia

- **Photo sharing**: Flickr, Zooomr, Photobucket, SmugMug, Picasa
- **Video sharing**: YouTube, Vimeo, sevenload
- **Livecasting**: Ustream.tv, Justin.tv, Stickam
- **Audio and Music Sharing**: imeem, The Hype Machine, Last.fm, ccMixter

Reviews and Opinions

- **Product Reviews**: epinions.com, MouthShut.com
- **Community Q&A**: Yahoo! Answers, WikiAnswers, Askville, Google Answers

Entertainment

- **Media & Entertainment Platforms**: Cisco Eos
- **Virtual worlds**: Second Life, The Sims Online, Forterra
- **Game sharing**: Miniclip, Kongregate

Other

- **Information aggregators**: Netvibes, Twine (website)
- **Platform providers**: Huzu

C. User Requirements:

1. The Contractor's presence on such sites must include an Avatar and/or a Username that clearly indicates what company is being represented; and cannot use the AHCCCS logo or State of Arizona seal. When registering for Social Networking applications, all contractors shall use their company email address. If the application requires a username, the following syntax shall be used:
   http://twitter.com/< contractor_identifier><username>

2. Interactions must be personalized from the Contractor to include an identifying handle or representative code so as to specify which Contractor employee has issued the communication. Records must be kept of each update and who is responsible for the update as it occurs.

3. All Social Networking connections must be initiated by the external user and not the Contractor.

4. All interactions with the public must either be general broadcast message of information availability or responses to inquiry that contain only referral to authoritative resources such as Contractor, State Agency, or Federal Agency websites (including emergency public health advisories). Contractors shall not reference, cite, or publish information, views or ideas of any third party without their written consent and only as permitted by AHCCCS for the purpose of conducting business on behalf of AHCCCS.

5. Updates, messages and reminders must only be distributed to registered friends/followers who have chosen to receive these types of communication whether actively or passively (through a subscription initiated by the external user).

6. External user-generated content (comments/posts) is not permitted unless an intermediary approval process is in place.

7. All static, distributed, or broadcast content must be generated by the Contractor and submitted for approval to AHCCCS DHCM.

8. Under no circumstance should AHCCCS authorized business that involves the communication of personal identifying, confidential or sensitive information be conducted on a Social Network, web blog or blog system.

9. Photographs placed on pages must be hosted on the site and not linked from outside web pages. Contractors shall not post information, photos, links/URLs or other items

online that would reflect negatively on any individual(s), its citizens, AHCCCS or the state.

10. No video may be placed/embedded on Social Networking sites.

11. Additionally, the Contractor is prohibited from tagging photographic or video content and must remove all tags placed by others upon discovery.

12. No ads, whether targeted or general, will be permitted on Social Networking sites.

13. No affiliate/referral links or banners are permitted. This includes links to other non-Medicaid lines of business that the Contractor or a parent company is engaged in. Any site that automatically generates such linkage, recommendation, or endorsement on side bars or pop-ups must contain a message prominently displayed in the area under the Contractor's control that such items, resources, and companies are NOT endorsed by the Contractor or AHCCCS.

D. Functionalities

The Following Functionalities are Permitted:

1. Search - Finding information through keyword search

2. Links - Guides to other related information

3. Signals - The use of syndication technology such as RSS to notify users of content changes.

The Following Functionalities are Prohibited:

1. Authoring - The ability to create and update content leads to the collaborative work of many rather than just a few web authors. In wikis, users may extend, undo and redo each other's work. In blogs, posts and the comments of individuals build up over time.

2. Tags - Categorization of content by users adding one-word descriptions to facilitate searching, without dependence on pre-made categories.

3. Extensions - Software that makes the Web an application platform as well as a document server.

V. References

Government Information Technology Agency, Statewide Policy P505, Social Networking
PARIS IT Plan AHCCCS 2010

426 - ELIGIBILITY REVIEWS FOR CRS APPLICANTS AND REFERRALS

Original Date: 01/01/11
Effective Date: 01/01/11
Revision Date:

Staff responsible for policy: The Division of Health Care Management, Medical Management and Operations departments.

I. Purpose

This policy defines the processes used to accept and process applications and referrals to the CRS program. The CRS Contractor is responsible for processing and responding appropriately to all requests for acceptance and coverage of AHCCCS enrolled members who have been identified as having a CRS-covered condition as defined in AHCCCS Medical Policy Manual Policy 330, Covered Conditions in the CRS Program.

II. Definitions

III. Policy

The CRS Contractor will accept and process a referral and application for CRS service coverage of an AHCCCS member that is submitted in the manner described in this policy. CRS provides covered services defined in AMPM Policy 340 only to individuals who have been confirmed as having a CRS-covered condition as defined in AMPM Policy 330. AHCCCS will monitor, through required reporting and periodic audit, adherence to the criteria and the quality of decision-making by the CRS Contractor.

IV. Procedure

A. Eligibility Requirements

All AHCCCS enrolled children under the age of twenty-one (21) are eligible for enrollment in the CRS Program when the presence of a CRS-covered condition – as defined by AMPM Policy 330 – is confirmed through medical review by the CRS Contractor.

B. Form Requirements

1. The CRS Contractor shall place a copy of all required referral/application documentation on their website in an area that is accessible to any qualified physician or health plan regardless of contract status.
2. Referral/application forms will be submitted to AHCCCS for review and approval at any time that there is a change to content or requirements. Approval of forms will follow the process and timelines for material changes to policy outlined in Section D, Paragraph 29, Network Management.
3. Any qualified provider - regardless of CRS affiliation - or any AHCCCS Contractor, may submit a referral for CRS services.
4. The CRS Referral/Application Form may be faxed, mailed, or delivered in person to the CRS Contractor as indicated at the website address. And must contain, at a minimum, the following information:
    a. Name; Address; and Phone number of Referral Source
    b. Relationship of person completing the referral/application form to the applicant.
    c. Applicant's name; DOB; Social Security Number; Sex; Home Address and Contact Information; Race; Citizenship; and Preferred Language
    d. If the applicant is a child, the name of at least one parent/guardian of the applicant.
    e. If known to the referral source:
        i. Diagnosis;
        ii. List of allergies;
        iii. PCP name;
        iv. Previous CRS enrollment dates;
        v. The reason that the referral source believes the applicant may be eligible for CRS services.
5. The following additional documentation may be submitted with the application:
    a. Documentation supporting the medical diagnosis
    b. Diagnostic testing results that support the medical diagnosis

C. Processing

1. Within fourteen (14) calendar days of receipt of a referral/application, the CRS Contractor’s Medical Director or designee must review the documentation provided to determine an applicant’s eligibility for CRS.

2. The CRS Contractor will use the Prepaid Medical Management Information System (PMMIS) as verification of Title XIX/XXI enrollment, age, residency, and citizenship/qualified alien status. Applicants who are not enrolled in Title XIX/XXI cannot be enrolled in CRS.

3. The CRS Contractor Medical Director or designee shall review all submitted referral/application materials in accordance with Attachment J of the Contract with the following possible outcomes.
    a. The applicant is eligible;
    b. The applicant is not eligible;
    c. Further information is needed to determine eligibility; or
    d. A physical examination is needed to determine the presence of a CRS medical condition. The physical examination must be scheduled within 30 calendar days of the decision.

D. Notifications

1. When an applicant is determined eligible for CRS, notification will be made to the following parties:

    a. Applicant
    b. Referral Source
    c. AHCCCS – Upon identification of the member as a CRS recipient, the Contractor will notify AHCCCS through the appropriate Recipient Roster Reconciliation tape. AHCCCS will make appropriate update to the AHCCCS Contractors' enrollment files.
    d. Health Plan/Program Contractor – The Contractor will notify the Health Plan/Program Contractor of enrollment, through a documented process, of the:
        i. Recipient's CRS Qualifying Diagnosis;
        ii. Enrollment Effective Date; and
        iii. Assigned CRS Specialty Clinic.

2. When an applicant is determined ineligible for CRS, notification will be made to the following parties:

    a. Applicant – the applicant shall receive a notification of denial, in writing, that contains the statement of denial; the reasons for the denial and any information regarding potential gaps in documentation that may be resolved; and outlines all appeal rights and processes; within fourteen (14) calendar days of the determination of ineligibility.
    b. Referral Source – The Contractor shall inform the referral source, in writing, within five (5) working days of the determination of ineligibility.
    c. Health Plan/Program Contractor – The Contractor shall inform the Health Plan/Program Contractor within five (5) working days of the determination of ineligibility.

Notice Requirements

The Children's Rehabilitative Services (CRS) Contractor must issue a Notice of Eligibility/Enrollment Determination for the following reasons:

a. The CRS Contractor's denial of an applicant's request for CRS eligibility and enrollment, or
b. The CRS Contractor's disenrollment of a CRS member for any reason.

The CRS Contractor must use Attachment 1 of this policy when issuing a Notice of Eligibility/Enrollment Determination. This form may not be modified without prior approval by AHCCCS other than as directed on the form in those areas marked [Insert]. The inserted language must accurately and adequately describe the following:

a. The factual basis for the CRS Contractor's determination of ineligibility or disenrollment, and
b. The legal basis supporting that decision.

3. If further information is needed in order to make a determination of medical eligibility for the CRS program, the Contractor will issue notifications to the following:

   a. Applicant – The applicant shall receive written notification within fourteen (14) days of the need for further information specifying: the information needed; possible methods of fulfillment; and the timeframe for submitting the information (thirty- (30) days from the date of the notice).
   b. Referral Source - The referral source shall receive written notification within fourteen (14) days of the need for further information specifying: the information needed; possible methods of fulfillment; and the timeframe for submitting the information (thirty- (30) days from the date of the notice).

4. If a physical examination is needed to determine the presence of a CRS qualifying medical condition, notice shall be provided to:

   a. Applicant – upon deciding that a physical examination is needed to determine the presence of a CRS qualifying medical condition, the Contractor shall notify the applicant within fourteen (14) calendar days of receipt of the referral/application of the need for the examination, indicate a scheduled appointment date and time for the evaluation (must occur within (30) days of the notification), and outline the possible outcomes should the applicant not complete the indicated steps.

E. Enrollment Requirements

The CRS Contractor will enroll an AHCCCS member as a CRS recipient if the requirements of Section IV(A) of this policy are met.

1. The CRS Contractor shall enroll the applicant in CRS effective on the same date as the eligibility determination.
2. The expiration date at the time of enrollment is the day before the recipient's 21st birthday.
3. If an applicant is inpatient at the time of the eligibility determination, enrollment cannot occur until the applicant has been discharged.

F. Termination of Enrollment

The CRS Contractor may terminate a recipient's enrollment in the CRS Program for the following reasons:

1. The CRS Contractor determines that the recipient no longer meets the medical and/or any of the non-medical eligibility requirements for CRS (age, residency, citizenship/qualified alien, and a CRS medical condition).
2. The recipient is terminated from Title XIX/XXI eligibility.
3. The recipient or, if the recipient is a minor, the recipient's parent requests termination of the recipient's enrollment in the CRS program. A recipient who does not have third-party insurance shall be advised by the CRS Contractor of the financial implications of termination and referred back to the AHCCCS Health Plan Contractor of enrollment for additional information on seeking services related to the CRS condition.

Notification Requirements Regarding Termination

a. The CRS Contractor shall complete a CRS Clinic Patient Discharge Form and place the form in the medical record.
b. Notify the AHCCCS Administration, through established mechanisms, of the termination through the eligibility update process.
c. Send written notice of termination to the recipient or, if the recipient is a child, a parent of the recipient that includes hearing rights or instruction of hearing process for AHCCCS eligibility.
d. Send a copy of the written notice of termination to the recipient's Primary Care Physician, if known, and the Health Plan/Program Contractor of enrollment.

G. Re-enrollment

1. Re-enrollment shall occur, without the necessity of a new referral/application, upon re-enrollment in the AHCCCS program or upon request.
2. Re-enrollment shall be effective on the date that the request for enrollment is made, provided that eligibility is confirmed.
3. If re-enrollment occurs as a result of a determination of eligibility for Title XIX/XXI services that contains a Prior Period Coverage segment, written notification of re-enrollment should advise the recipient/parent that appointments should be rescheduled and that any services provided during the PPC period may be reimbursed with proper documentation of the request.
4. Upon re-enrollment, the CRS Contractor shall review any previous service plan documentation to determine if disruptions to treatment occurred and update the service plan accordingly.

H. Appeals of CRS eligibility determinations

1. A decision made by a CRS Contractor to deny a request for eligibility and enrollment, or to disenroll a CRS member, is subject to appeal by requesting a review through the CRS Contractor.
2. Who May File
   a. The applicant or disenrolled member, or if the member is a minor, the member's parent or other legal guardian.
   b. The person's legally authorized representative.
3. An applicant or authorized representative must submit a written request for review of the determination to the CRS Contractor within thirty- (30) days of receiving the Notice of Eligibility Determination.
4. The written request shall minimally contain:
   a. The name and address of the applicant or member, or if
   b. The member is a minor, the name and address of the parent, legal guardian, or other legally authorized representative;
   c. The adverse decision made by a CRS Contractor; and
   d. The reason for the review request.

Notice of Eligibility Determination Review

The CRS Contractor shall mail a written notice to the recipient/recipient's representative stating that the request for eligibility determination review was received and will be reviewed and responded to within thirty- (30) days.

Notice of Final Eligibility Determination

The CRS Contractor will review all pertinent information regarding the eligibility determination, including any additional information submitted with the appeal letter,

to make a final decision regarding the validity of the original determination. The Contractor will issue a formal response, in writing, to the recipient/recipient's representative within thirty (30) days of receipt of the request for Eligibility Determination Review; which will contain an explanation of the determination including reference to any pertinent policies, rules, or statutes and describing the right to request a State Fair Hearing.

Request for State Fair Hearing regarding Eligibility Determinations

The recipient/recipient's representative may file a written request for State Fair hearing within sixty- (60) days of receipt of the Final Eligibility Determination. The request for State Fair Hearing must include the Final Eligibility Determination reason and a statement that the recipient continues to disagree with this determination.

Requests for State Fair Hearing will be forwarded to the AHCCCS Office of Administrative Legal Services (OALS), within five- (5) days of receipt by the Contractor, for scheduling.

Notice of Request for State Fair Hearing

The Office of Administrative Hearings shall mail a Notice of Hearing to all parties under A.R.S. § 41-1092.05 if the request for an Administrative Hearing is timely and contains the information listed above.

The Notice shall contain:

a. A statement of time, place, and nature of the hearing;
b. A statement of the legal authority and jurisdiction under which the hearing is to be held;
c. A reference to the statutes and rules involved; and
d. A short plain statement as to the matters in question.

Denial of a Request for a State Administrative Hearing

The Office of Administrative Legal Services shall deny a request for an Administrative Hearing if:

a. The request for an Administrative Hearing is untimely;
b. The request for an Administrative Hearing is moot based on the factual circumstances of the case; or
c. The sole issue presented is a Federal or State law requiring an automatic change adversely affecting some or all similarly situated applicants.

Withdrawal of a Request for a State Administrative Hearing

The Office of Administrative Legal Services shall accept a written request for withdrawal from the applicant, member, or authorized representative if Notice of Hearing has not been mailed. If OALS has mailed a Notice of Hearing, OALS shall forward the written request for withdrawal to the Office of Administrative Hearings (OAH).

Notice of Hearing Decision

AHCCCS shall mail a Decision to the applicant or member or if the member is a minor, the parent, legal guardian, or other legally authorized representative, no later than thirty- (30) days after the date of the administrative law judge's recommended decision.

Motion for Rehearing or Review

Under A.R.S. § 41-1092.09, AHCCCS shall grant a rehearing or review for any of the following reasons materially affecting an applicant or member's rights:

a. Irregularity in the proceedings of a State Fair Administrative Hearing that deprived a person filing a petition (petitioner) of a fair hearing;
b. Misconduct of AHCCCS, OAH, or a party;
c. Newly discovered material evidence that could not, with reasonable diligence, have been discovered and produced at the hearing;
d. The decision is the result of passion or prejudice;
e. The decision is not justified by the evidence or is contrary to law; or
f. Good cause is established for the nonappearance of a party at the hearing.

V. References

427 - CRS CONTRACTOR NO-SHOW POLICY

Original Date: 01/01/11
Effective Date: 01/01/11
Revision Date:

Staff responsible for policy: DHCM Operations; CRS Contractor

I. Purpose

This policy shall explicitly describe no-show monitoring and notification processes to ensure medically necessary care is received according to the recipient's Service Plan.

II. Definitions

Appointment: A scheduled medical visit to a specialist or clinic that has been documented in the recipient's Service Plan.

CRS Contractor: The AHCCCS Contractor responsible for provision of CRS-Covered Services.

Health Plan: The AHCCCS Contracted health plan in which a CRS recipient is enrolled for Acute medical services.

Contractor: The AHCCCS Contracted health plan in which a CRS recipient is enrolled for Long Term Care medical services.

III. Policy

In addition to monitoring appointment accessibility under Policy 417 of this manual, the CRS Contractor is expected to ensure that recipients receive scheduled care for their complex medical conditions. The CRS Contractor is expected to have proactive monitoring mechanisms for ensuring completion of scheduled care indicated in the recipient's Service Plan. The Contractor will monitor completed appointments using the process outlined in this policy.

IV. Procedure

For the first and second missed appointments, the CRS Contractor shall contact the recipient/recipient's representative by phone or letter to reschedule appointments. If the recipient/recipient's representative does not respond after two attempts to contact (with at least forty-eight (48) hours between attempts), the CRS Contractor must send a letter to the recipient/recipient's representative requesting a rescheduled appointment.

For the third missed appointment, the CRS Contractor shall send a letter to the recipient/recipient's representative, and the Health Plan/Contractor of enrollment, stating that the recipient/recipient's representative needs to contact the CRS Clinic to reschedule the appointment.

If the recipient/recipient's representative do not respond within ninety (90) days to any of the CRS Contractor's verbal and written notifications regarding missed appointments, the CRS Contractor shall send a written notice to the recipient/recipient's representative, and the Health Plan/Contractor of enrollment, stating that the recipient/recipient's representative need to contact the CRS Clinic to reschedule an appointment. The notice must inform the recipient that the Health Plan/Contractor will not cover CRS related services.

The CRS Contractor must document all attempts to contact the recipient/recipient's representative.

A CRS Contractor cannot terminate a recipient from the program for no-show appointments.

V. References

Acute Care Contract, Attachment J, Paragraph 33

428 - CRS SERVICE AUTHORIZATION PROCESSES

Original Date: 01/01/11
Effective Date: 01/01/11
Revision Date:

Staff responsible for policy: DHCM Medical Management; CRS Contractor

I. Purpose

To define the processes specific to the CRS program with regard to Prior Authorizations as defined in the AHCCCS Medical Policy Manual Chapter 1000, Medical Management.

II. Definitions

CRS Contractor: The AHCCCS Contractor responsible for provision of CRS-Covered Services.

Provider Service Requisition (PSR): The form, or electronic version of the same form, that is uniformly utilized by all subcontracted and non-contracted providers to request service authorization for a CRS Recipient, related to the CRS Condition.

III. Policy

The CRS Contractor is responsible for administering benefits for AHCCCS members who have been enrolled as CRS recipients for the treatment of specific covered conditions. In providing these services, care coordination is of paramount importance. The CRS Contractor is responsible to develop internal policies and procedures that comport with this Policy.

IV. Procedure

A. Provider Service Requisitions (PSR)

1. The provider/physician shall complete a Provider Service Requisition Form (PSR) and transmit it to the CRS Contractor.
2. A PSR form shall include (at a minimum) the following required elements:
   a. CRS member name and date of birth;
   b. Requesting physician's name and specialty;
   c. Requesting physician's National Provider Identifier number;
   d. Service provider's name and specialty if different from requesting physician;

e. Service provider's National Provider Identifier number if different from requesting physician;
f. CRS diagnosis;
g. Proposed date of service, (if known);
h. Proposed service to be provided;
i. Narrative description or supporting documentation/reason of medical necessity for the proposed service;
j. Record date that PSR request is received by CRS Contractor;
k. Type of authorization request (standard or expedited);
l. Complete referral/service type requested (place of service and/or type of service inpatient, ambulatory, physician's office);
m. Place for name of authorizing medical professional and date of prior authorization approval;
n. Date authorization notice was sent to provider, physician, or facility.

3. CRS Contractor shall have a process for authorizing the PSR that shall determine whether the requested services are medically necessary and appropriate. Decisions on CRS coverage and medical necessity shall be based on the criteria found in AMPM Chapters 300, 900 and 1000.
4. CRS Contractor shall investigate or verify other coverage(s) to which the individual may be entitled, including any requirements for pre-certification by other carriers or liable parties.
5. CRS Contractor's prior authorization staff (RN, BSN, MD) shall be named and date the authorization for services and send notice of the authorization to the requesting provider when completed.
6. CRS Contractor shall place appropriate limits on services based on a reasonable expectation that the amount of services authorized will achieve the expected outcome.

B. Out-of-State Services Requirements

1. Services provided outside the state of Arizona are covered for CRS recipients when all of the following are verified:
   a. The out-of-state services are related to a CRS condition;
   b. The medical specialty, treatment, or procedure is not available in Arizona;
   c. Two CRS physicians of the appropriate medical specialty recommend out-of-state treatment;
   d. The treatment is considered to be lifesaving or will result in significant functional improvement based on favorable data published in peer reviewed national medical literature;
   e. Prior authorization is obtained from the CRS Medical Director and Administrator.
2. The procedures for obtaining out-of-state services are as follows:
   a. The request will be reviewed by the CRS Contractor Medical Director to determine medical necessity; appropriateness of request based on in-state

availability of the service requested; and, in consultation with an appropriate sub-specialist, whether the requested provider/facility is capable, willing, and certified to perform the service.

b. The CRS Contractor will be responsible for scheduling, coordinating transportation and lodging as appropriate, and ensuring that any acute or long term care needs are coordinated with the Health Plan/Contractor of enrollment for the duration of the necessary stay.
c. Payment for travel and lodging are not covered by the CRS Contractor and are considered patient responsibility.
d. The out-of-state treatment site must provide a discharge summary for the recipient in order to receive reimbursement for services rendered regardless of prior approval.

C. Denial or Reduction of Services

CRS Contractor procedures for determining that a requested service is not a CRS-covered benefit shall include:

1. A clinical review by the CRS Medical Director of decisions to deny authorization on the grounds of medical appropriateness, medical necessity, or CRS coverage;
2. The ability of the CRS Medical Director to consult with another appropriately credentialed CRS physician(s) regarding the requested procedure when the requesting physician challenges the denial;
3. Written notification to the requesting provider of any decision to refer, deny, limit, or discontinue authorization of services, including appropriate steps for appealing the decision (See AMPM Chapter 1000, and ACOM Policy 417);
4. Proper documentation regarding the reasons behind the adverse decision; and
5. Assurance that adverse decisions shall only be rendered by the CRS Medical Director or designee; who must sign all adverse decisions or denials.

V. References

- AHCCCS Medical Policy Manual Chapter 1000
- Acute Care Contract, Section D, Paragraph 24
- Acute Care Contract, Attachment J, Paragraph 24
- 42 CFR 438.400 et seq.

429 – DIRECT CARE WORKER TRAINING AND TESTING PROGRAM
UNDER DEVELOPMENT

430 – ELECTRONIC MEMBER CHANGE REPORT (MCR)

Effective Date: 05/01/2012
Revision Date: 05/01/2012

Staff responsible for policy: DHCM/ALTCS Unit/Case Management

I. Purpose

This policy applies to Arizona Long Term Care System (ALTCS) Contractors. This policy provides a tutorial on the process for reporting to AHCCCS, via the electronic Member Change Report (MCR), when a change needs to be made on a member's eligibility or enrollment record.

II. Overview/General Information

Prior to November 2007, Member Change Reports were submitted in hard copy form to either the local eligibility office (Division of Member Services) or the Division of Health Care Management (DHCM) for a variety of member change types.

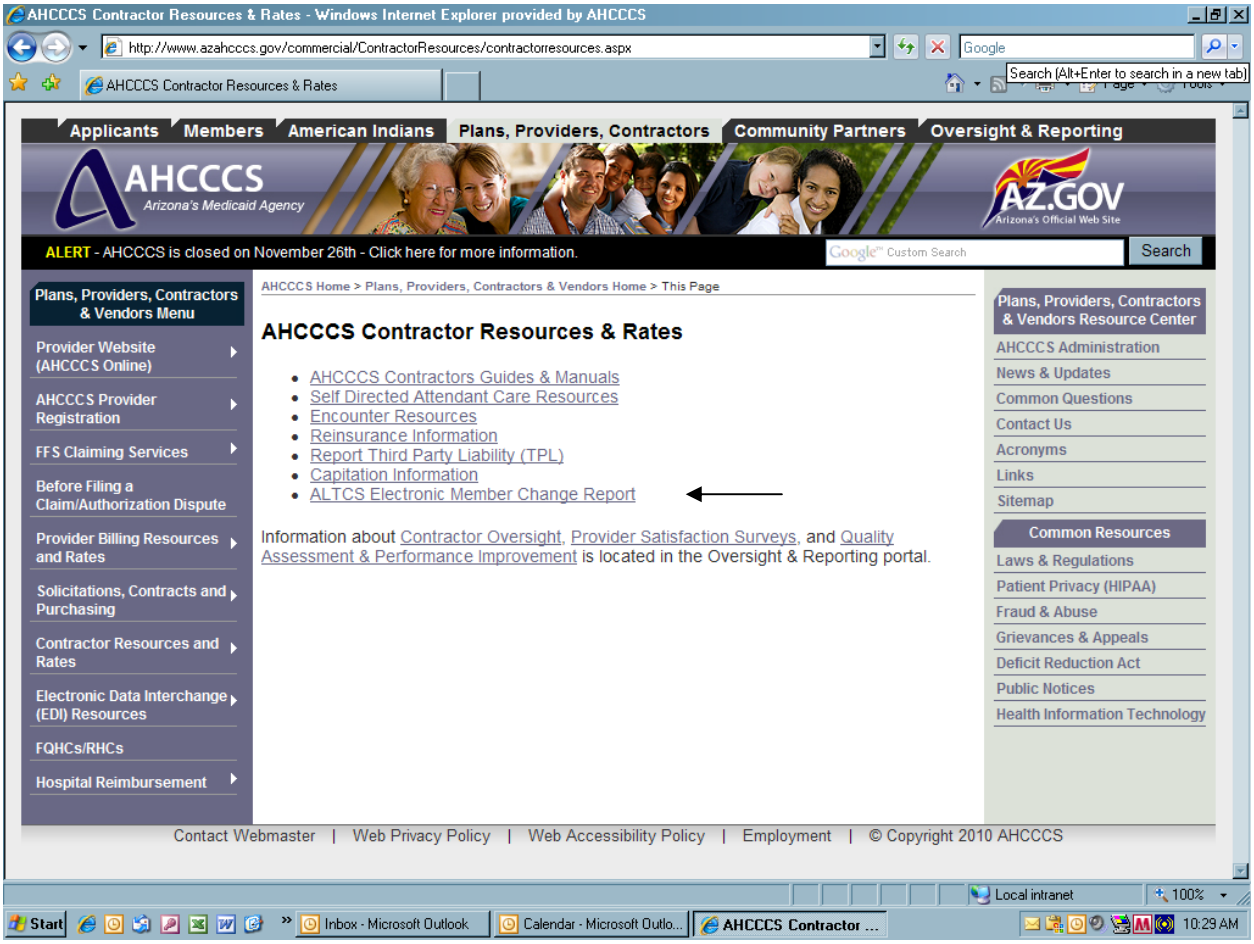
That was replaced by the electronic process to increase efficiency and create better tracking and reporting mechanisms for both AHCCCS and the Contractors.

III. Electronic Member Change Report

The pages that follow will show examples of all the screens used to complete the various types of Member Change Reports.

A. Accessing the Electronic Member Change Report link

The Electronic Member Change Report is accessed via the AHCCCS website (www.azahcccs.gov) on the Contractors Resources and Rates page as shown below.

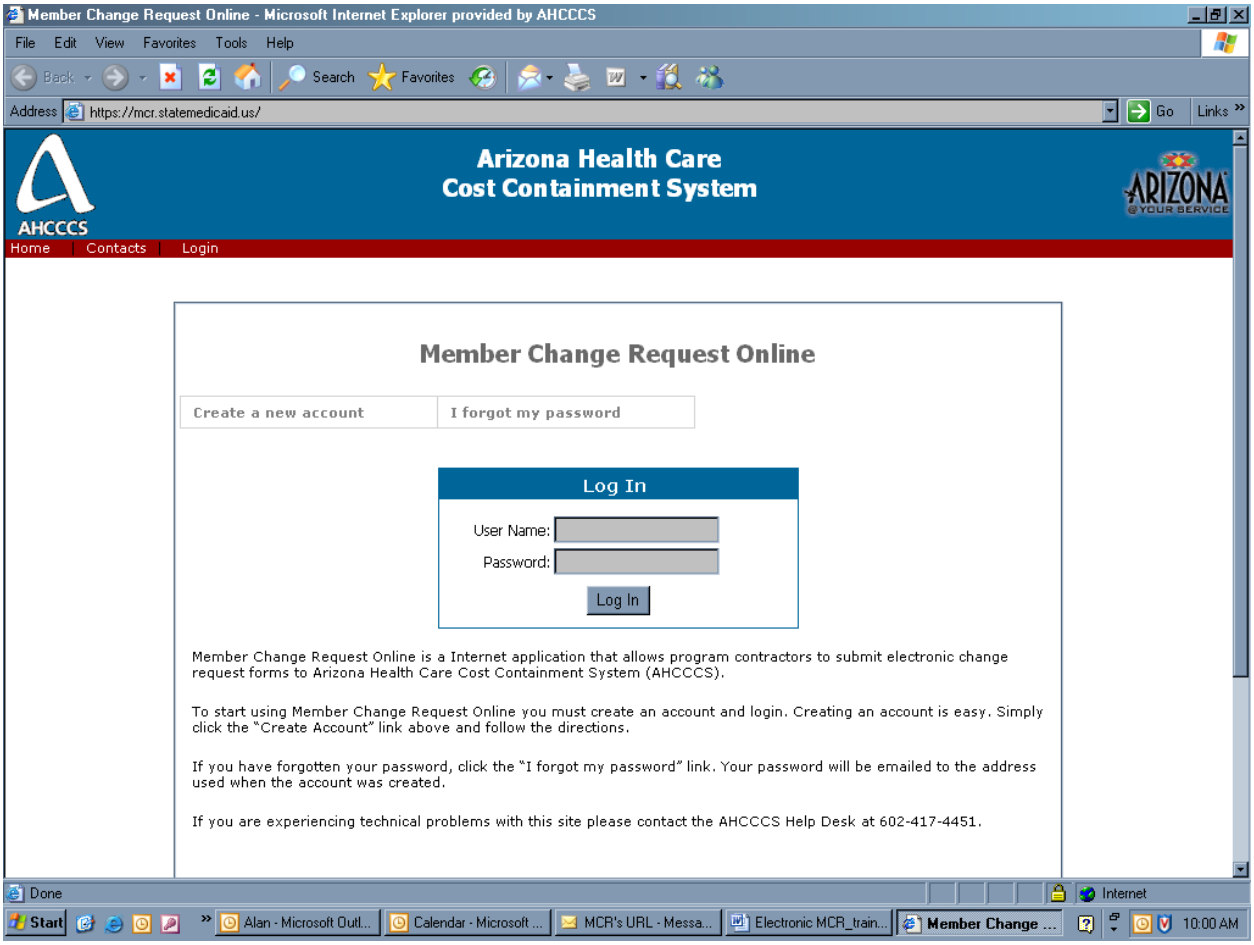


B. Log-In screen

The screen shown below is used to log-in to the Contractor's home page once a user has created an account.

First time users must click on the "Create a new Account" button before being able to access the home page. See the next 2 pages for details about how to create an account.

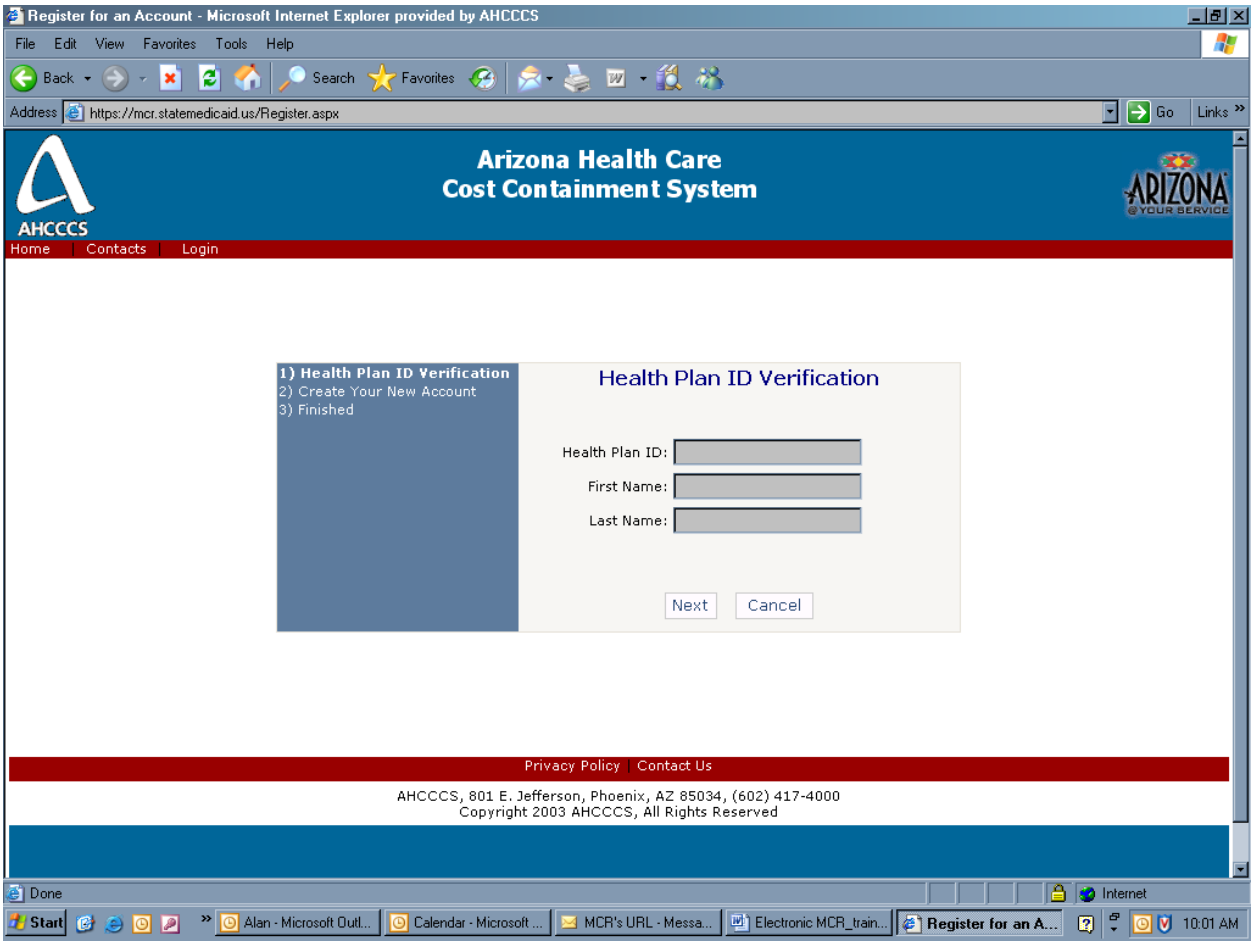
Once an account is created, users may try up to 5 times to enter their password in this log-in before getting locked out and needing to have the password reset. It is strongly recommended for users who have forgotten their password that they click on "I forgot my password" to request their password be emailed to them before trying 5 times. If locked out, the user must call AHCCCS Customer Support at (602) 417–4451 to be reset.



C. Creating a new Account

1. Health Plan ID Verification

Accounts will be created for individuals to be associated with a specific Program Contractor. The user must enter the 6-digit Health Plan ID# of the Program Contractor they work with, their First and Last Name as shown below and then click on NEXT.



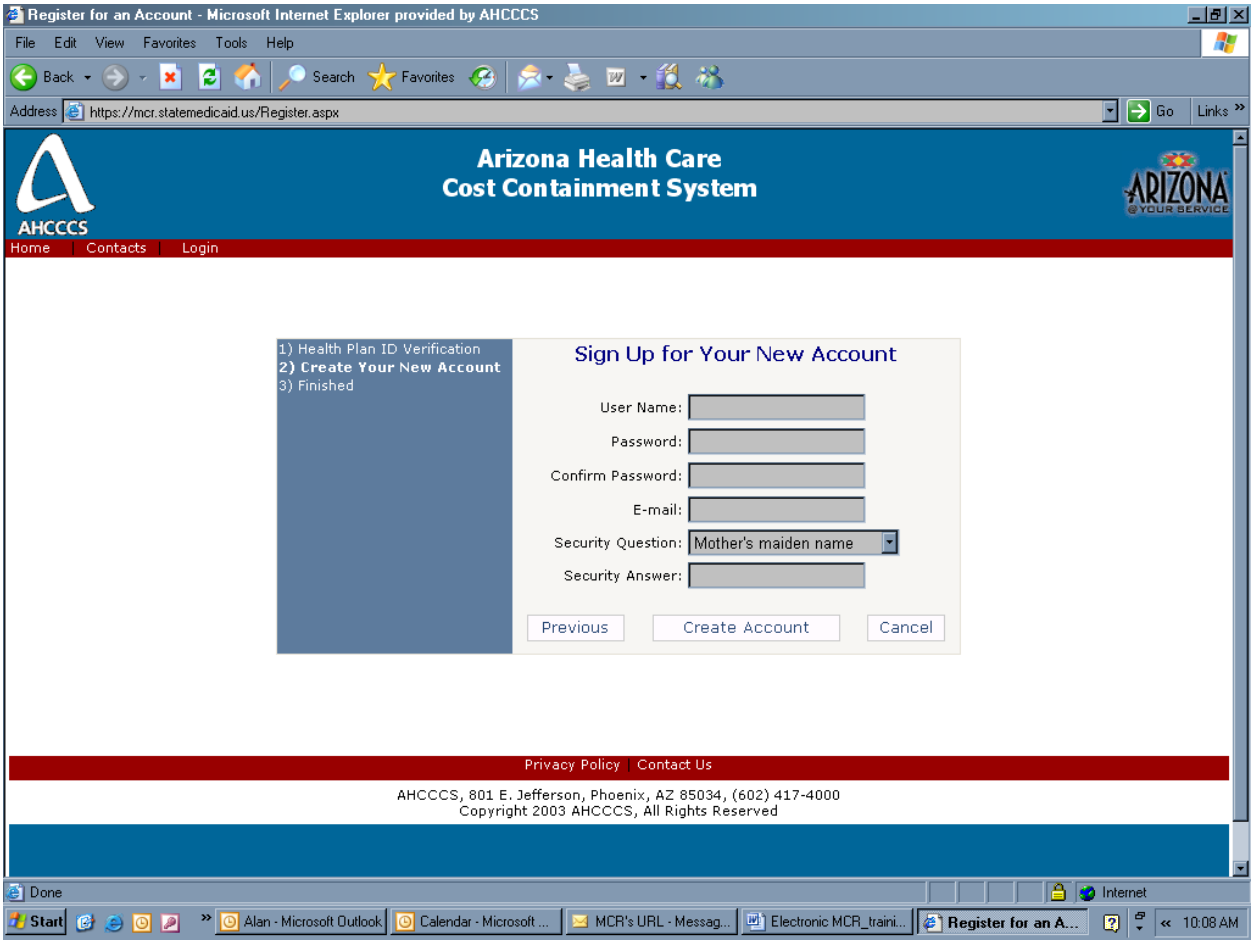
ALTCS Health Plan ID#s:

Program Contractor	Health Plan ID
Bridgeway Health Solutions	110088
DES/DDD	110007
Evercare Select	110049
Mercy Care Plan	110306

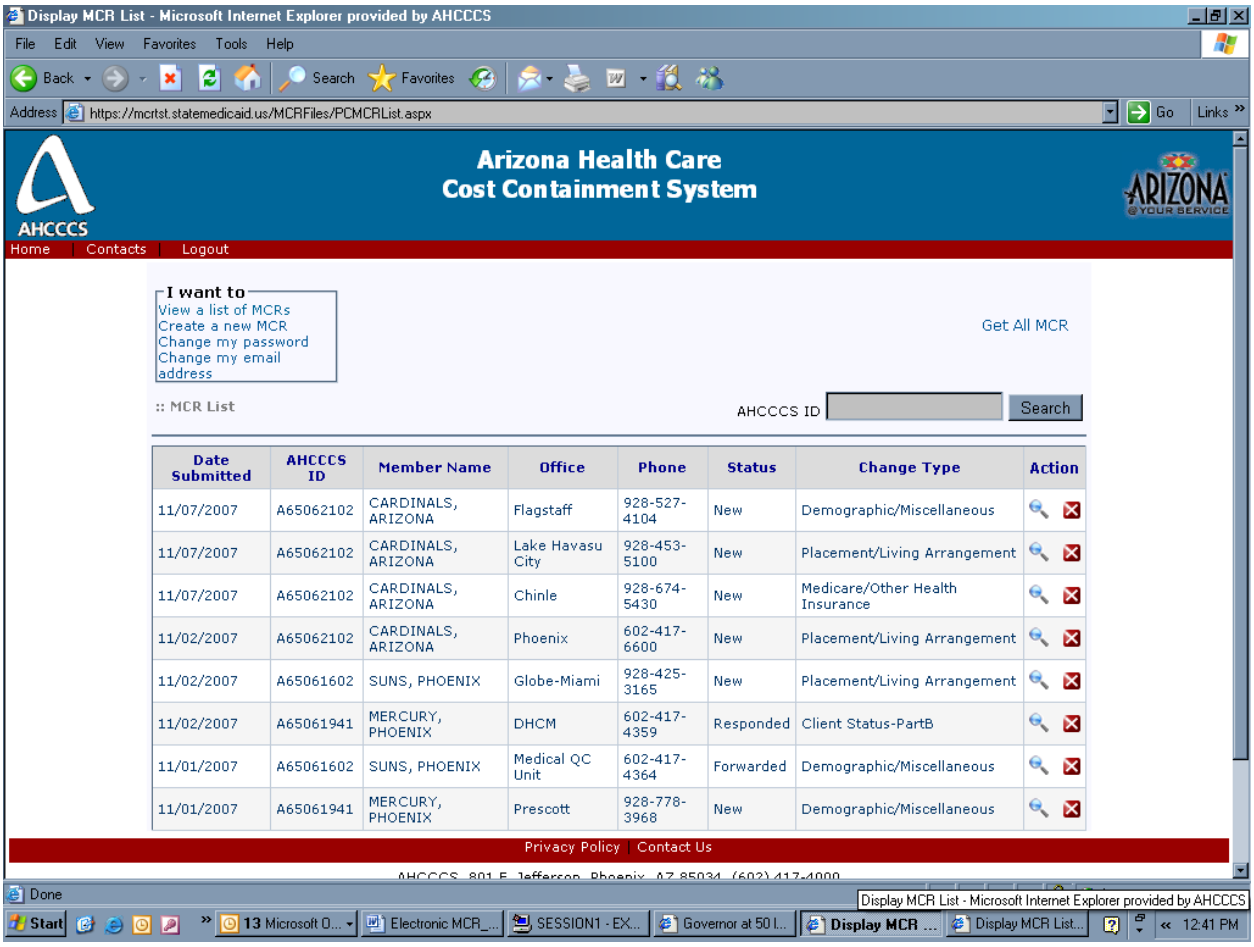
2. User Name

Users will be registered with their Program Contractor account using an email address and a password. The email address will be used to communicate with the user in the event the password is forgotten.

- User Names are case sensitive but there are no specific requirements regarding length and/or alpha/numeric characters. It is recommended that users use their real name for this entry.
- Passwords must be a minimum of 6 characters long and can be alpha or numeric or a combination of both. Passwords are also case sensitive.
- Each user can only be assigned to one Health Plan by email address at a time.
- The user should choose a security question from the drop down list and enter an answer to that question. These will be used to verify the user if the password is forgotten.



D. Contractor "Home" Page



Whenever a user associated with a Program Contractor logs in, a page similar to the one shown above will appear as the "home page" for that Contractor. This page will list all MCRs submitted by the Contractor. The default sort is by "Date Submitted" but the list can be re-sorted by any column data by clicking on the header name, for example, "Member Name" or "Change Type".

Clicking on the image in the "Action" column of a specific MCR will display the details of that MCR. The "Status" for each MCR listed will show one of the following:

- New – submitted by the Contractor but not yet assigned or processed by AHCCCS
- Assigned – the MCR has been assigned to an AHCCCS staff person to process the change but that action has not yet been taken. Who the assigned staff person is and their contact information can be viewed in the details of the MCR by clicking on the image.
- Forwarded – the MCR was forwarded from the AHCCCS location where the Contractor sent it to another AHCCCS location that is more appropriate to process it.

- Responded – AHCCCS has responded to the submitted MCR. Typically this will be following action taken to process the change reported but it may also indicate that no action was taken for some reason. Comments from the AHCCCS location responding should be included to explain any non-action.

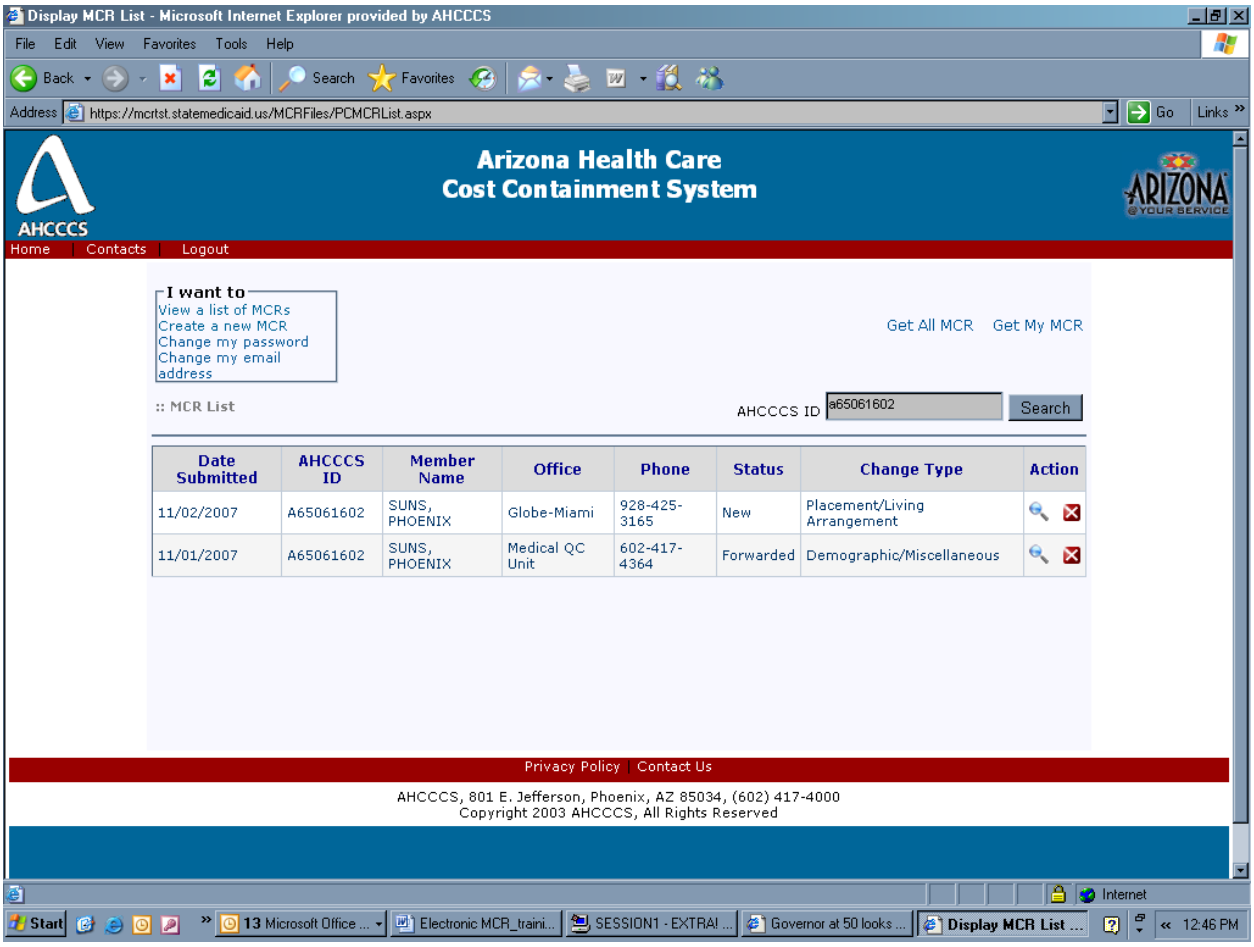
Clicking on the image in the "Action" column of a specific MCR will "close" that MCR and remove it from the Program Contractor's list. **This should only be done after an MCR has been responded to by AHCCCS** (either action taken or information to indicate why no action was or will be taken) because the MCR can **not** be retrieved once it is closed.

The "Create a new MCR'' button in the "I Want to" box (upper left) will display a screen where a new MCR can be created.

The "Search" button (upper right) can be used to search, by AHCCCS ID#, the Contractor's master list of MCRs for all MCRs submitted and not yet closed for a specific member. A filtered list will be displayed (see page 8 of this policy). Clicking on "Get all MCRs" will then return the user to the unfiltered, master list of MCRs.

From this screen, users can also change their password and/or email address that was entered when their account was created.

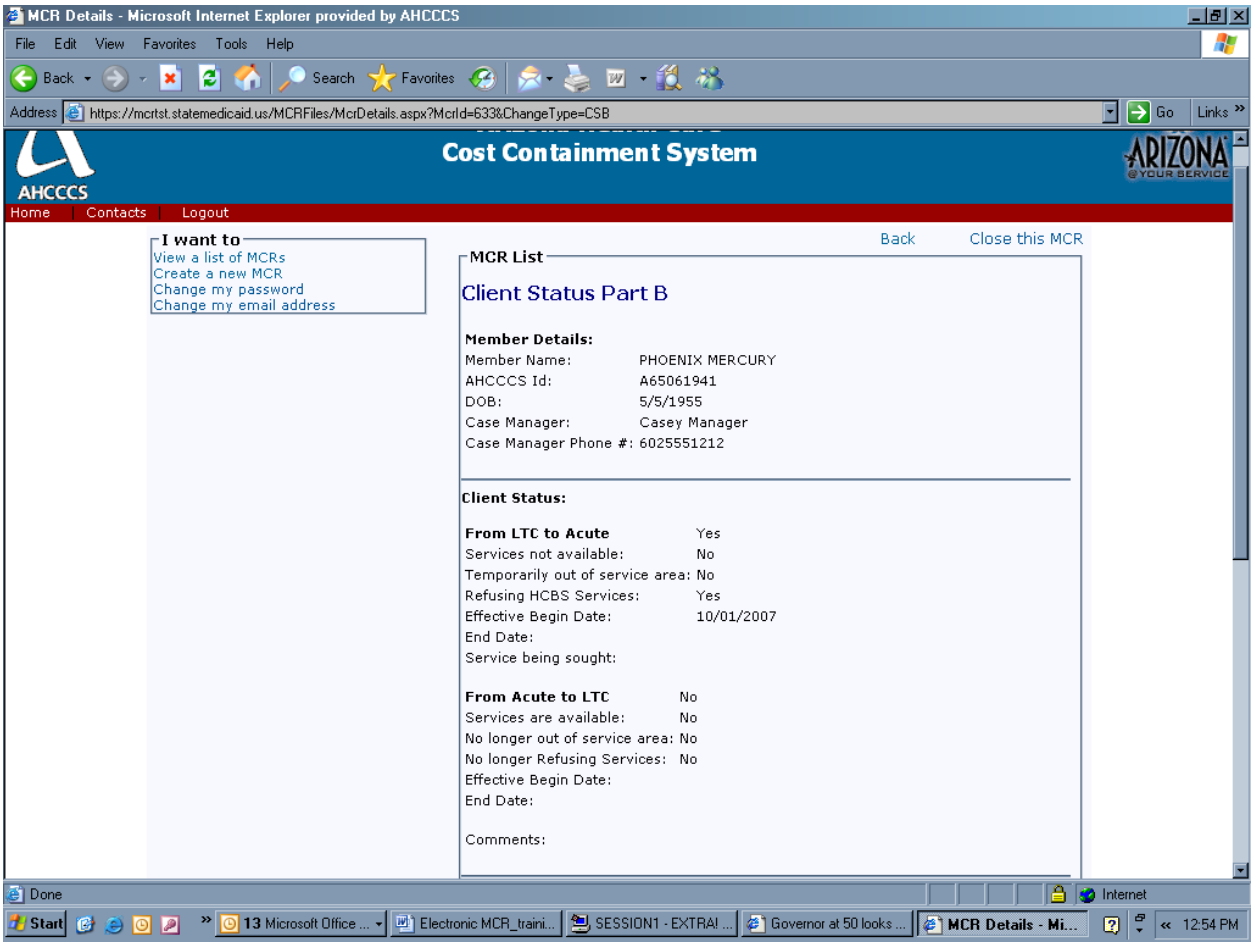
1. Home Page - Search by AHCCCS ID



This screen example shows how all the still-open MCRs for a selected member will be displayed when the member's AHCCCS ID# is entered and the "Search" function is used.

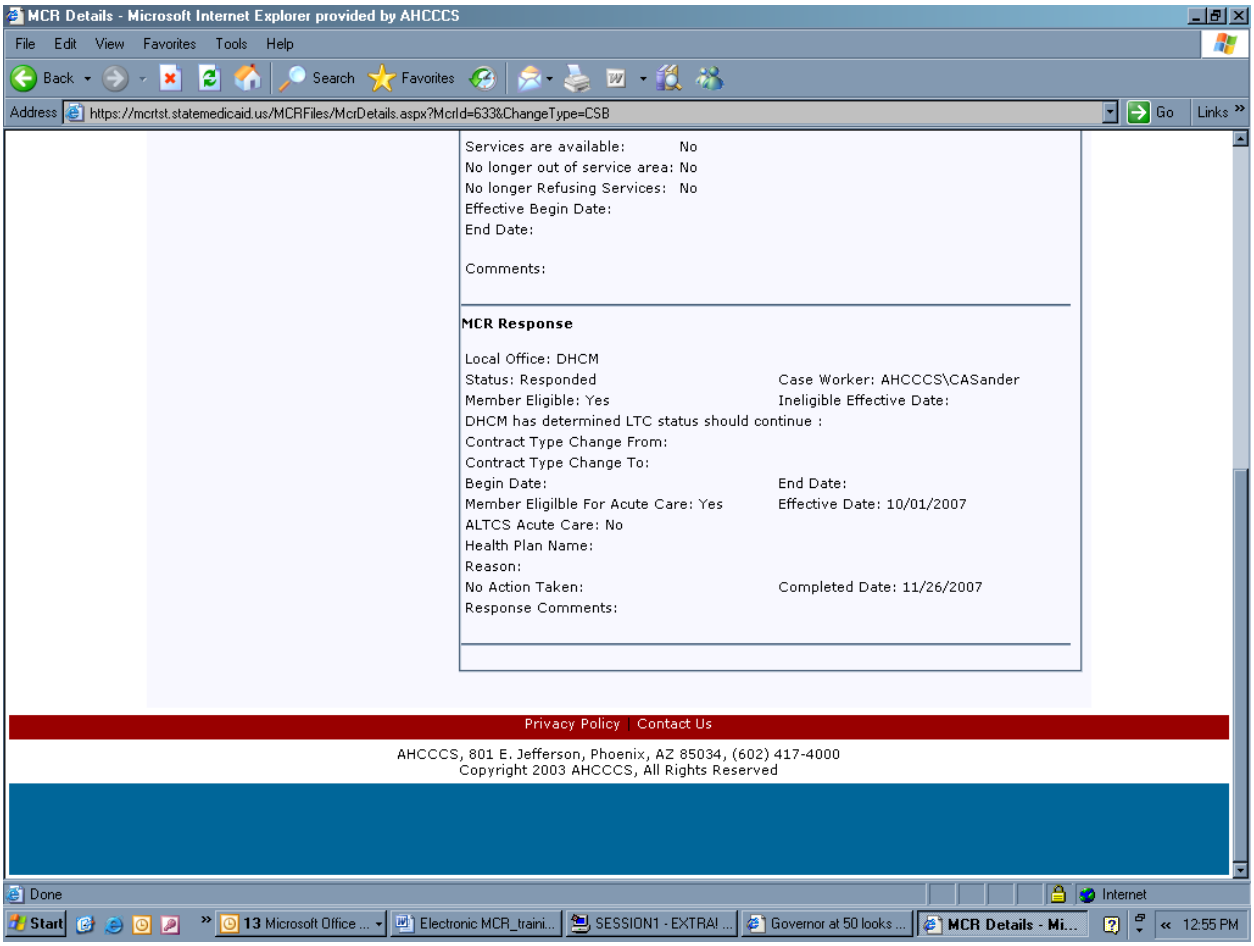
The "Get all MCR" button can be used to return the user to the master list of all still-open MCRs for the Contractor on their "home" page.

2. Home Page - Responded MCR view



- This screen, and the continuation on the following page, shows an example of the view of a "Responded" MCR that the user will see by clicking on the image in the "Action" column of the specific MCR.

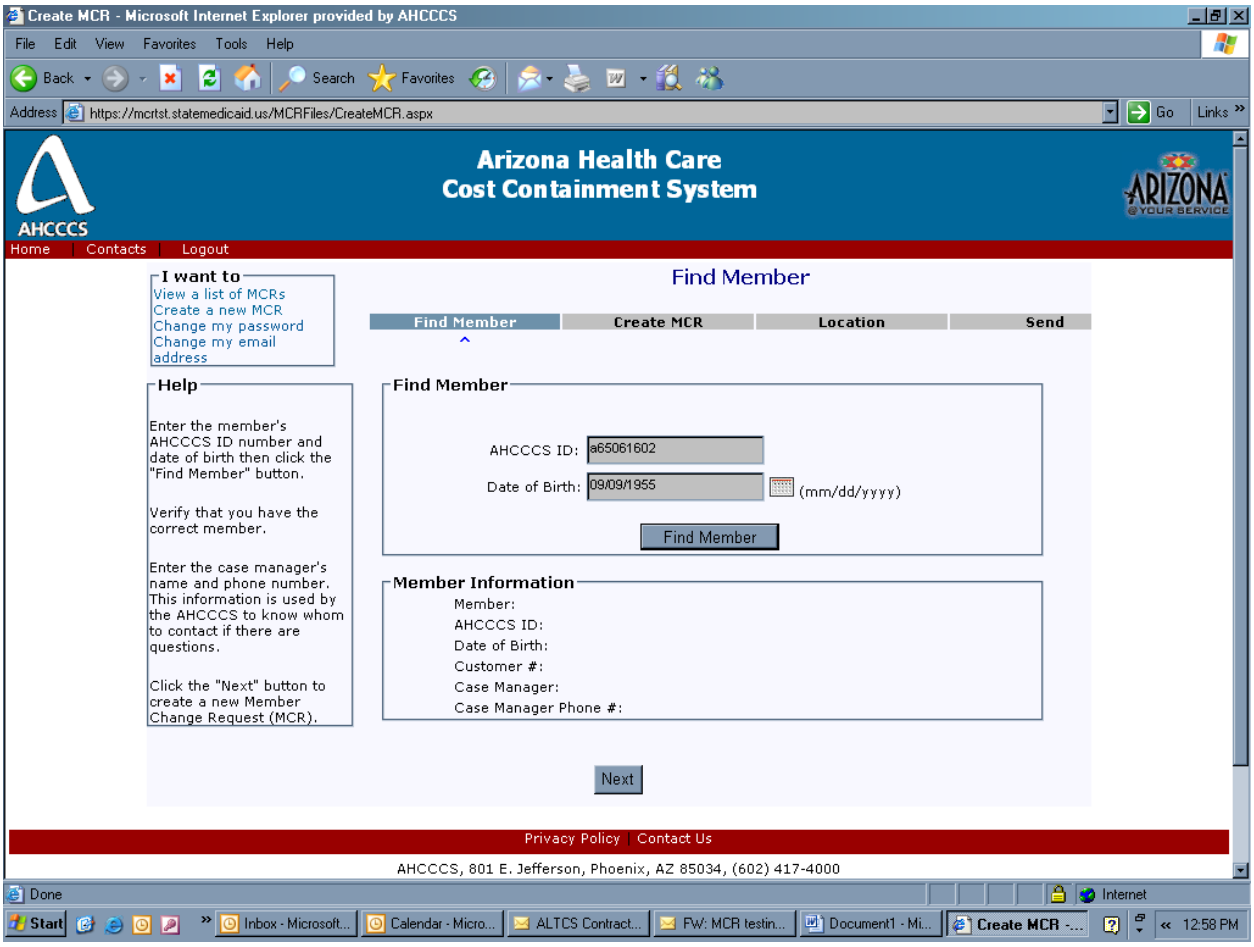
Responded MCR view – cont'd



- The bottom of this screen, as shown above, shows the action(s) taken by AHCCCS based on the MCR submitted by the Contractor and any comments that the AHCCCS representative may have with regard to that action.
- "No Action Taken" may be the action response sent by AHCCCS if the change requested could not be made for some reason. Comments should be included to explain that.
- The Contractor/user should click on "Close this MCR" at the top of the screen after reviewing the response to remove this completed MCR from the list of pending MCRs on the Contractor's home page. Once closed, an MCR can not be retrieved.
- If the Contractor feels further action is still required on this case, the case manager should contact the appropriate AHCCCS staff regarding the action. Another MCR will likely be needed but may need to be clarified or submitted differently. The original MCR can not be re-submitted.

E. Create a New MCR

1. Find Member Part 1

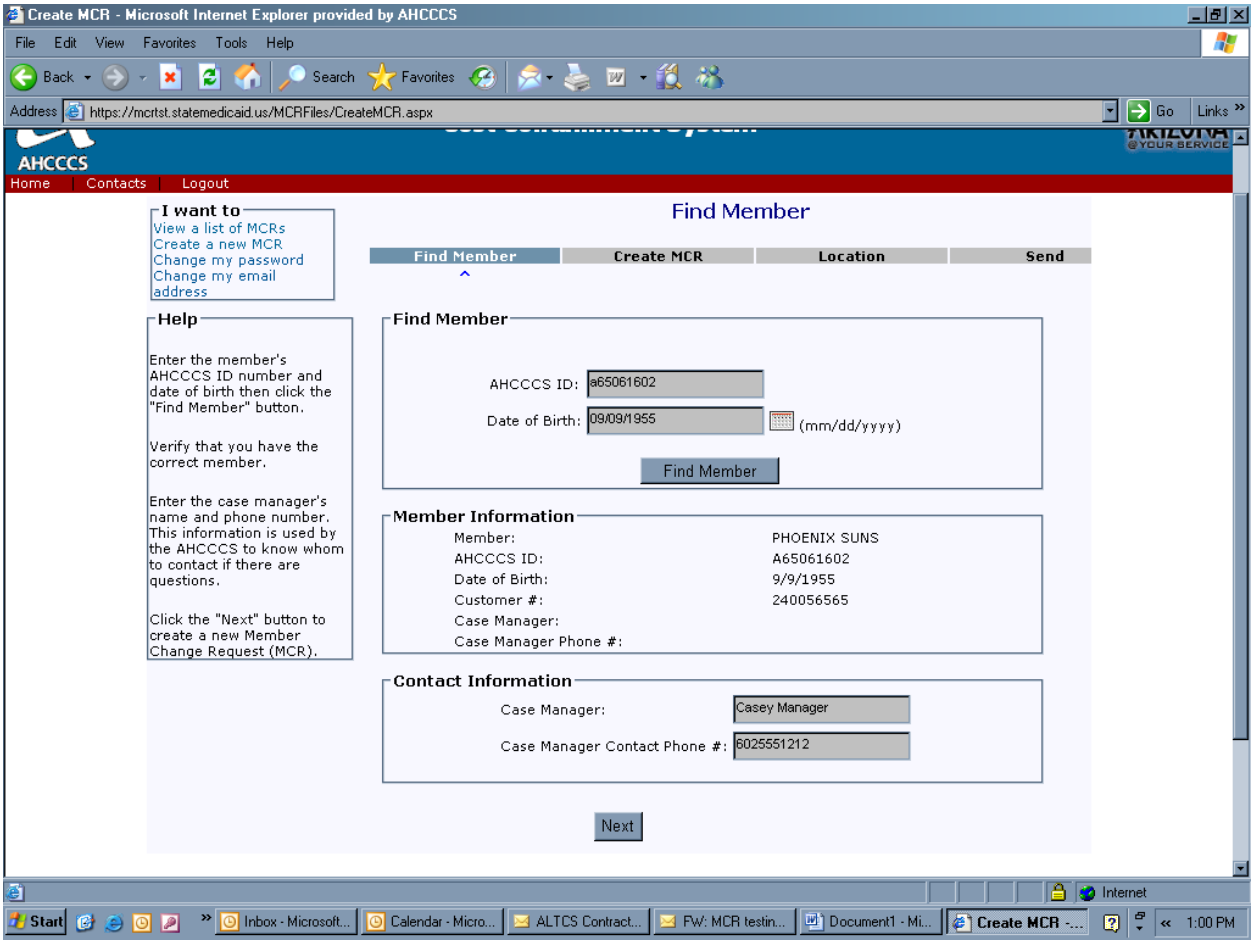


- This page is shown when "Create a New MCR" is chosen from the "I Want to" box.
- In order to begin this process, an AHCCCS ID# and Date of Birth for the member must be entered and then "Find Member" clicked. Only members currently enrolled with the Contractor will be available and displayed in the "Member information" box at the bottom of the page when/if found.
- A message "Member not Found" will be displayed under the following conditions:
  - The member ID# entered is not recognized
  - The Date of Birth entered does not correspond to the member ID# entered
  - The member is not currently enrolled with the Contractor
- After the desired member is "found", his/her information will be displayed in the "Member Information" box. The user will then be prompted to enter case manager information as shown on the following page.

- If an MCR needs to be sent to AHCCCS on a member who is not currently enrolled with the Contractor, a hard copy MCR needs to be completed and mailed or faxed in. A copy of the paper MCR can be found in the AHCCCS Medical Policy Manual, Chapter 1600.

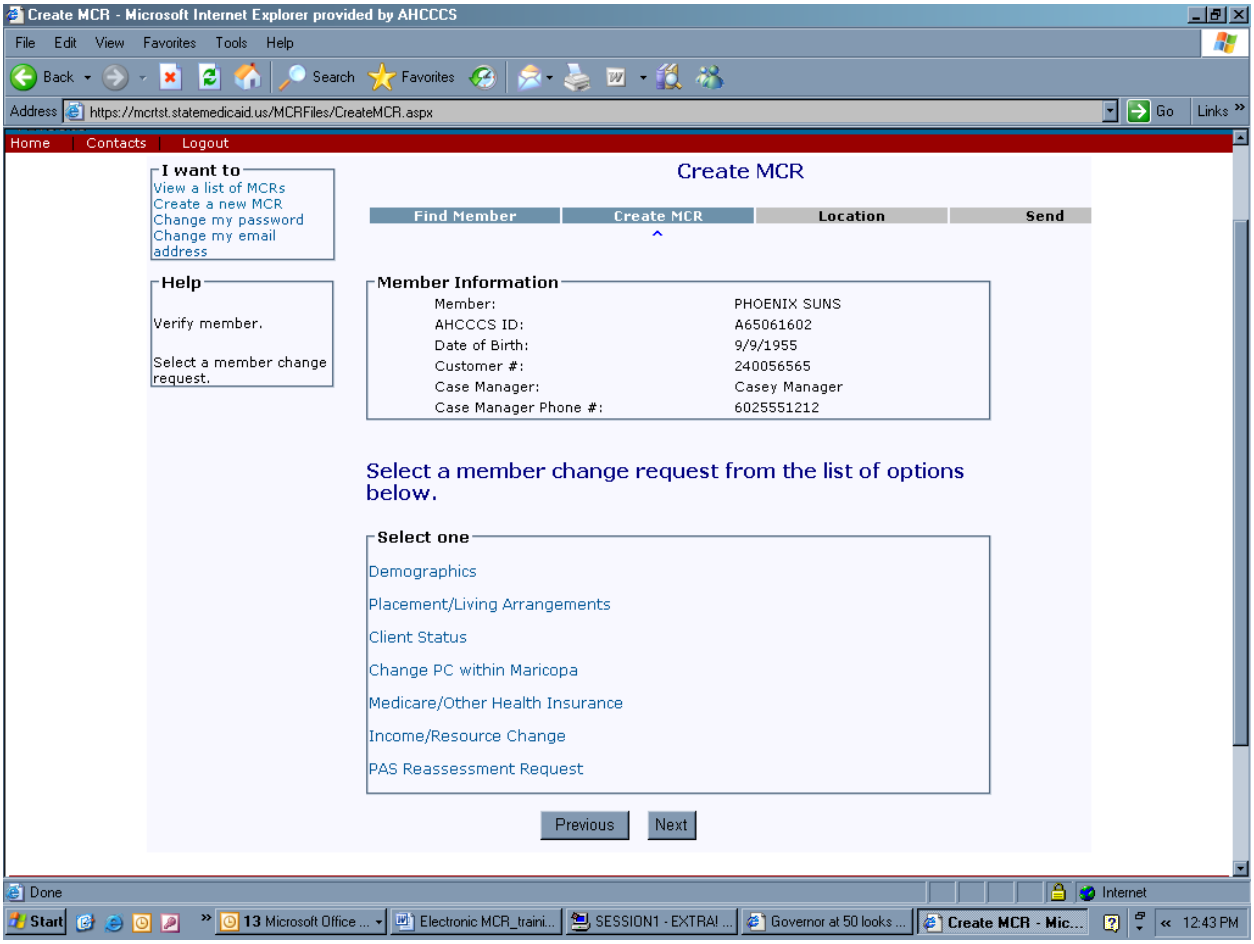
- Help information about each screen will be displayed in the column on the left.

2. Find Member Part 2 – Case Manager Data



- Once the member sought from the previous screen is displayed, the user must enter the name and phone number of the member's case manager as shown above in the "Contact Information" box.
- This information will be used by AHCCCS staff processing the MCR who may have a question about the MCR. The person's name entered here could be the assigned case manager or anyone at the Contractor who would be able to answer questions about the member status being reported on the MCR.
- Once the "case manager" information is entered, the user should click "Next" to continue the process.

3. Change Type

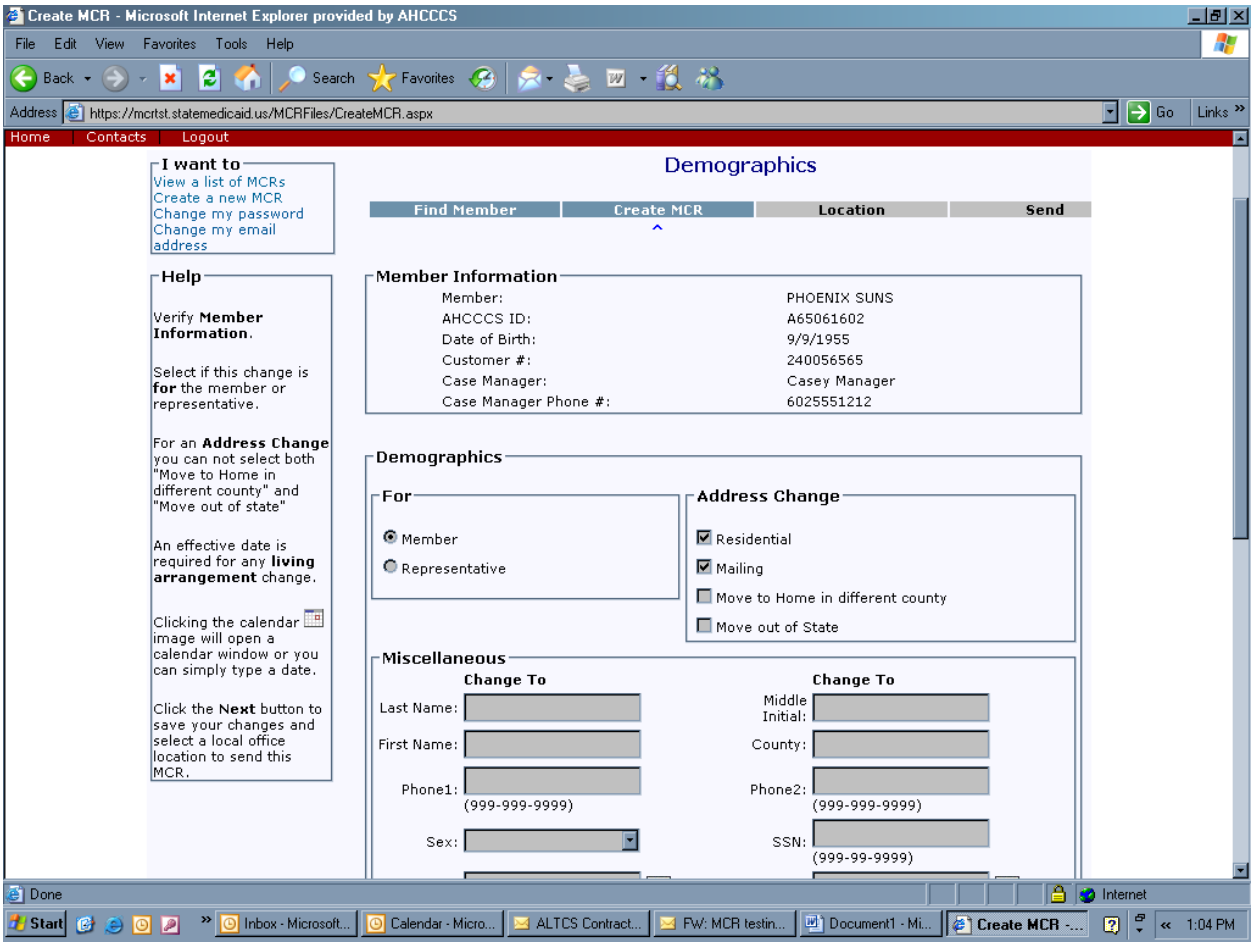


- From the page shown above, the user will select the type of change to be reported with this MCR for the member. The options are:
  - **Demographics** – address or phone number changes for member and/or representative, change of county for member, changes to name, date of birth or death and Social Security Number. This does **not** include placement changes.
  - **Placement/Living Arrangements** – changes to member's placement type (for example, home to NF, ALF to home, ALF to NF, etc).
  - **Client Status** – Voluntary Discontinuances, temporarily out of state, changes from LTC to Acute Care Only and from ACO to LTC.
  - **Change PC within Maricopa County** – changes in Contractor in Maricopa County requested by member/representative outside of Annual Enrollment Choice period.
  - **Medicare/Other Health Insurance** – changes in enrollment in Medicare or other health insurances

- **Income/Resource Change** – changes in member's or spouse's income and/or resources
- **PAS Reassessment Request** – to request a PAS reassessment due to change of member's condition (no longer appears eligible), Transitional member admitted to a nursing facility or, for DD members, when member is no longer DD eligible.

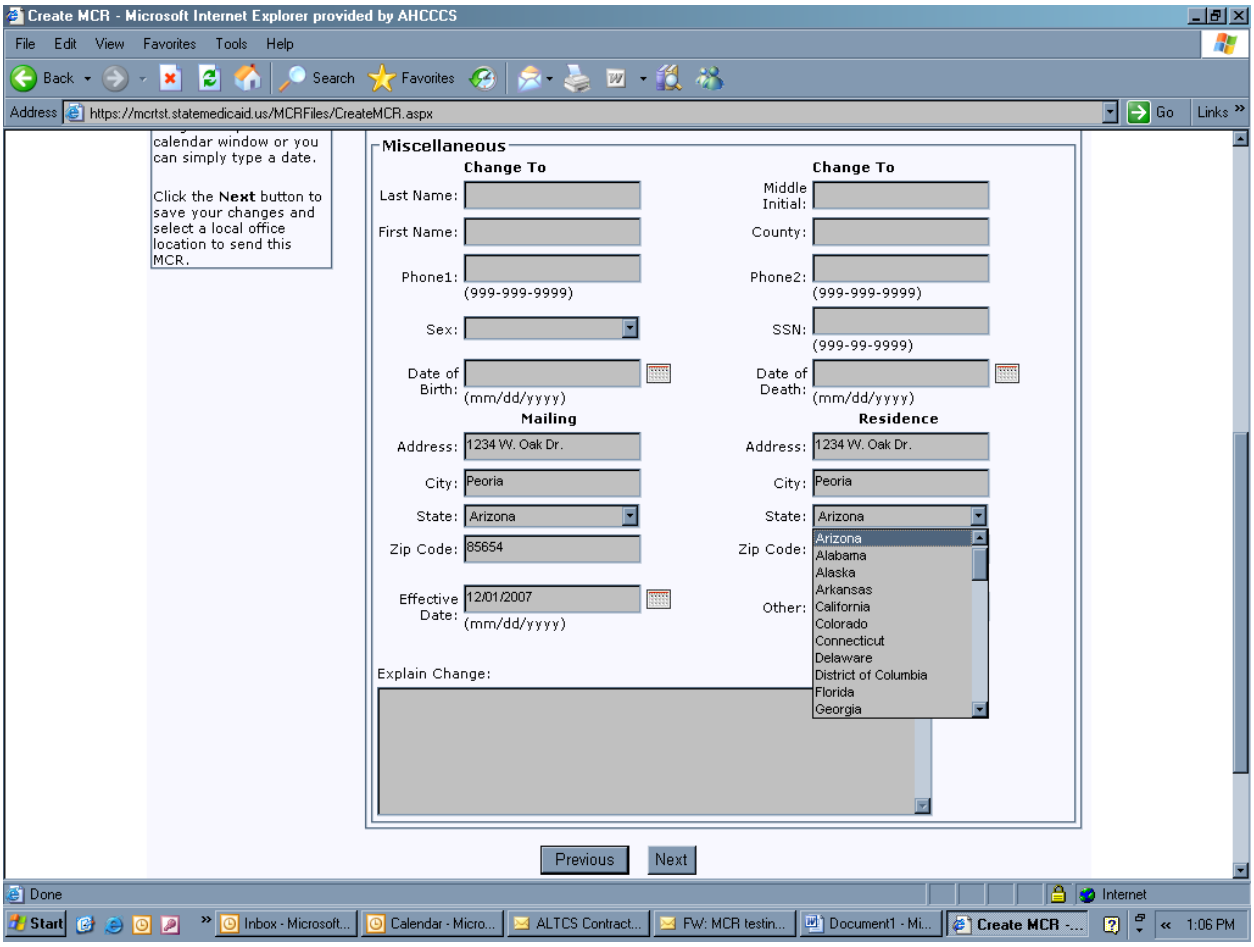
- Clicking the "Next" button will take the user to the first screen for the Change Type selected above.

F. Create a New MCR – Demographics



- This page and the following page show those fields on the Demographic screen which may be completed to report a demographic change for the member and/or representative. Using the scroll bar on the right makes those on the following page visible.
- In the box marked “Demographics”, the user must indicate who the change to be reported is for, the member or the member’s representative.
- In addition, the type of change(s) must be checked in the “Address Change” box. Address changes can be Residential and/or Mailing and Move to Home in a different county or Move out of State (these last 2 may not be chosen together).
- In the top portion of the “Miscellaneous” section visible on this page, the user will begin to enter applicable changes. Only the “Change To” information needs to be provided.
- If “Move to Home in a different county” is checked, new county information must be entered in the box labeled “County”.
- Note the required format for entering phone numbers and the Social Security Number – dashes are required.

Create a New MCR – Demographics, cont'd

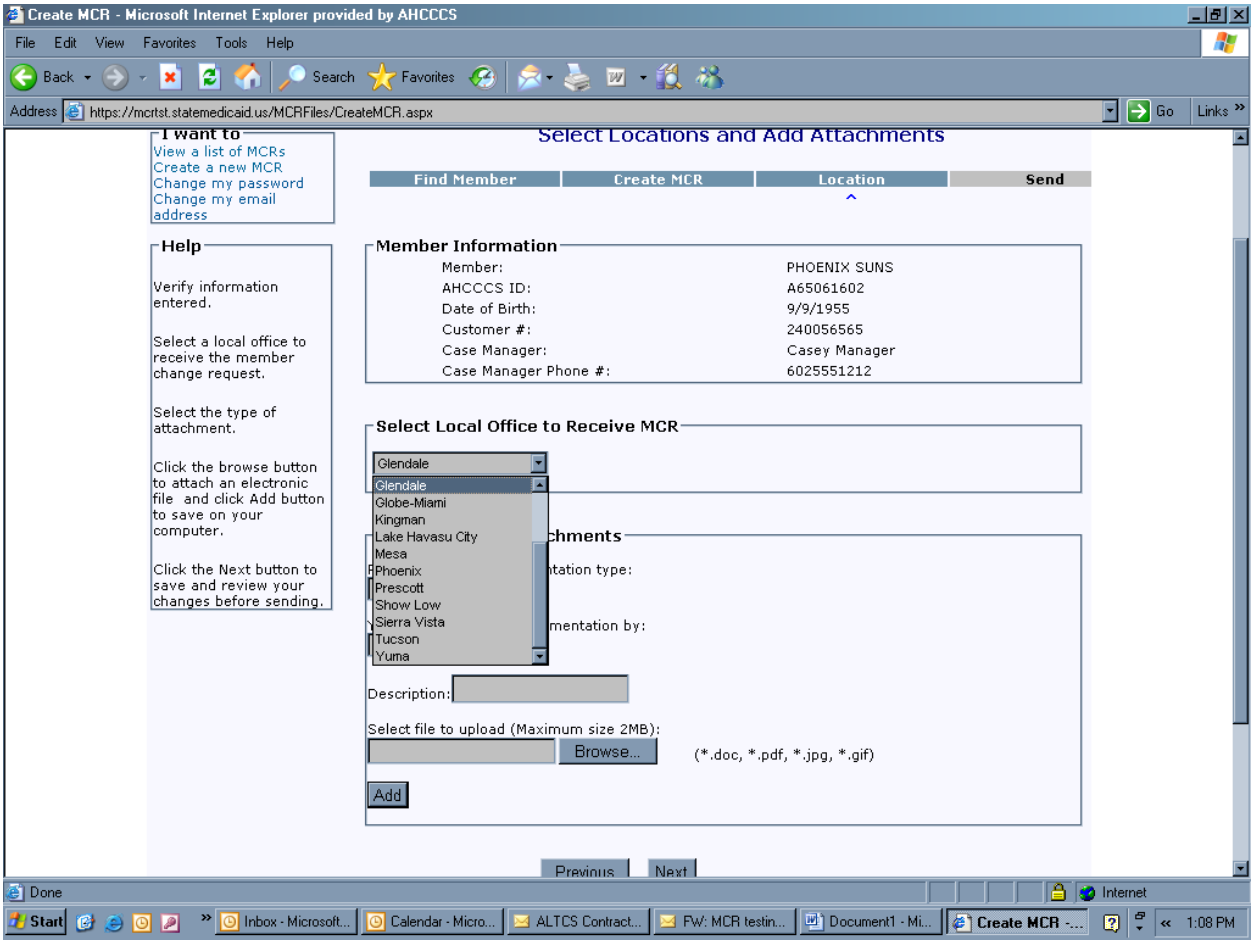


- In this bottom half of the Demographic screen, the user may enter a change of Date of Birth and/or Date of Death. Please note the required format (mm/dd/yyyy). Clicking on the calendar icon will display a calendar of the current month. The user will need to scroll backwards to find an earlier date.
- Once the calendar icon is clicked, the user must pick a date from the calendar. The date chosen can be changed but can **not** be deleted except by clicking on the "Previous" button and starting over. **It is recommended that users simply enter the desired date in the format shown (mm/dd//yyyy) rather than using the calendar icon.**
- Mailing and/or Residence address changes should be entered as shown in the example above. The system does **not** edit for misspelled street or city names, incorrect zip codes or mismatches between zip code and city.
- **Address changes associated with Placement changes (admissions to and discharges from residential settings) should be reported as a Placement/Living Arrangements change, not a Demographic change. Address changes in the Demographic section are limited to moves between "own home" settings.**

- Arizona will appear as the Default if/when the user simply types an "A" in the state field. Alternately, Arizona can be chosen from the drop down list. It appears at the top of that list and all other states are in alphabetical order following this.
- An "Effective Date" of the change reported must be entered.
- Clicking the "Next" button will take the user to a screen where the local office location to which the MCR will be sent is selected.

G. Select Location and Add Attachments

This screen is the same for all types of MCR changes

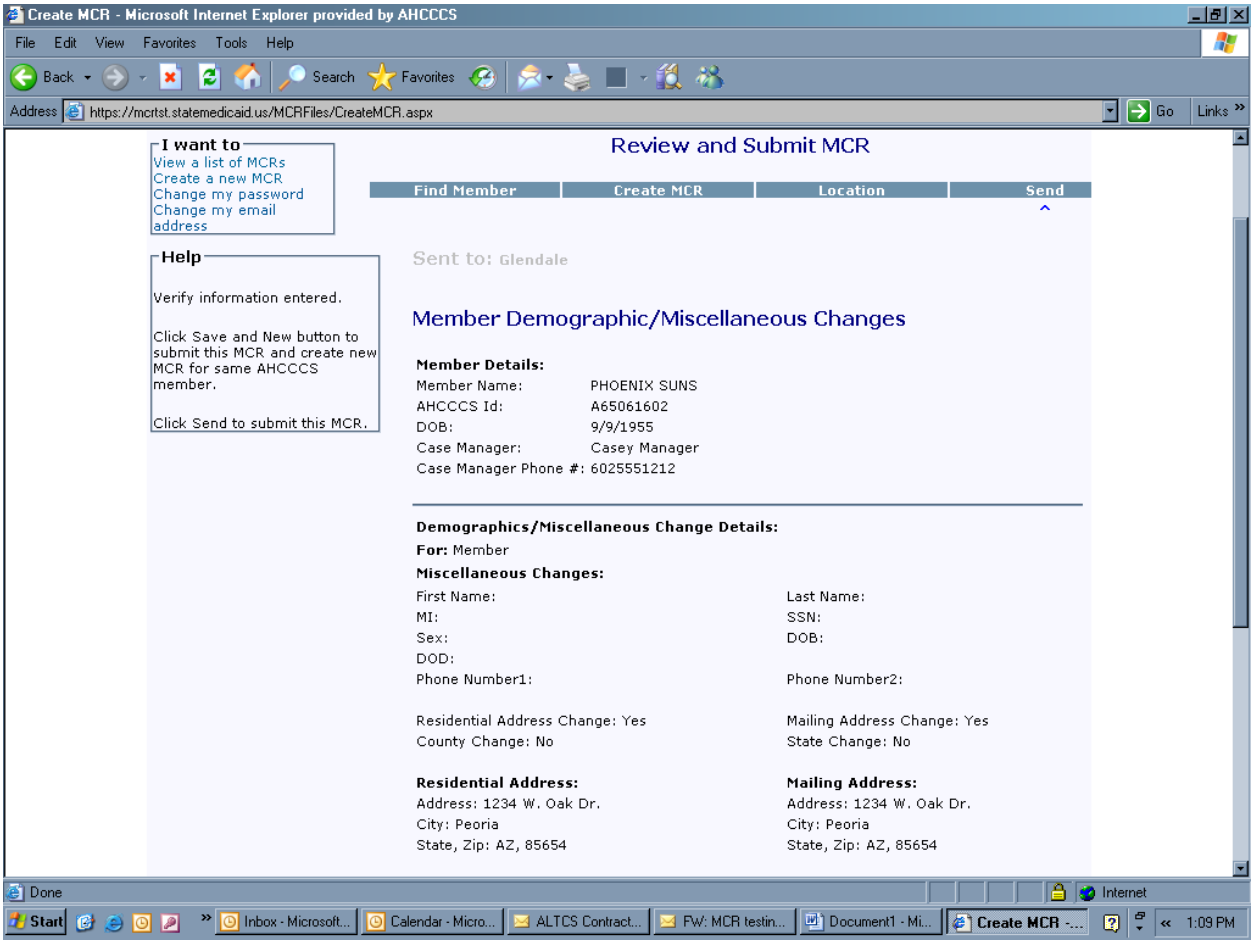


- This screen will appear after the data entry screens for all Change types.
- From the drop down list available in the "Select Local Office to Receive MCR", the user should choose where the MCR should be sent. The choices available in the list will depend on the type of change being reported. For example, Demographic, Placement and Income/Resource changes can only be sent to one of the local eligibility offices whereas Client Status changes for LTC to ACO and vice versa can only be sent to the Division of Health Care Management.
- For changes to be reported to the local eligibility office, the user must know which office is responsible for the case. This information is available on CA166 with an "Office" code (list of code definitions can be found in Policy 411 of this manual on PMMIS).
- From this screen, the user can either add attachments or indicate attachments will be sent via fax or US Mail. More information is provided on how to add attachments on page 27 of this policy.
- Clicking the "Next" button will take the user to a screen where the details of the MCR just created can be reviewed prior to sending it to AHCCCS.

- If the user moves on to the next screen for review and then finds something that needs to be changed, s/he must scroll backward to the appropriate screen to make that change as described on the following pages.
  When the user then scrolls forward again, the location where the MCR should be sent must be chosen again on this Select Location screen as it will not have been saved. Any attachments previously added will have been saved, though.

H. Review and Submit MCR

This screen is the same for all types of MCR changes

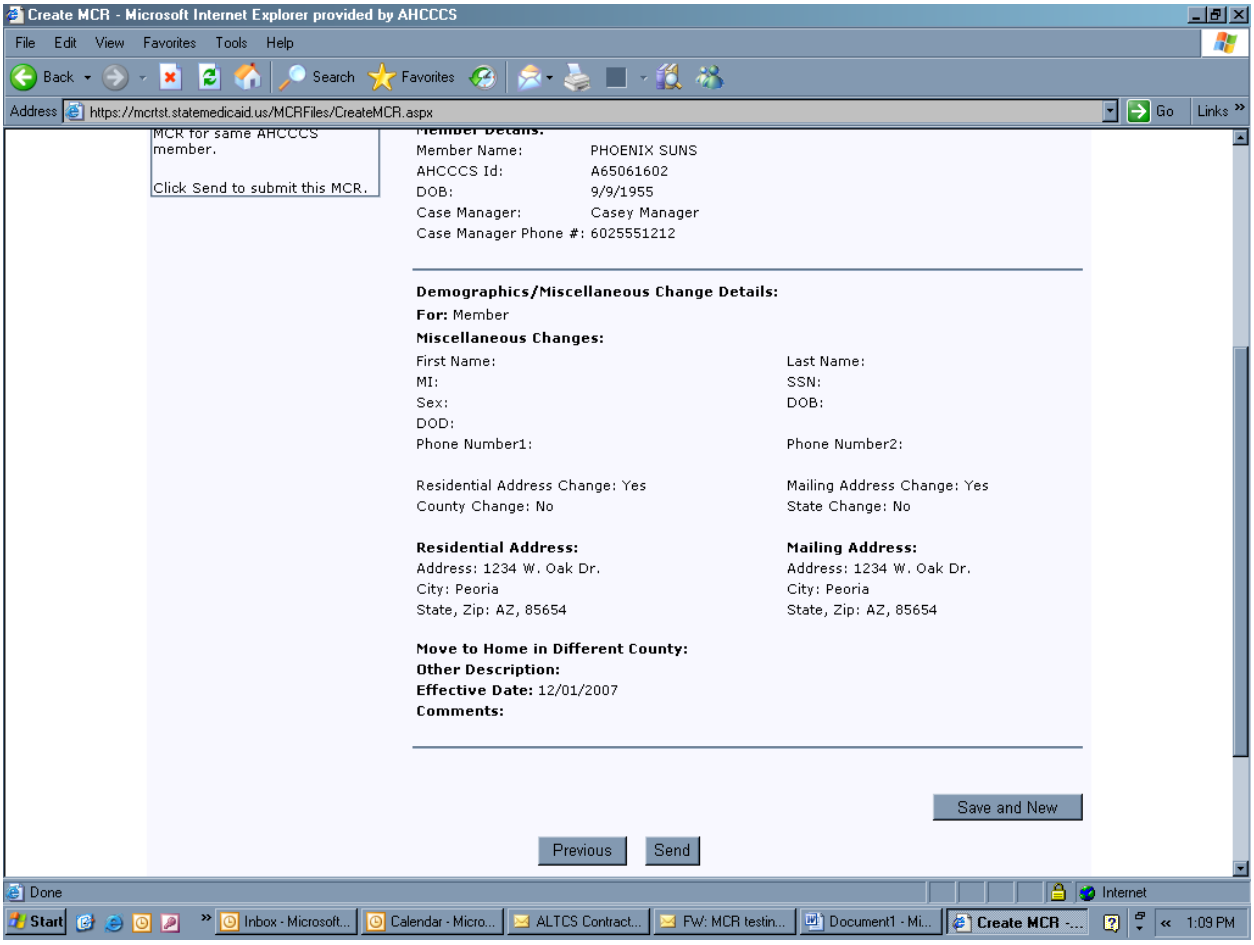


- This page and the following one display all the change data that was filled in on the prior screens by the user. It should be reviewed to ensure accuracy before sending the MCR to AHCCCS, including the location where the MCR will be sent (shown above the title of the MCR Change Type as "Sent To:").

- A review screen similar to the one shown above will appear after the data entry and Select Location screens for **all** Change types.

Review and Submit MCR – cont'd

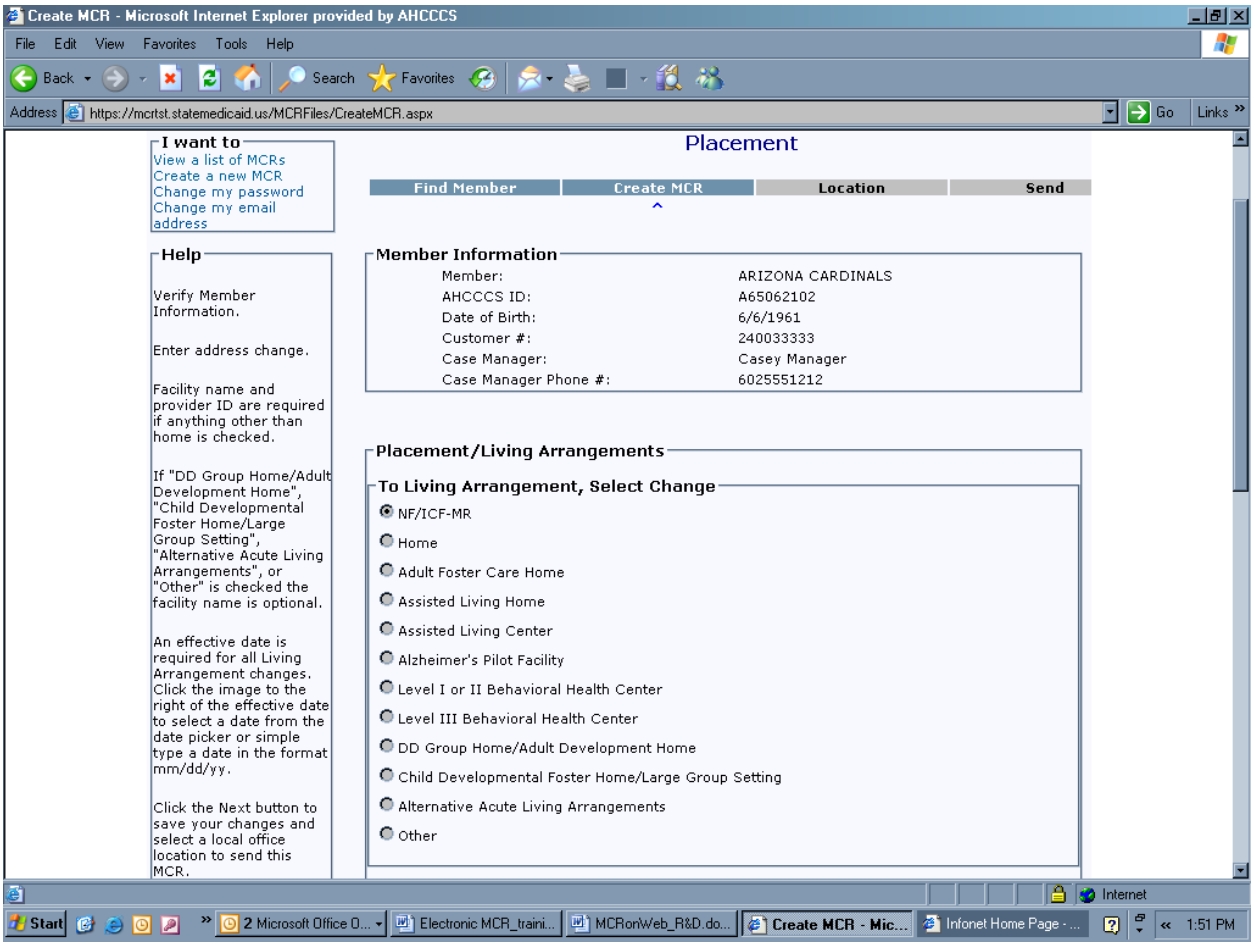
This screen is the same for all types of MCR changes



- Clicking the "Send" button submits the MCR to selected AHCCCS location and then returns the user to the Contractor's "home" page. The just created MCR will appear on that page in the Contractor's MCR list with Status "New".
- The "Save and New" button saves the change information already entered and allows the user to create another MCR for a different change type for the same member. For example, if the user just finished reporting an address change for the member and now wants to also report an Income/Resource change. The user is returned to the "Create MCR" page to choose the new change type to be reported (page 13 of this policy).
- When all MCRs for the same member have been created, the user will click "Send" from this screen and all will be sent as designed. Each MCR/change type for the member will be listed separately on the Contractor's "home" page.
- If the user discovers an error in the entered data, clicking the "Previous" button will take the user, screen by screen, back through the previous screens to find the location where the data needs to be changed.

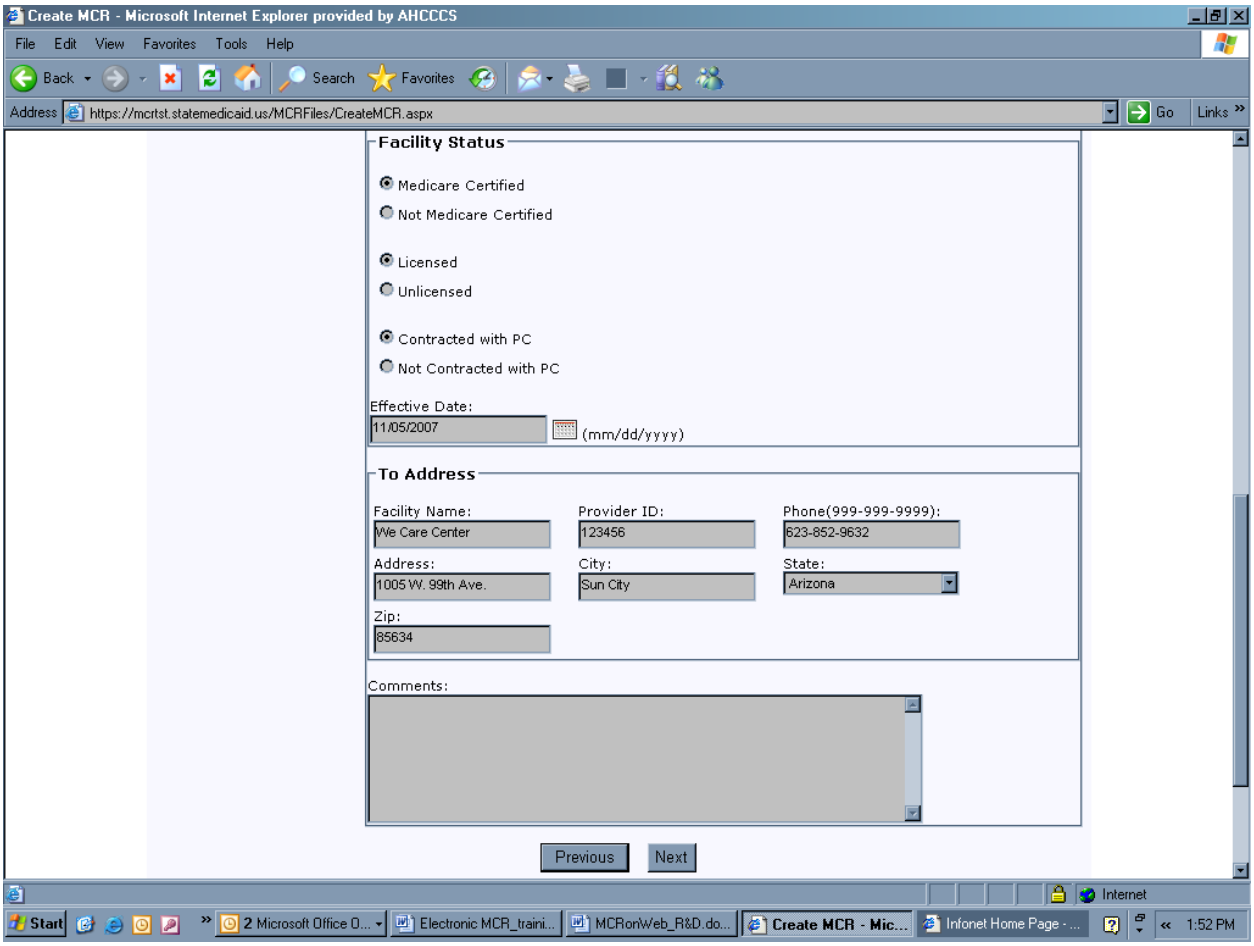
As before, clicking the "Next" button, after making those changes, will bring the user forward again to the "Select Location" screen and then this review screen. On the "Select Location" screen, the AHCCCS location to which the MCR should be sent must be chosen again, it is not saved when the user back-tracks. If, however, an attachment was added electronically (explained on pages 27-29of this policy), that document will be saved.

I. Create a New MCR – Placement/Living Arrangements



- This page and the following page show those fields on the Placement/Living Arrangements screen which need to be completed to report this type of change for the member.
- The box shown on this page lists the placement types to which the member may have moved.
- Note that a member who moves to their "own home" from a residential setting (or vice versa) should have that change reported as a Placement/Living Arrangement change, not a Demographic change (as described on pages 16-17 of this policy). Demographic changes are only used when a member moves from one "own home" address to another "own home" address.
- The "Other" box on this list should be used to report **Loss of Contact** with a member to the eligibility office. Additional information needed for this change type can be found on the following page.

Create a New MCR – Placement/Living Arrangements - cont'd



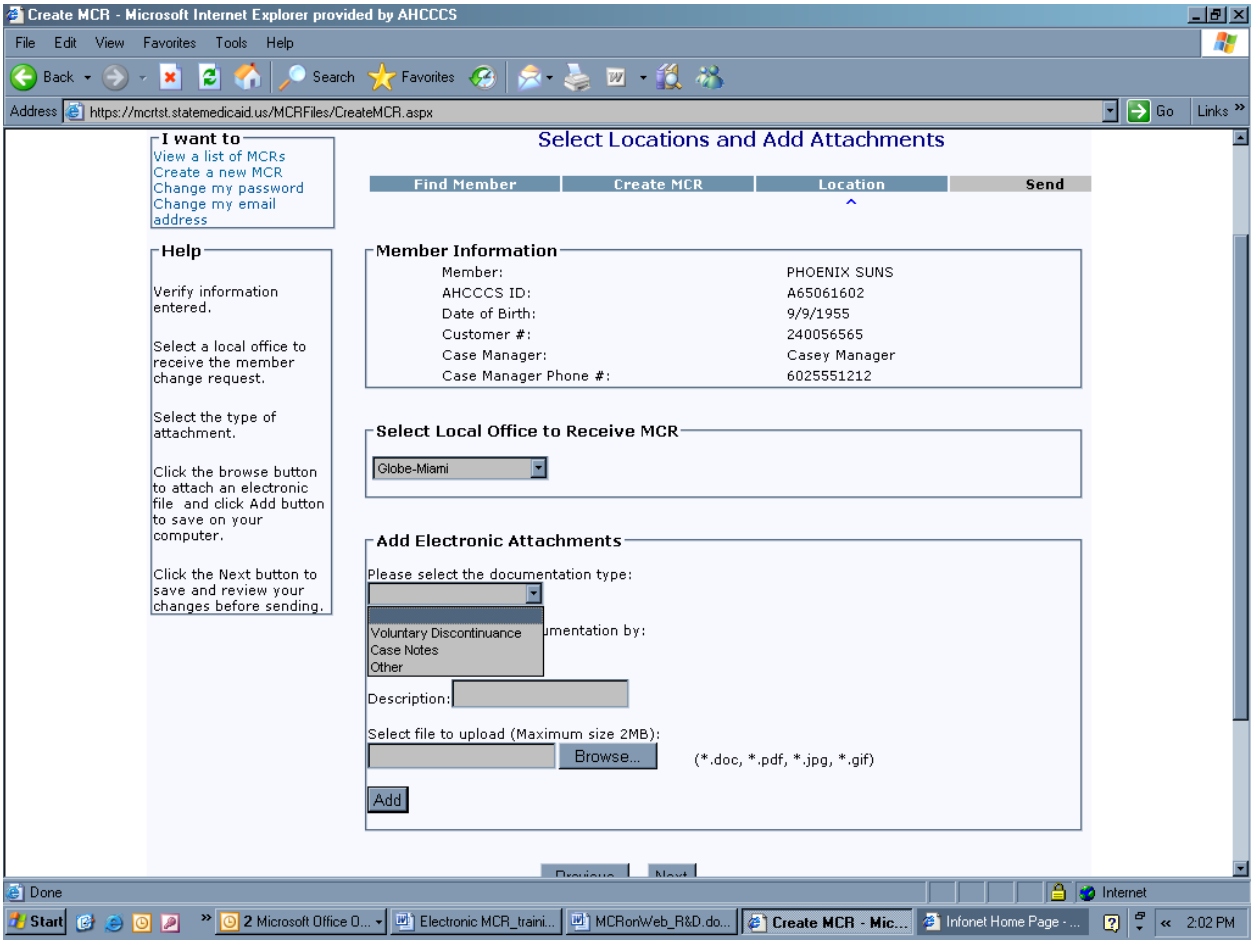
- None of the pairs of choices in the "Facility Status" box are required but, if known, should be marked to provide information to Eligibility.
- An Effective Date of the Placement change is required, in the designated format (mm/dd/yyyy), however, for **all** placement type changes.
- The Facility Name, Provider ID and phone # (in the designated format, with dashes) are required except for the following changes:
  - Home
  - DD Group Home/Adult Developmental Home
  - Child Developmental Foster Home/Large Group Setting
  - Alternative Acute Living Arrangement
  - Other
- The address information, including city, state and zip code, is required for all changes, except "Home".
- For **Loss of Contact** – enter the last known phone number and address information for the member and a comment to explain that the case manager has been unable to contact the

member at these. Eligibility may have updated information that they can send back to the case manager for contact.

- Clicking the "Next" button will take the user to a screen where the local office location to which the MCR will be sent is selected.

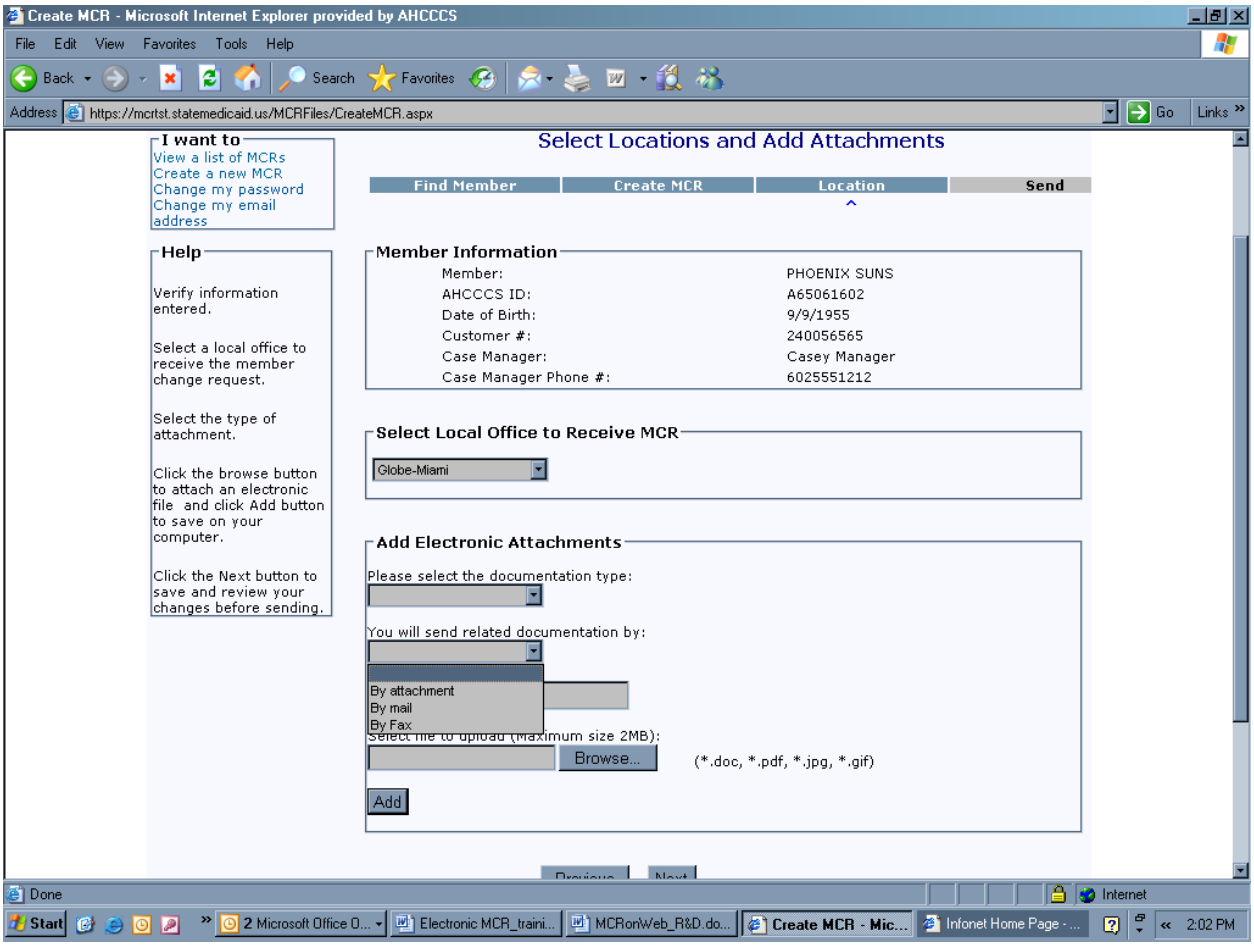
J. Add Attachments

This screen is the same for all types of MCR changes



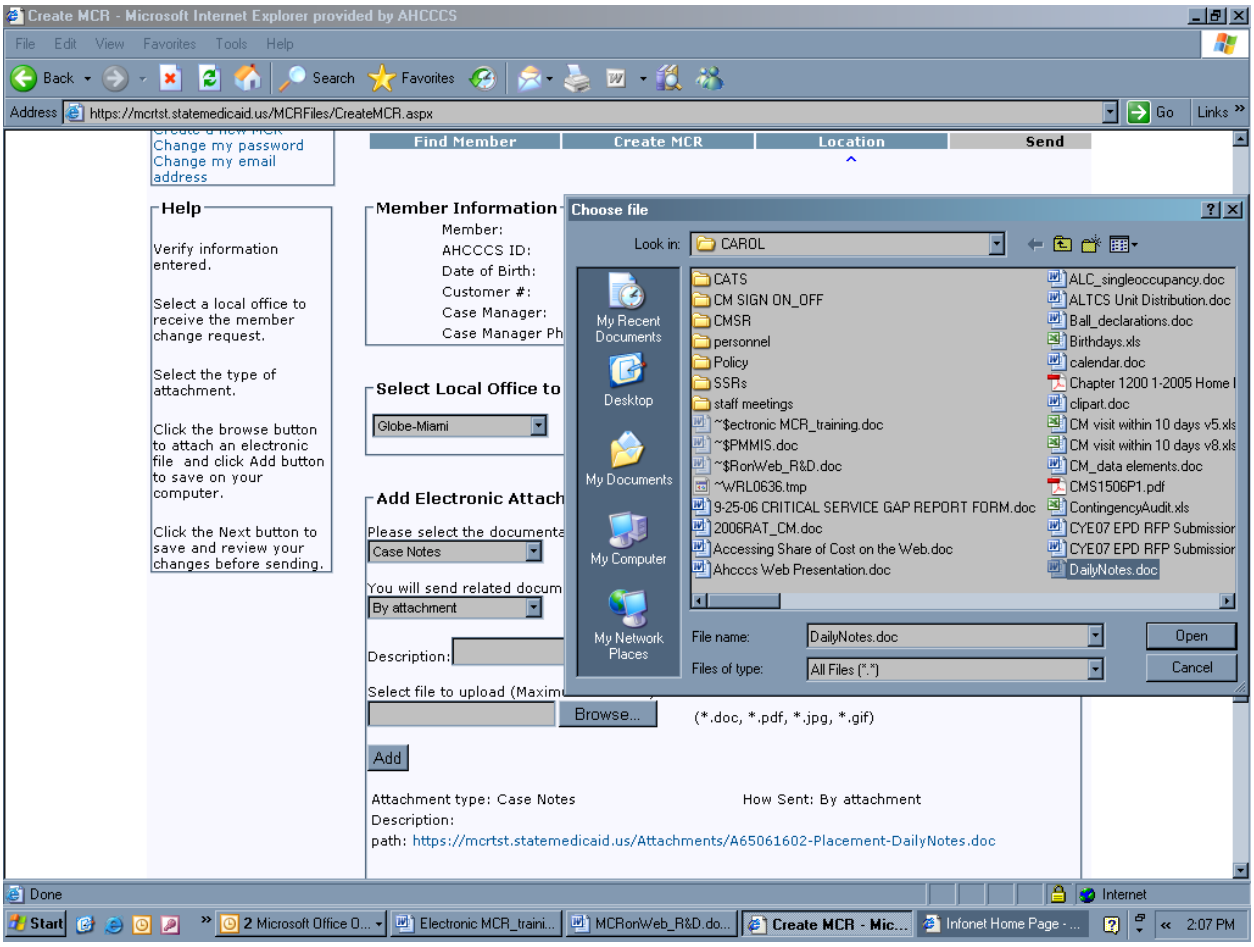
- This is the screen described on page 19 of this policy related to Selecting a Location for the MCR. Adding Attachments will be described here and the next 3 pages that follow.
- The user must first select the "documentation type" from the drop down, as shown above.
- A "Description" can be added to explain the attachment but this is not necessary.

Add Attachments – cont'd



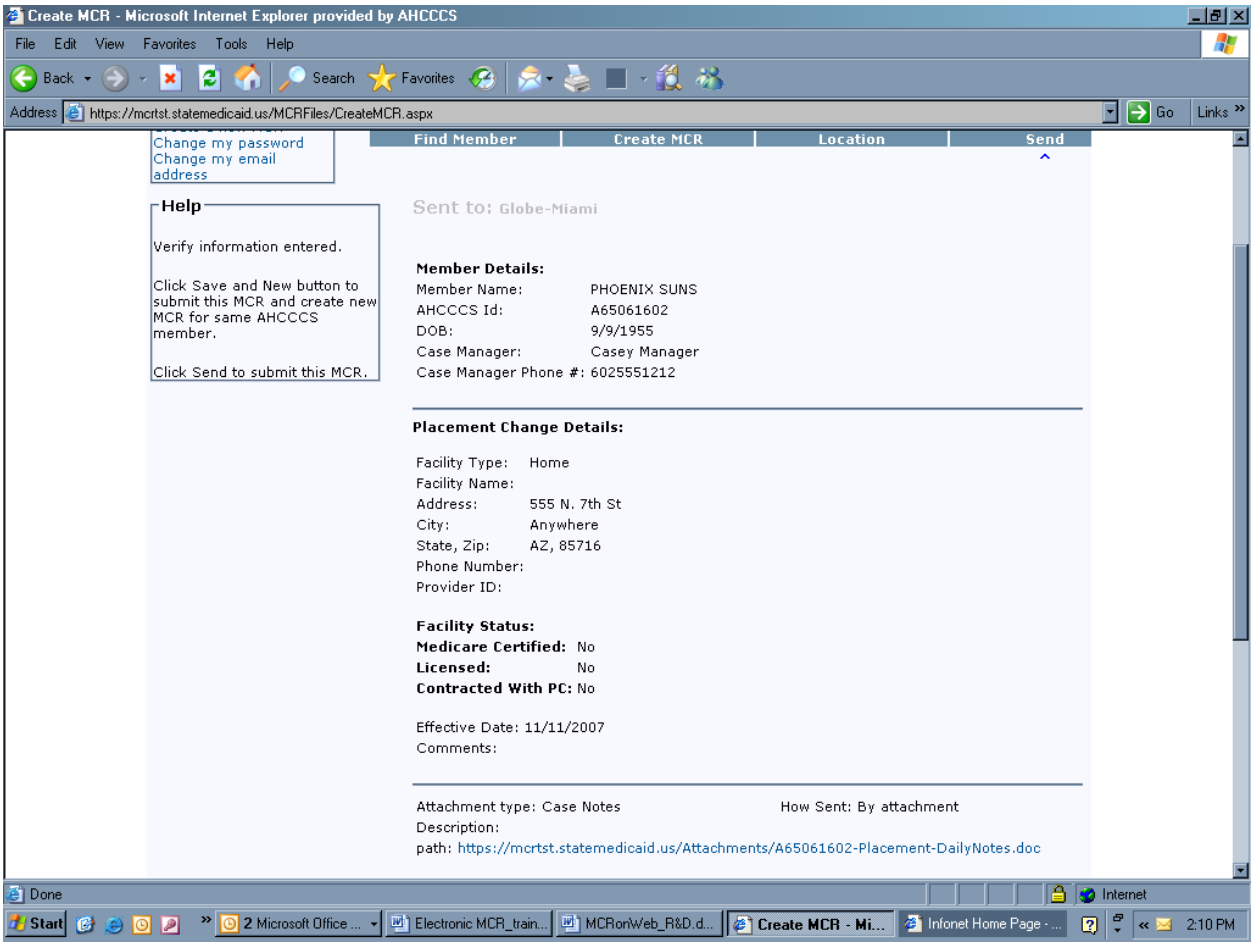
- In this next box, the user will designate how related documents will be attached or sent: by electronic attachment to the MCR, by mail to follow the MCR or by fax to follow the MCR.
- Regardless of the method by which the related documents will be sent, the user should then click the "Add" button. Clicking this button adds a note at the bottom of the Review screen (shown on page 30 of this policy) to alert AHCCCS of the attachment and how it will be sent.
- The user MUST click the "Add" button if "Voluntary Discontinuance" was selected, even when the document will be sent by Mail or by Fax.
- When documents associated with an MCR are faxed or mailed to AHCCCS, the sender should clearly indicate on the document that they are related to an MCR which was submitted electronically so they can be routed and filed correctly.
- If documents will be attached to the MCR electronically, the following 2 pages describe the steps necessary.

Add Attachments – cont'd 2



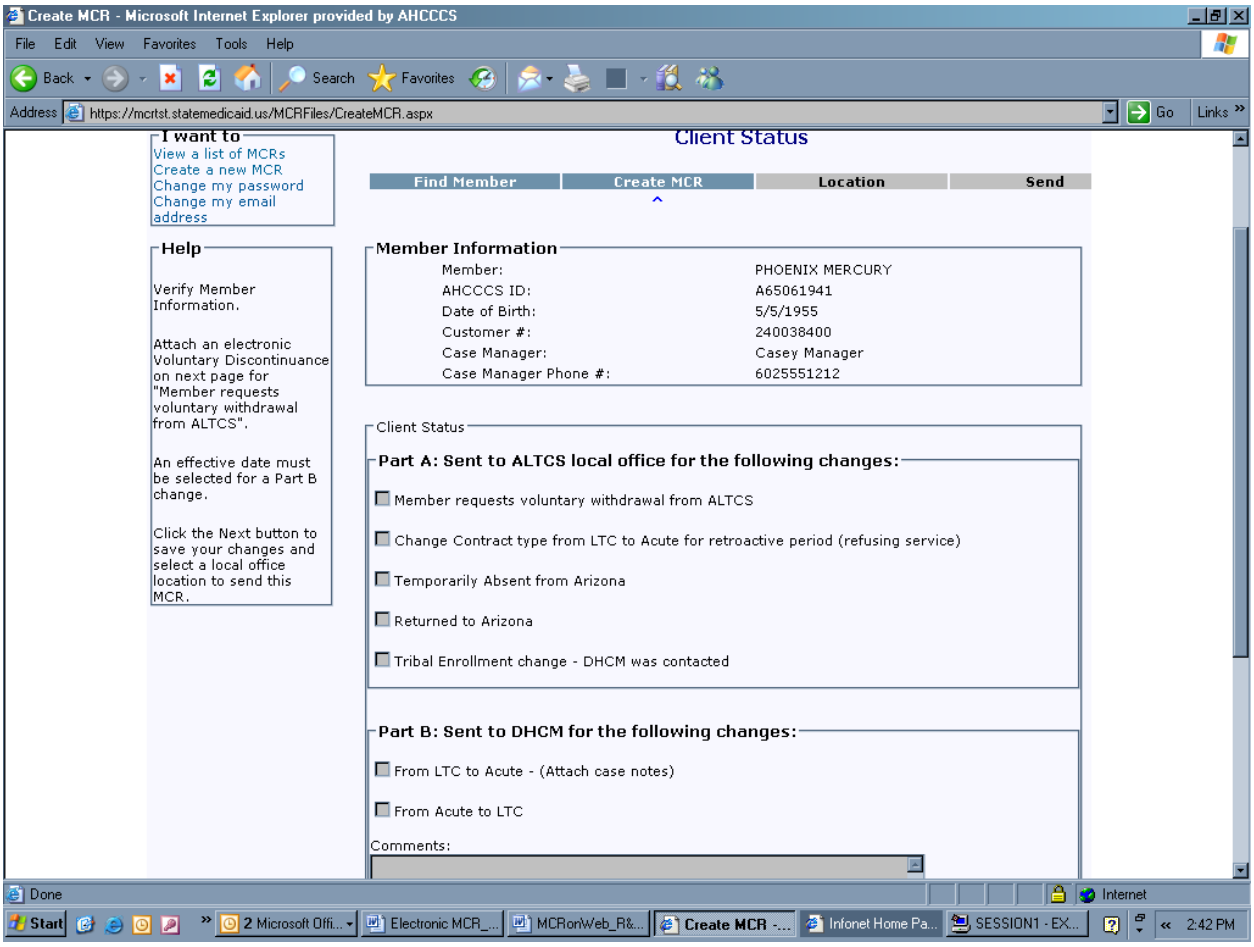
- By clicking the "Browse" button, the user should be able to access available drives within their Contractor's system in order to attach any files or documents saved there that may pertain to the MCR.
- The user should click the "Open" button in the Choose File window after highlighting the file(s) that need to be attached to the MCR.
- **The user must then click the "Add" button on the MCR screen.** If this button is not clicked, the document(s) will not be attached to MCR. When the document is attached, its path will appear at the bottom of the screen (see example above).
- More than one document can be added by repeating the above 3 steps for each document.
- **Once a document is attached in this manner it can not be deleted.**
- If the user back-tracks (using the "Previous" button) to make changes to the data entered on the MCR after adding an attachment, that document will still be attached when the user returns to this screen to re-select the location to send the MCR to.
- Clicking the "Next" button will take the user to a screen where the details of the MCR just created can be reviewed prior to sending it to AHCCCS.

K. Review and Submit MCR – Attachments



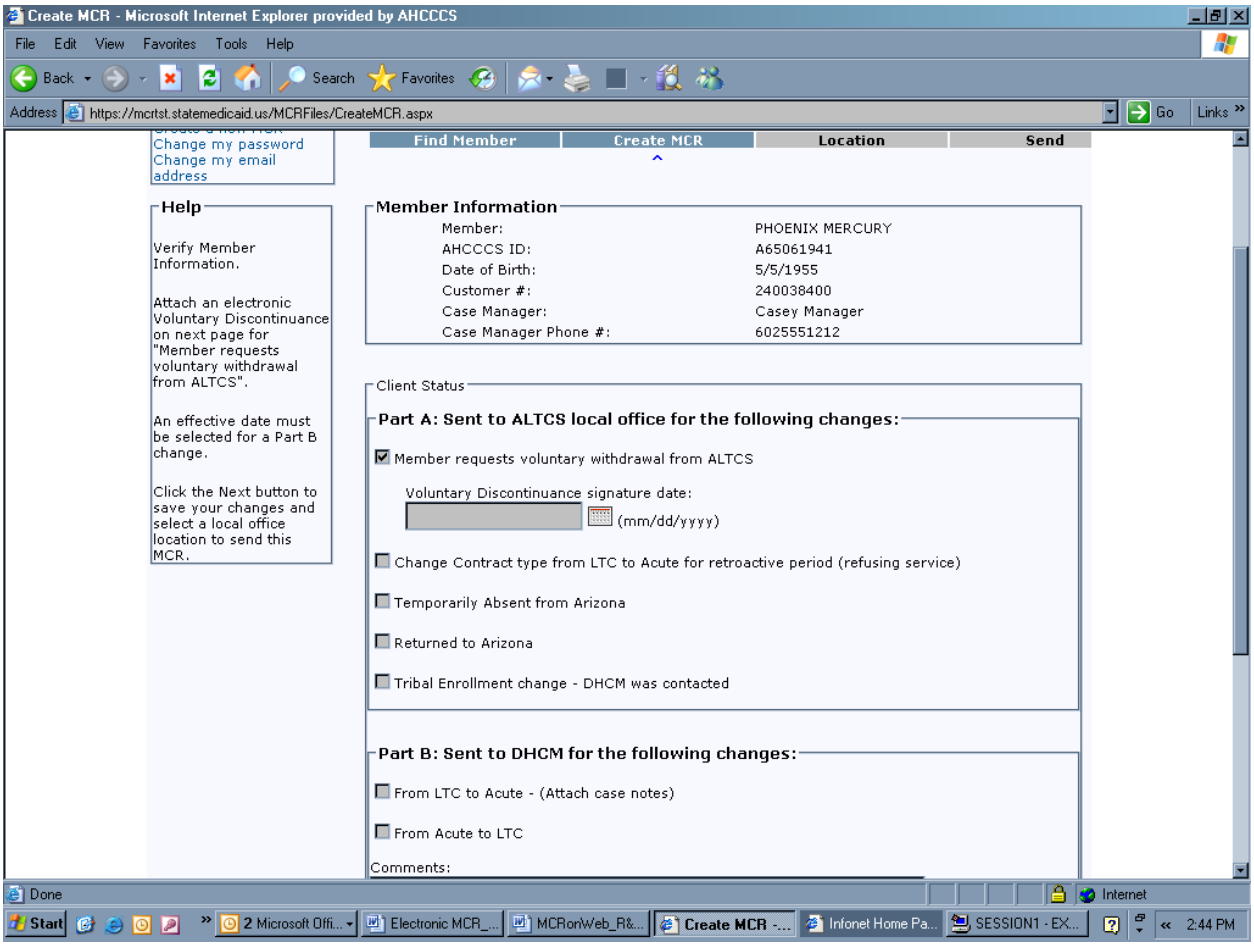
- In the above example, the review screen shows the Attachment Type, How Sent and because a document was attached electronically, the path of that document. When AHCCCS receives this MCR and clicks on the path, the document will appear.
- If more than one document was added, whether by electronic attachment, mail or fax or a combination of these, each should be listed separately as an attachment here.
- If the user intended to attach a document and it does not appear here, the "Add" button may not have been clicked on the prior screen and the user will need to go back and try to add the document again.

L. Create a New MCR – Client Status Changes



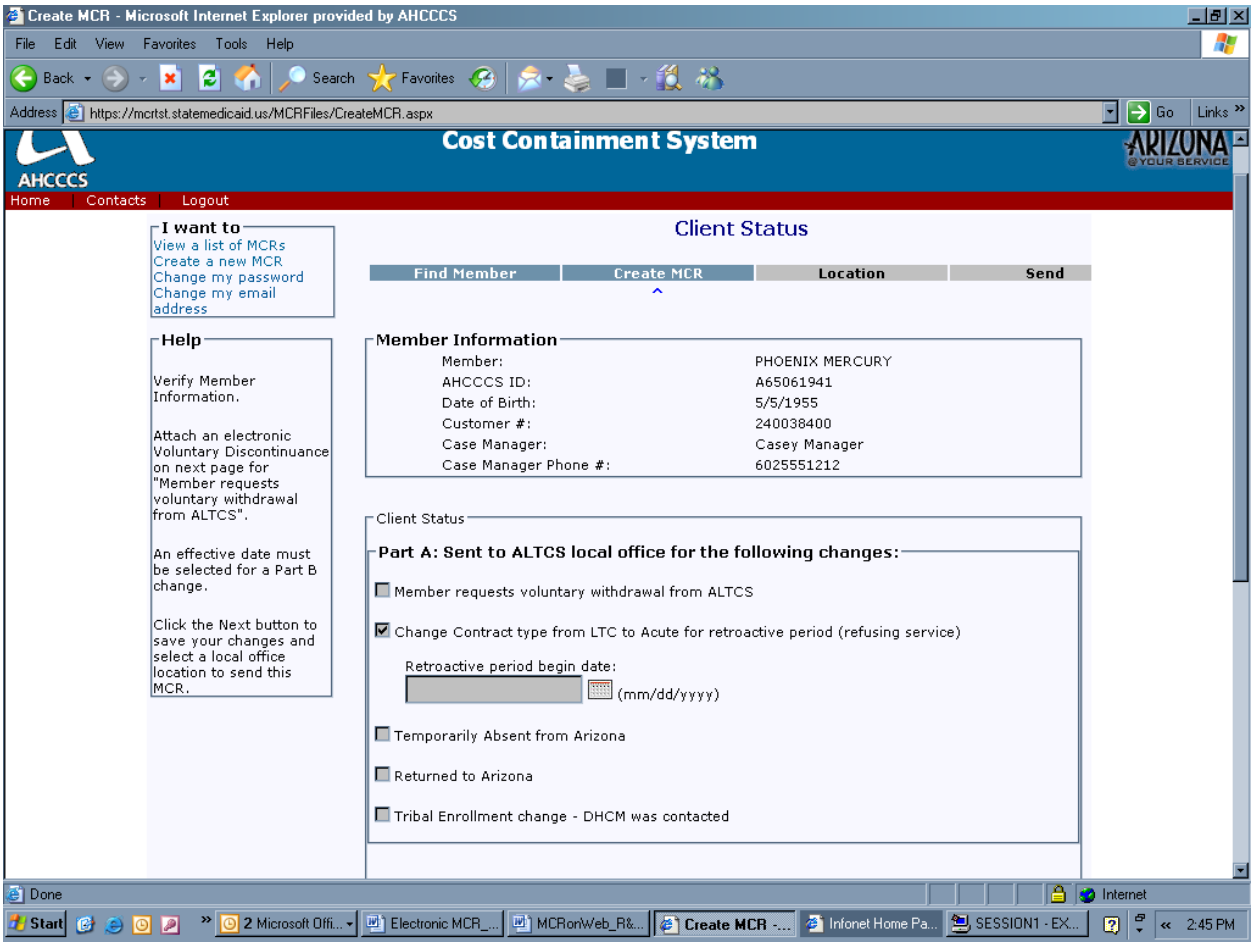
- The change types listed in Part A on this screen are sent to the local eligibility office for processing.
- The change types listed in Part B are sent to the Division of Health Care Management (DHCM) for processing.
- The next several pages of this policy explain how those changes are reported.

4. Client Status Part A Changes - Voluntary Discontinuance



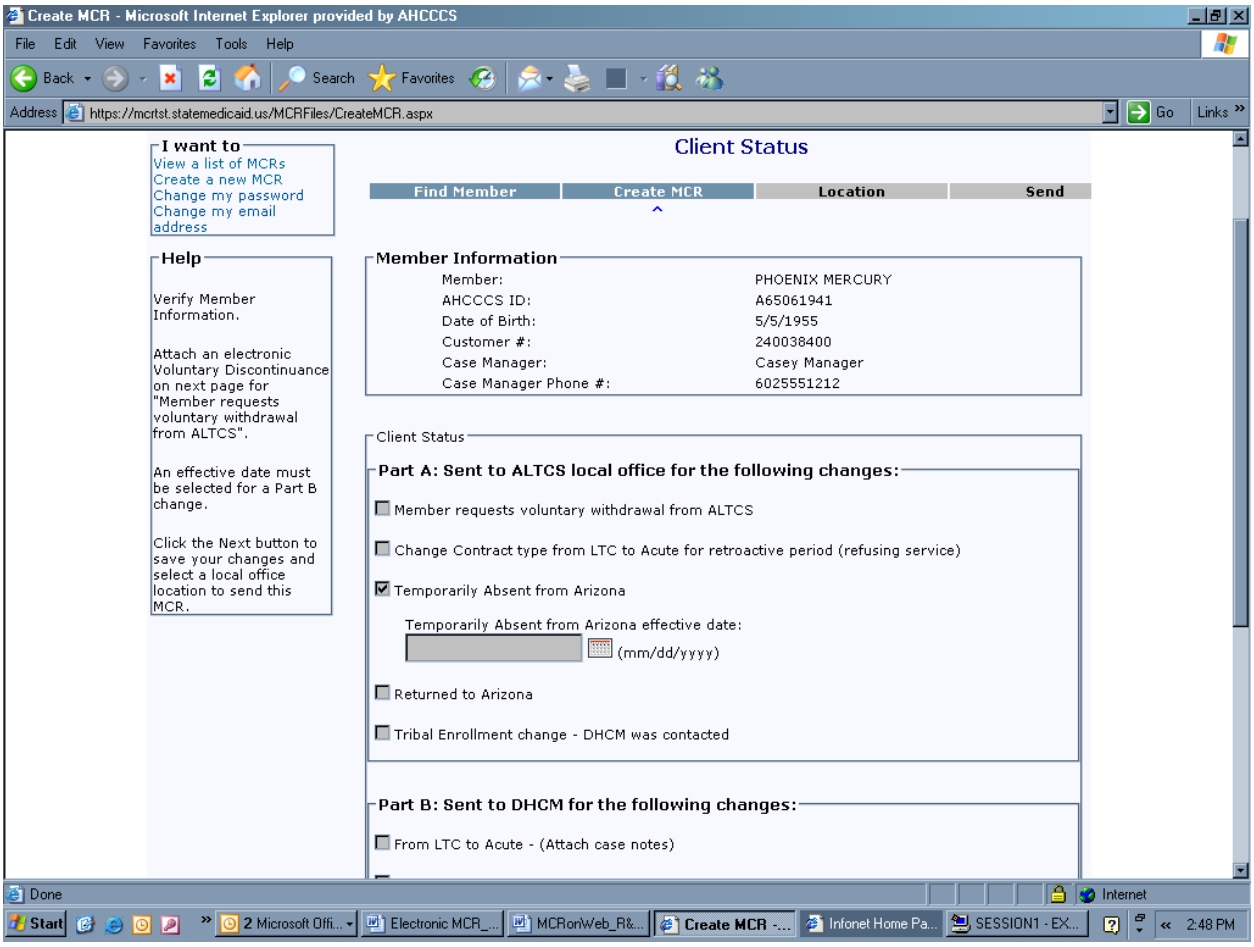
- For Voluntary Discontinuances, the date of the member/representative signature on the Voluntary Discontinuance form is required here, in the designated format (mm/dd/yyyy).
- The Voluntary Discontinuance form is listed on the Add Attachment screen as an option to be sent along with the MCR if signed. The signed form may be attached electronically if a scanned copy is available or it can be sent by mail or fax to the local eligibility office.
- When documents associated with an MCR are faxed or mailed to AHCCCS, the sender should clearly indicate on the document that they are related to an MCR which was submitted electronically so they can be routed and filed correctly.
- Clicking the "Next" button at the bottom of this screen will take the user to a screen where the local office location to which the MCR will be sent is selected.

4. Client Status Part A Changes – Retro Contract Type Change



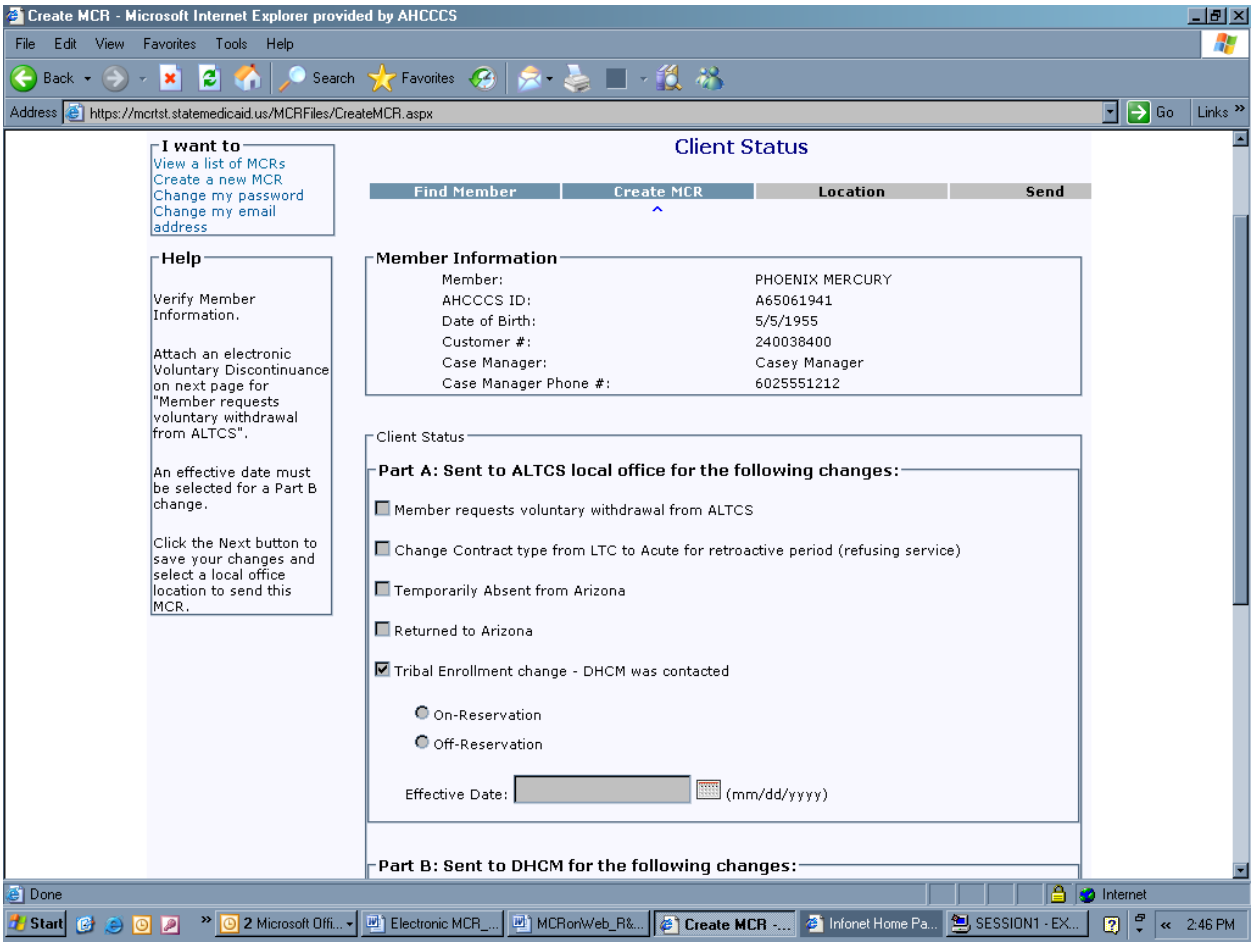
- The Retro Contract Type change option is used, in conjunction with the Voluntary Discontinuance, when the member, who is disenrolling from ALTCS, has a retro period of time for which the member's status should be changed to Acute Care Only (ACO) because the member was not receiving LTC services prior to disenrollment.
- See instructions beginning on page 36 of this policy for cases in which the member's status needs to be changed to ACO retroactively but the member has **not** requested discontinuance from the ALTCS program.
- A begin date for the retroactive ACO period is required in the designated format (mm/dd/yyyy) on this screen.
- Clicking the "Next" button at the bottom of this screen will take the user to a screen where the local office location to which the MCR will be sent is selected.

4. Client Status Part A Changes – Temporary Absence from AZ and Returned to AZ



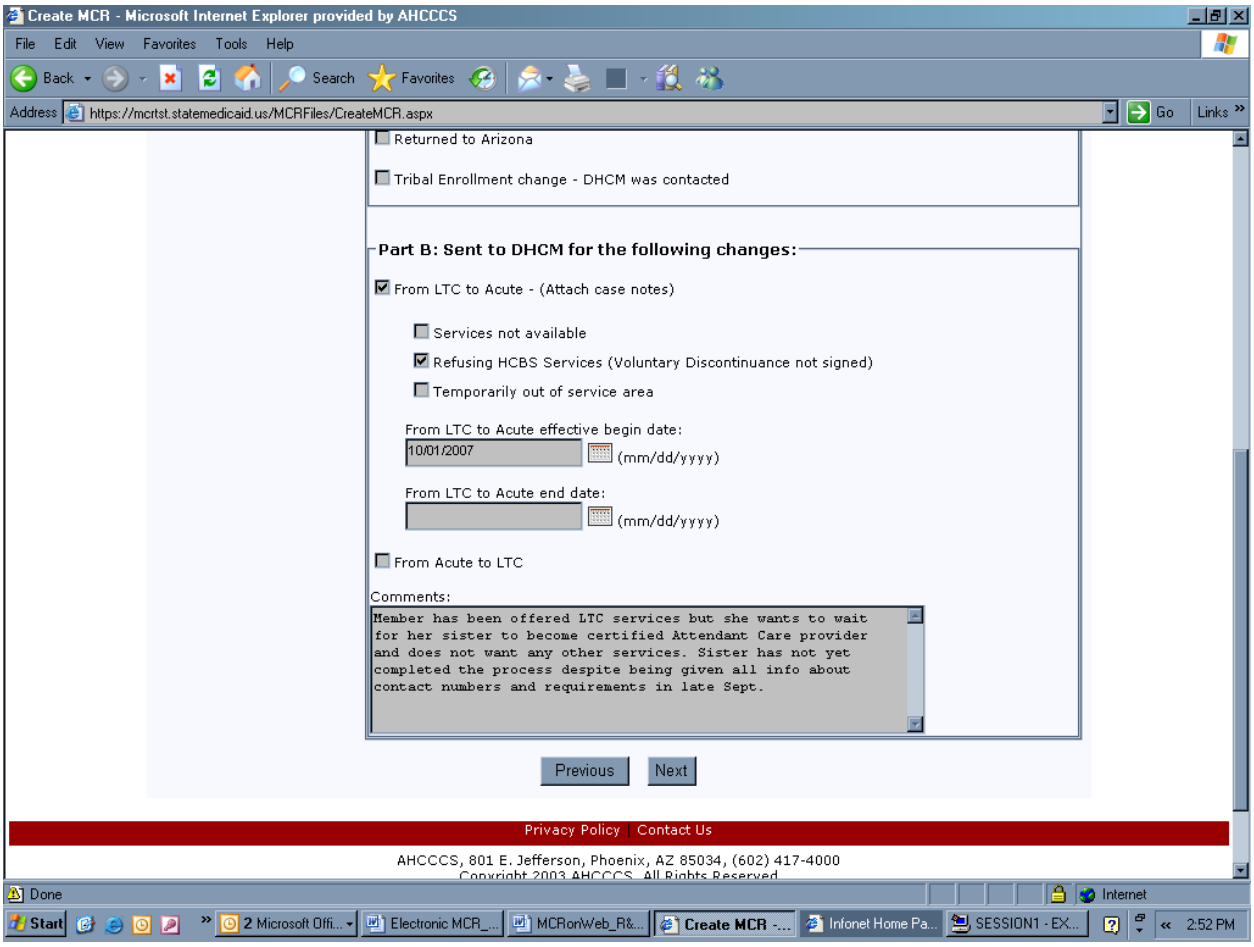
- "Temporary Absence from Arizona" can NOT be reported on the same MCR as "Returned to Arizona".
- A box for the effective date of the change will appear for both of these options when either is checked. The effective date of the change in the designated format (mm/dd/yyyy) will be required on this screen.
- Clicking the "Next" button at the bottom of this screen will take the user to a screen where the local office location to which the MCR will be sent is selected.
- If the member did or will not get any LTC services for a full calendar month while absent from the state, an MCR to request a change of contract type from LTC to Acute Care Only for that period of time will also be needed. See instructions for Client Status Part B changes beginning on page 36 of this policy.

4. Client Status Part A Changes –Tribal Enrollment Change



- This option is used to report when a Native American member either moves on or off a reservation to an "own home" placement and an enrollment change to or from a Tribal Contractor will be required.
  This type of enrollment change, processed via MCR, will be effective the first of the following month. If the enrollment change needs to be effective sooner than the first of the following month, a Program Contractor Change Request (PCCR) form should be used instead.
- The AHCCCS Division of Health Care Management (DHCM)/Case Management Unit should have been contacted, prior to the creation of this MCR, to assist with this type of transition between Program and Tribal Contractors.
- The effective date of the move, in the designated format (mm/dd/yyyy), will be required on this screen.
- Clicking the "Next" button at the bottom of this screen will take the user to a screen where the local office location to which the MCR will be sent is selected.

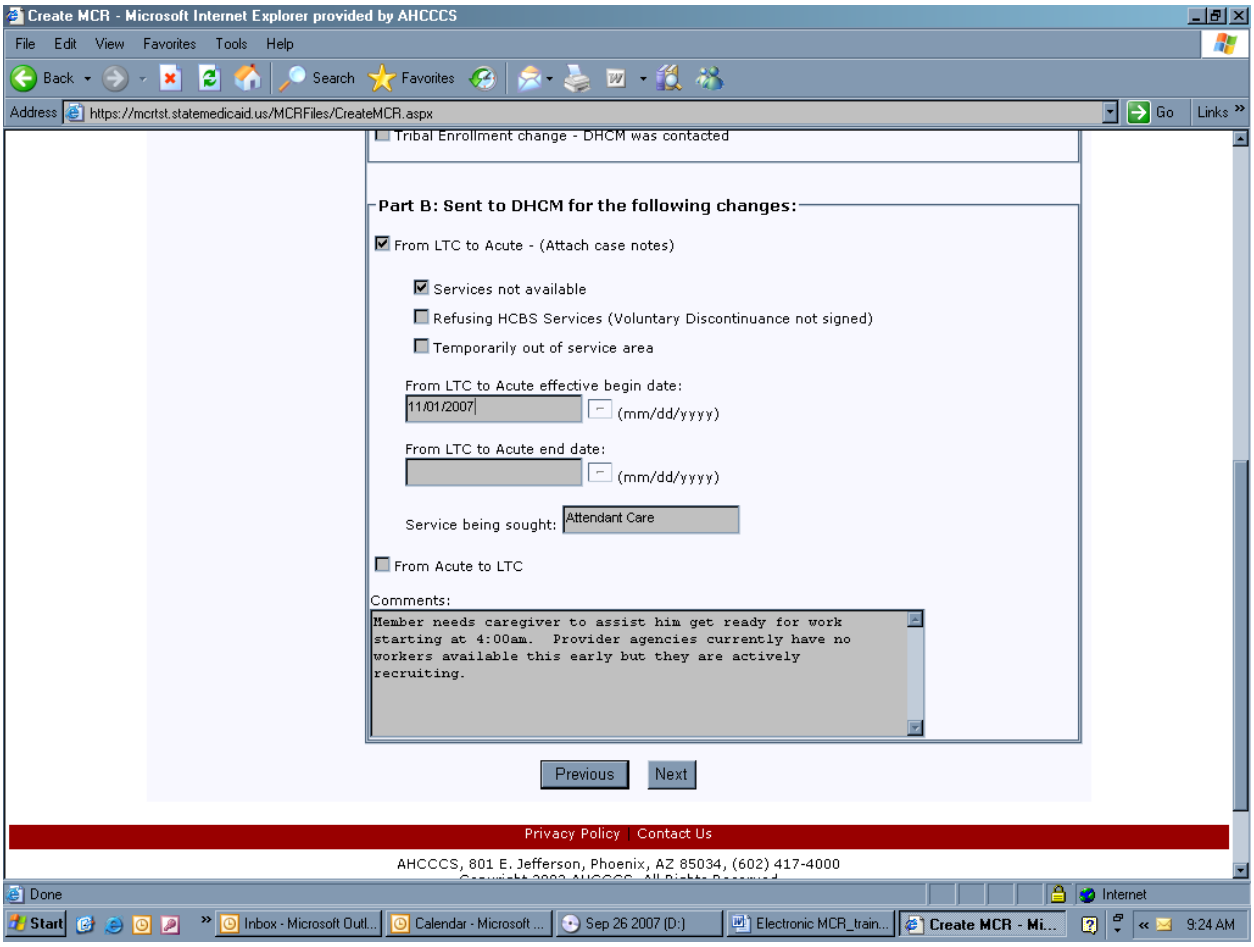
M. Client Status Part B Changes – LTC to Acute Care Only (ACO)



- When LTC to Acute is checked as above, the 3 reasons/options will appear:
  - Services not available – member requests a service(s) that the Contractor can not provide. If this reason/option is chosen, a box will appear to enter the service being sought (see next page).
  - Refusing HCBS services – member will not accept a service(s) that the Contractor has available and has been offered
  - Temporarily out of service area – member is temporarily out of the Contractor's service area (but is expected to return) and is not receiving any LTC services during that time. A separate MCR should be sent to the local eligibility office, using the instructions for Temporary Absence from AZ found on page 34 of this policy if the member is still out of state at the time the MCR is being completed.
- The effective begin date of this changed contract status must be entered in the designated format (mm/dd/yyyy). This date must match the begin date of the "D" placement on CA161 for the member.
- The effective end date should only be entered if this date is in the past. The end date of acute care only status should not be predicted.

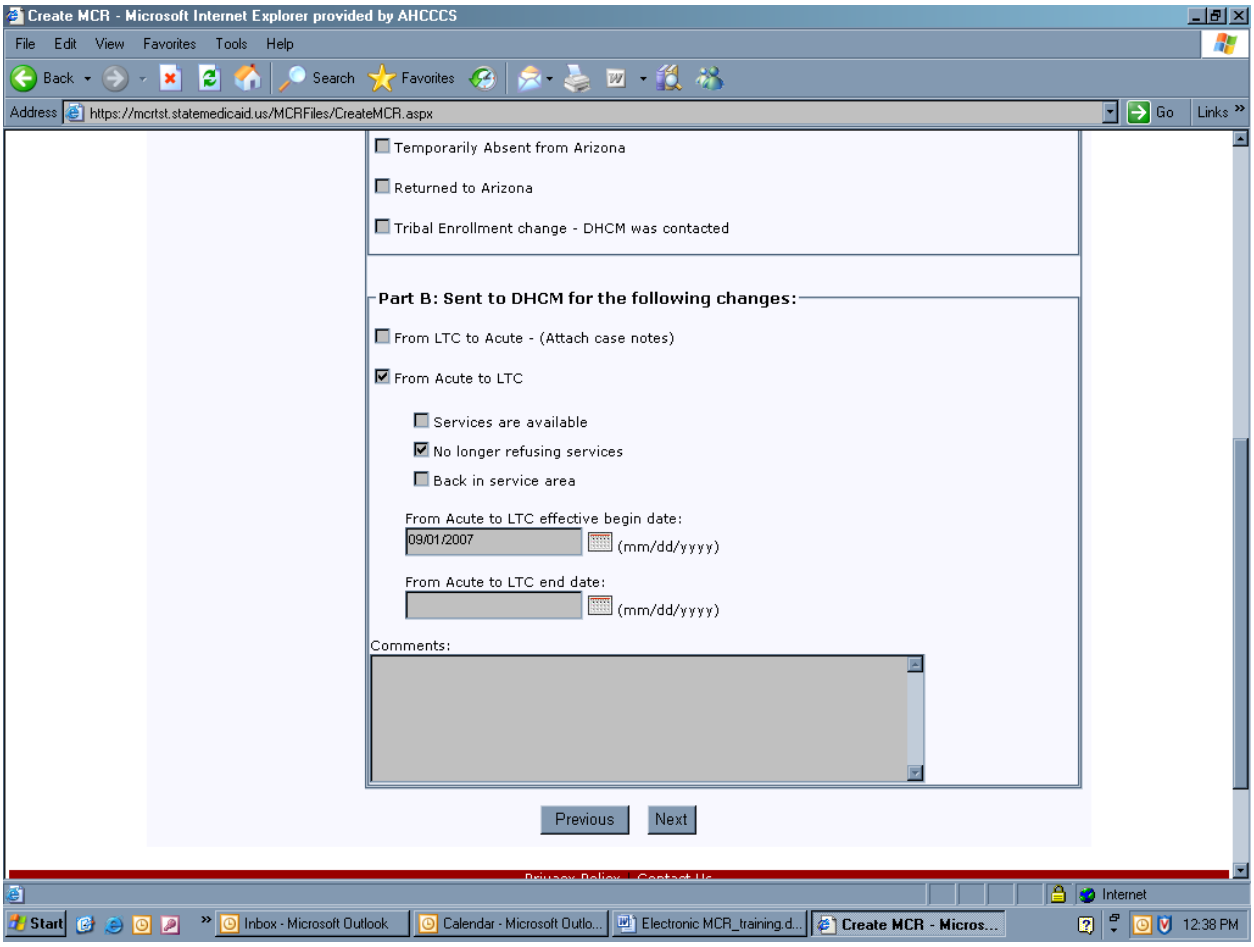
- In lieu of sending case notes, the case manager should write comments here to explain the case. Those comments must support the reason/option chosen and describe the member's situation.
- Case notes can still be sent however, by fax, mail or electronically as an attachment to the MCR.
  - Fax number for DHCM is (602) 417 – 4855
- Clicking the "Next" button will take the user to a screen where the AHCCCS location to which the MCR will be sent is selected. DHCM will be the only option for where to send this type of change.
- If a member's contract type needs to be changed for a specific and fixed time period retroactively, one MCR can be used to change both the LTC to ACO and ACO to LTC at the same time instead of sending 2 separate MCRs. An example would be when a member had been refusing services during the previous full calendar month but then began accepting services before another calendar month passed and before the LTC to ACO MCR was sent.

2. Client Status Part B Changes – LTC to ACO – Services not Available



- If the "Services not available" reason/option is chosen, a box will appear, as shown above, in which the case manager should indicate which service is being sought that is currently unavailable.
- Comments need to be entered to explain why services are not available as well as what actions are being taken to resolve this issue.
- If alternative services are provided to the member as a substitution for the requested service, a Client Status change MCR is not needed since the member is receiving LTC services.
- Clicking the "Next" button will take the user to a screen where the AHCCCS location to which the MCR will be sent is selected. DHCM will be the only option for where to send this type of change.

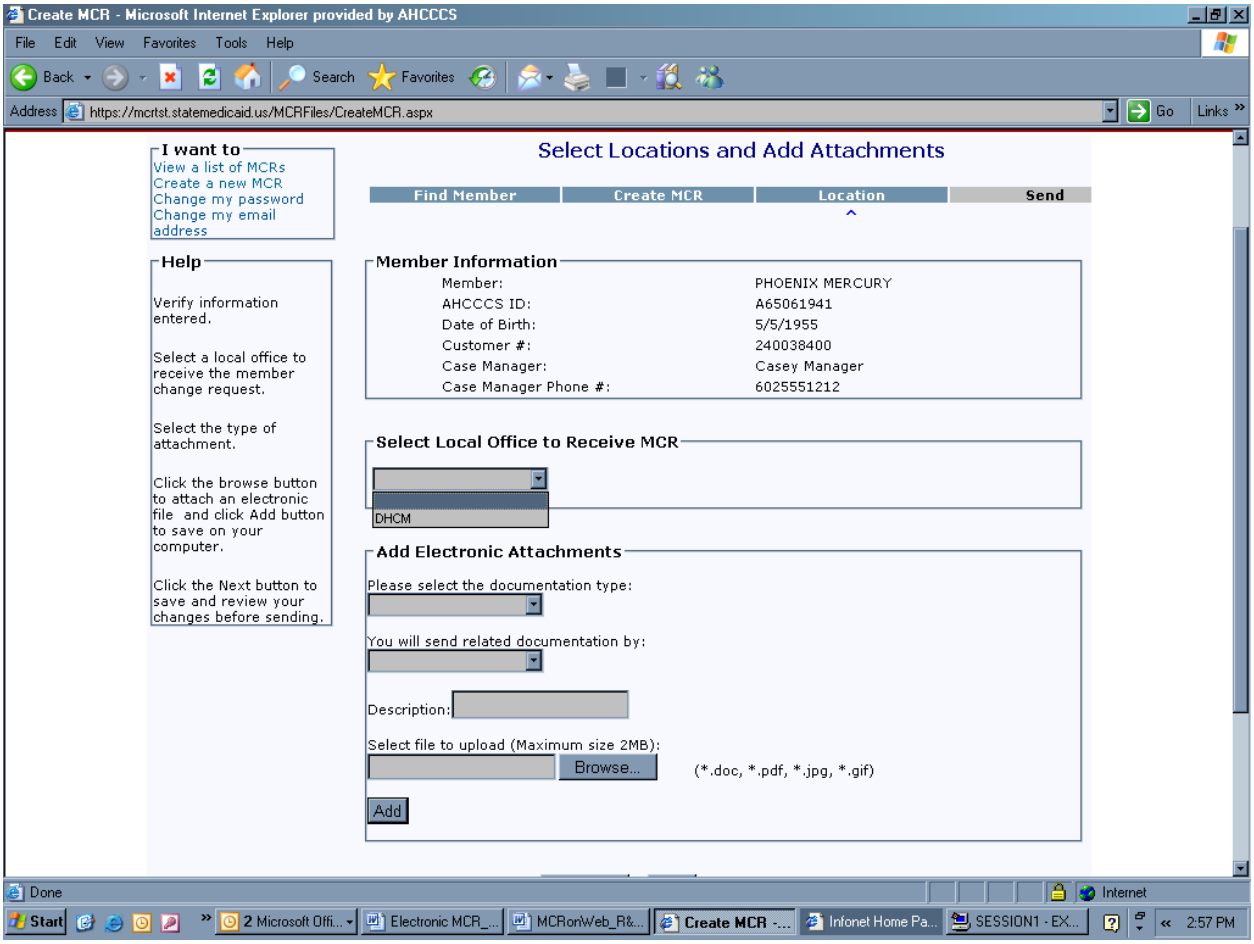
N. Client Status Part B Changes – Acute to LTC



- When Acute to LTC is checked as above, the 3 reasons/options will appear:
  - Services are available – service member requested is now available and being provided.
  - No longer refusing services – member is now accepting LTC services from the Contractor
  - Back in service area – member is back in the Contractor's service area and receiving LTC services.
- The reason/option checked should correspond to the reason/option that was indicated on the prior MCR that changed the member's status from LTC to Acute. For example, if "Services not available" was checked before, "Services are available" must be checked now.
- A date, in the designated format (mm/dd/yyyy), is required only in the Effective Begin date field on this screen. The date the member's status needs to be changed back to LTC should be reported as the Effective Begin date here. No end date is needed for this type of change. This date must match the begin date of the "H" or "Q" placement on CA161 for the member.

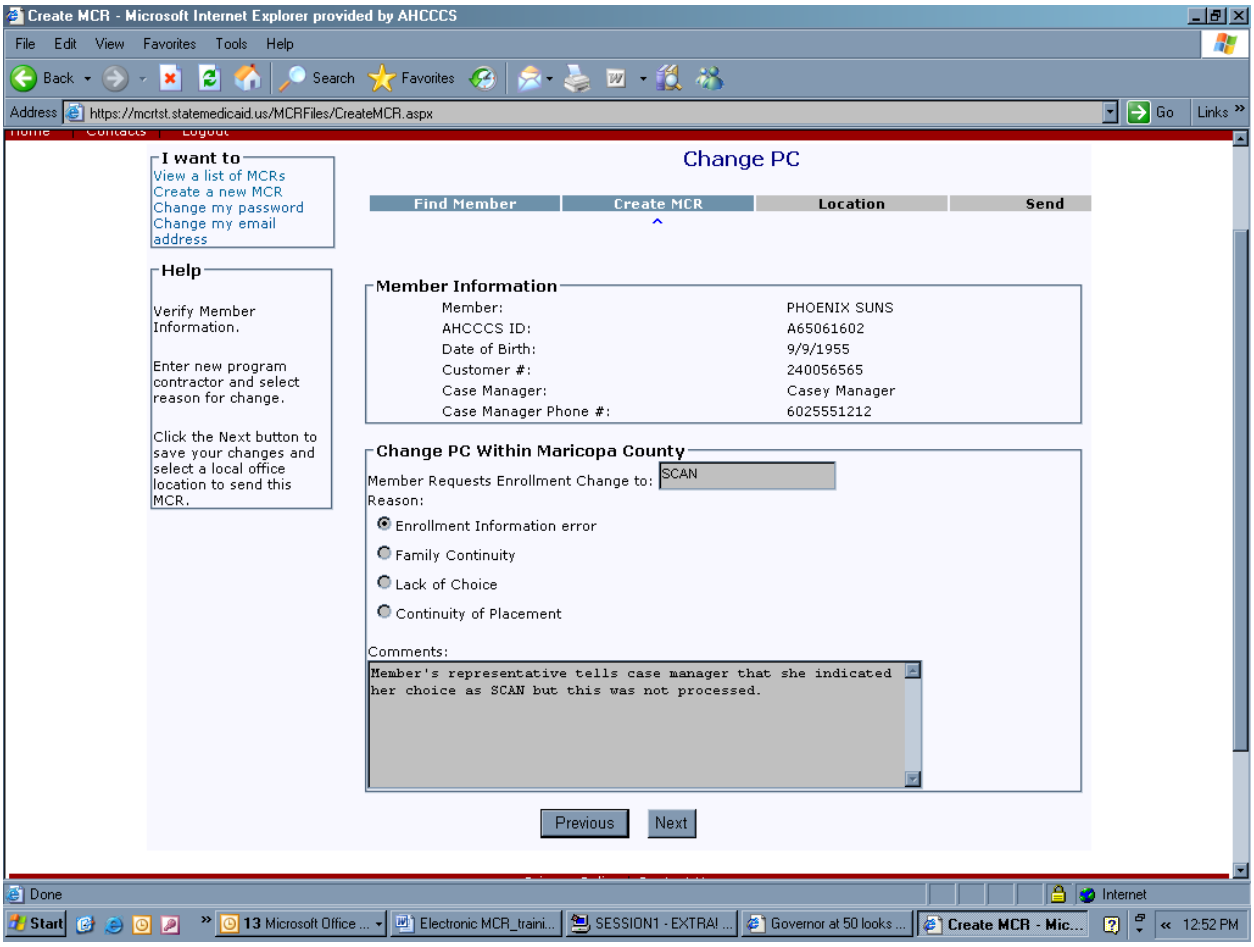
- Comments are not necessary but may be used to explain the circumstances of the case as needed.
- Clicking the “Next” button will take the user to a screen where the AHCCCS location to which the MCR created will be sent is selected. DHCM will be the only option for where to send this type of change.

O. LTC to ACO and ACO to LTC - Select Location and Add Attachments



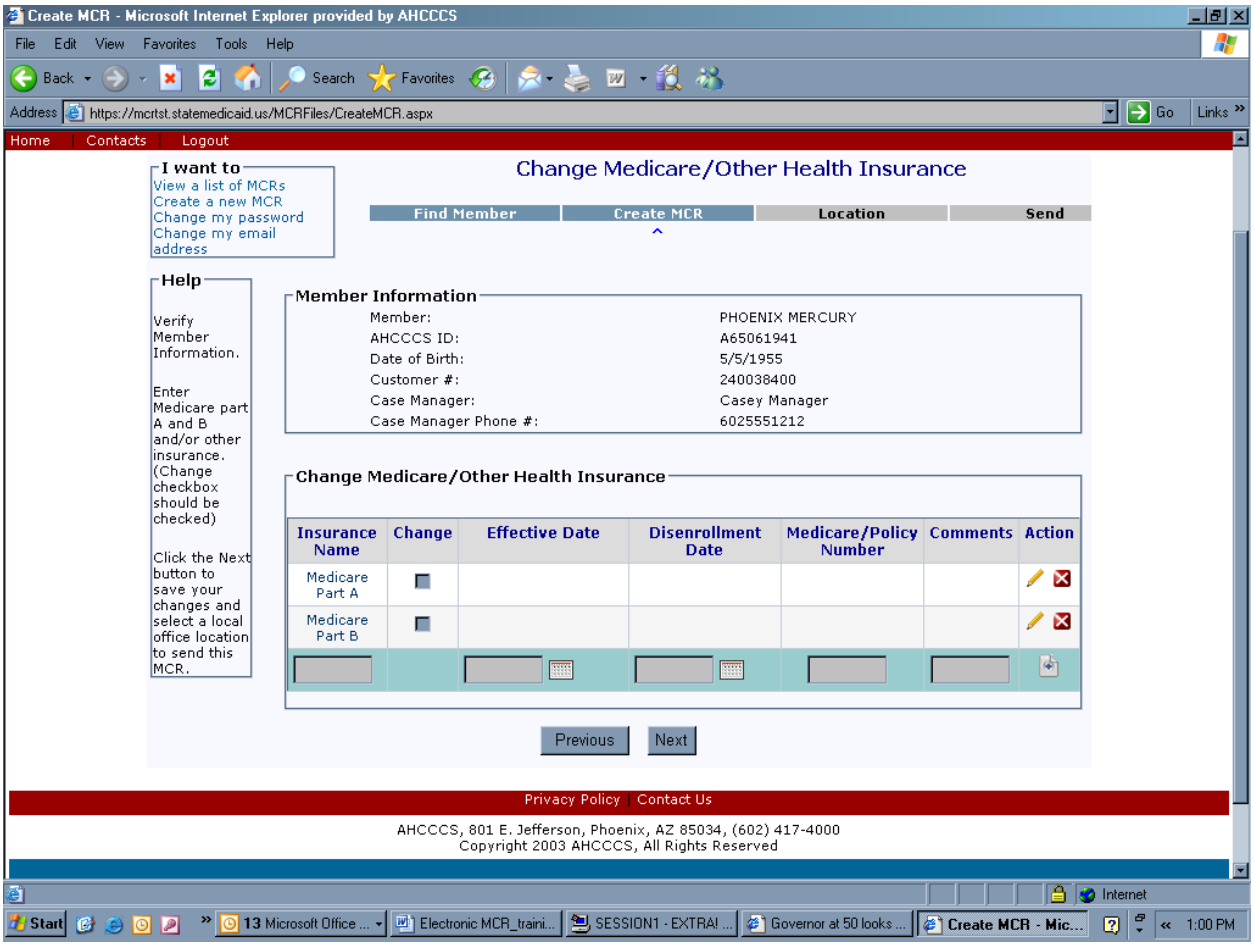
- On this screen for selecting the location for where to send the MCR, DHCM is the only option when Part B type changes (LTC to ACO and ACO to LTC) are being reported.
- As described on pages 27-29 of this policy, attachments may be added here as needed, prior to sending the MCR.
- Clicking the "Next" button at the bottom of the screen (not visible in the picture above) will take the user to a screen where the details of the MCR just created can be reviewed prior to sending it to AHCCCS.

P. Program Contractor Change within Maricopa (or Pima) County



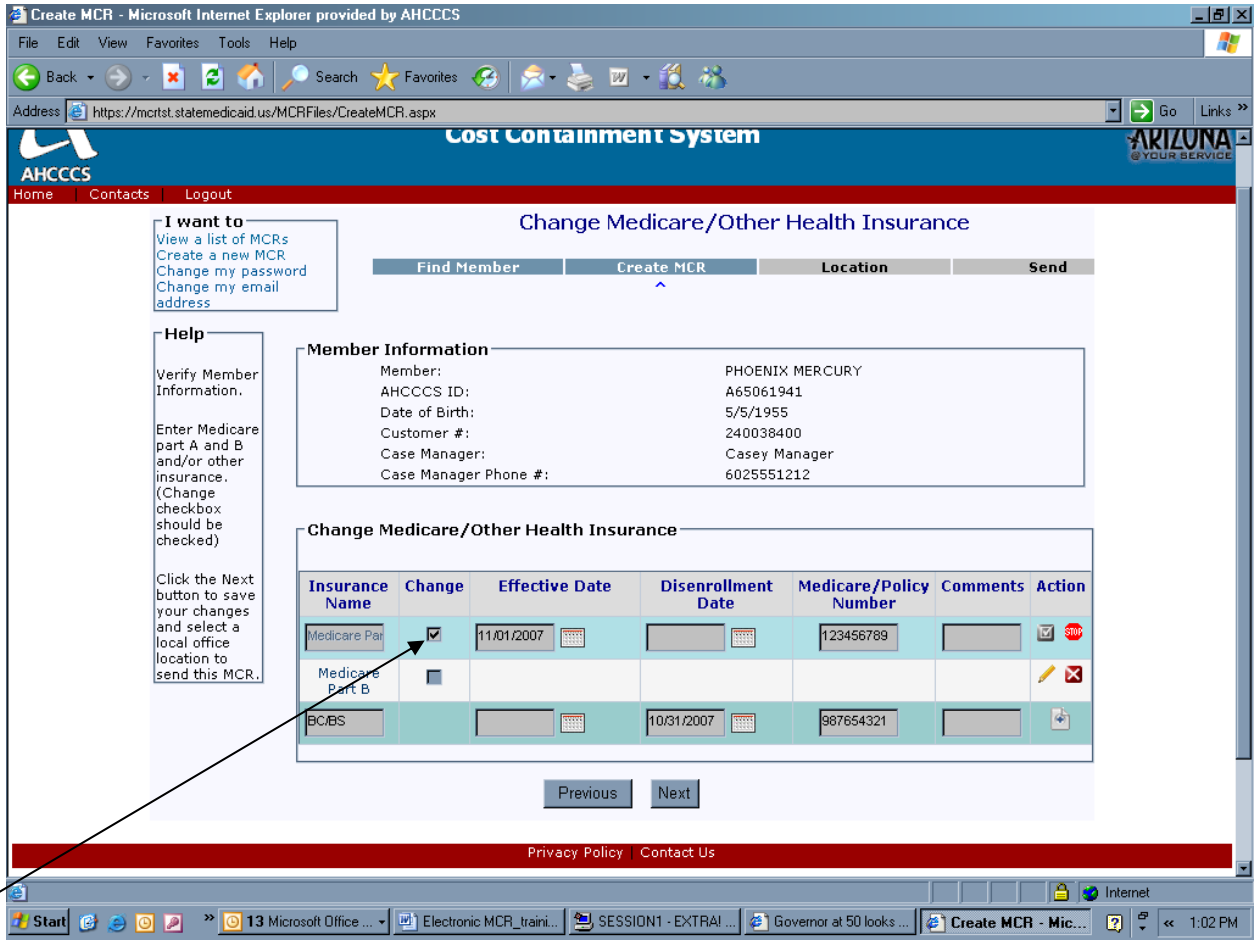
- Enter the name of the Program Contractor that the member is requesting his/her enrollment to be changed to, as indicated in the example above.
- One of the 4 reasons shown above must also be checked to indicate why the member's enrollment needs to be changed outside the Annual Enrollment Choice process. See Policy 403 of this manual and/or AHCCCS Eligibility Policy Manual, Section 1106.02 for more information about these reasons.
- Comments are not required on this screen but are strongly encouraged to explain the member's circumstances as best understood by the case manager in order to assist the Eligibility Specialist in determining whether the change is valid or not.
- Clicking the "Next" button will take the user to a screen where the local office location to which the MCR will be sent is selected.

Q. Medicare/Other Health Insurance



- On this screen changes to Medicare Part A and Part B information are initiated by clicking on the icon in the Action column on the far right.
- For other health insurance changes, the type of insurance should be entered in the blank "Insurance Name" box which follows the Medicare rows.
- More than one insurance change can be reported on a single MCR but each insurance change must be entered separately on this screen.
- The following page of this policy shows how the screen view changes after the icon is clicked for a Medicare change.

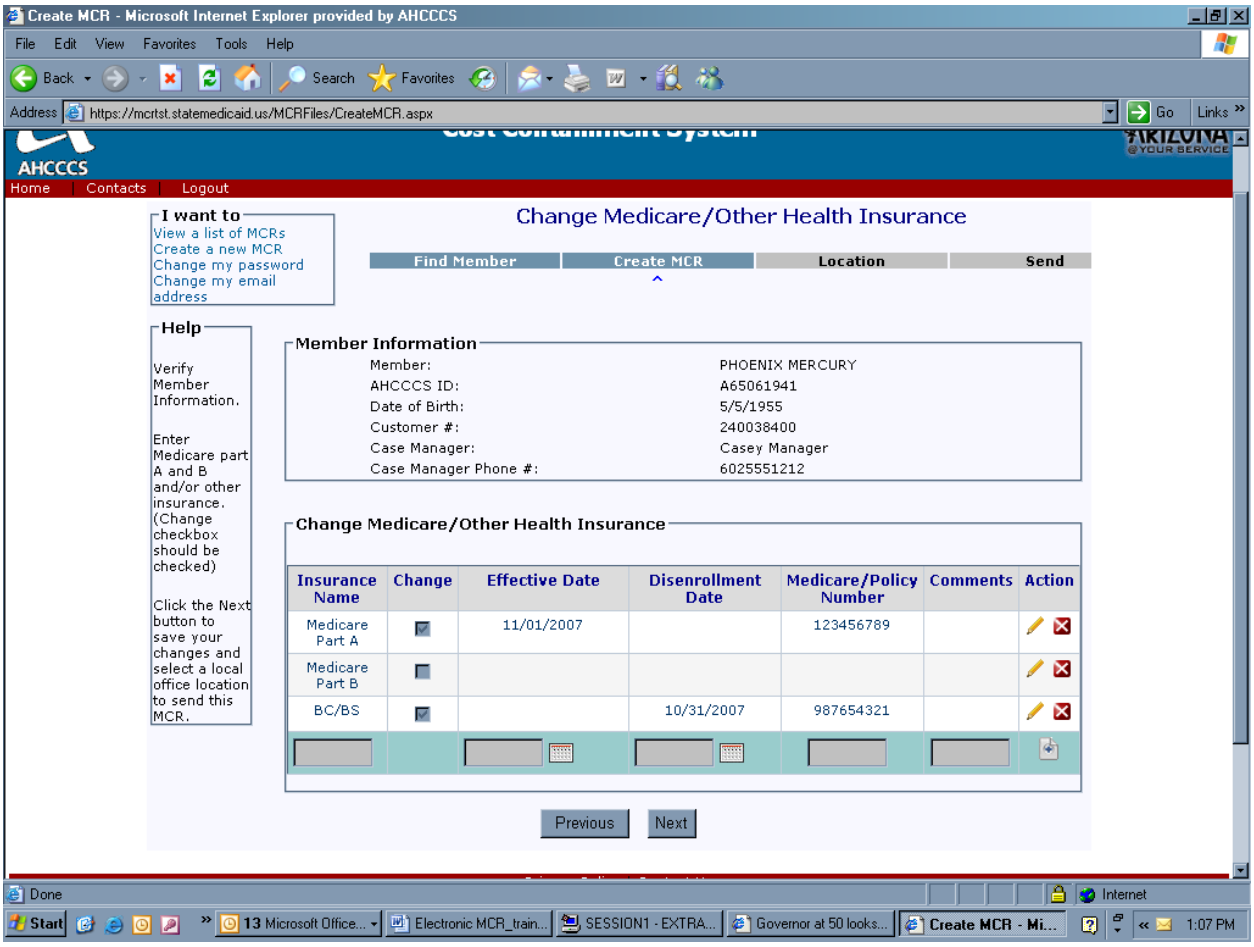
Medicare/Other Health Insurance – cont'd



- In the example above, the user had clicked on the icon for a change to Medicare Part A on the previous screen.
- On this screen, the user must click on the box in the "Change" column so that a check mark appears (as shown above) next to the Medicare Part for which a change is being reported.
- An Effective Date or Disenrollment Date must be entered to indicate whether the change is the begin or end of this type of insurance coverage.
- A Policy Number will be required for all reported changes.
- Comments are not required but may be added if needed.
- Medicare changes are saved/added to the MCR by clicking on the icon in the Action column. **This step must be done before additional insurance changes can be entered on the MCR.**
- Other insurance changes (shown in the example above as BC/BS) are saved/added to the MCR by clicking on the icon in the Action column.

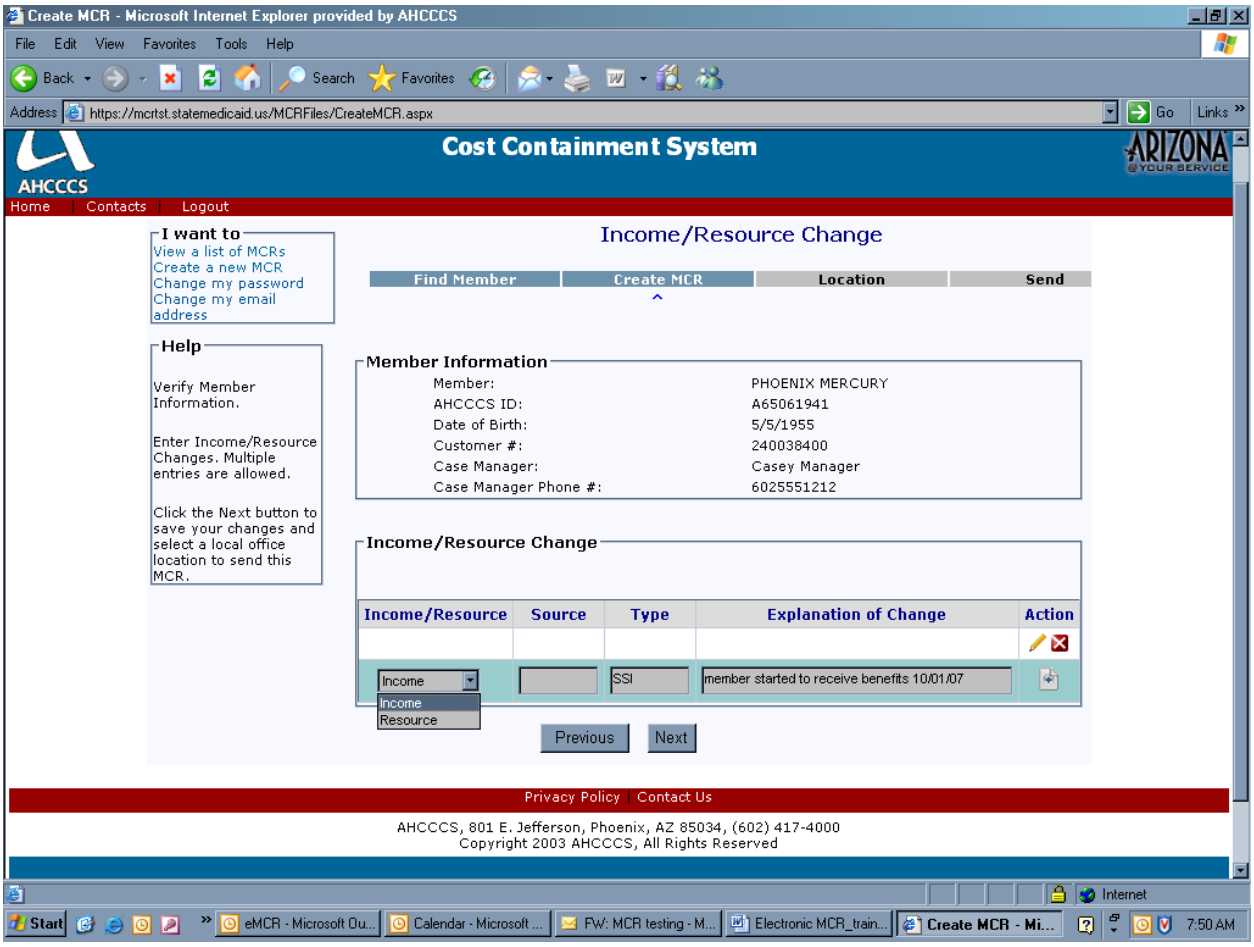
- Clicking on the icon in the Action column (for Medicare changes only) will cancel the action being entered before it is added.
- Clicking the “Next” button will show the user a screen that indicates the changes that were added (see following page).

Medicare/Other Health Insurance – cont'd, 2



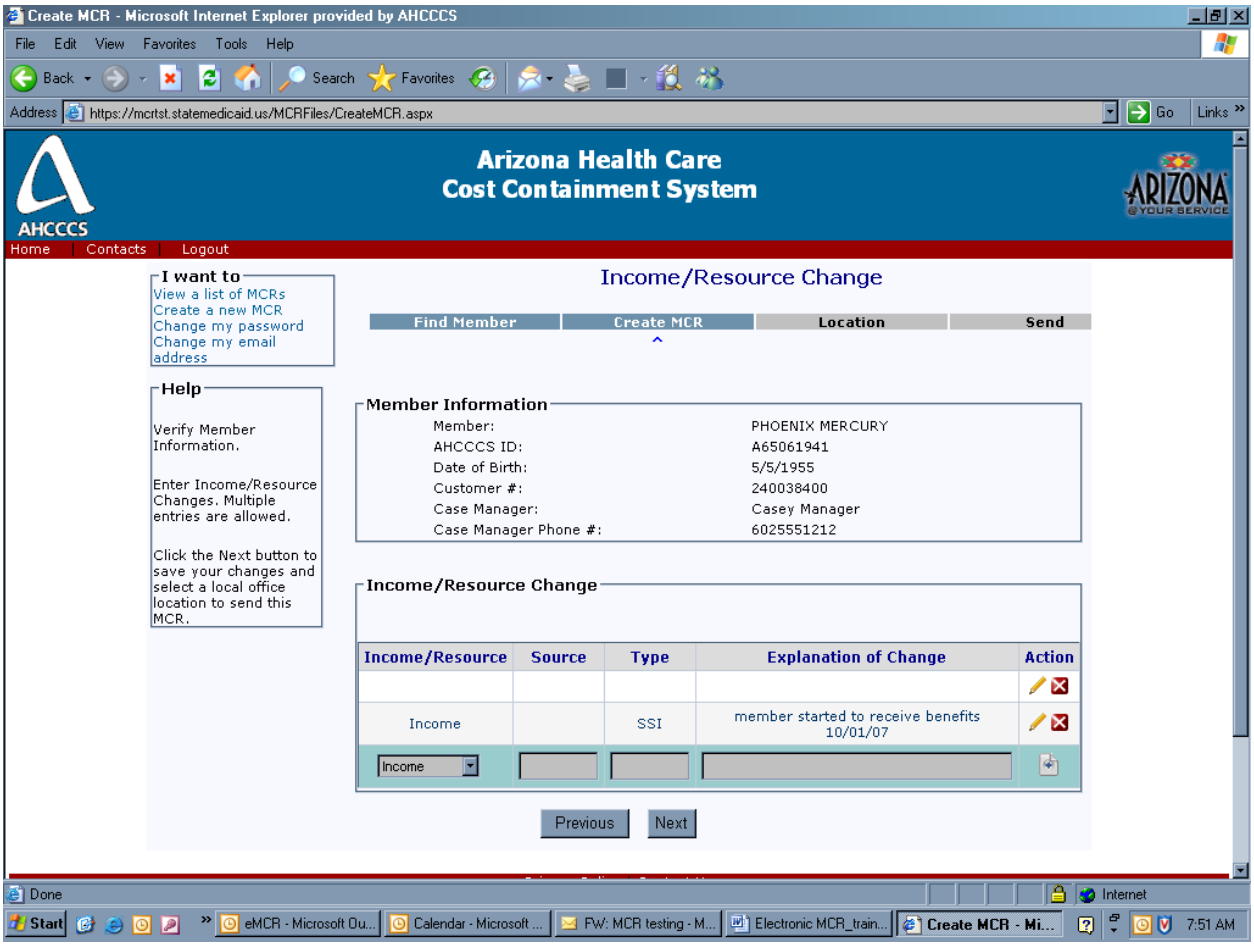
- This screen is like a preview screen that shows the insurance changes that have been added.
- If changes to entered information are needed, the user should click on icon in the Action column for the type needing a change. In the example above, clicking on icon in the Medicare Part B row will also allow changes to be entered now even though nothing was entered previously.
- Clicking on the icon in the Action column will delete the change entered for that row after it has been added/saved. A message box asking if the user is sure they want to delete the entry should appear. Click "OK" when this appears.
- Clicking the "Next" button will take the user to a screen where the local office location to which the MCR will be sent is selected.

R. Income/Resources Change



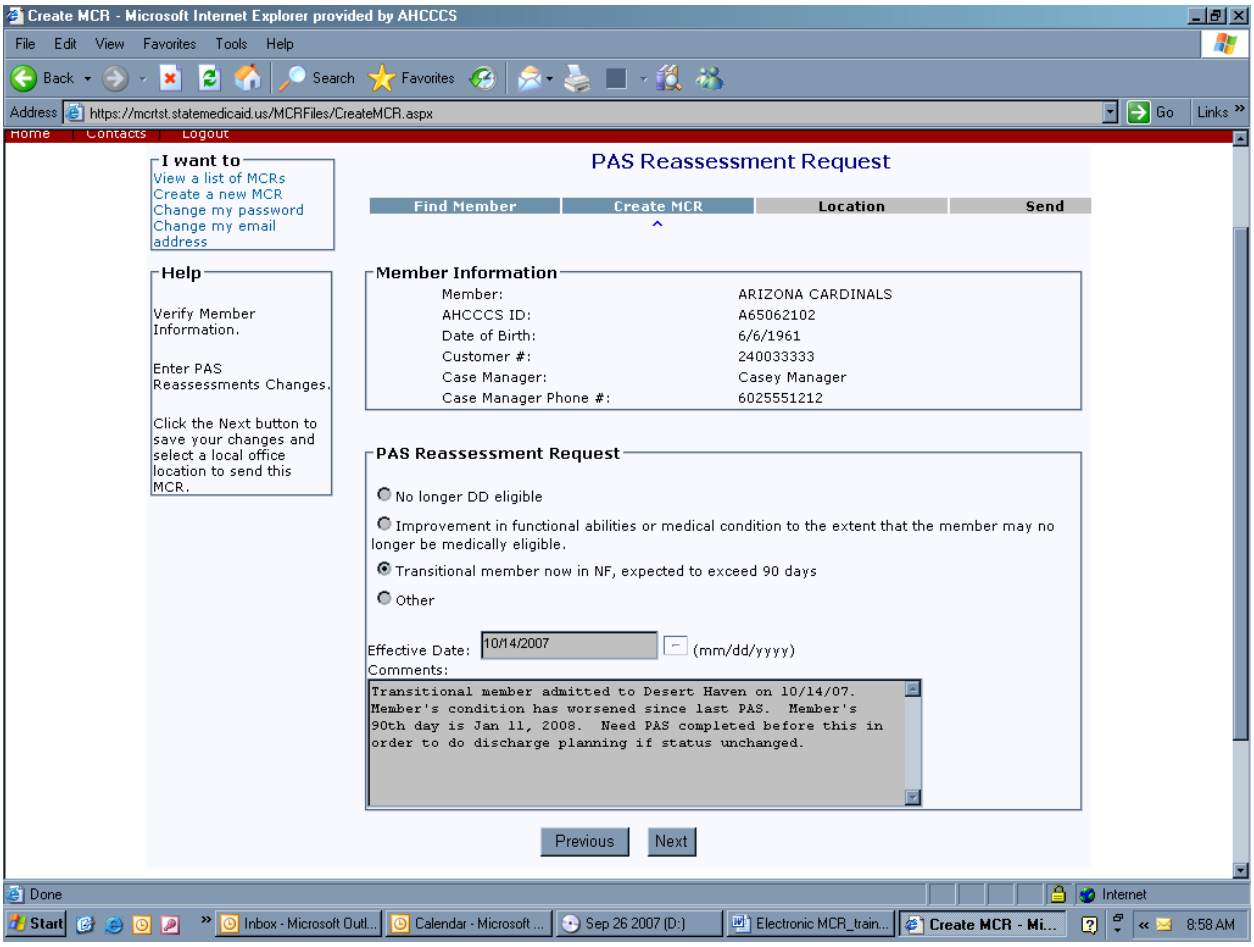
- An Income or Resource change can be reported by choosing the type from the drop down box as shown above.
- If a second Income or Resource change needs to be reported at the same time, the user may click on the icon in the Action column. Another drop down box will appear for the user to choose the type in the same way as shown above.
- The "Source" and "Type" of the income or resource are not required fields but should be used to provide information about where the income/resource is coming from, if known. Examples: Social Security, SSI, VA income, Pension, Wages and Retirement benefits.
- Comments are not required but should be entered if information is available that would assist the Eligibility Specialist in processing the change.
- **Comments should be used to alert AHCCCS about the change in household income status when/if the member's spouse becomes the paid caregiver.**
- Clicking on the icon in the Action column will add the change entered on that line.

Income/Resources Change – cont'd



- This screen is like a preview screen that shows the income/resource changes that have been added.
- If changes to entered information are needed, the user should click on the icon in the Action column for the income/resource needing a change.
- Clicking on the icon in the Action column will delete the change entered for that row.
- Clicking the "Next" button will take the user to a screen where the local office location to which the MCR will be sent is selected.

S. PAS Reassessment Request

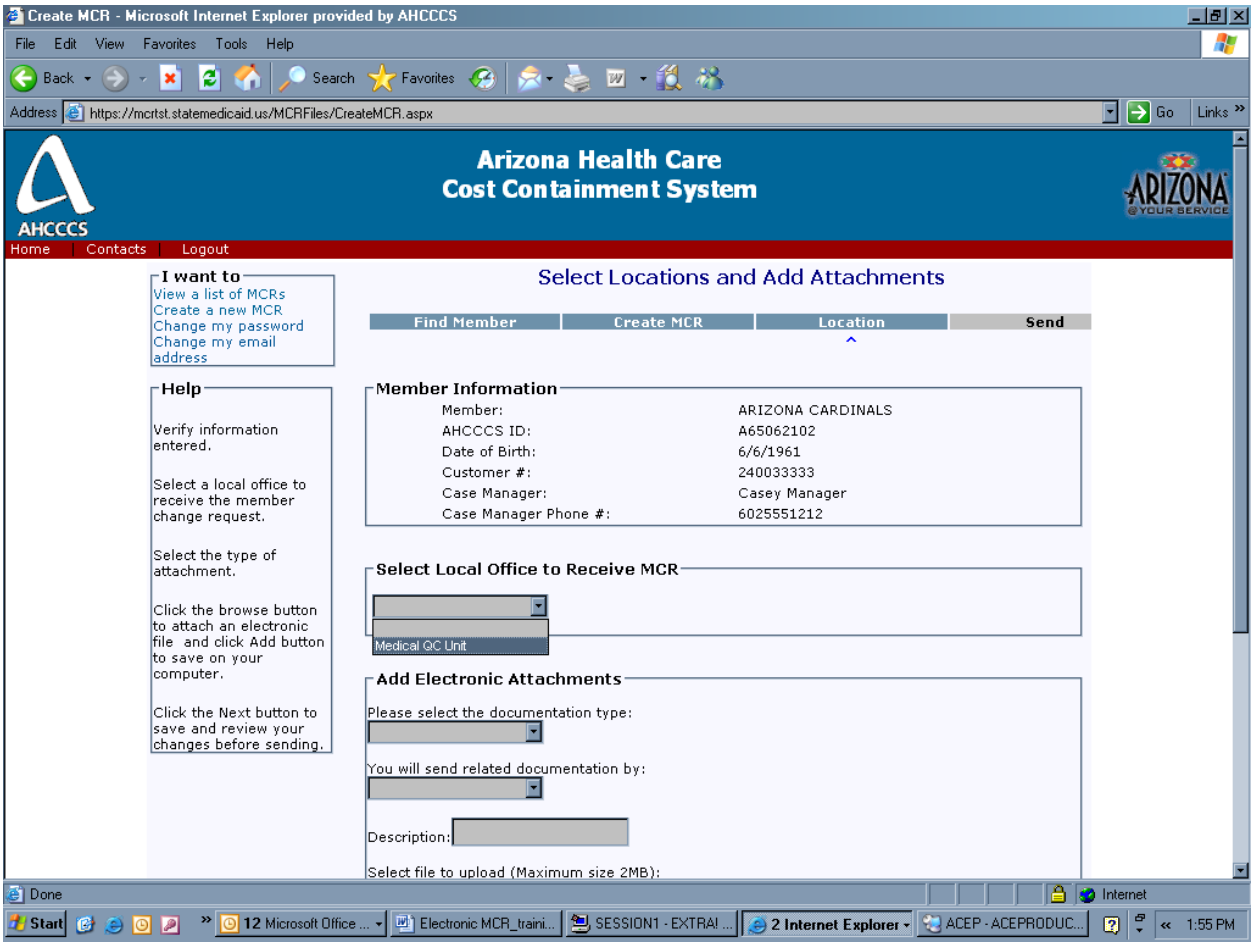


- A reason for the PAS Reassessment must be indicated by choosing one of the choices shown on this screen.
- The "No longer DD eligible" option is used, by DES/DDD only, to indicate that a PAS needs to be completed on a member who no longer meets DDD criteria in order to determine if the individual will continue to be ALTCS eligible as an E/PD member.
- An Effective Date is only required when "No longer DD" is checked. The date entered should reflect the effective date of DD ineligibility.
- An Effective date can be entered for other options even though they are not required. In the example above, the user entered the effective date of a Transitional member's admission to a NF.
- Comments are required when:
  - a PAS is requested due to improvement in the member's status – these comments should include the type and extent of the member's improvement and/or what makes the case manager think the member may no longer be medically eligible
  - for a Transitional member admitted to a NF - these comments should include the name of the NF, admission date and information about the timeframe when a PAS needed

- Other – should explain "other" circumstances which indicate a PAS is needed

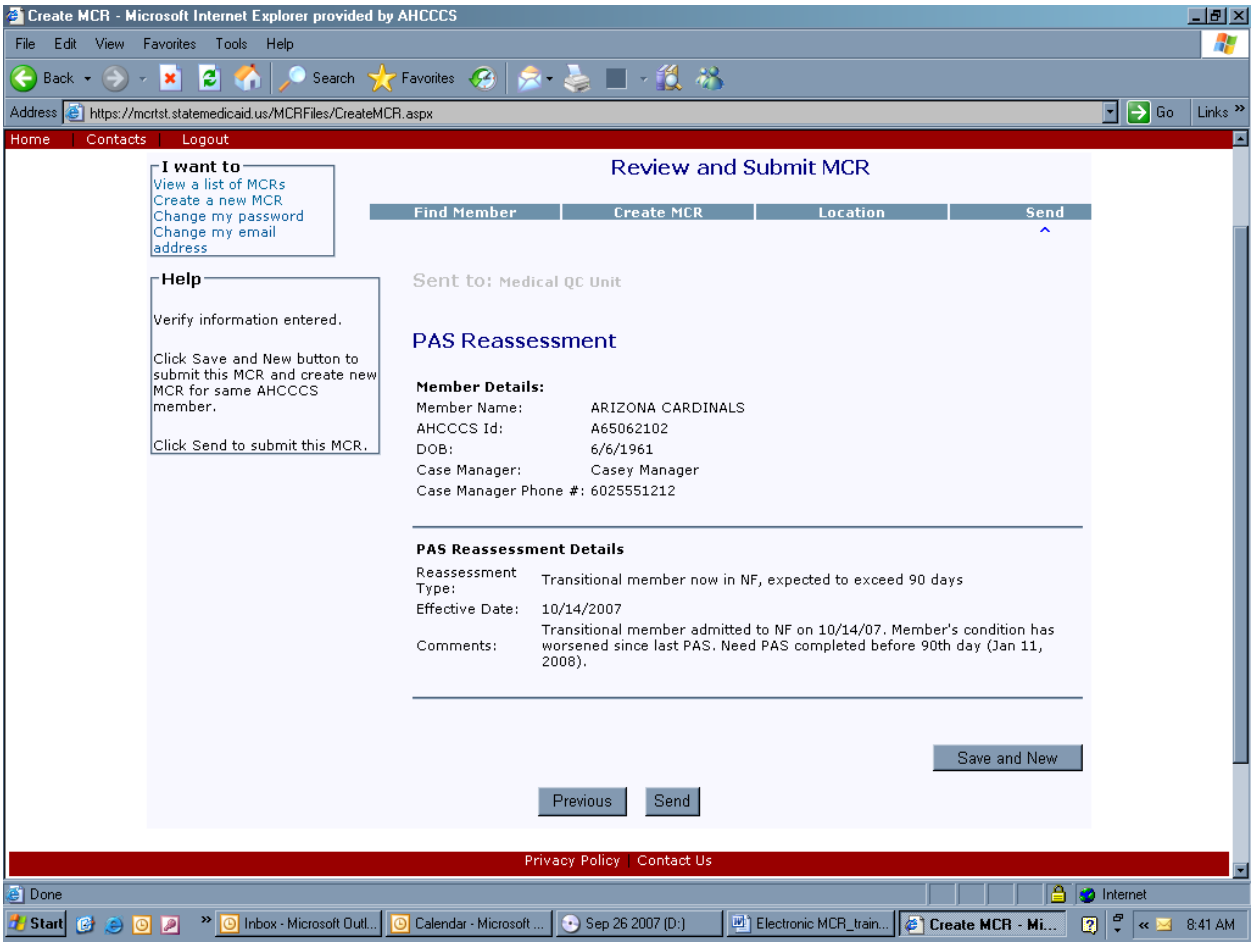
- Clicking the "Next" button will take the user to a screen where the AHCCCS location to which the MCR will be sent is selected. The Medical QC unit in the AHCCCS Central office will be the only option for where to send this type of change.

2. PAS Request - Select Location and Add Attachment



- On this screen for selecting the location for where to send the MCR, Medical QC is the only option when a PAS reassessment is being requested.
- As described on pages 27-29 of this policy, attachments may be added here as needed, prior to sending the MCR.
- Clicking the "Next" button at the bottom of the screen (not visible in the picture above) will take the user to a screen where the details of the MCR just created can be reviewed prior to sending it to AHCCCS.

2. PAS Request - Review and Submit MCR



- Clicking the "Send" button submits the MCR to the selected AHCCCS location and then returns the user to the Contractor's "home" page. The just-created MCR will appear on that page in the Contractor's MCR list with Status "New".
- The "Save and New" button saves the change information already entered and allows the user to create another MCR for the same member. The user is returned to the "Create MCR" page to choose the type of change to be reported (page 14 of this policy).

Note - Currently, if the Effective Date was left blank on the screen where the PAS Reassessment MCR was created (page 48 of this policy), a default date of 01/01/1900 appears in the field here.

IV. References

- AHCCCS Medical Policy Manual, Chapter 1200
- AHCCCS Medical Policy Manual, Chapter 1600

431 – COPAYMENT POLICY

Original Date: 05/01/2012
Effective Date: 04/01/2012
Revision Date:

Staff responsible for policy: DHCM Operations

I. Purpose

This policy establishes requirements for the application of copayments.

II. Scope (Overview/General Information)

To outline the copayment requirements described in A.A.C. R9-22-711, including mandatory and optional copayment amounts for certain populations, and provide clarification on services and populations which are exempt from copayments.

The copayments referenced in this policy are only those copayments charged under AHCCCS, and does not apply to other copayments such as Medicare copayments.

III. Definitions

Copayments

A monetary amount that a member may be required to pay directly to a provider at the time a covered service is rendered. AHCCCS has two types of copayments:

a. Mandatory (also known as "hard"): Providers can deny services to members who do not pay the copayment.
b. Optional (also known as "nominal"): Providers are prohibited from denying the service when the member is unable to pay the copayment.

Copayment Levels

Copayment requirements will be indicated via a member specific copayment level found in all AHCCCS eligibility verification processes other than Interactive Voice Response (IVR). Every member will be assigned a copayment level which will reflect whether they are exempt from copayments, subject to optional (nominal) copayments, or subject to mandatory (hard) copayments.

Taxi A vehicle that has been issued a taxi special license plate pursuant to A.R.S. § 28-2515.

Visit All services received in one day from a single provider, or components of the same service received in one day from multiple providers, e.g. a surgery in an Ambulatory Surgical Center (ASC) where both the ASC and the surgeon provide the same service.

IV. Policy

A. Mandatory Copayments

Individuals eligible for AHCCCS through the Transitional Medical Assistance (TMA) and Childless Adults/TWG (AHCCCS Care) programs are subject to mandatory copayments for the services listed below (see tables):

TMA Copayments

Service	Copayment
Prescriptions (per drug)	$2.30
Doctor or other provider outpatient office visits for evaluation and management	$4.00
Physical, Occupational and Speech Therapies	$3.00
Outpatient non-emergency or voluntary surgical procedures	$3.00

AHCCCS Care/TWG Copayments

Service	Copayment
Generic prescriptions and brand name prescriptions when no generic is available (per drug)	$4.00
Brand name prescriptions when there is a generic that can be used (per drug)	$10.00
Non-emergency use of an emergency room	$30.00
Doctor or other provider outpatient office visits for evaluation and management	$5.00
Taxi transportation (members residing in Maricopa and Pima Counties Only) ** The $2.00 copayment will be charged each time a taxi is called. If a taxi waits for a member, e.g., while the member picks up a prescription, then a $2.00 co-pay cannot be charge for the continuation of the one-way trip.*	$2.00 each trip

B. Optional Copayments

Individuals eligible for AHCCCS through the following programs are subject to Optional Copayments:

1. AHCCCS for Families with Children (1931)
2. Young Adult Transitional Insurance (YATI) for young adults who were in foster care
3. State Adoption Assistance for Special Needs Children
4. Receiving Supplemental Security Income (SSI) through the Social Security Administration for people who are age 65 or older, blind or disabled
5. SSI Medical Assistance Only (SSI MAO) for individuals who are age 65 or older, blind or disabled
6. Freedom to Work (FTW)
7. Breast and Cervical Cancer Treatment Program (BCCTP) for Women
8. Members receiving child welfare services under Title IV-B on the basis of being a child in foster care or receiving adoption or foster care assistance under Title IV-E.

Optional Co-payments for members enrolled in the programs listed above are as follows:

Optional Copayments

Service	Copayment
Prescriptions (per drug)	$2.30
Physical, Occupational and Speech therapies	$2.30
Doctor or other provider outpatient office visits for evaluation and management	$3.40

C. Members and Services Exempted from Copayments

Some populations and services are never subject to copays as outlined below:

1. Copayments are **never charged** to the following persons:
   a. Children under age 19
   b. People determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services
   c. Individuals through age 20 eligible to receive services from the Children's Rehabilitative Services program
   d. People who are acute care members and who are residing in nursing homes or residential facilities such as an Assisted Living Home and only when the acute care member’s medical condition would otherwise require hospitalization. The exemption from copayments for acute care members is limited to 90 days in a contract year
   e. People who are enrolled in the Arizona Long Term Care System

f. People who are eligible for Medicare Savings Programs only
g. People who receive hospice care
h. American Indian members who are active or previous users of the Indian Health Service, tribal health programs operated under P.L. 93-638, or urban Indian health programs

2. Copayments are **never charged** for the following services:
   a. Hospitalizations
   b. Emergency services
   c. Family Planning services and supplies
   d. Pregnancy related health care and health care for any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for pregnant women

D. Copayment Collection

Providers may bill members for the copayment amount at the time of service. This applies to members with optional copayments as well as members with mandatory copays.

1. Mandatory copayments permit providers to deny services to members who do not pay the copayment. Payments to providers will be reduced by the amount of a member's copayment obligation regardless of whether or not the provider successfully collects the mandatory copayment.
2. Optional copayments apply to AHCCCS members who are not required to make the mandatory copayments. When a member has an optional copayment, providers are prohibited from denying the service when the member is unable to pay the copayment. The provider's reimbursement cannot be reduced by the amount of the copayment for members with optional copayments if the member is unable to pay.

E. Encounter Submissions

Refer to the AHCCCS Encounter Manual for more information on the reporting of copayments on encounter submissions.

F. Copayment Tracking

1. A member receiving TMA 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.)
2. The AHCCCS Administration will track each member's specific copayment levels by service type, and this information will also identify those TMA members who have reached the 5% copayment limit.

3. In the event a Contractor identifies a member whose copayment status should be must set to an exempt status as identified Attachment A. The Contractor must complete and fax The AHCCCS Notification to Set Member's Copay Flag to Exempt Form to AHCCCS MDMA within in five days of admission or services being provided.

G. 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.

H. Copayment Information

For more information regarding copays refer to the AHCCCS Copayments webpage - http://www.azahcccs.gov/commercial/providerbilling/copayments.aspx

V. References

- A.A.C. R9-22-711
- A.R.S. § 28-2515
- Acute Care Contract
- Behavioral Health Contract
- CRS Contract

Attachment A

ACUTE CARE PLANS ONLY

AHCCCS NOTIFICATION TO SET MEMBERS CO-PAY FLAG TO EXEMPT

Fax to AHCCCS MDMA 602-253-4807

The circumstances listed below require that a member's co-pay status be manually set to exempt status. Therefore, please complete and fax this form to AHCCCS MDMA within five days of admission or services being provided.

- Members in nursing facilities and residential facilities such as assisted living when the member's medical condition would otherwise require hospitalization. This exemption is limited to 90 days in a contract year.
- Members receiving hospice services.

The exemption does not apply to members residing in their own homes receiving home and community based services.

Member Information:

Member's name:_____ AHCCCS ID:_____DOB:_____

Select one that applies:

☐ Nursing home
☐ Residential facility such as assisted living
☐ Hospice

Provider name:_____
Provider address/phone number:_____
Provider number:_____
Admission date:_____

****Please refax when the member is discharged or meets 90 day maximum in nursing and residential facilities.**

Discharge date or 90 day maximum:_____
Comments:_____
_____

Health plan name:_____
Contact person:_____
Phone number:_____
Date submitted:_____

432 - BENEFIT COORDINATION AND FISCAL RESPONSIBILITY FOR BEHAVIORAL HEALTH SERVICES PROVIDED TO MEMBERS ENROLLED IN THE ACUTE CARE SERVICES PROGRAM

Original Date:
Effective Date: 07/01/2012*
Revision Date:

Staff Responsible for policy: Behavioral Health

I. Purpose

This Policy applies to AHCCCS Acute Care Contractors and the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) for the purposes of benefit coordination and delineating financial responsibility for AHCCCS covered behavioral health services provided to AHCCCS members who are enrolled with Acute Care Contractors. For dates of service on and after October 1, 2010, Acute Care Contractors are no longer responsible for payment of behavioral health services provided to their enrolled members, including behavioral health services received during the prior period and emergency inpatient behavioral health services received during the initial seventy-two hours of an emergency inpatient stay, except as otherwise stated in this policy.

This policy specifies that financial responsibility is determined by the primary diagnosis appearing on a claim (defined as the principal diagnosis on a UB claim from a facility or the first-listed diagnosis on a CMS 1500 claim) even if a combination of both medical and behavioral services are listed on the claim.

*This policy applies to dates of service on or after 10/1/2010 with the exception of Section B2 and C5, which are effective 07/01/2012.

II. Scope (Overview/General Information)

ADHS/DBHS is responsible for payment of all behavioral health services received by members enrolled in the AHCCCS Acute Care Program, except as described in Section B. AHCCCS assigns all Acute Care enrolled members into a Regional Behavioral Health Authority (RBHA) or Tribal Regional Behavioral Health Authority (TRBHA) based on the member's zip code in which s/he resides (with the exception of CMDP) at the time of enrollment. This information is included on member identification cards issued on and after October 1, 2010.

Definitions

Acute Care Member	An eligible person who is enrolled in an AHCCCS acute care health plan.
Acute Care Hospital	A general hospital that provides surgical services and emergency services and registered as an AHCCCS provider Type 02.
ADHS/DBHS	Arizona Department of Health Services/ Division of Behavioral Health Services, the state agency responsible for the provision of all medically necessary covered behavioral health services to AHCCCS TXIX and TXXI acute care members. ADHS/DBHS contracts with T/RBHAs (Tribal/Regional Behavioral Health Authorities) to administer covered behavioral health services in geographically specific areas of the state.

	ADHS/DBHS is responsible for ensuring that T/RBHAs comply with the requirements of this policy and for timely addressing any deficiencies and compliance issues attributable to the T/RBHAs.
AIHP	American Indian Health Program
Assignment	The process of designating a T/RBHA for a member based on the member's zip code in which s/he resides. Assignment does not confirm a member has or is actively receiving behavioral health care services. Members enrolled with the Children's Medical/Dental Plan (CMDP) are assigned to a T/RBHA based on the zip code of the court of jurisdiction.
Behavioral Health Recipient	A member who is receiving or has received behavioral health services from the member's respective T/RBHA during any time as an AHCCCS acute care member.
Behavioral Health Diagnosis	Behavioral health diagnoses can be located on the ADHS/DBHS website at http://www.azdhs.gov/bhs/covserv.htm and can also be located in PMMIS by entity type of MHS on reference table RF 724.

Child	A TXIX/TXXI member under the age of 18 years old as per R9-20-101. For purposes of this policy, the designation of "Child" in the AHCCCS PMMIS does not apply the Early and Periodic Screening, Diagnosis and Treatment for persons under 21 years of age, as described in AHCCCS Rules R9-22, Article 2.
Disenrollment	The discontinuance by AHCCCS of a member's ability to receive covered services through a Contractor.
Eligibility	The process of determining, through a written application and required documentation, whether an applicant meets the qualifications for Title XIX or Title XXI.
Enrollment	The process by which an eligible person becomes a member of a Contractor's plan.
GMH/SA	General Mental Health/Substance Abuse
PCP	Primary Care Provider/Physician

Primary Diagnosis	The condition established after study to be chiefly responsible for occasioning the admission or care for the member, (as indicated by the principal diagnosis on a UB claim form from a facility or the first-listed diagnosis on a CMS 1500 claim).
Prior Period	The period of time, prior to the member's enrollment with an acute care contractor, or if the member is Fee for Service, prior to the date of AHCCCS eligibility determination, during which a member is eligible for covered services. The prior period time frame begins with the first day of the month in which eligibility for Title XIX benefits begin to the date of Title XIX prospective enrollment, or the date of eligibility determination for Fee-for-Service members, whichever is applicable.
SMI	Seriously Mentally Ill; a person 18 years of age or older who is seriously mentally ill as defined in A.R.S. §36-550.

T/RBHA	Tribal/Regional Behavioral Health Authority- an organization under contract with ADHS/DBHS that administers covered behavioral health services in a geographically specific area of the state. Tribal governments, through an agreement with ADHS, may operate a Tribal Regional Behavioral Health Authority for the provision of behavioral health services to American Indian members.

III. Policy

A. General

Effective October 1, 2010, AHCCCS assigns all Acute Care enrolled members into a Regional Behavioral Health Authority (RBHA) or Tribal Regional Behavioral Health Authority (T/RBHA) based on the zip code in which the members resides. The T/RBHA will be identified on the member's AHCCCS ID card, the AHCCCS website and 270-271 transactions on and after October 1, 2010.

Although members are assigned to their geographically assigned T/RBHA, members must still contact their respective T/RBHA to initiate services. Members are notified of their behavioral health enrollment and how to access behavioral health services by AHCCCS and ADHS/DBHS through their member handbook in addition to their membership card.

Acute care members will always be enrolled in their assigned T/RBHA whether or not they are actively receiving behavioral health services. Therefore, members will never be disenrolled from the T/RBHA even when treatment is successfully completed or members choose to terminate behavioral health services.

B. Acute Care Contractor Responsibilities/Roles in serving behavioral health recipients

1. Acute Care Contractors are responsible for assisting members in obtaining behavioral health services if requested. The Acute Care Contractor's Behavioral Health Coordinator can facilitate the member's appointment for behavioral health services.
2. Acute Care Contractors are responsible for transportation for the member to the initial T/RBHA scheduled appointment and to the emergency department of an acute care hospital when the transport is emergent.
3. Acute Care Contractors are responsible for non-behavioral health professional fees related to co-morbid conditions such as treatment for diabetes, asthma, hypertension etc.
4. Acute care contractors are *not* responsible for reimbursement of inpatient facility and professional behavioral health services to hospitalized members with primary behavioral health diagnoses. Reimbursement is unrelated to the bed or floor where the member is placed.
5. Acute Care Contractors are responsible for the following when provided in an emergency department and there is no admission to the facility:

    a) Reimbursement of all facility covered services, including triage and diagnostic tests, regardless of primary diagnosis.

b) Reimbursement of non behavioral health *professional* claims, regardless of the presenting problem or diagnosis.

Acute Care Contractors are not responsible for payment of claims for behavioral health professional services provided in the emergency department. For example, if a behavioral health professional evaluates a member in the emergency room, the T/RBHA is responsible for payment, and the behavioral health professional must bill the T/RBHA for the evaluation.

In the event of an admission from the emergency department, the responsible payor is determined by the primary diagnosis appearing on the claim for the inpatient stay.

6. Acute Care Contractors are responsible for reimbursement of primary care provider visits, prescriptions, laboratory and other diagnostic tests necessary for diagnosis and treatment of depression, anxiety and/or attention deficit hyperactive disorder.
    a) Acute Care Contractors may implement step therapy for behavioral health medications used for these disorders except when the ADHS/DBHS Referral Form 4.3.1 indicates that 1) step therapy has occurred or 2) the treating T/RBHA provider recommends that the member remain on the current prescribed medication for psychiatric stability.

    b) Members maycontinue to receive medication management from their primary care providers (which are the fiscal responsibility of the acute care contractor) while simultaneously receiving counseling and other medically necessary rehabilitative services from the T/RBHA.

7. Acute Care Contractors are responsible for ensuring that the member's supply of psychotropic medications, including antipsychotic medication, is adequate to last through the date of the member's first appointment with a T/RBHA prescriber even if the first appointment is delayed. Acute Care Contractors are responsible for forwarding all relevant member medical information to the T/RBHA prescriber so that it is received prior to the first appointment.
8. Acute Care Contractors are responsible for contacting the T/RBHA for problem resolution regarding access to/delivery of behavioral health services. In the event the T/RBHA is unable to timely resolve the issue, the Acute Care Contractor must notify ADHS/DBHS Member Services (and Quality Management regarding quality of care issues) for assistance in resolving the issue.

C. ADHS/DBHS Roles/Responsibilities for behavioral health services for acute care members

1. The T/RBHA is responsible for accepting and acting upon referrals for behavioral health services, including emergency referrals, in accordance with contractual timelines. A referral is any oral, written, faxed, or electronic request for services made by the member, Acute Care Contractor and or the PCP.
2. The T/RBHA is responsible for ensuring that the final disposition of all referrals for behavioral health services, including emergency referrals from PCPs and Acute Care Contractors is communicated to the referral source and Acute Care Contractor Behavioral Health Coordinator no later than 30 days from the date of the member's initial assessment. If the member declines behavioral health services the final disposition must be

communicated back to the referral source and Acute Care Contractor Behavioral Health Coordinator, when applicable, within 30 days from the date of the referral. The T/RBHA is responsible for notifying the Acute Care Contractor if the member does not show up for a scheduled initial appointment and the date of the next scheduled appointment in order for the Acute Care Contractor to assure that the member's psychiatric medications are not interrupted.

3. The T/RBHA is responsible for ensuring a timely response to all appointment requests and shall schedule emergency, urgent and routine evaluations consistent with the member's needs and within contractual appointment standards.
4. The T/RBHA is responsible for reimbursement of detoxification services provided to a member who is medically stable regardless of setting or bed type.
5. The T/RBHA is *not* responsible for transportation for the member to the initial T/RBHA scheduled appointment or to the emergency department of an acute care hospital when the transport is emergent.
6. The T/RBHA is responsible for reimbursement of both the inpatient facility services and the professional behavioral health services for hospitalized members with primary behavioral health diagnoses unrelated to the bed or floor where the member is placed. Reimbursement of professional behavioral health services, including consultations, is unrelated to the bed or floor where the member is placed even if the member has or is being treated for other co-morbid physical conditions such as diabetes, asthma, hypertension etc. T/RBHAs are not responsible for non-behavioral health professional fees related to the co-morbid conditions.

7. In the event of an admission from the emergency department, the responsible payor is determined by the primary diagnosis appearing on the claim for the inpatient stay.
8. The T/RBHA is responsible for payment of medically necessary professional psychiatric consultations provided to acute care members in either emergency room or inpatient settings, when the primary diagnosis on the professional claim is behavioral health (regardless of primary diagnosis on the facility claim for the inpatient stay). This includes but is not limited to surgeries, procedures or therapies for which behavioral health support for a member is indicated to determine if there are any behavioral health contraindications.
9. The T/RBHA is responsible for reimbursement of ambulance transportation and/or other medically necessary transportation provided to a member who requires behavioral services after s/he has been medically stabilized. For example, the T/RBHA is responsible for transporting a medically stabilized member from the emergency room to another level of care or setting when behavioral health services are medically necessary.
10. The T/RBHA is not responsible for ambulance transportation and/or other medically necessary transportation when the member is enrolled in the AIHP and the primary diagnosis is not behavioral health (unspecified diagnosis code is not considered a behavioral health diagnosis code).

11. The T/RBHA is responsible for ensuring that the member's supply of psychotropic medications for the treatment of depression, anxiety and attention deficit/hyperactive disorder is adequate to last through the date of the member's first appointment with the PCP, when the T/RBHA has confirmed acceptance of transferring the member to back to the PCP with the PCP. The T/RBHA is responsible for forwarding all relevant member medical information to the PCP that it is received prior to the first/next appointment.
12. The T/RBHA is responsible for reimbursement of laboratory and other diagnostic tests necessary for the initial and ongoing treatment of behavioral health conditions. The primary diagnosis must be a behavioral health diagnosis.
13. The T/RBHA is responsible for submitting the ADHS/DBHS Referral Form 4.3.1 to member's Primary Care Providers (PCPs) for all members referred by the PCP. In such instances the T/RBHA must notify the PCP of the members' diagnosis, the critical laboratory values as defined by the laboratory, and the prescribed medications, including notification of changes in class of medications. For all other members receiving behavioral health services, the above information must be provided by the T/RBHA to the PCP no later than 10 days from the date of the request.
14. Payment of pre-petition screening and court ordered evaluation services are the fiscal responsibility of a county. For payment responsibility for other court ordered services refer to the AHCCCS Contractors Operational Manual Policy 423.
15. The T/RBHA and/or ADHS/DBHS are responsible for contacting and responding to Acute Care Contractors in a timely manner whenever problems with accessing behavioral health services are identified.

D. AHCCCS Responsibilities/Roles

1. AHCCCS assigns each acute care member to his/her respective T/RBHA based on the zip code in which s/he resides with the exception of CMDP children who are enrolled based on the zip code of the court of jurisdiction.
2. AHCCCS sends daily/monthly electronic 834 files to ADHS/DBHS of all enrolled acute care members.
3. AHCCCS identifies each acute care member as "Seriously Mentally Ill" (SMI), "General Mental Health/Substance Abuse" (GMH/SA) or "Child" in the AHCCCS PMMIS system based on ADHS/DBHS submitted designation of each member.
4. AHCCCS designates each acute care member as either TXIX or TXXI as determined by the member's eligibility category.
5. AHCCCS identifies acute care members who are actively receiving behavioral health services in the AHCCCS PMMIS system based on ADHS/DBHS submitted designation of each member.
6. AHCCCS is responsible for payment of medically necessary transportation (emergent and non-emergent) for TRBHA enrolled AIHP members and the diagnosis code on the claims is unspecified (799.9).

Matrix of Financial Responsibility

Setting/Service Type	*Facility Fee*	*Behavioral Health Professional Fee (as defined by a primary diagnosis on the professional claim)*	*Non Behavioral Health Professional Fee (as defined by a primary diagnosis on the professional claim)*	
Inpatient Acute Hospital non psychiatric bed when psychiatric bed unavailable and primary diagnosis is psychiatric	T/RBHA	T/RBHA	Acute Care Contractor	
Inpatient Acute Hospital (psychiatric bed)	T/RBHA	T/RBHA	Acute Care Contractor	
Inpatient Acute Hospital (detox bed)	T/RBHA	T/RBHA	Acute Care Contractor	
Residential Treatment Center or any other BH Facility Charges	T/RBHA	T/RBHA	Acute Care Contractor	
Emergency Department (not resulting in an Inpatient admission regardless of primary diagnosis)	Acute Care Contractor	T/RBHA	Acute Care Contractor	
Service Type	***Initial BH Appointment***	***Transfer from an Inpatient Acute Hospital to a BH setting***	***For other BH related services***	
Non Emergency Transportation	Acute Care Contractor	T/RBHA	T/RBHA	

Service Type	***From BH Facility to Hospital ER***	***From the community to Hospital ER***	***From the community to Psychiatric Hospital***	***From the Hospital ER to Psychiatric Hospital***
Emergency Transportation	Acute Care Contractor	Acute Care Contractor	T/RBHA	T/RBHA
Situation/Service Type	***Prescriptions***	***Primary Care Visit***		***Other BH Services***
Treatment of depression, anxiety and/or attention deficit hyperactive disorder *by the primary care physician*	Acute Care Contractor	Acute Care Contractor		T/RBHA (as defined by the primary diagnosis)
	Prior to initial appointment with Prescriber	***Ongoing (including transition to PCP for depression, anxiety and/or attention deficit hyperactive disorder)***		
Psychotropic Medications	Acute Care Contractor	T/RBHA		

Service Type	***From BH Facility to Hospital ER***	***From the community to Hospital ER***	***From the community to Psychiatric Hospital***	***From the Hospital ER to Psychiatric Hospital***
Emergency Transportation	Acute Care Contractor	Acute Care Contractor	T/RBHA	T/RBHA
Situation/Service Type	***Prescriptions***	***Primary Care Visit***		***Other BH Services***
Treatment of depression, anxiety and/or attention deficit hyperactive disorder *by the primary care physician*	Acute Care Contractor	Acute Care Contractor		T/RBHA (as defined by the primary diagnosis)
	Prior to initial appointment with Prescriber	***Ongoing (including transition to PCP for depression, anxiety and/or attention deficit hyperactive disorder)***		
Psychotropic Medications	Acute Care Contractor	T/RBHA		

AHCCCS

Arizona Health Care Cost Containment System

ENCOUNTER DATA VALIDATION

TECHNICAL DOCUMENT

Division of Health Care Management

Data Analysis & Research

August, 2009

AHCCCS ENCOUNTER DATA VALIDATION
TECHNICAL DOCUMENT

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New Contractor Data Validation Medical Record Pilot Study (A and B Studies)…….23

Introduction

The Centers for Medicare and Medicaid Services (CMS) requires the Arizona Health Care Cost Containment System Administration (AHCCCSA) to oversee and report on the utilization of medical services of AHCCCS's prepaid capitated Contractors. Contractors report service utilization on an encounter. An encounter is a record of a service rendered by a provider who is registered with AHCCCSA to a recipient who is enrolled with an AHCCCS Contractor. Contractors are required to submit encounters to AHCCCSA for all services.

CMS requires AHCCCSA to submit progress reports on the encounter data collection process. AHCCCSA must take appropriate action to correct deficiencies identified in the collection of encounter data and enforce financial penalties on Contractors that are not in compliance with data collection requirements.

AHCCCSA's encounter collection actions are based on the results of encounter data validation studies. Collecting accurate, timely and complete encounters is a high priority for AHCCCSA. Encounter data is used to support programmatic budget assumptions and in actuarial analyses to set capitation rate ranges. In addition, this data is used for AHCCCS Contractor Performance Measures and Performance Improvement Projects.

This document provides Contractors with the methodology and statistical formulae used in Encounter Data Validation. The encounter validation process for both Acute and Behavioral Health, Professional and Institutional, encounter studies are discussed first, followed by the random sampling methodology, the selection of medical record entries, and error rate and sanction calculation. Examples of each of these calculations follow the discussion. The encounter validation process for the Acute and Behavioral Health, Pharmacy and ALTCS, Professional and Institutional encounter studies are discussed next. Finally, the procedures for calculating error rates and sanctions are discussed, each of which is followed by an example of these calculations.

Encounter Data Validation Medical Record Study Steps (Acute, Behavioral Health, CMDP, and CRS)

1. At random, a measurement period is selected by AHCCCS. The measurement period will consist of dates10/1 thru 1/31, 2/1 thru 5/31, or 6/1 thru 9/30.

2. Approximately 9 months after the end of a contract year, a sample size for the study is calculated based on prior study results and the median number of encounters reported in the prior contract years. For sample size formulas, calculations and methods see Random Sample Selection. The sample members must meet the following criteria:
   a. The sample will consist of members receiving services in the measurement period.
   b. At least half of members selected, by Contractor, for the study must have received institutional services.
   c. The members must be continuously enrolled with same Contractor for the entire measurement period.

3. The sample is requested through the Information Management Subsystem of the Prepaid Medicaid Management Information System (PMMIS). Files for each Contractor are downloaded and the sample list of members by Contractor is generated.

4. For the members selected at random, an extract from each Contractor's claims system and Explanation of Benefits (EOB)s are requested for the selected measurement period. All Dental, Case Management, Pharmacy and Non-Emergency Transportation services will be excluded from medical record review. However, these services will be included in an electronic file match (see Encounter Data Validation Electronic File Study Steps).

5. A complete list of providers, utilizing claims and encounter data, is generated by AHCCCS and sent to Contractors.

6. Health Plans then have 2 weeks to collect provider addresses and return them to AHCCCS is a predetermined format.

7. AHCCCSA uses this information to coordinate the request for medical records directly from the providers.

8. Providers will have four weeks from the time of request to submit records to Health Plans for verification. Contractors will then have two additional weeks to collect any additional missing information and submit all records to AHCCCS. Contractors may be fined up to $1000.00 per medical record, per day, for each medical record not received by the deadline.

9. All medical records are scored (coded) for correctness errors in a double blind study. The records are scored for correctness in the following areas, if applicable:
   a. Payment with or without adjustments
      i. For UB Total Charges and Line by Line
   b. Diagnosis Code
      i. One Correct Diagnosis
      ii. All Correct Diagnoses
      iii. For UB Correct Primary Diagnosis
      iv. For UB All Diagnoses in Correct Order
   c. Procedure Codes
      i. Procedure
      ii. Modifiers
      iii. Units
      iv. Correct level
      v. Revenue Codes
   d. AHCCCS ID
   e. NPI/Provider ID/Provider Type
   f. Date of Service
   g. Unbundling/Global Services
   h. Place of Service
   i. Encounter matches Medical Record
   j. Encounter matches EOB
   k. Encounter matches Claim

   The records are then entered into the Encounter Reporting Validation System 2.0 (ERVS2) by each analyst without knowing how the other analyst coded the record

10. As each medical record is scored and entered into ERVS2, the analyst compares that record to an encounter in the downloaded file to determine if the analyst's coding matches that of the corresponding encounter. If a corresponding encounter cannot be found, the analyst marks the record as an encounter omission error. Any encounters that are not matched to a medical record at the end of the study are considered a medical record omission error.

11. Timeliness errors are calculated using SPSS and automatically assigned.

12. When all the records are scored, an ERVS2 report is printed that compares the codes of each record by each analyst; analysts then resolve any differences in coding through a reconciliation process.

13. Once differences are resolved, the preliminary error reports are generated and distributed to Contractors for their comments.

14. Contractors have the option to comment on these preliminary reports and provide additional documentation within 30 days.

15. Analysts review Contractors comments and adjust, if appropriate, the number of errors.

16. Following any adjustments to the preliminary data, final correctness, omissions, and timeliness reports are generated and sent to Contractors. Sanctions are applied based on the data in these reports.

17. Contractors may challenge and/or grieve the study results. Adjustments are made in the study results only if a challenge or grievance has been successful.

18. The final report and results are sent to CMS.

19. Data will be examined for trends and results of these findings will be distributed to Contractors.

Random Sample Calculation

The number of records previously scored is the beginning sample size (n) for the sample calculation. The omission, timeliness, and correctness error rates (p) are based on the previous year's error rates by Contractor.

1) The upper limit of a 95% confidence interval is calculated for each type of error for each Contractor according to the following formula for a large sample confidence interval assuming a normal distribution.

   $i = p + z \times \sqrt{(p(1-p))/n}$, where:
   z = 1.96 (Z score for a two-tailed 95% confidence interval),
   p = error rate (number of errors/n), and
   n = sample size.

2) The upper limit of the confidence interval is increased by a 10% safety cushion.

   $i_1 = i \times 1.1.$

3) The number of records (n_0) is calculated for each type of error for each Contractor.

   $n_0 = (z^2 \times i_1 (1 - i_1)) / \alpha^2$, where:
   α = 5% (with a 95% confidence interval an α of 5% is two standard deviations from mean).

4) The calculated number of records is then decreased by the calculated omission rate for each Contractor.

   $n_1 = n_0 \times (1 - i_1)$, where:
   n_1 = number of encounters left after omission.

5) The number of records left after omission is compared to the number of encounters needed. Since the number of encounters left is smaller than the actual number needed, an extra number needed is calculated for timeliness and correctness.

   $e = n_0 - n_1$, with:
   e = number of extras.

6) The greater value for either timeliness or correctness number of extras needed is taken and increased by the upper limit of the confidence interval including the safety cushion.

   $e_{tot} = Max (e_t, e_c) \times (1 + i_1)$, with e_t = extras for timeliness and e_c = extras for

correctness.

7) The number of records left after omission added to the total number of extras is the total number of cases needed.

   $n_{tot} = n_1 + e_{tot,}$ with n_{tot} = total number of cases needed.

8) The sum of the number of records obtained from each member is divided by the sum of the number of members requested from each Contractor. This results in a yield for each Contractor.

   $y = n_{tot} / n_{mr,}$ where:
   n_{tot} = number of cases and,
   n_{mr} = number of members requested.

9) The yield per sampled member based on a floating five-year average is used to calculate the records needed for this year. The total number of cases needed is divided by the calculated yield.

   $n_{need} = n_{tot} / y_t$, where: $y_t = (y_5 + y_4 + y_3 + y_2 + y_1) / 5$.

   Note: until a five year yield per sample member can be established the number of encounters yielded for the measurement prior and encounter data in the prior measurement period will be used to establish y_t,

10) If the Contractor did not have previous study results (e.g., a new Contractor) the sample size may be maximized by assuming an error rate of 50% as the worst case scenario for the Contractor.

    $n = \{z^2(p(1-p)\} / k^{2,}$ where:
    n = sample size,
    z = 1.96 (Z score for a two-tailed 95% confidence interval),
    p = error rate, and
    k = precision level desired.

    Using a 95% confidence interval with a .05 precision level and assuming an error rate of 50%, then $n = \{(1.96)^2(.5)(.5)\} / .05^2 = 384$.

Example of Random Sample Calculation

In this example, assume that Nearly Perfect Health Plan had the following error rates from the previous year:

Omission	Correctness	Timeliness
10.5%	15.5%	12.2%

and the sample size for Nearly Perfect from the previous year was:

Omission	Correctness	Timeliness
398	350	350

Step 1 - Calculate the upper limit of a 95% confidence interval using the formula $i = p + z \times \sqrt{(p(1-p))/n}$. For Nearly Perfect the confidence interval for the omission, correctness, and timeliness rates would be:

omission rate *i*

$= .105 + 1.96 \times \sqrt{(.105(1-.105))/398}$

$= .105 + 1.96 \times \sqrt{.000236}$

$= .105 + 1.96 \times .015366$

$= .105 + .030118 = .135$ *or 13.5%.*

correctness rate *i*

$= .155 + 1.96 \times \sqrt{(.155(1-.155))/350}$

$= .155 + 1.96 \times \sqrt{.000374}$

$= .155 + 1.96 \times .019345$

$= .155 + .037915 = .193$ *or 19.3%.*

correctness rate *i*

$= .122 + 1.96 \times \sqrt{(.122(1-.122))/350}$

$= .122 + 1.96 \times \sqrt{.000306}$

$= .122 + 1.96 \times .017494$

$= .122 + .034289 = .156$ *or 15.6%.*

Step 2 - The upper limit is increased by a 10% safety cushion using the formula $i_1 = i \times 1.1$. For Nearly Perfect the increase in the omission, correctness, and timeliness rates would be:

omission rate $i_1 = 13.5\% \times 1.1 = 14.9\%$.
correctness rate $i_1 = 19.3\% \times 1.1 = 21.2\%$.
timeliness rate $i_1 = 15.6\% \times 1.1 = 17.2\%$.

Step 3 - Calculate the number of encounters for each error using the formula

$n_0 = (z^2 \times i_1 (1 - i_1)) / \alpha^2$. For Nearly Perfect the number of encounters for the omission, correctness, and timeliness errors would be:

omission n_0
$= (1.96^2 \times .149 \times (1 - .149)) / .05^2$
$= (3.84 \times .126539) / .0025$
$= .486111 / .0025 = 194.$

correctness n_0
$= (1.96^2 \times .212 \times (1 - .212)) / .05^2$
$= (3.84 \times .167175) / .0025$
$= .64222 / .0025 = 257.$

timeliness n_0
$= (1.96^2 \times .172 \times (1 - .172)) / .05^2$
$= (3.84 \times .142362) / .0025$
$= .546897 / .0025 = 219.$

Step 4 - The calculated number of encounters is decreased by the omission rate using the formula $n_1 = n_0 \times (1 - i_1)$. For Nearly Perfect the decreased number of encounters would be:

$n_1 = 194 \times (1 - .149)$

Random Sample Calculation Example Continued

$n_1 = 194 \times .851 = 166.$

Step 5 - Comparison of the number of encounters needed by using the formula $e = n_0 - n_1$. For Nearly Perfect the comparison would be:

The extra number needed for:
correctness is e = 257 - 166 = 91, and
timeliness is e = 219 - 166 = 53.

Step 6 - Greatest value of extras needed is increased by the safety cushion using the formula $e_{tot} = Max (e_t, e_c) \times (1 + i_1)$. For Nearly Perfect the larger number of extras needed is from correctness *[91 (correctness)>53 (timeliness)],* so the number of extras assuming omissions would be:

$e_{tot} = Max (e_t, e_c) \times (1 + i_1)$
$= 91 \times (1 + .149)$
$= 91 \times 1.149$
$= 105.$

Step 7 - Calculate the total number of cases needed by using the formula

$n_{tot} = n_1 + e_{tot}$. For Nearly Perfect the total number of cases needed would be:

$n_{tot} = 166 + 105 = 271$.

Step 8 - Calculate the yield of the number of cases to the number of members requested using the formula $y = n_{tot} / n_{mr}$. For Nearly Perfect assume the number of members requested from the previous study was 110, therefore, the yield would be:

$y = 271 / 110 = 2.46$.

Step 9 - Calculate the total number of members needed based on a floating 5 year average yield using the formula $n_{need} = n_{tot} / y_t$, and $y_t = (y_3 + y_2 + y_1) / 5$.

The five year average yield for Nearly Perfect was:

Year 5	Year 4	Year 3	Year 2	Year 1
2.46	2.77	2.98	1.50	2.12

$y_t = (y_5 + y_4 + y_3 + y_2 + y_1) / 5$
$y_t = (2.46 + 2.77 + 2.98 + 1.50 + 2.12) / 5$
$y_t = 11.83 / 5$
$y_t = 2.37.$

For Nearly Perfect the total number of members needed would be:

$n_{need} = n_{tot} / y_t$
$n_{need} = 271 / 2.37$
$n_{need} = 115.$

Therefore, the sample size requested from Nearly Perfect Health Plan would be 115 members' medical records.

Error Rate Calculation

1) The sample error rate is calculated. The error rate is determined by taking the number of errors and dividing it by the sample size.

   p (error rate) = number of errors / n, where:
   n = sample size.

2) The lower limit of a 95% confidence interval is calculated based on a standard statistical formula to account for limitations caused by sampling. The formula is:

   $L = p - z \times \sqrt{(p(1-p))/n}$, where:
   L = lower limit of the confidence interval,
   p = error rate,
   z = 1.96 (Z score for a two-tailed 95% confidence interval), and
   n = sample size.

Example of Error Rate Calculation

Step 1 - The error rate is calculated with the formula *p = # errors / n*. In this example, for Nearly Perfect Health Plan the omission sample size is 418 with 40 errors. The omission error rate for Nearly Perfect would be:

p = 40 / 418 = 9.6%.

Step 2 - Calculate the lower limit of a 95% confidence interval using the formula $L = p - z \times \sqrt{(p(1-p))/n}$. For Nearly Perfect the lower limit of a 95% confidence interval for omission errors would be:

$L = .095694 - 1.96 \times \sqrt{(.095694(1-.095694))/418}$

$L = .095694 - 1.96 \times \sqrt{.000207}$

L = .095694 - 1.96 x .014388

L = .095694 - .028201 = .067 or 6.7%.

The lower limit of the confidence interval (6.7% in this example) is then used in the sanction calculation.

Nearly Perfect's error rate calculations for correctness and timeliness errors would be likewise calculated.

Sanction Calculation

The sanction amount by Contractor is calculated by applying the sanction formula:

$S = P \times ((L - A) \times N_{Adj})$, where:
S = sanction amount,
P = per-error sanction amount,
L = lower limit of the confidence interval,
A = allowable error rate of 5%, and
N_{Adj} = total number of encounters by form type adjusted for omissions by Contractor.

$N_{Adj} = N_{tot} / (1-L_{Om})$, where:
N_{Tot} = total number of encounters submitted by form type by Contractor, and
L_{Om} = the lower limit of the omission error by Contractor.

The per-error base sanction amounts are:

Error Type	Professional "A" Study	Institutional "B" Study
Omission	$2.00	$5.00
Correctness	$1.00	$1.00
Timeliness	$1.00	$1.00

Sanction Adjustments

Per-error sanction amounts are adjusted upward or downward for each of the three measures – omission, correctness, and timeliness – separately, as compared to the prior year.

- If the error rate declines from the previous year's rate for a specific measure, the per-error sanction amount is reduced by 50%.

- If the error rate remains constant from the previous year for a specific measure, the per-error sanction amount will be 100%.

- If the error rate for a specific measure in the current year increases from the previous year's rate:

  - and the new rate exceeds the overall weighted average, the per-error sanction amount will be increased by 25%.

  - and new rate is below the overall weighted average, the per-error sanction amount will be 100%.

Error Assignment

Omission and correctness errors are assumed to be Contractor error, unless supporting documentation demonstrates the error was caused by the provider.

- Plan errors: sanctioned at 100%.
- Provider errors: 75% of sanction earmarked for provider training.
- Plan outlay: 100% for plan errors + 25% for provider errors.
- Diagnosis correctness errors:
  - sanctioned at 100% if diagnosis is incorrect; or
  - 25% if non-specific (diagnosis root correct, but 4th or 5th digit missing or incorrect.

Example of Sanction Calculation

The sanction is calculated by applying the sanction formula,
$S = P \times (L - A) \times N_{adj}$ where $N_{Adj} = N_{tot} / (1-L_{Om})$. Assume Nearly Perfect had submitted 855,933 encounters for the year. Recall that Nearly Perfect's omission lower limit is 6.7% and the allowable error rate is 5%. The per-error base sanction amount for omission errors is $2.00. Their adjusted encounters would be:

$N_{Adj} = N_{tot} / (1-L_{om})$
$N_{Adj} = 855,933 / (1-.067)$
$N_{Adj} = 855,933 / .933 = 917,399.$

The omission base sanction for Nearly Perfect would be:

$S = P \times (L - A) \times N_{adj}$
$S = \$2.00 \times (.067 - .05) \times 917,399$
$S = \$2.00 \times .017 \times 917,399$
$S = \$31,192.$

Recall that that Nearly Perfect Health Plan's omission error rate from the previous year was 10.5%. This year's error rate of 9.6% is less than last year's rate of 10.5%. Therefore the per-error sanction amount for omission errors is 50% of the base sanction amount ($2.00 x .5) or $1.00, which is the revised per-error sanction amount.

According to Nearly Perfect's preliminary findings documentation submitted to AHCCCSA, 2 of the 40 omission errors were attributed to the plan and the remaining 38 errors were due to provider errors. Plan errors are sanctioned at 100% of the revised per-error sanction amount, i.e., $1.00. For provider errors, plans are sanctioned for 25% of the revised per-error sanction amount and must earmark the remaining 75% for provider training and education.

The revised or adjusted sanction amount for Nearly Perfect would be:

$S_r = P_r \times (L - A) \times N_{adj} \times (O_{pl} / O) + (P_r \times .25) \times (L - A) \times N_{adj} \times (O_{pr} / O)$, where

S_r = revised or adjusted sanction amount
P_r = revised per-error sanction amount
$O_{p\,l}$ = omission errors attributed to the plan
O_{pr} = omission errors attributed to the provider
O = total omission errors

$S_r = [P_r \times (L - A) \times N_{adj} \times (O_{pl} / O)] + [(P_r \times .25) \times (L - A) \times N_{adj} \times (O_{pr} /O)]$
$S_r = [\$1.00 \times (0.67 – 0.5) \times 917,399 \times (2 /40)] + [(\$1.00 \times .25) \times (0.67 – 0.5) \times 917,399 \times (38 /40)]$
$S_r = [\$1.00 \times 0.17 \times 917,399 \times 0.05] + [\$0.25 \times 0.17 \times 917,399 \times 0.95]$

S_r = *[$780] + [$3,704]*
S_r = *$4,484*

As a result of provider omission errors, the amount earmarked for provider education and training would be:

$S_t = (P_r \times .75) \times (L - A) \times N_{adj} \times (O_{pr} / O)$, where

S_t = *funds earmarked for provider education and training*

$S_t = (P_r \times .75) \times (L - A) \times N_{adj} \times (O_{pr} / O)$
S_t = *($1.00 x .75) x (0.67 – 0.5) x 917,399 x (38 /40)*
S_t = *$0.75 x 0.17 x 917,399 x 0.95*
S_t = *$11,112*

For Nearly Perfect Health Plan, the correctness and omission lower limit are calculated the same. Nearly Perfect had 60 correctness errors out of a sample of 378. The correctness error rate is 15.9% with a lower limit of 12.2%. The correctness base sanction for Nearly Perfect would be:

$S = P \times (L - A) \times N_{adj}$
S = $1.00 x (.122 - .05) x 917,399
S = $1.00 x .072 x 917,399
S = $66,053

Recall that that Nearly Perfect Health Plan's correctness error rate from the previous year was 15.5%. This year's error rate of 15.9% is greater than last year's rate of 15.5%. Therefore the per-error sanction amount for correctness errors is 125% of the base sanction amount ($1.00 x 1.25) or $1.25, which is the revised per-error sanction amount.

According to Nearly Perfect's preliminary findings documentation submitted to AHCCCSA, three of the 60 correctness errors were attributed to the plan and the remaining 57 errors were due to provider errors. Plan errors are sanctioned at 100% of the revised per-error sanction amount, i.e., $1.25. For provider errors, plans are sanctioned for 25% of the revised per-error sanction amount, and the remaining 75% must be earmarked for provider training and education.

In addition, one of the plan's three correctness errors was identified as a diagnosis specificity error due to data entry. Twenty-six of the provider's 57 correctness errors were categorized as diagnosis specificity errors. Diagnosis correctness errors are sanctioned at 100% of the per-error sanction amount. Diagnosis errors due to specificity errors are sanctioned at 25% of the per-error amount.

The revised or adjusted sanction amount for Nearly Perfect would be:

$S_r = P_r \times (L - A) \times N_{adj} \times (C_{pl} / C) + (P_r \times .25) \times (L - A) \times N_{adj} \times (C_{plx} / C) + (P_r \times .25) \times (L - A) \times N_{adj} \times (C_{pr} / C) + (P_r \times .25 \times .25) \times (L - A) \times N_{adj} \times (C_{prx} / C)$, where

S_r = revised or adjusted sanction amount
P_r = revised per-error sanction amount
$C_{p\,l}$ = correctness errors, excluding specificity, attributed to the plan
C_{plx} = specificity correctness errors attributed to the plan
C_{pr} = correctness errors, excluding specificity, attributed to the provider
C_{prx} = specificity correctness errors attributed to the provider
C = total correctness errors

$S_r = [P_r \times (L - A) \times N_{adj} \times (C_{pl} / C)] + [(P_r \times .25) \times (L - A) \times N_{adj} \times (C_{plx} / C)] + [(P_r \times .25) \times (L - A) \times N_{adj} \times (C_{pr} /C)] + [(P_r \times .25 \times .25) \times (L - A) \times N_{adj} \times (C_{prx} /C)]$
$S_r = [\$1.25 \times (0.122 – 0.05) \times 917{,}399 \times (2 /60)] + [(\$1.25 \times .25) \times (0.122 – 0.05) \times 917{,}399 \times (1 /60)] + [(\$1.25 \times .25) \times (0.122 – 0.05) \times 917{,}399 \times (31 /60)] + [(\$1.25 \times .25 X .25) \times (0.122 – 0.05) \times 917{,}399 \times (26 /60)]$
$S_r = [\$2{,}752] + [\$344] + [\$10{,}665] + [\$2{,}236]$
$S_r = \$15{,}997$

As a result of provider correctness errors, the amount earmarked for provider education and training would be:

$S_t = (P_r \times .75) \times (L - A) \times N_{adj} - S_r$, where

S_t = funds earmarked for provider education and training

$S_t = P_r \times (L - A) \times N_{adj} - S_r$
$S_t = \$1.25 \times (0.122 – 0.05) \times 917{,}399 - \$15{,}997$
$S_t = \$1.25 \times 0.072 \times 917{,}399 – \$15{,}997$
$S_t = \$82{,}566 - \$15{,}997$
$S_t = \$66{,}569$

Nearly Perfect's sanction calculation for timeliness errors would be calculated similar to the omission sanction, except there is no assignment of plan or provider liability and therefore no adjustment based on provider-based error.

Encounter Data Validation Electronic File Study Steps

1) The following areas of study are included in the electronic file match: ALTCS, Dental, Case Management, Non-Emergency Transportation and Pharmacy studies

2) Approximately 9 months after the end of a contract year, encounter extract files by Contractor are requested through the Information Management Subsystem on the Prepaid Medicaid Management Information System (PMMIS). Files for each Contractor are downloaded, sorted, and prepared for matching.

3) An extract from each Contractor's claims system is requested.

4) Contractors submit the claims file extract to the AHCCCSA Encounter Validation Unit. Those files are uploaded, sorted, and prepared for matching.

5) Duplicates and inappropriate codes are removed from the extract files. Procedure, revenue codes, diagnosis codes, dates of service, and provider and member identification numbers from the claims file extract are compared and contrasted to the encounter files extract. Three separate trials at matching the encounter data to the claims data are performed.

6) At each trial, fields from the extract files are matched to each other. If all the fields examined are exactly matched, the encounter is not an omission. If after the last trial the fields do not match, the claim in the claims extract file is counted as an omission error.

7) When all the data has been reviewed, a report by Contractor is printed that lists each claim that did not match to an encounter; analysts then check the encounter database on PMMIS in an effort to locate the matching encounter.

8) After the analysts have checked the encounter database and adjusted, if necessary, the number of omissions, the preliminary error report is generated and sent to Contractors for their comments.

9) Contractors have the option to comment on this preliminary report, and provide additional documentation within 30 days.

10) Analysts review the comments of Contractors and adjust, if appropriate, the number of errors.

11) Following any adjustments to the preliminary data, final omission reports are generated and sent to Contractors. Sanctions are applied based on the data in these reports.

12) Contractors may challenge and/or grieve the study results. Adjustments are made in the study results only if a challenge or grievance has been successful.

13) The final report and results are sent to CMS.

Error Rate Calculation

1) The sample error rate is calculated. The error rate is determined by taking the number of errors and dividing it by the sample size.

   p (error rate) = number of errors / n, where:
   n = sample size.

2) The lower limit of a 95% confidence interval is calculated based on a standard statistical formula to account for limitations caused by sampling. The formula is:

   $L = p - z \times \sqrt{(p(1-p))/n}$, where:
   L = lower limit of the confidence interval,
   p = error rate,
   z = 1.96 (Z score for a two-tailed 95% confidence interval), and
   n = sample size.

Example of Error Rate Calculation

Step 1 - The error rate is calculated with the formula *p = # errors / n*. In this example, for Nearly Perfect Health Plan the omission sample size is 300 with 27 errors. The omission error rate for Nearly Perfect would be:

p = 27 / 300 = 9.0%.

Step 2 - Calculate the lower limit of a 95% confidence interval using the formula $L = p - z \times \sqrt{(p(1-p))/n}$. For Nearly Perfect the lower limit of a 95% confidence interval for omission errors would be:

$L = .09 - 1.96 \times \sqrt{(.09(1-.09))/300}$

$L = .09 - 1.96 \times \sqrt{.000273}$

$L = .09 - 1.96 \times .016523$

$L = .09 - .032385 = .058$ *or 5.8%.*

The lower limit of the confidence interval (5.8% in this example) is then used in the sanction calculation.

Sanction Calculation

The sanction amount by Contractor is calculated by applying the sanction formula:

$S = P \times ((L - A) \times N_{Adj})$, where:
S = sanction amount,
P = per-error sanction amount,
L = lower limit of the confidence interval,
A = allowable error rate of 5%, and
N_{Adj} = total number of encounters by form type adjusted for omissions by Contractor.

$N_{Adj} = N_{tot} / (1-L_{Om})$, where:
N_{Tot} = total number of encounters submitted by form type by Contractor, and
L_{Om} = the lower limit of the omission error by Contractor.

Example of Sanction Calculation

The sanction is calculated by applying the sanction formula,
$S = P \times (L - A) \times N_{adj}$ where $N_{Adj} = N_{tot} / (1-L_{Om})$. Assume Nearly Perfect had submitted 1,931,630 encounters for the year. Recall that Nearly Perfect's lower limit is 5.8% and the allowable error rate is 5%. The per-error sanction amount for omission errors is $1.00. Their adjusted encounters would be:

$N_{Adj} = N_{tot} / (1-L_{om})$
$N_{Adj} = 1,931,630 / (1-.05762)$
$N_{Adj} = 1,931,630 / .94238 = 2,049,726.$

The sanction for Nearly Perfect would be:

$S = P \times (L - A) \times N_{adj}$
$S = \$2.00 \times (.05762 - .05) \times 2,049,726$
$S = \$2.00 \times .00762 \times 2,049,726$
$S = \$31,220.$

For the current ALTCS studies, only omission errors are evaluated and sanctioned.

New Contractor Data Validation Medical Record Pilot Study (A and B Studies)

Introduction

CMS waiver requirement number 23 for the Encounter Data Validation Study for New MCOs or PIHPs reads as follows: if the State contracts with new MCOs or PIHPs the state shall conduct a validation study 18 months after the effective date of the contract to determine completeness and accuracy of the encounter data. The initial study shall include validation through a sample of medical records of Demonstration enrollees.

Sampling

1. In order to meet number 23 of the current CMS waiver, the AHCCCS Data Validation Unit will select a random representative sample, by new MCO.
2. The sampling formula ($n=(Z^2*K^2*N)/(Z^2*K^2+(P/(1/(1-P))*(N-1))$) will be utilized with the following assumptions: a 15% error rate, a 95% confidence interval, and a +/- 5% confidence level.
3. A minimum of 35 members will be selected for this study to yield a statistically significant number of encounters for scoring. It is also supported that a sample greater than 30 members, by current epidemiological and statistical standards, will allow significant representation of key demographic variables (race, gender, age, placement, etc.) for extrapolation of results and maintains external and internal validity.
4. Members must be continuously enrolled with the new MCO for at least 4 of the first 6 months of that MCO's new contract.

Timeline

1. The Data Validation Unit study measurement period will consist of the first 6 months of the contract year of study.
2. The study will be initiated 45 days after the end of the first contract year. A request for records will be sent to the MCO. This timeframe has been selected to allow an approximate lag of 9 months for the submission of encounters.
1. The MCO will have 30 days to collect records and return them to AHCCCS.
2. AHCCCS will log all medical records within 15 days and select records to be scored beginning its evaluation on January 1.
3. On January 1, a double blind descriptive study will be conducted examining correctness and omission errors. Like all studies conducted for data validation, all case management and transportation records will be excluded. Utilizing the current methodology a double blind study consists of two data validation certified coders scoring each record as if they were going to bill for each service. These records are then compared to the encounter universe. The results of each coder are then compared to one another. Any differences are then reconciled.
4. The Data Validation Unit will use half of the records to conduct the study by the current methodology, as described, and it will use the other half of the records to

conduct a reverse validation. This study will compare a random selection of encounters to the medical record. This additional component will allow for a complete picture of how services are being reported.

5. Due to the compressed timeline, unlike current Data Validation methodology, preliminary results will not be sent to MCOs to refute findings. This step is not necessary because no sanctions will be imposed. However, if plans fail to meet the current CMS standard of greater than a 5% error rate, a Corrective Action Plan will be required for each area that is deficient.
6. The data validation study will be completed by March and sent for internal review and approval.
7. After any needed revisions, the study results will be sent to new MCOs and CMS by the end of March.
8. Along with completion of this pilot study each new MCOs will be subject to the normal annual data validation study that is conducted for each contract year.

Data

The data warehouse will be used to extract members meeting the sample frame. SPSS will then be utilized to select a representative random sample. The data warehouse will then be utilized to extract the encounter data for those members selected. This information will then be placed into a custom Access database for use by the data validation staff for the completion of the study. All results will be calculated using SPSS and Excel.

Grievance System Reporting Guide

Version 3.2
April 2010

Introduction:

The Grievance System Reporting Guide contains instructions on how to complete three separate reports for submission and review by the Division of Health Care Management (DHCM) as required by the applicable contract paragraph for Acute and ALTCS Contractors providing service to AHCCCS enrollees. The three reports are addressed in this order:

1. Claim Dispute Report
2. Authorization Request and Appeal Report
3. Enrollee Grievance Report

The instructions for completion are given in the paragraphs that follow and the formatting templates are also provided in attachments A, B, C, D, E, F & G.

Definition of Terms:

Action – The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of previously authorized services; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner as set forth in contract; the failure of a Contractor to act within the timeframes specified in contract; and for enrollees residing in a rural area with only one Contractor, the denial of an enrollee's right to obtain services outside the Contractor's network.

Appeal – A request for review of an action (other than those made on Provider Claim submissions) as "action" is defined in this policy.

Authorization Request (Standard) – A request for the authorization of services for which a Contractor must provide a decision as expeditiously as the member's health condition requires, but not later than fourteen (14) calendar days following the receipt of the authorization request with a possible extension of up to fourteen (14) calendar days if the member or provider requests an extension or if the Contractor justifies a need for additional information and the delay is in the member's best interest. (42 CFR 438.210)

Authorization Request (Expedited) – A request for the authorization of services which the provider or a Contractor determines that using the standard timeframe could seriously jeopardize the member's life or health or the ability to attain, maintain or regain maximum function. The Contractor must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires but no later than three (3) working days following the receipt of the authorization request, with a possible extension of up to fourteen (14) calendar days if the member or

provider requests an extension or if the Contractor justifies a need for additional information and the delay is in the enrollee's best interest. (42 CFR 438.210)

Claim Dispute – A dispute involving payment of a claim, the denial of a claim. For the purposes of recording the accurate number of disputes, each individual claim addressed in a filling is equal to one dispute e.g. a provider that included 10 claims in a single submission, would be counted as 10 separate Claim Disputes.

Contractor – A Managed Care Organization (MCO) providing health care to acute or long term care enrollees.

Date of Decision (DOD) – For Authorization Requests the date that the Contractor makes and communicates the decision to the member and/or their designated representative.

Date of Processing (DOP) – Date that the appeal, claim or claim dispute decision is communicated by the Contractor.

Date of Receipt (DOR) – Date that the authorization request, appeal, claim or claim dispute is received by the Contractor.

Day – Calendar day unless otherwise specified.

Enrollee – A person eligible for AHCCCS and who is enrolled with a Contractor, also known as a member.

Notice of Action – The written notice to the member regarding an action by the Contractor. The contents of a Notice of Action are strictly defined in Contract and Policy.

Notice of Appeal Resolution - The written notice to the member and/or their designated representative regarding the final determination of an appealed action. The contents of a Notice of Appeal Resolution are strictly defined in Contract and Rule.

Notice of Decision – The written notice to the provider regarding the final determination of a disputed claim payment or claim denial. The contents of a Notice of Decision are strictly defined in Contract and Rule.

Overturned – The original decision of the Contractor is determined incorrect or incomplete and is reversed. This category is further divided into those disputes that are reversed due to Contractor error in processing (**overturned due to incorrect handling or secondary review**) and those that are reversed due to additional information being submitted by the member or

provider in support of reversal (**overturned due to additional information submitted**).

Partially Overturned – The original decision of the Contractor was reversed, but the outcome is not entirely in the member and/or provider's favor. This category is further divided into those disputes that are reversed due to Contractor error in processing (**partially overturned due to incorrect handling or secondary review**) and those that are reversed due to additional information being submitted by the member or provider in support of reversal (**partially overturned due to additional information submitted**).

Turn Around Time (TAT) – The time from the date of receipt to the date of decision.

Upheld – The original determination of the Contractor is maintained.

Claim Dispute Report

General Instructions:

The Claim Dispute report must be completed using the guidelines below and the report must be submitted on the first day of the 2nd month following the month being reported to the address below:

Compliance Officer
AHCCCS Division of Health Care Management
701 E. Jefferson St. (MD 6500 for Acute, MD 6100 for ALTCS)
Phoenix, AZ 85034

1. The Contractor must generate and submit the report with an accompanying cover letter that summarizes the data; explains significant trending in either direction (positive or negative); any interventions applied to areas of concern; as well as any changes to categorical sub-classification that may have been implemented due to Contractor drill-down on a specific category of complaint.

2. Categorical sub-classifications for Claim Disputes are at the discretion of the Contractor based on its internal definitions, but must be clearly defined in an attached legend in the format of the Contractor's choosing. Suggested classifications are included in the instructions that follow.

Spreadsheet Instructions: (Spreadsheet is Attachment A)

A. Summary of Claim Disputes:

The numbers in Section A must be reported by age of the Claim Dispute as determined by Date of Receipt (DOR) through Date of Processing (DOP); and also by total number in the category.

A1. The number of Claim Disputes that remained open from the previous reporting period (reported in Row A4) must be carried over to this report.

A2. Total number of Claim Disputes logged as received during the reporting period.

A3. Total number of Claim Disputes closed during the reporting period.

A4. The total number of Claim Disputes remaining from the previous reporting period added to those received during the current period and subtracting those closed during the current period (A1 + A2 – A3 = A4).

B. Claim Dispute Decisions:

The numbers in Section B must be reported as a total number of disputes that can be assigned to the category.

B1. The total number of upheld Claim Disputes (excluding untimely dispute filings) during the current period including those that were opened in previous periods.

B2. The total number of upheld Claim Disputes received by the Contractor later than twelve (12) months after the date of service, later than twelve (12)months after the date that eligibility is posted or later than sixty (60) days after the date of the denial of a timely claim submission.

B3. The total number of overturned Claim Disputes during the current period; including those received in previous periods.

I. Overturned due to a secondary review finding that with all available information at the time of first review, the claim was inappropriately denied based on medical necessity or administrative criteria.
II. Overturned due to additional information which was not available at the time of the initial review and may or may not have substantially affected the Contractor's ability to determine the appropriate action.

B4. The total number of partially overturned Claim Disputes during the current period, including those received in previous periods.

I. Partially overturned due to a secondary review finding that with all available information at the time of first review, the claim was inappropriately denied based on medical necessity or administrative criteria.
II. Partially overturned due to additional information which was not available at the time of the initial review and may or may not have substantially affected the Contractor's ability to determine the appropriate action.

B5. The total number of Claim Disputes requiring an extension.

B6. The total number of Claims forwarded for reprocessing as the result of an overturned, or partially overturned, Claim Dispute.

C. State Fair Hearing Statistics:

The numbers in Section C must be reported by the total number of Hearing Requests meeting the categorical criteria.

C1. The total number of requests for State Fair Hearing (RFH) received during the reporting period.

C2. The number of RFH that were forwarded to the AHCCCS Office of Administrative Legal Services (OALS) within five (5) business days of receipt by the Contractor.

C3. The number of RFH that were forwarded to the AHCCCS Office of Administrative Legal Services (OALS) more than five (5) business days from the date of Contractor receipt.

C4. The total number of cancelled (withdrawn or vacated) RFH.

I. Those cancelled (withdrawn or vacated) RFH that resulted from a settlement agreement initiated by the Contractor.

C5. The total number of Director's Decisions received during the reporting period that found in favor of the Provider, either in whole or in part.

C6. The total number of Director's Decisions received during the reporting period that found in favor of the Contractor's determination (; excluding Decisions reported in C4).

D. Categorical Trending Analysis:

The numbers in Section D must be reported as both a total number per category and as a percentage of the total number of disputes received for the reporting period.

D1-D5. List the top 5 categories of dispute by volume using the agreed upon acronym or abbreviation,

Available categories (not exclusive of new categories as needed and explained in a separate cover letter) include:

COD (Coding Dispute) – Disputes of a coding nature such as claims containing incorrect HCPCS; CPT; ICD-9 codes; Revenue Codes and/or modifiers.

DSI (Data Source Issues) – Disputes that are in reference to incorrect recognition of contract; provider registration or member enrollment status.

NPA (No Prior Authorization) – Instances where a claim was denied for requiring prior authorization.

NAM (No Authorization Match) – Instances where a claim was denied because the billed charges or length of stay do not correlate to the Contractor's prior authorization records.

CPE (Claim Processing Error) – Disputes that challenge the correctness of information presented on the Remittance Advice (Examples include: processed to incorrect provider, incorrect member, incorrect procedure code, etc...).

TOC (Timeliness of Claim) – Claims that are resubmitted as a challenge to the finding of timeliness of the original claim submission.

TOP (Timeliness of Payment) – Disputes that are filed on claims that have not been adjudicated.

NPC (Not Paid Correctly) – Dispute filed due to a difference in the expected reimbursement and the Contractor's remittance.

E. Provider Trending Analysis:

The numbers in Section E must be reported with both a total number per provider and the category with the largest number of disputes received from the provider in the reporting period.

E1-E5. List the top five (5) providers, by NPI or AHCCCS PIN number if no NPI is available, with the largest volume of claim disputes filed during the reporting period and the category of the largest percentage of disputes filed by that provider for the period (Example: Provider X; 145 Disputes; NPC).

Authorization Request and Appeal Report

General Instructions:

The Authorization Request and Appeal Report must be completed using the guidelines below and the report must be submitted on the first day of the 2nd month following the month being reported to the address below:

Compliance Officer
AHCCCS Division of Health Care Management
701 E. Jefferson St. (MD 6500 for Acute, MD 6100 for ALTCS)
Phoenix, AZ 85034

1. The Contractor must generate and submit the report with an accompanying cover letter that summarizes the data; explains significant trending in either direction (positive or negative); any interventions applied to areas of concern.

Spreadsheet Instructions: (Spreadsheet is Attachment B)

A. Summary of Authorization Requests:

A1. The total number of authorization requests received during the reporting period to contain all categories of prior authorization requests regardless of urgency or assigned priority (i.e. Standard, Expedited, Extended, etc.). ALTCS Program Contractors must recognize one Authorization Request for each Case Manager Assessment that occurs during the reporting period. This is inclusive of in-home, alternative residential setting and nursing facility member assessments.

A2. The number of authorization requests that were not approved as requested during the reporting period (denials, suspensions, reductions, terminations). Further subdivided into the following categories (refer to ACOM 414 for more information regarding the categories):

I. Not a Covered Benefit/Benefit Exhausted
II. Not Medically Necessary
III. Out of Network Provider
IV. Not Enough Information to Render a Decision within the legal timeframe
V. System/Program Issues, Including Coverage by Another Entity (BHS, CRSA, TPL)

A3. The percentage of authorization requests that resulted in an action: A2 divided by A1 x 100.

B. Type of Request: **IMPORTANT NOTE: The data in this section, and only the data in this section, is related to those cases received within the reporting period and completed prior to report submission.**

Section B contains a breakdown of the categories summarized in section A. The data in this section must be reported by the Total Number of Authorization Requests received during the reporting period, the Total Number of Authorization Requests Completed within Timeliness Standard and the Percentage of Authorization Requests Completed Timely (as calculated by dividing the timely completed requests by the total number of completed requests within the category).

B1. The number of standard authorizations as defined under the guidelines of this reporting guide.

B2. The number of standard authorization requests that were extended by fourteen (14) days due to member request or Contractor determination of necessity.

B3. The number of expedited authorization requests as defined under the guidelines of this reporting guide.

B4. The number of expedited authorization requests that were extended by fourteen (14) days due to member request or Contractor determination of necessity.

B5. The number of expedited authorization requests that were determined not to require expedited review based on medical necessity and were, therefore, handled under the standard process guidelines.

C., D. & E. Standard Appeals: This section contains information regarding Standard appeals of a Contractor's action as defined in this guide.

The data in Section C is reported by age of the standard appeal as determined by subtracting DOR from the last day of the reporting period and the total number of appeals that meet the criteria for standard appeals as defined in this guide.

C1. The number of standard appeals opened on the first (1st) day of the current reporting period, as reported in line C5 of the previous period.

C2. The number of standard appeals received during the reporting period.

C3. The number of standard appeals closed during the reporting period.

C4. The number of standard appeals closed during the reporting period that were completed within thirty (30) days.

C5. The number of standard appeals remaining open on the last day of the current reporting period.

The data in Section D is reported as a total count of appeals closed during the reporting period that fall into each category.

D1. The total number of upheld standard appeals.

D2. The total number of standard appeals received by the Contractor later than sixty (60) days from the date of the Notice of Action.

D3. The total number of overturned standard appeals. This category is further divided as follows:

I. Overturned due to a secondary review finding that with all available information at the time of first review, the request was inappropriately denied based on medical necessity or administrative criteria.
II. Overturned due to additional information which was not available at the time of the initial review and may or may not have substantially affected the Contractor's ability to determine the appropriate action.

D4. The total number of partially overturned standard appeals.

I. Partially overturned due to a secondary review finding that with all available information at the time of first review, the request was inappropriately denied based on medical necessity or administrative criteria.
II. Partially overturned due to additional information which was not available at the time of the initial review and may or may not have substantially affected the Contractor's ability to determine the appropriate action.

D5. The total number of standard appeals requiring fourteen (14) day extensions to the thirty (30) day review period.

The data in Section E is to be reported as a total count of Member State Fair Hearing (RFH) files that meet the criteria listed below by category.

E1. The total number of RFH files received during the reporting period.

E2. The number of RFH that were forwarded to the AHCCCS Office of Administrative Legal Services (OALS) within the appropriate timeframe as dictated by the Arizona Administrative Code and the nature of the request

(i.e. five (5) days for standard or same-day for expedited hearing requests).

E3. The number of RFH that were forwarded to the AHCCCS Office of Administrative Legal Services (OALS) outside of the appropriate timeframe as dictated by the Arizona Administrative Code and the nature of the request (i.e. five (5) days for standard or same-day for expedited hearing requests).

E4. The total number of cancelled (withdrawn or vacated) RFH.

I. Those cancelled (withdrawn or vacated) RFH that resulted from a settlement agreement initiated by the Contractor

E5. The total number of Director's Decisions received during the reporting period that found in favor of the Member either in whole or in part.

E6. The total number of Director's Decisions received during the reporting period that found in favor of the Contractor's determination (Excluding Decisions reported in E4).

F., G. & H. Expedited Appeals: This section contains information regarding requests for expedited review of an appeal of a Contractor's action as defined in this guide.

The data in Section F is reported by age of the appeal as determined by subtracting DOR from the last day of the reporting period and the total number of appeals that meet the criteria for expedited appeals as defined in this guide.

F1. The number of expedited appeals that remained open on the first (1st) day of the current reporting period, as reported in line F5 of the previous period.

F2. The number of expedited appeals that were received during the reporting period.

F3. The number of expedited appeals that were closed during the reporting period.

F4. The number of expedited appeals closed during the reporting period that were completed within three (3) days.

F5. The number of expedited appeals that remained open on the last day of the current reporting period.

The data in Section G is reported as a total count of appeals closed during the reporting period that fall into each category.

G1. The total number of upheld expedited appeals.

G2. The total number of expedited appeals received by the Contractor later than sixty (60) days from the date of the Notice of Action.

G3. The total number of overturned expedited appeals. This category is further divided as follows:

I. Overturned due to a secondary review finding that with all available information at the time of first review, the request was inappropriately denied based on medical necessity or administrative criteria.
II. Overturned due to additional information which was not available at the time of the initial review and may or may not have substantially affected the Contractor's ability to determine the appropriate action.

G4. The total number of partially overturned expedited appeals.

I. Partially overturned due to a secondary review finding that with all available information at the time of first review, the request was inappropriately denied based on medical necessity or administrative criteria.
II. Partially overturned due to additional information which was not available at the time of the initial review and may or may not have substantially affected the Contractor's ability to determine the appropriate action.

G5. The total number of expedited appeals requiring fourteen (14) day extensions to the three (3) day review period that were requested and/or granted by either party to the appeal.

G6. The total number of expedited appeal requests that did not meet the criteria for expedited review based on medical necessity and were, therefore, handled under the standard appeal process.

The data in Section H is to be reported as a total count of Expedited Member State Fair Hearing (RFH) files that meet the criteria listed below by category.

H1. The total number of RFH files received during the reporting period.

H2. The number of RFH that were forwarded to the AHCCCS Office of Administrative Legal Services (OALS) within the appropriate timeframe as

dictated by the Arizona Administrative Code and the nature of the request (i.e. five (5) days for standard or same-day for expedited hearing requests).

H3. The number of RFH that were forwarded to the AHCCCS Office of Administrative Legal Services (OALS) outside of the appropriate timeframe as dictated by the Arizona Administrative Code and the nature of the request (i.e. five (5) days for standard or same-day for expedited hearing requests).

H4. The total number of cancelled (withdrawn or vacated) RFH.

I. Those cancelled (withdrawn or vacated) RFH that resulted from a settlement agreement initiated by the Contractor

H5. The total number of Director's Decisions received during the reporting period that found in favor of the member either in whole or in part (sustained or partially sustained).

H6. The total number of Director's Decisions received during the reporting period that found in favor of the Contractor's determination (excluding Decisions reported in H4).

Enrollee Grievance Report

General Instructions:

The Enrollee Grievance Report must be completed using the guidelines below and the report must be submitted on the first day of the 2nd month following the month being reported to the address below:

(Appropriate Compliance Officer)
AHCCCS Division of Health Care Management (DHCM)
701 E. Jefferson, MD 6500

1. A separate spreadsheet will be submitted for each of three (3) categories of grievance:

   Attachment C. Transportation
   Attachment D. Medical Service Provision
   Attachment E. Contractor/Program Contractor Service Level
   Attachment F. Wheelchair
   Attachment G. Access to Care

2. The Contractor must generate and submit the report with an accompanying cover letter that summarizes the data; explains trending in either direction (positive or negative); any interventions applied to areas of concern; as well as any changes to categorical sub-classification that may have been implemented due to Contractor drill-down on a specific category of complaint. Any delayed resolutions (those more than ninety (90) days from receipt) must be explained in this cover letter. The cover letter must also include the total number of cases received and closed due to transfer to Quality Management for review.

3. Categorical sub-classifications of:

   - Transportation – Complaints made by a member or advocate related to the provision of non-emergent transportation services; which can either be related to timeliness or service level.
   - Medical Service Provision – Complaints made by a member or advocate related to the service received from a provider/doctor/facility; which include behavioral and physical plant complaints. These do not include Quality of Care concerns that are reviewed through the quality and peer review processes or Access to Care complaints as defined below (e).
   - Contractor/Program Contractor Service Level – Any complaint made by a member/advocate relating to the Contractor's administrative processes or behavior of contractor staff members.

- Wheelchair related grievances - The Contractor must use the following: Power: Purchase/Rental, Manual: Purchase/Rental; Power: Repair and Manual: Repair.
- Access to Care – Reported separately from Medical Service Provision (b). Access to care complaints are those complaints received from members/advocates relating to the inability to obtain an appointment; the length of time between a request for appointment and fulfillment; and/or the lack of available providers (PCP or specialists).

4. Any grievance process, or portion of the grievance process, that has been delegated to a Subcontractor through an approved arrangement, the Contractor will remain ultimately responsible for adhering to the reporting requirements contained within this guideline.

5. All questions regarding the reporting requirements must be directed to the Acute Care or ALTCS Compliance Officer assigned to the Contractor.

Spreadsheet Instructions: (Spreadsheet is Attachments C, D, E, F and G)

All figures reported on the spreadsheet must be as listed below:

A. Total Received: The total number of grievances related to each sub-classification during the month beginning on the first (1st) calendar day and ending on the last.

B. Total Resolved: The total number of grievances that were closed through verbal or written methods based on research and response during the month beginning on the first (1st) calendar day and ending on the last.

C. First Contact Resolution: Total number of grievances resolved at the time of receipt.

D. 1-10 Days: Total number of grievances resolved within ten (10) days of receipt.

E. 11-30 Days: The total number of grievances resolved in more than ten (10) days, but less than thirty one (31) days.

F. 31-60 Days: The total number of grievances resolved in more than thirty (30) days, but less than sixty one (61) days.

G. 61-90 Days: The total number of grievances that were either resolved more than sixty (60) days after receipt but in less than ninety one (91) days. *Subtracting the totals from each of the timeframe columns from the Total Resolved column will leave the reviewer with those grievances that were resolved more than one (1) quarter from receipt. Please address any

delayed resolutions in the cover letter if necessary. Contractor non-compliance with the Enrollee Grievance Policy located in the AHCCCS Contractor Operations Manual (ACOM) for timely resolution of grievances may result in corrective action and escalation as defined in the Sanction paragraph of the applicable contract.

H. Average Time to Resolve (ATR): Sum of days to resolve each case individually divided by Column B.

I. Previous Month's ATR: Column H from report submitted for previous month.

J. Current Month from Previous Year ATR: Column H from report submitted for the coinciding month in the previous contract year.

K. (ROW) Summary Totals of each column: Please sum columns A-J appropriately at the bottom of each column as defined by row K.

Program Integrity Reporting Guide

Definition of Terms:

Claim edits: This is a cost avoidance tool whereby rules or filters in the AHCCCS Contractor's claims payment system identifies elements/codes of claims that are incorrectly billed or may be overbilled. The system may adjust or deny claims in this process.

Coordination of Benefits (**COB):** Those claims for which another health or disability carrier, workers' compensation carrier, or a government payer such as Medicare or Veterans Administration has primary responsibility for payment of the claim. The AHCCCS Contractor generally identifies the existence of another payer's responsibility prior to payment and denies the claim until an explanation of benefits (EOB) is submitted indicating payment by the primary payer. The AHCCCS Contractor pays only the amount that has not been paid by the primary payer up to the amount that would be payable by the Contractor. At times another payer is identified after payment of the claim by the Contractor and the claim payment is recouped.

For the purposes of this report - only claims that the Contractor did not pay any amounts and did not previously encounter (whether identified pre or post claim payment) should be included in this category. Partially paid claims should not be included. The amount saved is calculated based upon either the allowable charges or a percent of billed charges between 27%-32% which is determined by the Contractor according to its analysis.

Third Party Liability (TPL/Subrogation): Those claims resulting from care for conditions resulting from an accident or occurrence which another person or entity (other than a health insurer or government health care program) has liability.

For example: Court ordered restitution payments, automobile or slip and fall accidents for which another person or entity is liable for causing some or all of the accident and therefore responsible for costs of medical care for the injured person.

TPL is always pay and chase, i.e., claims identified as having TPL are paid by the AHCCCS Contractor which will coordinate reimbursement (chase) from the liable party (and/or its insurer).

General Instructions:

1. Each Program Integrity (PI) Report is dedicated to one line of business [ALTCS (EDPD or DD) or Acute]. The report(s), along with all attachments, should be sent to the Contractor's Financial Coordinator in the Division of Health Care Management (DHCM) via email on the 15th day of the second month following the quarter (approximately 45 days after the end of the quarter). If you should have any questions regarding the report or requirements, please contact your Financial Coordinator.

2. All reported amounts should be the actual amounts recovered/identified during the quarter being reported (not the quarter of the date of service etc.). Thus the quarter in which the claim is adjudicated (for COB, claim edits, and "other" category) or, in case of TPL, the date the monies are received, is the quarter in which the sums are included.

3. To calculate PM/PM, divide the amount reported in the category by the total of the actual Contractor membership (for the reported line of business) for the 3 months constituting the quarter. Membership should match the reported membership from the dashboard reports for the quarter.

4. Dental is included in all categories.

5. Pharmacy COB should be included by those Contractors that have access to that data and this should be indicated on Line I of the report. For Contractors that don't include this data, please indicate a timeline for when that data may be included.

6. Reinsurance and other recoveries from AHCCCS should not be included; however, some plans have indicated that they were reported in previous reporting. If reinsurance and other recoveries are included, this should be indicated on Line J of the report.

7. For Contractors that are including reinsurance recoveries in their data, the box on chart indicating reinsurance is included should be checked.

8. Full billed charges should not be used to value claims. The actual savings, avoidance of cost, or recovery should be reported.

Cost Avoidance / Savings / Recoveries Report Instructions:
(See template at the end of this guide)

Contractor's Name, Line of Business and Membership: As of the first day of the month, following the month for which data is reported, per AHCCCS website which can be found in the Oversight and Reporting section of the website under AHCCCS Population Statistics should be entered.
(http://www.azahcccs.gov/reporting/enrollment/enrollment.aspx)

A. **TPL/Subrogation Dollars:** Identify claims where TPL was recovered or applied and calculate total dollar amount saved through application of TPL payments during the month (the difference between the total Contractor's allowable amount of claims and the total Contractor's payments made net or any recovery or reimbursement).

B. **TPL/Subrogation PM/PM:** The total dollar amount on line A divided by the sum of the three months of enrollment during the quarter reported.

C. **COB Dollars:** Identify claims with COB that resulted in no payment by the plan and calculate the total dollar amount saved due to other payment coverage.

D. **COB PM/PM:** The total dollar amount on line C divided by the sum of the three months of enrollment during the quarter reported.

E. **Claim Edits Dollars**: The total amount of cost avoidance achieved on claims processed during the quarter, through system edits listed below:
   1. Bundling (CCI)
   2. Unbundling (CCI)
   3. Medically unlikely edits (Cannot be billed together) (CCI)
   4. Age/Gender Edit (e.g. Diagnosis conflict with gender)
   5. Maximum Units (Exceeding Medical Necessity)
   6. Multiple procedure ranking and reduction
   7. Assistant Surgeon/Co-Surgeon; codes allowable and reduction
   8. Service to diagnosis code mismatch
   9. Invalid CPT, HCPCS, and modifier combination
   10. Global days
   11. Benefit limit

F. **Claim Edits PM/PM:** The total dollar amount on line E divided by the sum of the three months of enrollment during the quarter reported.

G. **Other Savings Dollars:** Total dollar amount recovered during the month for reasons and through mechanisms not previously discussed in the earlier sections of these instructions. Examples of situations or edits are:
   1. AHCCCS cat/svc invalid
   2. AHCCCS cert. termed
   3. AHCCCS registration terminated
   4. Membership inactive
   5. No provider ID for location
   6. Non contracted provider
   7. Provider not registered with AHCCCS
   8. W-9 needed for payment

H. **Other Savings PMPM**: The total dollar amount on line G divided by the sum of the three months of enrollment during the quarter reported.

I. **Pharmacy COB Included**: Indicate Yes or No

J. **Reinsurance Recoveries Included:** Indicate Yes or No

Template for the Cost Avoidance / Savings / Recoveries Report

COST AVOIDANCE/SAVINGS/RECOVERIES REPORT

Name of Contractor:

Line of Business:

Membership:

Line	Item	Quarterly results
A	TPL/Subrogation Dollars	
B	TPL/Subrogation PMPM	
C	COB Dollars	
D	COB PMPM	
E	Claim Edits Dollars	
F	Claim Edits PMPM	
G	Other Savings Dollars	
H	Other Savings PMPM	
I	Pharmacy COB Included (Yes/No)	
J	Reinsurance Recoveries Included (Yes/No)	

If Pharmacy COB is not included, estimated date when it can be included:

Provider Affiliation Transmission

User Manual

Version 6.7
October 1, 2009

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O V E R V I E W

AHCCCS has contracts and agreements with health plans, the AHCCCS Pharmacy Benefit Manager and other AHCCCS contractors to deliver medically necessary services to AHCCCS eligible recipients. The AHCCCS Division of Health Care Management is charged with the responsibility of monitoring the provider networks of these entities to assure that they are adequate and that they meet the minimum contractual requirements.

The Provider Affiliation Transmission (PAT) is an integral part of this monitoring process. Every quarter the contractors submit information about each individual provider within their network. Each contractor is responsible for submitting true and valid information. AHCCCSA will regularly conduct verification procedures to monitor the accuracy of the data submitted by the contractors. Submission of false or erroneous information may result in sanctions imposed upon the contractors.

Contractors must use the specifications found in the following pages. Although certain fields are not edited prior to acceptance of the PAT, these fields may be reviewed by Health Plan Operations in the Division of Health Care Management. If incorrect, the contractor may be considered to be noncompliant with their obligation to submit an accurate PAT. The contractor may be required to make corrections immediately, submit a corrective action plan and be subject to sanctions.

If there are any questions regarding the Provider Affiliation Transmission or its submission, they should be directed to the ACUTE Care Operations Specialist in the Division of Health Care Management at AHCCCS.

DEFINITION OF TERMS

♦ AHCCCS	Arizona Health Care Cost Containment System
♦ AHCCCSA	Arizona Health Care Cost Containment System Administration
♦ BC Indicator	Indicates whether or not the provider is board certified.
♦ BH Indicator	Indicates whether or not the provider performs behavioral health services.
♦ BH/PCP	Indicates if the PCP treats ADHD, Anxiety or Depression
♦ City	The city where the provider performs services.
♦ Conditional	Whether a field is required to be populated on the transmission depends upon the value of another field.
♦ Contract Code	Defines the contractor's contracted relationship with the provider and the type of financial arrangements the contractor has with the provider.
♦ Contractor	An Acute Care health plan, the AHCCCS Pharmacy Benefit Manager or other AHCCCS contractor.
♦ Contractor ID	An AHCCCSA assigned number identifying the contractor on the AHCCCS contractor database.
♦ Contractor ID 999999 Invalid on T0 Header Record	The Header Contractor ID is not numeric.
♦ Contractor ID 999999 on T0 Header Record Not on File	The Header Contractor ID is not on the AHCCCS Contractor Database.
♦ County Code	An AHCCCSA assigned code that identifies that the service location is in a specific county in Arizona, the service location is outside of Arizona, or that services are performed on a statewide basis.

♦ CR Indicator	Indicates whether or not the provider has completed a residency.
♦ Create Date Invalid	T0 Header Record Creation Date is not a valid date.
♦ Create Date Mismatch	The date in the file name does not match the Create Date in the T0 Header Record.
♦ Creation Date	The date that the provider affiliation transmission file is transmitted to AHCCCS.
♦ Dental Indicator	Indicates whether or not the provider provides services other than routine and preventive care.
♦ EPSDT Indicator	Indicates whether or not the provider provides services through primary prevention, early intervention, diagnosis and medically necessary treatment of physical and behavioral health problems for all enrolled AHCCCS members less than twenty one years of age.
♦ Group	An organization through which more than one provider contracts under the same contract.
♦ Health Plan Mismatch	The Header Record Contractor ID is blank or not found in AHCCCS Contractor Database.
♦ Language Spoken Code - Provider	A code associated with a specific language, other than English, used by the provider.
♦ Language Spoken Code - Provider Staff	A code associated with a specific language, other than English, used by the provider's staff.
♦ Member Capacity	The maximum number of members accepted by the provider.
♦ Member Count	The total number of members currently assigned to the provider.
♦ Multiple T0 Headers on File	More than one T0 Header Record in PAT File.

♦ National Provider Identifier (NPI)	A unique standard identification number assigned to the provider by CMS.
♦ No T0 Header Record	T0 Header Record Missing from PAT File.
♦ No T9 Trailer Record	T9 Trailer Record Missing from PAT File.
♦ OB Indicator	Indicates whether or not the provider provides obstetric services.
♦ OB/PCP	Indicates whether or not the PCP is willing to be responsible for the management/obstetrics of a member's health care through term.
♦ PO Indicator	The Provider Open (PO) Indicator denotes whether the provider is accepting new members.
♦ PAT	Abbreviation for provider affiliation transmission.
♦ Pay For Performance	Physician Incentive Plans that base compensation (in whole or in part) on the use or cost of services furnished to Medicaid recipients in order to improve statistical measures or outcomes.
♦ PCP	Primary Care Provider is an individual who is responsible for the management of a member's health care.
♦ PCP Indicator	Indicates whether or not the provider is available as a primary care provider to the general membership.
♦ Provider Affiliation	The relationship between a provider and a contractor.
♦ Provider Type Code	An AHCCCSA assigned code that identifies services that may be rendered by the provider. For example, 07 (Dentist), 08 (Physician, Allopath), 10 (Podiatrist), 19 (Registered Nurse Practitioner), and 31 (Physician, Osteopath).
♦ Record Count Mismatch	Records submitted do not match actual records read
♦ Record Type	An AHCCCSA assigned field that identifies a specific record on the file.

♦ Service Provider Registration ID	An AHCCCSA assigned number identifying the provider on the AHCCCS provider database.
♦ Specialty Code	AHCCCSA assigned codes that are subsets of the Provider Type Codes.
♦ Street Address	The physical street address where the provider performs services. ***PO Boxes must not be used.*** If a street address does not exist, you may use a physical description/location as long as it would serve to direct members to where care is provided. Providers who are Hospitalists should use the hospital address as their service street address**. This field is for physical service location only. Information regarding practice names or the names of ancillary providers must not be entered into this field.**
♦ Total Record Count	The total number of records submitted in the provider affiliation transmission.
♦ VPN	Virtual Private Network
♦ ZIP Code	The ZIP code where the provider performs services.

RULES AND ASSUMPTIONS

Effective Date. This manual is effective for transmissions submitted on or after 1 October 2009.

- Each contractor is required to submit a minimum of four Provider Affiliation Transmissions per contract year, at least one per quarter. The transmissions must be submitted on or before the 15th of the first month in each quarter.

FIRST SUBMISSION DUE ON OR BEFORE	LATE & RE-SUBMISSION DUE ON OR BEFORE	FOR QUARTER
10/15	11/20	10/01 - 12/31
01/15	02/20	01/01 - 03/31
04/15	05/20	04/01 - 06/30
07/15	08/20	07/01 - 09/30

Please note: If the 15th or the 20th of the month falls on an AHCCCSA non-business day (e.g. Saturday, Sunday, holiday), the transmission will be due on the next AHCCCSA routine business day.

- Before an approved PAT is loaded to the AHCCCS PAT database, all existing PAT records for the current contractor are deleted from the database. Therefore, **each PAT must represent the contractor's entire provider network.**

- Because the contractor's entire network is replaced by each transmission, a transmission that has an error rate of more than three percent (3.0%) will not be accepted for processing.

- An Outside Server Directory has been created for each contractor. Each contractor will be able to add or read files only under its own in directory.

- Contractors will use the following production Outside Server Directory to load data:

  https://sftp.statemedicaid.us/AZ/AAA//PROD/IN/PAMMDDYY.TXT
  'AAA' is the health plan acronym and 'MMDDYY' is the transmission date.

- **The following conditions must be adhered to or the PAT will be rejected by AHCCCSA:**

  - The file must be submitted to the AHCCCS Outside Server Directory
  - The record length must be 180 bytes.
  - A single file header (T0) record is required.
  - At least one file detail (A1) record is required.
  - A single file trailer (T9) record is required.
  - The Contractor ID on the file header record must be a registered AHCCCSA Contractor.
  - The Creation Date on the file header record must be a valid date (MMDDYY). The Creation Date must be the date the file is transmitted to AHCCCS.
  - The Total Record Count on the file trailer record must be formatted as a numeric with a value of greater than zero.

- Service Provider Registration ID is required and must be a valid registered AHCCCSA provider. Each AHCCCS assigned Service Provider Registration ID number is compared to the AHCCCS Provider Registration file to assure that it belongs to a registered provider. If it does not, that Registration ID will appear on each of the load exception reports. This report will be given to each contractor so errors can be corrected.

- National Provider Identifier is required beginning March 01, 2008 for all provider types listed in table 'Provider Types Requiring NPI' on pages 23-24. Note however that AHCCCS Provider Registration may make exceptions to the rule for specific providers. When edits are conducted against the transmitted file, each provider record will be checked for exceptions to the requirement. One A2 record must be transmitted for each active NPI for a provider. Edits will be performed in the following order.

  Only one error will be counted if any of the following occur:
  1) The provider is required to have an NPI, it is on or after March 1, 2008 and no NPI is submitted.
  2) The NPI field is populated but is not numeric regardless of the date.
  3) The NPI is numeric but is an invalid NPI.
  4) If a valid NPI is submitted and it is active on a different provider in AHCCCSA then an error will be counted. Otherwise the NPI will be added to AHCCCSA for that provider.

- **All text must be in upper case, including the file name**.

- A single Service Provider Registration ID with multiple service sites within the same unique ZIP and county code requires a separate detail (A1) record for each service site.

- Service Street Address – 1 is required but is not edited prior to acceptance of the transmission (*except under the prior condition, i.e., multiple service sites*). Providers who are Hospitalists should use the hospital address as their service street address. Punctuation and/or other symbols must not be entered into this field. To provide a uniform method to abbreviate an address, use the street abbreviations found on page 15, and the directional abbreviations and secondary unit abbreviations found on page 16 of this document. **Information regarding practice names or the names of ancillary providers must not be entered into this field.**

- Service Street Address – 2 is optional and is not edited prior to acceptance of the transmission *(except under the prior condition).*

- City is required and is not edited *(except under the prior condition).*

- ZIP Code is required and may be submitted as a 5 or 9 digit code (*do not include a hyphen if submitting a 9 digit code*).

- County Codes must be valid as defined by the County Code table found on page 17 of this document. The County Code should represent the county in Arizona where the provider performs services or should indicate that the provider performs services either out-of-state or on a statewide basis.

- The following yes/no indicators must contain a valid 'Y' or 'N' value.
  - BH Indicator
  - BC Indicator
  - PCP Indicator
  - EPSDT Indicator
  - OB Indicator
  - PO Indicator
  - BH/PCP Indicator
  - OB/PCP Indicator
  - Dental Indicator

- Completed Residency Indicator is optional. However, if completed the field entry should contain an indicator of 'Y' or 'N'.

- Member Count and Capacity are required when the PCP indicator is set to 'Y'. Member count and capacity must be formatted as numeric. Capacity must have a value greater than zero for PCP health care providers. Member Count may be zero. Member Count and Capacity must be reported at the site level.

- Contract Codes are required and must be valid as defined by the Contract Code table found on page 17 of this document. If the contractor uses a provider frequently, but does not have a signed contract with the provider, that provider should be reported using the '00' code indicating "No Contract."

- Language Spoken Codes - Provider is optional unless the provider speaks a language other than English. Field entries must be valid as defined by the Language Spoken Code table found on pages 18-19 of this document (*maximum of two language codes are permitted).*

- Language Spoken Codes – Provider Staff is optional unless staff speak a language other than English. Field entries must be valid as defined by the Language Spoken Code table found on pages 18-19 of this document (*maximum of two language codes are permitted).*

- Specialty Codes must be valid as defined by the Specialty Code table found on pages 20-22 of this document (*a maximum of three Specialty Codes are permitted*).

- Specialty Code 999-Other, should ONLY be used if the provider's specialty is not listed in the table beginning on page 20.

- The Transmission Validation Report (sample on page 25) provides information about the status of the submitted PAT. If all conditions are met, the transmission passes and is accepted for loading to the PAT database. If the transmission fails any of the required conditions, the transmission is rejected and returned to the contractor for correction and re-submission.

- The Load Exceptions by Provider Report (sample on page 26) provides a list of all exception errors that occurred during the PAT database load process, sorted by Provider Registration ID. The report is designed to aid the contractor in error correction. All exception errors must be corrected prior to the next submission. This report will appear in the contractor's "out" directory in filename EPMMDDYY.TXT.
  https://sftp.statemedicaid.us/AZ/AAA/PROD/OUT/EPMMDDYY.TXT
  'AAA' is the health plan acronym and 'MMDDYY' is the transmission date.

- The Load Exceptions by Field Report (sample on page 26) provides the same list of exception errors reported on the 'by Provider' Exception Report, but is sorted by the field in error. The report is designed to aid the contractor in error correction. All exception errors must be corrected prior to the next submission. This report will appear in the contractor's "out" directory in filename EFMMDDYY.TXT.
  https://sftp.statemedicaid.us/AZ/AAA/PROD/OUT/EFMMDDYY.TXT
  'AAA' is the health plan acronym and 'MMDDYY' is the transmission date.

- The Load Detail Report (sample on page 27) provides a complete listing of all PAT data loaded to the PAT database, sorted by Provider Registration ID. The sort sequence for this report is contractor name/ county name/ city name/ provider type name/ provider specialty name/ provider last name alphabetically. This report will appear in the contractor's "out" directory in filename LDMMDDYY.TXT.
  https://sftp.statemedicaid.us/AZ/AAA/PROD/OUT/LDMMDDYY.TXT
  'AAA' is the health plan acronym and 'MMDDYY' is the transmission date.

- The Provider Affiliation Duplicate Report (sample on page 28) provides a list of providers who were reported more than once within the same zip code. This report is designed to aid the contractor in identifying and removing duplicate listings of providers.

- The Load Summary Report (sample on page 28) provides summarized information about the PAT load process including the total number of records read and the total number of records with exception errors.

- The Summary Totals Report (sample on page 29) Provides summarized information about the providers listed on the PAT. The sort sequence for this report is contractor name/ county name/ city name/ provider type name/ provider specialty name. The report will provide the overall total for each provider type/ provider specialty. From the overall total, the report provides the total number of PCPs, PCPs who provide EPSDT services, PCPs who provide OB services, the total number of OB providers and the total number of BH providers. This report will appear in the contractor's "out" directory in filename STMMDDYY.TXT.

  https://sftp.statemedicaid.us/AZ/AAA/PROD/OUT/STMMDDYY.TXT
  'AAA' is the health plan acronym and 'MMDDYY' is the transmission date.

- Reports are downloaded to the contractor's Outside Server Directory on the day that processing completes. An email is sent notifying the contractor of the result (sample on page 32). The email will confirm whether the transmission passed or failed, error % and will indicate if any other errors were encountered that should be corrected before the PAT is resubmitted.

- The results will be loaded to the contractor's out directory:

  https://sftp.statemedicaid.us/AZ/AAA/PROD/OUT/RTMMDDYY.TXT
  'AAA' is the health plan acronym 'MMDDYY' is the transmission date and 'RT' is the report type.

  Report Types (RT):
  LD = Load Detail
  ST = Summary Totals
  EP = Exceptions by Provider
  EF = Exceptions by Field

- All new AHCCCSA contractors must submit a test PAT to AHCCCSA prior to the first production file submission. The test PAT must conform to all requirements as outlined in this document. The test PAT should be received by AHCCCSA at least two weeks prior to the submission of the production transmission. To submit a test PAT, contractors will use the following test Outside Server Directory to load data:
  https://sftp.statemedicaid.us/AZ/AAA/TEST/IN/PAMMDDYY.TXT
  'AAA' is the health plan acronym and 'MMDDYY' is the transmission date.

F I L E S P E C I F I C A T I O N S

F I L E H E A D E R - **T0 – ONE PER FILE**

DATA NAME	PIC	POS		EDITING PERFORMED
CONTRACTOR ID	X(6)	01	06	Must be an AHCCCSA registered and active Contractor
FILLER	X(6)	07	12	NONE
CREATION DATE	X(6)	13	18	Valid date in 'MMDDYY' format and equal the date data is transmitted to AHCCCS.
FILLER	X(12)	19	30	NONE
PRODUCE LOAD DETAIL REPORT	X(1)	31	31	'Y' or 'N'
FILLER	X(147)	32	178	NONE
RECORD TYPE	X(2)	179	180	'T0'.

F I L E T R A I L E R - **T9 – ONE PER FILE**

DATA NAME	PIC	POS		EDITING PERFORMED
TOTAL RECORD COUNT	9(9) *	01	09	A valid numeric count that is equal to the total number of records on the file (T0+A1+A2+T9)
FILLER	X(169)	10	178	NONE
RECORD TYPE	X(2)	179	180	'T9'

FILE DETAIL - A1 - ONE PER PROVIDER

DATA NAME	PIC	POS		DEMAND	EDITING PERFORMED
SERVICE PROVIDER REGISTRATION ID	X(6)	1	6	Required	An active AHCCCSA registered provider
SERVICE STREET 1	X(25)	7	31	Required	NONE
SERVICE STREET 2	X(25)	32	56	Required	NONE
SERVICE CITY	X(20)	57	76	Required	NONE
SERVICE ZIP	X(9)	77	85	Required	NONE (5 or 9 digit number)
COUNTY CODE	X(2)	86	87	Required	See list of valid codes in this document
PCP INDICATOR	X(1)	88	88	Required	'Y' or 'N'
OB INDICATOR	X(1)	89	89	Required	'Y' or 'N'
OB/PCP INDICATOR	X(1)	90	90	Optional	'Y' or 'N'
BH INDICATOR	X(1)	91	91	Required	'Y' or 'N'
BH/PCP INDICATOR	X(1)	92	92	Optional	'Y' or 'N'
DENTAL INDICATOR	X(1)	93	93	Required	'Y' or 'N'
EPSDT INDICATOR	X(1)	94	94	Required	'Y' or 'N'
PO INDICATOR	X(1)	95	95	Required	'Y' or 'N'
BC INDICATOR	X(1)	96	96	Required	'Y' or 'N'
CR INDICATOR	X(1)	97	97	Optional	'Y' or 'N'
MEMBER COUNT	9(6) *	98	103	Conditional	A valid numeric greater than or equal to zero
MEMBER CAPACITY	9(6) *	104	109	Conditional	A valid numeric greater than zero
RESERVED FOR FUTURE USE	X(3)	110	112	N/A	NONE
RESERVED FOR FUTURE USE	X(3)	113	115	N/A	NONE
CONTRACT CODE	X(2)	116	117	Required	See list of valid codes in this document
LANGUAGE CODE - PROVIDER 1	X(2)	118	119	Optional	See list of valid codes in this document
LANGUAGE CODE - PROVIDER 2	X(2)	120	121	Optional	See list of valid codes in this document
LANGUAGE CODE - PROVIDER STAFF 1	X(2)	122	123	Optional	See list of valid codes in this document
LANGUAGE CODE - PROVIDER STAFF 2	X(2)	124	125	Optional	See list of valid codes in this document
SPECIALTY CODE 1	X(3)	126	128	Conditional	See list of valid codes in this document
SPECIALTY CODE 2	X(3)	129	131	Conditional	See list of valid codes in this document
SPECIALTY CODE 3	X(3)	132	134	Conditional	See list of valid codes in this document
RESERVED FOR FUTURE USE	X(44)	135	178	N/A	NONE
RECORD TYPE	X(2)	179	180	Required	'A1'

* Numeric

F I L E D E T A I L - A2 - Zero To Many Per Provider (Required on 1/1/08 if Provider Type requires a NPI)

DATA NAME	PIC	POS		DEMAND	EDITING PERFORMED
SERVICE PROVIDER REGISTRATION ID	X(6)	1	6	Required	An active AHCCCSA registered provider
NATIONAL PROVIDER IDENTIFIER	X(10)	7	16	Conditional	See list of provider types required to have an NPI by 01/01/2008
RESERVED FOR FUTURE USE	X(162)	17	178	N/A	NONE
RECORD TYPE	X(2)	179	180	Required	'A2'

S T R E E T A B B R E V I A T I O N S

Primary Name	Postal Service Standard Abbreviation
Avenue	AVE
Boulevard	BLVD
Center	CTR
Circle	CIR
Court	CT
Drive	DR
Expressway	EXPY
Freeway	FWY
Highway	HWY
Junction	JCT
Lane	LN
Parkway	PKWY
Place	PL
Road	RD
Roadway	RDWY
Route	RT
Square	SQ
Station	STA
Street	ST
Terrace	TER
Trail	TRL

DIRECTIONAL ABBREVIATIONS

Description	Approved Abbreviation
East	E
North	N
Northeast	NE
Northwest	NW
South	S
Southeast	SE
Southwest	SW
West	W

SECONDARY UNIT ABBREVIATIONS

Description	Approved Abbreviation
Administration	ADMN
Annex	ANX
Apartment	APT
Branch	BR
Building	BLDG
Company	CO
Convalescent	CONVAL
Department	DEPT
Division	DIV
Floor	FL
Hospice	HSPC
Hospital	HOSP
Laboratory	LAB
Lobby	LBBY
Office	OFC
Room	RM
Space	SPC
Suite	STE
Trailer	TRLR

COUNTY CODES

CD	DESCRIPTION
01	APACHE
03	COCHISE
05	COCONINO
07	GILA
09	GRAHAM
11	GREENLEE
13	MARICOPA
15	MOHAVE
17	NAVAJO
19	PIMA
21	PINAL
23	SANTA CRUZ
25	YAVAPAI
27	YUMA
29	LA PAZ
31	OUT OF STATE
99	STATEWIDE

CONTRACT CODES

CD	DESCRIPTION
00	NO CONTRACT
01	SALARY
02	SALARY WITH WITHHOLD
03	SALARY WITH BONUS
04	FEE FOR SERVICE
05	FEE FOR SERVICE WITH WITHHOLD
06	FEE FOR SERVICE WITH BONUS
07	CAPITATED
08	CAPITATED WITH WITHHOLD
09	CAPITATED WITH BONUS
10	CAPITATION FEE FOR SERVICE MIX
11	PAY FOR PERFORMANCE
99	OTHER

LANGUAGE SPOKEN CODES

CD	DESCRIPTION	AREA OF ORIGIN
01	SPANISH	
02	ALBANIAN	
03	AMERICAN SIGN LANGUAGE	
04	APACHE	
05	ARABIC	
06	ARMENIAN	
07	BOSNIAN	
08	CHINESE	
09	CROATIAN	
10	CZECH	
11	DANISH	
12	DUTCH	
13	EDO	NIGERIA
14	FINNISH	
15	FRENCH	
16	GERMAN	
17	GREEK	
18	GUJARATI	INDIA
19	HEBREW	
20	HINDI, INDIAN, EAST INDIAN	
21	HOPI	
22	IRANIAN, PERSIAN, FARSI	
23	ITALIAN	
24	JAPANESE	
25	KANNADA	INDIA
26	KOREAN	
27	MARATHI	AFGHANISTAN, BANGLADESH, INDIA, IRAN, NEPAL, PAKISTAN, AND SRI LANKA
28	NAVAJO	
29	NIGERIAN	
30	NORWEGIAN	
31	IGBO	NIGERIA
32	POLISH	
33	PORTUGUESE	
34	PUNJABI	PAKISTAN
35	ROMANIAN	
36	RUSSIAN	
37	SERBIAN	

L A N G U A G E S P O K E N C O D E S (continued)

CD	DESCRIPTION	AREA OF ORIGIN
38	SINGHALESE	SRI LANKA
39	SWEDISH	
40	TAGALOG (FILIPINO)	
41	TAIWANESE	
42	TAMIL	INDIA
43	THAI, SIAMESE	
44	TOHONO O'ODHAM	
45	UKRANIAN	
46	URDU, PAKISTANI	
47	VIETNAMESE	
48	YAQUI	
49	YORUBA	WESTERN AFRICA
50	AMHARIC	
51	CANTONESE	
52	HAITIAN/CREOLE	
53	ENGLISH	
54	SOMALI	
55	HMONG	
56	HUNGARIAN	
57	KHMER	
58	NATIVE AMERICAN	
59	YIDDISH	
60	LAOTIAN	
61	MANDARIN	
62	MON-KHMER	
99	OTHER	

SPECIALTY CODES

CD	DESCRIPTION
010	ALLERGIST/IMMUNOLOGIST
011	ALLERGIST
012	IMMUNOLOGIST
020	ANESTHESIOLOGIST
030	SURGERY-COLON/RECTAL
040	DERMATOLOGIST
050	FAMILY PRACTICE
055	GENERAL PRACTICE
060	INTERNAL MEDICINE
062	CARDIOVASCULAR MEDICINE
063	ENDOCRINOLOGIST
064	GASTROENTEROLOGIST
065	HEMATOLOGIST
066	INFECTIOUS DISEASES
067	NEPHROLOGIST
068	PULMONARY DISEASES
069	RHEUMATOLOGIST
070	SURGERY-NEUROLOGY
075	NEUROLOGIST
076	PEDIATRIC NEUROLOGIST
080	NUCLEAR MEDICINE
082	GERONTOLOGIST
083	PSYCHOLOGIST
084	RN FAMILY NURSE PRACTITIONER
085	RN SCHOOL NURSE PRACTITIONER
086	RN PEDIATRIC NURSE ASSOCIATE
087	RN PEDIATRIC NURSE PRACTITIONER
088	RN GERIATRIC NURSE PRACTITIONER
089	OBSTETRICIAN AND GYNECOLOGIST
090	GYNECOLOGIST
091	OBSTETRICIAN
092	MATERNAL AND FETAL MEDICINE
093	REPRODUCTIVE ENDOCRINOLOGIST
094	RN MIDWIFE
095	WOMEN'S HC/OB-GYN NP
096	NEONATAL NURSE PRACTITIONER
097	RN ADULT NURSE PRACTITIONER
100	OPHTHALMOLOGIST
110	SURGERY-ORTHOPEDIC

S P E C I A L T Y C O D E S (continued)

CD	DESCRIPTION
120	OTOLARYNGOLOGIST
122	LARYNGOLOGIST
124	OTOLOGIST
125	RHINOLOGIST
150	PEDIATRICIAN
151	PEDIATRIC CARDIOLOGIST
152	PEDIATRIC HEMATOLOGIST
153	SURGERY-PEDIATRIC
154	PEDIATRIC NEPHROLOGIST
155	PEDIATRIC NEONATAL/PERINATAL
156	PEDIATRIC ENDOCRINOLOGIST
157	PEDIATRIC ALLERGIST
158	RADIOLOGY PEDIATRIC
159	PEDIATRIC PULMONARY
160	PHYSICAL MEDICINE/REHABILITATION
161	OSTEOPATHIC MANIPULATIVE THERAPY
165	THERAPIST-SPEECH
166	THERAPIST-OCCUPATIONAL
167	THERAPIST-PHYSICAL
170	SURGERY-PLASTIC
171	SURGERY-PLASTIC, OTOLARYNGOLOGICAL FACIAL
175	ACUPUNCTURIST
176	ADOLESCENT MEDICINE
181	SURGERY-OBSTETRICAL
182	PREVENTIVE MEDICINE
183	OCCUPATIONAL MEDICINE
187	NUTRITIONIST
188	PHARMACOLOGIST
189	PSYCHOSOMATIC MEDICINE
191	PEDIATRIC-PSYCHIATRIST
192	PSYCHIATRIST
195	PSYCHIATRIST AND NEUROLOGIST
200	RADIOLOGY
201	RADIOLOGY-DIAGNOSTIC
205	RADIOLOGY-THERAPEUTIC
210	SURGERY
211	SURGERY-ABDOMINAL
212	SURGERY-CARDIOVASCULAR

S P E C I A L T Y C O D E S (continued)

CD	DESCRIPTION
213	SURGERY-HAND
214	SURGERY-HEAD AND NECK
215	SURGERY-MAXILLOFACIAL
216	SURGERY-TRAUMA
217	SURGERY-UROLOGICAL
218	SURGERY-VASCULAR
219	SURGERY-GYNECOLOGICAL
220	SURGERY-THORACIC
230	UROLOGIST
241	ONCOLOGIST
250	EMERGENCY MEDICINE
251	CRITICAL CARE MEDICINE
441	SURGERY-OPHTHALMOLOGICAL
484	SURGERY-PODIATRIST
490	IMMUNOHEMATOLOGY
503	PHYSIOLOGICAL TESTING
600	OPTOMETRIST
650	PODIATRIST
714	EYE (LOW VISION SPECIALIST)
798	PHYSICIAN ASSISTANT
800	DENTIST-GENERAL
801	DENTIST-ORTHODONTIST
802	DENTIST-ENDODONTIST
803	DENTIST-ORAL PATHOLOGIST
804	DENTIST-PEDIATRIC
805	DENTIST-PROSTHODONTIST
806	DENTIST-PERIODONTIST
808	DENTIST-ORAL SURGEON
809	DENTIST-ANESTHESIOLOGIST
900	PROCEDURES-ANY CERTIFIED LAB
901	EMERGENCY ROOM PHYSICIANS
925	AUDIOLOGIST
927	CARDIOLOGIST
935	OTORHINOLARYNGOLOGIST (ENT)
943	PEDIATRIC ORTHOPEDIST
950	ORTHOPEDIST
958	GYNECOLOGICAL ONCOLOGY
963	PEDIATRIC HEMATOLOGY-ONCOLOGY
968	RADIOLOGY ONCOLOGY
970	HEMATOLOGY & ONCOLOGY
999	OTHER

PROVIDER TYPES REQUIRING NPI

CD	DESCRIPTION
A2	LEVEL III BEHAVIORAL HTH RESIDENTIAL
A3	COMMUNITY SERVICE AGENCY
A4	LIC INDEP SUBSTANCE ABUSE COUNS (LISAC)
A5	THERAPEUTIC FOSTER CARE PROVIDER
A6	RURAL SUBSTANCE ABUSE TRANSITIONAL AGCY
B1	RESID TRTMENT CTR-SECURE (17+BEDS)(IMD)
B2	RESID TRTMENT CTR-NON-SECURE (1-16 BEDS)
B3	RESID TRTM CTR-NON-SECURE (17+BEDS)(IMD)
B5	SUBACUTE FACILITY (1-16 BEDS)
B6	SUBACUTE FACILITY (17+BEDS)(IMD)
B7	CRISIS SERVICES PROVIDER
C2	FEDERALLY QUALIFIED HEALTH CENTER (FQHC)
C3	FAMILY PLANNING SERVICES
DG	DOC GENERAL PROVIDER
DN	DOC NON-PAY PROVIDER
D1	DENTIST-ENDODONTIST
D2	DENTIST-PEDODONTIST
D3	DENTIST-ORAL SURGEON
D4	CLINIC - DENTAL SERVICES
E1	INDEPENDENT TESTING FACILITIES
02	HOSPITAL
03	PHARMACY
04	LABORATORY
05	CLINIC
06	EMERGENCY TRANSPORTATION
07	DENTIST
08	MD-PHYSICIAN
09	CERTIFIED NURSE-MIDWIFE
10	PODIATRIST
11	PSYCHOLOGIST
12	CERTIFIED REGISTERED NURSE ANESTHETIST
13	OCCUPATIONAL THERAPIST
14	PHYSICAL THERAPIST
15	SPEECH/HEARING THERAPIST
16	CHIROPRACTOR
17	NATUROPATH
18	PHYSICIANS ASSISTANT
19	REGISTERED NURSE PRACTITIONER
20	RESPIRATORY THERAPIST
22	NURSING HOME

PROVIDER TYPES REQUIRING NPI (continued)

CD	DESCRIPTION
23	HOME HEALTH AGENCY
26	MIPS SPEECH THERAPIST/AUDIOLOGISTS
29	COMMUNITY/RURAL HEALTH CENTER
30	DME SUPPLIER
31	DO-PHYSICIAN OSTEOPATH
33	REHABILITATION CENTER
35	HOSPICE
41	DIALYSIS CLINIC
43	AMBULATORY SURGICAL CENTER
46	NURSE (PRIVATE-RN/LPN)
54	DENTAL HYGENIST
59	DENTAL LAB
62	AUDIOLOGIST
63	DRUG AND ALCOHOL REHAB
64	DETOX CENTER
67	PERFUSIONIST
68	HOMEOPATHIC
69	OPTOMETRIST
71	PSYCHIATRIC HOSPITAL
74	ALTERNATIVE RESIDENTIAL FACILITY
77	MENTAL HEALTH REHABILITATION
78	MENTAL HEALTH RESIDENTIAL TREATMENT CNTR
79	VISION CENTER
82	SURGICAL FIRST ASSISTANT
83	FREE-STANDING BIRTHING CENTER
84	LICENSED MIDWIFE
85	LICENSED CLINICAL SOCIAL WORKER (LCSW)
86	LICENSED MARRIAGE & FAMILY THERAPIST LMFT
87	LICENSED PROFESSIONAL COUNSELOR (LPC)
88	SCHOOL BASED GUIDANCE COUNSELOR
89	SCHOOL BASED CERTIFIED SCHOOL PSYCHOLOGIST
90	QMB ONLY PROVIDER
94	SCHOOL BASED NURSE (RN/LPN)
97	AIR TRANSPORTATION

SAMPLE REPORTS

REPORT ID: HP07Q082
PROGRAM #: HP07L082

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
PROVIDER AFFILIATION TRANSMISSION REPORT
TRANSMISSION TRANSMTTAL VALIDATION REPORT

PAGE: 1
RUN: 07/15/06
TIME: 17:11

	TRANSMITTAL	TRANSMISSION HEADER	TRANSMISSION DETAIL	TRANSMISSIONTRAILER	ACTUAL	PASS/ FAIL
FOUND:	YES	YES (1)	YES (2204)	YES (1)	-	PASS
RECORD COUNT:	2206		-	2206	2206	PASS
HEALTH PLAN:	100100	100100	-	-	-	PASS
FILE NAME:	PA071506.TXT		-	-	-	PASS
FILE CREATION DATE:	07/15/2006	07/15/2006	-	-	-	PASS
PERIOD START DATE:	07/15/2006	07/15/2006	-	-	-	PASS
PERIOD END DATE:	07/15/2006	07/15/2006	-	-	-	PASS

TRANSMISSION ERROR PERCENT: 0.47%

PROCESSING RUN COMPLETE -- TRANSMISSION LOAD ACCEPTED

TRANSMISSION HAS BEEN ACCEPTED

REPORT ID: HP07Q082
PROGRAM #: HP07L082

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
PROVIDER AFFILIATION TRANSMISSION REPORT
TRANSMISSION TRANSMITTAL VALIDATION REPORT

PAGE: 1
RUN: 07/15/06
TIME: 17:11

	TRANSMITTAL	TRANSMISSION HEADER	TRANSMISSION DETAIL	TRANSMISSIONTRAILER	ACTUAL	PASS/ FAIL
FOUND:	YES	YES (1)	YES (644)	YES	-	PASS
RECORD COUNT:	2206	-	-	646	646	FAIL
HEALTH PLAN:	100100	100100	-	-	-	PASS
FILE NAME:	PA071506.TXT		-	-		PASS
FILE CREATION DATE:	07/15/2006	07/15/2006	-	-	-	PASS
PERIOD START DATE:	07/15/2006	07/15/2006	-	-	-	PASS
PERIOD END DATE:	07/15/2006	07/15/2006	-	-	-	PASS

TRANSMISSION ERROR PERCENT: 20.47% -- TRANSMISSION NOT PROCESSED

TRANSMISSION HAS BEEN REJECTED

S A M P L E R E P O R T S (continued)

REPORT ID: HP07Q86A ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM PAGE: 1
PROGRAM #: HP07L086 PROVIDER AFFILIATION TRANSMISSION REPORT RUN: 07/15/06
LOAD EXCEPTIONS BY PROVIDER
PLAN NAME:

PR ID	REC NO	FIELD	FIELD VALUE	ERROR
000000	12	SERVICE PROVIDER ID	000000	NOT REGISTERED WITH AHCCCS
123456	123	OB INDICATOR	X	MUST BE ‘Y’ OR ‘N’
123456	123	PCP INDICATOR	X	MUST BE ‘Y’ OR ‘N’
123456	123	COUNTY CODE	XX	SEE PAT USER MANUAL FOR VALID CODE
123678	134	BC INDICATOR	1	MUST BE ‘Y’ OR ‘N’
156364	1256	SERVICE PROVIDER ID	156364	NOT REGISTERED WITH AHCCCS
156364	1256	OB INDICATOR	Z	MUST BE ‘Y’ OR ‘N’
167485	4506	COUNTY CODE	SS	SEE PAT USER MANUAL FOR VALID CODE
167485	4506	CONTRACT CODE	SS	SEE PAT USER MANUAL FOR VALID CODE

REPORT ID: HP07Q86B ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM PAGE: 1
PROGRAM #: HP07L086 PROVIDER AFFILIATION TRANSMISSION REPORT RUN: 07/15/06
LOAD EXCEPTIONS BY FIELD
PLAN NAME:

PR ID	REC NO	FELD	FIELD VALUE	ERROR
000000	000012	SERVICE PROVIDER ID	000000	NOT REGISTERED WITH AHCCCS
156364	001256	SERVICE PROVIDER ID	156364	NOT REGISTERED WITH AHCCCS
123678	000134	BC INDICATOR	1	MUST BE ‘Y’ OR ‘N’
123456	000123	OB INDICATOR	X	MUST BE ‘Y’ OR ‘N’
156364	001256	OB INDICATOR	Z	MUST BE ‘Y’ OR ‘N’
123456	000123	PCP INDICATOR	X	MUST BE ‘Y’ OR ‘N’
123456	000123	COUNTY CODE	XX	SEE PAT USER MANUAL FOR VALID CODE
167485	004506	COUNTY CODE	SS	SEE PAT USER MANUAL FOR VALID CODE
167485	004506	CONTRACT CODE	SS	SEE PAT USER MANUAL FOR VALID CODE

SAMPLE REPORTS (continued) - LOAD DETAIL

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REPORT ID: HP07Q099          ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM          PAGE: 1
PROGRAM #: HP07L099           PROVIDER AFFILIATION TRANSMISSION REPORT           RUN: 07/15/06
                                        PLAN NAME:

PR-ID:                    101001              101002          101003              101004
NPI:                      1992789200          1316903412      1609895333          1780690610
                          1244387755                                              1544997711
                          1887544321
NAME:                     LENKAITIS, D.       KALLENBACH, T.  ATCHISON, J.        MUDRY, T.
ADDRESS 1:                1234 E MAIN ST      4056 N 17TH ST  333 W ROCKY RD      160 N AVONDALE
ADDRESS 2:                                                                        STE 16B
CITY:                     PHOENIX             PHOENIX         PHOENIX             PHOENIX
ZIP:                      85040               85046           85041               85048
COUNTY:                   MARICOPA            MARICOPA        MARICOPA            MARICOPA
PROVIDER TYPE:            MD-PHYSICIAN        MD-PHYSICIAN    MD-PHYSICIAN        MD-PHYSICIAN
MEMBER COUNT:             000345              000115          000345              000022
MEMBER CAPACITY:          000460              000200          000460              000080
BOARD CERTIFIED?:         YES                 NO              YES                 YES
COMPLETED RESIDENCY?:     YES                 NO              YES                 YES
EPSDT?:                   YES                 YES             YES                 YES
OBSTETRICS?:              NO                  NO              NO                  NO
OBSTETRICS PCP?:          NO                  NO              NO                  NO
PCP?:                     YES                 NO              YES                 YES
OPEN TO NEW MEMBERS?:     YES                 NO              NO                  YES
BEHAVIORAL HEALTH?:       NO                  NO              NO                  NO
BEHAVIORAL HEALTH PCP?:   NO                  NO              NO                  NO
CONTRACT TYPE:            SALARY              FEE FOR SERVICE CAPITATED           NO CONTRACT
LANGUAGE – PRV(1) :       SPANISH             SPANISH                             SPANISH
LANGUAGE – PRV(2):        FRENCH                                                  FRENCH
LANGUAGE – PRV STAFF(1):  SPANISH                             SPANISH             SPANISH
LANGUAGE – PRV STAFF(2):  BOSNIAN             NAVAJO
SPECIALTY (1):            FAMILY PRACTICE     PEDIATRICIAN    OBSTETRICIAN AND GYN
SPECIALTY (2):            PEDIATRIC NEUROLOGIST                                   MATERNAL AND
SPECIALTY (3):
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S A M P L E R E P O R T S (continued)

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REPORT ID: HP07Q089             ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM        PAGE:   1
PROGRAM #: HP07L089                PROVIDER AFFILIATION DUPLICATE REPORT           RUN: 07/15/06

                  HEALTH PLAN:


PROVIDER NUMBER         PROVIDER NAME                ZIP CODE          COUNTY

194720                  MILLER/WILLIAM A.            85938             APACHE
362450                  MEMON/ABDUL-QADIR            85938             APACHE

TOTAL NUMBER OF DUPLICATE PROVIDERS:     2
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REPORT ID: HP0786QD          ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM            PAGE:    1
PROGRAM #: HP07L086            PROVIDER AFFILIATION TRANSMISSION REPORT             RUN:  07/15/06
                                          LOAD SUMMARY

                       HEALTH PLAN:

                       FILENAME:                        PA071506.TXT

                       CREATION DATE:                   07/15/2006

                       PERIOD START DATE:               07/01/2006

                       PERIOD END DATE:                 09/30/2006

                       DATE LOGGED:                     07/15/2006

                       RECORDS READ:                          2602

                       RECORDS WITH ERRORS:                      6

                       TOTAL EXCEPTION ERRORS:                  11
```

SAMPLE REPORTS (continued)

REPORT ID: HP07Q99A — ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM — PAGE: 1
PROGRAM #: HP07L099 — HEALTH PLANS PROVIDER AFFILIATION — RUN: 04/15/09
SUMMARY TOTALS FOR

				OVERALL	PCP	PCP EPSDT	PCP OB	OB	OB PCP	BH	BH PCP
COCONINO	FLAGSTAFF	DENTIST	DENTIST-GENERAL	2	0	0	0	0	0	0	0
				5	0	0	0	0	0	0	0
		DO-PHYSICIAN OSTEOPATH	NONE	1	0	0	0	0	0	0	0
			ORTHOPEDIST	3	0	0	0	0	0	0	0
		HOSPITAL	NONE	1	0	0	0	0	0	0	0
		MD-PHYSICIAN	DERMATOLOGIST	5	0	0	0	0	0	0	0
			FAMILY PRACTICE	2	1	0	0	0	0	0	0
			NEPHROLOGIST	1	0	0	0	0	0	0	0
			NEUROLOGIST	1	0	0	0	0	0	0	0
			ONCOLOGIST	1	0	0	0	0	0	0	0
			OPHTHALMOLOGIST	2	0	0	0	0	0	0	0
			ORTHOPEDIST	14	0	0	0	0	0	0	0
			PHYSICAL MEDICINE/REHAB	1	0	0	0	0	0	0	0
			SURGERY	1	0	0	0	0	0	0	0
			SURGERY-ORTHOPEDIC	1	0	0	0	0	0	0	0
		PHYSICAL THERAPIST	THERAPIST-PHYSICAL	1	0	0	0	0	0	0	0
		PHYSICIANS ASSISTANT	PHYSICIAN ASSISTANT	10	0	0	0	0	0	0	0
		PODIATRIST	SURGERY-PODIATRIST	1	0	0	0	0	0	0	0
		REGISTERED NURSE PRACTI	RN FAMILY NURSE PRACTIT	2	0	0	0	0	0	0	0
	WILLIAMS	DENTIST	DENTIST-GENERAL	2	0	0	0	0	0	0	0
	PCP COUNT FOR COCONINO COUNTY:		1								
GILA	PAYSON	MD-PHYSICIAN	OPHTHALMOLOGIST	1	0	0	0	0	0	0	0
	PCP COUNT FOR GILA COUNTY:		0								
GRAHAM	THATCHER	NON-EMERGENCY TRANSPORT	NONE	1	0	0	0	0	0	0	0
	PCP COUNT FOR GRAHAM COUNTY:		0								
MARICOPA	AVONDALE	DENTIST	DENTIST-GENERAL	1	0	0	0	0	0	0	0
		MD-PHYSICIAN	OPHTHALMOLOGIST	8	0	0	0	0	0	0	0
	PCP COUNT FOR MARICOPA COUNTY:		2								
	CAVE CREEK	DME SUPPLIER	NONE	1	0	0	0	0	0	0	0
	CHANDLER	DENTIST	DENTIST-GENERAL	5	0	0	0	0	0	0	0
		MD-PHYSICIAN	FAMILY PRACTICE	1	1	0	0	0	0	0	0
			OPHTHALMOLOGIST	2	0	0	0	0	0	0	0

NOTIFICATION EMAIL

From: DHCMOPS@AZAHCCCS.GOV [mailto:DHCMOPS@AZAHCCCS.GOV]
Sent: Friday, August 01, 2008 3:05 AM
To:
Cc: DHCM OPS
Subject: PAT LOAD RESULTS

WE RECEIVED THE SUBMISSION OF YOUR HEALTH PLAN'S QUARTERLY PROVIDER AFFILIATION TRANSMISSION (PAT). THIS RESULTED IN A 2.15% ERROR RATE FOR ALL RECORDS READ. A TRANSMISSION THAT HAS AN ERROR RATE OF MORE THAN 3.0% WILL NOT BE ACCEPTED FOR PROCESSING.

ALTHOUGH YOUR ERROR PERCENT WAS ACCEPTABLE YOUR TRANSMISSION WAS REJECTED FOR THE FOLLOWING REASON:

RECORD COUNT ON T9 TRAILER RECORD DOES NOT MATCH RECORDS READ.

AFTER THE ERRORS IDENTIFIED IN THE LOAD EXCEPTIONS REPORTS HAVE BEEN CORRECTED, YOU MUST RESUBMIT YOUR PAT FILE BY THE 20TH OF **XXXX**. AS A REMINDER, THE CREATION DATE MUST BE THE DATE THAT THE PAT FILE IS TRANSMITTED TO AHCCCS.

THE SUMMARY TOTALS REPORT AND THE LOAD EXCEPTIONS BY PROVIDER AND BY FIELD REPORTS ARE NOW AVAILABLE ON THE AHCCCS SERVER.

Disclaimer: *Arizona 2703 Project, Analysis of AHCCCS Encounter and Eligibility Files*

The *Arizona 2703 Project, Analysis of AHCCCS Encounter and Eligibility Files* is provided to assist Offerors in preparing its proposals with planning for integration of physical and behavioral health, including service delivery, care management, provider network requirements and other components of the RFP that are not related to development of capitation rates. The *Arizona 2703 Project, Analysis of AHCCCS Encounter and Eligibility Files* is provided for informational purposes only to assist Offerors to gain insight and understand SMI members' behavioral and physical health service utilization patterns, especially for those members with one or more co-morbid conditions. .

NOTE: OFFERORS SHOULD NOT CONSIDER DATA OR INFORMATION FROM *THE ARIZONA 2703 PROJECT, ANALYSIS OF AHCCCS ENCOUNTER AND ELIGIBILITY FILES,* IN WHOLE OR IN PART, WHEN REVIEWING CAPITATATION RATES. THE DATA CONTAINED IN *THE ARIZONA 2703 PROJECT, ANALYSIS OF AHCCCS ENCOUNTER AND ELIGIBILITY FILES* WAS EXTRACTED USING MARKEDLY DIFFERENT ASSUMPTIONS THAN THE ADHS DATA BOOK AND RELATED SUPPLEMENTAL INFORMATION. ANY ATTEMPT BY AN OFFEROR TO USE DATA OR INFORMTION FROM *THE ARIZONA 2703 PROJECT, ANALYSIS OF AHCCCS ENCOUNTER AND ELIGIBILITY FILES* IN CONNECTION WITH CAPITATION RATE REVIEW WILL RESULT IN INCORRECT COMPUTATIONS AND INVALID CONCLUSIONS. ACCORDINGLY ANY CLAIM, ALLEGATION OR

ASSERTION BY AN OFFEROR THAT CAPITATION RATES SHOULD BE MODIFIED OR ADJUSTED BASED ON DATA OR INFORMATION FROM *THE ARIZONA 2703 PROJECT, ANALYSIS OF AHCCCS ENCOUNTER AND ELIGIBILITY FILES*, IN WHOLE OR IN PART, WILL BE REJECTED BY ADHS.

DRAFT

Arizona 2703
Data Analysis Summary Presentation

Burns & Associates, Inc.

October 31, 2011

Enrollment Tables

Arizona 2703 Project
Number of Members by Months Enrolled
FFY 2008-2010

Presentation Master

Total Months Enrolled	Total Enrollment			Enrollment Excluding < 6 Mos		
	Frequency	Cumulative Frequency	Cumulative Percentage	Frequency	Cumulative Frequency	Cumulative Percentage
1	177	177	0.9%			
2	190	367	1.9%			
3	246	613	3.2%			
4	265	878	4.5%			
5	269	1,147	5.9%			
6	409	1,556	8.0%	409	409	2.1%
7	345	1,901	9.8%	345	754	3.9%
8	287	2,188	11.3%	287	1,041	5.4%
9	265	2,453	12.6%	265	1,306	6.7%
10	289	2,742	14.1%	289	1,595	8.2%
11	307	3,049	15.7%	307	1,902	9.8%
12	326	3,375	17.4%	326	2,228	11.5%
13	337	3,712	19.1%	337	2,565	13.2%
14	348	4,060	20.9%	348	2,913	15.0%
15	333	4,393	22.6%	333	3,246	16.7%
16	309	4,702	24.2%	309	3,555	18.3%
17	288	4,990	25.7%	288	3,843	19.8%
18	269	5,259	27.1%	269	4,112	21.2%
19	312	5,571	28.7%	312	4,424	22.8%
20	306	5,877	30.3%	306	4,730	24.4%
21	302	6,179	31.9%	302	5,032	25.9%
22	297	6,476	33.4%	297	5,329	27.5%
23	271	6,747	34.8%	271	5,600	28.9%
24	281	7,028	36.2%	281	5,881	30.3%
25	295	7,323	37.7%	295	6,176	31.8%
26	313	7,636	39.4%	313	6,489	33.4%
27	328	7,964	41.1%	328	6,817	35.1%
28	312	8,276	42.7%	312	7,129	36.7%
29	313	8,589	44.3%	313	7,442	38.4%
30	324	8,913	45.9%	324	7,766	40.0%
31	329	9,242	47.6%	329	8,095	41.7%
32	371	9,613	49.6%	371	8,466	43.6%
33	425	10,038	51.7%	425	8,891	45.8%
34	494	10,532	54.3%	494	9,385	48.4%
35	656	11,188	57.7%	656	10,041	51.8%
36	9,359	20,547	105.9%	9,359	19,400	100.0%

Excludes clients who lived outside Maricopa County at any time during FFY 08-10
Excludes clients with less than 6 months of enrollment during FFY 08-10

Arizona 2703 Project
Number of Clients by Months Enrolled
FFY 2008-2010

Total Enrollment

Number of Months Enrolled	FFY 2008		FFY 2009		FFY 2010	
	Frequency	Cumulative Frequency	Frequency	Cumulative Frequency	Frequency	Cumulative Frequency
1	360	360	391	391	248	248
2	358	718	384	775	275	523
3	449	1,167	439	1,214	327	850
4	418	1,585	416	1,630	387	1,237
5	423	2,008	420	2,050	461	1,698
6	518	2,526	527	2,577	539	2,237
7	455	2,981	479	3,056	453	2,690
8	526	3,507	480	3,536	414	3,104
9	537	4,044	515	4,051	470	3,574
10	588	4,632	610	4,661	525	4,099
11	889	5,521	618	5,279	582	4,681
12	11,791	17,312	12,379	17,658	13,528	18,209

Enrollment Excluding < 6 Mos

Number of Months Enrolled	FFY 2008		FFY 2009		FFY 2010	
	Frequency	Cumulative Frequency	Frequency	Cumulative Frequency	Frequency	Cumulative Frequency
1	257	257	373	373	149	149
2	271	528	355	728	174	323
3	350	878	413	1,141	195	518
4	322	1,200	397	1,538	252	770
5	331	1,531	409	1,947	309	1,079
6	518	2,049	527	2,474	539	1,618
7	455	2,504	479	2,953	453	2,071
8	526	3,030	480	3,433	414	2,485
9	537	3,567	515	3,948	470	2,955
10	588	4,155	610	4,558	525	3,480
11	889	5,044	618	5,176	582	4,062
12	11,791	16,835	12,379	17,555	13,528	17,590

Excludes clients who lived outside Maricopa County at any time during FFY 08-10
Excludes clients with less than 6 months of enrollment during FFY 08-10

Arizona 2703 Project
Number of Clients by Months Enrolled
FFY 2008-2010

Fiscal Year	Clients in Each Year	Clients in Both Years		Estimated Turnover
2008	16,835	15,769		
2009	17,555		16,387	6.33%
2010	17,590			6.65%

Excludes clients who lived outside Maricopa County at any time during FFY 08-10
Excludes clients with less than 6 months of enrollment during FFY 08-10

Arizona 2703 Project
AHCCCS Enrollment vs. Magellan Reported Enrollment by Month
FFY 2008-2010

FFY 2008		
Month	Monthly Enrollment (B&A)	Magellan Enrolled in EOC
October 2007	14,177	11,089
November 2007	14,480	10,958
December 2007	14,547	11,712
January 2008	14,650	10,860
Febuary 2008	14,783	9,780
March 2008	14,931	10,883
April 2008	14,907	10,808
May 2008	14,915	10,994
June 2008	14,931	11,053
July 2008	14,983	11,811
August 2008	14,997	11,691
September 2008	14,976	11,356
Unique Clients	16,835	

FFY 2009		
Month	Monthly Enrollment (B&A)	Magellan Enrolled in EOC
October 2008	14,945	11,416
November 2008	14,841	11,346
December 2008	14,919	11,386
January 2009	14,950	11,451
Febuary 2009	15,023	11,478
March 2009	15,073	11,418
April 2009	15,163	11,627
May 2009	15,217	11,595
June 2009	15,358	11,625
July 2009	15,542	11,510
August 2009	15,648	11,652
September 2009	15,712	11,764
Unique Clients	17,555	

FFY 2010		
Month	Monthly Enrollment (B&A)	Magellan Enrolled in EOC
October 2009	15,778	11,942
November 2009	15,813	12,049
December 2009	15,844	12,161
January 2010	15,875	12,236
Febuary 2010	15,919	12,329
March 2010	15,946	12,390
April 2010	16,129	12,524
May 2010	16,090	12,621
June 2010	16,140	12,751
July 2010	16,073	13,081
August 2010	16,013	13,184
September 2010	15,950	13,235
Unique Clients	17,590	

Magellan Penetration figures are taken from "Arizona Department of Health Services, Division of Behavioral Health Services, Enrolled in Episode of Care - Penetration Report" for 2008 and 2011 found at:
http://www.azdhs.gov/bhs/pdf/enroll_pen/Enrollment_Penetraton_2009_2011SFY_2011.pdf (Page 14, Title XIX SMI)
http://www.azdhs.gov/bhs/en05_08.pdf (Page 14, Title XIX SMI)

B&A totals exclude clients who lived outside Maricopa County at any time during FFY 08-10
B&A totals exclude clients with less than 6 months of enrollment during FFY 08-10

Arizona 2703 Project
Dual Eligibles by Fiscal Year
FFY 2008-2010

FFY 2008		
Month	**Dual Eligibles**	**Percent of Clients Who Are Dual Eligible**
October 2007	953	6.7%
November 2007	930	6.4%
December 2007	934	6.4%
January 2008	939	6.4%
Febuary 2008	961	6.5%
March 2008	985	6.6%
April 2008	976	6.5%
May 2008	987	6.6%
June 2008	957	6.4%
July 2008	988	6.6%
August 2008	998	6.7%
September 2008	998	6.7%

FFY 2009		
Month	**Dual Eligibles**	**Percent of Clients Who Are Dual Eligible**
October 2008	993	6.6%
November 2008	984	6.6%
December 2008	973	6.5%
January 2009	986	6.6%
Febuary 2009	1,053	7.0%
March 2009	1,070	7.1%
April 2009	1,127	7.4%
May 2009	1,156	7.6%
June 2009	1,183	7.7%
July 2009	1,237	8.0%
August 2009	1,268	8.1%
September 2009	1,258	8.0%

FFY 2010		
Month	**Dual Eligibles**	**Percent of Clients Who Are Dual Eligible**
October 2009	1,272	8.1%
November 2009	1,257	7.9%
December 2009	1,261	8.0%
January 2010	1,307	8.2%
Febuary 2010	1,332	8.4%
March 2010	1,301	8.2%
April 2010	1,376	8.5%
May 2010	1,429	8.9%
June 2010	1,461	9.1%
July 2010	1,446	9.0%
August 2010	1,458	9.1%
September 2010	1,460	9.2%

Excludes clients who lived outside Maricopa County at any time during FFY 08-10
Excludes clients with less than 6 months of enrollment during FFY 08-10

Behavioral Health Classification Tables

Psychiatric Classification Assignment Process

We attempt to classify each enrolled SMI client into a psychiatric diagnosis classification system to differentiate the types of psychiatric illnesses grouped under the SMI umbrella. In consultation with medical directors from several Arizona state agencies we developed six classifications:

1. Psychotic Disorders
2. Bipolar Disorders
3. Mood Disorders
4. Anxiety Disorders
5. Personality Disorders
6. Not Classified

The classifications are ordered by severity and the selection process for an individual is hierarchical – the individual is classified into the most severe (lowest numbered) classification for which they qualify in that year. We assign a specific classification to each client for each Federal Fiscal Year, so the same client may actually have different classifications in different years.

The primary data source for diagnoses is the DBHS demographic data file, which includes the principal diagnosis as well as 5 AXIS I diagnoses. Each of those diagnoses that qualify for one of the five psychiatric classifications are retained. If multiple records exist for the same client in the same year, we retain the last record as the defining diagnosis for the year. In addition, if there was not a record for one of the FFYs, but there were records before and after that FFY, we carry forward the previous diagnosis into the unused year. For example, if a client had a bipolar diagnosis in FFY08, no record in FFY09 but was enrolled, and a psychotic diagnosis in FFY10, we would classify him as bipolar for FFY09.

For clients who were enrolled in Title XIX but were not classified by the demographic file, we search the AHCCCS encounter data for their diagnoses to see if there would be qualifying entries in that data. The rules for classification from the encounters are stricter. A client must have at least two separate diagnoses for the same psychiatric classification in order to qualify, and the diagnoses must be made by one of a limited set of provider types: hospital, physician, psychologist, physician osteopath, psychiatric hospital, or behavioral health outpatient clinic. Diagnoses made by other types of providers are ignored. We use all three years of encounter data to make the classifications, therefore there are no FFY classification assignments as there are with the demographic-derived classes.

Finally, we combine the demographic-derived classifications and the encounter-derived classifications. If a client has a classification from the DBHS demographic data, that one trumps any classification from the encounters, even if the encounters' was more severe. The encounters are only used to fill in classifications for people who were enrolled during that FFY but did not have a qualifying diagnosis from the demographic data. Those remaining without a psychiatric classification after this process are labeled as "Not Classified."

Arizona 2703 Project
Summary of Psychiatric Classification
FFY08 - FFY10

Presentation Master

	DUGS	Encounters	DUGS + Encounters	Not Enrolled	Total	AHCCCS Enrolled
Total						
FFY08	13,411	18,352	16,835	2,565	19,400	16,835
FFY09	15,058		17,555	1,845	19,400	17,555
FFY10	12,876		17,590	1,810	19,400	17,590
Psychotic Disorders, Group 1						
FFY08	5,761	9,988	7,270			
FFY09	6,555		7,524			
FFY10	5,713		7,850			
Bipolar Disorders, Group 2						
FFY08	3,440	4,899	4,044			
FFY09	4,002		4,375			
FFY10	3,543		4,413			
Mood Disorders, Group 3						
FFY08	3,545	3,004	4,001			
FFY09	3,828		4,124			
FFY10	3,157		3,823			
Anxiety Disorders, Group 4						
FFY08	558	392	668			
FFY09	536		612			
FFY10	395		520			
Personality Disorders, Group 5						
FFY08	107	69	121			
FFY09	137		136			
FFY10	68		85			
Not Classified						
FFY08			731			
FFY09			784			
FFY10			899			

Arizona 2703 Project

Top 50 Diagnosis for People not in 5 BH Classes

Rank	Diagnosis Description	Count
1	29540: Schizophreniform disorder, unspecified	72
2	30480: Combinations of drug dependence excluding opioid type d	66
3	3009: Unspecified nonpsychotic mental disorder	58
4	2988: Other and unspecified reactive psychosis	45
5	30390: Other and unspecified alcohol dependence, unspecified	44
6	2979: Unspecified paranoid state	39
7	30430: Cannabis dependence, unspecified	33
8	29980: Other specified pervasive developmental disorders, curr	29
9	30928: Adjustment disorder with mixed anxiety and depressed mo	27
10	29580: Other specified types of schizophrenia, unspecified	24
11	30400: Opioid type dependence, unspecified	22
12	29500: Simple type schizophrenia, unspecified	20
13	29505: Simple type schizophrenia, in remission	14
14	30500: Alcohol abuse, unspecified	14
15	29682: Atypical depressive disorder	13
16	30924: Adjustment disorder with anxiety	13
17	30520: Cannabis abuse, unspecified	12
18	30751: Bulimia nervosa	12
19	29582: Other specified types of schizophrenia, chronic	10
20	30440: Amphetamine and other psychostimulant dependence, unspe	10
21	3090: Adjustment disorder with depressed mood	10
22	V6289: Other psychological or physical stress, not elsewhere c	10
23	30420: Cocaine dependence, unspecified	8
24	30550: Opioid abuse, unspecified	8
25	31234: Intermittent explosive disorder	7
26	29552: Latent schizophrenia, chronic	6
27	30393: Other and unspecified alcohol dependence, in remission	6
28	30540: Sedative, hypnotic or anxiolytic abuse, unspecified	6
29	30750: Eating disorder, unspecified	6
30	29501: Simple type schizophrenia, subchronic	5
31	30570: Amphetamine or related acting sympathomimetic abuse, un	5
32	V6120: Counseling for parent-child problem, unspecified	5
33	29543: Schizophreniform disorder, subchronic with acute exacer	4
34	30189: Other personality disorders	4
35	30392: Other and unspecified alcohol dependence, episodic	4
36	30573: Amphetamine or related acting sympathomimetic abuse, in	4
37	3099: Unspecified adjustment reaction	4
38	3159: Unspecified delay in development	4
39	29383: Mood disorder in conditions classified elsewhere	3
40	29503: Simple type schizophrenia, subchronic with acute exacer	3
41	29900: Autistic disorder, current or active state	3
42	30432: Cannabis dependence, episodic	3
43	30493: Unspecified drug dependence, in remission	3
44	30560: Cocaine abuse, unspecified	3
45	31239: Other disorders of impulse control	3
46	29502: Simple type schizophrenia, chronic	2
47	29544: Schizophreniform disorder, chronic with acute exacerbat	2
48	29550: Latent schizophrenia, unspecified	2
49	29554: Latent schizophrenia, chronic with acute exacerbation	2
50	29583: Other specified types of schizophrenia, subchronic with	2

Co Morbidity Tables

Co-Morbidity Assignment

Comorbid diagnoses for clients are determined by processing all three years of encounter data (FFY08-10) through the Chronic Illness and Disability Payment System (CDPS) grouper CDPS+Rx, which combines diagnosis data from encounters with pharmacy utilization data to group people into comorbid conditions. For the purposes of our analysis comorbid conditions are considered present for the client during all three years of the analysis, regardless of when the actual onset or original diagnosis occurred.

For our analysis we selected 18 comorbid conditions to analyze in addition to the psychiatric diagnoses. Clients are flagged for each comorbid condition into which they are assigned by the grouper. A client may be flagged for multiple comorbidities or none at all.

Arizona 2703 Project
Ranks of Comorbidities by Number of Clients
FFY 2008-10

Presentation Master

Comorbidity	Clients	Per 1000 SMI Clients	Rank
Cardiovascular	5,043	260	1
Pulmonary	3,853	199	2
Skeletal	3,826	197	3
Gastrointestinal	2,725	140	4
Diabetes	2,558	132	5
Substance Abuse	2,216	114	6
CNS	1,865	96	7
Skin	1,406	72	8
Infectious Disease	1,132	58	9
Renal	834	43	10
Metabolic	827	43	11
Pregnancy	817	42	12
Genital	704	36	13
Hematologic	428	22	14
Cancer	355	18	15
Eye	331	17	16
Developmental	304	16	17
Cerebrovascular	125	6	18

Comorbidities are identified using three years of data: FFY08-10

Arizona 2703 Project
Count of Clients by Number of Comorbidities
FFY 2008-10

Count of Comorbidities	FFY 2008		FFY 2009		FFY 2010	
	Client Counts	Clients per 1000	Client Counts	Clients per 1000	Client Counts	Clients per 1000
None	6,200	368.3	6,480	369.1	6,717	381.9
1	3,783	224.7	3,998	227.7	3,976	226.0
2	2,563	152.2	2,683	152.8	2,628	149.4
3	1,681	99.9	1,736	98.9	1,704	96.9
4	1,077	64.0	1,111	63.3	1,082	61.5
5	696	41.3	697	39.7	666	37.9
6	384	22.8	392	22.3	378	21.5
7	232	13.8	238	13.6	226	12.8
8	130	7.7	131	7.5	127	7.2
9	47	2.8	46	2.6	44	2.5
10	34	2.0	34	1.9	34	1.9
11	6	0.4	7	0.4	6	0.3
12	2	0.1	2	0.1	2	0.1
Total	16,835		17,555		17,590	

Client Counts

Count of Comorbidities	Behavioral Health Classification, FFY 2008						
	Psychotic Disorders, Group 1	Bipolar Disorders, Group 2	Mood Disorders, Group 3	Anxiety Disorders, Group 4	Personality Disorders, Group 5	Not classified	Total
None	2,946	1,359	1,234	214	62	385	6,200
1	1,645	968	844	149	36	141	3,783
2	1,057	619	661	122	10	94	2,563
3	661	419	461	85	6	49	1,681
4	401	282	317	40	4	33	1,077
5	263	194	195	25	2	17	696
6	134	99	131	12	-	8	384
7	83	52	84	10	-	3	232
8	40	37	47	5	-	1	130
9	24	3	17	3	-	-	47
10	13	9	9	2	1	-	34
11	2	2	1	1	-	-	6
12	1	1	-	-	-	-	2
Total	7,270	4,044	4,001	668	121	731	16,835

Count of Comorbidities	Behavioral Health Classification, FFY 2009						
	Psychotic Disorders, Group 1	Bipolar Disorders, Group 2	Mood Disorders, Group 3	Anxiety Disorders, Group 4	Personality Disorders, Group 5	Not classified	Total
None	3,092	1,465	1,244	190	64	425	6,480
1	1,714	1,045	914	136	39	150	3,998
2	1,087	690	675	120	13	98	2,683
3	662	460	478	75	11	50	1,736
4	416	287	334	36	5	33	1,111
5	253	207	195	25	1	16	697
6	135	113	122	13	1	8	392
7	82	59	86	8	-	3	238
8	42	35	49	4	-	1	131
9	24	3	16	3	-	-	46
10	13	9	9	1	2	-	34
11	3	1	2	1	-	-	7
12	1	1	-	-	-	-	2
Total	7,524	4,375	4,124	612	136	784	17,555

Count of Comorbidities	Behavioral Health Classification, FFY 2010						
	Psychotic Disorders, Group 1	Bipolar Disorders, Group 2	Mood Disorders, Group 3	Anxiety Disorders, Group 4	Personality Disorders, Group 5	Not classified	Total
None	3,284	1,514	1,173	188	44	514	6,717
1	1,764	1,057	845	117	25	168	3,976
2	1,118	665	640	97	5	103	2,628
3	700	455	429	60	8	52	1,704
4	414	292	318	22	2	34	1,082
5	259	206	170	15	-	16	666
6	129	117	112	12	-	8	378
7	94	58	67	4	-	3	226
8	49	33	43	1	-	1	127
9	21	5	16	2	-	-	44
10	14	10	8	1	1	-	34
11	2	1	2	1	-	-	6
12	2	-	-	-	-	-	2
Total	7,850	4,413	3,823	520	85	899	17,590

Clients per 1000

Count of Comorbidities	Behavioral Health Classification, FFY 2008						
	Psychotic Disorders, Group 1	Bipolar Disorders, Group 2	Mood Disorders, Group 3	Anxiety Disorders, Group 4	Personality Disorders, Group 5	Not classified	Total
None	175.0	80.7	73.3	12.7	3.7	22.9	368.3
1	97.7	57.5	50.1	8.9	2.1	8.4	224.7
2	62.8	36.8	39.3	7.2	0.6	5.6	152.2
3	39.3	24.9	27.4	5.0	0.4	2.9	99.9
4	23.8	16.8	18.8	2.4	0.2	2.0	64.0
5	15.6	11.5	11.6	1.5	0.1	1.0	41.3
6	8.0	5.9	7.8	0.7	-	0.5	22.8
7	4.9	3.1	5.0	0.6	-	0.2	13.8
8	2.4	2.2	2.8	0.3	-	0.1	7.7
9	1.4	0.2	1.0	0.2	-	-	2.8
10	0.8	0.5	0.5	0.1	0.1	-	2.0
11	0.1	0.1	0.1	0.1	-	-	0.4
12	0.1	0.1	-	-	-	-	0.1
Total	431.8	240.2	237.7	39.7	7.2	43.4	1,000.0

Count of Comorbidities	Behavioral Health Classification, FFY 2009						
	Psychotic Disorders, Group 1	Bipolar Disorders, Group 2	Mood Disorders, Group 3	Anxiety Disorders, Group 4	Personality Disorders, Group 5	Not classified	Total
None	176.1	83.5	70.9	10.8	3.6	24.2	369.1
1	97.6	59.5	52.1	7.7	2.2	8.5	227.7
2	61.9	39.3	38.5	6.8	0.7	5.6	152.8
3	37.7	26.2	27.2	4.3	0.6	2.8	98.9
4	23.7	16.3	19.0	2.1	0.3	1.9	63.3
5	14.4	11.8	11.1	1.4	0.1	0.9	39.7
6	7.7	6.4	6.9	0.7	0.1	0.5	22.3
7	4.7	3.4	4.9	0.5	-	0.2	13.6
8	2.4	2.0	2.8	0.2	-	0.1	7.5
9	1.4	0.2	0.9	0.2	-	-	2.6
10	0.7	0.5	0.5	0.1	0.1	-	1.9
11	0.2	0.1	0.1	0.1	-	-	0.4
12	0.1	0.1	-	-	-	-	0.1
Total	428.6	249.2	234.9	34.9	7.7	44.7	1,000.0

Count of Comorbidities	Behavioral Health Classification, FFY 2010						
	Psychotic Disorders, Group 1	Bipolar Disorders, Group 2	Mood Disorders, Group 3	Anxiety Disorders, Group 4	Personality Disorders, Group 5	Not classified	Total
None	186.7	86.1	66.7	10.7	2.5	29.2	381.9
1	100.3	60.1	48.0	6.7	1.4	9.6	226.0
2	63.6	37.8	36.4	5.5	0.3	5.9	149.4
3	39.8	25.9	24.4	3.4	0.5	3.0	96.9
4	23.5	16.6	18.1	1.3	0.1	1.9	61.5
5	14.7	11.7	9.7	0.9	-	0.9	37.9
6	7.3	6.7	6.4	0.7	-	0.5	21.5
7	5.3	3.3	3.8	0.2	-	0.2	12.8
8	2.8	1.9	2.4	0.1	-	0.1	7.2
9	1.2	0.3	0.9	0.1	-	-	2.5
10	0.8	0.6	0.5	0.1	0.1	-	1.9
11	0.1	0.1	0.1	0.1	-	-	0.3
12	0.1	-	-	-	-	-	0.1
Total	446.3	250.9	217.3	29.6	4.8	51.1	1,000.0

Arizona 2703 Project
Counts of Comorbidities by Each Comorbidity and Behavioral Health Classification
FFY 2010 Enrolled
Total

	Cardiovascular	Pulmonary	Skeletal	Gastrointestinal	Diabetes	Substance Abuse	CNS	Skin	Infectious Disease	Renal	Metabolic	Pregnancy	Genital	Hematologic	Cancer	Eye	Developmental	Cerebrovascular
Cardiovascular	**4,755**	1,906	1,738	1,392	1,698	701	936	706	519	565	524	100	291	235	173	221	92	95
Pulmonary	1,906	**3,612**	1,488	1,254	874	682	775	596	474	353	423	160	255	191	159	125	61	66
Skeletal	1,738	1,488	**3,643**	1,152	765	688	857	595	444	352	382	113	264	159	115	131	42	53
Gastrointestinal	1,392	1,254	1,152	**2,600**	653	503	562	427	435	303	359	78	243	184	111	102	44	50
Diabetes	1,698	874	765	653	**2,411**	233	526	415	203	282	257	52	127	116	70	140	53	43
Substance Abuse	701	682	688	503	233	**2,073**	336	346	346	87	181	119	97	88	38	26	4	24
CNS	936	775	857	562	526	336	**1,761**	364	214	215	262	64	143	89	63	61	85	43
Skin	706	596	595	427	415	346	364	**1,317**	251	145	188	55	91	86	45	53	44	21
Infectious Disease	519	474	444	435	203	346	214	251	**1,041**	92	153	26	50	110	42	27	13	15
Renal	565	353	352	303	282	87	215	145	92	**794**	155	8	127	56	49	54	30	17
Metabolic	524	423	382	359	257	181	262	188	153	155	**785**	25	73	83	42	31	16	26
Pregnancy	100	160	113	78	52	119	64	55	26	8	25	**782**	88	15	4	0	8	2
Genital	291	255	264	243	127	97	143	91	50	127	73	88	**680**	29	33	21	11	9
Hematologic	235	191	159	184	116	88	89	86	110	56	83	15	29	**396**	28	19	16	8
Cancer	173	159	115	111	70	38	63	45	42	49	42	4	33	28	**307**	15	7	4
Eye	221	125	131	102	140	26	61	53	27	54	31	0	21	19	15	**324**	9	5
Developmental	92	61	42	44	53	4	85	44	13	30	16	8	11	16	7	9	**297**	4
Cerebrovascular	95	66	53	50	43	24	43	21	15	17	26	2	9	8	4	5	4	**116**

Arizona 2703 Project
Count of Clients by Behavioral Health Classification and Type of Comorbidities
FFY 2008-10

Raw Counts

	Clients	Cardiovascular	Pulmonary	Skeletal	Gastrointestinal	Diabetes	Substance Abuse	CNS	Skin	Infectious Disease	Renal	Metabolic	Pregnancy	Genital	Hematologic	Cancer	Eye	Developmental	Cerebrovascular
Totals (3 years)		5,043	3,853	3,826	2,725	2,558	2,216	1,865	1,406	1,132	834	827	817	704	428	355	331	304	125
Behavioral Health Classification, FFY 2008																			
Psychotic Disorders, Group 1	7,270	1994	1371	1,143	965	1062	882	707	515	419	311	294	208	199	201	132	107	199	37
Bipolar Disorders, Group 2	4,044	1089	965	990	637	528	525	423	367	272	204	201	248	204	89	77	77	45	25
Mood Disorders, Group 3	4,001	1299	1001	1,145	762	667	472	501	365	299	235	249	202	205	105	104	95	41	49
Anxiety Disorders, Group 4	668	193	155	177	119	76	82	71	61	45	26	26	49	42	6	14	18	6	7
Personality Disorders, Group 5	121	18	12	13	12	10	11	6	5	1	2	5	5		3		2	5	
Not Classified	731	128	89	118	62	68	47	50	33	29	24	12	43	26	8	9	16	6	2
Totals	16,835	4,721	3,593	3,586	2,557	2,411	2,019	1,758	1,346	1,065	802	787	755	676	412	336	315	302	120
Behavioral Health Classification, FFY 2009																			
Psychotic Disorders, Group 1	7,524	2,033	1,397	1,170	977	1,084	899	724	514	416	318	302	192	208	200	133	114	196	37
Bipolar Disorders, Group 2	4,375	1,167	1,043	1,094	697	573	567	449	388	292	206	224	272	209	88	75	83	42	30
Mood Disorders, Group 3	4,124	1,338	1,030	1,150	788	664	508	525	373	302	245	246	213	209	109	103	97	45	46
Anxiety Disorders, Group 4	612	177	146	169	107	74	77	59	51	51	21	24	41	37	6	16	14	8	6
Personality Disorders, Group 5	136	23	13	22	17	14	16	7	5	1	6	6	7	2	4		2	4	
Not Classified	784	129	91	122	68	68	49	49	33	29	22	12	47	25	8	10	15	6	2
Totals	17,555	4,867	3,720	3,727	2,654	2,477	2,116	1,813	1,364	1,091	818	814	772	690	415	337	325	301	121
Behavioral Health Classification, FFY 2010																			
Psychotic Disorders, Group 1	7,850	2,096	1,460	1,225	986	1,133	910	741	540	414	319	307	206	221	200	124	116	210	42
Bipolar Disorders, Group 2	4,413	1,148	1,015	1,074	731	555	585	448	376	292	204	230	285	221	85	80	84	37	28
Mood Disorders, Group 3	3,823	1,231	923	1,080	728	591	466	484	327	267	226	216	196	176	98	86	96	34	40
Anxiety Disorders, Group 4	520	133	116	127	74	51	58	35	37	36	17	17	37	32	4	6	10	7	4
Personality Disorders, Group 5	85	12	6	8	9	9	7	4	2	1	5	2	5	2	1		2	2	
Not Classified	899	135	92	129	72	72	47	49	35	31	23	13	53	28	8	11	16	7	2
Totals	17,590	4,755	3,612	3,643	2,600	2,411	2,073	1,761	1,317	1,041	794	785	782	680	396	307	324	297	116

Arizona 2703 Project
Count of Clients by Behavioral Health Classification and Type of Comorbidities
FFY 2008-10

Count per 1,000 Clients

	Clients	Cardiovascular	Pulmonary	Skeletal	Gastrointestinal	Diabetes	Substance Abuse	CNS	Skin	Infectious Disease	Renal	Metabolic	Pregnancy	Genital	Hematologic	Cancer	Eye	Developmental	Cerebrovascular
Behavioral Health Classification, FFY 2008																			
Psychotic Disorders, Group 1	7,270	274.3	188.6	157.2	132.7	146.1	121.3	97.2	70.8	57.6	42.8	40.4	28.6	27.4	27.6	18.2	14.7	27.4	5.1
Bipolar Disorders, Group 2	4,044	269.3	238.6	244.8	157.5	130.6	129.8	104.6	90.8	67.3	50.4	49.7	61.3	50.4	22.0	19.0	19.0	11.1	6.2
Mood Disorders, Group 3	4,001	324.7	250.2	286.2	190.5	166.7	118.0	125.2	91.2	74.7	58.7	62.2	50.5	51.2	26.2	26.0	23.7	10.2	12.2
Anxiety Disorders, Group 4	668	288.9	232.0	265.0	178.1	113.8	122.8	106.3	91.3	67.4	38.9	38.9	73.4	62.9	9.0	21.0	26.9	9.0	10.5
Personality Disorders, Group 5	121	148.8	99.2	107.4	99.2	82.6	90.9	49.6	41.3	8.3	16.5	41.3	41.3	-	24.8	-	16.5	41.3	-
Not Classified	731	175.1	121.8	161.4	84.8	93.0	64.3	68.4	45.1	39.7	32.8	16.4	58.8	35.6	10.9	12.3	21.9	8.2	2.7
Total	16,835	280.4	213.4	213.0	151.9	143.2	119.9	104.4	80.0	63.3	47.6	46.7	44.8	40.2	24.5	20.0	18.7	17.9	7.1
Behavioral Health Classification, FFY 2009																			
Psychotic Disorders, Group 1	7,524	270.2	185.7	155.5	129.9	144.1	119.5	96.2	68.3	55.3	42.3	40.1	25.5	27.6	26.6	17.7	15.2	26.0	4.9
Bipolar Disorders, Group 2	4,375	266.7	238.4	250.1	159.3	131.0	129.6	102.6	88.7	66.7	47.1	51.2	62.2	47.8	20.1	17.1	19.0	9.6	6.9
Mood Disorders, Group 3	4,124	324.4	249.8	278.9	191.1	161.0	123.2	127.3	90.4	73.2	59.4	59.7	51.6	50.7	26.4	25.0	23.5	10.9	11.2
Anxiety Disorders, Group 4	612	289.2	238.6	276.1	174.8	120.9	125.8	96.4	83.3	83.3	34.3	39.2	67.0	60.5	9.8	26.1	22.9	13.1	9.8
Personality Disorders, Group 5	136	169.1	95.6	161.8	125.0	102.9	117.6	51.5	36.8	7.4	44.1	44.1	51.5	14.7	29.4	-	14.7	29.4	-
Not Classified	784	164.5	116.1	155.6	86.7	86.7	62.5	62.5	42.1	37.0	28.1	15.3	59.9	31.9	10.2	12.8	19.1	7.7	2.6
Total	17,555	277.2	211.9	212.3	151.2	141.1	120.5	103.3	77.7	62.1	46.6	46.4	44.0	39.3	23.6	19.2	18.5	17.1	6.9
Behavioral Health Classification, FFY 2010																			
Psychotic Disorders, Group 1	7,850	267.0	186.0	156.1	125.6	144.3	115.9	94.4	68.8	52.7	40.6	39.1	26.2	28.2	25.5	15.8	14.8	26.8	5.4
Bipolar Disorders, Group 2	4,413	260.1	230.0	243.4	165.6	125.8	132.6	101.5	85.2	66.2	46.2	52.1	64.6	50.1	19.3	18.1	19.0	8.4	6.3
Mood Disorders, Group 3	3,823	322.0	241.4	282.5	190.4	154.6	121.9	126.6	85.5	69.8	59.1	56.5	51.3	46.0	25.6	22.5	25.1	8.9	10.5
Anxiety Disorders, Group 4	520	255.8	223.1	244.2	142.3	98.1	111.5	67.3	71.2	69.2	32.7	32.7	71.2	61.5	7.7	11.5	19.2	13.5	7.7
Personality Disorders, Group 5	85	141.2	70.6	94.1	105.9	105.9	82.4	47.1	23.5	11.8	58.8	23.5	58.8	23.5	11.8	-	23.5	23.5	-
Not Classified	899	150.2	102.3	143.5	80.1	80.1	52.3	54.5	38.9	34.5	25.6	14.5	59.0	31.1	8.9	12.2	17.8	7.8	2.2
Total	17,590	270.3	205.3	207.1	147.8	137.1	117.9	100.1	74.9	59.2	45.1	44.6	44.5	38.7	22.5	17.5	18.4	16.9	6.6

Arizona 2703 Project
Counts of Comorbidities by Each Comorbidity and Behavioral Health Classification
FFY 2010 Enrolled
Psychotic Disorders, Group 1

	Cardiovascular	Pulmonary	Skeletal	Gastrointestinal	Diabetes	Substance Abuse	CNS	Skin	Infectious Disease	Renal	Metabolic	Pregnancy	Genital	Hematologic	Cancer	Eye	Developmental	Cerebrovascular
Cardiovascular	**2,096**	793	584	556	774	303	399	299	208	231	205	35	104	114	73	85	72	33
Pulmonary	793	**1,460**	501	473	372	295	319	244	186	148	178	37	92	83	61	29	44	26
Skeletal	584	501	**1,225**	353	293	261	308	219	152	119	120	32	76	57	45	34	33	18
Gastrointestinal	556	473	353	**986**	276	211	207	172	163	117	138	12	84	69	45	27	34	11
Diabetes	774	372	293	276	**1,133**	109	222	185	91	120	110	21	56	64	32	51	41	15
Substance Abuse	303	295	261	211	109	**910**	147	147	134	38	81	41	44	35	17	5	4	7
CNS	399	319	308	207	222	147	**741**	157	85	94	104	18	56	35	22	24	63	16
Skin	299	244	219	172	185	147	157	**540**	104	67	81	18	31	37	17	17	35	7
Infectious Disease	208	186	152	163	91	134	85	104	**414**	38	56	10	19	47	12	12	12	6
Renal	231	148	119	117	120	38	94	67	38	**319**	65	2	50	20	20	18	22	3
Metabolic	205	178	120	138	110	81	104	81	56	65	**307**	8	27	29	20	10	13	6
Pregnancy	35	37	32	12	21	41	18	18	10	2	8	**206**	20	7	1		3	
Genital	104	92	76	84	56	44	56	31	19	50	27	20	**221**	11	16	1	9	4
Hematologic	114	83	57	69	64	35	35	37	47	20	29	7	11	**200**	12	7	16	2
Cancer	73	61	45	45	32	17	22	17	12	20	20	1	16	12	**124**	2	5	2
Eye	85	29	34	27	51	5	24	17	12	18	10		1	7	2	**116**	8	1
Developmental	72	44	33	34	41	4	63	35	12	22	13	3	9	16	5	8	**210**	2
Cerebrovascular	33	26	18	11	15	7	16	7	6	3	6		4	2	2	1	2	**42**

Arizona 2703 Project
Counts of Comorbidities by Each Comorbidity and Behavioral Health Classification
FFY 2010 Enrolled
Bipolar Disorders, Group 2

	Cardiovascular	Pulmonary	Skeletal	Gastrointestinal	Diabetes	Substance Abuse	CNS	Skin	Infectious Disease	Renal	Metabolic	Pregnancy	Genital	Hematologic	Cancer	Eye	Developmental	Cerebrovascular
Cardiovascular	**1,148**	490	489	363	396	177	234	173	137	136	150	34	81	51	38	57	10	23
Pulmonary	490	**1,015**	448	362	236	192	215	172	132	88	115	72	81	44	44	38	8	13
Skeletal	489	448	**1,074**	372	190	209	233	182	143	94	126	42	91	36	29	40	1	17
Gastrointestinal	363	362	372	**731**	153	140	159	130	123	72	93	32	80	42	31	33	6	14
Diabetes	396	236	190	153	**555**	58	136	92	51	68	70	15	34	22	21	34	7	10
Substance Abuse	177	192	209	140	58	**585**	95	94	106	20	54	47	30	20	9	6		5
CNS	234	215	233	159	136	95	**448**	100	66	44	63	26	41	19	19	18	9	7
Skin	173	172	182	130	92	94	100	**376**	69	36	54	21	39	19	9	18	4	5
Infectious Disease	137	132	143	123	51	106	66	69	**292**	24	46	6	14	24	11	3	1	
Renal	136	88	94	72	68	20	44	36	24	**204**	40	3	29	15	12	12	4	5
Metabolic	150	115	126	93	70	54	63	54	46	40	**230**	8	25	20	11	11	1	4
Pregnancy	34	72	42	32	15	47	26	21	6	3	8	**285**	36	4	2		3	
Genital	81	81	91	80	34	30	41	39	14	29	25	36	**221**	5	10	9		2
Hematologic	51	44	36	42	22	20	19	19	24	15	20	4	5	**85**	7	4		1
Cancer	38	44	29	31	21	9	19	9	11	12	11	2	10	7	**80**	7	2	1
Eye	57	38	40	33	34	6	18	18	3	12	11		9	4	7	**84**		
Developmental	10	8	1	6	7		9	4	1	4	1	3			2		**37**	
Cerebrovascular	23	13	17	14	10	5	7	5		5	4		2	1	1			**28**

Arizona 2703 Project
Counts of Comorbidities by Each Comorbidity and Behavioral Health Classification
FFY 2010 Enrolled
Mood Disorders, Group 3

	Cardiovascular	Pulmonary	Skeletal	Gastrointestinal	Diabetes	Substance Abuse	CNS	Skin	Infectious Disease	Renal	Metabolic	Pregnancy	Genital	Hematologic	Cancer	Eye	Developmental	Cerebrovascular
Cardiovascular	**1,231**	528	568	406	433	190	268	203	145	170	148	22	83	58	55	65	6	34
Pulmonary	528	**923**	448	357	229	167	214	152	124	99	114	37	64	55	46	46	7	21
Skeletal	568	448	**1,080**	363	240	185	273	164	121	120	121	28	76	55	36	48	4	15
Gastrointestinal	406	357	363	**728**	196	135	168	108	125	101	109	26	64	64	27	35	2	21
Diabetes	433	229	240	196	**591**	56	147	120	51	80	70	13	29	26	14	42	3	16
Substance Abuse	190	167	185	135	56	**466**	82	90	89	24	41	22	20	31	12	12		9
CNS	268	214	273	168	147	82	**484**	96	56	71	83	15	37	30	21	15	10	16
Skin	203	152	164	108	120	90	96	**327**	62	41	47	11	20	28	19	17	4	8
Infectious Disease	145	124	121	125	51	89	56	62	**267**	30	44	5	15	35	16	8		8
Renal	170	99	120	101	80	24	71	41	30	**226**	42	1	35	19	15	22	4	7
Metabolic	148	114	121	109	70	41	83	47	44	42	**216**	8	16	30	10	9	2	13
Pregnancy	22	37	28	26	13	22	15	11	5	1	8	**196**	19	4	1		1	1
Genital	83	64	76	64	29	20	37	20	15	35	16	19	**176**	12	7	7		1
Hematologic	58	55	55	64	26	31	30	28	35	19	30	4	12	**98**	8	6		2
Cancer	55	46	36	27	14	12	21	19	16	15	10	1	7	8	**86**	5		1
Eye	65	46	48	35	42	12	15	17	8	22	9		7	6	5	**96**	1	3
Developmental	6	7	4	2	3		10	4		4	2	1				1	**34**	1
Cerebrovascular	34	21	15	21	16	9	16	8	8	7	13	1	1	2	1	3	1	**40**

Arizona 2703 Project
Counts of Comorbidities by Each Comorbidity and Behavioral Health Classification
FFY 2010 Enrolled
Anxiety Disorders, Group 4

	Cardiovascular	Pulmonary	Skeletal	Gastrointestinal	Diabetes	Substance Abuse	CNS	Skin	Infectious Disease	Renal	Metabolic	Pregnancy	Genital	Hematologic	Cancer	Eye	Developmental	Cerebrovascular
Cardiovascular	**133**	59	49	35	36	20	17	15	16	8	12	7	11	4	2	4	1	4
Pulmonary	59	**116**	52	42	15	19	16	17	17	10	12	9	14	4	3	4	1	4
Skeletal	49	52	**127**	36	17	18	21	17	16	9	10	5	13	4	3	3	2	3
Gastrointestinal	35	42	36	**74**	10	12	11	12	15	6	10	7	10	4	2	1	1	4
Diabetes	36	15	17	10	**51**	4	9	8	2	2	4		4	2	1	4		2
Substance Abuse	20	19	18	12	4	**58**	6	12	13	3	3	4	2	1		1		2
CNS	17	16	21	11	9	6	**35**	7	4	3	7	4	5	2	1	1	1	3
Skin	15	17	17	12	8	12	7	**37**	9		6	3	1	2				1
Infectious Disease	16	17	16	15	2	13	4	9	**36**		3	3	2	2				1
Renal	8	10	9	6	2	3	3			**17**	4	2	7	1				1
Metabolic	12	12	10	10	4	3	7	6	3	4	**17**	1	5	2				2
Pregnancy	7	9	5	7		4	4	3	3	2	1	**37**	6				1	1
Genital	11	14	13	10	4	2	5	1	2	7	5	6	**32**	1		2	1	2
Hematologic	4	4	4	4	2	1	2	2	2	1	2		1	**4**				2
Cancer	2	3	3	2	1		1								**6**			
Eye	4	4	3	1	4	1	1						2			**10**		
Developmental	1	1	2	1			1					1	1				**7**	1
Cerebrovascular	4	4	3	4	2	2	3	1	1	1	2	1	2	2			1	**4**

Arizona 2703 Project
Counts of Comorbidities by Each Comorbidity and Behavioral Health Classification
FFY 2010 Enrolled
Personality Disorders, Group 5

	Cardiovascular	Pulmonary	Skeletal	Gastrointestinal	Diabetes	Substance Abuse	CNS	Skin	Infectious Disease	Renal	Metabolic	Pregnancy	Genital	Hematologic	Cancer	Eye	Developmental	Cerebrovascular
Cardiovascular	**12**	2	2	5	7	1	1	1	1	3	2		1	1		1	1	
Pulmonary	2	**6**	1	2	1		1		1	1	1			1		1		
Skeletal	2	1	**8**	1	1	1	1		1	1	1			1		2		
Gastrointestinal	5	2	1	**9**	3	2	2		1	1	2		2	1		1		
Diabetes	7	1	1	3	**9**		1	1	1		1			1		1	1	
Substance Abuse	1		1	2		**7**				1	1					1		
CNS	1	1	1	2	1		**4**		1		1		1	1		1		
Skin	1				1			**2**										
Infectious Disease	1	1	1	1	1		1		**1**		1			1		1		
Renal	3	1	1	1		1				**5**			1					
Metabolic	2	1	1	2	1	1	1		1		**2**			1		1		
Pregnancy												**5**						
Genital	1			2			1			1			**2**					
Hematologic	1	1	1	1	1		1		1		1			**1**		1		
Cancer																		
Eye	1	1	2	1	1	1	1		1		1			1		**2**		
Developmental	1				1												**2**	
Cerebrovascular																		

Arizona 2703 Project
Counts of Comorbidities by Each Comorbidity and Behavioral Health Classification
FFY 2010 Enrolled
Not classified

	Cardiovascular	Pulmonary	Skeletal	Gastrointestinal	Diabetes	Substance Abuse	CNS	Skin	Infectious Disease	Renal	Metabolic	Pregnancy	Genital	Hematologic	Cancer	Eye	Developmental	Cerebrovascular
Cardiovascular	**135**	34	46	27	52	10	17	15	12	17	7	2	11	7	5	9	2	1
Pulmonary	34	**92**	38	18	21	9	10	11	14	7	3	5	4	4	5	7	1	2
Skeletal	46	38	**129**	27	24	14	21	13	11	9	4	6	8	6	2	4	2	
Gastrointestinal	27	18	27	**72**	15	3	15	5	8	6	7	1	3	4	6	5	1	
Diabetes	52	21	24	15	**72**	6	11	9	7	12	2	3	4	1	2	8	1	
Substance Abuse	10	9	14	3	6	**47**	6	3	4	1	1	5	1	1		1		1
CNS	17	10	21	15	11	6	**49**	4	2	3	4	1	3	2		2	2	1
Skin	15	11	13	5	9	3	4	**35**	7	1		2				1	1	
Infectious Disease	12	14	11	8	7	4	2	7	**31**		3	2		1	3	3		
Renal	17	7	9	6	12	1	3	1		**23**	4		5	1	2	2		1
Metabolic	7	3	4	7	2	1	4		3	4	**13**			1	1			1
Pregnancy	2	5	6	1	3	5	1	2	2			**53**	7					
Genital	11	4	8	3	4	1	3			5		7	**28**			2	1	
Hematologic	7	4	6	4	1	1	2		1	1	1			**8**	1	1		1
Cancer	5	5	2	6	2				3	2	1			1	**11**	1		
Eye	9	7	4	5	8	1	2	1	3	2			2	1	1	**16**		1
Developmental	2	1	2	1	1		2	1					1				**7**	
Cerebrovascular	1	2				1	1			1	1			1		1		**2**

Expenditure Tables

Expenditure Tables

Expenditures for the Entire Enrolled Population

Total Enrollment

	Federal Fiscal Year									
	2008			2009			2010			
	Paid Amt	Medicare Paid Amt	Total Paid	Paid Amt	Medicare Paid Amt	Total Paid	Paid Amt	Medicare Paid Amt	Total Paid
***** TOTAL *****	$258,104,169	$28,787,174	$286,891,343	$310,693,264	$29,651,717	$340,344,981	$346,716,985	$35,027,232	$381,744,217
Plan Group									
ALTCS DD	$26,797,635	$820,280	$27,617,915	$27,429,769	$870,831	$28,300,600	$25,549,702	$976,976	$26,526,678
Acute FFS	$1,779,042	$0	$1,779,042	$2,076,378	$0	$2,076,378	$2,241,165	$0	$2,241,165
Acute MCO	$78,210,842	$24,018,786	$102,229,628	$87,430,916	$28,222,532	$115,653,448	$84,965,631	$31,244,847	$116,210,478
BHS RBHA	$150,916,735	$3,948,108	$154,864,843	$193,397,445	$558,354	$193,955,799	$233,544,375	$2,805,409	$236,349,784
BHS TRBHA	$399,915	$0	$399,915	$358,755	$0	$358,755	$416,113	$0	$416,113
Total Plan Group	$258,104,169	$28,787,174	$286,891,343	$310,693,263	$29,651,717	$340,344,980	$346,716,986	$35,027,232	$381,744,218

Total Enrollment

	Federal Fiscal Year								
	2008			2009			2010		
	Paid Amt	Medicare Paid Amt	Total Paid	Paid Amt	Medicare Paid Amt	Total Paid	Paid Amt	Medicare Paid Amt	Total Paid
Provider Type									
AIR TRANSPORTATION	$43,905	$11,644	$55,549	$42,918	$7,977	$50,895	$40,958	$22,554	$63,512
ALTERNATIVE RESIDENTIAL FACILITY	$15,634,913	$0	$15,634,913	$17,204,553	$0	$17,204,553	$17,735,001	$0	$17,735,001
AMBULATORY SURGICAL CENTER	$556,010	$273,667	$829,677	$750,237	$301,310	$1,051,547	$647,056	$332,154	$979,210
ASSISTED LIVING CENTER	$13,754	$0	$13,754						
ATTENDANT CARE	$187,221	$0	$187,221	$186,081	$0	$186,081	$24,579	$540	$25,119
AUDIOLOGIST	$1,432	$5,194	$6,626	$4,026	$4,838	$8,864	$1,796	$1,263	$3,059
BEHAVIORAL HEALTH THERAPEUTIC HOME	$790,180	$0	$790,180	$836,517	$0	$836,517	$571,128	$0	$571,128
BH OUTPATIENT CLINIC	$67,526,585	$341,964	$67,868,549	$102,690,694	$199,304	$102,889,998	$129,516,345	$15,425	$129,531,770
CERTIFIED NURSE-MIDWIFE	$16,394	$232	$16,626	$20,432	$1,243	$21,675	$12,499	$3,134	$15,633
CERTIFIED REGISTERED NURSE ANESTHETIST	$90,220	$20,782	$111,002	$119,169	$32,028	$151,197	$144,659	$46,107	$190,766
CHIROPRACTOR	$239	$966	$1,205	$743	$1,215	$1,958	$678	$2,975	$3,653
CLINIC	$54,200	$319	$54,519	$6,940	$256	$7,196	$1,526	$210	$1,736
COMMUNITY SERVICE AGENCY	$7,248,263	$0	$7,248,263	$11,691,509	$0	$11,691,509	$10,489,373	$0	$10,489,373
CRISIS SERVICES PROVIDER				$690	$0	$690			
DENTIST	$670,919	$166	$671,085	$615,312	$1,560	$616,872	$612,590	$5,921	$618,511
DIALYSIS CLINIC	$294,455	$247,095	$541,550	$259,374	$280,672	$540,046	$247,606	$330,708	$578,314
DME SUPPLIER	$797,255	$399,654	$1,196,909	$989,226	$536,097	$1,525,323	$964,755	$578,867	$1,543,622
DO-PHYSICIAN OSTEOPATH	$3,237,931	$1,246,395	$4,484,326	$3,884,347	$1,416,731	$5,301,078	$3,966,798	$1,511,091	$5,477,889
EMERGENCY TRANSPORTATION	$4,024,864	$1,256,459	$5,281,323	$4,704,817	$1,397,329	$6,102,146	$5,288,070	$1,568,233	$6,856,303
EPD HCBS				$2,607	$0	$2,607			
FISCAL INTERMEDIARIES	$1,745	$0	$1,745	$1,039	$0	$1,039	$1,120	$0	$1,120
GROUP-PAYMENT ID				$1,997	$3,712	$5,709	$12,043	$12,628	$24,671
HABILITATION PROVIDER	$24,530,444	$0	$24,530,444	$25,008,980	$0	$25,008,980	$23,505,687	$0	$23,505,687
HOME HEALTH AGENCY	$316,401	$39,043	$355,444	$431,848	$70,925	$502,773	$438,578	$111,489	$550,067
HOSPICE	$87,129	$0	$87,129	$106,195	$0	$106,195	$46,482	$113	$46,595
HOSPITAL	$54,727,565	$15,588,030	$70,315,595	$55,839,492	$16,084,690	$71,924,182	$60,712,259	$19,769,176	$80,481,435
INDEPENDENT TESTING FACILITIES	$100,339	$56,330	$156,669	$137,677	$53,065	$190,742	$121,785	$64,130	$185,915
LABORATORY	$2,579,897	$276,286	$2,856,183	$2,338,792	$358,405	$2,697,197	$1,962,211	$378,427	$2,340,638
LEVEL III BEHAVIORAL HTH RESIDENTIAL	$2,808,300	$0	$2,808,300	$3,372,871	$0	$3,372,871	$2,992,709	$0	$2,992,709
LIC INDEP SUBSTANCE ABUSE COUNS (LISAC)	$20,110	$0	$20,110	$25,699	$0	$25,699	$1,197	$0	$1,197
LICENSED CLINICAL SOCIAL WORKER (LCSW)	$238,970	$10,037	$249,007	$286,636	$8,246	$294,882	$306,218	$1,842	$308,060
LICENSED MARRIAGE & FAMILYTHERAPISTLMFT	$37,151	$0	$37,151	$10,531	$0	$10,531			
LICENSED PROFESSIONAL COUNSELOR (LPC)	$340,017	$1,780	$341,797	$280,328	$718	$281,046	$203,085	$271	$203,356
MD-PHYSICIAN	$19,061,659	$6,337,384	$25,399,043	$21,873,301	$7,194,428	$29,067,729	$22,090,297	$7,593,496	$29,683,793
MENTAL HEALTH RESIDENTIAL TREATMENT CNTR	$199,207	$0	$199,207	$386,112	$0	$386,112	$25,152	$0	$25,152
NON-EMERGENCY TRANSPORTATION PROVIDERS	$4,247,526	$38,158	$4,285,684	$7,933,981	$44,420	$7,978,401	$9,844,528	$22,870	$9,867,398

Total Enrollment

	Federal Fiscal Year								
	2008			2009			2010		
	Paid Amt	Medicare Paid Amt	Total Paid	Paid Amt	Medicare Paid Amt	Total Paid	Paid Amt	Medicare Paid Amt	Total Paid
NON-MEDICARE CERTIFIED HOME HTH AGENCIES	$3,799	$0	$3,799	$10,863	$1,441	$12,304	$11,448	$0	$11,448
NURSING HOME	$2,175,216	$345,506	$2,520,722	$2,585,805	$463,932	$3,049,737	$2,486,060	$558,869	$3,044,929
OCCUPATIONAL THERAPIST	$35,063	$15,073	$50,136	$33,976	$17,636	$51,612	$27,921	$17,002	$44,923
OPTOMETRIST	$16,009	$3,498	$19,507	$29,948	$13,042	$42,990	$50,455	$32,127	$82,582
OUT-OF-STATE ENC OR 1 TIME FFS PROV	$12,211	$955	$13,166	$104	$0	$104	$233	$0	$233
PERFUSIONIST	$870	$1,809	$2,679	$1,685	$0	$1,685	$894	$0	$894
PHARMACY	$27,835,147	$33,494	$27,868,641	$28,121,832	$13,242	$28,135,074	$30,564,124	$31,451	$30,595,575
PHYSICAL THERAPIST	$403,486	$179,276	$582,762	$503,026	$237,121	$740,147	$582,508	$240,339	$822,847
PHYSICIANS ASSISTANT	$776,715	$118,714	$895,429	$947,204	$159,831	$1,107,035	$1,189,306	$227,905	$1,417,211
PODIATRIST	$223,219	$121,414	$344,633	$240,346	$121,170	$361,516	$254,312	$138,172	$392,484
PSYCHIATRIC HOSPITAL	$7,067,790	$1,673,422	$8,741,212	$8,664,337	$478,794	$9,143,131	$11,557,673	$1,235,686	$12,793,359
PSYCHOLOGIST	$180,473	$30,662	$211,135	$266,380	$42,080	$308,460	$330,738	$31,880	$362,618
QMB ONLY PROVIDER	$2,313	$970	$3,283	$1,421	$266	$1,687	$0	$0	$0
REGIONAL ADMINISTRATIVE ENTITY	$64,245	$0	$64,245	$160,438	$0	$160,438	$49,586	$0	$49,586
REGISTERED DIETICIAN	$906	$651	$1,557	$883	$944	$1,827	$2,065	$1,367	$3,432
REGISTERED NURSE PRACTITIONER	$1,027,626	$106,697	$1,134,323	$1,503,113	$100,475	$1,603,588	$1,671,568	$133,409	$1,804,977
RESID TRTM CTR-NON-SECURE (17+BEDS)(IMD)	$161,145	$0	$161,145	$64,376	$0	$64,376	$9,457	$0	$9,457
RESID TRTMENT CTR-SECURE (17+BEDS)(IMD)	$1,208,572	$0	$1,208,572	$471,233	$0	$471,233			
SPEECH LANGUAGE PATHOLOGY ASSISTANT							$79	$0	$79
SPEECH/HEARING THERAPIST	$1,690	$438	$2,128	$4,598	$72	$4,670	$6,834	$0	$6,834
SUBACUTE FACILITY (1-16 BEDS)	$5,719,841	$0	$5,719,841	$4,977,740	$0	$4,977,740	$5,371,832	$0	$5,371,832
SUBACUTE FACILITY (17+BEDS)(IMD)	$688,763	$0	$688,763	$40,810	$0	$40,810			
SURGICAL FIRST ASSISTANT	$13,870	$3,009	$16,879	$17,475	$2,504	$19,979	$21,125	$5,402	$26,527
Total Provider Type	$258,104,169	$28,787,173	$286,891,342	$310,693,264	$29,651,719	$340,344,983	$346,716,986	$35,027,233	$381,744,219

Total Enrollment

	Federal Fiscal Year								
	2008			2009			2010		
	Paid Amt	Medicare Paid Amt	Total Paid	Paid Amt	Medicare Paid Amt	Total Paid	Paid Amt	Medicare Paid Amt	Total Paid
Category of Service									
ADULT FOSTER CARE	$140,784	$0	$140,784						
ASSISTED LIVING	$13,754	$0	$13,754						
ATTENDANT CARE	$1,011,340	$0	$1,011,340	$753,904	$0	$753,904	$529,344	$0	$529,344
DENTAL	$669,832	$0	$669,832	$610,290	$0	$610,290	$610,138	$0	$610,138
DME AND APPLIANCES	$834,019	$367,516	$1,201,535	$965,406	$503,701	$1,469,107	$1,015,894	$579,240	$1,595,134
EMERGENCY TRANSPORTATION	$3,296,333	$1,147,154	$4,443,487	$3,794,939	$1,282,944	$5,077,883	$4,056,588	$1,399,943	$5,456,531
HABILITATION	$23,046,524	$0	$23,046,524	$23,799,718	$0	$23,799,718	$22,381,866	$0	$22,381,866
HOME HEALTH AID SERVICE							$422	$0	$422
HOME HEALTH NURSE SERVICE	$323,404	$29,531	$352,935	$469,013	$50,612	$519,625	$486,987	$78,970	$565,957
HOMEMAKER SERVICE				$5,143	$0	$5,143	$2,788	$0	$2,788
HOSPICE HOME CARE	$36,821	$0	$36,821	$43,959	$0	$43,959	$15,055	$0	$15,055
HOSPICE INPATIENT CARE	$50,307	$0	$50,307	$62,236	$0	$62,236	$31,427	$0	$31,427
ICF	$2,550	$0	$2,550						
INPATIENT HOSPITAL (RM&BD AND ANCILLARY)	$53,017,216	$12,478,049	$65,495,265	$51,745,908	$10,745,720	$62,491,628	$59,270,999	$13,709,101	$72,980,100
MEDICAL SUPPLIES	$192,437	$93,643	$286,080	$240,951	$100,266	$341,217	$208,416	$102,806	$311,222
MEDICINE	$21,360,634	$5,518,371	$26,879,005	$22,269,134	$6,185,167	$28,454,301	$22,306,347	$6,657,113	$28,963,460
MENTAL HEALTH SERVICES	$83,170,522	$414,943	$83,585,465	$115,088,865	$286,232	$115,375,097	$134,603,410	$173,641	$134,777,051
NON-EMERGENCY TRANSPORTATION	$7,369,395	$159,107	$7,528,502	$11,815,371	$166,782	$11,982,153	$14,427,867	$213,714	$14,641,581
OUT-PATIENT FACILITY FEES	$13,121,227	$5,040,813	$18,162,040	$14,707,900	$6,098,379	$20,806,279	$14,755,508	$7,625,906	$22,381,414
PATHOLOGY & LABORATORY	$2,718,744	$328,470	$3,047,214	$2,502,099	$411,069	$2,913,168	$2,141,883	$434,988	$2,576,871
PERFORMANCE MEASURE				$21	$31	$52	$35	$2	$37
PERSONAL CARE SERVICES	$8,206,815	$0	$8,206,815	$20,879,807	$0	$20,879,807	$27,288,276	$0	$27,288,276
PHARMACY	$29,636,472	$53	$29,636,525	$29,394,626	$2,456	$29,397,082	$31,399,647	$5,527	$31,405,174
PHYSICAL THERAPY	$29,741	$11,195	$40,936	$27,663	$20,039	$47,702	$27,644	$13,254	$40,898
RADIOLOGY	$3,151,748	$1,262,085	$4,413,833	$3,671,965	$1,473,913	$5,145,878	$3,483,084	$1,491,358	$4,974,442
REHABILITATION	$470,625	$202,558	$673,183	$566,489	$268,921	$835,410	$693,319	$297,055	$990,374
RESPIRATORY THERAPY	$62,159	$27,329	$89,488	$77,750	$32,373	$110,123	$94,629	$35,634	$130,263
RESPITE CARE SERVICES	$493,934	$0	$493,934	$476,571	$0	$476,571	$499,903	$0	$499,903
SKILLED TECHNICIAN SERVICING COST							$2,171	$0	$2,171
SNF	$2,162,731	$333,806	$2,496,537	$2,546,998	$463,932	$3,010,930	$2,483,009	$558,869	$3,041,878
SPECIALIZED SERVICES	$1,745	$0	$1,745	$1,039	$0	$1,039	$1,120	$0	$1,120
SPEECH/HEARING THERAPY	$1,727	$438	$2,165	$5,661	$182	$5,843	$7,143	$301	$7,444
SURGERY	$3,510,629	$1,372,112	$4,882,741	$4,169,840	$1,558,999	$5,728,839	$3,892,057	$1,649,808	$5,541,865
Total Category of Service	$258,104,169	$28,787,173	$286,891,342	$310,693,266	$29,651,718	$340,344,984	$346,716,987	$35,027,230	$381,744,217

Expenditure Tables

Expenditures for the Population Enrolled Six Months or More

Enrollment Excluding < 6 Months

	Federal Fiscal Year											
	2008				2009				2010			
	Paid Amt	Medicare Paid Amount	Total Paid		Paid Amt	Medicare Paid Amount	Total Paid		Paid Amt	Medicare Paid Amount	Total Paid	
***** TOTAL *****	$256,116,870	$28,363,195	$284,480,065		$310,223,328	$29,581,383	$339,804,712		$343,148,928	$34,796,481	$377,945,409	
Plan Group												
ALTCS DD	$26,797,635	$820,280	$27,617,915		$27,429,769	$870,831	$28,300,599		$25,549,304	$976,976	$26,526,280	
Acute FFS	$1,709,765	$0	$1,709,765		$2,002,341	$0	$2,002,341		$1,977,264	$0	$1,977,264	
Acute MCO	$77,067,041	$23,608,281	$100,675,321		$87,289,711	$28,152,920	$115,442,631		$83,733,095	$31,038,150	$114,771,245	
BHS RBHA	$150,142,513	$3,934,634	$154,077,147		$193,142,752	$557,633	$193,700,385		$231,473,153	$2,781,355	$234,254,508	
BHS TRBHA	$399,915	$0	$399,915		$358,755	$0	$358,755		$416,113	$0	$416,113	
Total Plan Group	$256,116,869	$28,363,195	$284,480,063		$310,223,328	$29,581,384	$339,804,711		$343,148,929	$34,796,481	$377,945,410	

Excludes clients with less than 6 months of enrollment during FFY08-10

Enrollment Excluding < 6 Months

	Federal Fiscal Year											
	2008				2009				2010			
	Paid Amt	Medicare Paid Amount	Total Paid		Paid Amt	Medicare Paid Amount	Total Paid		Paid Amt	Medicare Paid Amount	Total Paid	
Provider Type												
AIR TRANSPORTATION	$42,074	$11,644	$53,719		$42,918	$7,977	$50,895		$34,565	$22,554	$57,119	
ALTERNATIVE RESIDENTIAL FACILITY	$15,593,147	$0	$15,593,147		$17,186,579	$0	$17,186,579		$17,691,151	$0	$17,691,151	
AMBULATORY SURGICAL CENTER	$553,757	$273,379	$827,136		$750,237	$301,310	$1,051,547		$646,582	$332,021	$978,603	
ASSISTED LIVING CENTER	$13,754	$0	$13,754									
ATTENDANT CARE	$187,221	$0	$187,221		$186,081	$0	$186,081		$24,579	$540	$25,119	
AUDIOLOGIST	$1,432	$5,194	$6,626		$4,026	$4,838	$8,864		$1,796	$1,263	$3,060	
BEHAVIORAL HEALTH THERAPEUTIC HOME	$790,180	$0	$790,180		$836,517	$0	$836,517		$571,128	$0	$571,128	
BH OUTPATIENT CLINIC	$67,160,703	$341,964	$67,502,667		$102,587,126	$199,304	$102,786,430		$128,645,258	$15,409	$128,660,667	
CERTIFIED NURSE-MIDWIFE	$16,394	$232	$16,626		$20,432	$1,243	$21,675		$12,499	$3,134	$15,632	
CERTIFIED REGISTERED NURSE ANESTHETIST	$89,994	$20,782	$110,776		$118,269	$31,424	$149,692		$144,659	$46,107	$190,765	
CHIROPRACTOR	$239	$966	$1,205		$743	$1,215	$1,958		$678	$2,975	$3,653	
CLINIC	$53,810	$319	$54,129		$6,940	$256	$7,196		$1,526	$210	$1,736	
COMMUNITY SERVICE AGENCY	$7,226,365	$0	$7,226,365		$11,688,547	$0	$11,688,547		$10,412,824	$0	$10,412,824	
CRISIS SERVICES PROVIDER					$690	$0	$690					
DENTIST	$670,194	$166	$670,359		$614,795	$1,130	$615,925		$603,754	$5,921	$609,675	
DIALYSIS CLINIC	$292,240	$238,213	$530,453		$259,374	$280,672	$540,046		$247,606	$330,708	$578,314	
DME SUPPLIER	$793,253	$399,397	$1,192,650		$989,154	$536,097	$1,525,251		$962,967	$573,515	$1,536,482	
DO-PHYSICIAN OSTEOPATH	$3,200,795	$1,231,634	$4,432,429		$3,881,616	$1,415,872	$5,297,488		$3,930,387	$1,506,465	$5,436,851	
EMERGENCY TRANSPORTATION	$3,958,366	$1,244,973	$5,203,339		$4,689,967	$1,396,595	$6,086,562		$5,204,718	$1,562,922	$6,767,639	
EPD HCBS					$2,607	$0	$2,607					
FISCAL INTERMEDIARIES	$1,745	$0	$1,745		$1,039	$0	$1,039		$1,120	$0	$1,120	
GROUP-PAYMENT ID					$1,997	$3,712	$5,709		$12,043	$12,628	$24,671	
HABILITATION PROVIDER	$24,530,444	$0	$24,530,444		$25,008,980	$0	$25,008,980		$23,505,289	$0	$23,505,289	
HOME HEALTH AGENCY	$316,187	$38,959	$355,145		$431,848	$70,925	$502,773		$430,360	$107,556	$537,916	
HOSPICE	$85,087	$0	$85,087		$106,195	$0	$106,195		$46,091	$113	$46,204	
HOSPITAL	$53,839,037	$15,321,169	$69,160,206		$55,677,810	$16,031,301	$71,709,112		$59,221,153	$19,594,962	$78,816,115	
INDEPENDENT TESTING FACILITIES	$97,700	$55,879	$153,579		$137,677	$53,065	$190,741		$121,785	$64,130	$185,915	
LABORATORY	$2,564,229	$275,545	$2,839,774		$2,337,364	$358,405	$2,695,769		$1,948,021	$378,019	$2,326,040	
LEVEL III BEHAVIORAL HTH RESIDENTIAL	$2,808,300	$0	$2,808,300		$3,372,871	$0	$3,372,871		$2,935,086	$0	$2,935,086	
LIC INDEP SUBSTANCE ABUSE COUNS (LISAC)	$19,983	$0	$19,983		$25,699	$0	$25,699		$1,153	$0	$1,153	
LICENSED CLINICAL SOCIAL WORKER (LCSW)	$237,881	$10,037	$247,918		$285,280	$8,246	$293,525		$304,720	$1,842	$306,562	
LICENSED MARRIAGE & FAMILYTHERAPISTLMFT	$35,644	$0	$35,644		$10,531	$0	$10,531					
LICENSED PROFESSIONAL COUNSELOR (LPC)	$338,637	$1,780	$340,417		$280,002	$718	$280,720		$202,954	$271	$203,224	
MD-PHYSICIAN	$18,850,263	$6,228,595	$25,078,858		$21,833,483	$7,180,182	$29,013,665		$21,875,481	$7,561,291	$29,436,771	
MENTAL HEALTH RESIDENTIAL TREATMENT CNTR	$199,207	$0	$199,207		$386,112	$0	$386,112		$25,152	$0	$25,152	
NON-EMERGENCY TRANSPORTATION PROVIDERS	$4,232,987	$37,639	$4,270,627		$7,928,694	$44,420	$7,973,114		$9,783,278	$22,870	$9,806,148	

Excludes clients with less than 6 months of enrollment during FFY08-10

Enrollment Excluding < 6 Months

	Federal Fiscal Year								
	2008			2009			2010		
	Paid Amt	Medicare Paid Amount	Total Paid	Paid Amt	Medicare Paid Amount	Total Paid	Paid Amt	Medicare Paid Amount	Total Paid
NON-MEDICARE CERTIFIED HOME HTH AGENCIES	$3,799	$0	$3,799	$10,863	$1,441	$12,304	$11,448	$0	$11,448
NURSING HOME	$2,173,336	$345,506	$2,518,842	$2,585,805	$463,932	$3,049,737	$2,477,202	$558,869	$3,036,072
OCCUPATIONAL THERAPIST	$35,063	$15,073	$50,136	$33,976	$17,636	$51,611	$27,921	$17,002	$44,923
OPTOMETRIST	$16,009	$3,498	$19,507	$29,807	$13,042	$42,849	$49,938	$31,730	$81,668
OUT-OF-STATE ENC OR 1 TIME FFS PROV	$12,070	$955	$13,026	$104	$0	$104	$233	$0	$233
PERFUSIONIST	$870	$1,809	$2,679	$1,685	$0	$1,685	$397	$0	$397
PHARMACY	$27,668,743	$33,494	$27,702,237	$28,093,420	$13,242	$28,106,662	$30,383,303	$31,409	$30,414,712
PHYSICAL THERAPIST	$401,085	$178,869	$579,955	$503,026	$237,121	$740,146	$579,630	$240,339	$819,970
PHYSICIANS ASSISTANT	$769,237	$118,161	$887,399	$946,626	$159,831	$1,106,457	$1,179,057	$227,338	$1,406,395
PODIATRIST	$219,985	$121,344	$341,329	$240,346	$121,170	$361,516	$253,340	$137,767	$391,107
PSYCHIATRIC HOSPITAL	$6,975,052	$1,663,776	$8,638,828	$8,601,676	$478,794	$9,080,470	$11,274,932	$1,233,399	$12,508,331
PSYCHOLOGIST	$179,402	$30,618	$210,020	$266,123	$42,080	$308,204	$328,511	$31,432	$359,942
QMB ONLY PROVIDER	$2,313	$970	$3,283	$1,421	$266	$1,687	$0	$0	$0
REGIONAL ADMINISTRATIVE ENTITY	$64,062	$0	$64,062	$157,414	$0	$157,414	$49,586	$0	$49,586
REGISTERED DIETICIAN	$906	$651	$1,556	$883	$944	$1,828	$2,065	$1,367	$3,433
REGISTERED NURSE PRACTITIONER	$1,018,720	$106,557	$1,125,276	$1,500,789	$100,402	$1,601,190	$1,649,612	$133,002	$1,782,615
RESID TRTM CTR-NON-SECURE (17+BEDS)(IMD)	$161,145	$0	$161,145	$64,376	$0	$64,376	$9,457	$0	$9,457
RESID TRTMENT CTR-SECURE (17+BEDS)(IMD)	$1,208,572	$0	$1,208,572	$471,233	$0	$471,233			
SPEECH LANGUAGE PATHOLOGY ASSISTANT							$79	$0	$79
SPEECH/HEARING THERAPIST	$1,690	$438	$2,127	$4,598	$72	$4,669	$6,834	$0	$6,834
SUBACUTE FACILITY (1-16 BEDS)	$5,705,551	$0	$5,705,551	$4,959,017	$0	$4,959,017	$5,293,898	$0	$5,293,898
SUBACUTE FACILITY (17+BEDS)(IMD)	$684,141	$0	$684,141	$40,465	$0	$40,465			
SURGICAL FIRST ASSISTANT	$13,870	$3,009	$16,879	$17,475	$2,504	$19,979	$21,125	$5,402	$26,527
Total Provider Type	$256,116,870								

Excludes clients with less than 6 months of enrollment during FFY08-10

Enrollment Excluding < 6 Months

	Federal Fiscal Year									
	2008			2009			2010			
	Paid Amt	Medicare Paid Amount	Total Paid	Paid Amt	Medicare Paid Amount	Total Paid	Paid Amt	Medicare Paid Amount	Total Paid	
Category of Service										
ADULT FOSTER CARE	$140,784	$0	$140,784							
ASSISTED LIVING	$13,754	$0	$13,754							
ATTENDANT CARE	$1,011,340	$0	$1,011,340	$753,904	$0	$753,904	$529,344	$0	$529,344	
DENTAL	$669,106	$0	$669,106	$609,870	$0	$609,870	$601,302	$0	$601,302	
DME AND APPLIANCES	$829,260	$367,481	$1,196,741	$964,528	$503,701	$1,468,229	$1,013,973	$574,005	$1,587,978	
EMERGENCY TRANSPORTATION	$3,237,719	$1,136,608	$4,374,328	$3,784,842	$1,282,784	$5,067,626	$3,995,220	$1,395,780	$5,391,000	
HABILITATION	$23,046,524	$0	$23,046,524	$23,799,718	$0	$23,799,718	$22,381,468	$0	$22,381,468	
HOME HEALTH AID SERVICE							$422	$0	$422	
HOME HEALTH NURSE SERVICE	$323,404	$29,531	$352,934	$469,013	$50,612	$519,625	$473,793	$75,223	$549,016	
HOMEMAKER SERVICE				$5,143	$0	$5,143	$2,788	$0	$2,788	
HOSPICE HOME CARE	$36,679	$0	$36,679	$43,959	$0	$43,959	$14,663	$0	$14,663	
HOSPICE INPATIENT CARE	$48,408	$0	$48,408	$62,236	$0	$62,236	$31,427	$0	$31,427	
ICF	$2,550	$0	$2,550							
INPATIENT HOSPITAL (RM&BD AND ANCILLARY)	$52,141,793	$12,233,053	$64,374,846	$51,537,026	$10,695,689	$62,232,716	$57,575,845	$13,559,804	$71,135,650	
MEDICAL SUPPLIES	$190,636	$92,572	$283,208	$240,948	$100,266	$341,213	$208,075	$102,503	$310,578	
MEDICINE	$21,141,451	$5,423,498	$26,564,949	$22,236,763	$6,172,718	$28,409,481	$22,075,152	$6,628,630	$28,703,783	
MENTAL HEALTH SERVICES	$82,750,834	$414,744	$83,165,578	$114,946,312	$286,232	$115,232,544	$133,626,619	$172,604	$133,799,223	
NON-EMERGENCY TRANSPORTATION	$7,334,672	$157,649	$7,492,321	$11,803,706	$166,209	$11,969,915	$14,323,328	$212,566	$14,535,894	
OUT-PATIENT FACILITY FEES	$13,010,038	$5,000,420	$18,010,458	$14,685,793	$6,095,021	$20,780,815	$14,594,699	$7,598,703	$22,193,401	
PATHOLOGY & LABORATORY	$2,701,222	$324,987	$3,026,209	$2,500,422	$411,069	$2,911,491	$2,125,242	$434,303	$2,559,545	
PERFORMANCE MEASURE				$21	$31	$52	$35	$2	$37	
PERSONAL CARE SERVICES	$8,199,850	$0	$8,199,850	$20,879,800	$0	$20,879,800	$27,225,181	$0	$27,225,181	
PHARMACY	$29,470,073	$53	$29,470,126	$29,366,780	$2,456	$29,369,236	$31,228,299	$5,485	$31,233,784	
PHYSICAL THERAPY	$29,591	$11,169	$40,760	$27,663	$20,039	$47,702	$27,599	$13,254	$40,853	
RADIOLOGY	$3,122,100	$1,246,156	$4,368,256	$3,668,501	$1,472,892	$5,141,393	$3,463,337	$1,486,588	$4,949,925	
REHABILITATION	$466,826	$202,093	$668,919	$566,489	$268,921	$835,410	$690,486	$297,055	$987,542	
RESPIRATORY THERAPY	$61,727	$27,051	$88,778	$77,750	$32,373	$110,124	$94,487	$35,603	$130,090	
RESPITE CARE SERVICES	$493,934	$0	$493,934	$476,571	$0	$476,571	$499,903	$0	$499,903	
SKILLED TECHNICIAN SERVICING COST							$2,171	$0	$2,171	
SNF	$2,160,851	$333,806	$2,494,657	$2,546,998	$463,932	$3,010,930	$2,474,151	$558,869	$3,033,020	
SPECIALIZED SERVICES	$1,745	$0	$1,745	$1,039	$0	$1,039	$1,120	$0	$1,120	
SPEECH/HEARING THERAPY	$1,727	$438	$2,165	$5,661	$182	$5,843	$7,143	$301	$7,444	
SURGERY	$3,478,270	$1,361,888	$4,840,158	$4,161,873	$1,556,256	$5,718,129	$3,861,643	$1,645,202	$5,506,845	
Total Category of Service	$256,116,868	$28,363,197	$284,480,065	$310,223,329	$29,581,383	$339,804,714	$343,148,926	$34,796,480	$377,945,408	

Excludes clients with less than 6 months of enrollment during FFY08-10

Expenditure Tables

Expenditures for the Population Enrolled Six Months or More

Presented by "Decile" with deciles derived based on:

- Overall Spending (PMPM)
- Behavioral Health Spending (PMPM)
- Acute Spending (PMPM)

Also presented by Behavioral Health Category by decile

Overall Decile	BH Expenditures Sum	Acute Expenditures Sum	BH Medicare Expenditures Sum	Acute Medicare Expenditures Sum	Total Expenditures (incl. DD) Sum	Member Months Sum	DD N	Total (incl. DD) N	BH Expenditures PMPM	Acute Expenditures PMPM	Total Expenditures (incl. DD) PMPM
FFY 2008											
None						4,734	-	625			
1	$641,649	$337,555	$2,259	$96,961	$1,079,176	16,649	4	1,621	$38.54	$20.27	$64.82
2	$1,927,427	$826,639	$9,193	$365,768	$3,129,026	17,290	-	1,621	$111.48	$47.81	$180.97
3	$3,238,141	$1,357,587	$18,459	$647,902	$5,264,946	17,244	3	1,621	$187.78	$78.73	$305.32
4	$4,736,534	$2,230,199	$33,914	$901,018	$7,910,407	17,366	5	1,621	$272.75	$128.42	$455.51
5	$6,498,385	$3,374,740	$34,968	$1,238,579	$11,164,321	17,390	7	1,621	$373.69	$194.06	$642.00
6	$8,767,931	$4,616,691	$155,385	$1,801,655	$15,349,010	17,441	3	1,621	$502.72	$264.70	$880.05
7	$11,383,584	$7,384,479	$326,324	$2,257,111	$21,449,757	17,479	9	1,621	$651.27	$422.48	$1,227.17
8	$17,061,263	$10,738,010	$565,313	$3,066,837	$31,790,168	17,429	24	1,621	$978.90	$616.10	$1,823.98
9	$29,286,166	$15,587,858	$1,418,250	$5,305,115	$53,157,528	17,218	44	1,621	$1,700.90	$905.32	$3,087.32
10	$67,001,349	$32,323,048	$1,370,570	$7,927,335	$133,365,445	17,037	240	1,621	$3,932.70	$1,897.23	$7,827.99
Totals	$150,542,428	$78,776,806	$3,934,634	$23,608,281	$283,659,785	177,277	339	16,835	$849.19	$444.37	$1,600.09
FFY 2009											
None						7,341	-	909			
1	$773,692	$435,516	$2,089	$143,938	$1,358,416	16,560	3	1,664	$46.72	$26.30	$82.03
2	$2,439,332	$940,541	$5,884	$424,079	$3,811,706	17,339	2	1,665	$140.68	$54.24	$219.83
3	$4,068,888	$1,587,856	$6,534	$784,889	$6,452,378	17,430	5	1,664	$233.44	$91.10	$370.19
4	$5,854,232	$2,663,766	$11,806	$1,090,904	$9,627,473	17,648	5	1,665	$331.72	$150.94	$545.53
5	$7,910,573	$3,843,414	$21,269	$1,640,913	$13,442,154	17,764	5	1,665	$445.31	$216.36	$756.71
6	$10,894,717	$5,757,544	$42,319	$2,016,124	$18,726,041	17,824	2	1,664	$611.24	$323.02	$1,050.61
7	$14,897,038	$7,977,865	$74,994	$2,962,112	$26,070,277	17,783	12	1,665	$837.71	$448.62	$1,466.02
8	$21,419,011	$11,980,018	$116,232	$4,247,610	$38,216,255	17,642	23	1,664	$1,214.09	$679.06	$2,166.21
9	$36,965,945	$18,171,159	$125,049	$5,677,093	$63,127,366	17,568	56	1,665	$2,104.16	$1,034.33	$3,593.32
10	$88,278,081	$35,934,371	$151,457	$9,165,257	$158,101,815	17,492	231	1,665	$5,046.77	$2,054.33	$9,038.52
Totals	$193,501,508	$89,292,052	$557,633	$28,152,920	$338,933,881	182,391	344	17,555	$1,060.92	$489.56	$1,858.28
FFY 2010											
None						8,139	-	871			
1	$824,803	$485,535	$4,015	$152,066	$1,467,695	17,467	1	1,671	$47.22	$27.80	$84.03
2	$2,909,375	$933,362	$9,927	$489,360	$4,344,389	18,109	3	1,672	$160.66	$51.54	$239.90
3	$4,582,207	$1,810,311	$23,750	$795,971	$7,224,552	18,106	5	1,672	$253.08	$99.98	$399.01
4	$6,717,227	$2,780,437	$24,492	$1,405,223	$10,928,888	18,584	2	1,672	$361.45	$149.61	$588.08
5	$9,437,541	$3,892,278	$62,009	$1,882,983	$15,292,440	18,538	4	1,672	$509.09	$209.96	$824.92
6	$12,607,548	$5,993,497	$135,898	$2,363,419	$21,133,116	18,595	5	1,672	$678.01	$322.32	$1,136.49
7	$17,523,810	$8,300,729	$295,256	$3,084,116	$29,424,370	18,436	14	1,672	$950.52	$450.25	$1,596.03
8	$25,703,331	$11,944,217	$459,158	$4,834,725	$43,519,277	18,614	26	1,672	$1,380.86	$641.68	$2,337.99
9	$45,699,997	$16,286,442	$795,584	$5,937,304	$71,395,281	18,595	66	1,672	$2,457.65	$875.85	$3,839.49
10	$105,883,428	$33,283,551	$971,266	$10,092,982	$172,238,426	18,387	213	1,672	$5,758.60	$1,810.17	$9,367.40
Totals	$231,889,266	$85,710,358	$2,781,355	$31,038,150	$376,968,433	191,570	339	17,590	$1,210.47	$447.41	$1,967.78

BH PMPM Decile	BH Expenditures Sum	Acute Expenditures Sum	BH Medicare Expenditures Sum	Acute Medicare Expenditures Sum	Total Expenditures (incl. DD) Sum	Member Months Sum	DD N	Total (incl. DD) N	BH Expenditures PMPM	Acute Expenditures PMPM	Total Expenditures (incl. DD) PMPM
FFY 2008											
None		$6,300,129		$1,299,041	$8,164,607	17,590	8	1,924		$358.17	$464.16
1	$610,836	$5,929,943	$2,682	$2,485,380	$11,334,505	15,781	33	1,491	$38.71	$375.76	$718.24
2	$1,572,961	$4,086,702	$8,220	$3,301,901	$12,977,522	16,470	53	1,491	$95.50	$248.13	$787.95
3	$2,527,189	$4,697,362	$11,625	$2,646,990	$12,287,701	16,383	31	1,491	$154.26	$286.72	$750.03
4	$3,615,763	$5,808,176	$14,706	$2,055,335	$14,259,082	15,895	35	1,491	$227.48	$365.41	$897.08
5	$5,210,773	$7,042,885	$31,651	$1,860,856	$16,793,149	16,005	27	1,491	$325.57	$440.04	$1,049.24
6	$7,231,301	$8,174,773	$45,174	$1,803,779	$19,705,831	15,935	32	1,491	$453.80	$513.01	$1,236.64
7	$10,000,160	$8,731,724	$187,722	$1,669,847	$23,237,028	15,893	35	1,491	$629.22	$549.41	$1,462.09
8	$14,599,593	$8,847,972	$432,943	$1,731,987	$28,523,376	15,893	38	1,491	$918.62	$556.72	$1,794.71
9	$26,542,742	$8,923,262	$1,084,724	$2,270,694	$41,054,617	15,781	26	1,491	$1,681.94	$565.44	$2,601.52
10	$78,631,110	$10,233,878	$2,115,187	$2,482,470	$95,322,366	15,651	21	1,492	$5,024.03	$653.88	$6,090.50
Totals	$150,542,428	$78,776,806	$3,934,634	$23,608,281	$283,659,785	177,277	339	16,835	$849.19	$444.37	$1,600.09
FFY 2009											
None		$6,585,748		$1,418,079	$8,493,844	20,902	10	2,259		$315.08	$406.37
1	$823,066	$4,189,423	$5,076	$2,787,333	$11,181,832	15,618	50	1,529	$52.70	$268.24	$715.96
2	$2,111,989	$4,164,384	$6,000	$3,486,792	$13,027,649	16,588	46	1,530	$127.32	$251.05	$785.37
3	$3,309,022	$6,151,069	$7,495	$3,509,168	$15,909,955	16,414	31	1,529	$201.60	$374.75	$969.29
4	$4,640,781	$6,455,166	$9,334	$2,391,432	$15,754,083	16,052	29	1,529	$289.11	$402.14	$981.44
5	$6,587,512	$7,346,490	$12,515	$2,643,911	$19,582,206	16,309	37	1,531	$403.92	$450.46	$1,200.70
6	$9,067,501	$9,342,043	$27,680	$1,807,391	$22,607,477	16,242	28	1,529	$558.27	$575.18	$1,391.91
7	$12,861,264	$10,114,095	$63,116	$2,408,484	$27,962,766	16,269	29	1,530	$790.54	$621.68	$1,718.78
8	$18,890,432	$9,692,377	$81,394	$2,228,430	$34,194,485	15,868	33	1,529	$1,190.47	$610.81	$2,154.93
9	$33,955,684	$11,764,182	$186,813	$2,828,125	$50,459,346	16,041	25	1,530	$2,116.81	$733.38	$3,145.65
10	$101,254,258	$13,487,076	$158,208	$2,643,775	$119,760,240	16,088	26	1,530	$6,293.78	$838.33	$7,444.07
Totals	$193,501,508	$89,292,052	$557,633	$28,152,920	$338,933,881	182,391	344	17,555	$1,060.92	$489.56	$1,858.28
FFY 2010											
None		$7,669,963		$2,084,015	$10,292,755	22,672	10	2,226		$338.30	$453.99
1	$984,047	$4,743,754	$7,303	$3,021,593	$11,748,427	16,239	48	1,536	$60.60	$292.12	$723.47
2	$2,519,254	$4,544,822	$18,214	$3,559,690	$14,287,485	17,076	53	1,536	$147.53	$266.15	$836.70
3	$3,835,308	$6,579,730	$20,854	$3,596,473	$16,719,735	16,987	31	1,537	$225.78	$387.34	$984.27
4	$5,400,111	$6,292,645	$22,976	$2,709,698	$17,447,499	16,897	36	1,536	$319.59	$372.41	$1,032.58
5	$7,578,576	$8,077,578	$48,531	$2,796,098	$20,319,975	16,827	22	1,537	$450.38	$480.04	$1,207.58
6	$10,802,265	$8,903,223	$66,747	$2,869,584	$25,898,525	16,870	37	1,536	$640.32	$527.75	$1,535.18
7	$15,377,898	$8,474,343	$179,390	$2,512,108	$28,812,689	16,866	28	1,536	$911.77	$502.45	$1,708.33
8	$23,539,633	$9,163,946	$352,063	$2,422,019	$37,741,386	16,962	28	1,537	$1,387.79	$540.26	$2,225.06
9	$41,809,387	$10,340,294	$838,919	$2,876,307	$56,990,117	17,030	21	1,536	$2,455.04	$607.18	$3,346.45
10	$120,042,787	$10,920,060	$1,226,359	$2,590,564	$136,709,840	17,144	25	1,537	$7,002.03	$636.96	$7,974.21
Totals	$231,889,266	$85,710,358	$2,781,355	$31,038,150	$376,968,433	191,570	339	17,590	$1,210.47	$447.41	$1,967.78

Acute PMPM Decile	BH Expenditures Sum	Acute Expenditures Sum	BH Medicare Expenditures Sum	Acute Medicare Expenditures Sum	Total Expenditures (incl. DD) Sum	Member Months Sum	DD N	Total (incl. DD) N	BH Expenditures PMPM	Acute Expenditures PMPM	Total Expenditures (incl. DD) PMPM
FFY 2008											
None	$13,070,881		$214,931		$39,966,922	24,354	325	2,698	$536.70		$1,641.08
1	$11,392,007	$137,524	$225,034	$27,681	$11,784,725	15,507	4	1,413	$734.64	$8.87	$759.96
2	$12,258,272	$435,280	$177,622	$126,674	$13,064,049	15,490	2	1,414	$791.37	$28.10	$843.39
3	$12,845,650	$813,507	$320,364	$278,611	$14,283,801	15,268	4	1,414	$841.34	$53.28	$935.54
4	$13,746,963	$1,360,610	$412,555	$464,319	$15,993,012	15,469	1	1,413	$888.68	$87.96	$1,033.87
5	$13,930,891	$2,059,562	$343,973	$737,258	$17,071,683	15,340	-	1,414	$908.14	$134.26	$1,112.89
6	$15,027,805	$3,179,044	$463,377	$1,085,600	$19,764,606	15,328	2	1,414	$980.42	$207.40	$1,289.44
7	$12,788,229	$5,000,848	$533,834	$1,579,559	$19,902,471	15,369	-	1,413	$832.08	$325.39	$1,294.97
8	$13,435,684	$7,715,096	$445,650	$2,638,380	$24,234,809	15,260	-	1,414	$880.45	$505.58	$1,588.13
9	$14,931,498	$13,519,654	$406,980	$4,130,280	$32,988,412	15,356	-	1,414	$972.36	$880.42	$2,148.24
10	$17,114,549	$44,555,683	$390,313	$12,539,918	$74,605,295	14,536	1	1,414	$1,177.39	$3,065.20	$5,132.45
Totals	$150,542,428	$78,776,806	$3,934,634	$23,608,281	$283,659,785	177,277	339	16,835	$849.19	$444.37	$1,600.09
FFY 2009											
None	$14,975,355		$23,831		$41,931,446	24,839	327	2,901	$602.90		$1,688.13
1	$14,310,092	$146,282	$12,369	$28,758	$14,769,057	15,866	4	1,465	$901.93	$9.22	$930.86
2	$16,085,826	$457,212	$46,436	$135,519	$16,802,474	15,711	4	1,465	$1,023.86	$29.10	$1,069.47
3	$18,544,033	$896,609	$24,489	$309,082	$19,778,929	16,019	2	1,466	$1,157.63	$55.97	$1,234.72
4	$17,398,538	$1,483,884	$43,009	$515,309	$19,445,611	15,693	1	1,465	$1,108.68	$94.56	$1,239.13
5	$17,157,429	$2,342,525	$47,507	$846,381	$20,431,281	15,841	2	1,466	$1,083.10	$147.88	$1,289.77
6	$18,978,201	$3,619,120	$65,369	$1,244,274	$23,909,927	15,776	1	1,465	$1,202.98	$229.41	$1,515.59
7	$17,247,097	$5,666,767	$55,259	$1,883,635	$24,919,218	15,828	1	1,465	$1,089.66	$358.02	$1,574.38
8	$17,294,425	$9,064,821	$70,391	$3,026,042	$29,484,745	16,051	1	1,466	$1,077.47	$564.75	$1,836.94
9	$19,608,595	$15,043,917	$91,289	$5,672,548	$40,419,306	15,860	1	1,465	$1,236.36	$948.54	$2,548.51
10	$21,901,917	$50,570,915	$77,684	$14,491,372	$87,041,888	14,907	-	1,466	$1,469.24	$3,392.43	$5,838.99
Totals	$193,501,508	$89,292,052	$557,633	$28,152,920	$338,933,881	182,391	344	17,555	$1,060.92	$489.56	$1,858.28
FFY 2010											
None	$15,175,279				$40,800,408	26,422	334	2,719	$574.34		$1,544.18
1	$18,395,737	$143,636	$256,770	$31,646	$18,827,789	16,502	-	1,487	$1,114.76	$8.70	$1,140.94
2	$19,806,323	$455,238	$260,758	$142,234	$20,685,996	16,548	1	1,487	$1,196.90	$27.51	$1,250.06
3	$20,550,898	$869,258	$152,988	$319,502	$21,892,645	16,538	-	1,487	$1,242.65	$52.56	$1,323.78
4	$20,453,276	$1,467,997	$250,579	$542,880	$22,714,944	16,553	1	1,487	$1,235.62	$88.68	$1,372.26
5	$22,818,895	$2,344,824	$114,567	$829,850	$26,155,893	16,628	2	1,487	$1,372.32	$141.02	$1,573.00
6	$22,432,038	$3,551,707	$291,383	$1,301,760	$27,579,166	16,441	1	1,487	$1,364.40	$216.03	$1,677.46
7	$21,823,809	$5,379,179	$240,788	$2,192,513	$29,636,289	16,726	-	1,487	$1,304.78	$321.61	$1,771.87
8	$20,986,137	$8,665,017	$436,354	$3,370,701	$33,458,210	16,770	-	1,487	$1,251.41	$516.70	$1,995.12
9	$24,099,122	$15,407,024	$287,426	$5,191,624	$44,985,197	16,608	-	1,487	$1,451.06	$927.69	$2,708.65
10	$25,347,753	$47,426,479	$342,225	$17,115,441	$90,231,898	15,834	-	1,488	$1,600.84	$2,995.23	$5,698.62
Totals	$231,889,266	$85,710,358	$2,633,838	$31,038,150	$376,968,433	191,570	339	17,590	$1,210.47	$447.41	$1,967.78

Arizona 2703 Project
Group Expenditures and MM
FFY 2010

		Total Exp				Member Months		
	Decile	N	% of Total Decile	% of Total Classified	SUM	N	SUM	PMPM
Psychotic Disorders, Group 1	**None**	303	34.8%	46.3%		303	2,755	$ -
	1	515	30.8%	39.0%	$493,732	515	5,325	$ 92.72
	2	676	40.4%	42.9%	$1,796,832	676	7,408	$ 242.55
	3	666	39.8%	41.7%	$2,923,829	666	7,294	$ 400.85
	4	685	41.0%	42.1%	$4,573,738	685	7,782	$ 587.73
	5	694	41.5%	42.4%	$6,402,114	694	7,765	$ 824.48
	6	728	43.5%	44.2%	$9,307,398	728	8,147	$ 1,142.43
	7	716	42.8%	43.4%	$12,659,376	716	7,925	$ 1,597.40
	8	806	48.2%	48.5%	$21,262,347	806	9,054	$ 2,348.39
	9	953	57.0%	57.4%	$41,205,419	953	10,633	$ 3,875.24
	10	1,108	66.3%	66.5%	$117,600,463	1,108	12,411	$ 9,475.50
Totals		7,850	44.6%	47.0%	$218,225,248	7,850	86,499	$ 2,522.86
Bipolar Disorders, Group 2	**None**	158	18.1%	24.1%		158	1,363	$ -
	1	340	20.3%	25.8%	$294,074	340	3,357	$ 87.60
	2	420	25.1%	26.7%	$1,080,781	420	4,495	$ 240.44
	3	463	27.7%	29.0%	$1,986,979	463	4,955	$ 401.00
	4	459	27.5%	28.2%	$2,934,322	459	4,950	$ 592.79
	5	467	27.9%	28.6%	$4,211,586	467	5,097	$ 826.29
	6	480	28.7%	29.2%	$6,055,633	480	5,336	$ 1,134.86
	7	489	29.2%	29.7%	$8,559,952	489	5,371	$ 1,593.74
	8	449	26.9%	27.0%	$11,580,861	449	4,952	$ 2,338.62
	9	384	23.0%	23.1%	$15,925,538	384	4,224	$ 3,770.25
	10	304	18.2%	18.2%	$30,025,969	304	3,232	$ 9,290.21
Totals		4,413	25.1%	26.4%	$82,655,695	4,413	47,332	$ 1,746.30
Mood Disorders, Group 3	**None**	175	20.1%	26.7%		175	1,629	$ -
	1	371	22.2%	28.1%	$342,222	371	3,908	$ 87.57
	2	388	23.2%	24.6%	$994,533	388	4,174	$ 238.27
	3	392	23.4%	24.5%	$1,677,738	392	4,237	$ 395.97
	4	416	24.9%	25.6%	$2,674,487	416	4,584	$ 583.44
	5	411	24.6%	25.1%	$3,772,318	411	4,561	$ 827.08
	6	385	23.0%	23.4%	$4,811,951	385	4,255	$ 1,130.89
	7	397	23.7%	24.1%	$7,052,661	397	4,420	$ 1,595.62
	8	361	21.6%	21.7%	$9,327,242	361	4,014	$ 2,323.68
	9	298	17.8%	18.0%	$12,649,902	298	3,311	$ 3,820.57
	10	229	13.7%	13.7%	$21,788,094	229	2,427	$ 8,977.38
Totals		3,823	21.7%	22.9%	$65,091,148	3,823	41,520	$ 1,567.71

Arizona 2703 Project
Group Expenditures and MM
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		Total Exp				Member Months		
	Decile	N	% of Total Decile	% of Total Classified	SUM	N	SUM	PMPM
Anxiety Disorders, Group 4	**None**	13	1.5%	2.0%		13	119	$ -
	1	81	4.8%	6.1%	$80,267	81	890	$ 90.19
	2	78	4.7%	5.0%	$189,006	78	821	$ 230.21
	3	67	4.0%	4.2%	$292,705	67	725	$ 403.73
	4	55	3.3%	3.4%	$372,734	55	623	$ 598.29
	5	55	3.3%	3.4%	$492,660	55	601	$ 819.73
	6	45	2.7%	2.7%	$542,699	45	481	$ 1,128.27
	7	45	2.7%	2.7%	$733,469	45	464	$ 1,580.75
	8	39	2.3%	2.3%	$967,293	39	423	$ 2,286.74
	9	21	1.3%	1.3%	$880,582	21	237	$ 3,715.54
	10	21	1.3%	1.3%	$1,752,364	21	203	$ 8,632.33
Totals		520	3.0%	3.1%	$6,303,779	520	5,587	$ 1,128.29
Personality Disorders, Group 5	**None**	6	0.7%	0.9%		6	50	$ -
	1	13	0.8%	1.0%	$13,040	13	155	$ 84.13
	2	13	0.8%	0.8%	$33,013	13	139	$ 237.50
	3	9	0.5%	0.6%	$40,519	9	101	$ 401.18
	4	12	0.7%	0.7%	$78,232	12	135	$ 579.50
	5	8	0.5%	0.5%	$74,377	8	95	$ 782.92
	6	8	0.5%	0.5%	$99,611	8	91	$ 1,094.63
	7	2	0.1%	0.1%	$25,156	2	16	$ 1,572.25
	8	6	0.4%	0.4%	$148,585	6	67	$ 2,217.69
	9	4	0.2%	0.2%	$196,923	4	46	$ 4,280.93
	10	4	0.2%	0.2%	$470,989	4	43	$ 10,953.23
Totals		85	0.5%	0.5%	$1,180,445	85	938	$ 1,258.47
Subtotal Classified	**None**	655	75.2%	100.0%	-	655	5,916	$ -
	1	1,320	79.0%	100.0%	1,223,335	1,320	13,635	$ 89.72
	2	1,575	94.2%	100.0%	4,094,165	1,575	17,037	$ 240.31
	3	1,597	95.5%	100.0%	6,921,770	1,597	17,312	$ 399.82
	4	1,627	97.3%	100.0%	10,633,513	1,627	18,074	$ 588.33
	5	1,635	97.8%	100.0%	14,953,055	1,635	18,119	$ 825.27
	6	1,646	98.4%	100.0%	20,817,292	1,646	18,310	$ 1,136.94
	7	1,649	98.6%	100.0%	29,030,614	1,649	18,196	$ 1,595.44
	8	1,661	99.3%	100.0%	43,286,328	1,661	18,510	$ 2,338.54
	9	1,660	99.3%	100.0%	70,858,364	1,660	18,451	$ 3,840.35
	10	1,666	99.6%	100.0%	171,637,879	1,666	18,316	$ 9,370.93
Totals		16,691	94.9%	100.0%	$373,456,315	16,691	181,876	$ 2,053.36

Arizona 2703 Project
Group Expenditures and MM
FFY 2010

		Total Exp				Member Months		
	Decile	N	% of Total Decile	% of Total Classified	SUM	N	SUM	PMPM
Not Classified	**None**	216	24.8%	33.0%		216	$2,223	$ -
	1	351	21.0%	26.6%	$244,360	351	$3,832	$ 63.77
	2	97	5.8%	6.2%	$250,225	97	$1,072	$ 233.42
	3	75	4.5%	4.7%	$302,782	75	$794	$ 381.34
	4	45	2.7%	2.8%	$295,375	45	$510	$ 579.17
	5	37	2.2%	2.3%	$339,385	37	$419	$ 809.99
	6	26	1.6%	1.6%	$315,823	26	$285	$ 1,108.15
	7	23	1.4%	1.4%	$393,756	23	$240	$ 1,640.65
	8	11	0.7%	0.7%	$232,949	11	$104	$ 2,239.89
	9	12	0.7%	0.7%	$536,916	12	$144	$ 3,728.58
	10	6	0.4%	0.4%	$600,548	6	$71	$ 8,458.42
Totals		899	5.1%	5.4%	$3,512,119	899	9,694	$ 362.30

All Categories	**None**	871	100%			871	8,139	$ -
	1	1,671	100%		$1,467,695	1,671	17,467	$ 84.03
	2	1,672	100%		$4,344,390	1,672	18,109	$ 239.90
	3	1,672	100%		$7,224,552	1,672	18,106	$ 399.01
	4	1,672	100%		$10,928,888	1,672	18,584	$ 588.08
	5	1,672	100%		$15,292,440	1,672	18,538	$ 824.92
	6	1,672	100%		$21,133,115	1,672	18,595	$ 1,136.49
	7	1,672	100%		$29,424,370	1,672	18,436	$ 1,596.03
	8	1,672	100%		$43,519,277	1,672	18,614	$ 2,337.99
	9	1,672	100%		$71,395,280	1,672	18,595	$ 3,839.49
	10	1,672	100%		$172,238,427	1,672	18,387	$ 9,367.40
Grand Totals		17,590	100%		$376,968,434	17,590	191,570	$ 1,967.78

Expenditure Tables

Expenditures for the Population Enrolled Six Months or More

Movement of clients through the Deciles over time

FFY08 Decile	FFY09 Decile											Total
	None	1	2	3	4	5	6	7	8	9	10	
None												
1		573	263	132	88	60	52	36	31	34	17	1,286
2		315	412	260	126	99	74	50	41	30	13	1,420
3		161	276	320	253	163	96	79	74	43	18	1,483
4		112	187	255	284	210	159	113	90	50	30	1,490
5		69	129	149	248	296	221	165	109	70	33	1,489
6		48	73	121	175	254	279	242	152	112	33	1,489
7		37	58	102	132	168	255	295	232	147	76	1,502
8		32	43	57	88	134	193	248	318	272	120	1,505
9		26	27	54	53	73	115	170	270	417	273	1,478
10		17	10	19	28	40	31	75	134	291	846	1,491
Total		1,390	1,478	1,469	1,475	1,497	1,475	1,473	1,451	1,466	1,459	14,633

34%	Increase Decile
38%	Decrease Decile
28%	In Same Decile

FFY08 Decile	FFY10 Decile											Total
	None	1	2	3	4	5	6	7	8	9	10	
None												
1		469	262	142	96	73	72	68	50	37	37	1,306
2		252	349	241	147	111	76	72	65	38	28	1,379
3		163	250	269	207	164	108	75	78	62	33	1,409
4		112	193	207	238	205	144	109	102	81	46	1,437
5		88	116	182	228	211	199	146	122	96	52	1,440
6		64	84	116	167	205	232	213	159	118	58	1,416
7		43	58	110	136	158	203	230	207	163	90	1,398
8		49	48	67	110	136	173	199	262	229	123	1,396
9		50	43	40	70	94	117	144	234	322	241	1,355
10		31	18	31	37	46	49	85	105	235	703	1,340
Total		1,321	1,421	1,405	1,436	1,403	1,373	1,341	1,384	1,381	1,411	13,876

38%	Increase Decile
39%	Decrease Decile
24%	In Same Decile

FFY09 Decile	FFY10 Decile											Total
	None	1	2	3	4	5	6	7	8	9	10	
None												
1		579	275	144	73	67	54	36	35	30	26	1,319
2		305	434	301	163	86	66	53	48	34	10	1,500
3		153	310	327	269	169	107	74	51	32	21	1,513
4		85	180	277	304	250	168	113	88	50	24	1,539
5		50	102	195	290	284	237	176	112	71	28	1,545
6		47	62	121	187	239	312	219	169	135	50	1,541
7		41	64	89	117	197	244	310	246	169	75	1,552
8		38	34	45	89	145	198	279	343	251	121	1,543
9		31	27	29	42	82	114	185	329	454	247	1,540
10		17	11	15	18	29	38	75	109	296	931	1,539
Total		1,346	1,499	1,543	1,552	1,548	1,538	1,520	1,530	1,522	1,533	15,131

35%	Increase Decile
37%	Decrease Decile
28%	In Same Decile

FFY08 BH Decile	FFY09 BH Decile											Total
	None	1	2	3	4	5	6	7	8	9	10	
None	706	108	60	46	40	37	37	29	27	46	22	1,158
1	191	429	218	107	74	50	43	34	26	19	24	1,215
2	51	318	405	241	123	72	39	28	24	25	11	1,337
3	22	182	288	305	201	131	77	55	31	31	11	1,334
4	21	108	170	248	275	197	125	77	63	56	17	1,357
5	15	88	105	166	238	270	191	127	81	72	24	1,377
6	15	46	66	127	173	226	263	219	103	78	26	1,342
7	7	33	43	63	108	184	259	286	217	127	48	1,375
8	7	20	30	52	70	97	177	281	339	215	88	1,376
9	4	25	24	27	49	66	93	159	290	389	250	1,376
10	5	26	8	18	18	27	44	61	105	274	800	1,386
Total	1,044	1,383	1,417	1,400	1,369	1,357	1,348	1,356	1,306	1,332	1,321	14,633

31%	Increase Decile
38%	Decrease Decile
31%	In Same Decile

FFY08 BH Decile	FFY10 BH Decile											Total
	None	1	2	3	4	5	6	7	8	9	10	
None	613	104	47	52	47	59	61	48	39	52	39	1,161
1	186	337	209	136	78	59	46	51	43	29	29	1,203
2	78	270	326	208	128	74	64	28	32	43	22	1,273
3	49	165	238	256	183	140	77	51	47	49	18	1,273
4	44	105	169	206	212	174	114	99	77	55	36	1,291
5	22	82	114	157	195	217	155	136	96	63	41	1,278
6	20	71	87	122	173	198	202	169	106	79	43	1,270
7	13	54	71	93	115	151	226	236	157	122	75	1,313
8	7	54	36	53	77	104	168	224	253	188	106	1,270
9	11	40	33	35	73	71	106	151	239	304	206	1,269
10	11	27	18	20	35	46	60	76	132	225	625	1,275
Total	1,054	1,309	1,348	1,338	1,316	1,293	1,279	1,269	1,221	1,209	1,240	13,876

34%	Increase Decile
40%	Decrease Decile
26%	In Same Decile

FFY09 BH Decile	FFY10 BH Decile											Total
	None	1	2	3	4	5	6	7	8	9	10	
None	827	119	44	30	27	23	19	19	23	37	18	1,186
1	181	448	248	109	74	35	40	30	23	31	18	1,237
2	48	283	423	273	133	77	44	36	28	27	17	1,389
3	20	161	294	341	251	150	72	33	35	27	10	1,394
4	12	112	170	256	286	242	111	78	62	44	18	1,391
5	10	75	95	169	276	276	212	138	97	32	28	1,408
6	8	51	56	110	160	271	306	212	114	72	46	1,406
7	7	31	38	74	107	166	290	334	197	125	50	1,419
8	4	22	24	39	57	103	168	281	381	239	93	1,411
9	2	21	19	22	36	62	108	177	310	455	228	1,440
10	1	16	14	6	19	21	40	63	121	279	870	1,450
Total	1,120	1,339	1,425	1,429	1,426	1,426	1,410	1,401	1,391	1,368	1,396	15,131

31%	Increase Decile
37%	Decrease Decile
33%	In Same Decile

FFY08 Acute Decile	FFY09 Acute Decile											
	None	1	2	3	4	5	6	7	8	9	10	Total
None	849	252	176	141	79	69	47	39	39	29	25	1,745
1	209	340	202	154	98	76	60	34	32	27	25	1,257
2	130	189	263	179	155	126	71	43	51	37	25	1,269
3	114	137	187	205	201	138	99	65	51	52	26	1,275
4	78	118	138	180	161	170	141	121	84	57	43	1,291
5	67	81	107	142	159	187	182	141	108	91	42	1,307
6	42	53	72	101	144	169	208	205	150	109	71	1,324
7	43	32	64	73	107	143	197	234	183	143	84	1,303
8	40	35	26	65	99	102	119	210	240	223	144	1,303
9	21	21	29	45	60	90	113	167	241	284	239	1,310
10	26	22	21	26	40	44	71	75	144	251	529	1,249
Total	1,619	1,280	1,285	1,311	1,303	1,314	1,308	1,334	1,323	1,303	1,253	14,633

39%	Increase Decile
37%	Decrease Decile
24%	In Same Decile

FFY08 Acute Decile	FFY10 Acute Decile											
	None	1	2	3	4	5	6	7	8	9	10	Total
None	700	254	171	145	126	82	64	60	43	38	40	1,723
1	211	254	183	139	115	77	70	55	41	49	28	1,222
2	120	178	211	164	146	130	75	84	45	35	34	1,222
3	104	140	171	176	140	148	113	97	66	55	40	1,250
4	84	95	133	173	153	160	122	101	94	61	51	1,227
5	69	66	113	131	135	161	155	140	108	96	66	1,240
6	49	62	72	84	126	149	179	168	165	127	82	1,263
7	41	47	52	90	109	125	166	161	173	149	106	1,219
8	33	41	48	58	66	94	132	164	207	197	169	1,209
9	36	36	34	44	65	78	95	149	191	240	243	1,211
10	36	23	34	33	33	44	62	86	130	193	416	1,090
Total	1,483	1,196	1,222	1,237	1,214	1,248	1,233	1,265	1,263	1,240	1,275	13,876

42%	Increase Decile
37%	Decrease Decile
21%	In Same Decile

FFY09 Acute Decile	FFY10 Acute Decile											
	None	1	2	3	4	5	6	7	8	9	10	Total
None	791	241	164	134	89	66	55	43	34	24	30	1,671
1	233	337	218	154	108	86	64	41	27	31	22	1,321
2	152	229	251	197	141	111	81	68	40	39	20	1,329
3	78	182	214	202	184	170	108	86	69	48	23	1,364
4	59	114	150	176	208	173	162	129	85	60	37	1,353
5	57	79	102	145	194	208	195	152	98	93	46	1,369
6	39	41	80	103	143	172	211	199	176	105	80	1,349
7	31	34	54	87	107	150	197	215	228	162	93	1,358
8	36	29	39	67	74	103	150	193	255	264	174	1,384
9	35	24	44	45	55	83	95	176	221	299	271	1,348
10	33	18	18	38	35	49	45	89	145	246	569	1,285
Total	1,544	1,328	1,334	1,348	1,338	1,371	1,363	1,391	1,378	1,371	1,365	15,131

40%	Increase Decile
37%	Decrease Decile
23%	In Same Decile

FFY 10 Utilization Tables

FFY 10 Utilization Tables

Utilization by client by Deciles by Behavioral Health category

All Clients

	Primary/Preventative Units	ED Claims	IP Admissions	IP Expenditures	Pharmacy Claims	Case Mngt Units	Crisis Services Units	Peer Svcs Units	Member Months	Clients
Total	128,461	28,530	8,864	$52,775,314	502,105	2,488,683	32,910	583,786	191,570	17,590
FFY10 Overall Decile										
None	.	.	.	.	.	.	.	.	8,139	871
1	2,816	337	11	$3,786	6,644	27,572	76	572	17,467	1,671
2	5,880	526	33	$30,394	15,176	86,792	217	1,736	18,109	1,672
3	8,297	896	55	$95,605	25,776	118,126	417	4,831	18,106	1,672
4	10,957	1,326	142	$297,268	36,910	146,535	606	11,949	18,584	1,672
5	12,882	1,627	251	$766,246	46,621	180,166	1,243	18,812	18,538	1,672
6	15,479	2,313	495	$1,777,198	59,019	208,555	1,674	40,723	18,595	1,672
7	17,600	3,071	833	$3,454,803	67,348	268,454	2,881	66,426	18,436	1,672
8	19,199	4,359	1,278	$6,612,005	77,576	353,138	4,429	105,852	18,614	1,672
9	18,267	5,366	2,146	$12,563,778	77,092	485,680	7,685	164,824	18,595	1,672
10	17,084	8,709	3,620	$27,174,231	89,943	613,665	13,682	168,061	18,387	1,672
FFY10 Acute Decile										
None	1,126	396	180	$1,241,459	21,161	183,672	1,231	33,079	26,422	2,719
1	2,048	57	151	$689,134	16,769	196,191	755	54,092	16,502	1,487
2	4,129	287	192	$1,248,786	23,098	199,751	988	48,446	16,548	1,487
3	6,479	563	216	$1,141,143	26,371	197,402	1,374	55,352	16,538	1,487
4	8,008	957	292	$1,367,927	31,706	213,455	1,813	63,401	16,553	1,487
5	10,513	1,303	326	$1,742,330	41,457	226,055	2,244	55,114	16,628	1,487
6	13,009	1,889	467	$2,069,734	49,390	234,552	2,897	58,679	16,441	1,487
7	15,359	2,679	675	$2,813,117	55,613	230,016	3,241	56,998	16,726	1,487
8	18,790	3,598	1,028	$4,400,097	65,840	237,377	3,534	49,900	16,770	1,487
9	22,834	5,486	1,604	$7,882,031	82,198	277,571	5,305	65,031	16,608	1,487
10	26,166	11,315	3,733	$28,179,555	88,502	292,641	9,528	43,694	15,834	1,488
FFY10 BH Decile										
None	9,305	1,892	399	$2,662,129	24,097	65	1	.	22,672	2,226
1	7,873	1,422	282	$2,118,654	15,295	32,701	247	592	16,239	1,536
2	10,433	1,434	285	$2,075,698	22,849	79,776	344	1,665	17,076	1,536
3	11,703	1,708	346	$2,479,541	33,176	109,675	376	2,254	16,987	1,537
4	11,575	1,911	398	$2,426,654	40,507	135,791	734	6,066	16,897	1,536
5	12,901	2,506	498	$3,346,450	46,052	168,407	1,000	9,523	16,827	1,537
6	12,832	2,409	491	$2,949,319	58,645	194,583	1,692	24,994	16,870	1,536
7	13,257	2,836	717	$3,708,681	61,919	248,338	2,359	43,025	16,866	1,536
8	13,347	3,227	995	$5,137,001	63,586	338,121	4,274	100,596	16,962	1,537
9	12,228	4,221	1,792	$9,725,368	62,569	483,464	8,163	166,589	17,030	1,536
10	13,007	4,964	2,661	$16,145,819	73,410	697,762	13,720	228,482	17,144	1,537

Not classified

	Primary/Preventative Units	ED Claims	IP Admissions	IP Expenditures	Pharmacy Claims	Case Mngt Units	Crisis Services Units	Peer Svcs Units	Member Months	Clients
Total	3,790	569	100	$634,703	10,127	440	94	36	9,694	899
FFY10 Overall Decile										
None	.	.	.	.	.	.	.	.	2,223	216
1	870	129	2	$1,085	1,748	101	12	.	3,832	351
2	656	87	2	$1,390	1,743	102	24	.	1,072	97
3	528	81	6	$13,484	1,370	133	9	.	794	75
4	401	56	11	$38,052	1,451	54	34	.	510	45
5	446	43	14	$56,051	943	14	1	36	419	37
6	284	71	15	$69,046	553	19	14	.	285	26
7	278	30	15	$116,989	962	15	.	.	240	23
8	113	17	13	$107,174	445	.	.	.	104	11
9	193	46	15	$128,764	821	2	.	.	144	12
10	21	9	7	$102,667	91	.	.	.	71	6
FFY10 Acute Decile										
None	16	2	1	$7,595	71	36	5	.	2,438	237
1	73	3	0	.	142	68	.	.	934	82
2	174	23	1	$0	299	108	1	.	972	89
3	239	46	0	.	450	69	19	.	960	86
4	349	67	2	$1,394	719	31	15	.	849	81
5	422	57	1	$1,081	1,214	49	7	.	766	67
6	543	75	1	$1,378	1,223	37	5	36	730	70
7	399	58	11	$30,386	1,494	13	28	.	631	59
8	661	66	17	$65,382	1,737	19	12	.	632	55
9	462	95	26	$156,910	989	8	2	.	437	40
10	452	77	40	$370,578	1,789	2	.	.	345	33
FFY10 BH Decile										
None	3,515	490	93	$615,118	9,401	2	.	.	8,915	827
1	170	51	4	$14,802	339	136	24	.	480	45
2	24	10	2	$3,240	113	63	51	.	109	10
3	31	5	0	.	45	13	.	.	48	4
4	22	8	1	$1,543	105	153	12	.	78	7
5	15	3	0	.	56	66	7	36	52	5
6										
7	13	2	0	.	68	7	.	.	12	1
8										
9										
10										

Psychotic Disorders, Group 1

	Primary/Preventative Units	ED Claims	IP Admissions	IP Expenditures	Pharmacy Claims	Case Mngt Units	Crisis Services Units	Peer Svcs Units	Member Months	Clients
Total	48,454	12,169	4,255	$25,605,852	221,306	1459202	19,065	377,016	86,499	7,850
FFY10 Overall Decile										
None	.	.	.	.	.	.	.	.	2,755	303
1	552	55	3	$1,354	1,603	12,869	29	316	5,325	515
2	1,963	156	14	$12,040	4,965	40,348	82	856	7,408	676
3	2,449	286	14	$30,353	8,767	55,569	209	2,703	7,294	666
4	3,568	487	51	$92,083	13,324	69,765	288	6,398	7,782	685
5	4,112	545	94	$268,570	18,173	85,561	479	9,831	7,765	694
6	5,084	730	173	$630,134	23,231	107,059	826	23,682	8,147	728
7	5,822	1,041	332	$1,342,101	25,957	135,811	1,466	35,165	7,925	716
8	6,841	1,742	562	$2,889,880	31,338	204,073	2,407	60,550	9,054	806
9	8,462	2,376	1,053	$6,078,541	37,461	312,412	4,705	109,446	10,633	953
10	9,601	4,751	1,959	$14,260,797	56,487	435,735	8,574	128,069	12,411	1,108
FFY10 Acute Decile										
None	795	315	145	$907,447	14,901	132,706	837	24,395	13,974	1,401
1	1,271	34	111	$563,529	10,930	141,974	507	43,570	9,513	843
2	2,356	161	140	$984,306	14,174	137,526	708	35,256	8,986	796
3	3,305	268	148	$815,012	14,747	126,990	974	38,030	8,097	714
4	3,713	459	193	$987,868	16,292	131,747	1,234	45,035	7,720	681
5	4,628	591	197	$1,187,935	21,167	142,664	1,497	36,232	7,542	662
6	5,131	796	247	$1,290,605	22,422	130,805	1,590	36,215	6,740	603
7	5,216	1,162	361	$1,622,518	22,054	119,895	1,915	32,674	6,175	542
8	6,236	1,483	501	$2,280,439	24,051	121,238	2,053	29,432	6,192	545
9	7,209	1,998	692	$3,381,129	29,533	136,184	2,724	34,849	5,795	519
10	8,594	4,902	1,520	$11,585,064	31,035	137,473	5,026	21,328	5,765	544
FFY10 BH Decile										
None	993	325	104	$770,063	2,753	.	1	.	4,332	457
1	1,916	394	85	$852,922	4,930	12,377	102	245	5,823	550
2	2,833	409	70	$478,235	5,715	30,669	69	772	6,450	580
3	3,110	476	98	$693,884	9,148	40,155	183	812	6,296	562
4	3,664	642	127	$882,537	13,557	58,217	283	2,934	7,194	655
5	3,830	983	172	$1,266,985	14,690	71,760	424	4,760	7,021	631
6	4,774	993	185	$927,610	23,532	90,484	743	12,235	7,921	708
7	5,220	1,120	320	$1,577,278	26,499	126,386	1,064	20,960	8,452	759
8	6,531	1,589	451	$2,534,621	34,788	198,263	2,134	52,868	9,470	852
9	6,323	2,173	932	$5,125,229	32,515	306,670	4,953	103,292	10,455	936
10	9,260	3,065	1,711	$10,496,487	53,179	524,221	9,109	178,138	13,085	1,160

Bipolar Disorders, Group 2

	Primary/Preventative Units	ED Claims	IP Admissions	IP Expenditures	Pharmacy Claims	Case Mngt Units	Crisis Services Units	Peer Svcs Units	Member Months	Clients
Total	36,897	8,206	2,293	$13,461,681	134,971	571,101	8,144	120,123	47,332	4,413
FFY10 Overall Decile										
None	.	.	.	.	.	.	.	.	1,363	158
1	478	57	1	$0	1,024	6,692	11	162	3,357	340
2	1,387	123	11	$12,174	3,410	22,766	51	442	4,495	420
3	2,531	226	15	$20,017	7,179	34,075	100	952	4,955	463
4	3,231	375	36	$65,845	9,776	38,601	137	2,877	4,950	459
5	3,880	445	64	$190,159	13,815	49,774	443	3,652	5,097	467
6	4,935	832	159	$521,185	18,205	57,907	548	9,771	5,336	480
7	5,474	1,059	264	$1,075,968	19,333	74,661	805	21,367	5,371	489
8	6,380	1,432	342	$1,731,267	24,194	85,301	1,097	28,272	4,952	449
9	4,853	1,556	577	$3,407,069	20,780	102,382	1,945	28,354	4,224	384
10	3,748	2,101	824	$6,437,997	17,255	98,942	3,007	24,274	3,232	304
FFY10 Acute Decile										
None	161	46	19	$121,934	3,438	29,600	185	6,214	4,887	539
1	366	11	28	$95,025	3,249	31,956	195	6,762	3,081	286
2	825	51	39	$171,890	4,394	33,664	188	7,006	3,235	297
3	1,605	131	43	$203,476	6,486	41,486	231	11,930	3,991	364
4	2,020	237	53	$230,830	7,491	45,720	305	8,971	4,118	378
5	2,532	335	78	$351,867	9,197	44,159	397	9,255	4,088	378
6	3,436	529	111	$393,595	11,913	57,522	857	12,815	4,429	404
7	4,914	820	175	$697,686	16,645	63,252	831	15,325	4,934	440
8	5,674	1,052	268	$1,122,655	20,841	62,870	762	10,775	4,787	428
9	7,220	1,913	481	$2,411,432	25,619	82,813	1,738	19,952	5,108	459
10	8,144	3,081	998	$7,661,293	25,698	78,059	2,455	11,118	4,674	440
FFY10 BH Decile										
None	1,105	360	57	$334,876	2,693	.	.	.	2,965	321
1	2,610	415	82	$544,639	3,867	9,055	53	187	4,377	422
2	3,262	436	81	$674,638	6,167	22,933	54	398	4,764	429
3	3,945	560	108	$738,901	10,687	34,177	41	598	5,111	469
4	3,716	659	158	$950,491	12,607	40,444	285	1,238	4,900	449
5	4,617	730	130	$853,619	15,546	47,647	265	2,419	4,870	453
6	4,279	870	185	$1,184,402	18,798	56,926	630	6,221	4,952	460
7	4,259	894	214	$1,021,298	19,159	68,126	763	13,733	4,748	435
8	3,706	891	278	$1,325,016	16,318	82,749	1,163	30,129	4,357	397
9	3,414	1,202	484	$2,675,314	18,333	108,773	1,969	37,009	3,930	360
10	1,984	1,189	516	$3,158,487	10,796	100,271	2,921	28,191	2,358	218

Mood Disorders, Group 3

	Primary/Preventative Units	ED Claims	IP Admissions	IP Expenditures	Pharmacy Claims	Case Mngt Units	Crisis Services Units	Peer Svcs Units	Member Months	Clients
Total	35,207	6,602	2,019	$11,928,154	120,035	407,836	5,086	81,109	41,520	3,823
FFY10 Overall Decile										
None	.	.	.	.	.	.	.	.	1,629	175
1	703	63	5	$1,346	1,846	6,436	24	89	3,908	371
2	1,571	113	6	$4,790	3,783	19,589	29	370	4,174	388
3	2,353	246	18	$30,166	6,926	23,877	83	931	4,237	392
4	3,231	345	41	$93,748	10,268	32,427	112	2,260	4,584	416
5	3,925	516	70	$214,566	11,697	39,110	262	4,644	4,561	411
6	4,645	583	129	$488,633	14,938	38,755	246	6,987	4,255	385
7	5,563	835	202	$831,450	19,266	52,050	575	9,309	4,420	397
8	5,346	970	314	$1,678,142	19,638	56,847	857	16,604	4,014	361
9	4,457	1,262	459	$2,669,192	16,950	65,464	946	25,374	3,311	298
10	3,413	1,669	775	$5,916,120	14,723	73,281	1,952	14,541	2,427	229
FFY10 Acute Decile										
None	124	32	14	$202,939	2,472	18,141	202	2,399	4,414	471
1	260	6	12	$30,580	1,909	17,284	53	3,272	2,327	217
2	677	39	11	$92,390	3,769	25,552	78	5,551	2,852	260
3	1,151	98	25	$122,656	4,205	25,530	142	5,272	3,007	279
4	1,621	153	43	$138,956	5,896	30,474	218	8,738	3,124	281
5	2,431	262	44	$184,543	7,984	33,990	306	9,170	3,513	314
6	3,557	436	105	$373,688	12,181	42,855	422	9,438	4,090	366
7	4,181	549	115	$425,232	13,236	41,256	399	8,803	4,323	386
8	5,653	858	218	$835,042	16,971	48,359	675	9,111	4,565	406
9	7,341	1,307	360	$1,716,358	24,307	53,685	759	9,809	4,755	422
10	8,211	2,862	1,072	$7,805,770	27,105	70,710	1,832	9,546	4,550	421
FFY10 BH Decile										
None	2,828	504	111	$763,710	6,943	63	.	.	5,086	490
1	2,939	501	108	$696,239	5,649	9,566	65	149	4,826	452
2	3,935	460	122	$864,475	9,792	22,731	97	492	4,950	442
3	4,139	578	126	$913,427	11,345	30,328	122	657	4,712	429
4	3,688	552	102	$516,575	11,822	32,135	132	1,761	4,115	368
5	4,003	713	176	$1,123,341	13,951	42,836	276	2,220	4,256	391
6	3,461	519	116	$734,015	14,592	40,992	291	5,479	3,498	322
7	3,468	733	169	$1,044,243	14,977	47,784	484	7,713	3,267	304
8	2,769	621	241	$1,188,591	11,129	51,123	849	15,985	2,813	257
9	2,326	752	329	$1,654,691	11,058	61,056	1,155	25,150	2,411	219
10	1,651	669	419	$2,428,847	8,777	69,222	1,615	21,503	1,586	149

Anxiety Disorders, Group 4

	Primary/Preventative Units	ED Claims	IP Admissions	IP Expenditures	Pharmacy Claims	Case Mngt Units	Crisis Services Units	Peer Svcs Units	Member Months	Clients
Total	3,772	886	178	$969,457	14,063	43,209	445	4,855	5,587	520
FFY10 Overall Decile										
None	.	.	.	.	.	.	.	.	119	13
1	191	24	0	.	395	1,280	.	.	890	81
2	278	43	0	.	1,156	3,193	20	62	821	78
3	421	54	1	$200	1,451	3,640	13	215	725	67
4	459	49	3	$7,540	1,793	4,756	35	73	623	55
5	456	63	7	$25,535	1,731	5,013	48	649	601	55
6	474	95	18	$66,657	1,795	3,905	35	199	481	45
7	450	106	20	$88,296	1,722	5,787	35	482	464	45
8	478	183	44	$186,479	1,793	5,796	68	397	423	39
9	284	104	32	$225,495	903	4,590	54	1,637	237	21
10	281	165	53	$369,255	1,324	5,249	137	1,141	203	21
FFY10 Acute Decile										
None	17	1	0	.	186	2,228	1	35	492	50
1	53	3	0	.	328	3,389	.	447	466	43
2	84	13	1	$200	414	2,564	13	621	461	41
3	164	18	0	.	433	2,976	5	117	432	39
4	256	25	1	$8,880	1,021	4,620	30	265	610	54
5	464	55	6	$16,904	1,828	4,852	37	450	671	62
6	331	48	3	$10,469	1,488	3,193	23	72	430	42
7	527	66	11	$33,322	1,841	4,831	42	164	531	49
8	559	138	23	$90,160	2,138	4,557	32	574	558	50
9	599	159	43	$199,788	1,680	4,728	82	421	489	45
10	718	360	90	$609,733	2,706	5,271	180	1,689	447	45
FFY10 BH Decile										
None	857	197	33	$173,417	2,286	.	.	.	1,265	120
1	207	52	1	$2,247	473	1,297	.	8	589	55
2	368	117	10	$55,110	1,002	2,920	62	1	688	64
3	423	81	14	$133,329	1,785	4,382	30	187	724	65
4	450	43	10	$75,508	2,229	4,099	15	122	526	50
5	381	61	17	$83,442	1,404	4,871	28	58	491	45
6	269	23	4	$18,485	1,578	5,143	21	723	418	38
7	257	86	14	$65,862	1,010	5,625	48	535	339	33
8	315	120	18	$46,066	1,092	4,993	121	1,498	265	25
9	141	77	43	$256,580	609	6,105	57	1,109	191	17
10	104	29	14	$59,410	595	3,774	63	614	91	8

Personality Disorders, Group 5

	Primary/Preventative Units	ED Claims	IP Admissions	IP Expenditures	Pharmacy Claims	Case Mngt Units	Crisis Services Units	Peer Svcs Units	Member Months	Clients
Total	341	98	19	$175,466	1,603	6,895	76	647	938	85
FFY10 Overall Decile										
None	.	.	.	.	.	.	.	.	50	6
1	22	9	0	.	28	194	.	5	155	13
2	25	4	0	.	119	794	11	6	139	13
3	15	3	1	$1,385	83	832	3	30	101	9
4	67	14	0	.	298	932	.	341	135	12
5	63	15	2	$11,364	262	694	10	.	95	8
6	57	2	1	$1,543	297	910	5	84	91	8
7	13	.	0	.	108	130	.	103	16	2
8	41	15	3	$19,063	168	1,121	.	29	67	6
9	18	22	10	$54,717	177	830	35	13	46	4
10	20	14	2	$87,394	63	458	12	36	43	4
FFY10 Acute Decile										
None	13	.	1	$1,543	93	961	1	36	217	21
1	25	.	0	.	211	1,520	.	41	181	16
2	13	.	0	.	48	337	.	12	42	4
3	15	2	0	.	50	351	3	3	51	5
4	49	16	0	.	287	863	11	392	132	12
5	36	3	0	.	67	341	.	7	48	4
6	11	5	0	.	163	140	.	103	22	2
7	122	24	2	$3,973	343	769	26	32	132	11
8	7	1	1	$6,419	102	334	.	8	36	3
9	3	14	2	$16,414	70	153	.	.	24	2
10	47	33	13	$147,117	169	1,126	35	13	53	5
FFY10 BH Decile										
None	7	16	1	$4,945	21	.	.	.	109	11
1	31	9	2	$7,804	37	270	3	3	144	12
2	11	2	0	.	60	460	11	2	115	11
3	55	8	0	.	166	620	.	.	96	8
4	35	7	0	.	187	743	7	11	84	7
5	55	16	3	$19,063	405	1,227	.	30	137	12
6	49	4	1	$84,807	145	1,038	7	336	81	8
7	40	1	0	.	206	410	.	84	48	4
8	26	6	7	$42,706	259	993	7	116	57	6
9	24	17	4	$13,554	54	860	29	29	43	4
10	8	12	1	$2,588	63	274	12	36	24	2

FFY 10 Utilization Tables

Utilization by 1,000 clients by Deciles by Behavioral Health category

All Clients

	Primary/Preventative Units	ED Claims	IP Admissions	IP Expenditures	Pharmacy Claims	Case Mngt Units	Crisis Services Units	Peer Svcs Units
Total	7,303	1,622	504	3,000,302	28,545	141,483	1,871	33,189
FFY10 Overall Decile								
None								
1	1,685	202	7	2,266	3,976	16,500	45	342
2	3,517	315	20	18,178	9,077	51,909	130	1,038
3	4,962	536	33	57,180	15,416	70,650	249	2,889
4	6,553	793	85	177,792	22,075	87,641	362	7,147
5	7,705	973	150	458,281	27,883	107,755	743	11,251
6	9,258	1,383	296	1,062,917	35,298	124,734	1,001	24,356
7	10,526	1,837	498	2,066,270	40,280	160,559	1,723	39,728
8	11,483	2,607	764	3,954,548	46,397	211,207	2,649	63,309
9	10,925	3,209	1,283	7,514,221	46,108	290,478	4,596	98,579
10	10,218	5,209	2,165	16,252,531	53,794	367,025	8,183	100,515
FFY10 Acute Decile								
None	414	146	66	456,587	7,783	67,551	453	12,166
1	1,377	38	102	463,439	11,277	131,937	508	36,377
2	2,777	193	129	839,802	15,533	134,332	664	32,580
3	4,357	379	145	767,413	17,734	132,752	924	37,224
4	5,385	644	196	919,924	21,322	143,547	1,219	42,637
5	7,070	876	219	1,171,708	27,880	152,021	1,509	37,064
6	8,748	1,270	314	1,391,886	33,215	157,735	1,948	39,461
7	10,329	1,802	454	1,891,807	37,399	154,685	2,180	38,331
8	12,636	2,420	691	2,959,043	44,277	159,635	2,377	33,557
9	15,356	3,689	1,079	5,300,626	55,278	186,665	3,568	43,733
10	17,585	7,604	2,509	18,937,873	59,477	196,667	6,403	29,364
FFY10 BH Decile								
None	4,180	850	179	1,195,925	10,825	29	0	
1	5,126	926	184	1,379,332	9,958	21,290	161	385
2	6,792	934	186	1,351,366	14,876	51,938	224	1,084
3	7,614	1,111	225	1,613,234	21,585	71,357	245	1,466
4	7,536	1,244	259	1,579,853	26,372	88,406	478	3,949
5	8,394	1,630	324	2,177,261	29,962	109,569	651	6,196
6	8,354	1,568	320	1,920,130	38,180	126,682	1,102	16,272
7	8,631	1,846	467	2,414,506	40,312	161,678	1,536	28,011
8	8,684	2,100	647	3,342,226	41,370	219,988	2,781	65,450
9	7,961	2,748	1,167	6,331,620	40,735	314,755	5,314	108,456
10	8,463	3,230	1,731	10,504,762	47,762	453,977	8,926	148,655

Not classified

	Primary/Preventative Units	ED Claims	IP Admissions	IP Expenditures	Pharmacy Claims	Case Mngt Units	Crisis Services Units	Peer Svcs Units
Total	4,216	633	111	706,010	11,265	489	105	40
FFY10 Overall Decile								
None								
1	2,479	368	6	3,091	4,980	288	34	
2	6,763	897	21	14,330	17,969	1,052	247	
3	7,040	1,080	80	179,787	18,267	1,773	120	
4	8,911	1,244	244	845,600	32,244	1,200	756	
5	12,054	1,162	378	1,514,892	25,486	378	27	973
6	10,923	2,731	577	2,655,615	21,269	731	538	
7	12,087	1,304	652	5,086,478	41,826	652		
8	10,273	1,545	1,182	9,743,091	40,455			
9	16,083	3,833	1,250	10,730,333	68,417	167		
10	3,500	1,500	1,167	17,111,167	15,167			
FFY10 Acute Decile								
None	68	8	4	32,046	300	152	21	
1	890	37	0		1,732	829		
2	1,955	258	11	0	3,360	1,213	11	
3	2,779	535	0		5,233	802	221	
4	4,309	827	25	17,210	8,877	383	185	
5	6,299	851	15	16,134	18,119	731	104	
6	7,757	1,071	14	19,686	17,471	529	71	514
7	6,763	983	186	515,017	25,322	220	475	
8	12,018	1,200	309	1,188,764	31,582	345	218	
9	11,550	2,375	650	3,922,750	24,725	200	50	
10	13,697	2,333	1,212	11,229,636	54,212	61		
FFY10 BH Decile								
None	4,250	593	112	743,794	11,368	2		
1	3,778	1,133	89	328,933	7,533	3,022	533	
2	2,400	1,000	200	324,000	11,300	6,300	5,100	
3	7,750	1,250	0		11,250	3,250		
4	3,143	1,143	143	220,429	15,000	21,857	1,714	
5	3,000	600	0		11,200	13,200	1,400	7,200
6								
7	13,000	2,000	0		68,000	7,000		
8								
9								
10								

Psychotic Disorders, Group 1

	Primary/Preventative Units	ED Claims	IP Admissions	IP Expenditures	Pharmacy Claims	Case Mngt Units	Crisis Services Units	Peer Svcs Units
Total	6,172	1,550	542	3,261,892	28,192	185,886	2,429	48,028
FFY10 Overall Decile								
None								
1	1,072	107	6	2,629	3,113	24,988	56	614
2	2,904	231	21	17,811	7,345	59,686	121	1,266
3	3,677	429	21	45,575	13,164	83,437	314	4,059
4	5,209	711	74	134,428	19,451	101,847	420	9,340
5	5,925	785	135	386,988	26,186	123,287	690	14,166
6	6,984	1,003	238	865,569	31,911	147,059	1,135	32,530
7	8,131	1,454	464	1,874,443	36,253	189,680	2,047	49,113
8	8,488	2,161	697	3,585,459	38,881	253,192	2,986	75,124
9	8,879	2,493	1,105	6,378,322	39,308	327,820	4,937	114,844
10	8,665	4,288	1,768	12,870,755	50,981	393,263	7,738	115,586
FFY10 Acute Decile								
None	567	225	103	647,714	10,636	94,722	597	17,413
1	1,508	40	132	668,480	12,966	168,415	601	51,684
2	2,960	202	176	1,236,565	17,807	172,771	889	44,291
3	4,629	375	207	1,141,473	20,654	177,857	1,364	53,263
4	5,452	674	283	1,450,614	23,924	193,461	1,812	66,131
5	6,991	893	298	1,794,464	31,974	215,505	2,261	54,731
6	8,509	1,320	410	2,140,307	37,184	216,924	2,637	60,058
7	9,624	2,144	666	2,993,576	40,690	221,208	3,533	60,284
8	11,442	2,721	919	4,184,292	44,130	222,455	3,767	54,004
9	13,890	3,850	1,333	6,514,699	56,904	262,397	5,249	67,146
10	15,798	9,011	2,794	21,296,074	57,050	252,708	9,239	39,206
FFY10 BH Decile								
None	2,173	711	228	1,685,039	6,024		2	
1	3,484	716	155	1,550,767	8,964	22,504	185	445
2	4,884	705	121	824,543	9,853	52,878	119	1,331
3	5,534	847	174	1,234,669	16,278	71,450	326	1,445
4	5,594	980	194	1,347,385	20,698	88,881	432	4,479
5	6,070	1,558	273	2,007,900	23,281	113,724	672	7,544
6	6,743	1,403	261	1,310,184	33,237	127,802	1,049	17,281
7	6,877	1,476	422	2,078,100	34,913	166,516	1,402	27,615
8	7,665	1,865	529	2,974,907	40,831	232,703	2,505	62,052
9	6,755	2,322	996	5,475,672	34,738	327,639	5,292	110,355
10	7,983	2,642	1,475	9,048,696	45,844	451,915	7,853	153,567

Bipolar Disorders, Group 2

	Primary/Preventative Units	ED Claims	IP Admissions	IP Expenditures	Pharmacy Claims	Case Mngt Units	Crisis Services Units	Peer Svcs Units
Total	8,361	1,860	520	3,050,460	30,585	129,413	1,845	27,220
FFY10 Overall Decile								
None								
1	1,406	168	3	0	3,012	19,682	32	476
2	3,302	293	26	28,986	8,119	54,205	121	1,052
3	5,467	488	32	43,233	15,505	73,596	216	2,056
4	7,039	817	78	143,453	21,298	84,098	298	6,268
5	8,308	953	137	407,193	29,582	106,582	949	7,820
6	10,281	1,733	331	1,085,802	37,927	120,640	1,142	20,356
7	11,194	2,166	540	2,200,344	39,536	152,681	1,646	43,695
8	14,209	3,189	762	3,855,829	53,884	189,980	2,443	62,967
9	12,638	4,052	1,503	8,872,576	54,115	266,620	5,065	73,839
10	12,329	6,911	2,711	21,177,622	56,760	325,467	9,891	79,849
FFY10 Acute Decile								
None	299	85	35	226,223	6,378	54,917	343	11,529
1	1,280	38	98	332,255	11,360	111,734	682	23,643
2	2,778	172	131	578,754	14,795	113,347	633	23,589
3	4,409	360	118	559,000	17,819	113,973	635	32,775
4	5,344	627	140	610,661	19,817	120,952	807	23,733
5	6,698	886	206	930,865	24,331	116,823	1,050	24,484
6	8,505	1,309	275	974,245	29,488	142,381	2,121	31,720
7	11,168	1,864	398	1,585,650	37,830	143,755	1,889	34,830
8	13,257	2,458	626	2,623,026	48,694	146,893	1,780	25,175
9	15,730	4,168	1,048	5,253,664	55,815	180,420	3,786	43,468
10	18,509	7,002	2,268	17,412,030	58,405	177,407	5,580	25,268
FFY10 BH Decile								
None	3,442	1,121	178	1,043,227	8,389			
1	6,185	983	194	1,290,614	9,164	21,457	126	443
2	7,604	1,016	189	1,572,583	14,375	53,457	126	928
3	8,412	1,194	230	1,575,482	22,787	72,872	87	1,275
4	8,276	1,468	352	2,116,906	28,078	90,076	635	2,757
5	10,192	1,611	287	1,884,369	34,318	105,181	585	5,340
6	9,302	1,891	402	2,574,787	40,865	123,752	1,370	13,524
7	9,791	2,055	492	2,347,811	44,044	156,611	1,754	31,570
8	9,335	2,244	700	3,337,572	41,103	208,436	2,929	75,892
9	9,483	3,339	1,344	7,431,428	50,925	302,147	5,469	102,803
10	9,101	5,454	2,367	14,488,472	49,523	459,959	13,399	129,317

Mood Disorders, Group 3

	Primary/Preventative Units	ED Claims	IP Admissions	IP Expenditures	Pharmacy Claims	Case Mngt Units	Crisis Services Units	Peer Svcs Units
Total	9,209	1,727	528	3,120,103	31,398	106,680	1,330	21,216
FFY10 Overall Decile								
None								
1	1,895	170	13	3,628	4,976	17,348	65	240
2	4,049	291	15	12,345	9,750	50,487	75	954
3	6,003	628	46	76,954	17,668	60,911	212	2,375
4	7,767	829	99	225,356	24,683	77,950	269	5,433
5	9,550	1,255	170	522,058	28,460	95,158	637	11,299
6	12,065	1,514	335	1,269,177	38,800	100,662	639	18,148
7	14,013	2,103	509	2,094,332	48,529	131,108	1,448	23,448
8	14,809	2,687	870	4,648,593	54,399	157,471	2,374	45,994
9	14,956	4,235	1,540	8,957,020	56,879	219,678	3,174	85,148
10	14,904	7,288	3,384	25,834,585	64,293	320,004	8,524	63,498
FFY10 Acute Decile								
None	263	68	30	430,868	5,248	38,516	429	5,093
1	1,198	28	55	140,922	8,797	79,650	244	15,078
2	2,604	150	42	355,346	14,496	98,277	300	21,350
3	4,125	351	90	439,627	15,072	91,505	509	18,896
4	5,769	544	153	494,505	20,982	108,448	776	31,096
5	7,742	834	140	587,717	25,427	108,248	975	29,204
6	9,719	1,191	287	1,021,005	33,281	117,090	1,153	25,787
7	10,832	1,422	298	1,101,637	34,290	106,881	1,034	22,806
8	13,924	2,113	537	2,056,754	41,800	119,111	1,663	22,441
9	17,396	3,097	853	4,067,199	57,600	127,216	1,799	23,244
10	19,504	6,798	2,546	18,541,021	64,382	167,957	4,352	22,675
FFY10 BH Decile								
None	5,771	1,029	227	1,558,592	14,169	129		
1	6,502	1,108	239	1,540,352	12,498	21,164	144	330
2	8,903	1,041	276	1,955,826	22,154	51,428	219	1,113
3	9,648	1,347	294	2,129,200	26,445	70,695	284	1,531
4	10,022	1,500	277	1,403,736	32,125	87,323	359	4,785
5	10,238	1,824	450	2,872,995	35,680	109,555	706	5,678
6	10,748	1,612	360	2,279,550	45,317	127,304	904	17,016
7	11,408	2,411	556	3,435,010	49,266	157,184	1,592	25,372
8	10,774	2,416	938	4,624,868	43,304	198,922	3,304	62,198
9	10,621	3,434	1,502	7,555,667	50,493	278,795	5,274	114,840
10	11,081	4,490	2,812	16,300,987	58,906	464,577	10,839	144,315

Anxiety Disorders, Group 4

	Primary/Preventative Units	ED Claims	IP Admissions	IP Expenditures	Pharmacy Claims	Case Mngt Units	Crisis Services Units	Peer Svcs Units
Total	7,254	1,704	342	1,864,340	27,044	83,094	856	9,337
FFY10 Overall Decile								
None								
1	2,358	296	0		4,877	15,802		
2	3,564	551	0		14,821	40,936	256	795
3	6,284	806	15	2,985	21,657	54,328	194	3,209
4	8,345	891	55	137,091	32,600	86,473	636	1,327
5	8,291	1,145	127	464,273	31,473	91,145	873	11,800
6	10,533	2,111	400	1,481,267	39,889	86,778	778	4,422
7	10,000	2,356	444	1,962,133	38,267	128,600	778	10,711
8	12,256	4,692	1,128	4,781,513	45,974	148,615	1,744	10,179
9	13,524	4,952	1,524	10,737,857	43,000	218,571	2,571	77,952
10	13,381	7,857	2,524	17,583,571	63,048	249,952	6,524	54,333
FFY10 Acute Decile								
None	340	20	0		3,720	44,560	20	700
1	1,233	70	0		7,628	78,814		10,395
2	2,049	317	24	4,878	10,098	62,537	317	15,146
3	4,205	462	0		11,103	76,308	128	3,000
4	4,741	463	19	164,444	18,907	85,556	556	4,907
5	7,484	887	97	272,645	29,484	78,258	597	7,258
6	7,881	1,143	71	249,262	35,429	76,024	548	1,714
7	10,755	1,347	224	680,041	37,571	98,592	857	3,347
8	11,180	2,760	460	1,803,200	42,760	91,140	640	11,480
9	13,311	3,533	956	4,439,733	37,333	105,067	1,822	9,356
10	15,956	8,000	2,000	13,549,622	60,133	117,133	4,000	37,533
FFY10 BH Decile								
None	7,142	1,642	275	1,445,142	19,050			
1	3,764	945	18	40,855	8,600	23,582		145
2	5,750	1,828	156	861,094	15,656	45,625	969	16
3	6,508	1,246	215	2,051,215	27,462	67,415	462	2,877
4	9,000	860	200	1,510,160	44,580	81,980	300	2,440
5	8,467	1,356	378	1,854,267	31,200	108,244	622	1,289
6	7,079	605	105	486,447	41,526	135,342	553	19,026
7	7,788	2,606	424	1,995,818	30,606	170,455	1,455	16,212
8	12,600	4,800	720	1,842,640	43,680	199,720	4,840	59,920
9	8,294	4,529	2,529	15,092,941	35,824	359,118	3,353	65,235
10	13,000	3,625	1,750	7,426,250	74,375	471,750	7,875	76,750

Personality Disorders, Group 5

	Primary/Preventative Units	ED Claims	IP Admissions	IP Expenditures	Pharmacy Claims	Case Mngt Units	Crisis Services Units	Peer Svcs Units
Total	4,012	1,153	224	2,064,306	18,859	81,118	894	7,612
FFY10 Overall Decile								
None								
1	1,692	692	0		2,154	14,923		385
2	1,923	308	0		9,154	61,077	846	462
3	1,667	333	111	153,889	9,222	92,444	333	3,333
4	5,583	1,167	0		24,833	77,667		28,417
5	7,875	1,875	250	1,420,500	32,750	86,750	1,250	
6	7,125	250	125	192,875	37,125	113,750	625	10,500
7	6,500		0		54,000	65,000		51,500
8	6,833	2,500	500	3,177,167	28,000	186,833		4,833
9	4,500	5,500	2,500	13,679,250	44,250	207,500	8,750	3,250
10	5,000	3,500	500	21,848,500	15,750	114,500	3,000	9,000
FFY10 Acute Decile								
None	619		48	73,476	4,429	45,762	48	1,714
1	1,563		0		13,188	95,000		2,563
2	3,250		0		12,000	84,250		3,000
3	3,000	400	0		10,000	70,200	600	600
4	4,083	1,333	0		23,917	71,917	917	32,667
5	9,000	750	0		16,750	85,250		1,750
6	5,500	2,500	0		81,500	70,000		51,500
7	11,091	2,182	182	361,182	31,182	69,909	2,364	2,909
8	2,333	333	333	2,139,667	34,000	111,333		2,667
9	1,500	7,000	1,000	8,207,000	35,000	76,500		
10	9,400	6,600	2,600	29,423,400	33,800	225,200	7,000	2,600
FFY10 BH Decile								
None	636	1,455	91	449,545	1,909			
1	2,583	750	167	650,333	3,083	22,500	250	250
2	1,000	182	0		5,455	41,818	1,000	182
3	6,875	1,000	0		20,750	77,500		
4	5,000	1,000	0		26,714	106,143	1,000	1,571
5	4,583	1,333	250	1,588,583	33,750	102,250		2,500
6	6,125	500	125	10,600,875	18,125	129,750	875	42,000
7	10,000	250	0		51,500	102,500		21,000
8	4,333	1,000	1,167	7,117,667	43,167	165,500	1,167	19,333
9	6,000	4,250	1,000	3,388,500	13,500	215,000	7,250	7,250
10	4,000	6,000	500	1,294,000	31,500	137,000	6,000	18,000

Deceased Client Tables

Presentation Master

Clients Who Died in FFY08

				Percentage of Deceased Clients			Percentage of All Clients		
	Clients in BH Decile	Clients in Acute Decile	Clients in Overall Decile	Percent in BH Decile	Percent in Acute Decile	Percent in Overall Decile	Percent of BH Decile	Percent of Acute Decile	Percent of Overall Decile
None	2	8	0	2%	7%	0%	0.2%	0.4%	0.0%
1	5	2	3	4%	2%	3%	0.3%	0.1%	0.2%
2	7	5	4	6%	5%	3%	0.5%	0.4%	0.2%
3	20	4	7	18%	4%	6%	1.3%	0.3%	0.4%
4	10	7	1	9%	7%	1%	0.7%	0.5%	0.1%
5	5	2	3	4%	2%	3%	0.3%	0.1%	0.2%
6	11	5	8	10%	5%	7%	0.7%	0.4%	0.5%
7	13	5	10	12%	5%	9%	0.9%	0.4%	0.6%
8	11	11	21	10%	10%	18%	0.7%	0.8%	1.3%
9	14	18	16	12%	17%	14%	0.9%	1.3%	1.0%
10	17	48	42	15%	45%	37%	1.1%	3.4%	2.6%
Totals	113	107	115	100%	100%	100%	0.8%	0.8%	0.7%

Presentation Master

Clients Who Died in FFY09, by Their FFY09 and FFY08 Deciles

FFY08 BH Decile	FFY09 BH Decile											Total
	None	1	2	3	4	5	6	7	8	9	10	
None	1	0	0	0	0	0	1	0	0	1	1	4
1	2	0	2	0	1	0	0	0	0	0	1	6
2	1	4	7	2	3	0	0	0	0	1	0	18
3	1	3	3	3	3	2	2	0	2	0	0	19
4	0	1	2	0	3	1	1	0	0	0	0	8
5	2	0	1	5	3	3	2	1	0	1	0	18
6	1	2	1	1	1	3	1	4	2	1	0	17
7	1	2	0	1	2	4	6	2	3	0	2	23
8	0	1	0	2	1	2	6	5	8	4	0	29
9	0	2	1	1	0	0	1	2	4	6	3	20
10	0	0	3	0	1	0	1	0	2	3	13	23
Total	9	15	20	15	18	15	21	14	21	17	20	185

FFY08 Acute Decile	FFY09 Acute Decile											Total
	None	1	2	3	4	5	6	7	8	9	10	
None	7	0	0	0	0	0	1	1	0	1	4	14
1	0	0	1	0	0	1	1	1	1	1	1	7
2	1	3	1	0	0	2	0	0	1	1	1	10
3	0	0	0	0	0	0	1	0	0	0	2	3
4	3	2	0	0	3	1	0	2	0	1	2	14
5	1	0	0	1	1	0	0	1	0	2	3	9
6	0	0	0	1	2	1	0	2	0	1	5	12
7	1	1	0	0	0	1	3	2	2	2	6	18
8	2	1	0	0	0	1	1	1	1	2	6	15
9	1	1	0	0	0	3	3	4	1	4	13	30
10	0	3	0	0	0	0	1	1	2	7	39	53
Total	16	11	2	2	6	10	11	15	8	22	82	185

FFY08 Overall Decile	FFY09 Overall Decile										
	1	2	3	4	5	6	7	8	9	10	Total
1	0	0	0	0	0	0	0	1	1	1	3
2	1	3	1	1	0	0	1	2	0	1	10
3	1	1	1	1	1	0	1	1	0	2	9
4	1	1	1	1	0	1	1	0	1	2	9
5	1	3	0	0	0	0	0	2	3	1	10
6	1	1	1	0	1	1	3	0	0	5	13
7	0	1	0	5	2	3	3	7	6	5	32
8	2	0	2	2	0	2	2	5	6	5	26
9	0	1	0	0	0	3	0	2	9	12	27
10	1	0	1	1	2	0	2	3	7	29	46
Total	8	11	7	11	6	10	13	23	33	63	185

Presentation Master

Clients Who Died in FFY10, by Their FFY09 and FFY10 Deciles

	FFY10 BH Decile											
FFY09 BH Decile	**None**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**
None	2	2	0	0	0	0	0	0	0	0	0	4
1	2	7	2	1	1	2	0	0	0	1	0	16
2	1	4	3	3	0	0	0	1	0	0	0	12
3	0	5	5	5	1	1	4	1	0	0	0	22
4	0	1	0	1	2	3	1	1	1	0	1	11
5	2	1	2	3	5	2	2	1	3	1	0	22
6	0	0	0	0	4	4	4	1	2	2	1	18
7	0	4	0	1	1	3	3	3	3	0	0	18
8	1	1	0	1	1	1	2	2	9	6	0	24
9	0	1	0	1	0	2	3	2	10	7	3	29
10	0	0	0	0	0	1	0	2	1	6	14	24
Total	8	26	12	16	15	19	19	14	29	23	19	200

FFY09 Acute	FFY10 Acute Decile											
Decile	**None**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**
None	5	0	0	1	0	0	0	0	0	1	1	8
1	2	2	1	0	0	0	1	1	0	1	2	10
2	2	3	1	0	1	0	0	0	1	2	4	14
3	1	1	1	1	0	3	1	0	0	1	2	11
4	1	0	0	0	1	0	0	0	1	0	4	7
5	1	0	1	0	1	0	1	2	0	2	7	15
6	0	1	0	1	0	0	2	2	2	2	4	14
7	0	0	0	1	0	3	3	1	1	1	6	16
8	0	0	0	0	0	1	0	1	2	5	12	21
9	0	0	0	0	0	0	1	3	2	3	11	20
10	3	1	0	0	1	0	1	2	2	5	49	64
Total	15	8	4	4	4	7	10	12	11	23	102	200

FFY09 Overall	FFY10 Overall Decile										
Decile	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**
1	1	1	0	0	0	0	1	0	0	2	5
2	1	4	1	0	0	0	0	0	2	2	10
3	0	3	2	2	1	0	0	1	0	1	10
4	1	2	2	1	0	1	3	1	4	2	17
5	0	0	0	2	0	0	6	3	2	3	16
6	1	0	0	2	1	3	2	3	4	2	18
7	1	1	1	1	1	1	2	2	5	5	20
8	1	2	0	0	0	2	3	4	1	8	21
9	0	0	0	0	3	4	3	5	9	15	39
10	1	0	0	0	0	1	0	5	7	30	44
Total	7	13	6	8	6	12	20	24	34	70	200

Practice Protocol

Assessing Suicidal Risk

Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services

Effective 10/01/2006
Last Revised 12/04/2007

Purpose
To provide guidelines to improve the practice of assessing suicidal risk, thereby ensuring appropriate clinical practice and affecting positive clinical outcomes through appropriate and timely identification of symptoms and delivery of services for persons at risk for suicide and their families.

Targeted Population(s)
All at-risk populations (i.e., youth, adults, and families) statewide.

Introduction
As part of the 2005-2009 Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) Strategic Plan strategy to promote the understanding of the importance of behavioral health in overall wellness, DBHS convened a workgroup to improve suicide prevention and treatment services in collaboration with other organizations. Key objectives included the identification of best practices for assessing suicide risk and developing standardized risk assessments and treatment guidelines for persons at risk for suicide and their families.

Background
Behavioral health disorders are closely linked with suicidal behaviors. Studies show that 90 percent of individuals who die by suicide were suffering from a diagnosable and treatable behavioral health disorder at the time of their deaths. A significant number had contact with a physician in the last 12 months of their lives, and many physicians were unaware of the patients' suicidal intent. Thirty-four percent of suicidal persons were undergoing active treatment at the time of their deaths. These findings suggest that early efforts for improved risk identification and assessment might ultimately be successful in getting more at-risk individuals into treatment; therefore, it is essential that professionals are competent to assess, treat, and provide services that may help avoid or prevent suicidal behaviors.

Procedures
The following guidelines are established for use by behavioral health professionals or others involved in assessing those individuals at risk for suicide. The attached Special Suicide Risk Assessment tool will be incorporated as an addendum to the ADHS/DBHS Core Assessment and available for use at the initial intake (to supplement the Risk Assessment portion) or during follow up appointments, as indicated. In addition to the use of the ADHS/DBHS Special Suicide Risk Assessment addendum, T/RBHAs/providers may utilize other written documents and assessment tools for providing information and for additional documentation purposes. However, the T/RBHAs should periodically review all forms used to ensure the forms are consistent with nationally recognized practice guidelines such as those referred to in this document. Although not specifically required, it is highly recommended that the Special Suicide Risk Assessment tool be used as the primary clinical guidance document for assessing suicidal risk.

The Special Suicide Risk Assessment was also designed for use in crisis situations when the Core Assessment cannot be completed. It can be utilized in a variety of settings including, but not limited to: clinics, residential treatment facilities, crisis and first responder teams, etc. It can also be used for incoming crisis telephone calls, although that was not the primary intent. It is best used in face-to-face interactions. In some cases, phone staff may initiate the assessment,

but completion of the form would occur by a mobile team, urgent care center, or outpatient clinic provider.

During the evaluation of new or existing persons/behavioral health recipients, persons conducting assessments should follow the six steps outlined below in assessing suicide risk:

1. Conduct a thorough assessment,
2. Specifically inquire about suicide,
3. Determine the extent of suicidal ideation,
4. Assess lethality and determine level of risk,
5. Determine if a Crisis Plan exists, and
6. Complete a Next Steps Interim Service Plan or Crisis Plan to ensure the safety of the person/behavioral health recipient.

1. Conduct a thorough assessment

Behavioral health professionals/assessors should conduct a thorough assessment at the initial interview/intake or annual update appointment, adhering to ADHS/DBHS protocol. In the course of the interview, information on the person's history, psychosocial situation, and individual strengths and vulnerabilities should be obtained as follows:

- Previous or current medical diagnoses and treatments, including surgeries or hospitalizations, medications;
- Previous psychiatric diagnoses and treatments, including illness onset and course, psychiatric hospitalizations, medications, as well as substance use disorders;
- Current signs and symptoms of psychiatric disorders with particular attention to mood disorders (primarily major depressive disorder or mixed episodes), schizophrenia, substance use disorders, anxiety disorders (including post traumatic stress disorder (PTSD)), and personality disorders (especially borderline and antisocial personality disorder);
- Family history of mental illness, including substance abuse and suicide;
- Acute psychosocial crises and chronic psychosocial stressors, which may include actual or perceived interpersonal losses, financial difficulties, or changes in socioeconomic status, family discord, domestic violence, and past or current sexual or physical abuse or neglect;
- Employment status, living situation (including whether or not there are infants or children in the home), and presence or absence of external supports;
- Family constellation and quality of family relationships;
- Cultural or religious beliefs about behavioral health issues;
- Coping skills;
- Past responses to stress (including prior suicide attempts); and
- Ability to tolerate psychological pain and satisfy psychological needs.

All persons should be assessed for risk of harm towards self or others. Any person who shows evidence of depressed mood, anxiety, or substance abuse should be specifically assessed for suicidal risk. Because one interview may not be sufficient, screening should continue over a series of visits whenever possible, and risk should be reevaluated regularly. The goal is always to ensure the safety of the person.

2. Specifically inquire about suicide

Asking persons/behavioral health recipients about suicide will not give them the idea or incentive to commit suicide. Most who consider suicide are ambivalent about the fact and will feel relieved that the behavioral health professional is interested and willing to discuss their ideas and plans. Unfortunately, not all persons/behavioral health recipients are forthcoming about psychiatric symptoms and thoughts of suicide; therefore, it is recommended that assessors make an introductory statement followed by specific questions, and ask follow up questions to indirect statements of suicidal intent.

In assessing the current presentation of suicidality, behavioral health professionals/assessors should evaluate the following:

1. Suicidal or self-harming thoughts, plans, behaviors, and intent;
2. Specific methods considered for suicide, including their lethality and the patient's expectation about lethality, as well as whether the means are accessible;
3. Evidence of hopelessness, impulsiveness, panic attacks, or anxiety (including PTSD);
4. Reasons for living and plans for the future;
5. Alcohol or other substance use (type, recency, frequency); and
6. Thoughts, plans, or intentions of violence toward others.

It is also important to inquire about previous suicide attempts, aborted attempts, or other self-harming behaviors, as well as to determine if there is a family history of suicide or suicide attempts, as those are two of the risk factors most strongly correlated with predicting suicide risk.

3. Determine the extent of suicidal ideation

Suicidal ideation is having thoughts of suicide or of taking action to end one's own life. Suicidal ideation includes all thoughts of suicide, both when the thoughts include a plan to commit suicide and when they do not include a plan. If suicidal intent is expressed or discovered, persons conducting assessments should probe further to specifically investigate the onset and duration of suicidal ideation.

- When did thoughts of suicide begin?
- Did any event (stressor) precipitate the suicidal thoughts?
- How often do suicidal thoughts occur?
- What makes the person feel better (i.e., contact with family, use of substances)?
- What makes the person feel worse (i.e., being alone)?
- Does the person have a plan to end his/her life?
- How much control over his/her suicidal ideas does the person have?
- What stops the person from killing him/herself (i.e., family, religious beliefs)?

When determining the level of risk, the use of a Likert scale is recommended. A Likert scale uses survey questions where respondents are asked to rate the level at which they agree or disagree with a given statement in order to measure attitudes, preferences, and subjective reactions. For example:

I experience suicidal thoughts often.

Strongly Disagree Strongly Agree
1 2 3 4 5 6 7 8 9 10

The person conducting the assessment should ask follow up questions to determine what that number signifies to the individual; for example, “On a good day, how would you rate yourself?”

4. Assess lethality and determine level of risk

Plan

If the person has identified a plan, what are the specific methods considered? Culture and gender play an important role. For example, in some cultures, the subject of death is taboo and not discussed. Additionally, some methods may be more prevalent among a particular culture or population. Males typically choose more lethal methods, such as the use of firearms; on the other hand, females most commonly overdose on medications. It is crucial that persons conducting the assessment approach this portion of the interview with care and sensitivity. Avoid bringing your own belief system into the situation. Take caution to prevent instilling any feelings of guilt. Try to identify what the meaning of this act would be to this individual.

Lethality

Possible follow up questions include:

1) How far did you get with your plan? (For example, has the person “practiced” by holding the gun to his/her head or the medications in his/her hand?)
2) Have you considered the outcome of your suicide? or What would it be like if you were dead? (For example, has the person imagined their funeral? How people will react to his/her death?)
3) Have you made any specific arrangements? (For example, has he/she given away possessions, changed a will or life insurance policy, gone to confession or sought spiritual counsel, or spoken to friends about plans?)

Accessibility

Examples: Does he/she own a gun or have access to firearms or any other potentially lethal weapon? Is there access to potentially harmful medications or illicit drugs?

5. Determine if a Crisis Plan exists

If an individual has established an At-Risk Crisis Plan (also referred to as a crisis plan or safety plan) in the past, care should be taken to identify the plan and ensure that guidelines are followed. For example, the assessor or dispatcher should ask: “Have you developed a safety plan?” Individuals that work closely with at-risk persons who have identified plans should be aware of the person’s individualized safety plan. If the person is a behavioral health recipient, this should be referenced in the Interim Service Plan.

6. Complete a Next Steps Interim Service Plan or Crisis Plan to ensure the safety of the person/behavioral health recipient

The goal is to ensure the safety of the individual. In the context of a crisis call taken via telephone, if the person indicates that he/she does not feel safe, initiate the most appropriate action(s): (1) engage the individual further to determine if you can de-escalate the situation, (2) ask to speak with a family member or significant other in the home in order to enlist their

assistance in keeping the individual safe until additional support arrives, (3) ask the family member or significant other to transport the individual to the nearest crisis center for additional evaluation, or (4) discontinue the assessment and immediately dispatch a mobile crisis response team.

For behavioral health recipients, individualized safety plans will be addressed in the Interim Service Plan (ISP) at intake. In the initial assessment, the person's current living situation, family relationships, and support system will be identified. It is the responsibility of the behavioral health professional to assess the immediate safety of the individual, and to determine what additional referrals may be necessary. It is important to respect individual and cultural preferences in the ISP and involve families as appropriate.

In other settings, other means can be used. Safety or "no-suicide" contracts are not essential. The person might not be competent to accept or understand the contract, and the person conducting the assessment should know not to relax his/her vigilance because a contract has been signed (AACAP, 2000).

Crisis and First Responder Teams

Crisis and first responder teams are expected to follow the steps outlined above whenever possible. Recognizing the nature of the crisis situation, it may not always be possible to conduct a complete assessment; however, it is crucial that teams follow guidelines for steps 2-4 outlined above (Specifically inquire about suicide; Determine extent of suicidal ideation; Assess lethality, and Determine level of risk) to evaluate suicide risk. The immediate need is to get the person to a safe place. After the immediate crisis is handled, a thorough assessment should be completed.

Phones/Front Line Staff

T/RBHAs and providers should periodically review their existing protocol and operational procedures for responding to crisis calls, as well as training staff in this area. At minimum, all staff should be knowledgeable about the following:

1. Signs and symptoms for suicide risk,
2. Indirect cues/requests for help,
3. Sensitivity to callers in crisis/cultural competence,
4. Identifying the existence of a safety plan,
5. Referral procedures specific to the agency, and
6. Local resources for assistance.

Understanding the Relevance and Limitations of Assessment Tools

These recommendations are based on the latest evidence base and practice guidelines from nationally recognized sources. However, it is important to keep in mind that the majority of assessment tools have low validity in their ability to accurately predict suicidal behavior, and often result in high rates of false positive findings. For that reason, suicide assessment scales may be used as aids to suicide assessment but should not be used as predictive instruments or as substitutes for a thorough clinical evaluation (APA, 2003). This tool is therefore intended to help behavioral health professionals conduct a thorough assessment by stimulating an enhanced line of questioning.

References:

American Academy of Child and Adolescent Psychiatry. (2000). Practice Parameter for the Assessment and Treatment of Children and Adolescents With Suicidal Behavior. Washington (DC): American Academy of Child and Adolescent Psychiatry.

American Psychiatric Association. (2003). Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors. American Journal of Psychiatry, Vol. 160, No. 11.

Berman, L. (2004). E&T Rationale. Unpublished manuscript.

Gliatto, M. & Rai, A. (1999). Evaluation and Treatment of Patients with Suicidal Ideation. Philadelphia, PA: American Academy of Family Physicians.

SPECIAL SUICIDE RISK ASSESSMENT ADDENDUM

Person's Name: _____ **ID#:** _____**DOB:**_____
Address: _____ **Date:** _____
Phone: _____ **Contact Type:** Telephone ☐ Walk-in ☐ **Time:** _____
Location of Person (if other than above): _____
Gender: M ☐ F ☐ **Primary/Preferred Language:** _____**Crisis Plan?** N ☐ Y ☐ **Date:** _____

1. **PRESENTING PROBLEM OR REQUEST FOR ASSISTANCE:**	
2. **TRIAGE:** a. Are you able to keep yourself safe until this assessment is completed? ☐ Yes ☐ No b. Are you in possession of a gun or weapon or do you have easy access to a gun or weapon? ☐ Yes ☐ No c. Have you felt like hurting yourself? ☐ Yes ☐ No or anyone else? ☐ Yes - *Refer to Core Risk Assessment for Harm to Others* ☐ No d. Have you already hurt yourself or anyone else? ☐ Yes ☐ No	
Note: *If person answers "Yes" to 2d above and the level of risk is determined to be severe at this point, and a mobile crisis response team has been dispatched to continue the assessment, it is unnecessary to complete the remainder of this form.*	
3. **IDEATIONS:** (Describe any thoughts of dying or killing oneself in detail, using person's own words. Include circumstances that trigger suicidal thoughts.) Ideation is: Fleeting ☐ Periodic ☐ Constant ☐ Increasing in: Severity ☐ Urgency ☐ Frequency ☐	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (No thoughts←→Obsessive thoughts)
4. **PLAN**: (How would person carry out ideations? Use details, person's own words.)	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (Unclear ←→ Detailed & specific)
5. **MEANS:** (Instruments/methods to be used; access to instruments. Use details, person's own words.)	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (No access ←→ Continuous access)
6. **LETHALITY:** (Dangerousness of plan. Use details, person's own words.)	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (Minimal risk←→Certainty of death)
7. **INTENT:** (Reports desire and intent to act on suicidal thoughts. Use details, person's own words.)	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (No desire/denial←→Desire to complete plan)
8. **HISTORY:** (Suicide and self-harming behaviors, self and family; Attempts: number, when, method, lethality, rescues, etc. Begin with past three months.) What has prevented person from acting on suicidal thoughts in the past?	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (No history←→Multiple life threatening acts or severe attempts)
9. **SUBSTANCE ABUSE/USE:** (History of use/abuse, access to substances, including family member substance abuse) Is person currently using? If so, list substance(s), amount, and when taken.	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (None ←→ Heavy use/dependence)
10. **ACUTE LIFE STRESSORS:** (Situation/recent changes with family, relationship, job, school, health, divorce, marriage, grief, losses, financial, residential instability, bullying, etc.)	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (Few stressors←→Many stressors)

SPECIAL SUICIDE RISK ASSESSMENT ADDENDUM

11. **DEPRESSION/AGITATION:** (Affect, anxiety, restlessness, symptoms of depression)	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (Normal affect←→Severe depression)
12. **HOPELESSNESS:** (Future orientation)	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (Can see future←→Unable to see)
13. **PSYCHOTIC PROCESSES:** (History/symptoms of psychosis, delusions, auditory/visual hallucinations. Include dates, diagnoses, meds.)	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (No history←→Severe delusions)
14. **MEDICAL FACTORS:** (History/current medical conditions including chronic and severe pain, terminal illness, etc.)	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (No history←→Multiple symptoms)
15. **BEHAVIORAL CUES:** (Isolation, impulsivity, hostility, rage, etc.)	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (Minimal ←→ Extreme)
16. **COPING SKILLS:** (Helplessness, negation of self and others)	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (Good coping skills←→Poor coping)
17. **SUPPORT SYSTEM:** (Family, friends, co-workers, roommates, spiritual affiliation, civic, school, etc. Define relationship(s) and details using person's own words.)	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (Supportive contacts←→No support)
18. **OTHER FACTORS:** (OPTIONAL. If previously mentioned, describe any recent lifestyle changes, sexual identity/orientation issues, involvement w/justice system, communication skills, other diagnoses.)	☐ ☐ ☐ ☐ ☐ None Low Med High Severe (Small significance←→Severe impact)
19. **CULTURAL CONSIDERATIONS:** (OPTIONAL. If mentioned, describe person's attitude towards suicide—acceptance, ambivalence, rejection, etc; cultural views on death and suicide; specific concerns)	
20. **OVERALL RISK LEVEL (based on clinical judgment):**	Low ☐ Med ☐ High ☐
21. **REASONING:** (Identify risk factors and factors offsetting/mitigating identified risks)	
RISKS:	**OFFSETS:**
22. **ACTION TAKEN:** (Client signed Crisis Plan? Y ☐ N ☐ Interim Service Plan Completed? Y ☐ N ☐ Include details of appointments/referrals made)	

Clinician/BHP/Assessor: _____ _____ _____
Print Name and Credentials *Signature* *Date*

Clinical Liaison: _____ _____ _____
Print Name and Credentials *Signature* *Date*

Supervisor: _____ _____ _____
Print Name and Credentials *Signature* *Date*

Practice Protocol

Buprenorphine Guidance Protocol

Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services

Effective Date: 02/23/11

Title
Buprenorphine Guidance Protocol

Goal/What Do We Want to Achieve Through the Use of this Protocol?
The purpose of this document is to provide guidance to Behavioral Health Medical Practitioners within the State of Arizona. This document addresses practice which is consistent with Arizona Department of Health Services (ADHS) Office of Behavioral Health Licensing (OBHL) and Division of Behavioral Health Services (DBHS) standards. This document describes diagnostic requirements, prescribing and dosing strategies, laboratory monitoring strategies and recommendations and physical assessment prior to dosing recommendations. Guidance on psychotherapies that are consistent with buprenorphine treatment, patient selection recommendations, opiate withdrawal assessment protocols and issues relevant to special populations will be reviewed. Additionally, record storage and maintenance, informed consent, patient education, patient residential storage and confidentiality recommendations will be covered in this document.

Target Audience
Waived buprenorphine providers and OBHL licensed facilities within the State of Arizona.

Target Population(s)
Tribal and Regional Behavioral Health Authorities (T/RBHA) enrolled individuals above the age of 16 with the diagnosis of opiate dependency.

Definitions
Buprenorphine (Subutex, Suboxone)

Opiate Dependency

Opiate Withdrawal

.
Waived physician prescriber

.
Informed Consent

Background
The prevalence of opioid dependency has had a dramatic impact in the U.S. There are 810,000 to 1,000,000 chronic users of heroin in the U.S. (Office of National Drug Control Policy, 2003). The National Survey on Drug Use and Health (NSDUH) indicates that 53% of individuals who abused heroin become dependent.

The lifetime use of opioid analgesics reached 29,611,000 in the U.S. in 2002 (NSDUH). Opioid dependency resulted in an increase in emergency room visits from 36,000 to 72,000 between 1991 and 1995 in the U.S. During the same time period, opioid-related

deaths increased from 2,300 to 4,000 in the U.S. (Substance Abuse and Mental Health Services Administration (SAMHSA) Mortality Data from DAWN, 2002).

The prevalence of opioid abuse is increasing. Office-based buprenorphine treatment is intended to make opioid addiction treatment more available and to place the treatment of opioid dependency into mainstream medical practice.

Recommended Process/Procedures

A. Diagnostic requirements:

DSM-IV-TR Criteria for Opioid Dependence: A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the DSM-IV-TR criteria occurring over a 12-month period. Examples of drugs which can lead to dependency include:

1. diacetylmorphine (heroin);
2. hydromorphine (Dilaudid),
3. oxycodone (OxyContin, Percodan, Percocet, and Tylox);
4. meperidine (Demerol);
5. hydrocodone (Lortab, Vicodin);
6. morphine (MS Contin, Oramorph), fentanyl (Sublimaze);
7. propoxyphene (Darvon);
8. methadone (Dolophine);
9. codeine and opium.

Special Diagnostic Considerations for Individuals released from Corrections: Diagnostic decisions shall be based on the following factors before starting opioid dependency treatment which requires a review of clinical history:

1. length of incarceration;
2. post release addiction patterns and cycles;
3. addiction treatment history;
4. self-help involvement; and
5. reported triggers of illegal drug use and addiction upon release. (SAMHSA's TIP 40)

B. Prescribing requirements:

DATA 2000 enables qualifying physicians to receive a waiver from the special registration requirements in the Controlled Substances Act for the provision of medication-assisted opioid therapy. This waiver allows qualifying physicians to practice medication-assisted opioid addiction therapy with Schedule III, IV, or V narcotic medications specifically approved by the Food and Drug Administration (FDA).

The Drug Enforcement Administration (DEA) assigns the physician a special identification number. DEA regulations require this ID number to be included on all buprenorphine prescriptions for opioid addiction therapy, along with the physician's regular DEA registration number.

To qualify for a waiver under DATA 2000 a licensed physician (MD or DO) must meet any one or more of the following criteria:

1. The physician holds a subspecialty board certification in addiction psychiatry from the American Board of Medical Specialties;
2. The physician holds an addiction certification from the American Society of Addiction Medicine;
3. The physician holds a subspecialty board certification in addiction medicine from the American Osteopathic Association;
4. The physician has, with respect to the treatment and management of opioid-addicted patients, completed not less than eight hours of training (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) that is provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Psychiatric Association, or any other organization that the Secretary determines is appropriate for purposes of this subclause.
5. The physician has participated as an investigator in one or more clinical trials leading to the approval of a narcotic drug in schedule III, IV, or V for maintenance or detoxification treatment, as demonstrated by a statement submitted to the Secretary by the sponsor of such approved drug.
6. The physician has such other training or experience as the State medical licensing board (of the State in which the physician will provide maintenance or detoxification treatment) considers to demonstrate the ability of the physician to treat and manage opioid-addicted patients.
7. The physician has such other training or experience as the Secretary of U.S. Department of Health and Human Services (DHHS) considers to demonstrate the ability of the physician to treat and manage opioid-addicted patients. Any criteria of the Secretary under this subclause shall be established by regulation. Any such criteria are effective only for 3 years after the date on which the criteria are promulgated, but may be extended for such additional discrete 3-year periods as the Secretary considers appropriate for purposes of this subclause. Such an extension of criteria may only be effectuated through a statement published in the Federal Register by the Secretary during the 30-day period preceding the end of the 3-year period involved.

C. <u>Clinical observation at critical phases of treatment:</u>
Waived buprenorphine providers must consider the entire process of treatment, which includes induction through stabilization, and then maintenance. Below are suggested algorithms developed by Center for Substance Abuse Treatment.[1]

[1] Center for Substance Abuse Treatment, Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction. Treatment Improvement Protocol (TIP) Series 40. DHHS Publication No. (SMA) 04-3939. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004.

Figure 4–1

Induction Days 1–2

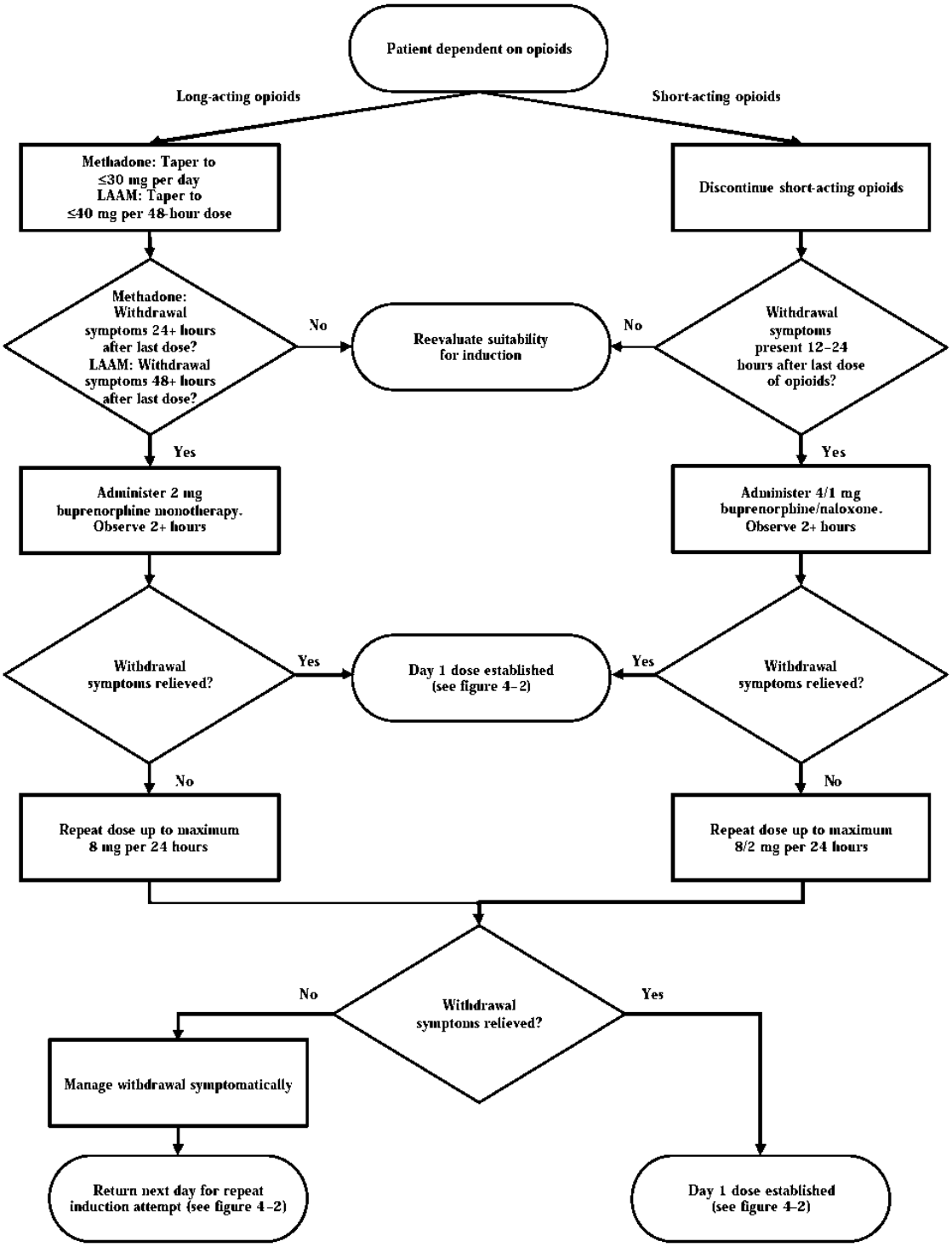
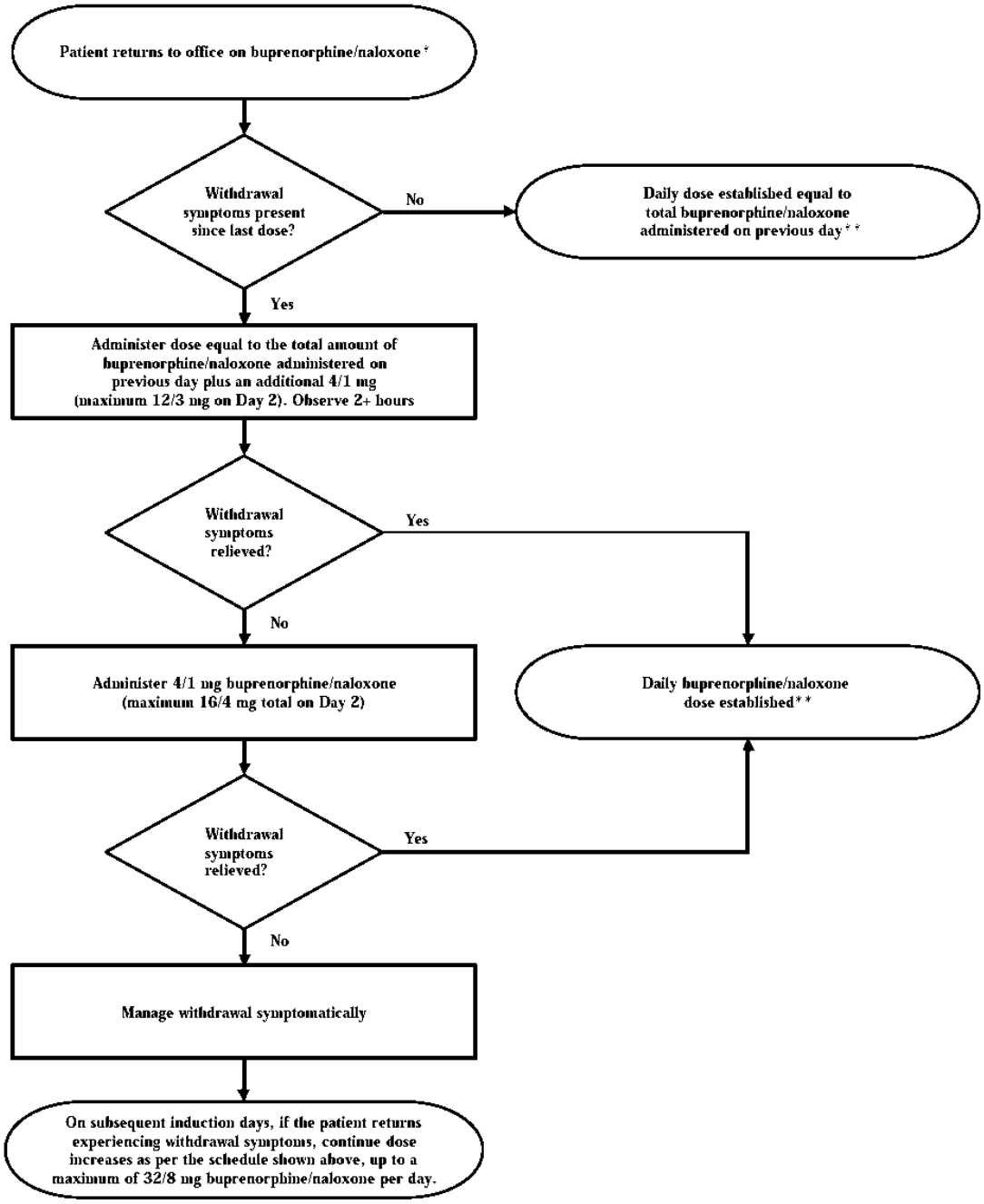


Figure 4–2

Induction Day 2 Forward



*If buprenorphine monotherapy was administered on Day 1, switch to buprenorphine/naloxone on Day 2 (for a patient who is not pregnant).

**Dose may be increased by 2/0.5–4/1 mg increments on subsequent days as needed for symptom relief. Target dose of 12/3–16/4 mg buprenorphine/naloxone per day by the end of the first week.

Figure 4-3

Stabilization Phase

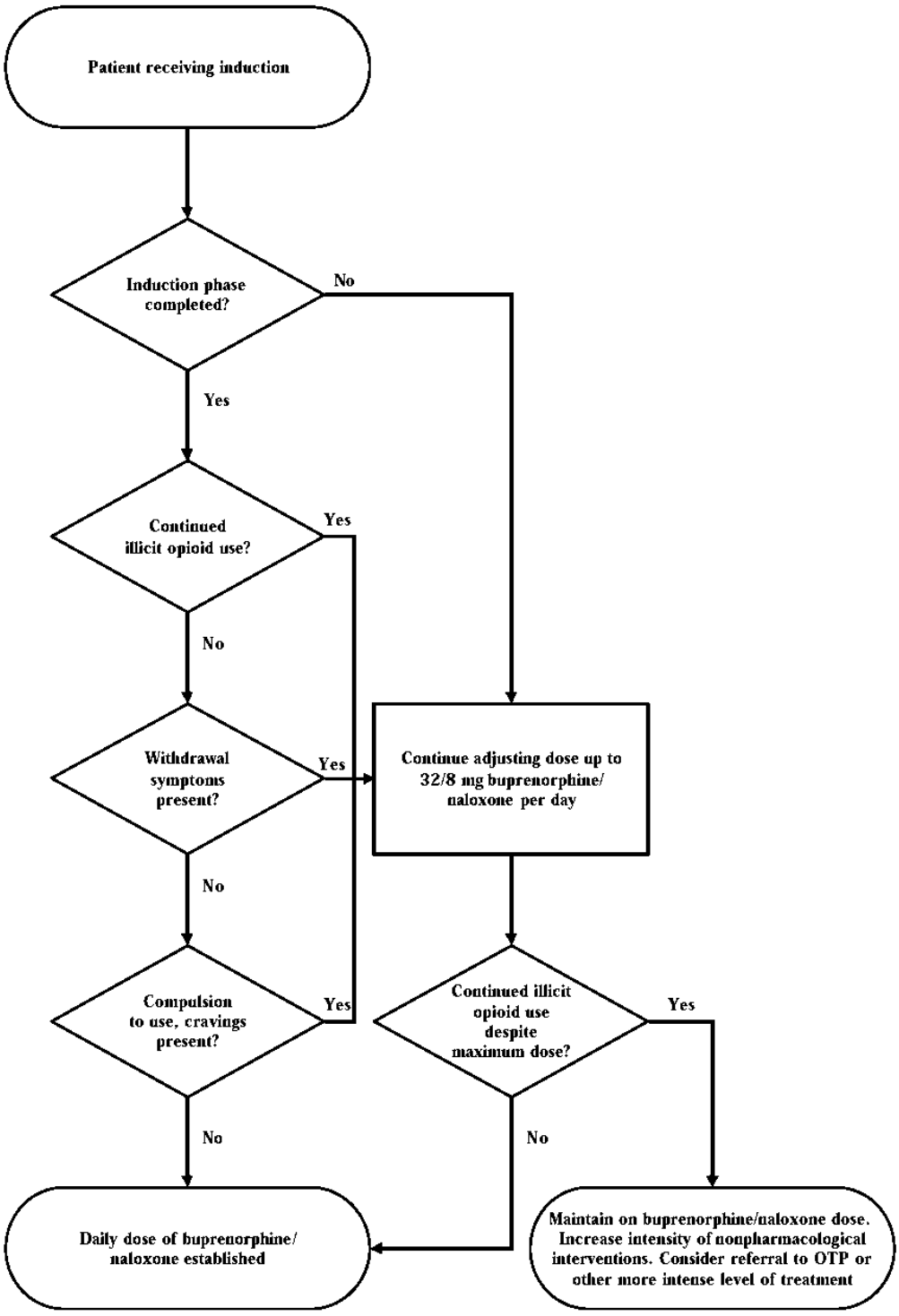


Figure 4–4

Detoxification From Short-Acting Opioids

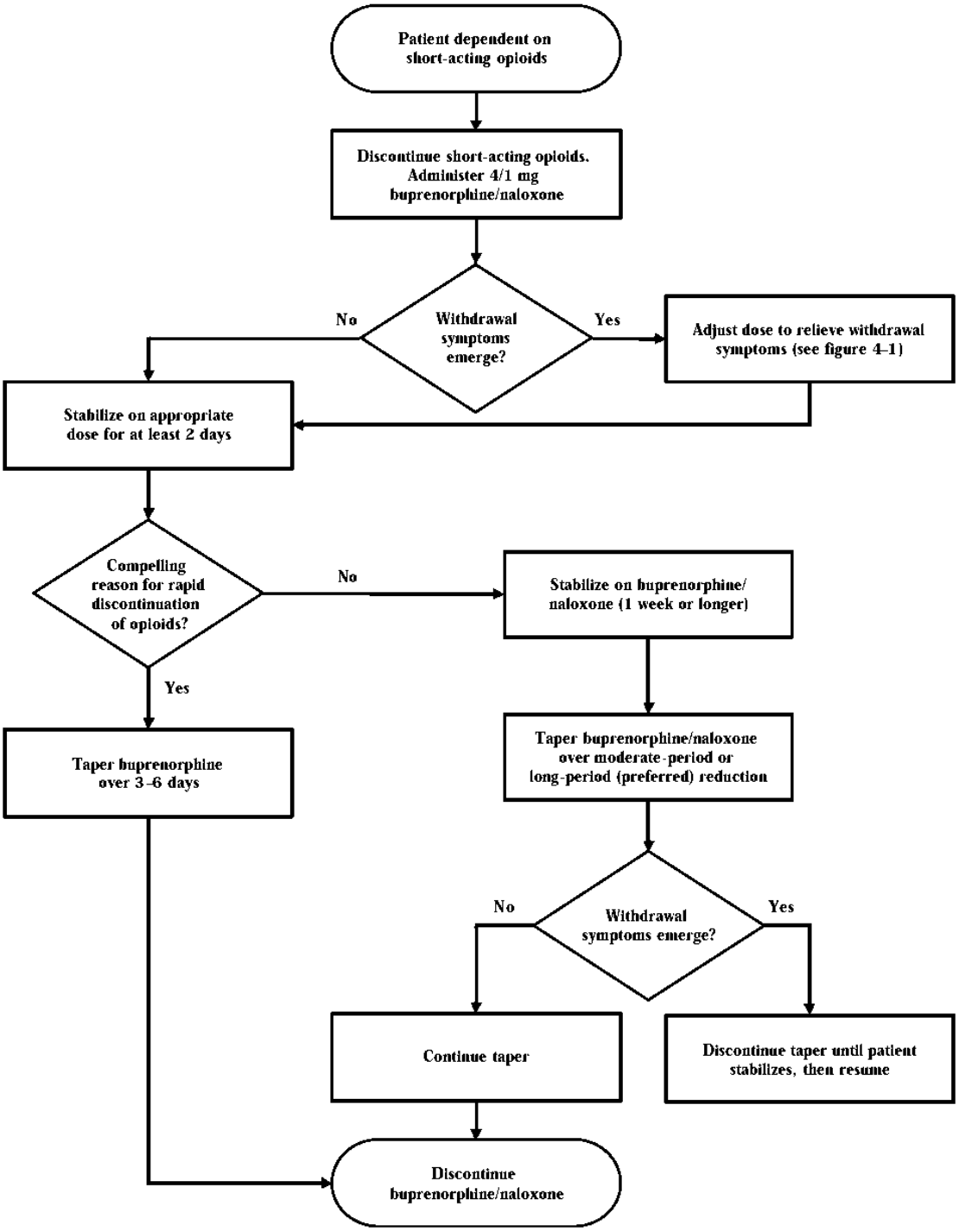
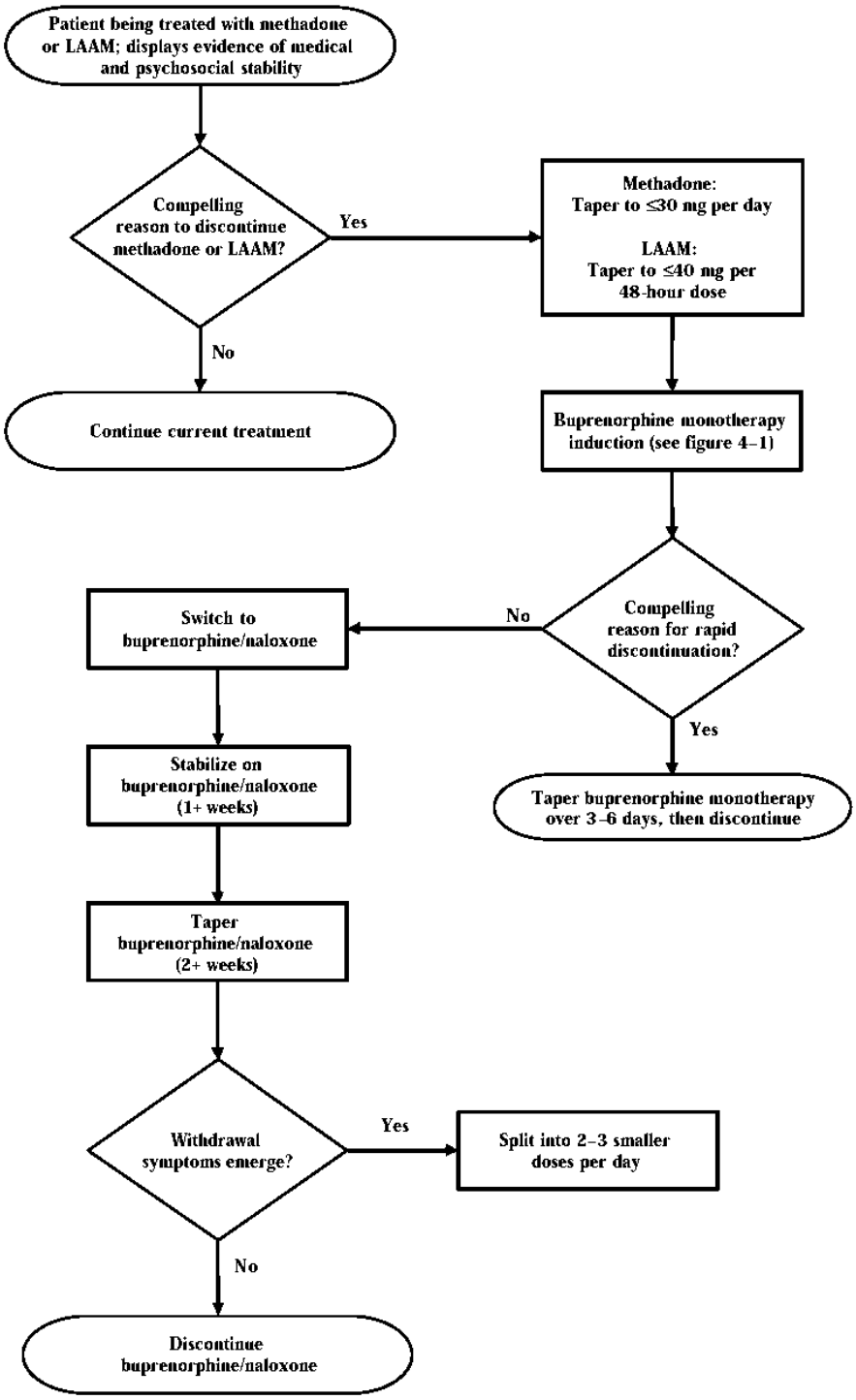


Figure 4–5

Discontinuation of OAT Using Buprenorphine



D. History and physical assessment prior to induction:
The physical assessment must be supported by a comprehensive and accurate clinical history. The history should encompass the types of opioids abused and the history of usage. The provider should review first use, illicit vs. licit use, frequency and amounts, routes of administration, and recent use. The provider should consider tolerance and withdrawal, relapse frequency, and history of non-opioid substance use disorders. Psychiatric and medical histories should be components of the overall history.

The physical assessment should evaluate the patient's sensorium and mental status. The medical provider should assess for dilated pupils (opioid withdrawal), constricted pupils (opioid intoxication), unstable vital signs, possible pregnancy, and medical conditions such as chronic pain, renal insufficiency, hepatitis, and HIV/AIDS. The provider should assess the patient for needle marks, cellulitis or dermal abscesses. Laboratory testing should be based on clinical history and the physical examination. Certain high risk medical illnesses should mandate specific laboratory tests. (American Academy of Addiction Psychiatry, 2008)

E. Laboratory studies prior to induction and post-induction:
The ordered laboratory studies should be based on the findings of the history and physical. The examiner should order pregnancy testing on all women of child-bearing years with noted exceptions (i.e., hysterectomy, history of tubal ligation).

Urine drug testing enhances treatment outcomes in patients receiving buprenorphine treatment. Urine drug testing is an integral part of on-going evaluation and treatment planning. The provider should consider mechanisms to maintain the validity of the results. In-office buprenorphine practice policies should cover in-office vs. off-site collection, random vs. scheduled, and observed vs. non-observed. Urine drug testing can allow for the monitoring of co-occurring substance use disorders. (American Academy of Addiction Psychiatry, 2008)

Practice and prescribing should be based on the patient needs and FDA and State guidelines.

F. Each behavioral health recipient has the right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment. It is important for persons seeking behavioral health services to agree to those services and be made aware of the service options and alternatives available to them as well as specific risks and benefits associated with these services. Providers shall reference ADHS/DBHS Provider Manual Section 3.11, General and Informed Consent to Treatment for additional guidance.

G. Storage of records
The patient record is:

1. Maintained on the premises of the behavioral health agency at which the patient is admitted until the patient is discharged;
2. Available and accessible to staff members who provide behavioral health services to the patient;
3. Retained after a patient's discharge:
   a. For a patient who is an adult, for 7 years after the date of the patient's discharge, unless otherwise provided by law or this chapter (9 A.A.C.20, Article 211 A);
   b. For a patient who is a child, for 7 years after the date of discharge or for at least 3 years after the date of the patient's 18th birthday, whichever is a longer period of time; and
   c. Disposed of in a manner that protects patient confidentiality.
4. Storage of Buprenorphine in the physician's office must include being stored under locked conditions and include record keeping tracking information on who received Buprenorphine and the quantity of drug dispensed.

Pade (2008) reported the following:
"DEA record keeping requirements for office-based opioid therapy go beyond the Schedule III record keeping requirements. According to DEA: Practitioners must keep records (including an inventory that accounts for amounts received and amounts dispensed) for all controlled substances dispensed, including Subutex and Suboxone (21 CFR Section 1304.03[c]). In some cases, patients return to the prescribing physician with their filled Subutex or Suboxone prescriptions so that the practitioner can monitor the induction process. While it is acceptable for the patient to return to the practitioner with their filled prescription supplies, practitioners shall not store and dispense controlled substances that are the result of filled patient prescriptions."

Practitioners must keep records for controlled substances prescribed and dispensed to patients for maintenance or detoxification treatment (21 CFR Section 1304.03[c]). Many practitioners comply with this requirement by creating a log that identifies the patient (an ID number may be used instead of name), the name of the drug prescribed or dispensed, as well as the strength and quantity and date of issuance or dispensing. Some physicians comply with this requirement by keeping a copy of the prescription in the patient record.

Alternatively, DEA suggests that practitioners could keep separate records for controlled substances prescribed and dispensed for maintenance or detoxification treatment to facilitate the record reviews during physician inspections for DATA compliance. This way, DEA will only review those records related to controlled substances prescribed and dispensed for maintenance or detoxification treatment for physicians maintaining separate records."

H. Storage of buprenorphine in the patient's home

It is best to store the medication in a location other than where vitamins, aspirin or other over-the-counter medications are stored to avoid any confusion.

Buprenorphine must be stored in a location that is safe and kept away from children or pets. If buprenorphine is taken by a family member or a person by mistake he or she should be evaluated by a physician immediately.

I. Special Treatment Populations

The physician should take special considerations when prescribing in the populations below:

1. Pregnant women
2. Adolescents
3. Geriatric Population
4. Persons suffering from pain
5. Persons with a comorbidities (e.g. Hepatitis, HIV, TB, etc)
6. High risk psychiatric patients with suicidal ideation and impaired judgment
7. Under the jurisdiction of the criminal justice system
8. Persons who have a concurrent alcohol or other substance abuse disorders

J. Opioid Withdrawal Protocols

The physician should consider the use of objective opiate withdrawal assessment instruments (e.g., Clinical Opiate Withdrawal Scale (COWS).

Training and Supervision Recommendations

Per DATA 2000, training that meets the requirement for a waiver may be provided by the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Academy of Addiction Medicine, the American Psychiatric Association, the American Society of Addiction Medicine, and other organizations that the Secretary of the Department of Health and Human Services determines are appropriate for this purpose. DATA-qualifying training must include not less than eight hours of instruction on the treatment and management of opioid-addicted patients.

Also, as part of training in the treatment of opioid addiction, physicians should at a minimum be a licensed physician to practice medicine in the state of Arizona and obtain some knowledge about the basic principles of brief intervention in case of relapse. Physicians considering providing opioid addiction care should ensure that they are capable and capable of providing psychosocial services. In fact, DATA 2000 stipulates that when physicians submit notification to SAMHSA to obtain the required waiver to practice opioid addiction treatment outside the outpatient treatment program setting, they must attest to their capacity to refer such patients for appropriate counseling and other non-pharmacological therapies.

Anticipated Outcomes

Maintenance of Office of Behavioral Health Licensing license:

A. Measured by office inspections conducted by Office of Behavioral Health Licensing.

Avoidance of Critical Events within the office practice:

A. Measured by critical incidence reporting by T/RBHA to ADHS/DBHS.

Resources:

American Academy of Addiction Psychiatry (AAAP)
www.aaap.org/buprenorphine/buprenorphine.html

Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction: A Treatment Improvement Protocol (TIP) 40
http://buprenorphine.samhsa.gov/Bup_Guidelines.pdf

SAMHSA Buprenorphine Information Center at:
http://buprenorphine.samhsa.gov

Suboxone manufacturer's web page at:
http://www.suboxone.com

ADHS/DBHS Practice Protocol
Buprenorphine Guidance Protocol
Desktop Guide

- Key elements to remember about this best practice:
  - Establishing a maintenance dosage of medications
  - Regulatory issues related to buprenorphine
  - Licensed physicians must be capable and comfortable with opioid addiction

- Benefits of using this best practice:
  - Understanding the practice associated with buprenorphine
  - Intended to make opioid addiction treatment more available
  - Intended to place the treatment of opioid dependency into mainstream medical practice

DBHS Practice Protocol

Clinical Supervision

Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services
Effective November 1, 2008

Title:

Clinical Supervision

Goal/What Do We Want to Achieve Through the Use of this Protocol?:

The goal of this Practice Protocol is to ensure the appropriate frequency and content of clinical supervision at the Tribal/Regional Behavioral Health Authority (T/RBHA) and Provider levels, and to avoid the tendency to substitute administrative supervision for clinical supervision. By stressing the importance and content of good clinical supervision, it is also the goal of this protocol to increase the behavioral health professional's ability to provide quality and consistent care from the first point of contact throughout the continuum of care by:

- Enhancing the supervisee's personal and professional development (skills/knowledge)
- Providing regular supervision grounded in best practices
- Assessing and evaluating supervisee competence and effectiveness on a regular basis
- Adhering to agency, licensing, and accrediting requirements
- Monitoring legal, ethical, and cultural issues
- Ensuring staff retention and overall welfare.

The application of this protocol is broad in nature with the intent that all direct care staff, regardless of education, licensure, or certification are receiving regular, quality, clinical supervision appropriate to the service tasks for which they are responsible. This protocol is also intended as an enhancement, not a replacement, to the specific guidelines for the frequency and broad content areas of clinical supervision set down in Arizona Administrative Code R9-20-205. The unique issues of those seeking or maintaining licensure or certification in a specific discipline are not directly addressed within this protocol.

Target Audience:

This protocol is directed to those practitioners at the T/RBHA and their subcontracted Network and Provider agencies who are ultimately responsible for the supervision, monitoring, evaluating, and/or training of all direct care staff.

Target Population(s):

All behavioral health direct care providers receiving supervision.

Definitions:

Clinical Supervision is an intervention by a more senior member of a profession to a more junior member or members of that same profession. This relationship is evaluative, extends over time, and enhances the professional functioning, monitors service quality, and acts as a gate-keeping process for those who are entering the profession (Bernard and Goodyear, 2004).

Administrative Supervision, on the other hand, is concerned with the correct, effective, and appropriate implementation of agency policies and procedures. The supervisor has been given authority by the agency to oversee the work of the supervisee. The primary goal is to ensure adherence to policy and procedure (Kadushin 1992)

Background:

Although clinical supervision is a distinct professional competency, standards and training have been substantially neglected in that most clinicians have not had formal training in clinical supervision (Scott,

Ingram, Vitanza, & Smith, 2000). Providing skilled and effective clinical supervision extends beyond the skill set required when providing therapeutic services to behavioral health recipients. In other words, being a good clinician does not automatically mean being a good clinical supervisor.

The Florida Institute for Continuing Professional Development states that clinical supervision is a formal process of professional support which provides a means of encouraging self-assessment and the development of analytical and reflective skills. It is a practice-focused professional relationship that enables the supervisee to develop knowledge and competence, and to reflect on his/her clinical work with the support of a skilled supervisor.

Clinical Supervision is also a process that facilitates the evaluation of a supervisee's interactions with a consumer to ensure the best quality of care is provided. It is a dynamic, collaborative process which includes the components of teaching and mentorship and aims to enable the supervisee to develop, achieve, and sustain a high quality of practice. This process provides an opportunity for regular protected time for facilitated, in-depth reflection on clinical practice and professional issues. This reflective practice translates into improvements in the supervisee's practice. Clinical Supervision both empowers and supports those in practice and should continue throughout the clinician's career.

Front line clinicians and their supervisors report that clinical supervision has been compromised by financial, regulatory, and administrative demands on service programs. This has resulted from redundant accountabilities to federal, state, county, city, and private regulatory bodies that produce an exponential growth in standards and monitoring visits. Clinical directors and supervisors report that pockets of high quality clinical supervision continue to flourish, but that they now represent the exception. (White and Schwartz, 2007).

Due to the many expectations placed on clinicians and their supervisors, formal clinical supervision has, in many cases, been limited to a brief case review, data validation, or a focus on "problem" or critical/emergency issues. This tension between clinical and administrative supervision can make regular, quality supervision of all direct care staff more an exception rather than the rule. The clinical supervisor is continually challenged to maintain a proper balance between the growth of the supervisee and the effectiveness of the organization.

Finally, the lack of consistent, focused supervision can lead to low staff morale, high staff turnover, and reduced quality care. In this sense, the lack of quality clinical supervision can reduce the amount of direct care (and billable) hours available to consumers even more than the hours invested in solid clinical supervision. In other words, the time spent in best practice driven, clinical supervision can potentially increase the quality and effectiveness of consumer contact hours, consumer retention, clinician retention and wellbeing, and the overall quality of care to service recipients.

A study by DeStefano et al. (2003) highlighted this last point. They surveyed 848 rural Arizona professional and paraprofessional clinicians in the Northern Arizona Behavioral Health Authority (NARBHA) and the two service areas now served by Cenpatico Behavioral Health of Arizona. The survey results indicated higher than normal levels of burnout and job dissatisfaction. They found that "those surveyed were less satisfied with all aspects of supervision including their relationship with their clinical supervisor." Respondents reported that they did not trust in their supervisor's competency in helping them make important decisions. In addition, the study found that 31.2% of respondents scored in the medium or high range for all three sub-scales in the Maslach Burnout Inventory (MBI) (Maslach and Jackson, 1996) reporting significantly higher levels of Emotional Exhaustion than the normed group. Finally, 42% of the 132 participants that agreed to a structured interview in addition to the survey reported that high stress would or might possibly cause them to leave their present jobs.

In addition to recommending improved training and orientation of new staff, the authors suggested that key to responding to the high burnout and job dissatisfaction of those surveyed would be improved clinical supervision. They recommended that this supervision include skill building in case conceptualization, in treatment planning, and in developing treatment strategies. They further pointed out that too often clinical supervision was "hit or miss" and rarely regular. As a result of that information, strongly recommended that both the quality and quantity of supervision had to improve. Their recommendations included formalized training of new clinical supervisors at the RBHA level to include ethical and legal issues as well as models of clinical supervision.

The study found that regular, quality clinical supervision conducted by specially trained clinical supervisors is one of the top contributors to high job satisfaction, job longevity, and the overall emotional well-being of direct care staff. The addition of regular, quality, clinical supervision hours will actually increase productivity and quality of care rather than detract from or hinder it.

Recommended Processes and Procedures:

Enhancing the supervisee's personal and professional development:

Quality clinical supervision builds on the skills training that direct care staff receive. However, clinical supervisors should encourage supervisees to go beyond required trainings and seek out opportunities to build on existing skills as well as expand their fund of knowledge in their respective areas of responsibility.

While clinical supervision focuses on professional skills development, it also emphasizes growth in self-awareness and understanding on the part of supervisees. Direct care staff face a number of challenges to their professional abilities but often more so to their personal well-being. Large case loads, crisis situations, budget constraints can take their toll on supervisees. As a result, clinical supervisors should monitor signs of "burn-out" and job dissatisfaction so that any related concerns may be detected and addressed early on. Guiding the supervisee in greater self-awareness and self-care can increase the overall well-being of the clinician and, in turn, the quality of care to service recipients.

Because supervisees respond to the needs of a wide variety of populations on a large continuum of need, clinical supervisors also must be aware of, trained in, and able to direct supervisees in a number of specific areas, most especially those within the scope of work of the supervisee. Therefore, personal and professional development is also the responsibility of the clinical supervisor as well.

Providing regular supervision grounded in best practices:

Best practices in behavioral health services address the fact that all direct care staff should be receiving consistent, substantive supervision. In other words, clinical supervision done on a regular basis for a length of time that will allow for focus on both a review and discussion of the supervisee's cases as well as discussion and evaluation of the supervisee's skills and self-awareness. While some supervisees have specific supervision requirements mandated by state statute and/or professional license or certification, other supervisees may not have such requirements. It is especially important that those direct care staff without specific, mandated supervision still receive the benefits of regular, substantive supervision.

The clinical supervisor should first of all establish a safe, private environment for supervision with clear expectations and processes. In the supervision process, the supervisor should:

- Explore and clarify the critical thinking skills of the supervisee by giving them practice in case conceptualization
- Foster the supervisee's intuitive skills by guiding them to look beyond words and objective materials

- Train and supervise the proper and ethical use of assessment tools and procedures
- Maintain clear professional boundaries between supervisor and supervisee also teaching proper boundaries between supervisees and service recipients
- Provide clear, specific, objective feedback on both strengths and weaknesses of supervisee skills
- Discuss conflict with supervisees when it occurs
- Respect human diversity and individual differences that may exist between the supervisor and supervisee providing safe venue for the discussion of those differences
- Share information, experience, and skills from his/her own professional practice
- Ensure that supervisees remain within their level of training and competency
- Confront personal and professional blocks to growth and self-awareness of supervisees including behaviors and conditions that may cause impairment
- Be aware of organizational contracts, policies, procedures, which the supervisee must follow
- Keep records of supervision which include the cases, skills, and possible concerns discussed
- Be aware of the different models of clinical supervision that reflect the differing professional training and expectations, work contexts, and needs of staff
- Be knowledgeable of the National Board of Certified Counselors' Approved Clinical Supervisor (ACS) Code of Ethics as well as those ethical codes which guide the supervisee

Assessing and evaluating supervisee competence and effectiveness on a regular basis:

A major role of clinical supervision is to ensure that the supervisee's professional competence is equal to the responsibilities and unique expectations of their respective jobs. When it is determined that the supervisee needs to improve certain competencies, it is the responsibility of the clinical supervisor to point out the areas that need improvement and assist/direct the supervisee in taking appropriate steps to remediate those skills. When reviewing cases, guidance should be provided to the supervisee in the process of case conceptualization – seeing the bigger picture rather than focusing too narrowly on specific diagnostic criteria. Understanding the needs and challenges of the whole person provides a more appropriate framework for effective service planning and case management.

This understanding is also essential for consumer retention, satisfaction, and successful service planning. Supervisees are to be guided in developing the broader, foundational skills of consumer engagement and rapport building, and involving consumers in their service planning process. They should also identify and incorporate the consumer's personal goals, strengths, expectations, cultural uniqueness, and past experiences into service planning. These basic supervisee competencies are essential to effective consumer service.

Clinical supervisors should also strongly encourage their supervisees to briefly survey consumers at the end of each engagement to evaluate their level of effectiveness with the consumer. This will also gauge whether or not the consumer feels part of the process and is likely to continue. There are a number of formal and informal instruments available for this purpose and applicable to a number of different levels of training and licensure. Clinical supervisors and their supervisees should explore available tools that evaluate the working alliance between clinician and recipient and use these tools on a regular basis.

Adhering to agency, licensing, and accrediting requirements:

Clinical supervisors are responsible to see that supervisees are aware of the practice expectations of the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS). These expectations include, but are not limited to, the "Arizona Vision and 12 Principles," the special needs of children, the Developmentally Disabled, substance use disorders, as well as appropriate state statutes, and applicable ethical and legal issues. Clinicians/supervisees should have a general, working knowledge of the ADHS/DBHS Provider Manual and applicable Clinical Practice Protocols, as well as a basic understanding of the Psychosocial Rehabilitation Model. Finally, and very importantly, both clinical

supervisors and their supervisees should have a solid grasp of the concepts of recovery and resiliency as they apply to human service provision; understanding that these are not part of, but rather the core of best practice in the field.

Monitoring legal, ethical, and cultural competency issues:

Early detection of any ethical or legal issues that may be involved as well as the dynamics of transference, counter-transference, and maintaining appropriate boundaries are also essential skills to be developed and fostered early on in the supervisory relationship. Clinical supervisors need to ensure that supervisees have a working knowledge of the Arizona Administrative Code R-9-20 and R-9-21 as it applies to their specific responsibilities. In addition, clinical supervisors should ensure that supervisees:

- have a knowledge and understanding of their respective licensing/accrediting body's code of ethics where applicable
- initiate and organize their own personal and professional practice development
- are accountable for their own work and inform the supervisor of any difficulties
- identify specific practice issues for discussion and improvement
- are open to receiving and integrating feedback in their practice
- are sensitive to and make effort to respond to specific cultural needs of the consumer
- understand that culture is not limited to ethnicity, but includes issues of gender, sexual orientation, spirituality, and economics

Ensuring staff retention and overall welfare:

Not only are clinical supervisors responsible for ongoing training, skills enhancement, and professional growth, they must also monitor and teach supervisees to self-monitor in the areas of burnout, compassion fatigue, and impairment. Pearlman and Mac Ian (1995) note that one of the ten best ways to guard against burnout and impairment is regular, quality clinical supervision. Helping supervisees to grow in their self-awareness, as well as monitoring for signs of emotional stress and potential impairment can enable the supervisor to take early supportive action.

In addition to the lack of regular clinical supervision some factors that can threaten supervisee wellness and competence include, but are not limited to:

- the nature of the service recipients (e.g. vulnerable children, complexity of problems, safety concerns)
- the nature of the workplace (e.g. insufficient resources or vacation time, lack of input into the decision-making process of the organization, current policies that may prohibit best practice treatment)
- training, education and experience, current stressors, and/or changes in life outside of work, natural coping style, a personal history of trauma, and beliefs that limit the likelihood to seek support (Catherall, 1995; Cerney, 1995; Saakvitne, Pearlman & Mac Ian, 1996).

The American Counseling Association's (ACA) Task Force on Impaired Counselors has examined a number of self-assessment instruments designed to identify vulnerabilities to impairment. Two instruments in particular seem to be especially helpful in identifying areas of vulnerability across the many spheres of wellness with which counselors should be concerned. The Professional Quality of Life (ProQOL-III) assessment measures compassion fatigue, compassion satisfaction, vicarious traumatization, and potential for burnout in counselors (Stamm, 2002). As a balance to the ProQOL-III the task force also recommends the Self-Care Assessment (Saakvitne, Pearlman & Staff of TSI/CAAP, 1996). This assessment focuses on the wellness activities in which counselors may participate across several domains of wellness (physical, psychological, spiritual, and professional).

Training and Supervision Recommendations

This Practice Protocol applies to T/RBHAs and their subcontracted network and provider agencies for all behavioral health representatives who supervise direct care staff. Each T/RBHA shall establish their own process for providing training and guidance to those who provide clinical supervision to ensure they have current knowledge and skill, up to date information, and awareness of best practices in clinical supervision.

A number of national professional organizations provide guidelines and best practices in clinical supervision of their practitioners. A number of companies who provide continuing education units (CEUs) nationwide offer workshops as well as online courses specifically designed for clinical supervisors. T/RBHAs should strongly encourage clinical supervisors to attend/participate in regular training that specifically addresses clinical supervision theories and practice as well as training in best practices in their respective fields and the service areas of those whom they supervise.

Finally, clinical supervisors are also expected to be knowledgeable regarding the ADHS/DBHS Provider Manual Section 9.1 Training Requirements to insure that their supervisees are in compliance.

Anticipated Outcomes:

It is anticipated that by maintaining regular, quality, clinical supervision sessions with direct care staff (supervisees), the following outcomes will be realized:

- Supervisees will experience growth in self-awareness, as well as skill and knowledge base
- Supervisees will be aware of and trained in best practices in their respective areas of service
- Supervisees will be regularly evaluated and given feedback on professional competency
- Supervisees will be better aware of agency, licensing, ethical, and state requirements
- Supervisees will experience greater work satisfaction, health, and employment longevity
- Supervisees will provide more effective, high quality service to recipients

Desktop Guide

Key Elements to remember about this best practice:

- Clinical supervision is distinct from administrative supervision
- Clinical supervision includes attention to both professional and personal growth
- High quality clinical supervision often represents the exception rather than the norm
- There is a need for better training and clearer standards for clinical supervision
- Clinical supervisors need to be highly skilled in the areas of practice of their supervisees
- Clinical supervisors should continually update their skills and knowledge in supervision
- Consistent clinical supervision promotes staff retention and wellbeing as well as quality of care delivered to consumers

Benefits of using this best practice:

- Greater work satisfaction, retention, and well being of direct care staff
- Greater self-awareness and skill building for supervisees
- Better monitoring of quality of care to consumers
- Greater adherence to legal, ethical, and cultural issues
- More frequent and substantial feedback is given to the supervisee
- Greater monitoring of supervisee wellness and potential impairment

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DBHS Practice Protocol

COMPREHENSIVE ASSESSMENT AND TREATMENT FOR SUBSTANCE USE DISORDERS IN CHILDREN AND ADOLESCENTS

(Formerly known as Practice Improvement Protocol #10)

Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services
(ADHS/DBHS)
Effective- August 30, 2009

NOTE:
This Clinical Practice Protocol has required implementation elements. Providers are required to implement the identified Service Expectations, as clearly identified in this document.

Title

Comprehensive Assessment and Treatment for Substance Use Disorders in Children and Adolescents

Goal/What Do We Want to Achieve Through the Use of this Protocol?

To strengthen the capacity of Arizona's behavioral health system to utilize evidence-based, culturally relevant, and developmentally appropriate practices in the assessment and treatment of substance use disorders in children and adolescents.

Target Audience

This protocol is specifically targeted for Tribal and Regional Behavioral Health Authorities (T/RBHAs) and their subcontracted network and provider agency staff who complete assessments, participate in the service planning process, provide therapy, case management and other clinical services, or supervise staff that provide these services to children and adolescents with substance use disorders and their families.

Target Population(s)

This practice protocol has been developed for all children and adolescents referred to the behavioral health system at risk for or with substance use disorders and their families.

Attachments

Attachment A: Adolescent Substance Abuse Screening Instruments

Attachment B: Adolescent Substance Abuse Comprehensive Assessment Instruments

Attachment C: Evidence Based Practices for Adolescent Substance Abuse Treatment

Attachment D: Recommended Specialty Topics for Trainings

Definitions

Alcohol and Drug Abuse Program

Alcohol and/or Drug Services, Intensive Outpatient Program (IOP)

Evidence Based Practices (EBP)

Background

Substance use disorders usually start during adolescence; early age of onset and more rapid progression through the stages of substance use are risk factors for substance use disorders.[1] It is critical that treatment programs be designed specifically for adolescents as there are numerous differences between adolescent and adult substance use disorders. Adolescent substance use disorders have far-reaching neurological, developmental, social and economic ramifications. The numerous adverse consequences associated with adolescent substance use disorders include fatal and nonfatal injuries from alcohol- and drug-related motor vehicle accidents, suicides, homicides, violence, delinquency, psychiatric disorders, and risky sexual practices.[2]

Longitudinal studies have also established associations between adolescent substance use disorders and (1) impulsivity, alienation, and psychological distress,[3] (2) delinquency and criminal behavior,[4] (3) irresponsible sexual activity that increases susceptibility to HIV infection,[5] (4) psychiatric or neurological impairments associated with drug use, especially inhalants, and other medical complications.[6]

The trend toward early onset of substance use disorders has increasingly resulted in adolescents who enter treatment with greater developmental deficits and possibly greater neurological deficits than have been previously observed[7].

Academic Problems: Impairment in academic functioning is a hallmark of substance use disorders in adolescence.[8] A deterioration in school performance, including attentional difficulties in the classroom and declining grades, warrants investigation into the potential causes, which should include a screening for substance use disorders.

Developmental Problems*:* Substance use can prevent an adolescent from completing the developmental tasks of adolescence and young adulthood and influence later behaviors such as dating, marrying, bearing and raising children, establishing a career, and building rewarding personal relationships.[9] [10] Because substance use alters the way individuals approach and experience interactions, the adolescent's psychological and social development is compromised, as is the formation of a strong self-identity. Instead of developing a sense of empowerment from healthy personal development, the substance-using adolescent is likely to acquire a superficial and false self-image as he becomes more deeply entrenched in the drug experience.[11] Use of alcohol or drugs may also hinder adolescents' emotional and intellectual growth. Some adolescents may use substances to compensate for a lack of rewarding personal relationships. Treating an adolescent with substance use disorders as early as possible maximizes the opportunity to stem these initially short-term, but potentially long-term, ill effects.

Family and Peer effects: Substance abuse disorders tend to aggregate in the families. This may be in part due to some common genetic influences within families; however, there is substantial evidence of environmental mediation. Parental drug use, as well as drug use by older siblings, is a significant risk factor for the development of adolescent

substance use. However, the mechanism of transmission is complex, with individual personality dimensions mediating the effect of sibling and parent influences.[12] Association with delinquent peers has been one of the hallmarks of the development of adolescent substance use disorders. However, while the common notion has been that peers create "peer pressure" to consume substances, most studies support the notion that there exists a complex process by which individuals select peer groups, then in turn influence these, as well as influenced by them. [13]

Genetic and Environmental Influences: Twin and adoption studies have demonstrated that considerable shared environmental influences exist for initiation of substance use, and that genetic influences become more apparent when environments allow for their expression.[14] Genetic influences on the development of substance use disorders may act through a direct effect on psycho-physiological reactions to substances or their metabolism, or indirectly through genetic effects on personality traits such as behavioral disinhibition, which leads to substance experimentation.[15] Thus, genetic factors influence individual risks, but do not account for population wide shifts in patterns of substance use.

Juvenile Delinquency and Crime*:* There is a strong and consistent association between conduct disorder and substance use among adolescents.[16] An increasing number of adolescents entering residential treatment for substance use disorders have been criminally active and mandated to treatment by the criminal justice system.[17] Drug testing data collected on male juvenile arrestees through the National Institute of Justice (NIJ) confirms a strong and continuing relationship between the extent of drug use and juvenile crime.[18]

Mortality*:* Alcohol-related motor vehicle accidents exact a heavy toll on society in terms of economic costs and lost productivity. Nearly half (45.1 percent) of all traffic fatalities are alcohol-related, and it is estimated that 18 percent of all drivers between the ages of 16 to 20 years, totaling 2.5 million adolescents and young adults, drive under the influence of alcohol.[19]

Sexually Risky Practices: Adolescents who use alcohol and illicit drugs are more likely than others to engage in sexual intercourse and other sexually risky behaviors. A positive correlation has been demonstrated between alcohol use and frequency of sexual activity. Substance use among adolescents is also associated with early sexual activity, an important factor in the prevalence of sexually transmitted diseases (STDs) including human immunodeficiency virus (HIV) infection. Substance use can also decrease an individual's discrimination in the selection of sexual partners and can increase the number of partners and the likelihood of risky sexual practices thereby heightening the risk of STDs.[20]

Another substance use consequence related to sexual behavior is unwanted pregnancy. Out of an estimated 200,000 young women under the age of 18 who gave birth to a live infant each year, an estimated 12.4 percent used alcohol, 21.9 percent smoked cigarettes

and 5.7 percent used marijuana or cocaine while they were pregnant; these behaviors increase the risks of fetal alcohol syndrome, miscarriage, and restricted fetal growth. [21]

Trauma: Multiple pathways have been proposed to explain the temporal link between trauma and substance abuse in adolescents.[22] A review of these theories demonstrates that the road connecting these disorders runs both ways: trauma increases the risk of developing substance abuse, and substance abuse increases the likelihood that adolescents will experience trauma.

Although it is unclear exactly how many adolescents who abuse drugs or alcohol also have experienced trauma, numerous studies have documented a correlation between trauma exposure and substance abuse in adolescents. In the National Survey of Adolescents, individuals who had experienced physical or sexual abuse/assault were three times more likely to report past or current substance abuse than those without a history of trauma.[23] In surveys of adolescents receiving treatment for substance abuse, more than 70% of patients had a history of trauma exposure.[24] [25] This correlation is particularly strong for adolescents with posttraumatic stress disorder (PTSD). Studies indicate that up to 59% of adolescents with PTSD subsequently develop substance abuse problems. [18] [21] [26] [27] [28] Recent research in this area also suggests that traumatic stress or PTSD may make it more difficult for adolescents to stop using, as exposure to reminders of the traumatic event have been shown to increase drug cravings in people with co-occurring trauma and substance abuse.[29] [30]

Procedures

Because of the unique challenges faced by adolescents with substance use disorders, including the potentially damaging and long-term consequences of substance use, it is critical that treatment programs be tailored to effectively screen, diagnose, and treat this population. The following eight elements must be incorporated into all adolescent substance abuse treatment programs:

Comprehensive Screening and Assessment
Integrated Treatment
Family Involvement in Treatment
Developmentally Appropriate Treatment
Gender and Culturally Competent Treatment
Engagement and Retention in Treatment
Treatment Outcomes
Continuing Care

1. Comprehensive Screening and Assessment

Screening is a relatively brief process designed to identify adolescents who are at increased risk of having substance use disorders that warrant immediate attention, intervention, or more comprehensive evaluation. Screening is a triage process, and should

be employed with all children and adolescents entering the system; please refer to Attachment A: Adolescent Substance Abuse Screening Instruments. Screening instruments should not be used to provide a psychiatric diagnosis; rather, they are utilized to help identify possible substance use issues and the need for further assessment and evaluation. If the screening raises concerns about substance use, the clinician should conduct a more formal evaluation to determine whether the adolescent meets criteria for substance use disorders.

The adolescent substance abuse ***assessment*** process is a more comprehensive and individualized examination of the psychosocial needs and problems identified during the initial screening; this includes assessing for mental health and substance abuse disorders, other associated issues, and recommendations for treatment intervention. Of note, this assessment process differs from the ADHS/DBHS Core Assessment, as the adolescent substance abuse assessment is specialized for adolescents who have screened positive. Components of an adolescent substance abuse assessment should include, but are not limited to clinical interviewing and review of previous records. Consideration should be given to psychological testing if clinically indicated. The assessment should be completed by staff that is trained and qualified in administering and interpreting the standardized assessment. Valid and reliable instruments are necessary for creating an effective assessment process; equally important is the knowledge on how best to use these instruments. Please refer to Attachment B: Adolescent Substance Abuse Comprehensive Assessment Instruments.

The completed comprehensive assessment for the adolescent should include substance use disorder assessment and diagnosis, toxicology evaluation through the collection of bodily fluids or specimens, mental health assessment and diagnosis, testing for STDs if clinically indicated (including HIV, Hepatitis B and C), TB screening if clinically indicated, and assessment of the need for medical detoxification if clinically indicated. A comprehensive list of assessment components as recommended in the Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment (SAMSHA/CSAT) Treatment Improvement Protocol 31 includes: [31]

- History of use of substances, including over-the-counter and prescription drugs, tobacco, and inhalants; age of first use; frequency, length, and pattern of use; mode of ingestion; treatment history; and signs and symptoms of substance use disorders, including loss of control, preoccupation, and social and legal consequences
- Strengths and resources to build on, including self-esteem, family, other community supports, coping skills, and motivation for treatment
- Medical health history and physical examination, noting, for example, previous illnesses, ulcers or other gastrointestinal symptoms, chronic fatigue, recurring fever or weight loss, nutritional status, recurrent nosebleeds, infectious diseases, medical trauma, and pregnancies
- Sexual history, including sexual orientation, sexual activity, sexual abuse, and STD/HIV risk behavior status
- Developmental history

- Mental health history, with a focus on depression, suicidal ideation or attempts, attention-deficit disorders, anxiety disorders, and behavioral disorders, as well as details about prior evaluation and treatment for mental health problems
- Family history, including the parents, guardians', and extended family's history of substance use, mental and physical health problems and treatment, chronic illnesses, incarceration or illegal activity, child management concerns, and the family's ethnic and socioeconomic background and degree of acculturation
- School history, including academic and behavioral performance, and attendance problems
- Vocational history, including paid and volunteer work
- Peer relationships, interpersonal skills, gang involvement, and neighborhood environment
- Juvenile justice involvement and delinquency, including types and incidence of behavior and attitudes toward that behavior
- Social service agency program involvement, child welfare agency involvement (number and duration of foster home placements), and residential treatment
- Leisure-time activities, including recreational activities, hobbies, and interests

Service Expectations:

- **Substance use disorder screening must be employed with all adolescents entering the behavioral health system using standardized screening instruments**
- **Adolescent substance use disorder treatment providers/programs must conduct comprehensive assessments that include the following:**
    - **Comprehensive substance use assessment and diagnosis using standardized assessment instruments and interview with the adolescent and caregiver**
    - **Screening and assessment of medical issues**
    - **STD screening (including HIV, Hepatitis B and C) if clinically indicated**
    - **TB screening if clinically indicated**
    - **Assessment of the need for detoxification if clinically indicated**
    - **Toxicology evaluation, through the collection of bodily fluids or specimens**

2. Integrated Treatment Approach

Individualized service plans (ISPs) should be comprehensive, addressing each of the adolescent's needs including their substance use disorder. The substance use disorder should not be the only focus of treatment; treatment should also address medical, psychiatric, psychological, social, vocational, and legal problems. In addition, adolescents with substance use disorders should be treated in the least restrictive setting that is safe and effective. [1]

A matching of treatment settings, interventions, and services to the strengths and needs of each adolescent and their family is imperative, given that a single treatment approach will not adequately address the complex needs of all adolescents. At a minimum, the ISP should identify the following:

- *Strengths* of the adolescent and their family, including available natural supports
- *Problems* of the adolescent and their family, including substance use, psychosocial issues, medical problems, and psychiatric disorders
- *Goals* to address the target problems, including those that help the adolescent recognize and acknowledge responsibility for the problems associated with their substance use and take into account their preference for addressing these problems
- *Objectives* that are realistic and measurable steps for achieving each goal
- *Time frames* for the achievement of the stated goals/objectives
- *Appropriate interventions* including treatment strategies and services that are needed to achieve the goals/objectives. The specified treatment strategies and services should include the identification of the individuals who will be providing treatment, an expected timetable for achieving the objectives, the date the ISP will be reviewed, and where treatment is to take place[32] [33]
- Assessment methods for *measuring* the extent to which goals/objectives and interventions are fulfilled
- *Collaborating* with educational, legal, and external support systems and their role in the ISP

Implementing Evidence Based Practices for adolescents with substance use disorders is recommended in order to maximize positive treatment outcomes; please refer to Attachment C: Evidence Based Practices for Adolescent Substance Abuse Treatment. In order to use EBP effectively, staff must be trained and qualified, as indicated by adequate training and implementing practices to fidelity. Programs must be able to demonstrate which EBP is implemented, how training is conducted, and how fidelity is monitored.

Psychopharmacologic interventions for the underlying substance use disorder can also be considered for adolescents. Evidence is mounting for medications targeting alcohol-related cravings such as naltrexone, acamprosate, and ondansetron in adolescent case reports[1] and for a buprenorphine in the treatment of adolescent opiate dependence in a randomized control trial.[34] Due to the need for more research in this area, the informed consent process should include detailed rationale when treating adolescents with these medications.

Psychiatric disorders that are co-occurring with substance use disorders should be treated; specific psychotherapeutic interventions, depending on the co-occurring psychiatric condition, should be employed.[1]

Treatment outcomes should be continually assessed; the ISP should be modified to ensure that it meets the adolescent's changing needs and to ensure that progress is being made

toward the treatment goals. If progress is not being made, a re-evaluation of the ISP should occur to determine what changes are necessary to promote progress.

Service Expectations:

- **The ISP must comprehensively address the adolescent's substance use, medical, psychiatric, psychosocial, vocational/educational, and legal issues**
- **The ISP must be updated to reflect the changing needs of the adolescent and to ensure progress is being made**
- **Programs must be able to demonstrate which EBP is implemented, how training is conducted, and how fidelity is monitored**

3. Family Involvement in Treatment

Engaging both the adolescent and caregiver, as well as maintaining close links with the adolescent's family, community, school, and other involved systems, ensures greater success in treatment.

As family members and caregivers play an important role in treatment initiation, engagement and in treatment outcomes, all efforts should be made to engage families. As previously reviewed, substance use disorders tend to aggregate in families. Therefore, it is important to not only engage family members and caregivers in the adolescent's treatment, but to also consider referring them for substance use disorder treatment if needed. Adolescents benefit from the integration of their family in their substance use disorder treatment in several ways. These benefits include positive treatment outcomes, increased likelihood of the adolescent's ongoing recovery, increased help for the family's recovery, and the reduction of the impact of substance use disorders on different generations in the family. The benefits for the treatment professionals include reduced resistance from adolescents, increased flexibility in treatment planning, an increased skill set, and improved treatment outcomes.

Some of the specific benefits of family involvement in adolescent substance abuse treatment are:[35]

- *Family interventions can help modify the maladaptive family relationship patterns that can contribute to, or result from, adolescent drug abuse.* Research has shown that family interventions can bring about improvements in overall family functioning and parenting practices by helping parents: create clearer rules and standards for behavior; develop predictable rewards and consequences; and improve their effectiveness in monitoring school performance and peer relationships.

- *Family members are key to helping with co-occurring disorders.* The treatment of adolescents who use alcohol and drugs is often complicated by the presence of a co-occurring psychiatric disorder. The ability of family members to observe psychiatric conditions and to support the adolescent in seeking help when psychiatric conditions worsen may be a critical component of the adolescent recovery process.

- *Family members are needed as change agents in the adolescent's environment.* Interventions that can help parents understand these complex systems, the potential allies that exist within them, and how to change the systems most effectively can have a profound impact on the long-term well being of the adolescent

- *Family interventions can result in beneficial effects long after the "treatment" phase is over.* The amount of time for the addiction treatment phase is typically brief, although current understanding is that recovery from addiction is not a linear process- still it can be a long process. When parents develop skills to guide their child though the process the positive impact may continue for many years to come

- *Family interventions can be used to bring an adolescent to treatment for the first time or can help to retain the adolescent in treatment.* With the family members serving as allies, the likelihood that an adolescent will continue to participate in treatment is greatly increased

Service Expectations:
The caregiver should be actively included in the adolescent's treatment planning whenever possible in order to maximize outcomes.

4. Developmentally Appropriate Treatment

The period of adolescence is a period of cognitive, emotional, social and physical growth. Adolescence is characterized by rapid physical growth including sexual maturation and development of secondary sexual characteristics. It is also characterized by motivational and emotional changes. Cognitive development includes maturation of impulse control, judgment, and planning. Due to this unique and rapid development, it is important that substance use disorder programs are specifically designed for adolescents rather than merely modified from adult programs.

Children and adolescents who present with substance use disorders often manifest with significant changes in mood, cognition, and behavior.[1] Behavioral changes may include disinhibition, lethargy, hyperactivity, agitation, somnolence, and hyper vigilance. Changes in cognition may include impaired concentration and perceptual disturbances in thinking. Mood changes can range from depression to euphoria. The manifestations of substance use and intoxication vary with the type of substance(s) used, the quantity used

during a given time period, the setting and context of use, and a host of characteristics of the individual such as experience with the substance, expectations of drug effect, and the presence or absence of other psychopathology.

A hallmark of substance use disorders in adolescents is impairment in psychosocial and academic functioning.[14] Impairment can include family conflict or dysfunction, interpersonal conflict, and academic failure. Associated characteristics include deviant and risk-taking behavior and comorbid psychiatric disorders such as conduct, attention-deficit/hyperactivity, mood, anxiety, and learning disorders.[36] [37] [38] Almost all psychoactive substances, including alcohol and nicotine, are illegal for adolescents to obtain, possess, and use; this can result in legal implications such as involvement with the juvenile justice system.

Recent research by scientists at the National Institute of Mental Health (NIMH) using magnetic resonance imaging (MRI) has found that the adolescent brain is not a finished product, but rather a work in progress. Until recently, most scientists believed that the major wiring of the brain was completed by as early as three years of age and that the brain was fully mature by the age of twelve. New findings indicate that the greatest changes to the parts of the brain that are responsible for functions such as self-control, judgment, emotions, and organization occur between puberty and adulthood. This may help to explain certain adolescent behavior, such as poor decision-making, recklessness, and emotional outbursts.[39]

Regardless of the specific model used when treating adolescents, the following are some recommendations provided by SAMSHA/CSAT:[40]

- Adolescents must be approached differently than adults because of their unique developmental issues, differences in their values and belief systems, and unique environmental considerations such as peer pressure
- Not all adolescents who use substances are, or will become, dependent. Programs and counselors must be careful not to prematurely diagnose or label adolescents or otherwise pressure them to accept that they have a disease. This may do more harm than good in the long run
- Programs should be developed to take into account the different developmental needs based on the age of the adolescent; younger adolescents have different needs than older adolescents
- Some delay in normal cognitive and social-emotional development is often associated with substance use during the adolescent period. Treatment for these adolescents should identify such delays and their connections to academic performance, self-esteem, and social considerations
- In addition to age, treatment for adolescents must also take into account gender, ethnicity, disability status, stage of readiness to change, and cultural background.
- Programs should make every effort to involve the adolescent 's family because of its possible role in the origins of the problem and its importance as an agent of change in the adolescent's environment
- Although it may be a necessity in certain geographic areas where availability of adolescent treatment programs is limited, using adult programs for treating

adolescents is not advised. If this must occur, it should be done only with great caution and with alertness to the inherent complications that may threaten effective treatment for adolescents

- Many adolescents have explicitly or implicitly been coerced into attending treatment. However, coercive pressure to seek treatment is not readily conducive to the behavior change process. Consequently, treatment providers must be sensitive to motivational barriers to change at the outset of intervention. There are several strategies suggested by Miller and Rollnick for encouraging reluctant clients to consider behavioral change.

Service Expectations:
Treatment must be tailored to address the unique cognitive, social, emotional and developmental needs of the adolescent

5. Gender and Culturally Competent Treatment

Adolescent substance use disorder treatment programs should provide services appropriate for the adolescent's age, gender, ethnicity, sexual orientation and culture. According to SAMHSA/CSAT Treatment Improvement Protocol 47 [41], culture is important to consider when providing substance use disorder treatment as the adolescent's experiences of culture precede and influence their clinical experience. Culture is a broad concept that refers to a shared set of beliefs, norms, and values among any group of people, whether based on ethnicity or a shared affiliation and identity. Therapeutic alliance should be informed by the clinician's understanding of the adolescent's cultural identity, social supports, self-esteem, and reluctance about treatment resulting from social stigma. The treatment provider is responsible for ensuring that treatment is effective for diverse clients.

SAMHSA/CSAT Treatment Improvement Protocol 47 provides guidelines for steps programs should take to ensure culturally competent treatment for their clients which includes:

- Assess the program for policies and practices that might pose barriers to culturally competent treatment for diverse populations. Removing these barriers could entail something as simple as rearranging furniture to accommodate clients in wheelchairs or as involved as hiring a counselor who is from the same cultural group as the population the program serves.
- Ensure that all program staff receives training about the meaning and benefits of cultural competence in general and about the specific cultural beliefs and practices of client populations that the program serves.
- Provide program materials on audiotapes, in Braille, or in clients' first languages. All materials should be sympathetic to the culture of clients being served.
- Ensure that client materials are written at an appropriate reading level.
- Include a strong outreach component. People who are unfamiliar with U.S. culture may be unaware that substance abuse treatment is available or how to access it.

- Hire counselors and administrators and appoint board members from the diverse populations that the program serves.
- Incorporate elements from the culture of the populations being served by the program (e.g., Native-American healing rituals or Talking Circles).
- Partner with agencies and groups that deliver community services to provide enhanced services, such as child care, transportation, medical screening and services, parenting classes, English-as-a-second-language classes, substance-free housing, and vocational assistance. These services may be necessary for some clients to be able to stay in treatment.

Service Expectations:
Adolescent substance use disorder treatment programs implement specialized programming that reflects the unique needs of the individuals they serve.

6. Engagement and Retention in Treatment

Adolescents are far more likely to seek assistance for problems with employment, relationships, and family than they are for mental health issues including substance use disorders. Entities that can act as resource centers and offer a variety of services are more likely to be sought after by adolescents. Successful outcomes often depend upon retaining the person long enough to gain full benefits of treatment. Because adolescents often leave treatment prematurely, programs should employ evidence based strategies to engage and keep adolescents in treatment such as motivational interviewing.

Listed below are some recommendations included in Treatment Improvement Protocol 31 by SAMSHA/CSAT of ways mental health professionals can increase the likelihood that an adolescent will attend the first session and continue in treatment: [27]

- Orientation. This initial stage in treatment is very important to the adolescent. Many new activities may be threatening to the adolescent, and initiating treatment can intensify feelings of fear and self-consciousness. Moreover, adolescents frequently have incomplete and inaccurate information about the nature of substance use disorders and treatment programs. A non-confrontational approach in explaining the treatment program is the most effective method in clarifying the expectations and role of the adolescent in treatment.
- Make reminder calls. Call the adolescent's home prior to the appointment and speak with both the adolescent and their caregiver. Inform them that you look forward to meeting them; discuss the importance of arriving at the sessions on time; mention a couple of success stories; and ask about any anticipated obstacles
- Be especially welcoming at the first session. Praise the adolescent and family for making it to the first session.
- Be culturally aware and sensitive. When engaging adolescents and their caregivers, it is essential to be aware of cultural values and expectations that guide social interaction, mental health/substance abuse treatment, and salient themes in their communities. Establishing the trust of adolescents and their families from

diverse backgrounds is an important factor in determining whether they will continue in treatment. If staff members are not familiar with the cultural background of the adolescent and the families they are assisting, they must receive training in cultural competence

- Reach out to the family. Make intense outreach efforts beginning with the first session. Obtain several ways to contact the adolescent and caregiver and obtain contact information for those involved in their care. Make follow-up phone calls, letting them know that you care and that you want to continue to see them. This is particularly important for adolescents who are court-mandated for treatment
- Stay "at their level" when making the first contact. Showing the adolescent that you understand his or her language and culture will facilitate engagement. Let him or her know that you are knowledgeable about the issues faced by adolescents
- Present treatment options in a non-threatening, appealing manner. Avoid asking personal questions, and stress that adolescents similar to him or her have participated in and benefited from the program
- Avoid blaming. Reframe current situations (e.g., drug behavior, living in a shelter) in terms of relational factors rather than personal failure
- Convey hope and empowerment. Communicate that change is possible and that the adolescent will have control over his or her participation in treatment
- Respect his or her concerns, such as those surrounding confidentiality and engaging primary caregivers. Be open to negotiation

Addressing relapse is also critical in engaging and retaining adolescents in treatment. Relapse is currently understood as part of the recovery process and therefore: 1) Programs should address relapse in the treatment and aftercare plans; 2) Program ejection policies should not be based on relapse.

Areas of confidentiality should be reviewed with the adolescent during all phases of assessment and treatment. Adolescents are more likely to be forthcoming if they believe that their information will not be shared. Prior to conducting the first interview with the adolescent, the provider should review all confidentiality issues, including exactly what information the mental health professional is obliged to share and with whom.[1] These confidentiality discussions should continue during the course of treatment.

Service Expectations:
Programs must employ strategies to engage and keep adolescents in treatment.

7. Treatment Outcomes

A process which evaluates a program's treatment effectiveness and outcomes is essential in assuring the quality of services provided; program improvements should be targeted to address the findings of these evaluations. Examples of methods employed to measure outcomes during and after adolescent substance disorder treatment include the use of

standardized tools at the beginning of treatment and at regular intervals during and after treatment, exit surveys and post-treatment telephone surveys.

Service Expectations:
Programs should evaluate treatment effectiveness and outcomes and implement program improvements to address the findings of these evaluations.

8. Continuing Care

The adolescent's Child and Family Team (CFT) should be involved in all stages of substance disorder treatment including aftercare. For example, if an adolescent is receiving substance disorder treatment through a Residential Treatment Center (RTC), the CFT should be involved throughout the course of treatment in this setting. The coordination of care between the substance disorder treatment team and the adolescent's CFT will maximize the adolescent's success when transitioning to after-care services (see Out of Home Services Practice Protocol for additional information).

Participation in after-care services following treatment in a program is related to improved outcomes. [42] Greater attendance during the first three months of continuing care has been significantly related to more days of abstinence during that period. [43] Adolescents attending more intensive aftercare programs involving case management and community reinforcement were more likely than those who did not receive these services to be abstinent from marijuana and reduce their alcohol use at 3 months post-discharge. [44]

Having a history of relapse is common for adolescents in treatment for substance use disorders. [45] Because an adolescent who has relapsed in the past is at greater risk for further relapses, it is important to evaluate precipitants for relapse and to adjust aftercare/continuing care plans to address these precipitants. The aftercare should also include plans for addressing relapse if it should occur. Components of effective relapse prevention consists of comprehensive discharge planning including:

- Referrals to community resources, including twelve-step programs specifically designed for adolescents
- Active coordination of care with outpatient providers and all involved agencies
- Arrangements for therapy and other applicable psychiatric services provided in a timely manner after discharge

Service Expectations:
Methods are implemented by adolescent substance disorder treatment programs to maximize successful outcomes for youth after treatment completion, including plans for addressing relapse.

Training and Supervision Expectations

It is the expectation of ADHS/DBHS that behavioral health staff who complete evaluations and provide interventions for the treatment of adolescents with substance use disorders be adequately trained and clinically supervised in the tenets of this protocol. Additional specialty training topics can be found in Attachment D: Recommended Specialty Topics for Trainings. Each T/RBHA shall establish their own process for ensuring that clinical staff working with this population follows the recommended process and procedures and whenever this Practice Protocol is updated or revised ensures that their subcontracted network and provider agencies are notified and required staff is retrained as necessary on the changes.

Anticipated Outcomes and How They Will Be Measured

Anticipated Outcomes include:

- Improved recognition of substance use disorders in adolescents through the use of standardized screening instruments leading to improved outcomes
- Improved treatment of substance use disorders in adolescents through the use of standardized assessment instruments and EBP leading to improved outcomes

How Will Outcomes/Fidelity Be Measured?

- Facilities providing adolescent substance disorder treatment will be monitored with the T/RBHA Adolescent Substance Abuse Treatment Program Evaluation Tool.

Guidelines for Comprehensive Assessment and Treatment for Substance Use Disorder in Children and Adolescents
Desktop Guide

Service Expectations:

- Substance use disorder screening must be employed with all adolescents entering the behavioral health system using standardized screening instruments
- Adolescent substance use disorder treatment providers/programs must conduct comprehensive assessments that include the following:
  - Comprehensive substance use assessment and diagnosis using standardized assessment instruments and interview with the adolescent and caregiver
  - Screening and assessment of medical issues
  - STD screening (including HIV, Hepatitis B and C) if clinically indicated
  - TB screening if clinically indicated
  - Assessment of the need for detoxification if clinically indicated
  - Toxicology evaluation, through the collection of bodily fluids or specimens
- The ISP must comprehensively address the adolescent's substance use, medical, psychiatric, psychosocial, vocational/educational, and legal issues
- The ISP must be updated to reflect the changing needs of the adolescent and to ensure progress is being made
- Programs must be able to demonstrate which EBP is implemented, how training is conducted, and how fidelity is monitored
- The caregiver should be actively included in the adolescent's treatment planning whenever possible in order to maximize outcomes.
- Treatment must be tailored to address the unique cognitive, social, emotional and developmental needs of the adolescent.
- Adolescent substance use disorder treatment programs implement specialized programming that reflects the unique needs of the individuals they serve.
- Programs must employ strategies to engage and keep adolescents in treatment.
- Programs should evaluate treatment effectiveness and outcomes and implement program improvements to address the findings of these evaluations.
- Methods are implemented by adolescent substance disorder treatment programs to maximize successful outcomes for youth after treatment completion, including plans for addressing relapse.

- Key elements to remember about this best practice:
  - Adolescent substance use disorders have far-reaching neurological, developmental, social and economic ramifications
  - A hallmark of substance use disorders in adolescents is impairment in psychosocial and academic functioning [14]
  - Because of the unique challenges faced by adolescents with substance use disorders, including the potentially damaging and long-term consequences of substance use, it is critical that treatment programs be tailored to effectively screen, diagnose, and treat this population
  - A matching of treatment settings, interventions, and services to the strengths and needs of each adolescent and their family is imperative, given that a single treatment approach will not adequately address the complex needs of all adolescents.
  - Psychiatric disorders that are co-occurring with substance use disorders should be treated; specific psychotherapeutic interventions, depending on the co-occurring psychiatric condition, should be employed [1]
  - As adolescents often leave treatment prematurely, programs should employ strategies to engage and keep adolescents in treatment. Engaging both the adolescent and caregiver, as well as maintaining close links with the adolescent's family, community, school, and other involved systems, ensures greater success in treatment
  - Relapse is currently understood as part of the recovery process and therefore: 1) Programs should address relapse in the treatment and aftercare plans; 2) Program ejection policies should not be based on relapse

- Benefits of using this best practice:
  - Improved recognition of substance use disorders in adolescents through the use of standardized screening and assessment instruments leading to improved outcomes
  - Improved treatment of substance use disorders in adolescents through the use of standardized assessment instruments and EBP leading to improved outcomes

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Practice Protocol

CO-OCCURRING PSYCHIATRIC AND SUBSTANCE DISORDERS

Developed by the
Department of Health Services
Division of Behavioral Health Services

Effective Date: February, 2002
Revised April 3, 2003
Revision date: 12/8/08

Title
Practice Protocol, Co-Occurring Psychiatric and Substance Disorders, formerly known as “Practice Improvement Protocol #6.

What Do We Want to Achieve Through the Use of this Protocol?
To set forth Department of Behavioral Health Services (DBHS) expectations for recognition and treatment of co-occurring disorders.

Target Audience
This protocol will be made available to Tribal and Regional Behavioral Health Authorities (T/RBHAs) and behavioral health representatives who implement behavioral health services to behavioral health adults diagnosed with a co-occurring disorder.

Target Population
This protocol affects behavioral health individuals who have at least one mental health disorder as well as at least one alcohol or drug use disorder.

Background
Co-Occurring disorders may include any combination of one or more substance use disorders and mental health disorders identified in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM IV-TR-IV). While these disorders may interact differently in any one person, at least one disorder of each type can be diagnosed independently of the other (Center for Substance Abuse Treatment (CSAT) TIP 42, 2005). It is estimated that 41-65% of people with serious mental illness (SMI) are also affected by substance abuse/dependence. Seven to 10 million individuals in the United States have at least one mental health disorder as well as an alcohol or drug use disorder. Research has yielded that dual disorders are linked to increased rates of relapse, violence, incarceration, homelessness and serious infections such as HIV and Hepatitis thus making prevention efforts and treatment challenging to the Nation’s public health system (Kessler et al., 1996; U.S. DHHS, 1999; SAMHSA Report to Congress, 2002; SAMHSA National Household Survey, 2002; Smith 2007).

Researchers have made strides over the last two decades by increasing the awareness of and employing evidence based treatment modalities for treatment of individuals with co-occurring disorders. Clinical findings indicate that treatment success is dependent upon timely screening, comprehensive assessment and integrated, client-centered treatment (Minkoff, 2000; SAMHSA Report to Congress, 2002).

Best practice guidelines are outlined in this document for assessment, treatment and psychopharmacology of individuals with co-occurring disorders. Before delineating the practice guidelines themselves, however it is important to describe some of the consensus-based recommended procedures.

Recommended Process/Procedures

1. Access to treatment- Access to assessment or to any service should not require individuals to be defined as mental health or substance disordered before arrival. Similarly, no one should be denied access to substance disorder assessment or treatment due to the presence of a co-morbid psychiatric disorder and/or the presence of a regime of non-addictive psychotropic medication (Minkoff, 2000; CSAT TIP 42, 2005).

2. Collaboration/Coordination- Both ongoing and episodic interventions require consistent collaboration and coordination between all involved in treatment i.e family, caregivers, peer support specialists, natural supports, and external systems. Collaboration with families and/or an individual's primary support systems should be considered an expectation for all individuals at all stages of change, as families and/or an individual's primary support system may provide significant assistance in developing strategies for motivational enhancement and contingent learning behavior, and in actively supporting participation in recovery-based programming to promote relapse prevention (Minkoff,2000). Communication and coordination of care between behavioral health providers, PCPs and Medicare providers must occur on a regular basis to ensure safety and positive clinical outcomes for persons receiving care.

3. Treatment appropriateness- Evidence based best practices for each separate disorder should be integrated into treatment. Interventions need to be matched to each diagnosis, phase of recovery, stage of treatment and stage of change (Prochaska & DiClemente,1982; Prochaska & DiClemente,1992). It is essential to be aware of cultural values and expectations that guide social interaction, and mental health/substance abuse treatment in their communities. Analysis of multiple program models indicate that treatment does not imply a single type of intervention, but that the formation of an empathetic, hopeful treatment relationship between the behavioral health representative and the individual is developed throughout treatment (Minkoff, 2001).

Assessment and Diagnosis of Co-Occurring Disorders

Clinical evaluation begins at the first point of clinical contact, regardless of the individual's presentation. Assistance should be provided in accessing services regardless of whether the client is appropriate for agency service. This "no wrong door" policy is expected be incorporated into the assessment process meaning individuals will be welcomed into treatment wherever they enter and should receive a person centered assessment that addresses both substance and mental health issues. A strength based approach that includes an appreciation of the person's racial and ethnic culture, gender, sexual orientation and traditions is recommended. One of the goals of the assessment process is to engage the individual in an ongoing process of evaluation as treatment progresses, during which diagnoses may be continually revised as new data emerges (Minkoff, 2001).

An accurate assessment for individuals with co-occurring disorders is complicated by the difficulty of distinguishing symptoms resulting from patterns that proceed from primary psychiatric illness from symptom patterns that are caused or exacerbated by primary substance use disorders. In many individuals with co-occurring disorders, both psychiatric and substance disorders are simultaneously and interactively contributing to symptoms. Consequently, diagnostic determination requires a careful approach to assessment often over a period of time, in order to best elucidate diagnosis accurately (Minkoff, 2001; Smith 2007).

CSAT TIP 42 (2005), Kanwischer (2001) and Minkoff, (2001) identify three fundamental principles of assessment:

1. Screening and Detection:

A variety of tools, such as checklists, are available for screening and evaluation. Assessment instruments can be used as a part of the evaluation process but should not constitute an assessment. Screening and evaluation are expected to include interaction with family, peers, case managers, probation officers, physicians and others as appropriate. Permission for interaction should always be obtained (see ADHS/DBHS Provider Manual Section 4.1, Disclosure of Behavioral Health Information). Drug testing can be a valuable tool in the screening process. Urine or saliva drug analysis can provide objective clinical data and may help determine treatment goals.

2. Diagnostic Determination:

Diagnosis of either mental illness or substance use disorder can rarely be established only by assessment of current substance use, mental health symptoms, or mental status exam. In most cases, diagnosis is more reliably established by obtaining a thorough biopsychosocial history (see ADHS/DBHS Provider Manual Section 3.9, Intake, Assessment and Service Planning). To establish a substance disorder consideration of past and current patterns of substance use needs to occur, while observing whether the patterns meet the criteria for substance dependent or substance abuse as defined in the DSM IV-TR IV. Similarly, the diagnosis of psychiatric disorders entails close examination of past and current symptoms in relation to the presence or absence of appropriate psychotropic medication and periods of substance abstinence or reduced use (CSAT TIP 9, 2005; CSAT TIP 42, 2005). The determination of SMI eligibility requires establishing a presumptive diagnosis of an SMI eligible psychiatric disorder, persistence of that disorder, and determining the functional incapacity of the person in accordance with state guidelines for SMI eligibility determination. More information can be found in the ADHS/DBHS Provider Manual Section 3.10, SMI Eligibility Determination.

Prior to treatment implementation, it is essential that the behavioral health representative evaluate where the individual is in terms of stage of recovery,

level of impairment and level of care required for successful treatment. Prochaska & Di Clemente's (1992) stage-of-change model identifies five stages of change: pre-contemplation, contemplation, preparation, action and maintenance (see Attachment A). In each of these stages, a person has to work through a different set of issues and tasks that relate to changing behavior. By identifying the stages readiness of change, appropriate treatment strategies can be employed. For example, a person in the pre-contemplation state is not yet considering making changes or is unable to. Strategies such as establishing rapport and building trust would be an appropriate intervention.

Level of impairment can be determined by the extent in which the individual requires care and support and in what areas. The capacity to learn recovery skills and participate in treatment must be measured. External contingencies such as legal and child protective services involvement must be considered as well as a close assessment of the resiliency factors that influence a person ability to recover. This includes determining a person's natural level of support, a person's abilities and strengths that can be highlighted and used to foster self-efficacy.

To effectively inform a level of care decision, an assessment of functional domains that include relapse potential, recovery environment, motivation, emotional/behavioral conditions and difficulties, biomedical conditions and complications and acute intoxication and/or withdrawal potential. These domains are included in the American Society of Addiction Medicine (ASAM) Level of Care Criteria, which can be accessed through at http://www.asam.org/. The ASAM 2R can effectively determine the level of care an individual needs and has the capacity to address comorbidity in level of care assessment (ASAM, 2001).

Treatment Interventions

Minkoff (2001) and Drake (2001) state, there is not one single correct intervention for individuals with co-occurring disorders. However several treatment elements are correlated with better treatment outcomes. Some of these elements are described below. Minkoff (2001) emphasizes the "importance of a flexible empathetic, hopeful continuing treatment relationship with an individual or team of clinicians, and a community of recovering peers, in which integrated treatment and coordination of care take place across multiple treatment episodes".

Integrated treatment implies that mental health and substance interventions are linked. Experts in co-occurring substance use and psychiatric disorders conclude that effective dual diagnosis treatment is comprised of interventions for both substance issues and mental health. Specifically, the treating behavioral health representative is expected to address both presentations. This concept is often referred to as "no wrong door policy". Specifically, a panel of experts write, "effective systems must ensure that an individual needing treatment will be identified and assessed and will receive treatment, either directly or through

appropriate referral, no matter where he or she enters the realm of services" (CSAT TIP 42, 2005).

During the assessment process it is important to gage what treatment services are needed for both presentations and to assist the individual in accessing them through coordinated efforts. It is recommended that service providers stay engaged and follow-up to ensure that the individual is linked to appropriate services according to ones gender, cultural background, diagnosis, level of functioning, stage of preparedness to change and motivation level (Minkoff, 2001). Treatment should appear seamless to the behavioral health recipient with a unified philosophy, set of goals and recommendation.

When mental illness and substance disorders co-exist, both disorders are considered primary and intensive simultaneous interventions for each disorder is necessary. Treatment for co-occurring disorders can involve a variety of methods by which diagnosis-specific, evidenced-based strategies for each disorder are appropriately combined and coordinated. Treatment for known diagnosed mental illness must be initiated and maintained. Regimens such as, dialectic behavioral therapy for borderline personality disorder may be appropriately utilized to develop cognitive-behavioral skills to manage the mental illness, while applying similar skills to managing substance use and integrating direct substance disorder treatment interventions as well.

A plethora of information indicates that substance abuse treatment should incorporate individual and group interventions to help individuals make and implement better choices regarding substance use in relation to their mental illness. Addiction treatment for substance dependence for individuals with co-occurring disorders is fundamentally similar to addiction treatment for anyone, with abstinence as a goal, and with the need to develop specific skills for attaining and maintaining abstinence (Barreira & Espey et a., 2000; Ilgen & Moos, 2006; Moos et al., 2003; Mueser et al., 2003).

Treatment strategies also vary depending on the stage of change the individual is in. As described earlier, motivational enhancement techniques are best applied during the precontemplative stage of change to assist with movement towards contemplation. Miller and Rollnick (1995) suggest providing information about co-occurring disorders to evoke reasons to change, during the contemplation stage. Attachment A. identifies the five stages of change and recommended accompanying tasks.

Program Types:

Program Categories:

Before delineating programmatic characteristics, it is important to review co-occurring categories. Within any system of care, programmatic interventions can be categorized according to dual diagnosis capability. The American Addiction

Medicine's Taxonomy, breaks down program categories into three types: Addiction only Services (AOS), Dual Diagnosis Capable (DDC) and Dual Diagnosis Enhanced (DDE) (ASAM, 2001; Minkoff, 2000). These are described as follows:

1. Addiction Only Services (AOS):
   Programs that cannot accommodate adults who have psychiatric illnesses requiring ongoing treatment, however it stabilizes the illness and level of functioning of the client.

2. Dual Diagnosis Capable (DDC):
   Programs that have a primary focus on the treatment of substance-related disorders, but are also capable of treating adults who have a relatively stable co-occurring disorder. Provisions for comorbidity are integrated into screening, assessment, treatment planning and implementation, psychopharmacology, discharge planning and staff competency and training.

3. Dual Diagnosis Enhanced (DDE):
   Programs that are designed to treat adults who have more unstable or disabling co-occurring disorders in addition to their substance-related disorder.

Program Models:

Program descriptions vary in structure, level of intensity and treatment approaches. Before delineating programmatic models, it is imperative to highlight an evidence-based approach that can be used with any program model or intervention: motivational interviewing.

Motivational interviewing is a client-centered, direct method for enhancing motivation to change by exploring and resolving ambivalence. This style of interaction helps move individuals through stage change, seeks to create and amplify discrepancy between present behavior and broader goals. It works to develop a cognitive dissonance between where one is and where one wants to be. Four principles are essential to motivational interviewing: expressing empathy, rolling with resistance, developing discrepancy and promoting self-efficacy and change (CSAT TIP 35, 1999; Miller & Rollnick, 2002; Rollnick & Miller, 1995). Motivational interviewing is associated with improved consumer engagement and treatment retention (Carroll, et al., 2008)

Outpatient treatment models serve the greatest number of adults, making it imperative that these programs use the most effective services to reach the greatest number of persons with co-occurring disorders. Two outpatient models have shown to be valuable in treating co-occurring disorders: Assertive Community Treatment and Intensive Case Management.

A. Assertive Treatment (ACT):

ACT is a service-delivery model that provides comprehensive, intensive outreach activities and active and continued engagement with individuals. Services are provided through a multidisciplinary team that is trained in rehabilitation, case management, supportive services, and other key areas of treatment. Members include mental health and substance abuse individuals, case managers, nursing staff, psychiatric consultants, peer support workers and rehabilitation specialists. By working collaboratively, the team delivers a majority of the treatment rehabilitation and supportive services that the individual needs to sustain independence in the community. Unlike the traditional models where individuals are given resources to obtain independently, ACT goes to the individual as needed, 24-hours a day.

B. Intensive Case Management (ICM):

Intensive case management assists individuals in accessing basic needs and using brokered services. The model emphasizes developing trusting relationship with individuals through rapport building and engagement. Rigorous services are provided distinguishing this model from standard case management. A fundamental component of ICM is a smaller caseload per case manager, so that these services can be rendered (CSAT TIP 42, 2005).

C. Self-help:

Self help groups are based on the premise that a group of individuals who share a common behavior they identify as undesirable can collectively support each other and eliminate that behavior. They learn to accept their problem, and share their experiences, strengths, and hopes. The only requirement for attending a given self-help group is the desire to abstain from the problem behavior. This mutual, honest sharing affords participants a forum where often-stigmatized habits can be discussed in an accepting, trusting environment. It also provides a source of strategies to cope with the behavior and an opportunity to help others by sharing experiences and becoming a helper and a role model to others (CSAT TIP 42, 2005).

Most self-help groups follow some version of the 12-step model originally developed by the founders of Alcohol Anonymous (AA). One of the essential aspects of self-help, in contrast to other, more traditional forms of treatment for addictions, is the absence of “professional” involvement. Individuals come together to share with one another and to help one another in an active, self-enhancing role instead of being viewed as service recipients, a passive and often demeaning role. More information can be found on the AA website (http://www.aa.org).

D. Crisis intervention model:

Any type of mental health and/or substance use presentation is welcome in this model. Methods are used to offer immediate, short-term help to individuals. The purpose is to reduce the intensity of a person’s emotional,

mental, physical and behavioral reactions to the presenting crisis and to facilitate moving the person to the previous level of functioning before the crisis. Behavioral health representatives employ active listening techniques and motivational interviewing to engage the individual. Careful screening and risk assessment are critical elements.

E. Inpatient Psychiatric Treatment:

Individuals who require acute psychiatric care and are in need of stabilization before returning to the community and may need intensive medically monitored 24-hour assistance. Inpatient psychiatric treatment is short term and aims to minimize symptoms and help the person reenter the community.

F. Partial Hospitalization:

Partial hospitalization can be an option once the person's psychiatric treatment stabilizes the presenting condition. Individualized and attentive services are given less than 24-hours a day. Individual and group therapy are provided as well as services to help the person maintain their abilities to function in the community. Because their treatment setting fosters the development of social networks that can help monitor the condition when not in the hospital the individual can return home at night and on weekends.

G. Detoxification Programs (Detox):

Detox programs can be categorized into two types: social and medical (CSAT TIP 45, 2006):

- Social detox usually requires no medication or medical personnel. 24-hour staff is available to the adult with the process usually taking 5-10 days. Some social detox programs offer peer support services and substance use education.
- Medical detox is recommended for individuals with poor health, with existing medical conditions and/or those who have the potential for severe withdrawal symptoms. Individuals are screened by medical personnel and closely monitored by hospital staff. Medications may be needed as a part of treatment.

H. Day Treatment:

These services are intermediate to long-term and specifically for psychiatric support. Varying degrees of stage specific curriculum and case management are offered. The primary consideration is to reduce or relieve the effects of mental health symptoms while providing support and training to foster the individual to live independently in the community.

I. Residential Programs:

Empirical evidence demonstrates the effectiveness of residential programs for persons with co-occurring disorders (CSAT TIP 42, 2005; Moggie, 1999). Residential treatment programs vary in length of stay, levels of intensity and psychiatric capability. Modified Therapeutic Communities (MTC) are drug free

residential settings that utilize peer influence to help individuals assimilate to social norms and develop effective social skills. Therapeutic community principles are adjusted to the person's needs, circumstance and treatment goal. MTCs are successfully being adopted in community residential programs to treat individuals with co-occurring disorders. A growing amount of research demonstrates the effectiveness of this model for people with co-occurring disorders. Outcomes show improved psychological functioning and decrease in substance use in men and women as well as culturally diverse populations (Alexander, 1996; Coletti et al.,1997; Rawlings & Yates, 2001).

J. Psychiatric Housing Programs:

These programs provide housing supports for individuals with psychiatric disabilities. As discussed previously, positive treatment outcomes are connected to matching individual needs and stage of change to clinical interventions. The Abstinence-expected ("dry") housing model is most appropriate for individuals with comorbid substance disorders who choose abstinence, and who want to live in a sober group setting to support achievement of abstinence. Such models may range from typical staffed group homes to supported independent group sober living.

Individuals who are not in the action stage of change, but recognize their need to limit use and are willing to live in supported settings where uncontrolled use by themselves and others is actively discouraged, might prefer a program model that focuses on eliminating dangerous behavior, rather than substance use per se. Such programs are referred to as abstinence-encouraged or "damp" housing.

"Wet" housing, also known as consumer-choice housing model recommends abstinence but does not penalize the person for using. Premotivational and motivational interventions are incorporated into the overall treatment approach. Independent supported housing with case management and peer supportive services are offered.

K. Intensive Outpatient Program

A structured treatment program with a well defined schedule that provides targeted interventions to address symptoms associated with primary or co-morbid substance dependence disorder. The program must provide evidence-based treatment, education, skill building and support services at least 9 hours per week. Services must be individualized as evidenced by the assessment and service plan. The program must include regular drug screening and must include an aftercare component for a defined period of time.

Psychopharmacology Practice Guidelines

Recognition of co-occurring disorder is essential to adequately addressing either disorder. Assessment for treatment should expect that all persons presenting might

have a co-occurring disorder, and that the assessment process may need to be ongoing in order to determine all diagnoses.

Treatment is expected to include appropriate intervention for all co-occurring disorders. Arbitrary barriers to treatment should be eliminated. Assessment for treatment of psychiatric disorder or substance disorder should not be made conditional on absence of either of the co-occurring disorders.

Each co-occurring disorder should receive specific appropriate intervention and treatment. Intervention strategy must be appropriately matched to individualized clinical assessment.

Informed consent must be obtained. Informed consent is an ongoing educational process geared to what the person receiving medication, family, and caregivers can comprehend, retain, and use. Parameters of informed consent include the diagnosis and target symptoms for which the medication is given, the intended benefits of treatment, the possible risks and side-effects and what to do if they occur, possible alternatives, possible results of not taking the treatment, and the possible course of treatment.

Safety in prescribing is paramount. Risk of prescription of medication as well as risk of not prescribing medication must be carefully considered. Proper monitoring of prescribed medications for effects, side effects, abuse, and misuse is expected.

Medications previously taken, outcome of prior treatment with medications, current medications, and effects and side effects of current medications should be documented. Family history of response to medications should be ascertained. Reproductive status of females of childbearing age should be determined, and medications, which may cause birth defects, avoided if possible in females who may become pregnant.

Many people with co-occurring psychiatric and substance abuse disorder also have concomitant medical disorder, such as liver disease, heart disease, lung disease, or metabolic disorder. Close communication and cooperation with the primary care physician and other health care providers is expected. Prescription of medication which could unfavorably interact with other prescribed medications or which could worsen medical disease generally should be avoided.

History of impulsive behavior or of overdose on medications and current and future risk of it should be considered carefully prior to prescription of medication likely to be lethal in overdose.

Risk of medication abuse, misuse or diversion should be carefully considered. Prescription beyond a detoxification period of medications with significant sedative potential or abuse potential should be reserved for selected persons with well-established abstinence demonstrating specific beneficial response without signs of misuse. Continued prescription of medications with abuse potential should occur only

with careful discussion of risks and benefits with the patient (and where indicated, the family or other caregivers) and documentation of expert consultation or peer review with a prescribing clinician experienced in treatment of substance dependency if possible.

Medications with abuse, misuse, or diversion potential include scheduled medications such as stimulants or benzodiazepines, medications with sedative effects such as some antipsychotic medications, and medications with significant anticholinergic properties.

Particular care should be taken in prescription of medication to persons receiving opiates for chronic pain or substance dependence, with avoidance of medications which could potentiate opiate effect and lead to death. This is particularly important for persons receiving methadone for chronic pain which has been implicated in sudden death.

Polypharmacy (prescription of multiple medications simultaneously) generally is not desirable. Polypharmacy increases likelihood of undesirable medication interaction, decreases likelihood of adherence, and makes it difficult to determine effects and side effects of each individual medication.

Medications with potential for side effects, particularly long term side effects such as movement disorders or metabolic disorders, should be given only when potential benefit outweighs potential risk. Close monitoring must occur, and may include such parameters as blood counts, lipid status, glucose status, hepatic status, renal status, thyroid status, heart rate, blood pressure, weight, waistline girth, and screening for abnormal involuntary movements. Presence or absence of side effects should be documented and any side effects present should be addressed.

Medications prescribed should be indicated for the patient's diagnoses and for documented target symptoms which then can be followed to assess effectiveness of medication. If prescribed medication is not effective for the intended target symptoms, it should be discontinued or a reason should be documented for continuing, such as inadequate length of trial or need for dosage increase.

The most common reason for medication failure is nonadherence. Laboratory study of blood medication level may be useful for medications in which such are available. Depot medications may be desirable for persons who are poorly adherent with medications, which may be available in depot form.

Another common reason for medication failure is ongoing substance abuse. A variety of modalities are available for monitoring for ongoing substance abuse, including report of the person receiving medication, report of other significant persons, and biologic fluid monitoring such as urine drug screening.

The first step in treatment is to establish medical and psychiatric safety in acute situations. Provision for safe detoxification and then maintenance of sobriety must be

made. A controlled environment for close monitoring to protect safety may be necessary during acute detoxification.

Medication for co-occurring psychiatric disorder should be directed to the treatment of known or probable psychiatric disorder. Some medications useful for co-occurring psychiatric disorder may also help promote sobriety, and may be considered preferentially.

Medication strategies to promote sobriety should be strongly considered, including medications, which have been to shown to increase likelihood of sobriety and are indicated for such.

Training and Supervision Recommendations

When training behavioral health representatives to employ evidence-based practices and develop clinical skills to work with an adult with co-occurring disorders, it is recommended that practitioners are able to demonstrate the following (CSAT TIP 42, 2005; Minkoff, 2001):

- A welcoming, empathetic, hopeful attitude in the provision of services to person with co-occurring disorders.
- Working knowledge of the needs and concerns of persons with co-occurring disorders as a special, unique population.
- Basic knowledge of etiology of mental health and substance use disorders and evidence-based treatment for co-occurring disorders.
- An understanding of change and recovery model use in the treatment of mental health and substance disorders.
- Practical knowledge on a range of crisis interventions and resolution approaches.
- The skills to complete basic screenings for co-occurring disorders and integrated, longitudinal, strength-based assessments.
- Ability to design, implement and ensure highly individualized, integrated treatment, discharge and continuing care plans.
- Able to identify stages of recovery and applying stage wise treatment.
- Network with other agencies to link behavioral health recipients to needed additional services.
- Knowledge and skills to facilitate the individual's experience of integrated, continuous and coordinated services.
- Facilitate individual learning and recovery through ongoing supportive engagement.
- Recognize the importance of treating the person as a whole using a multidimensional assessment that crosses the psychiatric and addiction treatment system.

Sound treatment depends on well-trained staff. Elements such as creating a supportive working environment that fosters professional development help build the infrastructure needed for quality clinical services (Powell & Brodsky, 2004). Successive quality clinical guidance as set forth in the Arizona Administrative Code R9-20-205, is recommended for each behavioral health representative providing services to persons with co-

occurring disorders. Through this clinicians can continue to acquire, maintain and enhance their direct practice skills. Some key elements Powell & Brodsky (2004) identify for effective clinical guidance include:

- Promoting professional development
- Assessing the delivery of high quality, ethical and culturally sound clinical interventions and performance
- Mentoring competencies
- Increasing awareness and abilities in best practices
- Monitoring workloads
- Providing feedback and recognition
- Supporting effective team work

For further information, the ADHS/DBHS Provider Manual Section 9.1, Training Requirements can be referred to.

Anticipated Outcomes

It is anticipated that by providing supportive, continuous, stage wise and integrated treatment over time to behavioral health individual diagnosed with co-occurring disorders the following will occur:

- Reduction of psychiatric symptomology, increased functioning and stability
- Improved outcomes, long and short term, of substance disorder
- Improved service delivery to persons with co-occurring disorders
- Reduction in high end service utilization

Co-Occurring Psychiatric and Substance Abuse Disorder

Desktop Guide

Key elements to remember about this best practice:

- Co-occurring disorders are the expectation, not the exception
- Recovery is a long-term process of internal change, in which progress occurs in stages.
- Treatment success derives from the implementation of an empathetic, hopeful, continuous treatment relationship.
- Integrated treatment treats both disorders simultaneously.
- Sound service delivery is dependent on well-trained staff who receives regular, quality supervision.
- There is no one type of co-occurring program or intervention.
- Treatment intervention must be individualized according to diagnosis, phase of recovery and level of functioning.

Benefits of Using This Best Practice:

- Applies the most current research and application available that demonstrates improvements for persons with co-occurring disorders.
- Greater success in achieving desired client outcomes.
- Better assessment and treatment matching.
- Person centered and individualized services.

Attachment A
Prochaska & DiClemente (1992)
Stages of Change Model

Stage of Change	*Characteristics*	*Techniques*
Pre-contemplation	Not currently considering change: "Ignorance is bliss"	Validate lack of readiness Clarify: decision is theirs Encourage re-evaluation of current behavior Encourage self-exploration, not action Explain and personalize the risk
Contemplation	Ambivalent about change: "Sitting on the fence" Not considering change within the next month	Validate lack of readiness Clarify: decision is theirs Encourage evaluation of pros and cons of behavior change Identify and promote new, positive outcome expectations
Preparation	Some experience with change and are trying to change: "Testing the waters" Planning to act within 1month	Identify and assist in problem solving re: obstacles Help patient identify social support Verify that patient has underlying skills for behavior change Encourage small initial steps
Action	Practicing new behavior for 3-6 months	Focus on restructuring cues and social support Bolster self-efficacy for dealing with obstacles Combat feelings of loss and reiterate long-term benefits
Maintenance	Continued commitment to sustaining new behavior Post-6 months to 5 years	Plan for follow-up support Reinforce internal rewards Discuss coping with relapse

Relapse	Resumption of old behaviors: "Fall from grace"	Evaluate trigger for relapse Reassess motivation and barriers Plan stronger coping strategies

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Technical Assistance Document 5

Information Sharing with Family Members of Adult Behavioral Health Recipients

Developed by the
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Division of Behavioral Health Services

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Division of Behavioral Health Services

Introduction

Engaging family members* and others who are actively participating in an adult behavioral health recipient's care, treatment, and/or supervision is an important part of the assessment, treatment, support, and recovery process. Individuals who participate as part of the team bring accumulated expertise to the treatment process and can serve as a source of significant support to the adult behavioral health recipient. Members of the Adult Clinical Team should continuously work to promote this engagement.

Under certain conditions, agencies may legally and appropriately share certain information with family members and others actively participating in the adult behavioral health recipient's care, treatment, and/or supervision with either the behavioral health recipient's verbal or written authorization. This document explains procedures, specific limitations and exceptions surrounding the sharing of confidential information.

The confidentiality requirements of the law should never interfere with a clinician's responsibility to engage family members and others actively participating in a behavioral health recipient's care, treatment, and/or supervision, if their engagement is in the behavioral health recipient's best interest. Clinicians may and should listen to and take into account information shared by those participating in the behavioral health recipient's care, treatment, and/or supervision.

Purpose

To support meaningful participation by family members and others actively participating in an adult behavioral health recipient's care, by allowing such persons to access confidential information as necessary to support the treatment and recovery process. Sharing of information is supported by allowing members of the clinical team to accept all information provided by family members and by allowing behavioral health participants to provide verbal or written authorization to share otherwise confidential information.

Targeted Population

Behavioral health recipients who are eighteen years of age or older and are enrolled in Arizona's public behavioral health system, as well as family members and others actively participating in their care, treatment and supervision.

Guidelines

Accepting Information from Family Members

Family members or other persons actively participating in the behavioral health recipient's care and treatment often have important and valuable information concerning the behavioral health recipient's treatment and recovery and want to share that information with the adult clinical team. **Confidentiality laws do not prohibit an**

* Please note that definitions for terms used in this document are located in the back.

agency from accepting information. Simply put, an agency never needs an authorization to accept information from family members or other persons. Confidentiality laws should not be interpreted as a barrier to accepting information and engaging family members or others to participate in the behavioral health recipient's care, treatment and/or supervision. **Always *accept* information from family members or other persons and document its receipt.**

Sharing Information With an Authorization

An agency may share information if the behavioral health recipient provides authorization for its disclosure. This can occur in one of two ways: either with a verbal authorization or a written authorization.

Verbal Authorization

If the behavioral health recipient or the health care decision maker does not want to sign a written authorization, an agency may still share certain types of information with family members and others actively participating in the behavioral health recipient's care, treatment and/or supervision provided the behavioral health recipient or the health care decision maker provides verbal authorization. **Prior to sharing any information, the agency must determine whether the behavioral health recipient or the health care decision maker objects to any disclosure and whether it is in the behavioral health recipient's best interest to share the information**. After given the opportunity to object, verbal authorization occurs when the behavioral health recipient or the health care decision maker does not object to the sharing of that information.

When a behavioral health recipient or the health care decision maker has given verbal authorization to share information, the agency should notify the behavioral health recipient or the health care decision maker exactly what information is to be shared either verbally or in writing. If the behavioral health recipient does not object and sharing the information will not cause harm to the behavioral health recipient, it may be shared with whomever the behavioral health recipient or the health care decision maker indicates. If sharing the information may be harmful to the behavioral health recipient, **the information must not be shared**. If only part of the information may be harmful, **information must be limited to only the parts that are not harmful.**

There are eight types of information that can be shared when the behavioral health recipient or the health care decision maker provides verbal authorization:

- Anticipated length of stay;
- Diagnosis;
- Discharge plan;
- Medication;
- Medication side effects;
- Need for hospitalization;
- Prognosis; and
- Short and long-term treatment goals.

Alcohol or drug abuse information and/or HIV related information that falls into one of these eight categories **cannot** be shared unless the behavioral health recipient or the health care decision maker signs a written authorization.

The agency must inform the behavioral health recipient or the health care decision maker which of the eight types of information will be shared with family members and/or others who are actively participating in the behavioral health recipient's care, treatment, and/or supervision. If the behavioral health recipient or the health care decision maker wishes to share information other than the eight types described above, the agency must obtain a written authorization indicating the information to be shared.

Written Authorization

A written authorization allows an agency to share confidential information to whomever the behavioral health recipient designates in the authorization. The authorization must be signed by the behavioral health recipient or the behavioral health recipient's health care decision maker and contain certain elements depending upon the type of information to be shared.

Type of Information	Needed Elements within Authorization
♦ Drug or Alcohol Diagnosis ♦ Drug or Alcohol Treatment ♦ Drug or Alcohol Referral	See Attachment A
♦ HIV/AIDS Information ♦ Other Communicable Disease Information	See Attachment B
♦ Evaluation ♦ Treatment ♦ Provision of Behavioral Health Services*	See Attachment C

*Provision of behavioral health services **other** than the eight types previously mentioned that only require verbal authorization.

Whenever possible, and if it is in the behavioral health recipient's best interest, an agency should always encourage a behavioral health recipient to sign a written authorization that allows the agency to share confidential information with family members and others actively participating in the behavioral health recipient's care, treatment and/or supervision.

Refusal to Provide Authorization

A behavioral health recipient's refusal to authorize sharing information that may help family members or others provide appropriate care may offer the opportunity for clinical intervention. While respecting the behavioral health recipient's refusal, issues surrounding the refusal may be therapeutically helpful to explore.

Right to Request a Review for a Decision to Deny a Request for Information

Family members and others actively participating in the behavioral health recipient's care, treatment, and/or supervision have the **right to request an agency director review for** a decision to deny a request for information. The agency's director must conduct the review for the decision to withhold information and make a determination based on all the facts within five business days of the review. If the agency director sustains the decision to withhold information, the person requesting the information has the right to file a petition with the superior court to have the agency director's decision reviewed. The court is required to hold a hearing within five business days of the request.

Procedures and Exceptions

The following procedures and exceptions will assist agencies in determining whether or not to share information with family members and others actively participating in the behavioral health recipient's care, treatment, and/or supervision.

The following step-by-step guide should be used to determine when an agency can share information with family members and others actively participating in the behavioral health recipient's care, treatment, and/or supervision. In using this guide, begin at Step 1 and proceed to subsequent steps as prompted. **Do not attempt to "shortcut" the process by looking for a specific kind of information in the middle of the guide**. Doing so may lead to the wrong result, and perhaps a violation of the law. The reader will have completed the analysis and will know whether sharing information with family members or others actively participating in the behavioral health recipient's care, treatment, and/or supervision is permissible when the reader sees the phrase, **"You are done."** For purposes of using this guide, the phrase "family member" includes all persons actively participating in the behavioral health recipient's care, treatment, and/or supervision.

Steps

Step 1. Determine whether the information to be shared with the family member is related to HIV/AIDS or other communicable disease information.

> **If Yes**, the information **is** related to HIV/AIDS or other communicable disease information. Proceed to **Step 2**.
>
> **If No,** the information **is not** related to HIV/AIDS or other communicable disease information. Proceed to **Step 3**.

Step 2. Determine whether the behavioral health recipient has signed a written authorization that contains all of the elements in **Attachment B** allowing the family member to receive HIV/AIDS or other communicable disease information.

> **If Yes,** the behavioral health recipient **has** signed a written authorization that contains all of the elements in **Attachment B**. Proceed to **Step 12**.

If No, the behavioral health recipient **has not** signed a written authorization that contains all of the elements in **Attachment B**. Proceed to **Step 13**.

Step 3. Determine whether the information to be shared by the agency relates to referral, diagnosis or treatment for a drug or alcohol use disorder.

If Yes, the information **is** related to referral, diagnosis, or treatment for a drug or alcohol use disorder. Proceed to **Step 4**.

If No, the information **is not** related to referral, diagnosis, or treatment for a drug or alcohol use disorder. Proceed to **Step 5**.

Step 4. Determine whether the behavioral health recipient has signed a written authorization that contains all of the elements in **Attachment A,** allowing the family member to receive information related to referral, diagnosis or treatment of a drug or alcohol use disorder.

If Yes, the behavioral health recipient **has** signed a written authorization that contains all of the elements in **Attachment A**. Proceed to **Step 14**.

If No, the behavioral health recipient **has not** signed a written authorization that contains all of the elements in **Attachment A**. Proceed to **Step 15**.

Step 5. Determine whether the behavioral health recipient has signed a written authorization that contains all of the elements in **Attachment C,** which allows family members to receive information that relates to evaluation, treatment or the provision of behavioral health services.

If Yes, the behavioral health recipient **has** signed a written authorization that contains all of the elements in **Attachment C**. Proceed to **Step 16**.

If No, the behavioral health recipient **has not** signed a written authorization that contains all of the elements in **Attachment C**. Proceed to **Step 6**.

Step 6. Determine whether the family member requesting the information is **actively participating** in the behavioral health recipient's care, treatment, and/or supervision.

If Yes, the person **is** an individual or family member actively participating in the behavioral health recipient's care, treatment, and/or supervision. Proceed to **Step 7**.

If No, the person or family member **is not** actively participating in the behavioral health recipient's care, treatment, and/or supervision. Proceed to **Step 11**.

Step 7. The treating professional must interview the behavioral health recipient to determine whether the behavioral health recipient has the capability to make health care decisions.

If Yes, the behavioral health recipient **has** the capability to make health care decisions. Proceed to **Step 8.**

If No, the behavioral health recipient **lacks** the capability to make health care decisions. Proceed to **Step 9.**

Step 8. The treating professional must interview the behavioral health recipient or the health care decision maker to determine whether the behavioral health recipient or the health care decision maker agrees or objects to sharing the information with the family member.

If Yes, the behavioral health recipient **agrees** to the disclosure of the information to the family member. Proceed to **Step 9**.

If No, the behavioral health recipient **objects** to the disclosure of the information to the family member. Proceed to **Step 11**.

Step 9. The agency should determine whether the sharing of information is in the behavioral health recipient's best interest.

If Yes, the agency determines **it is** in the behavioral health recipient's best interest to share the information with the family member. Proceed to **Step 10**.

If No, the agency determines **it is not** in the behavioral health recipient's best interest to share the information with the family member. Proceed to **Step 11**.

Step 10. The agency **can and should** share information with the family member. However, the agency should only disclose information that relates to the behavioral health recipient's anticipated length of stay, diagnosis, discharge plan, medication, medication side effects, need for hospitalization, prognosis, and short and long-term treatment goals, unless the behavioral health recipient signs written authorization to allow the sharing of additional information. **You are done.**

Step 11. The agency **cannot** share information with the family member. You must advise the family member requesting the information that they have the right to request an agency director review of the decision. The agency's director must conduct a review of the decision to withhold information and make a determination based on all the facts within five business days of the review. If the director maintains the decision to withhold information, the person requesting the information has the right to file a petition with the superior court to have the director's decision reviewed. The court is required to hold a hearing within five business days of the request. **You are done**.

Step 12. The agency **must** share information related to HIV/AIDS or other communicable diseases with the family member. Proceed to **Step 3** to assess the disclosure of other information.

Step 13. The agency **cannot** share the HIV/AIDS information with the family member. Proceed to **Step 3** to assess the disclosure of other information.

Step 14. The agency **must** share information related to referral, diagnosis or treatment of a drug and alcohol use disorder with the family member. Proceed to **Step 5** to assess the disclosure of other information.

Step 15. The agency **cannot** share information related to referral, diagnosis or treatment of a drug and/or alcohol use disorder with the family member. Proceed to **Step 5** to assess the disclosure of other information.

Step 16. The agency **must** share the information with the family member. **You are done.**

Even though Steps 11, 13, and 15 do not allow the agency to share information, the agency may still obtain the behavioral health recipient's or the health care decision maker's written authorization at these steps that would then allow the agency to share information.

Definitions

Actively Participating: Having a role in the care, treatment, or supervision of a behavioral health recipient. Agencies must make a determination of whether someone is actively participating on a case-by-case basis.

Adult Clinical Team: A group of individuals working in collaboration who are actively involved in a person's assessment, service planning and service delivery. At a minimum, the team consists of the person, their guardian (if applicable) and a qualified behavioral health representative. The Team may also include members of the enrolled person's family, physical health providers, mental health or social service providers, representatives of other agencies serving the person, professionals representing disciplines related to the person's needs, or other persons identified by the enrolled person.

Anticipated Length of Stay: The anticipated amount of time a behavioral health recipient will remain in a program or treatment regimen.

Behavioral Health Recipient's Best Interests: The determination by a treating professional or the treating professional's designee that a disclosure of confidential information is reasonably likely to promote improved prognosis or life circumstances for the behavioral health recipient.

Clinical factors to consider include:

1. The behavioral health recipient's choice to live with family members and others participating in his or her care, treatment, and/or supervision;

2. The behavioral health recipient's ability to meaningfully communicate information such as medication side effects or target symptoms, without the assistance from family members and others participating in his or her care;

3. The behavioral health recipient's risk of non-adherence to the service plan or treatment plan, potential consequences of that non-adherence and the importance of family members or others participating in his or her care in identifying non-adherence;

4. Issues that may be influencing the behavioral health recipient to not consent to the disclosure;

5. Clinical issues that may be adversely affected if the disclosure is made, including the effect on the therapeutic relationship and/or potential safety issues.

6. Supportive roles that family members may play in the behavioral health recipient's recovery plans.

Diagnosis: A determination of a category or name of a condition, including the severity of such a condition, based on signs and symptoms observed or reported according to the Diagnostic and Statistical Manual for the person being evaluated.

Diagnostic and Statistical Manual: A manual published by the American Psychiatric Association to set forth diagnostic criteria, descriptions and other information to guide the classification and diagnosis of mental disorders.

Discharge Plan: A component of the service or treatment plan prepared in the anticipation of discharging a behavioral health recipient from a program.

Family Members: A spouse, parent, adult child, adult sibling, or other blood relative of a person undergoing treatment, evaluation, or receiving community services.

Health Care Decision Maker: A person who is authorized to make health care decisions for the behavioral health recipient, including a parent of a minor. A person may be authorized to make health care decisions by being a guardian, or a designated agent in a health care power of attorney or mental health care power of attorney. Unless specifically prohibited in a court order or in the document that designates the health care decision maker's authority, a health care decision maker may have access to confidential information and make decisions about disclosure of confidential information. A health care decision maker may also be called a personal representative.[*]

Health Care Power of Attorney: A behavioral health recipient may designate an adult to act as an agent to make health care decisions on the behavioral health recipient's behalf. The behavioral health recipient may also designate an alternate adult or adults to act as agent if the original designated agent or agents are unwilling or unable to act. A power of attorney is effective when the behavioral health recipient is incapable of

[*] Title 14, Chapter 5, Article 2 Guardians of Minors Title 14, Chapter 5, Article 3 Guardians of Adults 8-514.05 Foster Care provider access to child health information; consent to treatment 36-3221 Health Care power of attorney; scope; requirements; limitations 36-3231 Surrogate Decision Makers 36-3281 Mental Health power of attorney, scope, definitions

making his or her own health care decisions. To be valid, a power of attorney must be in writing and contain all of the elements required by A.R.S. 36-3221.

Long-Term Treatment Goals: A component of the service or treatment plan that is developed and actively pursued by the behavioral health recipient with the support of the Adult Clinical Team, during and beyond the immediate treatment goals.

Medication: A pharmaceutical agent prescribed by a qualified professional with the intent of treating a behavioral health recipient by preventing or alleviating the symptoms.

Medication Side Effects: An action or effect of a pharmaceutical agent that is in addition to the intended purpose of the medication.

Mental Health Care Power of Attorney: A behavioral health recipient may designate an adult to act as an agent to make mental health care decisions on the behavioral health recipient's behalf. A power of attorney is effective when the behavioral health recipient is incapable of making his or her own mental health care decisions. To be valid, a power of attorney must be in writing and contain all of the elements required by A.R.S. 36-3282.

Need for Hospitalization: An indication of the necessity of treatment in a hospital or in-patient setting.

Others: Individuals, other than family members, actively participating in a person's care, treatment, or supervision.

Prognosis: A treating professional's or the treating professional's designee's determination of the likelihood of a client's progression in treatment and the rationale of such a determination, that is made with the consideration of the behavioral health recipient's motivation, program adherence, resources, and other circumstances.

Short-Term Treatment Goals: A component of the service or treatment plan that is actively pursued by the behavioral health recipient with the support of the Adult Clinical Team, typically within one to three months and up to six months.

Treating Professional: A member of the behavioral health recipients' Adult Clinical Team who is:

a physician who is licensed in the State of Arizona who is a specialist in psychiatry, or;
a psychologist who is licensed in the State of Arizona, or;
a Nurse Practitioner, who is licensed in the State of Arizona and is a specialist in the mental health field.

Verbal Authorization: A verbal agreement by the behavioral health recipient or the Health Care Decision Maker to allow sharing of the behavioral health recipient's confidential information.

Written Authorization: A signed written agreement by the behavioral health recipient or the Health Care Decision Maker to allow sharing of the behavioral health recipient's confidential information.

Attachment A

Elements of an Authorization to Share Information Related to the Diagnosis, Referral or Treatment of a Drug or Alcohol Use Disorder

An authorization that allows a family member (Individual) to receive information related to a drug or alcohol use disorder must contain the following elements:

- The name or general designation of the agency that is sharing the information;
- The name of the individual or organization that will receive the information;
- The name of the person;
- The purpose or need for sharing the information;
- How much and what kind of information will be shared;
- A statement that the person may revoke the authorization at any time, except to the extent that the agency 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.
- 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, both the minor and his or her parent or legal guardian shall give authorization.
- 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.

Attachment B

Elements of an Authorization to Share Information Related to HIV/AIDS or Other Communicable Diseases

An authorization that allows a family member (Individual) to receive information related to a HIV/AIDS or other communicable diseases must contain the following elements:

- A description of the information identified in a specific and meaningful fashion;
- The name or other specific identification of the person authorized to share the information;
- The name or names of the family members (Individuals) that will receive the information;
- A description of each purpose for sharing the information. The statement "at the request of the person" is a sufficient description of the purpose when a person 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 person or the purpose for sharing the information;
- Signature of the person and date. If a personal representative of the person signed the authorization, a description of the representative's authority to act for the person must also be provided;
- The person's right to revoke the authorization in writing, and either:
- The exceptions to the right to revoke and a description of how the person may revoke the authorization; or
- A reference to the covered entity's notice of privacy if the notice of privacy tells the person how to revoke the authorization;
- 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.

Attachment C

Elements of an Authorization to Share Information Related to the Provision of Evaluation, Treatment or Behavioral Health Services

An authorization that allows a family member (Individual) to receive information related to the provision of evaluation, treatment or behavioral health services must contain the following elements:

- A description of the information identified in a specific and meaningful fashion;
- The name or other specific identification of the person authorized to share the information;
- The name or names of the family members (Individuals) that will receive the information;
- A description of each purpose for sharing the information. The statement "at the request of the person" is a sufficient description of the purpose when a person 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 person or the purpose for sharing the information;
- Signature of the person and date. If a personal representative of the person signed the authorization, a description of such representative's authority to act for the person must also be provided;
- The person's right to revoke the authorization in writing, and either:
- The exceptions to the right to revoke the authorization and a description of how the person may revoke the authorization; or
- A reference to the agency's notice of privacy if the notice of privacy tells the person how to revoke the authorization;
- The ability or inability to condition treatment, payment, enrollment or eligibility for benefits on the authorization;
- The potential that information shared can be re-disclosed by the family member (Individual).

DBHS Practice Protocol
Older Adults: Behavioral Health Prevention, Early Intervention, and Treatment.

Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services
Effective September 1, 2011
Last Revision August 24, 2011

Title

Older Adults: Behavioral Health Prevention, Early Intervention, and Treatment.

Goal/What Do We Want to Achieve Through the Use of this Protocol?

The purpose of this protocol is to improve the quality and accessibility of prevention, early intervention, and treatment programs targeting older adult populations.

Target Population(s)

This practice protocol refers to prevention, early intervention, support, and treatment services for adults who are age 55 and older, their caregivers, and professionals who have contact with this population.

Prevention targets populations who do not have a diagnosable behavioral health problem and who are not enrolled in the behavioral health system.

Early Intervention targets populations who are showing signs and symptoms of a behavioral health problem or "failure to thrive" as diagnosed by primary care provider.

Treatment targets persons with diagnosable behavioral health disorders of sufficient severity to require symptom focused services and recovery supports.

Recovery Support targets persons with a diagnosed behavioral health disorder who are in recovery.

Background

According to the governor's report 'Aging 2020: Arizona's Plan for an Aging population", by year 2020, a quarter of Arizona's population will be over the age of 60. Approximately 16% of older adults suffer from a behavioral health disorder, the most common of which are substance abuse, depression, anxiety (Bartels, Dums, Oxman, Schneider, Arean, Alexopoulos, Jeste, 2002). The most common mental health disorders among older adults are depression and anxiety.

The prevalence of depression in older adults ranges from 8 to 20% in the general population, 37 % in primary care and 50 % in nursing homes. Physical illnesses, such as a stroke and diabetes, as well as diseases that cause chronic pain, such as arthritis, make a person more likely to suffer from depression. In the older adult population, 80% of older adults have one chronic health issue, 50% of older adults have 2 or more. Depression is most common in individuals who have other illnesses, such as heart disease or cancer, or whose function becomes limited, (CDC, 2009). Additionally, the more medications a person takes, the more likely they are to develop depression (Bartels, et Al., 2005; CMHS, 2005; December, 2006; National Center on Elder Abuse 2000).

Approximately 3-14% of older adults are affected by anxiety disorders in a given year. Anxiety disorders typically manifest themselves at the same time as other illnesses. In older adults, anxiety disorders often occur at the same time as depression, heart disease, diabetes, and other medical problems. Risk factors associated with developing anxiety disorders later in life include: being female; having several chronic medical conditions; being single, divorced or separated; and having less education. Treatment of anxiety disorders in older adults can be achieved through medication and/or psychotherapy (National Institute of Mental Health, 2010).

Suicide

The population of individuals age 65 and over represent 13% of the U.S. population, and account for nearly one-fifth of U.S. suicides. Older adults are less likely to report thoughts of suicide compared to younger adults. The methods of suicide are more likely to be deliberate and lethal. The common methods that older adults use for suicide are firearms and poisons. Of firearm use men account for 77%, women 34%; and for poison men account for 12% and women 29% (SAMHSA, 2006). Men over the age of 65 commit suicide at a rate three times that of other adults and account for 20% of all suicide deaths. Non-Hispanic white men 85 or older have a higher rate with 48 suicide deaths per 100,000, (NIMH, 2009). Depression is a risk factor for suicide. Depression may be caused by many situations that an individual may be going through such as loss of loved one, having to move out of one's home, or not being able to care for oneself. It is important to bring awareness of the preventable issue of suicide in the older adult population. One way to prevent suicides is to increase access to geriatric specialty health care.

Substance Abuse

Men aged 60 and older have a prevalence rate of alcohol abuse/dependence ranging from 1.4% to 3.7%, which is higher than the rate for women and lower than the rate for younger people. Two thirds of older adults who abuse alcohol are life span abusers of alcohol and are more likely to suffer health related consequences related to substance use. A third are new abusers who commenced drinking heavily in late life precipitated by a negative life event such as the death of a spouse, physical illness or other negative event. Substance abuse commonly co-occurs with a mental health disorder such as depression. Women receive twice the number of prescriptions obtained by men and are more likely to be prescribed psychotropic medications, (any medication capable of affecting the mind, emotions, and behavior; medications that are used to treat mental health patients. (MedicineNet.com, 2010)), so there is a higher risk for drug misuse among women than men. High income, well-educated seniors are more likely to engage in heavy drinking. Older men who are separated or divorced have higher rates of alcohol problems than other groups with marital disruption. For females however, alcohol problems are correlated with marriage, especially when married to a man with an alcohol addiction (Benshoff, 2003; Carlson, 1994; Nemes, 2004; Rigler, 2000).

Rates for illegal drug use among those 60 or older are less than one percent, and commencement of illicit substance abuse in older adults is very rare. As the baby boomer generation ages, substance abuse is increasing in prevalence (Patterson, 1999). By 2015 baby boomers will represent 45% of the U.S. population (Center for Disease Control and Prevention, 2010).

Risk Factors

Risk factors for development of behavioral health disorders include age, ethnicity, income, medical conditions, and changes in social supports, bereavement, and hopelessness. African Americans and Native Americans are likely to have fewer substance abuse problems as seniors because they have a higher mortality rate at a younger age. Between 5 and 10% of older adults suffer from chronic insomnia, which is a risk factor for depression. Seniors who are socially active are more susceptible to heavy drinking, and those who are isolated are less likely to drink heavily, but have a higher risk of depression and suicide. Older adults are prone to experiencing loss. In some cases grief develops into pathological symptoms, including guilt, obsession with death, hopelessness, loss of self-worth, and other impairments (Carlson, 1994; CSAP 2006; NCEA, 2000; Kurlowicz, 2003, NIMH, 2003; Patterson, 1999; Reynolds & Kumpfer, 1999).

Healthy Aging

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) prevention, treatment, and recovery programs seek to promote healthy aging, which may be defined as the absence of serious illness or disability. A number of factors contribute to the positive emotional and psychological well-being of older adults including positive spirituality, social support, and physical health, avoidance of substance use, socio-economic status, coping skills, and personal attributes.

Positive spirituality

Spirituality increases with age, although attendance at religious services decreases after age 70. Belonging to a religious denomination that prohibits alcohol use is an important factor associated with less drinking and depression (Carlson, 1994; Gall and Swazbo, 2002; Vaillant and Mukamal, 2001; Faison and Steffen, 2001).

Sense of purpose or meaning in life

Older adults who have a sense of meaning or purpose in life are less likely to attempt and complete suicide (Holkup, 2002).

Social support

Supportive social contacts, particularly family and close friends are an important component of healthy aging and are correlated with healthy eating, and less use of alcohol, tobacco, and drugs. (Abeles, et al., 1998; American Psychological Association, 2003; Volz, 2000). A warm marriage is highly correlated with successful aging in men (Vaillant and Mukamal, 2001). Having children is a protective factor for women against completion of suicide (Holkup, 2002).

Good physical health/ physical activity

Good physical health, regular physical activity, and a healthy diet are correlated with life satisfaction, healthy aging, and cognitive functioning in older adults (Abeles, et al., 1998; Gall and Swazbo, 2002; Weuve, Kang, Manson, Breteler, Ware, and Grodstein, 2004). Some examples of physical activity with positive effects for older adults include weight bearing exercises, stretching, walking, swimming, water aerobics, as well as low impact aerobics. Getting involved in a sport such as golf or tennis not only provides exercise but also creates an opportunity for social interaction. Community sports programs are excellent ways to become socially interactive.

Abstinence from alcohol and cigarette use

Individuals who avoid engaging in alcohol or cigarette use as young adults are more likely to be happy and healthy as they age. In the older adult population, 9.3% of adults aged 65 years and older are current smokers (CDC, 2009).

Non use of tobacco is more important to healthy aging than non-use of alcohol, due to the severe physical health effects of tobacco (Peel, McClure, and Bartlett, 2005; Valiant and Mukamal, 2001). The absence of tobacco use and alcohol will bring a healthier way of aging.

Autonomy

The ability to have a sense of control in one's life lowers the risk of developing behavioral health problems. The ability to care for oneself is closely linked to life satisfaction. Being engaged in the community includes involvement in relationships with other people, being involved in spiritual institutions, volunteering, participating in social activities, and civic involvement. Older adults with a strong sense of attachment to their community are more likely to feel satisfied with their life. Older adults who live in a community have lower rates of depression than older adults who are rehabilitated in older adult care facilities, or isolated due to location, disability, financial circumstances,(Abeles, et al., 1998; Faison and Steffen, 2001).

Personal attributes

Personal attributes including optimism, self-acceptance, a sense of humor, a sense of purpose and flexibility can protect older adults from the development of behavioral health problems, such as depression and substance abuse. Older adults who are willing to try new experiences and engage in challenging activities are better able to maintain neural connections in their brains, thus protecting cognitive functioning (American Psychological Association, 2003; Hong, 2004).

Use of healthy coping skills protects against development of behavioral health disorders for persons of all ages. Humor is an example of a coping skill that works by alleviating stress and reducing perception of pain (Vaillant and Mukamal, 2001).

Barriers to Service

The majority (63%) of older adults who have a behavioral health disorder do not receive the services they need. Barriers to services include stigma, misdiagnosis, social isolation, and poor coordination between physical and behavioral health care. Family and physicians may view depression as a natural process in aging, or believe that older adults at that age are too old to be treated for a substance abuse problem. Older adults, health care providers, and caretakers may mistakenly believe signs and symptoms associated with behavioral health problems to be a normal part of aging or view psychological pain and discomfort as a normal process, which should be endured without complaint (Connel, 1999). Few older adults seek help from a behavioral health treatment professional (American Psychological Association Online, 2006). Older adults with psychiatric illnesses are more likely to receive inappropriate pharmacological treatment and are less likely to be treated with psychotherapeutic interventions than younger primary care patients (Bartels, et al, 2002).

Stigma

Some older adults will reject treatment for behavioral health disorders or diagnosis of behavioral health disorders because of stigma (Reynolds and Kumpfer, 1999). Many older adults see substance abuse as a moral failing rather than a legitimate behavioral health problem (Benshoff, Harrawood, and Koch, 2003). Stigma also contributes to early discontinuation of treatment or noncompliance with treatment regimens (Ell, 2006).

Misdiagnosis

Depression and substance abuse in older adults can be manifested as physical ailments, failure to thrive and/or dementia, "pseudo-dementia or reversible dementia". Symptoms of depression include insomnia, loss of appetite, weight loss, and fatigue. Each of these symptoms is easily mistaken for physical illness (Reynolds and Kumpfer, 1999). Comorbid medical conditions, inability to express somatic complaints, and language barriers are all factors that complicate appropriate diagnosis in older adults. A large number of older adults with behavioral health disorders remain undetected and untreated. Older adults are less likely than younger adults to complain of depression or sad feelings. Language barriers and practitioner focus on physical health conditions can complicate the screening process (Patterson, 1999).

Isolation

Social isolation brought about by physical ailments, depression, education, or transportation limitations presents a barrier to service seeking (Benshoff et al, 2003; Reynolds and Kumpfer, 1999).

Coordination between physical and behavioral health

Half of older adults who seek treatment for behavioral health conditions receive that treatment from their primary care provider rather than a behavioral health professional (American Association for Geriatric Psychiatry, 2006). Although physical illness is a risk factor for depression, substance abuse, and suicidal behaviors among the elderly, primary care providers do not always screen for behavioral health problems among their patients. A large number of older adults who complete suicide have visited their primary care provider within the same month, week, or even day of their suicide (Klausner and Alexopoulos, 1999).

Recommended Process/Procedures

Prevention and treatment in older adults should center on the concept of healthy aging, respect, and promotion of autonomy. Healthy aging involves positive spirituality, social connections, good physical health, cognitive functioning, autonomy, and high engagement with life.

Common elements of best practice across prevention, early intervention, and treatment include cultural competency, age appropriateness, group-based activities, provision of transportation and/or location of services in a setting comfortable and accessible to the participant (Benshoff, et al., 2003; Blow, 1998).

Effective programs enhance social support through peers, families, groups, and teaching relationship building skills. Peer support and education programs may be provided in a group, community, or home setting. Older adults benefit more from group interaction, when groups are composed of other older adults (Bartels, et al., 2002). Effective programs attend to physical health issues such as nutrition, sleep habits, medication, and pain (Kurlowicz, 2003). Staff and

volunteers who work with older adults should receive specialized training in geriatrics as well as behavioral health (Shafer, 2001).

Prevention

Effective prevention programs support healthy aging among persons who do not have a diagnosable behavioral health problem, but who may be at risk to develop one. Appropriate target populations include: the bereaved, pre-retirement/newly retired, persons who are not yet older adults (ages 50-55), adults with a serious medical condition and/or physical disability, and caregivers of older adults. Although there are a number of prevention programs targeting working age adults which are on the National Register of Effective Programs, (http://www.modelprograms.samhsa.gov/matrix_all.cfm) there are no nationally recognized exemplary programs targeting older adults.

Effective strategies include gatekeeper training, peer leadership, caregiver support, and life skills training. Prevention programs should involve multiple strategies and coordination with other community organizations through local substance abuse coalitions.

Training

Gatekeeper training is one of the most common approaches to prevention of suicide. This strategy involves training persons who have contact with older adults to recognize signs and symptoms of behavioral health problems, strategies for intervening with a suicidal person and the process for making referrals into treatment. Gatekeeper programs designed to educate physicians about signs and symptoms of suicide in older adults have been shown to have short term reductions in suicide (Klaussner and Alexopoulos, 1999; Rosenberg, 1996).

Gatekeeper training should involve multiple sessions over time with opportunities to practice skills. Trainings should be grounded in principals of adult learning involving hands on activities. Gatekeepers to target include medical professionals, care home staff, home based services staff, peers, and senior center staff (APA Online, 2006; Bartels, et al, 2002).

Prevention programs can help gatekeepers to recognize the importance of screening for depression and substance abuse. Prevention programs can help educate gatekeepers about screening tools and their use in medical settings. Some noteworthy gatekeeper training programs for suicide prevention are “Applied Suicide Intervention Skills Training”, “safeTALK”, and “Question Persuade and Refer”.

Peer Leadership

Peer leadership involves a variety of activities such as service learning, peer education, peer facilitated education, support groups, and home visitation.

Service learning: Volunteer and community service programs can reduce symptoms of depression, cognitive decline, and decrease mortality rates (Lum and Lightfoot, 2005). Volunteer work may involve activities such as mentoring children, answering phones for a warm line, provision of support and/or transportation to home bound peers, or participation in community based coalitions concerned with health and wellness issues (Rosenberg, 1996).

Community health educators (also called promotoras, senior companions, or peer educators) are trained paid or unpaid lay health workers who work with individuals or groups of people to provide support, health education, advocacy, screening, and assessment of home environmental

issues that may create risk for development of behavioral health problems. Services may be provided in a group community or home setting. Community health educators are usually of the same age, ethnic and racial background of the targeted population and are fluent in the preferred language of the population. Community health educators can break through age-related barriers that younger professionals may not be able to bridge. Use of community health educators to convey health messages has been rigorously evaluated with older Latino, White, African American, and Asian populations and found to improve participation in screening, preventative health care, decrease utilization of behavioral health treatment services, improve overall health, and improve cognitive function (Philis-Tsimikas, Walker, Rivard, Talavera, Reimann, Salmon, Araujo, 2004; Siegel, Berliner, Adams, and Wasengarz, 2003, Whitley, 2006).

Support groups, peer education, and counseling: Support groups facilitated by trained peers are effective in preventing behavioral health problems. Group interventions have been shown to be effective with older adult populations (SAMHSA, 2006).

Family and Caregiver support and Education

Caregiver support and education programs can delay the placement of older adults with medical or psychiatric disabilities into rehabilitation facilities. Two types of caregivers are of particular importance, caregivers of disabled older adults and older adults who provide full time care to grandchildren. Caregivers of disabled older adults benefit from education in the cognitive and behavioral changes experienced by their care recipient (Abeles, et al., 2002). Grandparents who are parenting young children need support in their role as a grandparent.

Education

Life skills training is provided in a group format to older adults at risk to develop a behavioral health problem. At least 16 hours of training is provided over multiple sessions. Some form of booster sessions should be offered after completion of the program. Services should be provided in locations accessible by older adults such as community centers, health care facilities, residential care facilities and senior centers. Suggested topics of training include: medication management, bereavement, maintaining cognitive health, healthy aging, and development of coping skills, information about changes in metabolism of alcohol and other drugs, physical activity, healthy diet (Carlson, 1994). Materials for older adult programs should be age appropriate and developed with consideration of the cultural beliefs of the target population. Education should be grounded in principles of adult learning and use of a variety of teaching tools in order to be successful. The needs and characteristics of the older population should be taken into consideration when preparing age and culturally appropriate materials. For example, using a large type and attractive format can make materials more visually appealing to older adults.

Community Development and Coalition Utilization

Prevention is most effective when grounded within a holistic community approach (Siegel, Berliner, Adams, and Wasengarz, 2003). Prevention services should always be coordinated with other community organizations through grass roots coalitions that are formed to address issues of concern to the community, which include participation of older adults. Prevention programs serving older adults should be active participants in local substance abuse prevention coalitions, healthy community coalitions, domestic violence coalitions, and behavioral health and aging coalitions. Coalitions can develop alcohol and substance abuse policy guidelines for long term

care facilities, create of hotlines, and most importantly, create partnerships for provision of services (Carlson, 1994; Ell, 2006; US Department of Health and Human Services, 2004).

Personal and Cultural Development

Personal and cultural development enhances sense of growth, accomplishment and purpose. The focus of personal and cultural development activities should be on participatory activities that build self-awareness and self-confidence, particularly in relation to their community environment. Examples of personal and cultural development activities include: reminiscence activities, visual arts, theater arts, holiday/cultural celebrations, and community gardens.

Engagement strategies

Outreach and engagement are key components of effective prevention programs (SAMHSA, 2006). Core strategies include selection of an appropriate service setting, provision of transportation, childcare, and delivery of services in a culturally competent manner.

Service Setting: Services should be provided in places that are most comfortable to the senior citizen such as residential homes and senior centers. Prevention programs are encouraged to integrate older adults into the community rather than providing all services within the home setting, which may contribute to isolation of the older adult from social supports in the community.

Transportation: Medical and physical conditions may prohibit/limit driving capabilities, promote isolation, reduce independence, and diminish quality of life and health. Provision of transportation is a critical element of effective prevention programs. When services are rendered outside of the participant's home, prevention programs should offer transportation to the program site (Siegel, Berliner, Adams, and Wasengarz, 2003).

Child Care: Child care should be provided for older adults who are caring for young children such as grandchildren.

Cultural competency: Recognition of and respect for the diversity within older adult populations is a critical element of program success. Gender, age, language, and culture have substantial impact on engagement of participants and effectiveness of services rendered. Staff should be aware of the diversity within older adult populations and receive training in cultural competency and gerontological issues.

Culturally competent prevention programs involve the targeted population in assessment of community need and design of preventative services. Prevention services should be provided in the language preferred by participants. Programs should utilize staff and volunteers who are of the same age group, gender, ethnic, and racial group of the targeted population. Programming should be grounded in the traditional beliefs and practices of the targeted population. Programs should consider that older adults being served may have lived through negative experiences that have shaped their lives (i.e., Bureau of Indian Affairs boarding schools, segregation, and discrimination). As a result, they may harbor distrust of healthcare providers and staff member of different cultural and ethnic backgrounds from themselves. It is important to keep in mind the referrals made for the individual. The U.S. Administration on Aging has provided an excellent resource for professionals on providing respectful, inclusive and culturally sensitive services for older adults and their families.

The name of the resource is “A tool kit for Serving Diverse Communities” and can be downloaded on this link: http://www.aoa.gov/AoAroot/Press_Room/For_The_Press/pr/archive/2010/June/DiversityToolkit.aspx

Early Intervention

Early intervention in behavioral health problems facilitates effective treatment. Early intervention practices include identification of behavioral health problems and facilitation of acquisition of treatment services through hotlines, warm lines, mobile crisis intervention, means restriction, and screening. Diagnosis of behavioral health conditions among older adults can be complicated, as the symptoms of many physical health problems can mimic the symptoms of behavioral health issues. For example, confusion or memory issues may be related to depression or to dementia. Several approaches to early intervention and/or diagnosis are detailed below.

Hotlines and warm lines: Hotlines, which provide over the phone crisis intervention, are not commonly used by older adults. Warm lines which provide education, support, companionship, and referral can be staffed by trained and supervised volunteers (Rosenberg, 1996).

Means restriction involves removing any tools a person could use to complete a suicide from their environment, thus making an impulsive act of suicide less likely. An example of this would be a family member removing all firearms from the home of a depressed older adult (Rosenberg 1996).

Screening for behavioral health problems such as depression and substance abuse is an essential element of early intervention. Screening can facilitate access to behavioral health treatment services earlier in the course of their disease. It is particularly effective when included as a routine component of medical examinations because many older adults with behavioral health disorders will seek medical care rather than behavioral health care. Patients should be educated about the purpose of the screening and have an opportunity to provide active consent (Ell, 2006; Blow, 1998; Nemes, Rao, Zeiler, Munly, Holtz, Hoffman, 2004).

Major life changes should trigger a new behavioral health screening. Clinicians and medical providers should use screening tools that have been normed with older adults (Abeles, 1998). It is important to note that most assessment instruments have not been normed with ethnic minority older adults and may therefore be of limited utility with these populations.

Instruments normed with older adults and recommended by SAMHSA, the American Psychological Association and others include (SAMHSA, 2006; Abeles, et al., 2002; Irwin, Artin, and Oxman, 1999, Ell, 2006):

1. Alcohol Use Disorders Identification Test (AUDIT)
2. Beck Depression Inventory
3. Brief Psychiatric Rating Scale (Available online at http://www.priory.com/psych/bprs.htm.).
4. Center for Epidemiological Studies Depression Scale (CES-D)
5. CAGE: (A questionnaire for drinking alcohol and drug use provided by SAMHSA) Responses on the CAGE are scored 0 for “no” and 1 for “yes,” with a higher score being an indication of alcohol problems. A total score of 2 or greater is considered clinically significant.
6. Hamilton Depression Rating Scale

7. Michigan Alcohol Screening Test-Geriatric Version (MAST-G)
8. Patient health Questionnaire Module (PHQ-9)
9. The Geriatric Depression Scale (GDS) (Available online at http://www.geridoc.net/gds.txt)

Pocket screening instruments may be found at: http://kap.samhsa.gov/products/brochures/pdfs/Pocket_2.pdf (Blow, 1998).

Diagnostic Issues

Mood disorders often manifest differently in older adults than in younger adults. Symptoms may include anxiety, problems with memory, agitation, and somatic complaints (Abeles, et al., 1998). Co-occurrence of dementia and/or delirium is common, occurring in up to 20% of older adults with major depression. It is important to differentially diagnose between these conditions.

Depression has a more abrupt onset than dementia and commonly occurs with a significant life change, loss of family member, friends, following major surgeries, loss or change in ability to perform activities of daily living or activities the person had been involved in prior to the life changing event, and sudden changes in motivation and mental status. Memory may be patchy, but the patient is able to think. The thought process involves helplessness, hopelessness, and guilt. Important indicators of depression include down cast moods; tearfulness; recurrent thoughts of suicide and death, family history of mood disorders, lack of interest, psychomotor disturbances, appetite change, weight loss, fatigue or loss of energy, history of behavioral health problems, insomnia, fear, memory problems, poor concentration and preoccupation with poor health. Older adults with depression should be screened for suicide risk (Reynolds, et al., 2002; Registered Nurse Association of Ontario, 2003; Rynn, DeMartinis, and Rickels, 1999).

Dementia has a slower, more progressive onset involving diminishment of recent and past memory. In dementia, the person may have difficulty finding words and understanding abstract concepts. Agitation is more symptomatic of physical health problems (Registered Nurse Association of Ontario, 2003). However, it is important to remember that the nature of dementia and the type of depression has an impact on its onset. For example, Alzheimer's type dementias with co-morbid depression have a quicker onset. Pseudodementia, dementia secondary to depression can only be ruled out by an empirical treatment with antidepression treatment, the most effective being electroconvulsive therapy.

Delirium which is an acute confusion state of mind is a transient global disorder of cognition (Alagiakrishnan, MD, MBBS, Blanchette, MD, 2010). It has a sudden onset and is of short duration, usually waxing and waning in nature (less than a month). Delirium is considered a syndrome and not a disease, and should be treated as a medical emergency. It is often unrecognized or misdiagnosed, and commonly mistaken for dementia, depression, acute schizophrenic reaction, or part of old age, (Alagiakrishnan, MD, MBBS, Blanchette, MD, 2010). It is usually secondary to medical problems such as medication side effects, infections, toxic or metabolic problems; cardiac and pulmonary conditions leading to low oxygen delivery to the brain, neurological illnesses, etc. It is characterized by impaired memory, distorted, incoherent thinking and hallucinations, which get worse at night and first thing in the morning (Registered Nurse Association of Ontario, 2003). Delirium can occur at any age, but usually affects patients and older adults who have compromised mental status. The diagnosis of delirium requires a

careful review of the individuals' mental status as well as a complete history of the patient's family, the staff, and medical chart review (Alagiakrishnan, MD, MBBS, Blanchette, MD, 2010).

Suicide: Any person with a history of suicide attempts should be screened for suicidal ideation. Other indicators of suicide include: hoarding of medications, purchasing of weapons, writing a will, depression, substance abuse decline in health, isolation, abnormal sleep patterns, and sudden change in religious belief or practice. Older adults should be screened for suicide following major life changes (Holkup, 2002).

Substance Abuse: Older adults experience changes in their tolerance for alcohol due to physiological changes associated with aging. This means smaller amounts of use may be indicative of abuse. More than one drink per day or more than two drinks during a special occasion could be indicative of substance abuse (Patterson, 1999; Blow, 1998; Widlitz and Marin, 2002). Substance abuse is easily confused with physical health problems, dementia or depression (Benshoff, et al., 2002). Indicators of substance abuse include falls, vehicular accidents, and malnutrition. Prescribed medications can also be the source of problems; opiates, anti-cholinergic medications, anti-anxiety medications, whether they are taken as prescribed or abuse (taken in excess of how prescribed.

Laboratory tests of thyroid function are recommended when behavioral health conditions are suspected. Episodes of depression in older adults are commonly associated with a slightly decreased level of thyroxin and a slightly higher level of thyroid stimulating hormone. Patients can have normal levels of TSH and thyroxin, but low levels of T3. Additionally B12, foliate, vitamin D and magnesium deficiencies are quite common among this group and should be tested for. Oxygenation and cardiac ejection fraction should be evaluated as indicated. Serology for HIV and syphilis should be considered as well.

Treatment – Counseling

A combination of medication (see medical services below) and counseling is the most effective treatment. Patients should be evaluated for the potential benefit of medications in addition to counseling. Some patients will refuse counseling and medication or ECT is the only treatment choice (For example, the diabetic who is overweight and refuses to change diet or exercise). A number of therapeutic approaches are effective with older adult populations including: motivational interviewing, interpersonal psychotherapy, cognitive-behavioral therapy, and problem solving therapy. These therapies are more effective when offered in combination with anti-depressants, psycho education, and/or case management. Treatment can be effectively co-located within medical settings. For a thorough resource on best practices in substance abuse treatment with older adults, see SAMHSA TIP 26: Substance Abuse among Older Adults (Bartels, et al., 2002; Reynolds and Kumpfer, 1999; Blow, 1998).

Therapeutic Approaches

Supportive counseling, interpersonal psychotherapy, and cognitive-behavioral therapy are effective in reduction of symptoms associated with depressive disorders, anxiety, sleep disturbances, and other behavioral health problems. Overall goals of therapy include helping older adults to find their strengths, build social support networks, and develop hope and meaning in their lives (Kurlowicz, 2003; Abeles, et al., 1998).

Cognitive behavioral therapy modifies distorted thought processes and helps in development of coping skills. This form of therapy has been shown to be effective in older adults, particularly in treating late-life alcohol abuse (Bartels, et al., 2002; Faison and Steffen, 2001; Ell, 2006).

Interpersonal therapy helps people to cope with grief, conflicts, and changes in life. This type of therapy has been shown to be effective with older adults (Faison and Steffen, 2001; Ell, 2006).

Reminiscence therapy involves review of past successes and challenges. The clinician helps the patient to find meaning in past experiences, forgive people, and reinterpret past experiences. Reminiscence therapy is effective in both group and individual settings and is effective in development of resiliency social intimacy, and self-esteem. It has been shown to be more effective when combined with other forms of therapy such as problem solving therapy (Gaskamp, et al., 2004, Abeles, et al., 1998, Klaussner and Alexopoulos, 1999; Faison and Steffen, 2001).

Problem-Solving Therapy is an approach in which behavioral health recipients identify problems contributing to their behavioral health problems and work on development of solutions to those problems. This type of therapy is effective in treatment of depression (Ciechanowski, Wagner, Schmaling, Schwartz, Williams, Diehr, Kulzer, Gray, Collier, and Logerfo, 2004; Blow, 1998, Kurlowicz, 2003; Klausner and Alexopoulos, 1999; Ell, 2006).

Other therapeutic approaches: Dialectical behavior therapy, music therapy, relaxation therapy, and art therapy can also be effective in older adult populations. Research on psychodynamic therapy has had inconsistent results in older adult populations (Faison and Steffen, 2001; Klausner and Alexopoulos, 1999; Kurlowicz, 2001).

Group based education and therapy: Older adults benefit from group interaction, particularly when groups are composed of other older adults and are supportive rather than confrontational (Benshoff, 2003). Group therapy is effective in the treatment of bereavement, depression, anxiety, and other behavioral health disorders as well as in reduction of symptoms such as pain (Abeles, et al., 1998; Blow, 1998). Groups can teach skills to rebuild social support networks as well as address issues such as coping with depression, loneliness and loss. Studies indicate that groups may be effectively facilitated by persons who are not behavioral health professionals (Klausner and Alexopoulos, 1999; Ell, 2006).

Case management services that reinforce compliance with medication and therapy can have a positive impact on treatment of behavioral health disorders in older adults (Katon, Schoenbaum, Fan, Callahan, Williams, Hunkeler, Harpole, Zhou, Langston, Unutzer, 2005).

Unskilled respite care: Caregivers of older adults with physical and mental disabilities benefit from provision of respite care. Respite may be provided in a variety of settings: community center.

Self-help/peer services (peer support): Older adults can effectively facilitate support and education groups for other older adults as described above.

Home care training family (family support): Support services provided to family members and/or caregivers can assist caregivers to better understand the behavioral health needs of their loved one and focus on effective resolution of problems related to care giving.

Supported housing: This approach assists older adults to continue to live independently. Supportive services may include case management, socialization, recreation activities, vocational and independent living skills training such as; personal hygiene, household tasks, transportation utilization, money management, and the development of natural supports needed to access services in the community provided at the client's home.

Adult foster care home: A licensed 24-hour personal care, protection, and supervised facility for individuals who are mentally ill, over 60 and cannot live alone but who do not need continuous nursing care. This level of care provides room and board and may require assistance with bathing, grooming, dressing, eating, walking, toileting and administration of medication. People requiring this level of care are referred to Arizona Long Term Care System (ALTCS) for this form of placement. Please note that ALTCS has programmatic levels of care defined to their specifications.

Semi-independent living: A community based therapeutic living environment designed for residents with deficits in independent living skills but offers a less restrictive and less programmed environment than 24-hour residential treatment program or skilled living facility. These placements may be in an apartment or house model setting. Residents go into the community for socialization, work and outside activities as they please. Services are voluntary and may be delivered on-site or in the community.

Health promotion strategies are designed to disseminate information to at-risk older adults in order to increase knowledge and change attitudes about substance abuse through activities such as group discussion. Health promotion and education services aid in understanding behavioral health diagnosis, medications, and cognitive changes as well as to develop problem solving skills and adherence to treatment. Health promotion strategies can be used to help patients develop a healthier diet, encourage exercise, and understand strategies for improving sleep (Kurlowicz, 2003). This intervention acts as an addition to any kind of therapy (Reynolds, Alexopoulos, and Katz, 2002).

Health promotion should include age-appropriate written materials with large, easily read fonts. Education should take place at a slower pace and be adapted for an older adult audience. Education is effective when peer led. Some older adults are more willing to participate in educational activities than therapeutic groups (Ell, 2006).

Participant engagement and retention

Motivating change is a key element of treatment. Understanding reasons that motivate older adults to stop drinking, such as health effects and costs, can help stimulate change. Motivational interviewing is an effective method of engaging people and helping them to develop motivation for change. Caring touch (holding hands, pats on the shoulder) can have positive impacts on an older adult's sense of well-being, self-esteem and satisfaction with life (Gaskamp, Sutter, Meraviglia, 2004). Reinforcement should be provided for change in behavior (Shafer, 2004).

Treatment should be culturally relevant, age-specific, and non-confrontational while promoting self-esteem and respect. Additionally, staff should receive training in working with older adult populations. Gender based treatment should be available.

Home based provision of treatment services has been shown to be effective in the treatment of depression in older adults with co-morbid medical conditions that limit mobility (Ciechanowski, et al., 2004). Transportation should be provided as needed.

Medical services

Combining anti-depressant medication with psychotherapy for treatment of severe depression is recommended as these two approaches are most effective when used together (Bartels, et al., 2002; Reynolds and Kumpfer, 1999). Older adult patients are more sensitive to medications and highly prone to side effects, adverse reactions, and drug-drug interactions. Clinicians should consider starting at low doses and making changes cautiously and slowly. Medications in older adults can complicate existing medical conditions and can mimic the physiologic symptoms of dementia. Coordination with primary care providers is essential.

Training and Supervision Recommendations

DBHS will provide a training of trainers for key Tribal and Regional Behavioral Health Authorities (T/RBHAs) and provider trainers in the application of this protocol. T/RBHAs will ensure that each staff member who works with older adults participates in the training.

Anticipated Outcomes: How will this doc be used to get those outcomes?

It is anticipated that this protocol will result in:

1. Increased referrals of older adults to treatment services;
2. Improved outcomes for prevention programs serving older adults;
3. Increased community and professional awareness of behavioral health issues among older adults;
4. Increased professional knowledge of best practices among older adults; and
5. Effective treatment practices with older adults.

Older Adults: Behavioral Health Prevention, Early Intervention, and Treatment Desktop Guide

Key elements to remember about this protocol:

1. Prevention approaches that are effective include gatekeeper training, peer leadership, family and caregiver support, education, personal and cultural development and community development.
   A. Group activities are highly effective with older adults and are preferable to delivery of in home preventative services as they are more likely to decrease isolation.
   B. Older adults can be effectively engaged as peers in the delivery of support and education services to persons of all ages.
   C. Prevention services should always be coordinated with the local substance abuse prevention coalition and coalitions addressing behavioral health and aging issues.
   D. Engagement strategies include location of services in a place comfortable to the participants, provision of transportation, respite care and delivery of culturally competent services.
2. Early Intervention involves identification of behavioral health problems.
   A. Warm lines staffed by volunteers are more likely to be used than hotlines.
   B. Screening for behavioral health conditions should be a routine component of primary health care visits.
   C. Several screening tools have been normed and validated with older adults. Most have not been tested with older adults of diverse ethnic backgrounds.
   D. Behavioral health conditions are easily confused with dementia, delirium, and other health problems. Care should be taken in diagnosis of older adults
   E. Any older adult with symptoms of depression, a history of suicide, and/or a serious life change should be screened for behavioral health disorders and suicide.
3. Treatment
   A. Therapeutic approaches that are effective with older adults include: cognitive behavioral therapy, interpersonal therapy, reminiscence therapy, problem solving therapy, and group based education and support.
   B. Support services that are effective with older adults include: case management, respite, peer support, family support, and supported housing.
   C. Participant engagement and retention involves delivery of culturally competent care.
   D. Medical services
      a. Physiological changes that occur in older adults affect metabolism of medications;
      b. Select medications with the least side effects;
      c. Start with the lowest dose and build slowly;
      d. Medical services should be delivered in collaboration with the primary care provider; and
      e. Detox with older adults may take longer. Care should be taken to closely monitor detox services.

Benefits of using this best practice:

Anticipated benefits to be gained by using this Protocol:

1. A larger number of older adults will be served because services delivered will be more cost-effective and efficient;
2. The quality of programs serving older adults will increase; and
3. Integrate effective prevention practices in older adults programs.

Definitions

1. *Addiction:* The compulsion and craving to use alcohol or other drugs regardless of negative or adverse consequences

2. *Assessment:* The ongoing collection and analysis of a person's medical, psychological, psychiatric and social condition to determine if a behavioral health disorder exists, the need for behavioral health services, and to ensure that the person's service plan meets the individual's (and family's) current needs and long-term goals.

3. *Best practices*: Strategies, activities and approaches that have been shown to be effective, through research and evaluation at preventing and/or or delaying substance abuse, violence, or other problem behaviors.

4. *Caregiver:* An individual who has the principal responsibility for caring for a child or dependent adult.

5. *Cultural competence*: A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals to enable that system, agency or those professionals to work effectively in cross cultural situations.

6. *Culturally based:* Developed in collaboration with or by the targeted population.

7. *Culturally relevant:* A prevention program, message, or strategy development that is meaningful to the identified population.

8. *Culture:* The shared values, norms, traditions, customs, arts, history, folklore, music, religion, and institutions of a group of people.

9. *Curriculum:* A written document that details the workshops, lessons, and/or presentations used in life skills education, parent/family education, public information, marketing, alternative activities, community education, and/or training services.

10. *Dependent Adult:* A person 18 years of age or older who is unable to protect his/her own interests or unable to adequately perform or obtain services necessary to meet essential human needs, as a result of a physical or mental condition that requires assistance from another, or as defined by department rule. (Definition from Iowa Human Services Department).

11. *Early Intervention*: The identification of individuals with suspected behavioral health problems for the purpose of addressing the problems before they become worse. It may involve referring individuals for assessment and treatment, for example, and routine evaluations done by health care providers.

12. *Evidence Based:* Programs or practices that have several of the characteristics listed below: replication, sustained effects, published in a peer reviewed journal, a control group study, cost benefit analysis, adequately prepared and trained staff, appropriate supervision, include assessment and quality assurance processes, consumer and family involvement, cultural, gender, and age appropriateness, and coordination of care.

13. *Gatekeeper:* An individual who has access to a group of people.

14. *Older adult:* A person who is age 55 or older.

15. *Outcome:* The immediate desired change in attitudes, values, behaviors, or conditions. Stated in the following format: "By a specified date, there will be a change (increase or decrease) in the target behavior, among the target population."

16. *Prevention:* The creation of conditions, opportunities, and experiences that encourages and develops healthy, self-sufficient children and that occur before the onset of problems (Arizona Revised Statutes). Prevention is an active process that creates and rewards conditions that lead to healthy behaviors and life styles (Center for Substance Abuse Prevention, (CSAP)).

17. *Protective factor:* An attribute, situation, condition, or environmental context that develops resiliency in individuals and prevents the likelihood of Alcohol Tobacco and Other Drug (ATOD) use.

18. *Resilience:* The personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, and other stresses and to go on with life with a sense of mastery, competence, and hope (New Freedom Commission on Mental Health, 2003).

19. *Risk factors:* Conditions that increase the risk of a particular problem from developing.

20. *Substance abuse:* The continued use of alcohol or other drugs in spite of negative consequences.

21. *Substance use*: The ingestion of alcohol or other drugs without the experience of any negative consequences.

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Practice Improvement Protocol 16

PERVASIVE DEVELOPMENTAL DISORDERS AND DEVELOPMENTAL DISABILITIES

Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services

Effective July 8, 2005

ISSUE: The treatment of individuals with Pervasive Developmental Disorders and Developmental Disabilities requires a comprehensive evaluation of life domains and service provisions by multiple agencies that approach interventions with unique perspectives, goals and desired results. A collaborative and integrated approach to care, with agreed upon values, priorities and expectations can promote improved treatment outcomes.

PURPOSE: To institute and maintain a process that promotes best practices for individuals with Pervasive Developmental Disorders and Developmental Disabilities that:

- Establishes protocols to effectively reduce target symptoms, improve overall functioning, and strengthen the community and family supports that enhance outcomes.
- Ensures that behavioral health services are coordinated and integrated with those provided by the Division of Developmental Disabilities (DDD), Child Protective Services (CPS) and all other agencies involved.

TARGET POPULATION: All Title XIX and Title XXI eligible children and adults diagnosed with Pervasive Developmental Disorders and/or Mental Retardation[1] and all individuals with both a serious mental illness and Pervasive Developmental Disorder and/or Mental Retardation.

BACKGROUND: ADHS/DBHS is committed to the provision of services through family focused practice and in the context of Child and Family Teams (CFT) or Adult Clinical Teams (ACT). In order to extend this commitment to children, adolescents and adults with Pervasive Developmental Disorders and/or Mental Retardation, service provision and planning should:

- Explore and document the strengths and needs of the individual and family;
- Establish and prioritize service goals;
- Identify the most appropriate services and supports necessary to meet those goals;
- Ensure that the services provided are of the intensity necessary to accomplish identified service goals;
- Describe a course of action encompassed in a written service plan developed by team members and informed by all involved agencies;
- Monitor the accomplishments of the individual and family; and
- Determine the responsibilities of all team members involved in these efforts.

PROTOCOL:

Assessment

The evaluation of both children and adults requires input from numerous sources and settings, structured and unstructured observations of behavior, and a thorough assessment of emotional, environmental, health (including dental), and social factors. Outcomes improve when behavioral health needs are identified and treated early. Assessment and services should be initiated at the first indication of behavioral concerns in order to limit the development of more severe

[1] Please refer to DSM –IV-TR for a comprehensive list of all disorders covered under these broad categories.

symptoms.

As with all behavioral health conditions, the assessment process should begin with the ADHS/DBHS Behavioral Health Assessment. The underlying needs, strengths and resources of each individual and family must be continually reassessed and addressed on an ongoing basis in the context of a CFT or ACT. The assessment process must include input, when appropriate and available, from the individual being assessed as well as from schools, places of employment, other involved systems and family. As individuals with these disorders are often poor reporters of their own behaviors or symptoms, every attempt should be made to involve others capable of contributing meaningfully to the assessment process.

Parallel assessment and service planning processes like DES Family Decision Making or permanency planning meetings, DDD Person-Centered Planning Meetings and Individual Support Planning Meetings (ISP) and Individualized Education Plan (IEP) meetings in special education should be coordinated with CFT or ACT processes to avoid duplicative endeavors.

Compared to the general population, individuals with Pervasive Developmental Disorders and/or Mental Retardation are more likely to experience a variety of coexisting behavioral and physical health conditions. As symptoms may overlap, mimic or accentuate coexisting disorders, the following should be carefully assessed through psychiatric consultation, educational testing, primary care or specialty evaluations, and psychological testing, as indicated:

- Receptive language delay/disorder
- Expressive language delay/disorder
- Communication Disorder
- Attention Deficit Hyperactivity Disorder (ADHD)
- Learning Disorders
- Rett's Disorder
- Selective mutism
- Bipolar Disorder
- Schizophrenia with childhood onset
- Anxiety Disorders
- Mood Disorders
- Post Traumatic Stress Disorders
- Tic Disorders, including Tourette's
- Hearing impairment
- Endocrine Disorders
- Seizure Disorders
- Dental conditions
- Infections

- Constipation and other gastrointestinal disorders

For children, screening tools such as the Vineland Adaptive Scale may be given to parents and teachers at the initiation of the assessment. The Test of Nonverbal Intelligence (TONI) together with the Vineland is recommended if intelligence quotient (IQ) testing must be performed, especially between the ages of four and eight.

If standard verbal IQ tests are used after the age of eight, the psychologist should be familiar with the array of language deficits associated with these disorders. IQ testing prior to the age of eight is not recommended; an IQ prematurely diagnosed as low because of language deficits can lead to inappropriate labeling and lack of encouragement to parents and to their children as they develop. In all cases, testing in older children and adults should be completed with the use of a standardized culturally appropriate instrument.

Evaluators must be cognizant of the tendency for diagnostic overshadowing, which is the attribution of all symptoms or behaviors to an underlying Developmental Disorder or Pervasive Developmental Disorder, rather than looking for behavioral, medical, social, environmental, and other factors, and losing sight of the fact that individuals with these conditions suffer from the full range of psychiatric disorders that others do.

Psychiatric assessments and management for individuals less than 13 years of age should be performed by or in consultation with child and adolescent psychiatrists.

Service Planning

In collaboration with the family, caregivers, other primary social supports and other involved professionals, and in the context of CFT and ACT processes, a list of targeted symptoms, individual and family strengths, and treatment goals should be developed. The frequency and severity of target signs and symptoms should be documented at the initiation of therapy. Decreases in frequency and severity of target signs and symptoms, as well as enhancement of strengths, should be documented as therapy progresses. The CFT or ACT should determine realistic goals and a realistic pace for change.

Although communication and services must always be geared to the individual's level of comprehension and attention, it should never be assumed that the presence of Pervasive Developmental Disorders and/or Mental Retardation automatically precludes the individual's participation in goal setting or treatment planning, or would render any particular treatment modality ineffectual. Thus, the full range of covered services, including individual and group therapy, should be considered as potentially beneficial to any given individual.

Non-Pharmacological Approaches

All service provisions should be family focused and should rest on connections to natural supports, community based services and respect for the individual's unique cultural heritage and needs.

Given the unique and challenging needs of these individuals, RBHAs must designate Clinical Liaisons with specialized training, expertise, and invested interest in working with them.

"Specialized" Clinical Liaisons must:

- Be assigned to all cases for which Pervasive Developmental Disorder or Developmental Disability is diagnosed;
- Provide behavioral health consultation to the DD/ALTCS case manager;
- Coordinate behavioral health care with the DD/ALTCS case manager and other involved agencies, providers, or parties; and
- Work as an integral part of the Child and Family Team, or Adult Team.

I. Individual Counseling:

Cognitive-behavioral strategies may be used, with increased weight on the behavioral component, for lower functioning individuals. Achievable and relevant goals and objectives should be identified, and realistic expectations of progress established, as chaining and generalization of goals may occur slowly.

For individuals with verbal functioning, individual therapy can be very helpful to address feelings of isolation and to improve social adjustment. Play therapy or expressive therapies may assist those with impairments in verbal functioning.

For changes in life circumstances and other stresses that lead to emotional or behavioral disturbances, brief supportive treatments should be employed, as for any other individual, by clinicians who are competent to perform psychotherapeutic interventions geared to the developmental level of the individual.

II. Family Support:

Supports offered to family members may include:

- Support activities to assist the family's adjustment to the individual's disability,
- Developing skills to effectively interact with and/or manage the individual,
- Understanding the individual's limitations,
- Understanding the treatment of behavioral health issues,
- Effectively utilizing the system, or
- Planning long term for the individual and the family.

III. Behavioral Assessment/Functional Analysis:

Challenging behaviors, like appropriate behaviors, are maintained by environmental, social and physical reinforcers. The clinicians' task is to determine the function that the challenging behaviors play in the individual's daily routine. This task is usually accomplished by conducting a "Functional Analysis." A functional analysis includes an examination of the following:

- Antecedents and/or consequences that affect or control a behavior;
- Whether the behavior represents a deficit or an excess, or is situationally appropriate;
- Whether different behavior patterns occur with different situations;
- Possible schedules of reinforcements that maintain the behavior;

- An examination of environmental aspects and potential physical health issues that may relate to the challenging behaviors; and
- Potential reinforcers and potential alternative behaviors that may be used in the treatment plan to strengthen alternative behaviors.

Behaviors must be viewed in the situational and environmental context in which they occur and in relation to the influences that manifest before, during and after the behaviors. Antecedents may provoke behaviors naturally (like a loud noise causing an individual to jump) or through learning (recognizing, over time, that self-injurious behavior lead to increased attention). Events following a behavior can alter the likelihood of it recurring if it is positively or negatively reinforced. Thus, knowing antecedents and consequent events can be critical to understanding the reasons for challenging behaviors and to developing therapeutic interventions.

Behavioral assessments must also explore the effects that challenging behaviors have on caregivers, and who is most challenged by the behaviors. This allows service providers the opportunity to support and promote the most effective caregiver responses and an opportunity not only to change behaviors but also to shape and enhance the interpersonal environment in which they occur.

In order to conduct a functional analysis the clinician will be required to interview family members, other observers of the behaviors, and the individual as well as directly observe the individual while he/she is engaged in target behaviors.

The results of the functional analysis lead directly to the formulation of a treatment intervention by the CFT or ACT. Since interventions will need to occur throughout the day, family members, teachers or other direct care staff must understand the rationale for the method, the exact procedures to follow and the documentation that is required to measure the effectiveness of the interventions.

IV. Behavior Management:

The overall treatment strategy for behavioral interventions should emphasize the teaching of social, communication and cognitive skills to the individual and effective behavior shaping techniques to parents, to be used both during and after termination of therapy. Applied Behavioral Analysis Techniques and other behavioral management approaches should emphasize:

- The development and encouragement of constructive and effective ways for individuals to seek the attention they desire.
- Positive reinforcement for appropriate behavior and acknowledgment and reward of the individual's ability to establish age-appropriate autonomy to the extent possible.
- Identification and minimization of the antecedents to behavioral disruptions, agitation or self-injury by defining and utilizing positive or negative reinforcers.
- The enhancement of the individual's repertoire of social and communicative behaviors through social-pragmatic teaching.

- The careful documentation in the service plan of desired outcomes and measurable goals consistent with the individual's behavioral health needs.

Behavioral interventions must be coordinated with other agencies like DDD, which may be providing similar interventions as part of habilitation. Habilitation services use a variety of methods designed to maximize the person's abilities. Services typically are offered in the person's home or community and include activities specific to learning to become more independent.

Caregivers, family members and other providers in the individual's environment should be actively engaged, including involvement with "homework" assignments. Strategies must be integrated with other services and must be based on a thorough familiarity of the individual's environment, routine, strengths and limitations and the assured cooperation of the individual's caretakers, guardians, educators and other staff. As for all other service strategies, signs/symptoms of relapse or recurrence and exacerbating factors for co-occurring behavioral health disorders should be identified and strategies developed for coping with exacerbating factors.

Psychopharmacological Interventions

To promote the safe and efficient use of psychotropic medications in the treatment of Pervasive Developmental Disorders and Mental Retardation:

- All medication approaches must be consistent with the ADHS/DBHS Provider Manual Section 3.15, Psychotropic Medication Prescribing and Monitoring and, in the case of children or adolescents, *The Use of Psychotropic Medication in Children and Adolescents Practice Improvement Protocol*.
- To rule out environmental causes of symptoms, the individual should demonstrate the targeted symptoms in at least two out of three settings before a psychopharmacological trial is considered.
- To rule out a medical or dental etiology for behavioral symptoms, consultation with the individual's primary care physician or dentist should be considered, especially in situations where the individual has little or no ability to verbally communicate his or her physical distress.
- In general, basic treatments for these conditions do not differ from that of the general population. If a general psychiatric condition is identified, the appropriate pharmacological approach for that condition should be employed, regardless of the presence of Mental Retardation or Pervasive Developmental Disorder. There are no psychotropic medication interventions that have been found to positively influence the specific symptoms of Mental Retardation or Pervasive Developmental Disorders. Medications are used to mitigate associated or coexisting concerning symptoms.
- It is important to consider that individuals with mental retardation are generally more sensitive to medications and more likely to experience side effects. This is particularly true in children. These side effects may, in turn, result in an increase in behavioral disturbance. Atypical antipsychotic-induced constipation, for example, may increase agitation in an individual with mental retardation and psychotic

symptoms. Starting psychotropic medications with low dosages and adjusting/increasing dosages slowly is commonly recommended.

- A large percentage of individuals with mental retardation or pervasive developmental disorder (in some surveys, over 33%) receive 3 or more psychotropic medications. For DD members with complex drug regimens, expanding the length of medication reviews, and their frequency to at least monthly, must be considered. This practice should yield improvements in family participation, diagnostic clarity, more appropriate use of dedication and improved outcomes.
- The use of multiple medications should be evaluated carefully. Because of possible drug interactions, over-the-counter medications, non-traditional healing substances, herbs, and foods such as grapefruit juice should also be reviewed and assessed.
- For those individuals who do not have a separate identified psychiatric condition, but primarily have behavioral symptoms associated with their primary disorder, treatment should be symptomatic, using a thoughtful rationale to select an initial drug trial based on observed behaviors

Data Collection for Psychiatric and Behavioral Interventions

Data collection is a quantitative, systematic means of gathering specific information. Progress notes and anecdotal reports, although helpful, do not constitute objective data. Specific psychiatric symptoms and challenging behaviors must be objectively defined, quantified and tracked using empirical measurement methods in order to impartially monitor the effectiveness of behavioral interventions and/or psychotropic medication efficacy. These measurements include, but are not limited to, frequency, severity, duration, time sampling and rating scales. Treatment response must be linked to specific objectives and goals that are documented in the Behavioral Health Service Plan.

Physical Health Concerns

Behavioral health providers must assess physical health factors and coordinate all service provision with acute care providers, consistent with the following expectations:

- The psychiatrist, primary behavioral health professional or assigned clinician must ensure that there is coordination among all medical providers, including PCPs and psychological, pediatric, neurological, endocrinological and dental specialists and that service plans collaboratively developed.
- All relevant information, including the initial assessment and treatment plan, must be communicated to the primary care physician.
- As with behavioral health services, medical services are most effective when implemented as early as possible. Efforts to help a child learn and use language by age 8 are essential. These services should include a combination of behavioral and language based interventions, such as speech therapy, occupational therapy, sensory communication boards or picture boards, and evaluations for oral apraxias, expressive and receptive language abilities and hearing. Care and consultation between specialists should be coordinated with the client's Primary Care Provider (PCP). Referrals to appropriate specialists should be made as soon as deficits are identified.

Alternative Interventions

Although there remain limited well-controlled efficacy studies to support their use, a number of alternative interventions have demonstrated potential benefits to individuals with autistic spectrum disorders in some circumstances. The prescription of gluten- and casein- free diets has been beneficial to some individuals, as has the intake of Omega-3 fatty acid supplements. Omega-3 fatty acids are non-prescription and not on theADHS medication list or RBHA formularies. Alternative interventions should be coordinated with the client's nutritionist and PCP and/or behavioral pediatrician.

Protection and Advocacy

While remaining aware of the incidence of self-injurious behavior in this population, reports to Child/Adult Protective Services (CPS/APS) must be made when there is suspicion of neglect or abuse, including medical or emotional. For open CPS or APS cases, the protective services case plan must be coordinated with the behavioral health services. CPS or APS case managers must be invited to all behavioral health services staffings and reviews.

Division of Developmental Disabilities

The Division of Developmental Disabilities provides support and habilitative services for individuals with significant functional limitations due to: Cerebral Palsy, Epilepsy, Mental Retardation and Autism. (Diagnoses of Pervasive Developmental Disorder not otherwise specified, Asperger's Disorder, Rett's Disorder and Childhood Disintegrative Disorder do not confer eligibility.)

Diagnosis is necessary but not sufficient for DDD eligibility; the individual must also have substantial functional limitations in at least three of seven domains of activities of daily living, which are directly attributable to the developmental disability. If individuals are found to be eligible for DDD-ALTCS, they may receive all Title XIX covered services. If individuals are eligible for DDD, but are not DDD-ALTCS or Title XIX/XXI eligible, services are provided based on availability and funding. The DDD non-ALTCS, Non-Title XIX/XXI individual may be placed on a waiting list if needed services or funds are not available.

If the individual is not yet enrolled in DDD, and mental retardation, autism, cerebral palsy or epilepsy is diagnosed, referral to DDD should be made for eligibility determination. An assessment and qualifying diagnosis made by a Behavioral Health psychiatrist or psychologist may offer sufficient clinical information for DDD to determine clinical grounds for eligibility, provided that the symptoms of the developmental disability diagnosis are adequately recorded in the documentation of the evaluation and the symptoms and diagnoses meet the criteria that required to confer eligibility.

If DDD provides services, such services must be coordinated with the behavioral health services. DDD Support Coordinators should be invited to all CFT meetings, ACT meetings and medication reviews. All relevant information, including the initial assessments and treatment plan, must be communicated to DDD to ensure coordination of services. Per the ADHS/DES/DDD Intergovernmental Agreement (IGA) and Operational Procedure Manual, for DDD/ALTCS individuals, the DDD support coordinator is the lead Case Manager.

Education

The parent/legal guardian will be advised to request the school district's cooperation. This will include the school's participation in the initial and ongoing evaluation and interventions. The parent may also request the school to provide a comprehensive educational evaluation to determine the need for additional support services such as occupational, physical, or speech therapy, special education eligibility, IQ testing, or an accommodation assessment. The behavioral health professional should participate in the development of the Individual Education Program (IEP) to assist the school in maintaining the individual in the least restrictive individual educational setting.

Vocational Rehabilitation

Vocational training may be available through the school to individuals who are under the age of 16 and designated as emotionally handicapped (EH). For persons 16 and over, referral to VR services should be considered and services coordinated, if appropriate.

Clinical Supervision

Regularly scheduled and predictable clinical supervision should be provided to Behavioral Health Technicians and Behavioral Health Professionals. Individuals with expertise in positive behavioral support techniques and experience with Developmental Disability and Pervasive Developmental Disorder populations can assist providers in modifying and adapting therapeutic interventions to their unique needs. All clinicians can benefit from added assistance in adjusting counseling to shorter attention spans, limited language skills, and difficulties retaining information for expected periods of time.

Practice Protocol

Neuropsychological Evaluations

Jointly Developed by the Arizona Department of Health Services/Division of Behavioral Health Services and AHCCCS/Health Plans

Effective June 30, 2006
Revised December 4, 2007

Purpose

To identify appropriate referrals and procedures for neuropsychological evaluations.

Targeted Population(s)

Individuals with identified physical, neurological or behavioral health conditions who may benefit from undergoing a neuropsychological evaluation.

Individuals who have experienced congenital or acquired brain damage and currently present with suspected impairments in higher cognitive functions or organic brain functions who may require a neuropsychological evaluation in order to make informed decisions regarding their treatment.

Introduction

A neuropsychological evaluation provides an assessment of brain function that can be useful in making the diagnosis of acquired or congenital problems presumed to be a result of brain disease or trauma. The evaluation assesses brain function inferred from an individual's cognitive, sensory, motor, emotional, or social behavior.

The diagnosis of brain damage has become increasingly accurate in recent decades as a result of improved visualization of brain structure by computerized tomography (CT), magnetic resonance imaging (MRI), angiography, and other advancements in diagnostic procedures. A neuropsychological assessment is still a useful diagnostic indicator of brain dysfunction for many conditions, but the above diagnostic procedures have allowed a shift in the focus of neuropsychological evaluation from the diagnosis of possible brain damage to a better understanding of specific brain-behavior relationships and of the psychosocial consequences of brain damage.

Neuropsychological evaluations can be quite useful in the early stages of recovery when placement from the acute care hospital is an issue and rehabilitation goals are being established. There are also certain diseases that can have serious cognitive effects which may resolve over time but have occasionally resulted in a premature diagnosis of dementia. For example, elevated ammonia levels secondary to liver disease or necrotizing fasciitis can produce dramatic cognitive impairment.

Multiple factors can potentially affect the results of neuropsychological evaluation. Age, educational level, ethnicity, cultural influences, gender, psychiatric disorders, and effects of substance abuse can impact the results of

the evaluation and must be factored into the analysis and recommendations. Many medications can also disrupt cognition through their subtle or profound effects on alertness, attention, and memory.

Referrals

Patients referred to a neuropsychologist for assessment may be classified into one of three groups:

1) Patients with known brain damage:

   Examples: cerebrovascular disorders, head injury, hydrocephalus, Alzheimer's disease, Parkinson's Disease, Multiple Sclerosis, Huntington's Chorea, tumors, seizures, and infections.

2) Patients with a recognized risk factor for brain damage and who demonstrate a change in behavior which might be the result of disease or injury to the brain:

   Examples: systemic illnesses, endocrinopathies, metabolic and electrolyte disturbances, diseases of the kidney, liver, and pancreas, nutritional deficiencies, toxins, including substance abuse (particularly alcohol), conditions producing decreased blood supply to the brain (e.g., trauma, vascular disorders, cardiac disease, pulmonary disease, anemia, carbon monoxide exposure, and complications of anesthesia or surgery).

3) Patients in which brain disease or trauma is suspected but no specific etiology or risk factor has been identified:

   Examples: patients with observed and well-documented changes in behavior or mental deterioration, lack of identifiable risk factors for brain injury, and other potential medical illnesses have been excluded. In such cases, history taking, physical examination, laboratory, or other tests, and interviews with the patient's family or close associates should be conducted prior to referring for neuropsychological testing. The diagnostic workup should include CT and MRI visualization of the brain to rule out structural lesions.

Benefits of Neuropsychological Evaluation

Neuropsychological testing assists in defining the nature and severity of resulting functional problems. The assessment provides information about the patient's cognition, personality characteristics, social behavior, emotional status, and adjustment to functional limitations. Information about the patient's cognitive and behavioral strengths and weaknesses can be used for more effective,

individualized treatment planning, vocational training, competency determination, and counseling for both patients and their families.

It is important to consider when referring an individual for neuropsychological testing that a valid evaluation is dependent upon obtaining the patient's best performance. It is usually impossible to obtain satisfactory evaluations of patients who are uncooperative, fatigued, actively psychotic, seriously depressed, or highly anxious. Likewise, a valid and reliable evaluation is impossible to obtain if the individual is intoxicated or, depending on the substance (e.g., stimulants), has recently abused illicit substances or prescribed medications. However, maintenance treatment with opioids (i.e., methadone) should be considered baseline if the individual is properly medicated. Preparation of the patient for the evaluation is important in order to obtain the patient's cooperation and alleviate unnecessary anxiety. It is important to note that a neuropsychological evaluation generally requires at least 1 1/2 hours, and depending on the person's clinical/medical, cognitive, emotional, or physical condition, and the battery of tests used, may take up to 16 hours to complete the testing process and report preparation.

Testing in children or adolescents may be indicated when children/adolescents have difficulties that are neurologically-based and can provide valuable information to aid the treatment planning process. Understanding the strengths and weaknesses related to learning, information processing, and retention of information can facilitate more appropriate, beneficial educational experiences and better outcomes of treatment.

It is of utmost importance that the referring practitioner/provider identify specific questions that he/she desires to have answered by obtaining the evaluation. The more explicit the referral questions are, the more likely it is that the evaluation will be individually constructed to provide useful information. Referral questions that are framed around potential impact on treatment planning and recommendations are most helpful.

The Evaluation Process

The neuropsychological evaluation is conducted by a subspecialty-trained and qualified neuropsychologist with advanced training in testing and interpretation and differs substantially from a general psychological evaluation. Interview and observation are the chief means by which neuropsychological evaluations are conducted. The tests used by neuropsychologists are standardized and specialized observation tools that, in many instances, have the added advantage of providing normative data that aid in interpreting the observations.

The two main approaches are individually tailored examinations and fixed assessment procedures. The more information that can be gained before the assessment procedure begins, the more testing procedures and tools can be specifically tailored to respond to the referral questions. Commonly, intellectual testing is used along with standardized batteries of neuropsychological testing, such as the Halstead-Reitan or Luria-Nebraska test batteries.

When should a request for a neuropsychological evaluation be directed to the Health Plan for consideration?

A neuropsychological evaluation is generally a health plan covered service, and should be directed to the health plan when the purpose for the evaluation is to obtain additional information regarding the nature and severity of functional problems involving higher mental functions that *may be the result of organic brain damage*. The request for the evaluation should also be directed to the health plan when such information may be useful in making important treatment decisions that can guide treatment planning for a *medical condition*.

Examples of conditions that are frequently associated with significant organic brain dysfunction affecting higher mental functions include, but are not limited to:

- Traumatic Brain Injury/Head injury
- Cerebral Vascular Disorders/Stroke
- Hydrocephalus
- Epilepsy
- Brain Tumors (Primary or Metastatic; Malignant or Benign)
- Cerebral Anoxia or Hypoxia
- Exposure to toxic chemicals, substances, or other treatments that are known to cause toxic effects on the brain (acute or chronic) such as lead poisoning, intrathecal methotrexate, cranial irradiation
- Exposure to infectious diseases that affect brain functions or cause brain damage (e.g., Herpes Encephalitis)
- Chronic toxic/metabolic encephalopathic states resulting from systemic medical illnesses or conditions
- Neurological conditions resulting in chronic deteriorating course of illness affecting brain functions, including Alzheimer's Disease, Parkinson's Disease, Huntington's Disease, Multiple Sclerosis, Acquired Immune Deficiency Syndrome (AIDS), and others.
- Prenatal, perinatal, or infant exposure to alcohol or drugs of abuse

A neuropsychological evaluation is generally not a health plan covered service for evaluation of:

- Mental disorders that are primarily attributable to organic brain damage that results in significant higher level mental organic brain dysfunction (e.g., Mood Disorder - Depression with psychosis secondary to traumatic brain injury; Mood Disorder due to cerebrovascular accident (CVA) with Major Depressive-Like Episode; Inhalant-Induced Persisting Dementia)[1]
- Evaluation of individuals who have permanent, persistent, and static organic brain dysfunction, and for whom it is unlikely that evaluation results would provide new information that could be utilized to help alter the course of treatment or treatment planning.
- Evaluation of an individual's condition that may be covered by another service agency: Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS), Arizona Department of Education (ADE), Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD), Arizona Health Care Cost Containment System (AHCCCS), Arizona Long Term Care Services (ALTCS), or other responsible agencies.

When should a request for a neuropsychological evaluation be directed to the T/RBHA for consideration?

A neuropsychological evaluation should generally be referred to the Tribal and Regional Behavioral Health Authority (T/RBHA) for evaluation of significant mental health dysfunction not responding to standard treatment in order to better clarify the extent of organicity and if *responsiveness to psychotherapeutic, counseling, rehabilitation/recovery, or treatment with psychotropic medications* can be positively impacted with appropriate modifications in approach.

If the individual referred is not currently T/RBHA enrolled, the T/RBHA must determine whether the individual should be scheduled for initial enrollment/re-enrollment and assessment of the person's behavioral health needs, including any need for neuropsychological evaluation, prior to authorizing a neuropsychological evaluation**.**

When should a request for a neuropsychological evaluation be directed to another agency for consideration?

Arizona Department of Education: If the request for neuropsychological testing is for a child or adolescent and requested primarily for the purpose of educational needs and/or vocational training, the request and/or approval should come from

[1] If the basis of the referral is to obtain treatment recommendations for the use of psychotropic medications for these conditions, a direct referral to the T/RBHA for psychiatric consultation should be made.

the school. The individuals who are served under the Disabilities Education Improvement Act (DEIA) have some Individual Education Program (IEP) services that are covered by Medicaid, but the services must be outlined in the IEP. The service would be provided by the school district.

Procedures

How to Request a Neuropsychological Evaluation

1) An AHCCCS Health Plan provider or T/RBHA behavioral health provider who would like to request a neuropsychological evaluation for a member shall submit a request in writing to the Health Plan/T/RBHA Medical Director or designee, which shall at a minimum include the following information:

    a. The specific reasons why the evaluation is being requested; identify the specific diagnostic or treatment-related question(s) to be answered by the evaluation.
    b. The complete current list of diagnoses and current medications.
    c. The most recent complete history and physical examination and pertinent findings identified, including findings of laboratory and diagnostic procedures, which may be relevant to the evaluation request.
    d. Results of any consultations from sub-specialists in neurology or psychiatry/mental health, if available.
    e. Results of any prior psychological testing that may be available.
    f. The specific areas of concern for evaluation that could impact the proposed course of treatment or treatment planning.
    g. The desired or expected outcome of treatment identified by the referring practitioner/provider, which may result from the evaluation or testing. Address how this testing could benefit or impact the overall treatment approach for the patient.

2) Prior to referral to a neuropsychologist for a neuropsychological evaluation, the Health Plan/T/RBHA Medical Director or designee shall review the above information to determine if the evaluation will assist the requesting provider in further assessing and treating the particular member's presenting clinical profile, and whether to authorize the evaluation.

3) If the Health Plan/T/RBHA Medical Director or designee determines that the request does not contain adequate or complete information, or the request is not indicated or appropriate to obtain, the reviewer shall return the packet of information to the referring practitioner/provider to obtain the necessary information, or to communicate the specific reasons for the denial of the request.

4) Following review of the above, if a decision is made to continue with the referral of the member for the evaluation, the Health Plan/T/RBHA Medical Director or designee shall determine whether or not the Health Plan/T/RBHA will authorize payment for the service requested. If the Health Plan/T/RBHA Medical Director or designee determines that the Health Plan/T/RBHA will authorize payment, he/she shall forward the request to a neuropsychologist under contract to perform the evaluation.

5) Denials by AHCCCS Health Plan: If the Health Plan Medical Director or designee determines that the Health Plan will not authorize payment of the evaluation, and determines that the evaluation is still appropriate and the reason for the evaluation falls within the domain of ADHS/DBHS covered services, the AHCCCS Health Plan Medical Director or designee shall forward a complete packet of the referral information and request, including the rationale for his/her determination to the assigned T/RBHA Medical Director or designee, or to another appropriate agency, to obtain the evaluation. Whenever a request for neuropsychological evaluation is forwarded to the T/RBHA, the Health Plan will issue a "re-direct letter" to the provider and the member.

   (a) The T/RBHA Medical Director or designee will either review the referral packet him/herself or forward the referral request packet to an appropriate Child/Adolescent or Adult Psychiatrist (depending on the age of the patient) or psychologist for review. For referrals of T/RBHA enrolled members, the assigned psychiatrist or psychologist shall determine whether or not the evaluation request should be authorized for payment by the T/RBHA. For referrals of non-T/RBHA enrolled Health Plan members, the assigned psychiatrist or psychologist shall determine whether or not the individual should be scheduled for initial enrollment/re-enrollment and assessment of the person's behavioral health care needs, including the need for neuropsychological evaluation, prior to authorizing this service.

   (b) The referral to the T/RBHA should identify the specific questions the referring provider wishes to have answered by obtaining the evaluation. Referral questions should be related to the differential diagnosis of mental disorders and identify how the results of the evaluation would be expected to impact behavioral treatment recommendations and planning for the individual. (In many cases, a general psychological evaluation is sufficient to determine differential diagnosis, assess intellectual functioning, and inform treatment planning and should be considered before requesting a neuropsychological evaluation.)

   (c) If the evaluation request is authorized, the request packet will be forwarded to a neuropsychologist to perform the evaluation.

(d) If the assigned psychiatrist or psychologist determines that the request is not appropriate or necessary, and does not authorize the evaluation, the packet shall be returned to the T/RBHA Medical Director with an explanation of the reasons for not authorizing it. The T/RBHA Medical Director shall then make a determination to authorize the evaluation, or deny authorization and return the request packet back to the Health Plan.

(e) If the T/RBHA Medical Director denies the request and the member is enrolled with the T/RBHA, the T/RBHA is responsible to provide appropriate written notice of the denial to the member. The T/RBHA Medical Director is responsible to provide the Health Plan Medical Director with the disposition, and if denied, an explanation for the denial. If the member is not T/RBHA enrolled, and the Health Plan and the T/RBHA both deny the request, the Health Plan will issue the final denial notice to the member.

(f) If the Health Plan and T/RBHA Medical Directors cannot agree as to who should authorize/pay for the evaluation, but agree that it is necessary, the dispute may be referred to the AHCCCS Medical Director, or designee for resolution.

6) Denials by T/RBHA: If the initial referral comes from a T/RBHA behavioral health provider, and the T/RBHA Medical Director or designee determines that the T/RBHA will not authorize payment of the evaluation, and determines that the evaluation is still appropriate and the reason for the evaluation falls within the domain of the acute care health plan's covered services, the T/RBHA Medical Director or designee shall instruct the referring behavioral health provider to forward a complete packet of the referral information and request, including the rationale for his/her determination, to the assigned Health Plan Medical Director or designee or to another appropriate agency, to obtain the evaluation.

DBHS Practice Protocol

Psychiatric Best Practice Guidelines for Children: Birth to Five Years of Age

Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services
Effective 10-2-09

NOTE:
This Clinical Practice Protocol has required implementation elements. Providers are required to implement the identified Service Expectations, as clearly identified in this document.

Title
Psychiatric Best Practice Guidelines for Children: Birth to Five Years of Age

Goal/What Do We Want to Achieve Through the Use of this Protocol?
To define best practice guidelines for psychiatric evaluation and the use of psychotherapeutic and psychopharmacological interventions with children birth to five years of age.

Target Audience
This Protocol is specifically targeted to Tribal/Regional Behavioral Health Authorities (T/RBHAs) and their subcontracted network and provider agency behavioral health staff who complete psychiatric evaluations, prescribe psychopharmacological treatment, and identify psychotherapeutic interventions for the treatment of children birth to five years of age.

Target Population(s)
All enrolled behavioral health recipients, birth to five years of age (up to age 5), in collaboration with their caregiver(s).

Attachments

Attachment A: Sleep Hygiene

Definitions

Assessment

Behavioral Health Medical Professional (BHMP)

Child and Family Team

Designated Child Psychiatric Provider

Infant and Early Childhood Mental Health

Privileging

Young Child

Background

"In 2000 the American Academy of Child and Adolescent Psychiatry's Research Forum highlighted the developmental, logistical, and ethical challenges related to preschool psychopharmacological research (Greenhill et al., 2003). The group recommended the development of guidelines for the pharmacological treatment of preschoolers with psychiatric disorders. Where randomized controlled data were not available, the group recommended that guidelines be derived from clinical experience and community standards. To date, our

field lacks these guidelines. Thus, clinicians and families face a delicate balancing process, weighing the risks of medications with the risks of not intervening in complex clinical situations that are resistant to nonpharmacological interventions. The risks associated with psychiatric disorders are not insignificant; preschool psychiatric disorders can be associated with child care expulsion, inability to participate in family activities, impaired peer relationships, high-risk behaviors (Byrne et al., 2003; Egger and Angold, 2006; Gilliam, 2005), and future mental health problems (e.g. Lavigne et al., 1998).

Of preschoolers with psychiatric disorders, only a small proportion are referred for mental health treatment, and the primary treatment modality for most very young children is psychotherapeutic rather than psychopharmacological (AACAP, 1997b; Egger and Angold, 2006; Lavigne et al., 1993). Studies using varied methods yielded estimates that 3 to 9/1,000 U.S. preschoolers received prescriptions for psychotropic medications in the 1990's (DeBar et al., 2003; Zito et al., 2000).

A few studies have examined patterns of prescriptions for children with psychiatric diagnoses. Across a variety of populations including community, HMO, and Medicaid, the majority of prescriptions written for preschoolers are for stimulants (DeBar et al., 2003; Luby et al., 2007; Zito et al., 2007). In a community sample, Luby et al. (2007) reported that 12% (12/123) of preschoolers with a DSM-IV diagnosis had received medication for at least 1 month.

These early studies of preschool psychopharmacological practices suggest that the majority of preschoolers with mental health problems do not receive psychopharmacological treatment. Access to other mental health services appears variable. Prescription patterns support the value of clearly defined treatment recommendations for rational use of medications."[1]

Best practice recommendations state a trial of psychotherapeutic interventions should always be used prior to initiating medications. Despite this, the literature reflects that a majority of these young children do not receive psychotherapeutic interventions prior to the initiation of medications. [1]

Procedures

"Child and Family Team (CFT) practice and the 12 Arizona Principles support the critical components of mental health practice with children age birth to five and their families."[2] Refer to the *ADHS/DBHS Practice Protocol: Working with the Birth to Five Population* for additional information on developmental screening, assessment, and evaluation considerations, as well as service planning guidelines through the use of CFT practice. For requirements regarding assessment, refer to *ADHS/DBHS Provider Manual Section 3.9*.

Psychiatric Assessment/Evaluation Process: A comprehensive assessment may include a psychiatric evaluation when clinically indicated. The psychiatric evaluation should take multiple sessions and must be completed prior to the initiation of psychotropic medication. The evaluation must be completed by a Behavioral Health Medical Professional (BHMP) with training and experience in the assessment and treatment of children age birth to five years of age. The BHMP must meet privileging standards per *ADHS/DBHS Provider Manual Section 3.20, Credentialing and Privileging* and be able to demonstrate the competencies and expertise in providing mental health treatment with this young population. Whenever possible, psychiatric evaluation should be conducted by a board certified or board qualified child and adolescent psychiatrist.

[1] Gleason, M.D., Mary Margaret et al. (2007, December). Psychopharmacological Treatment for Very Young Children: Contexts and Guidelines [Special Communication]. *Journal of the American Academy of Child & Adolescent Psychiatry*, 46(12), 1532-1572.
[2] *ADHS/DBHS Practice Protocol: Working with the Birth to Five Population*

While the psychiatric evaluation process for young children is similar to the process for older children, adolescents, and adults, special attention to the following guidelines is required when providing mental health evaluation services for this young population:

- Psychiatric evaluation as part of assessment practice must include gathering information from those persons who are most familiar with the child, as well as direct observation of the child with his/her parent/primary caregiver(s);

- Evaluation components must include the following:
    1. Reason for referral including child's social, emotional, and behavioral symptoms
    2. Detailed medical and developmental history
    3. Current medical and developmental concerns and status
    4. Family, community, child care and cultural contexts which may influence a child's clinical presentation
    5. Parental and environmental stressors and supports
    6. Parent/Caregiver(s) perception of the child, ability to read/respond to child's cues, and willingness to interact with the child
    7. Children birth to five mental status exam:
        - Appearance and general presentation
        - Reaction to changes (e.g., new people, settings, situations)
        - Emotional and behavioral regulation
        - Motor function
        - Vocalizations/speech
        - Thought content/process
        - Affect and mood
        - Ability to play/explore
        - Cognitive functioning
        - Relatedness to parent/primary caregiver(s)
    8. Use of standardized instruments to identify baseline functioning and track progress over time. Examples of such instruments include yet are not limited to the following:
        - Brief parent report questionnaires focused on child symptomatology such as:
            - Infant Toddler Social-Emotional Assessment (Briggs-Gowan, 1998)
            - Child Behavior Checklist 1-5 (Achenbach and Rescoria, 2000)
        - Diagnostic interviews:
            - Preschool Age Psychiatric Assessment (Egger et al., 2006b)
        - Structured observations of parent-child interactions:
            - Clinical Problem Solving Procedure (Crowell and Fleischmann, 2000)
        - *ADHS/DBHS Behavioral Health Assessment: Birth-Five* which includes age-appropriate developmental checklists
        - Additional screening tools:
            - Ages and Stages Questionnaires (ASQ)
            - Hawaii Early Learning Profile (HELP)
            - Parents Evaluation of Developmental Status (PEDS)
    9. Collaboration with pediatrician/primary care physician and/or developmental pediatricians involved
    10. Collaboration with other agencies involved with the child and family (e.g. Arizona Early Intervention Program [AzEIP], Child Protective Services [CPS], Division of Developmental Disabilities [DDD], childcare, Head Start, the local school district, Healthy Families Arizona, other educational programs, etc.)

Service planning is done as part of a collaborative process according to Child and Family Team practice. Refer to the *ADHS/DBHS Practice Protocol: Child and Family Team Practice* for further information on effective CFT practice related to service planning development and implementation.

Service Expectation: The psychiatric evaluation, as part of a comprehensive assessment, must be completed prior to the initiation of psychotropic medication.

Diagnosis: Not all preschoolers who have clinically significant symptoms will meet full criteria for a diagnosis. For those who do not, recognizing subthreshold disorders can help focus service planning. The *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition, Text Revision (DSM-IV-TR)* lacks attention to young children. The *Research Diagnostic Criteria: Preschool Age* (AACAP Task Force on Research Diagnostic Criteria: Infancy Preschool Age, 2003) and the *Diagnostic Classification of Mental Health and Developmental Disorders in Infancy and Early Childhood: Revised Edition (DC: 0-3R)* (Zero to Three Diagnostic Classification Task Force, 2005) are both developmentally sensitive, evidence-informed modifications of the DSM-IV criteria for young children. The updated DC: 0-3R addresses developmentally specific clinical presentations of mental health concerns with infants and toddlers and their relationships with primary caregivers while providing age-appropriate diagnostic criteria for many of the DSM-IV-TR child psychiatric disorders. In addition, the DC: 0-3R adds Regulation Disorders of Sensory Processing (defined as constitutionally based responses to sensory stimuli) on Axis I and Relationship Disorders on Axis II. An additional resource for use is the *ADHS/DBHS Crosswalk*, which cross-references the DC: 0-3R, DSM-IV-TR, and the *International Classification of Diseases, Ninth Revision-Clinical Modification Manual (ICD-9 CM)*. This crosswalk is strictly a tool to assist the behavioral health provider in assigning the correct diagnostic code when working with children in the first four years of life and is referenced as a sample document. **Maintenance of this document with up-to-date diagnostic codes is a T/RBHA responsibility.**

Treatment: There is a relatively strong evidence base for the use of psychotherapeutic interventions. Psychotherapeutic approaches should be considered as the initial intervention before psychopharmacological treatment, be clearly documented in the clinical record, must include the active participation of the child's parents/primary caregiver(s), and be developed and implemented in conjunction with the Child and Family Team. Psycho-educational and supportive therapeutic approaches are considered the most basic interventions and should form the basis of any comprehensive service plan.

Medications are to be reserved for children with moderate to severe psychiatric symptoms that significantly interfere with their normal development and result in impairment that persists despite the use of clinically appropriate psychotherapeutic interventions. Even with the use of psychopharmacological treatment, psychotherapeutic interventions should continue during the period of medication treatment. The use of medication is not indicated in situations when mild or single context impairment is present.

Clear and specific target symptoms must be identified and documented in the clinical record prior to the initiation of a medication trial. Target symptoms and progress are continually documented in the clinical record throughout the course of treatment consistent with criteria contained in the *ADHS/DBHS Provider Manual 3.15 Psychotropic Medication: Prescribing and Monitoring*.

In children who have a positive response to medication, as indicated by a remission of symptoms, a taper off medication should be considered at six to eight months of treatment. This consideration must be clearly documented in the clinical record. The BHMP must weigh the risks vs. benefits of each approach with the guardian, which includes the importance of reassessing the need for medication in the rapidly developing young child. Every six to eight months, a medication taper should be considered until the child reaches the age of five.

If the decision to taper the child off medication is made, the Child and Family Team must be informed of this decision in order to discuss and address possible behavior disruptions that may arise as a result of this taper. The Child and Family Team must also ensure that additional supports or services for the child and/or caregiver be implemented to maintain the child's stability. Documentation of this taper should be made with clinical rationale provided if the taper is unsuccessful.

As noted earlier with assessment and evaluation practice standards, BHMPs who provide treatment services have completed training and possess experience in both psychotherapeutic and psychopharmacological interventions for young children age birth to five. In addition, BHMPs meet privileging standards that demonstrate expertise and competency in performing these treatment interventions. Medication management should be provided by a board certified or qualified child and adolescent psychiatrist whenever possible. In rural or underserved locations where this may not be possible, the non-child psychiatrist BHMP must adhere to the following when prescribing psychotropic medication for children birth to five years of age:

- After the psychiatric evaluation has been completed and it is determined that the child may benefit from psychotropic medication(s), the case must be reviewed with the designated child psychiatric provider as determined by the T/RBHA. The review shall include, at a minimum, the following elements:
    1. The proposed medication with the starting dosage
    2. Identified target symptoms
    3. The clinical rationale for the proposed treatment
    4. Review of all medications the child is currently taking, including over the counter and those prescribed by other medical/naturalistic providers
    5. A plan for monitoring, including monitoring frequency (e.g., weekly, monthly)
    6. Identified targeted outcomes
- Re-consultation with a designated child psychiatric provider must occur in the following instances:
    1. When the child is not making progress towards identified treatment goals *at a minimum of every three months*
    2. In the event that a taper off of medications *at six to eight months* of treatment is either not clinically indicated or unsuccessful

Service Expectations:

1. Clear and specific target symptoms must be identified and documented in the clinical record prior to the initiation of a medication trial.

2. The non-child psychiatrist BHMP must consult with the designated child psychiatric provider in the following situations:

- **Prior to the initiation of medication;**
- **If the child is not making progress towards identified treatment goals *at a minimum of every three months*; and**
- **In the event that a taper off of medications *at six to eight months* of treatment is not clinically indicated or unsuccessful.**

3. In children who have a positive response to medication, a taper off medication is considered and clearly documented in the clinical record every six to eight months of treatment until the child reaches the age of five.

Dosing: Medication is always started at the lowest possible dose with subsequent increases in medication undertaken with caution. Dosing can be challenging as young children may metabolize medications more

rapidly than older individuals. In addition, children age birth to five experience rapid growth during this timeframe which may change the dose that is required for optimal treatment over short periods of time. Since these young children are often very sensitive to side effects they must be monitored closely.

Monitoring: Medications that have been shown to adversely affect hepatic, renal, endocrine, cardiac and other functions or require serum level monitoring must be assessed via appropriate laboratory studies and medical care must be coordinated with the child's primary care physician. Please refer to *ADHS/DBHS Provider Manual 3.15 Psychotropic Medication: Prescribing and Monitoring* for further information.

Coordination of Care: In Arizona, the behavioral health program was developed as a carve-out from the acute care Medicaid program (Title XIX) and the State Children's Health Insurance Program (KidsCare/SCHIP/Title XXI), a model in which eligible persons receive general medical services through health plans and covered behavioral health services through the T/RBHAs. Because of this separation in responsibilities, communication and coordination between behavioral health providers, AHCCCS Health Plan Primary Care Providers (PCPs) and Behavioral Health Coordinators is essential to ensure the well-being of young children receiving services from both systems.

Duplicative medication prescribing, contraindicated combinations of prescriptions and/or incompatible treatment approaches could be detrimental to a young child. For this reason, communication and coordination of care between behavioral health providers and PCPs must occur on a regular basis to ensure safety and positive clinical outcomes for young children receiving care. For T/RBHA enrolled children not eligible for Title XIX or Title XXI coverage, coordination and communication should occur with any known health care provider.[3] Documentation in the clinical record is required showing the communication and coordination of care efforts with the health care provider related to the child's behavioral health psychopharmacological treatment. Please refer to *Provider Manual Section 4.3 Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers* for further information.

Service Expectation: Documentation in the clinical record by the BHMP is required showing the communication and coordination of care efforts with the health care provider related to the child's behavioral health psychopharmacological treatment.

Polypharmacy: Polypharmacy is defined as using more than one psychotropic medication at a time in this population and is not recommended for children age birth to five. It is important to note that the use of the term polypharmacy in this population differs from the definition used in other age groups. In addition, this definition excludes a medication cross-taper, where the young child may be on two medications for a short period of time in order to avoid abrupt withdrawal symptoms. Please refer to *ADHS/DBHS Provider Manual 3.15 Psychotropic Medications: Prescribing and Monitoring* for further information.

Polypharmacy should only be considered and used in extreme situations where severe symptoms and functional impairment are interfering with the child's ability to form close relationships, experience, regulate and express his/her emotions, and progress developmentally. Complementary, alternative and over-the-counter medications should be taken into consideration when evaluating the use of polypharmacy and potential drug interactions. If more than one medication is prescribed there must be documentation of clear target symptoms for each medication in the child's clinical record. If the BHMP prescribing the medications is not a child and adolescent psychiatrist, consultation with the designated child and adolescent psychiatric provider must occur before the young child receives more than one medication.

[3] *ADHS/DBHS PM Section 4.3 Coordination of Care with AHCCCS Health Plans, Primary Care Providers & Medicare Providers*

Service Expectation: When more than one medication is prescribed there must be documentation of clear target symptoms for each medication in the child's clinical record. If the BHMP prescribing the medications is not a child and adolescent psychiatrist, re-consultation with the designated child psychiatric provider must occur before the young child receives more than one medication.

FDA indicated medications: The following medications are approved by the Food and Drug Administration (FDA) for young children under the age of five at the time of this writing: haloperidol (Haldol), dextroamphetamines (Dexedrine, Dextrostat), chlorpromazine (Thorazine), and risperidone (Risperdal) (Greenhill, 1998). A FDA indication reflects empirical support but is not synonymous with a recommendation for use consistent with current studies and best practice. Only two of the FDA-approved medications (dextroamphetamines and risperidone) listed above are recommended treatment interventions consistent with current studies and best practices for this population. Lack of an FDA indication does not necessarily reflect a lack of evidence for efficacy.

The Physicians Desk Reference states the following, "Accepted medical practice includes drug use that is not reflected in approved drug labeling." In the United States only a small percentage of medications are FDA indicated for use in pediatrics. As new drugs become available and approved, or research demonstrates usefulness, safety and efficacy, practitioners should document the rationale for medication choice and the provision of informed consent to parents/caregivers/guardians. Informed consent includes the following:

- FDA status of the medication
- Level of evidence supporting the recommended medication; for example, the use of methylphenidate as a first line medication for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in young children
- Potential risks, benefits, and alternatives to its use

Service Expectation: The behavioral health medical practitioner shall document in the child's clinical record the rationale for medication choice and the provision of informed consent to parents/caregivers/guardians must contain the elements outlined in this protocol.

Recommended Treatment: The following recommended psychotherapeutic and psychopharmacological treatment interventions are supported by current studies and best practice, and are diagnosis specific. Psychoeducation and early intervention are essential components of any psychotherapeutic intervention program and therefore should be included in the treatment of all disorders. **A trial of one of the recommended psychotherapeutic interventions should always precede a psychopharmacologic trial.** If it is determined that a psychopharmacologic intervention is indicated, goals of treatment should include facilitating normative developmental processes and maximizing the potential for effective psychotherapeutic interventions.

While the following psychotherapeutic interventions are supported by studies and best practice for specific diagnoses, other examples of accepted therapeutic approaches with this population are referenced in the *ADHS/DBHS Practice Protocol: Working with the Birth to Five Population*. Determination of the best psychotherapeutic approach is done in conjunction with the Child and Family Team and other qualified infant and early childhood mental health practitioners.

While not all of the medications listed below have FDA indications, all the listed medications are supported by clear evidence demonstrating efficacy with this age group. First (1st) line and other medication options are outlined below. **However, BHMPs should exercise their clinical judgment and determine if an alternative psychopharmacologic intervention is preferential in meeting the optimal and unique needs of each child.**

1. **Attention Deficit Hyperactivity Disorder**:

- Psychotherapeutic Interventions: Psychotherapy for a minimum of 8 weeks: Parent Management Training or other Behavioral Intervention
- Psychopharmacologic Trial:
  I. Methylphenidate (Ritalin, Concerta, Metadate): 1st line
  II. Dextroamphetamine/amphetamine formulations (Adderall), detroamphetamine formulations (Dexedrine, Dextrostat): 2nd line
  III. Alpha-agonists: clonidine (Catapres), guanfacine (Tenex): 3rd line
  IV. Atomoxetine (Strattera): 3rd line

2. Disruptive Behavior Disorders:

- Psychotherapeutic Interventions: Psychotherapy for a minimum of 10-20 weeks: Parent Management Training or other Behavioral Intervention
- Psychopharmacologic Trial:
  I. Presence of co-morbid disorder: follow recommendations for the co-occurring disorders first, such as ADHD where there is more treatment evidence
  II. Medications should be considered only after a trial of psychotherapy and in the case of safety concerns or extreme impairment in multiple settings and relationships for the treatment of disruptive behavior disorders. Risperidone (Risperdal) is recommended as the first medication choice for treating children with disruptive behavior disorders with severe aggression without co-occuring ADHD.

3. Major Depressive Disorder:

- Psychotherapeutic Interventions: Psychotherapy for a minimum of 3 to 6 months: interventions that target dyadic relationship between the young child and his/her parent/primary caregiver
- Psychopharmacologic Trial:
  I. Presence of co-morbid disorder: follow recommendations for the co-occurring disorders first, such as ADHD where there is more treatment evidence
  II. Fluoxetine (Prozac): 1st line for treatment of clear depressive symptoms

4. Bipolar disorder:

- Psychotherapeutic Interventions: Psychotherapy for a minimum of 8 to 12 sessions: dyadic psychotherapy, target emotional regulation
- Psychopharmacologic Trial:
  I. Risperidone (Risperdal): 1st line
  II. Consider adding lithium (Lithonate, Eskalith, Lithobid, Cibalith) or valproic acid (Depakene), divalproex sodium (Depakote) with partial response to risperidone and extreme symptoms
  III. With an insufficient or negative response to risperidone, may consider another atypical antipsychotic such as quetiapine (Seroquel) or olanzapine (Zyprexa)

5. Anxiety Disorders: Separation Anxiety Disorder, Generalized Anxiety Disorder, Selective Mutism, Specific Phobia

- Psychotherapeutic Interventions: Psychotherapy for a minimum of 12 weeks: Behavioral Interventions, Cognitive Behavioral Therapy (CBT)
- Psychopharmacologic Trial:
  I. Fluoxetine (Prozac): 1st line

II. With insufficient response and extreme impairment and distress in multiple settings, may try fluvoxamine (Luvox)

6. **Post Traumatic Stress Disorder:**
   - Psychotherapeutic Interventions: Psychotherapy: Child-Parent Psychotherapy for a minimum of 6 months, Preschool CBT for a minimum of 12 weeks, or Play therapy for a minimum of 6 months
   - Psychopharmacologic Trial: With extreme impairment after failure of, or inability to participate in psychotherapeutic intervention, consider use of a selective serotonin reuptake inhibitor or alpha-agonist

7. **Obsessive Compulsive Disorder**:
   - Psychotherapeutic Interventions: Psychotherapy for a minimum of 12 weeks: CBT with parent involvement
   - Psychopharmacologic Trial:
     I. Fluoxetine (Prozac), fluvoxamine (Luvox), or sertraline (Zoloft): 1st line
     II. Clomipramine (Anafranil)-only for severe resistant symptoms

8. **Pervasive Developmental Disorders:**
   - Psychotherapeutic Interventions: Multi-modal, Multidisciplinary treatment focused on language, social development, adaptive functioning, decreasing aggression, and repetitive behaviors
   - Psychopharmacologic Trial:
     I. Risperidone (Risperdal) is approved by the FDA for treatment of severe aggression/irritability in children with autism in this age group: 1st line

9. **Sleep Disorders**:
   - Psychotherapeutic Interventions: Parent education, Behavioral-based sleep interventions including sleep hygiene implementation for a minimum of 2 to 4 weeks; please refer to *Attachment A: Sleep Hygiene*
   - Psychopharmacologic Trial:
     I. Melatonin 1-3 mg at bedtime for a minimum of 10 days if tolerated -1st line (**Special Note: Melatonin is an over the counter supplement that is not regulated by the FDA nor covered on the ADHS/DBHS formulary**)
     II. With insufficient response and severe symptoms may try short term use of clonidine (Catapres)

Training and Supervision Expectations

The T/RBHA shall implement a privileging mechanism which reviews the level of skills and training, as well as the scope of practice of behavioral health staff who are prescribing psychopharmacological treatments to the birth to five population. Each T/RBHA shall implement a process which allows for child psychiatric oversight for non-child psychiatrist BHMPs who are prescribing medication treatment to young children. For non-child psychiatrist BHMPs, the T/RBHA will define the frequency of communication and collaboration with a designated child psychiatric provider over the course of the child's psychopharmacological treatment to be consistent with the minimum standards established in this practice protocol.

It is the expectation of ADHS/DBHS that behavioral health staff who complete psychiatric evaluations, prescribe psychopharmacological treatment, and identify psychotherapeutic interventions for the treatment of children birth to five years of age be adequately trained and clinically supervised in the application of this

protocol. Each T/RBHA shall establish their own process for ensuring that clinical staff working with this population understands the recommended process and procedures and whenever this Practice Protocol is updated or revised ensures that their subcontracted network and provider agencies are notified and required staff are retrained as necessary on the changes.

Anticipated Outcomes and How They Will Be Measured

Anticipated Outcomes include:

- Improved use of effective psychiatric evaluation procedures specific to the needs of young children
- Increased awareness of the risks involved with polypharmacy use with young children
- Improved outcomes through the use of accepted psychotherapeutic and psychopharmacological treatment interventions in working with young children

How will outcomes be measured?

- Record reviews utilizing the ADHS/DBHS Birth-5 Practice Protocol Review Tool
- Monitoring of medication utilization quarterly reviews in Birth-5 population by provider type

How will Fidelity be Monitored?

Each T/RBHA must have a process in place to monitor the use of medications and psychotherapeutic interventions with this population**.** At a minimum, this will include record reviews utilizing the ADHS/DBHS Birth-5 Practice Protocol Review Tool.

T/RBHAs: Monitoring of referrals/second opinion reviews in the following situations:

- Children prescribed 4 or more psychotropic medications: chart review and medication utilization quarterly reviews
- Children prescribed 5 or more psychotropic medications: face-to-face assessment and medication utilization quarterly reviews

ADHS/DBHS will monitor fidelity through:
Monitoring and Oversight Department audits (audit of T/RBHA provider chart reviews, quarterly medication utilization submissions).

Service Expectation: The T/RBHA is responsible for maintaining a process to monitor the use of medications with this population.

Psychiatric Best Practice Guidelines for Children: Birth to Five Years of Age
Desktop Guide

- **Service Expectations:**
  - **The psychiatric evaluation, as part of a comprehensive assessment, must be completed prior to the initiation of psychotropic medication.**
  - **Clear and specific target symptoms must be indentified and documented in the clinical record prior to the initiation of a medication trial.**
  - **The non-child psychiatrist BHMP must consult with the designated child psychiatric provider in the following situations:**
    - **Prior to the initiation of medication**
    - **If the child is not making progress towards identified treatment goals *at a minimum of every three months***
    - **In the event that a taper off of medications *at six to eight months* of treatment is not clinically indicated or unsuccessful**
  - **In children who have a positive response to medication, a taper off medication is considered and clearly documented in the clinical record every 6 to 8 months of treatment until the child reaches the age of five.**
  - **Documentation in the clinical record by the BHMP is required showing the communication and coordination of care efforts with the health care provider related to the child's behavioral health psychopharmacological treatment.**
  - **When more than one medication is prescribed there must be documentation of clear target symptoms for each medication in the child's clinical record. If the BHMP prescribing the medications is not a child and adolescent psychiatrist, re-consultation with the designated child psychiatric provider must occur before the young child receives more than one medication.**
  - **The behavioral health medical practitioner shall document in the child's clinical record the rationale for medication choice and the provision of informed consent to parents/caregivers/ guardians must contain the elements outlined in this protocol.**
  - **The T/RBHA is responsible for maintaining a process to monitor the use of medications with this population.**

- **<u>Key elements to remember about this best practice:</u>**
  - Preschool psychiatric disorders can be associated with child care expulsion, inability to participate in family activities, impaired peer relationships, high-risk behaviors and future mental health problems.
  - Psychiatric evaluation as part of assessment practice must include gathering information from those persons who are most familiar with the child, as well as direct observation of the child with his/her parent/primary caregiver(s).
  - Not all preschoolers who have clinically significant symptoms will meet full criteria for a diagnosis.
  - Psychotherapeutic approaches should be considered as the initial intervention before psychopharmacological treatment.
  - Medications are to be reserved for children with moderate to severe psychiatric symptoms that significantly interfere with their normal development and result in impairment that persists despite the use of clinically appropriate psychotherapeutic interventions.
  - Psychotherapeutic interventions should continue during the period of medication treatment.
  - Dosing can be challenging as young children may metabolize medications more rapidly than older individuals.
  - Young children are often very sensitive to side effects and must be monitored closely.
  - Polypharmacy should only be considered and used in extreme situations where severe symptoms and functional impairment are interfering with the child's ability to form close relationships, experience, regulate and express his/her emotions, and progress developmentally.
  - Lack of an FDA indication does not necessarily reflect a lack of evidence or a prohibition of use in this population.
  - Psychoeducation and early intervention are essential components of any psychotherapeutic intervention program and therefore should be included in the treatment of all disorders.

- **<u>Benefits of using this best practice:</u>**
  - Improved use of effective psychiatric evaluation procedures specific to the needs of young children
  - Increased awareness of the risks involved with polypharmacy use with young children
  - Improved outcomes through the use of accepted psychotherapeutic and psychopharmacological treatment interventions in working with children age birth to five