CHAPTER 3 – PROVIDER RESPONSIBILITIES

3.2 – MEMBER CHOICE AND TRANSFERS BETWEEN PROVIDERS

3.2.1 – INTRODUCTION
The best care comes about when individuals and families have a voice in selecting a provider that they believe can best meet their needs and that reflects their cultural and linguistic preferences. HCIC fully supports the right of members to choose the provider that will be assigned primary responsibility for meeting their needs.

To eliminate barriers to services AHCCCS implemented Auto-Enrollment for Title XIX/XXI enrolled members into the behavioral health system as of October 1, 2010. The auto-enrollment process assigns Title XIX/XXI enrolled members according to their residential zip code within a geographic service area. For the Northern Region, each TXIX/XXI auto-enrolled member is assigned to a Health Home according to the member’s residential address zip code and Health Home specialty, if applicable (i.e. adults only). In addition to the Health Home, Title XIX Integrated SMI members are assigned a PCP. Integrated SMI members between the ages of 18 and 20 will also be assigned a Primary Dental Provider (PDP) to manage dental services. If there is more than one PCP, PDP or Health Home within the geographic area, member assignment is based upon HCIC’s assignment process. The assigned Health Home will assist the Title XIX/XXI member with opening an episode of care and coordinating medically necessary services.

The auto-enrollment process does not limit the member’s right to choose a provider. In addition, HCIC requires that its providers honor members’ requests for specific practitioners within the agency, whenever possible.

Individuals seeking services in the Northern Region can access HCIC Health Homes (Intake/Service Agencies) directly, without the need for an HCIC referral, or can request assistance from HCIC Member Services staff in locating a provider who meets their needs. Both referral pathways offer prompt access to providers in or near the individual’s home community who can provide the type of services requested or needed by the individual or his/her family.

3.2.2 – MEMBER CHOICE OF HEALTH HOME
Due to the auto-enrollment process, a Title XIX/XXI member is assigned to a Health Home. When a Title XIX/XXI member presents or receives services, the assigned Health Home is responsible for opening an episode of care (EOC). Dependent upon available funding, the Health Home submits the enrollment 834 and/or EOC for Non-Title XIX/XXI members.

Individuals seeking services in the HCIC service area may select the Health Home of their choice. Given the dispersed, rural nature of HCIC’s service area, HCIC encourages individuals to select the Health Home closest to their home. HCIC’s Health Homes have intake sites in most Northern Arizona communities. If an individual accepts a referral to the Health Home nearest to his/her home, s/he is offered an intake appointment and is enrolled/assigned to that agency as his/her primary behavioral health provider. If the individual indicates a preference for a Health Home in a more distant community, s/he is referred and subsequently enrolled/assigned to that Health Home unless there is a clinical reason to not refer.
Transportation. If a member chooses to receive services from a health home other than the one closest to their home, transportation to and from services may not be a covered benefit. In these cases, health home responsibility of coverage for transportation services will be determined by HCIC after a case review.

In its largest counties in the Northern Region (Yavapai, Coconino, Gila and Mohave), HCIC offers members choice of more than one local Health Home. If the member’s choice is different than HCIC’s auto-assignment process and an EOC has not been submitted by any provider, then the selected Health Home must submit the EOC as identified in policy allowing re-assignment to be identified. This EOC will generate the re-assignment within HCIC’s system and a transfer will not be required.

Individuals seeking referrals through the **HCIC Member Services Department** are advised of the Health Homes available in their community and are provided with information about each agency’s services to assist the individual in making an informed choice of provider.

HCIC contractually requires Health Homes to accept all eligible persons. HCIC monitors all Health Homes to ensure that they have appointment availability. If for any reason a Health Home is unable to accept new members, it must notify HCIC immediately and report a reason for limiting capacity and provide a date by which they will be accepting referrals again. Any Health Home that limits availability may be subject to performance improvement and/or financial sanction.

### 3.2.3 – MEMBER CHOICE OF IN-NETWORK AND OUT-OF-NETWORK SERVICES

Health Homes, through the Child and Family Team/Adult Recovery Team (CFT/ART) process, may secure a wide range of covered services from providers within the HCIC network based on individual member/family needs. CFTs and ARTs must offer a choice of practitioners within the Health Home, and choice within the HCIC provider network. However, an individual practitioner is not required to accept a member’s request if there is not sufficient capacity or expertise to care for the member.

**In-Network Services** – refers to any provider contracted (not including Single Case Agreements) in the HCIC network. A full listing of providers is available on the HCIC website at [http://www.healthchoiceintegratedcare.com/providers/find-a-provider/](http://www.healthchoiceintegratedcare.com/providers/find-a-provider/). Child and Family Teams and Adult Recovery Teams can secure services not requiring prior authorization directly from the full network of providers to meet families’ individualized behavioral health needs.

**Out-of-Network Services** – refers to medically necessary covered behavioral health services which may be available from providers who are not part of the HCIC network of providers. If a member requests an out-of-network service, the clinical team should secure the service if it is the most appropriate for meeting the member’s needs and if the service cannot be secured through an in-network provider. Out-of-Network providers must be willing and able to meet HCIC contract requirements and establish a Single Case Agreement with HCIC. (Reference PM [Chapter 13 - Service Authorization](http://www.healthchoiceintegratedcare.com/providers/find-a-provider/) for more specific procedural information and HCIC PM [Chapter 20.0](http://www.healthchoiceintegratedcare.com/providers/find-a-provider/) and [20.3 for Notice of Action Requirements](http://www.healthchoiceintegratedcare.com/providers/find-a-provider/).)
3.2.4 – MEMBER TRANSFERS BETWEEN HEALTH HOMES (INTRA-RBHA TRANSFERS)
An episode of care closure is not required within the HCIC region when transferring from one Health Home to another. The transfer will reassign the new Health Home within the existing EOC. Health Homes must utilize the ‘Transfer-In’ process, which is facilitated by the use of the ‘Transfer Checklist’, created by HCIC to assist Health Homes in following a standardized transfer process by outlining the responsibilities of the ‘Transfer FROM Agency’ to the ‘Transfer TO Agency’. HCIC requires that this checklist be completed for every transfer (See HCIC Intra-RBHA Transfer Checklist.)

When planning and implementing a Transfer, the involved Health Homes must discuss and address clinical considerations in order to ensure coordination and continuity of care. Member transfers should be handled in a clinically appropriate manner and the member or guardian must be in agreement with the transfer.

3.2.5 – REASONS FOR TRANSFER
HCIC’s members may transfer Health Homes for two reasons:
- Member or Parent/Guardian Choice OR
- Member relocation to a new address
  - Member relocation includes moves to Halfway Houses and Shelters.
  - 72-Hour Responses (DCS Removals) continue to be completed by the Health Home in the area from which the child was removed. The member remains with the Health Home where the guardian is located.

3.2.6 – WHO CAN INITIATE A TRANSFER
Members can request a transfer directly through their current Health Home and/or CFT/ART. The current Health Home where the person is enrolled then initiates the Transfer Process.

OR, members can request that a transfer be initiated by the new Health Home they wish to transfer to. The newly requested Health Home would then initiate the Transfer Process through coordinating with the current Health Home.

Regardless of which Health Home (existing or new) initiates the transfer, the receiving Health Home will submit the transfer checklist to the HCIC Production Department. The receiving Health Home will coordinate care by completing the Intra-RBHA checklist to demonstrate coordination. Once the checklist is completed and signed off by both the transferring from and transferring to Health Homes, the check list is emailed to HCIC_Production@iasishealthcare.com for approval and processing.

3.2.7 – LIMITS TO TRANSFERS
HCIC does not generally limit a member’s choice of Health Home. Once a member has been enrolled and is receiving services, HCIC believes that members, families, and their clinical teams are best suited to make decisions directly about service needs and provider preferences. In specific and clinically appropriate circumstances, HCIC may limit a member’s choice of Health Home for the primary oversight and coordination of his/her treatment services.

Disagreements about transfers: Any time a team is unable to reach agreement on the clinical appropriateness of the request, the team, the consumer, or the member’s guardian may request a review by calling HCIC Member Services at 1-800-640-2123.
These limits are intended to maximize the clinical appropriateness and coordination of care for members in the following circumstances:

- **Inpatient or Residential Treatment**: HCIC considers inpatient and residential care to be intensive, time-limited treatments that require a high level of consistency in clinical management and continuity in clinical team planning. Therefore, transfers of Intake/Case Management Provider (Health Home) assignment are limited during a member's treatment in a psychiatric acute hospital, a sub-acute facility, a Behavioral Health Inpatient Facility (previously called RTC) for persons under the age of 21, a Behavioral Health Residential Facility, long-term chemical dependency facilities, and HCTC treatment homes.

- **Clinical reasons**: HCIC may limit transfers based on other member clinical needs (e.g. voluntary/involuntary status or geographic distance in relation to intensity of service availability). If there is a question about the appropriateness of the transfer either by the member, guardian, transferring agency or accepting agency, a provider’s clinical team may refer the request for transfer to the HCIC Medical Management Specialist who is authorizing those services in HCIC’s Medical Management Department if the member is in a prior authorized treatment setting for clinical review; or to the HCIC Chief Clinical Officer for all other settings, upon which HCIC will determine if the transfer is clinically appropriate, and will also follow up to ensure that the transfer, if agreed upon, occurs with continuity.

- **Adolescents 17 ½ years to 18 years old**: HCIC discourages transfers of adolescents within six months of turning 18, due to the high degree of coordination and team consistency needed during the youth’s transition to a new system of care. If a youth or family/guardian requests transfer to a different Health Home during this time, the clinical team will review and may recommend to HCIC that a transfer be accommodated.

- **Members with frequent transfers**: HCIC tracks Member Transfers and may limit transfers for individuals who demonstrate frequent transfers (e.g. three or more in a 12 month period). HCIC’s Chief Clinical Officer will review further requests and determine if transfer is appropriate and will work with the member and their CFT/ART to assist in resolving any care issues.

- **Non-emergency transportation**: AHCCCS covers medically necessary non-emergency ground and air transportation to and from a required medical service for most recipients. Since medically necessary transportation is provided to and from the nearest appropriate AHCCCS registered provider, as per AHCCCS AMPM 310-BB Transportation, transportation may not be covered if members choose to not receive services at the assigned health home location. If there is a disagreement in the transportation coverage, HCIC’s Chief Clinical Officer will review requests and determine if transportation is appropriate and covered based on member need, reason for the request to change health homes, intensity of services needed and ability of the assigned health home to provide needed services.

### 3.2.8 – HEALTH HOME TRANSFER PROCEDURES

Member requests for transfer must be handled in a timely and clinically appropriate manner using the following procedure:

- The Transfer Effective Date is the date that the new Health Home assumes clinical and administrative responsibility.
• This date must occur as soon as possible, but no more than 14 days after the transfer request, unless 1) otherwise agreed upon by the member or their guardian and 2) documented on the member’s Service Plan.
• This transfer date is negotiated and agreed upon by the two Health Homes and the member/guardian.
• If the transfer process becomes stalled, Health Homes should utilize their transfer process point-people to negotiate a settlement of whatever issues are causing the problem. If a final resolution is not reached, point-people may contact HCIC_Production@iasishealthcare.com for assistance.

Transfer FROM Agency responsibilities:
• Service provision until the Transfer Effective Date
• Any open authorizations should be end-dated prior to the Transfer Effective Date
• Contacting the Transfer TO agency to schedule a CFT/ART within 3 days of the request to transfer
• A CFT/ART meeting must occur with the transfer FROM and the transfer TO agency prior to the transfer effective date, in order to ensure continuity and coordination of care for members/families
• Negotiating a Transfer Effective Date
• Establishing a Transition Plan. The Transition Plan must ensure that there are no service delays or gaps in critical services during the transition.
• Sending copies of the Transfer Packet to the Transfer TO agency
• Provide prescriptions of current psychotropic medications for persons receiving psychotropic medications, sufficient in quantity to last until the first appointment with the new Health Home’s medical practitioner.
• As part of the Transfer Packet, and in order to confirm the member/parent/guardian’s consent to receiving services at the new agency, obtain written agreement of the transfer from the member/parent/guardian by completing and signing the Universal Consent to Treat Form.

Transfer TO Agency responsibilities:
• Ensure that the Transfer TO agency’s enrollment department submits an electronic Transfer-In Request to HCIC’s Production Department. The request must include the Transfer Effective Date and the Reason for Transfer.
• Initiate new authorizations for existing services concurrent with the Transfer Effective Date.
• Review the Transfer Packet.
• Ensure that a plan is in place to provide for any crisis/safety issues.
• Ensure that a plan is in place to provide for interim services, which are identified in the Transition Plan.
• Provide an appointment within 7 days of receipt of the Transfer Packet and within a maximum of 14 days of the Transfer Effective Date. It is recommended that Health Homes complete the minimum amount of “intake” paperwork needed for their agency in order to minimize the impact of multiple intakes and assessments on members. AHCCCS does not require that a new Comprehensive Assessment be performed as long as it was completed within 12 months and a BHP has reviewed the assessment and has made any needed updates.
• If clinically indicated, provide an appointment with an individual qualified to prescribe psychotropic medications within a timeframe indicated by clinical need, but no later than 30 days from the
referral/initial request for services to ensure that the member does not have a gap in medications. (See Chapter 2.1 - Appointment Standards and Timeliness of Services.)

3.2.9 – HCIC PRODUCTION DEPARTMENT VERIFICATION

- Following Health Home notification of Transfer-In Request, HCIC’s Production Department will generate an electric notification to the Transfer FROM agency and the Transfer TO Agency verifying the transfer agreement.
- Both agencies must ensure receipt of this notification.
- HCIC Production will generate reports on a daily basis that identify all transfers.