



Comprehensive Medical and Dental Program (CMDP) "Serving Arizona's Children in Out-of-Home Care"



2019-2020 Member Handbook

CMDP
Member Services
dcs.az.gov/services
602.351.2245 local
1.800.201.1795 toll free

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ARIZONA
DEPARTMENT
of **CHILD SAFETY**
Comprehensive Medical
and Dental Program

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WELCOME TO CMDP

The Comprehensive Medical and Dental Program (CMDP) is a program administered by the Arizona Department of Child Safety (DCS). CMDP is the health plan for Arizona's children and youth placed in out-of-home care. Members are enrolled with CMDP by their custodial agency (the agency that placed them in out-of-home care).

Custodial agencies are:

- Arizona Department of Child Safety (DCS)
- Arizona Department of Juvenile Corrections (ADJC)
- Administrative Office of the Court/Juvenile Probation Office (AOC/JPO)

Each CMDP member has a DCS Specialist or custodial agency representative assigned to them. The specialist or custodial agency representative will call or visit you in person to talk about the member's health care needs and the services you can get. They will ask you questions about the member's health.

New Member Packet

You should receive a New Member Enrollment Packet from the DCS Specialist or custodial agency representative. The New Member Enrollment Packet includes a welcome letter, CMDP Member ID card, information on choosing a health care provider, cultural competency information, EPSDT notice, family planning notification letter (if the member is age appropriate), Notice of Privacy Practices and instructions on how to access the CMDP Member Handbook and Newsletters.

The New Member Packet will also include a form titled *Notice to Providers (Out-of-Home, Educational and Medical)*. The form will have the member's nine digit CMDP Identification Number. If the number is not nine digits, add zeros to the front of the number until there is a total of nine digits. For example, the ID number is 123456 (not nine numbers), add 000 to the 123456 to get 000123456 (nine numbers).

Show the Notice to Provider form to health care providers and pharmacies, or give them the CMDP ID number. Use this form until a permanent ID card is given to you by the member's DCS Specialist or custodial agency representative.

If you do not receive a New Member Packet or CMDP Member ID Number, contact the DCS Specialist or custodial agency representative. You can also contact Member Services at 602.351.2245, toll free, 1.800.201.1795, or by email, CMDPMemberServices@azdcs.gov

This is Your Member Handbook

The CMDP Member Handbook is for members and their caregivers. Please take time to read this handbook. It will answer many questions you may have. If you have any problems reading or understanding this handbook, please contact Member Services at 602.351.2245, toll free, 1.800.201.1795, or by email, CMDPMemberServices@azdcs.gov. We can help explain the

information to you. We can also provide the information in your primary language at no cost to you.

The CMDP Member Handbook is revised every year. The handbook can be found on our website at <https://dcs.az.gov/services/cmdp>.

Covered services are funded under contract with AHCCCS. The Arizona Health Care Cost Containment System (AHCCCS) is Arizona’s Medicaid and KidsCare programs. CMDP is the AHCCCS plan for its members. Members do not have to be eligible for AHCCCS or the KidsCare program. CMDP provides the same services for all members in out-of-home placement regardless of AHCCCS eligibility status.

CONTACT US

CMDP service representatives are available to assist you with questions, concerns or issues about the member’s health care coordination.

CMDP Service Representatives Can:

- Answer questions about health care benefits;
- Help solve a problem or concern you might have with your doctor or any part of the health plan;
- Help you find a doctor;
- Tell you about our doctors, their backgrounds and care facilities;
- Help you if you get a medical bill;
- Tell you about community resources available to you; and
- Help you if you speak another language, are visually impaired, need interpreter services, or sign language services.

You can contact us by phone or in writing for assistance. You can also visit the CMDP website at <https://dcs.az.gov/services/cmdp> for additional information.

Call Us

Local	602.351.2245
Toll Free (24 hours/7 days a week).....	1.800.201.1795
TDD (for the hearing impaired)	711 or 1.800.367.8939
Grievances	602.351.2245
Pharmacy Member Helpline.....	1.855.577.6310
Child Abuse Hotline (24hours/7 days a week).....	1.888.767.2445

Fax Us

Member Services	602.264.3801
Medical Services	602.351.8529
Administration	602.255.3551

Email Us

Member Services	CMDPMemberServices@azdcs.gov
Medical Services	CMDPNurse@azdcs.gov
CRS Services	CMDPCRSNurse@azdcs.gov
Behavioral Health	DCSBHUnit@azdcs.gov

When You Call Us:

We ask questions to check your identity. We do this to protect the member’s privacy. This is federal and state law.

Gather the following information before you call:

- Member ID number;
- Member’s address and phone number; and
- Member’s date of birth.

Write To Us:

Arizona Department of Child Safety
 Comprehensive Medical and Dental Program S/C C010-18
 P.O. Box 29202
 Phoenix, AZ 85038

AFTER HOURS (URGENT) CARE

After hours care is also called urgent care. If the member needs care right away, but is not in danger of lasting harm or losing their life, they can visit an urgent care center. There are some injuries and illnesses that are probably not an emergency but can turn into an emergency if they are not treated within 24 hours.

Some examples of non-emergent matters are:

- Minor burns or cuts
- Earaches
- Cough
- Muscle sprains/strains

If you do not know whether you need to visit an urgent care center, call your health care provider, even at night and on weekends. **If it is a life-threatening emergency, call 911.** You do not need to get prior authorization before you do so. Always tell your health care provider about any visits to an urgent care center or hospital.

You can find the closest urgent care center by checking the Provider Directory on the CMDP website at <https://dcs.az.gov/services/cmdp> or contact Member Services at 602.351.2245, toll free, 1.800.201.1795, or by email, CMDPMemberServices@azdcs.gov, for assistance.

BEHAVIORAL HEALTH CRISIS SERVICES

Most CMDP members get behavioral health services, including drug and alcohol abuse services, from the AHCCCS Regional Behavioral Health Authority (RBHA). Members are assigned to a

RBHA when enrolled with CMDP. The RBHA assignment is based on the member’s court of jurisdiction.

If the member has a behavioral health emergency, it is important to get help right away. If you think the member might hurt themselves or someone else, call 911 or a behavioral health crisis phone number listed below.

RBHA Listings

Arizona Complete Health

Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz and Yuma Counties

Foster Care Hotline.....	1.844.365.3144
Children’s Liaison.....	520.809.6432
Member Services	1.866.495.6738
Crisis Line	1.866.495.6735
Email	AzCHDCS@azcompletehealth.com

Mercy Care

Maricopa County

Foster Care Hotline.....	602.633.0763
Children’s Liaison.....	602.453.8095
Member Services	1.800.564.5465
Crisis Line.....	1.800.631.1314
Email.....	DCS@mercyareaz.org

Steward Health Choice Arizona

Apache, Coconino, Gila, portions of Graham, Mohave, Navajo and Yavapai Counties

Foster Care Hotline.....	928.293.7038
Children’s Liaison.....	928.214.2370
Member Services.....	1.800.640.2123
Crisis Line.....	1.877.756.4090
Email	HCIC_dcs@steward.org

LANGUAGE AND CULTURAL SERVICES

Clear communication is important to get the health care the member needs. CMDP provides you with member materials in a language or format that may be easier for you to understand. We can also provide you with printed health care materials, including this handbook, in a language or format that is easier for you to read. We have interpreters for you to use if the health care provider does not speak your language.

If a health care provider does not understand your cultural needs, or if you have a problem reading or understanding this information or any other CMDP information, contact Member Services at 602.351.2245, toll free, 1.800.201.1795, or by email at CMDPMemberServices@azdcs.gov, for help. We can explain this information, in English or in your primary language at no cost to you.

Auxiliary Aids

Auxiliary Aids are services or devices that help those with vision, speech or hearing impairments. We can assist you in obtaining auxiliary aids including readers, braille materials, audio recordings, and other similar services and devices. These materials are available at no cost to you. For more information on how to obtain auxiliary aids and services, contact Member Services at 602.351.2245, toll free, 1.800.201.1795, TTD (for the hearing impaired) 711 or 1.800.367.8939, or by email, CMDPMemberServices@azdcs.gov.

PROVIDER NETWORK

The CMDP provider network includes doctors, specialists, hospitals, pharmacies and other providers who will work to meet the unique health care needs for our members. Our providers will make sure that health care is accessible, continuous, comprehensive, coordinated, compassionate, and culturally effective.

CMDP works with all AHCCCS registered providers including providers credentialed by CMDP. If you would like to see a provider not registered with CMDP or AHCCCS, contact CMDP Member Services at 602.351.2245, toll free, 1.800.201.1795, or by email, CMDPMemberServices@azdcs.gov. We will contact the health care provider with information regarding the registration process.

The CMDP Provider Directory lists the names, locations, telephone numbers, and languages other than English spoken by our plan providers. This includes dental providers and other health care specialists. We can help you find a provider who can accommodate members with physical disabilities, and provide a skilled medical interpreter at the provider's office. You can access the CMDP Provider Directory by visiting the CMDP website at <https://dcs.az.gov/services/cmdp>. If you would like a copy of the CMDP Provider Directory mailed to you at no cost, contact Member Services at 602.351.2245, toll free, 1.800.201.1795, or by email, CMDPMemberServices@azdcs.gov.

MANAGED CARE PROGRAMS

Managed care is a system that manages health care delivery to control costs. A managed care organization is also called a health plan. CMDP is the member's health plan and is responsible for the member's health care.

As a managed care program, CMDP requires the health care provider to submit a request for authorization for certain services. CMDP also reviews the services provided to verify that appropriate services are provided. The Primary Care Provider (PCP) is the health care provider that coordinates health care for the member and makes necessary referrals for services.

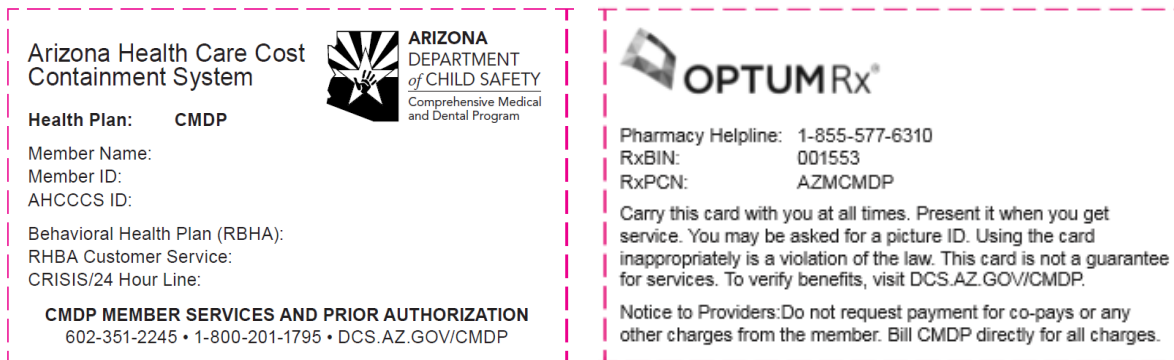
MEMBER IDENTIFICATION (ID) CARD

When a member is enrolled, you will receive a Member Identification (ID) card similar to the one below. The card is your key to getting health care services for the member. It has the member's ID

number, name, and other important information. The Member ID Card will look similar to the card below.

FRONT

BACK



Your ID card has a phone number to access behavioral health and substance use services. Services are assigned to a provider based on where you live. If you have questions or need help getting behavioral health services, please call the number on your card.

Pharmacy information is located on the back of the Member ID card. If you have problems getting a prescription at the pharmacy, call the Pharmacy Helpline telephone number shown on the back of the card.

If the member has an Arizona driver's license or state issued ID, AHCCCS will obtain the member's picture from the Arizona Department of Transportation Motor Vehicle Division (MVD). The AHCCCS eligibility verification screen viewed by providers contains the member's picture (if available) and coverage details.

The Member ID card should be kept safe. Do not throw the card away. You will need it each time you get medical services for the member. Do not let someone else use the Member ID card. It is against the law. Selling or letting someone else use the member's card is fraud. Legal action could be taken against you including loss of eligibility.

The Member ID card is available at no cost to the member. If you do not receive the Member ID card or you need a replacement card, contact CMDP Member Services at 602.351.2245, toll free, 1.800.201.1795, or by email, CMDPMemberServices@azdcs.gov.

MEMBER AND CAREGIVER RESPONSIBILITIES

CMDP members and caregivers have the following responsibilities:

- Protect the member's ID card at all times and inform CMDP of the loss or theft of a member ID card.
- Present the CMDP member ID card when using healthcare services.
- Present the Notice to Provider form when using health care services if the CMDP member ID card is not available.
- Always list DCS/CMDP as the responsible party for payment of health care services.

- Provide health care providers with accurate and complete medical information.
- Follow instructions given to you by health care providers and ask questions if you do not understand the instructions.
- Inform CMDP about any other insurance coverage the member may have.
- Follow the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible.
- Schedule appointments with the doctor during office hours whenever possible before using urgent care or a hospital emergency room.
- Schedule appointments outside of the member's school hours whenever possible.
- Make every effort to keep any agreed upon appointments and follow-up appointments, and access preventive care services.
- Take the member to medical appointments and dental exams or contact the assigned DCS Specialist, custodial agency representative or CMDP for assistance with transportation.
- Use the Multi-Specialty Interdisciplinary Clinics (MSIC) if the member has a CRS qualifying condition when asked to do so by CMDP or the health care provider.
- Cooperate with the DCS Specialist, custodial agency representative, CMDP and health care providers to make certain the member is receiving the best care possible.
- Notify CMDP and health care providers if there is any change in address or phone number.
- Notify DCS/CMDP when family size or any other demographic information changes.

CHANGES IN INFORMATION

If you are moving with a member to another county, state, or country, contact CMDP Member Services and the member's DCS Specialist or custodial agency representative for assistance in getting health care services in the new state. Member Services can assist you with finding a new pharmacy for the member, or with problems filling medications. You should also contact member's Primary Care Provider (PCP) and Primary Dental Provider (PDP). Advance notice of the member's new address will allow time for the transfer of medical files to a new provider. This ensures continuity of care for the member.

The member's DCS Specialist or custodial agency representative will find out if the member can get health care services in the new state. They will also inform you on how to apply for Medicaid services on behalf of the member. If the member is not eligible for Medicaid services in the new state, CMDP will cover all medically necessary health care services. CMDP will also work with the DCS Specialist or custodial agency representative to locate and register providers.

The Arizona Department of Child Safety (DCS) will, to the greatest extent possible, consult with the biological parents of the child and the member when making health care decisions.

If DCS has temporary custody of a child or has legal custody pursuant to a court order, DCS may consent to the following services:

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

- General anesthesia.
- Blood transfusion.
- Testing for presence of the human immunodeficiency virus.

Services caregivers cannot authorize:

- General anesthesia
- Blood transfusions
- Pregnancy termination
- Any surgery or medical treatment that is not routine

CHANGING HEALTH PLANS

CMDP facilitates transition of care for all members to ensure continued access to services when members are exiting out-of-home care and need to change their health plan. We will coordinate transition services for members who are no longer AHCCCS eligible for up to 60 days. This allows continued coverage for the member.

Members who are exiting out-of-home placement but are Medicaid eligible continue health care coverage with another AHCCCS Health Plan until a re-determination is made.

Members 18 years of age who are AHCCCS eligible while in out-of-home placement may qualify for the Young Adult Transitional Insurance (YATI) Program for continued medical coverage with AHCCCS.

Contact the member's DCS Specialist or custodial agency representative for more information on AHCCCS enrollment and transition to another AHCCCS health plan.

EMERGENCY SERVICES AND TRANSPORTATION

An emergency is a sudden condition that puts the member's life in danger or can cause harm to the member if not treated fast.

Examples of emergency matters are:

- Major bleeding;
- Broken bones;
- Trouble breathing;
- Seizures; and
- Unconsciousness.

You can get emergency care 24 hours a day, seven days a week. **If you need emergency care, call 911 or go to the nearest hospital emergency room.** Emergency services are covered by CMDP and do not require prior authorization.

Emergency services should not take the place of doctor's office visit.

Notify the member's DCS Specialist or custodial agency representative and CMDP immediately after a member has received emergency services.

Emergency Transportation

If the member needs transportation in a life-threatening emergency, dial 911 or contact the local ambulance service. Emergency transportation services are covered by CMDP and do not require prior authorization.

Medically Needed Non-Emergency Transportation

Caregivers should transport members to and from medical appointments. If you need a ride to an appointment, ask a relative, friend or use public transportation. If you are unable to obtain a ride, contact the member's DCS Specialist or custodial agency representative, or contact Member Services at 602.351.2245, toll free, 1.800.201.1795, or by email, CMDPMemberServices@azdcs.gov, at least 24 hours in advance of the medical appointment.

COVERED HEALTH CARE SERVICES

Covered services are health care services that CMDP pays for. This includes physical health and behavioral health care, services, supports, supplies, prescription and over-the-counter drugs, equipment and other services. The care must be medically necessary. Medically necessary means reasonable and necessary to prevent or treat illnesses or health conditions or disabilities. This includes care that keeps you from going into a hospital. It also means the services, supplies, or drugs that meet accepted standards of medical practice.

CMDP pays for health care services that are medically necessary. Medically necessary services include:

- Doctor office visits;
- Well-child exams or Early and Periodic Screening, Diagnosis and Treatment (EPSDT);
- Well visits for members 21 years and older;
- Screening tests such as tuberculosis, lead, anemia, hearing, vision, sexually transmitted infection, cervical cancer screening etc.;
- Immunizations;
- Behavioral health services (see Behavioral Health Services section of this handbook);
- Hospital care;
- Specialist care, as needed;
- Family planning services;
- Home and community-based services;
- Lab and X-ray services;
- Pregnancy care;
- 24-hour emergency medical care;
- Preventative, diagnostic and restorative dental care;
- Emergency transportation;
- Vision care and eyeglasses;
- Medically-needed transportation;

- Pharmacy services, medical supplies and equipment, and
- Transplants covered by AHCCCS.

CMDP does not pay for:

- Care that is not medically needed;
- Hospital admission, service or item that needed prior authorization (PA) but was not approved in advance or was denied;
- Services or items for cosmetic purposes;
- Services needed for the psychological well-being of the member, as these services are provided by the RBHA. If these services are asked of CMDP, they will need a PA;
- Services or items that are free of charge or for which charges are not usually made;
- Pregnancy termination, unless prior approved and pregnancy termination counseling;
- Personal care items such as: shampoo, mouthwash, diapers for newborns to three years old;
- Dietary formulas or diet supplements that are provided by WIC (unless they are the only source of nutrition and/or medically necessary and not covered by WIC). WIC provides services to members under 5 years of age;
- Medical services to an inmate of a public institution, such as a jail or correction facility;
- Care provided by individuals who are not properly licensed or certified and who are not CMDP registered.

CMDP pays for routine dental services without Prior Authorization (PA) or predetermination. Routine dental services include:

- Dental exams and X-rays;
- Treatment for pain, infection, swelling and dental injuries;
- Cleanings and fluoride treatments;
- Dental sealants;
- Fillings, extractions and medically-necessary amalgam crowns;
- Pulp therapy and root canals;
- Fluoride varnish applied by a PCP or PDP, and
- Dental education.

A dentist needs a PA for major dental services including general anesthesia and braces.

CMDP pays for routine vision services without Prior Authorization (PA) or predetermination. Routine vision services include:

- Eye exams;
- Eyeglasses and bifocals;
- Scratch coating;
- Repairs and replacement of eyeglasses;
- Tinted lenses (when medically needed), and
- Contact lenses (with a statement of why they are medically needed).

Incontinence Briefs

Incontinence briefs (pants), including pull-ups and/or incontinence pads, may be paid for by CMDP if the member is older than 3 years of age and has a documented medical condition that is causing them to have problems with bladder and/or bowel control.

CMDP uses the following guidelines to determine coverage for incontinence briefs:

- The child must be older than 3 years of age;
- The child needs the incontinent briefs to prevent skin breakdown and to enable participation in social community, therapeutic, and educational activities under limited circumstances; and
- The health care provider has written a prescription for incontinence briefs (Total of 240 incontinence briefs per month are allowed). If more are needed, the health care provider will need to provide specific documentation as to why.

If the Department of Child Safety is currently providing a stipend toward the purchase of the incontinent briefs and CMDP is going to supply them, the stipend will discontinue. CMDP will have the incontinence briefs delivered to the home by a designated supply company. For questions about incontinence briefs, please contact CMDP Medical Services at 602.351.2245, toll free, 1.800.201.1795, or by email, CMDPMemberServices@azdcs.gov.

Well Visits (Members 21 Years and Older)

Well visits (well exams) such as well woman exams, breast exams, and prostate exams are covered for members 21 years of age and older. Most well visits (also called checkups or physicals) include a medical history, physical exam, health screenings, health counseling and medically necessary immunizations.

For members under 21 years of age, see the EPSDT section of this handbook.

Contact Member Services at 602.351.2245, toll free, 1.800.201.1795, or by email, CMDPMemberServices@azdcs.gov, if you have any questions about covered health services.

END OF LIFE CARE SERVICES

End of Life (EOL) care is a member-centric approach to health care with the goal of maintaining the member's rights and dignity as they receive other medically necessary Medicaid covered services. EOL care includes information on being healthy and selecting treatment throughout all stages of the member's illness.

EOL care, when necessary, may include advance care planning. Advance Directives are prepared by the Arizona Attorney General's office for CMDP members under age 18.

SPECIALISTS AND OTHER PROVIDERS

The Primary Care Provider (PCP) and Primary Dental Provider (PDP) can take care of most of the member's health care needs. We also have other providers (doctors) who are specialists. CMDP

registers providers who meet CMDP quality standards. We want our members to get the best care possible.

A referral means you need your doctor's approval to get a service or go to another doctor to get special care. You do not need a referral from your PCP or PDP to see a specialist. Initial evaluations and consultations do not need Prior Authorization (PA) from CMDP, with the exception of chiropractic, podiatry, naturopathic, and pediatric developmental/behavioral health assessments. Your doctor will take care of any referrals you need.

Once the specialty provider has decided to provide health care treatment, the specialty provider will request a PA from CMDP before health care services begin. If CMDP denies services, the DCS Specialist or custodial agency representative will receive a denial letter stating why and how to appeal the decision.

Female members have direct access to preventative care and well care services from a Gynecologist within the CMDP network without a referral from a primary care provider. Pregnant members may choose their Obstetrician-Gynecologist (OB-GYN) provider as their PCP.

The CMDP Provider Directory has a list of specialty providers. You can access the Provider Directory on the CMDP website at <https://dcs.az.gov/services/cmdp>. If you need assistance with selecting a specialty provider or to request a copy of the Provider Directory at no cost to you, contact Member Services at 602.351.2245, toll free, 1.800.201.1795, or by email, CMDPMemberServices@azdcs.gov.

If a provider does not cover a service, including counseling or referral services, due to moral or religious objections, contact CMDP Member Services for assistance with finding a different provider.

American Indian members are able to receive health care services from any Indian Health Service provider or tribally owned and/or operated facility at any time.

PRIMARY CARE PROVIDERS (PCP) AND PRIMARY DENTAL PROVIDERS (PDP)

Whether you're new to CMDP, recently moved or are just ready for a change, selecting a Primary Care Provider (PCP) and Primary Dental Provider (PDP) is an important first step toward managing the member's health care.

The PCP and PDP are the providers the member will visit the most for medical and dental needs, including wellness visits and routine screenings, and non-emergency illnesses like earaches and sore throats. The PCP and PDP are part of the Medical Home and Dental Home that coordinate care for the member.

The PCP and PDP will:

- Review and track the member's medical and dental history;
- Provide coordination of care to meet the member's needs;
- Work with specialists, pharmacies, hospitals and other providers to track all care a member receives; and

- Provide the member's medical and dental information to those who need it.

Choosing a PCP and PDP

You can select a PCP and PDP from the CMDP Provider Directory. The directory includes languages that the provider speaks and services they provide to those with physical disabilities. You can search the list of providers by location, specialty or name. The directory is available on the CMDP website at <https://dcs.az.gov/services/cmdp>, or contact Member Services at 602.351.2245, toll free, 1.800.201.1795, or by email, CMDPMemberServices@azdcs.gov, to have a copy of the directory mailed to you at no cost.

Changing a PCP and PDP

You may change the member's PCP and PDP at any time, for any reason. Reasons to change a PCP and PDP include:

- Member moves;
- You or the member do not feel comfortable;
- The office is far from you and the member, and
- You or the member do not understand what the PCP says.

If you change the member's PCP and PDP, ask the current providers to transfer the member's medical records to the new PCP and PDP. To request a change, or to notify CMDP of a change, contact Member Services at 602.351.2245, toll free, 1.800.201.1795, or by email, CMDPMemberServices@azdcs.gov.

Make, Change or Cancel PCP and PDP Appointments

Contact the PCP and PDP to schedule appointments for the member. When you call, tell the office that the member is covered by CMDP.

Have the following information ready:

- Member's name;
- Member's CMDP ID number, and
- Reason you need the appointment.

To cancel or change medical and dental appointments, contact the provider at least one day before the appointment. Some providers may attempt to charge a fee for missed appointments. By State of Arizona law, CMDP cannot pay for missed or no-show appointments.

Access and Availability for Appointments

CMDP members should be able to get an appointment to see providers when needed. Contact Member Services at 602.351.2245, toll free, 1.800.201.1795, or by email, CMDPMemberServices@azdcs.gov, if you are unable to get appointments within the timelines listed below:

For primary care appointments:

- Urgent Care – as quickly as the member’s health condition requires but no later than two business days of request.
- Routine Care - within 21 calendar days of request.

For specialty appointments including dental specialty:

- Urgent Care - as quickly as the member’s health condition requires but no later than two business days of request.
- Routine Care - within 45 calendar days of referral.

For dental appointments:

- Urgent Care - as quickly as the member’s health condition requires but no later than three business days of request.
- Routine Care - within 30 calendar days of request.

For maternity care appointments (prenatal care):

- First trimester - within 14 calendar days of request.
- Second trimester - within seven calendar days of request.
- Third trimester - within three days business of request.
- High-risk pregnancies - as quickly as the member’s health condition requires but no later than three business days of identification of high risk or immediately if an emergency exists.

Keeping Children Healthy

As a caregiver, you can help keep members healthy if you:

- Make sure members get all their well-child and dental visits.
- Follow up on all referrals made during visits with the PCP.
- Make sure members receive all their vaccines (shots). Be sure shots are up-to-date (See the Center for Disease Control and Prevention website for immunization schedules and more information: <http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html>).
- Make sure teens go to their well visits. These include well woman visits for girls. The teen’s doctor should talk about reproductive health and birth control with them. They should also talk about safe sex. Safe sex includes how to prevent sexually transmitted diseases. There is often discussion of drugs and alcohol use at these visits. The member’s caregiver should also talk to them about these subjects.

All CMDP members must have a full well visit and a dental visit within the first 30 days of removal and placement in out-of-home care. Please schedule a physical exam and a dental visit for members. If the member had an exam before removal, CMDP requests that the appointment for the full well visit and dental visit be scheduled again within 30 days of the removal and placement into out-of-home care.

CHILDREN’S CARE AND EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

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 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS state plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness do not apply to EPSDT services.

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.

Amount, Duration and Scope: 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 U.S.C. 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 29 optional and mandatory categories of “medical assistance” as defined in the Medicaid Act. Services covered under EPSDT include all 29 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 services that are solely for cosmetic purposes, or that are not cost effective when compared to other interventions.

Developmental Screening Tools

It is important for health care providers to use a Developmental Screening Tool during an EPSDT exam. Your provider can choose one of three different Developmental Screening Tools:

- Parents' Evaluation of Developmental Status tool (PEDS)
- Modified Checklist for Autism in Toddlers (M-CHAT), or
- Ages and Stages Questionnaire (ASQ).

Caregivers should ensure that a developmental screening is done at each EPSDT well-child visit. Only providers who are certified by AHCCCS in the use of the PEDS Tool, M-CHAT, and ASQ can complete these screenings. It is important to find a provider who is certified in these developmental screening tools.

Contact CMDP Medical Services at 602.351.2245, toll free, 1.800.201.1795, or by email, CMDPNurse@azdcs.gov, if you have any questions regarding EPSDT.

CMDP supports the enhanced visit schedule recommended by the American Academy of Pediatrics for children placed in out-of-home care. Additional well-child visits allow health care providers to address complex health issues children may face when adjusting to new placements, schools, etc.

Substance Exposed Newborns (SENs)

Many children placed in out-of-home care are identified as having substance-exposure at birth and are considered substance-exposed newborns (SENs). Substances identified by hospitals and other medical professionals can include exposure to alcohol, amphetamines, cocaine, inhalants, marijuana, heroin, prescription pain medications, opioids and other drugs of abuse. Being aware of the signs of a substance-exposed newborn is very important for those caring for these vulnerable infants and children.

Not all infants/children exposed to substances at birth will have problems. There are several myths associated with substance exposed newborns. The labels of “ice babies” or “meth babies” are inaccurate due to lack of scientific evidence to support these labels.

The effects of drugs on infants/children will depend upon the amount of drug used and how long the drug was used during the pregnancy. The drug-exposed infant may be at risk for problems later in life, such as speech delay, attention deficit hyperactivity disorder and behavioral problems that may not be clinically present until the child is over age two or even school age.

Signs of drug exposure are not exclusive to a substance exposed newborn and may be present in other instances. A detailed history of drug/alcohol used during pregnancy, in addition to stressors and environmental effects is the key to the diagnosis of substance-exposure.

Some babies who are substance exposed newborns may have signs of fussiness or difficulty feeding. As they grow older the symptoms may change. It is important to talk with your PCP and obtain help from an Infant/Toddler Mental Health Specialist if needed.

The care plan for substance exposed newborns should be made with the infant/child's PCP to ensure appropriate medical needs are met. Care and/or treatment is based on symptoms the infant/child may be showing, and not on the fact that the child is drug exposed.

It is important that the PCP follow the child closely to monitor growth and development. It is also important to get services from Infant/Toddler Mental Health specialists when needed to deal with behavior difficulties.

CMDP publishes a brochure titled "*Handle with Care: Special Care for the Substance Exposed Newborn*". This brochure contains information and tips on caring for substance exposed newborns. You can get the brochure from the CMDP website at <https://dcs.az.gov/services/cmdp>. Or contact Medical Services at 602.351.2245, toll free, 1.800.201.1795, or by email, CMDPNurse@azdcs.gov, for copy of the brochure or if you have any questions regarding available services.

Safe Sleep for Babies

The following are safe sleep guidelines to reduce the risk of Sudden Infant Death Syndrome (SIDS) and other sleep related causes of infant death:

- Always place the baby on their back for safe sleeping.
- Use safety-approved crib covered by a fitted sheet.
- No pillows, blankets, sheepskins, or crib bumpers.
- No soft objects, toys, and loose bedding near the baby's sleep area.
- No smoking around the baby.
- Baby should not sleep in an adult bed, on a couch, or on a chair alone or with you.
- Nothing should cover or be near the baby's head.

If you have any questions or for more information on safe sleep for babies visit the CMDP website at <https://dcs.az.gov/services/cmdp>.

IMMUNIZATIONS (SHOTS)

Immunizations (shots) can keep children and youth from getting sick in the future. Talk with the member's PCP about the immunizations that are needed and when they are needed. You should use an immunization schedule and have the schedule updated when you visit the member's doctor.

To request an immunization card, contact CMDP Member Services at 602.351.2245, toll free, 1.800.201.1795, or by email, CMDPMemberServices@azdcs.gov.

Recommended Immunization Schedules

Caregivers in the State of Arizona are obligated to abide by the statutes governing the health of children placed in out-of-home care. Article 58, of the Arizona Administrative Code, R6-5-5830, Medical and Dental Care, states:

“A caregiver shall arrange for a foster child to have routine medical and dental care, which shall include an annual medical exam, semi-annual dental exams, immunizations and standard medical tests”.

Arizona law requires schoolchildren and childcare enrollees to be age-appropriately immunized. The exceptions and additions to the rules are:

- Biological parents whose religious beliefs do not allow immunizations must sign a religious exemption.
- The child’s doctor must sign a medical exemption form if there is evidence of immunity or a medical reason why the child cannot receive shots. A copy of the lab results must be kept on file to prove the child’s immunity.

It is the policy of the Department of Child Safety (DCS) that all children placed in out-of-home care are to be age-appropriately immunized except when:

- A parent objects based solely on religious grounds; or
- The immunization is medically contraindicated.

Immunization refusals for children placed in out-of-home care are addressed by the DCS Specialist, the Assistant Attorney General and the court of jurisdiction.

Vaccine reactions rarely happen. Serious reactions are very rare. The dangers of not being immunized are far worse than the possibility of serious reaction.

Vaccines are not just for babies. Children get most of their vaccines between birth and 4-6 years. Teenagers also need vaccines. Talk to your PCP about the vaccines needed.

For more information on vaccines and to review recommended immunization schedules, visit the Centers for Disease Control and Prevention at <https://www.cdc.gov/vaccines/schedules/easy-to-read/index.html> or contact CMDP Medical Services at 602.351.2245, toll free, 1.800.201.1795, or by email, CMDPNurse@azdcs.gov.

Note: The recommended immunization schedules are periodically changed by the Centers for Disease Control and Prevention. Discuss immunizations with the member’s PCP or doctor.

WOMEN’S HEALTH AND PREGNANCY SERVICES

It is very important for sexually active or age-appropriate female members to get a well-woman exam at least once a year. Well-woman exams assist providers to determine the appropriate preventative well care services.

Women’s health and pregnancy services include:

- PAP smear;
- Breast exam;
- Mammogram (when medically required);
- Vaccinations (including HPV vaccine); and
- Screening for sexually transmitted infections

Well-woman care is available from the PCP and often incorporated into the EPSDT or well check.

Female members have direct access to preventative care and well care services from a Gynecologist within the CMDP network, without a referral from a PCP.

Pregnancy/Maternity Care

CMDP covers maternity services for all members. Maternity services include:

- Identification of pregnancy;
- Prenatal care;
- Labor and delivery services;
- Postpartum care;
- Education and treatment of pregnancy-related conditions;
- Family planning education; and
- Prenatal testing including HIV testing and counseling.

If a member thinks she is pregnant, she should make an appointment with the PCP right away. The PCP can provide the names of Obstetricians (OB) for the member to choose.

CMDP pays for obstetric services. The OB provider monitors and treats pregnant women during pregnancy. The services include care during pregnancy, the delivery and post-partum or after-delivery care. It is recommended that members remain with the same OB provider for the entire pregnancy. If a member moves or has to change her OB provider for any reason, efforts are made to ensure communication between the OB providers so there is no interruption in care.

If the member is new to CMDP and has already been receiving care from an OB provider, the member can continue to see the same OB provider for care. If the OB provider is not registered with CMDP, efforts will be made to register the OB provider with CMDP so that the member can continue to see them.

The OB provider will see the member for regular checkups to make sure pregnancy is going well. Early health care and regular checkups during pregnancy are important to the health of the mother and baby.

The standards for appointment times for all pregnant members to see their OB provider are:

- First Trimester (the first 3 months of pregnancy), within 14 days of request;
- Second Trimester (the second 3 months of pregnancy), within 7 days of request;
- Third Trimester (the last 3 months of pregnancy), within 3 days of request;
- High Risk (having special needs that put the mother or the baby at risk of harm), within 3 days of request; and
- Emergency (when a member has to be seen immediately because of a crisis, like bleeding, etc.), immediately.

It is important for the member to keep all appointments with the OB provider including the postpartum visit. The postpartum visit is extremely important for the health of the new mother and should occur within 56 days after delivery.

If the member is having problems scheduling check-up appointments within the standard timeframes, contact Member Services at 602.351.2245, toll free, 1.800.201.1795, or by email, CMDPMemberServices@azdcs.gov.

Maternal Health Coordinators

CMDP Maternal Health Coordinators (MHC) are available to assist with needed services for pregnant members. The MHC works with the member and the DCS Specialist or custodial agency representative to ensure the member is getting prenatal care. The MHC ensures the OB provider offers the member the appropriate testing and screening during and after her pregnancy. This includes testing for HIV and screening for depression during and after the pregnancy. The MHC will also follow up with the DCS Specialist or custodial agency representative to coordinate care for services and counseling, as needed.

If you need assistance or have any questions regarding pregnancy and maternity care, contact Medical Services at 602.351.2245, toll free, 1.800.201.1795, or by email, CMDPNurse@azdcs.gov and request a Maternal Health Coordinator.

Sexually Transmitted Infections (STIs)

CMDP providers teach members about sexually transmitted infections (STIs) and how they are passed on to others. Additional counseling services are available in the event the test is positive. They also teach members how to prevent STIs. CMDP covers tests for STIs including HIV (the virus that causes AIDS).

If HIV testing is needed, the member must receive HIV testing counseling from a health care provider or from the local health department. Members 12 years old and older can request and consent for HIV testing. No other approval is needed. Members less than 12 years old must have approval from the caregiver, DCS Specialist or custodial agency representative. Approval can also come from a juvenile justice representative if the member is in the care and custody of Arizona Department of Juvenile Corrections (ADJC) or the Administrative Office of the Court/Juvenile Probation Office (AOC/JPO).

Human papillomavirus (HPV) Vaccine

Human papillomavirus (HPV) is a common virus. It can cause cancer of the cervix. The virus is spread through sexual contact. Often HPV has no symptoms. This makes it hard for someone to know they have it. It is important that both males and females get the HPV vaccine. They should get the vaccine before they are sexually active. This is when the vaccine can give the most protection.

FAMILY PLANNING SERVICES

Family planning services are available at no cost for both male and female members of reproductive age. Family planning services do not require a referral. Family planning services are often incorporated into the EPSDT or well check for age appropriate members. Members can

choose any AHCCCS registered doctor, clinic, hospital, pharmacy or family planning office to get family planning services.

Family planning services include:

- Education on how to prevent a pregnancy;
- Medications;
- Supplies (including diaphragms, condoms, foams, patches, and implanted birth control methods);
- Annual physical exams;
- Lab tests;
- Radiological exams related to family planning;
- Treatment of problems caused by the use of contraceptives, and
- Emergency oral contraception within 72 hours after unprotected sex.

The following services are NOT covered for the purpose of family planning:

- Infertility services;
- Pregnancy termination counseling;
- Pregnancy termination;
- Sterilization, and
- Hysterectomy.

Members wanting birth control should talk to their doctor. Physical exams and lab tests may be needed before starting birth control. Regularly scheduled check-up appointments may also be needed. Female members can see their PCP or choose a Gynecologist without a referral.

Medically Necessary Pregnancy Terminations

Pregnancy terminations are an AHCCCS covered service only in special situations. AHCCCS covers pregnancy termination if one of the following criteria is present:

1. The pregnant member suffers from a physical disorder, physical injury or physical illness including a life-endangering physical condition caused by, or arising from, the pregnancy itself that would, as certified by a physician, place the member in danger of death, unless the pregnancy is terminated.
2. The pregnancy is a result of incest.
3. The pregnancy is a result of rape.
4. The pregnancy termination is medically necessary according to the medical judgment of a licensed physician, who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or behavioral health problem for the pregnant member by:
 - a. Creating a serious physical or behavioral health problem for the pregnant member,
 - b. Seriously impairing a bodily function of the pregnant member,
 - c. Causing dysfunction of a bodily organ or part of the pregnant member,

- d. Exacerbating a health problem of the pregnant member, or
- e. Preventing the pregnant member from obtaining treatment for a health problem.

DENTAL CARE

Dental services include comprehensive dental care through primary prevention, early intervention, diagnosis, medically necessary treatment and follow-up care.

All CMDP members must have a full well visit and a dental visit within the first 30 days of removal and placement in out-of-home care.

CMDP members can choose a Primary Dental Provider (PDP) and Dental Home upon enrollment in CMDP. You can change the member's PDP/Dental Home at any time, for any reason. Some reasons to change a PCP and PDP are:

- If the member moves;
- If you or the member do not feel comfortable;
- If the office is far from you and the member, or
- If you or the member do not understand what the PCP says.

If you change the member's PDP, ask the current providers to transfer the member's medical records to the new PDP.

To request a change or to notify CMDP of a change, contact Member Services at 602.351.2245, toll free, 1.800.201.1795, or by email, CMDPMemberServices@azdcs.gov.

Tooth decay can occur at any age including in the baby teeth, so it is important to start dental care at an early age and continue regularly. CMDP members should start dental services by 1 year of age. This early visit is known as a well-baby checkup and establishes a Dental Home for future care. Regular dental checkups should occur every 6 months following the first visit. Checkups include dental cleaning and fluoride treatment to help ensure the long-term health of the child's teeth and gums.

An oral health screening is part of an EPSDT screening done by a PCP. Other providers can apply fluoride varnish to members who are at least 6 months of age, with at least one tooth eruption. The oral health screening at the EPSDT visit does NOT take the place of an exam by a dentist. The baby should still be seen by the dentist by 1 year of age.

Members do not need a referral for dental care and can see any dentist listed in the Provider Directory. To make, change or cancel a dental appointment, call the provider at least one day before the appointment. Some providers may attempt to charge a fee for a missed appointment. Arizona law states CMDP cannot pay for missed or no-show appointments.

GETTING PRESCRIPTIONS (MEDICINES)

CMDP covers medicines that are medically necessary, cost effective, and allowed by federal and state law. When a provider writes a prescription, it should be filled at a pharmacy that is registered

with AHCCCS and in the CMDP Pharmacy Network. Medically necessary over-the-counter medications are also covered with a prescription from the health care provider.

CMDP pharmacies are listed in the CMDP Provider Directory. Many pharmacies are open 24 hours, seven days a week. If you have questions regarding pharmacy services during or after business hours, call the pharmacy Member Helpline at 1.888.577.6310. The Pharmacy Member Helpline telephone number is also shown on the back of the CMDP Member ID card. If you are denied prescriptions at a pharmacy, you can call the Pharmacy Member Helpline or the provider who prescribed the medication for assistance.

CMDP has a Preferred Drug List (PDL). The PDL, or formulary, is a list of drugs approved by CMDP. Health care providers should refer to the PDL when prescribing drugs. For drugs not on the PDL, your provider will need a Prior Authorization (PA) from CMDP before you go to the pharmacy.

Prescriptions written by RBHA providers should be filled using the RBHA ID number, not the CMDP ID card.

Medicare Drug Coverage

For CMDP recipients with Medicare, CMDP does NOT pay for any drugs paid by Medicare Part D, or for the cost sharing (co-insurance, deductibles, and copayments) for these drugs.

Medicare Drug Coverage for Barbiturates and Benzodiazepines

CMDP does not pay for barbiturates to treat epilepsy, cancer, or mental health problems or any benzodiazepines for members with Medicare Part D. CMDP pays for barbiturates for Medicare members that are NOT used to treat epilepsy, cancer or chronic mental health conditions.

Pharmacy Restriction

CMDP evaluates the use of medications that have a potential for abuse or misuse. CMDP may restrict a member to using a specific pharmacy and/or prescriber, for up to a 12 month period, if the following criteria are met:

Evaluation Parameter	Minimum Criteria for Initiating Interventions
Over-utilization	Member utilized the following in a 3 month time period: > 4 prescribers; and > 4 different abuse potential drugs; and > 4 pharmacies. OR Member has received 12 or more prescriptions of the following medications in the past three months: <ul style="list-style-type: none"> • Atypical antipsychotics, • Benzodiazepines,

	<ul style="list-style-type: none"> • Hypnotics, • Muscle relaxants, • Opioids, and • Stimulants.
Fraud	Member has presented a forged or altered prescription to the pharmacy.

This does not apply to members who are in treatment for cancer, in hospice or in a skilled nursing facility.

BEHAVIORAL HEALTH SERVICES

Behavioral health issues are the most common health problems reported in children in out-of-home placements. If issues are not addressed, problems may arise resulting in long-term behavior problems. Services include Infant/Toddler Mental Health services as well as services for older children and teens.

Members can receive behavioral health coverage through an AHCCCS contracted Regional Behavioral Health Authority (RBHA) and/or CMDP.

Behavioral health services are delivered according to the following system principles:

- Easy access to care;
- Behavioral health recipient and family member involvement;
- Collaboration with the greater community;
- Effective innovation;
- Expectation for improvement, and
- Cultural competency.

The Twelve Principles for the Delivery of Services to Children:

1. Collaboration with the child and family:
 - a. Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes, and
 - b. Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.
2. Functional outcomes:
 - a. Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults, and
 - b. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.
3. Collaboration with others:

- a. When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented,
 - b. Client-centered teams plan and deliver services, and
 - c. Each child's team includes the child and parents and any foster parents, any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including, as appropriate, the child's teacher, the child's DCS and/or DDD caseworker, and the child's probation officer.
 - d. The team:
 - i. Develops a common assessment of the child's and family's strengths and needs,
 - ii. Develops an individualized service plan,
 - iii. Monitors implementation of the plan, and
 - iv. Makes adjustments in the plan if it is not succeeding.
4. Accessible services:
- a. Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need,
 - b. Case management is provided as needed,
 - c. Behavioral health service plans identify transportation the parents and child need to access behavioral health services, and how transportation assistance will be provided, and
 - d. Behavioral health services are adapted or created when they are needed but not available.
5. Best practices:
- a. Behavioral health services are provided by competent individuals who are trained and supervised,
 - b. Behavioral health services are delivered in accordance with guidelines that incorporate evidence-based "best practices."
 - c. Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children who are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, and the need for stability and the need to promote permanency in class member's lives, especially class members in foster care, and
 - d. Behavioral health services are continuously evaluated and modified if ineffective in achieving desired outcomes.
6. Most appropriate setting:
- a. Children are provided behavioral health services in their home and community to the extent possible, and
 - b. Behavioral health services are provided in the most integrated setting appropriate to the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's needs.
7. Timeliness:
- a. Children identified as needing behavioral health services are assessed and served promptly.

8. Services tailored to the child and family:
 - a. The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided, and
 - b. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.

9. Stability:
 - a. Behavioral health service plans strive to minimize multiple placements,
 - b. Service plans identify whether a class member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk,
 - c. Behavioral health service plans anticipate crises that might develop and include specific strategies and services that will be employed if a crisis develops,
 - d. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and the criminal justice system, and
 - e. Behavioral health service plans anticipate and appropriately plan for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services.

10. Respect for the child and family's unique cultural heritage:
 - a. Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family, and
 - b. Services are provided in Spanish to children and parents whose primary language is Spanish.

11. Independence:
 - a. Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self-management, and
 - b. Behavioral health service plans identify parents' and children's need for training and support to participate as partners in the assessment process, and in the planning, delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with understanding written materials, will be made available.

12. Connection to natural supports:
 - a. The behavioral health system identifies and appropriately utilizes natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

Behavioral health services include, but are not limited to:

- Behavior management (behavioral health personal assistance, family support, home care training, self-help, peer support);
- Behavioral health case management services (limited);

- Behavioral health nursing services;
- Behavioral health residential facilities/BHRFs (previously called Therapeutic Group Homes or TGHs);
- Behavior health therapeutic home care services (HCTCs sometimes called therapeutic foster care);
- Emergency behavioral health care;
- Emergency and non-emergency transportation;
- Evaluation and assessment;
- Individual, group, and family therapy and counseling;
- Inpatient hospital services;
- Non-hospital inpatient psychiatric facilities (Behavioral Health Inpatient Facilities/BHIFs previously called residential treatment centers or RTCs);
- Laboratory and radiology services for psychotropic medication regulation and diagnosis;
- Opioid agonist treatment;
- Partial care (supervised day program, therapeutic day program, and medical day program);
- Psychosocial rehabilitation (living skills training, health promotion, supportive employment services);
- Psychotropic medication, adjustment and monitoring
- Respite care;
- Rural substance abuse transitional agency services, and/or
- Behavioral health screening.

A PCP may treat members that have depression, anxiety, and attention deficit-hyperactivity disorders. The PCP can prescribe medications and perform medication-monitoring visits.

Behavioral health services are always recommended for children placed in out-of-home care to address their behavioral issues. This is especially important for children under six years of age. It is best practice to have a behavioral health medical professional, such as a psychiatrist, assess, evaluate, and monitor the unique behavioral health needs of children placed in out-of-home care.

All CMDP members have experienced trauma and should receive a rapid response service within 24 to 96 hours from removal and placement into out-of-home care. This service is to assess the member for any acute behavioral health needs they may have. Additionally, the member should have a behavioral health evaluation within 7 days of the rapid response service, and should begin receiving behavioral health services, if needed, within 21 days of the evaluation.

CMDP covers transportation to the evaluation and other behavioral health services until the Regional Behavioral Health Authority (RBHA) is assigned.

Regional Behavioral Health Authority (RBHA)

Most AHCCCS and KidsCare eligible CMDP members get behavioral health services, which include drug and alcohol abuse services, from the AHCCCS Regional Behavioral Health Authority (RBHA). Members are assigned to a RBHA when enrolled with CMDP. The assignment of a RBHA is based on the member's court of jurisdiction.

CMDP Member ID cards have a phone number to access behavioral health and substance abuse services. Services are assigned to a provider based on where the member lives. The RBHA will pay for most behavioral health services including prescriptions for behavioral health conditions.

Please do not use the CMDP ID card to pay for RBHA medications. CMDP does not cover this service. The RBHA is responsible for payment. Ask the RBHA provider which pharmacy to use, and give the member's RBHA ID number to the pharmacist.

Published information about Behavioral Health services and additional contacts can be located on the AHCCCS website:

<https://www.azahcccs.gov/Members/AlreadyCovered/MemberResources/Foster/>

If you would like to share any difficulties or appreciation obtaining Behavioral Health services, contact AHCCCS Clinical Resolution at 1-800-867-5808, or at dcs@azahcccs.gov

For information about Serious Mental Health (SMI) designation please contact your assigned RBHA.

Behavioral Health Information and Privacy

There are laws about who can see your behavioral health information with or without your permission. Substance abuse treatment and communicable disease information (for example, HIV/AIDS information) cannot be shared with others without your written permission.

At times, your permission is not needed to share your behavioral health information to help arrange and pay for your care. These times could include the sharing of information with:

- Physicians and other agencies providing health, social, or welfare services;
- Your medical primary care provider;
- Certain state agencies involved in your care and treatment, as needed; and
- Members of the clinical team involved in your care.

At other times, it may be helpful to share your behavioral health information with other agencies, such as schools. Your written permission may be required before your information is shared.

CHILDREN'S REHABILITATIVE SERVICES (CRS)

What is CRS?

Children's Rehabilitative Services (CRS) is a designation given to certain AHCCCS members who have qualifying health conditions. Members with a CRS designation can get the same AHCCCS covered services as non-CRS AHCCCS members and are able to get care in the community, or in clinics called Multispecialty Interdisciplinary Clinics (MSIC). MSICs bring many specialty providers together in one location. Your health plan will assist a member with a CRS designation with closer care coordination and monitoring to make sure special healthcare needs are met. Eligibility for a CRS designation is determined by the AHCCCS Division of Member Services (DMS).

Who is Eligible for a CRS Designation?

AHCCCS members may be eligible for a CRS designation when they are:

- Under age 21; and
- Have a qualifying CRS medical condition.

The medical condition must:

- Require active treatment; and
- Be found by AHCCCS DMS to meet criteria as specified in R9-22-1301-1305.

Anyone can fill out a CRS application including a family member, doctor, or health plan representative. To apply for a CRS designation mail or fax:

- A completed CRS application; and
- Medical documentation that supports that the applicant has a CRS qualifying condition that requires active treatment.

CMDP will provide medically necessary care for physical and health services and care for the CRS condition.

CMDP is responsible for screening, evaluating, and providing medical treatment and rehabilitation for members under the age of 18 with a Children's Rehabilitative Services (CRS) qualifying chronic and disabling condition(s) as defined in A.A.C. R9-22-1303. Members must also be AHCCCS (Title XIX) eligible to receive specialty care services.

Some CRS qualifying conditions include:

- Spina bifida;
- Heart conditions due to congenital defects/deformities;
- Cerebral palsy;
- Certain birth defects, cleft lip and/or palate;
- Club feet;
- Dislocated hips;
- Metabolic Disorders;
- Muscle and nerve disorders;
- Neurofibromatosis, and
- Sickle Cell Anemia.

When a member with a possible CRS qualifying condition is known, CMDP completes the CRS application process with the DCS Specialist or custodial agency representative. Evaluation and treatment for the member's CRS qualifying condition, and all other health care services, will be provided by CMDP.

Members with CRS qualifying diagnosis(es) are assigned to a Multi-Specialty Interdisciplinary Clinic (MSIC). MSICs are facilities where multiple providers in primary care, specialty care and behavioral health can meet with members and provide interdisciplinary services at the same location and appointment. The MSIC is where all the specialists can evaluate the member in a

coordinated manner to provide the best care. At the MSIC, you can meet face-to-face with the member's care team and receive medical services.

The services offered by MSICs include:

- Audiology for hearing and balance disorders;
- Cardiology for heart conditions due to congenital defects;
- Endocrinology for hormone conditions and hormone related diseases;
- ENT for conditions of the ear, nose and throat;
- Gastroenterology for conditions of the digestive tract;
- Genetics for conditions that can cause hereditary problems;
- Nephrology for conditions that affect the kidneys;
- Neurology for conditions that affect the brain, spine and nerves;
- Neurosurgery for surgical care for conditions that affect the brain, spine and nerves;
- Nutrition for counseling on nutrients in food and how the body uses nutrients;
- Occupational therapy for specialized help that supports independence with everyday activities;
- Ophthalmology for conditions that affects the health and structure of the eye;
- Orthopedics for conditions involving musculoskeletal system including congenital disorders;
- Pediatric surgery for infants, children and adolescents;
- Physical therapy for movement, exercise and massage that promote flexibility and function;
- Plastic surgery for surgical reconstruction or repair of body part to improve function;
- Psychology for study of the mind and behavior;
- Psychiatry for specialty care of behavioral health conditions including the use of medication;
- Rheumatology for conditions involving joints, muscles and ligaments such as arthritis;
- Scoliosis for condition that involves the spine curving to a specific side or degree;
- Speech and language therapy for rehabilitation of a person's use of language, feeding/swallow;
- Urology for conditions involving urinary tract;
- Child Life Specialists to promote coping skills through play for children and families dealing with hospitalization, illness or medical procedure;
- Patient and family services including social workers and patient advocates to provide members and their families with support, information and community resources.

To make, change or cancel the member's appointment at the MSIC, contact the member's assigned MSIC who will be able to help you. The MSICs and the services they offer are listed below:

<i>Central Region</i>	
DMG (District Medical Group) Children’s Rehabilitative Services <ul style="list-style-type: none"> • Specialty care • Primary care services • Expanded behavioral health services 	DMG Children’s Rehabilitative Services 3141 N 3rd Avenue Phoenix, AZ 85013 602-914-1520 1-855-598-1871 www.dmgaz.org
<i>South Region</i>	
Children’s Clinics for Rehabilitative Services <ul style="list-style-type: none"> • Specialty care • Primary care services • Expanded behavioral health services 	Children’s Clinics Square & Compass Building 2600 North Wyatt Drive Tucson, AZ 85712 520-324-5437 1-800-231-8261 www.childrensclinics.org
<i>North Region</i>	
Children’s Rehabilitative Services at Flagstaff Regional Medical Center <ul style="list-style-type: none"> • Specialty care 	Children’s Rehabilitative Services 1215 North Beaver Flagstaff, AZ 86001 928-773-2054 1-800-232-1018 https://nahealth.com/childrens-health-center/
<i>Southwest Region</i>	
Yuma Regional Medical Center Children’s Rehabilitative Services <ul style="list-style-type: none"> • Specialty care 	Children’s Rehabilitative Services Tuscany Medical Plaza 2851 S Avenue B, Suite 25 Yuma, AZ 85364 928-336-7095 or 1-800-837-7309 www.yumaregional.org/Medical-Services/Pediatric-Care/Pediatric-Sub-Specialty-Clinic/Children-s-Rehabilitation-Services

PRIOR AUTHORIZATION PROCESS

A Prior Authorization (PA) is the process by which your PCP or specialist contacts CMDP for approval to provide special services. It is up to the health care provider to get a PA from CMDP. CMDP reviews the service request from you or your PCP or specialist. Your doctor will tell you if the service is approved.

Normal authorization decisions are made within 14 calendar days from the date the request is received. Extensions of up to 14 calendar days can be granted if it is in the member’s best interest.

For example, we may be waiting to receive your medical records from your doctor. Instead of making a decision without those records, we may ask you if it's okay to get more time to receive the records. That way, the decision can be made with the best information. We will send you a letter asking for the extension.

Expedited (rush) decisions in urgent, life-threatening situations are made within 72 hours following the receipt of the authorization request unless an extension is in effect.

If the service has been denied, CMDP will send you a letter, called a Notice of Adverse Benefit Determination (NOA). You have the right to appeal the decision (see *Member Complaints* section of this handbook).

You can review a list of services that require prior authorization on the CMDP website at <https://dcs.az.gov/services/cmdp> (under Prior Authorization).

For more information on the PA process or to request the criteria used to make a PA decision, contact CMDP Medical Services at 602.351.2245, toll free, 1.800.201.1795, or by email, CMDPNurse@azdcs.gov.

Prior Approval for an Out-of-Network Provider

We recommend that you use providers registered with AHCCCS and CMDP. You can review a list of those providers from our Provider Network located on the CMDP website at <https://dcs.az.gov/services/cmdp>.

However, there may be times when the member needs care from a provider not listed on our network. If you would like to see a provider not registered with CMDP or AHCCCS, contact CMDP Member Services at 602.351.2245, toll free, 1.800.201.1795, or by email, CMDPMemberServices@azdcs.gov. We will contact the health care provider with information regarding the registration process.

IF YOU ARE BILLED

You are not responsible to pay out of pocket costs, including AHCCCS (Medicaid) co-payments. If you receive a bill, contact CMDP Member Services at 602.351.2245, toll free, 1.800.201.1795, or by email, CMDPMemberServices@azdcs.gov. We will contact the health care provider to address the billing problem.

Do not agree to pay for any services unless you have spoken to CMDP first or it is an emergency.

You may be billed if you ask for a non-covered service and agree in writing to pay for it before you get the service.

PLEASE NOTE: When the PCP writes a prescription for a medication that is not on the preferred drug list, an alternative generic medication may be available. If you insist on the medication when an alternative is available, you may be held responsible for payment of the medication.

CMDP should be listed as the responsible party on any forms you are asked to sign. Do not list your home address, phone number or Social Security Number on any bills or claims. If you are asked to sign any forms, please write the following information on the form:

(Your name) for DCS/CMDP
Send all bills or claims to:
DCS/CMDP C010-18
P.O. Box 29202
Phoenix, AZ 85038-9202

There are no payments, fees, or copayments for members. You should NOT be billed for any services that CMDP covers.

OTHER INSURANCE AND MEDICARE

CMDP is the payer of last resort for members with other health insurance. CMDP coordinates benefits with the other health insurance plans. Deductibles and co-pays are paid by CMDP. Caregivers and custodial agency representatives should notify Member Services in writing if a new member has other health insurance. This should be done at the time of enrollment or as soon as it is known.

Do not pay out of pocket costs for services. Ask the provider to bill CMDP.

Dual Eligibility

CMDP members who are eligible for Medicare and Medicaid (AHCCCS) services have dual eligibility. They may be classified as a Qualified Medicare Beneficiary (QMB) or as non-QMB eligible. QMB-eligible members receive coverage for all Medicaid services including inpatient psychiatric, psychological, respite and chiropractic services.

For dual eligible members, Medicare is the primary payer and CMDP is the secondary payer. CMDP is responsible for payment of coinsurance or deductibles. (In this instance, please call CMDP Member Services for instructions on submitting these charges for reimbursement.) CMDP members must use health care providers registered with AHCCCS and CMDP.

Medicare Drug Coverage

For CMDP recipients with Medicare, AHCCCS does not pay for any cost-sharing, coinsurance, deductibles, or copayments for medications that are eligible for coverage under Medicare Part D. AHCCCS may cover drugs that are excluded from coverage under Medicare Part D based on medical necessity. An excluded drug is a medication that is not eligible for coverage under Medicare Part D. AHCCCS may cover some medications that are Over-the-Counter, refer to the CMDP Over-the-Counter Drug List for a list of products available on our website at

https://dcs.az.gov/sites/default/files/CMDP_AdditionalListofDrugs.pdf or call Member Services to request a printed copy."

Prescription Drugs NOT Covered (Medicare Recipients)

CMDP does not pay for any medications paid by Medicare. We do not pay for any out of pocket costs for these medications. If you have questions about how to coordinate benefits between Medicare or your private insurance and CMDP, contact Member Services at 602.351.2245, toll free, 1.800.201.1795, or by email, CMDPMemberServices@azdcs.gov.

Medicare Drug Coverage for Barbiturates and Benzodiazepines

CMDP does not pay for barbiturates to treat epilepsy, cancer, or mental health problems or any benzodiazepines for members with Medicare Part D. CMDP pays for barbiturates for Medicare members that are **NOT** used to treat epilepsy, cancer or chronic mental health conditions.

MEMBER COMPLAINTS

A grievance is a complaint you want to file because you are not happy with health services received. Reasons to file a grievance could include:

- You or the member are not satisfied with the quality of care or services provided;
- You or the member experienced rudeness of a provider or employee, or
- You or the member's rights were not respected.

How to File a Grievance

A member or a custodial representative can file a grievance. A provider can file a grievance on the member's behalf, but only with the written consent of the member's authorized representative. A grievance can be filed at any time orally or in writing. To file a grievance, contact CMDP Member Services at 602.351.2245, toll free, 1.800.201.1795, fax 602.264.3801 or by email, CMDPMemberServices@azdcs.gov.

You can also write to us at:

Arizona Department of Child Safety
CMDP C010-18
Attention: Member Grievances
P.O. Box 29202
Phoenix, AZ 85038-9202

A determination is completed and a response provided no later than 90 days after the day CMDP received the grievance. A grievance determination/response cannot be appealed or be the subject of a hearing.

Corporate Compliance

It is the duty of each CMDP employee to make the right decision when encountering situations involving legal and ethical issues in their daily activity. If you would like to report, in good faith, concerns involving CMDP employees and potential fraud, unethical, illegal, or unacceptable practices or compliance violations, contact the CMDP Corporate Compliance Hotline.

The Corporate Compliance Hotline is a confidential voice mailbox available 24 hours a day, 7 days a week. All calls are kept confidential to the extent permitted by law. Callers may identify themselves or the call can be an anonymous report. The CMDP Compliance Officer will investigate all reports of improper conduct, and take action equitably and consistently. Reports can be made by calling the Corporate Compliance Hotline at 602-771-3555.

How to File an Appeal

An appeal is a request to review an adverse decision made by CMDP. An adverse decision is when CMDP:

- Denies the care requested;
- Decreases the amount of care;
- Ends care that has previously been approved; or
- Denies payment for care and you may have to pay for it.

You will know that CMDP has made an adverse decision because we will send you a letter. The letter is called a Notice of Adverse Benefit Determination (NOA). If you do not agree with the action, you may request an appeal by phone or in writing. The request must be made within 60 days from the date of the NOA. Information on how to file an appeal is provided in the NOA.

CMDP will make a final decision on appeals within 30 days of receiving a written or oral appeal. A letter will be mailed to the appellant (whomever filed the appeal), stating CMDP's decision and the reason for the decision.

Expedited Appeal

If you believe that the member's life or health could be in danger by waiting 30 days for CMDP's final decision on your appeal, you can request an expedited appeal. An expedited appeal is a faster review. The member's health care provider must provide documentation to support the request for an expedited appeal.

If we agree to make a faster decision, a decision will be made within 72 hours of receipt of the expedited appeal. If we deny your request for a faster decision, you will get a phone call with a follow-up letter in two working days. The follow-up letter will tell you that you will receive a decision in 30 calendar days.

Notice of Extension

Sometimes more information is needed to make an appeal decision. If a decision cannot be made in time, a 14 day extension may be requested. This can be done by the member, authorized custodial agency representative or CMDP.

Request for a State Fair Hearing

If the member or authorized representative disagrees with the final decision that CMDP has made on an appeal, a State Fair Hearing may be requested. The request for a State Fair Hearing must be made in writing to CMDP within 120 days from the date of the appeal decision.

CMDP will forward the case file and information to the AHCCCS Office of Administrative Legal Services (OALS). If the member or authorized representative has questions or needs more information regarding a State Fair Hearing, contact the CMDP Dispute and Appeal Manager at 602-351-2245 or 1-800-201-1795.

The member or authorized representative may request continuation of services while the appeal or state fair hearing is pending. Requests for continuation must be filed within 10 days after the date CMDP mailed the NOA or the effective date of the action as indicated in the NOA. You may be required to pay the cost of services if the appeal or state fair hearing is not resolved in your favor.

CMDP and our providers cannot discriminate against anyone exercising their appeal rights or if they are filing a grievance. If you have any questions or need more information, call the CMDP Dispute and Appeal Manager at 602-351-2245 or 1-800-201-1795, or write to:

Arizona Department of Child Safety
CMDP C010-18
Attention: Dispute and Appeal Manager
P.O. Box 29202
Phoenix, AZ 85038-9202

MEMBERS' RIGHTS

CMDP members and caregivers have the right to be treated with respect and consideration when receiving health care services they need and deserve.

Members and caregivers have the following rights:

- Right to receive information about CMDP, the services CMDP provides, the CMDP provider network and the CMDP provider directory at no charge.
- Right to not be discriminated against in the delivery of health care services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.
- Right to services provided in a culturally competent manner, with consideration for members with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds as well as members with visual or auditory limitation at no cost.
- Right to know about providers who speak languages other than English.

- Right to use any hospital or other setting for emergency care [42 CFR 457.1207, 42 CFR 438.10]
- Right to be treated fairly regardless of race, ethnicity, national origin, religion, gender, age, age, behavioral health condition (intellectual) or physical disability, sexual preference, genetic information, or ability to pay.
- Right to choose a primary care provider (PCP) and primary dental provider (PDP) within the limits of the provider network, and choose other providers as needed from among those affiliated with the network; this also includes the right to refuse care from specified providers.
- Right to a second opinion from a qualified health care professional registered with AHCCCS at no cost to the member.
- Right to receive information on available treatment options and alternatives, in a manner appropriate to the member condition and ability to understand.
- Right to review his/her medical records in accordance with applicable federal and state laws.
- Right to request annually and receive at no cost a copy of his/her medical records as specified in 45 CFR 164.524. The member's right of access to inspect and obtain a copy of his/her medical records may be denied if the information is:
 - Psychotherapy notes;
 - Information compiled for, or in reasonable anticipation of, a civil, criminal or administrative action; or
 - Protected health information that is subject to the Federal Clinical Laboratory Improvements Amendments of 1988, or exempt pursuant to 42 CFR 493.3(a)(2). An individual may be denied access to read or receive a copy of medical record information without an opportunity for review in accordance with 45 CFR Part 164 (above) if:
 - The information meets the criteria stated above;
 - The provider is a correctional institution or acting under the direction of a correctional institution as defined in 45 CFR 164.501;
 - The information is obtained during the course of current research that includes treatment and the member agreed to suspend access to the information during the course of research when consenting to participate in the research;
 - The information was compiled during a review of quality of care for the purpose of improving the overall provision of care and services;
 - The denial of access meets the requirements of the Privacy Act, 5 U.S.C. 552a; or
 - The information was obtained from someone other than a health care provider under the protection of confidentiality, and access would be reasonably likely to reveal the source of the information.
- Right to seek review if access to inspect or request to obtain a copy of medical record information is denied when:
 - A licensed health care professional has determined the access requested would reasonably be likely to endanger the life or physical safety of the member or another person; or

- The protected health information refers to another person and access would reasonably be likely to cause substantial harm to the member or another person. CMDP must respond within 30 days to the member's request for a copy of the records, the response may be the copy of the record or, if necessary to deny the request, the written denial must include the basis for the denial and written information about how to seek review of the denial in accordance with 45 CFR Part 164.
- Right to amend or correct his/her medical records as specified in 45 CFR 164.526 (CMDP may require the request be made in writing).
- Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
- Right to get information on beneficiary and plan information;
- Right to be treated with respect and with recognition of the member's dignity and need for privacy; the right to privacy includes protection of any identifying information except when otherwise required or permitted by law;
- Right to know that coordination of care with schools and state agencies may occur, within the limits of applicable regulations.
- Right to participate in decisions regarding his or her health care, including the right to refuse treatment (42 CFR 438.100), and/or have a representative facilitate care or treatment decisions when the member is unable to do so;
- Right to receive information, in a language and format that the member understands, about member rights and responsibilities, the amount, duration and scope of all services and benefits, service providers, services included and excluded as a condition of enrollment, and other information including:
 - Provisions for after-hours and emergency health care services, which includes the right to access emergency health care services from a provider without prior authorization, consistent with the member's determination of the need for such services as prudent;
 - Information about available treatment options (including the option of no treatment) or alternative courses of care;
 - Procedures for obtaining services, including authorization requirements and any special procedures for obtaining mental health and substance abuse services, or referrals for specialty services not furnished by the member's PCP;
 - Procedures for obtaining services outside the CMDP provider network;
 - Provisions for obtaining AHCCCS covered services that are not offered or available through CMDP, and notice of the right to obtain family planning services from an appropriate AHCCCS registered provider, and
 - A description of how CMDP evaluates new technology for inclusion as a covered benefit.
- Right to request information regarding if CMDP has physician incentive plans that affect referral from doctors;
- Right to know about the type of compensation arrangements with providers, whether stop-loss insurance is required of providers and the right to review member survey results;
- Right to request information on the structure and operation of CMDP or CMDP's contractors (42 CFR 438.10(g)(3)(i));
- Right to the criteria used as a basis for decisions

- Right to receive information regarding grievances, appeals and requests for a hearing about CMDP or the care provided.
- Right to request a state fair hearing after CMDP has made an adverse determination
- Right to file grievances and appeals
- Right to receive assistance filing grievances and appeals
- Right to file a complaint to CMDP about inadequate Notice of Adverse Determination letters or any aspect of CMDP's service.
- Right to file a complaint with AHCCCS, Division of Health Care Management, Medical Management Unit at medicalmanagement@azahcccs.gov, if CMDP does not resolve the complaints about the Notice of Adverse Benefit Determination Letter to the member's satisfaction.
- Right to contact Member Services if there are any questions regarding member rights.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

The privacy of our members' medical information is very important to us. We want to keep member information private and confidential. CMDP verifies the identity of all incoming callers before releasing any information. Our Member Services staff will only give information to the member's custodial agency representative, the member's caregiver and/or the member. Any other callers requesting information are referred to the member's custodial agency representative for further assistance.

The Health Insurance Portability and Accountability Act (HIPAA) affects health care in several ways. CMDP is required to have safeguards for protecting members' health information. This applies to all health care providers and other stakeholders.

A member's Protected Health Information (PHI) may be used for treatment, payment and health plan operations and as permitted by law. The member or the legal guardian must give written approval for any non-health care uses of PHI.

CMDP provides a notice of members' rights and responsibilities on the use, disclosure and access to PHI. It is called the "Notice of Privacy Practices" (NPP). The NPP is sent to the member's custodial agency representative. It is also included in the New Member Packets. The CMDP Privacy Officer can explain the NPP and answer questions about HIPAA. For assistance from the CMDP Privacy Officer, call 602-351-2245 or 1-800-201-1795 and ask to speak to the Privacy Officer.

FRAUD, ABUSE AND WASTE

Fraud is defined in federal law and described as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable State or Federal law. [42 CFR 455.2].

Abuse is defined in federal law and described as provider practices that are inconsistent with sound fiscal, business, or medical practices and result in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. [42 CFR 455.2].

Waste is defined in federal law and described as over-utilization or inappropriate utilization of services, misuse of resources, or practices that result in unnecessary costs to the Medicaid program.

An example of provider fraud and abuse is a doctor billing for services that were not given to the member or services that the member did not need. An example of member fraud and abuse is loaning, giving or selling CMDP ID cards to others. Fraud and abuse are subject to penalty under law.

If you have been made aware of fraud, waste and abuse or if you feel fraud or abuse has occurred, contact Member Services immediately at 602.351.2245, toll free, 1.800.201.1795, or by email, CMDPMemberServices@azdcs.gov. You can also make an anonymous report to the CMDP Corporate Compliance Hotline at 602.771.3555.

TOBACCO CESSATION

There are products that can help CMDP members to stop using tobacco. CMDP will pay for these products if the doctor writes a prescription. This includes over-the-counter products and products like Nicotine replacement treatment. Members may also call the Arizona Smokers Helpline (ASH) at 1-800-556-6222 at no cost. This phone service helps people to quit smoking. Other information about tobacco cessation, treatment care and services can be found at on the Arizona Department of Health Services website at <https://www.azdhs.gov/prevention/tobacco-chronic-disease/tobacco-free-az/index.php>.

COMMUNITY RESOURCES

Supplemental Nutrition Program for Women, Infants and Children (WIC)

The Supplemental Nutrition Program for Women, Infants and Children (WIC) serves to safeguard the health of women, infants and children up to the age of 5 who are at risk nutritionally. CMDP members qualify for WIC services. WIC provides many family services and many nutritious foods to supplement diets. They also give information on healthy eating and referrals for health care. WIC provides services to pregnant, breastfeeding or post-partum women, as well as children under 5 years. Coverage for the mother lasts for 6 months after pregnancy if not breastfeeding. They cover for 1 year if breastfeeding. WIC's toll-free number is 1.800.252.5942. Additional information can also be found on the Arizona Department of Health Services website at <https://www.azdhs.gov/prevention/azwic/index.php>.

Head Start

Head Start and Early Head Start are child development programs that serve children from birth to age 5, pregnant women and their families. They have the overall goal of increasing school readiness of young children in low-income families. Children in out-of-home care are given preference to participate in Head Start programs. For more information on Head Start, call 1.866.763.6481 or visit their website at www.azheadstart.org.

The Arizona Early Intervention Program (AzEIP)

The Arizona Early Intervention Program (AzEIP) is a statewide system of programs and services. AzEIP is designed to provide support for families of infants and toddlers, newborn to 3 years old,

with disabilities or delays. The goal is to help these children reach their full potential. A newborn to 3-year-old child who is the victim of abuse or neglect can get an AzEIP evaluation. For more information on the AzEIP program, call 602.532.9960, toll free 1.888.439.5609 or visit the website at www.azdes.gov/azeip/.

Area Agency on Aging

The Area Agency on Aging is a statewide system of programs, services and advocacy to support adults aged 60 and older, adults aged 18 and older with HIV/AIDS, disabilities, long-term care needs. To find your local office, visit their website at <https://des.az.gov/services/aging-and-adult/aging-and-disability-services/area-agency-aging>.

Alzheimer's Association

Alzheimer's Association is a statewide system of information and resources for those living with or caring for someone with Alzheimer's or other dementias. For more information, call their toll free, 24/7 Helpline at 1.800.272.3900 or visit their website for resources in your area, <https://www.alz.org/dsw>

Mentally Ill Kids in Distressed (MIKID)

Mentally Ill Kids in Distressed (MIKID) is a statewide non-profit organization serving children and families with mental health needs through family support, community education and support groups. To find a location close to you, click on <http://www.mikid.org/locations/> or contact the Phoenix office at 602.253.1240 for assistance.

AZ Suicide Prevention Coalition

AZ Suicide Prevention Coalition is a statewide non-profit organization whose mission is to change those conditions that result in suicidal acts in Arizona through awareness, intervention and action. Coalition meetings are held the second Tuesday of every odd month. Please email AZSPC@gmail.com for more information.

National Alliance on Mental Illness (NAMI)

The NAMI is a National grassroots organization dedicated to advocating for quality treatment for persons with mental illness, promoting community support programs, and serving as a center within Arizona for the collection and dissemination of information. Check their website at <http://www.namiarizona.org/> for a local affiliate near you.

Raising Special Kids (RSK)

A statewide non-profit organization whose mission to improve the lives of children with the full range of disabilities or special health care needs, from birth to age 26, by providing support, training, information and individual assistance so families can become effective advocates for their children. To find a location close to you, click on <http://www.raisingpecialkids.org> or contact the Phoenix office at 602-242-4366, toll free 800-237-3007 for assistance.

Dump the Drugs AZ

To locate a drop-box for disposing of unwanted medications, click on <https://www.azdhs.gov/gis/dump-the-drugs-az/>.

Additional resources for treating obesity and nutritional information include: Nutrition, Physical Activity and Obesity (NUPAO) at www.azdhs.gov/phs/bnp/nupao/ and Arizona Nutrition Network at www.eatwellbewell.org/.

You can also contact CMDP Member Services at 602.351.2245, toll free, 1.800.201.1795, or by email, CMDPMemberServices@azdcs.gov, for help getting services from any of these programs.

Teen Lifeline

Teen Lifeline is a safe, confidential, crucial crisis service where teens help teens make healthy decisions through a 24-hour peer counseling crisis hotline and suicide prevention services.

602-248-8336 (TEEN) or Statewide in Arizona 800-248-8336 (TEEN)
<https://teenlifeline.org/>

National Suicide Prevention Hotline

The National Suicide Prevention Lifeline is a United States-based suicide prevention network of 161 crisis centers that provides a 24/7, toll-free hotline available to anyone in suicidal crisis or emotional distress.

1-800-273-8255
<https://suicidepreventionlifeline.org/>

Additional Resources

www.healtharizonaplus.gov
www.azlinks.gov

All Medicaid eligible CMDP members are transitioned to another AHCCCS health plan when their CMDP coverage ends.

Members who are not Medicaid eligible may access primary and preventative care at no or low cost. 2-1-1 Arizona provides information and referral services for general health and dental services available statewide.

- Website:
<https://211Arizona.org>
- By Phone
 - 2-1-1 within Arizona
 - 877-211-8661 from anywhere
 - 02-263-0979 Fax
 - 7-1-1 or 800-367-8939 TDD (Arizona Relay)
- By Mail
 - 1275 W Washington St. Ste 102
 - Tempe AZ 85281-1859

MEMBER ADVOCATES

An advocate is anyone who supports and promotes the rights of the member. Listed below are advocates for children and youth placed in out-of-home care:

- Member's PCP or doctor
- DCS Specialist and the Supervisor or the Program Manager.
- Member's Juvenile Justice Probation or Parole Officer.
- Assistant Attorney General (AAG) assigned to the member's case.
- The Arizona Center for Disability Law: a non-profit public interest law firm dedicated to protection and advocacy of individuals with disabilities. For more information, visit their website at <https://www.azdisabilitylaw.org/> or call Phoenix, 602.274.6287/toll free 1.800.927.2260, and Tucson 520.327.9547/ toll free 1-800-922-1447.
- The Arizona Ombudsman-Citizens Aide: if you feel you have been treated unfairly by a state administrator, if you find yourself in a disagreement or dispute with a state agency or department contact the ombudsman-citizen aide at 602.277.7292; toll free 1.800.872.2879.
- National Alliance on Mental Illness (NAMI): a National grassroots organization dedicated to advocating for quality treatment for persons with mental illness, promoting community support programs, and serving as a center within Arizona for the collection and dissemination of information. Check their website at <http://www.namiarizona.org/> for a local affiliate near you.
- Arizona Coalition to End Sexual and Domestic Violence: a helpline for information and answers to questions relating to Sexual and Domestic Violence Services in Arizona including the legal system, your legal rights, resources and referral and safety planning. Visit their website at <http://www.azcadv.org/>. The Sexual and Domestic Violence Services Helpline can be reached via (602) 279-2900, toll-free 1 (800) 782-6400, and TTD/TTY (602) 279-7270. Or email INFO@acesdv.org

GLOSSARY

Appeal: To ask for review of a decision that denies or limits a service.

Copayment: Money a member is asked to pay for a covered health service, when the service is given.

Durable Medical Equipment: Equipment and supplies ordered by a health care provider for a medical reason for repeated use.

Emergency Medical Condition: An illness, injury, symptom or condition (including severe pain) that a reasonable person could expect that not getting medical attention right away would:

- Put the person's health in danger; or
- Put a pregnant woman's baby in danger; or
- Cause serious damage to bodily functions; or
- Cause serious damage to any body organ or body part.

Emergency Medical Transportation: See Emergency Ambulance Services

Emergency Ambulance Services: Transportation by an ambulance for an emergency condition.

Emergency Room Care: Care you get in an emergency room.

Emergency Services: Services to treat an emergency condition.

Excluded Services: See Excluded

Excluded: Services that AHCCCS does not cover. Examples are services that are:

- Above a limit,
- Experimental, or
- Not medically needed.

Grievance: A complaint that the member communicates to their health plan. It does not include a complaint for a health plan's decision to deny or limit a request for services.

Habilitation Services and Devices: See Habilitation

Habilitation: Services that help a person get and keep skills and functioning for daily living.

Health Insurance: Coverage of costs for health care services.

Home Health Care: See Home Health Services

Home Health Services: Nursing, home health aide, and therapy services; and medical supplies, equipment, and appliances a member receives at home based on a doctor's order.

Hospice Services: Comfort and support services for a member deemed by a Physician to be in the last stages (six months or less) of life.

Hospital Outpatient Care: Care in a hospital that usually does not require an overnight stay.

Hospitalization: Being admitted to or staying in a hospital.

Medically Necessary: A service given by a doctor, or licensed health practitioner that helps with health problem, stops disease, disability, or extends life.

Network: Physicians, health care providers, suppliers and hospitals that contract with a health plan to give care to members.

Non-Participating Provider: See Out of Network Provider

Out of Network Provider: A health care provider that has a provider agreement with AHCCCS but does not have a contract with your health plan. . You may be responsible for the cost of care for out-of-network providers.

Participating Provider: See In-Network Provider

In-Network Provider: A health care provider that has a contract with your health plan.

Physician Services: Health care services given by a licensed physician.

Plan: See Service Plan

Service Plan: A written description of covered health services, and other supports which may include:

- Individual goals;
- Family support services;
- Care coordination; and
- Plans to help the member better their quality of life.

Preauthorization: See Prior Authorization

Prior Authorization: Approval from a health plan that may be required before you get a service. This is not a promise that the health plan will cover the cost of the service.

Premium: The monthly amount that a member pays for health insurance. A member may have other costs for care including a deductible, copayments, and coinsurance.

Prescription Drug Coverage: Prescription drugs and medications paid for by your health plan.

Prescription Drugs: Medications ordered by a health care professional and given by a pharmacist.

Primary Care Physician: A doctor who is responsible for managing and treating the member's health.

Primary Care Provider (PCP): A person who is responsible for the management of the member's health care. A PCP may be a:

- Person licensed as an allopathic or osteopathic physician, or
- Practitioner defined as a physician assistant licensed or
- Certified nurse practitioner.

Provider: A person or group who has an agreement with AHCCCS to provide services to AHCCCS members.

Rehabilitation Services and Devices: See Rehabilitation

Rehabilitation: Services that help a person restore and keep skills and functioning for daily living that have been lost or impaired.

Skilled Nursing Care: Skilled services provided in your home or in a nursing home by licensed nurses or therapists.

Specialist: A doctor who practices a specific area of medicine or focuses on a group of patients.

Urgent Care: Care for an illness, injury, or condition serious enough to seek immediate care, but not serious enough to require emergency room care.

Maternity Care

Certified Nurse Midwife (CNM) is certified by the American College of Nursing Midwives (ACNM) on the basis of a national certification examination and licensed to practice in Arizona by the State Board of Nursing. CNMs practice independent management of care for pregnant women and newborns, providing antepartum, intrapartum, postpartum, gynecological, and newborn care, within a health care system that provides for medical consultation, collaborative management, referral, or management.

Free Standing Birthing Centers are Out-of-hospital, outpatient obstetrical facilities, licensed by the ADHS and certified by the Commission for the Accreditation of Free Standing Birthing Centers. These facilities are staffed by registered nurses to provide assistance with labor and delivery services. They are equipped to manage uncomplicated, low-risk labor and delivery. These facilities shall be affiliated with, and in close proximity to, an acute care hospital for the management of complications, should they arise.

High-risk pregnancy refers to a pregnancy in which the mother, fetus, or newborn is, or is anticipated to be, at increased risk for morbidity or mortality before or after delivery. High risk is determined through the use of the Medical Insurance Company of Arizona (MICA) or American College of Obstetricians and Gynecologists (ACOG) standardized medical risk assessment tools.

Licensed Midwife means an individual licensed by the Arizona Department of Health Services to provide maternity care pursuant to Arizona Revised Statutes (A.R.S.) Title 36, Chapter 6, Article 7 and Arizona Administrative Code Title 9, Chapter 16 (This provider type does not include certified nurse midwives licensed by the Board of Nursing as a nurse practitioner in midwifery or physician assistants licensed by the Arizona Medical Board).

Maternity care includes identification of pregnancy, prenatal care, labor/delivery services, and postpartum care.

Maternity care coordination consists of the following maternity care related activities: determining the member's medical or social needs through a risk assessment evaluation; developing a plan of care designed to address those needs; coordinating referrals of the member to appropriate service providers and community resources; monitoring referrals to ensure the services are received; and revising the plan of care, as appropriate.

Maternity Services include, but are not limited to, medically necessary preconception counseling, identification of pregnancy, medically necessary education and prenatal services for the care of pregnancy, the treatment of pregnancy-related conditions, labor and delivery services, and postpartum care.

Perinatal Services are Medical services for the treatment and management of obstetrical patients and neonates (A.A.C. R9-10-201).

Postpartum refers to the period beginning the day of parturition and ends the last day of the month in which the 57th day following parturition occurs.

Postpartum care is the health care provided for a period of up to 60 days post-delivery. Family planning services are included if provided by a physician or practitioner, as addressed in the AHCCCS Medical Policy Manual

Practitioner refers to certified nurse practitioners in midwifery, physician's assistants and other nurse practitioners. Physician's assistants and nurse practitioners are defined in A.R.S. Title 32, Chapters 25 and 15 respectively.

Preconception counseling services, as part of a well woman visit, are provided when medically necessary. This counseling focuses on the early detection and management of risk factors before pregnancy, and includes efforts to influence behaviors that can affect a fetus (even before conception is confirmed), as well as regular health care. The purpose of preconception counseling is to ensure that a woman is healthy prior to pregnancy. Preconception counseling does not include genetic testing.

Prenatal care is the health care provided during pregnancy and is composed of three major components:

- Early and continuous risk assessment
- Health education and promotion, and
- Medical monitoring, intervention, and follow-up.

NON DISCRIMINATION NOTICE

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at 602-542-0419; TTY/TDD Services: 7-1-1. Free language assistance for DCS services is available upon request. Disponible en español en línea o en la oficina local.



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