100-D DEFINITIONS

REVISION DATE: 5/24/2021, 7/3/2015, 9/1/2014
EFFECTIVE DATE: June 30, 1994
REFERENCES: A.R.S. §§ 36- 29, 36-553, 36-2901, 36-2904, 36-2931, 36-3401; A.A.C. R9-22-101, R6-6-903, R9-22-1201(w).

1115 Waiver – The 1115 Waiver refers to section 1115 of the Social Security Act (SSA). States must comply with Title XIX (Medicaid) and Title XXI (Children's Health Insurance Program) of the SSA. Since Arizona began providing Medicaid on October 1, 1982, the Arizona Health Care Cost Containment System (AHCCCS) has been exempt from specific provisions of the SSA, pursuant to an 1115 Research and Demonstration Waiver. The 1115 Waiver specifies provisions in the SSA and corresponding regulations AHCCCS is exempt from; terms and conditions that AHCCCS must fulfill; and approved federal budget amounts. (Arizona Section 1115 Demonstration Project Waiver).

Arizona Administrative Code (A.A.C.) - The Arizona Administrative Code is a publication of the official rules of the State of Arizona. Rules are adopted by state agencies, boards or commissions, with specific rulemaking authority from the State Legislature. Rule sections are published in Titles and Chapters.

Arizona Developmental Disabilities Planning Council (ADDPC) –The ADDPC works to support advocacy, bring about systems change and create increased capacity to support persons with developmental disabilities in the community. The ADDPC was established pursuant to Public Law 106-402, also known as the Developmental Disabilities Assistance and Bill of Rights Act of 2000. Pursuant of an Executive Order by the Governor of the State of Arizona on September 3, 2009, the Council was created. Council members are appointed by the Governor of Arizona.

Arizona Health Care Cost Containment System (AHCCCS) – The single State Medicaid agency, as described in A.R.S. § Title 36, Chapter 29, Arizona Medicaid Agency. AHCCCS is composed of the AHCCCS Administration, Contractors and other arrangements through which health care services (acute, long-term care, and behavioral) are provided to members.

Arizona Long Term Care System (ALTCS)- An AHCCCS program which delivers long term, acute, behavioral health care, and case management services as authorized by A.R.S. § 36-2931 *et seq*, to eligible members who are either elderly and/or have physical disabilities and to members with developmental disabilities, through contractual agreements and other arrangements.

Arizona Long Term Care System (ALTCS) Contractor- A contracted managed care organization (also known as a Program Contractor), that provides long term care, acute care, behavioral health and case management services to Title XIX eligible individuals who are either elderly and/or who have physical or developmental disabilities who are determined to be at immediate risk of institutionalization.

Arizona Revised Statute (A.R.S. §) - Laws of the State of Arizona.

Assistant Director Approval – Includes approval from the Assistant Director's designee.

Centers for Medicare and Medicaid Services (CMS) – An organization within the United States Department of Health and Human Services that administers the Medicare and Medicaid programs and the State Children's Health Insurance Program (known as KidsCare in Arizona).

Code of Federal Regulations (CFR) - The general and permanent rules published in the Federal Register by the departments and agencies of the federal government.

Comprehensive Health Plan (CHP) - The Comprehensive Health Plan (CHP) is a health care program for Arizona's children who are wards of the court and placed out of home. Eligibility is based on State law. Department of Child Safety (DCS) coordinates services related to CHP.

Contractor - An organization, person, or entity that has a prepaid capitated contract with AHCCCS pursuant to A.R.S. § 36-2904 to provide goods and services to members, either directly or through subcontracts with providers, in conformance with contractual requirements, AHCCCS statutes and rules, and federal law and regulations.

Developmental Disabilities Advisory Council (DDAC) – Advisory Council to the Division of Developmental Disabilities whose duties have been established by A.R.S. § 36-553 whose voting members are also appointed by the Governor of Arizona.

Direct Care Worker – A person who assists individuals with activities necessary to allow them to reside in their home. These workers may also be known as Direct Support Professionals.

Durable Medical Equipment (DME) – An item or appliance that is not an orthotic or prosthetic; is designed for medical purpose; is generally not useful to a person in the absence of an illness or injury; can withstand repeated use; and, is generally reusable by others.

Durable Medical Equipment (DME), Customized - Equipment that has been altered or built to specifications unique to a member's medical needs and which, most likely, cannot be used or reused to meet the needs of another individual.

Fee-For-Service (FFS) - A method of payment to an AHCCCS registered provider on an amount-per-service basis.

Focus – The automated web-based system used to maintain information on each member eligible for the Division.

Home and Community Based Services (HCBS) - Services provided, in lieu of institutionalization, to ALTCS members who reside in their own home or in an ALTCS approved home and community based alternative residential setting in order to maintain the member's highest level of functioning. Members enrolled in the ALTCS Transitional Program also receive HCBS.

Home Program – The Home Program provides for specific activities for the member to do with their families/caregivers during the course of their daily activities to enhance progress towards the chosen treatment goals.

Human Rights Committee (HRC) – This Committee provides independent oversight to monitor and ensure the civil and human rights for persons with developmental disabilities as guaranteed in the U.S. Constitution, federal law regulations, and the Arizona Revised Statutes.

Institutional Settings – Means a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF).

Medically Necessary - As defined in A.A.C. R9-22-101, medically necessary means a covered service provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability or other adverse conditions or their progression, or to prolong life.

Member – A person enrolled with the Division of Developmental Disabilities.

Planning Document – A plan which is developed by the Planning Team, such as an Individualized Family Service Plan (IFSP), Individualized Support Plan (ISP), and Person Centered Plan (PCP).

Primary Care Provider (PCP) - An individual who meets the requirements of A.R.S. § 36-2901, and who is responsible for the management of the member's health care. A PCP may be a physician defined as a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17, or a practitioner defined as a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a nurse practitioner licensed under A.R.S. Title 32, Chapter 15. The PCP must be an individual, not a group or association of persons, such as a clinic.

Prior Authorization (PA) – Process by which the Division approves a service.

Program Review Committee (PRC) – As defined in agency rules at A.A.C. R6-6 903, the PRC is an assembly designated by the District Program Manager that reviews any behavior treatment plans which meet the criteria also outlined in the same rules. The PRC approves plans, or makes recommendations for changes as necessary.

Regional Behavioral Health Authority (RBHA) – As defined in A.R.S. § 36-3401, the RBHA is an organization under contract with the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) to administer covered behavioral health services in a geographically specific service area of the state. Tribal governments, through an agreement with the ADHS/DBHS, may operate a Tribal Regional Behavioral Health Authority (TRBHA), as defined in A.A.C. R9-22-1201(w), for the provision of behavioral health services to American Indian members living on-reservation. Through an intergovernmental agreement with ADHS/DBHS, the Division is responsible for all behavioral health services provided to members eligible for ALTCS.

Service Plan Year – The annual period of time beginning at the member's "ISP Start Date" as identified in Focus through the "ISP End Date" as identified in Focus.

Title XIX - Known as Medicaid, Title XIX of the Social Security Act provides for federal funds to the states for medical assistance programs.

200 BEHAVIORAL HEALTH PRACTICE TOOLS

210 WORKING WITH THE BIRTH THROUGH FIVE POPULATION

EFFECTIVE DATE: May 4, 2022

REFERENCES: AMPM Chapter 200, A.R.S. §13-3620, A.A.C. R9-20-205

PURPOSE

This policy applies to the Division of Developmental Disabilities (Division) and the system of care for behavioral health services for members enrolled with Medicaid. This policy is an optional resource for the Tribal Health Program; it is not a requirement. The policy is designed to strengthen the capacity of Arizona's Behavioral Health System in response to the unique needs of children age birth through five and emphasizes early intervention through the use of clinical assessment, service planning and treatment, all of which focus on identification of situations that may potentially impede infants'/toddlers' ability to:

1. Form close parent/caregiver relationships with those in the child's environment (these may be long term or temporary, familial, or non-familial),
2. Experience, regulate and express their emotions, and
3. Explore their environment in an accessible manner.

DEFINITIONS

Assessment (Behavioral Health) means the ongoing collection and analysis of an individual's medical, psychological, psychiatric, and social conditions in order to initially determine if a health disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensure that the individual's service plan is designed to meet the individual's (and family's) current needs and long-term goals.

Child and Family Team (CFT) means a group of individuals that includes, at a minimum, the child and their family, or Health Care Decision Maker (HCDM). A behavioral health representative, and any individuals important in the child's life that are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches, and community resource providers, representatives from churches, temples, synagogues, mosques, or other places of worship/faith, agents from other service systems like the Arizona

Department of Child Safety (DCS) or the Division of Developmental Disabilities (DDD). The size, scope, and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore, expand and contract as necessary to be successful on behalf of the child.

Service Plan means a complete written description of all covered health services and other informal supports which includes individualized goals, family support services, peer and recovery support, care coordination activities and strategies to assist the member in achieving an improved quality of life.

POLICY

A. TARGET AUDIENCE

This policy is specifically targeted to the Division's Behavioral Health Administration in relation to their role with oversight of the AdSS and the role of Support Coordination. While the Division delegates the responsibility to AdSS for the implementation of behavioral health services in alignment with this practice tool, the Division remains responsible for case management (Support Coordination) and oversight of the AdSS. Support Coordination shall receive training on the practices outlined in this tool for purposes of increasing their ability to coordinate services for their members. The Division shall conduct formal oversight of the AdSS.

Refer to AdSS Medical Policy 210 for the roles and responsibilities of the AdSS and their subcontracted network, and provider agency behavioral health staff who complete assessments, participate in the service planning process, provide therapy, case management, and other clinical services.

B. TARGET POPULATION(S)

All Division members birth through five years of age (up to age six), who are ALTCS eligible and are receiving behavioral health services, in collaboration with their caregivers.

C. BACKGROUND AND EVIDENCE-BASED SUPPORT

The promotion of behavioral health in infants and toddlers is critical to the

prevention and mitigation of mental disorders throughout the lifespan. Over the past decade, the research has demonstrated mounting evidence pointing to the detrimental impact that early, negative childhood experiences can have on the developing brain. A well-known example of that research is a study conducted by a California Health Maintenance Organization. This longitudinal study, known as the ACES study (Adverse Early Childhood Experiences), showed a positive correlation between frequency of negative early childhood events (e.g., neglect, violence, trauma) and development of physical and behavioral health challenges in adulthood. The more negative events that occurred during early childhood, the more adults tended to have physical and behavioral health conditions in adulthood such as depression, alcoholism, obesity, and heart disease. Although the ACES study points to the negative impact of adverse early childhood experience, the field of infant behavioral health has promulgated the knowledge in intervention techniques designed to mitigate negative effects of early abuse, trauma, or violence.

Early childhood experiences can build strong foundations or fragile ones and can affect the way children react and respond to the world around them for the rest of their lives. The early social and emotional development of infants and toddlers is vulnerable to factors, such as repeated exposure to violence, persistent fear and stress, abuse and neglect, severe chronic maternal depression, biological factors such as prematurity and low birth weight, and conditions associated with prenatal substance exposure. Without intervention, these risk factors can result in behavioral health disorders including depression, attachment disorders, and traumatic stress disorders, which can have an effect on later school performance and daily life functioning.

Children who have been maltreated are at an increased risk for behavioral health concerns, poor psychological adaptation and lifelong health difficulties. Children entering the child welfare system have higher rates of exposure to traumatic events with most victims of child abuse and neglect being under the age of five. Important assets such as healthy attachment, social and emotional competency, self-assurance, confidence, and independence can be undermined as a result of

trauma.

1. An effective approach to promoting healthy social and emotional development shall include equal attention to the full continuum of behavioral health services including promotion, prevention, and treatment, plus improvement in system capacity for effective service delivery. Essential components of a comprehensive system include:

    a. Supporting the use of evidence-based early childhood service delivery models,

    b. Increasing the quality and capacity of trained infant and early childhood behavioral health professionals, and

    c. Improving access to services.

    Untreated behavioral health disorders can have disastrous effects on children's functioning and future outcomes. Unlike adults, infants and toddlers have a fairly limited repertoire of coping responses to stress and trauma. Behavioral Health disorders in young infants might be reflected through physical symptoms such as poor weight gain, slow growth, and constipation, as well as overall delayed development and inconsolable crying. In older infants, excessive tantrums, eating and sleeping problems, aggressive or impulsive behavior and developmental delays can be present. Toddlers may also present with paralyzing fears and withdrawal from social interaction.

    Early attachment disorders (including those resulting from early traumatic separations from parents and placement in foster care) can predict subsequent aggressive behavior. Some early behavioral health disorders have lasting effects and may appear to be precursors of behavioral health problems later in life. Early signs and symptoms of behavioral health disorders may include withdrawal, sleeplessness, or lack of appetite due to depression, anxiety, and trauma stress reactions.

    Increasingly, young children are being expelled from childcare and preschool

for behavior problems, including biting, tantrums, hitting, throwing objects, or inconsolable crying. Even if they do remain in a program, young children with behavioral concerns are challenging to teach and quickly lose motivation for learning. Additionally, they may withdraw from their peers or face social rejection.

Healthy social-emotional development is strongly linked to success in elementary school. Children who are not secure in relating to others and do not trust adults are not motivated to learn. Furthermore, children who are unable to respond to calming influences initiated by themselves or others will not be responsive to teaching methods or benefit from their early educational experiences and may lag behind their peers.

2. Parent's behavioral health can affect young children. Maternal depression, anxiety disorders and other forms of chronic depression often disrupt the parent-child bond as parents with an untreated mental disorder are less able to provide developmentally- appropriate stimulation and parent-child interactions. Parenting and child development are most affected when depression simultaneously occurs with other factors such as extreme poverty, substance abuse, adolescence, and maltreatment. Infants of clinically depressed mothers often withdraw from their caregivers, which ultimately affects their language skills, as well as their physical and cognitive development. Older children of depressed mothers show poor self-control, aggression, poor peer relationships, and difficulties in school. Although these sources cite maternal depression as a factor, these effects can also be attributed to relationships the young child has with other primary caregivers.

   Increased training in early childhood behavioral health is necessary and essential. In-depth knowledge of child development systems and multi-disciplinary approaches, as well as possession of diagnostic and clinical skills are critical components for professionals who assess and treat young children. Additionally, practitioners need to acquire and demonstrate a range of interpersonal skills in their work in order to build individualized, respectful,

responsive, and supportive relationships with families. These skills include:

a. The ability to listen and observe carefully,

b. Demonstrate concern and empathy,

c. Promote reflection,

d. Observe and highlight the child-parent/caregiver relationship,

e. Respond thoughtfully during emotionally intense interactions, and

f. Understand, regulate, and use one's own feelings.

Scientific advances in neurobiology have provided birth through five practitioners with greater insight into the complex system of the brain. The development of the central nervous system begins with the formation of the neural tube, which nears completion by three to four weeks of gestation and is the basis for all further nervous system development. Genes determine when specific brain circuits are formed, and each child's experiences then shape how that formation develops. Stable and responsive relationships along with proper sensory input through hearing and vision are what build healthy "brain architecture". Thus, the most important relationships begin with the child's family and extend outward to other adults important in that child's life such as day care and educational providers.

3. Empirical evidence has shown that young children are greatly impacted by their early development and experiences. By understanding how specific events impact a young child's brain function, the behavioral health professional is able to formulate individualized interventions. Therefore, it is incumbent upon all practitioners to become educated about brain development, functions of various parts of the brain and their role in the physical and emotional development of the child. Some additional resources in the area of brain development include:

a. "Brain Facts, A Primer on the Brain and Nervous System" through the Society for Neuroscience,

b. "Starting Smart, How Early Experiences Affect Brain Development,"

c. "From Neurons to Neighborhoods: The Science of Early Childhood Development," and

d. C.H. Zeanah, Jr., (Ed.). (2009). Handbook of Infant Toddler Behavioral Health.

D. METHODOLOGY

In an ongoing effort to improve the delivery of behavioral health services in an effective and recovery-oriented fashion, the Arizona Vision, as established by the Jason K. Settlement Agreement in 2001, implemented the use of the Child and Family Team (CFT) practice model and the 12 Arizona Principles, both of which strongly support the critical components of behavioral health practice with children birth through five and their families. Infant and Early Childhood Behavioral Health practice integrates all aspects of child development such as organic factors (genetics and health) with the child's experiences (relationships, events, opportunities for exploration). This is especially important in the first three years of life when changes in social-emotional development and adaptive functioning are rapid and significant.

The nature and pace of these changes, as well as the preverbal nature of this young population present the behavioral health professionals with uniquely complex challenges. It is crucial for children to rely on the knowledge of the parents/ caregivers and the expertise of a multidisciplinary team of professionals to provide them with information when conducting behavioral health evaluations, developing service plans, and implementing clinical interventions. Qualified professionals shall have an understanding of the correct use and interpretation of screening, assessment, and evaluation tools and processes, plus how to use these results for service planning and implementing clinical interventions.

1. Assessment and treatment of children age birth through five is based on the philosophical orientation that work is done on behalf of the child, predominantly through the child's parent or caregiver(s). Child development takes place within the context of the caregiving relationship, which is strongly influenced by child characteristics, parent/caregiver characteristics, and

perhaps most importantly the unique match or "fit" between a child and the child's caregivers. It is important that trained personnel:

a. Have comprehensive knowledge of early childhood development,

b. Possess excellent observational and relationship-building skills with children and adults,

c. Be able to identify resources and needs within the family/caregiving environment, and

d. Communicate assessment results in a comprehensible and accessible manner to parents/primary caregivers and other professionals.

2. For children who are ALTCS eligible and are under the custody of Department of Child Safety (DCS) and are being served by an AdSS who are referred through the Rapid Response process, it is important for the behavioral health provider to consider a full range of services at the time of removal. Multiple Division policies provide additional information regarding expectations working with children served by DCS including but not limited to the below:

a. Division Operations Policy 417,

b. Division Operations Policy 449,

c. Division Medical Policy 310-B

d. Division Medical Policy 320-O, and

e. Division Medical Policy 541.

As part of the assessment process, ongoing evaluation of the child after the initial removal is needed to assess the child's physical appearance, areas of functioning, the child's relationships, and adjustment to the new environment. If the child is placed with a different caregiver, re-assess again to monitor the child's adjustment to the new setting. When assessing children involved with DCS who are showing delays which can be due to the trauma of removal, neglect, or abuse, determine if a referral for additional trauma

informed care services or any other type of assistance is needed. Refer to AMPM 210 Attachment A for use with children living in a kinship placement, DCS resource parents (foster or adoptive), or congregate care (shelter or group home). Additional information outlining special considerations for providing services to infants, toddlers and preschool-aged children involved in the child welfare system can be accessed through: "The Unique Behavioral Health Service Needs of Children, Youth and Families Involved with DCS" (refer to AMPM Behavioral Health Practice Tool 260).

II. ESSENTIAL PROCESSES FOR ASSESSMENT, SCREENING AND SERVICE PLANNING

Evaluation practices with respect to children age birth through five involve awareness on the part of the behavioral health practitioner that all children have their own individual developmental progression, affective, cognitive, language, motor, sensory and interactive patterns. All children age birth through five are participants in relationships, with the child's most significant relationships being those with their primary caregiver(s). A full evaluation requires a clear understanding of how the child is developing in each area of functioning and the quality of the child's most significant relationships. This is best done over several sessions, in different settings (e.g., home, childcare, clinic), and whenever possible with all significant caregivers. In order to support a child in demonstrating the child's true capacities, screening and assessment processes are most effectively offered in natural and non-threatening settings, in the presence of a familiar and trusted caregiver, with materials and activities that are culturally sensitive and that reflect their daily life experiences. Identification of all significant caregivers and the child's relationship with each individual is a critical part of assessment practice.

A. DEVELOPMENTAL SCREENING

Division eligible children undergo developmental screening prior to enrollment with the Division. Refer to Division Medical Policies 430 and 541 for details. In addition, when a child aged birth to five is receiving behavioral health services, screening for sensory, behavioral, and developmental concerns continues as an ongoing process that organizes continuous observations regarding the needs, challenges, strengths

and abilities of the child and parent/caregiver. Screening or testing instruments become part of comprehensive assessment practice, are intended to be used for the specified purpose they were designed for, shall be reliable and valid, and are not to be used in isolation to render a diagnosis.

The use of AMPM 210 Attachment B provides assessors and caregivers with a set of dimensional milestones (e.g., movement, visual, hearing, smell, touch, speech, social and emotional, language, cognitive, hand and finger skills), as well as growth and developmental "red flags". As part of the assessment process for infants and young children, developmental checklists establish a baseline to which subsequent screenings during the course of treatment can be compared. Developmental checklists provide opportunities to assess the degree to which children are meeting developmental milestones. Should there be delays in meeting standard developmental milestones, it may be necessary to refer to the child's PCP for further evaluation. For children three to five, a referral to the public school system may be more appropriate. The various professionals supporting the child and family shall plan and communicate to avoid duplication of screening services. Multiple developmental screening tools are available. Some are suggested directly within this document and others are provided as attachments to AMPM 210. These tools are available as accompaniments to this Practice.

B. ASSESSMENT CONSIDERATIONS

It is essential that behavioral health practitioners continually evaluate their screening and assessment tools because the practice of infant and early childhood behavioral health is dynamic and continually changes due to improved technology and newly developed research techniques, strategies, and results. While the Division does not require the use of a specific assessment tool, minimum elements have been established that shall be included in any comprehensive behavioral health assessment as specified in Division Medical Policy 320-O. Refer to AMPM 210 Attachment C, as one example of an assessment tool for children age birth through five. Additional options for assessments specific to children birth through five, are included as AMPM 210 attachments.

1. There is no single tool that encompasses the full range of social, emotional,

and developmental skills and challenges that can occur in young children. The following tools and resources can provide additional information when assessing developmental milestones, behavioral, emotional, and social concerns, trauma and attachment:

a. Ages and Stages Questionnaire (ASQ): developmental and social-emotional screening for children aged one month to five and ½ years,

b. Hawaii Early Learning Profile (HELP): curriculum-based assessment covering regulatory/sensory organization, cognitive, language, gross and fine motor, social and self-help areas for children birth to three years, separate profile available for three- to six-year-old children,

c. Infant-Toddler Social-Emotional Assessment (ITSEA©): measures social-emotional and behavioral domains for children one to three years of age,

d. Connor's Early Childhood Assessment: aids in the early identification of behavioral, social, and emotional concerns and achievement of developmental milestones for children two to six years of age,

e. Parents' Evaluation of Developmental Status (PEDS): evidence-based screening of developmental and behavioral concerns for children birth to eight years, and

f. Trauma-Attachment Belief Scales (TABS™): measure cognitive beliefs about self and others for parents/caregivers age 17 and older to assist with identifying possible trauma history and its potential impact on the attachment relationship between the parent/caregiver and the child.

Considerable skill is required in the administration of the assessment process, integration of the data obtained from the assessment, and development of initial clinical conceptualizations and intervention recommendations. Refer to Technical Assistance Paper No. 4, "Developmental Screening, Assessment, and Evaluation: Key Elements for Individualizing Curricula in Early Head Start Programs" for further information on other resources and test reviews of

screening and assessment instruments.

Assessment with children age birth through five is a specialty area that requires specific competencies. Competent providers recognize the limitations of their knowledge and scope of practice. When necessary, they make use of the expertise of more experienced behavioral health practitioners, as well as the range of disciplines that address questions related to early development (e.g., pediatrics, speech/language therapy, occupational therapy, physical therapy) through collaboration, consultation, and referral practices.

2. Behavioral Health Assessment practice with children age birth through five typically involves:

   a. Interviewing the parent/primary caregiver(s) about the child's birth, developmental and medical histories,

   b. Direct observation of family functioning,

   c. Gaining information, through direct observation and report, about the child's individual characteristics, language, cognition, and affective expression,

   d. Assessment of sensory reactivity and processing, motor tone, and motor planning capacities,

   e. Observation of how the child uses the primary caregiving relationship to develop a sense of safety and security, to support exploration/ learning, and to help regulate emotions,

   f. Obtaining information on how the child and parent/caregiver think and feel about each other and themselves within the context of the relationship, and

   g. Interviewing the parent/primary caregiver(s) with respect to their own history and experiences (e.g., medical, behavioral health, parenting, legal, educational, domestic violence, military).

Division Medical Policy 310-B and Division Medical Policy 320-O provide additional information on the types of behavioral health providers that may conduct assessments.

C. DIAGNOSTIC CONSIDERATIONS

The diagnostic process consists of two aspects: the classification of disorders and the assessment of individuals. In classifying disorders, practitioners are able to communicate with one another about descriptive syndromes using universal terms and language. The diagnostic process is ongoing rather than a one-time "snapshot" of symptoms. Behavioral Health practitioners collect information over time in order to understand multiple aspects of the presenting concerns, as well as variations in adaptation and development that are revealed on different occasions within various contexts.

It is suggested that clinical personnel who conduct assessments of young children receive training to become proficient in the use of the Diagnostic Classification of Behavioral Health and Developmental Disorders in Infancy and Early Childhood (DC: 0-5). This diagnostic manual, which draws on empirical research and clinical practice that has occurred worldwide since the manual was first published in 1994 as the DC: 0-3 and revised in 2016. The DC: 0-5 is designed to help behavioral health and other professionals recognize behavioral health and developmental challenges in young children, understand how relationships and environmental factors contribute to behavioral health and developmental disorders, use diagnostic criteria effectively for classification and intervention, and work more effectively with parents and other professionals to develop effective service plans. The updated version provides clear and specific criteria for all diagnostic categories. Examples include:

1. Criteria for identifying autism spectrum disorders in children as young as 2, introduces.
2. New criteria for disorders of sleep, eating, relating, and communicating.
3. Clarifies the Parent-Infant Relationship Global Assessment Scale (PIRGAS).
4. Checklists for identifying relationship problems, psychosocial and

environmental stressors.

Copies of the DC: 0-5 manual are available through the Zero to Three Press. This manual contains the DC: 0-5 codes that correspond to DSM-5 codes, as well as the ICD-10 codes.

D. ANNUAL ASSESSMENT UPDATE

While assessment is an ongoing process that offers new information throughout the continuum of service delivery, a formal assessment update shall be completed on an annual basis, or sooner, if there has been a significant change in the child's/family's status. A child's response to treatment might be affected by significant events or trauma that have occurred since the last assessment/update, such as changes in the child's living environment, childcare arrangements, death of a primary caregiver, as well as medical/developmental conditions and hospitalizations. Input from the family/ caregiver, as well as observation(s) of the child in conjunction with a review of the clinical record, provides the information necessary for summarizing their response to treatment and progress toward meeting goals over the past year.

A review of the child's current level of functioning would include updating information related to the child's emotional and behavioral regulation, quality of the parent-child interaction, relationships with caregivers/significant others, living environment, family stressors, safety concerns, and stability of home/relationships. Developmental screening as part of the annual update, and during the course of treatment, will assist the behavioral health provider with identifying any potential developmental concerns that may require additional intervention or referral.

E. SERVICE PLANNING CONSIDERATIONS

1. Use of CFT Practice

   The early development of an engaged relationship with the child, parent/ caregiver, and family as part of the CFT process, is required practice when working with children age birth through five. This critical work directly involves the entire family, and it is the family that guides the therapeutic process. Refer to the Child and Family Team Practice Tool on the AHCCCS website under Guides - Manuals – Policies – AMPM Chapter 200. This Practice

Tool provides additional information on the specific components and the required service expectations of this practice model.

Infants and young children benefit from planning processes that support the inclusion of the following components:

a. Ongoing and nurturing relationships with one or two deeply attached individuals,

b. Physical protection, safety and regulation at all times,

c. Experiences suited to individual differences to include regular one-to-one interaction between the caregiver and child,

d. Developmentally appropriate experiences (e.g., one-to-one interaction that encourages an emotional dialogue that fosters a sense of self, problem solving, communication skills and a sense of purpose),

e. Limit setting, structure and expectations (e.g., clear messages and routines), and

f. Stable, supportive communities and cultural continuity which can be met through solid relationships between the child and one or two primary caregivers.

Families with young children are often socially isolated especially if they have a child who is exhibiting behavioral concerns and/or developmental delays. An essential part of the therapeutic process is to help reduce this social isolation. Encouraging the exploration of natural supports can spur a family to begin thinking differently about their support system(s).

Whenever possible, the utilization of natural environments for clinical intervention is recommended. If the natural environment is not a conducive setting due to a lack of privacy, site of traumatic event for the child/parent and/or safety concerns, alternative settings need to be considered with input from the family. In addition to location, natural environments also include

the everyday routines, relationships, activities, people and places in the lives of the child and family. health, right, and safeguards

2. Community Collaboration

Starting with the assessment process, intervention strategies incorporate information from all involved providers serving the child, parent, or caregiver. This may include healthcare, childcare, and early intervention providers, the parent's/caregiver's behavioral health provider(s), as well as friends and extended family that are important in the family's life. Examples of several early intervention providers include Head Start/Early Head Start, the Arizona Early Intervention Program, Early Childhood Education through the Arizona Department of Education, and the Division of Developmental Disabilities. These individuals, if the parent/caregiver wishes, then become part of the Child and Family Team who will develop an effective service plan that employs natural supports in conjunction with formalized services (Refer to Division Medical Policy 220 Child and Family Team). The size, scope and intensity of team member involvement are determined by the objectives established for the child and needs of the family in providing for the child.

In order to make informed referrals as part of the service planning process it is imperative that behavioral health professionals and technicians (BHPs & BHTs) who work with children age birth through five and their families, become familiar with community services and programs that serve young children, as well as the local school district programs for children three to five years of age. At minimum, BHPs and BHTs should have familiarity with AzEIP, Head Start, Division of Developmental Disabilities, ADHS Office of Children with Special Health Care Needs, First Things First, and school district services that may be available for children eligible for preschool.

If at any time throughout the assessment, treatment delivery, or service planning processes a behavioral health practitioner believes that a child is or has been the victim of non-accidental physical injury, abuse, sexual abuse or deprivation, there is a duty to report that belief to a peace officer or DCS per A.R.S. §13-3620. Behavioral Health staff is to consult with their supervisor if

they are unclear about their duty to report a situation.

Duplicative medication prescribing, contraindicated combinations of prescriptions and/or incompatible treatment approaches could be detrimental to a young child. For this reason, communication, and coordination of care between behavioral health providers and PCPs shall occur on a regular basis to ensure safety and positive clinical outcomes for young children receiving care. For non-enrolled children who are not Medicaid eligible, coordination and communication should occur with any known health care provider. Refer to Division Medical Policy 211 for additional information on the use and coordination of psychotherapeutic and psychopharmacological interventions.

Documentation in the clinical record is required to show the communication and coordination of care efforts with the health care provider related to the child's behavioral health treatment (refer to Division Medical Policy 320-O and 940).

F. SERVICE PLAN DEVELOPMENT

1. While a comprehensive and accurate assessment forms the foundation for effective service planning and is required before a service plan can be fully developed, needed services should not be delayed while the initial assessment process is being completed. In addition to consideration of clinical disorders, findings from a comprehensive assessment of children birth through five years of age should lead to preliminary ideas about:

    a. The nature of the child's pattern of strengths and difficulties, risk, and protective factors,

    b. Level of overall adaptive capacity and functioning in the major developmental areas as compared to age-expected developmental patterns,

    c. Contribution of family relationships, environmental protective factors, stress, interactive and maturational patterns, etc. to the child's

competencies and difficulties, and

d. How the service planning process will address these areas.

Service plans should be strength-based in addressing needs and whenever possible draw upon natural supports. For young children, home-based services, which virtually always include the child's principal caregiver, may be especially well-suited to enhancing parents' well-being and the child-parent relationship.

A comprehensive and intensive approach to service planning would include attention to those factors that place young children's healthy attachment and social-emotional development at risk. Critical planning includes interventions that address a parent's/caregiver's behavioral health concerns and how these may affect the ability of that parent/caregiver to interact with and respond sensitively to the child's emotional and physical needs. Prematurity, low birth weight and conditions associated with prenatal substance exposure may require specific interventions when they affect the early social and emotional development of infants and toddlers.

Service planning also needs to address a child's ability to form close parent/ caregiver relationships. These relationships can be undermined by traumatic events such as repeated exposure to violence, abuse, or neglect, or when children experience multiple caregiver changes. When the child/family has multi-agency involvement, every effort should be made to collectively develop a single, unified plan that addresses the needs and mandates of all the parties involved. Additionally, planning should address collaboration with early intervention service providers and early education programs. This is especially important for those children who are experiencing expulsion from childcare or preschool settings due to behavioral concerns.

The use of all service settings, the full array of covered services, and skilled, experienced providers are to be considered as identified by the Child and Family Team during the service planning process. Service planning that includes the use of Support and Rehabilitative Services is often an essential

part of community-based practice and culturally competent care, which focuses on helping young children to live successfully with their families as part of their community (refer to AMPM 230).

All service plan development with children age birth through five is completed collaboratively with the child's parent or primary caregiver. Development and prioritization of service plan goals are not focused solely on the child. It is essential to include the parent, caregiver, and the needs of the family as a whole. Due to the age of the birth through five population and the rapid changes in the growth and development of children during this time, monitoring activities need to include frequent reviews of the service plan goals and objectives. At the time of the Annual Update, the service plan should be modified to align with the needs identified in the updated Assessment. Refer to Division Medical Policy 320-O for further information on the minimum elements for Assessments, Service Plans, and required timeframes for completion.

2. Clinical Practice

The guiding principle in the practice of infant and early childhood behavioral health is to "do no harm". Clinical intervention assumes a preventative, early intervention treatment focus based on sound clinical practice, delivered in a timely and accessible manner across all settings, and implementation in accordance with the Arizona Vision and 12 Principles. Relationship-based models of intervention have been found to be the most effective in working with young children and their caregivers.

a. Infant and early childhood therapeutic approaches are supported by the following conceptual premises:

i. The child's attachment relationships are the main organizer of the child's responses to danger and safety in the first five years of life,

ii. Emotional and behavioral problems in early childhood are best

addressed within the context of the child's primary attachment relationships, and

iii. Promoting growth in the child-caregiver relationship supports healthy development of the child after the intervention ends.

b. The following skills and strategies are fundamental to the work of infant and early childhood behavioral health:

i. Building relationships and using them as instruments of change,

ii. Meeting with the infant and parent/caregiver together throughout the period of intervention,

iii. Sharing in the observation of the infant's growth and development,

iv. Offering anticipatory guidance to the parent/caregiver that is specific to the infant,

v. Alerting the parent/caregiver to the infant's individual accomplishments and needs,

vi. Helping the parent/caregiver to find pleasure in the relationship with the infant,

vii. Creating opportunities for interaction and communication exchange between parent/caregiver(s) and infant or parent/caregiver(s) and practitioner,

viii. Allowing the parent/caregiver to take the lead in interacting with the infant or determining the agenda or topic for discussion,

ix. Identifying and enhancing the capacities that each parent/ caregiver brings to the care of the infant,

x. Wondering about the parent/caregiver's thoughts and feelings

related to the presence and care of the infant and the changing responsibilities of parenthood,

xi. Wondering about the infant's experiences and feelings in interaction with and relationship to the caregiving parent,

xii. Listening/observing for the past as it is expressed in the present, inquiring, and talking,

xiii. Allowing core relational conflicts and emotions to be expressed by the parent/caregiver; holding, containing, and talking about them as the parent is able,

xiv. Attending and responding to parental histories of abandonment, separation, and unresolved loss as they affect the care of the infant's development, the parent/caregiver's emotional health and the early developing relationship,

xv. Attending and responding to the infant's history and early care within the developing parent/caregiver-infant relationship,

xvi. Identifying, treating and/or collaborating with others if needed, in the treatment of the disorders of infancy, delays and disabilities, parental mental illness and family dysfunction, and

xvii. Remaining open, curious and reflective.

While all the skills and strategies noted above are pertinent in working with children and families, item "xi" through "xvii" are of unique importance to the practice of the infant and early childhood behavioral health practitioner. These seven strategies address the emotional health and development of both the parent/caregiver and the child. The practitioner focuses on past and present relationships and the complexities many parents/caregivers encounter when nurturing, protecting, and responding to the emotional needs of their children. Within this context, the practitioner and parent/caregiver

may think deeply about the care of the young child, the emotional health of the parent/caregiver, the many challenges of early parenthood, and the possibilities for growth and change.

3. Clinical Approaches

Information obtained through the assessment process will guide infant and early childhood trained practitioners in determining which intervention(s) is most conducive in meeting the needs of the young child and the child's family. More than one approach may be utilized and integrated into the service plan.

Support is the most basic intervention, where behavioral health personnel function as a resource to assist primary caregivers in accessing community resources, such as housing, employment, childcare, health services and food. Emotional support may also be provided to families when they are faced with a crisis related to the care of their child(ren). This support can be shown by the clinician's attention to the expressed concerns of the caregiver, acknowledgement of the caregiver's needs and strengths, and showing empathy in response to the situation. Support and Rehabilitation services can also assist with reducing the family's distress so that they are able to focus on the care requirements of their young child.

Advocacy can take the form of helping caregivers in expressing their needs and navigating systems of care. It can be challenging for clinicians to know when and how to speak effectively on behalf of young children and their families, especially those who may be involved with the child welfare system.

Developmental Guidance provides information to the primary caregiver(s) on a young child's abilities, developmental milestones and needs, as well as practical caretaking guidance that may be delivered individually or in a group format. Within the therapeutic environment, the clinician can offer opportunities to the caregiver to enhance positive interaction and playful exchange with the child. These exchanges, if based on the child's developmental needs, reinforce what the caregiver is able to do with the child

and may promote a mutually pleasurable experience and purposeful response at the child/caregiver relationship level.

Relational Guidance helps primary caregivers to increase their knowledge of and experience with their infant or young child through spontaneous interactions. Caregivers are taught how to attend to their child's distinctive cues with clinicians modeling parenting behavior. When using guided interaction strategies, clinicians can then provide feedback directly or review videotapes with the caregiver.

The following two approaches to therapy focus on the relationship between the primary caregiver and the infant. *Child-parent psychotherapy* offers the opportunity for thoughtful exploration with the caregiver of the child's ideas about parenthood and the continuing needs of the infant or toddler. The clinician assists the primary caregiver in gaining access to repressed early experiences, re-examining the feelings associated with them and achieving insight into how these experiences may affect the caregiver's capacity to be responsive to the infant. Relational difficulties with the infant may take the form of a caregiver's inability to hold or feed their baby, set limits that are appropriate in keeping young children safe, or interacting and communicating in ways that will arouse the child's curiosity. The infant is included as a catalyst for change, with the clinician guiding the caregiver to interact in a different way with their infant. A second approach, *child-parent dyadic therapy*, reflects the perspective that infants contribute to relationships and holds that the infant is able to use the time therapeutically for him/herself, similarly to the caregiver.

Attachment theory based in part on John Bowlby's *internal working model*, proposes that early experiences with the parent or primary caregiver forms the basis of memory patterns or "internal working models" that influence behaviors for other social relationships. Interventions are consistent with attachment theory if they include the following elements:

a. Provide emotional and physical access to the mother/caregiver,

b. Focus directly on maternal/caregiver sensitivity and responsiveness to the infant's behavior and emotional signals,

c. Place the mother/caregiver in a non-intrusive stance,

d. Provide space in which the infant can work through relational struggles through play and interaction with the mother/caregiver, and

e. Provide a clinician who functions as a secure base for the dyad.

Developmental approaches to therapy offer an alternative to the traditional behavioral approach. Modalities under this approach can provide a framework for understanding and organizing assessment and intervention strategies when working with children with developmental delays and behavioral health concerns.

Reference materials on infant and early childhood mental health practice have been provided as a supplemental resource. This resource list is not meant to be exhaustive, given that research and clinical practice in this area continue to evolve.

G. TRAINING AND SUPERVISION RECOMMENDATIONS

Behavioral Health over the past several decades, has experienced significant advances in the understanding of early child development and the effects of trauma on early brain development. The need to have providers with trained expertise in this area has risen dramatically and is well recognized nationally and in Arizona. AHCCCS is focused on efforts in several areas to build workforce expertise and availability of services to children age birth through five and their families.

H. WORKFORCE DEVELOPMENT

The Infant and Toddler Behavioral Health Coalition of Arizona (ITMHCA) has adopted the Michigan Association for Infant Behavioral Health Endorsement® for Culturally Sensitive, Relationship-Based Practice Promoting Infant Behavioral Health. Endorsement® recognizes the professional development of practitioners within the diverse and rapidly expanding infant and family field. This endorsement® model

describes the areas of expertise, responsibilities, and behaviors that demonstrate competency and verifies that professionals have attained a specified level of understanding and functioning linked to the promotion of infant behavioral health. Of additional importance, endorsement provides an organized approach to workforce development that identifies competency- based trainings and reflective supervision experiences that enhance confidence and credibility among infant, toddler and family clinicians (Behavioral Health Professionals), as well as other professionals who work with this population (Behavioral Health Technicians/Behavioral Health Paraprofessionals). While competency-based training and reflective supervision supports behavioral health practitioners who work primarily with young children and their families, this expertise may also be applied to professionals working with adults with a serious mental illness or substance use concerns who are parenting their own infants/toddlers.

It is recommended that provider agencies have practitioners endorsed as appropriate to the mission of the agency. Endorsement® through the ITMHCA includes four levels of competency:

1. Level 1: Infant Family Associate - Individuals who possess Child Development Associate (CDA), or academic degree, or two years of infant and early childhood related paid work experience; recommended for childcare or respite workers.

2. Level 2: Infant Family Specialist - Bachelor's, Master's or Doctoral (e.g. Social Work, "Applied" studies, nursing, behavioral health related) degree and a minimum of two years' work related experience with infants/toddlers and families; recommended for behavioral health staff involved in service planning and delivery such as case management and peer/family support, support and rehabilitation service provider personnel, parent educators, childcare consultants, and DCS workers.

3. Level 3: Infant Behavioral Health Specialist - Masters, MSN (Nursing), PhD, PsyD, EdD, M.D. or D.O. with two years post-graduate work and training in infant, early childhood, and family fields; recommended for behavioral health

clinicians and supervisors, infant behavioral health specialists, clinical nurse practitioners, psychologists, and early intervention specialists. Reflective Supervision is required.

4. Level 4: Infant Behavioral Health Mentor - (Clinical, Policy, or Research/ Faculty) Individuals at the mastery level (Master's, Postgraduate, Doctorate, Post Doctorate, MD or DO) qualified to train other professionals; recommended for infant and early childhood program supervisors, administrators, policy specialists, and physicians/psychiatrists.

Endorsement information and application materials are available through the local Infant Toddler Behavioral Health website: Infant Toddler Behavioral Health Coalition of Arizona (www.itmhca.org).

I. TRAINING

This Practice Tool applies to the Division and their subcontracted network and provider agencies, including the behavioral health staff that provide direct service delivery to children age birth through five and their families. Behavioral health practitioners working with this population (children age birth through five) require specialized training. Professional development in the area of infant and early childhood behavioral health is necessary at all levels of the Behavioral Health System, along with the personnel of service systems that interface with behavioral health professionals, such as DCS, the Division, AzEIP, and other community-based early intervention programs.

Behavioral Health practitioners seeking increased knowledge in this area are encouraged to attend infant and early childhood behavioral health trainings that include:

1. A multidisciplinary approach that is strengths-based.
2. Effective interviewing, communicating and observational techniques.
3. Assessment of parent-infant relationships.
4. Screening and diagnostic measures for infants and toddlers.

5. Early childhood development.
6. Effects of early adverse experiences and trauma.
7. Understanding parent-child interactions and healthy attachment.
8. Cultural influences in parenting and family development.
9. Building a therapeutic alliance.
10. Treatment and intervention strategies/modalities endorsed by AHCCCS.
11. Collaboration practices with other providers/caregivers.
12. A reflective practice focus.

It is the expectation of the Division that behavioral health staff who complete assessments, participate in the service planning process, provide therapy, case management and other clinical services, or supervise staff that provide service delivery to children age birth through five and their families, be well trained and clinically supervised in the application of this tool. Each AdSS shall establish their own process for ensuring that all agency clinical and support services staff working with this population understand the recommended processes and procedures contained in this tool. Whenever this Practice Tool is updated or revised, each AdSS ensures that their subcontracted network and provider agencies are notified and required staff are retrained as necessary on the changes.

J. SUPERVISION

Supervision regarding implementation of this Practice Tool is to be incorporated into other supervision processes which the AdSS and their subcontracted network and provider agencies have in place for direct care clinical staff, in alignment with A.A.C. R9-20-205 Clinical Supervision requirements.

Reflective Supervision, as one aspect of Reflective Practice, is a distinctive style of professional development (different from administrative or clinical supervision) that focuses attention on supporting the growth of relationships that is critical to effective infant and early childhood behavioral health practice. How each of these relationships interrelates and influences the others is explored through reflective supervision and is referred to as the "parallel process."

1. Relationship between supervisor and practitioner.
2. Relationship between practitioner, parent/caregiver/child.
3. Relationship between parent/caregiver/child.
4. Relationship between all of the above.

In each of these relationships there is an emphasis on learning, personal growth, and empathy. Through this process, supervisors assist practitioners in professional skill development and ensure that practitioners are maintaining the agency's standards for clinical performance.

Key elements of reflective supervision include reflection, collaboration, and consistency. With supervisory support, the practitioner reflects on the emotional content of the work and how one's reaction to this content affects their work. Supervisors support a practitioner's professional development through the acquisition of new knowledge by encouraging the supervisee to assess their own performance. The supervisor's ability to listen and wait allows the practitioner an opportunity to analyze their own work and its implications, and to discover solutions, concepts or perceptions on one's own, without interruption. Collaborative supervision is characterized by the development of a trusting relationship between the supervisor and practitioner in which both parties can safely communicate ideas and share responsibility for decision-making without fear of judgment. Establishment of a consistent and predictable schedule of supervisory sessions supports the professional development of infant and early childhood behavioral health practitioners.

It is the recommendation of the Division that personnel who supervise staff providing service delivery to children age birth through five and their families, receive adequate training in the elements of Reflective Practice and Supervision before implementing this approach in their supervisory activities. Criteria for provision of reflective practice is outlined on the Michigan Infant Toddler Behavioral Health website, but at minimum, Reflective Supervision requires Endorsement® for Infant Behavioral Health Specialist or Infant Behavioral Health Mentor with a minimum of 50 clock hours within a one-to-two-year timeframe. Additional information is also

available within AMPM 210 Attachment E for additional resource materials on reflective supervision and consultative practices.

Training and supervision support the acquisition of specific knowledge, skills, and competencies critical to delivering effective relationship-based services to children age birth through five and their families. While training and other academic learning venues build the practitioner's understanding of core concepts, it is through supervision that practitioners can assess their level of competency when applying these concepts within their scope of practice. When evaluating a practitioner's level of knowledge as part of supervisory activities, supervisors can compare the skills of the clinician with Endorsement® Competency Guidelines and Requirements available on either the Arizona or Michigan Infant Toddler Behavioral Health websites. However, possession of similar knowledge and skills does **not** equate to actual Endorsement®, given the proprietary nature of the Endorsement® process (e.g., evidence-based training standards, testing, ethical standards).

The Division delegates the delivery of behavioral health services to subcontracted health plans. The Division shall monitor and ensure the AdSS establish their own process for ensuring that all staff have been trained and understand how to implement the practice elements as outlined in this document. Whenever this Behavioral Health Practice Tool is updated or revised, the Division shall ensure the AdSS and their subcontracted network and provider agencies are notified and required staff is retrained as necessary on the changes. The Division upon request from AHCCCS, is required to provide documentation demonstrating that all required network and provider staff have been trained on this Practice Tool.

The Division shall monitor and ensure that the AdSS incorporates this behavioral health practice tool into other supervision processes which the AdSS and their subcontracted network and provider agencies have in place for direct care clinical staff, in alignment with A.A.C. R4-6-212 Clinical Supervision requirements.

K. ANTICIPATED OUTCOMES

1. Increased community and professional awareness of infant and early childhood behavioral health,

2. Improved use of effective screening, assessment, and service planning practices specific to the needs of children age birth through five and their families,

3. Increased knowledge and referrals to early intervention resources in the community, and

4. Improved outcomes through the use of accepted approaches in working with children age birth through five and their caregivers.

L. DIVISION OVERSIGHT OF AdSS

The Division shall complete oversight of the AdSS utilizing, but not limited to, the following methods to ensure compliance with this and associated policies:

1. Annual Operational Review of each standard related to birth to age five, including but not limited to:

   a. Policies/procedures to ensure, and evidence of, appropriate high-need identification for the birth to five population.

   b. Policies/procedures to promote/increase availability of, and evidence of, availability of trained specialists (ITMHCA standards).

   c. Policies/procedures to ensure, and evidence of, staff training and supervision is completed as outlined in this policy.

   d. Ongoing monitoring of, and evidence of, adequate network capacity for children age birth to five.

2. Review and analyze deliverable reports submitted by the AdSS.

3. Conduct oversight meetings with the AdSS for the purpose of reviewing compliance, addressing concerns with access to care or other quality of care concerns, discussing systemic issues and providing direction or support to the AdSS as necessary.

4. Ensure AdSS conducts ongoing monitoring and evidence of compliance through Behavioral Health Clinical Chart Reviews.

Signature of Chief Medical Officer: Anthony Dekker (Apr 28, 2022 10:38 PDT)
Anthony Dekker, D.O.

211 PSYCHIATRIC AND PSYCHOTHERAPEUTIC BEST PRACTICES FOR CHILDREN BIRTH THROUGH FIVE YEARS OF AGE

EFFECTIVE DATE: May 4, 2022
REFERRENCES: AMPM 211

PURPOSE

This policy applies to the Division of Developmental Disabilities (Division) and the system of care for behavioral health services for members enrolled with Medicaid. This policy is an optional resource for the Tribal Health Program; it is not a requirement. The policy establishes best practice processes and goals for psychiatric evaluation and the use of psychotherapeutic and psychopharmacological interventions for children birth through five years of age.

POLICY

A. TARGET AUDIENCE

This policy is specifically targeted to the Division's Behavioral Health Administration in relation to their role with oversight of the AdSS and the role of Support Coordination. While the Division delegates the responsibility to AdSS for the implementation of behavioral health services in alignment with this practice tool, the Division remains responsible for case management (Support Coordination) and oversight of the AdSS. Support Coordination shall receive training on the general practices outlined in this policy for purposes of increasing their ability to coordinate services for members. The Division shall conduct formal oversight of the AdSS. Refer to AdSS Medical Policy 211 for the roles and responsibilities of the AdSS, their subcontracted network, and providers, who furnish psychotherapeutic assessments and interventions, complete psychiatric evaluations and prescribe psychopharmacological treatment for children birth through five years of age.

B. TARGET POPULATION(S)

The target populations include all Division members eligible for ALTCS, birth through five (up to age six), receiving behavioral health services in collaboration with their caregiver(s) and Child and Family Teams (CFT). Additionally, this policy is also

applicable when working with parents and/or caregivers who have children aged birth through five, regardless of whether the child(ren) or parent were referred or are seeking services.

C. BACKGROUND AND EVIDENCE-BASED SUPPORT

Psychiatric disorders presenting in young children are a public health concern, and they can negatively impact normative developmental trajectories in all spheres, physical, social, emotional, and cognitive. One of the challenges in the field of behavioral health care for young children is the belief that young children cannot develop behavioral health disorders. Yet, these disorders if not recognized and appropriately diagnosed, may result in challenging behaviors, such as significant aggression toward others (e.g., biting, hitting, kicking) and emotional dysregulation (e.g., uncontrollable tantrums or crying). These behaviors, when not addressed, can result in serious consequences such as childcare expulsion, difficulty participating in family activities, and impaired peer relationships, making early intervention extremely important for families and caregivers that have young children with behavioral challenges.

Because of the complexities in treating infants and toddlers, the field of infant behavioral health has evolved to promote recognition of the rapid developmental processes and the importance of a healthy relationship between a secure child and the caregiver (either temporary or permanent caregiver for treatment purposes). Given the unique needs of infants and toddlers, numerous therapeutic interventions exist, summarized in a table (page 8), that can aid in reducing potentially damaging consequences. There is robust evidence supporting the use of relationship-based interventions, which focus on the child and parent/guardian/designated representative relationship. Generally, these treatment approaches focus on improving child and family/ guardian/designated representative functioning relative to the identified emotional and/or behavioral challenges and can often be successful without introduction of pharmacological intervention.

In the absence of marked or sustained improvement, it may be necessary to follow the appropriate steps toward psychotropic intervention. However, "Psychotropic

medications are only one component of a comprehensive biopsychosocial treatment plan that shall include other components in addition to medication," according to American Academy of Child and Adolescent Psychiatry.

It is critical to recognize that there are physical causes for behavioral health and developmental delays that may cause signs and symptoms which overlap with behavioral and developmental concerns. It is therefore essential to first ensure that potential physical health issues have been ruled out. Division Medical Policy 430 provides guidance for standard screening and testing for lead poisoning, which includes blood testing whenever a concern arises that indicates a need for blood lead testing.

The use of medications to treat psychiatric disorders in young children raises unique developmental and ethical challenges. While considering whether medication should be introduced in treatment, the benefits of the medication shall be evaluated and compared to the potential biological and psychosocial side effects. According to a 2007 set of Guidelines by the Preschool Psychological Working Group, little is known about the potential effects on neurodevelopmental processes in very young children when exposed to psychotropic medications. Research summaries indicate that younger children metabolize medications differently than older children. Moreover, a review of the current literature demonstrates that there is more evidence to support psychotherapeutic rather than psychopharmacologic interventions in young children presenting with psychiatric symptoms. Despite this, the literature reflects that a majority of these young children do not receive psychotherapeutic interventions prior to the initiation of medications. Best practice recommends at least three months of extensive assessment and psychotherapeutic intervention prior to any consideration of psychopharmacological intervention.

Due to the concerns outlined above, evidence of substantial increases in prescribing antipsychotics for children and increased federal and state attention toward prescribing practices, Arizona has recognized the need to implement revised initiatives for young children to address psychotropic medication use. As of May 2016, AHCCCS provided analysis and trending of current psychotropic prescribing

practices, particularly for young children and children in the foster care system. Data analysis for this report, revealed several key findings including:

- For Arizona in general, psychotropic prescribing rates in 2013 were higher for all foster children zero to 18, when compared to non-foster care children zero to 18.
- For Arizona, foster care children zero to six were prescribed psychotropics at a rate 4.6 times higher than non-foster care children zero to six in Arizona's Medicaid system.

Based on the AHCCCS May 2016 report and the recognition that, despite continued lack of consistent national guidelines, AHCCCS has reorganized the original practice guideline into five sections, which align with current process within Arizona. Additional revisions focus on updated research and findings with regard to psychotropic prescribing practices. Focus has been added to align with current Maternal Child Health/Early and Periodic Screening Diagnostic and Treatment (MCH/EPSDT) practice, plus Bright Futures. As such, the Guidelines within this document now comprise:

- Assessment by Behavioral Health Professional/Provider
- Psychotherapeutic Interventions
- Psychiatric Evaluation
- Psychopharmacological Interventions
- EPSDT: Assessing Physical and Behavioral Needs Through Developmental Surveillance, Anticipatory Guidance, and Social/ Emotional Growth.

Refer to Division Medical Policy 210 for additional information on behavioral health screening, assessment, and treatment for children birth through five years of age.

D. ASSESSMENT BY BEHAVIORAL HEALTH PROFESSIONAL/PROVIDER

The initial assessment for a young child, at a minimum, consists of the following components as described in The American Academy for the Psychiatric Assessment of Infants and Toddlers (0-36 Months):

1. Gathering information from those individuals who are most familiar with the child, as well as direct observation of the child with their health care decision maker (HCDM) or caregiver, if directly involved with the child for treatment purposes (caregiver may be a family member or foster parent – either temporary or permanent).

2. Reason for referral including the child's social, emotional, and behavioral symptoms,

3. Detailed medical and developmental history,

4. Current medical and developmental concerns and status,

5. Family, community, childcare, and cultural contexts which may influence a child's clinical presentation,

6. Parental and environmental stressors and supports,

7. Parent/guardian/designated representative perception of the child, ability to read/ respond to child's cues, and willingness to interact with the child,

8. Children's birth through five mental status exam:

    - Appearance and general presentation
    - Reaction to changes (e.g., new people, settings, situations)
    - Emotional and behavioral regulation
    - Motor function
    - Vocalizations/speech
    - Thought content/process
    - Affect and mood
    - Ability to play by self and with peers, explore
    - Cognitive functioning
    - Relatedness to parent/guardian/designated representative

9. Use of standardized instruments to identify baseline functioning and track progress over time. Examples of such instruments include, yet are not limited to the following:

NAME OF TOOL	PURPOSE/DESCRIPTION	AGE/POPULATION	USER
INFANT TODDLER SOCIAL-EMOTIONAL ASSESSMENT (BITSEA)	*Social/Emotional* Brief report questionnaire focused on child symptomatology	12 to 36 mos. Multicultural	Professional or Parents/guardians/ designated representatives
BEHAVIORAL ASSESSMENT OF BABY'S EMOTIONAL AND SOCIAL STYLE (BABES)	*Behavioral Screening for temperament*, ability to self-soothe and regulate	Ages birth to 36 months	Parent/guardian/designated representative (for use in pediatric practices or early intervention programs)
CHILD BEHAVIOR CHECKLIST 1-5 (ASEBA) (ACHENBACH AND RESCORLA; 2001)	*Social/Emotional* Parent and teacher ratings, descriptions and concerns of child behaviors; Corresponds to DSM	Ages 1.5 years+ Multicultural	Professional Training required
PRESCHOOL AGE PSYCHIATRIC ASSESSMENT (PAPA); (EGGER & ANGOLD, 2006)	Psychiatric diagnosis incorporating both DSM and DC:0-3R	Ages 2 to 5 years Boys/Girls Multicultural	Professional only Training required
CLINICAL PROBLEM-SOLVING PROCEDURE (CROWELL AND FLEISHMANN; 2000)	Structured observations of parent/child interactions	Ages 1 year to 5 years	Professional Videotaping essential
AGES AND STAGES QUESTIONNAIRE (ASQ-3)	Routine screening to assess developmental performance	Ages at various points from 1 month to 66 months; Boys & girls Multicultural	Parent completion
CONNOR'S EARLY CHILDHOOD ASSESSMENT	Measures specific patterns related to ADHD, cognitive and behavioral challenges	Ages 3 to 6+ Boys and Girls	Parent & teacher responses

HAWAII EARLY LEARNING PROFILE (HELP)	Assessment of developmental skills and behaviors	Ages 0 to 3 Boys & girls	Training required for use
PARENTS' EVALUATION OF DEVELOPMENTAL STATUS (PEDS)	Developmental Screening Tool – variety of domains	Birth to 8 years Boys & girls	Parent completion
TRAUMATIC SYMPTOM CHECKLIST FOR YOUNG CHILDREN (TSCYC)	Assessment of PTSD Symptoms	Normed separately for boys and girls Ages 3 to 5	Can be completed by paraprofessionals
MCHAT (2009)	A parent report screening tool to assess risk for Autism Spectrum Disorder (ASD)	Designed for use at 18 – 24 months of age	Completed by parents and scored by pediatricians, child psychiatrists or child psychologists

E. PSYCHOTHERAPEUTIC INTERVENTIONS

There is strong evidence base for the use of psychotherapeutic interventions for young children with psychiatric diagnoses. Thus, these specialized approaches should be the initial interventions before considering a psychopharmacologic trial (see table on following page and the Division Medical Policy 210).

The recommended psychotherapeutic treatment interventions outlined in the table below are supported by current studies and best practice. Determination of the best psychotherapeutic approach is done in conjunction with the CFT and qualified infant and early childhood behavioral health practitioners. Psychoeducation and early intervention are essential components of any psychotherapeutic intervention program and therefore should be included in the treatment of all disorders. Other examples of accepted therapeutic approaches with this population are referenced in Division Medical Policy 210. The psychotherapeutic intervention selected and length of treatment should be clearly documented in the clinical record.
Suggested Best Practice Interventions for Infants and Toddlers (Table not inclusive of all available therapeutic modalities – any modalities utilized will be at the discretion of the treating BHP or BHMP).

TYPE OF INTERVENTON	TREATMENT APPROACH	TARGETED POPULATIONS	TREATMENT GOALS	GUIDING ASSUMPTION AND THEORETICAL ORIENTATION
FAMILY THERAPY Training through various organizations, institutional or educational settings; Numerous master's level educational programs have dedicated programs in marriage and family therapy Marriage and Family Therapists receive specific training and clinical supervision that focuses on working with family members at the relationship level (e.g., parent- parent, parent-child or child- child)	Focus on conflict management and influence of marital conflict during high-risk perinatal period; can also be used prenatally; Goal is to ensure parent/guardian/ designated representative consensus regarding child's behavioral health status AND that parenting strategies are consistent	Infants, toddlers, preschoolers and family triad (e.g., including mother and father);	Intervention takes place at the marital relationship level, as well as the relationships between each parent and the child; focus on evaluating and changing interaction patterns between triadic members	Behavioral challenges are linked to patterns of relationship challenges; an intervention directed at one family member will always have an effect on another family member; Can change behavior by changing relationships (dyadic, triadic, family system) Theoretical assumptions, which guide family therapy intervention techniques, provide essential element of clinical framework for relationship- based work within Circle of Security, and Infant/Child Parent Psychotherapy
CHILD PARENT PSYCHOTHERAPY (CPP) Training through various organizations, institutional or educational settings; Lieberman and Van Horn are originators of intervention principals	Relationship-based; focus on parent perceptions and behaviors to promote mutual positive exchanges between child and parent/ guardian/ designated representative	Infants, toddlers, & preschoolers with or at risk for behavioral health problems along with their high-risk parents/ guardian/ designated representative	Work at relationship level to promote partnership between child and parent/guardian/ designated representative that results in increased positive interaction and reduced discordant relationship styles	Based on premise that "nurturance, protection, culturally and age-appropriate socialization from the attachment figure(s) comprise the cornerstone of behavioral health in infancy and early childhood…"

TYPE OF INTERVENTION	TREATMENT APPROACH	TARGETED POPULATIONS	TREATMENT GOALS	GUIDING ASSUMPTION AND THEORETICAL ORIENTATION
INFANT PARENT PSYCHOTHERAPY Training through various organizations, institutional or educational settings; Lieberman and Van Horn are originators of intervention principals	Similar to Child Parent Psychotherapy, but with greater emphasis on impact of upbringing of parent/guardian/ designated representative and how that impacts current parent/guardian/ designated representative perceptions of infant and relationship with infant	Infants, typically birth to 24 months or prior to onset of language, locomotion, and ability to express feelings	Focus on parent/child relationship to build relationship with parent by helping caregiver understand the basis for infant behaviors and perceptions of their world (e.g., behavior based on need for safety and security)	IPP more reliant on the psychoanalytic work of Selma Fraiberg; focus on impact of psychological challenges of parent/guardian/ designated representative as child and how those challenges impact ability to act as nurturing, protective parent/guardian/ designated representative
CIRCLE OF SECURITY Training through Circle of Security International	Therapist builds trusting relationship with parent/guardian/ designated representative (secure base) as therapist moves through relationship-based interventions to identify relational distress	Infants, toddlers & preschoolers and their parent/guardian / designated representative	Use Circle of Security interview to gain information about parent/guardian /designated representative "internal working model" regarding relationship with their child	The need for a secure attachment base is essential for building healthy relationships *Based on Attachment Theory (joint work of John Bowlby and Mary Ainswort also based on relationship-based interventions arising out of family therapy and family systems guiding assumptions and psychoanalytic theory*

TYPE OF INTERVENTION	TREATMENT APPROACH	TARGETED POPULATIONS	TREATMENT GOALS	GUIDING ASSUMPTION AND THEORETICAL ORIENTATION
APPLIED BEHAVIORAL ANALYSIS	Applied behavior analysis is the process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree, and to demonstrate that the interventions employed are responsible for the improvement in behavior	Applied Behavioral Analysis Techniques can be used with persons of all ages, with both behavioral health and developmental disabilities diagnoses. An Early Intensive ABA (EI/ABA) program specifically for children with Autism Spectrum Disorder who begin treatment before age 4 has been described by Lovaas and others.	ABA techniques are used to decrease unwanted behaviors and increase desired behaviors through a systematic and consistent intervention. EI/ABA is provided with the goal of integrating a young child with ASD into a regular education classroom with reduced behavioral symptoms by the entry into Grade 1.	That systematic behavioral intervention can decrease unwanted behaviors and increase desired behaviors.

F. PSYCHIATRIC EVALUATION

General practice within Arizona's System of Care includes a comprehensive behavioral health assessment prior to a psychiatric evaluation. A psychiatric evaluation may be completed based on CFT decision making and when clinically indicated. The psychiatric evaluation may take multiple sessions and is completed prior to the initiation of psychotropic medication. Birth through five behavioral health significant efforts should be made to ensure that the psychiatric evaluation is conducted by a board certified or board qualified child and adolescent psychiatrist with training or experience in the treatment of young children, aged 0 to 5.

The psychiatric evaluation for a young child continues to focus on gathering supplemental information that may be needed since completion of the comprehensive assessment. This is especially critical for identification of any additions or changes that may impact the child's functioning. Components may be

very similar:

1. Information from those persons who are most familiar with the child, as well as direct observation of the child with their parent/guardian/designated representative especially if changes have occurred within the caregiver constellation since the initial assessment.

2. Any potential changes in the reason for referral including changes in the child's social, emotional, and behavioral symptoms.

3. Updates related to the detailed medical and developmental history.

4. Updates related to current medical and developmental concerns and status.

5. Changes in family, community, childcare, and cultural contexts which may influence a child's clinical presentation.

6. Newly identified parental and environmental stressors and supports.

7. Ongoing or recent changes in parent/guardian/designated representative perception of the child, ability to read/respond to child's cues, and willingness to interact with the child.

8. Use of the Division Medical Policy 210 to ensure use of evidence-based Behavioral Health Practice Tool for working with infants and toddlers.

9. Collaboration with pediatrician/primary care physician and/or developmental pediatricians involved.

10. Collaboration with other agencies involved with the child and family including but not limited to Department of Child Safety (DCS), Division of Developmental Disabilities (DDD), Arizona Early Intervention Program (AzEIP), First Things First, Head Start, the local school district, Healthy

Families Arizona and other educational programs.

11. Development of DSM-5 Diagnoses and DC: 0 TO 5 Diagnosis following:

- Diagnostic Classification of Behavioral health and Developmental Disorders in Infancy and Early Childhood" (DC: 0-5).
- The Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, (DSM-5).

Current best practice for infants and toddlers, utilizes the DC: 0-5 for a number of reasons. First, it is based on Behavioral Health normed developmental trajectories, family systemic and relationship-based approaches, along with attention to individual differences in motor, cognitive, sensory, and language capabilities. Secondly, it allows for more thorough and developmentally appropriate diagnosis of behavioral health conditions in early childhood. An important feature of the DC: 0-5 is that it includes both the DSM-5 diagnostic references, as well as the corresponding ICD-10 codes. The DC: 0-5 manual was first published in 1994 as the "DC 0-3" and then revised in 2016 by Zero to Three: National Center for Infants, Toddlers, and Families (now known as "Zero to Three").

G. PSYCHOPHARMACOLOGICAL INTERVENTIONS

1. General Guidelines

If it is determined that a psychopharmacologic intervention is indicated, goals of treatment should include facilitating normative developmental processes and maximizing the potential for effective psychotherapeutic interventions. Medications are to be reserved for children with moderate to severe psychiatric symptoms that significantly interfere with their normal development and result in impairment that persists despite the use of clinically appropriate psychotherapeutic interventions, as the evidence base for the treatment of young children under the age of five is quite limited.

Clear and specific target symptoms shall be identified and documented in the clinical record prior to the initiation of a medication trial. Target symptoms and progress are continually documented in the clinical record throughout the course of treatment (Division Medical Policy 940).

Medication is always started at the lowest possible dose with subsequent increases in medication undertaken with caution. Dosing can be challenging as young children may metabolize medications more rapidly than older children. In addition, children age birth through five experience rapid growth during this timeframe, which may change the dose that is required for optimal treatment over short periods. Since these young children are often very sensitive to side effects, they shall be monitored closely.

2. Informed Consent

Informed consent, as specified in Division Medical Policy 320-Q, is an active, ongoing process that continues over the course of treatment through active dialogue between the prescribing BHMP and parent or Health Care Decision Maker about the following essential elements (Please refer to Division Medical Policy 310-V and AMPM Policy 310-V Attachment A for more information):

- The diagnosis and target symptoms for the medication recommended
- The possible benefits/intended outcome of treatment
- The possible risks and side effects
- The possible alternatives
- The possible results of not taking the recommended medication
- FDA status of the medication
- Level of evidence supporting the recommended medication

Although there are medications approved by the Food and Drug Administration (FDA) for young children under the age of five, an FDA indication reflects empirical support but is not synonymous with a recommendation for use consistent with current studies and best practice. In

addition, lack of an FDA indication does not necessarily reflect a lack of evidence for efficacy. The Physician's Desk Reference states the following: "Accepted medical practice includes drug use that is not reflected in approved drug labeling." In the United States only a small percentage of medications are FDA indicated for use in pediatrics. Thus, BHMPs shall document the rationale for medication choice and the provision of informed consent to parents/ guardians/designated representatives.

3. Monitoring

Medications that have been shown to adversely affect hepatic, renal, endocrine, cardiac and other functions or require serum level monitoring shall be assessed via appropriate laboratory studies and medical care shall be coordinated with the child's primary care physician.

4. Coordination of Care

In Arizona, the behavioral health program has historically been separated from the acute care Medicaid program (Title XIX) and the State Children's Health Insurance Program (KidsCare/SCHIP/Title XXI). Both models have been structured in the past in such a way that eligible persons received general medical services through health plans and covered behavioral health services through a separate Contractor. Because of this separation in responsibilities, communication and coordination between behavioral health providers, AHCCCS Health Plan Primary Care Providers (PCPs) and Behavioral Health Coordinators is essential to ensure the well-being of young children receiving services from both systems. Since October 1, 2019, there has been a system-wide shift toward medical health homes and provision of integrated and coordinated care, which is bringing about a shift in provider practices to address early intervention needs using a more holistic approach. Since October 1, 2019, the Division has contracted with the AdSS to implement integrated and coordinated behavioral health and physical health care.

Duplicative medication prescribing, contraindicated combinations of

prescriptions and/or incompatible treatment approaches could be detrimental to a young child. For this reason, communication and coordination of care between behavioral health providers and PCPs shall occur on a regular basis to ensure safety and positive clinical outcomes for young children receiving care.

5. Polypharmacy

Polypharmacy is defined as using more than one psychotropic medication at a time with this population and is not recommended. This definition excludes a medication cross taper, where the young child may be on two medications for a short period in order to avoid abrupt withdrawal symptoms. More than one medication should only be considered and used in extreme situations where severe symptoms and functional impairment are interfering with the child's ability to form close relationships, experience, regulate and express their emotions, and developmental progress.

Complementary, alternative, and over-the-counter medications should be taken into consideration when evaluating the use of polypharmacy and potential drug interactions. If more than one medication is prescribed, there shall be documentation of clear target symptoms for each medication in the child's clinical record. When applicable, the Controlled Substance Prescription Monitoring Program (CSPMP) database should be checked (Refer to Division Medical Policy 940).

6. Medication Taper

In children who have a positive response to medication, as indicated by a remission of symptoms, a taper off medication should be considered at six to eight months of treatment. This consideration shall be clearly documented in the clinical record. The BHMP shall weigh the risks vs. benefits of each approach with the parent/guardian/designated representative, which includes the importance of reassessing the need for medication in the rapidly developing young child. Every six to eight months, a medication taper should

be considered until the child reaches the age of five. The BHMP should reassess for a persistent diagnosis and need for continuing medication at reasonable intervals beyond age five.

If the decision to taper the child off medication is made, the CFT shall be informed of this decision in order to discuss and address possible behavior disruptions that may arise as a result of this taper. The CFT shall also ensure that the need for additional supports or services for the child and/or caregiver be considered and implemented as necessary to maintain the child's stability (For specific guidelines for children involved with the Department of Child Safety and/or foster care, refer to AMPM Behavioral Health Practice Tool 260, Division Medical 320-Q, and A.R.S. § 8-514.05). Documentation of medication taper should be made with clinical rationale provided.

7. Prescription by a Non-Child Psychiatrist

As noted earlier with assessment and evaluation practice standards, BHMPs who provide treatment services to young children shall have training and possess experience in both psychotherapeutic and psychopharmacological interventions for children age birth through five. Medication management should be provided by a board certified or qualified child and adolescent psychiatrist whenever possible; in rural or underserved locations, this may be met through the use of telemedicine. A non-child psychiatrist BHMP shall adhere to the following when prescribing psychotropic medication for children birth through five years of age:

a. After the psychiatric evaluation has been completed and it is determined that the child may benefit from psychotropic medication(s), the case shall be reviewed with the designated child psychiatric provider as determined by the Contractor. The review shall include, at a minimum, the following elements:

   i. The proposed medication with the starting dosage,
   ii. Identified target symptoms,

iii. The clinical rationale for the proposed treatment,

iv. Review of all medications the child is currently taking, including over the counter and those prescribed by other medical/holistic providers,

v. Drug Review/Adverse Reactions,

vi. A plan for monitoring, potential side effects such as weight gain, and/or abnormal/involuntary movements, (based on recommended standards of care, and

vii. Identified targeted outcomes.

b. Follow-up consultation with a designated child psychiatric provider shall occur in the following instances:

i. If the child is not making progress towards identified treatment goals (at minimum of every three months),

ii. In the event that reconsideration of diagnosis is appropriate,

iii. When a new medication is being considered or when more than one medication is prescribed.

H. BIRTH THROUGH FIVE EPSDT: ASSESSING PHYSICAL AND BEHAVIORAL NEEDS THROUGH DEVELOPMENTAL SURVEILLANCE, ANTICIPATORY GUIDANCE AND SOCIAL/EMOTIONAL GROWTH

AHCCCS has historically incorporated the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program to ensure that members under the age of 21 receive appropriate preventive and early intervention services for physical and behavioral health conditions (refer to Division Medical Policy 430). Through formal policy and reporting requirements under CMS guidelines, participation has been measured in part through use of forms designated as "EPSDT Tracking Forms" (refer to AMPM Policy 430, Attachment E).

Although AHCCCS requires use of specific EPSDT forms available on the AHCCCS website, further guidance on the use of the forms is also available through Bright

Futures. Both the Bright Futures website and Bright Futures Pocket Guide offer more detailed guidance on use of content within the tracking forms. The focus of the last section of this policy is to assist PCPs and/or pediatricians in identifying concerns related to three central EPSDT domains:

- Anticipatory Guidance,
- Developmental Surveillance, and
- Social/Emotional Growth.

Often, the primary care setting is the most robust situation available for parents to address early developmental or behavioral concerns. During the course of EPSDT-required well-child visits, physicians and pediatricians have multiple opportunities over time to build relationships with parents and their young children, while simultaneously gathering valuable information. Through discussions guided by the use of the three domains listed above, they have the chance to identify strengths, needs and stressors for the parents and children that they follow. With thoughtful use of items within these domains, it is possible for physicians to identify a physical health concern that may also involve the need for further behavioral health services. For example, a language delay or developmental regression could be due to numerous physical causes. However, both are also symptoms of early childhood trauma for children birth to three years of age. Additionally, symptoms often associated with attention deficit hyperactivity disorder (ADHD) can mirror child traumatic stress.

The challenge for physicians, due to lack of training and knowledge, is often the ability to clearly identify behavioral and developmental concerns and then link parents/guardians/ designated representatives to adequate resources. Some physicians are comfortable providing basic treatment, whereas others are not. According to one study, PCPs had various comfort levels to conduct treatment or make referrals, but it related to the diagnoses involved. There was a comfort level treating ADHD but not depression – the preference for the latter, in most instances was to make a behavioral health referral.

Given acknowledgement to the lack of behavioral health training within the pediatric

community, dedicated and thorough use of EPSDT forms, as well as guidance provided under Bright Futures, can aid physicians in providing appropriate and early intervention treatment for children birth through five. The center sections of EPSDT forms offer opportunity to work with parents/guardians/designated representatives to offer guidance and encourage referrals to and use of behavioral health system when there is concern about behaviors that may indicate a potential behavioral health condition.

Although it is not the purpose of this policy to offer extensive details regarding early childhood developmental and behavioral health issues, the table below provides some examples of how EPSDT Developmental Screening sections can prompt opportunities (based on specific age-appropriate EPSDT domains) for discussion between parents/Responsible Person and PCPs regarding observations and concerns identified during visits. PCPs have multiple options at these visits to suggest community supports, case manager involvement (if available under the Medical Health Home model) or refer to behavioral health system/provider for further assistance (Refer to Division Medical Policy 580 for information on the Behavioral Health Referral Process).

The table below is designed to present bivariate ways (e.g., physical or behavioral) to examine developmental milestones, environmental factors and level of social/emotional growth. Because physical and familial environments have such a tremendous impact on the developing brain, it is important to recognize that if infants and toddlers are not meeting milestones, there could be either physical, environmental or behavioral health reasons.

EPSDT Domain Sample Table: Potential indicators for referral to Behavioral Health Services (Based on age, domain & need). (AMPM Policy 430, Attachment E; Bright Futures, 4th Edition)

EPSDT DOMAINS	AGE	DISCUSSION CHECKLIST ELEMENT	POTENTIAL BEHAVIORAL HEALTH NEED
DEVELOPMENTAL SURVEILLANCE	6 months	Sits without support, babbles sound such as "ma", "ba", "ga", looks when name is called.	Parent/guardian/designated representative engages with and is attentive toward infant; if infant is engaging in these early milestone behaviors, and there is lack of reaction or acknowledgement from parent, or reciprocal engagement explore further for evidence of potential maternal depression or other environmental factors (unsafe environment, violence, neglect) that may be causing stress or trauma for the infant.
ANTICIPATORY GUIDANCE PROVIDED	6 months	Discussion of social determinants of health (e.g., safe sleep, sleep/wake cycles, tobacco use, safe environment).	Any potential risk factors identified under this domain may warrant referral for community supports or referral for behavioral health services if there is concern about parental depression, substance use, neglect of child or dangerous environment).
SOCIAL EMOTIONAL HEALTH	6 months	Appropriate bonding and responsive to needs.	Is parent/guardian/designated representative feeding infant and engaging while feeding or is infant being fed via bottle propping while in carrier or crib? Lack of infant/parent engagement may warrant further discussion and referral to behavioral health system due to potential indicators for maternal depression or lack of appropriate bonding/attachment. Lack of appropriate bonding can manifest in multiple ways (lack of eye contact between baby and caregiver, baby shows signs of discomfort when being held, inability for caregiver to help baby sooth).
ANTICIPATORY GUIDANCE PROVIDED	1 yr.	Continued focus on social determinants of health such as food security, safe environment, parental use of tobacco, alcohol or other substances.	If there are parental risk factors for social determinants of health, there are opportunities to refer for community supports or behavioral health; in case there are underlying behavioral health needs (e.g., parental depression, substance use).
SOCIAL EMOTIONAL HEALTH	1 yr.	Prefers primary caregiver over others, shy with others, tantrums.	Lack of preference for primary caregiver could indicate insecure attachment for variety of reasons (e.g., lack of trust, abuse, neglect, early trauma); consider unaddressed behavioral health issues in parent.

EPSDT DOMAINS	AGE	DISCUSSION CHECKLIST ELEMENT	POTENTIAL BEHAVIORAL HEALTH NEED
DEVELOPMENTAL SURVEILLANCE	3 yrs.	Eats independently, uses three word sentences, plays cooperatively and shares.	Lack of these observed developmental milestones may be indicative of physical issues or lack of parental engagement with child; consider referral for community supports and/or behavioral health system to address potential for undiagnosed behavioral health issue on the part of the parent or child (barring any evidence of physical reasons).
ANTICIPATORY GUIDANCE PROVIDED	3 yrs.	Allow child to play independently; be available if child seeks out parent or caregiver.	Attachment issues can manifest as fear in child to play independently, even if allowed (over-dependence on caregiver), or reluctance of child to seek out parent/guardian/designated representative due to lack of secure "attachment" base. Could also be signs/symptoms related to abuse.
SOCIAL EMOTIONAL HEALTH	3 yrs.	Separates easily from parent, shows interest in other children, kindness to animals.	Observe parental conversations and interaction; is parent positive with child, offering praise, setting appropriate boundaries; lack of these observed behaviors on the part of either parent or child may indicate unaddressed child/parent relationship issues or potential mental issue issues for either parent or child.

I. DIVISION OVERSIGHT OF AdSS

The Division shall complete oversight of the AdSS utilizing, but not limited to, the following methods to ensure compliance with this and associated policies:

1. Annual Operational Review of standards related to birth to age five.
2. Conduct oversight meetings with the AdSS for the purpose of reviewing compliance, addressing concerns with access to care or other quality of care concerns, discussing systemic issues and providing direction or support to the AdSS as necessary.
3. Ensure AdSS conducts ongoing monitoring and evidence of compliance through Behavioral Health Clinical Chart Reviews.

Signature of Chief Medical Officer: Anthony Dekker (Apr 28, 2022 10:35 PDT)

Anthony Dekker, D.O.

230 SUPPORT AND REHABILITATION SERVICES FOR CHILDREN, ADOLESCENTS AND YOUNG ADULTS

EFFECTIVE DATE: June 15, 2022

REFERENCES: A.A.C. R9-10-115, AMPM Chapter 200, Division Medical Policy 320-O

PURPOSE

This policy applies to the AHCCCS System of Care for ALTCS eligible members. The policy is specifically targeted to the Division's Behavioral Health Administration in relation to their role with oversight of the Administrative Services Subcontractors (AdSS) and the role of Support Coordination. The policy establishes the expectations for the implementation of support and rehabilitation services as they are used in CFT practice. This policy does not apply to the Division's Tribal Health Program but may be used as an optional resource.

DEFINITIONS

Child and Family Team (CFT) means a group of individuals that includes, at a minimum, the child and their family, or health care decision maker. A behavioral health representative, and any individuals important in the child's life that are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches, and community resource providers, representatives from churches, temples, synagogues, mosques, or other places of worship/faith, agents from other service systems like the Arizona Department of Child Safety (DCS) or the Division of Developmental Disabilities (DDD). The size, scope, and intensity of involvement of the team members are determined by the objectives established for the child, the

needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore, expand and contract as necessary to be successful on behalf of the child.

Service Plan means a complete written description of all covered health services and other informal supports which includes individualized goals, family support services, peer-and-recovery support, care coordination activities and strategies to assist the member in achieving an improved quality of life.

Support and Rehabilitation Service Providers provide either a limited scope of Support and Rehabilitation Services (such as primarily specializing in respite services or skills training services) and/or services that may be designed for a specific population, age, gender, frequency, duration, or some other factor (such as a service specializing in working with teenagers or those with a history of displaying harmful sexual behaviors).

BACKGROUND

In March of 2007, ADHS/DBHS launched the Meet Me Where I Am (MMWIA) campaign with the intention of increasing the availability of Support and Rehabilitation Services. As a result of administrative simplification this goal remains a priority of AHCCCS. As part of the MMWIA campaign, nine modules were created and placed online offering assistance to practitioners of direct support services. These modules can be accessed at mmwia.com and referenced in this document.

POLICY

Support and rehabilitation services are an essential part of community-based practice and culturally competent care. These services help children live

successfully with their families in the community. Adhering to the expectations of this policy will enhance behavioral health outcomes for children and young adults. The Division delegates the responsibility to AdSS for the implementation of behavioral health services in alignment with this policy, and whose contract includes this requirement. The Division remains responsible for support coordination and oversight of the AdSS. Support Coordination shall receive training on the general practices outlined in this policy for purposes of increasing their ability to coordinate services for their members and participants of Child and Family Team (CFT) meetings. The Division shall conduct formal oversight of the AdSS. Refer to AdSS Medical Policy 230 for responsibilities of the AdSS implementing this policy.

A. SERVICE DEVELOPMENT

1. The Division performs oversight of the AdSS to ensure the following occurs in relation to service development:

    a. CFTs have access to the full range of Support and Rehabilitation Services;

    b. CFT facilitators and families are aware of the value of Support and Rehabilitation Services, as well as specific and current information regarding the different provider options available in their area;

    c. The AdSS adopt a Support and Rehabilitation Services system model outlining how these services will be structured in their region and their relation to other behavioral health services and providers. (Refer to Module 9, System and Program Models for Support and Rehabilitation Services Provision, of the online MMWIA modules for more information.)

d. Support and Rehabilitation Services are available to meet the behavioral health needs of youth and families as identified in their CFTs.

2. Division Support Coordinators shall participate in member CFT meetings to ensure integrated care coordination.

B. INTEGRATING SUPPORT AND REHABILITATION SERVICES WITH CFT PRACTICE

The CFT shall complete the following tasks when planning and arranging for Support and Rehabilitation Services. (Refer to Module 4, Assessing, Coordinating and Monitoring Support Services through the CFT, of the online MMWIA modules for detailed information about each task.)

1. Assess the underlying needs of the child/family and consider the various options presented through Support and Rehabilitation Services for meeting those needs. These options may include family, natural and community resources, resources of other involved stakeholder agencies (such as DCS, DDD, and family-run support or advocacy organizations) as well as paid behavioral health resources. The CFT determines which of the identified needs will be met through Support and Rehabilitation Services and documents these interventions in a service plan. The CFT determines which of the identified needs will be met through Support and Rehabilitation Services and documents these interventions in a service plan. (Refer to Division Medical

Policy 320-O.)

2. Locate and select Support and Rehabilitation Services provider(s) to help implement the plan. Collaborate with and use information provided by the Contractors to do the following:

   a. Determine which Support and Rehabilitation Services providers may meet the needs identified, determine whether those providers have current capacity, and

   b. Make a referral to the selected provider(s).

3. Work with the Support and Rehabilitation Services provider(s) to define their roles and tasks, specifying the anticipated frequency and duration associated with the Support and Rehabilitation Services requested. The CFT ensures this information is recorded in the service plan and the Support and Rehabilitation Services provider(s) promptly receive a copy of the plan. If unplanned services are needed due to crisis situations, the CFT notes this change in the service plan and the Support and Rehabilitation Services provider is authorized to respond with additional support if needed.

4. Coordinate effectively with the Support and Rehabilitation Services providers on an ongoing basis. This may be accomplished through CFT meetings as well as through regular communication with the Support and Rehabilitation Services provider. The CFT Facilitator/case manager sends the Support and Rehabilitation Services provider a complete Referral Packet

which includes copies of any updated assessments, service plans, notice of change to funding status, and other important documents whenever updates occur.

5. Support and Rehabilitation Services shall be documented accurately and differentiate between which services were provided. Module 1, Overview of Support and Rehabilitation Service Provision, of the MMWIA modules provides several appendices intended to assist with code differentiation and billing limitations of Support and Rehabilitation Services.

6. Monitor progress and adjust the Support and Rehabilitation Services provision as necessary. The CFT, which includes the Support and Rehabilitation Services provider, makes necessary adjustments to the authorized Support and Rehabilitation Services. These include the type, anticipated frequency and duration of the service(s), as well as and documents any changes in the service plan. CFTs meet regularly and make needed adjustments in the implementation of Support and Rehabilitation Services, both when services are successful and when they need to be modified because they are not achieving desired results.

7. All support and Rehabilitation Services should be provided using a Positive Behavior Support (PBS) philosophy. Module 3, Using Positive Behavior Support to Provide Effective Support and Rehabilitation Services, of the online MMWIA modules contains information regarding this type of approach. PBS is intended as

a meta-theory to guide Support and Rehabilitation Services provision rather than as a specific type of program. It is not the intent of the Division to prescribe specific programming practices, but rather to endorse the principles underlying Positive Behavior Support, such as focus on strengths, enhancing quality of life and eliminating coercive or punitive approaches.

8. When clinically appropriate, the CFT will direct a plan to discontinue formal Support and Rehabilitation Services delivery ensuring that the youth and family have been connected to community resources or services and natural support services that will provide ongoing support. (Refer to MMWIA Module 4, Assessing, Coordinating and Monitoring Support Services through the CFT, for more information about when it may be appropriate to end Support and Rehabilitation Services as well as suggestions for transition from these services.)

C. RESPONSIBILITIES REGARDING SUPPORT AND REHABILITATION SERVICES PROCESSES

1. AdSS and their network of behavioral health providers shall maintain and make available to the CFT, current and accurate information regarding Support and Rehabilitation Services providers and their current capacity/availability to provide support.

2. AdSS and their network of behavioral health providers shall require that Support and Rehabilitation Services providers use a standardized referral process that helps providers receive, store,

track, and respond in writing to all referrals received from CFT facilitators/case managers.

3. To better assess the need for increased Support and Rehabilitation Services capacity, AdSS and their network of behavioral health providers shall monitor information from CFT Facilitators/case managers who are unable to locate Support and Rehabilitation Services requested by the CFT in a timely manner. Information gathered may include the date of the request(s), number of providers approached, the type and/or amount of Support and Rehabilitation Services sought by the team, and what the team did as an alternative to address the needs of the youth and family.

4. AdSS and their network of behavioral health providers shall create and oversee a process whereby Support and Rehabilitation Services providers receive copies of any and all of the following documents in a timely manner each time they are updated. These documents are needed for quality service provision, and may also be necessary in the event of data validation audits they include:

    a. Assessments and Addenda,

    b. Review of Progress forms,

    c. Service Plan Documents,

    d. Data demographic forms,

e. Crisis/Safety Plans,

f. Strengths, Needs and Culture Discoveries, and

g. Child and Family Team Notes (if separate from the above items).

5. AdSS and their network of behavioral health providers shall ensure that procedures are in place to require Support and Rehabilitation Services providers to do the following:

a. Respond to referrals in a timely manner, (Refer to AdSS Operations Policy 417),

b. Participate actively in Child and Family Teams

c. Provide information regarding service delivery as it relates to established child/family goals, and

d. Provide training and supervision necessary to help staff provide effective Support and Rehabilitation Service as outlined by the CFT.

6. AdSS and their network of behavioral health providers shall develop a process to ensure that when children and families are receiving intense Support and Rehabilitation Services or are receiving them for an extended period of time, services are reviewed periodically to ensure resources are being used effectively. Such review should be done in person with the CFT rather than outside of the team. During such reviews, case-specific factors identified by the CFT as being important to the success of the family must be considered.

7. AdSS and their network of behavioral health providers shall develop processes to track outcomes of Support and Rehabilitation Services both qualitatively (such as narrative success stories) and quantitatively (such as outcome data).

D. TRAINING AND SUPERVISION RECOMMENDATIONS

1. AdSS and their network of behavioral health providers shall establish processes for ensuring all clinical and support services staff working with children and adolescents understand the elements for development and use of Support and Rehabilitation Services as specified in this document through formal training as noted here, including required reading of this Policy.

2. Several training resources have been developed as part of the MMWIA campaign to assist families, providers, and community members in using Support Rehabilitation Services effectively. Specifically, nine self-guided training modules/toolkits are available for any individuals or agencies across the state that participates in CFTs. These modules may be accessed online at www.mmwia.com.

3. AdSS and their network of behavioral health providers shall provide documentation, upon request from the Division or AHCCCS, demonstrating that all required network and provider staff have been trained on the elements contained in this policy. Whenever this policy or the attendant training modules are updated or revised, AdSS shall ensure their subcontracted network and provider agencies are notified and required staff are

retrained as necessary on the changes.

4. Supervision regarding implementation of this policy is to be incorporated into other supervision processes which the AdSS and their subcontracted network and provider agencies have in place for direct care clinical staff, in accordance with A.A.C. R9-10-115, Behavioral Health Paraprofessionals, Behavioral Health Technicians.

E. AdSS OVERSIGHT

1. The Division shall complete oversight of the AdSS utilizing, but not limited to, the following methods to ensure compliance with this policy and policies referenced within this policy:

    a. Annual Operational Review of compliance with this policy and related standards, including but not limited to:

        i. Policies/procedures for, and evidence of, assessing and prioritizing identified need for MMWIA services.

        ii. Policies/procedures for, and evidence of, tracking and documenting demand/unmet need for MMWI services.

        iii. Policies/procedures, and evidence of, implementing strategy for addressing the lack of timely availability of MMWIA services.

        iv. Policies/procedure for, and evidence of, managing and documenting service utilization/length of stay for MMWIA services.

        v. Evidence of training as described in section Training and Supervision above.

b. Receive and analyze deliverable reports or other data as submitted by the AdSS.

c. Conduct oversight meetings with the AdSS for the purpose of reviewing compliance and addressing concerns with access to care or other quality of care.

d. Ensure AdSS complete ongoing monitoring and evidence of compliance through Behavioral Health Clinical Chart Reviews.

Signature of Chief Medical Officer: Anthony Dekker (Jun 14, 2022 17:33 PDT)

Anthony Dekker, D.O.

280 TRANSITION TO ADULTHOOD

EFFECTIVE DATE: June 29, 2022

REFERENCES: A.A.C. R4-6-212, IDEA Part B, Section 1415 (m), Section 504 of the Rehabilitation Act of 1973

PURPOSE

This policy applies to the AHCCCS System of Care for ALTCS eligible members. This policy is specifically targeted to the Division's Behavioral Health Administration in relation to their role with oversight of the Administrative Services Subcontractors (AdSS) and the role of support coordination. This policy is an optional resource for the Tribal Health Program and is not a requirement for the Tribal Health Program.

The Division delegates the responsibility to AdSS for the implementation of behavioral health services in alignment with this policy. The Division remains responsible for support coordination and oversight of the AdSS.

The purpose of this policy is to strengthen practice in the system of care and promote continuity of care through collaborative planning by:

1. Supporting individuals transitioning into early adulthood in ways that reinforce their recovery process.
2. Ensuring a smooth and seamless transition from the AHCCCS Children System of Care to the AHCCCS Adult System of Care.
3. Fostering an understanding that becoming a self-sufficient adult is a process that occurs over time and can extend beyond the age of 18.

DEFINITIONS

Adult Recovery Team (ART) is a group of individuals that, following the Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, work in collaboration and are actively involved in a member's assessment, service planning, and service delivery. At a minimum, the team consists of the member, member's health care decision maker (if applicable), advocates (if assigned), and a qualified behavioral health representative. The team may also include the member's family, physical health, behavioral health or social service providers, other agencies serving the member, professionals representing various areas of expertise related to the member's needs, or other individuals identified by the member.

Assessment – Behavioral Health means the ongoing collection and analysis of an individual's medical, psychological, psychiatric, and social conditions in order to initially determine if a health disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensure that the individual's service plan is designed to meet the individual's (and family's) current needs and long-term goals.

Child and Family Team (CFT) is a group of individuals that includes, at a minimum, the child and their family, or health care decision maker. A behavioral health representative, and any individuals important in the child's life that are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches, and community resource providers, representatives from churches, temples, synagogues, mosques, or other places of worship/faith, agents from other service systems like the Arizona Department of Child Safety (DCS) or the Division. The size, scope, and

intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore, expand and contract as necessary to be successful on behalf of the child.

Service Plan means a complete written description of all covered health services and other informal supports which includes individualized goals, family support services, peer-and-recovery support, care coordination activities and strategies to assist the member in achieving an improved quality of life.

Serious Mental Illness is a designation as specified in A.R.S. 36-550 and determined in an individual 18 years of age or older.

Serious Mental Illness Evaluation is the process of analyzing current and past treatment information including assessment, treatment other medical records and documentation for purposes of making a determination as to an individual's serious mental illness eligibility.

BACKGROUND

The psychological and social development of adolescents transitioning into young adulthood is challenged by the economic, demographic, and cultural shifts that have occurred over several generations. Sociologist researcher, Frank F. Furstenberg, Jr., as Network Chair of the Network on Transitions to Adulthood stated: "Traditionally, early adulthood has been a period when young people acquire the skills they need to get jobs, to start families, and to contribute to their communities. But, because of the changing nature of families, the education system, and the workplace, the process has become more complex. This means that early adulthood has become a difficult

period for some young people, especially those who are not going to college and lack the structure that school can provide to facilitate their development." While some individuals adapt well as they transition into the responsibilities of adulthood, others experience challenges such as those youth who have mental health concerns.

Between 2008 and 2017, the amount of adults that experienced serious psychological distress in the last month increased among most age groups, with the largest increases seen among younger adults aged 18-25 (71%). Notably, rates of serious psychological distress increased by 78% among adults aged 20-21 during the time period. Meanwhile, there was a decline among adults aged 65 and older.

These findings were consistent across other measures, with the rate of adolescents and young adults experiencing depressive symptoms in the last year increasing by 52% and 63%, respectively, while rates remained stable adults aged 26 and older.

As the transition to adulthood has become more challenging, youth with mental health needs struggle to achieve the hallmarks of adulthood such as finishing their education, entering the labor force, establishing an independent household, forming close relationships, and potentially getting married and becoming parents. While these may be considered the trademarks of adulthood from a societal viewpoint, some studies suggest that youth may conceptualize this transition in more "intangible, gradual, psychological, and individualistic terms." Top criteria endorsed by youth as necessary for a person to be considered an adult emphasized features of individualism such as accepting "responsibility for the consequences of your actions," deciding one's "own beliefs and values independently of parents or other influences," and establishing "a relationship with parents as an equal

adult."

Oftentimes, youth who successfully transition to adulthood are those that acquire a set of skills and the maturational level to use these skills effectively. Transition planning can emphasize interpersonal skill training through a cognitive-behavioral approach to help youth develop positive social patterns, assume personal responsibility, learn problem-solving techniques, set goals, and acquire skills across various life domains.

With transition to adulthood occurring at later ages and over a longer span of time, many young people in their 20's may still require the support of their families. Involving families in the transition planning process and identifying the individual support needs of their children recognizes the diversity that is needed when accessing services and supports. Youth who have been enrolled in government programs due to family hardship, poverty, physical, or mental health challenges are often the least prepared to assume adult responsibilities. For others, such as youth leaving foster care, they must acquire housing without the financial support of a family.

Eligibility for public programs, such as Medicaid, Social Security, and vocational rehabilitation, as well as housing and residential services, may engender planning for changes at the age of 18. Youth who have disabilities that significantly impact their ability to advocate on their own behalf may require a responsible adult to apply for guardianship. Other youth may benefit from a referral to determine eligibility for services as an adult with a serious mental illness. Thus, it is the responsibility of the behavioral health system to ensure young adults are provided with the supports and services they need to acquire the capacities and skills necessary to navigate through this transitional period to adulthood.

POLICY

This policy addresses the recommended practice for transitioning youth from the AHCCCS Children System of Care to the AHCCCS Adult System of Care, with a focus on the activities that will assist youth in acquiring the skills necessary for self-sufficiency and independence in adulthood, and as specified in AMPM 520 which requires that transition planning begins when the youth reaches the age of 16, however, if the Child and Family Team (CFT) determines that planning should begin prior to the youth's 16th birthday, the team may proceed with transition planning earlier to allow more time for the youth to acquire the necessary life skills, while the team identifies the supports that will be needed. Age 16 is the latest this process should start. For youth who are age 16 and older at the time they enter the AHCCCS System of Care, planning shall begin immediately. It is important that members of the CFT look at transition planning as not just a transition into the AHCCCS Adult System of Care, but also as a transition to adulthood.

Support Coordination shall receive training on the general practices outlined in this policy for purposes of increasing their ability to coordinate services for their members. The Division shall provide formal oversight of the AdSS to ensure compliance with AdSS Medical Policy 280.

A. SERIOUS MENTAL ILLNESS DETERMINATIONS

1. When the adolescent reaches the age of 17 and the CFT believes that the youth may meet eligibility criteria as an adult designated as having a Serious Mental Illness (SMI), the Division and subcontracted providers shall ensure the young adult receives an eligibility determination at the age of 17.5, as specified in Division Medical Policy 320-P.

2. If the youth is determined eligible, or likely to be determined eligible for services as a person with a SMI, the adult behavioral health services case manager is then contacted to join the CFT and participate in the transition planning process. After obtaining permission from the parent/guardian, it is the responsibility of the children's behavioral health service provider to contact and invite the adult behavioral health services case manager to upcoming planning meetings. When more than one behavioral health service provider is involved, the responsibility for collaboration lies with the provider who is directly responsible for behavioral health service planning and delivery.

3. If the young adult is not eligible for services as a person with a SMI, it is the responsibility of the children's behavioral health provider, through the CFT, to coordinate transition planning with the adult general mental health provider. Whenever possible, it is recommended that the young adult and their family be given the choice of whether to stay with the children's provider or transition to the adult behavioral health service provider. The importance of securing representation from the adult service provider in this process cannot be overstated, regardless of the person's identified behavioral health category assignment (SMI, General Mental Health, Substance Use). The children's behavioral health provider should be persistent in its efforts to make this occur.

B. REQUIREMENTS FOR INFORMATION SHARING PRACTICES, ELIGIBLE SERVICE FUNDING, AND DATA SUBMISSION UPDATES

1. Prior to releasing treatment information, the CFT, including the adult service provider, will review and follow health record disclosure guidelines per AMPM 940.
2. If the young adult is not Medicaid eligible, services that can be provided under non-Medicaid funding will follow policy guidelines as specified in AMPM Policy 320-T1.
3. The behavioral health provider will ensure that the behavioral health category assignment is updated along with other demographic data consistent with the AHCCCS Technical Interface Guidelines.
4. Youth, upon turning age 18, will be required to sign documents that update their responsibilities with relation to their behavioral health treatment as an adult. Some examples include a new consent to treatment and authorizations for sharing protected health information to ensure that the team members can continue as active participants in service planning. A full assessment is not required at the time of transition from child to adult behavioral health services unless an annual update is due or there have been significant changes to the young adult's status that clinically indicate the need to update the Assessment or behavioral health Service Plan.

C. KEY PERSONS FOR COLLABORATION

1. Team Coordination:

   When a young person reaches age 17 it is important to begin establishing team coordination between the child and adult service delivery systems. This coordination must be in place no

later than four-six months prior to the youth turning age 18. In order to meet the individualized needs of the young adult on the day s/he turns 18 a coordinated effort is required to identify the behavioral health provider staff who will be coordinating service delivery, including the services that will be needed and the methods for ensuring payment for those services. This is especially critical if the behavioral health provider responsible for service planning and delivery is expected to change upon the youth's transition at the age of 18.

Orientation of the youth, their family and CFT to potential changes they may experience as part of this transition to the AHCCCS Adult System of Care will help minimize any barriers that may hinder seamless service delivery and support the youth's/family's understanding of their changing roles and responsibilities. It might be helpful to engage the assistance of a liaison (e.g., family and/or peer mentor) from the adult system to act as an ambassador for the incoming young adult and their involved family and/or caregiver.

As noted in AMPM 220, the young adult, in conjunction with other involved family members, caregivers or guardian, may request to retain their current CFT until the youth turns 21. Regardless of when the youth completes their transition into the AHCCCS Adult System of Care, the CFT will play an important role in preparing the Adult Recovery Team (ART) to become active partners in the treatment and service planning processes throughout this transitional period. Collaboration between the child and adult service provider for transition age youth is more

easily facilitated when agencies are dually licensed to provide behavioral health service delivery to both children and adult populations.

2. Family involvement and culture must be considered at all times especially as the youth prepares for adulthood. Although this period in a young person's life is considered a time for establishing their independence through skill acquisition, many families and cultures are interdependent and may also require a supportive framework to prepare them for this transition. With the assistance of joint planning by the child and adult teams, families can be provided with an understanding of the increased responsibilities facing their young adult while reminding them that although their role as legal guardian may change, they still remain an integral part of their child's life as a young adult. It is also likely that the youth's home and living environment may not change when they turn 18 and are legally recognized as an adult.

   During this transitional period, the role that families assume upon their child turning 18 will vary based on:

   a. Individual cultural influences,

   b. The young adult's ability to assume the responsibilities of adulthood,

   c. The young adult's preferences for continued family involvement, and

   d. The needs of parents/caregivers as they adjust to upcoming changes in their level of responsibility.

3. Understanding each family's culture can assist teams in promoting successful transition by:

   a. Informing families of appropriate family support programs available in the AHCCCS Adult System of Care,

   b. Identifying a Family Mentor who is sensitive to their needs to act as a "Liaison" to the AHCCCS Adult System of Care,

   c. Recognizing and acknowledging how their roles and relational patterns affect how they view their child's movement toward independence, and

   d. Addressing the multiple needs of families that may exist as a result of complex relational dynamics or those who may be involved with one or more state agencies.

   Some youth involved with DCS may express a desire to reunite with their family from whose care they were removed. In these situations it is important for the CFT to discuss the potential benefits and challenges the youth may face.

D. SYSTEM PARTNERS

Coordination among all involved system partners promotes collaborative planning and seamless transitions when eligibility requirements and service delivery programs potentially change upon the youth turning 18. Child welfare, juvenile corrections, education, developmental disabilities, and vocational rehabilitation service delivery systems can provide access to resources specific to the young adult's needs within their program guidelines. For example, students in special education services may continue their schooling through the age of 21. Youth in foster care may be eligible for services through a

program referred to as the Arizona Young Adult Program (AYAP) or Independent Living Program (ILP) through the Arizona Department of Child Safety (DCS).

System partners can also assist young adults and their families/caregivers in accessing or preparing necessary documentation, such as:

1. Birth certificates.
2. Social security cards and social security disability benefit applications.
3. Medical records including any eligibility determinations and assessments.
4. Individualized Education Program (IEP) Plans.
5. Certificates of achievement, diplomas, General Education Development transcripts, and application forms for college.
6. Case plans for youth continuing in the foster care system,
7. Treatment plans.
8. Documentation of completion of probation or parole conditions.
9. Guardianship applications.
10. Advance directives.

E. NATURAL SUPPORT

Maintaining or building a support structure will continue to be important as the youth transitions to adulthood and has access to new environments. This is especially relevant for young adults who have no family involvement. For some youth, developing or sustaining social

relationships can be challenging. The child and adult teams can assist by giving consideration to the following areas when planning for transition:

1. Identify what supports will be needed by the young adult to promote social interaction and relationships.
2. Explore venues for socializing opportunities in the community.
3. Determine what is needed to plan time for recreational activities.
4. Identify any special interests the youth may have that could serve as the basis for a social relationship or friendship.

F. PERSONAL CHOICE

Although young adults are free to make their own decisions about treatment, medications, and services, they are generally aware that their relationships, needs, and supports may not feel different following their 18th birthday. They may require assurance that their parents are still welcomed as part of their support system, that they still have a team, rules still apply, and that information will be provided to assist them with making their own treatment decisions. However, some young adults may choose to limit their parent's involvement, so working with youth in the acquisition of self-determination skills will assist them in learning how to speak and advocate on their own behalf. This may involve youth developing their own understanding of personal strengths and challenges along with the supports and services they may need. When planning for transition, teams may also need to provide information to young adults on how the behavioral health service delivery systems operate in accordance with the following:

1. Arizona Vision and 12 Principles for Children's Service Delivery, and
2. Nine Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems.

G. CLINICAL AND SERVICE PLANNING CONSIDERATIONS

The Division supports clinical practice and behavioral health service delivery that is individualized, strengths-based, recovery-oriented, and culturally sensitive in meeting the needs of children, adults, and their families. Transitioning youth to adulthood involves a working partnership among team members between the children's behavioral health service system and the AHCCCS Adult System of Care. This partnership is built through respect and equality, and is based on the expectation that all people are capable of positive change, growth, and leading a life of value. Individuals show a more positive response when there is a shared belief and collaborative effort in developing goals and identifying methods (services and supports) to meet their needs.

H. CRISIS AND SAFETY PLANNING

The team is responsible for ensuring that crisis and safety planning is completed prior to the youth's transition as specified in AMPM 220. For some youth, determining potential risk factors related to their ability to make decisions about their own safety may also need to be addressed. Collaboration with the adult case manager and/or ART will ensure that the transitioning young adult is aware of the type of crisis services that will be available through the AHCCCS Adult System of Care and how to access them in their time of need.

I. TRANSITION PLANNING

The length of time necessary for transition planning is relevant to the needs, maturational level, and the youth's ability to acquire the necessary skills to assume the responsibilities of adulthood. When planning for the young person's transition into adulthood and the adult behavioral health system, a transition plan that includes an assessment of self-care and independent living skills, social skills, work and education plans, earning potential, and psychiatric stability must be incorporated into the Service Planning. Living arrangements, financial, and legal considerations are additional areas that require advance planning.

1. Self-care and Independent Living Skills

   As the youth approaches adulthood, the acquisition of daily living skills becomes increasingly important. Personal care and hygiene can include grooming tasks such as showering, shaving (if applicable), dressing, and getting a haircut. Learning phone skills, how to do laundry and shop for clothes, cleaning and maintaining one's personal living environment, use of public transportation or learning how to drive are other suggested areas for transition planning. Acquisition of various health-related skills includes fitness activities such as an exercise program, nutrition education for planning meals, shopping for food, and learning basic cooking techniques. Planning around personal safety would address knowing their own phone number and address, who to contact in case of emergency, and awareness of how to protect themselves when out in the community.

2. Social and Relational Skills

The young adult's successful transition toward self-sufficiency will be supported by their ability to get along with others, choose positive peer relationships, and cultivate sustainable friendships. This will involve learning how to avoid or respond to conflict when it arises and developing an understanding of personal space, boundaries, and intimacy. Some youth may require additional assistance with distinguishing between the different types of interactions that would be appropriate when relating to strangers, friends, acquaintances, boy/girlfriend, family member, or colleague in a work environment. For example, teams may want to provide learning opportunities for youth to practice these discrimination skills in settings where they are most likely to encounter different types of people such as a grocery store, shopping mall, supported employment programs, etc. Planning for youth, who have already disclosed to the behavioral health service provider their self-identity as gay, lesbian, bisexual, or transgender, may include discussions about community supports and pro-social activities available to them for socialization. Adolescents who do not have someone who can role model the differing social skills applicable to friendship, dating, and intimate relationships may need extra support in learning healthy patterns of relating to others relevant to the type of attachment.

3. Vocational/Employment

An important component of transitioning to adulthood includes vocational goals that lead to employment or other types of

meaningful activity. While a job can provide financial support, personal fulfillment, and social opportunities, other activities such as an internship or volunteering in an area of special interest to the young adult can also provide personal satisfaction and an opportunity to engage socially with others. The CFT along with involved system partners work together to prepare the young adult for employment or other vocational endeavors. It is imperative that a representative from the adult behavioral health system be involved in this planning to ensure that employment related goals are addressed before, during, and after the youth's transition to adulthood.

Service planning that addresses the youth's preparation for employment or other meaningful activity can include:

a. Utilizing interest inventories or engaging in vocational assessment activities to identify potential career preferences or volunteer opportunities,

b. Identifying skill deficits and effective strategies to address these deficits,

c. Determining training needs and providing opportunities for learning through practice in real world settings,

d. Learning about school-to-work programs that may be available in the community and eligibility requirements,

e. Developing vocational skills such as building a resume, filling out job applications, interviewing preparation, use of online job sites, etc. and

f. Learning federal and state requirements for filing annual

income tax returns.

Youth involved in school-based work activities (paid or non-paid) are able to "test the waters'' of the work world, develop a work history, better understand their strengths and weaknesses, explore likes and dislikes, and begin to develop employment related skills necessary for their success in competitive work settings. School based work activities can start as early as middle school yet should begin no later than the youth's freshman year of high school. When youth reach the age of 14 they can be given work experience in the community, whether it is through a volunteer or internship experience. It is best for school and community-based work experience to be short term, so that youth can experience a variety of employment settings and perform different job duties in more than one vocation to assist them in identifying possible career choices. These work-related opportunities will assist teams in determining where the youth excels or struggles in each type of work undertaken, the types of supports that might be needed, and what the best "job match" might be in terms of the youth's personal interests and skill level.

As youth narrow their career focus, it is useful to tour employment sites, job shadow, and interview employers and employees who work in the youth's chosen fields of interest. It may be necessary to plan for on-going support after a job has been obtained to assist the young adult in maintaining successful employment. Identifying persons in the job setting who can provide natural support such as supervisors and co-workers, as

well as employer related accommodations may be necessary to ensure that the young adult can continue to perform their job duties.

4. Vocational/Employment Considerations for Youth with Disabilities

For youth who have a disability, regardless of whether they are in Special Education, may be eligible for services through the Arizona Department of Economic Security/Rehabilitation Services Administration (DES/RSA) under a Vocational Rehabilitation (VR) program when transitioning from school to work. The school can refer youth with a disability to the VR program as early as age 14 or at any time thereafter when they are ready to work with VR to address their career plans. Students with disabilities between the ages of 14 and 22 are able to participate in Pre-Employment Transition Services as potentially eligible students, meaning they do not have to be VR clients. Pre-Employment Transition Services are group based, general workshops covering five topic areas that may provide the information a youth needs to begin the career exploration process, develop skills for successful employment and learn about post-secondary education opportunities. Planning for employment is done in conjunction with the youth's VR counselor through the development of an Individual Plan of Employment. Including the VR counselor in the school's IEP planning that might involve VR services is necessary since only VR personnel can make commitments for DES/RSA program services. Refer to DES/RSA for information on the VR process regarding intake/eligibility, planning for employment, services, and program limitations.

5. Education

Collaboration between the CFT and the education system is helpful with preparing youth and their parents/caregivers in developing an understanding of what happens as young adults transition from secondary education to adult life. Asking the youth to share their individualized plans with the rest of the team may provide information to assist with transition planning. Individualized plans could include:

a. Education Career Action Plan (ECAP),

b. 504 Plan,

c. Transition Plan, and

d. Summary of Performance.

6. Individualized Plans

a. Educational Consideration for all Students:

i. Education Career Action Plan - In 2008 the Arizona State Board of Education approved Education and Career Action Plans for all Arizona students in grades 9-12. The ECAP is intended to develop the young adult's individual academic and career goals. An ECAP process portfolio has attributes that should be documented, reviewed, and updated, at a minimum, annually; academic, career, postsecondary, and extracurricular.

b. Education Considerations for Youth with Disabilities:

i. 504 Plan — Section 504 of the Rehabilitation Act of 1973 protects the civil rights of individuals with disabilities in programs and activities that receive federal funds. Recipients of these funds include public school districts, institutions of higher education, and other state and local education agencies. This regulation requires a school district to provide accommodations that can be made by the classroom teacher(s) and other school staff to help students better access the general education curriculum through a 504 Plan that outlines the individualized services and accommodations needed by the student.

ii. Transition Plan - While youth are in secondary education, Individuals with Disabilities Educational Act (IDEA) requires public schools to develop an individualized transition plan for each student with an IEP. The transition plan is the section of the IEP that is put in place no later than the student's 16th birthday. The purpose of the plan is to develop postsecondary goals and provide opportunities that will reasonably enable the student to meet those goals for transitioning to adult life. All of the following components are required as part of the transition plan:

1) Student invitation to all IEP meetings where transition topics are discussed.

2) Age-appropriate transition assessments.

3) Measurable Postsecondary Goals (MPGs) in the areas of:

   a) Education/Training,

   b) Employment, and

   c) Independent living, (if needed).

4) Annually updated MPGs.

5) Instruction and services that align with the student's MPGs:

   a) Coordinated set of transition activities,

   b) Courses of study, and

   c) Annual goals.

6) Outside agency participation with prior consent from the family or student that has reached the age of majority.

   a) Summary of Performance (SOP). The SOP is required under the reauthorization of the IDEA Act of 2004. An SOP is completed for every young adult whose special education eligibility terminates due to graduation from high school with a regular diploma or due to exceeding the age eligibility for FAPE under State law. In Arizona, the student reaches the maximum age of eligibility upon

completing the school year in which the student turns 22. A Public Education Agency must provide the youth with a summary of their academic achievement, functional performance, and recommendations on how to assist in meeting the young adult's postsecondary goals. The SOP must be completed during the final year of a student's high school education.

7. Other Considerations

   a. Transfer of Rights' Requirement for Public Education Agencies. Under Arizona State law, a child reaches the age of majority at 18. The right to make informed educational decisions transfers to the young adult at that time.

      i. According to IDEA, "beginning not later than one year before the child reaches the age of majority under State law, a statement that the child has been informed of the child's rights under this title, if any, that will transfer to the child on reaching the age of majority under section 1415(m)" must be included in the student's IEP. This means that schools must inform all youth with disabilities on or before their 17th birthday that certain rights will automatically transfer to them upon turning age 18, and

      ii. In order to prepare youth with disabilities for their transfer of rights, it is necessary for

parents/caregivers to involve their child in educational decision-making processes early. The CFT or ART, in conjunction with the adult behavioral health provider, should assist the youth/parent/caregiver with this process.

b. A student with a disability between the age of 18 and 22, who has not been declared legally incompetent, and has the ability to give informed consent, may execute a Delegation of Right to Make Educational Decisions. The Delegation of Right allows the student to appoint their parent or agent to make educational decisions on their behalf. The student has the right to terminate the agreement at any time and assume their right to make decisions.

8. Postsecondary Education Considerations

When postsecondary education is the goal for young adults, transition planning may include preparatory work in a number of areas, including, but not limited to, matching the young adult's interests with the right school, connecting the youth to the preferred schools Disability Resource Center if accommodations are needed, assisting with applications for scholarships or other financial aids, etc. The CFT should anticipate and help plan for such needs. If accommodations are needed, connect the youth with the Disability Resource Centers from their preferred postsecondary institutions, and

9. Medical/Physical Healthcare

Planning can include assisting the youth with:

a. Transferring healthcare services from a pediatrician to an adult health care provider, if pertinent,

b. Applying for medical and behavioral health care coverage, including how to select a health plan and a physician,

c. Preparing an application for submission at age 18 to AHCCCS for ongoing Medicaid services,

d. Obtaining personal and family medical history (e.g., copies of immunization records, major illnesses, surgical procedures),

e. Information on advance directives as indicated in the Division Medical Policy 640,

f. Methods for managing healthcare appointments, keeping medical records, following treatment recommendations, and taking medication,

g. How to identify healthcare concerns, address questions during appointments, and consult with doctors regarding diagnosis, treatment, and prognosis, and

h. Assuming responsibility for understanding and managing the symptoms of their mental illness and obtaining knowledge of the benefits, risks, and side effects of their medication.

10. Living Arrangements

Where young adults will live upon turning age 18 could change based on their current housing situation (e.g., living at home

with family, with a relative, in a behavioral health inpatient or residential facility, other out-of-home treatment setting), or whether they decide to choose housing on-site while pursuing their postsecondary education. Youth who do not have the support of their parents or extended family, or who may be under the care and custody of the child welfare system, may require intensive planning to evaluate their ability to live independently, identify the level of community supports needed, and match the type of living environment to their individual personality and preferences. Each situation will require planning that specifically uses the young adult's strengths in meeting their needs and addresses any personal safety concerns.

The most common types of living situations range from living independently in one's own apartment, with or without roommates, to a supported or supervised type of living arrangement. If needed, the team may assist the young adult with completing and filing applications for public housing or other subsidized housing programs. Refer to Arizona 2-1-1 for further information on housing options, state and federally funded programs, and other areas for consideration when addressing housing needs**.**

Youth living in a behavioral health inpatient facility at the time they turn age 18 can continue to receive residential services until the age of 22 if they were admitted to the facility before their 21st birthday and continue to require treatment.

Licensed residential agencies may continue to provide behavioral health services to individuals aged 18 or older if the following

conditions are met as specified in A.A.C. R9-10-318 (B):

a. Person was admitted before their 18th birthday and is completing high school or a high school equivalency diploma, or is participating in a job training program, is not 21 years of age or older, or

b. Through the last day of the month of the person's 18th birthday.

11. Financial

Assessing the financial support needed will include identifying how much money is required to support the young adult's living situation and how s/he will obtain it. This will include determining whether the income from employment will pay the bills or if Social Security Disability programs, food stamps, or other emergency assistance will cover the young adult's financial responsibilities. Depending on the special needs of the young adult, arranging for a conservator or guardian may also be necessary.

Together, the team should review and update any federal and/or state financial forms to reflect the young adult's change in status to ensure there is no disruption in healthcare or financial assistance services. Youth who are eligible for Social Security Income (SSI) benefits as a child will have a disability redetermination during the month preceding the month when they attain age 18. This determination will apply the same rules as those used for adults who are filing new applications for SSI benefits. The team can assist the young adult and their

family/caregiver with identifying any changes related to Social Security benefits, including opportunities for Social Security Work Incentives.

Young adults who learn about financial matters prior to age 18 have a better opportunity to acquire the skills necessary for money management. Skill development can include:

a. Setting up a simple checking and/or savings account to learn how it can be used to pay bills, save money, and keep track of transactions,

b. Identifying weekly/monthly expenses that occur such as food, clothes, school supplies, and leisure activities and determining the monetary amount for each area,

c. Learning how to monitor spending and budget financial resources,

d. Education on how credit cards work and differ from debit cards, including an understanding of finance charges and minimum monthly payments, and

e. Understanding the short and long-term consequences of poor financial planning (e.g., overdrawn account [Non-Sufficient Funds fee], personal credit rating, eligibility for home and/or car loans, potential job loss).

12. Legal Considerations

Transition planning that addresses legal considerations ideally begins when the youth is 17.5 years of age to ensure the young adult has the necessary legal protections upon reaching the age

of majority. This can include the following:

a. Document Preparation

Some families/caregivers may decide to seek legal advice from an attorney who specializes in mental health, special needs and/or disability law in planning for when their child turns 18 if they believe legal protections are necessary. Parents, caregivers, or guardians may choose to draw up a Will or update an existing one to ensure that adequate provisions have been outlined for supporting their child's continuing healthcare and financial stability. Other legal areas for consideration can include:

i. Guardianship,

ii. Conservator,

iii. Special needs trust, and

iv. Advance directives (e.g., living will, powers of attorney).

b. Legal Considerations for Youth with Disabilities

Persons with developmental disabilities, their families and caregivers may benefit from information about different options that are available when an adult with a disability needs the assistance of another person in a legally recognized fashion to help manage facets of their life. Refer to the Arizona Center for Disability Law's Legal Options Manual for access to information and forms. This publication also addresses tribal jurisdiction in relation to

the guardianship process for individuals who live on a reservation. While this resource is focused on planning for individuals with disabilities, teams can utilize this information to gain a basic understanding of the legal rights of individuals as they approach the age of majority.

13. Transportation

A training program, whether a formal or informal one, may be useful in helping the young adult acquire the skills necessary for driving or when using public transportation. Planning can include assisting the youth with test preparation and acquiring a driver's permit. Use of a qualified instructor, family member, or other responsible adult can provide the youth with "behind the wheel" driving experience including how to read maps or manage roadside emergencies. If obtaining a driver's license is not feasible, skill training activities for using public transportation can include reviewing bus schedules, planning routes to get to a designated location on time, and learning how to determine the cost and best method of transportation for getting to and from work or scheduled appointments.

When transitioning to the adult behavioral health system, educate the family and young adult on the transportation options available through the adult service delivery system. This will help support the young adult's continued attendance at behavioral health treatment appointments, as well as assist the team with identifying and planning for other transportation needs that are not necessarily associated with accessing medical or behavioral

health services.

14. Personal Identification

The team can assist the youth with acquiring a State issued identification card in situations where the young adult may not have met the requirements for a driver's license issued by the Arizona Motor Vehicle Division. An identification card is available to all ages (including infants); however, the youth may not possess an Arizona identification card and a valid driver's license at the same time.

15. Mandatory and Voluntary Registrations

Selective Service registration is required for almost all male U.S. and non-U.S. citizens who are 18 through 25 years of age and residing in the United States. Registration can be completed at any U.S. Post Office and a Social Security Number is not needed. When a Social Security Number is obtained after registration is completed, it is the responsibility of the young adult male to inform the Selective Service System.

Upon turning age 18 the young adult can register to vote. Online voter registration is available through Arizona's Office of the Secretary of State.

J. TRAINING AND SUPERVISION RECOMMENDATIONS

1. The practice elements of this policy apply to Division, AdSS, and subcontracted network and provider behavioral health staff who participate in assessment and service planning processes, provider case management and other clinical services, or who

supervise staff that provide service delivery to adolescents, young adults, and their families.

2. The Division shall monitor the AdSS to ensure each AdSS has established a process for ensuring the following:

   a. Staff are trained and understand how to implement the practice elements outlined in this policy;

   b. The AdSS' network and provider agencies are notified of changes in policy and additional training is available if required; and

   c. Upon request from AHCCCS or the Division, the AdSS shall provide documentation demonstrating that all required network and provider staff have been trained on this policy.

3. The Division shall monitor the AdSS for incorporation of this policy into other supervision processes the AdSS and their network and provider agencies have in place for direct care clinical staff, in alignment with A.A.C. R4-6-212, Clinical Supervision Requirements.

K. AdSS OVERSIGHT

The Division shall use, at a minimum, the following methods to ensure the AdSS are in compliance with AdSS Medical Policy 280 and associated policies:

1. Annual Operational Review of compliance with standards for Transition Aged Youth (TAY) and related evidence-based programs, including but not limited to:

a. Policies/procedures to promote, and evidence of, adequate programming for TAY utilizing the Transition to Independence (TIP) Model, or other evidence-based programs for this population.

b. Policies/procedures to track numbers, and evidence of, staff currently trained in TIP evidence-based programs.

c. Policies/procedures to analyze, and evidence of, sufficiency of current First Episode Psychosis (FEP) programming for TAY (aged 18-24).

d. Evidence of the AdSS completing an analysis of the data in Sections J.(1)(a.)(b.)(c.) and any related plans for developing additional FEP programming for TAY.

2. Analyze deliverable reports or other data as required, including but not limited to, Provider Network Development and Management Plans demonstrating network adequacy and plans to promote specialty services described in this policy.

3. Conduct oversight meetings with each AdSS for the purpose of reviewing compliance and addressing any access to care concerns or other quality of care concerns.

4. Review data submitted by the AdSS demonstrating ongoing compliance monitoring of their network and provider agencies through Behavioral Health Clinical Chart Reviews.

Signature of Chief Medical Officer: Anthony Dekker (Jun 24, 2022 10:14 PDT)
Anthony Dekker, D.O.

300 CHAPTER OVERVIEW

REVISION DATE: 10/01/2021, 5/24/2021, 5/13/2016, 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994

The services described in this Chapter are available to members enrolled in Title XIX. This includes Targeted (Title XIX Acute) and Arizona Long Term Care Services (ALTCS) members.

Contracted Health Plans

Members who are eligible for Long Term Care services are required to join one of the Division's contracted health plans, where available. The exception is Native Americans who may choose to enroll in DDD Tribal Health Program (THP).

The contracted health plan subcontracts with physicians, hospitals, therapists, dentists, laboratories, pharmacies, medical equipment suppliers, and other providers to deliver acute care services to enrolled members.

All services must be delivered or ordered by the Primary Care Provider (PCP), determined to be medically necessary by the health plan and delivered by a contracted provider. The PCP is the member's designated physician who coordinates all aspects of the member's medical care. Members who are eligible for Long Term Care services that fail to follow these procedures and receive services that are not approved/provided by a health plan provider are responsible to pay for these services.

The members who are eligible for Long Term Care services may choose to use their own doctor if the physician is an Arizona Health Care Cost Containment System (AHCCCS) registered provider and is contracted with the health plan. In these instances, the health plan's or the Division's approval is still needed for services covered by Arizona Long Term Care System (ALTCS).

If the member who is long term care eligible is enrolled in a health plan and has a PCP, but also chooses to use another physician who may not be registered with AHCCCS, services provided or ordered by this physician are not covered by the AHCCCS. Services by a physician who is not registered with the AHCCCS can be covered by the health plan if approved by the PCP and the health plan. If approval is not received from the PCP and the health plan, the member will be required to pay for the services personally or through private insurance.

Children's Rehabilitative Services

Members eligible for ALTCS may also be eligible for Children's Rehabilitative Services (CRS). Members eligible for the Division and CRS will receive CRS specialty services and behavioral health services through United Healthcare Community Plan or its successor. These members will continue to receive acute care services through their Division acute health plan.

Extended Care Coverage

Health plans for members who are eligible for Long Term Care are financially responsible for a maximum of 90 days. This financial responsibility includes nursing facility care, and room and board, after hospital discharge. Nursing Facility (NF) care must be in lieu of hospitalization. If the member's place of residence prior to hospitalization was a NF the health plan is not financially responsible for placement. Members requiring nursing facility placement beyond 90 days are the financial responsibility of the Division. Preadmission Screening/Annual Resident Review (PASRR) Level II reviews must occur for each member whose expected stay in the NF will exceed 90 days.

Division staff will work expeditiously with the health plan's discharge planners to place the member in the least restrictive environment as required by state law.

Comprehensive Health Plan

The Comprehensive Health Plan (CHP) is a health care program for Arizona's children who are wards of the court and placed out of home. Eligibility is based on State law. Department of Child Safety (DCS) coordinates services related to CHP.

Member Acute Care Card

Members who are determined eligible for Long Term Care services will receive a membership card from the Division or the Division's contracted acute health plan, and will be enrolled in a contracted acute health plan by the Division or receive services on a fee-for-service basis through the Division.

Health Plan Responsibilities

Each contracted acute health plan is required to send members a health plan member handbook. The handbook explains the services that are covered, how to access these services, and what to do when emergency services are needed. It outlines the member's responsibility to follow procedures. All services must be provided or approved by the primary care provider

An ALTCS member who fails to follow procedures outlined in the member handbook and receives services that are not approved or provided by a health plan contracted physician may be responsible to pay for those services.

The Division may delegate some or all of its responsibility to a health plan for the following non-inclusive health care responsibilities. These services are rendered on behalf of members who are ALTCS members and enrolled with the health plan:

A. Prior authorization of services and procedures as specified by the health plan.

B. Claims processing according to policies and procedures defined by the health plan.

C. Concurrent review, including certification and denial of inpatient hospital stay days, according to health plan procedures.

D. Investigation and resolution of complaints and grievances according to policy and procedure specified by both AHCCCS and the health plan.

E. Provider relations and member services activities.

F. Financial monitoring and reporting as mandated under AHCCCS rules.

G. All other quality assurance and utilization management activities as defined in the Title 42 of the Code of Federal Regulations (http://www.gpoaccess.gov/cfr/), AHCCCS Rules (azahcccs.gov/Regulations/), and the health plan's quality assurance/utilization review procedures.

All such services/responsibilities must be in compliance with AHCCCS/ALTCS Rules and Regulations (azahcccs.gov/Regulations/Arizona).

310-A AUDIOLOGY

EFFECTIVE DATE: March 3, 2017

REFERENCES: 42 CFR 440.110

The Division of Developmental Disabilities (Division) covers medically necessary audiology services to evaluate hearing loss for all members, on an inpatient and outpatient basis. Only an AHCCCS-registered dispensing audiologist or an AHCCCS-registered individual with a valid hearing aid dispensing license may dispense hearing aids. Hearing aids, provided as a part of audiology services, are covered only for members for members age 21 and under who are eligible for AHCCCS.

Audiology services must be provided by an audiologist who is licensed by the Arizona Department of Health Services (ADHS) and who meets the federal requirements specified under Title 42 of the Code of Federal Regulations (42 CFR 440.110). Out-of-state audiologists must meet the federal requirements.

The federal requirements mandate that the audiologist have a master‘s or doctoral degree in audiology and meet one of the following conditions:

A. Have a certificate of clinical competence in audiology granted by the American Speech-Language-Hearing Association (ASHA), or

B. Have successfully completed a minimum of 350 clock-hours of supervised clinical practicum (or be in the process of accumulating such supervised clinical experience under the supervision of a qualified master’s or doctoral-level audiologist), performed at least nine months of supervised full-time audiology services under the supervision of a qualified master or doctoral-level audiologist after obtaining a master‘s or doctoral degree in audiology or a related field, and successfully completed a national examination in audiology approved by the Secretary of the U.S. Department of Health and Human Services.

310-B TITLE XIX/XXI BEHAVIORAL HEALTH SERVICES

REVISION DATE: 8/2/2023, 3/17/2021
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.A.C. R9-22-210.01; CFR 493, Subpart A; CFR Title 42, Chapter IV, Subchapter G, Part 482; 42 CFR 440.10; 42 CFR 441; 42 CFR 483; A.R.S. Title 32, Chapter 33; A.R.S. Title 36, Chapter 4; A.R.S. §32-3251; A.R.S. §36-501; A.R.S. §32-2061; A.R.S. §32-2091; A.A.C. 14-101; A.A.C. R4-6-101; A.A.C. R9-10-200; A.A.C. Title 9, Chapter 10 (9 A.A.C. 10); A.A.C. R9-10-1016; A.A.C. R9-10-1012; A.A.C. R9-21-20; A.A.C. R9-10-316; A.A.C. R9-10-318; A.A.C. R9-10-316; A.A.C. R9-10-1025; A.A.C. R9-10- 1600; A.A.C. R9-10-1000; A.A.C. R9-10-300; AMPM Chapter 100; AMPM 109; AMPM Exhibit 310-1; AMPM 310-B; AMPM 310-BB; AMPM 310-V; AMPM 320-0; AMPM 320-S; AMPM 320-V; AMPM 320-W; AMPM 320-X; AMPM 570; AMPM 590; AMPM 963; AMPM 964; AMPM 965; ACOM Policy 447; ACOM Policy 436

PURPOSE

This policy describes the Division of Developmental Disabilities (Division) responsibilities for providing Title XIX/XXI Behavioral Health Services to Members who are eligible for Arizona Long Term Care System (ALTCS), including additional requirements for Members that have chosen the DDD Tribal Health Program (THP) as their health plan.

DEFINITIONS

1. "Bed Hold" means days in which the facility reserves the Member's bed, or Member's space in which they have been

residing, while the member is on an authorized/planned overnight leave from the facility for the purposes of therapeutic leave to enhance psychosocial interaction or as a trial basis for discharge planning as specified the Arizona State Plan under Title XIX of the Social Security Act.

2. "Behavioral Health Paraprofessional" or "BHPP" means an individual who is not a Behavioral Health Professional who provides Behavioral Health Services at or for a Health Care Institution according to the Health Care Institution's policies and procedures that:

   b. If the Behavioral Health Services were provided in a setting other than a licensed Health Care Institution, the individual would be required to be licensed as a behavioral professional under A.R.S, Title 32, Chapter 33; and

   c. Are provided under supervision by a Behavioral Health Professional.

3. "Behavioral Health Professional" or "BHP" means

   b. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:

i. Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251, or

ii. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S.§32-3251 under direct supervision as defined in A.A.C. R4-6-101,

c. A psychiatrist as defined in A.R.S. §36-501,

d. A psychologist as defined in A.R.S. §32-2061,

e. A physician,

f. A behavior analyst as defined in A.R.S. §32-2091,

g. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or

h. A registered nurse with:

i. A psychiatric-mental health nursing certification, or

ii. One year of experience providing Behavioral Health Services

4. "Behavioral Health Services" means physician or practitioner services, nursing services, health-related services, or ancillary

services provided to an individual to address the individual's behavioral health needs.

5. "Behavioral Health Technician" or "BHT" means an individual who is not a BHP who provides Behavioral Health Services at or for a Health Care Institution according to the Health Care Institution's policies and procedures that:

   b. If the Behavioral Health Services were provided in a setting other than a licensed Health Care Institution, would be required to be licensed as a Behavioral Health Professional under A.R.S. Title 32, Chapter 33, and

   c. Are provided with Clinical Oversight by a BHP.

6. "Clinical Oversight" means monitoring the Behavioral Health Services provided by a Behavioral Health Technician to ensure that the Behavioral Health Technician is providing the Behavioral Health Services according to the Health Care Institution's policies and procedures by:

   a. Providing on-going review of a Behavioral Health Technician's skills and knowledge related to the provision of Behavioral Health Services,

b. Providing guidance to improve a Behavioral Health Technician's skills and knowledge related to the provision of Behavioral Health Services, and

c. Recommending training for a Behavioral Health Technician to improve the Behavioral Health Technician's skills and knowledge related to the provision of Behavioral Health Services.

7. "Clinical Team" means Child and Family Teams and Adult Recovery Teams.

8. "Community Service Agencies" or "CSAs" means an unlicensed provider of non-medical, health related, support services. CSAs provide:

a. Individualized habilitation

b. Developmental learning,

c. Rehabilitation

d. Relearning or readapting,

e. Employment,

f. Advocacy services,

g. Peer support, and

h. Family support.

6. "Family Support Services" means home care training or family support with family member(s) directed toward restoration, enhancement, or maintenance of the family functions in order to increase the family's ability to effectively interact and care for the individual in the home and community.

7. "Health Care Institution" means every place, institution, building or agency, whether organized for profit or not, that provides facilities with medical services, nursing services, Behavioral Health Services, health screening services, other health-related services, supervisory care services, personal care services or directed care services and includes home health agencies, outdoor behavioral health care programs and hospice service agencies.

8. "Medication Management" means medication management services such as:

   a. Review of medication(s) side effects, and

   b. The adjustment of the type and dosage of prescribed medications.

9. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
10. "Peer-and-Recovery Support" means intentional partnerships based on shared, lived experiences of living with behavioral health and/or substance use disorders to provide social and personal support. This support is coupled with specific, skill-based training, coaching, or assistance to bring about social or personal change at the individual, family, or community level. These services can include a variety of individualized and personal goals, including living preferences, employment or educational goals and development of social networks and interests.
11. "Peer Services" means supports intended for enrolled Members or their families who require greater structure and intensity of services than those available through community-based recovery fellowship groups and who are not yet ready for independent access to community-based recovery groups.
12. "Planning Team" means a defined group of individuals that shall include the member/Responsible Person and with the

member's/Responsible Person's consent, their individual representative, Designated Representative (DR), and any individuals important in the member's life, including but not limited to extended family members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems like Department of Child Safety (DCS). The size, scope, and intensity of involvement of the team members are determined by the objectives of the Planning Team to best meet the needs and individual goals of the member.

13. "Room and Board" means the amount paid for food and/or shelter. Medicaid funds can be expended for Room and Board when an individual lives in an institutional setting. Medicaid funds cannot be expended for Room and Board when a Member resides in an Alternative Home and Community Based Service (HCBS) Setting.
14. "Service Plan" means a complete written description of all covered health services and other informal supports which includes individualized goals, Peer-and-Recovery Support, Family

Support Services, care coordination activities and strategies to assist the Member in achieving an improved quality of life.

15. "Vocational Rehabilitation" means a program under Rehabilitation Services Administration (RSA) that provides a variety of services to persons with disabilities, with the goal to prepare for, enter into, or retain employment.

POLICY

A. GENERAL REQUIREMENTS

1. The Division shall ensure medically necessary Title XIX/XXI Behavioral Health Services for Members eligible for ALTCS are covered as a health plan benefit.
2. The Division shall require providers utilize national coding standards including the use of applicable modifier(s) as listed in the AHCCCS Medical Coding Resources webpage and AHCCCS Behavioral Health Services Matrix.
3. The Division shall ensure medically necessary outpatient Behavioral Health Services are covered, regardless of a Member's diagnosis, so long as there are documented behaviors or symptoms that will benefit from Behavioral Health Services.

4. The Division shall ensure that Service Plan services are provided timely and in accordance with requirements included in AHCCCS Medical Policy Manual (AMPM) 320-0.
5. The Division shall ensure that services are not delayed or pended in order to have all team members present for a Service Planning meeting or until all team members are able to sign off on the Service Plan.
6. The Division shall require providers to make available and offer the option of having a Peer Recovery Support Specialist (PRSS) or Family Support Specialist for child or adult members and their families to provide covered services when appropriate.
7. The Division shall ensure policies and procedures are established by the AdSS to ensure Members on any form of Medication Assisted Treatment (MAT) are not excluded from services or admission to any treatment program or facility based upon the use of MAT.
8. The Division shall ensure emergency Behavioral Health Services are being provided, including crisis intervention services, without prior authorization being required.

9. The Division shall require that BHPs provide supervision to BHPPs and BHTs that provide services in the public behavioral health system.
10. The Division shall ensure that the BHPs providing Clinical Oversight of BHTs demonstrate the following key competencies:
    a. Knowledge of the relevant best clinical practices and policies that guide the services being provided,
    b. Knowledge of the policies and principles governing ethical practice,
    c. Ability to develop individualized BHT competency development goals and action steps to accomplish these goals, and
    d. Ability to advise, coach, and directly model behavior to improve interpersonal and service delivery skills.
11. The Division shall ensure that Behavioral Health Services are provided to the Member's family members who consent to receiving these services, regardless of the family member's Title XIX/XXI entitlement status, as long as the Member's Service

Plan reflects that the provision of these services is aimed at accomplishing the Member's Service Plan goals.

12. The Division shall not require that the Member be present when the services are being provided to family members.
13. The Division shall allow as a covered service provided through indirect contact with Members includes:
    a. Email or phone communication, excluding leaving voicemails, specific to a Member's services;
    b. Obtaining collateral information; and
    c. Picking up and delivering medications. Refer to the AHCCCS behavioral health service matrix and AHCCCS medical coding resource webpage for requirements for billing and indirect contacts.
14. The Division shall not cover Room and Board except for inpatient hospitals, Intermediate Care Facilities for individuals with Intellectual Disability (ICF/ID), and nursing facilities.
15. The Division shall ensure the referral process to initiate Behavioral Health Services meets the following requirements:
    a. A referral may be made, but is not required;

b. A Member, guardian, or designated representative may initiate requests;

c. If a provider's service array does not include a service required by a member, the provider shall make a referral to a provider with the member's assigned health plan, who does offer the necessary service; and

d. Comply with the Rules set forth in A.A.C. Title 9, Chapters 10 and 21, as applicable.

16. The Division shall ensure that transportation is provided as referenced in AMPM 310-BB.

17. The Division shall ensure that behavioral health providers are eligible to bill for travel per AMPM 310-B to provide a covered Behavioral Health Service. The Division shall ensure that behavioral health providers are adhering to the following travel limitations:

a. Provider travel mileage may not be billed separately except when it exceeds 25 miles,

b. When a provider is traveling to one destination and returns to the office, the 25 miles is assumed to be included in the round trip, and

c. If a provider is traveling to multiple out-of-office settings, each segment of the trip is assumed to include 25 miles of travel.

18. The Division shall ensure providers do not bill for travel for missed appointments. This includes time spent conducting outreach without successfully finding the Member and for time spent driving to do a home visit and the Member is not home.

B. COVERED BEHAVIORAL HEALTH SERVICES

1. The Division shall ensure the following treatment services are covered under the behavioral health benefit:

a. Assessment, non-court ordered evaluation, and screening services, when provided by individuals who are qualified BHPs or BHTs supervised by BHPs when clinically appropriate as specified in AMPM 320-U.

b. Behavioral health counseling and therapy when provided by individuals who are qualified BHPs or BHTs supervised by BHPs when clinically appropriate, and

c. Psychophysiological therapy and biofeedback when provided by qualified BHPs.

2. The Division shall ensure the following Rehabilitation Services are covered as a health plan benefit:

a. Skills training and development and psychosocial rehabilitation living skills training.

i. Skills training includes teaching independent living, social, and communication skills to Members or their families.

ii. Services may be provided to a Member, a group of individuals or their families with the Member(s) present.

iii. Skills training and development and psychosocial rehabilitation living skills training is provided by individuals who are qualified BHPs or BHTs/BHPPs supervised by BHPs or qualified BHT.

iv. More than one provider agency may bill for skills training and development services provided to a Member at the same time if indicated by the Member's clinical needs as identified in their Service Plan.

b. Cognitive rehabilitation

i. Provided by qualified BHP's to facilitate recovery from cognitive impairments in order to achieve independence or the highest level of functioning possible.

ii. Goals of cognitive rehabilitation include:

1) Relearning of targeted mental abilities,

2) Strengthening of intact functions,

3) Relearning of social interaction skills,

4) Substitution of new skills to replace lost functioning, and

5) Controlling the emotional aspects of one's functioning.

iii. Training is done through exercises or stimulation, cognitive neuropsychology, cognitive psychology and behavioral psychology, or a holistic approach to include social and emotional aspects.

iv. Training is provided one on one and customized to each individual's strengths, skills, and needs.

c. Health promotion

i. Provided to educate and train about health-related topics to an individual or a group of people or their families.

ii. Presented using a standardized curriculum with the purpose of increasing an individual's behavioral knowledge of a health-related topic such as:

1) The nature of an illness,

2) Relapse and symptom management,

3) Medication management,

4) Stress management,

5) Safe sex practices,

6) Human Immunodeficiency Virus (HIV) education,

7) Parenting skills education, and

8) Healthy lifestyles.

iii. DUI health promotion education and training approved by Arizona Department of Health Services (ADHS), Division of Licensing Services (DLS).

iv. More than one provider agency may bill for health promotion provided to a Member at the same time if indicated by the Member's clinical needs as identified in their Service Plan.

d. Pre-Vocational Psychoeducational Services and ongoing support to maintain employment, post-vocational services, or job coaching that are designed to:

i. Assist Members to choose, acquire, and maintain employment or other meaningful community activity as outlined in AMPM 1240-J.

i. Prepare Members to engage in meaningful work-related activities, such as full- or part-time, competitive employment.

ii. Provided individually or in a group setting, but not telephonically and may include, but are not limited to the following:

1) Career or educational counseling;
2) Job training, assistance in the use of educational resources necessary to obtain employment;
3) Attendance to Vocational Rehabilitation Orientations;
4) Attendance to job fairs;
5) Assistance in finding employment, and other training, like resume preparation, job interview skills, study skills, budgeting skills;
6) Professional decorum; and
7) Time management.

iv. Provided only if the services are not available through the federally funded Rehabilitation Act program administered by Arizona Department of Economic Security/Rehabilitation Service Administration (ADES/RSA) DES-RSA, which is required to be the primary payer for Title XIX/XXI eligible individuals. The following services are not TXIX/TXXI covered treatment services:

1) Rehabilitative employment support assessments when available through the federally funded Rehabilitation Act program administered by the Tribal Rehabilitation Services Administration,

2) Preparation of a report of a Member's psychiatric status for primary use with a court.

e. Ongoing support to maintain employment services

i. Post-vocational services, often called job coaching, which enable Members to maintain their current employment.

ii. Utilized when assisting employed Members with services traditionally used as pre-vocational in order to gain skills for promotional employment or alternative employment.

iii. Provided individually or in a group setting, as well as telephonically.

iv. Services may include, but are not limited to, the following:

1) Monitoring and supervision,

2) Assistance in performing job tasks, and

3) Supportive counseling.

f. Pre-vocational services and ongoing support to maintain employment to include the following:

i. Provided using tools, strategies, and materials which meet the Member's support needs;

ii. Services are tailored to support Members in a variety of settings;

iii. Service may be utilized for exploring strengths and interests when a Member is not ready to identify an educational or employment goal;

iv. Provided by individuals who are qualified BHPs or BHTs/BHPPs supervised by BHPs or Qualified BHTs; and

v. Billed by more than one provider agency for services provided to a Member at the same time, if indicated by the Member's clinical needs as identified in their Service Plan.

vi. For Community Service Agencies, see AMPM Policy 965 for further detail on service standards and provider qualifications for this service.

3. The Division shall ensure medical services provided or ordered within the scope of practice by a licensed physician, nurse practitioner, physician assistant, or nurse are covered as a health plan benefit to reduce a Member's symptoms and improve or maintain functioning.

a. For covered medications, the Division shall maintain its own formulary list to meet the unique needs of Members with behavioral health disorders. At a minimum, the Division formulary shall include all of the medications listed on the AHCCCS formulary per AMPM 310-V.

b. Laboratory, radiology, and medical imaging services shall be prescribed by a licensed physician, nurse practitioner, or physician assistant within the scope of their practice for screening, diagnosis or monitoring of a behavioral health condition.

    i. Laboratory services shall be provided in Clinical Laboratory Improvement Act (CLIA) approved hospitals, medical laboratories and other health care facilities that meet state licensure requirements as specified in A.R.S. Title 36, Chapter 4, with the exception of specimen collections in a medical practitioner’s office.

c. Medical management services shall be provided within the scope of practice by a licensed physician, nurse

practitioner, physician assistant or nurse to an individual as part of their medical visit for ongoing treatment purposes. Medical management includes:

1) Review of medication(s) side effects, and
2) The adjustment of the type and dosage of prescribed medications.

d. Outpatient Electroconvulsive Therapy (ECT) and outpatient Transcranial Magnetic Stimulation (TMS) performed by a physician within their scope of practice.

4. The Division shall ensure support services are covered as a health plan benefit to facilitate the delivery of or enhance the benefit received from other Behavioral Health Services and are provided by individuals who are qualified BHPs or BHTs/BHPPs supervised by BHPs. Support services are classified into the following subcategories:

a. Provider Case management as specified in AMPM 570.

b. Personal care services which involve the provision of support activities that assist an individual in carrying out daily living activities.

i. May be provided in an unlicensed setting such as a Member's own home or community setting.

ii. Parents including natural parent, adoptive parent and stepparent may be eligible to provide personal care services if the Member receiving services is 21 years or older and the parent is not the Member's legal guardian.

iii. Personal care services provided by a Member's spouse are not covered.

iv. More than one provider agency may bill for personal care services provided to a Member at the same time if indicated by the Member's clinical needs as identified through their Service Plan.

c. Home care training or Family Support Services which are directed toward restoration, enhancement, or maintenance of the family functioning to increase the family's ability to effectively interact and care for the Member in the home and community.

i. Family Support Services involve activities to assist the family to adjust to the Member's illness, developing skills to effectively interact or guide the Member, understanding the causes and treatment of behavioral health issues, and understanding and effectively utilizing the healthcare system.

i. More than one provider agency may bill for family support provided to a Member at the same time if indicated by the Member's clinical needs as identified through their Service Plan.

d. Peer Services which provide intentional partnerships based on shared lived experiences of living with behavioral health or substance use disorders, to provide social and personal support.

e. Therapeutic Foster Care (TFC) for Children as specified in AMPM 320-W and Adult Behavioral Health Therapeutic Home as specified in AMPM 320-X.

f. Unskilled respite care (respite) which provides an interval of rest or relief to a family Member or other individual

caring for the Member receiving Behavioral Health Services and delivered by providers who meet the requirements in A.A.C. R9-10-1025 and A.A.C. R9-10-1600.

i. The availability and use of informal supports and other community resources to meet the caregiver's respite needs shall be evaluated by the Division's Support Coordinator, and Provider Case Manager authorizing the respite services, in addition to formal respite services.

ii. The Service Plan shall identify if respite services will be provided by the behavioral health system or by the Division's Qualified Vendor system.

iii. Respite services are limited to 600 hours per year (October 1 through September 30) per person and are inclusive of both behavioral health and ALTCS respite care.

iv. Respite may include a range of activities to meet the social, emotional, and physical needs of the Member during the respite period. These services may be

provided on a short-term basis, a few hours during the day, or for longer periods of time involving overnight stays.

v. Respite services can be planned or unplanned. If unplanned respite is needed, the Division shall ensure the behavioral health provider assesses the situation with the caregiver and recommends the appropriate setting for respite.

vi. CSAs cannot provide respite services.

vii. Respite services covered as a behavioral health benefit may be provided in a variety of settings including:

1) Habilitation Provider,
2) Outpatient Clinic,
3) Adult Therapeutic Foster Care,
4) Behavioral Health Respite Homes,
5) Behavioral Health Residential Facilities,
6) Member's home, and
7) Community settings.

viii. A Member's Planning Team shall consider the appropriateness of the setting in which the recipient receives respite services:

1) When respite services are provided in a home setting, household routines and preferences shall be respected and maintained when possible.

2) The respite provider shall receive orientation from the family or caregiver regarding the Member's needs and the Service Plan.

3) Respite services, including the goals, setting, frequency, duration, and intensity of the service shall be defined in the Member's Service Plan.

4) Respite services are not a substitute for other covered services.

5) Summer day camps, day care, or other ongoing, structured activity programs are not respite unless they meet the definition or

criteria of respite services and the provider qualifications.

ix. Members who are parents and receive Behavioral Health Services receive necessary respite services for their non-enrolled children as indicated in their Service Plan, and

x. Non-enrolled siblings of a child receiving respite services are not eligible for behavioral health respite benefits.

g. Permanent Supportive Housing (PSH) Support Services which provide flexible housing-based supports targeted towards individuals most at need based upon their health condition, housing status, and current or potential system costs.

i. Scope, frequency, delivery, and setting should be individualized to the Member's need, circumstances, and choice.

ii. Services shall be consistent with PSH evidence-based standard, nationally recognized or identified best practice.

iii. Services shall be voluntary to the Member.

iv. Staff providing these services shall be knowledgeable and provide services consistent with evidence-based practice for PSH models.

5. The Division shall ensure intensive outpatient and behavioral health day programs are covered as a health plan benefit and include the following:

a. Intensive outpatient treatment programs

i. Structured non-residential treatment programs that address mental health and substance use disorders through a combination of individual, group and family counseling and therapy and educational groups but do not require detoxification.

b. Behavioral Health Day Programs

i. Regularly scheduled program of individual, group or family services related to the Member's treatment

plan designed to improve the ability of the person to function in the community and may include the following rehabilitative and support services:

1) Skills training and development,
2) Behavioral health prevention or promotion,
3) Medication training and support,
4) Pre-vocational services and ongoing support to maintain employment,
5) Peer and Recovery Support, and
6) Home care training or Family Support.

ii. May be provided by either ADHS DLS licensed behavioral health agencies or Title XIX certified CSA.

iii. Staff members that deliver specific services within the supervised behavioral health day program shall meet the individual provider qualifications associated with those services.

iv. BHT's shall supervise behavioral health treatment and day programs provided by a CSA.

c. Therapeutic behavioral health day programs

i. Regularly scheduled program of active treatment modalities which may include services such as:

a) Individual, group or family behavioral health counseling and therapy;

b) Skills training and development;

c) Behavioral health prevention or promotion;

d) Medication training and support;

e) Pre-vocational services and ongoing support to maintain employment;

f) Homecare training or family support;

g) Medication monitoring;

h) Case management;

i) Peer and Recovery Support; and

j) Medical monitoring.

ii. Provided by an ADHS licensed behavioral health agency and in accordance with applicable service requirements set forth in A.A.C. Title 9, Chapter 10.

iii. Under the direction of a BHP.

iv. Staff members that deliver specific services within the therapeutic behavioral health day program shall meet the individual provider qualifications associated with those services.

v. Behavioral health day programs cannot be provided on the same day Day Treatment and Training is provided.

d. Community Psychiatric Supportive Treatment Program

i. Provide regularly scheduled program of active treatment modalities, including medical interventions, in a group setting and may include:

1) Individual, group or family behavioral health counseling and therapy;

2) Skills training and development;

3) Behavioral health prevention/promotion;

4) Medication training and support;

5) Ongoing support to maintain employment;

6) Pre-vocational services;

7) Home care training or Family Support,

8) Peer and Recovery Support; and

9) Other nursing services such as medication monitoring, methadone administration, and medical/nursing assessments.

ii. Services are provided by an ADHS licensed behavioral health agency and as specified with applicable service requirements set forth in A.A.C. Title 9, Chapter 10.

iii. Programs shall be under the direction of a licensed physician, nurse practitioner or physician assistant.

iv. Staff members that deliver specific services within the medical behavioral health day program shall meet the individual provider qualifications associated with those services.

6. The Division shall ensure Behavioral Health Residential Facility Services are covered as a health plan benefit as specified in AMPM 320-V.

7. The Division shall ensure Behavior Analysis services are covered as a health plan benefit as specified in AMPM 320-S.

8. The Division shall ensure timely follow up and care coordination for Members after receiving crisis services as specified in AMPM 590.

10. The Division shall ensure Inpatient Services provided by ADHS licensed inpatient facilities are covered in accordance with A.A.C. R9-10-300 which provides a structured treatment setting with 24-hour supervision and an intensive treatment program, including medical support services and are further classified into the following subcategories:

    a. Hospital services that provide continuous treatment with 24-hour nursing supervision and physicians on site and on call that includes:

        i. General psychiatric care,

        ii. Medical detoxification,

        iii. Forensic services in a general hospital,

        iv. A general hospital with a distinct psychiatric unit, or

        iv. A freestanding psychiatric facility.

            1) General and freestanding hospitals that provide services to Members if the hospital:

a) Meets the requirements of 42 CFR 440.10 and CFR Title 42, Chapter IV, Subchapter G, Part 482.

b) Is licensed pursuant to A.R.S. Title 36, Chapter 4 and A.A.C. Title 9, Chapter 10.

2) Prior authorization is required for Bed Hold or Therapeutic Leave.

a) For Members age 21 and older, therapeutic leave may not exceed nine days, and Bed Hold days may not exceed 12 days, per contract year; and

b) For Members under 21 years of age, total therapeutic leave or Bed Hold days may not exceed 21 days per contract year.

b. Behavioral Health Inpatient Facilities (BHIF) which provide continuous treatment to a person who is experiencing acute and significant behavioral health symptoms. BHIFs may provide observation or stabilization services and child and adolescent residential treatment services, in addition

to other behavioral health or physical health services, as identified under their licensure capacity.

i. Observation or Stabilization Services

1) Services in addition to 24-hour nursing supervision and physicians on site or on call, include:

a) Emergency reception,

b) Screening,

c) Assessment,

d) Crisis intervention and stabilization,

e) Counseling, and

f) Referral to appropriate level of services or care. Refer A.A.C. R9-10- 1016 on facility-based crisis intervention services for more information.

2) Observation or stabilization services, within a BHIF, shall be provided according to the requirements in A.A.C. R9-10-1012 for outpatient treatment centers.

3) Facilities shall meet the requirements for reporting and monitoring the use of Seclusion and Restraint (S&R) as set forth in Arizona Administrative Code. The use of S&R Seclusion and Restraint shall only be used to the extent permitted by and in compliance with A.A.C. R9-21-204 and A.A.C. R9-10-316. For additional information and requirements regarding reporting and monitoring of seclusion and restraint, refer to AMPM 962.

ii. Partial Hospitalization programs (PHP) Include intensive therapeutic treatment and must be targeted to meet the goals of alleviating impairments and maintaining or improving functioning to prevent relapse or hospitalization.

1) May include the following rehabilitative and support services:

a) Individual therapy,

b) Group and family therapy, and

c) Medication management

2) PHP service shall be provided by an appropriately licensed ADHS DLS Outpatient Treatment Center.

3) Staff who deliver the specific services shall meet the individual provider qualifications.

iii. Residential treatment services shall be accredited and shall meet the requirements for seclusion and restraint specified set forth in 9 A.A.C. R9-10-316 and in accordance with 42 CFR 441 and 42 CFR 483 if the facility has been authorized by ADHS DLS to provide seclusion and restraint.

1) Child and adolescent residential treatment services shall be provided by a BHIF to an individual who is under 18 years of age or under 21 years of age and meets the criteria in A.A.C. R9-10-318.

C. DIVISION OVERSIGHT

1. The Division shall oversee the AdSS utilizing the following methods to ensure compliance with policy:
   a. Annual Operational Review of each AdSS,
   b. Review and analyze deliverable reports submitted by the AdSS, and
   c. Conduct oversight meetings with the AdSS for the purpose of:
      i. Reviewing compliance,
      ii. Addressing concerns with access to care or other quality of care concerns,
      iii. Discussing systemic issues, and
      iv. Providing direction or support to the AdSS as necessary.

Signature of Chief Medical Officer: Anthony Dekker (Jul 26, 2023 16:09 PDT)
Anthony Dekker, D.O.

SUPPLEMENTAL INFORMATION

Provider Travel

Provider travel is the cost associated with certain provider types traveling to provide a covered Behavioral Health Services. This is different than transportation, which is provided to take a Member to and from a covered Behavioral Health Services. Certain behavioral health professionals are eligible to bill for provider travel services as outlined below.

The mileage cost of the first 25 miles of provider travel is included in the rate calculated for each service, therefore, provider travel mileage may not be billed separately except when it exceeds 25 miles. In these circumstances providers bill the additional miles traveled in excess of 25 miles using the HCPCS code A0160. When a provider is traveling to one destination and returns to the office, the 25 miles is assumed to be included in the round trip. If a provider is traveling to multiple out-of-office settings, each segment of the trip is assumed to include 25 miles of travel.

- If Provider A travels a total of 15 miles (to the out-of-office setting in which the service is delivered and back to the provider's office), travel

time and mileage is included in the rate and may not be billed separately.

- If Provider B travels a total of 40 miles (to the out-of-office setting in which the service is delivered and back to the provider's office), the first 25 miles of provider travel are included in the rate but the provider may bill 15 miles using the provider code A0160 (40 miles minus 25 miles).
- If Provider C travels to multiple out-of-office settings (in succession), he/she shall calculate provider travel mileage by segment. For example:

  First segment = 15 miles, 0 travel miles are billed,

  Second segment = 35 miles, 10 travel miles are billed,

  Third segment = 30 miles, 5 travel miles are billed, and iv. Total travel miles billed = 15 miles are billed using provider code A0160. The provider may bill for travel miles in excess of 25 miles for the return trip to the provider office.

Provider Travel Limitations

If a BHP, BHT or BHPP travels to provide case management services, or provider type 85, 86, 87 or A4 travels to provide services to a client, and the client misses the appointment, the intended service may not be billed. Additionally, providers may not bill for travel for missed appointments. This applies for time spent conducting outreach without successfully finding the Member and for time spent driving to do a home visit and the Member is not home.

Skills Training

Examples of areas that may be addressed include self-care, household management, relationships, avoidance of exploitation, budgeting, recreation, development of social support networks, and use of individuals or their families with the Member(s) present.

Psychoeducational Services (pre-vocational services)

Psychoeducational Services are pre-vocational services that prepare Members to engage in meaningful work-related activities, such as full- or part-time, competitive employment. Such activities may include, but are not limited to, the following: career/educational counseling, job training,

assistance in the use of educational resources necessary to obtain employment, attendance to RSA Vocational Rehabilitation Orientations, attendance to job fairs, assistance in finding employment, and other training, like resume preparation, job interview skills, study skills, budgeting skills (when it pertains to employment), professional decorum, and time management.

Ongoing Support to Maintain Employment Services

Services may include, but are not limited to, the following: monitoring and supervision, assistance in performing job tasks, and supportive counseling. Ongoing Support to Maintain Employment can also be used.

Pre-vocational Services and Ongoing Support to Maintain Employment

While the goal may be for Members to achieve full-time employment in a competitive, integrated work environment, having other employment goals may be necessary prior to reaching that level.

Provider Case Management (provider level)

A supportive service provided to improve treatment outcomes. Examples of case management activities to meet Member's Service Plan goals include:

- Attendance and participation as a team Member in the Division's planning process including implementing the Planning Document/Service Plan,
- Assistance in maintaining, monitoring, and modifying Behavioral Health Services,
- Assistance in finding necessary resources other than Behavioral Health Services,
- Coordination of care as identified with the Planning Team, with the Member's healthcare providers, family, community resources, and other involved supports including educational, social, judicial, community and other State agencies,
- If needed, and as identified by the Planning Team, coordination of care activities related to continuity of care between levels of care (e.g., inpatient to outpatient care) and across multiple services (e.g., personal assistant, nursing services, and family counseling),

- Assisting Members in applying for Social Security benefits when using the SSI/SSDI Outreach, Access, and Recovery (SOAR) approach. SOAR activities may include:
    - Face-to-face meetings with Member,
    - Phone contact with Member, and
    - Face-to-face and phone contact with records and data sources (e.g., jail staff, hospitals, treatment providers, schools, Disability Determination Services, Social Security Administration, physicians).
- For provider case management used to facilitate a CFT, the modifier U1 is required and the claim must be submitted to the health plan the Member is enrolled with.
- SOAR services shall only be provided by staff who have been certified in SOAR through SAMHSA SOAR Technical Assistance Center. Additionally, when using the SOAR approach, billable activities do not include:
    - Completion of SOAR paperwork without Member present,
    - Copying or faxing paperwork,

- Assisting Members with applying for benefits without using the SOAR approach, and
- Email

For provider case management utilized when assisting Members in applying for Social Security benefits (using the SOAR approach) the modifier HK is required. Billing T1016 with an HK modifier indicates the specific usage of the SOAR approach and it cannot be used for any other service. Claims must be submitted to the health plan the Member is enrolled with.

Outreach and follow-up of crisis contacts and missed appointments, and Participation in staffing, case conferences, or other meetings with or without the Member or their family participating.

Case Management Limitations

Billing for case management is limited to providers who are directly involved with providing services to the Member.

Provider Case management services provided by licensed inpatient, behavioral health residential facility or day program providers are included in

the rate for these settings and cannot be billed separately; however, providers other than the inpatient, behavioral health residential facility or day program can bill case management services provided to the Member, iii. A single practitioner may not bill case management simultaneously with any other service.

For assessments, the provider may bill all time spent in direct or indirect contact (e.g., indirect contact may include email or phone communication specific to a Member's services) with the Member and other involved parties involved in implementing the Member's Treatment/Service Plan.

More than one provider agency may bill for case management at the same time, if it is clinically necessary and documented within the Member's Treatment/Service Plan. More than one individual within the same agency may bill for case management at the same time, if it is clinically necessary and documented within the Member's Treatment/Service Plan.

When a provider is picking up and dropping off medications for more than one Member, the provider shall divide the time spent and bill the appropriate case management code for each involved Member.

Peer and Recovery Support

Assists Members with accessing services and community supports, partnering with professionals, overcoming service barriers, and/or understanding and coping with the stressors of the Member's behavioral health condition. These services are aimed at assisting in the creation of skills to promote long-term sustainable recovery. This support is coupled with specific, skill-based training, coaching, or assistance to bring about social or personal change at the individual, family or community level. Peer and Recovery Support is intended for enrolled members and their families who require greater structure and intensity of services than those available through informal community-based support groups (e.g., 12-Step Programs, SMART Recovery).

310-C BREAST RECONSTRUCTION AFTER MASTECTOMY

EFFECTIVE DATE: October 26, 2022
REFERENCES: 42 U.S. Code § 300gg-52, A.A.C. R9-22-205, AMPM Policy 820

PURPOSE

This policy describes covered breast reconstruction surgery services following a mastectomy for DDD members who are eligible for ALTCS.

DEFINITIONS

1. "Contralateral" means relating to or denoting the side of the body opposite to that on which a particular structure or condition occurs.

POLICY

A. COVERED SERVICES

1. The Division shall cover breast reconstructive surgery post-mastectomy per 42 U.S. Code § 300gg-52.
2. The Division shall cover reconstructive breast surgery of the unaffected contralateral breast following mastectomy if required to achieve relative symmetry with the reconstructed affected breast.

3. The Division shall cover breast reconstruction surgery either immediately following the mastectomy or after the breast reconstruction, based on the choice of the member.
4. The Division shall cover medically necessary breast implant removal when the original implant was the result of a medically necessary mastectomy.
5. The Division shall cover an external prosthesis, including a surgical brassiere, for DDD Long Term Care members who choose not to have breast reconstruction post-mastectomy, or who choose to delay breast reconstruction until a later time.
6. The Division shall require Prior Authorization (PA) from the AHCCCS Division of Fee-For-Service Management to be obtained for breast reconstruction surgery provided to Tribal Health Program members.

B. LIMITATIONS

1. The Division shall not cover services provided solely for cosmetic purposes, per A.A.C. R9-22-205. If a member has had a breast implant procedure for cosmetic purposes, (i.e., augmentation),

not related to a mastectomy, medically necessary removal of the implant is covered, but implant replacement is not covered.

Signature of Chief Medical Officer: Anthony Dekker (Oct 19, 2022 10:26 PDT)
Anthony Dekker, D.O.

310-D1 EMERGENCY DENTAL SERVICES FOR MEMBERS 21 YEARS OF AGE AND OLDER

EFFECTIVE DATE: July 19, 2023
REFERENCES: A.R.S. § 32-1207 and 32-1231; AMPM 310-D1

PURPOSE

This policy establishes requirements for the provision of medically necessary dental services for Members of the Division of Developmental Disabilities (Division) who are age 21 and older.

DEFINITIONS

1. "Dental Emergency" means an acute disorder of oral health resulting in severe pain or infection due to pathology or trauma.
2. "Dental Provider" means an individual licensed under A.R.S. Title 32, Chapter 11, whose scope of practice allows the individual to:
    a. Independently engage in the practice of dentistry as defined in A.R.S. §32-1202,
    b. A dentist as defined in A.R.S. §32-1201,
    c. A dental therapist as defined in A.R.S. §32-1201,
    d. A dental hygienist as defined in A.R.S. §32-1201,

e. An affiliated practice dental hygienist as defined in A.R.S. §32-1201.

3. "Informed Consent" means a process by which the provider advises the Responsible Person of the diagnosis, proposed treatment and alternate treatment methods with associated risks and benefits of each, as well as the associated risks and benefits of not receiving treatment.
4. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
5. "Physician Service" means medical assessment, treatments, and surgical services provided by licensed allopathic or osteopathic physicians within the scope of practice.
6. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability, or an adult with a developmental disability who is a member or an applicant for whom no guardian has been appointed.
7. "Simple Restoration" means silver amalgam or composite resin fillings, stainless steel crowns or preformed crowns.

POLICY

A. GENERAL COVERED DENTAL SERVICES

1. The Division shall require the following dental services are covered and provided by a licensed Dental Provider for Members who are 21 years of age or older:
    a. Emergency dental services up to $1,000 per Member per contract year (October 1st to September 30th) as specified in A.R.S. § 36-2907.
    b. Medical and surgical services furnished by a Dental Provider when:
        i. The services may be performed under state law either by a physician or by a Dental Provider, and
        ii. The services would be considered a Physician Service if furnished by a physician.
2. The Division shall ensure emergency services relate to treatment of the following medical conditions:
    a. Acute pain,
    b. Infection, or
    c. Fracture of the jaw.

3. The Division shall ensure the following emergency services, which are not subject to the $1,000 adult emergency dental limit, are covered:
    a. Limited problem focused examination of the oral cavity,
    b. Required radiographs,
    c. Complex oral surgical procedures such as treatment of maxillofacial fractures,
    d. Administration of an appropriate anesthesia, and
    e. Prescription of pain medication and antibiotics.
4. The Division shall not cover the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJ) except for reduction of trauma. This item is not subject to the $1,000 adult emergency dental limit.
5. The Division shall ensure the following limited dental services, which are not subject to the $1,000 adult emergency dental limit, are covered for Members needing medically necessary dental services as a prerequisite to Division-covered organ or tissue transplantation:

a. Elimination of oral infections and the treatment of oral disease, which include:

i. Dental cleanings,

ii. Treatment of periodontal disease,

iii. Medically necessary extractions, and

iv. Provision of Simple Restorations.

6. The Division shall ensure services outlined in subsection (5) of this section are covered only after a transplant evaluation determines that the Member is an appropriate candidate for organ or tissue transplantation.

7. The Division shall ensure prophylactic extraction of teeth are covered in preparation for radiation treatment of cancer of the jaw, neck or head. This item is not subject to the $1,000 adult emergency dental limit.

8. The Division shall ensure cleanings for Members who are in an inpatient hospital setting and experiencing the following are covered:

a. Placed on a ventilator, or

b. Physically unable to perform oral hygiene.

B. EMERGENCY DENTAL SERVICES COVERAGE FOR PERSONS AGE 21 AND OLDER

1. The Division shall ensure medically necessary emergency dental care and extractions are covered for persons aged 21 years and older who meet the criteria for a Dental Emergency.
2. The Division shall ensure the following services and procedures are covered as emergency dental services:
    a. Emergency oral diagnostic examination;
    b. Radiographs and laboratory services, limited to the symptomatic teeth;
    c. Composite resin due to recent tooth fracture for anterior teeth;
    d. Prefabricated crowns, to eliminate pain due to recent tooth fracture only;
    e. Recementation of clinically sound inlays, onlays, crowns, and fixed bridges;
    f. Pulp cap, direct or indirect plus filling;
    g. Root canals and vital pulpotomies when indicated for the treatment of acute infection or to eliminate pain;

h. Apicoectomy performed as a separate procedure, for treatment of acute infection or to eliminate pain, with favorable prognosis;

i. Immediate and palliative procedures, including extractions if medically necessary, for relief of pain associated with an oral or maxillofacial condition;

j. Tooth reimplantation of accidentally avulsed or displaced anterior tooth, with favorable prognosis;

k. Temporary restoration which provides palliative/sedative care limited to the tooth receiving emergency treatment;

l. Initial treatment for acute infection, including:

   i. Periapical and periodontal infections, and

   ii. Abscesses by appropriate methods.

m. Preoperative procedures and anesthesia appropriate for optimal patient management; and

n. Cast crowns limited to the restoration of root canal treated teeth only.

3. The Division shall ensure follow-up procedures needed to stabilize teeth due the emergency services are covered, and subject to the $1,000 limit.

C. ADULT EMERGENCY DENTAL SERVICES LIMITATIONS FOR PERSONS AGE 21 YEARS AND OLDER

1. The Division shall not cover the following adult dental services:
    a. Maxillofacial dental services provided by a Dental Provider, except to the extent prescribed for the reduction of trauma, including reconstruction of regions of the maxilla and mandible;
    b. Diagnosis and treatment of temporomandibular joint dysfunction, except for the reduction of trauma;
    c. Routine restorative procedures and routine root canal therapy;
    d. Treatment for the prevention of pulpal death and imminent tooth loss, except for:
        1. Non-cast fillings,
        2. Crowns constructed from pre-formed stainless steel,
        3. Pulp caps, and

4. Root canals and vital pulpotomies when indicated for the treatment of acute infection or to eliminate pain.

e. Fixed bridgework to replace missing teeth; and

f. Dentures.

D. DIVISION AND FFS PROGRAM RESPONSIBILITIES

1. The Division shall require the AdSS to provide the following:

a. Coordination of covered dental services for enrolled Division Members;

b. Documentation of current valid contracts with Dental Providers who practice within the AdSS service area(s);

c. Primary care provider to initiate Member referrals to Dental Provider(s) when the Member is determined to need emergency dental services, or Members may self-refer to a Dental Provider when in need of emergency dental services;

d. Monitoring of the provision of dental services and reporting of encounter data to the Division; and

e. Assurance that copies of adult emergency dental policies and procedures have been provided to contracted Dental Provider(s).

2. The Division shall ensure the annual $1,000 adult emergency dental limit is Member specific and remains with the Member if the Member transfers between AdSS's or between Fee-For-Service (FFS) and an AdSS.
3. The Division shall ensure dental services provided to American Indian/Alaska Native Members within an IHS/638 Tribal facility are not subject to the $1,000 adult emergency dental limit.
4. The Division shall require the AdSS or Tribal Case Manager transferring the Member notifies the accepting entity regarding the current balance of the dental benefit.
5. The Division shall require the relinquishing AdSS to use the ALTCS Enrollment Transition Information (ETI) (DDD-1541A) and Division Medical Policy 520 for reporting dental benefit balance to the receiving AdSS that meet the following requirements:
   a. All services are subject to retrospective review to determine whether they satisfy the criteria for a Dental

Emergency. Services determined to not meet the criteria for a Dental Emergency are subject to recoupment;.

b. The Member is not permitted to carry-over unused benefit from one year to the next; and

c. A year begins on October 1st and ends September 30th.

6. The Division shall not require prior authorization for emergency dental services for Members enrolled with either FFS or Managed Care.

E. NOTIFICATION REQUIREMENTS FOR CHARGES TO MEMBERS

1. The Division shall ensure emergency dental services of $1,000 per contract year for Members age 21 years and older are covered. Billing of Division Members for emergency dental services in excess of the $1,000 annual limit is permitted only when the provider meets the requirements of A.A.C R9-22-702 for acute Members, and A.A.C. R9-28-701.10 for ALTCS Members.

2. The Division shall ensure providers who bill Members for emergency dental services exceeding the $1,000 limit conduct the following:

a. The provider must first inform the Member or Responsible Person in a way they understand, that the requested dental service exceeds the $1,000 limit and is not covered by the Division;

b. The provider must furnish the Member or Responsible Person with a document to be signed in advance of the service stating that the Member understands that the dental service will not be fully paid by the Division;

c. The document shall contain information describing the type of service to be provided and the charge for the service;

d. The Member agrees to pay for the amount exceeding the $1,000 emergency dental services limit, as well as services not covered by the Division; and

e. The Member must sign the document before receiving the service in order for the provider to bill the Member.

F. FACILITY AND ANESTHESIA CHARGES

1. The Division shall ensure facility and anesthesia charges are subject to the $1,000 emergency dental limit when:

a. A Member has an underlying condition which necessitates that services provided under the emergency dental benefit be provided in:

i. An ambulatory service center, or

ii. An outpatient hospital.

b. Anesthesia is required as part of the emergency service.

2. The Division shall require Dental Providers performing General Anesthesia (GA) on Members shall bill using dental codes and the cost will count towards the $1,000 emergency dental limit.

3. The Division shall require Physicians performing GA on Members for a dental procedure shall bill medical codes and the cost shall count towards the $1,000 emergency dental limit.

G. INFORMED CONSENT

1. The Division shall require providers to complete the appropriate Informed Consents and treatment plans for Members, in order to provide quality and consistent care.

2. The Division shall require Informed Consents for oral health treatment include the following:

a. A written consent for examination or any treatment measure, which does not include an irreversible procedure;

b. The consent is completed at the time of initial examination and is updated at each subsequent six-month follow-up appointment;

c. A separate written consent is completed for:

   i. Any irreversible procedures,

   ii. Invasive procedures,

   iii. Dental fillings, or

   iv. Pulpotomies.

d. Consent is used in a manner that protects the Member and is easily understood by the:

   i. Member,

   ii. Guardian, or

   iii. Designated representative.

e. A written treatment plan must be reviewed and signed by a Responsible Person with the Member;

f. Consents and treatment plans must be:

   i. In writing, and

ii. Signed and dated by both the provider and the Member, or Responsible Person, if:

1) The Member is under 18 years of age, or

2) The Member is 18 years of age or older and considered an incapacitated adult as specified in A.R.S. §14-5101.

g. The Responsible Person receives a copy of the complete treatment plan.

h. Extends to all Contractor mobile unit providers.

3. The Division shall require completed consents and treatment plans be maintained in the Members chart and are subject to audit.

Signature of Chief Medical Officer: Anthony Dekker (Jul 13, 2023 09:15 PDT)

Anthony Dekker, D.O.

310-D2 ARIZONA LONG TERM CARE SYSTEM ADULT ROUTINE DENTAL SERVICES

EFFECTIVE DATE: July 19, 2023
REFERENCES: AMPM 310-D2

PURPOSE

This Policy establishes requirements regarding the provision of medically necessary dental services for members in the Arizona Long Term Care Program (ALTCS).

DEFINITIONS

1. "Dental Provider" means an individual licensed under A.R.S. Title 32, Chapter 11, whose scope of practice allows the individual to:
    a. Independently engage in the practice of dentistry as defined in A.R.S. §32-1202,
    b. A dentist as defined in A.R.S. §32-1201,
    c. A dental therapist as defined in A.R.S. §32-1201,
    d. A dental hygienist as defined in A.R.S. §32-1201,
    e. An affiliated practice dental hygienist as defined in A.R.S. §32-1201.

2. "Informed Consent" means a process by which the provider advises the Responsible Person of the diagnosis, proposed treatment and alternate treatment methods with associated risks and benefits of each, as well as the associated risks and benefits of not receiving treatment.
3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
4. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a member or an applicant for whom no guardian has been appointed.

POLICY

A. GENERAL REQUIREMENTS

1. The Division shall ensure the following medically necessary dental benefits are covered up to $1,000 per member per contract year for ALTCS members age 21 or older in accordance with A.R.S. § 36-2939:

a. Diagnostic care,

b. Therapeutic care, and

c. Preventative care, including dentures.

2. The Division shall refer to AMPM 430 for dental services for Members under the age of 21.

3. The Division shall require emergent services for Members are covered as specified in AMPM 310-D1. These services do not count towards the ALTCS $1,000 limit.

B. DIVISION OVERSIGHT

1. The Division shall ensure the following is provided:

a. Coordination of covered dental services for enrolled members;

b. Documentation of current valid contracts with dentists who practice within the AdSS service area(s);

c. Monitoring of the provision of dental services and reporting of encounter data to the Division; and

d. Assurance that copies of dental policies and procedures have been provided to contracted dentist(s).

2. The Division shall require primary care providers initiate member referrals to dentist(s) when the member is determined to be in need of dental services. Members may also self-refer to a dentist when in need of dental services.
3. The Division shall ensure the annual dental benefit limit remains with the Member is the Member transfers to the following:
    a. Between one AdSS to another, or
    b. Between Fee-For-Service and an AdSS.
4. The Division shall require the transferring AdSS notifies the receiving AdSS regarding the current balance of the Member's dental benefit.
5. The Division shall ensure the AdSS utilizes the ALTCS Enrollment Transition Information (ETI) form, AMPM Policy 1620, Exhibit 1620-9, must be utilized for reporting any dental benefit balance.
6. The Division shall ensure dental services provided to American Indian/Alaska Native members within an Indian Health Service (IHS) or 638 Tribal Facility are also not subject to the ALTCS dental benefit $1,000 limit.

7. The Division shall require the Member is aware they are not permitted to carry-over unused benefit from one contract year to the next.
8. The Division shall refer to the Dental Uniform Prior Authorization List as listed on the AHCCCS website under Resources: Guides-Manuals-Policies to ensure frequency limitations and services that require prior authorization are met as specified in AMPM 431.

C. FACILITY AND ANESTHESIA CHARGES

1. The Division shall ensure facility and anesthesia charges are subject to the $1,000 emergency dental limit when:
    a. A member may have an underlying medical condition which necessitates that services provided under the dental benefit be provided in an ambulatory surgery service center or an outpatient hospital, and
    b. Anesthesia is required as part of the routine service.
2. The Division shall require dentists performing General Anesthesia (GA) on members shall bill using dental codes and the cost will count towards the $1,000 limit.

D. INFORMED CONSENT

1. The Division shall require providers complete the appropriate informed consents and treatment plans for Members, in order to provide quality and consistent care.
2. The Division shall require informed consents for oral health treatment include the following:
    a. A written consent for examination or any treatment measure, which does not include an irreversible procedure,
    b. The consent is completed at the time of initial examination and is updated at each subsequent six-month follow-up appointment,
    c. A separate written consent is completed for:
        i. Irreversible procedures,
        ii. Invasive procedures,
        iii. Dental fillings, or
        iv. Root canals and vital pulpotomies when indicated for the treatment of acute infection or to eliminate pain.
    d. Consent is used in a manner that protects the Member and is easily understood by the:

i. Member,

ii. Guardian, or

iii. Responsible Person.

e. A written treatment plan must be reviewed and signed by the Responsible Person with the Member,

f. Consents and treatment plans must be:

i. In writing, and

ii. Signed and dated by both the provider and the Member, or Responsible Person, if:

1) The Member is under 18 years of age; or

2) The Member is 18 years of age or older and considered an incapacitated adult as specified in A.R.S. §14-5101.

g. The Responsible Person receives a copy of the complete treatment plan.

3. The Division shall require completed consents and treatment plans are maintained in the Members chart and are subject to audit.

E. NOTIFICATION REQUIREMENTS FOR CHARGES TO MEMBERS

1. The Division shall ensure medically necessary services are provided within the $1,000 dental benefit allowable amount.
2. The Division shall ensure services are provided as set forth in A.A.C. R9-28-701(10) and R9-22-702, when medically necessary services are greater than $1,000.
3. The Division shall require the following notification when the provider informs the Member that the dental service requested is not covered and exceeds the $1,000 limit:
    a. Verbally,
    b. In writing, and
    c. In the member's primary language.
4. The Division shall require the following if the Member agrees to pursue the receipt of services:
    a. The provider shall supply the member a document describing the service and the anticipated cost of the service, and
    b. Prior to service delivery, the Member must sign and date a document indicating that they understand that they will be

responsible for the cost of the service to the extent that it exceeds the ALTCS $1,000 limit.

Signature of Chief Medical Officer: Anthony Dekker (Jul 11, 2023 16:25 PDT)

Anthony Dekker, D.O.

310–E DIALYSIS

EFFECTIVE DATE: March 3, 2017

The Division of Developmental Disabilities (Division) covers hemodialysis and peritoneal dialysis are covered services when provided by participating hospitals and End Stage Renal Disease facilities. All services, supplies, diagnostic testing (including routine medically necessary laboratory tests), and drugs medically necessary for the dialysis treatment are covered.

A. Medically necessary outpatient dialysis treatments are covered. Inpatient dialysis treatments are covered when the hospitalization is for the following:

   1. Acute medical condition requiring dialysis treatments (hospitalization related to dialysis)

   2. Division-covered medical condition requiring inpatient hospitalization experienced by a member routinely maintained on an outpatient chronic dialysis program

   3. Placement, replacement, or repair of the chronic dialysis route.

B. Hospital admissions solely to provide chronic dialysis are not covered.

C. Hemoperfusion is covered when medically necessary.

310-H HEALTH RISK ASSESSMENT AND SCREENING TESTS

EFFECTIVE DATE: MAY 13, 2016

A. The Division covers health risk assessment and screening tests provided by a physician, primary care provider or other licensed practitioner within the scope of his/her practice under State law for all members.

B. These services include appropriate clinical heath risk assessments and screening tests, immunizations, and health education, as appropriate for age, history and current health status. Health risk assessment and screening tests are also covered for members under the Early and Periodic Screening, Diagnosis and Treatment Program.

C. Preventive health risk assessment and screening test services are covered for adults, except when the adult member is hospitalized. Services include, but are not limited to:

1. Hypertension screening (annually).

2. Cholesterol screening (once, additional tests based on history).

3. Routine mammography annually after age 40 and at any age if considered medically necessary.

4. Cervical cytology, including pap smears (annually for sexually active women; after three successive normal exams the test may be less frequent).

5. Colon cancer screening (digital rectal exam and stool blood test, annually after age 50, as well as baseline colonoscopy after age 50).

6. Sexually transmitted disease screenings (at least once during pregnancy, other based on history).

7. Tuberculosis screening (once, with additional testing based on history, or, for members residing in a facility, as necessary per health care institution licensing requirement).

8. HIV screening.

9. Immunizations (See AHCCCS Policy AMPM 310 M for details).

10. Prostate screening (annually after age 50; and, screening is recommended annually for males 40 and older who are at high risk due to immediate family history), and

11. Physical examinations (includes well visits and well exams), periodic health

examinations or assessments, diagnostic work ups or health protection packages designed to:

a. Provide early detection of disease,

b. Detect the presence of injury or disease,

c. Establish a treatment plan,

d. Evaluate the results or progress of a treatment plan or the disease, or

e. Establish the presence and characteristics of a physical disability, which may be the result of disease or injury.

D. Screening services provided more frequently than these professionally recommended guidelines will not be covered unless medically necessary.

Exclusions

Physical examinations not related to covered health care services or performed to satisfy the demands of outside public or private agencies such as the following are not covered services:

A. Qualification for insurance.

B. Pre-employment physical examination.

C. Qualifications for sports or physical exercise activities.

D. Pilots examinations (Federal Aviation Administration).

E. Disability certification for the purpose of establishing any kind of periodic payments.

F. Evaluation for establishing third party liability.

310-I HOME HEALTH SERVICES

REVISION DATE: 12/07/2022, 7/3/2015, 9/15/2014

EFFECTIVE DATE: June 30, 1994

REFERENCES: A.R.S. § 32-1601, A.R.S. §36-2939, 42 CFR 440.70, AMPM 310-I, AMPM Policy 1240-G

PURPOSE

This policy describes and establishes requirements for covered Home Health Services for Division of Developmental Disabilities (Division) members who are eligible for Arizona Long Term Care System (ALTCS).

DEFINITIONS

1. "Face-to-Face Encounter" means a Face-to-Face visit, in person or via telehealth, with a member's Primary Care Physician (PCP) or physician of record, related to the primary reason the member requires Home Health Services (42 CFR 440.70).
2. "Home Health Agency (HHA)" means a public or private agency or organization, or part of an agency or organization, that is licensed by the State and meets requirements for participation in Medicare, including the capitalization requirements under 42 CFR 489.28 (42

CFR 440.70).

3. "Home Health Services" means nursing services, home health aide services, therapy services, and medical supplies, equipment, and appliances provided to a member at their place of residence and on the member's physician's orders, or ordered by the member's nurse practitioner, physician assistant, or clinical nurse specialist, as a part of the plan of care and reviewed by the practitioner annually as part of a written plan of care.
4. "Licensed Health Aide (LHA)" means a person who is licensed to provide or assist in providing nursing-related services and:
    a. Is the parent, guardian, or family member of the Arizona Long Term Care System (ALTCS) member who is under 21 years of age and eligible to receive Skilled Nursing or skilled nursing respite care services who may provide Licensed Health Aide (LHA) services only to that member and only consistent with that member's plan of care; and
    b. Has a scope of practice that is the same as a Licensed Nursing Assistant (LNA) and may also provide medication administration,

tracheostomy care, enteral care and therapy, and any other tasks approved by the State Board of Nursing in rule.

POLICY

A. HOME HEALTH AGENCIES

1. The Division shall cover Home Health Services that are medically necessary and provided by a Medicare Certified Home Health Agency (HHA) licensed by the Arizona Department of Health Services (ADHS) that is contracted by the Division. All other requirements of 42 CFR 440.70 apply; however, intermittent nursing services shall be provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN).
2. The Division shall permit a non-Medicare certified, State certified HHA or an Arizona Health Care Cost Containment System (AHCCCS) registered Independent RN to provide Home Health Services only under the following circumstances:
   a. Intermittent nursing services are needed in a geographic service area not currently served by a Medicare certified HHA;

b. The Medicare certified HHA in the applicable geographic service area lacks adequate staff to provide the necessary services for the member(s); or

c. The Medicare certified HHA is not willing to provide services to, or contract with the Division .

3. The Division shall permit Home Health Services provided by a non-Medicare State certified HHA or AHCCCS registered Independent RN when the following apply:

a. Non-Medicare certified HHAs shall be licensed by the State and:

i. The Division shall maintain documentation supporting at least one of the three circumstances specified in subsections (2)(a), (b) and (c) above;

ii. The State licensed HHA shall be an AHCCCS registered provider which employs the individuals providing Home Health Services; and

iii. Intermittent nursing services shall be provided by an RN who is employed by the State licensed HHA.

b. Independent RNs shall be registered as an AHCCCS registered provider and:

i. Shall receive written orders from the member's PCP or physician of record, are responsible for all documentation of member care;

ii. Are responsible for the transmission of said documentation to the member's PCP or physician of record; and

iii. Sub-contractors who contract with Independent RNs to provide home health skilled nursing shall develop oversight activities to monitor service delivery and quality of care provided by the Independent RN.

B. INTERMITTENT NURSING AND HOME HEALTH AIDE SERVICES

1. The Division shall cover nursing services that are provided on an intermittent basis as ordered by a treating physician.
2. The Division shall require that home health aides provide non-skilled services under the direction and supervision of an RN.
3. The Division shall cover home health aide services in units of one

visit. Visits include at least one of the following components:

a. Monitoring the health and functional level, and assistance with the development of the HHA plan of care for the member;

b. Monitoring and documenting of member vital signs, as well as reporting results to the supervising HHA RN, PCP or physician of record;

c. Providing members with personal care;

d. Assisting members with bowel, bladder and/or ostomy programs, as well as catheter hygiene (does not include catheter insertion);

e. Assisting members with self-administration of medications;

f. Assisting members with eating, if required, to maintain sufficient nutritional intake, and providing information about nutrition;

g. Assisting members with routine ambulation, transfer, use of special appliances and/or prosthetic devices, range of

motion activities or simple exercise programs;

h. Assisting members in activities of daily living to increase member independence;

i. Teaching members and families how to perform home health tasks; and

j. Observation of and reporting to the HHA Provider or the support coordinator for members who exhibit the need for additional medical or psychosocial support, or a change (decline or improvement) in condition during the course of service delivery.

4. The Division shall cover intermittent nursing services only when provided by an RN or LPN under the supervision of an RN or PCP or physician of record as specified in A.A.C. R4-19-401.
5. The Division shall cover intermittent nursing services provided by an LPN only if they are working for an HHA.
6. The Division shall cover intermittent nursing services in 15 minute units, not to exceed two hours (eight units) per single visit.

7. The Division shall not cover more than four hours (16 units) per calendar day.
8. The Division shall cover intermittent nursing services to members residing in an Assisted Living Facility (ALF) when skilled nursing services are not included in the facility's per diem rate.
9. The Division shall cover home health aide services provided by a family member, including but not limited to parents and guardians of minor children or adults when the individual is a Licensed Nursing Assistant (LNA) and employed by a Medicare Certified HHA.

C. LICENSED HEALTH AIDE

1. The Division shall cover LHA services in units of one visit that include one or more of the following:
   a. Monitoring the health and functional level, and assistance with the development of the HHA plan of care for the member;
   b. Monitoring and documenting of member vital signs, as well

as reporting results to the supervising RN, PCP or physician of record;

c. Providing members with personal care;

d. Assisting members with bowel, bladder and/or ostomy programs, as well as catheter hygiene (does not include catheter insertion);

e. Administering or assisting members with self-administration of medications;

f. Assisting members with eating if required, to maintain sufficient nutritional intake and providing information about nutrition;

g. Assisting members with routine ambulation, transfer, use of special appliances and/or prosthetic devices, range of motion activities or simple exercise programs;

h. Assisting members in activities of daily living to increase member independence;

i. Teaching members and families how to perform home health tasks; and

j. Observation and reporting to the HHA Provider and/or the support coordinator of members who exhibit the need for additional medical or psychosocial support or a change (decline or improvement) in condition during the course of service delivery.

D. PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH THERAPY SERVICES

1. The Division shall cover physical therapy, occupational therapy, and speech therapy services provided by an HHA for members as specified in AMPM Policy 310-X.

E. MEDICAL EQUIPMENT, APPLIANCES AND SUPPLIES

1. The Division shall cover medical equipment, appliances, and supplies provided by an HHA as specified in AMPM Policy 310-P.

F. FACE-TO-FACE ENCOUNTER REQUIREMENTS

1. The Division shall require the practitioner to complete a

Face-to-Face encounter with Tribal Health Program members for initiation of Home Health Services, that relates to the primary reason the member requires Home Health Services no more than 90 days before or within 30 days after start of services.

2. The Division shall require the Face-to-Face encounter for Tribal Health Program members be conducted by one of the following:
   a. The ordering PCP or physician of record or
   b. For members admitted to home health immediately after an acute or post-acute stay, the attending acute or post-acute physician.
3. The Division shall allow the practitioner to perform the Face-to-Face encounter for Tribal Health Program members to occur through telehealth.

Signature of Chief Medical Officer: Anthony Dekker (Nov 29, 2022 09:27 MST)
Anthony Dekker, D.O.

310–J HOSPICE SERVICES

REVISION DATE: 5/8/2019
EFFECTIVE DATE: November 17, 2017
REFERENCES: A.R.S. §§ 36-2907 and 2989, 42 CFR 418.20 and 70, and Arizona's Section 115(a) Medicaid Demonstration Extension.

This Policy establishes requirements for Hospice Services. Hospice services are covered for members eligible for AHCCCS. Hospice services are allowable under A.R.S. §§ 36-2907 and 2989, and 42 CFR 418.20, for terminally ill members who meet the specified medical criteria/requirements. Hospice services provide palliative and support care for terminally ill members and their family members or caregivers in order to ease the physical, emotional, spiritual, and social stresses, which are experienced during the final stages of illness and during dying and bereavement.

Hospice services are provided in the member's own home, an alternative residential setting, or the following inpatient settings when the conditions of participation are met as specified in 42 CFR 418:

A. Hospital

B. Nursing care institution

C. Freestanding hospice.

Providers of hospice must be Medicare certified, licensed by the Arizona Department of Health Services (ADHS), and have a signed AHCCCS provider agreement.

As directed by the Affordable Care Act, members receiving Early Periodic Screening, Diagnosis, and Treatment (EPSDT) may continue to receive curative treatment for their terminal illness while receiving hospice services. Adult members age 21 and older who elect hospice services must forgo curative care.

For dual eligible members, Medicare is the primary payer of hospice services.

Definitions

The following definitions apply to Hospice Services:

A. Bereavement Counseling - Emotional, psychosocial, and spiritual support and services provided before and after the death of a member to assist the family with issues related to grief, loss, and adjustment.

B. Continuous home care - Services provided during periods of crisis for a minimum of eight hours per 24-hour day (the hours do not have to be continuous) to maintain residence in their own home as specified in 42 CFR 418.204(a). Care must be predominantly nursing care, provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN). Homemaker and home health aide services may also be provided to supplement the care.

C. Palliative care - Member and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering and is provided to address physical, intellectual, emotional, social, and spiritual needs and to facilitate member autonomy, access to information, and choice.

D. Period of crisis - A period (up to 24 hours per day) in which the hospice-eligible member

requires continuous care to achieve palliation or management of acute medical symptoms.

E. Terminally ill - A medical prognosis of life expectancy for six months or less if the illness runs its normal course.

Policy

Hospice Care is a comprehensive set of services identified and coordinated by an interdisciplinary group to provide palliative and support care for terminally ill members and their family members and caregivers for the physical, psychosocial, spiritual, and emotional needs as delineated in a specific patient plan of care.

Hospice Services are covered for all terminally ill members who meet the specified medical criteria and requirements under A.R.S. §§ 36-2907, 36-2939, and 36-2989, and 42 CFR Part 418 et seq.

In order to receive Hospice Care, Members must waive the right to duplicative services including: hospice care provided by a non-designated hospice service; services that are related to the treatment of the terminal condition or a related condition, unless provided by the designated hospice, provided by the attending physician, or provided as room and board by a nursing facility where the member is a resident as specified in CMS Medicaid Manual section 4305.2. This waiver does not apply to EPSDT-aged members.

If the Hospice agency is unable or unwilling to provide or cover medically necessary services related to the hospice diagnosis, the services must be provided by the Contractor. The Contractor however must report such cases to ADHS as the hospice licensing agency in Arizona.

A. Eligibility

1. A physician must provide a signed certification stating that the member's prognosis is terminal, with the member's life expectancy not exceeding six months. However, due to the uncertainty of predicting courses of illness, the hospice benefit is available beyond six months, provided additional physician certifications are completed.

2. A member may elect to receive Hospice Care during one or more of the following election periods:

   a. An initial 90-day period,

   b. A subsequent 90-day period, or

   c. An unlimited number of subsequent 60-day periods.

3. As specified in Section 2302 of the Affordable Care Act, EPSDT-aged members may continue to receive curative treatment for a terminal illness while receiving hospice services. Adult members age 21 and older who elect hospice services must forgo curative care related to the terminal diagnosis but may continue to receive services unrelated to the hospice diagnosis.

B. Hospice Services

Hospice services provide palliative and support care for terminally ill members and

their family members and caregivers in order to ease the physical, emotional, spiritual, and social stresses, which are experienced during the final stages of illness and during dying and bereavement. When the conditions of participation are met as specified in 42 CFR Part 418, hospice services are provided in the member's own home, or the following inpatient settings:

1. Hospital.

2. Nursing care institution.

3. Free standing Hospice Unit.

Hospice providers must also have social services, counseling, dietary services, homemaker, personal care and home health aide services, and inpatient services available as necessary to meet the member's needs. The following bundled hospice services are covered when provided in approved settings:

1. Physicians' services for the treatment of the member's terminal illnesses and related administrative and general supervisory activities, except for attending physician services provided by non-hospice employees;

2. Continuous Home Care;

3. Dietary services, which include a nutritional evaluation and dietary counseling when necessary;

4. Home health aide services;

5. Homemaker services;

6. Nursing services provided by or under the supervision of a registered nurse;

7. Pastoral/counseling services provided by an individual who is qualified through the completion of a degree in ministry, psychology, or a related field and who is appropriately licensed or certified;

8. Hospice respite care services which are provided on an occasional basis, not to exceed more than five consecutive days at a time. Respite care may not be provided when the member is a nursing facility resident or is receiving services in an inpatient setting;

9. Routine Home Care;

10. Social services provided by a qualified social worker;

11. Therapies that include physical, occupational, or speech therapy;

12. A 24 hour on-call availability to provide services such as reassurance, information, and referral for members and family members and caregivers;

13. Volunteer services provided by individuals who are specially trained in hospice and who are supervised by a designated hospice employee. Under 42 C.F.R. 418.70, if providing direct patient care, the volunteer must meet qualifications required to provide such services;

14. Medical supplies, appliances, and equipment, including:

    a. Pharmaceuticals, which are used in relationship to the palliation or management of the member's terminal illness; and

    b. Medical equipment and appliances may include but are not limited to:

        i. Wheelchairs,

        ii. Hospital beds, and

        iii. Oxygen equipment.

15. Bereavement counseling to the member's family and caregiver both before and up to 12 months following the death of that member. Bereavement Counseling, to the member's family and caregiver both before and up to 12 months following the death of the member, is part of the bundled hospice services and is not separately reimbursable, as specified in 42 CFR 418.204.30.

310-K HOSPITAL INPATIENT SERVICES

REVISION DATE: 11/29/2018, 11/17/2017, 7/3/2015, 3/2/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994
REFERENCES: A.R.S. § 32-801 through 871

The Division of Developmental Disabilities (Division) covers medically necessary inpatient hospital services, provided by a licensed participating hospital, for all members eligible for ALTCS. Inpatient hospital services are medically necessary services delivered or directed by a Primary Care Provider (PCP), a specialist physician, practitioner or dentist. These services are ordinarily furnished in an acute care hospital, except for services in public or correctional facilities, or Behavioral Health settings.

Inpatient hospital services for members include, but are not limited to, the following:

A. Hospital accommodation, and appropriate staffing, supplies, equipment and services for any or all of the following:

1. Acute physical care and behavioral health care
2. Intensive care and coronary care
3. Neonatal intensive care
4. Maternity care including labor, delivery and recovery rooms, birthing centers, and nursery and related services
5. Nursery for newborns and infants
6. Surgery including surgical suites and recovery rooms, and anesthesiology services
7. Nursing services necessary and appropriate for the member's medical condition, including assistance with activities of daily living asneeded
8. Medical detoxification and treatment services
9. Behavioral health forensic services
10. Dietary services
11. Medical supplies, appliances and equipment consistent with the level of accommodation
12. Perfusion and perfusionist services.

B. Ancillary Services

Ancillary services include any or all of the following:

1. Audiology services
2. Chemotherapy

3. Dental surgery for members in the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT)

4. Dental surgery for members 21 years of age and older within limitations as described in Division Medical Policy 310-D

5. Dialysis

6. Laboratory services

7. Pharmaceutical services and prescribed drugs

8. Radiological and medical imaging services

9. Rehabilitation services including physical, occupational and speech therapies

10. Respiratory therapy

11. Behavioral health assessments, and behavioral health therapy (including electroconvulsive therapy)

12. Services and supplies necessary to store, process, and administer blood and blood derivatives

13. Total parenteral nutrition

14. Wound care.

Limitations and Exclusions

The Division covers semiprivate inpatient hospital accommodations, except when the member's medical condition requires isolation.

The Division does not separately cover home-based services, such as Attendant/Personal Care, while the member is in inpatient settings.

310-L HYSTERECTOMY

REVISION DATE: 2/7/2024
REVIEW DATE: 7/3/2023
EFFECTIVE DATE: November 17, 2017
REFERENCES: 42 CFR 441.250 et seq, 42 CFR 441.251, 42 CFR 441.255, AMPM 820.

PURPOSE

This Policy establishes the requirements for coverage of Hysterectomy services in accordance with 42 CFR 441.250 et seq for Members within the Division of Developmental Disabilities who seek to obtain a medically necessary Hysterectomy.

DEFINITIONS

1. "Hysterectomy" means a medical procedure or operation for the purpose of removing the uterus as specified in 42 CFR 441.251.

2. "Initial Medical Acknowledgement" means documentation of the Member's understanding prior to surgery, the procedure will render them sterile.

3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

4. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a member or an applicant for whom no guardian has been appointed.

5. "Second Level Review" means a review performed by a Division of Developmental Disabilities (Division) Medical Director who has the appropriate clinical expertise in managing a Member's condition or disease. Second Level Review is used to screen for medical necessity and compare the findings to clinical data in the Member's medical record to ensure Division Members are receiving medically appropriate and high quality care.

6. "Sterilization" means any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing as specified in 42 CFR 441.251.

POLICY

A. CONDITIONS WHEN A HYSTERECTOMY SHALL BE COVERED IF DEEMED MEDICALLY NECESSARY

1. The Division shall cover a Hysterectomy for the following conditions when medically necessary:

   a. Dysfunctional Uterine Bleeding or Benign Fibroids associated with Dysfunctional Bleeding, when medical and surgical therapy has failed, and childbearing is no longer a consideration;

   b. Endometriosis, with severe disease when future child-bearing is not a consideration, and when disease is refractory to medical or surgical therapy; or

   c. Uterine Prolapse, when childbearing is no longer a consideration and for whom non-operative or surgical correction, suspension or repair, will not provide the Member adequate relief.

B. CONDITIONS WHERE MEDICAL OR SURGICAL INTERVENTION IS NOT REQUIRED PRIOR TO HYSTERECTOMY

1. The Division shall cover medically necessary Hysterectomy services without prior trial of medical or surgical intervention in the following cases:
   a. Invasive carcinoma of the cervix;
   b. Ovarian carcinoma;
   c. Endometrial carcinoma;
   d. Carcinoma of the fallopian tube;
   e. Malignant gestational trophoblastic disease;
   f. Life-threatening uterine hemorrhage, uncontrolled by conservative therapy;
   g. Potentially life-threatening hemorrhage as in cervical pregnancy, interstitial pregnancy, or placenta abruption; or
   h. Other potentially life threatening conditions where removal of the reproductive organs is necessary and considered the standard of care.
2. The Division shall require the provider to complete AMPM

Attachment 820-A prior to performing Hysterectomy procedures.

C. MEDICAL ACKNOWLEDGEMENT AND DOCUMENTATION

1. The Division shall require providers comply with the following requirements prior to performing the Hysterectomy:
   a. Inform the Responsible Person both orally, in the Member's medical records and in AMPM Attachment 820-A that the Hysterectomy will render the Member incapable of reproducing, resulting in sterility;
   b. Obtain from the Responsible Person a signed and dated written acknowledgment stating that the information in AMPM Attachment 820-A has been received and that the individual has been informed and understands that the Hysterectomy will result in sterility.
2. The Division shall require the Primary Care Provider (PCP) keep a signed, and dated written acknowledgment in the Member's medical records.

3. The Division shall require providers use AMPM Attachment 820-A as specified in AMPM 820.

D. EXCEPTIONS FROM INITIAL MEDICAL ACKNOWLEDGEMENT

1. The Division shall not require the physician performing the Hysterectomy to obtain Initial Medical Acknowledgment in either of the following situations:
   a. The Member was already sterile before the Hysterectomy.
      i. In this instance the physician must certify in writing that the Member was already sterile at the time of the Hysterectomy and specify the cause of sterility.
      ii. Documentation shall include the specific tests and test results conducted to determine sterility if the cause of sterility is unknown; or
   b. The Member requires a Hysterectomy because of a life-threatening emergency situation in which the physician determines that Initial Medical Acknowledgement is not possible. In this circumstance, the physician must certify

in writing that the Hysterectomy was performed under a life-threatening emergency situation in which the physician determined that Initial Medical Acknowledgement was not possible.

2. The physician shall include a description of the nature of the emergency in the Member's medical record and when AMPM Attachment 820-A is submitted to AHCCCS.

E. LIMITATIONS

1. The Division shall not cover a Hysterectomy if:
   a. It is performed solely to render the individual permanently incapable of reproducing; or
   b. There was more than one purpose to the procedure, and the procedure would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

F. SECOND LEVEL REVIEW

1. The Division Medical Director shall:

   a. Complete a Second Level Review of all approvals or denials for all requests for Hysterectomies for Members prior to the completion of the procedure, except in the event of a life-threatening emergency situation;

   b. Ensure all life-threatening emergency Hysterectomy cases are submitted to the Division for retrospective review;

   c. Consult with the AHCCCS Medical Director for Tribal Health Plan (THP) or the assigned AdSS health plan's Medical Director when there are questions regarding the Hysterectomy; and

   d. Have the final authority to approve or deny a Hysterectomy, except in the event of a life-threatening emergency situation.

G. DIVISION OVERSIGHT

1. The Division shall oversee the AdSS utilizing the following methods to ensure compliance with policy:
   a. Annual Operational Review of each AdSS,
   b. Review and analyze deliverable reports submitted by the AdSS, and
   c. Conduct oversight meetings with the AdSS for the purpose of:
      i. Reviewing compliance,
      ii. Addressing concerns with access to care or other quality of care concerns,
      iii. Discussing systemic issues, and
      iv. Providing direction or support to the AdSS as necessary.

SUPPLEMENTAL INFORMATION

Coverage of Hysterectomy services is limited to those cases in which medical necessity has been established by careful diagnosis. Prior to

performing a Hysterectomy, providers shall establish medical necessity in part by providing documentation relating to the trial of medical or surgical therapy which has not been effective in treating the Member's condition. The length of such trials shall also be documented in the Member's medical records.

Signature of Chief Medical Officer: Anthony Dekker (Jan 30, 2024 10:24 MST)
Anthony Dekker, D.O.

310-M IMMUNIZATIONS

REVISION DATE: 05/10/2023, 10/26/2022, 04/24/2019
EFFECTIVE DATE: November 17, 2017
REFERENCES: A.R.S. § 32-1974, AMPM 310-V, AMPM 430

PURPOSE

The purpose of this policy is to describe covered immunization services for DDD members who are eligible for ALTCS.

DEFINITIONS

1. "Adult" means an individual 18 years of age and older.
2. "Child" means an individual under the age of 18 years.
3. "Immunization" means the administration of a vaccine to promote the development of immunity or resistance to an infectious disease.
4. "Vaccine" means the preparation administered to stimulate the production of antibodies and provide immunity against one or several diseases.

POLICY

A. COVERAGE

1. The Division shall allow pharmacists and pharmacy interns under the supervision of a pharmacist, within their scope of practice, to administer AHCCCS covered immunizations to adults 19 years and older as specified in A.R.S. § 32-1974.
2. The Division shall cover immunizations as appropriate for age, history, and health risk, for adults and children.
3. The Division shall follow recommendations as established by the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP).
4. The Division shall not require prior authorization for medically necessary covered immunizations when administered by an AHCCCS-registered provider.
5. The Division shall cover immunizations for adults that include, but are not limited to:
    a. Diphtheria-tetanus,
    b. Influenza,

c. Coronavirus Disease 2019 (COVID-19),

d. Pneumococcus,

e. Rubella,

f. Measles,

g. Hepatitis A,

h. Hepatitis B,

i. Pertussis,

j. Zoster vaccine, for members 50 years of age and older,

k. Human Papillomavirus (HPV) vaccine.

6. The Division shall cover vaccinations for children as described in AMPM 430.

7. The Division shall not cover immunizations for members for passport, visa clearance, or for travel outside of the United States.

8. The Division shall cover pharmacy reimbursement for adult immunizations as described in AMPM 310-V.

Signature of Chief Medical Officer: Anthony Dekker (May 4, 2023 10:39 PDT)
Anthony Dekker, D.O.

310-N LABORATORY

REVISION DATE: 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994

Clinical Laboratory, Radiological and Medical Imaging Services (Acute Care Services)

Clinical laboratory procedures (including routine screening for Hepatitis B), radiological and medical imaging services prescribed by a Primary Care Provider (PCP) or by another physician, practitioner, or dentist upon referral by a PCP, and which are ordinarily administered in hospitals, clinics, physicians' offices or other health care facilities by licensed health care providers, shall qualify as covered services if medically necessary.

Clinical laboratory, radiological, and medical imaging service providers shall satisfy all applicable State license and certification requirements, be registered with the Arizona Health Care Cost Containment System (AHCCCS), and shall perform only those services specific to their license and certification.

310-P MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT, AND PROSTHETIC DEVICES (ACUTE CARE SERVICES)

REVISION DATE: 3/25/2016, 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994
REFERENCES: §36-2907; Laws 2015, Chapter 264, Section 3 (HB 2373); §36-2907.

A. Medical supplies, durable medical equipment (DME) orthotic and prosthetic devices provided to members who are eligible for Arizona Long Term Care System (ALTCS) services qualify as covered services if prescribed by a, specialist physician, practitioner or dentist upon referral by a Primary Care Provider (PCP). Medical supplies and DME include:

1. Surgical dressings, splints, casts, and other disposable items covered by Medicare (Title XVIII).

2. Rental or purchase of DME, including, customized equipment.

3. Other items as determined medically necessary by joint consultation of the Medical Directors of the health plan and the Division.

B. Requirements for specific services:

1. Incontinence Briefs

a. Incontinence briefs for members over the Age of 21 Years:

i. The Division's acute care contracted health plans shall provide incontinence briefs, including pull-ups, for members 21 years of age and older to treat a medical condition or to prevent skin breakdown when all the following are met:

- The member is incontinent due to a documented medical condition that causes incontinence of bowel and/or bladder.

- The Primary Care Provider (PCP) or attending physician has issued a prescription ordering the incontinence briefs.

- Incontinence briefs do not exceed 180 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 180 briefs per month.

- The member obtains incontinence briefs from vendors within the Contractor's network.

– Prior authorization has been obtained if required by the Administration, Contractor, or Contractor's designee, as appropriate. Contractors shall not require a new prior authorization to be issued more frequently than every 12 months.

ii. Authorized services must be for at least a 12 month period of time.

iii. Contractors may require a new prior authorization to be issued no more frequently than every 12 months.

iv. Payments for the use of incontinence briefs for the convenience of caregivers will not be authorized.

v. If a member is eligible for Fee-For-Service coverage, the Health Care Services Unit will prior authorize using the same criteria outlined above. Health Care Services Prior Authorization can be contacted by calling 602-771-8080.

vi. Any exceptions to this policy section must have the approval of the Assistant Director.

b. Incontinence briefs for members over three and under the Age of 21 Years:

Incontinence briefs are covered for members when necessary to treat a medical condition and/or for preventative purposes. For information on coverage and limitations see the *Division Medical Policy Manual Chapter 400, Section 430*.

2. DME means sturdy, long lasting items and appliances that can withstand repeated use, are designed to serve a medical purpose and are not generally useful to a person in absence of a medical condition, illness or injury.

Experience has demonstrated that the cost-effective provision of Durable Medical Equipment (DME) includes the involvement of a physical therapist in ordering and fitting customized equipment.

Documentation from therapists who have treated the member may be required. That documentation must establish the need for equipment and a comprehensive explanation of how the member will benefit from the equipment.

a. Orthotics- A device prescribed by a physical or other licensed practitioner to support a weak, injured, or deformed portion of the body.

i. Members 21 years of age and older:

Orthotics are covered within certain limitations if all of the following apply:

- The use of the orthotic is medically necessary as the preferred treatment option consistent with Medicare Guidelines.
- The orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition.
- The orthotic is ordered by a Physician or Primary Care Practitioner.

ii. Members under 21 years of age:

Orthotics are covered for members under the age of 21 as outlined in the *Division Medical Policy Manual Chapter 400 Section 430-C*.

iii. Orthotics Limitations- Reasonable repairs or adjustments of purchased orthotics are covered for all members to make the orthotic serviceable and/or when the repair cost is less than purchasing another unit. The component will be replaced if, at the time authorization is sought, documentation is provided to establish that the component is not operating effectively.

310-S OBSERVATION SERVICES

EFFECTIVE DATE: March 3, 2017

The Division of Developmental Disabilities (Division) covers Observations services. Observation services are those reasonable and necessary services provided on a hospital's premises for evaluation to determine whether the member should be admitted for inpatient care, discharged, or transferred to another facility. Observation services include: the use of a bed, periodic monitoring by a hospital's nursing or, if appropriate, other staff necessary to evaluate, stabilize or treat medical conditions of a significant degree of instability and/or disability on an outpatient basis.

It is not Observation when a member with a known diagnosis enters a hospital for a scheduled procedure/treatment that is expected to keep the member in the hospital for less than 24 hours (this is an outpatient procedure, regardless of the hour in which the member presented to the hospital, whether a bed was utilized, or whether services were rendered after midnight).

Extended stays after outpatient surgery must be billed as recovery room extensions.

Observation must be ordered in writing by a physician, or other individual authorized by hospital staff bylaws, in order to admit patients to the hospital or to order outpatient diagnostic tests or treatments. There is no maximum time limit for Observation services as long as medical necessity exists. The medical record must document the basis for Observation services.

Factors That Must Be Considered by the Physician or Authorized Individual When Ordering Observation

The following factors must be considered by the physician or authorized individual when ordering Observation:

A. Severity of the signs and symptoms of the member

B. Degree of medical uncertainty that the member may experience an adverse occurrence

C. Need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the member to remain at the hospital for 24 hours or more) to assist in assessing whether the member should be admitted

D. The availability of diagnostic procedures at the time and location where the member presents

E. It is reasonable, cost effective and medically necessary to evaluate a medical condition or to determine the need for inpatient admission

F. Length of stay for Observation is medically necessary for the member's condition.

Required Medical Record Documentation

The following are requirements for documenting medical records:

A. Orders for Observation must be written on the physician's order sheet, not the emergency room record, and must specify, "Observation." Rubber-stamped orders are not acceptable.

B. Follow-up orders must be written within the first 24 hours, and at least every 24 hours if Observation is extended.

C. Changes from "Observation to inpatient" or "inpatient to Observation" must be made per physician order.

D. Inpatient/outpatient status change must be supported by medical documentation.

Limitations

The following services are not Division-covered Observation services:

A. Substitution of Observation services for physician ordered inpatient services

B. Services that are not reasonable, cost effective and necessary for diagnosis or treatment of member

C. Services provided solely for the convenience of the member or physician

D. Excessive time and/or amount of services medically required by the condition of the member

E. Services customarily provided in a hospital-based outpatient surgery center and not supported by medical documentation of the need for Observation.

310-V PRESCRIPTION MEDICATION/PHARMACY SERVICES

REVISION DATE: 1/24/2024, 1/10/2024, 9/30/2020, 7/3/2015, 9/15/2014
REVIEW DATE: 12/23/2022
EFFECTIVE DATE: June 30, 1994
REFERENCES: 42 CFR 431.52; 42 CFR 438.3(s); 42 USC 1396A(OO); A.R.S. § 32-1974; A.R.S. § 36-550; A.R.S. §36-551; A.R.S. § 36-2918(A)(1); A.R.S. §36-2918(A)(3)(b); A.R.S. § 36-2930.03; A.A.C. R4-23-409; R9-22-201 et seq; A.A.C. R9-22-209(C); A.A.C. R9-22-702; A.A.C. R9-22-709; A.A.C. R9-22-710(C); A.A.C. R9-22-711; A.A.C. R9-28-201 et seq; A.A.C. R9-31-201 through R9-31-216; Social Security Act Section 1927 (g) Drug Use Review; AMPM 310-M; AMPM 320-N; AMPM 320 T-1; AMPM 320 T-2; AMPM 660; AMPM Attachment 310-V (A); AMPM Attachment 310-V (B); AMPM Exhibit 300-1; AHCCCS Fee For Service Billing Manual Chapter 12; AHCCCS IHS/Tribal Provider Billing Manual Chapter 10; ACOM 111; ACOM 201; ACOM Policy 414; ACOM 432; Division Medical 310-DD; Division Medical 320-M; Division Medical 320-Q; Division Medical 510.

PURPOSE

This policy specifies the requirements for the the Division of Developmental Disabilities (Division) oversight and monitoring of the medication, Device and pharmacy coverage requirements and limitations of the Arizona Health Care Cost Containment System (AHCCCS) pharmacy benefit administered by the Administrative Services Subcontractors (AdSS) for Division Members enrolled in health plans managed by the AdSS and Members enrolled in the Tribal Health Program (THP) pharmacy benefits administered by AHCCCS Division of Fee-For-Service Management (DFSM) and it’s contracted

Pharmacy Benefits Manager (PBM).

DEFINITIONS

1. "340B Ceiling Price" means the maximum price that drug manufacturers may charge covered entities participating in the 340B Drug Pricing Program as reported by the drug manufacturer to the United States Department of Health and Human Services. The 340B Ceiling Price per unit is defined as the Average Manufacturer Price (AMP) minus the Federal Unit Rebate Amount.

2. "340B Contracted Pharmacies" means a separate pharmacy that a 340B Covered Entity contracts with to provide and dispense prescription and physician-administered drugs using medications that are subject to 340B Drug Pricing Program.

3. "340B Covered Entity" means an organization as defined by 42 United States Code Section 256b that participates in the 340B Drug Pricing Program.

4. "340B Drug Pricing Program" means the discount drug

purchasing program described in Section 256b of 42 United States Code.

5. "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Division program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care, including beneficiary practices that result in unnecessary cost to the Division Program.

6. "Actual Acquisition Cost" or "AAC" means the purchase price of a drug paid by a pharmacy net of all discounts, rebates, chargebacks, and other adjustments to the price of the drug, not including Professional Fees.

7. "Adverse Drug Event" or "ADE" means an injury resulting from medical intervention related to a drug including harms that occur during medical care that are directly caused by the drug including but not limited to Medication Errors, adverse drug

reactions, allergic reactions, and overdose.

8. "AHCCCS/Division of Fee-For-Service Management" or "DFSM" means the division responsible for the clinical, administrative and claims functions of the Fee-For-Service (FFS) members.

9. "AHCCCS Drug List" means a list of Preferred Drugs in specific therapeutic categories that are Federally and State reimbursable behavioral health and physical health care medications and Medical Devices that the Division utilizes for the administration of acute and long-term care pharmacy benefits. The AHCCCS Drug List includes Preferred Drugs and was developed to encourage the use of safe, effective, clinically appropriate, and the most cost-effective medications and is supported by current evidence-based medicine.

10. "AHCCCS Fee For Service (FFS) PA criteria effective 10/1/22" means criteria which is based on clinical appropriateness, scientific evidence, and any of the following standards of practice:

    a. FDA approved indications and limits;

b. Published practice guidelines and treatment protocols;

c. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits, and potential Member outcomes;

d. Drug Facts and Comparisons;

e. American Hospital Formulary Service Drug Information;

f. United States Pharmacopeia – Drug Information;

g. DRUGDEX Information System;

h. UpToDate;

i. MicroMedex;

j. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies; or

k. Other drug reference resources.

11. "AHCCCS Pharmacy and Therapeutics Committee" or "AHCCCS P&T Committee" means the advisory committee to AHCCCS, which is responsible for developing, managing, updating, and administering the AHCCCS Drug List. The AHCCCS Pharmacy and Therapeutics Committee (AHCCCS P&T Committee) is primarily composed of physicians, pharmacists, nurses, other health care professionals and community members.

12. "Average Manufacturer Price" or "AMP" means the average price paid by wholesalers for drugs distributed to the retail class of trade, net of customary prompt pay discounts.

13. "Biosimilar" means a biological drug approved by the Food and Drug Administration (FDA) based on a showing that it is highly similar to an FDA-Approved biological drug, known as the reference product, and has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

14. "Centers For Medicare and Medicaid Services" or CMS" means the Federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare

program and works in partnership with State governments to administer Medicaid.

15. "Chronic Intractable Pain" means as specified in A.R.S. § 32-3248.01, meets both of the following:
    a. The pain is excruciating, constant, incurable and of such severity that it dominates virtually every conscious moment; and
    b. The pain produces mental and physical debilitation.

16. "Dual Eligible Member" means a Member who is eligible for both Medicare and Medicaid. There are two types of Dual Eligible Members:
    a. A Qualified Medicare Beneficiary (QMB) Dual Eligible Member (a QMB Plus or a QMB Only); or
    b. A Non-QMB Dual Eligible Member (a Special Low-Income Beneficiary [SLMB] Plus or an Other Full Benefit Dual Eligible).

17. "Emergency Medication" means for the purposes of this policy,

emergency epinephrine and diphenhydramine.

18. "Federal Supply Schedule" or "FSS" means the collection of multiple award contracts used by Federal agencies, U.S. territories, Indian tribes, and other specified entities to purchase supplies and services from outside vendors. Federal Supply Schedule (FSS) prices for the pharmaceutical schedule are negotiated by the Veterans Affairs and are based on the prices that manufacturers charge their "most-favored" non-Federal customers under comparable terms and conditions.
19. "Federal Unit Rebate Amount" means a calculation using the drug manufacturer's pricing. The specific methodology used is determined by statute, and depends upon whether a drug is classified as:
    a. Single source ("S" drug category) or Innovator multiple source ("I" drug category);
    b. "S" or "I" Line Extension Drug;
    c. Non-innovator multiple source ("N" drug category);
    d. Clotting Factor drug (CF); or

e. Exclusively Pediatric drug (EP).

20. "First Line Drug" a generic drug or lower-cost drug.

21. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person, including any act that constitutes Fraud under applicable State or Federal law.

22. "Generic Drug" means a drug that contains the same active ingredients as a brand name drug and the FDA has approved it to be manufactured and marketed after the brand name drugs patent expires. Generic Drug substitution shall be completed in accordance with Arizona State Board of Pharmacy rules and regulations.

23. "Grandfathering of Non-Preferred Drugs" means the continued authorization of Non-Preferred Drugs for Members who are currently utilizing Non-Preferred Drugs without having completed Step Therapy of the Preferred Drugs on the AHCCCS Drug List,

as appropriate.

24. "Guest Dosing" means A mechanism for Members who are not eligible for take-home medication to travel from their home clinic for business, pleasure, or family emergencies and which also provides an option for Members who need to travel for a period of time that exceeds the amount of eligible take-home doses.

25. "Initial Prescriptions for Short Acting Opioid Medication" means a short-acting opioid medication for which the Member has not previously filled any prescription for a short-acting opioid medication within 60 days of the date of the pharmacy filling the current prescription as evidenced by the Member's PBM prescription profile.

26. "JW Modifier" means a Healthcare Common Procedure Coding System (HCPCS) Level II modifier required to be reported on a claim to report the amount of drug that is discarded and eligible for payment under the discarded drug policy.

27. "Medical Device" means per Section 201(h) of the Food, Drug,

and Cosmetic Act, a Device is: An instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar related article, including a component part, or accessory which is:

a. Recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them;

b. Intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals;

c. Intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals; and

d. Which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes. The term "Device" does not include software

functions excluded pursuant to Section 520(o) of the Federal Food, Drug and Cosmetic Act.

28. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

29. "Naloxone" means a prescription medication that reverses the effects of an opioid overdose.

30. "Nominal Price" means a drug that is purchased for a price that is less than 10% of the AMP in the same quarter for which the AMP is computed.

31. "Non-Preferred Drug" means a medication that is not listed on the AHCCCS Drug List. Non-Preferred Drugs require Prior Authorization (PA).

32. "Non-Title XIX/XXI Member" means a Member who needs or may be at risk of needing covered health-related services but does not meet Federal and State requirements for Title XIX or Title XXI eligibility.

33. "Preferred Drug" means a medication that has been clinically

reviewed and approved by the AHCCCS P&T Committee for inclusion on the AHCCCS Drug List as a Preferred Drug due to its proven clinical efficacy and cost effectiveness.

34. "Professional Fee" means the amount paid for the professional services provided by the pharmacist for dispensing a prescription. The Professional Fee does not include any payment for the drug being dispensed.

35. "Repack" or "Repackage" means the act of taking a finished drug product or unfinished drug from the container in which it was placed in commercial distribution and placing it into a different container without manipulating, changing, or affecting the composition or formulation of the drug.

36. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed A.R.S. §36-551.

37. "Standing Order" means an AHCCCS registered prescriber's order that can be exercised by other health care workers for a Member that meets the designated criteria by the prescribing provider.

38. "Step Therapy" means the practice of initiating drug therapy for a medical condition with the most cost-effective and safe drug and stepping up through a sequence of alternative drug therapies if the preceding treatment option fails.

39. "Usual and Customary Price" or "U&C Price" means the dollar amount of a pharmacy's charge for a prescription to the general public, a special population, or an inclusive category of customers that reflects all advertised savings, discounts, special promotions, or other programs including membership-based discounts.

40. "Waste" means over-utilization or inappropriate utilization of services, misuse of resources, or practices that result in unnecessary costs to the Medicaid Program.

POLICY

A. THE AHCCCS DRUG LIST

1. The Division shall require the AdSS to maintain its own drug list to meet the unique needs of the Members they serve. The Division shall ensure the AdSS drug list includes all the drugs listed on the AHCCCS Drug List.

2. The Division shall require the AdSS to cover all medically necessary, clinically appropriate, and cost-effective medications that are Federally and State reimbursable regardless of whether these medications are included on the AHCCCS Drug List.

3. The Division shall require the AdSS to maintain Preferred Drug lists that include every drug exactly as listed on the AHCCCS Drug List.

4. The Division shall not permit the AdSS to add other Preferred Drugs to their Preferred Drug lists in those therapeutic classes when the AHCCCS Drug List specifies a Preferred Drug in a particular therapeutic class.

5. The Division shall require the AdSS to inform their Pharmacy Benefit Managers (PBM) of the Preferred Drugs and shall require the AdSS' PBM to institute Point-of-Sale (POS) edits that communicate back to the pharmacy the Preferred Drugs of a therapeutic class whenever a claim is submitted for a Non-Preferred Drug.

6. The Division shall require the AdSS to cover the Preferred Drugs recommended by the AHCCCS P&T Committee and approved by AHCCCS, with an effective date by the first day of the first month of the quarter following the AHCCCS P&T Committee meeting, unless otherwise communicated by AHCCCS.

7. The Division shall require AdSS to approve the Preferred Drugs listed for the therapeutic classes contained on the AHCCCS Drug List, as appropriate, before approving a Non-Preferred Drug unless:
   a. The Member has previously completed Step Therapy using the Preferred Drugs; or
   b. The Member's prescribing clinician provides documentation

supporting the medical necessity of the Non-Preferred Drug over the Preferred Drug for the Member.

8. The Division shall require that the AdSS does not disadvantage one Preferred Drug over another Preferred Drug when AHCCCS has approved Preferred Drugs or supplemental rebates for a therapeutic class.

9. The Division shall not permit the AdSS to require a trial and failure of one preferred agent when there are others that are also preferred and have the same indication as part of their Prior Authorization(PA) criteria.

10. The Division shall require the AdSS to require PA for the Non-Preferred Drug when the prescribing clinician is not in agreement with transition to the Preferred Drug.

11. The Division shall not require the AdSS to provide a Notice of Adverse Benefit Determination when the prescribing clinician agrees with the change to the First Line or Preferred Drug.

12. The Division shall require the AdSS to issue a Notice of Adverse

Benefit Determination for service authorizations when a PA request for a Preferred Drug is denied or a previously approved authorization is terminated, suspended, or reduced.

13. The Division shall require the AdSS to Grandfather Members on medications that AHCCCS has communicated to the Division and AdSS as approved for Grandfathering.

14. The Division shall ensure all Federally and State reimbursable drugs that are not listed on the AHCCCS Drug List or the AdSS drug lists are available through the PA process.

15. The Division shall require the AdSS to not deny a Federally and State reimbursable medication solely due to the lack of an FDA indication. Off-Label prescribing may be clinically appropriate when evidenced by subsections (a) through (k) above.

16. The Division shall prohibit the AdSS from adding PA or Step Therapy requirements to medications listed on the AHCCCS Drug List when the List does not specify these requirements.

17. The Division shall prohibit the AdSS from denying coverage of a

medically necessary medication when the Member's primary insurer, other than Medicare Part D, refuses to approve the request and the primary insurer's grievance and appeals process has been completed.

18. The Division shall require the AdSS to evaluate the medical necessity of the submitted PA for all Federally and State reimbursable medications, including those listed and those not listed on the AHCCCS Drug List.
19. The Division shall require the AdSS to evaluate the submitted PA request on an individual basis for medications that are Non-Preferred Drugs and not listed on the AHCCCS Drug List.
20. The Division shall require the AdSS to submit requests for medication additions, deletions, or other changes to the AHCCCS Drug List to the AHCCCS P&T Committee for review no later than 60 days prior to the AHCCCS P&T Committee meeting to the AHCCCS Pharmacy Department email at: AHCCCSPharmacyDept@azahcccs.gov.
21. The Division shall require the AdSS to provide the following

information with the request for medication additions, deletions, or other changes to the AHCCCS Drug List:

a. Name of medication requested (brand name and generic name);

b. Dosage forms, strengths, and corresponding costs of the medication requested;

c. Average daily dosage;

d. FDA indication and accepted off-label use;

e. Advantages or disadvantages of the medication over currently available products on the AHCCCS Drug List;

f. Adverse Drug Event (ADE) reported with the medication;

g. Specific monitoring requirements and costs associated with these requirements; and

h. A clinical summary for the addition, deletion, or change request.

22. The Division shall require the AdSS to adopt the quantity limits and Step Therapy requirements exactly as they are presented on the AHCCCS Drug List for all Preferred Drugs specified on the

AHCCCS Drug List.

23. The Division shall require the AdSS to develop Step Therapy requirements for therapeutic classes when there are no Preferred Drugs identified on the AHCCCS Drug List.

24. The Division shall require the AdSS to obtain PA for the second-line drug when the prescribing clinician is not in agreement with the transition request to the first-line drug.

25. The Division shall require the AdSS to issue a Notice of Adverse Benefit Determination for service authorizations when a PA request for quantity limits or Step Therapy is denied, or a previously approved authorization is terminated, suspended, or reduced.

B. GENERIC AND BIOSIMILAR DRUG SUBSTITUTIONS

1. The Division shall require the AdSS to utilize a mandatory Generic Drug substitution policy that requires the use of a generic equivalent drug whenever one is available, except for the following:

a. A brand name drug shall be covered when a generic equivalent is available and the AHCCCS negotiated rate for the brand name drug is equal to or less than the cost of the Generic Drug; or

b. When the cost of the Generic Drug has an overall negative financial impact to the State. The overall financial impact to the State includes consideration of the Federal and supplemental rebates.

2. The Division shall require the AdSS to require prescribing clinicians to clinically justify the use of a brand-name drug over the use of its generic equivalent through the PA process.

3. The Division shall not permit the AdSS to transition to a Biosimilar drug until AHCCCS has determined that the Biosimilar drug is overall more cost-effective to the State than the continued use of the brand name drug.

4. The Division shall require the AdSS to provide the Generic Drug substitution policy during the Operational Review.

5. The Division shall review the Generic Drug substitution policy provided by the AdSS during the Operational Review.

C. ADDITIONAL INFORMATION FOR MEDICATION COVERAGE

1. The Division shall require the AdSS to cover medications for Members transitioning to a different health plan or FFS as follows:
   a. The transferring AdSS or AHCCCS DFSM provide coverage for medically necessary, cost-effective, and Federally and State reimbursable medications until such time that the Member transitions to their new health plan or FFS Program; and
   a. The AdSS, providers, and Tribal Regional Behavioral Health Authorities (TRBHAs) are responsible for coordinating care when transferring a Member to a new health plan or FFS Program to ensure that the Member's medications are continued during the transition.

2. The Division shall require the AdSS to provide coverage for medically necessary, cost-effective, and Federally and State

reimbursable behavioral health medications provided by a Primary Care Physician (PCP) within their scope of practice which includes the monitoring and adjustments of behavioral health medications.

3. The Division shall require the AdSS to obtain PA for antipsychotic medication class based on age limits depending on the form of the medication.

4. The Division shall require the AdSS to ensure PCPs and BHMPs coordinate the Member's care and that the Member has a sufficient supply of medications to last through the date of the Member's first appointment with the PCP or BHMP when a Member is transitioning from a BHMP to a PCP or from a PCP to a BHMP.

5. The Division shall require the AdSS to allow an individual receiving Methadone or Buprenorphine administration services who is not a recipient of take-home medication to receive Guest Dosing of Methadone or Bupenorphine from the area contractor when the individual is traveling outside of home Opioid

Treatment Program (OTP) center.

6. The Division shall require the AdSS to allow a Member to be administered sufficient daily dosing from an OTP center other than their home OTP center when:
   a. A Member is unable to travel to the home OTP center, or
   b. When traveling outside of the home OTP center's area.

7. The Division shall require the AdSS to allow a Member to receive Guest Dosing from another OTP center (guest OTP center) within their Geographic Service Areas (GSA), or outside their GSA.

8. The Division shall require the AdSS to approve Guest Dosing outside the State of Arizona when the prescribing physician determines the Member's health would be endangered if travel were required back to the state of residence.

9. The Division shall require the AdSS to permit a Member to qualify for Guest Dosing when:
   a. The Member is receiving administration of Medications for Opioid Use Disorder (MOUD) services from a

SAMHSA-Certified OTP (Substance Abuse and Mental Health Services Administration);

b. The Member needs to travel outside their home OTP center area,

c. The Member is not eligible for take home medication, and

d. The home OTP center (sending OTP center) and guest OTP center have agreed to transition the Member to the guest OTP center for a scheduled period of time.

10. The Division shall require the AdSS does not charge Title XIX/XXI Members for Guest Dosing except as permitted by A.A.C. R9-22-702 and A.A.C. R9-22-711.

11. The Division shall require the AdSS does not charge Non-Title XIX/XXI eligible Members copayments for Guest Dosing.

D. OVER THE COUNTER MEDICATION

The Division shall require the AdSS to cover an over-the-counter (OTC) medication under the pharmacy benefit when it is prescribed in place

of a covered prescription medication when it is clinically appropriate, equally safe, effective, and more cost effective than the covered prescription medication.

E. PRESCRIPTION DRUG COVERAGE, BILLING LIMITATIONS, AND PRESCRIPTION DELIVERY

1. The Division shall require the AdSS to not cover a new prescription or refill prescription in excess of a 30-day supply unless:
    a. The medication is prescribed for chronic illness and the prescription is limited to no more than a 90-day supply;
    b. The Member will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed 90 days; or
    c. The medication is prescribed for contraception and the prescription is limited to no more than a 90-day supply.
2. The Division shall require the AdSS to provide prescription drugs for covered transplant services in accordance with AdSS Medical

Policy Manual Policy 310-DD.

3. The Division shall require the AdSS to cover the following for Members who are eligible to receive Medicare:
   a. OTC medications that are not covered as part of the Medicare Part D prescription drug program and the drug meets the requirements in Section (D) of this policy;
   b. A drug that is excluded from coverage under Medicare Part D by the Centers For Medicare and Medicaid Services (CMS) and the drug is medically necessary and Federally reimbursable; and
   c. Cost sharing for medications to treat behavioral health conditions for individuals with an SMI designation.
4. The Division shall not permit the AdSS to allow pharmacies to charge a Member the cash price for a prescription, other than an applicable copayment, when the medication is Federally and State reimbursable and the prescription is ordered by an AHCCCS registered prescribing clinician.

5. The Division shall not permit the AdSS to allow pharmacies to split-bill the cost of a prescription claim to the AdSS PBMs for Members.

6. The Division shall not permit the AdSS PBMs pharmacies to allow a Member to pay cash for a partial prescription quantity for a Federally and State reimbursable medication when the ordered drug is written by an AHCCCS registered prescribing clinician.

7. The Division shall require the AdSS to communicate to the pharmacies that they are prohibited from auto-filling prescription medications.

8. The Division shall not permit the AdSS to allow pharmacies to submit prescription claims for reimbursement in excess of the Usual and Customary Price (U&C Price) charged to the general public.

9. The Division shall require the AdSS to ensure that the sum of charges for both the product cost and dispensing fee does not exceed a pharmacy's U&C Price for the same prescription.

10. The Division shall require the AdSS to ensure that the U&C Price submitted ingredient cost is the lowest amount accepted from any Member of the general public who participates in the pharmacy provider's savings or discount programs including programs that require the Member to enroll or pay a fee to join the program.

11. The Division shall require the AdSS to ensure pharmacies that purchase drugs at a Nominal Price outside of 340B or the FSS bill their Actual Acquisition Cost (AAC) of the drug.

F. PA REQUIREMENTS FOR LONG-ACTING OPIOID MEDICATIONS

1. The Division shall require the AdSS, AdSS' PBM or AHCCCS' PBM, as applicable, to require the prescriber to obtain PA for all long-acting opioid prescription medications unless the Member's diagnosis is one the following:
   a. Active oncology diagnosis with neoplasm related pain;
   b. Hospice care; or
   c. End of life care (other than hospice).

2. The Division shall require the AdSS, AdSS' PBM or AHCCCS' PBM as applicable, to require the prescriber to obtain their approval or an exception for all long-acting opioid prescription medications.

G. 5-DAY SUPPLY LIMIT OF PRESCRIPTION SHORT-ACTING OPIOID MEDICATIONS FOR MEMBERS UNDER 18 YEARS OF AGE

1. The Division shall require the AdSS to require a prescriber to limit the initial and refill prescriptions for any short-acting opioid medication for a Member under 18 years of age to no more than a 5-day supply, except as otherwise specified in Section (G) (2) below, "Conditions and Care Exclusion from the 5-day Supply Limitation".

2. The Division shall require the AdSS abide by the following Conditions and Care Exclusions from the 5-day Supply Limitation:

   a. The initial and refill prescription 5-day supply limitation for short- acting opioid medications does not apply to prescriptions for the following conditions and care

instances:

i. Active oncology diagnosis;

ii. Hospice care;

iii. End-of-life care (other than hospice);

iv. Palliative Care;

v. Children on an opioid wean at the time of hospital discharge;

vi. Skilled nursing facility care;

vii. Traumatic injury, excluding post-surgical procedures;

viii. Chronic conditions for which the provider has received PA approval through the AdSS;

b. The initial prescription 5-day supply limitation for short-acting opioid medications does not apply to prescriptions for post-surgical procedures. However, Initial Prescriptions for Short-Acting Opioid Medications for postsurgical procedures are limited to a supply of no more than 14 days. Refill prescriptions for short-acting opioid medications for post-surgical procedures are limited to no more than a 5-day supply.

H. 5-DAY SUPPLY LIMIT OF PRESCRIPTION SHORT-ACTING OPIOID MEDICATIONS FOR MEMBERS 18 YEARS OF AGE AND OLDER

1. The Division shall require the AdSS to require a prescriber to limit the initial prescription for any short-acting opioid medication for a Member 18 years of age and older to no more than a 5-day supply, except as otherwise specified in Section (H) (2) below, "Conditions and Care Exclusion from the 5-day Supply Limitation".

2. The Division shall require the AdSS to abide by the following Conditions and Care Exclusions from the 5-day Initial Supply Limitation:

    a. The initial prescription 5-day supply limitation for short-acting opioid medications does not apply to prescriptions for the following conditions and care instances:

        i. Active oncology diagnosis;

        ii. Hospice care;

        iii. Palliative Care;

iv. Skilled nursing facility care;

v. Traumatic injury, excluding post-surgical procedures;

vi. Post-surgical procedures; and

vii. The medication is for SUD treatment.

b. Initial Prescriptions for Short-Acting Opioid Medications for post-surgical procedures are limited to a supply of no more than 14 days.

I. ADDITIONAL FEDERAL OPIOID LEGISLATION (42 USC 1396A(OO)) MONITORING REQUIREMENTS

1. The Division shall require the AdSS to implement automated processes to monitor the following opioid safety edits at the POS:

a. A 5 days supply limit for opioid naïve members;

b. Quantity limits;

c. Therapeutic duplication limitations;

d. Early fill limitations;

e. Opioid naïve Members prescribed an opioid, and the Morphine Equivalent Daily Dose (MEDD) is 50 or greater;

f. Member utilization when the cumulative current utilization of opioids is a MEDD of greater than 90 and the Member is not opioid naive;

g. Members with concurrent use of an opioid in conjunction with a benzodiazepine or an antipsychotic;

h. Members are prescribed an opioid after being prescribed drugs used for MOUD for an Opioid Use Disorder (OUD);

i. OUD diagnosis;

j. Antipsychotic prescribing for children;

k. Fraud, Waste, and Abuse by enrolled Members, pharmacies, and prescribing clinicians; and

l. Prospective and retrospective opioid reviews.

2. The Division shall require the AdSS to report Drug Utilization Review management activities annually to the Division.

3. The Division shall require the AdSS to allow a health care professional to write for a prescription that is more than 90 Morphine Milligram Equivalents (MME) per day if the prescription is:

   a. A continuation of a prior prescription order issued within the previous 60 days;

   b. An opioid with a maximum approved total daily dose in the labeling as approved by the U.S. Food and Drug Administration (FDA);

   c. For a Member who has an active oncology diagnosis or a traumatic injury;

   d. Receiving opioid treatment for perioperative surgical pain;

   e. For a Member who is hospitalized;

   f. For a Member who is receiving hospice care, end-of-life care, palliative care, skilled nursing facility care or treatment for burns;

   g. For a Member who is receiving MAT for a substance use

disorder; or

h. For chronic intractable pain.

J. NALOXONE

1. The Division shall require the AdSS to cover and consider Naloxone as an essential prescription medication to reduce the risk and prevent an opioid overdose death.

2. The Division shall require the AdSS to require a prescription, ordered by an AHCCCS registered provider, be on file at the pharmacy when Naloxone is dispensed to or for a specific Member.

3. The Division shall require the AdSS to adhere to the following process:

   a. Have a Standing Order written by the Director of the Arizona Department of Health Services on file at all Arizona pharmacies;

   b. Identify the following eligible candidates that may obtain

Naloxone:

i. Members who use illicit or non-prescription opioids with a history of such use;

ii. Who have a history of opioid misuse, intoxication, or a recipient of emergency medical care for acute opioid poisoning;

iii. Members who have been prescribed high dose opioid prescriptions of 90 MEDD or less if there are other risk factors;

iv. Members who have been prescribed an opioid with a known or suspected concurrent alcohol use;

v. Members who are from opioid detoxification and mandatory abstinence programs;

vi. Members who have been treated with methadone for addiction or pain;

vii. Members who have an opioid addiction and smoking or Chronic Obstructive Pulmonary Disease (COPD) or

other respiratory illness or obstruction;

viii. Members who have been prescribed opioids who also have renal, hepatic, cardiac, or HIV/AIDs (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) disease;

ix. Members who have difficulty accessing emergency services;

x. Members who have been assigned to a pharmacy or prescribing clinician;

xi. Members who voluntarily request Naloxone and are the family member or friend of a Member at risk of experiencing an opioid related overdose; and

xii. Members who voluntarily request Naloxone and are in the position to assist a Member at risk of experiencing an opioid related overdose.

4. The Division shall require the AdSS to cover:

a. Naloxone Solution plus syringes,

b. Naloxone Nasal Spray known as Narcan Nasal Spray, and

c. Refills of the above Naloxone products on an as needed basis.

5. The Division shall require the AdSS to require the pharmacy to educate every Member on the use of Naloxone by the pharmacist dispensing the medication in accordance with Arizona State Board of Pharmacy Regulations.

K. PHARMACY BENEFIT EXCLUSIONS

1. The Division shall require the AdSS to treat the following pharmacy benefits as excluded and shall not be covered:

a. Medications prescribed for the treatment of a sexual or erectile dysfunction, unless:

i. The medication is prescribed to treat a condition other than a sexual or erectile dysfunction, and

ii. The FDA has approved the medication for the specific

condition.

b. Medications that are personally dispensed by a physician, dentist, or other provider except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed;

c. Drugs classified as Drug Efficacy Study Implementation (DESI) drugs by the FDA;

d. Outpatient medications for Members under the Federal Emergency Services Program, except for dialysis related medications for extended services individuals;

e. Medical Marijuana;

f. Drugs eligible for coverage under Medicare Part D for Members eligible for Medicare whether or not the Member obtains Medicare Part D coverage except for Dual Eligible Members that have creditable coverage or individuals with an SMI designation;

g. Experimental medications as specified in A.A.C. §

9-22-203;

h. Medications furnished solely for cosmetic purposes;

i. Medications used for weight loss treatment; or

j. Complementary and Alternative Medicines.

L. RETURN OF AND CREDIT FOR UNUSED MEDICATIONS

1. The Division shall require the AdSS to require the return of unused medications to the outpatient pharmacy from Nursing Facilities (NFs) upon the discontinuance of prescriptions due to the transfer, discharge, or death of a Member.
2. The Division shall require the AdSS to have the outpatient pharmacy issue a payment or credit reversal to the AdSS or the AdSS PBM for unused prescription medications. The pharmacy may charge a restocking fee when agreed upon with AHCCCS and the Division or AdSS.
3. The Division shall require the AdSS to require the return of unused prescription medication in accordance with Federal and

State laws.

4. The Division shall require the AdSS to maintain documentation and include the quantity of medication dispensed and utilized by the Member.

5. The Division shall require the AdSS to issue a credit to AHCCCS if the Member is enrolled in the THP, TRBHA, or FFS Program, to the Member's AdSS for Members who are not FFS when the unused medication is returned to the pharmacy for redistribution.

M. DISCARDED PHYSICIAN-ADMINISTERED MEDICATIONS

1. The Division shall allow any discarded portion of Federally and State reimbursable, physician-administered drugs that are unit-dose or unit-of-use designated products in MediSpan or First DataBank to be billed to the AdSS.

2. The Division shall require AdSS to ensure prescribers use the most cost-effective product(s) for the required dose to be

administered.

3. The Division shall require the AdSS to not allow billing from the prescriber or reimburse the prescriber for any use or discarded portion of a unit-of-use or unit dose Repackaged drugs.

4. The Division shall require the AdSS to ensure, for multidose products, prescribers only bill for the actual amount of drug that was used and the AdSS only reimburse the actual amount of used drug.

N. PRIOR AUTHORIZATION CRITERIA FOR SMOKING CESSATION AIDS

The Division shall require the AdSS to follow the AHCCCS established PA criteria for tobacco cessation aids.

O. VACCINES AND EMERGENCY MEDICATIONS ADMINISTERED BY PHARMACISTS TO INDIVIDUALS THREE YEARS OF AGE AND OLDER

1. The Division shall require the AdSS to cover vaccines and Emergency Medication without a prescription order when

administered by a pharmacist who is currently licensed and certified by the Arizona State Board of Pharmacy consistent with the limitations of this Policy and A.R.S. § 32-1974.

2. The Division shall require the AdSS to ensure pharmacists, pharmacy technicians, and pharmacy interns under the supervision of a pharmacist, within their scope of practice, only administer influenza and COVID immunizations to Members who are at least three years of age through 18 years of age.

3. The Division shall require the AdSS to ensure pharmacists, pharmacy technicians, and pharmacy interns under the supervision of a pharmacist, within their scope of practice, administer AHCCCS covered immunizations to adults at least 18 years and older as specified in A.R.S. § 32-1974.

4. The Division shall require the AdSS to ensure the pharmacies providing the vaccine are an AHCCCS registered provider.

5. The Division shall require the AdSS to retain the discretion to determine the coverage of vaccine administration by

pharmacists, pharmacy interns and technicians under the supervision of a pharmacist and that coverage is limited to the AdSS network pharmacies unless otherwise directed by AHCCCS.

P. 340B COVERED ENTITIES AND CLAIM SUBMISSION

1. The Division shall require the AdSS to ensure that 340B covered entities submit the AAC of the drug for Member's POS prescription and physician-administered drug claims that are identified on the 340B pricing file, whether or not the drugs are purchased under the 340B Drug Pricing Program.

2. The Division shall require the AdSS to reimburse POS claims at the lesser of:
   a. The AAC, or
   b. The 340B Ceiling Price, and
   c. A Professional Fee (dispensing fee).

3. The Division shall require the AdSS to ensure physician administered drugs are reimbursed at the lesser of the AAC or the 340B ceiling price, and the Professional (dispensing) Fee is

not reimbursed and is not permitted when a physician administered drug is administered by the prescribing clinician.

4. The Division shall require the AdSS to not reimburse 340B Contracted Pharmacies for drugs that are purchased, dispensed, or administered as part of or subject to the 340B Drug Pricing Program.

5. The Division shall require the AdSS to comply with any changes to reimbursement methodology for 340B entities.

Q. PHARMACEUTICAL REBATES

1. The Division shall require the AdSS, including the THP PBM and AdSS' PBM, to be prohibited from negotiating any rebates with drug manufacturers for preferred or other pharmaceutical products when AHCCCS has a supplemental rebate contract for the product.

2. The Division shall require the AdSS or its PBM's consider outpatient drug claims, including provider-administered drugs for which AHCCCS is obtaining supplemental rebates, to be exempt

from such rebate agreements if they have an existing rebate agreement with a manufacturer.

R. INFORMED CONSENT

1. The Division shall require the AdSS to ensure the prescriber obtains informed consent from the Responsible Person for each psychotropic medication prescribed.

2. The Division shall require the AdSS to ensure that prescribers are documenting the essential elements for obtaining informed consent in the comprehensive clinical record, utilizing AMPM Attachment 310-V (A).

S. YOUTH ASSENT

1. The Division shall require the AdSS to ensure prescribers educate youth under the age of 18 on options, are allowed to provide input, and are encouraged to assent to medications

being prescribed.

2. The Division shall require the AdSS to ensure prescribers discuss this information with the youth in a clear and age-appropriate manner consistent with the developmental needs of the youth.

3. The Division shall require the AdSS to ensure prescribers share information with Members who are under the age of 18 that is consistent with the information shared in obtaining informed consent from adults.

4. The Division shall require the AdSS to ensure the prescribers obtain informed consent for a minor through the minor's authorized Responsible Person unless the minor is emancipated.

5. The Division shall require the AdSS to ensure prescribers discuss the youth can give consent for medications when they turn 18.

6. The Division shall require the AdSS to begin the discussion about consent for medication no later than age 17½ years old, especially for youth who are not in the custody of their parents.

7. The Division shall require the AdSS to ensure prescribers address

the effect of medications on the reproductive status and pregnancy, as well as long term effects on weight, abnormal involuntary movements, and other health parameters.

8. The Division shall require the AdSS to ensure the prescribers document evidence of the youth's consent to continue medications after their 18th birthday through use of AMPM Attachment 310-V (A).

T. PRESCRIPTION DRUG COUNSELING

The Division shall require the AdSS to communicate to the pharmacy network that pharmacists, and graduate and non-graduate pharmacy interns, under the supervision of a pharmacist are to provide counseling on prescription drugs, prescribed and dispensed to AHCCCS members, in accordance with the Arizona State Board of Pharmacy A.A.C. 4-23-402.

U. DIVISION OVERSIGHT AND MONITORING

1. The Division shall oversee the AdSS utilizing the following methods to ensure compliance with policy:

a. Annual Operational Review of each AdSS,

b. Review and analyze deliverable reports submitted by the AdSS, and

c. Conduct oversight meetings with the AdSS for the purpose of:

i. Reviewing compliance,

ii. Addressing concerns with access to care or other quality of care concerns,

iii. Discussing systemic issues, and

iv. Providing direction or support to the AdSS as necessary.

SUPPLEMENTAL INFORMATION

1. A controlled substance is defined in A.R.S. § 32-3248.01. For opioid prescribing guidelines refer to the Arizona Opioid Epidemic Act.
2. The Division shall require the AdSS to cover medically necessary,

cost-effective and federally and State reimbursable medications and devices for Members as prescribed or administered by a physician, physician's assistant, nurse practitioner, dentist, or other AHCCCS registered practitioner with prescriptive authority in the State of Arizona and dispensed by an AHCCCS registered licensed pharmacy pursuant to 9 A.A.C. 22 Article 2, 9 A.A.C. 28 Article 2, and 9 A.A.C. 31 Article 2, and for persons with a SMI designation, pursuant to A.R.S. § 36-550.

3. Generic and Biosimilar substitutions shall adhere to Arizona State Board of Pharmacy rules and regulations.

4. Arizona 340B entity hospitals, and outpatient facilities owned and operated by a 340B entity hospital, are not exempt from the reimbursement methodology listed in Section (P) (2).

5. Effective with a future date to be determined, 340B hospitals and outpatient facilities, owned and operated by a 340B hospital, shall be required to submit claims at the entity's AAC.

6. The provider shall use the most cost-effective product(s) for the

required dose to be administered. For example, if the dose to be administered is 12mg and the product is available in a 10mg and 50mg vial, the provider shall use two - 10mg vials to obtain the 12mg dose. The 12mg dose shall be billed as the administered dose and 8mg shall be billed as discarded waste using the JW modifier.

7. Effective 01/01/22 repackaged medications are not Federally and State reimbursable.

8. Mental Health Block Grant (MHBG) provisions shall apply to Children with Serious Emotional Disturbance (SED), Individuals in First Episode Psychosis (FEP), and Adults with SMI designation. For individuals with a Substance Use Disorder (SUD), Substance Abuse Block Grant (SABG) provisions shall apply.

9. The AHCCCS Pharmacy and Therapeutics (P&T) Committee is responsible for developing, managing, and updating the AHCCCS Drug List to assist providers in selecting clinically appropriate

and cost-effective drugs or devices for Members.

10. The AHCCCS Drug List is not an all-inclusive list of medications for Members.

11. The AHCCCS P&T Committee shall make recommendations to the AdSS on the Grandfathering status of each Non-Preferred Drug for each therapeutic class reviewed by the committee.

12. The AHCCCS Drug List specifies which medications require PA prior to dispensing the medication.

13. Step Therapy programs apply coverage rules at the point of service when a claim is adjudicated that typically require the use of a more cost effective drug that is safe and effective to be used prior to approval of a more costly medication.

14. Guest Dosing is consistent with Substance Abuse and Mental Health Services Administration's (SAMHSA's) guidance regarding medication safety and recovery support.

15. Pharmacies, at their discretion, shall deliver or mail prescription medications to a Member or to an AdSS registered provider's

office for a specific Member.

The Sending OTP Center

1. The Sending OTP Center shall forward information to the Receiving OTP Center prior to the Member's arrival, information shall include:
    a. A valid release of information signed by the Member;
    b. Current medications;
    c. Date and amount of last dose administered or dispensed;
    d. Physician order for Guest Dosing, including first and last dates of Guest Dosing;
    e. Description of clinical stability including recent alcohol or illicit drug Abuse; and
    f. Any other pertinent information.
2. The Sending OTP Center shall provide a copy of the information to the Member in a sealed, signed envelope for the Member to present to the Receiving OTP Center.
3. The Sending OTP Center shall submit notification to the AdSS of

enrollment of the Guest Dosing arrangement.

4. The Sending OTP Center shall accept the Member upon return from the Receiving OTP Center unless other arrangements have been made.

The Guest OTP Center

1. The Guest OTP Center shall:
    a. Respond to the Sending OTP Center in a timely fashion, verifying receipt of information and acceptance of the Member for guest medication as quickly as possible;
    b. Provide the same dosage that the Member is receiving at the Member's Sending OTP Center, and change only after consultation with Sending OTP Center;
    c. Bill the Member's Contractor of enrollment for reimbursement utilizing the appropriate coding and modifier;
    d. Provide address of Guest OTP Center and dispensing hours;

e. Determine appropriateness for dosing prior to administering a dose to the Member. The Guest OTP Center has the right to deny medication to a Member if they present inebriated or under the influence, acting in a bizarre manner, threatening violence, loitering, or inappropriately interacting with other Members;

f. Communicate any concerns about a guest-dosing the Member to the Sending OTP Center including termination of guest-dosing if indicated; and

g. Communicate the last dose date and amount back to the Sending OTP Center.

Signature of Chief Medical Officer: Anthony Dekker (Jan 18, 2024 17:39 MST)
Anthony Dekker, D.O.

310-X REHABILITATIVE THERAPY

REVISION DATE: 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994

Rehabilitation is the process of re-establishing former functions or skills. This includes physical, occupational, and speech therapies. This service may occur after a trauma has decreased the functioning of a member. Rehabilitative therapies are not designed to build a skill or functioning level that had not been previously present in the member.

310–Y RESPIRATORY THERAPY

EFFECTIVE DATE: March 3, 2017
REFERENCES: A.R.S. § 32-3501

The Division of Developmental Disabilities (Division) covers respiratory therapy treatment service for members eligible for ALTCS, when ordered by a primary care provider, to restore, maintain, or improve respiratory functioning.

Services include:

A. Administering pharmacological, diagnostic, and therapeutic agents related to respiratory and inhalation care procedures

B. Observing and monitoring signs and symptoms

C. General behavioral and physical response(s) to respiratory treatment and diagnostic testing, including a determination of whether these signs, symptoms, reactions, or response(s) exhibit abnormal characteristics

D. Implementing appropriate reporting referral

E. Implementing respiratory care protocols or changes in treatment based on observed abnormalities.

The Division covers medically necessary respiratory therapy services for all members eligible for ALTCS on both an inpatient and outpatient basis. Services must be provided by a qualified respiratory practitioner under A.R.S. § 32-3501 (respiratory therapist or respiratory therapy technician), licensed by the Arizona Board of Respiratory Care Examiners. Respiratory practitioners providing services to Division members outside the State of Arizona must meet the applicable state and/or federal requirements.

310-BB TRANSPORTATION FOR PHYSICAL AND BEHAVIORAL HEALTH SERVICES

REVISION DATE: 02/22/2023, 10/1/2021, 11/17/2017, 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994
REFERENCES: A.R.S. § 28-2515; A.A.C. R9-22-211, A.A.C. R9-22-211,AMPM 310, AMPM 310-BB, AMPM 320-I, AMPM 700

PURPOSE

This policy describes covered transportation services for members who are eligible for Arizona Long Term Care System (ALTCS).

DEFINITIONS

1. "Alternative Destination Partner" means an Arizona Health Care Cost Containment System (AHCCCS) registered provider, such as a Federally Qualified Healthcare Center/Rural Health Clinic (FQHC/RHC), primary care provider doctor, specialist, behavioral health center or urgent care clinic.

2. "Certificate of Necessity (CON)" means regulations that require healthcare providers to get special permission from the government before adding or expanding healthcare services or

facilities.

3. "Emergency Transportation" means ground and air ambulance services that are medically necessary to manage an emergency physical or behavioral health condition and which provide transport to the nearest appropriate facility capable of treating the individual's condition. Emergency transportation is needed when due to a sudden onset of a physical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could be expected to result in:
   a. Placing the member's health in serious jeopardy, or
   b. Serious impairment of bodily functions, or
   c. Serious dysfunction of any bodily organ or part, or
   d. Serious physical harm to self or another individual.

4. "Emergency Triage, Treat, and Transport", "ET3" means a program designed to allow greater flexibility for ambulance providers registered with AHCCCS as Emergency Transportation providers to address a member's health care needs following a

9-1-1 call. ET3 permits Emergency Transportation providers to transport a member to the nearest appropriate AHCCCS-registered facility, and to initiate and facilitate a members' receipt of medically necessary covered service(s) at the scene of a 9-1-1 response either in-person on the scene or via telehealth.

5. "Maternal Transport Program (MTP)"/" Newborn Intensive Care Program (NICP)" means programs that are administered by the ADHS that provide special training and education to designated staff in the care of maternity and newborn emergencies during transport to a perinatal center.

POLICY

A. EMERGENCY TRANSPORTATION

1. The Division shall cover Emergency Transportation in emergent situations in which specially staffed and equipped ambulance transportation is required to safely manage the member's condition.

2. The Division shall cover basic life support, advanced life support, and air ambulance services when medically necessary.
3. The Division shall cover emergency transportation for an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could be expected to result in:
    a. Placing the member's health in serious jeopardy,
    b. Serious impairment of bodily functions,
    c. Serious dysfunction of any bodily organ or part, or
    d. Serious physical harm to another person (for behavioral health conditions).
4. The Division shall not require prior authorization for emergency transportation.
5. The Division shall cover Emergency Transportation that includes the transportation of a member to a higher level of care for immediate medically necessary treatment, including when occurring after stabilization at an emergency facility.

6. The Division shall cover emergency medical transportation to the nearest appropriate AHCCCS-registered facility capable of meeting the member's physical and behavioral health needs.

B. AIR AMBULANCE

1. The Division shall cover air ambulance services under the following conditions:
   a. The air ambulance transport is initiated at the request of:
      i. Emergency response unit,
      ii. Law enforcement official,
      iii. Clinic or hospital medical staff member, or
      iv. Physician or practitioner.
   b. The point of pickup is:
      i. Inaccessible by ground ambulance,
      ii. There is a great distance from the nearest hospital or other provider with appropriate facilities to treat the member's condition and ground ambulance will not suffice, or

iii. The medical condition of the member requires immediate intervention of emergency ambulance personnel or providers with the appropriate facilities to treat the member's condition.

2. The Division shall ensure that air ambulance companies are licensed by the Arizona Department of Health Services (ADHS) and registered as a provider with AHCCCS.

C. EMERGENCY TRIAGE, TREAT AND TRANSPORT PROGRAM (ET3)

1. The Division shall cover the Emergency Triage, Treat, and Transport Program (ET3) when an Emergency Transportation provider responds to a "9-1-1", fire, police, or other locally established system for emergency calls.

2. The Division shall require the Emergency Transportation provider be AHCCCS-registered and have a Certificate of Necessity (CON) from ADHS; or are tribal providers who have a signed AHCCCS attestation of CON equivalency in order to transport a member to an appropriate AHCCCS-registered provider or provide

treatment to the member on the scene.

3. The Division shall cover transportation to an Alternative Destination Partner when the emergency response team's field evaluation of the member shows the services are medically necessary but not emergent, when the following conditions are met:

   a. Transport to an Alternative Destination Partner will meet the member’s level of care more appropriately than transport to an emergency department;

   b. The appropriate AHCCCS-registered provider is within or near the responding Emergency Transportation provider’s services area;

   c. The Emergency Transportation provider has a pre-established arrangement with the AHCCCS-registered provider located within their region; and

   d. The Emergency Transportation provider has knowledge of the AHCCCS-registered provider’s:

i. Hours of operation;

ii. Clinical Staff available;

iii. Services provided; and

iv. Ability to arrange transportation for the member to return home, as needed.

4. The Division shall cover emergency treatment on the scene when:

a. The emergency response team's evaluation of the member shows that services are medically necessary but not emergent;

b. The Emergency Transportation provider treats the member in accordance with the provider's scope of practice and their emergency transport service's medical direction, including the use of telemedicine when medically indicated.

D. EMERGENCY TRANSPORTATION PROVIDER REQUIREMENTS FOR EMERGENCY TRANSPORTATION SERVICES PROVIDED TO MEMBERS LIVING ON TRIBAL LANDS

1. The Division shall ensure that in addition to other requirements specified in this policy, Emergency Transportation providers rendering services on tribal lands meet the following requirements:

   a. Tribal emergency transportation providers shall be certified by the Tribe and Center for Medicare and Medicaid Services (CMS) as a qualified provider and shall be registered as an AHCCCS provider.

   b. If a non-tribal emergency transportation provider renders services under a contract with a Tribe, either on-reservation or to and from an off-reservation location, the provider shall be State licensed and certified and shall be registered as an AHCCCS provider.

   c. Non-tribal emergency transportation providers not under contract with a Tribe shall meet requirements specified in this Policy for emergency transport providers.

E. MEDICALLY NECESSARY NON-EMERGENCY TRANSPORTATION FOR MEDICAL AND BEHAVIORAL HEALTH SERVICES

1. The Division shall cover medically necessary, non-Emergency Transportation when furnished by non-Emergency Transportation providers to transport the member to and from a covered physical or behavioral service. Such transportation services may also be provided by Emergency Transportation providers after assessment by the Emergency Transportation team or paramedic team that the team determines the member's condition requires medically necessary transportation. Medically necessary non-emergency transportation is also referred to as Non-Emergency Medical Transportation (NEMT).

2. The Division shall cover NEMT services under the following conditions:

   a. The physical or behavioral health service for which the transportation is needed, is a service covered by the Division;

   b. The member is not able to provide, secure, or pay for their

own transportation, and free transportation is not available; and

c. The transportation is provided to and from the nearest appropriate AHCCCS-registered provider.

3. The Division shall also cover NEMT services to transport a member to obtain their Medicare Part D covered prescriptions.

4. The Division shall cover medically necessary NEMT services furnished by all AHCCCS-registered providers who offer transportation for members traveling to a pharmacy. For those members living in Maricopa and Pinal counties, the travel mileage to a pharmacy is limited to 15 miles. Mileage is calculated from the pick-up location to the drop off location, one direction. NEMT trips for members traveling to Multi-Specialty Integrated Clinics (MSIC) or IHS/638 facilities are exempt from this limitation.

5. The Division shall cover non-Emergency Transportation of a family member or caregiver without the presence of the member

when provided for the purpose of carrying out medically necessary services identified in the member's service/treatment plan.

6. The Division shall cover medically necessary non-Emergency Transportation provided by non-ambulance providers when:
   a. The member must not require medical care enroute;
   b. Passenger occupancy must not exceed the manufacturer's specified seating occupancy;
   c. Members, companions, and other passengers must follow state laws regarding passenger restraints for adults and children;
      i. Vehicle must be driven by a licensed driver, following applicable State laws;
      ii. Vehicles must be insured;
      iii. Vehicles must be in good working order;
      iv. Members, companions, and other passengers must be transported inside the vehicle; and
      v. School-based providers should follow the

school-based policies in effect.

7. The Division may cover the cost of non-Emergency Transportation, if medically necessary, provided by a non-ambulance air or equine NEMT provider only when all of the following conditions are met:
   a. The service is exclusively used to transport the member to ground accessible transportation;
   b. The member's point of pick-up or return is inaccessible by ground transport; and
   c. Ground transport is not accessible because of the nature and extent of the surrounding rural or tribal terrain.

8. The Division shall cover non-Emergency Transportation when medically necessary and furnished by ambulance providers when the following conditions are met:
   a. Other methods of transportation are contraindicated, this must be documented;
   b. The medical condition (regardless of bed confinement) of

the member requires the medical treatment be provided by qualified staff in an ambulance;

c. For hospitalized members only:

i. The Division shall cover round trip air or ground transportation services if an inpatient hospitalized member travels to another facility to obtain necessary specialized diagnostic or therapeutic services.

d. The Division shall cover the cost of the transportation if the services are not available in the hospital in which the member is hospitalized.

9. The Division shall ensure public transportation is offered as an option to a member when it is available within the service area and NEMT services are requested and is limited to AHCCCS approved services. The following shall be considered when offering public transportation:

a. Location of the member to a transportation stop;

b. Location of the Provider and/or AHCCCS approved services to a transportation stop;

c. Coordination of the member's appointment with the public transportation schedule;

d. Ability of the member to travel alone on public transportation; or

e. Member preference.

F. MATERNAL AND NEWBORN TRANSPORTATION

1. The Division shall cover medically necessary maternal and newborn transportation through the Maternal Transport Program (MTP) and the Newborn Intensive Care Program (NICP).

Signature of Chief Medical Officer: Anthony Dekker (Feb 14, 2023 15:08 MST)
Anthony Dekker, D.O.

310-DD COVERED TRANSPLANTS AND RELATED IMMUNOSUPPRESSANT MEDICATIONS

REVISION DATE: 4/26/2023, 3/1/2023, 5/18/2022, 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994
REFERENCES: A.R.S. §36-2907, 2939; A.A.C. R9-22-202, 203, 28-201, 42 CFR 438.208, AHCCCS Medical Policy Manual Chapter 300 Policy 310-DD

PURPOSE

This policy outlines the coverage for transplants, related services, and immunosuppressant medications.

DEFINITIONS

1. "Behavioral Health Professional" or BHP" means
    a. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:
        i. Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251, or
        ii. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S.§32-3251 under direct supervision as defined in A.A.C. R4-6-101,
    b. A psychiatrist as defined in A.R.S. §36-501,

c. A psychologist as defined in A.R.S. §32-2061,

d. A physician,

e. A behavior analyst as defined in A.R.S. §32-2091,

f. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or

g. A registered nurse with:

i. A psychiatric-mental health nursing certification, or

ii. One year of experience providing behavioral health services

2. "Disability" means a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment.

3. "Early and Periodic Screening, Diagnostic, and Treatment" or EPSDT" is a comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for members under the age of 21, 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 conditions 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 as specified in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and behavioral health 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.

4. "Foundation for the Accreditation of Cellular Therapy" or FACT" is a non-profit corporation co-founded by the International Society for Cellular Therapy (ISCT) and the American Society of Blood and Marrow Transplantation (ASBMT) for the purposes of

voluntary inspection and accreditation in the field of cellular therapy.

5. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
6. "Organ Procurement and Transplantation Network" or "OPTN" is a public-private partnership operated through the United States Department of Health and Human Services and established through the National Organ Transplant Act (NOTA). The OPTN policies govern operation of all Member transplant hospitals, Organ Procurement Organizations (OPOs) and histocompatibility labs in the United States.
7. "Standard of Care" means a medical procedure or process that is accepted as treatment for a specific illness, injury or medical condition through custom, peer review or consensus by the professional medical community.
8. "Second Level Review" means a review performed by a Division of Developmental Disabilities (Division) Medical Director who has the appropriate clinical expertise in managing a Member's condition or disease. Second Level Review is used to screen for

medical necessity and compare the findings to clinical data in the Member's medical record to ensure Division Members are receiving medically appropriate and high quality care.

9. "United Network for Organ Sharing" or UNOS" means a Private, non-profit organization that manages the nations' organ transplant system under contract with Organ Procurement and Transplantation Network , including managing the national transplant Waiting List and maintaining the database that contains all organ transplant data for every transplant event that occurs in the United States.
10. "Waiting List" as defined by OPTN, is a computerized list of candidates who are waiting to be matched with specific deceased donor organs for transplant.

POLICY

A. GENERAL INFORMATION

1. The Division of Developmental Disabilities (Division) shall follow all Federal, State and Arizona Health Care Cost Containment System (AHCCCS) requirements for coverage of transplants, related services, and immunosuppressant medications.

2. The Division shall delegate the responsibility of implementing this policy to the Administrative Services Subcontractors (AdSS) for Members enrolled in a subcontracted health plan.
3. The Division shall coordinate physical and behavioral health services for Members enrolled in the Tribal Health Program (THP), while the provision and administration of organ transplant benefits will be completed by AHCCCS Department of Fee for Service Management (DFSM).

B. COVERED TRANSPLANTS

1. The Division shall cover the following transplant types for Members aged 21 and older:
    a. Heart;
    b. Single lung and double lung ;
    c. Heart-Lung;
    d. Liver
    e. Cadaveric kidney and living donor kidney;
    f. Simultaneous liver and kidney;
    g. Simultaneous pancreas and kidney;
    h. Pancreas after kidney; and

i. Hematopoietic Stem Cell Transplants:

i. Allogeneic related,

ii. Allogeneic unrelated,

iii. Autologous, and

iv. Tandem Hematopoietic Stem Cell Transplant.

2. The Division shall cover all non-experimental transplants for Members under the age of 21 under the Early and Periodic Screening Diagnostic and Treatment (EPSDT) Program that are medically necessary to correct or ameliorate defects, illnesses, and physical conditions. Transplants for EPSDT Members are covered when medically necessary irrespective of whether the particular non-experimental transplant is specified as covered in AMPM 310-DD.

3. The Division shall ensure that transplants are medically necessary, non-experimental, and federally reimbursable, state reimbursable, and fall within the medical Standard of Care for coverage.

4. The Division shall use national standards for transplantation which include policy for:

a. Organ Procurement Transplant Network,

b. Centers for Medicare and Medicaid Services (CMS),

c. United Network for Organ Sharing, and

d. Foundation for the Accreditation of Cellular Therapy.

5. The Division shall cover Circulatory Assist Devices (CADs), including Left Ventricular Assist Devices (LVADs) services for destination therapy and as a bridge to transplant when medically necessary and non-experimental.

6. The Division shall cover corneal transplants and bone grafts when medically necessary, cost effective and non-experimental as specified in AMPM Exhibit 300-1 and AMPM Policy 820.

7. The Division Medical Director shall:

a. Complete a Second Level Review of all denials for transplant services and transplant related immunosuppressant medications for Members,

b. Have the final authority to approve or deny transplant services, and

c. Consult with the AHCCCS Medical Director for THP or the assigned subcontracted health plan’s Medical Director

when there are questions regarding the transplant services.

C. COVERED TRANSPLANT SERVICES

1. The Division shall cover the following services, as required by the specific type of transplant:
   a. Inpatient or outpatient pre-transplant evaluation , which includes, but is not limited to, the following:
      i. Physical examination,
      ii. Psychological evaluation,
      iii. Laboratory studies,
      iv. Radiology and diagnostic imaging or procedures, and
      v. Biopsies.
   b. Donor search, Human Leukocyte Antigen (HLA) typing, and harvest as necessary for hematopoietic transplants;
   c. Pre-transplant dental evaluation and treatment as described in AMPM Policy 310-D1 under Exception for Transplant Cases;
   d. Transplantation;

e. Inpatient or outpatient post-transplant care, which may include the following:

i. Laboratory studies,

ii. Radiology and diagnostic imaging or procedures,

iii. Biopsies,

iv. Home health,

v. Skilled nursing facility services,

vi. All related transplant medications, including transplant related immunosuppressant medications, as referenced in Division Medical Manual Policy 310-V, and

vii. Transportation, and room and board for the transplant candidate, donor and, if needed, one adult caregiver as identified by the transplant facility.

1) Coverage is limited to medical treatment transportation, to and from the facility, during the time it is necessary for the Member to remain in close proximity to the transplant center.

2) Coverage includes the periods of evaluation, on-going testing, transplantation, and post-transplant care by the transplant center.

2. The Division shall ensure the Living Donor Coverage is limited to the following when provided in the United States:
   a. Evaluation and testing for suitability;
   b. Solid organ or hematopoietic stem cell procurement, processing, and storage; and
   c. Transportation and lodging when it is necessary for:
      i. The potential donor to travel for testing to determine if they are a match, and
      ii. Donating either stem cells or organs.

D. CONDITIONS FOR TRANSPLANTATION

1. The Division through oversight of the AdSS shall ensure the following conditions are met for transplantation:
   a. Transplant candidates meet the criteria to be added to the Waiting List.

b. Medical comorbidities are assessed through history and physical with a plan developed for appropriate care and ensure the following:

   i. Changes in medical conditions shall be assessed for the impact upon transplant candidacy.

   ii. All transplant candidates shall undergo routine age-condition appropriate screening for disease.

c. Identified indolent or chronic infections have a plan of containment in accordance with an infectious disease specialist's recommendation.

d. Members with identified neoplasms are assessed in accordance with an oncologist's recommendations.

e. Psychosocial environment is assessed, and appropriate plans are generated to mitigate issues of adherence.

f. For Members with prior adherence issues, plans with a BHP are developed.

g. The Division shall ensure that Members with substance use disorder(s) have:

i. Plans for treatment before and after the organ replacement; and

ii. Consultation with a BHP who will work as a part of the treatment team to support the Member needs and maintain wellness and recovery oriented treatment, services and supports.

E. TRANSPLANT SERVICES AND SETTINGS

1. The Division through oversight of the AdSS shall ensure solid organ transplant services are provided in a CMS certified and UNOS approved transplant center which meets the Medicare conditions for participation and special requirements for transplant centers as specified in 42 CFR Part 482.
2. The Division through oversight of the AdSS shall ensure hematopoietic stem cell transplant services are provided in a facility that has achieved FACT accreditation. The facility shall meet the Medicare conditions for participation and any additional federal requirement for transplant facilities.

3. The Division through oversight of the AdSS shall ensure reimbursement is only available for transplant centers that meet the above requirements.

F. ADDITIONAL REQUIREMENTS

1. The Division shall ensure the AdSS covers out-of-network solid organ or hematopoietic stem cell transplants that meet the following requirements:
   a. Services are covered for Members who have current medical requirements that cannot be met by an AHCCCS contracted transplant center.
   b. Medical requirements for an out-of-network transplant request are clearly documented, specifying the level of technical expertise or program coverage that is not provided at an AHCCCS contracted facility.
   c. Review the quality and outcome data published for the out-of-network facility.
   d. The Division shall ensure the AdSS cover solid organ living donor-related costs for pediatric kidney and liver transplants and adult kidney transplants.

2. The Division shall consider living donor transplants on a case-by-case basis for solid organs other than pediatric and adult kidney and pediatric liver when medically necessary and cost effective.
    a. Payment is limited for solid organ living donors other than pediatric and adult kidney and pediatric liver to the surgical procedure and follow-up post-op care provided to the donor through post-op day three.
    b. For any additional charges, the living donor shall accept the terms of financial responsibility for the charges associated with the transplant that are in excess of the AHCCCS Specialty Contract for Transplantation Services.
3. The Division shall provide limited coverage for medically necessary and non-experimental services following the discharge from the acute care hospital, if a Division Member receives a transplant that is not covered by AHCCCS guidelines.
    a. Excluded services:
        i. Evaluations and treatments to prepare for transplant candidacy,

ii. The actual transplant procedure and accompanying hospitalization, or

iii. Organ or tissue procurement.

b. Covered services include:

i. Transitional living arrangements appropriately ordered for post-transplant care when the Member does not live in close proximity to the transplant center,

ii. Essential laboratory and radiology procedures,

iii. Therapies that are medically necessary post-transplant,

iv. Immunosuppressant medications, and

v. Transportation that is medically necessary post-transplant.

4. The Division shall utilize the AHCCCS Specialty Contract for Transplantation Services for second covered organ transplant performed during the follow-up care periods of the first transplant.

5. The Division shall utilize the AHCCCS Reinsurance Processing Manual for transplantation reinsurance standards.
6. The Division shall utilize the AHCCCS Specialty Contract for Transplantation Services for detailed information regarding transplant coverage and payment for transplant services and transplant related services.

G. TRANSPLANT CARE COORDINATION

1. The Division's Transplant Coordinator shall coordinate with the AdSS Transplant Coordinator or the AHCCCS Transplant Coordinator at least quarterly and on an ad hoc basis to ensure Member's health services needs are being met and to ensure continuity of care.
2. The Division shall ensure on a quarterly basis, the subcontracted health plans submit Division specific AHCCCS Transplant Logs for review and tracking.
3. The Division shall ensure Members receiving care through the Tribal Health Program who are being considered for transplant services, will coordinate with the Transplant Coordinator to ensure continuity of care for the Member is maintained.

4. The Division Transplant Coordinator shall notify the Division Support Coordinator regarding the Member's transplant status. The Division Support Coordinator will work with the planning team, the Division Transplant Coordinator, and other adjunct services or support representatives and the Member to identify and address needs, modify the planning document to support the delivery of services and support as needed.

H. ORGAN TRANSPLANT ELIGIBILITY

1. The Division shall not, solely on the basis of a Member's Disability, do any of the following:
   a. Determine that the Member is ineligible to receive an organ transplant
   b. Deny the Member's medical or other services related to an organ transplant, including:
      i. Evaluation,
      ii. Surgery,
      iii. Counseling, and
      iv. Postoperative treatment.

c. Refuse to refer the Member to a transplant hospital or other related specialist for evaluation or receipt of an organ transplant.

d. Refuse to place the individual on an organ transplant Waiting List or place the Member at a position lower in priority on the list than the position the Member would be placed if not for the Member's Disability.

e. Decline insurance coverage for the Member for any procedure associated with the receipt of an organ transplant or related services associated with the receipt of an organ transplant or for related services if the procedure or services would be covered under such insurance for the Member if not for the Member's Disability.

2. The Division shall not consider a Member's inability to independently comply with posttransplant medical requirements as medically significant if the Member has a known Disability and the necessary support system to assist the Member in reasonably complying with the requirements.

I. DIVISION OVERSIGHT

1. The Division shall oversee the AdSS utilizing the following methods to ensure compliance with policy:
    a. Annual Operational Review of each AdSS,
    b. Review and analyze deliverable reports submitted by the AdSS, and
    c. Conduct oversight meetings with the AdSS for the purpose of:
        i. Reviewing compliance,
        ii. Addressing concerns with access to care or other quality of care concerns,
        iii. Discussing systemic issues, and
        iv. Providing direction or support to the AdSS as necessary.

Signature of Chief Medical Officer: Anthony Dekker (Apr 24, 2023 10:21 PDT)
Anthony Dekker, D.O.

310-FF MONITORING CONTROLLED AND NON-CONTROLLED MEDICATION UTILIZATION

REVISION DATE: 1/3/2024, 09/06/2023, 09/30/2020
REVIEW DATE: 9/6/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR 431.54; 42 CFR 455.2; 42 USC 1396A(OO); 21 U.S.C § 802(6); A.A.C. R9-34-302; A.A.C. R9-43-202; A.A.C. Title 9, Chapter 34, Articles 2 and 3; AMPM 310-FF; AMPM 310-V; AMPM 520; AMPM 910; AMPM 1024; ACOM 103.

PURPOSE

This policy sets forth the requirements for monitoring controlled and non-controlled medication use and the requirements to ensure Members receive clinically appropriate prescriptions. This policy applies to the Division's Administrative Services Subcontractors (AdSS) that includes delegated health plans and pharmacy benefits manager.

DEFINITIONS

1. "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the AdSS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also

includes beneficiary practices that result in unnecessary cost to the Division Program.

2. "Controlled Substance" means drugs and other substances that are defined as Controlled Substances under 21 U.S.C § 802(6).

3. "CSPMP" means the Arizona State Board of Pharmacy Controlled Substance Prescription Monitoring Program.

4. "Drug Diversion" means redirection of prescription drugs for illicit purposes.

5. "Emergencies" means medical services provided for the treatment of an emergency medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

   a. Placing the Member's health in serious jeopardy;

   b. Serious impairment to bodily functions;

c. Serious dysfunction of any bodily organ or part;

d. The medication is out-of-stock at the Exclusive Pharmacy; or

e. The Exclusive Pharmacy is closed.

6. "Exclusive Pharmacy" means an individual pharmacy, which is chosen by the Member or assigned by the AdSS to provide all medically necessary federally reimbursable pharmaceuticals to the Member.

7. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes Fraud under applicable State or Federal law.

8. "Intervention" means for the purpose of this policy, the requirements to ensure Members receive clinically appropriate prescriptions.

9. "Member" means the same as "Client" as defined in A.R.S. §

36-551.

10. "Waste" means over-utilization or inappropriate utilization of services, misuse of resources, or practices that result in unnecessary costs to the Medicaid Program.

POLICY

A. MONITORING REQUIREMENTS

1. The AdSS shall monitor controlled and non-controlled medications on an ongoing basis for any Member who has received one of the medications listed in Section (A)(4) through their health plan.

2. The AdSS shall monitor the evaluation of prescription use by Members, prescribing patterns by clinicians, and dispensing by pharmacies.

3. The AdSS shall use drug utilization data to identify and screen high-risk Members and providers who may facilitate Drug Diversion.

4. The AdSS shall identify monitoring requirements that determine potential misuse of the drugs used in the following therapeutic classes:
    a. Atypical Antipsychotics,
    b. Benzodiazepines,
    c. Hypnotics,
    d. Muscle Relaxants,
    e. Opioids, and
    f. Stimulants.

5. The AdSS shall use the following resources, when available for their monitoring activities:
    a. Prescription claims data;
    b. Controlled Substance Prescription Monitoring Program (CSPMP); and
    c. Pertinent data used for monitoring controlled and non-controlled medication utilization.

6. The AdSS shall monitor the prescription claims data quarterly to identify:

a. Medications filled prior to the calculated days-supply,

b. Number of prescribing clinicians,

c. Number of different pharmacies used by the Member, and

d. Other potential indicators of medication misuse.

B. DIVISION OVERSIGHT OF INTERVENTION REQUIREMENTS

1. The AdSS shall implement the following required Interventions to ensure Members receive the appropriate medication, dosage, quantity, and frequency:

   a. Provider education;

   b. Point-of-Sale (POS) safety edits and quantity limits;

   c. Care management;

   d. Assignment of Members who meet either of the following evaluation parameters listed below to an Exclusive Pharmacy, exclusive provider or both for up to a 12-month period:

      i. A Member using the following in a three-month time period:

a) Greater than four prescribers, and

b) Greater than four different Abuse potential drugs, and

c) Four Pharmacies; or

d) The Member has received 12 or more prescriptions of the medications listed in the Monitoring Requirements section in the past 3 months.

ii. A Member presenting a forged or altered prescription to the pharmacy.

2. The AdSS may implement additional interventions and more restrictive parameters for referral to, or coordination of care with behavioral health service providers or other appropriate specialists when the AdSS deems it necessary or beneficial to their Members.

3. The AdSS shall provide a written notice detailing the factual and legal basis based for the restriction, to any Member who has

been assigned to an exclusive provider or pharmacy or both for up to 12 months utilizing AMPM 310-FF, Attachment A.

4. The AdSS shall treat this restriction as an "action" pursuant to A.A.C. R9-43-202 and A.A.C. R9-34-302.

5. The AdSS shall provide the written notice that informs the Member of the opportunity to file an appeal to the restriction and the timeframes and process for doing so as described in A.A.C. Title 9, Chapter 34, Articles 2 and 3.

6. The AdSS shall not implement the restriction before providing the Member written notice of the restriction and the opportunity for an appeal or State fair hearing.

7. The AdSS shall not impose a restriction if the Member has filed an appeal until:
    a. The Medical Director of the AdSS' decision has affirmed the restriction;
    b. The Member has voluntarily withdrawn the appeal or request for hearing; or

c. The Member fails to file an appeal or request for hearing no later than 30 calendar days from the date of the notice.

8. The AdSS shall review the Member's prescription and other utilization data to determine whether the Intervention will be continued or discontinued at the end of the designated time period, which is no longer than every 12 months.

9. The AdSS shall notify the Member in writing of the decision to continue or discontinue the assignment of the pharmacy or provider.

10. The AdSS shall utilize AMPM 310-FF Attachment A to include instructions for the appeals or fair hearing process in the notification letter to the Member if the decision is to continue the assignment.

11. The AdSS shall not apply the Intervention of assigning an Exclusive Pharmacy or provider to emergency services furnished to the Member.

12. The AdSS shall ensure that the Member has reasonable access to

services, taking into account the geographic location and reasonable travel time.

13. The AdSS shall provide specific instructions to the Member, the assigned Exclusive Pharmacy or exclusive provider, and their Pharmacy Benefit Manager (PBM), on how to address Emergencies.

14. The AdSS may assign Members who meet any of the parameters in Section (B)(15) to a single prescriber in addition to the assignment to an Exclusive Pharmacy.

15. The AdSS shall not subject Members with one or more of the following conditions to the Intervention requirements described in Section (B)(1):
    a. Treatment for an active oncology diagnosis,
    b. Receiving hospice care, or
    c. Residing in a skilled nursing facility or intermediate care facility.

C. REPORTING REQUIREMENTS

1. The AdSS shall refer all identified cases of Member deaths due to medication poisoning, overdose or toxic substances to the Division's Quality Management department as an incident report for research and review.

2. The AdSS shall report all suspected Fraud, Waste, and Abuse to the appropriate entity, and copy the Division as specified in ACOM 103 and the contract with the Division.

3. The AdSS shall submit to the Division the number of Members on that day that are assigned to an Exclusive Pharmacy, or single prescriber, or both due to excessive use of prescription medications,controlled and non-controlled medications utilizing AMPM Attachment 1024-A.

4. The AdSS shall report to the Division, any material changes that the AdSS implements additional Interventions and more restrictive parameters as noted in this policy.

Signature of Chief Medical Officer: Anthony Dekker (Dec 29, 2023 10:24 MST)
Anthony Dekker, D.O.

310-GG NUTRITIONAL THERAPY, METABOLIC FOODS, AND TOTAL PARENTERAL NUTRITION

REVISION DATE: 2/7/2024
REVIEW DATE: 7/25/2023
EFFECTIVE DATE: 06/07/2023
REFERENCES: A.R.S. § 20-2327, AMPM 310-GG, AMPM Policy 430, AMPM 520, AMPM Policy 820

PURPOSE

This policy describes coverage of and requirements for nutritional therapy, metabolic foods and Total Parenteral Nutrition (TPN) for Division of Developmental Disability (DDD) Members, 21 years of age and older, who are eligible for Arizona Long Term Care System (ALTCS).

DEFINITIONS

1. "Commercial Oral Supplemental Nutrition" means nourishment available without a prescription that serves as sole caloric intake or additional caloric intake.

2. "Enteral Nutrition" means liquid nourishment provided directly to the digestive tract of a Member who cannot ingest an appropriate amount of calories to maintain an acceptable

nutritional status. Enteral nutrition is commonly provided by Jejunostomy Tube (J-Tube), Gastrostomy Tube (G-Tube) or Nasogastric (N/G Tube).

3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

4. "Metabolic Medical Food Formulas" or "Medical Foods" means nutrition and specialized diets used to treat inherited metabolic disorders that are rare genetic conditions in which normal metabolic function is inhibited by a deficiency in a critical enzyme. Metabolic formula or modified low protein foods are produced or manufactured specifically for persons with a qualifying metabolic disorder and are not generally used by persons in the absence of a qualifying metabolic disorder. In order to avoid toxic effects, the treatment of the associated metabolic disorder depends on dietary restriction of foods containing substances that cannot be metabolized by the Member.

5. "Responsible Person" means the parent or guardian of a minor

with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed.

6. "Total Parenteral Nutrition", "TPN" means nourishment provided through the venous system to Members with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength appropriate for the individual's general condition. Nutrients are provided through an indwelling catheter.

POLICY

A. NUTRITIONAL ASSESSMENT AND THERAPY

1. The Division shall require a nutritional assessment for a Member who has been identified as having a health status which may improve or be maintained with nutritional interventions.

2. The Division shall require a nutritional assessment as determined medically necessary and as a part of health risk assessment and

screening services provided by the Member's Primary Care Provider (PCP) be covered.

3. The Division shall require Nutritional assessment services provided by a registered dietitian also are covered when ordered by the Member's PCP.

4. The Division shall require nutritional therapy on an enteral, parenteral or oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a Member's daily nutritional and caloric intake be covered.

5. The Division shall ensure nutritional supplementation is procured and funded for any other nutritional supplementation medically necessary for Women, Infants, and Children (WIC) exempt formula.

6. The Division shall implement protocols for transitioning a Member who is receiving nutritional therapy to or from subcontractors or providers.

B. PRIOR AUTHORIZATION

1. The Division shall require Prior Authorization (PA) for commercial oral nutritional supplements, enteral nutrition, and parenteral nutrition unless:
   a. The Member is currently receiving nutrition through enteral or parenteral feedings for which PA has already been obtained; or
   b. For the first 30 days with Members who require oral supplemental nutritional feedings on a temporary basis due to an emergent condition, i.e. post-hospitalization.

C. COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS

1. The Division shall require the Member's PCP or specialty provider to determine the medical necessity for commercial oral nutritional supplements on an individual basis using the criteria specified in this policy.
2. The Division shall require the PCP or specialty provider to use AMPM Attachment 310-GG (A) to obtain authorization.

3. The Division shall require AMPM Attachment 310-GG (A) be used when assessing the medical necessity of providing commercial oral nutritional supplements.

4. The Division shall require the Member meet each of the following requirements in order to obtain medically necessary oral nutritional supplements:

   a. The Member is currently underweight with a Body Mass Index (BMI) of less than 18.5, presenting serious health consequences for the Member, or has already demonstrated a medically significant decline in weight within the past three months prior to the assessment;

   b. The Member is not able to consume or eat more than 25% of their nutritional requirements from typical food sources;

   c. The Member has been evaluated and treated for medical conditions that may cause problems with weight gain and growth (e.g. feeding problems, behavioral conditions or psychosocial problems, endocrine or gastrointestinal

problems); and

d. The Member has had a trial of higher caloric foods, blenderized foods, or commonly available products that may be used as dietary supplements for a period no less than 30 days in duration.

5. The Division shall require the provider to submit AMPM Attachment 310-GG (A), along with supporting documentation from the Division's Medical Director or designee's consideration, demonstrating the risk posed to the Member in approving the provider's PA request, if it is determined through clinical documentation and other supporting evidence that a trial of higher caloric foods would be detrimental to the Member's overall health.

6. The Division shall require supporting clinical documentation received with AMPM Attachment 310-GG (A) is provided to the authorizing health plan that demonstrates the Member meets all of the following required criteria:

   a. Initial Requests:

i. Documentation demonstrating that nutritional counseling has been provided as a part of the health risk assessment and screening services provided to the Member by the PCP or specialty provider, or through consultation with a registered dietitian;

ii. Clinical notes or other supporting documentation dated no earlier than three months prior to date of the request, providing a detailed history and thorough physical assessment and demonstrating evidence of the Member meeting all of the required criteria listed in AMPM Attachment 310-GG (A). The physical assessment shall include the Member's current and past height, weight, and BMI;

iii. Documentation detailing alternatives that were tried in an effort to boost caloric intake or changes in food consistencies that have proven unsuccessful in resolving the nutritional concern identified, as well as Member adherence to the prescribed dietary

plan and alternatives attempted.

b. Ongoing Requests:

i. Subsequent submissions shall include a clinical note or other supporting documentation dated no earlier than three months prior to the date of the request that includes the Member's overall response to supplemental therapy and justification for continued supplement use. This shall include the Member's tolerance, recent hospitalizations, current height, weight, and BMI;

ii. Documentation demonstrating encouragement and assistance provided to the caregiver in weaning the Member from supplemental nutritional feedings should be included, when appropriate;

iii. Members receiving nutritional therapy shall be physically assessed by the Member's PCP, specialty provider, or registered dietitian at least annually; and

iv. Initial and ongoing certificate of medical necessity is

considered valid for a period of six months.

D. METABOLIC MEDICAL FOODS

1. The Division shall require metabolic formulas and medical foods are covered for Members diagnosed with metabolic conditions that are screened for using the Newborn Screening Panel authorized by the Arizona Department of Health Services.

   p. The Division shall require Metabolic formulas and medical foods are covered as specified in A.R.S. § 20-2327 and within the following limitations:

   a. Metabolic formula or modified low protein foods shall be:

      i. Processed or formulated to be deficient in the nutrients specific to the Member's metabolic condition;

      ii. Meet the Member's distinctive nutritional requirements;

      iii. Determined to be essential to sustain the Member's optimal growth within nationally recognized height,

weight, BMI and metabolic homeostasis;

iv. Obtained under physician order; and

v. The Member's medical and nutritional status is supervised by the Member's PCP, attending physician or appropriate specialist.

b. Modified low protein foods shall be formulated to contain less than 1 gram of protein per unit or serving. For purposes of this policy, modified low protein foods do not include foods that are naturally low in protein;

c. Soy formula is covered only for Members receiving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, and only until the Member is able to eat solid lactose-free foods;

d. Foods that are available in the grocery store or health food store are not covered as a metabolic food; and

e. Education and training is required regarding proper

sanitation and temperatures to avoid contamination of foods which are blended or specially prepared for the Member if the Responsible Person elects to prepare the Member's food.

E. TOTAL PARENTERAL NUTRITION

1. The Division shall follow Medicare requirements for the provision of Total Parenteral Nutrition (TPN) services.

2. The Division shall require TPN is covered for Members over age 21 when it is medically necessary and the only method to maintain adequate weight and strength.

3. The Division shall require TPN when medically necessary, is covered for members receiving EPSDT.

F. DIVISION OVERSIGHT

1. The Division shall oversee the AdSS utilizing the following methods to ensure compliance with policy:

   a. Annual Operational Review of each AdSS,

b. Review and analyze deliverable reports submitted by the AdSS, and

c. Conduct oversight meetings with the AdSS for the purpose of:

i. Reviewing compliance,

ii. Addressing concerns with access to care or other quality of care concerns,

iii. Discussing systemic issues, and

iv. Providing direction or support to the AdSS as necessary.

G. SUPPLEMENTAL INFORMATION

For a listing of metabolic conditions and the Newborn Screening Panel refer to the Arizona Department of Health Services at https://www.azdhs.gov/documents/preparedness/state-laboratory/newborn-screening/providers/az-newborn-screening-panel-of-conditions.pdf?v=20230504.

Signature of Chief Medical Officer: Anthony Dekker (Jan 30, 2024 14:06 MST)

Anthony Dekker, D.O.

310-HH END OF LIFE CARE AND ADVANCE CARE PLANNING

EFFECTIVE DATE: June 22, 2022
REFERENCES: A.R.S §§ 36-3231, 36-551; 42 C.F.R. 489.102; AdSS 310-J, 415, 640

PURPOSE

This policy establishes guidelines for the concept of End of Life (EOL) care and the provision of Advance Care Planning.

DEFINITIONS

1. "Advance Care Planning" is a part of the End of Life care concept and is a billable service that is a voluntary face-to-face ongoing discussion between a qualified health care professional and the member to:
    a. Educate the member/responsible person about the member's illness and the health care options that are available to them.
    b. Develop a written plan of care that identifies the member's choices for treatment.
    c. Share the member's wishes with family, friends, and his or her physicians.
2. "Advance Directive" is a document by which a person makes provision for health care decisions in the event that, in the future, he/she becomes unable to make those decisions.

3. "Curative Care" includes health care practices that treat patients with the intent of curing them, not just reducing their pain or stress. An example is chemotherapy, which seeks to cure cancer patients.
4. "End-of-Life Care" is a concept of care, for the duration of the member's life, that focuses on Advance Care Planning, the relief of stress, pain, or life limiting effects of illness to improve quality of life for a member at any age who is currently or is expected to experience declining health, or is diagnosed with a chronic, complex or terminal illness.
5. "Hospice Services" is a program of care and support for terminally ill members who meet the specified medical criteria/requirements.
6. "Practical Support" includes non-billable services provided to a member by a family member, friend or volunteer to assist or perform functions such as, but not limited to housekeeping, personal care, food preparation, shopping, pet care, or non-medical comfort measures.
7. "Qualified Direct Care Worker" is an individual who demonstrates Direct Care Worker (DCW) competencies by passing the required knowledge and skills tests. The DCW Agency is responsible for determining the DCWs competency to provide care utilizing the agency's policies and procedures, the DCW job description and the supports needs of the members served

by the DCW. In some instances, qualified DCWs may not yet be employed or contracted by a DCW Agency.

8. "Qualified Healthcare Professional" is, for the purposes of Advance Care Planning, a Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), or Nurse Practitioner (NP).
9. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed. A.R.S. § 36-551.

POLICY

A. END OF LIFE CARE

The Division shall ensure that members receive End of Life (EOL) care that is member-centric, includes Advance Care Planning, and the delivery of appropriate health care services and practical supports by the AdSS and Support Coordination.

The goals of EOL care shall focus on providing treatment, comfort, and quality of life for the duration of the member's life. Care management

is provided to qualifying members/responsible persons to coordinate with treatment provider(s) to meet the member's individual needs.

EOL care is available to members under the age of 21 in conjunction with curative care and hospice care. EOL care for members aged 21 and older can be provided in conjunction with curative care until the member chooses to receive hospice care.

EOL care strives to ensure members achieve quality of life through the provision of services coordinating between the AdSS care management and Division Support Coordination to determine the services and supports necessary to meet the member's needs, including:

1. Physical and/or behavioral health medical treatment to:
    a. Treat the underlying illness and other comorbidities,
    b. Relieve pain,
    c. Relieve stress.
2. Referrals to community resources for services such as, but not limited to:
    a. Pastoral/counseling services,

b. Legal services.

3. Practical supports are non-billable services provided by a family member, friend or volunteer, who are not paid as Direct Care Workers, to assist or perform functions such as, but not limited to:

a. Housekeeping,

b. Personal care,

c. Food preparation,

d. Shopping,

e. Pet care,

f. Non-medical comfort measures.

B. ADVANCE CARE PLANNING

Advance Care Planning shall be initiated by the member's qualified healthcare professional for a member at any age that is currently or is expected to experience declining health or is diagnosed with a chronic, complex or terminal illness. Advance Care Planning shall be an ongoing process for the duration of the member's life.

1. The AdSS shall ensure network providers perform the following as part of the Advance Care Planning/EOL concept of care when treating Division members:

    a. Conduct a face-to-face discussion with the member/responsible person.

    b. Educate the member/responsible person about the member's illness and the health care options that are available to the member to enable them to make educated decisions.

    c. Identify the member's healthcare, social, psychological and spiritual needs.

    d. Develop a written member centered EOL plan of care that identifies the member's choices for care and treatment, as well as life goals.

    e. Share the EOL plan with the care manager and Division Support Coordinator.

f. Share the member's wishes with appropriate designated family, friends, and specialty providers, as appropriate, his or her physicians.

g. Complete Advance Directives.

h. Complete referrals to community resources based on member's needs.

i. Assist the member/responsible person in identifying practical supports to meet the member's needs.

2. The AdSS ensures Advanced Care Planning is a covered, reimbursable service when provided by a qualified health care professional. The service may be billed separately during a well or sick visit.

C. ADVANCE DIRECTIVES

Advance Care Planning often results in the creation of an Advance Directive for the member. Members have the right to have information provided to them about the importance of Advance Directives including their rights to establish and rescind Directives at any time.

1. The AdSS shall ensure providers comply with AdSS Medical Policy 640 pertaining to Advance Directives. At a minimum, providers shall comply with the following:

    a. Maintain written policies for adult members receiving care through their organization regarding the member's ability to make decisions about medical care, including the right to accept or refuse medical care and the right to execute an Advance Directive.

    b. Provide written information to adult members regarding the provider's policies concerning Advance Directives, including any conscientious objections.

    c. Document in the member's medical record whether or not the adult member has been provided the information, and whether an Advance Directive has been executed.

    d. Prevent discrimination against a member because of his or her decision to execute or not execute an Advance Directive, and not place conditions on the provision of care to the member, because of his/her decision to execute or not execute an advance directive.

e. Provide education to staff on issues concerning Advance Directives including notification to staff who provide services such as home health care and personal care services (e.g., attendant care, respite, personal care) if any Advance Directives are executed by members to whom they are assigned to provide services.

f. Ensure alternative Home and Community Based Services (HCBS) setting staff have immediate access to advance directive documents to provide to first responder requests.

2. All AdSS enrolled adult members, and when the member is incapacitated or unable to receive information, the member's family or surrogate as defined in A.R.S. §36-3231, shall be provided written information regarding Advance Directives as delineated in 42 CFR 489.102(e) concerning:

a. The member's rights, regarding Advance Directives under Arizona State law.

b. The AdSS's policies respecting the implementation of those rights, including a statement of any limitation regarding

the implementation of advance directives as a matter of conscience.

c. Written policies including a clear and precise statement of limitations if the provider cannot implement an Advance Directive as a matter of conscience. This statement, at a minimum, shall:

i. Clarify institution-wide conscientious objections and those of individual physicians,

ii. Identify state legal authority permitting such objections, and

iii. Describe the range of medical conditions or procedures affected by the conscience objection.

d. A description of the applicable state law and information regarding the implementation of these rights.

e. The member's right to file complaints with ADHS Division of Licensing Services.

3. AdSS providers shall provide a copy of a member's executed Advance Directive or documentation of refusal, to the member's

Primary Care Provider (PCP) for inclusion in the member's medical record and provide education to staff on issues concerning Advance Directives.

D. HOSPICE SERVICES

The AdSS shall provide hospice services in accordance with Division AdSS Medical Policy 310-J.

E. TRAINING

1. The AdSS shall ensure providers and their staff are educated in the concepts of EOL care, Advance Care Planning and Advance Directives.

2. The appropriate AdSS staff shall be educated in the concepts of EOL care, Advance Care Planning and Advanced Directives.

    a. Documentation of the training and attendance shall be submitted to the Division on an annual basis.

F. NETWORK ADEQUACY

The AdSS shall ensure an adequate network of providers who are trained to conduct Advance Care Planning in accordance with AdSS Operations Manual Policy 415.

G. OVERSIGHT

At least quarterly, the Division meets with the AdSS to provide ongoing evaluation including data analysis and recommendations to refine processes to optimize results. On an annual basis, the Division performs an Operational Review of the AdSS to review compliance.

Signature of Chief Medical Officer: Anthony Dekker (Jun 14, 2022 17:42 PDT)
Anthony Dekker, D.O.

310-II GENETIC TESTING

REVIEW DATE:
EFFECTIVE DATE: December 13, 2023
REFERENCES: AMPM 310-II

PURPOSE

This policy establishes the coverage requirements and limitations of Genetic Testing for Division of Developmental Disabilities (Division) Members who are eligible for ALTCS.

DEFINITIONS

1. "Genetic Testing" means the sequencing of human Deoxyribonucleic Acid (DNA) obtained from a small sample of body fluid or tissue in order to discover genetic differences, anomalies, or mutations.
2. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

POLICY

A. GENETIC TESTING

1. The Division shall cover medically necessary Genetic Testing and counseling when the following criteria are met:
    a. When the Member:
        i. Displays clinical features of a suspected genetic condition;
        ii. Is at direct risk of inheriting the genetic condition in question which could be due to:
            a) A causative familial variant has been identified in a close family member, or
            b) The Member's family history indicates a high risk.
        iii. Is being considered for treatment which has significant risk of serious adverse reactions, or is ineffective, in a specific genotype.
    b. The results of the Genetic Testing are necessary to:
        i. Differentiate between treatment options;
        ii. The Member has indicated they will pursue treatment based on the results of the testing; and

iii. An improved clinical outcome is probable as evidenced by:

a) Clinical studies of fair-to-good quality published in peer-reviewed medical literature have established that actions taken as a result of the test will improve clinical outcome for the Member; or

b) Treatment has been demonstrated to be safe and likely to be effective based on the weight of opinions from specialists who provide the service or related services if the condition is rare.

c. The test is proven to be scientifically valid for the identification of the specific genetically-linked disease or clinical condition; and

d. A licensed genetic counselor or the ordering provider has counseled the Member about the medical treatment options prior to the genetic test being conducted.

2. The Division shall cover the following medically necessary Genetic Testing and counseling, irrespective of the requirements listed above:
    a. The results of the Genetic Testing will confirm either:
        i. A diagnosis and by so doing avoid further testing that is invasive and has risks of complications; or
        ii. A significant developmental delay in an infant or child and the cause has not been determined through routine testing with one of the following met:
            a) The genetic testing is limited to Chromosomal Microarray (CMA),
            b) Chromosomal testing for Fragile X, or
            c) Any further gene testing meets all other criteria in this policy.
    b. The test is proven to be scientifically valid for the identification of the specific genetically-linked disease or clinical condition; and

c. A licensed genetic counselor or the ordering provider has counseled the Member prior to the genetic test being conducted.

B. LIMITATIONS

1. The Division shall not cover Genetic Testing under the following circumstances:
   a. To determine specific diagnoses or syndromes when such diagnoses would not definitively alter the medical treatment of the Member except as described above in A (2)(a);
   b. To determine the likelihood of associated medical conditions occurring in the future;
   c. As a substitute for ongoing monitoring or testing of potential complications or sequelae of a suspected genetic anomaly;
   d. For purposes of determining current or future reproductive decisions;
   e. For determining eligibility for a clinical trial; or

f. Paying for panels or batteries of tests that include one or more medically necessary tests, along with tests that are not medically necessary, when the medically necessary tests are available individually.

C. PRIOR AUTHORIZATIONS

1. The Division shall require that prior authorization requests include documentation regarding how the Genetic Testing is consistent with the Genetic Testing coverage and include:
   a. Recommendations from a licensed genetic counselor or ordering provider;
   b. Clinical findings including family history and any previous test results;
   c. A description of how the genetic test results will differentiate between treatment options for the Member or meet the requirements of section A(2)(a) or A(2)(b);
   d. The rationale for choosing one of these types of Genetic Testing:
      i. Full gene sequencing,
      ii. Deletion or duplication,

iii. Microarray, and

iv. Individual variants.

e. Medical literature citations as applicable.

D. AdSS MONITORING AND OVERSIGHT

1. The Division shall meet with the AdSS at least quarterly to:

   a. Provide ongoing evaluation including data analysis and recommendations to refine processes; and

   b. Identify successful interventions and care pathways to optimize results.

2. The Division shall perform an Operational Review of the AdSS on an annual basis that includes review of compliance.

SUPPLEMENTAL INFORMATION

Pursuant to A.R.S. §36-694, all babies born in Arizona are tested for specific congenital disorders through the Arizona Department of Health Newborn Screening Program. Newborn screening including confirmatory testing is not subject to the requirements of this Policy.

Signature of Chief Medical Officer: Anthony Dekker (Dec 7, 2023 10:16 MST)

Anthony Dekker, D.O.

310-KK BIOMARKER TESTING

REVIEW DATE:
EFFECTIVE DATE: December 13, 2023
REFERENCES: AMPM 310-KK

PURPOSE

This policy establishes the coverage requirements of Biomarker Testing for the Division of Developmental Disabilities (Division).

DEFINITIONS

1. "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes or pharmacologic responses to a specific therapeutic intervention which includes gene mutations or protein expression.
2. "Biomarker Testing" means the analysis of a patient's tissue, blood or other biospecimen for the presence of a biomarker, which includes single-analyte tests, multiplex panel tests and whole genome sequencing.
3. "Clinical Utility" means the test result provides information that is used in the formulation of a treatment or monitoring strategy

that informs a patient's outcome and impacts the clinical decision. The most appropriate test may include both information that is actionable and some information that cannot be immediately used in the formulation of a clinical decision.

4. "Member" means the same as "Client" as defined in A.R.S. §36-551.

POLICY

A. BIOMARKER TESTING

1. The Division shall require medically necessary non-experimental Biomarker Testing is covered for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a Member's disease or condition to guide treatment decisions when the test provides Clinical Utility as demonstrated by the following medical and scientific evidence:
    a. Labeled indications for tests that are approved or cleared by the United States Food and Drug Administration (FDA) or indicated tests for a drug that is approved by the FDA;

b. Centers for Medicare and Medicaid Services (CMS) national coverage determinations or Medicare administrative contractor local coverage determinations, or

c. Nationally recognized clinical practice guidelines and consensus statements as outlined in A.R.S. § 20-841.13.

2. The Division shall require Biomarker Testing is covered with the same scope, duration, and frequency as the system otherwise provides to Members pursuant to A.R.S. § 36-2907.03.

3. The Division shall require that coverage is provided in a manner that limits disruptions in care, including the need for multiple biopsies or biospecimen samples.

4. The Division shall require prior authorization for Biomarker Testing.

5. The Division shall require a clear and readily available process to accept electronic requests from providers for exceptions to a coverage policy.

6. The Division shall refer to AMPM Policy 810 for Tribal Health Plan (THP) prior authorization submission requirements.

B. AdSS MONITORING AND OVERSIGHT

1. The Division shall meet with the AdSS at least quarterly to:
   a. Provide ongoing evaluation including data analysis and recommendations to refine processes; and
   b. Identify successful interventions and care pathways to optimize results.
2. The Division shall perform an Operational Review of the AdSS on an annual basis that includes review of compliance.

Signature of Chief Medical Officer: Anthony Dekker (Dec 7, 2023 10:17 MST)
Anthony Dekker, D.O.

320-B MEMBER PARTICIPATION IN EXPERIMENTAL SERVICES AND CLINICAL TRIALS

EFFECTIVE DATE: March 1, 2023
REFERENCES: A.R.S. §36-1331; A.R.S. §36-1336; AMPM 320-B

PURPOSE

This policy describes the responsibilities related to Experimental Services and Qualifying Clinical Trials for Arizona Long Term Care System (ALTCS) eligible members.

DEFINITIONS

1. "Eligible Patient" means a patient who meets all of the following conditions:
    a. Has a life-threatening disease or condition or a severely debilitating illness, attested to by the patient's physician.
    b. Has considered all other treatment options currently approved by the United States Food and Drug Administration.
    c. Has received a recommendation from the patient's physician for an Individualized Investigational Treatment

based on an analysis of the patient's genomic sequence, human chromosomes, deoxyribonucleic acid, ribonucleic acid, genes, gene products, such as enzymes and other types of proteins, or metabolites.

d. Has given written informed consent for the use of the individualized investigational drug, biological product or device.

e. Has documentation from the patient's physician that the patient meets the requirements of this paragraph.

2. "Experimental Services" means a service which is not generally and widely accepted as a standard of care in the practice of medicine in the United States and is not a safe and effective treatment for the condition for which it is intended or used as specified in A.A.C. R9-22-203.

3. "Individualized Investigational Treatment" means

a. A drug, biological product or device that is unique to and produced exclusively for use by an individual patient based on the patient's own genetic profile.

b. Includes individualized gene therapy, antisense oligonucleotides and individualized neoantigen vaccines.

4. "Qualifying Clinical Trial" means any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life threatening disease or condition and is described in any of clauses (i)-(iii) of section 1905(gg)(2)(A) of the Act. A study or investigation must be approved, conducted, peer-reviewed, or supported (including by funding through in-kind contributions) by national organizations.

5. "Second Level Review" means a review performed by a Division of Developmental Disabilities (Division) Medical Director who has the appropriate clinical expertise in managing a member's condition or disease. Second Level Review is used to screen for medical necessity and compare the findings to clinical data in the member's medical record to ensure Division members are receiving medically appropriate and high quality care.

POLICY

A. PARTICIPATION IN CLINICAL TRIALS

1. The Division shall ensure that members may participate in clinical trials if they desire, but will not reimburse for the Experimental Service.
2. The Division shall cover services related to the Qualifying Clinical Trial, including but not limited to:
    a. Routine care,
    b. Screenings,
    c. Laboratory tests,
    d. Imaging services,
    e. Physician services,
    f. Treatment of complications arising from clinical trial participation, or
    g. Other medical services and costs.
3. The Division shall not block or attempt to block an Eligible Patient's access to an Individualized Investigational Treatment.
4. The Division Medical Director shall:

a. Complete a Second Level Review of all requests for participation in Experimental Services and/or clinical trials for members.

b. Have the final authority to approve or deny the member's participation in Experimental Services and/or clinical trials.

c. Consults with the assigned AHCCCS Medical Director for Tribal Health Plan (THP) or the assigned subcontracted health plan's Medical Director when there are questions regarding the member's participation in Experimental Services and/or clinical trials.

B. COVERAGE DETERMINATION

1. The Division shall ensure coverage for a member to participate in a Qualifying Clinical Trial. Coverage shall be:

   a. Expedited and completed within 72 hours regardless of the geographic location or if the provider is in network;

   b. Based on where the clinical trial is conducted, including out of state; or

c. Based on whether the provider treating the member is outside of the network, the member may not be denied.

2. The Division's Medical Director shall review a member's participation in an FDA Phase I or Phase II clinical trial for approval. Factors for consideration for approval will include:

a. The clinical regimen is well-designed, and adequate protection of the member's welfare is assured;

b. Provider specification of the clinical trial and any associated service are not provided to prevent, diagnose, monitor, or treat complications resulting from participation in the clinical trial;

c. Verification that full financial liability for the clinical trial is taken by the researcher or the sponsor, and not be charged to, or paid by AHCCCS;

d. The trial provides adequate participant information and assures participant consent;

e. Completion of Attachment A and Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial;

f. Fees, finder's fees, or other payment for referring members for clinical trials are not received; and

g. The member's primary care provider shall not have any financial interest in the clinical trial.

3. The Division shall ensure members rights are being protected when members are approved to participate in a clinical trial.

Signature of Chief Medical Officer: Anthony Dekker (Feb 21, 2023 12:22 MST)
Anthony Dekker, D.O.

320-F HIV/AIDS TREATMENT SERVICES

REVISION DATE: 10/01/2021
EFFECTIVE DATE: November 17, 2017
REFERENCES: A.A.C. R4-16-101

The Division of Developmental Disabilities (Division) covers medically necessary treatment services rendered by qualified providers, for members who are eligible for the Division, ALTCS, or DDD Tribal Health Program (THP), and who have been diagnosed with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS). The Division and the Administrative Services Subcontractors (AdSS) must follow the Centers for Disease Control and Prevention (CDC) guidelines for the treatment of HIV/ AIDS. The Division and the Administrative Services Subcontractors are responsible for distributing these guidelines, and all updates, to HIV/AIDS treatment professionals included in their network.

As appropriate, AHCCCS reviews new technological advances in HIV/AIDS treatment, including recommended pharmacological regimens.

This review shall include the AHCCCS Chief Medical Officer, the AHCCCS Medical Director, the Division Medical Director, the Administrative Services Medical Director, and physician experts in the treatment of HIV/AIDS.

The review may include, but is not limited to, information regarding:

A. Established treatment and pharmaceutical regimens

B. Changes in technology and treatment protocols

C. Cost implications of treatment/pharmaceutical regimens.

Monitoring

The Division and the AdSS must develop policies and protocols that document care coordination services provided to members with HIV/AIDS. This includes monitoring of member medical care in order to ensure that medical services, medication regimens, and necessary support services (e.g., transportation) are provided within specified timelines, as defined in contractual arrangements with the Division, and that these services are used appropriately. Support services may be coordinated with existing community resources.

The AdSS must also ensure that the care for members diagnosed with HIV/AIDS, who are receiving services specified by, and in accordance with, the guidelines set by AHCCCS, is well coordinated and managed in collaboration with the member‘s treating physician.

If a conflict regarding treatment or denial of treatment arises between the member‘s treating physician and the Division’s Medical Director, the issue may be referred to the AHCCCS Medical Director or designee. However, this does not preclude the member‘s right to file an appeal.

HIV/AIDS Treatment Professionals

AHCCCS compiles, updates, and makes available, upon request, a listing of qualified HIV/AIDS treatment professionals (physicians, nurse practitioners, and/or physician assistants). The listing will be based on information submitted by the Division as specified in contractor reporting requirements.

A qualified HIV/AIDS treatment professional, for the purpose of this policy, is defined as a physician or practitioner who:

A. Is recognized in the community as having a special interest, knowledge, and experience, in the treatment of HIV/AIDS

B. Agrees to adhere to CDC treatment guidelines for HIV/AIDS

C. Agrees to provide primary care services and/or specialty care to AHCCCS members with HIV/AIDS

D. Demonstrates ongoing professional development by clinically managing at least five patients with HIV/AIDS during the last year

E. Meets one of the criteria below:

   1. Current Board Certification or Recertification in Infectious Diseases, or

   2. Annual completion of at least ten hours of HIV/AIDS-related Continuing Medical Education (CME), which meet the CME requirements under A.A.C. R4-16-101.

Limitations

A physician or practitioner not meeting the criteria to be a qualified HIV/AIDS treatment professional who wishes to provide primary care services to a member with HIV/AIDS must send documentation to the Division or AdSS demonstrating that s/he has an established consultative relationship with a physician who meets the criteria for a qualified HIV/AIDS treatment professional as identified in this policy.

This documentation must be maintained in the Division and AdSS' credentialing file. These practitioners may treat members with HIV/AIDS under the following circumstances:

A. In geographic areas where the incidence of members with HIV/AIDS is low, and/or where there are no available AHCCCS-registered network HIV/AIDS treatment professionals meeting this criteria, or

B. When a member with HIV/AIDS chooses a provider who does not meet the criteria.

Contract Network

The Division and the AdSS must include in its individual provider network sufficient numbers of qualified HIV/AIDS treatment professionals (physicians, nurse practitioners and/or physician assistants). The AdSS must also have policies and procedures to assure that provider requirements and standards specified in the Division Policy Manuals and the AMPM are met. Each provider network of HIV/AIDS treatment professionals is subject to review and approval by AHCCCS, Division of Health Care Management (DHCM). The AdSS must submit, annually by December 15, a list of HIV/AIDS treatment providers (to the Division Health Care Services Unit, through the Compliance Unit) that includes:

A. Name and location of all qualified HIV/AIDS treatment professionals treating members with HIV/AIDS

B. For each Primary Care Provider (PCP) treating members with HIV/AIDS who is not a qualified HIV/AIDS treatment specialist, the name and location of the consulting HIV/AIDS treatment professional.

The AdSS must also notify the Division of any material change to the HIV/AIDS provider network during the year. The Division will notify AHCCCS of any major changes.

AdSS policies must reflect that members with HIV/AIDS have freedom of choice to select an HIV/AIDS provider from the AdSS's network. If the member selects a PCP in the AdSS's network who is not a provider designated by the AdSS as a qualified HIV/AIDS disease treatment professional, the member must be informed that only those designated providers are authorized to render treatment regimens such as antiretroviral therapies. The selected PCP must consult with a qualified HIV/AIDS provider and follow the recommendations of the consultant in order for the treatment regimen (such as protease inhibitors) to be a covered service.

320-G LUNG VOLUME REDUCTION SURGERY

REVISION DATE: 10/01/2021

EFFECTIVE DATE: March 3, 2017

The Division of Developmental Disabilities (Division) covers Lung Volume Reduction Surgery (LVRS), or reduction pneumoplasty, for members eligible for ALTCS with severe emphysema. This surgery must be performed at a facility approved by Medicare in accordance with all of the established Medicare guidelines.

The member's treating physician is responsible for providing appropriate documentation, establishing medical necessity, and verification of compliance with Medicare, Division of Developmental Disabilities (Division), and AHCCCS guidelines. When requesting authorization, the documentation must be sent to the Division's Administrative Services Subcontractor (AdSS) Medical Director or to the Division's Medical Director for Division's DDD Tribal Health Program (THP) (Fee-For-Service) members.

When possible, such surgeries, and the required pre- and post-operative therapies, will be performed at facilities approved by Medicare for LVRS reimbursement within the State of Arizona. However, this procedure may be covered at out-of-state facilities, if needed. All facilities must meet Medicare LVRS facility requirements as well as AHCCCS Provider Registration requirements.

If medically necessary, the Division or AdSS may pay for an adult caregiver to accompany members when out-of-state-travel is required. Transportation, lodging, and board may be covered as appropriate.

Medicare Criteria

The Centers for Medicare and Medicaid Services (CMS) has issued a National Coverage Decision (NCD) for LVRS specifying covered and non-covered criteria. Medicare established guidelines are followed for this procedure according to the NCD effective 11/17/2005. NCD for LVRS is contained in Exhibit 320-1, as adopted by the Division for use, and found in the AHCCCS Medical Policy Manual.

320-I TELEHEALTH AND TELEMEDICINE

REVISION DATE: 12/21/2022, 10/17/2017
EFFECTIVE DATE: May 13, 2016
REFERENCES: 42 U.S.C. 1396d, A.R.S. § 36-3602, A.R.S. § 36-3605, A.R.S. § 36-3606, A.R.S. § 36-3607, AMPM 310-P, AMPM Policy 431, AMPM 670, AMPM 820, ACOM 436.

PURPOSE

This policy describes covered Telehealth and Telemedicine services for Division of Developmental Disability (DDD) members who are eligible for Arizona Long Term Care System (ALTCS).

DEFINITIONS

1. "Asynchronous" means the transfer of data from one site to another through the use of a camera or similar device that records an image that is sent via Telecommunication to another site for consultation. Asynchronous applications would not be considered Telemedicine but may be utilized to deliver services. Asynchronous services are rendered after the initial collection of data from the member and are provided without real-time interaction with the member.

2. "Consulting Provider" means any Arizona Health Care Cost Containment System (AHCCCS)-registered provider who is not located at the Originating Site who provides an expert opinion to assist in the diagnosis or treatment of a member.

3. "Distant Site" means the site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via Telecommunications system.

4. "Originating Site" means the location of the patient at the time the service being furnished via a Telecommunications system occurs. Telepresenters may be needed to facilitate the delivery of this service. The Place of Service (POS) on the service claim is the Originating Site.

5. "Synchronous" means the "real time" two-way interaction between the member and provider, using interactive audio and video.

6. "Telecommunications Technology" (which includes Asynchronous applications) means the transfer of medical data from one site to

another through the use of a camera, electronic data collection system such as an Electrocardiogram (ECG), or other similar device, that records an image which is then sent via Telecommunication to another site for consultation. Services delivered using Telecommunications Technology, but not requiring the member to be present during their implementation, are not considered Telemedicine.

7. "Teledentistry" means the acquisition and transmission of all necessary subjective and objective diagnostic data through interactive audio, video or data communications by a AHCCCS-registered dental provider to a distant dentist for triage, dental treatment planning, and referral.

8. "Telehealth" means the use of Telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distances.

9. "Telemedicine" means the practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data between the Originating and Distant Sites through real time interactive audio, video or data communications that occur in the physical presence of the member.

POLICY

A. TELEHEALTH

1. The Division shall cover medically necessary, non-experimental, and cost-effective services delivered via Telehealth for Division covered services.

2. The Division shall cover services delivered via Telehealth in rural and urban regions; there are no geographic restrictions for Telehealth.

3. The Division shall not limit or deny the coverage of services provided through Telehealth and shall apply the same limits or exclusions on a service provided through Telehealth that are applicable to an in-person encounter for the same service,

except for services for which the weight of evidence, determines the service not to be appropriate to be provided through Telehealth, based on:

a. Practice guidelines,

b. Peer-reviewed clinical publications or research, or

c. Recommendations by the telehealth advisory committee on Telehealth best practices.

4. The Division shall not permit services delivered via Telehealth to replace member or provider choice for healthcare delivery modality.

5. The Division shall ensure a provider makes a good faith effort in determining both of the following:

   a. Whether a service should be provided through Telehealth instead of in-person. The provider shall use clinical judgment in considering whether the nature of the services necessitates physical interventions and close observation and the circumstances of the member, including:

i. Diagnosis,

ii. Symptoms,

iii. History,

iv. Age,

v. Physical location, and

vi. Access to Telehealth.

b. The communication medium of Telehealth and whenever reasonably practicable, the Telehealth communication medium that allows the provider to most effectively assess, diagnose and treat the member. Factors the provider may consider in determining the communication medium include:

i. The member's lack of access to or inability to use technology, or

ii. Limits in Telecommunication infrastructure necessary to support interactive Telehealth encounters.

6. The Division may allow a provider who is not licensed within the State of Arizona to provide Telehealth services to a member located in the state if the following conditions are met:
   a. The provider is an AHCCCS-registered provider, and
   b. The provider complies with all requirements listed within A.R.S. § 36-3606.

B. TELEMEDICINE SERVICES

1. The Division shall cover Telemedicine services, including health care delivery, diagnosis, consultation, treatment, and the transfer of medical data through real-time Synchronous interactive audio and video communications that occur in the physical presence of the member.

2. The Division shall reimburse providers at the same level of payment for equivalent services as identified by Healthcare Common Procedure Coding System (HCPCS) whether provided via Telemedicine or in-person.

C. ASYNCHRONOUS SERVICES

1. The Division shall provide reimbursement for consultation limited to clinically appropriate services that are provided without real-time interaction. Reimbursement is limited to the following services:
    a. Dermatology,
    b. Radiology,
    c. Ophthalmology,
    d. Pathology,
    e. Neurology,
    f. Cardiology,
    g. Behavioral Health,
    h. Infectious Diseases, or
    i. Allergy/Immunology.

D. E-CONSULT SERVICES

1. The Division shall cover medically necessary e-consult visits, to aid in the coordination of care between a Primary Care Provider

(PCP) and a specialist, and to improve timely access to specialty providers.

E. REMOTE PATIENT MONITORING SERVICES

1. The Division shall cover both Synchronous and Asynchronous remote patient monitoring.
2. The Division shall limit coverage of equipment and/or supplies for remote patient monitoring to when:
   a. The service being provided is an Division covered service eligible for remote monitoring, and
   b. The equipment and/or supplies are Division covered items.

F. AUDIO-ONLY SERVICES

1. The Division shall cover audio-only services if a Telemedicine encounter is not reasonably available due to the member's functional status, the member's lack of technology or Telecommunications infrastructure limits, as determined by the provider.
2. The Division shall reimburse providers at the same level of payment for equivalent in-person mental health and substance

use disorder services, as identified by HCPCS, if provided through Telehealth using an audio-only format.

G. TELEDENTISTRY SERVICES

1. The Division shall cover Teledentistry for members eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) when provided by an AHCCCS-registered dental provider.

2. The Division shall cover Teledentistry including the provision of preventative and other approved therapeutic services by the AHCCCS-registered Affiliated Practice Dental Hygienist, who provides dental hygiene services under an affiliated practice relationship with a dentist.

3. The Division shall not use Teledentistry to replace the dental examination by the dentist. Limited exams may be billed through the use of Teledentistry. Periodic and comprehensive examinations cannot be billed through the use of Teledentistry alone.

H. CONDITIONS AND LIMITATIONS

1. The Division shall ensure all Telehealth reimbursable services are provided by an AHCCCS-registered provider within their scope of practice.

2. The Division shall cover Non-Emergency Transportation (NEMT) to and from the Originating Site where applicable.

3. The Division shall ensure services provided through Telehealth or resulting from a Telehealth encounter are subject to all applicable statutes and rules that govern prescribing, dispensing and administering prescription medications and devices.

4. The Division shall ensure informed consent standards for Telehealth services adhere to all applicable statutes and policies governing informed consent.

5. The Division shall ensure privacy and confidentiality standards for Telehealth services adhere to all applicable statutes and policies governing healthcare services, including the Health Insurance Portability and Accountability Act (HIPAA).

6. The Division shall not place Place Of Service (POS) restrictions for a Distant Site.

7. The Division may qualify Telehealth as a Federally Qualified Healthcare Center/Rural Health Clinic (FQHC/RHC) visit, if all other applicable conditions in this Policy are met.

I. SUPPLEMENTAL INFORMATION

1. The AHCCCS Telehealth code set defines which codes are billable, the applicable modifier(s) and place of service that providers must use when billing for the following services when provided through remote patient monitoring:
   a. Telemedicine services,
   b. Asynchronous services,
   c. E-consult services,
   d. Remote patient monitoring services, and
   e. Audio-only services.

2. Telehealth includes such technologies as telephones, facsimile machines, electronic mail systems, and remote patient

monitoring devices, which are used to collect and transmit patient data for monitoring and interpretation. While they do not meet the Medicaid definition of Telemedicine, they are often considered under the broad umbrella of Telehealth services. Even though such technologies are not considered Telemedicine, they may nevertheless be covered and reimbursed as part of a Medicaid coverable service, such as laboratory service, x-ray service or physician services.

Signature of Chief Medical Officer: Anthony Dekker (Dec 19, 2022 08:06 MST)
Anthony Dekker, D.O.

320-K TOBACCO CESSATION PRODUCT POLICY

EFFECTIVE DATE: March 3, 2017

REFERENCES: AHCCCS Medical Policy Manual Exhibit 320-K-1

The Division of Developmental Disabilities (Division) covers tobacco cessation products, ordered by a Primary Care Provider (PCP), which include Nicotine Replacement Therapy (NRT) and tobacco use medications, for members who are eligible for the ALTCS who wish to stop using tobacco. The Division encourages members to enroll in a tobacco cessation program offered by the Arizona Department of Health Services (ADHS).

The following criteria apply to members choosing to receive a tobacco cessation product.

A. Members 18 years and older are encouraged to enroll in a tobacco cessation program through ADHS. To enroll in an ADHS cessation program the member must call 1-800-556-6222.

B. Members must contact their Primary Care Provider (PCP) for a prescription for a tobacco cessation product. The PCP will identify an appropriate tobacco cessation product. This includes all tobacco cessation products, including those that are available over-the-counter.

C. The maximum supply a member may receive of a tobacco cessation product is a 12-week supply in a six-month time period. The six-month period begins on the date the pharmacy fills the first tobacco cessation product.

D. The Division has adopted the prior authorization protocol described in AHCCCS Medical Policy Manual Exhibit 320-K-1, which must be followed by the Administrative Services Subcontractors.

320-M MEDICAL MARIJUANA AND CBD OIL PRODUCTS

REVISION DATES: 7/13/2022, 1/15/2020, 04/17/2015
EFFECTIVE DATE: March 2, 2015
REFERENCES: 9 A.A.C. 22, Article 2, 42 CFR 440.120, AMPM 320-M Medical Marijuana

PURPOSE

This policy applies to members who receive services from the Division and vendors and subcontractors who provide services to Division members. This policy establishes requirements for the coverage and use of medical marijuana and all cannabidiol (CBD) products (regardless of plant derivation).

DEFINITIONS

1. "AHCCCS Registered Provider" means a contracted provider or non-contracting provider who enters into a provider agreement with AHCCCS and meets licensing or certification requirements to provide AHCCCS-covered services.
2. "Medical Marijuana" means products that are a cannabis product requiring a medical marijuana card and are sold in a Marijuana Dispensary or a CBD Oil store.

POLICY

A. Medical Marijuana and CBD Products

The Division covers medically necessary federally and state reimbursable medications prescribed by a physician, physician assistant, nurse practitioner, dentist or other AHCCCS approved practitioner and dispensed by a licensed AHCCCS registered pharmacy, as defined in 9 A.A.C. 22, Article 2. Under 42 CFR 440.120 Medical Marijuana or CBD Oil products do not qualify as federally reimbursable medications. The Division does not cover medical marijuana or CBD Oil. The Division will not provide reimbursement for an office visit, these products or any other services that are primarily for the purpose of determining if a member would benefit from medical marijuana. The Division recognizes that AHCCCS registered providers operating within the scope of their license may recommend the use of medical marijuana or CBD Oil although it is not a covered benefit.

Under no circumstance shall any employee of the Department and any owner, director, principal, agent, employee, subcontractor, volunteer, and staff of the Division's service providers administer or

store medical marijuana or CBD Oil products (regardless of the plant) for Division members. Examples of medical marijuana products would include marijuana plants, pre-rolled marijuana cigarettes, marijuana edibles, marijuana vaping products etc.

B. FDA Approved Cannabidiol Products

This policy does not apply to the prescribing or administering of FDA approved medications that may include cannabidiol or its components. Under Federal Law, there are currently prescription medications commercially available that contain cannabidiol ingredients. Medications such as Epidiolex™ (cannabidiol) and Marinol™ (dronabinol), are allowed because they are FDA approved products requiring a prescription and dispensed by an AHCCCS registered pharmacy.

Signature of Chief Medical Officer: Anthony Dekker (Jul 6, 2022 12:06 PDT)
Anthony Dekker, D.O.

320-O BEHAVIORAL HEALTH ASSESSMENTS AND TREATMENT/SERVICE PLANNING

REVISION DATE: 10/01/2021
EFFECTIVE DATE: March 3, 2021
REFERENCES: A.R.S. § 32-2061, A.R.S. § 32-2091, A.R.S. § 32-3251 et seq., A.R.S. § 36-501; A.A.C. R4-6-101, A.A.C. R9-10, A.A.C R9-21

PURPOSE

The Division covers behavioral health assessments and treatment/service planning for members eligible for ALTCS regardless of the health plan they choose. The responsibilities of the Division for providing behavioral health assessments and treatment/service planning to members are outlined in this policy including additional requirements for members that have chosen THP as their Health Plan. The Division is responsible for collaborating with Tribal entities and behavioral health providers to ensure access to services for THP members. See AdSS Policy 320-O for responsibilities of the AdSS providing behavioral health assessments and treatment/service planning.

DEFINITIONS

Behavioral Health Assessment is the ongoing collection and analysis of an individual's medical, psychological, psychiatric and social conditions in order to initially determine if a health disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensure that the individual's service plan is designed to meet the individual's (and family's) current needs and long-term goals.

Behavioral Health Professional (BHP)

1. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:
    a. Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251, or
    b. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S.§32-3251 under direct supervision as defined in A.A.C. R4-6-101,
2. A psychiatrist as defined in A.R.S. §36-501,
3. A psychologist as defined in A.R.S. §32-2061,
4. A physician,
5. A behavior analyst as defined in A.R.S. §32-2091,
6. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or
7. A registered nurse with:

a. A psychiatric-mental health nursing certification, or

b. One year of experience providing behavioral health services.

Behavioral Health Technician (BHT) as specified in A.A.C. R9-10-101, an individual who is not a BHP who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:

1. If the behavioral health services were provided in a setting other than a licensed health care institution, would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33, and

2. Are provided with clinical oversight by a behavioral health professional.

DESIGNATED REPRESENTATIVE for purposes of this Policy, an individual chosen by a member who carries a serious mental illness designation and has been identified by AHCCCS Special Assistance. The Designated Representative protects the interests of the member during service planning, inpatient treatment discharge planning, and the SMI grievance, investigation or appeal process.

Health Care Decision Maker is an individual who is authorized to make health care treatment decisions for the patient. As applicable to the situation, this may include a parent of an un-emancipated minor or a person lawfully authorized to make health care treatment decisions pursuant to A.R.S. title 14, chapter 5, article 2 or 3; or A.R.S. §§ 8-514.05, 36-3221, 36-3231 or 36-3281.

Health Home is a provider that either provides or coordinates and monitors the provision of all primary, physical health, behavioral health services and supports to treat the whole person. A Health Home can be an Outpatient Behavioral Health Clinic, a Federally Qualified Health Center, or an Integrated Care Provider. Members may or may not be formally assigned to a Health Home.

Service Plan is a complete written description of all covered health services and other informal supports which includes individualized goals, peer and recovery support, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life.

Treatment Plan is a written plan of services and therapeutic interventions based on a complete assessment of a member's developmental and health status, strengths and needs that are designed and periodically updated by the multispecialty, interdisciplinary team.

Requirements for Behavioral Health Providers

A. Overview

1. The model for behavioral health assessment, treatment/service planning and service delivery shall be strength-based, member-centered, family-friendly, based on voice and choice, culturally and linguistically appropriate, and clinically supervised.

2. The model incorporates the concept of a "team," established for each member receiving behavioral health services.

3. The model is based on four equally important components:

   a. Input from the member, or when applicable the health care decision maker and designated representative regarding the member's needs, strengths, and preferences;

   b. Input from other individuals involved in the member's care who have important relationships with the member;

   c. Development of a therapeutic alliance between the member, or when applicable the health care decision maker and the designated representative, and behavioral health provider that promotes an ongoing partnership built on mutual respect and equality; and

   d. Clinical expertise/qualifications of individuals conducting the assessment, treatment/service planning, and service delivery.

2. For children, this team is the Child and Family Team (CFT). For adults, this team is the Adult Recovery Team (ART). At a minimum, the functions of the CFT and ART include:

   a. Ongoing engagement of the member, or when applicable the health care decision maker, and the designated representative, family, assigned Support Coordinator, and others who are significant in meeting the behavioral health needs of the member, including their active participation in the decision-making process and involvement in treatment. The member's Support Coordinator must participate in all CFT and ART meetings.

   b. An assessment process that is conducted to:

      i. Elicit information on the strengths and needs of the member and his/her family,

      ii. Identify the need for further or specialty evaluations, and

      iii. Support the development and updating of the treatment/service plan which effectively meets the member and family needs and results in improved health outcomes.

   c. Continuous evaluation of treatment effectiveness through the CFT or ART process, the ongoing assessment of the member, and input from the member, or when applicable the health care decision maker, and the designated representative, and Support Coordinator, resulting in modification to the treatment plan, as necessary.

d. Provision of all covered services as identified on the treatment/ service plan(s), including assistance in accessing community resources as appropriate.

e. For children, services are provided consistent with the Arizona Vision - 12 Principles as specified in the AMPM Policy 100 and the AHCCCS Child and Family Team Behavioral Health System Practice Tool. For adults, services are provided consistent with the Adult Service Delivery System - 9 Guiding Principles.

f. Ongoing collaboration with other people and/or entities with whom delivery and coordination of services is important to achieving positive outcomes (e.g., primary care providers, specialty service providers, school, child welfare, AdSS, justice system and others). This shall include sharing of clinical information as appropriate.

g. Ensure continuity of care by assisting members who are transitioning to a different treatment program, changing behavioral health providers, and/or transferring to another service delivery system (e.g., out of state). For more details see AdSS Operations Policy 402 and Division Medical Policy 520.

3. At least one Peer Recovery Support Specialist may be assigned to each ART to provide covered services, when appropriate, and provide access to peer support services for individuals with Substance Use Disorders, including Opioid Use Disorders, for purposes of navigating members to Medication Assisted Treatment (MAT) and increasing participation and retention in MAT treatment and recovery supports.

4. The Division requires subcontractors and subcontractor providers to make available and offer the option of having a Family Support Specialist for each CFT, to provide covered services when appropriate.

B. <u>Assessment and Service Planning</u>

Regardless of the Health Plan, including the Division's THP, the member is enrolled with the following requirements must be met. For members enrolled in THP, the Division's Support Coordinator is responsible for coordinating care between the physical health provider and behavioral health provider including Tribal Behavioral Health Authorities (TRBHA). Support Coordinators can request the Behavioral Health Administration and Health Care Services to assist in care coordination activities for THP members.

1. General Requirements for behavioral health assessments and treatment/service planning shall comply with the Rules in A.A.C. R9-10 and A.A.C. R9-21, as applicable. AMPM 320-O, Attachment A, shall be utilized by the member, or when applicable the health care decision maker, and the designated representative to indicate agreement or disagreement with Service Plan and awareness of rights to appeal

process if not in agreement with Service Plan.

2. Assessments, Service and Treatment Plans shall be completed by BHPs or BHTs under the clinical oversight of a BHP.

3. Behavioral health providers outside of the Health Home may complete assessment, service and treatment planning to support timely access to medically necessary behavioral health services as allowed under licensure. (A.A.C. R9, et. seq.)

    a. Should a specialty provider complete any type of behavioral health assessment, the specialty provider shall communicate with the Health Home regarding assessment findings. In situations where a specific assessment is duplicated and findings are discrepant, specialty provider and Health Home BHP or BHT shall discuss the differences and clinical implications for treatment needs. Differences shall be addressed within the CFT with participation from both the Health Home and Specialty Provider,

    b. Behavioral health providers shall supply completed Assessment and Service and Treatment Plan documentation to the Health Home for inclusion in the member's medical record,

    c. The assessment and service planning shall be implemented to align, as much as possible, with the Division's assessment and service planning, and

    d. For those Division members that have also been determined SMI, service planning and treatment shall be implemented to align with all requirements for SMI members under Division, AHCCCS and State of Arizona policy and rules including Division Medical Policies 310-B, 320-P, 320-Q and 320-R; Division Operational Policies 444 and 446.

4. If the assessment is completed by the BHT, the requirements of A.A.C. R9-10-1011(B)(3) shall be met.

5. At a minimum, the member, or when applicable the health care decision maker, and the designated representative, and a BHP, shall be included in the assessment process and development of the treatment/service Plan.

6. The assessment and treatment/service plan must be included in the clinical record in accordance with Division Medical Policy 940.

7. The treatment/service plan shall be based on the current assessment and identify the specific services and supports to be provided, as specified in Division Medical Policy 310-B. The Treatment Plan shall be developed based on specific treatment needs (e.g., out-of-home services, specialized behavioral health

therapeutic treatment for substance use or other specific treatment needs). Services within the Treatment/Service Plan are based on the range of services covered under AHCCCS policies.

8. The behavioral health provider shall document whether the member, or when applicable the health care decision maker, and the designated representative agrees with the treatment/service plan by either a written or electronic signature on the Service or Treatment Plan.

9. The member, or when applicable the health care decision maker, and the designated representative shall be provided with a copy of his/her service plan within seven calendar days of completion of the service plan and/or upon request.

10. SMI determination shall be completed for members who request an SMI determination in accordance with Division Medical Policy 320-P.

11. For members determined SMI:

    a. Assessment and treatment/service planning shall be conducted in accordance with A.A.C. R9-21-301 et seq. and A.A.C. R9-21-401 et seq.

    b. Special Assistance assessment shall be completed in accordance with Division Medical Policy 320-R.

    c. The completed treatment/service plan must be signed by the member, or when applicable the health care decision maker and the designated representative, in accordance with A.A.C. R9-21-308.

    d. For appeal requirements see A.A.C. R9-21-401 et seq. and Division Operations Policy 444.

12. The Health Home is responsible for maintaining the comprehensive assessment and conducting periodic assessment updates to meet the changing behavioral health needs for members who continue to receive behavioral health services.

13. Behavioral Health Assessments, Treatment and Service Plans shall be updated at a minimum of once annually, or more often as needed, based on clinical necessity and/or upon significant life events including but not limited to:

    a. Moving,

    b. Death of a friend or family member,

    c. Change in family structure (e.g., divorce, incarceration),

    d. Hospitalization,

e. Major illness of member or family member,

f. Incarceration, and

g. Any event which may cause a disruption of normal life activities.

14. The Health Home is responsible for maintaining the treatment/service plan and conducting periodic treatment/service plan updates to meet the changing behavioral health needs for members who continue to receive behavioral health services.

15. The Health Home shall coordinate with any entity involved in the member's Behavioral Health Assessment and Treatment and Service Planning care. (Refer to Division Medical Policy 541)

16. Special Circumstances:

a. Children Age 6 through 17 - An age-appropriate assessment shall be completed by the Health Home during the initial assessment and updated at least every six months, and this information shall be provided to the TRBHA or Division,

b. Children Age 6 through 17 - Strength, Needs and Culture Discovery Document shall be completed, as deemed appropriate, by the Health Home, and this information shall be provided to the TRBHA or Division, and

c. Children Age 11 through 17 - Standardized substance use screen and referral for further evaluation when screened positive shall be completed by the Health Home, and this information shall be provided to the TRBHA or Division.

E. Crisis and Safety Planning

1. General Purpose of a Crisis and Safety Plan

A Crisis and Safety Plan provides a written method for potential crisis support or intervention which identifies needs and preferences that are most helpful in the event of a crisis. The Crisis and Safety Plan shall be developed in accordance with the Vision and Guiding Principles of the Children's System of Care and the Nine Guiding Principles of the Adult System of Care as specified in AMPM Policy 100. Crisis and Safety plans shall be trauma informed with a focus on safety and harm reduction.

The development of a Crisis and Safety Plan shall be completed in alignment with the member's Service and Treatment Plan, and any existing Behavior Plan, if applicable. It shall be considered when clinically indicated. Clinical indicators may include, but are not limited, needs identified in members Treatment, Service, or Behavior Plan in addition to any one or a combination of the following:

a. Previous psychiatric hospitalizations,

b. Out-of-home placements,

c. HCBS settings,

d. Nursing facilities,

e. Group Home settings,

f. Special Health Care Needs,

g. Court-Ordered Treatment,

h. History of DTS/DTO,

i. Individuals with an SMI designation, and

j. Individuals identified as high risk/high needs.

Crisis and Safety Plans shall be updated annually, or more frequently if a member meets one or a combination of the above criteria, or if there is a significant change in the member's needs. A copy of the Crisis and Safety Plan shall be distributed to the team members that assisted with development of the Crisis and Safety Plan.

A Crisis and Safety Plan does not replace or supplant a Mental Health Power of Attorney or behavior plan, but rather serves as a compliment to these existing documents.

2. Essential Elements

A Crisis and Safety Plan shall establish goals to prevent or ameliorate the effects of a crisis and shall specifically address:

a. Techniques for establishing safety, as identified by the member and/or healthcare decision maker, as well as members of the CFT or ART,

b. Identification of realistic interventions that are most helpful or not helpful to the individual and his/her family members or support system,

c. Reduction of symptoms,

d. Guiding the support system toward ways to be most helpful,

e. Any physical limitations, comorbid conditions, or unique needs of the member (e.g., involvement with DCS or Special Assistance),

f. Adherence to Court-Ordered Treatment (if applicable),

g. Necessary resources to reduce the chance for a crisis or minimize the effects of an active crisis for the member. This may include but is not limited to:

i. Clinical (support staff/professionals), medication, family, friends, parent, guardian, environmental,

ii. Notification to and/or coordination with others, and

iii. Assistance with and/or management of concerns outside of crisis (e.g., animal care, children, family members, roommates, housing, financials, medical needs, school, work).

F. AdSS Oversight

The Division completes an annual Operational Review of each AdSS. Compliance with this policy and associated procedures may be reviewed during the Annual Operational Review. Each AdSS is expected to comply with requirements described in the associated AdSS Policy 320-O, Behavioral Health Assessments and Treatment/Service Planning

320-P SERIOUS EMOTIONAL DISTURBANCE AND SERIOUS MENTAL ILLNESS ELIGIBILITY DETERMINATIONS

REVISION DATE: 2/7/2024
REVIEW DATE: 9/19/2023
EFFECTIVE DATE: July 14, 2021
REFERENCES: A.R.S. 36-550, A.A.C. R9-21-101(B), AMPM Policy 320-P

PURPOSE

This policy applies to the Division of Developmental Disabilities (Division) and establishes requirements for eligibility determinations for individuals with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI).

Further, this policy describes requirements for Division oversight and monitoring of duties delegated to Administrative Services Subcontractors (AdSS) as specified in contract and AdSS Medical Policy 320-P.

DEFINITIONS

1. "Business Day" means a Monday, Tuesday, Wednesday, Thursday or Friday, excluding State and Federal Holidays.

2. "Determining Entity" means an entity designated by Arizona Health Care Cost Containment System (AHCCCS) and authorized to make SED and SMI eligibility determinations, or a Tribal Regional Behavioral

Health Authority (TRBHA) authorized to make the final determination of SED or SMI eligibility.

3. "Designated Representative" means an individual parent, guardian, relative, advocate, friend, or other individual, designated orally or in writing by a Member or Responsible Person who, upon the request of the Member, assists the Member in protecting the Member's rights and voicing the Member's service needs.

4. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

5. "Removal of Serious Emotional Disturbance Designation" means the process that results in the removal of the SED behavioral health category from the individual's most recent, active enrollment segment.

6. "Removal of Serious Mental Illness Designation" means the process that results in a modification to a Member's medical record by changing the behavioral health category designation from SMI to General Mental Health.

7. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been

appointed.

8. "Serious Emotional Disturbance" means a designation for individuals from birth up to age 18 who currently or at any time during the past year have had a diagnosable mental or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current version of the Diagnostic and Statistical Manual of Mental Disorders that resulted in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

9. "Serious Mental Illness" means a designation as defined in A.R.S. § 36-550 and determined in an individual 18 years of age or older.

10. "Serious Emotional Disturbance or Serious Mental Illness Eligibility Determination" means a process used to determine whether an individual meets the diagnostic and functional criteria established for the purpose of determining an individual's eligibility for SED or SMI services.

POLICY

A. GENERAL REQUIREMENTS

1. The Division shall ensure all Members from birth to 18 years of age are evaluated for SED eligibility by a qualified clinician and have an SED eligibility determination made by the Determining Entity if the Responsible Person or Designated Representative makes such a request.

2. The Division shall ensure all Members age 17.5 or older are evaluated for SMI eligibility by a qualified clinician, as defined in A.A.C. R9-21-101(B), and have an SMI eligibility determination made by the Determining Entity if:
   a. The Member or Designated Representative makes the request,
   b. An Arizona Court issues an order instructing a Member to undergo an SMI Evaluation,
   c. It is clinically indicated by the presence of a qualifying diagnosis, or
   d. There is reason to believe that the assessment may indicate the presence of a qualifying diagnosis and functional limitation(s), and
   e. The actual SMI eligibility category will not become effective until a member turns 18 years of age.

3. The Division shall require the SED and SMI eligibility evaluation records contain all documentation considered during the review, including current and historical treatment records, and may be maintained in either hardcopy or electronic format.

4. The Division shall provide assistance and guidance on SED and SMI eligibility evaluation record location and maintenance, if needed.

5. The Division shall use computation of time during the SED and SMI determination process as follows:
    a. Day zero: The day the initial assessment is completed by a qualified clinician, regardless of time of the assessment.
    b. Day one: The next business day after the initial assessment is completed. The individual or organization completing the initial assessment must provide it to the Determining Entity as soon as practicable, but no later than 11:59 pm on day one.
    c. Day three: The third business day after the initial assessment is completed. The Determining Entity shall have at least two business days to complete the final SMI determination, but the final SMI determination must be

completed no later than day three.

d. Determination due date: Day three, three business days after day zero, excluding weekends and holidays, and is the date that the determination decision must be rendered. This date may be amended if an extension is approved in accordance with this policy.

B. PROCESS FOR COMPLETION OF THE INITIAL SED OR SMI ASSESSMENT

1. The Division shall require behavioral health providers, upon receipt of a request, referral, or identification of the need for an SED or SMI determination, to schedule an assessment with the Member and a qualified clinician if one has not been completed within the past six months.
   a. Assessments are to be scheduled as expeditiously as the Member's health condition requires, but no later than seven business days after receipt of the request or referral.
   b. For urgent eligibility determination referrals for Members admitted to a hospital for psychiatric reasons, the Determining Entity is able to accept an assessment completed by the hospital if it meets the criteria needed to

render a decision.

2. During the assessment meeting with the Member, the qualified clinician shall:

   a. Make a clinical judgment as to whether the Member is competent to participate in an evaluation;

   b. Obtain written consent to conduct the assessment from the Member, or if applicable the Member's Responsible Person, unless the Member has been ordered to undergo evaluation as part of court-ordered treatment proceedings;

   c. Provide to the Member, and if applicable the Member's Responsible Person, the information required in A.A.C. R9-21 301(D)(2), a Member rights brochure, and the Member's notice of right to appeal required by A.A.C. R9-21- 401(B);

   d. Obtain authorization for the release of information, if applicable, for any documentation that would assist in the determination of the Member's eligibility for SED or SMI designation;

   e. Conduct an assessment that is an accurate representation of the Member's current level of functioning if one has not

been completed within the past six months;

f. Complete the SED or SMI determination packet on the AHCCCS SMI Provider Submission Portal; and

g. Upon completion, submit all information to the Determining Entity within one business day.

C. CRITERIA FOR SED ELIGIBILITY

1. The Division shall require the final determination of SED to include both a qualifying SED diagnosis and functional impairment because of the qualifying diagnosis.

2. The Division shall refer to the Medical Coding Page on the AHCCCS website for a list of qualifying diagnoses.

3. To meet the functional criteria for SED status, the Division shall require, as a result of a qualifying diagnosis, dysfunction in at least one of the following four domains for most of the past six months or for most of the past three months with an expected continued duration of at least three months:

   a. Seriously disruptive to family or community:

      i. Pervasively or imminently dangerous to self or others' bodily safety;

ii. Regularly engages in assaultive behavior;

iii. Has been arrested, incarcerated, hospitalized or is at risk of confinement because of dangerous behavior;

iv. Persistently neglectful or abusive towards others;

v. Severe disruption of daily life due to frequent thoughts of death, suicide, or self-harm, often with behavioral intent or plan; or

vi. Affective disruption causes significant damage to the Member's education or personal relationships

b. Dysfunction in role performance:

i. Frequently disruptive or in trouble at home or at school;

ii. Frequently suspended or expelled from school;

iii. Major disruption of role functioning;

iv. Requires structured or supervised school setting;

v. Performance significantly below expectation for cognitive or developmental level; or

vi. Unable to attend school or meet other developmentally appropriate responsibilities.

c. Child and Adolescent Level of Care Utilization System

(CALOCUS) recommended level of care 4, 5, or 6.

d. Risk of deterioration:

i. A qualifying diagnosis with probable chronic, relapsing, and remitting course;

ii. Comorbidities including developmental or intellectual disability, substance use disorder, or personality disorders;

iii. Persistent or chronic factors, such as social isolation, poverty, extreme chronic stressors; or

iv. Other, such as past psychiatric history, gains in functioning have not solidified or are a result of current compliance only, court-committed, care is complicated and requires multiple providers.

4. The Division shall not allow the following reasons alone to be sufficient for denial of SED eligibility:

a. An inability to obtain existing records or information; or

b. Lack of a face-to-face psychiatric or psychological evaluation.

D. CRITERIA FOR SMI ELIGIBILITY

1. The Division shall require the final determination of SMI to include a qualifying SMI diagnosis and functional impairment because of the qualifying diagnosis.

2. The Division shall refer to the Medical Coding Page on the AHCCCS website for a list of qualifying diagnoses.

3. To meet the functional criteria for SMI status, the Division shall require, as a result of a qualifying SMI diagnosis, dysfunction in at least one of the following four domains for most of the past 12 months or for most of the past six months with an expected continued duration of at least six months:
    a. Inability to live in an independent or family setting without supervision:
        i. Neglect or disruption of ability to attend to basic needs;
        ii. Needs assistance in caring for self;
        iii. Unable to care for self in a safe or sanitary manner;
        iv. Housing, food and clothing is provided or arranged for by others;
        v. Unable to attend to the majority of basic needs of hygiene, grooming, nutrition, medical and dental

care;

vi. Unwilling to seek prenatal care or necessary medical/dental care for serious medical or dental conditions;

vii. Refuses treatment for life threatening illnesses because of behavioral health disorder; or

viii. A risk of serious harm to self or others.

b. Seriously disruptive to family or community:

i. Pervasively or imminently dangerous to self or others' bodily safety;

ii. Regularly engages in assaultive behavior;

iii. Has been arrested, incarcerated, hospitalized or at risk of confinement because of dangerous behavior;

iv. Persistently neglectful or abusive towards others;

v. Severe disruption of daily life due to frequent thoughts of death, suicide, or self-harm, often with behavioral intent or plan; or

vi. Affective disruption causes significant damage to the Member's education, livelihood, career, or personal relationships.

c. Dysfunction in role performance:

i. Frequently disruptive or in trouble at work or at school;

ii. Frequently terminated from work or suspended/ expelled from school;

iii. Major disruption of role functioning;

iv. Requires structured or supervised work or school setting;

v. Performance significantly below expectation for cognitive/developmental level;

vi. Unable to work, attend school, or meet other developmentally appropriate responsibilities; or

d. Risk of deterioration:

i. A qualifying diagnosis with probable chronic, relapsing and remitting course;

ii. Comorbidities including developmental or intellectual disability, substance use disorder, personality disorders;

iii. Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors; or

iv. Other, such as past psychiatric history, gains in functioning have not solidified or are a result of current compliance only, court-committed, or care is complicated and requires multiple providers.

4. The Division shall not allow the following reasons alone to be sufficient for denial of SMI eligibility:
   a. An inability to obtain existing records or information; or
   b. Lack of a face-to-face psychiatric or psychological evaluation.

E. MEMBERS WITH CO-OCCURRING SUBSTANCE USE

1. The Division shall require the presumption of functional impairment as follows for Members with co-occurring substance use when assessing for SED or SMI eligibility:
   a. For psychotic diagnoses other than substance-induced psychosis (bipolar I disorder with psychotic features, delusional disorder, major depression, recurrent, severe, with psychotic features, schizophrenia, schizoaffective disorder, and any other diagnosis of persistent psychotic disorder) functional impairment is presumed to be due to

the qualifying mental health diagnosis.

b. For other qualifying psychiatric disorders, functional impairment is presumed to be due to the psychiatric diagnosis unless:

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

ii. The assessor can demonstrate, based on a historical or prospective period of treatment, that the functional impairment is present only when the Member is actively using substances or experiencing symptoms of withdrawal from substances; and

iii. To make such determinations, the assessor shall first look at a period of either 30 days or longer of abstinence, or 60 days or longer of reduced use that is less than the threshold expected to produce the resulting symptoms and disability, and establish that the symptoms and resulting disability were no longer present after the 30- or 60-day period and no longer

required mental health treatment to prevent recurrence of symptoms.

c. A diagnosis of substance-induced psychosis can only be made if both of the following conditions are present:

   i. There is no psychosis present before a period of substance use that is of sufficient type, duration, and intensity to cause psychotic symptoms; and

   ii. The psychosis remits completely (not partially) after a period of abstinence of 30 days or less.

d. Continuation of new onset psychotic symptoms after a 30-day period of abstinence requires a presumptive diagnosis of a persistent psychotic disorder.

e. For persistent psychosis of undetermined onset, the absence of clear remission of psychosis during a period of abstinence of 30 days or less should be considered presumptive evidence of a persistent psychotic disorder for SED or SMI eligibility purposes.

f. For Members who are not able to attain or maintain a period of abstinence from substance use, who continue to use substances or do not experience consecutive days of

abstinence, this is not a disqualifier to initiate the SED or SMI eligibility determination process.

g. For Members who do not meet the 30-day period of abstinence, this does not preclude them from the SED or SMI eligibility determination process.

F. ISSUES PREVENTING TIMELY COMPLETION OF ELIGIBILITY DETERMINATION AND EXTENSION OF TIME

1. The Division shall require the evaluating agency to respond to a Determining Entity's request for additional information to make a final SED of SMI eligibility determination within three business days of receipt of the request.

2. The Division shall allow an extension of no more than 20 calendar days to initiate or complete the SED or SMI eligibility determination if the individual agrees to the extension and:
   a. There is substantial difficulty scheduling a meeting in which all necessary participants can attend;
   b. The individual fails to keep an appointment for assessment, evaluation, or any other necessary meeting;
   c. The individual is capable of, but temporarily refuses to cooperate in the preparation of the completion of an

assessment or evaluation;

d. The individual, or if applicable the individual's Responsible Person, requests an extension of time;

e. Additional documentation has been requested but not received; or

f. There is insufficient functional or diagnostic information to determine SED or SMI eligibility within the required time periods.

3. The Division shall ensure that "insufficient diagnostic information" means that the information available to the reviewer is suggestive of two or more equally likely working diagnoses, only one of which qualifies as SED or SMI, and an additional piece of existing historical information or a face-to-face psychiatric evaluation is likely to support one diagnosis more than the other(s).

G. NOTIFICATION OF SED OR SMI ELIGIBILITY DETERMINATION

1. The Division Behavioral Health Administration shall review notifications of SED or SMI determination results received from the Determining Entity or AHCCCS Division of Fee-For-Service

Management (DFSM).

2. The Division Behavioral Health Administration shall notify the assigned Support Coordinator of the SED or SMI determination results.

3. The Division shall ensure the Member's record is updated to reflect the status of the Member's SED or SMI eligibility.

H. RE-ENROLLMENT OR TRANSFER

1. The Division shall require the following:
   a. If the Member's status is SED or SMI at disenrollment, while incarcerated, or transition to another Contractor, the Member's status shall continue as SED or SMI.
   b. A Member shall retain their SED or SMI status unless the Member's enrollment is active and a determination is made by a Determining Entity that the Member no longer meets criteria.
   c. The SMI determination process is initiated for adolescents as specified in Division Medical Policy 520.

I. REMOVAL OF SED OR SMI DESIGNATION

1. The Division shall ensure behavioral health providers are aware

of the following process for review of SED or SMI designations:

a. A review of the eligibility determination may not be requested within the first six months from the date the Member has been designated as SED or SMI eligible.

b. A behavioral health provider may request a review of a Member's SED or SMI designation from the Determining Entity:

   i. As part of an instituted, periodic review of all Members with an SED or SMI designation;

   ii. If there has been a clinical assessment that supports the Member no longer meets the functional or diagnostic criteria; or

   iii. As requested by the Member who has been determined to meet SED or SMI eligibility criteria, or their Responsible Person or Designated Representative.

c. Based on review of the request and clinical data provided, removal of the SED or SMI behavioral health category will occur if:

   i. The individual is an enrolled Member and has not

received any behavioral health service within the past six months, or

ii. The Member is determined to no longer meet the diagnostic and or functional requirements for SED or SMI designation.

d. In the event of the removal of the designation, the following shall occur:

i. The Determining Entity will inform the Member of changes that may result with the removal of the SED or SMI designation, and

ii. Provide written notice of the determination and the Member's right to appeal within 30 calendar days from the date the written notice is issued.

2. The Division shall ensure that services are continued in the event of a timely filed appeal and that services are appropriately transitioned.

J. DIVISION OVERSIGHT AND MONITORING OF ADMINISTRATIVE SERVICES SUBCONTRACTORS

1. The Division shall provide oversight and monitoring of compliance by Administrative Services Subcontractors serving

Members enrolled in a Division subcontracted health plan with respect to any contractual delegation of duties as specified in AdSS Medical Policy 320-P using the following methods:

a. Meet with the AdSS at least quarterly to provide ongoing evaluation, including data analysis, recommendations to refine processes, and address quality of care concerns.

b. Conduct an Operational Review of each AdSS on an annual basis that includes review of policy compliance.

c. Review data submitted by the AdSS demonstrating ongoing compliance monitoring of their network and provider agencies.

SUPPLEMENTAL INFORMATION

The information contained in Sections K through M of this policy are AHCCCS requirements for the Determining Entity authorized by AHCCCS to make the final SED and SMI designation determinations.

K. DETERMINING ENTITY RESPONSIBILITY FOR COMPLETION OF FINAL ELIGIBILITY DETERMINATION

1. A licensed psychiatrist, psychologist, or nurse practitioner designated by the Determining Entity shall make a final determination as to whether the Member meets the eligibility

requirements for SED or SMI status based on:

a. A face-to-face assessment or reviewing a face-to-face assessment by a qualified clinician; and

b. A review of current and historical information, if any, obtained orally or in writing by the assessor from collateral sources and/or present or previous treating clinicians.

2. The following shall occur if the designated reviewing psychiatrist, psychologist, or nurse practitioner has not conducted a face-to-face assessment and has a disagreement with the current evaluating or treating qualified behavioral health professional or behavioral health technician that cannot be resolved by oral or written communication:

a. Disagreement regarding diagnosis: Determination that the Member does not meet eligibility requirements for SMI status shall be based on a face-to-face diagnostic evaluation conducted by a designated psychiatrist, psychologist, or nurse practitioner. The resolution of (specific reasons for) the disagreement shall be documented in the Member’s comprehensive clinical record.

b. Disagreement regarding functional impairment:

Determination that the Member does not meet eligibility requirements shall be documented by the psychiatrist, psychologist, or nurse practitioner in the Member's comprehensive clinical record to include the specific reasons for the disagreement and will include a clinical review with the qualified clinician.

3. If there is sufficient information to determine SED or SMI eligibility, the Determining Entity shall provide the Member with notice, in writing, of the eligibility determination within three business days of the initial meeting with the qualified clinician.

4. The Determining Entity shall provide notification of the eligibility determination result to AHCCCS via the AHCCCS Behavioral Health Web Portal and to the provider who completed the Assessment/evaluation through an agreed upon medium. For Division THP members, the Determining Entity shall also provide notification to AHCCCS DFSM.

5. Once an SED or SMI eligibility determination decision is made and submitted to AHCCCS, AHCCCS will update the member's

behavioral health category to SED or SMI respectively and will provide the eligibility determination documentation to the MCO of enrollment, as applicable, via the AHCCCS Secured File Transfer Protocol (SFTP) server.

L. DETERMINING ENTITY RESPONSIBILITY DUE TO ISSUES PREVENTING TIMELY COMPLETION OF ELIGIBILITY DETERMINATION AND EXTENSION OF TIME

1. The Determining Entity shall:
    a. Document the reasons for the delay in the Member's eligibility determination record when there is an administrative or other emergency that will delay the determination of an SED or SMI status; and
    b. Not use the delay as a waiting period before determining an SED or SMI status or as a reason for determining that the Member does not meet the criteria for SED or SMI eligibility (because the determination was not made within the time standards).

2. In situations in which the extension is due to insufficient information:
    a. The Determining Entity shall request and obtain the

additional documentation needed (e.g., current and/or past medical records) and/or perform or obtain any necessary psychiatric or psychological evaluations;

b. The designated reviewing psychiatrist, psychologist, or nurse practitioner shall communicate with the Member's current treating clinician, if any, prior to the determination of an SED or SMI, if there is insufficient information to determine the Member's level of functioning; and

c. Eligibility shall be determined within three days of obtaining sufficient information, but no later than the end date of the extension.

3. If the evaluation or information cannot be obtained within the required time period because of the need for a period of observation or abstinence/reduction from substance use in order to establish a qualifying mental health diagnosis, the Member shall be notified by the Determining Entity that the determination may, with the agreement of the Member, be extended for up to 60 calendar days for an extended evaluation period. This is a 60-day period of abstinence, or reduced use from drug and/or alcohol use in order to help the reviewing

psychologist make an informed decision regarding SED or SMI eligibility.

4. This extension may be considered a technical re-application to ensure compliance with the intent of A.A.C. R9-21-303; however, the Member does not need to reapply. Alternatively, the determination process may be suspended and a new application initiated upon receipt of necessary information.

5. If the Member refuses to grant an extension, SED or SMI eligibility shall be determined based on the available information.

6. If SED or SMI eligibility is denied, the Member shall be notified of their appeal rights and the option to reapply in accordance with this policy.

M. DETERMINING ENTITY RESPONSIBILITY FOR NOTIFICATION OF SED OR SMI ELIGIBILITY DETERMINATION

1. If the Member is determined to qualify for an SED or SMI designation, this shall be reported to the Member, Responsible Person, or Designated Representative by the Determining Entity, in writing, including notice of the Member's right to appeal the decision on the form approved by AHCCCS.

2. If the eligibility determination results in a determination that the Member does not qualify for an SED or SMI designation, the Determining Entity shall provide written notice of the decision and include:
   a. The reason for denial of SED or SMI eligibility,
   b. The right to appeal, and
   c. The statement that Title XIX/XXI eligible Members will continue to receive needed Title XIX/XXI covered services. In such cases, the Member's behavioral health category assignment shall be assigned based on criteria in the AHCCCS Technical Interface Guidelines.

Signature of Chief Medical Officer: Anthony Dekker (Jan 30, 2024 14:17 MST)

Anthony Dekker, D.O.

320-S BEHAVIOR ANALYSIS SERVICES

EFFECTIVE DATE: March 17, 2021

PURPOSE

This policy applies to the Behavior Analysis Services delivered to Division members enrolled in ALTCS. The Division covers Behavior Analysis Services for members eligible for ALTCS regardless of the health plan they choose. The responsibilities of the Division for providing Behavior Analysis Services to members are outlined in this policy, including additional requirements for members that have chosen THP as their health plan. The Division is responsible for collaborating with Tribal entities and behavioral health providers to ensure access to services for THP members. See AdSS policy 320-S for responsibilities of the AdSS providing behavioral analysis services.

DEFINITIONS

Behavior Analysis Services - The use of behavior analysis to assist a person to learn new behavior, increase existing behavior, reduce existing behavior and emit behavior under precise environmental conditions in accordance with A.R.S. §32-2091.

Behavior Analysis Trainee - An individual who has met the credentialing requirements of a nationally recognized behavior analyst certification board as a board certified behavior analyst, assistant behavior analyst, or a matriculated graduate student or trainee whose activities are part of a defined behavior analysis program of study, practicum, intensive practicum, or supervised independent fieldwork. The practice under this role requires direct and ongoing supervision consistent with the standards set by a nationally recognized behavior analyst certification board as determined by the Arizona Board of Psychologist Examiners, and in accordance with A.R.S. §32-2091.08.

Behavior Analyst - A person who is licensed pursuant to A.R.S §32-2091 to practice behavior analysis.

Behavioral Health Professional (BHP)

1) An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:

   a) Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251, or

   b) Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S.§32-3251 under direct supervision as defined in A.A.C. R4-6-101,

2) A psychiatrist as defined in A.R.S. §36-501,

3) A psychologist as defined in A.R.S. §32-2061,

4) A physician,

5) A behavior analyst as defined in A.R.S. §32-2091,

6) A registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or

7) A registered nurse with:

   a. A psychiatric-mental health nursing certification, or

   b. One year of experience providing behavioral health services.

Behavior Technician - For purposes of this Policy, a paraprofessional credentialed by a nationally recognized Behavior Analyst certification board or as specified in A.A.C. R9-10-101(39), an individual who is not a BHP who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:

1) If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33, and

2) Are provided with clinical oversight by a Behavioral Health Professional as specified in A.A.C. R9-10-101 (39).

A. PROGRAM DESCRIPTION

Regardless of the Health Plan, including the Division's THP, the member is enrolled with the following program and services are available. For members enrolled in THP, the Division's Support Coordinator is responsible for coordinating care between the physical health provider and behavioral health provider including Tribal Behavioral Health Authorities. Support Coordinators can request the Behavioral Health Administration and Health Care Services to assist in care coordination activities for THP members.

Behavior Analysis Services are an AHCCCS covered benefit for individuals with Autism Spectrum Disorder and/or other diagnoses as justified by medical necessity. Behavior Analysis Services are designed to accomplish one or more of the following: Increase functional skills, increase adaptive skills (including social skills), teach new behaviors, increase independence and/or reduce or eliminate behaviors that interfere with behavioral or physical health.

Behavior Analysis Services are prescribed or recommended in specific dosages, frequency, intensity, and duration by a qualified Behavioral Health Professional as the result of an assessment of the member, the intensity of the behavioral targets, and complexity and range of treatment goals.

Refer to the Behavioral Health Services Billing Matrix and Medical Coding Resources on the AHCCCS website for more information regarding required coding information, including covered settings.

B. PROVIDER QUALIFICATIONS

Behavior Analysis Services shall be directed and overseen by Behavior Analysts and supported, where applicable, by Behavior Analysis Trainees and/or Behavior Technicians.

The Behavior Analyst is responsible for training Behavior Analysis Trainees and Behavior Technicians to implement assessment and intervention protocols with members. The Behavior Analyst is responsible for all aspects of clinical direction, supervision, and provider-level case management.

The Behavior Analyst shall be responsible for ensuring that the extent, kind, and quality of the Behavior Analysis Services the Behavior Analysis Trainee and Behavior Technician performs are consistent with his or her training and experience.

The Behavior Analyst shall be responsible for Behavior Analysis Trainee and Behavior Technician compliance with this Policy and Arizona State rules and regulations including those provisions set forth in A.R.S. §32-2091.

C. BEHAVIOR ANALYSIS ASSESSMENTS

Behavior Analysis Services are based upon assessment(s) that include standardized and/or non-standardized instruments through both direct and indirect methods.

1. Standardized instruments and procedures include, but are not limited to, behavior checklists, rating scales, and adaptive skill assessment instruments that comprise a fixed set of items and are administered and scored in a uniform way with all members (e.g., Pervasive Developmental Disabilities Behavior Inventory, Brigance Inventory of Early Development, Vineland Adaptive Behavior Scales).

2. Non-standardized instruments and procedures include, but are not limited to, curriculum-referenced assessments, stimulus preference assessment procedures, and other procedures for assessing behaviors and associated environmental events that are specific to the individual member and their behaviors.

D. SERVICE ADMINISTRATION

Behavior Analysis Services are rendered according to an Individualized Behavior Analysis Treatment Plan which will:

1) Be developed by a Behavior Analyst, based upon an assessment completed of the member and their behaviors as described above.

2) Be person-centered and individualized to the member's specific needs.

3) Specify the setting(s) in which services will be delivered.

4) Identify the modality by which the service will be delivered (whether in person or via telehealth, or in group or individual setting, or combination thereof).

5) Identify the baseline levels of target behaviors.

6) Specify long- and short-term objectives that are defined in observable, measurable, and behavioral terms.

7) Specify the criteria that will be used to determine treatment progress and achievement of objectives.

8) Include assessment and treatment protocols for addressing each of the target behaviors.

9) Clearly identify the schedule of services planned and roles and responsibilities for service delivery.

10) Include frequent review of data on target behaviors.

11) Include adjustments of the treatment plan and/or protocols by the LBA as needed based upon the review of data, including recommendations for treatment intensity and duration based upon the member's response to treatment.

12) Include training, supervision, and evaluation of procedural fidelity for BCaBA®s, Behavior Analysis Trainees, and Behavior Technicians implementing treatment protocols.

13) Include training and support to enable parents and/or other caregivers, if applicable, to participate in treatment planning and treatment plan implementation.

14) Include care coordination activities involving the member's team in order to assist in the generalization and maintenance of treatment targets. This may include Child and Family Team (CFT) or Adult Recovery Team (ART), Health Care Decision Maker, the Primary Care Provider (PCP), school, medical specialists, behavioral health prescribers, Department of Child Services, and/or other state-funded programs, and others as applicable.

15) Result in progress reports at minimum every six months. Progress reports includes, but are not limited to, the following components:

    i) Member Identification,

    ii) Background Information (family dynamics, school placement, cultural considerations, prenatal and/or developmental history, medical history, sensory, dietary and adaptive needs, sleep patterns, and medications),

    iii) Assessment findings (communication, social, motor, and self-help skills, maladaptive behaviors, and primary caregiver concerns), and

    iv) Outcomes (measurable objectives, progress towards goals, clinical recommendations, treatment dosage, family role and family outcomes, and nature of family participation).

    v) Care Coordination (transition statement and individualized discharge criteria).

16) Be consistent with applicable professional standards and guidelines relating to the practice of Behavior Analysis Services as well as Arizona Medicaid laws and regulations and Arizona state behavior analyst licensure laws and regulations (A.R.S. §32-2091).

E. Oversight of AdSS provision of Behavior Analysis Services

The Division will perform an annual operational review of each AdSS and at that time may review the receipt of Behavioral Analysis Services by the AdSS covered members. In addition, during the Division's quarterly Health Plan Oversight Committee the AdSS may be requested to report on tracking and trending of these services among their covered membership.

320-U PRE-PETITION SCREENING, COURT-ORDERED EVALUATION, AND COURT-ORDERED TREATMENT

EFFECTIVE DATE: June 16, 2021

PURPOSE

This policy applies to services delivered to Division members of the DDD Tribal Health Program (THP) by establishing guidelines, as applicable, for the provision and coordination of behavioral health services regarding the pre-petition screening, court-ordered evaluation, and court-ordered treatment process. The Division is responsible for collaborating with Tribal entities and behavioral health providers to endure access to services for THP members.

DEFINITIONS

Court-Ordered Evaluation (COE) - Evaluation ordered by the court (A.A.C R9-21-101). The COE process as specified in this Policy.

Court-Ordered Treatment (COT) - Treatment ordered by the court (A.A.C R9-21-101). The COT process as specified in this policy.

Evaluation Agency - A health care agency licensed by the Arizona Department of Health Services that has been approved pursuant to A.R.S. Chapter 5 Title 36, providing those services required of such agency.

Mental Disorder - A substantial disorder of the individual's emotional processes, thought, cognition, or memory as defined in A.R.S. §36-501.

Pre-Petition Screening - The review of each application requesting court-ordered evaluation, including an investigation of facts alleged in such application, an interview with each applicant and an interview, if possible, with the proposed individual. The purpose of the interview with the proposed member is to assess the problem, explain the application, and, when indicated, attempt to persuade the proposed member to receive, on a voluntary basis, evaluation or other services as specified in A.R.S. § 36-501.

Screening Agency - A health care agency licensed by ADHS and that provides those services required of such agency pursuant to A.R.S. Chapter 5 Title 36 (A.R.S. § 36-501).

Voluntary Evaluation - For purposes of this Policy, an inpatient or outpatient professional multidisciplinary service based on analysis of data describing the individual person's identity, biography, and medical, psychological, and social conditions that is provided after a determination that an individual willingly agrees to consent to receive the service and is unlikely to present a danger to self or others until the service is completed. A voluntary evaluation is invoked after the filing of a pre-petition screening but before the filing of a court-ordered evaluation and requires the informed consent of the individual. Additionally, the individual must be able to manifest capacity to give informed consent.

POLICY

This Policy outlines the processes and responsibilities applicable when it is necessary to initiate COE/COT proceedings detailed in A.R.S. §§ 36-501 et seq. This process is used to ensure the safety of an individual or the safety of others when, due to an individual's mental disorder, that individual is unable or unwilling to participate in treatment. The Division's

responsibilities may vary for Pre-Petition Screening and COE based on contractual arrangements between the Division, AHCCCS, TRBHA and the counties. The Division must ensure providers responsible for the COE/COT process adhere to requirements of this Policy.

When necessary, in accordance with A.A.C. R9-21-101 and A.R.S. § 36-520, any responsible person may submit an application when another individual is alleged to be, as a result of a mental disorder:

- Danger to Self (DTS).
- Danger to Others (DTO).
- Persistently or Acutely Disabled (PAD), or
- Gravely Disabled (GD).

If the individual who is the subject of a court-ordered commitment proceeding is subject to the jurisdiction of a tribal nation, rather than the state, the laws of that tribal nation will govern the commitment process. Information about the tribal court process and the procedures under state law for recognizing and enforcing a tribal court order are found in this Policy.

Pre-Petition Screening includes an examination of the individual's mental status and/or other relevant circumstances by a designated Screening Agency. Upon review of the application, examination of the individual and review of other pertinent information, a licensed Screening Agency's medical director or designee will determine if the individual meets criteria for DTS, DTO, PAD, or GD as a result of a mental disorder.

If the pre-petition application screening indicates that the individual may be DTS, DTO, PAD or GD, the Screening Agency will file an Application for Emergency Admission for Evaluation for a COE. Based on the immediate safety of the individual or others, an emergency admission for evaluation may be necessary. The Screening Agency, upon receipt of the application must determine the need for continued evaluation and immediately act as prescribed, not to exceed 48 hours of the filing of the application excluding weekends and holidays as specified in A.R.S. § 36-520.

Based on the COE, the Evaluating Agency may petition for COT on behalf of the

individual. The subsequent hearing is the determination as to whether the individual will be court ordered to treatment as specified in A.R.S. § 36-539. COT may include a combination of inpatient and outpatient treatment. Inpatient treatment days are limited contingent on the individual's designation as DTS, DTO, PAD, or GD. Individuals identified as:

- DTS may be ordered up to 90 inpatient days per year.
- DTO and PAD may be ordered up to 180 inpatient days per year, and
- GD may be ordered up to 365 inpatient days per year.

If the court orders a combination of inpatient and outpatient treatment, a mental health agency will be identified by the court to supervise the individual's outpatient treatment. Before the court can order a mental health agency to supervise the individual's outpatient treatment, the agency medical director must agree and accept responsibility by submitting a written treatment plan to the court.

At every stage of the Pre-Petition Screening, COE and COT process, an individual who manifests the capacity to give informed consent pursuant to A.R.S. § 36-518 will be provided an opportunity to change the status to voluntary. Under voluntary status, the individual will voluntarily receive an evaluation and is unlikely to present as DTO/DTS during the time pending the voluntary evaluation.

Entities responsible for COE must ensure the use of the following forms prescribed in 9

A.A.C. 21, Article 5 for individuals determined to have a Serious Mental Illness (SMI) and may also use these forms for all other populations:

Although the Division may not be contracted for providing Pre-Petition Screening services, emergency/crisis petition filing, and COE services in all counties, the Division must provide policies and procedures for providers outlining these processes.

A. Licensing Requirements

Behavioral health providers who are licensed by the ADHS/Division of Public Health Licensing as a COE or COT agency must adhere to ADHS licensing requirements.

B. Pre-Petition Screening

1. Unless otherwise indicated in an Intergovernmental Agreement (IGA) with a county, Arizona counties are responsible for managing, providing, and paying for Pre-Petition Screening and COEs and are required to coordinate provision of behavioral health services with the member's contractor or FFS program, responsible for the provision of behavioral health services. For additional information, visit the AHCCCS website, https://www.azahcccs.gov.

   During the Pre-Petition Screening, the designated Screening Agency must offer assistance, if needed, to the applicant in the preparation of the application for involuntary COE Any behavioral health provider that receives an application for COE (AMPM Attachment A, COE Deliverable Template) must immediately refer the application for Pre-Petition Screening and petitioning for COE to the Division-designated Pre-Petition Screening agency or county facility.

2. The Division shall develop policies that outline its role and responsibility related to the treatment of individuals who are unable or unwilling to consent to treatment. The policy must conform to the processes provided in A.R.S. §§ 36-501 et seq, and at a minimum address:

   a. Involuntary evaluation,

   b. Petitioning process,

   c. COE/COT process, including tracking the status of Court orders,

   d. Execution of Court orders, and

   e. Judicial Review.

C. Responsibility for Providing Pre-Petition Screening

When the Division is responsible through an IGA with a county for Pre-Petition Screening and petitioning for COE, the Division must refer the applicant to a subcontracted Pre-Petition Screening Agency.

The Pre-Petition Screening Agency must follow these procedures:

1. Provide Pre-Petition Screening within 48 hours excluding weekends and holidays.

2. Prepare a report of opinions and conclusions. If Pre-Petition Screening was not possible, the Screening Agency must report reasons why the screening was not possible, including opinions and conclusions of staff members who attempted to conduct the Pre-Petition Screening.

3. Ensure the agency's medical director or designee review of the report if the report indicates that there is no reasonable cause to support the allegations for COE by the applicant.

4. Prepare a Petition for COE and file the petition if the Screening Agency determines that due to a mental disorder, there is reasonable cause to believe that the individual meets the criteria set forth in § 36-521(D).

5. Ensure completion of Application for Emergency Admission for Evaluation and take all reasonable steps to procure hospitalization on an emergency basis, if it determines that there is reasonable cause to believe that the individual, without immediate hospitalization, is likely to harm themselves or others.

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

D. Emergent/Crisis Petition Filing Process for Contractors Contracted as Evaluating Agencies

When it is determined that there is reasonable cause to believe that the individual being screened is in a condition that without immediate hospitalization is likely to harm themselves or others, an emergent application must be filed. The petition must be filed at the appropriate agency as determined by the Division. Pursuant to A.R.S. § 36-501 et seq., when considering the emergent petition process, the following apply:

1. Only applications indicating DTS and/or DTO can be filed on an emergent basis.

2. The applicant shall have knowledge of the behavior(s) displayed by the individual that is a danger to self or others consistent with requirements specified in A.R.S. § 36-524.

3. The applicant shall complete an Application for Emergency Admission for Evaluation.

4. The applicant and all witnesses identified in the application as direct observers of the dangerous behavior(s) may be called to testify in court if the

application results in a petition for COE.

5. Immediately Upon receipt of an Application for Emergency Admission for evaluation and all corroborating documentation necessary to successfully complete a determination, the admitting physician will determine if enough evidence exists for an emergency admission for evaluation. If there is enough evidence to support the emergency admission for evaluation, the appropriate facility is not currently operating at or above its allowable member capacity, and the individual does not require medical care, then facility staff will immediately coordinate with local law enforcement for the detention of the individual and transportation to the appropriate facility.

6. If the individual requires a medical facility, or if appropriate placement cannot be arranged within the 48-hour timeframe identified above relating to an Application for Emergency Admission for Evaluation, the Medical Director of the Division will be consulted to arrange for a review of the case.

7. The Application for Emergency Admission for Evaluation may be discussed by telephone with the facility admitting physician, the referring physician, and a peace officer to facilitate transportation of the individual to be evaluated.

8. An individual proposed for emergency admission for evaluation may be apprehended and transported to the facility under the authority of law enforcement using the Application for Emergency Admission for Evaluation in accordance with A.R.S. §§ 36-524(D) and 36-525(A), which outlines criteria for a peace officer to apprehend and transport an individual based upon either a telephonic or written application for emergency admission.

9. An emergency admission for evaluation begins at the time the individual is detained involuntarily by the admitting physician who determines if there is reasonable cause to believe that the individual, as a result of a mental disorder, is a DTS or DTO and that during the time necessary to complete pre-screening procedures the individual is likely, without immediate hospitalization, to suffer harm or cause harm to others.

10. During the emergency admission period of up to 23 hours the following occurs:

    a. The individual's ability to consent to voluntary treatment is assessed,

    b. The individual must be offered and receive treatment to which the individual may consent; otherwise, the only treatment administered involuntarily will be for the safety of the individual or others, i.e.,

       seclusion/restraint or pharmacological restraint in accordance with A.R.S. § 36-513, and

    c. When applicable, the psychiatrist will complete the Voluntary Evaluation within 24 hours of determination that the individual no longer requires an involuntary evaluation.

E. Court-Ordered Evaluation

1. If, after review of the petition for evaluation, the individual is reasonably

believed to be DTS, DTO, PAD, GD as a result of a mental disorder, the court can issue an order directing the individual to submit to an evaluation at a designated time and place. The order must specify whether the evaluation will take place on an inpatient or an outpatient basis.

a. The court may also order that, if the individual does not or cannot submit, the individual be taken into custody by a peace officer and delivered to an Evaluation Agency. For further requirements surrounding COEs on an inpatient basis, refer to A.R.S. § 36-529.

2. If the Pre-Petition Screening indicates that the individual may be DTS, DTO, PAD, or GD, the Screening Agency will file a petition for COE. When, through an IGA with a county, the Division is contracted to provide COE, they must adhere to the following requirements when conducting COEs:

a. An individual who is reasonably believed to be DTO, DTS, PAD, or GD as a result of a mental disorder must have a petition for COE prepared, signed and filed by the Medical Director of the agency or designee,

b. An individual admitted to an Evaluation Agency must receive an evaluation as soon as possible, and receive care and treatment as required by their condition for the full period they are hospitalized,

c. A clinical record must be kept for each individual that details all medical and psychiatric evaluations and all care and treatment received by the individual,

d. An individual being evaluated on an inpatient basis must be released within 72 hours if further evaluation is not appropriate, unless the individual makes application for further care and treatment on a voluntary basis or unless an application for COT has been filed, and

e. On a daily basis, at minimum, an evaluation must be conducted throughout the COE process for the purpose of determining if an individual desires to be switched to a voluntary status or qualifies for discharge.

3. For information on individuals being released from COE, and on COE dispositions, refer to A.R.S. § 36-531.

F. Voluntary Evaluation

1. The Division shall require behavioral health providers who receive an application for Voluntary Evaluation to immediately refer the individual to a facility responsible for Voluntary Evaluations. The Voluntary Evaluation may be on an inpatient or outpatient basis. Voluntary Evaluation may be carried out only if chosen by the individual during the course of a Pre-Petition Screening after an application for evaluation has been made.

2. When an individual consents to Voluntary Evaluation, the evaluating agency shall follow these procedures:

a. Obtain the individual's informed consent prior to the evaluation,

b. Provide an evaluation at a scheduled time and place within five business days of the notice that the individual will voluntarily receive an evaluation, and

c. For inpatient Voluntary Evaluations, complete evaluations in less than 72 hours of receiving notice that the individual will voluntarily receive an evaluation.

3. The Division must require behavioral health providers that conduct Voluntary Evaluation services to include the following in the comprehensive clinical record (see Division Medical Policy 940):

a. A copy of the application for Voluntary Evaluation

b. A completed informed consent form (see Division Medical Policy 320-Q), and

c. A written statement of the individual's present medical condition.

G. Court-Ordered Treatment Following Civil Proceedings

Based on the COE, the evaluating agency may petition for COT. As specified in

A.R.S. §§ 36-501 et seq, the Division must require behavioral health providers to follow these procedures:

1. Upon determination that a person is DTS, DTO, GD or PAD, and if no alternatives to COT exist, the Medical Director of the agency that provided the COE shall file a petition with the court for COT.

2. Any behavioral health provider filing a petition for COT must do so in

consultation with the individual's clinical team prior to filing the petition.

3. The petition shall be accompanied by the affidavits of the two physicians who conducted the examinations during the evaluation period and by the affidavit of the applicant for the evaluation.

4. In cases of GD, a copy of the petition must be mailed to the public

fiduciary in the county of the individual's residence, or the county in which the individual was found before evaluation, and to any person nominated as guardian/legal representative. In addition, a copy of all petitions must be mailed to the superintendent of the Arizona State Hospital.

5. For information regarding court options for treatment, release, discharge, annual reviews, or COT violations, refer to A.R.S. §§ 36-540 et seq. For requirements relating to Judicial Review, see A.R.S. §§ 36-546 and 36-546.01.

a. For COT relating to DUI/Domestic Violence or other criminal offenses, refer to Division Operations Policy 423.

H. Individuals Who Are Title XIX/XXI Eligible and/or Determined to Have a Serious Mental Illness

When an individual referred for COT is Title XIX/XXI eligible and/or determined or suspected to have an SMI, the Division must:

1. Conduct an evaluation to determine if the individual has an SMI in accordance with the Division Medical Policy 320-P and conduct a behavioral health assessment to identify the individual's service needs, in conjunction with the individual's clinical team, as specified in the Division Medical Policy 320-O.

2. Provide necessary COT and other covered behavioral health services in accordance with the individual's needs, as determined by the individual's clinical team, family members, other involved parties.

3. Perform, either directly or by contract, all treatment required by A.R.S. Title 36, Chapter 5, Article 5, and 9 A.A.C. 21, Article 5.

I. Court-Ordered Treatment for American Indian Tribal Members in Arizona

Arizona tribes are sovereign nations and tribal courts have jurisdiction over their members residing on reservation. Tribal court jurisdiction, however, does not extend to tribal members residing off the reservation or to state issued COE or COT due to a behavioral health crisis occurs off reservation.

Several Arizona tribes have adopted procedures in their tribal codes, which are similar to Arizona law for COE and COT, however, each tribe has its own laws that must be followed for the tribal court process.

Additional information on the history of the tribal court process, legal documents and forms, a diagram of payment structures, as well as contact information for the tribes, tribal liaisons, TRBHAs, and tribal court representatives can be found on the AHCCCS website under Tribal Court Procedures for Involuntary Commitment.

1. Tribal (COT) for American Indian tribal members in Arizona is initiated by the tribal behavioral health staff, the tribal prosecutor or other individuals as authorized under tribal laws. In accordance with tribal codes, tribal members who may be a danger to themselves or others and in need of treatment due to a mental disorder are evaluated and recommendations are provided to the tribal judge for a determination of whether tribal COT is necessary. Tribal court orders specify the type of treatment needed.

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

3. The process for establishing a tribal court order for treatment under the jurisdiction of the state is a process of recognition or "enforcement" of the tribal court order (see A.R.S. § 12-136). Once this process occurs, the state recognized tribal court order is enforceable off reservation. The state recognition process is not a rehearing of the facts or findings of the tribal

court. Treatment facilities must provide treatment as identified by the tribe and recognized by the state. Attachment B (A.R.S. §12-136 Flow Chart) is a flow chart demonstrating the communication between tribal and state entities in accordance with A.R.S § 12-136

4. Contractors and providers shall comply with notice requirements as specified in A.R.S. §12-136(B) and A.R.S. §36-541.01.

5. The Division and providers shall comply with state recognized tribal court orders for Title XIX/XXI and Non-Title XIX individuals with an SMI determination. When tribal providers are also involved in the care and treatment of court-ordered tribal members, the Division and providers must involve tribal providers to ensure the coordination and continuity of care of the members for the duration of COT and when members are transitioned to services on the reservation, as applicable. The Division is encouraged to enter into agreements with tribes to address behavioral health needs and improve the coordination of care for tribal members.

6. The enforcement process must run concurrently with the tribal staff's initiation of the tribal court-ordered process in an effort to communicate and ensure clinical coordination with the Division. This clinical communication and coordination with the Division is necessary to assure continuity of care and to avoid delays in admission to an appropriate facility for treatment upon state/ county court recognition of the tribal court order. The Arizona State Hospital must be the last placement alternative considered and used in this process.

7. The Court must consider all available and appropriate alternatives for the treatment and care of the member. The Court must order the least restrictive treatment alternative available (A.R.S. § 36-540(B)). The Division is expected to partner with American Indian tribes, TRBHAs, and tribal courts in their geographic service areas to collaborate in finding appropriate treatment settings for American Indians in need of behavioral health services.

8. Due to the options American Indians have regarding their health care, including behavioral health services, AHCCCS eligible American Indians may be covered and/or coordinate behavioral health services through a TRBHA, THP (Division for THP DDD ALTCS members), AHCCCS contractor, Tribal ALTCS, IHS, or 638 tribal provider.

J. Reporting Requirements

COE and COT processes, tracking, and reporting shall align with and adhere to the requirements of A.R.S. Title 36 Chapter 5 and A.A.C. Title 9 Chapter 21 including requirements for COE and COT forms as delineated in A.A.C. Title 9 Chapter 21 Article 5:

- Exhibit A - Application for Involuntary Evaluation
- Exhibit B - Petition for Court-Ordered Evaluation
- Exhibit C - Application for Emergency Admission for Evaluation

- Exhibit D - Application for Voluntary Evaluation
- Exhibit E - Affidavit
- Exhibit F - Petition for Court-Ordered Treatment
- Exhibit G - Demand for Notice by Relative or Victim
- Exhibit H - Petition for Notice
- Exhibit I - Application for Voluntary Treatment

K. Reimbursement

1. Reimbursement for court-ordered screening and evaluation services are the responsibility of the county pursuant to A.R.S. § 36-545. For additional information regarding behavioral health services refer to 9 A.A.C. 22.

2. Refer to Division Operations Policy 437 for clarification regarding financial responsibility for the provision of medically necessary behavioral health services rendered after the completion of a COE.

3. Title XIX/XXI funds must not be used to reimburse COE services.

4. For COEs that do not require an inpatient stay, any medically necessary physical health services provided to the individual who is an THP ALTCS DDD member shall be the responsibility of the Division.

320-V BEHAVIORAL HEALTH RESIDENTIAL FACILITIES

REVISION DATES: 1/10/2024, 4/6/2022, 6/16/2021, 4/22/2020
REVIEW DATE: 6/3/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. §§ 32-2061, 32-2091, 32-3251 et seq., 36-501; A.A.C. R9-10-101, 702, 707, 708, 715, 814; International Classification of Diseases, 10th Revision, Clinical Modification.

PURPOSE

This policy establishes requirements of the Division of Developmental Disabilities' (Division) Administrative Services Subcontractors (AdSS) for the provision of care and services in a Behavioral Health Residential Facility.

DEFINITIONS

1. "Adult Recovery Team" means a group of individuals who, following the nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, collaborate and are actively involved in an assessment of the Member, service planning, and service delivery.

2. "Behavioral Health Condition" means a mental, behavioral, or neurodevelopmental disorder diagnosis defined by International Classification of Diseases, 10th Revision, Clinical Modification.

3. "Behavioral Health Professional" means:

   a. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:

      i. Independently engage in the practice of behavioral health as defined in A.R.S. § 32-3251; or

      ii. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. § 32-3251 under direct supervision as defined in A.A.C. R4-6-101;

   b. A psychiatrist as defined in A.R.S. § 36-501;

   c. A psychologist as defined in A.R.S. § 32-2061;

   d. A physician;

   e. A behavior analyst as defined in A.R.S. §32-2091;

   f. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse; or

   g. A registered nurse with a psychiatric-mental health nursing certification or one year of experience providing behavioral

health services.

4. "Behavioral Health Residential Facility" means, as specified in A.A.C. R9-10-101, a health care institution that provides treatment to a Member experiencing a behavioral health issue that limits the Member's ability to be independent or causes the Member to require treatment to maintain or enhance independence.

5. "Behavioral Health Residential Facility Staff" means any employee of the Behavioral Health Residential Facility, including administrators, Behavioral Health Professionals and Behavioral Health Technicians.

6. "Behavioral Health Technician" means an individual who is not a Behavioral Health Professional, who provides behavioral health services at or for a health care institution, according to the health care institution's policies and procedures, with clinical oversight by a behavioral health professional, and that if provided in a setting other than a licensed health care institution would require the individual to be licensed as a behavioral health professional under A.R.S Title 32, Chapter 33.

7. "Child and Family Team" means a group of individuals that includes, at a minimum, the child, the child's family, a behavioral health

representative, and any individuals important in the child's life that are identified and invited to participate by the child and family. The size, scope, and intensity of involvement by team members is determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective Service Plan and can expand and contract as necessary to be successful on behalf of the child.

8. "Crisis and Safety Plan" means a written description for potential crisis support or intervention which identifies needs and preferences that are most helpful in the event of a crisis; establishes goals to prevent or ameliorate the effects of a crisis, and specifically address techniques for establishing safety, identification of realistic interventions, physical limitations or unique needs of the Member, trauma informed, and developed in alignment with the Member's Service and Treatment Plans, and any existing behavior plan, if applicable, and adherence to court-ordered treatment when applicable.

9. "Medication Assisted Treatment" means the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.

10. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

11. "Outpatient Treatment Team" means a group of individuals working in collaboration with the Behavioral Health Residential Facility and are actively involved in a Member's assessment, service planning, and service delivery. Outpatient Treatment Team as used throughout this policy can indicate a Child and Family Team, Adult Recovery Team, Tribal Regional Behavioral Health Authority, American Indian Medical Home, Indian Health Services, Tribally operated 638 Facility, or the Division.

12. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

13. "Second Level Review" means a review performed by a Division Medical Director who has clinical expertise in managing a Member's condition or disease. Second Level Review is used to screen for medical necessity and compare the findings to clinical data in the Member's medical record to ensure Division Members are receiving

medically appropriate and high quality care.

14. "Secure Behavioral Health Residential Facility" means the same as specified in A.R.S. § 36-425.06(B) and A.A.C. R9-10-101 (36).

15. "Service Plan" means a complete written description of all covered health services and other informal supports, including individualized goals, family support services, care coordination activities, and strategies to assist the Member in achieving an improved quality of life.

16. "Treatment Plan" means a written description of all services to be provided by a Behavioral Health Residential Facility. The Treatment Plan is based on the intake assessments, outpatient Service Plan, and includes input from the Outpatient Treatment Team.

POLICY

A. BEHAVIORAL HEALTH RESIDENTIAL FACILITY REQUIREMENTS

1. The AdSS shall adhere to the following:
    a. Care and services provided in a Behavioral Health Residential Facility (BHRF):
        i. Are based on a 24-hour day per diem rate;

ii. Require prior and continued authorization; and

iii. Do not include room and board.

b. The BHRF level of care is inclusive of all treatment services provided by the BHRF in accordance with the Treatment Plan created by the Outpatient Treatment Team.

c. BHRFs are Arizona Department of Health Services licensed facilities in accordance with A.A.C. Title 9, Chapter 10, Article 7.

d. Refer to AdSS Operations Policy 414 for request timeframes and requirements regarding prior authorization.

e. Respond to all authorization requests for BHRF services as expedited requests within 72 hours of receipt of authorization.

f. Send all documentation associated with a denial of admission to a BHRF to the Division within one business day for a Second Level Review.

g. Do not require prior and continued authorization for admission to a Secure BHRF.

h. Adhere to the court order, as specified in A.R.S §

36-550.09, for admission and duration of stay in a Secure BHRF.

2. The AdSS shall have a process in place to ensure notification is sent to the Primary Care Provider, Behavioral Health Provider, and the Division's Support Coordinator upon admission to and discharge from the BHRF.

3. The AdSS shall develop medically necessary criteria for admission to, continued stay in, and discharge from BHRFs, and approved by the Division prior to publishing on the AdSS' website.

B. CRITERIA FOR ADMISSION

1. The AdSS shall develop admission criteria for medical necessity that contains the following elements:

   a. Member has a diagnosed Behavioral Health Condition that reflects the symptoms and behaviors necessary for a request for residential treatment level of care.

   b. The Behavioral Health Condition causing the functional or psychosocial impairment is evidenced in the assessment by

the following:

i. At least one area of significant risk of harm within the past three months as a result of:

a) Suicidal, aggressive, self-harm, homicidal thoughts or behaviors without current plan or intent;

b) Impulsivity with poor judgment or insight;

c) Maladaptive physical or sexual behavior;

d) Member's inability to remain safe within their environment despite environmental supports; or

e) Medication side effects due to toxicity or contraindications; and

ii. At least one area of serious functional impairment as evidenced by:

a) Inability to complete developmentally appropriate self-care or self-regulation due to a Behavioral Health Condition;

b) Neglect or disruption of ability to attend to

majority of basic needs, such as personal safety, hygiene, nutrition or medical care;

c) Frequent inpatient psychiatric admissions or legal involvement due to lack of insight or judgment associated with psychotic or affective/mood symptoms or major psychiatric disorders;

d) Frequent withdrawal management services, which can include detox facilities, Medication Assisted Treatment, and ambulatory detox;

e) Inability to independently self-administer medically necessary psychotropic medications despite interventions such as education, regimen simplification, daily outpatient dispensing, and long-acting injectable medications; or

f) Impairments persisting in the absence of situational stressors that delay recovery from the presenting problem.

c. A behavioral health need for 24-hour supervision to develop adequate and effective coping skills that will allow the Member to live safely in the community.

d. Anticipated stabilization cannot be achieved in a less restrictive setting.

e. Evidence that behavioral health treatment in a less restrictive level of care has not been successful or is not available, therefore warranting a higher level of care.

f. Member or Member's Responsible Person agrees to participate in treatment.

g. Agreement to participate is not a requirement for individuals who are court-ordered to a Secure BHRF.

h. Member's Outpatient Treatment Team is part of the pre-admission assessment and Treatment Plan formulation unless the Member is evaluated by a crisis provider, emergency department, or behavioral health inpatient facility.

i. The BHRF shall notify the Member's Outpatient Treatment

Team of admission prior to creation of the BHRF Treatment Plan.

C. EXPECTED TREATMENT OUTCOMES

1. The AdSS shall require treatment outcomes to align with the following:
   a. The Arizona Vision-12 Principles for Children's Behavioral Health Service Delivery as directed in AdSS Medical Manual Policy 430;
   b. The Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems; and
   c. The Member's individualized basic physical, behavioral, and developmentally-appropriate needs.
2. The AdSS shall require treatment goals to be developed in accordance with the following:
   a. Specific to the Member's Behavioral Health Condition;
   b. Measurable and achievable;
   c. Unable to be met in a less restrictive environment or lower level of care;

d. Based on the Member's unique needs and tailored to the Member and family/Responsible Person choices where possible; and

e. Support the Member's improved or sustained functioning and integration into the community.

D. EXCLUSIONARY CRITERIA

1. The AdSS shall not allow admission to a BHRF to be used as a substitute for the following:

   a. Detention or incarceration;

   b. Ensuring community safety in circumstances where a Member is exhibiting primarily conduct disordered behavior without the presence of risk or functional impairment;

   c. Providing safe housing, shelter, supervision, or permanency placement;

   d. A behavioral health intervention when other less restrictive alternatives are available and meet the Member's treatment needs, including situations when the Member or Member's Responsible Person is unwilling to participate in the less restrictive alternative; or

   e. An intervention for runaway behaviors unrelated to a

Behavioral Health Condition.

E. CRITERIA FOR CONTINUED STAY

1. AdSS shall develop medical necessity criteria for continued stay that contains the following elements:
   a. Assessment of continued stay by BHRF Staff in coordination with the Outpatient Treatment Team during each Treatment Plan review and update.
   b. Assessment of progress towards the treatment goals and continued display of risk and functional impairment.
   c. Treatment interventions, frequency, crisis and safety planning, and targeted discharge adjusted accordingly to support the need for continued stay.
2. The AdSS shall consider the following criteria when determining continued stay:
   a. The Member continues to demonstrate significant risk of harm or functional impairment as a result of a Behavioral Health Condition; and
   b. Providers and supports are not available to meet current

behavioral and physical health needs at a less restrictive lower level of care.

F. DISCHARGE READINESS

1. The AdSS shall develop medical necessity criteria for discharge readiness that contains the following elements:
    a. Discharge planning begins at the time of admission, and
    b. Discharge readiness is assessed by the BHRF Staff in coordination with the Outpatient Treatment Team during each Treatment Plan review and update.
2. The AdSS shall consider the following criteria when determining discharge readiness:
    a. Symptom or behavior relief is reduced as evidenced by completion of Treatment Plan goals;
    b. Functional capacity is improved;
    c. Essential functions such as eating or hydrating necessary to sustain life has significantly improved or is able to be cared for in a less restrictive level of care;
    d. Member is able to self-monitor for health and safety, or a caregiver is available to provide monitoring in a less

restrictive level of care; and

e. Providers and supports are available to meet current behavioral and physical health needs at a less restrictive level of care.

G. ADMISSION, ASSESSMENT, TREATMENT, AND DISCHARGE PLANNING

1. The AdSS shall establish a policy to ensure the admission, assessment, and treatment planning process is completed consistently among BHRF providers in accordance with A.A.C. R9-10-707 and 708, and as stated below:

   a. Except as provided in subsection A.A.C. R9-10-707(A)(9), a behavioral health assessment for a Member is completed before treatment is initiated and within 48 hours of admission.

   b. The Outpatient Treatment Team is included in the development of the Treatment Plan within 48 hours of admission.

   c. BHRF documentation reflects:

      i. All treatment services provided to the Member;

      ii. Each activity documented in a separate,

individualized medical record, including the date, time, and behavioral health professional conducting treatment activity;

iii. Which Treatment Plan goals are being achieved;

iv. Progress towards desired treatment goal; and

v. The frequency, length, and type of each treatment service or session.

d. BHRF Staff coordinates care with the Outpatient Treatment Team throughout the admission, assessment, treatment, and discharge process.

e. The BHRF Treatment Plan connects back to the Member's Service Plan.

f. For a Secure BHRF, the Treatment Plan aligns with the court-ordered treatment plan.

g. A discharge plan is created during the development of the initial Treatment Plan and reviewed and updated at each review thereafter.

h. A discharge plan documents the following:

i. Clinical status for discharge;

ii. The Responsible Person and Outpatient Treatment Team understands the follow-up treatment, Crisis and Safety Plan; and

iii. Coordination of care and transition planning are in process.

i. The BHRF Staff and the Outpatient Treatment Team meet to review and modify the Treatment Plan at least once a month.

j. A Treatment Plan may be completed by a Behavioral Health Professional, or by a Behavioral Health Technician with oversight and signature by a Behavioral Health Professional within 24 hours.

k. Implementation of a system to document and report on timeliness of the Behavioral Health Professional signature/review when the Treatment Plan is completed by a Behavioral Health Technician.

l. BHRF providers have a process to actively engage the family and Responsible Person, or other designated

individuals, in the treatment planning process as appropriate.

m. Clinical practices, as applicable to services offered and population served, demonstrate adherence to best practices for treating specialized service needs that includes:

i. Cognitive/intellectual disability;

ii. Cognitive disability with comorbid Behavioral Health Condition(s);

iii. Older adults and co-occurring disorders; and

iv. Comorbid physical and Behavioral Health Condition(s).

n. Members in a BHRF level of care cannot receive services under another level of care while receiving services in a BHRF.

o. Services deemed medically necessary and not offered at the BHRF are documented in the Member's Service Plan with a description of the need, identified goals, and

identification of providers who will be meeting the need.

p. The following services are made available and provided by the BHRF and cannot be billed separately unless otherwise noted below:

i. Counseling and Therapy (group or individual): Behavioral health counseling and therapy shall not be billed on the same day as BHRF services unless specialized behavioral health counseling and therapy have been identified in the Service Plan as a specific Member need that cannot otherwise be met as required within the BHRF setting.

ii. Skills Training and Development:

a) Independent Living Skills,

b) Community Reintegration Skill Building, and

c) Social Communication Skills.

iii. Behavioral Health Prevention/Promotion Education and Medication Training and Support Services:

a) Symptom management;

b) Health and wellness education;

c) Medication education and self-administration

skills;

d) Relapse prevention;

e) Psychoeducation services and ongoing support to maintain employment work/vocational skills, educational needs assessment and skill building;

f) Treatment for substance use disorder; and

g) Personal care services.

H. BHRF AND MEDICATION ASSISTED TREATMENT

The AdSS shall ensure BHRF providers have written policies and procedures to ensure Members on Medication Assisted Treatment are not excluded from admission and are able to receive Medication Assisted Treatment in compliance with Arizona Opioid Epidemic Act SB 1001, Laws 2018, First Special Session.

I. BHRF WITH PERSONAL CARE SERVICE LICENSE

1. The AdSS shall ensure that BHRFs providing personal care services are licensed to provide personal care services and that the services are offered in accordance with A.A.C. R9-10-702 and A.A.C. R9-10-715.

2. The AdSS shall ensure that BHRF providers can meet all identified needs in accordance with A.A.C. R9-10-814 (A)(C)(D) and (E).

SUPPLEMENTAL INFORMATION

Examples of Personal Care Services

- ACE wraps, arm and leg braces
- Administration of oxygen
- Application and care of orthotic devices
- Application and care of prosthetic devices
- Application of bandages and medical supports, including high elastic stockings
- ACE wraps, arm and leg braces
- Application of topical medications
- Assistance with ambulation
- Assistance with correct use of cane/crutches

- Bed baths
- Blood sugar monitoring, Accu-Check diabetic care
- Care of hearing aids
- Catheter care
- Denture care and brushing teeth
- Dressing member
- G-tube care
- Hair care, including shampooing
- Incontinence support, including assistance with bed pans/bedside commodes/ bathroom supports
- Measuring and giving insulin, glucagon injection
- Measuring and recording blood pressure
- Non-sterile dressing change and wound care
- Ostomy and surrounding skin care
- Passive range of motion exercise
- Radial pulse monitoring
- Respiration monitoring
- Shaving
- Shower assistance using shower chair
- Skin and foot care

- Skin maintenance to prevent and treat bruises, injuries, pressure sores and infections. (Members with a stage 3 or 4 pressure sore are not to be admitted to a BHRF pursuant to A.A.C. R9-10-715(3).
- Supervising self-feeding of members with swallowing deficiencies
- Use of chair lifts
- Use of pad lifts

Signature of Chief Medical Officer: Anthony Dekker (Jan 5, 2024 12:58 MST)
Anthony Dekker, D.O.

320-W THERAPEUTIC FOSTER CARE FOR CHILDREN

REVISION DATE: 1/10/2024
EFFECTIVE DATE: March 24, 2021
REFERENCES: A.R.S. Title 14, Chapter 5, Article 2 or 3; A.R.S. §§ 8-451.01, 8-514.05, 36-3221, 36-3231 or 36-3281; A.A.C. R9-10-101; ACOM Policy 414

PURPOSE

This policy applies to the Division of Developmental Disabilities (Division) Administrative Services Subcontractors (AdSS) and establishes requirements for the provision of Therapeutic Foster Care (TFC) and services provided to eligible Division Members enrolled in a Division subcontracted health plan.

DEFINITIONS

1. "Agency Worker" means a Therapeutic Foster Care Agency Worker that meets the minimum qualifications at the level of Behavioral Health Technician with a minimum of one year of experience in a human services field.
2. "AHCCCS" means the Arizona Health Care Cost Containment System.
3. "Arizona Department of Child Safety" means the department established pursuant to A.R.S. § 8-451 to protect children and to perform the following:

a. Investigate reports of abuse and neglect.

b. Assess, promote, and support the safety of a child in a safe and stable family or other appropriate placement in response to allegations of abuse or neglect.

c. Work cooperatively with law enforcement regarding reports that include criminal conduct allegations.

d. Without compromising child safety, coordinate services to achieve and maintain permanency on behalf of the child, strengthening the family and provide prevention, intervention, and treatment services pursuant to A.R.S. Title 8, Chapter 4.

4. "Behavioral Health Professional" means:

a. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:

i. Independently engage in the practice of behavioral health as defined in A.R.S. § 32-3251; or

ii. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. § 32-3251 under direct supervision as defined in A.A.C. R4-6-10;

b. A psychiatrist as defined in A.R.S. § 36-501;

c. A psychologist as defined in A.R.S. § 32-2061;

d. A physician;

e. A behavior analyst as defined in A.R.S. § 32-2091;

f. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse; or

g. A registered nurse with a psychiatric-mental health nursing certification or one year of experience providing behavioral health services.

5. "Behavioral Health Technician" means an individual who is not a Behavioral Health Professional, who provides behavioral health services at or for a health care institution, according to the health care institution's policies and procedures, and with clinical oversight by a Behavioral Health Professional, that if provided in a setting other than a health care institution would require the individual to be licensed as a Behavioral Health Professional under A.R.S Title 32, Chapter 33.

6. "Caregiver" means an adult who is providing for the physical, emotional, and social needs of a child.

7. **"**Child and Family Team" means a defined group of individuals that includes the child and their family, a behavioral health provider, and any individuals important in the child's life that are identified and

invited by the child and family to participate.

8. "Crisis Plan" means a written plan established by the Member that is designed to prevent or reduce the effects of a behavioral health crisis. This plan identifies what is or is not helpful in crisis prevention through the identification of contacts and resources, and actions to be taken by the Member, family, Responsible Person, parents, guardians, friends, or others.
9. "Immediate Jeopardy" means a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a Member.
10. "Service Plan" means a comprehensive written description of all covered health services and other informal supports which includes individualized goals, family support services, care coordination activities and strategies to assist the Member in achieving an improved quality of life. The Service Plan is created and managed by the CFT. It is a dynamic document that is regularly updated to adequately match the strengths and needs of the Member and family.
11. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
12. "Respite Care" means short-term relief for primary caregivers.

13. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.
14. "Telemedicine" means the practice of synchronous (real-time) health care delivery, diagnosis, consultation, and treatment and the transfer of medical data through interactive audio and video communications that occur in the physical presence of the Member.
15. "Therapeutic Foster Care" means a covered behavioral health service that provides daily behavioral interventions within a licensed family setting and is designed to maximize the Member's ability to live and participate in the community and to function independently, including assistance in the self-administration of medication and any ancillary services indicated by the Member's comprehensive Service Plan, as appropriate.
16. "Therapeutic Foster Care Agency Provider" means a TFC agency provider credentialed by a Managed Care Organization to oversee professional TFC Family Providers and holds contracts with pertinent health plans or the Department of Child Safety to provide TFC services

to children.

17. "Therapeutic Foster Care Family Provider" means specially trained adult(s) in a family unit licensed by the Department of Child Safety and endorsed to provide TFC services to children.

18. "Therapeutic Foster Care Treatment Plan" means a written plan that details the specific behavioral goals that the TFC Family and TFC Agency Providers will help the Member achieve during the Member's time in TFC. These TFC treatment goals are explicit, observable, attainable, tailored to the Member's strengths and needs, and align with the comprehensive Service Plan of the CFT. The TFC Treatment Plan outlines the steps the TFC Family and TFC Agency Providers will implement to help the Member attain the TFC treatment goals and successful discharge from TFC.

POLICY

A. THERAPEUTIC FOSTER CARE

1. The AdSS shall ensure TFC Agency Providers adhere to the following requirements:
    a. Programmatic support is available to the TFC Family Providers 24 hours per day, seven days per week.
    b. Care and services provided in TFC:

i. Are based on a 24-hour day per diem rate;

ii. Require prior and continued authorization; and

iii. Do not include room and board.

c. TFC services are provided for no more than three children in a professional foster home.

2. The AdSS shall ensure appropriate notification is sent to the primary care provider and behavioral health home agency or TRBHA, as applicable, upon admission to and discharge from TFC.

3. The AdSS shall ensure TFC Family Providers and TFC Agency Providers adhere to the Department of Child Safety (DCS) policies and procedures for children involved with DCS.

B. CRITERIA FOR ADMISSION

1. The AdSS shall develop medical necessity criteria for admission to TFC, and submit to the Division for approval, that contains the following elements:

a. Recommendation for TFC comes through the Child and Family Team (CFT) process.

b. Following an assessment by a licensed Behavioral Health

Professional (BHP), the Member has been diagnosed with a behavioral health condition that reflects the symptoms and behaviors necessary to warrant a request for TFC.

c. There is evidence that the Member has had a disturbance of mood, thought, or behavior within the past 90 days that renders the Member incapable of independent or age-appropriate self-care or self-regulation as a result of the Behavioral Health Condition, and that this moderate functional or psychosocial impairment, per assessment by a BHP:

   i. Cannot be reasonably expected to improve in response to a less intensive level of care; and

   ii. Does not require or meet clinical criteria for a higher level of care; or

   iii. Demonstrates that appropriate treatment in a less restrictive environment has not been successful or is not available, therefore warranting a higher level of care.

d. At the time of admission, in collaboration with the CFT and

other individuals as applicable, there are documented plans for discharge and transition that identifies:

i. Tentative living arrangement, and

ii. Recommendations for aftercare treatment based on treatment goals.

C. EXCLUSIONARY CRITERIA

1. The AdSS shall not allow admission to TFC to be used as a substitute for the following:

   a. Detention or incarceration;

   b. Ensuring community safety in an individual exhibiting primarily conduct disorder behaviors;

   c. Providing safe housing, shelter, supervision, or permanency placement;

   d. The Responsible Person's capacity or other agency's capacity to provide for the Member; or

   e. A behavioral health intervention when other less restrictive alternatives are available and meet the Member's treatment needs, including when the Responsible Person is

unwilling to participate in the less restrictive alternative.

D. EXPECTED TREATMENT OUTCOMES

1. The AdSS shall require treatment outcomes to align with:
    a. The Arizona Vision-12 Principles for Children's Behavioral Health Service Delivery as specified in AMPM Policy 100; and
    b. The Member's individualized physical, behavioral, and developmentally appropriate needs.
2. The AdSS shall require that the treatment goals for a Member's time in TFC are as follows:
    a. Specific to the Member's behavioral health condition that warranted treatment;
    b. Measurable and achievable;
    c. Cannot be met in a less restrictive environment;
    d. Based on the Member's unique needs;
    e. Include input from the Member's family, Responsible Person, and other designated representatives where

applicable; and

f. Support the Member's improved or sustained functioning and integration into the community.

3. The AdSS shall ensure active treatment with the services available at this level of care can reasonably be expected to:

a. Improve the Member's condition in order to achieve discharge from TFC at the earliest possible time, and

b. Facilitate the Member's return to primarily outpatient care in a non-therapeutic, non-licensed setting.

E. CRITERIA FOR CONTINUED STAY

1. The AdSS shall develop medical necessity criteria for continued stay, and submit to the Division for approval, that contains the following elements:

a. The Member continues to meet the diagnostic threshold for the behavioral health condition that warranted admission to TFC.

b. It can reasonably be expected that continued treatment will improve the Member's condition to the point that TFC

will no longer be needed.

c. The CFT is meeting at least monthly to review progress and revise the TFC Treatment Plan and Service Plan to respond to any lack of progress.

d. The transitioning Caregiver after discharge has been identified and is actively involved in the Member's care and treatment, if applicable.

e. The Member continues to demonstrate moderate functional or psychosocial impairment within the past 90 days as a result of the behavioral health condition, as identified through disturbances of mood, thought, or behavior, which substantially impairs independent or age-appropriate self-care or self-regulation.

f. Active treatment is reducing the severity of disturbances of mood, thought, or behaviors that were identified as reasons for admission to TFC, and treatment is empowering the Member to gain skills to successfully function in the community.

F. CRITERIA FOR DISCHARGE

1. The AdSS shall develop medical necessity criteria for discharge

from TFC, and submit to the Division for approval, that contains the following elements:

a. Sufficient symptom or behavior relief is achieved as evidenced by completion of the TFC treatment goals.

b. The Member's functional capacity is improved and the Member can be safely cared for in a less restrictive level of care.

c. The Member can participate in age-appropriate self-monitoring and follow-up services or a Caregiver is available to provide monitoring in a less restrictive level of care.

d. Appropriate services, providers, and supports are available to meet the Member's current behavioral health needs at a less restrictive level of care.

e. There is no evidence to indicate that continued treatment in TFC would improve the Member's clinical outcome.

f. There is potential risk that continued stay in TFC may precipitate regression or decompensation of the Member's

condition.

g. A current clinical assessment of the Member's symptoms, behaviors, and treatment needs has been reviewed by the CFT and has established that continued care in a TFC setting is no longer adequate to provide for the safety and treatment.

G. DISCHARGE PLANNING PROGRAM REQUIREMENTS

1. The AdSS shall require TFC Agency Providers to adhere to the following discharge planning program requirements:

   a. Discharge planning details are included in the TFC Treatment Plan, updated monthly, and align with the Service Plan.

   b. Discharge plans are completed using the approved standardized criteria.

   c. Discharge plans include identification of and consistent work with Responsible Persons, if applicable.

   d. The TFC team continues to plan for discharge as soon as an appropriate lower level of community-based care is identified.

e. Successful discharge planning includes engagement of the receiving caregiver to participate in transitionary visits.

f. The TFC team assesses the needs of the receiving caregiver and provides the appropriate coaching and mentorship.

g. The CFT shall review and approve the discharge plans to ensure successful implementation of discharge planning details such that sustainable transition into a less restrictive setting is possible.

h. If a decision is made to move the Member to a higher level of care, the TFC Family Provider and TFC Agency Provider work in collaboration with the CFT to make the transition as seamless as possible.

H. TREATMENT PLANNING PROGRAM REQUIREMENTS

1. The AdSS shall require the TFC Agency Provider to ensure the TFC Treatment Plan includes:

   a. Development in conjunction with the CFT;

   b. Strategies to address TFC Family Provider needs and successful transition for the Member to begin service with

the TFC Family Provider, including pre-service visits, when appropriate, as well as respite planning;

c. Complementing and not conflicting with the Service Plan and other defined treatments, and reference to the Member's:

   i. Current physical, emotional, behavioral health, and developmental needs;

   ii. Current educational placement and needs;

   iii. Current medical treatment;

   iv. Current behavioral treatment through other providers; and

   v. Current prescribed medications.

d. Updating Member's current Crisis Plan in alignment with the TFC setting;

e. Addressing safety, social and emotional well-being, discharge criteria, acknowledgement of Member's permanency objectives and post-discharge services; and

f. Short-term, proactive treatment goals that are measurable, time-limited, and in keeping with the Service

Plan.

g. When age and developmentally appropriate, youth and biological family, kinship family, and adoptive family participation in development of the TFC Treatment Plan is required;

h. Specific elements that build on the Member's strengths while also promoting pro-social, adaptive behaviors, interpersonal skills and relationships, community, family and cultural connections, self-care, daily living skills, and educational achievement; and

i. Specifics to coordinate with natural supports and informal networks as a part of treatment.

J. If the TFC Treatment Plan includes co-parenting engagement with the Member's Caregiver, development of specific goals to prepare the receiving Caregiver and successfully transition the Member to the new placement;

k. Plans for engagement of the Member's biological family, kinship family, adoptive family and or transition foster

family, and other natural supports that can support the Member during TFC placement and after transition;

l. Respite planning;

m. Review by:

i. The TFC Family Provider and TFC Agency Provider at each home visit;

ii. The TFC Agency Provider and clinical supervisor at each staffing; and

iii. The TFC Agency Provider and CFT at each revision or at minimum quarterly.

n. Documentation of the TFC Treatment Plan which is kept by the TFC Family Provider and the TFC Agency Provider and shared with the CFT.

I. THERAPEUTIC FOSTER CARE ROLES, RESPONSIBILITIES AND QUALIFICATIONS

1. The AdSS shall credential TFC Agency Providers.

2. The AdSS shall require that the TFC Agency Providers do the

following:

a. Ensure TFC Family Providers comply with all applicable state and local licensing requirements, including application, training, life safety inspections, and administrative requirements.

b. Ensure submission of deliverables.

c. Conduct one home visit per week during the initial six weeks of placement; these visits may be in person or Telemedicine.

d. Conduct a minimum of two home visits per month for continued stay beyond the initial six weeks of placement, with supporting documentation of each visit, including:

   i. Review of the TFC Treatment Plan with the TFC Family Provider;
   ii. Review case files and required documentation; and
   iii. Check medical records and medication logs.

e. Complete all AHCCCS required group biller requirements.

f. Conduct TFC Family Provider recruitment to maintain and

increase the number of providers that can meet the needs of Members receiving TFC services.

g. Conduct ongoing training per state licensing rule that develops the skills of TFC Family Providers to enable them to meet the needs of Members.

3. The AdSS shall require TFC Agency Providers to have staff to operate resource teams to support the TFC Family Provider as follows:

a. Beginning at the level of the Agency Worker, extending to the clinical supervisor;

b. Provide oversight by one or more independently licensed BHPs;

c. Work in concert, applying the specialized skills and knowledge for service planning, training, and support of direct service providers and the CFT; and

d. Each member of the team shall have in-depth familiarity with the strengths and needs of the TFC Family Provider in order to be effective resources in the provision of care,

developing training plans, and assisting in matching Members to service environments.

4. The AdSS shall require TFC Agency Providers to have a documented agency crisis response policy that specifies:

   a. Supervisor's availability and the use of crisis response provider to augment hours of availability;

   b. The TFC Agency Provider fulfilling the role of first-line support for the TFC Family Provider and Member during times of crisis;

   c. Access to a TFC Agency Provider or appropriate agency staff 24 hours a day, seven days a week; and

   d. Escalation to the appropriate TFC Agency Provider's clinical leadership is available at all times.

5. The AdSS shall require TFC Agency Providers to coordinate the TFC Treatment Plan with the Service Plan and incorporate the TFC Family Provider's participation in CFT meetings.

6. The AdSS shall require TFC Agency Providers to support the TFC Family Provider through clinical supervision available upon

request or as the TFC Agency Worker that identifies needs, including:

a. Provide training and specific skill building to enhance the family's ability to stabilize behaviors and intervene as challenges arise;

b. Facilitate respite;

c. Attend all CFT, court, and professional meetings with or on behalf of the family; and

d. Contact between the TFC Family Provider and other caregivers in preparation for discharge.

7. The AdSS shall require the TFC Agency Providers to ensure the following documentation, assessments, and records are updated and available:

a. Current TFC Treatment Plan;

b. Current Service Plan;

c. Crisis Plan;

d. Discharge plan;

e. Social history information;

f. Previous and current (within a year of referral date) behavioral health annual assessments, psychiatric evaluations, psychological evaluations;

g. School and educational information;

h. Medical information,

i. Previous placement history and outcomes; and

j. Member and family strengths and needs, including skills, interests, talents, and other assists.

8. The AdSS shall require TFC Agency Providers to have Agency Workers who are:

a. Qualified, at minimum, at the level of Behavioral Health Technician with a minimum one year of experience in a human services field.

b. Supervised by staff that possess a master's degree in a behavioral health field, and licensed in the state of Arizona, with a minimum two years of experience in a human

services field.

c. The primary agency representative at the CFT meetings who shall:

i. Be present to review the Service Plan,

ii. Document progress to those plans,

iii. Support the CFT,

iv. Support the TFC Family Provider, and

v. Participate in the CFT meetings.

9. The AdSS shall require TFC Agency Providers to have Agency Workers responsible for the following:

a. Lead the development of the TFC Treatment Plan with the TFC Family Provider and obtain clinical supervisor review.

b. Ensure the TFC Family Provider completes full and accurate clinical documentation of interventions on the TFC Treatment Plan to demonstrate progress toward meeting treatment needs is fully captured and provides an accurate record of case progress.

c. Ensure the TFC Treatment Plan is shared with the behavioral health agency and other treating providers or individuals, as applicable, as part of the Member's Service Plan to assure care coordination.

d. Monitor the number of Members assigned to a single Agency Worker.

   i. The preferred maximum number of Members assigned to a single Agency Worker is 10 Members.

   ii. The supervisor may lower the number of assigned Members to an Agency Worker if additional time is needed for one or more assigned families/members for oversight and support.

e. Have direct in-person or Telemedicine contact with the TFC Member and TFC Family Provider a minimum of once a week for the first six weeks of placement.

f. Have direct in-person or Telemedicine contact with the TFC Member and TFC Family Provider every other week or as needed for the remainder of the treatment, with one

visit per month with the TFC Member to assess physical, emotional, and behavioral health needs are being met.

g. Encourage coordination, collaboration, and advocacy with the educational system to support the TFC Family Provider and Member in meeting treatment and educational goals.

J. TFC AGENCY PROVIDER SUPERVISION REQUIREMENTS

1. The AdSS shall ensure TFC Agency Providers meet the following supervision requirements:

   a. Clinical Supervision requires behavioral professional or higher, with a graduate degree in a human services field, and licensed with a minimum two years of experience:

      i. Clinical supervision of TFC Agency staff that directly supports TFC Family Providers is completed by a qualified clinical professional through regular direct clinical supervision.

      ii. An Agency may employ a shared supervision model where administrative supervision is conducted by a

non-clinical professional.

b. Administrative supervision requires a master's degree in a human services field and a minimum two years of experience.

c. Treatment planning for all TFC Family Providers is overseen by a qualified clinical professional as specified below:

i. TFC Agency Provider shall define and document minimum frequency of TFC Treatment Plan reviews which shall occur no less than once per quarter.

ii. The clinical supervisor shall have direct in-person or Telemedicine contact with the TFC Family Provider at least once per month.

iii. The clinical supervisor is part of the treatment team and shall be active in the case review and not solely independently reviewing the TFC Treatment Plan.

iv. The clinical supervisor shall participate in the CFT meetings on an as-needed basis depending on the

progress of the TFC Treatment Plan.

K. TFC FAMILY PROVIDER REQUIREMENTS

1. The AdSS shall ensure TFC Family Providers meet the following requirements:

    a. Have at least one year of experience as an active licensed foster home working directly with Members or professional experience working directly with Members that have behavioral health issues or developmental disabilities or both.

    b. Meet AHCCCS requirements of registration as an AHCCCS registered provider.

    c. Complete all training requirements and evaluations in preparation to provide TFC services effectively and safely to Members and their families, as well as any ongoing training requirements as identified by the TFC Agency Provider in collaboration with the CFT.

    d. Abide by all licensing regulations as outlined in applicable state and federal statutes for family foster parent licensing

requirements, therapeutic level of licensure.

e. Provide basic parenting functions consistent with food, clothing, shelter, educational support, medical needs, transportation, teaching daily living skills, social skills, developing community activities, and supporting cultural, spiritual, and religious beliefs.

f. Provide behavioral interventions associated with anger management, crisis de-escalation, psychosocial rehabilitation, living skills training and behavioral intervention, and other behavioral interventions as needed, that aid the Member in making progress on TFC Treatment Plan goals.

g. Provide a family environment with opportunities for:

i. Familial and social interactions and activities;

ii. Use of behavioral interventions;

iii. Development of age-appropriate living and self-sufficiency skills; and

iv. Integration into a family and community-based

setting.

h. Meet the individualized needs of the Member in their home as defined in the Member's TFC Treatment Plan.

i. Be available to care for the Member 24 hours per day, seven days a week, for the entire duration that the Member is receiving out-of-home treatment services, including times the Member is with respite caregivers.

j. Ensure that the Member's needs are met when the Member is in Respite Care with other TFC Family Providers.

k. Participate in planning processes such as CFTs, TFC discharge planning, and individualized education programs.

l. Keep the following documentation per requirements of the TFC Agency Provider:

i. Record behavioral health symptoms,

ii. Incident reports,

iii. Interventions utilized,

iv. Progress toward the TFC Treatment Plan goals, and

v. Discharge plan.

m. Assist the Member in maintaining contact with their family and natural supports.

n. Assist in meeting the Member's permanency planning or TFC discharge planning goals.

o. Advocate for the Member in order to achieve TFC Treatment Plan goals and to ensure timely access to educational, vocational, medical, or other indicated services.

p. Provide medication management consistent with AHCCCS guidelines for Members in out-of-home care.

q. Report allegations of abuse, neglect, and misconduct toward Members as required by state and federal law.

r. Maintain confidentiality as required by state and federal law.

2. The AdSS shall require any request to move a Member from placement prior to successful completion of the TFC Treatment Plan is made through the CFT, and written notice provided following contractual time frames, with the only exception being Immediate Jeopardy.

3. The AdSS shall require TFC Family Providers to follow the Crisis Plan and work to preserve the placement, including consultation with the CFT for consideration of additional in-home supports and services as appropriate and necessary to support the Member and family.

4. The AdSS shall require the TFC Family Providers to utilize the Crisis Plan and accept Agency Worker and supervisor support, including the use of respite, to maintain the placement until an emergency CFT meeting is convened, services implemented, and the placement is preserved.

5. If a TFC placement cannot be preserved, The AdSS shall ensure TFC Agency Providers support the Member and TFC Family Provider until a transition is identified.

SUPPLEMENTAL INFORMATION

1. For aftercare planning for DCS involved Members, the TFC Family Provider may be the discharge placement. In such cases where the TFC Family Provider is the discharge placement, DCS foster care rates, policies, and procedures apply. Licensing agencies shall coordinate these actions through the CFT and DCS as they are not governed by this Policy.

2. Ongoing appropriate and approved relationship and communication with the TFC family provider after discharge is encouraged. This is determined with Responsible Person approval and in the best interest of the Member.

3. The TFC Family Providers are licensed by DCS and do not require credentialing by the AdSS.

Signature of Chief Medical Officer: Anthony Dekker (Jan 5, 2024 12:49 MST)
Anthony Dekker, D.O.

320-X ADULT BEHAVIORAL HEALTH THERAPEUTIC HOMES

REVISION DATE: February 2, 2022
EFFECTIVE DATE: March 24, 2021

PURPOSE

This Policy establishes requirements for the provision of care and services to Division members in Adult Behavioral Health Therapeutic Homes. The Division covers Adult Behavioral Health Therapeutic Home services for members eligible for ALTCS regardless of the health plan they choose. The Division is responsible for collaborating with Tribal entities and behavioral health providers to ensure access to services for Division members enrolled in the Tribal Health Program (THP). See AdSS Policy 320-X for responsibilities of the AdSS providing Adult Behavioral Health Therapeutic Home services.

DEFINITIONS

Adult Behavioral Health Therapeutic Home (ABHTH) - A licensed residence that provides behavioral health treatment, which maximizes the ability of an individual experiencing behavioral health symptoms to live and participate in the community and to function in an independent manner that includes assistance in the self- administration of medication and any ancillary services (such as living skills and health promotion) indicated by the member's treatment plan, as appropriate.

Adult Recovery Team (ART) – A group of individuals that follows the Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems. Working in collaboration and are actively involved in an individual's assessment, service planning, and service delivery.

Assessment – An analysis of a patient's needs for physical health services or behavioral health services to determine which services a health care institution shall provide to the patient as specified in A.A.C. R9-10-101

Behavioral Health Professional (BHP) –

A. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:

   1. Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251, or

   2. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. §32-3251 under direct supervision as defined in A.A.C. R4-6-101,

B. A psychiatrist as defined in A.R.S. §36-501,

C. A psychologist as defined in A.R.S. §32-2061,

D. A physician,

E. A behavior analyst as defined in A.R.S. §32-2091, or

F. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or

G. A registered nurse with:

1. A psychiatric-mental health nursing certification, or

2. One year of experience providing behavioral health services.

Collaborating Health Care Institution (CHI) – A health care institution licensed to provide outpatient behavioral health services that has a written agreement with an adult behavioral health therapeutic home or a behavioral health respite home to:

A. Coordinate behavioral health services provided to a resident at the adult behavioral health therapeutic home or a recipient at a behavioral health respite home, and

B. Work with the provider to ensure a resident at the adult behavioral health therapeutic home or a recipient at a behavioral health respite home receives behavioral health services according to the resident's treatment plan. A.A.C. R9-10-101 (51.)

Designated Representative – An individual acting on behalf of the member with the written consent of the member or member's legal guardian. As used in this policy the designated representative is distinct and separate from the health care decision maker.

Health Care Decision Maker – An individual who is authorized to make health care treatment decisions for the patient. As applicable to the particular situation, this may include a parent of an unemancipated minor or a person lawfully authorized to make health care treatment decisions pursuant to A.R.S. title 14, chapter 5, article 2 or 3; or A.R.S. §§8-514.05, 36-3221, 36-3231 or 36-3281.

Provider – Any individual or entity that contracts with AHCCCS or a Contractor for the provision of covered services to members according to the provisions A.R.S. §36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. §36-2901.

Service Plan – A complete written description of all covered health services and other informal supports which includes individualized goals, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life.

Treatment Plan – For the purpose of this policy, treatment plan is used to describe a complete written description of all services to be provided by the ABHTH based on the intake assessments and service plan.

POLICY

An Adult Behavioral Health Therapeutic Home (ABHTH) is a residential setting in the community that provides daily behavioral interventions within a licensed family setting. This service is designed to maximize the member's ability to live and participate in the community and to function independently, including assistance in the self-administration of medication and any ancillary services (such as living skills and health promotion) indicated by the member's service plan and/or treatment plan as appropriate.

Programmatic support is available to the ABHTH providers 24 hours per day, seven days per week by the collaborating health care institution (CHI). Care and services provided in an ABHTH are based on a per diem rate (24-hour day) and do not include room and board (Arizona State Plan for Medicaid).

ABHTH providers shall adhere to this policy as well as procedure requirements as specified in A.A.C. R9-10-1801 et. seq., and the Arizona State Plan for Medicaid.

A. Criteria for Admission

The Division shall develop admission criteria for medical necessity which, at a minimum, includes the below elements. The Division shall submit admission criteria to AHCCCS for approval and publish the approved criteria on the Division's website.

1. Criteria for Admission:

   a. The recommendation for ABHTH shall come through the Adult Recovery Team (ART) process,

   b. Following an assessment by a licensed behavioral health professional (BHP), the member has been diagnosed with a behavioral health condition which reflects the symptoms and behaviors necessary for a request for ABHTH,

   c. As a result of the behavioral health condition, there is evidence that the member has recently (within the past 90 days) had a disturbance of mood, thought, or behavior which renders the member incapable of independent or age-appropriate self-care or self-regulation. This moderate functional and/or psychosocial impairment per assessment by a BHP:

      i. Cannot be reasonably expected to improve in response to a less intensive level of care, and

      ii. Does not require or meet clinical criteria for a higher level of care, or

      iii. Demonstrates that appropriate treatment in a less restrictive environment has not been successful or is not available, therefore warranting a higher level of care.

   d. At time of admission to an ABHTH, in participation with the health care decision maker and all relevant stakeholders, there is a documented plan for discharge which includes:

      i. Tentative disposition/living arrangement identified, and

      ii. Recommendations for aftercare treatment based upon treatment goals.

B. Exclusionary Criteria

Admission to an ABHTH shall not be used as a substitute for the following:

1. An alternative to detention or incarceration.

2. As a means to ensure community safety in an individual exhibiting primarily conduct disordered behaviors.

3. As a means of providing safe housing, shelter, supervision or permanent placement.

   A behavioral health intervention when other less restrictive alternatives are available and meet the member's treatment needs, including situations when the member/health care decision maker is unwilling to participate in the less restrictive alternative.

C. Expected Treatment Outcomes

1. Treatment outcomes shall align with:

   a. The Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems as specified in AMPM, Policy 100, and

   b. The member's individualized physical, behavioral, and developmentally appropriate needs.

2. Treatment goals for members placed in an ABHTH shall be:

   a. Specific to the member's behavioral health condition that warranted treatment,

   b. Measurable and achievable,

   c. Unable to be met in a less restrictive environment,

   d. Based on the member's unique needs,

   e. Inclusive of input from the member's family/health care decision maker and designated representative's choices where applicable, and

   f. Supportive of the member's improved or sustained functioning and integration into the community.

3. Active treatment with the services available at this level of care can reasonably be expected to:

   a. Improve the member's condition in order to achieve discharge from the ABHTH at the earliest possible time, and

   b. Facilitate the member's return to primarily outpatient care in a non-therapeutic/non-licensed setting.

D. Adult Behavioral Health Therapeutic Homes Treatment Planning

The ABHTH treatment plan shall be developed by the CHI in collaboration with the ABHTH provider and the ART within the first 30 days of placement:

1. The treatment plan shall:

    a. Describe strategies to address ABHTH provider needs and successful transition for the member to begin service with ABHTH provider, including pre-service visits when appropriate,

    b. Compliment and not conflict with the ART service plan and other defined treatments, and shall also include reference to the member's:

        i. Current physical, emotional, behavioral health and developmental needs,

        ii. Current educational placement and needs,

        iii. Current medical treatment,

        iv. Current behavioral health treatment through other providers, and

        v. Current prescribed medications.

    c. Address safety, social, and emotional well-being, discharge criteria, acknowledgement of member's permanency objectives and post-discharge services,

    d. Include short-term, proactive treatment goals that are measurable, time-limited, and in keeping with the ART service plan,

    e. Clearly identify responsible individuals from treatment team to implement each aspect of the ABHTH treatment plan and the timing of completion. The CHI has the responsibility to ensure the treatment team is implementing the ABHTH treatment plan,

    f. Include specific elements that build on the members' strengths while also promoting pro-social, adaptive behaviors, interpersonal skills and relationships, community, family and cultural connections, self-care, daily living skills, and educational achievement,

    g. Include specifics to coordinate with natural supports and informal networks as a part of treatment,

    h. Include plans for engagement of the member's family of choice and other natural supports that can support the member during ABHTH placement and after transition,

    i. Be reviewed by the ABHTH provider and CHI at every home visit,

    j. Be reviewed by the CHI clinical supervisor at each staffing,

    k. Be revised as appropriate or quarterly at minimum, and

    l. Include documentation of the ABHTH treatment plan which shall be kept by the ABHTH Provider and CHI.

2. The Division and providers shall ensure that members/health care decision maker and designated representatives receive a copy of the treatment plan and any updated treatment plans.

E. Criteria for Continued Stay

The Division shall develop medically necessary criteria for continued stay which, at a minimum, include the below elements. The Division shall submit continued stay criteria to AHCCCS for approval and publish the approved criteria on the Division's website.

1. All of the following shall be met:

   a. The member continues to meet diagnostic threshold for the behavioral health condition that warranted admission to ABHTH,

   b. The member continues to demonstrate (within the last 90 days) moderate functional or psychosocial impairment as a result of the behavioral health condition, as identified through disturbances of mood, thought, or behavior, which substantially impairs independent or appropriate self-care or self-regulation,

   c. Active treatment is reducing the severity of disturbances of mood, thought, or behaviors, which were identified as reasons for admission to ABHTH, and treatment at the ABHTH is empowering the member to gain skills to successfully function in the community,

   d. There is an expectation that continued treatment at the ABHTH shall improve the member's condition so that this type of service shall no longer be needed, and

      The ART is meeting at least monthly to review progress and have revised the treatment plan and/or Service Plan to respond to any lack of progress.

F. Adult Behavioral Health Therapeutic Homes Discharge Planning

A comprehensive discharge plan shall be created during the development of the initial treatment plan and shall be reviewed and/or updated at each review thereafter. The discharge plan shall document the following:

1. Clinical status for discharge.

2. Follow-up treatment, crisis, and safety plan.

3. Coordination of care and transition planning are in process when appropriate.

G. Criteria for Discharge

The Division shall develop medical necessity criteria for discharge from an ABHTH setting which, at a minimum, includes the below elements. The Division shall submit discharge criteria to AHCCCS for approval, as specified in Contract, and publish the approved criteria on the Division's website.

1. Sufficient symptom or behavior relief is achieved as evidenced by completion of the ABHTH treatment goals.

2. The member's functional capacity is improved, and the member can be safely cared for in a less restrictive level of care.

3. The member can participate in needed monitoring and follow-up services or a Provider is available to provide monitoring in a less restrictive level of care.

4. Appropriate services, providers, and supports are available to meet the member's current behavioral health needs at a less restrictive level of care.

5. There is no evidence to indicate that continued treatment in an ABHTH would improve member's clinical outcome.

6. There is potential risk that continued stay in an ABHTH may precipitate regression or decompensation of member's condition.

H. The Division's Reporting Requirements

1. The Division shall monitor and report ABHTH bed utilization as specified in ACOM Policy 415, Attachment G, or as requested by AHCCCS.

2. The Division shall report medical necessity criteria for admission, continued stay, and discharge for prior approval as specified in Contract.

320-Z MEMBERS ON CONDITIONAL RELEASE

EFFECTIVE DATE: August 30, 2023
REFERENCES: A.R.S. § 12-136; A.R.S. § 13- 3991; A.R.S. §§ 13-3994 through 13-4000; APMPM 320-U; AMPM 320-Z; TRBHA Intergovernmental Agreement (IGA).

PURPOSE

This Policy establishes requirements for the Care Management and oversight of individuals who have been granted conditional release from the Arizona State Hospital (ASH) by the Superior Court.

DEFINITIONS

1. "Arizona State Hospital" or "ASH" means the state hospital providing long-term inpatient psychiatric care to Arizonans with mental illnesses who are under court order for treatment.

2. "Care Management" means a group of activities performed to identify and manage clinical interventions or alternative treatments for identified Members to reduce risk, cost, and help achieve better health outcomes. Distinct from Support Coordination, Care Management does not include the day-to-day duties of service delivery.

3. "Conditional Release Plan" or "CRP" means a supervised treatment plan ordered by the Superior Court in conjunction with the State mental health facility and behavioral health community providers which specifies the conditions of a Member's release.

4. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

5. "Service Plan" means a complete written description of all covered health services and other informal supports which includes individualized goals, peer-and-recovery support, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life. For purposes of this Policy, for fee-for-service populations, the term Treatment Plan may be used interchangeably with the term Service Plan.

6. "Support Coordination" means a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to

promote quality, cost-effective outcomes.

7. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. CARE MANAGEMENT

1. The Division shall not delegate the Superior Court Contractor Care Management functions to the Administrative Services Subcontractors (AdSS) for Members who have been granted conditional release from the Arizona State Hospital (ASH).

2. The Division's HCS Complex Care team shall be responsible for:
   a. Acting as the single key point of contact who is responsible for collaboration with the Arizona State Hospital (ASH) and the Superior Court;
   b. Coordinating with ASH for discharge planning, including ensuring the Member with diabetes has appropriate diabetic monitoring equipment and supplies, and has been educated and trained to the use prior to discharge;
   c. Participating in the development and implementation of the

CRP;

d. Participating in the modification of an existing or the development of a new Service Plan that complies with the CRP;

e. Ensuring coordination of care with the Member's treatment team, Tribal Regional Behavioral Health Authority (TRBHA) assigned Support Coordinator, and providers of both physical and behavioral health services to implement the Service Plan and the CRP;

f. Providing Member outreach and engagement at least once per month to assist the Superior Court in evaluating compliance with the approved CRP;

g. Attending outpatient staffing at least once per month either telephonically or face-to-face;

h. Providing routine review of administrative and clinical activities, submitting the Conditional Release Monthly Monitoring Report, and confirmation of delivery of

reporting to the Superior Court, and ASH;

2. The Division shall confirm immediate notification was completed by the outpatient provider to the Superior Court and ASH if a Member violates any term of his or her CRP, psychiatric decompensation, or use of alcohol, illegal substances or prescription medications not prescribed to the Member, and provide a copy to AHCCCS.

3. The Division, in conjunction with ASH and supervision of the courts shall engage the outpatient provider in care coordination as necessary, when there is any necessary revocation to inpatient or secured status for patients on full conditional release.

4. The Division shall provide outpatient provider monitoring to include:

   a. Monitoring activities and services provided to assure Member compliance with Conditional Release Plan (CRP); and

   b. Ensuring behavioral health provider completion and

notifications to the Superior Court, AHCCCS, and ASH including:

i. Mental health reports,

ii. Monitoring Conditional Release Monthly Monitoring Report, for Members on conditional release, and

iii. Providing additional documentation at the request of AHCCCS, ASH, or the Superior Court.

B. DIVISION RESPONSIBILITIES

1. The Division shall:

   a. Ensure AdSS provides training to outpatient providers serving Members on conditional release and ensure outpatient providers demonstrate understanding of A.R.S. § 13-3991 and A.R.S. §§ 13-3994 through 13- 4000, duties of outpatient providers; and

   b. Establish relationships with the Superior Court and ASH to support streamlined communication and collaboration between the Division, outpatient treatment team, ASH, and the Superior Court.

2. The Division Behavioral Health Complex Care Specialist shall coordinate with the Support Coordinator and care manager, as needed, for Members on Conditional Release from the Arizona State Hospital (ASH) consistent with the CRP issued by the Superior Court to facilitate discharge.

3. The Division shall monitor the status and outcomes of Members subject to a Conditional Release issued by the Superior Court and AHCCCS, including through the Conditional Release Monthly Monitoring Report as directed by the Contractor Chart of Deliverables

4. The Division shall follow all obligations, including those stated in this section, applicable to it as set forth as specified in A.R.S. § 13-3994.

C. FOR MEMBERS ENROLLED WITH TRIBAL HEALTH PLAN (THP) OR TRBHA

1. The Support Coordinator shall provide case management for THP members in collaboration with TRBHA or behavioral health case manager, as applicable.

2. The Support Coordinator shall notify the case managers of the requirement to directly coordinate with ASH and the Superior Court if case management is being provided by a FFS provider.

3. Support Coordination shall refer FFS behavioral health providers to AMPM 320-Z for requirements.

4. The Division shall refer to AMPM 320-U Pre-Petition Screening, Court Ordered Evaluation and Court Ordered Treatment for additional information regarding the recognition of tribal court orders.

Signature of Chief Medical Officer: Anthony Dekker (Aug 22, 2023 10:03 PDT)
Anthony Dekker, D.O.

330 CHILDREN'S REHABILITATIVE SERVICES

REVISION DATE: 10/1/2018, 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994
REFERENCES: A.R.S Title 32; A.A.C. R9-22-1301, A.A.C. R9-22-1303

Members eligible for Arizona Long Term Care System (ALTCS) with certain diagnoses may be eligible to receive Children Rehabilitative Services (CRS) at one the multi-specialty/interdisciplinary care settings, in addition to community based providers in independent offices. The respective Administrative Service Subcontractors (AdSS) provides covered medical, surgical, or therapy modalities for CRS enrolled members. The AdSS provides CRS covered services for CRS qualifying condition and conditions arising as a result of or related to the CRS qualifying condition when medically necessary. The AdSS does not cover routine, preventive, or other non-CRS related covered services. Members will receive acute care services through their Division acute health plan when being treated for a non-Children's Rehabilitative Services (CRS) diagnoses. Members who are 21 years of age and older are subject to all limitations and exclusions applicable to the adult population.

CRS medical services are in accordance with Arizona Administrative Code Title 9, Chapter 22, Article 2. Coverage limitations and exclusions for members 21 years of age and older apply.

The AdSS or authorized subcontractors provide medically necessary CRS services in both inpatient and outpatient settings, including contracted hospitals, multispecialty interdisciplinary clinics (MSICs), community-based field clinics, community based provider offices, behavioral health, and skilled nursing facilities.

Certain services may be available only in limited types of service settings or may be medically appropriate only for members with a particular clinical presentation. Services may require prior authorization from the AdSS and may require additional documentation to determine the medical necessity of the service requested for treating the CRS qualifying condition or a condition that is related to, or the result of, a CRS condition.

The AHCCCS Division of Member Services (DMS) will provide information to the AdSS related to the CRS qualifying condition(s) that are identified during the eligibility process. DMS may also provide information received for purposes of eligibility determination for the CRS designation regarding care, services or procedures that may have been approved or authorized by the member's current health plan. The AdSS is responsible for ensuring that information provided by AHCCCS Division of Member Services is made available to the appropriate areas and staff within its organization who may need the information. The AdSS is responsible for appropriately transitioning members utilizing established transition processes. Members are permitted to opt out of, or refuse enrollment into, the CRS designation.

The AdSS provides services through an approach to service delivery that is family centered, coordinated and culturally competent, in a manner that considers the unique medical and behavioral holistic needs of the member.

CRS members may been seen for care and specialty services by the AdSS contracted network providers within the community that are qualified or trained in the care of the

member's condition. CRS members may also benefit from treatment in clinic-based multi-specialty/interdisciplinary care settings when active treatment is required, in addition to care and services provided by community based providers in independent offices. The AdSS also provides community based services including services provided in field clinics. When medically necessary services are not available in state, the AdSS is required to provide services out of state.

Covered benefits for CRS Partially Integrated members are the same as those provided by the Acute Contractors and the Behavioral Health Contractors including any necessary placement settings such as skilled nursing facilities, chemotherapy, hospice, transplant services, and behavioral health placement settings, as determined to be medically necessary and resulting from the CRS qualifying condition or a condition that is related to, or the result of, a CRS condition.

Definitions

A. Active Treatment - a current need for treatment. The treatment is identified on the member's service plan to treat a serious and chronic physical, developmental, or behavioral condition requiring medically necessary services of a type or amount beyond that generally required by members that last, or is expected to last one year or longer, and requires ongoing care not generally provided by a primary care provider.

B. Chronic - expected to persist over an extended period of time.

C. CRS condition - any of the covered medical conditions in A.A.C. R9-22-1303 which are referred to as covered conditions in A.R.S. 36-2912.

D. CRS Fully Integrated - a coverage type which includes members who receive all services from the CRS AdSS including acute health, behavioral health and CRS-related services.

E. CRS Partially Integrated Acute - a coverage types which includes American Indian members who receive all acute health and CRS-related services from the CRS AdSS and who receive behavioral health services from a Tribal Regional Behavioral Health Authority (TRBHA).

F. CRS Partially Integrated Behavioral Health - a coverage type which includes DDD members who receive all behavioral health and CRS-related services from the primary program of enrollment.

G. CRS Only - a coverage type which includes members who receive all CRS-related services from the CRS AdSS, who receive acute health services from the from the primary program of enrollment, and DDD American Indian member who receive behavioral health services from the TRBHA.

H. CRS Provider - a person who is authorized by employment or written agreement with the AdSS to provide covered CRS services to a member or covered support services to a member or a member's family.

I. Field Clinic - a "clinic" consisting of single specialty health care providers who travel to health care delivery settings close to members and their families than the Multi-Specialty Interdisciplinary Clinics (MSICs) to provide a specific set of services including evaluation, monitoring, and treatment for CRS-related conditions on a periodic basis.

J. Functionally Limiting - a restriction having a significant effect on an individual's ability to perform an activity of daily living as determined by a CRS provider. (A.A.C. R9-22-1303)

K. Medically Eligible - meeting the medical eligibility requirements of A.A.C. R9-22-1303.

L. Multi-Specialty Interdisciplinary Clinic (MSIC) - an established facility where specialists form multiple specialties meet with members and their families for the purpose of providing interdisciplinary services to treat members.

Medical Services

Medical services are provided in accordance with A.A.C. R9-22, Article 2. The Administrative Services Subcontractor is responsible for the following services:

A. Audiology Services

Audiology is a covered service as described in Division Medical Policy 310-A-Audiology, within certain limitations, to evaluate and rehabilitate members with hearing loss. For purposes of providing CRS, the following applies:

1. Audiologic Assessments must be consistent with accepted standards of audiologic practice.

2. Hearing Aid Fittings and Evaluations are covered as follows:

a. Hearing aids

i. The member may have their hearing aid reevaluated annually.

ii. A hearing aid may be replaced once every three years, unless the member experiences a change in hearing levels or is determined by a CRS contracted audiologist to require a hearing aid replacement due to the hearing aid being lost, broken, or non-functioning.

b. Implantable bone conduction devices

c. Cochlear implants. For further information, refer to Division Medical Policy 430, Early Periodic Screening, Diagnostic and Treatment (EPSDT) Services.

B. Dental and Orthodontia Services

Dental and Orthodontia Services are covered services, with certain limitations as described in Division Medical Policy 431 Oral Health Care (EPSDT-Age Members). For purposes of providing CRS, the following applies:

1. Dental Services

Full ranges of dental services are covered for members eligible for CRS having at least one of the following:

a. Cleft lip and/or cleft palate

b. A cerebral spinal fluid diversion shunt where the member is at risk for subacute bacterial endocarditis

c. A cardiac condition where the member is at risk for subacute bacterial endocarditis

d. Dental complications arising as a result of treatment for a CRS condition

e. Documented significant functional malocclusion

i. When the malocclusion is defined as functionally impairing in a member eligible for CRS with a craniofacial anomaly or

ii. When one of the following criteria is present:

(a) Masticatory and swallowing abnormalities that affect the nutritional status of the individual resulting in growth abnormalities

(b) Clinically significant respiratory problems, induced by the malocclusion, such as dynamic or static airway obstruction

(c) Serious speech impairment, determined by a speech therapist, that indicates the malocclusion as the primary etiology for the speech impairment and that speech cannot be further improved by speech therapy alone.

2. Orthodontia Services

Medically necessary Orthodontia Services are covered for a member eligible for CRS with a diagnosis of cleft palate or documented significant functional malocclusion as described in B.1.a. and B.1.e. (above).

C. Diagnostic Testing and Laboratory Services

Medically necessary diagnostic testing and laboratory services are covered as described in Division Medical Policy 310. For purposes of providing CRS, the following applies:

Limitations

1. Genetic testing is only covered when the results of such testing are necessary to differentiate between treatment options as described in Division Medical Policy 310, and when related to a CRS condition.

2. Follow-up laboratory evaluations for conditions unrelated to the CRS condition are excluded. The member must be referred to his or her primary care provider for follow-up care.

D. Durable Medical Equipment (DME)

Medically necessary DME is covered as described in Division Medical Policy 310-P Medical Supplies, Durable Medical Equipment, and Prosthetic Devices (Acute Care Services). For purposes of providing CRS, the following applies:

- Durable medical equipment for rehabilitative care
- Equipment repairs
- Equipment modifications.

1. Exclusion and Limitations of Durable Medical Equipment Services

   Note: Refer to D.4 and D.5 (below) for specific information related to wheelchair and ambulation devices.

   a. Members are eligible for equipment only when ordered by a CRS-contracted provider and/or authorized by the AdSS.

   b. Cranial modeling bands are excluded except for members who are 24 months of age or younger who have undergone CRS-approved cranial modeling surgery and demonstrate postoperative progressive loss of surgically achieved correction and that without intervention would most likely require additional surgery.

2. Equipment Maintenance for Durable Medical Equipment Services

   Covered services include equipment modifications necessary due to the member's growth or due to a change in the member's orthopedic or health needs. The request for modification must come from a CRS contracted provider.

3. Equipment Replacement or Repair for Durable Medical Equipment Services

The AdSS must ensure that Durable Medical Equipment found to be unsatisfactory due to imperfect or faulty construction is corrected, adjusted, or replaced.

4. Wheelchairs and Ambulation Devices

a. Routine or custom wheelchairs and/or ambulation assistive devices (crutches, canes, and walkers) are provided for members eligible to receive CRS, based on medical necessity.

b. Medically necessary equipment modifications and replacement are covered.

c. Custom fit standards and parapodiums are covered for members eligible to receive CRS with spinal cord defects who have walking potential.

d. Trays for wheelchairs are provided when documentation indicates that the need is directly related to improvement in functional skill.

e. The member and/or their family must demonstrate that they can safely use all equipment provided to the member, as verified and documented by the treating provider or wheel chair fitting provider. Practical and functional use of the equipment must be documented in the CRS medical record.

5. Limitations and Exclusions Related to Wheelchairs and Ambulation Devices

a. Replacement of wheelchairs and ambulation devices is not a covered service when the equipment is functional and can be repaired such that the equipment is safe to operate.

b. Physical or structural modifications to a home are excluded.

c. After initial delivery, care and transportation of the equipment, including vehicle modifications, is the responsibility of the member and/or the member's guardian.

d. Repairs or maintenance to equipment that was not provided to the member by the AdSS are provided, when a CRS provider has determined the equipment to be safe and appropriate.

E. High Frequency Chest Wall Oscillation Therapy

High Frequency Chest Wall Oscillation (HFCWO) therapy is a covered service, for members under 21 years of age.

1. HFCWO is covered when there is:

a. A diagnosis of cystic fibrosis

b. Documentation of excessive sputum production combined with the member's inability to clear the sputum without assistance

c. Copy of chest x-ray report and pulmonary function tests showing findings consistent with moderate or severe Chronic Obstructive Pulmonary Disease (COPD)

d. Prescription signed by M.D. or D.O. with a specialty in pulmonary disease, indicating the need for at least daily chest physiotherapy

e. Member is two years of age or older, or has a documented chest size of 20 inches or greater, whichever comes first

f. Specific documentation supporting why HFCWO therapy for the member is superior to other more cost-effective therapy methods, including at least one of the following:

i. Promotes independent self-care for the individual

ii. Allows independent living or university or college attendance for the individual

iii. Provides stabilization in single adults or emancipated individuals without able partners to assist with Chest Physical Therapy (CPT), or

iv. Severe end-stage lung disease requiring complex or frequent CPT.

g. Evidence that the member can use the vest effectively, including continuing compliance with all forms of prescribed therapy and treatment and member and family acceptance of HFCWO therapy

h. Coordination prior to implementation of HFCWO therapy for long-term use between the CRS provider office/clinic or DDD Contractor, or other payer source has occurred.

2. Discontinuation Criteria for HFCWO

HFCWO services will be discontinued if there is:

1. Member and/or prescribing physician request, or

2. Patient treatment compliance at a rate of less than 50% usage, as prescribed in the medical treatment plan, that is verified at two and six months of use.

F. Home Health Care Services

Medically necessary home health care services, as described in Division Medical Policy 310-I Home Health Services. Home health care services include professional nurse visits, therapies, equipment, and medications. Home health

care services must be ordered by a CRS contracted provider. The home health care service is covered for a CRS member when the home health service is specifically for the treatment of a CRS or CRS-related condition.

G. Inpatient Services

The AdSS covers medically necessary inpatient services, as described in Division Medical Policy 310-K Hospital Inpatient Services. The hospitalization is covered for a member when the hospitalization is for the treatment of a CRS condition or a condition that is related to, or the result of, the CRS condition.

CRS requirements for admission and coverage for an inpatient acute care stay are as follows:

1. CRS authorized providers with admitting privileges can admit and treat CRS members for CRS qualifying conditions or those conditions related to, or the result of, a CRS condition. Providers must have a contract with the AdSS or receive an authorization from the AdSS. The admitting provider must obtain prior authorization from the AdSS for all non-emergency hospital CRS-related admissions.

2. Prior authorization is not required for an emergency service.

3. The primary reason for hospitalization must be related to, or the result of, the CRS condition.

H. Growth Hormone Therapy

Growth hormone therapy is only covered for members with panhypopituitarism.

I. Nutrition Services

CRS covers medically necessary nutritional services. For purposes of the CRS designation, nutrition services include screening, assessment, intervention, and monitoring of nutritional status. The AdSS must cover nutrition services for CRS members with special nutritional needs when the nutritional need is related to a CRS condition or resulting from the CRS condition. The CRS designation covers nutritional supplements upon referral from CRS providers with consultation by a registered dietician.

Note: Covered services also include special formula to meet the nutritional needs of members with metabolic needs.

Limitations

1. A registered dietitian must provide nutrition services.

2. Total Parenteral Nutrition (TPN) for long-term nutrition is covered if medical necessity and is related to, or resulting from, the CRS condition.

J. Outpatient Services

The AdSS is responsible for outpatient services where the diagnosis is a CRS qualifying condition or a condition that is related to, or the result of, a CRS condition.

CRS outpatient services include:

1. Ambulatory/outpatient surgery

2. Outpatient diagnostic and laboratory services

3. Ancillary services: Laboratory, Radiology, Pharmacy Services, Medical Supplies, Blood, Blood Derivatives, Therapies, Ambulatory Surgeries

4. Clinic services

   a. CRS members may benefit from multi-specialty, interdisciplinary care teams, in addition to community-based providers. The AdSS shall make available these care teams throughout the state.

      Community-based field clinics are specialty clinics that are held periodically in outlying towns and communities in Arizona, or on Indian Reservations.

   b. CRS members may be seen by AdSS community based providers in independent offices for CRS qualifying conditions or conditions that are related to, or the result of, a CRS condition.

Limitations

The member's primary health care system must be used for routine and acute medical care that is not related to the CRS condition, such as periodic visits for scheduled immunizations and periodic physical examinations and check-ups.

K. Pharmaceutical Services

The AdSS covers medically necessary prescription medication and pharmacy services, as described in Division Medical Policy 310-V Prescription Medication and Pharmacy Services. Under the CRS designation, pharmaceuticals are covered when appropriate for the treatment of the CRS condition or a condition that is related to, or the result of, a CRS condition, when ordered by the CRS provider, and provided through a CRS contracted pharmacy. The AdSS is required to provide community-based pharmacy services.

Limitations

1. Pharmaceuticals or supplies that would normally be ordered by the primary care provider for the non-CRS covered condition(s) are not covered.

2. Medications covered under Medicare Part D for CRS members who are dual eligible (AHCCCS/Medicare) enrollees are not covered by the CRS designation.

L. Physical and Occupational Therapy Services

The Division covers medically necessary physical and occupational therapy services, as described in Division Medical Policies 310-K Hospital Inpatient Services and 310-X Rehabilitative Therapies. For purposes of the CRS designation, physical therapy and occupational therapy services are provided when the service is medically necessary and prescribed to treat the CRS condition and other conditions arising as a result of the CRS qualifying condition. Limitations listed for members age 21 and older in AMPM Policy 310, Covered Services apply.

M. Physician Services

The Division covers medically necessary physician services, as described in Division Medical Policy 310-T Physician Services. For purposes of the CRS designation, physician services must be furnished by an AHCCCS registered, licensed physician and must be covered for members when rendered within the physician's scope of practice under A.R.S Title 32. The AdSS is responsible for contracting with physician specialists with expertise in pediatrics to provide CRS covered services.

Medically necessary physician services may be provided in an inpatient or outpatient setting.

N. Prosthetic and Orthotic Devices

The Division covers medically necessary prosthetic and orthotic services, as described in Division Medical Policy 310-P Medical Supplies, Durable Medical Equipment and Prosthetic Devices (Acute Care Services). Under the CRS designation, prosthetic and orthotic devices are provided when medically necessary to treat the CRS condition and other conditions arising as a result of the CRS qualifying condition.

1. Maintenance and Replacement

a. The CRS designation covers prosthetic and orthotic modifications or repairs that are related to the CRS condition and medically necessary.

b. The CRS designation covers ocular prostheses and replacements when medically necessary and when related to a CRS condition.

c. Prior authorization is required for replacement of lost or stolen prosthetic and orthotic devices.

The CRS designation must provide or fabricate orthotic/prosthetic devices that assist CRS members in performing normal living activities and skills. Requirements include:

i. All orthotic/prosthetic devices must be constructed or fabricated using high quality products.

ii. All orthotics must be completed, modified or repaired, and

delivered to the CRS member within 15 working days of the provider's order.

iii. All prosthetics must be completed, modified or repaired, and delivered to the CRS member within 20 working days following the member's provider order.

iv. Orthotic/prosthetic repairs ordered by a CRS provider as urgent must be delivered within five working days.

v. Same day service must be provided for emergency adjustments for members unable to undertake their normal daily activities without the repairs and/or modifications.

d. The CRS designation will assure there will be no additional charge for modifications and/or repairs during the normal life expectancy of the device, except as required to accommodate a documented change in the member's physical size, functional level, or medical condition.

2. Limitations and Exclusions

a. Myoelectric prostheses are excluded.

b. Limitations for members age 21 and older apply as described in AMPM 310-JJ.

O. Psychology/Behavioral Health Services

For discussion of behavioral health services, please see AMPM Policy 310-B, Behavioral Health Services.

P. Second Opinions

The CRS designation covers second opinions by other CRS contracted physicians, when available. If not available, CRS will provide a second opinion by a contracted specialty provider able to treat the condition or a same specialty non-CRS contracted provider.

Q. Speech Therapy Services

The Division covers medically necessary speech therapy services, as described in AMPM Policy 310. Speech therapy services are provided by the CRS designation when the service is medically necessary and prescribed to treat the CRS diagnosed or a related condition. Limitation for members age 21 and older apply as per AMPM Policy 310, Covered Services.

R. Transplant Services

The CRS designation covers transplant services for CRS qualifying conditions or those conditions related to, or resulting from, the CRS condition.

S. Telemedicine

The Division covers telemedicine, as described in Division Medical Policy 320-I Telehealth and Telemedicine. The CRS designation covers telemedicine when it is related to the member's CRS condition. The purpose of telemedicine is to provide clinical and therapeutic services by means of telemedicine technology. This technology is used to deliver care and services directly to the member and to maximize the provider network.

T. Transportation

The Division covers medically necessary transportation services, as described in Division Medical Policy 310-BB Transportation. The CRS designation covers transportation for a member who is receiving services for a CRS condition or a CRS-related service.

U. Vision Services

The CRS designation covers vision services including examinations, eyeglasses, and/or contact lenses for the treatment of a CRS or CRS-related condition.

410 MATERNITY CARE SERVICES

REVISION DATE: 10/25/2023, 6/08/2022
EFFECTIVE DATE: August 5, 2021
REFERENCES: A.A.C. R9-16-111 through 113, A.R.S. § 14-5101; AMPM 400:410; AMPM Attachment 410-B, C, D, and E; AMPM Exhibit 400-2A; Exhibit F3, Contractor Chart of Deliverables

PURPOSE

This policy establishes requirements for the Division of Developmental Disabilities (Division) regarding Maternity Care Services.

DEFINITIONS

1. "Certified Nurse Midwife" or "CNM" means an individual 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, or referral.

2. "Free Standing Birthing Centers" means an out-of-hospital, outpatient obstetric facility, 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 assist with labor and delivery services. They are equipped to manage uncomplicated, low-risk labor and delivery. These facilities are affiliated with, and in close proximity to, an acute care hospital for the management of complications, should they arise.
3. "High-Risk Pregnancy" means a pregnancy in which the birthing 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 American College of Obstetricians and Gynecologists (ACOG) standardized medical risk assessment tools.
4. "Licensed Midwife" or "LM" means an individual licensed by the Arizona Department of Health Services (ADHS) to provide Maternity Care pursuant to A.R.S. Title 36, Chapter 6, Article 7 and A.A.C. 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.

5. "Maternity Care" means identification of pregnancy, Prenatal Care, labor or delivery services, and Postpartum Care.
6. "Maternity Care Coordination" means the following Maternity Care related activities:
    a. Determining the member's medical or social needs through a risk assessment evaluation;
    b. Developing a plan of care designed to address those needs;
    c. Coordinating referrals of the member to appropriate service providers and community resources;
    d. Monitoring referrals to ensure the services are received; and
    e. Revising the plan of care, as appropriate.
7. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

8. "Postpartum" means the period beginning on the last day of pregnancy and extends through the end of the month in which the 60-day period follows the end of pregnancy. For individuals determined eligible for 12-months postpartum coverage, postpartum is the period that begins on the last day of pregnancy and extends through the end of the month in which the 12-month period following termination of pregnancy ends. For individuals determined eligible for 60-days postpartum coverage, postpartum is the period that begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends. Quality measures used in Maternity Care quality improvement may utilize different criteria for the Postpartum period.
9. "Postpartum Care" means care provided during the period beginning the last day of pregnancy and extends through the end of the month in which the 60-day period follows the end of pregnancy.
10. "Practitioner" means certified nurse Practitioners in midwifery, physician assistants, and other nurse Practitioners.

11. "Preconception Counseling" means the provision of assistance and guidance aimed at identifying/reducing behavioral and social risks, through preventive and management interventions, in women of reproductive age who are capable of becoming pregnant, regardless of whether she is planning to conceive. 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 prior to conception. The purpose of Preconception Counseling is to ensure that a woman is healthy prior to pregnancy. Preconception counseling is considered included in the well-woman preventive care visit and does not include genetic testing.
12. "Prenatal Care" means health care provided during pregnancy and is composed of three major components:
    a. Early and continuous risk assessment,
    b. Health education and promotion including written member educational outreach materials, and
    c. Medical monitoring, intervention, and follow-up.

13. "Providers" means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services, as specified in 42 CFR 457.10 and 42 CFR 438.2.
14. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a member or an applicant for whom no guardian has been appointed.
15. "Second Level Review" means a review performed by a Division of Developmental Disabilities (Division) Medical Director who has the appropriate clinical expertise in managing a Member's condition or disease. Second Level Review is used to screen for medical necessity and compare the findings to clinical data in the Member's medical record to ensure Division Members are receiving medically appropriate and high quality care.

POLICY

A. GENERAL REQUIREMENTS

1. The Division shall ensure the following Maternity Care Services are covered for all eligible, enrolled ALTCS members of childbearing age:
    a. Medically necessary Preconception Counseling;
    b. Identification of pregnancy;
    c. Medically necessary education and written member educational outreach materials;
    d. Treatment of pregnancy-related conditions;
    e. Prenatal services for the care of pregnancy;
    f. Labor and delivery services;
    g. Postpartum Care;
    h. Outreach;
    i. Family Planning Services and Supplies; and
    j. Related services.
2. The Division shall require all Maternity Care Services to be delivered by qualified Providers and in compliance with the most current ACOG standards for obstetrical and gynecological services.

3. The Division shall allow LM's to provide Prenatal Care, labor, delivery, and Postpartum Care services within their scope of practice, while adhering to AHCCCS risk-status consultation and referral requirements.
4. The Division shall require all cesarean sections include medical documentation of medical necessity.
    a. The Division shall require all inductions and cesarean sections done prior to 39 weeks follow the ACOG guidelines.
    b. The Division shall require any inductions performed prior to 39 weeks or cesarean sections performed at any time that are found not to be medically necessary are not eligible for payment.
    c. The Division shall require related services such as outreach and Family Planning Services and Supplies are covered, when appropriate, based on the member's current eligibility and enrollment as specified in AMPM 420.

B. REQUIREMENTS FOR PROVIDING MATERNITY CARE SERVICES

1. The Division shall have a written Maternity and Family Planning Services Annual Plan as specified in AMPM 410 that addresses:
   a. Minimum requirements;
   b. Objectives that are focused on achieving Division and AHCCCS requirements; and
   c. Monitoring and evaluation activities for these minimum requirements as specified in AMPM Exhibit 400-2A and AMPM 410.
2. The Division shall require the AdSS to establish and operate a Maternity Care program with program goals directed at achieving optimal birth outcomes.
3. The Division shall coordinate care for THP Members to ensure the same requirements are met.
4. The Division shall require the following minimum requirements of the Maternity Care program are met:
   a. Sufficient numbers of qualified local personnel to meet the requirements of the Maternity Care program for eligible enrolled Members and achieve contractual compliance;

b. Provision of written Member educational outreach utilizing mechanisms for Member dissemination to meet the following requirements as specified in AMPM Exhibit 400-3:

i. Risks associated with elective inductions and cesarean sections prior to 39 weeks gestation;

ii. Healthy pregnancy measures addressing at a minimum:

a) Nutrition;

b) Sexually transmitted infections;

c) HIV testing;

d) Alcohol, opioids, and substance use and other risky behaviors;

e) Measures to reduce risks for low or very low infant birth weight; and

f) Recognizing active labor.

iii. Dangers of lead exposure to birthing mother and baby during pregnancy and how to prevent exposure;

iv. Postpartum depression;

v. Postpartum services available and the importance of timely prenatal and Postpartum Care;

vi. Provision of information regarding the opportunity to change health plans to ensure continuity of Prenatal Care to newly assigned pregnant women and those currently under the care of an out-of-network Provider;

vii. Postpartum warning signs that require contacting a Provider;

viii. Maternity Care practices that are supportive of breastfeeding, and breastfeeding information;

ix. Safe sleep and ways to reduce Sudden Infant Death Syndrome (SIDS) or Sudden Unexpected Infant Death (SUID) risk;

x. Interconception spacing recommendations and family planning options, including Immediate Postpartum Long-Acting Reversible Contraceptives (IPLARC) as specified in AMPM Policy 420;

xi. Ways to minimize interventions during labor and birth as recommended by ACOG;

xii. Support resources and programs such as:

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

b) Strong Families AZ home visitation programs,

c) Arizona Department of Health Services breastfeeding hotline,

d) Early Head Start or Head Start, and

e) Birth to Five Helpline.

xiii. Information on how to obtain pregnancy related services and assistance with scheduling appointments;

xiv. A statement that there is no copayment or other charge for pregnancy-related services as specified in ACOM Policy 431;

xv. A statement that assistance with medically necessary transportation is available to obtain pregnancy

related services as specified in AMPM Policy 310-BB; and

xvi. Other selected topics.

c. Implementation of written protocols to inform pregnant women and Maternity Care providers of voluntary prenatal HIV or AIDS testing, and the availability of medical counseling and treatment, as well as the benefits of treatment, if the test is positive.

i. The Division shall require the AdSS to include information to encourage pregnant women to be tested and provide instructions on where testing is available as specified in AMPM Exhibit 400-3.

ii. The Division shall require the AdSS to report the number of pregnant women who are HIV or AIDS positive, as specified in Contract, and AMPM 410 Attachment A.

d. Conducting outreach and educational activities to identify currently enrolled Members who are pregnant and enter them into Prenatal Care as soon as possible.

i. The Division shall require programs include protocols for service Providers to notify the AdSS promptly when Members have tested positive for pregnancy.

ii. The Division shall require the AdSS to notify the Division at maternalandchildhealth@azdes.gov and dddcctreferral@azdes.gov when Members have tested positive for pregnancy.

iii. The Division shall require the AdSS to have an ongoing process to monitor and evaluate the effectiveness of outreach activities for all pregnant women and implement different activities if activities prove to be ineffective.

e. Participation in community and quality initiatives, including but not limited to, efforts to reduce maternal mortality and morbidity and address health disparities in maternal and infant health within the communities served by the AdSS.

f. Designation of a Maternity Care Provider for each Member who is pregnant for the duration of her pregnancy and Postpartum Care.

i. The Division shall require the AdSS to allow for freedom of choice, while not compromising the continuity of care.

ii. The Division shall require the AdSS to allow Members who transition to a different AdSS or become newly enrolled with an AdSS during their third trimester to complete Maternity Care with their current AHCCCS registered Provider, regardless of contractual status, to ensure continuity of care.

g. Written new Member assessment procedures for the provider that include identifying risk factors through the use of a comprehensive assessment tool from ACOG covering psychosocial, nutritional, medical and educational factors.

h. Mandatory Maternity Care Coordination services for all pregnant women to include:

i. Identified barriers with navigating the health care system, evident by missed visits,

ii. Difficulties with transportation, or

iii. Other perceived barriers.

i. Demonstration of an established process for assuring:

i. Network Physicians, Practitioners, and LMs adhere to the highest standards of care, including the use of a standardized medical risk assessment tool for initial and ongoing risk assessments, and appropriate consults or referrals for increased-risk or high-risk pregnancies using ACOG criteria;

ii. Maternity Care Providers educate Members about healthy behaviors during the perinatal period, including:

a) The importance of proper nutrition;

b) Dangers of lead exposure to birthing mother and child;

c) Tobacco cessation;

d) Avoidance of alcohol and other harmful substances, including illegal drugs;

e) Prescription opioid use;

f) Screening for sexually transmitted infections;

g) The physiology of pregnancy;

h) The process of labor and delivery;

i) Breast-feeding;

j) Other infant care information;

k) Interconception health and spacing;

l) Family planning services and supplies, including IPLARC;

m) Postpartum follow-up; and

n) Other education as needed for optimal outcomes.

iii. Members are referred for the following support services to:

a) Special Supplemental Nutrition Program for WIC,

b) Home visitation programs for pregnant women and their children, and

c) Other community-based resources to support healthy pregnancy outcomes.

iv. Maternity care providers maintain a complete medical record, documenting all aspects of Maternity Care;

v. Pregnant women have been referred to and are receiving appropriate care from a qualified physician; and

vi. Postpartum services are provided to Members within the time frame that aligns with performance measures as specified in AMPM 970.

j. Mandatory provision of initial Prenatal Care appointments within the following established timeframes and as specified in ACOM Policy 417:

i. First trimester - within 14 calendar days of a request for an appointment;

ii. Second trimester - within seven calendar days of a request for an appointment;

iii. Third trimester - within three business days of a request for an appointment; or

iv. High risk pregnancies as expeditiously as the Member's health condition requires and no later than three business days of identification of high risk by the AdSS, Division or Maternity Care Provider or immediately, if an emergency exists.

k. Verification of Members who are pregnant, to ensure that the above timeframes are met, and to effectively monitor Members are seen in accordance with those timeframes.

l. Monitoring and evaluation of infants born with low or very low birth weight, and implementation of interventions to decrease the incidence of infants born with low or very low birth weight.

m. Monitoring and evaluation of cesarean section and elective induction rates prior to 39 weeks gestation, and implementation of interventions to decrease occurrence, including addressing variations in provider cesarean section rates for first-time pregnant women with a term, singleton baby in a vertex or head down position.

n. Monitoring and evaluation of maternal mortality and implementation of interventions to decrease the occurrence of pregnancy-related mortality and health disparities in both the prenatal and Postpartum period.

o. Monitoring and evaluation to ensure that Maternity Care practices that support breastfeeding success are being utilized per ACOG and American Academy of Pediatrics (AAP) guidance.

p. Identification of Postpartum depression with the required use of any norm-criterion referenced validated screening tool to assist the Provider in assessing the Postpartum needs of women regarding depression and decisions regarding health care services provided by the Maternity Care Provider or subsequent referral for behavioral health services if clinically indicated.

q. Process for monitoring Provider compliance for perinatal and Postpartum depression screenings conducted at least once during the pregnancy and then repeated at the

Postpartum visit, with appropriate counseling and referrals made, if a positive screening is obtained.

r. Return visits scheduled in accordance with ACOG standards. A process shall be in place to monitor these appointments and ensure timeliness.

s. Inclusion of the first and last Prenatal Care dates of service and the number of obstetrical visits that the Member had with the Provider on claim forms to AHCCCS regardless of the payment methodology.

t. Continued payment of obstetrical claims upon receipt of claim after delivery and shall not postpone payment to include the Postpartum visit. The AdSS shall require a separate zero-dollar claim for the Postpartum visit.

u. Timely provision of medically necessary transportation services, as described in Division Medical Policy 310-BB.

v. Monitoring and evaluation of Postpartum activities and implementation of interventions to improve the utilization rate where needs are identified.

w. Participation in reviews of the Maternity Care Services program conducted by the Division as requested, including Provider visits and audits.

C. MATERNITY CARE PROVIDER REQUIREMENTS

1. The Division shall require Providers adhere to the following Maternity Care requirements:
   a. Maternity Care Providers follow the ACOG standards of care, including the use of a standardized medical risk assessment tool and ongoing health risk assessment.
   b. LMs, if included in the AdSS Provider network, adhere to the requirements contained within Division and AHCCCS policy, procedures, and contracts.
2. The Division shall monitor the AdSS to ensure that all Maternity Care Providers adhere to the following:
   a. Division Members have been referred to a qualified Provider and are receiving appropriate care;
   b. All pregnant women are screened through the Controlled Substances Prescription Monitoring Program (CSPMP) once a trimester and appropriate intervention and counseling

shall be provided, including referral of Members for behavioral health services as indicated for Substance Use Disorder (SUD) assessment and treatment, for those Members receiving opioids;

c. All pregnant women are screened for Sexually Transmitted Infections (STI), including syphilis during:
   i. First prenatal visit,
   ii. Third trimester, and
   iii. Time of delivery.

d. Members are educated about the following healthy behaviors during pregnancy:
   i. The importance of proper nutrition;
   ii. Dangers of lead exposure to birthing mother and child;
   iii. Tobacco cessation;
   iv. Avoidance of alcohol and other harmful substances, including illegal drugs;
   v. Prescription opioid use;
   vi. Screening for sexually transmitted infections;

vii. The physiology of pregnancy;

viii. The process of labor and delivery;

ix. Breastfeeding;

x. Other infant care information;

xi. Interconception health and spacing;

xii. Family Planning Services and Supplies, including IPLARC;

xiii. Postpartum follow-up; and

xiv. Other education as needed for optimal outcomes.

e. All pregnant women receive a brief verbal screening and intervention for substance use utilizing an evidence-based screening tool and an appropriate referral shall be made as needed,

f. Providers utilize evidence-based practices per ACOG and the AAP to increase the initiation and duration of breastfeeding including:

i. Provider recommendation for breastfeeding;

ii. Placement of the infant in skin-to-skin contact;

iii. Early initiation of breastfeeding;

iv. No food or drink other than breastmilk; unless medically necessary; and

v. Rooming in.

g. Perinatal and Postpartum depression screenings are conducted at least once during the pregnancy and then repeated at the Postpartum visit with appropriate counseling and referrals made if a positive screening is obtained.

i. Postpartum depression screening is not a separately reimbursable service as it is considered part of the global service.

ii. Providers shall refer to any norm-referenced validated screening tool to assist the Provider in assessing the Postpartum needs of birthing mother regarding depression and decisions regarding health care services provided by the PCP or subsequent referral to a behavioral health Provider, if clinically indicated.

h. Member medical records are appropriately maintained and document all aspects of the Maternity Care provided.

i. Members are referred to the following for support services to support healthy pregnancy and infant outcomes:

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

   ii. Strong Families Az home visiting programs,

   iii. Arizona Department of Health Services breastfeeding hotline,

   iv. Birth to Five Helpline, and

   v. Other community-based resources.

j. Members are notified where they may obtain low-cost or no-cost maternity services, in the event they lose AHCCCS eligibility.

k. The first and last Prenatal Care dates of service and the number of obstetrical visits that the Member had with the Provider are submitted on all claim forms, regardless of the payment methodology used.

l. Postpartum services as clinically indicated are provided to Members within the Postpartum period and adhere to current AHCCCS minimum performance measures.

1. The Division shall require Maternity Care Providers utilize a separate zero-dollar claim for the Postpartum visit.

D. PREGNANCY TERMINATION

1. The Division shall cover pregnancy termination, if one of the following criteria is present:
   a. The pregnant woman suffers from the following, which places the Member in danger of death unless the pregnancy is terminated, as certified by a physician:
      i. A physical disorder;
      ii. Physical injury; or
      iii. Physical illness including a life-endangering physical condition caused by, or arising from, the pregnancy itself.
   b. The pregnancy is a result of incest;
   c. The pregnancy is a result of rape; or

d. 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 woman by:

i. Creating a serious physical or behavioral health problem for the pregnant woman;

ii. Seriously impairing a bodily function of the pregnant woman;

iii. Causing dysfunction of a bodily organ or part of the pregnant woman;

iv. Exacerbating a health problem of the pregnant woman; or

v. Preventing the pregnant woman from obtaining treatment for a health problem.

2. The Division shall require the following to be met regarding Prior Authorization (PA) except in cases of medical emergencies:

a. The Provider obtains a prior authorization for all covered pregnancy terminations;

b. The attending physician submits a request for review of the pregnancy termination qualifying diagnosis and condition for enrolled pregnant women with clinical information that supports the medical necessity or other criteria met for the procedure;

c. The Division reviews the prior authorization request, as specified in AMPM 410 Attachments C and D, and expeditiously authorize the procedure, if the documentation meets the criteria for justification of pregnancy termination;

d. The attending physician submits all documentation of medical necessity within two working days of the date on which the pregnancy termination procedure was performed, in cases of medical emergencies.

3. The Division shall require that any decision to deny or authorize a service is made by a Healthcare Professional who has appropriate clinical expertise in treating the Member's condition or disease.

4. The Division shall require authorization requests for the following services are submitted to the Division, by the AdSS or directly from the Provider for a THP Member, for Second Level Review prior to issuing a decision:
    a. Hysterectomy;
    b. Sterilization; or
    c. Termination of pregnancy.
5. The Division shall review and respond to standard service authorization requests within seven business days and two business days for expedited service authorization requests.
6. The Division shall require expedited requests be clearly labeled as expedited.
7. The Division shall allow the AdSS Medical Director to request a peer-to-peer review with the Division Medical Director if there is a disagreement regarding a service authorization.
8. The Division may request a peer-to-peer directly with the Provider at the Division's discretion for THP Members.
9. The Division shall require:

a. A written consent obtained by the Provider and file in the Member's medical record for a pregnancy termination;

b. If the pregnant woman is younger than 18 years of age, or is 18 years of age or older and considered an incapacitated adult as specified in A.R.S. § 14-5101, a dated signature from the Responsible Person indicating approval of the pregnancy termination procedure is required;

c. When the pregnancy is the result of rape or incest, documentation that the incident was reported to the proper authorities, including the name of the agency to which it was reported, the report number if available, and the date the report was filed;

d. The documentation requirement above in subsection (c) is waived if the treating physician certifies that, in his or her professional opinion, the Member was unable, for physical or psychological reasons, to comply with the requirement;

e. Providers follow Food and Drug Administration (FDA) medication guidance for the use of medications to end a pregnancy, current standards of care per ACOG shall be

utilized when the duration of pregnancy is unknown or if ectopic pregnancy is suspected;

f. Pregnancy termination by surgery or standard of care is recommended in cases when medications are used and fail to induce termination of the pregnancy;

g. When medications are administered to induce termination of the pregnancy, the following documentation is also required:

i. Name of medications used,

ii. Duration of pregnancy in days,

iii. The date medication was given,

iv. The date any additional medications were given unless a complete abortion was already confirmed, and

v. Documentation that pregnancy termination occurred.

8. The Division shall require the following reporting requirements are submitted to AHCCCS and the Division:

a. AHCCCS Certificate of Necessity for Pregnancy Termination and AHCCCS Verification of Diagnosis by AdSS for

Pregnancy Termination Requests, AMPM 410 Attachments C and D, as specified in Contract; and

b. Pregnancy Termination Report and the required documentation as listed in AMPM 410 Attachment E, as specified in Contract.

9. The Division shall require the AdSS to develop procedures to identify and monitor all claims and encounters with a primary diagnosis of pregnancy termination.

E. ADDITIONAL RELATED SERVICES

1. The Division shall cover circumcision for males as follows:
   a. Circumcision for males, only when it is determined to be medically necessary, under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program;
   b. Routine circumcision for newborn males is not a covered service; and
   c. The procedure requires Prior Authorization (PA) if required by the newborn's Health Plan.
2. The Division shall require home uterine monitoring technology is covered when determined to be medically necessary as follows:

a. Covered for Members with premature labor contractions before 35 weeks gestation, as an alternative to hospitalization.

b. If the Member has one or more of the following conditions, home uterine monitoring may be considered for:

i. Multiple gestation, particularly triplets or quadruplets;

ii. Previous obstetrical history of one or more births before 35 weeks gestation;

iii. For a pregnant woman ready to be discharged home after hospitalization for premature labor before 35 weeks gestation with a documented change in the cervix, controlled by tocolysis.

c. These guidelines refer to home uterine activity monitoring technology and do not refer to daily Provider contact by telephone or home visit.

3. The Division shall require labor and delivery services provided in Free Standing Birthing Centers are covered.

a. For Members who meet medical criteria specified in this policy when labor and delivery services are provided by Maternity Care Providers.

b. Only Members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated may be scheduled to deliver at a Free Standing Birthing Center.

c. Risk status shall be determined by the attending physician or Certified Nurse Midwife (CNM), using the standardized ACOG assessment tools for high-risk pregnancies. In any area of the risk assessment where standards conflict, the most stringent will apply.

d. The age of the Member shall also be a consideration in the risk status evaluation as Members younger than 18 years of age are generally considered high risk.

e. Refer to A.A.C. R9-16-111 through 113 for a more detailed explanation of what are not considered low-risk deliveries, nor appropriate for planned home-births or births in Free Standing Birthing Centers.

4. The Division shall require labor and delivery services in a home setting provided by the Member's maternity Provider are covered.
    a. For Members who meet medical criteria, AHCCCS covers labor and delivery services provided in the home by:
        i. Member's maternity Provider physicians,
        ii. CNMs, or
        iii. LMs.
    b. Only AHCCCS Members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated, may be scheduled to deliver in the Member's home.
    c. Risk status is initially determined at the time of the first visit, and each trimester thereafter, by the Member's Maternity Care Provider, using the current standardized ACOG assessment criteria and protocols for High-Risk Pregnancies.

d. A risk assessment conducted when a new presenting complication or concern arises to ensure appropriate care and referral to a qualified Provider, if necessary.

e. Physicians and CNMs who render home labor and delivery services have admitting privileges at an acute care hospital in close proximity to the site where the services are provided in the event of complications during labor and delivery.

f. LMs who render home labor and delivery services have an established plan of action, including methods of obtaining services at an acute care hospital in close proximity to the site where services are provided for each anticipated home labor and delivery.

g. Referral information to an AHCCCS registered physician who can be contacted immediately, in the event that management of complications is necessary, are included in the plan of action.

h. The Maternity Care Provider notifies the birthing mother's AdSS or the AHCCCS Newborn Reporting Line of the birth

for infants born to THP Members. Notification is given no later than three days after the birth in order to enroll the newborn with AHCCCS.

5. The Division shall require licensed midwife services are provided by LMs for Members, if LMs are included in the AdSS' Provider network or AHCCCS registered Providers who accept THP.
   a. Members who choose to receive maternity services from this Provider type meet eligibility and medical criteria specified in this policy.
   b. Risk status is initially determined at the time of the first visit, and each trimester, thereafter, using the current standardized assessment criteria and protocols for high-risk pregnancies from ACOG.
   c. An ACOG risk assessment is conducted when a new presenting complication or concern arises to ensure proper care and referral to a qualified Provider, if necessary.
   d. Before providing midwife services, documentation certifying the risk status of the Member's pregnancy is submitted to the AdSS or to DFSM for THP Members.

e. A consent form signed and dated by the Member is submitted, indicating that the Member has been informed and understands the scope of services that will be provided by the LM, including the risks to a home delivery.

f. Members are immediately referred to an AHCCCS registered physician for THP or within the Provider network of the Member's AdSS for Maternity Care Services who:

   i. Are initially determined to have a High-Risk Pregnancy, or

   ii. Members whose physical condition changes to high-risk during the course of pregnancy.

g. Labor and delivery services provided by a LM cannot be provided in a hospital.

   i. LMs shall have a plan of action, including the name and address of an AHCCCS registered physician and an acute care hospital in close proximity to the planned location of labor and delivery for referral, in the event that complications should arise.

ii. This plan of action is submitted to the DFSM Medical Director or designee for THP Members, or to the AdSS Medical Director or designee for Members enrolled with an AdSS.

h. Upon delivery of the newborn, the LM is responsible for conducting newborn examination procedures, including:

i. A mandatory Bloodspot Newborn Screening Panel,

ii. A referral of the infant to an appropriate health care Provider for a mandatory hearing screening,

iii. A second mandatory Bloodspot Newborn Screening Panel, and

iv. A second newborn hearing screening.

i. The LM shall notify the birthing mother's AdSS or the AHCCCS Newborn Reporting Line for infants born to THP Members, of the birth no later than one day from the date of birth, in order to enroll the newborn with AHCCCS.

D. AdSS OVERSIGHT AND MONITORING

1. The Division shall meet with the AdSS at least quarterly to provide ongoing evaluation including data analysis and

recommendations to refine processes, identify successful interventions and care pathways to optimize results.

2. The Division shall perform an Operational Review of the AdSS on an annual basis that includes a review of compliance.

Signature of Chief Medical Officer: Anthony Dekker (Oct 21, 2023 09:07 PDT)
Anthony Dekker, D.O.

411 WOMEN'S PREVENTIVE CARE SERVICES

REVISION DATES: 6/08/2022, 10/1/2021, 7/3/2019
EFFECTIVE DATE: May 27, 2016

PURPOSE

This policy establishes requirements for well-woman preventive care visits as a covered benefit for women to obtain the recommended preventive services, including Preconception Counseling.

DEFINITIONS

1. "Clinical Breast Exam" means a physical examination of the breasts by a health care provider used as a primary diagnostic procedure for early detection of breast cancer.

2. "Family Planning Services and Supplies" means the provision of accurate information, counseling, and discussion with a health care provider to allow members to make informed decisions about the specific family planning methods available that align with the member's lifestyle and provision of indicated supplies.

3. "Human Papillomavirus (HPV)" means a sexually transmitted infection for which a series of immunizations are available for both males and females.

4. "Mammogram" means an x-ray of the breasts used to look for early signs of breast cancer.

5. "Preconception Counseling" means the purpose of Preconception Counseling is to ensure that a woman is healthy prior to pregnancy by identifying/reducing behavioral and social risks, through preventive and management interventions, in women of reproductive age who are capable of becoming pregnant, regardless of whether she is planning to conceive. 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 prior to conception. Preconception Counseling is considered included in the well-woman preventive care visit.

POLICY

A. A well-woman preventive care visit is covered on an annual basis.

B. Well-Woman Preventive Care Services include:

1. Well Exam - An annual well-woman preventive care visit is intended for the identification of risk factors for disease, identification of existing physical/behavioral health problems,

and promotion of healthy lifestyle habits essential to reducing or preventing risk factors for various disease processes.

C. Requirements for Well-Woman Preventive Care Services:

1. The Division's contracted health plans are responsible for covering Well- Woman Preventive Care Services for Division members enrolled in one of the subcontracted health plans in accordance with AdSS Policy 411.

D. AdSS Oversight And Monitoring

At least quarterly, the Division meets with the AdSS to provide ongoing evaluation including data analysis and recommendations to refine processes, identify successful interventions and care pathways to optimize results. On an annual basis, the Division performs an Operational Review of the AdSS that includes review of compliance.

Signature of Chief Medical Officer: Anthony Dekker (Jun 1, 2022 15:37 PDT)
Anthony Dekker, D.O.

420 FAMILY PLANNING SERVICES AND SUPPLIES

REVISION DATE: 1/10/2024, 9/6/2023, 6/8/2022, 10/1/2021, 10/01/2019, 8/22/2018, 7/3/2015, 9/15/2014
REVIEW DATE: 9/14/2023
EFFECTIVE DATE: June 30, 1994
REFERENCES: A.R.S. §36.2904(L), ACOM Policy 405, AMPM 420

PURPOSE

This policy establishes requirements and describes covered services regarding Family Planning Services and Supplies for Division of Developmental Disabilities (Division) Members.

DEFINITIONS

1. "Business Days" means Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.
2. "Family Planning Provider" means individuals who are involved in providing family planning services to individuals and may include physicians, physician assistants, nurse practitioners, nurse midwives, midwives, nursing staff and health educators.
3. "Family Planning Services and Supplies" means the provision of accurate information, counseling, and discussion with a

healthcare provider to allow Members to make informed decisions about the specific family planning methods available that align with the Member's lifestyle and provision of indicated supplies. Family Planning Services and Supplies include covered medical, surgical, pharmacological, and laboratory benefits specified in this policy.

4. "Hysterosalpingogram" means an X-ray procedure used to confirm sterility (occlusion of the fallopian tubes).
5. Immediate Postpartum Long-Acting Reversible Contraceptives" or "IPLARC" means immediate postpartum placement of reversible methods for family planning that provide effective contraception for an extended period of time with little or no maintenance or user actions required, including intrauterine devices and subdermal and implantable contraceptives.
6. "Long-Acting Reversible Contraceptives" or "LARC" means reversible methods for family planning that provide effective contraception for an extended period of time with little or no maintenance or user actions required, including intrauterine devices and subdermal and implantable contraceptives.

7. "Maternity Care Provider" means the following provider types who may provide maternity care when it is within their training and scope of practice:
    a. Arizona licensed allopathic or osteopathic physicians who are obstetricians or general practice or family practice providers who provide maternity care services,
    b. Physician Assistant,
    c. Nurse Practitioners,
    d. Certified Nurse Midwives, and
    e. Licensed Midwives
8. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
9. "Reproductive Age" means Division Members, regardless of gender, from 12 to 55 years of age.
10. "Second Level Review" means a review performed by a Division Medical Director who has the appropriate clinical expertise in managing a Member's condition or disease. Second Level Review is used to screen for medical necessity and compare the findings to clinical data in the Member's medical record to ensure Division

Members are receiving medically appropriate and high quality care.

POLICY

A. GENERAL REQUIREMENTS

1. The Division shall require Family Planning Services and Supplies to be covered for Members when provided by the appropriate Family Planning Providers or Maternity Care Providers, regardless of gender, who voluntarily choose to delay or prevent pregnancy.
2. The Division shall require that Family Planning services provided are within each provider's training and scope of practice.
3. The Division shall require the provision of medically accurate information and counseling to allow Members to make informed decisions about specific family planning methods available.
4. The Division shall ensure Members enrolled with a health plan maintain the option to choose Family Planning Services and Supplies from any appropriate provider regardless of whether or not the Family Planning Service Providers are network providers.

5. The Division shall ensure Members enrolled with DDD Tribal Health Program (THP) have the option to select any AHCCCS-registered Family Planning Provider.
6. The Division shall ensure pregnant or postpartum Members whose AHCCCS eligibility continues, may remain with their assigned maternity provider, or may select another provider for Family Planning Services and Supplies.

B. SECOND LEVEL REVIEW

1. The Division shall review the following services prior to approval or denial by the AdSS:
   a. Hysterectomy,
   b. Sterilization, or
   c. Termination of pregnancy.
2. The Division shall ensure the AdSS submits the following clinical documentation to support medical necessity for requested services:
   a. Medical records related to the request;
   b. AHCCCS Certificate of Necessity for Pregnancy Termination, if applicable;

c. Verification of diagnosis by contractor for a Pregnancy Termination, if applicable; and

d. Consent to Sterilization, if applicable.

3. The Division shall require the AdSS to submit requests in a timely manner, at minimum, seven Business Days, for review and response for standard service authorization requests.

4. The Division shall require the AdSS to submit expedited service requests within two Business Days and clearly label these requests as expedited.

5. The Division may request a peer-to-peer review with the AdSS Medical Director if there is a disagreement regarding a service authorization.

6. The Division shall make the final decision on prior authorization requests elevated for Second Level Review.

C. AMOUNT, DURATION, AND SCOPE

1. The Division shall require the AdSS to cover the following Family Planning Services and Supplies for Members:

a. Contraceptive counseling, medication, and supplies:

i. Oral and injectable contraceptives;

ii. LARC;

iii. IPLARC;

iv. Diaphragms;

v. Condoms;

vi. Foams; and

vii. Suppositories.

b. Associated medical and laboratory examinations and radiological procedures, including ultrasound studies related to family planning;

c. Treatment of complications resulting from contraceptive use, including emergency treatment;

d. Natural family planning education or referral to other qualified health professionals;

e. Post-coital emergency oral contraception, excluding Mifepristone (Mifeprex or RU-486) within 72 hours after unprotected sexual intercourse; and

f. Sterilization by Hysteroscopic Tubal Sterilization or Vasectomy

i. The Division shall require the provider counsels and recommends the Member continue another form of birth control to prevent pregnancy for up to 3 months following the Hysteroscopic Tubal Sterilization or Vasectomy.

ii. The Division shall require the provider to perform a Hysterosalpingogram or sperm count according to the current standard of care for the sterilization procedure to confirm the Member is sterile following the Hysteroscopic Tubal Sterilization or Vasectomy.

2. The Division shall ensure the following Family Planning Services and Supplies are covered:

a. Pregnancy screening;

b. Pharmaceuticals when associated with medical conditions related to family planning or other medical conditions;

c. Screening and treatment for Sexually Transmitted Infections (STI) for Members, regardless of gender;

d. Sterilization, regardless of Member's gender, when the requirements for sterilization services are met; and

e. Pregnancy termination only as specified in AMPM Policy 410.

3. The Division shall ensure service providers are aware the following services are not covered for the purpose of Family Planning Services and Supplies:

a. Infertility services including diagnostic testing, treatment services and reversal of surgically induced infertility;

b. Pregnancy termination counseling;

c. Pregnancy terminations, except as specified in AMPM Policy 410; and

d. Hysterectomy for the purpose of sterilization.

D. REQUIREMENTS FOR PROVIDING FAMILY PLANNING SERVICES AND SUPPLIES

1. The Division shall monitor required Member outreach per AMPM Exhibit 400-3 to notify Members of Reproductive Age, regardless of gender, of the specific covered Family Planning Services and Supplies available and how to request them.

2. The Division shall require the AdSS to ensure the following information is provided to Members:

a. A complete description of available covered Family Planning Services and Supplies,

b. Information advising how to request or obtain these services,

c. Information that assistance with scheduling is available,

d. A statement that there is no copayment or other charge for Family Planning Services and Supplies as specified in ACOM Policy 431, and

e. A statement that medically necessary transportation services as specified in AMPM 310-BB are available.

3. The Division shall require the AdSS to have policies and procedures in place to ensure Family Planning Providers are educated regarding covered and non-covered services, Family Planning Services and Supplies, including LARC and IPLARC options.

4. The Division shall ensure Family Planning Services and Supplies are:

a. Provided in a manner free from coercion or behavioral or mental pressure;

b. Available and easily accessible to Members;

c. Provided in a manner which assures continuity and confidentiality;

d. Provided by, or under the direction of, a qualified physician or practitioner; and

e. Documented in the medical record that each Member of Reproductive Age was notified verbally or in writing of the availability of Family Planning Services and Supplies.

5. The Division shall require the AdSS to ensure providers incorporate medical audits for Family Planning Services and Supplies within Quality Management activities to determine conformity with acceptable medical standards.
6. The Division shall require the AdSS to establish quality or utilization management indicators to effectively measure and monitor the utilization of Family Planning Services.
7. The Division shall require the AdSS to ensure that guidelines detail specific procedures for the provision of LARC or IPLARC and are written in accordance with acceptable medical standards.

8. The Division shall require that the Family Planning or Maternity Care Provider has provided proper counseling to the eligible Member prior to insertion of intrauterine and subdermal implantable contraceptives to increase the Member's success with the device according to the Member's reproductive goals.

E. PROTOCOL FOR MEMBER NOTIFICATION OF FAMILY PLANNING SERVICES

1. The Division requires the AdSS to have a process to ensure the sterilization reports specified in this policy comply with the procedural guidelines for encounter submissions.
2. The Division shall ensure the following minimum requirements are met specific for notification of covered Family Planning Services and Supplies:
    a. Members of Reproductive Age shall be notified either directly or through the Responsible Adult of the specific covered Family Planning Services and Supplies available to them, and a plan to provide those services and supplies to Members who request them by:

i. Provisions for written notification, other than the Member handbook;

ii. Member newsletter; and

iii. Verbal notification during a Member's visit with the PCP.

b. Family Planning notification is sent by the end of the second trimester for pregnant Members and includes information on LARC or IPLARC;

c. The AdSS shall conform to confidentiality requirements as specified in 45 C.F.R. 164.522(b) (i and ii);

d. Communications and correspondence shall be approved by the Division;

e. Distribution at least once per year by November 1st. For Members who enroll with the AdSS after November 1st, notification is sent at the time of enrollment;

f. Notification of the covered Family Planning Services and instructions given to Members regarding how to access these services;

g. Written notification at reading level and easily understood as specified in ACOM 404;

h. Notification in accordance with cultural competency requirements as specified in ACOM Policy 405;

i. The AdSS shall ensure Maternity Care Providers verbally notify Members of the availability of Family Planning Services during office visits; and

j. The AdSS shall report all Members under 21 years of age, undergoing a procedure that renders the Member sterilized, using the AHCCCS Sterilization Reporting Form, AMPM 420 Attachment B and submitting documentation supporting the medical necessity for the procedure.

F. STERILIZATION

1. The Division shall ensure the following criteria are met for the sterilization of a Member to occur:

   a. The Member is at least 21 years of age at the time the consent is signed, using AHCCCS Consent to Sterilization AMPM 420 Attachment A;

   b. The Member has not been declared mentally incompetent;

c. Voluntary consent was obtained by the Member or Responsible Person without coercion;

d. 30 days, but not more than 180 days, have passed between the date of informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery.

i. Members may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since they gave informed consent for the sterilization.

ii. Consent is given at least 30 days before the expected date of delivery in the case of premature delivery.

2. The Division shall ensure any Member requesting sterilization signs the AHCCCS Consent to Sterilization form with a witness present when the consent is obtained as specified in AMPM 420.

3. The Division shall ensure suitable arrangements are made to ensure the information in the consent form is effectively communicated to Members with limited English proficiency or

reading skills and those with diverse cultural and ethnic backgrounds, as well as Members with visual or auditory limitations as specified in ACOM 404 and ACOM 405.

4. The Division shall ensure the Member receives a copy of the consent form and is offered factual information prior to signing the consent form that includes the following:
   a. Consent form requirements as specified in 42 CFR 441.250;
   b. Answers to questions asked regarding the specific procedure to be performed;
   c. Notification that withdrawal of consent can occur at any time prior to surgery without affecting future care or loss of federally funded program benefits;
   d. Advice that the sterilization procedure is considered to be irreversible;
   e. A thorough explanation of the specific sterilization procedure to be performed;
   f. A description of available alternative methods;

g. A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the types and possible effects of any anesthetic to be used;

h. A full description of the advantages or disadvantages that may be expected as a result of the sterilization;

i. Notification that sterilization cannot be performed for at least 30 days post consent.

5. The Division shall ensure sterilization consents are not obtained when a Member is:

a. In labor or childbirth;

b. Seeking to obtain, or is obtaining, a pregnancy termination; or

c. Under the influence of alcohol or other substances that affect that Member's state of awareness.

G. OVERSIGHT AND MONITORING

1. The Division shall meet with the AdSS at least quarterly to provide:

a. Ongoing evaluation including data analysis,

b. Recommendations to refine processes,

c. Identify successful interventions, and

d. Care pathways to optimize results.

2. The Division shall perform an Operational Review of the AdSS that includes review of compliance on an annual basis.

Signature of Chief Medical Officer: Anthony Dekker (Jan 5, 2024 13:00 MST)

Anthony Dekker, D.O.

430 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES

REVISION DATES: 06/08/22, 10/01/2019, 3/25/2016, 7/3/2015, 4/15/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994
REFERENCES: 42 U.S.C. 1396d (a), Division Medical Policy Manual, 310-P

PURPOSE

This policy establishes requirements for the provision of Early and Periodic Screening, Diagnostic, and Treatment (EPDST) services.

DEFINITIONS

1. "Commercial Oral Supplemental Nutrition" means nourishment available without a prescription that serves as sole caloric intake or additional caloric intake.

2. "Diagnostic" means determination of the nature or cause of a condition, illness, or injury through the combined use of health history, physical, developmental, and psychological examination, laboratory tests, and X-rays, when appropriate.

3. "Early" means in the case of a child already enrolled with an AHCCCS Contractor, as soon as possible in the child's life, or in other cases, as soon after the member's eligibility for AHCCCS services has been established.

4. "Early and Periodic Screening, Diagnostic and Treatment (EPSDT)" means a comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for AHCCCS members under the age of 21. 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.

5. "Periodic" means at intervals established by AHCCCS for screening to assure that a condition, illness, or injury is not incipient or present.

6. "Screening" means regularly scheduled examinations and evaluations of the general physical and behavioral health, growth, development, and nutritional status of infants, children, and adolescents, and the identification of those in need of more

definitive evaluation. For the purpose of the AHCCCS EPSDT program, screening and diagnosis are not synonymous.

7. "Treatment" means any of the 29 mandatory or optional services described in 42 U.S.C. 1396d(a), even if the service is not covered under the (AHCCCS) State Plan, when necessary to correct or ameliorate defects and physical and mental illnesses and conditions detected by screening.

POLICY

A. EPSDT/Well Child Visit

The EPSDT/Well Child visit is all-inclusive and includes the following:

1. A comprehensive health and Developmental history, including growth and Developmental Screening which includes physical, nutritional, and behavioral health assessments. Refer to the Centers for Disease Control and Prevention website: www.cdc.gov/growthcharts/ for Body Mass Index (BMI) and growth chart resources.

2. Nutritional Screening provided by a primary care physician (PCP).

3. Nutritional Assessment provided by a PCP, refer to AdSS Medical Policy 430.

4. Behavioral Health Screening and Services provided by a PCP.

    a. The Division covers behavioral health services for members eligible for EPSDT. PCPs may provide behavioral health services within their scope of practice.

    b. American Indian members may receive behavioral health services through an Indian Health Service or Tribally operated 638 facility, regardless of health plan enrollment or behavioral health assignment.

5. Developmental Surveillance shall be performed with the PCP at each EPSDT visit.

6. A comprehensive unclothed physical examination.

7. Immunizations

    a. EPSDT covers all child and adolescent immunizations, as specified in the Centers for Disease Control and Prevention (CDC) recommended childhood immunization schedules.

b. Appropriate immunizations according to age and health history (administration of the immunizations may be billed in addition to the EPSDT visit using the CPT-4 code appropriate for the immunization with an SL modifier). Combination vaccines are paid as one vaccine.

c. Providers shall be registered as Vaccines for Children (VFC) providers and VFC vaccines shall be used.

8. Laboratory tests

a. Laboratory including, anemia testing and Diagnostic testing for sickle cell trait.

b. EPSDT covers blood lead Screening for all members at 12 months and 24 months of age and for those members between the ages of 24 through 6 years of age who have not been previously tested or who missed either the 12 month or 24 month test. Lead levels may be measured at times other than those specified if thought to be medically indicated by the provider, by responses to a lead poisoning verbal risk assessment, or in response to parent/responsible person's concerns. Additional

Screening for children under 6 years of age is based on the child's risk as determined by either the member's residential zip code or presence of other known risk-factors.

9. Health education, counseling, and chronic disease self-management.

10. Oral Health Screening

    a. Appropriate oral health Screening, intended to identify oral pathology, including tooth decay and/or oral lesions, and the application of fluoride varnish conducted by a physician, physician's assistant, or nurse practitioner.

    b. Fluoride varnish is limited in a primary care provider's office to 1 every 6 months, during an EPSDT visit for children who have reached 6 months of age with at least 1 tooth erupted, with recurrent applications up to 2 years of age.

11. Appropriate vision, hearing, and speech Screenings

a. EPSDT covers eye examinations as appropriate to age per the AHCCCS EPSDT Periodicity Schedule and as medically necessary using standardized visual tools.

b. Ocular photo screening with interpretation and report, bilateral is covered for children ages three through 6 as part of the EPSDT visit due to challenges with a child's ability to cooperate with traditional chart-based vision Screening techniques. Ocular photo screening is limited to a lifetime coverage limit of 1.

c. Automated visual Screening is for vision Screening only, and not recommended for or covered when used to determine visual acuity for purposes of prescribing glasses or other corrective devices.

d. Prescriptive lenses and frames are provided to correct or ameliorate defects, physical illness, and conditions discovered by EPSDT Screenings, subject to medical necessity. Frames for eyeglasses are also covered.

12. Tuberculosis (TB) Screening

a. Tuberculin skin testing as appropriate to age and risk.

b. Confirmed or suspected as having TB,

c. In jail or prison during the last 5 years,

d. Living in a household with an HIV-infected individual or the child is infected with HIV, and/or

e. Traveling/immigrating from or having significant contact with individuals indigenous to endemic countries.

B. Sick Visit Performed in Addition to an EPSDT

A "sick visit" can be performed at the same time as an EPSDT visit:

1. An abnormality is encountered, or a preexisting problem is addressed in the process of performing an EPSDT service and the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented Evaluation Management service, and.

2. The "sick visit" is documented on a separate note.

3. History, exam, and member/responsible person components of the separate "sick visit" already performed during an EPSDT visit are not to be considered when determining the level of the additional services. An insignificant or trivial

problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service, and which does not require additional work and the performance of the key components of a problem-oriented E/M service is included in the EPSDT visit and should not be reported.

C. AdSS Specific Requirements

For AdSS specific requirements, see AdSS Medical Policy 430.

D. Requirements for the EPSDT Program Plan Checklist

The Division and AdSS shall have a written EPSDT Program Plan Checklist that addresses minimum requirements. For AdSS specific requirements, see AdSS Medical Policy 430.

1. Provider Requirements

   EPSDT services shall be provided according to community standards of practice and Division rules and policies including the AHCCCS EPSDT and Dental Periodicity Schedules. Providers shall refer members for follow-up, diagnosis, and treatment. Treatment is to be initiated within 60 days of screening services.

a. Providers are required to provide health counseling/education at initial and follow-up visits.

b. Refer to the specific AdSS for managed care members and to the Division for Tribal Health Plan (THP) members, regarding (Prior Authorization) PA requirements.

c. A PCP referral is not required for Naturopathic services.

2. Additionally, providers shall adhere to the below specific standards and requirements for the following covered services, see AdSS Medical Policy 430:

a. Breastfeeding Support

b. Immunizations

c. Blood Lead Screening

d. Organ and Tissue Transplantation Services

Refer to AMPM Policy 310-DD for information regarding AHCCCS-covered transplants.

e. Metabolic Medical Foods

If a Division member has a congenital metabolic disorder identified through the Bloodspot Newborn Screening Panel (such as Phenylketonuria, Homocystinuria, Maple Syrup Urine Disease, or Galactosemia), refer to AMPM Policy 310-GG.

f. Nutritional Therapy

i. The Division covers nutritional therapy for EPSDT members on an Enteral Nutrition, TPN Therapy, or oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member's daily nutritional and caloric intake.

ii. PA is required from the AdSS or Tribal ALTCS Case Manager or The Division for Tribal Health Plan (THP) members for Commercial Oral Supplemental Nutrition, unless the member is also currently receiving nutrition through Enteral Nutrition or TPN Therapy.

g. Oral Health Services

As part of the physical examination, the physician, physician's assistant, or nurse practitioner shall perform an oral health Screening. A Screening is intended to identify gross dental or oral lesions but is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan. Referral to a dentist or dental home shall be made as outlined in policy, see AMPM Policy 431.

h. Cochlear and Osseointegrated Implantation

i. Cochlear implantation

j. Conscious Sedation

The Division covers conscious sedation for members receiving EPSDT services.

k. Behavioral Health Services

The Division covers behavioral health services for members eligible for EPSDT services as described in Contract and Policy. EPSDT behavioral health services include the services necessary to correct or ameliorate

mental illnesses and conditions discovered by the Screening services.

For the diagnosis of behavioral health conditions including, but not limited to Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD), depression (including postnatal depression), and/or anxiety disorders, there are clinical guidelines that include assessment tools and algorithms. If allowable within their scope of practice, the clinical guidelines are to be used by PCPs as an aid in treatment decisions.

l. Religious Non-Medical Health Care Institution Services

The Division covers religious non-medical health care institution services for members eligible for EPSDT services as specified in AMPM Policy 1210.

m. Care Management Services

The Division covers care management services for both physical and behavioral health care, as appropriate for members eligible for EPSDT services. In EPSDT, care management involves identifying the health needs of a

child, ensuring necessary referrals are made, maintaining health history, and initiating further evaluation/diagnosis and treatment when necessary.

n. Chiropractic Services

The Division covers chiropractic services to members eligible for EPSDT services, when ordered by the member's PCP and approved by the AdSS to ameliorate the member's medical condition.

o. Personal Care Services

The Division covers personal care services, as appropriate, for members eligible for EPSDT services.

p. Incontinence Briefs

q. Medically Necessary Therapies

The Division covers medically necessary therapies including physical therapy, occupational therapy, and speech therapy, necessary to correct or ameliorate defects, physical and mental illnesses, and conditions discovered by the Screening services. Therapies are

covered under both an inpatient and outpatient basis when medically necessary.

E. AdSS Oversight and Monitoring

At least quarterly, the Division meets with the AdSS to provide ongoing evaluation including data analysis and recommendations to refine processes, identify successful interventions and care pathways to optimize results. On an annual basis, the Division performs an Operational Review of the AdSS that includes review of compliance.

Signature of Chief Medical Officer: Anthony Dekker (Jun 1, 2022 16:32 PDT)

Anthony Dekker, D.O.

431 DENTAL/ORAL HEALTH SERVICES FOR EPSDT ELIGIBLE MEMBERS

REVISION DATE: 2/7/2024, 6/8/2022, 10/1/2021
REVIEW DATE: 7/26/2023
EFFECTIVE DATE: November 22, 2017
REFERENCES: 42 U.S.C. 1396d(a), 9 A.A.C. 22, Article 2; A.R.S. §36.-551, A.R.S. § 14-5101; AMPM 431 Attachment B, AMPM Policy 430 Attachment A, AMPM Policy 431 Attachment A

PURPOSE

This policy establishes requirements for dental/oral health care for Members under 21 years of age who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

DEFINITIONS

1. "Dental Home" means the ongoing relationship between the dentist and the member, inclusive of all aspects of oral healthcare delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. The dental home should be established no later than 12 months of age to help children and their families institute a lifetime of good oral health. A dental home addresses anticipatory guidance and preventive, acute, and comprehensive oral health care and

includes referral to dental specialists when appropriate. [American Academy of Pediatric Dentistry (AAPD)].

2. "Dental Provider" means an individual licensed as specified in A.R.S. Title 32, Chapter 11, whose scope of practice allows the individual to:
   a. Independently engage in the practice of dentistry as specified in A.R.S. § 32-1202,
   b. A dentist as specified in A.R.S. § 32-1201,
   c. A dental therapist as specified in A.R.S. § 32-1201,
   d. A dental hygienist as specified in A.R.S. § 32-1201, or
   e. An affiliated practice dental hygienist as specified in A.R.S. § 32-1201.
3. "Early and Periodic Screening, Diagnostic and Treatment" or "EPSDT" means a comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for AHCCCS members under the age of 21. 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.

4. "Informed Consent" means an agreement to receive physical or behavioral health services following the presentation of facts necessary to form the basis of an intelligent consent by the Member or Responsible Person with no minimization of known dangers of any procedures.
5. "Medically Necessary" means a covered service provided by a physician or other licensed practitioner of the health arts within the scope of practice under State law to prevent disease, disability or other adverse conditions or their progression, or to prolong life as specified in A.A.C. R9-22-101.
6. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

7. "Primary Care Provider" or "PCP" means an individual who meets the requirements as specified in A.R.S. § 36-2901, and who is responsible for the management of the member's health care. A PCP may be a physician defined as an individual licensed as an allopathic or osteopathic physician as specified in A.R.S. Title 32, Chapter 13 or Chapter 17, or a practitioner defined as a physician assistant licensed as specified in A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed as specified in A.R.S. Title 32, Chapter 15, or a naturopathic physician for AHCCCS members under the age of 21 receiving EPSDT services. The PCP shall be an individual, not a group or association of individuals, such as a clinic.
8. "Provider" means a person, institution, or group engaged in the delivery of services, or ordering and referring those services, who has an agreement with AHCCCS to provide services to AHCCCS members.
9. "Referral" means a verbal, written, telephonic, electronic, or in-person request for health services.

10. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed as defined in A.R.S. §36.-551
11. "Screening" means the regularly scheduled examinations and evaluations of the general physical and behavioral health, growth, development, and nutritional status of infants, children, and adolescents, and the identification of those in need of more definitive evaluation. For the purpose of the AHCCCS EPSDT program, screening and diagnosis are not synonymous.
12. "Treatment Plan" means a written plan of services and therapeutic interventions based on a complete assessment of a Member's developmental and health status, strengths and needs that are designed and periodically updated by the multi-specialty, interdisciplinary team.

POLICY

A. GENERAL REQUIREMENTS

1. The Division shall require an oral health screening to be conducted by a PCP as part of an EPSDT screening.
2. The Division shall require oral health screenings as part of the physical examination are performed by a:
    a. Physician,
    b. Physician's assistant, or
    c. Nurse practitioner.
3. The Division shall require PCPs to refer EPSDT Members for appropriate services based on needs identified through the screening process and for routine oral health care based on the AHCCCS EPSDT Periodicity Schedule.
4. The Division shall require the Referral be documented on the EPSDT Clinical Sample Template as specified in AMPM Policy 430, Attachment E and in the Member's medical record.
5. The Division shall require one of the following Referrals to a dental provider to be made depending on the results of the oral health screening:
    a. Urgent referrals as expeditiously as the Member's health condition requires, but no later than 3 days of request;

b. Routine referrals within 45 calendar days of request; or

c. Within 30 calendar days of request for the Department of Child Safety (DCS) Comprehensive Health Plan (CHP) only.

6. The Division shall require reimbursement for PCPs who have completed the AHCCCS-required training for fluoride varnish applications completed at the EPSDT visits for Members as early as six months of age with at least one tooth eruption.

7. The Division shall require reimbursement for PCPs according to AHCCCS-approved fee schedules for additional fluoride applications occurring every three months during an EPSDT visit, up until the member's fifth birthday.

8. The Division shall require that PCPs are notified that application of fluoride varnish by the PCP does not take the place of an oral health visit.

9. The Division shall require providers to submit a copy of their certificate upon completion of the required training prior to payment being issued for PCP-applied fluoride varnish.

B. DENTAL HOME

1. The Division shall require that the Dental Home provides:

a. Comprehensive oral health care including acute care and preventive services in accordance with AMPM 431 Attachment A;

b. Comprehensive assessment for oral diseases and conditions;

c. Individualized preventive oral health program based upon a caries-risk assessment and a periodontal disease risk assessment;

d. Anticipatory guidance about the following growth and development issues:

   i. Teething,

   ii. Digit,

   iii. Pacifier habits, or

   iv. Similar issues.

e. A plan for acute dental/oral trauma;

f. Information about proper care of the child's teeth and gingiva, including the prevention, diagnosis, and treatment of disease of the supporting and surrounding tissues and

the maintenance of health, function, and esthetics of those structures and tissues;

g. Dietary counseling; and

h. Referrals to dental specialists when care cannot directly be provided within the Dental Home.

2. The Division shall require THP Members be referred by a PCP to a Dental Provider by one year of age or upon enrollment.
3. The Division shall require Members enrolled with an AdSS are assigned a dental home by six months of age or upon enrollment, and seen by a Dental Provider for routine preventative care according to the AMPM 431 Attachment A.
4. The Division shall require PCPs to refer Members with identified additional oral health care concerns to a Dental Provider for evaluation or treatment.
5. The Division shall require PCPs are informed to refer EPSDT Members for a dental/oral health assessment at an earlier age, if their oral health screening reveals potential carious lesions or other conditions requiring assessment or treatment by a Dental Provider.

6. The Division shall require EPSDT Members are informed that they are allowed to self-refer to a Dental Provider who is included in the AdSS provider network.
7. The Division shall allow THP Members to self-refer to any AHCCCS registered Dental Provider.

C. COVERED SERVICES

1. The Division shall require the following EPSDT dental/oral health services are covered:
    a. Emergency dental/oral services including:
        i. Treatment for pain, infection, swelling or injury;
        ii. Extraction of:
            a) Symptomatic, infected, and non-restorable primary and permanent teeth, and
            b) Retained primary teeth.
        iii. General anesthesia, conscious sedation, or anxiolysis sedation where Members respond normally to verbal commands, when local anesthesia is contraindicated or when management of the member requires it, as specified in AMPM 430.

b. Preventive dental/oral health services provided as specified in AMPM Policy 431, Attachment A:

i. Diagnostic services including the following comprehensive and periodic examinations:

a) Two oral examinations, and two oral prophylaxis and fluoride treatments per Member per year for Members up to 21 years of age;

b) Fluoride varnish four times a year for Members up to five years of age; and

c) Additional examinations or treatments deemed Medically Necessary through the AdSS Prior Authorization process.

ii. Radiology services screening for diagnosis of dental abnormalities or pathology, including:

a) Panoramic or full-mouth x-rays;

b) Supplemental bitewing x-rays; and

c) Occlusal or periapical films, as medically necessary and following the recommendations

by the American Academy of Pediatric Dentistry.

iii. Panorex films as recommended by the American Academy of Pediatric Dentistry, up to three times maximum per provider for children between the ages of three to 20. Further panorex films needed above this limit shall be deemed Medically Necessary through the AdSS PA process;

iv. The following preventive services:

a) Oral prophylaxis performed by a Dental Provider that includes self-care oral hygiene instructions to Member, if able, or to the Responsible Person;

b) Application of topical fluorides and fluoride varnish with the exception of a prophylaxis paste containing fluoride or fluoride mouth rinses;

c) Dental sealants for first and second molars are covered twice per first or second molar, per

provider or location, allowing for three years intervention between applications up to 15 years of age which includes the ADHS school-based dental sealant program and the participating providers;

d) Additional applications deemed medically necessary and require prior authorization (PA); and

e) Space maintainers when posterior primary teeth are lost and when deemed medically necessary through the AdSS PA or AHCCCS PA for THP Members.

c. All of the following, although potentially subject to a PA as specified in the AdSS Dental Provider Manuals, when they are considered Medically Necessary and cost effective:

i. Periodontal procedures, scaling and root planing, curettage, gingivectomy, and osseous surgery;

ii. Crowns;

iii. Endodontic services including pulp therapy for permanent and primary teeth, except third molars unless a third molar is functioning in place of a missing molar;

iv. Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations unless the member is 18 to 21 years of age and has had endodontic treatment;

v. Restorations of anterior teeth for children under the age of five, when medically necessary;

vi. Extraction for children five years and over, with primary anterior tooth decay if presenting with pain or severely broken-down tooth structure, or be considered for observation until the point of exfoliation as determined by the Dental Provider;

vii. Removable dental prosthetics, including complete dentures and removable partial dentures when Medically Necessary;

viii. Orthodontic services and orthognathic surgery, when these services are Medically Necessary to treat a handicapping malocclusion, and are determined to be the primary treatment of choice or an essential part of an overall treatment plan developed by both the PCP and the Dental Provider in consultation with each other.

ix. Conditions that require the following orthodontic treatment:

a) Congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services;

b) Trauma requiring surgical treatment in addition to orthodontic services;

c) Skeletal discrepancy involving maxillary or mandibular structures; or

d) Other severe orthodontic malformations that meet PA criteria.

2. The Division shall not cover services or items furnished solely for cosmetic purposes.

D. PROVIDER REQUIREMENTS

1. The Division shall require that dental/oral health services are provided by AHCCCS-registered Dental Providers.
2. The Division shall require a written Informed Consent for examination or any preventative treatment measure, excluding irreversible or invasive procedure, is completed at the time of initial examination and is updated at each subsequent six months follow-up appointment.
3. The Division shall require a separate written consent is completed for any irreversible or invasive procedure.
4. The Division shall require all Dental Providers review and sign a written Treatment Plan with the Member or Responsible Person receiving a copy of the complete Treatment Plan.
5. The Division shall require all Dental Providers complete the appropriate Informed Consents and Treatment Plans for Division Members in order to provide quality and consistent care in a

manner that protects and is easily understood by the Member or Responsible Person.

6. The Division shall require consents and Treatment Plans are in writing, signed and dated by both the Dental Provider and the Member or Responsible person, if:
   a. The Member is under 18 years of age, or
   b. The Member is 18 years of age or older and considered an incapacitated person as defined in A.R.S. § 14-5101.
7. The Division shall require Dental Providers maintain completed consents and Treatment Plans in the Member's chart which are subject to audit.

E. ADSS REQUIREMENTS

The Division shall ensure the AdSS meets the requirements specified in AdSS Medical Policy 431.

F. REQUIREMENTS FOR THE DENTAL ANNUAL PLAN

1. The Division shall have a written Dental Annual Plan that:
   a. Addresses minimum requirements as specified in this policy;

b. Addresses the objectives of the Division and AdSS programs that are focused on achieving Division requirements; and

c. Incorporate monitoring and evaluation activities for these minimum requirements as outlined in AMPM 431 – Attachment B.

2. The Division shall submit the Dental Annual Plan no later than July 31st to the Division's Dental Director through the Compliance Unit for review and approval.

3. The Division shall require the following is contained in the written Dental Annual Plan:

a. Narrative Plan that includes:

i. A written narrative description of all planned dental activities to address the Division and AdSS minimum requirements for dental/oral health services, as specified in this policy;

ii. A narrative description of the AdSS activities to identify Member needs and coordination of care; and

iii. Follow-up activities to ensure appropriate treatment is received in a timely manner.

b. Dental Work Plan Evaluation of the previous year's Work Plan to determine the effectiveness of strategies, interventions, and activities used toward meeting stated objectives;

c. Dental Work Plan that includes:

i. Specific measurable objectives based on AHCCCS established Performance Measure Performance Standards (PMPS) as adopted by the Division;

ii. Strategies and specific measurable interventions to accomplish the following objectives:

a) Member outreach,

b) Provider education, and

c) Provider compliance with mandatory components of the Dental Program.

d. Targeted implementation and completion dates of work plan activities;

e. Assigned local staff positions responsible and accountable for meeting each established goal and objective;

f. Identification and implementation of new interventions, continuation of or modification to existing interventions, based on analysis of the previous year's Work Plan Evaluation; and

g. Relevant policies and procedures, referenced in the Dental Annual Plan, submitted as separate attachments.

F. AFFILIATED PRACTICE DENTAL HYGIENIST

1. The Division shall require the following in addition to the requirements as specified in A.R.S. §§ 32-1281 and 32-1289:

   a. Both the dental hygienist and the dentist in the affiliated practice relationship are registered AHCCCS providers;

   b. The affiliated practice dental hygienist maintains individual patient records of the following for Division Members in accordance with the Arizona State Dental Practice Act:

      i. Member identification,

      ii. Responsible Person identification,

      iii. Signed authorization for services,

iv. Patient medical history, and

v. Documentation of services rendered.

c. The affiliated practice dental hygienist registers with AHCCCS and is identified as the treating Dental Provider under his or her individual AHCCCS Provider identification number or National Provider Identification (NPI) number;

d. The affiliated practice dental hygienist and the dentist with whom he or she is affiliated is a credentialed network provider if the services are to be billed to an AdSS;

e. The affiliated practice dental hygienist is identified as the treating Dental Provider under their individual AHCCCS provider identification number or NPI number when practicing under an affiliated practice agreement;

f. The affiliated practice dental hygienist will only be reimbursed for providing services in accordance with:

i. State statute and regulations;

ii. AHCCCS policy;

iii. Division policy;

iv. Provider agreement; and

v. Affiliated practice agreement.

g. Affiliated practice dental hygienists provide documentation of the affiliation practice agreement with an AHCCCS registered dentist that is recognized by the dental board confirming the affiliation agreement.

h. Reimbursement for dental radiographs is restricted to Dental Providers who are qualified to perform both the exposure and the interpretation of dental radiographs.

G. AdSS OVERSIGHT AND MONITORING

The Division shall refer to Division Operations 438 for monitoring and oversight responsibilities of the AdSS.

SUPPLEMENTAL INFORMATION

A Screening is intended to identify gross dental or oral lesions, but it is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan. The oral health screening does not substitute for examination through direct Referral to a dental Provider.

AHCCCS-recommended training for fluoride varnish application is located on the Smiles for Life oral health website, https://www.aap.org/en/patient-care/oral-health/oral-health-education-and-training/
Refer to the website for training that covers caries-risk assessment, fluoride varnish, and counseling.

Crowns:
Stainless-steel crowns are used for both primary and permanent posterior teeth when appropriate.
Composite, prefabricated stainless steel crowns with a resin window or crowns with esthetic coatings should be used for anterior primary teeth.

Precious or cast semi-precious crowns may be used on functional permanent endodontically treated teeth, except third molars, for Members who are 18 to 21 years of age.

Certificate may be used in the credentialing process to verify completion of training necessary for reimbursement.

In cases where the Performance Measure Performance Standards have been met, other generally accepted benchmarks that continue the AdSS improvement efforts will be used (e.g., National Committee on Quality Assurance, Healthy People 2020 standards).

Dental work plan includes specific measurable goals and objectives aimed at enhancing the Dental Program when the PMPS have been met.

Signature of Chief Medical Officer: Anthony Dekker (Jan 30, 2024 10:19 MST)
Anthony Dekker, D.O.

450 OUT-OF-STATE PLACEMENTS FOR BEHAVIORAL HEALTH TREATMENT

EFFECTIVE DATE: August 4, 2021

PURPOSE

This policy applies to the Division's responsibility to manage members of the DDD Tribal Health Program (THP) and oversee compliance by the Administrative Services Subcontractors with their enrolled members.

The purpose of this Policy is to provide criteria and procedures for the Division when out-of-state placement of an ALTCS THP member for behavioral health treatment is clinically necessary and supported by the Child and Family Team (CFT) or Adult Recovery Team (ART). The Division shall evaluate compliance by the AdSS during its annual operational review of each AdSS and as noted in AdSS Policy 450.

DEFINITIONS

Adult Recovery Team (ART) - A group of individuals that, following the nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, work in collaboration and are actively involved in a member's assessment, service planning, and service delivery. At a minimum, the team consists of the members, guardian/designated representative (if applicable), advocates (if assigned), and a qualified behavioral health representative. The team may also include the enrolled member's family, physical health, behavioral health, or social service providers, other agencies serving the member, professionals representing various areas of expertise related to the member's needs, or other members identified by the enrolled member.

Child and Family Team (CFT) - A defined group of individuals that includes, at a minimum, the child and the child's family, a behavioral health representative, and any individuals important in the child's life that are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches, community resource providers, representatives from churches, synagogues, or mosques, and agents from other service systems like Department of Child Safety (DCS) or the Division of Developmental Disabilities (Division). The size, scope, and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan and can therefore expand and contract as necessary to be successful on behalf of the child.

Service Plan - A complete written description of all covered health services and other informal supports that includes individualized goals, family support services, care coordination activities, and strategies to assist the member in achieving an improved quality of life.

POLICY

A. General Requirements

It may be necessary to consider an out-of-state placement to meet the member's unique circumstances or clinical needs. Decisions to place members in out-of-state placements for behavioral health care and treatment shall be examined by the

Division and made after the CFT, ART, TRBHA, or THP FFS provider have reviewed all other in-state options. Other options may include single case agreements with in-state providers or the development of a Service Plan that incorporates a combination of support services and clinical interventions.

Services provided out-of-state shall meet the same requirements as those rendered in-state. The Division shall also ensure that out-of-state providers follow all AHCCCS reporting requirements, policies, and procedures, including appointment standards and timelines specified in AHCCCS Policy ACOM Policy 417.

Out-of-state placement providers shall coordinate with the Division, TRBHAs, DFSM, and Fee-For-Service providers to provide required updates.

The following factors may lead a member's CFT or ART to consider the temporary out-of-state placement:

1. The member requires specialized programming not currently available in Arizona to effectively treat a specified behavioral health condition.

2. An out-of-state placement's approach to treatment incorporates and supports the unique cultural heritage of the member.

3. A lack of current in-state bed capacity.

4. The geographic proximity of the out-of-state placement supports and facilitates family involvement in the member's treatment.

Prior to placing a member in an out-of-state facility for behavioral health treatment, the CFT, ART, THP FFS provider, and/or TRBHA shall ensure that:

1. The member's family/guardian/designated representative is in agreement with the out-of-state placement.

2. The out-of-state placement is registered as an AHCCCS provider.

3. Prior to placement, the Division, TRBHA, and Fee-For-Service providers shall have a plan in place to ensure the member has access to non-emergency medical needs by an AHCCCS registered provider.

4. The out-of-state placement meets the Arizona Department of Education Academic Standards for members up to the age of 21 years.

B. Out-Of-State Placement Documentation Requirements

The Division and/or TRBHA shall ensure that documentation in the clinical record indicates the following conditions have been met before a referral for an out-of-state placement is made:

1. The CFT or ART, FFS provider, and/or TRBHA has reviewed all in state options and determined that an out-of-state facility is required in order to meet the needs of the member.

2. The CFT or ART has been involved in the service planning process and is in agreement with the out-of-state placement.

3. The CFT or ART has documented how they will remain active and involved in service planning once the out-of-state placement has occurred.

4. A Service Plan has been developed.

5. All applicable prior authorization requirements have been met, including a review completed by the Division's Chief Medical Officer or designee.

6. The Arizona Department of Education has been consulted to ensure that the educational program in the out-of-state placement meets the Arizona Department of Education Academic Standards and the specific educational needs of the member as applicable.

7. Coordination has occurred with all other state agencies and/or Contractors or TRBHA involved with the member. Coordination shall also occur between FFS providers and DFSM Case Managers for all THP members prior to placement in the OOS facility. IHS/638 tribally operated facilities coordinating out-of-state placement for a Division enrolled member shall coordinate efforts with Division prior to placement, including coordinating with any IHS/638 providers located out of state.

8. Coordination shall occur between the member's primary care provider and the Division, FFS provider, and/or TRBHA to develop a plan for the provision of any necessary, non-emergency medical care All providers shall be registered AHCCCS providers.

C. Member's Service Plan

For a member placed out-of-state, the Service Plan developed by the CFT, ART, FFS provider, or TRBHA (including the member's Support Coordinator) shall require that:

1. Discharge planning is initiated at the time of admission and includes:

    a. The measurable treatment goals being addressed by the out-of-state placement and the criteria necessary for discharge back to in-state services;

    b. The possible or proposed in-state residence where the member will be returning;

    c. The recommended services and supports required, once the member returns from the out-of-state placement;

    d. How effective strategies implemented in the out-of-state placement will be transferred to the members' subsequent in-state placement; and

    e. The actions necessary to integrate the member into family and community life upon discharge, including the development of a crisis plan.

2. The Division, FFS provider, and/or TRBHA provider shall ensure coordination between the CFT/ART and the out-of-state placement, and document how they will remain active and involved in service planning by reviewing the member's progress, after significant events or at least every 30 days. TRBHAs shall notify DFSM Case Managers about the plan to place member out-of-state.

3. When appropriate, the member/Health Care Decision Maker and designated representative is involved throughout the duration of the placement. Involvement may include family counseling in-person or by teleconference or videoconference.

4. Home passes are allowed as clinically appropriate and as allowed by the provider type. For youth in DCS custody, approval of home passes is determined in collaboration with DCS.

5. The member's needs, strengths, and cultural considerations have been addressed.

D. Notifications to AHCCCS/Division Health Care Management (DHCM)

1. The Division, TRBHAs, and Fee-For-Service providers shall notify AHCCCS through the AHCCCS QM Portal, prior to or upon notification of a member being placed in an out-of-state placement.

2. AHCCCS shall review the information to ensure all the requirements in this Policy have been met. AHCCCS shall acknowledge receipt within one to three business days. If the information is incorrect or incomplete, AHCCCS shall notify the Division, TRBHA, and/or FFS provider to correct the submission within three business days.

3. The Division shall report progress updates to AHCCCS through the AHCCCS QM Portal every 30 days that the member remains in the out-of-state placement. The 30-day update timeline shall be based upon the original date the member is admitted to the out-of-state placement facility. If the date falls on a weekend or holiday, it shall be submitted on the next business day.

4. AHCCCS shall be notified via the AHCCCS QM Portal within five business days of the members discharge from the out-of-state facility.

5. All out-of-state providers shall meet the reporting requirements of all incidences of injury/accidents, abuse, neglect, exploitation, healthcare acquired conditions, and seclusion and restraint implementations as specified in AMPM Policy 960.

510 PRIMARY CARE PROVIDERS

REVISION DATE: 4/17/2024, 9/6/2023
REVIEW DATE: 5/10/2023
EFFECTIVE DATE: May 13, 2016
REFERENCES: AMPM 510

PURPOSE

This policy outlines the requirements applicable to the Division of Developmental Disabilities (Division) regarding Primary Care Providers participating in Arizona Health Care Cost Containment System (AHCCCS) programs.

DEFINITIONS

1. "Business Days" means 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding holidays listed in A.R.S. §1-301.
2. "Early and Periodic Screening, Diagnostic and Treatment" or "EPSDT" means a comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for Members under the age of 21. EPSDT services include:
    a. Screening services,

b. Vision services,

c. Dental services,

d. Hearing services, and

e. 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.

3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

4. "Non-Contracting Provider" means an individual or entity that provides services as prescribed in A.R.S. § 36-2901 who does not have a subcontract with an AHCCCS Contractor.

5. "Primary Care Provider" or "PCP" means a person who is responsible for the management of the member's health care. A PCP may be a:

a. Person licensed as an allopathic or osteopathic physician,

b. Practitioner defined as a licensed physician assistant, or

c. Certified nurse practitioner.

6. "Provider" means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services, as specified in 42 CFR 457.10 and 42 CFR 438.2.

7. "Resident Physician" means doctors who have graduated from medical school and are completing their residency in a specialty.

8. "Teaching Physician" means a physician other than another Resident Physician who involves residents in the care of his or her patients.

POLICY

A. PRIMARY CARE PROVIDER AND RESPONSIBILITIES

The Division shall ensure that PCPs are:

a. Providing initial and primary care services to assigned Members;

b. Initiating, supervising, and coordinating referrals for specialty care and inpatient services;

c. Maintaining continuity of Member care; and

d. Maintaining the Member's medical record as specified in AHCCCS Medical Policy Manual (AMPM) 940.

B. PROVISION OF INITIAL AND PRIMARY CARE SERVICES

1. The Division shall require PCPs to provide the following covered preventive and primary care services to Members:
   a. Health screenings,
   b. Routine illness,
   c. Maternity services if applicable,
   d. Immunizations, and
   e. EPSDT services.
2. The Division shall ensure that all Members under the age of 21 receive health screening and services to correct or ameliorate defects or physical and behavioral illnesses or conditions identified in an EPSDT screening as specified in AMPM Policy 430.
3. The Division shall ensure that Members 21 years of age and over receive health screening and medically necessary treatment as specified in AMPM Chapter 300.

C. BEHAVIORAL HEALTH SERVICES PROVIDED BY THE PRIMARY CARE PROVIDER

1. The Division shall cover medically necessary, cost-effective, Federal and State reimbursable behavioral health services provided by a PCP within their scope of practice.
2. The Division shall require that PCPs obtain prior authorization for antipsychotic class of medications if required, to include monitoring and adjusting behavioral health medication as specified in AMPM 310-V.
3. The Division shall require PCPs to coordinate and collaborate with behavioral health providers.

D. PRIMARY CARE COORDINATION RESPONSIBILITIES

1. The Division shall require PCPs in their care coordination role, serve as a referral agent for specialty and referral treatment, and services for physical or behavioral health services as needed for Members.
2. The Division shall require PCPs to meet the following coordination responsibilities:

a. Referring Members to Providers or hospitals within the AdSS network or AHCCCS registered Providers for Tribal Health Program (THP) Members;

b. Referring Members to Non-Contracting specialty Providers and non-contracting community benefit organizations if necessary;

c. Coordinating services with the Division with the following entities for THP Members:

   i. AHCCCS Division of Fee-For-Service Management (DFSM) for care coordination for physical and behavioral health prior authorizations; and

   ii. THP Members enrolled with the Tribal Regional Behavioral Health Authority (TRBHA) for behavioral health; and

   iii. American Indian Medical Home (AIMH) for coordination of physical and behavioral health services for American Indian Health Program (AIHP) Members enrolled with an AIMH, to include coordination with TRBHAs when applicable.

d. Coordinating when applicable with a Member's:

i. AdSS care manager, including maternity;

ii. Provider case manager;

iii. Division Support Coordinator;

iv. Division Behavioral Health Complex Care Team;

v. Behavioral Health Provider; and

vi. Division Nurses.

e. Conducting or coordinating follow-up for referral services that are rendered to their assigned Members by:

i. Other Providers,

ii. Specialty Providers, or

iii. Hospitals.

f. Coordinating the following medical care of Members:

i. Oversight of medication regimens to minimize side effects or drug interactions;

ii. Follow-up for all emergency services;

iii. Coordination of discharge planning post inpatient admission;

iv. Home visits if medically necessary;

v. Member education;

vi. Preventative health services;

vii. Screening and referral for health-related social needs;

viii. Coordination of the following services:

a) Specialty Providers;

b) Laboratory and Diagnostic Testing;

c) Behavioral health services;

d) Dental services;

e) Therapies including:

1) Occupational,

2) Physical, and

3) Speech language pathology.

f) Durable Medical Equipment;

g) Home health;

h) Palliative care; and

i) Hospice care.

ix. Oversight that care rendered by specialty Providers is appropriate and consistent with each Member's health care needs, and

x. Maintaining records of services provided by physical and behavioral health specialty Providers or hospitals.

g. Coordinating care for behavioral health medication management to include:

i. Require and ensure coordination of referral to the behavioral health Provider when a PCP has initiated medication management services for a Member to treat a behavioral health disorder, and it is subsequently determined by the PCP that the Member should be referred to a behavioral health Provider for evaluation or continued medication management.

ii. Policies and procedures that address the following:

a) Guidelines for PCP initiation and coordination of a referral to a behavioral health Provider for medication management;

b) Guidelines for transfer of a Member with a Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) designation for ongoing treatment coordination, as applicable;

c) Protocols for notifying entities of the Member's transfer, including:

    1) Reason for transfer,

    2) Diagnostic information, and

    3) Medication history.

d) Protocols and guidelines for the transfer or sharing of medical records information and protocols for responding to requests for additional medical record information;

e) Protocols for transition of prescription services, including:

1) Notification to the appropriate Providers of the Member's current medications and timeframes for dispensing and refilling medications during the transition period,
2) Ensuring that the Member does not run out of prescribed medication prior to the first appointment with the behavioral health Provider, allowing for at least a minimum of 90 days transition between Providers,
3) Forwarding all medical information, including the reason for transfer to the behavioral health Provider prior to the Member's first scheduled appointment.

f) AdSS monitoring activities to ensure that Members are appropriately transitioned for care and receive the services they are referred for.

E. PRIMARY CARE PROVIDER ASSIGNMENT AND APPOINTMENT STANDARDS

1. The Division shall require the AdSS to assign newly enrolled Members to a PCP.
2. The Division shall require the AdSS to notify Members within 12 Business Days of the enrollment notification.
3. The Division shall require that AHCCCS-registered contracted PCPs receive an AHCCCS Provider ID number.
4. The Division shall require the AdSS maintain a current file of Member PCP assignments to facilitate continuity of care, control utilization, and obtain encounter data.
5. The Division shall require the AdSS to make PCP assignment rosters and clinical information regarding Member's health and medications, including behavioral health providers, available to the assigned PCP within 10 Business Days of a Provider's request as specified in ACOM Policy 416.
6. The Division shall allow Members to choose PCPs available within the AdSS network.

7. The Division shall require the AdSS to automatically assign the Member to a PCP if the Member does not select one.
8. The Division shall allow Members to choose an AHCCCS registered PCP if the Member is enrolled with THP.
9. The Division shall monitor that PCPs provide Members with available and accessible services within the time frames specified in ACOM Policy 417.
10. The Division shall require that the AdSS provide information to the Member on how to contact the Member's assigned PCP.
11. The Division shall require that the AdSS assigns pregnant Members to a qualified physician and are receiving appropriate care as specified in AMPM Policy 410.
12. The Division shall require the AdSS assigns Members who are age 12 and younger and who have complex medical conditions to board certified pediatricians.
13. The Division shall require the AdSS to assign Members to Providers participating in value-based purchasing initiatives who have demonstrated high value services or improved outcomes.

F. REFERRALS AND APPOINTMENT STANDARDS FOR SPECIALITY CARE

The Division shall require that the AdSS oversee appropriate availability and monitoring of health care services and if required, referrals are in place.

G. PHYSICIAN ASSISTANT (PA) AND NURSE PRACTITIONER (NP) VISITS IN A NURSING FACILITY

The Division shall cover initial and any subsequent visits to a Member in a nursing facility made by a PA or NP when all of the following criteria are met:

a. The PA or NP is not an employee of the facility, and

b. The source of payment for the nursing facility stay is Medicaid.

H. AdSS MONITORING AND OVERSIGHT

1. The Division shall meet with the AdSS at least quarterly to:

   a. Provide ongoing evaluation including data analysis and recommendations to refine processes; and

   b. Identify successful interventions and care pathways to optimize results.

2. The Division shall perform an Operational Review of the AdSS on an annual basis that includes review of compliance.

Signature of Chief Medical Officer: Anthony Dekker (Apr 9, 2024 13:20 PDT)

Anthony Dekker, D.O.

520 MEMBER TRANSITIONS

REVISION DATE: 03/01/2023
EFFECTIVE DATE: April 1, 2016
REFERENCES: A.R.S. §§36-2931, 36-2901.01 and 36-2981; 42 CFR 431.300, 438.62, 440.70, 457.1216; AMPM 280, AdSS Medical Manual Policy 540, ACOM Policy 402, Division Operations Policy 406

PURPOSE

This policy establishes requirements applicable to the Division of Developmental Disabilities (Division) to identify and facilitate Member transitions between the Administrative Services Subcontractors (AdSS), the Division and other AHCCCS contractors and the Division's oversight of the AdSS.

DEFINITIONS

1. "Enrollment Transition Information" or "ETI" means Member specific information the Relinquishing Contractor must complete and transmit to the Receiving Contractor or Fee-For-Service (FFS) program for those members requiring coordination of services as a result of transitioning to another contractor or FFS program.

2. "Medical Equipment and Appliances" means an item as specified in 42 CFR 440.70, that is not a prosthetic or orthotic; and
   a. Can withstand repeated use, and
   b. Can be reusable by others or is removable.
3. "Member" means an eligible individual who is enrolled in AHCCCS, as specified in A.R.S. §36-2931, §36-2901.01 and A.R.S.§36-2981.
4. "Member Transition" is the process during which members change from one contractor or Fee-for-Service program to another.
5. "Receiving Contractor" is the contractor with which the Member will become enrolled as a result of Annual Enrollment Choice (AEC), open enrollment, a contractor change or a change in eligibility.
6. "Relinquishing Contractor" is the contractor from which the Member will be leaving as a result of AEC, open enrollment, a contractor change or a change in eligibility.
7. "Special Health Care Needs" or "SHCN" means serious and chronic physical, developmental, or behavioral conditions

requiring medically necessary health and related services of a type or amount beyond that required by Members generally; that lasts or is expected to last one year or longer and may require ongoing care not generally provided by a Primary Care Provider (PCP). All Division members are designated as individuals with Special Health Care Needs.

POLICY

A. MEMBER TRANSITIONS

1. The Division shall identify and facilitate coordination of care for all members eligible for Arizona Long Term Care System (ALTCS) during:
   a. Changes or transitions between health plans,
   b. Changes in service areas, or
   c. Changes in health care providers as specified in AMPM 520.
2. The Division shall work collaboratively with Members with special circumstances which may require additional or distinctive assistance during a period of transition such as:
   a. Pregnancy;

b. Major organ or tissue transplantation services which are in process;

c. Chronic illness, which has placed the Member in a high-risk category and/or resulted in hospitalization or placement in nursing, or other facilities;

d. Significant medical or behavioral health conditions that require ongoing specialist care and appointments;

e. Chemotherapy and/or radiation therapy;

f. Dialysis;

g. Hospitalization at the time of transition;

h. Members with the following ongoing health needs:

i. Durable Medical Equipment, including ventilators and other respiratory assistance equipment;

ii. Home health services;

iii. Medically necessary transportation on a scheduled basis;

iv. Prescription medications; or

v. Plan management services.

i. Members who frequently contact AHCCCS, State and local officials, the Governor's Office and/or the media;

j. Members with qualifying Children's Rehabilitation Services (CRS) conditions or are transitioning into adulthood;

k. Members diagnosed with Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (HIV/AIDS);

l. Members who are being considered for or are actively engaged in a transplant process and for up to one-year post transplant;

m. Members enrolled in the ALTCS program who are elderly and/or have a physical or developmental disability;

n. Members who are engaged in care or services through the Arizona Early Intervention Program (AzEIP);

o. Members who are diagnosed with a Serious Mental Illness (SMI).

p. Any child that has an Early Childhood Service Intensity Instrument/Child and Adolescent Level of Care Utilization System (ECSII/CALOCUS) score of 4+;

q. Members who have a Seriously Emotionally Disturbed (SED) diagnosis flag in the system;

r. Substance exposed newborns and infants diagnosed with Neonatal Abstinence Syndrome (NAS);

s. Members diagnosed with Severe Combined Immunodeficiency (SCID);

t. Members with a diagnosis of autism or who are at risk for autism;

u. Members diagnosed with opioid use disorder, separately tracking pregnant Members and Members with co-occurring pain and opioid use disorder;

v. Members enrolled with the Division of Child Safety/Comprehensive Health Program (CHP);

w. Members who transition out of the CHP up to one-year post transition;

x. Members identified as a High Need/High Cost Member;

y. Members on conditional release from Arizona State Hospital;

z. Other services not indicated in the State Plan for eligible Members but covered by Title XIX and Title XXI for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) eligible Members, including Members whose conditions require ongoing monitoring or screening;

3. At the time of transition, have received prior authorization or approval for:

a. Scheduled elective surgery(ies);

b. Procedures and/or therapies to be provided on dates after their transition, including post-surgical follow-up visits;

c. Sterilization and have a signed sterilization consent form, but are waiting for expiration of the 30 calendar day period;

d. Behavioral health services;

e. Appointments with a specialist located out of the AdSS service area; and

f. Nursing facility admission.

B. NOTIFICATION REQUIREMENTS

1. The Division shall ensure the relinquishing AdSS provides relevant information regarding Members who are transitioning to a receiving AdSS. The Enrollment Transition Information (ETI) Form shall be utilized for the transfer of information for Members with special circumstances who are transitioning enrollment to an AdSS, FFS program or other contractor.
2. The Division shall ensure the relinquishing AdSS completes and electronically transmits the appropriate ETI Form to the Division no later than 10 business days from date of receipt of the AHCCCS notification.
3. The Division shall ensure the relinquishing AdSS covers the Members care for up to 30 calendar days following the identified transition date if the relinquishing AdSS fails to notify the Division of transitioning Members with special circumstances, fails to send the completed ALTCS Enrollment Transition Information (ETI), or AHCCCS AMPM 520 Attachment for non-ALTCS Division Members.

4. The Division shall ensure the transfer of pertinent medical records as well as the timely notification to Members, subcontractors, or other providers during times of transition.
5. The Division shall provide new Members with a Member Handbook, provider directory and emergency numbers as specified in ACOM 406.
6. The Division shall follow-up with the Member to address the needs of the Member identified on the ETI form. Follow-up and care coordination may include support coordination, care management, pharmacy, behavioral health services, and transportation.
7. The Division, in coordination with AHCCCS DFSM, shall extend previously approved prior authorizations for a minimum of 30 calendar days from the date of the Member's transition unless a different time period is mutually agreed to by the Member or Member's representative.

C. COORDINATION ACTIVITIES

1. The Division's transition coordinator shall:

a. Ensure all pertinent Member information is communicated to support coordination to initiate assessment and review of a newly transitioned Member.

b. Collaborate with the Division internal partners, AHCCCS department and/or AdSS for all identified existing authorizations to be extended for up to 90 calendar days, as appropriate. Activities may include continuation of medically necessary covered services during the transition through any of the following:

   i. Contracting on a negotiated rate basis with the Member's current provider(s),

   ii. Negotiating a single Membercontract,

   iii. Assisting Members with referrals to alternate in-network providers.

c. Communicate with support coordination and, if applicable, Division Care Management to coordinate discharge planning with the relinquishing ALTCS or ACC contractor if the Member is hospitalized at the time of the transition.

d. Notify the behavioral health administrator when a Member who is receiving behavioral health services has transitioned between health plans.

e. Work collaboratively with the support coordinator and the AdSS to:

i. Avoid any disruption in care during the transition, enrollment or disenrollment.

ii. Ensure access to appropriate providers, level of care and facilitate resolution of any barriers though the established processes.

1) The support coordinator may request technical assistance from complex care and behavioral health specialists to ensure Members who are medically complex and require intensive physical, and/or behavioral health support services during the transition to avoid any disruption in care.

2. The support coordinator shall work with the Division transition coordinator and AdSS to ensure access to the appropriate level

of care, appropriate providers and facilitate the resolution of any barriers.

D. TRANSITION FROM CHILD TO ADULT SERVICES

1. The Division shall ensure transitions involving co-occurring behavioral and physical health conditions include the following:
    a. Coordination plan between child providers and the anticipated adult providers;
    b. Process that begins no later than when the child reaches the age of 16;
    c. A transition plan for the Member focused on assisting the Member with gaining the necessary skills and knowledge to become a self-sufficient adult within their capabilities and facilitates a seamless transition from child services to adult services;
    d. An SMI eligibility determination that is completed when the adolescent reaches the age of 17, but no later than age 17 and six months; and
    e. A coordination plan to meet the unique needs for Members with special circumstances.

2. The Division shall ensure additional stakeholder, behavioral or physical healthcare entity involved with the child shall be included in the transition process, as applicable.

E. MEMBERS HOSPITALIZED DURING ENROLLMENT CHANGE

1. The Division shall provide a smooth transition of care for Members who are hospitalized on the day of an enrollment change. These provisions shall include processes for the following:
   a. Notification to the receiving AdSS or FFS Program prior to the date of the transition.
   b. Notification to the hospital and attending physician of the transition by the relinquishing AdSS as follows:
      i. Notify the hospital and attending physician of the pending transition prior to the date of the transition,
      ii. Instruct the providers to contact the receiving AdSS or FFS Program for authorization of continued services,
      iii. Cover services rendered to the hospitalized Member for up to 30 calendar days if they fail to provide

notification to the receiving AdSS, hospital, and the attending physician, relative to the transitioning Member.

c. Coverage of the hospital stay by the AdSS in which the Member is enrolled upon discharge per Diagnosis Related Group (DRG).

d. Coordination with providers regarding activities relevant to concurrent review and discharge planning.

F. TRANSITION DURING MAJOR TRANSPLANTATION SERVICES

1. The Division shall ensure Members who have been approved for a major organ or tissue transplant are covered through the relinquishing or receiving AdSS.
2. The Division shall ensure each AdSS covers the respective dates of service if a Member changes to a different AdSS while undergoing transplantation at a transplant center that is not an AHCCCS contracted provider.

G. ENROLLMENT CHANGES FOR MEMBERS RECEIVING OUTPATIENT TREATMENT

1. The Division shall ensure ongoing care of Members with active or chronic health care needs during the transition period.
2. The Division shall ensure timely transition of the Member from the relinquishing PCP to the receiving PCP, in order to maintain continuity of care.
3. The Division shall ensure pregnant women who transition to a new AdSS within the last trimester of their expected date of delivery be allowed the option of continuing to receive services from their established physician and anticipated delivery site through the postpartum visits as specified in AMPM 410.

H. MEDICALLY NECESSARY TRANSPORTATION

1. The Division shall provide information to new Members on what and how medically necessary transportation can be obtained.
2. The Division shall provide information to providers on how to order medically necessary transportation for Members.

I. TRANSITION OF PRESCRIPTION MEDICATION SERVICES

1. The Division shall ensure the relinquishing AdSS:

a. Covers the dispensation of the total prescription amount of either continuing or time-limited medications, if filled before midnight on the last day of enrollment;

b. Does not reduce the quantity of the ordered prescription unless it exceeds a 30-day supply or 100 unit doses; and

c. Provides sufficient continuing medications for up to 15 days after the transition date.

2. The Division shall ensure previously approved prior authorizations are extended for a period of 30 calendar days from the date of the Member's transition unless a different time period is mutually agreed to by the Member or Member's representative.

3. The Division shall ensure Member's transitioning from a Behavioral Health Medical Professional (BHMP) to a PCP for behavioral health medication management shall continue on the medication(s) prescribed by the BHMP until the Member can transition to their PCP.

4. The Division shall coordinate care and ensure the Member has a sufficient supply of behavioral health medications to last through the date of the Member's first appointment with their PCP.

J. DISPOSITION OF MEDICAL EQUIPMENT, APPLIANCES, AND MEDICAL SUPPLIES DURING TRANSITION

1. The AdSS shall ensure the disposition of Medical Equipment, appliances, and supplies during a Member's transition period and develop policies that include the following:
    a. Non-customized Medical Equipment
        i. Relinquishing AdSS shall provide accurate information about Members with ongoing Medical Equipment needs to the receiving AdSS or FFS programs.
    b. Customized Medical Equipment
        i. Customized Medical Equipment purchased for Members by the relinquishing AdSS will remain with the Member after the transition. The purchase cost of the equipment is the responsibility of the relinquishing AdSS.

ii. Customized Medical Equipment ordered by the relinquishing AdSS but delivered after the transition to the receiving AdSS shall be the financial responsibility of the relinquishing AdSS.

iii. Maintenance contracts for customized Medical Equipment purchased for Members by a relinquishing AdSS will transfer with the Member to the new AdSS.

iv. Contract payments due after the transition will be the responsibility of the receiving AdSS, if the receiving AdSS elects to continue the maintenance contract.

c. Augmentative Communication Devices (ACD)

i. A 90-day trial period to determine if the ACD will be effective for the Member, or if it should be replaced with another device.

ii. If a Member Transitions from an AdSS during the 90-day trial period, one of the following shall occur:

1) The device shall remain with the Member if the ACD is proven to be effective. Payment for the

device shall be covered by the relinquishing AdSS.

2) The cost of any maintenance contract necessary for the ACD shall be the responsibility of the receiving AdSS if they elect to continue the maintenance contract.

3) The device shall be returned to the vendor if the ACD is proven to be ineffective. The receiving AdSS shall then coordinate a new device trial and purchase if it is determined to meet the Member's needs.

K. MEDICAL RECORDS TRANSFER

1. The Division shall ensure transition of medical records timely but no later than within 10 business days from receipt of the request for transfer to ensure continuity of Member care during the time of enrollment change as specified in AMPM 940.

L. THERAPEUTIC FOSTER CARE

1. The Division shall work closely with the Department of Child Safety (DCS) and other entities to ensure continuity of care

including access to covered services, treatment and supports, in-network and out-of-network providers as determined by the transition plan for children receiving behavioral health services in out-of-home placement.

a. The Division transition coordinator notifies the Division Behavioral Health Administration and support coordinator of all ALTCS Member transitions between health plans in which Members are receiving behavioral health services, including therapeutic foster care.

b. The Division Behavioral Health Administration provides technical assistance to the support coordinator supervisor to identify circumstances in which the provider is not in the new health plan's network.

c. The Behavioral Health Administration coordinates with the AdSS to ensure continuity of care is maintained for the Member.

M. DIVISION OVERSIGHT RESPONSIBILITIES

1. Health Care Services (HCS) shall review performance data and conduct quarterly meetings with the AdSS to ensure compliance,

evaluate performance, identify opportunities for improvement, make recommendations to refine processes and resolve barriers, identify successful interventions and care pathways to optimize results and improve outcomes.

2. The Division shall review compliance and performance during its annual operational review of the AdSS including performance metrics regarding Member Transitions for children and adults with behavioral health, complex care, and other Special Health Care Needs.

3. The HCS transition coordinator shall report performance metrics regarding Member Transitions to the Medical Management Committee quarterly. These metrics shall include the number of Member Transitions, unresolved barriers or concerns and any recommendations to improve performance.

Signature of Chief Medical Officer: Anthony Dekker (Feb 21, 2023 12:20 MST)

Anthony Dekker, D.O.

530 MEMBER TRANSFERS BETWEEN FACILITIES

REVISION DATE: 4/17/2024, 11/22/2017
REVIEW DATE: 8/18/2023
EFFECTIVE DATE: May 13, 2016
REFERENCES: A.R.S. § 36-2909(B), 42 CFR 422.113, 42 CFR 438.114

PURPOSE

This policy establishes requirements applicable to the Division of Developmental Disabilities (Division) when a Member transitions between facilities.

DEFINITIONS

1. "Emergency" means a serious and unexpected situation requiring immediate action to avoid harm to health, life, property, or environment.
2. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
3. "Primary Hospital" means hospitals that are licensed institutions with at least six beds whose primary function is to provide diagnostic and therapeutic patient services for medical conditions

by an organized physician staff and have continuous nursing services under the supervision of registered nurses.

4. "Secondary Hospital" means hospitals capable of providing the majority of hospital based services, both general medical and surgical, often Obstetrician (OB) and other services, but limited with regards to specialist access.
5. "Tertiary Hospital" means hospitals with access to a broad range of specialists and equipment necessary and usually receiving their patients from a large catchment area and referral base.

POLICY

A. TRANSFER BETWEEN FACILITIES

1. The Division shall require the following criteria are met when a transfer is initiated by the Administrative Services Subcontractors (AdSS) between inpatient hospital facilities following an Emergency hospitalization:
   a. The attending Emergency physician, or the attending provider treating the Member, determines that the Member

is stabilized for transfer and will remain stable for the period of time required for the distance to be traveled;

b. The receiving physician agrees to the Member transfer;

c. Transportation orders are prepared specifying:

i. The type of transport,

ii. Training level of the transport crew, and

iii. Level of life support.

d. A transfer summary accompanies the Member.

2. The Division shall require compliance with Medicaid Managed Care guidelines regarding the coordination of Post Stabilization Care as specified in 42 CFR 438.114 and 42 CFR 422.113.

3. The Division shall require the following criteria are met when a Member transitions to a lower level of care facility:

a. The Member's condition does not require the full capabilities of the transferring facility; or

b. The Member's condition has stabilized or reached a plateau and will not benefit further from intensive intervention in the transferring facility; and

c. The receiving physician agrees to a Member transfer;

d. Transportation orders are prepared specifying the:

i. Type of transport,

ii. Training level of the transport crew, and

iii. Level of life support.

e. A transfer summary accompanies the Member.

4. The Division shall require the following criteria are met when a Member transfers to a higher level of care facility:

a. The transferring hospital cannot provide the level of care needed to manage the Member beyond stabilization required to transport, or cannot provide the required diagnostic evaluation and consultation services needed;

b. The receiving physician agrees to the Member transfer;

c. Transport orders are prepared which specify:

i. The type of transport,

ii. Training level of the transport crew, and

iii. Level of life support. of transport.

d. A transfer summary accompanies the Member.

5. The Division shall require when the transfer is initiated by the AdSS, the attending Emergency physician or the attending

provider treating the Member and the AdSS Medical Director or designee are responsible for determining whether a particular case meets criteria established in this policy.

B. AdSS OVERSIGHT AND MONITORING

The Division shall refer to Division Operations 438 for monitoring and oversight responsibilities of the AdSS.

SUPPLEMENTAL INFORMATION

Transfer to a lower level of care facility (e.g., Tertiary to Secondary or primary, or Secondary to Primary Hospital, or transfer to a skilled nursing facility).

Transfers to a higher level of care facility (e.g., Primary to Secondary or Tertiary, or Secondary to Tertiary Hospital).

Signature of Chief Medical Officer: Anthony Dekker (Apr 9, 2024 13:15 PDT)
Anthony Dekker, D.O.

540 OTHER CARE COORDINATION ISSUES

REVISION DATE: 7/15/2016, 7/3/2015, 10/1/2015, 10/1/2014
EFFECTIVE DATE: July 3, 1993
REFERENCES: A.R.S. §§ 8-546, 15-765, 36-552(C), 36-558(A), 36-560(B); A.A.C. R9-28-509; and, Social Security Act § 1915 (k).

Acute Medical Care

The Support Coordinator, along with Health Care Services (HCS), ensures coordination of care for each member. Each subcontracted health plan has an identified liaison to assist with the coordination of care for Division members enrolled through the Arizona Long Term Care System (ALTCS) program.

The Support Coordinator will:

A. Contact the health plan liaison when a member has a concern related to medical services received or needed from the subcontracted health plan; and,

B. Contact HCS when there are issues that cannot be resolved with the liaisons.

Children's Rehabilitative Services

The Support Coordinator, along with Health Care Services (HCS), ensures coordination of care for each member receiving medical and behavioral health services from Children's Rehabilitative Services (CRS).

The Support Coordinator will:

A. Contact the CRS liaison when a member has a concern related to medical or behavioral health services received or needed from CRS; and,

B. Contact HCS when there are issues that cannot be resolved with the liaison.

Behavioral Health

When the Planning Document indicates a need for behavioral health services, the Support Coordinator shall initiate and coordinate such services with the Regional Behavioral Health Authority (RBHA). Additional information is available on the Arizona Division of Health Services/Division of Behavioral Health Services (ADHS/DBHS) website for each RBHA Provider Manual.

A. Qualified Behavioral Health Professional Consult (QBHP)

The Support Coordinator shall complete an initial consultation and quarterly consultations thereafter with the qualified behavioral health professional for all members receiving/needing behavioral health services. Quarterly consultations are not required for members who are stable on psychotropic medications and are not receiving any other behavioral health services.

B. Behavioral Health Treatment Plan (From RBHA Provider)

The Behavioral Health Treatment Plan from the RBHA Provider becomes part of the Division's Planning Document. The Support Coordinator must include outcomes relevant to a Behavioral Health Treatment Plan on the Division's Planning Document.

C. Child and Family Teams

The Child and Family Team (CFT) is a group of people that include, at a minimum, the child and the family, a behavioral health representative, the Support Coordinator, and any members important in the child's life who are identified and invited to participate by the child and family. The size, scope, and intensity of involvement of the team members are determined by the CFT outcomes, with oversight by the behavioral health representative.

Residential Placements

At the time of placement, the Support Coordinator is responsible for the following:

A. If a member's behaviors pose a danger to residents or staff, the Division will share this information with the parents/ guardians of other residents in the home. The agency director, designee, or Division staff will only provide non-personally identifiable information to the guardian.

B. For a member currently in placement or using out-of-home respite and potentially at risk, the Support Coordinator along with the Individual Support Plan (ISP) team will identify the appropriate person to inform the family of the risk.

In cases of emergency placement, the checklists capturing potential safety concerns for everyone in the home must be available to the guardian/family of the member moving in.

Department of Child Safety

The Support Coordinator is responsible for coordinating services with the Department of Child Safety (DCS) Case Manager when a child eligible for Division services is in the custody of DCS.

Department of Economic Security Vocational Rehabilitation

The Support Coordinator/Employment Specialist is responsible for submitting and coordinating referrals to DES Vocational Rehabilitation for employment related services.

Arizona Department of Education/ Local Education Agency

The Division shall coordinate services with the Arizona Department of Education Local Education Agency (LEA) under three distinct circumstances:

A. When the Division makes an out-of-home placement for educational purposes (A.R.S. §15-765, www.azleg.gov);

B. When the Division makes an out-of-home placement of a member receiving public education for other than educational purposes; and,

C. When a child receiving early intervention services (day treatment and training) from the Division reaches ages two years six months and two years nine months, in order to plan for preschool transition.

Residential Placement for Educational Reasons (A.R.S.§15-765)

A.R.S. § 15-765 allows for residential placements for children for educational reasons. It is not intended to provide long term or permanent residential placements for children. These placements should be for a limited period of time and only for the purpose of accomplishing specific educational goals that promote the child's ability to benefit from a special education program in a less restrictive environment. A.R.S. § 15-765 www.azleg.state.az.us/arizonarevisedstatutes.asp requires that residential placement be made for educational reasons only and not for other issues, such as family matters.

In the event the child may need some level of intervention beyond what is available through the Local Education Agency, a representative from the school should collaborate with the family or legal guardian to identify resources available to the child, This may include services covered by either private insurance or the Arizona Health Care Cost Containment System (AHCCCS) behavioral health benefits. If the child is currently not enrolled in AHCCCS but may be eligible through Title XIX/XXI (KidsCare), the Public Education Agency should assist the family in the enrollment process.
When an out-of-home placement is considered, priority should be given to placement in the home school district so the child can maintain placement, transition into the district when specific behavioral, or meet educational goals. Exceptions may exist for children with unusually complex educational needs that cannot be met in the home district, for example, in remote areas of the State. However, these reasons must be clearly documented before the placement is approved.

When the Individual Education Program (IEP) indicates that out-of-home placement for educational purposes may be necessary, the Support Coordinator shall immediately notify the District Program Manager for involvement in the placement process. If placement is to be made out of the Division District where the child resides, the Support Coordinator/originating District Program Manager must contact the District Program Manage in the receiving District in order to facilitate appropriate placement and services.

When requesting residential services for educational reasons through the Division, the following documentation must be provided by the requesting school district to the Support Coordinator. Copies of this documentation shall be placed in the case file. This information is then forwarded to the District Program Manager (DPM) and Central Office.

A. A letter of request for services.

B. Parental signature for consent for evaluation and services.

C. A copy of the Individual Education Program (IEP) that includes:

1. Documentation of least restrictive environment considerations, including the specific reasons why the child cannot be educated in a less restrictive environment;

2. Specific services requested, such as residential placement;

3. Length of time for the placement. For example, six months, one school year; and,

4. The exit criteria (goals which when accomplished will indicate that the child is ready to return home or to the home school district).

A. If the member is being placed outside the state and is eligible for the ALTCS, the AHCCCS must approve the placement in advance.

Incomplete documentation of the educational reasons for requesting residential placement will result in a delay. The Division Central Office may also deny the request.

Following approval and placement in an out-of-home setting for educational purposes, the need for placement shall be reviewed every 30 days after placement by the respective planning processes (Individual Education Program/Individualized Family Services Plan/Person Centered Plan meetings). The results of the review shall be documented in the progress notes. Requests for continuation of the placement must be submitted to the Division Central Office for approval by June 15 of each year. Requests for continued placement shall contain the same information and be submitted in the same manner as required for initial placements.

During the 30-day reviews, all parties shall consider progress according to the goals and objectives of the treatment plan and the Individual Educational Program (IEP) exit criteria. Each review shall also include a discussion surrounding the type of educational and behavioral health supports that would be needed to return the child to a less restrictive placement.

Anticipated transitional supports shall be discussed during the 30-day reviews. The Local Education Agency (LEA) and the Regional Behavioral Health Authority (RHBA) shall both strive to ensure that the necessary educational and Title XIX/XXI behavioral health supports shall be available to the child and family at time of discharge.

Any proposed change in a residential placement for educational reasons must be made through the IEP review process. Changes in placement must be consistent with the goals of the child's IEP and recommended by the team. Placements may not be changed for reasons other than those related to educational purposes. When a child's parents move to a new school district, the District that placed the child must notify the new school District of the placement arrangements.

The new District has the responsibility to review the appropriateness of the placement and use the IEP process to make any recommended changes.

When a child is promoted to a high school district, the District that placed the child must treat the promotion as a change of placement and must include the high school District in the IEP review process.

When the team determines that a child needs Extended School Year Services, no change in the residential placement may be made unless specified in the IEP.

Transition to the Community

A. When the child's treatment goals and the IEP exit criteria have been met, the Division, LEA, RBHA, family or legal guardian and residential provider shall collaborate on the necessary planning for transition to a less restrictive setting. At that time, the IEP shall be revised and the treatment plan updated.

B. The Division, LEA, RBHA and family or legal guardian shall coordinate with the residential facility provider to schedule a discharge date.

C. The Division, LEA and the RBHA shall ensure the agreed upon educational and Title XIX/XXI behavioral health supports are in place for the child and family upon discharge.

Post-discharge, the Division, the LEA and the RBHA shall continue to monitor the child's status in the less restrictive placement. Communication between the Division, the LEA and the RBHA shall continue in order to monitor and support the child's successful integration in the new setting.

Coordination of Care Between The Division And The School System

In addition to the review and annual due dates for the Planning Documents, the Support Coordinator is responsible for ensuring the overall provision of care in coordination of care with other agencies for each member, including educational services. It is important that the Support Coordinators and Support Coordinator Supervisors understand the appropriate ways to coordinate care with a local school system.

It is also important to develop working relationships with the various school districts within the proximity of the Support Coordinator's assigned Division office. This includes identifying the appropriate teachers and the school hierarchy for addressing any issues that may arise. The development of these relationships before serious concerns occur will assist in resolving issues in a more collaborative and timely manner.

The Support Coordinator should work with the family to identify the dates and times for meeting with the school, and participate in the development of the IEP. Coordinating the efforts of the education plan with the Division's Planning Documents can ensure these plans complement each other and provide better care for the member. If the family does not remember to invite the Division staff to the IEP meeting, the school representative should be invited to the Division's Planning Meeting.
When the Division identifies an educational need, the Support Coordinator will take the following steps:

A. Discuss identified need with the family;

B. Within five working days of obtaining the family's agreement, contact the local schoolteacher and/or principal to inquire about the identified educational need;

C. Contact the District Program Administrator/District Program Manager within two working days of contacting the school to request support with their counterpart in the local school district if the teacher and/or principle have not responded;

D. Contact the Division's Central Office within two weeks to request support in coordination with the Special Education Division of the Arizona Department of Education when there has not been a response from the local school district;

E. As appropriate, raise the general issue(s) at the Arizona Department of Education (ADDE) through Central Office; and,

F. Follow up with the member or the representative regarding whether or not the need has been/was met.

Discharge Planning

Discharge planning is a systematic process for the transition of a member from one health care setting to another or the transition of a medically involved member from one residential placement to another. The key to successful discharge planning is communication between member, family/caregiver and health care team. Depending on the specific needs of the member, the following people may participate in the discharge planning process:

A. Member/family/caregiver;

B. Primary care provider/specialist;

C. Discharge Coordinator/Social Worker/Quality Assurance Nurse;

D. Utilization Review Nurse (hospital, Division or Health plan);

E. The Division Discharge Planning Coordinator;

F. The Division Support Coordinator; and;

G. Other Planning Team members, as necessary.

In order to ensure that Support Coordinators and District Nurses are aware of hospitalizations of ALTCS eligible members, the Medical Services Representative will e-mail the Support Coordinator and District Nurse identified in Focus when notified of an admission. It is the responsibility of the Support Coordinator to notify the Division's District Nurse or Discharge Planning Coordinator of transfers of medically-involved members, or the hospitalization of a non-ALTCS eligible member.
The discharge planning process is applicable in health care settings, and in the transfer of a medically involved member from one Child Developmental Home, Adult Developmental Home, Group Home, and Intermediate Care Facility for Individuals with an

Intellectual Disability or Nursing Facility to another. The process will generally include the following activities:

A. Complete a Division Discharge Plan Assessment, e.g., nursing assessment;

B. Review of discharge orders written by doctor;

C. Ensure that the member/family/caregiver has received proper training to carry out the discharge orders;

D. Ensure that all necessary equipment and supplies have been ordered and will be available when needed;

E. Ensure that transportation arrangements have been made;

F. Reinstate applicable service(s) that may have been interrupted, or initiate services now determined needed (update Planning Documents);

G. The District Nurse or Discharge Planning Coordinator will complete a Utilization Review Nursing Worksheet – Health Care Services, and send copies to the Support Coordinator and Health Care Services (HCS); and,

H. Notification and/or signatures as required on the *Utilization Review Nursing Worksheet* – HCS form:

1. Health Care Services Representative (District Nurse and/or Discharge Planning Coordinator);

2. District Program Manager or designee (to be notified about all changes of placement);

3. Medical Director (to be notified by HCS of level of care changes); and,

4. The Division Assistant Director/designee (signature also required for placement in a planning document).

Members with Medical Needs

Members are considered to be medically involved when they require two or more hours per day of skilled nursing care. Thorough discharge planning for people who are medically involved ensures continuity of a members' services when the member is moving from one setting to another. Placement and services should be appropriate and established prior to the member being discharged.
The Support Coordinator, District Nurse, and/or the Discharge Planning Coordinator will work together to initiate the discharge planning process. Their communication can include a Planning Document. Convening a Planning Team meeting is at the discretion of any member.

The following procedures shall be implemented for all members who are medically involved:

A. The District Nurse will verify hospitalization notification and/or transfer intentions with the Support Coordinator;

B. The District Nurse or Discharge Planning Coordinator shall follow the hospitalization and keep the Support Coordinator updated on the member's condition and the concerns expressed by the member/family/caregiver; and,

C. A Planning Team meeting should be called prior to discharge for complex cases. The hospital discharge planner is considered the lead in this meeting, and should assemble the family/caregiver, attending physician, primary care provider (if possible), social services, the Support Coordinator and Division Nurse, and the health plan utilization review nurse. Other disciplines may be included, particularly if their role influences the member's discharge status/planning (i.e., Department of Child Safety or Adult Protective Services).

D. If placement is an issue:

1. A nursing assessment will be updated/completed, to assess the nursing/medical needs of the member and identify the appropriate type of facility/residence.

2. If behavioral health is a need, referral to the Regional Behavioral Health Authority (RBHA) should be made by the Support Coordinator to initiate assessment and their participation in the discharge planning process.

3. Based on the Planning Documents, the Support Coordinator will work with the appropriate staff to arrange for the facility/residence which will provide for the identified needs.

E. If the Division is expected to pay for a Planning Document placement, a thorough review is required, including HCS, before any admission is made. All placements in Planning Document(s) must have the approval of the Assistant Director. These facilities are restrictive environments, therefore, placement is temporary and transitional, occurring only after the following alternative options have been eliminated:

1. In-home supports;

2. Individually Designed Living Arrangement; and,

3. Community based placements, e.g.; Group Home; Child Developmental Home (CDH); or Adult Developmental Home (ADH).

See Division Medical Policy Manual for more information on Planning Document.

A. For those members who are returning to a Planning Document, the District Nurse or Discharge Planning Coordinator shall participate in the planning process. The entire planning process shall be completed before the discharge/transfer is made.

B. In the absence of a Planning Meeting, the District Nurse and/or Discharge Planning Coordinator will coordinate the discharge orders, caregiver training, equipment/supplies, home health care, and transportation.

C. The Division Nurse or Discharge Planning Coordinator shall complete a *Utilization Review Nursing Worksheet* –upon discharge, and send copies to the Support Coordinator and HCS.

D. The Discharge Plan shall take precedence over any Planning Document objectives that are in conflict. If there is a conflict, a new Planning Document shall be developed as soon as possible. The member/responsible person, primary care provider, or any other attending physician involved shall resolve disagreements. The medical records and a summary of the disagreement may be sent to the Discharge Planning Coordinator to be reviewed. The Division's Medical Director may be contacted to review the case and assist in the resolution of the disagreement.

E. The member's primary care provider shall be given the opportunity to participate in the discharge planning and review the completed Planning Document.

Nurse Consultation to Determine Medical Needs

The District Nurse or Discharge Planning Coordinator may be contacted directly by the Support Coordinator to review a member's hospitalization or transfer plans to determine if medical discharge planning is needed. A *Utilization Review Nursing Worksheet* should be completed by the District Nurse or Discharge Planning Coordinator and submitted with appropriate documentation to HCS and the Support Coordinator indicating if skilled nursing needs have been identified.

Members Without Medical Needs

For non-medically involved members who are being discharged from a hospital or skilled nursing facility, the following procedures shall be implemented:

A. The Support Coordinator shall assess for medical needs prior to discharge. If needed the District Nurse or Discharge Planning Coordinator will complete a Nursing Assessment - HCS to plan and recommend an appropriate level of care;

B. If the member is non-medically involved, the Support Coordinator will:

1. Ensure that training of caregivers has taken place;

2. Assess for and authorize in-home supports as appropriate;

3. Make arrangements for equipment, supplies, medications, etc. through appropriate systems; and,

4. Ensure that follow-up instructions are in place.

C. In those situations where a residential setting will change, the Planning Document process shall be an essential part of discharge planning.

Foster Care Discharge Planning

For all members in foster care, the following discharge planning procedures shall be implemented:

A. The Support Coordinator, District Nurse or Discharge Planning Coordinator will assess for medical needs prior to hospital discharge. If medical needs are present, the nurse will complete a Utilization Review Nursing Worksheet – HCS, and coordinate a plan of care, training for caregivers, and equipment and supply needs. A Nursing Assessment - HCS will be updated/completed to determine home based nursing services and/or placement needs.

B. The District Nurse or Discharge Planning Coordinator must be notified:

1. Prior to any foster child being admitted to or discharged from a planning document or Nursing Facility (NF).

2. Prior to any foster child that is medically involved, receiving home based nursing services, or being considered for a change in placement.

C. The Planning Team must be notified prior to this change of placement. The District Nurse or Discharge Planning Coordinator will complete the *Utilization Review Nursing Worksheet* – HCS, and coordinate plan of care, training, and equipment and supply needs. The District Nurse or Discharge Planning Coordinator will notify HCS of changes in placement. The Support Coordinator will notify the District. Specific to a planning document admission, the personal authorization of the Assistant Director (or designee) is required.

D. Children in foster care whose cases have been transferred from DCS to the Division may also require the participation of court appointed special advocates, attorneys, guardian ad litems, or other professionals from the juvenile court.

Discharge/Transition of Members with Severe Behavioral Challenges

When a member with severe behavioral health challenges is placed into a psychiatric hospital setting, the Support Coordinator will begin discharge planning immediately and District Personnel will attend a hospital staffing within 72 hours. Support Coordinators shall, if possible, attend all subsequent hospital staffings. Prior to discharge, the Support Coordinator will:

A. Involve staff responsible for contracting with Provider Agencies as soon as possible;

B. Begin the appropriate Planning Process; and,

C. Ensure that staff from the behavioral health system is invited to all planning sessions.

Use of the Discharge/Transition Checklist for Individuals with High Risk Behavioral Challenges is mandated when planning discharge from an inpatient setting for members with severe behavioral challenges. The form can also be used when someone with behavioral challenges moves from one setting to another. The form is intended to provide

reminders to the team about important areas to consider and should be used to plan for the discharge/move.

The Emergency Contact Plan is intended to record very basic information about the person that would be helpful to others coming in to assist in a crisis situation, such as crisis mobile team members or police officers. The form should be completed at the discharge/transition-planning meeting and updated as necessary. The representative from the behavioral health system should assist in filling out the form and the same information should, if possible, be on file with the Regional Behavioral Health Authority (RBHA). The Emergency Contact Plan should be kept in an easily accessible place in the setting, but it should never be posted.

The Emergency Contact Plan does not take the place of the Behavior Plan. Begin development of the behavior plan prior to discharge, so that the person is discharged with at least a rough draft of the plan that eventually gets submitted to the Program Review Committee. This initial plan may be called a "crisis plan." It should have information about precursors/antecedents and creative strategies for preventing challenging behaviors. It should give staff ideas for teaching replacement behaviors, and it should let staff know whom to call when a crisis occurs.

541 COORDINATION OF CARE WITH OTHER GOVERNMENT AGENCIES

REVISION DATE: 9/6/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. §§ 15-761 et seq, A.R.S. § 15-1181, AMPM 541, Division Operation Policy 417

PURPOSE

This policy outlines how the Division shall develop and maintain collaborative relationships with other government entities that deliver services to Members and their families, ensure access to services, and coordinate care with consistent quality. This policy also outlines how the Division shall provide monitoring and oversight of the Administrative Services Subcontractors (AdSS) in their performance of the coordination with other government agencies.

DEFINITIONS

1. "Adult Recovery Team" or "ART" means a group of individuals that, following the nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, work in collaboration and are actively involved in a Member's assessment, service planning, and service delivery. At a minimum, the team consists of the Member, the Member's Responsible Person if applicable, advocates if assigned, and a

qualified behavioral health representative. The team may also include the enrolled Member's family, physical health, behavioral health, or social service providers, the Support Coordinator, other agencies serving the Member, professionals representing various areas of expertise related to the Member's needs, or other Members identified by the enrolled Member.

2. "Child and Family Team" or "CFT" means a defined group of individuals that includes, at a minimum, the child and his or her family or Responsible Person, the assigned Support Coordinator, a behavioral health representative, and any individuals important in the child's life that are identified and invited to participate by the child and family or Responsible Person. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches, and community resource providers, representatives from churches, synagogues, mosques, or other places of worship and faith, agents from other service systems like the Department of Child Safety (DCS) or the Division of Developmental Disabilities (DDD), which includes AzEIP. The size, scope, and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by

who is needed to develop an effective Planning Document and can therefore expand and contract as necessary to be successful on behalf of the child.

3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

4. "Rapid Response" means a process that occurs when a child enters into DCS custody. When this occurs, a behavioral health service provider is dispatched within 72 hours, to assess a child's immediate behavioral health needs, and refer for further assessments through the behavioral health system.

5. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

6. "Service Plan" means a complete written description of all covered behavioral health services and other informal supports that includes individualized goals, family support services, care coordination activities, and strategies to assist the Member in achieving an improved quality of life.

7. "State Placing Agency" means the Department of Juvenile Corrections, Department of Economic Security (DES), Department of Child Safety (DCS), the Arizona Health Care Cost Containment System (AHCCCS), or the Administrative Office of the Court. (A.R.S. §15- 1181(12).

8. "Team Decision Making" or "TDM" means when an emergency removal of a child has occurred or the removal of a child is being considered, a TDM Meeting is held. The purpose of the meeting is to discuss the child's safety and where they will live.

POLICY

A. COORDINATION OF CARE WITH OTHER GOVERNMENT AGENCIES

1. The Division shall have policies, protocols, and procedures that describe how the Division coordinates and manages Member care with other governmental entities.

2. The Divisions shall ensure collaboration by participating in the Member's:

   a. Planning Team meetings,

   b. Child and Family Team (CFT) meetings, and

c. Adult Recovery (ART) meetings.

3. The Division shall ensure all required protocols and agreements with State agencies are specified in the provider manuals.

4. The Division shall develop and maintain mechanisms and processes to identify barriers to timely services for Members served by other governmental entities.and work collaboratively with them to remove barriers to Member care and to resolve any Member quality of care concerns.

5. The Division shall work in collaboration with DCS to coordinate Member care.

6. The Division shall coordinate with Tribal Regional Behavioral Health Authorities (TRBHAs) for Members receiving behavioral health services through a TRBHA.

7. The Division shall participate in the Member's Planning Team meetings, CFTs or ARTs to coordinate services for the family and temporary caregivers for Members referred through the Arizona Families F.I.R.S.T. (AFF) program.

8. The Division shall work in collaboration with the Arizona Department of Education and the Member’s school to assist with

resources and referral linkages to help a Member achieve success in school for children with behavioral health needs.

9. The Division shall not be financially responsible for services provided by Local Educational Authorities (LEAs), as specified in AMPM Policy 710, for Members receiving special education services.

10. The Division shall collaborate and coordinate care for Members involved with the following governmental entities as outlined in AMPM Policy 1021 and 1022:

    a. Arizona Department of Corrections (ADOC),

    b. Arizona Department of Juvenile Corrections (ADJC),

    c. Administrative Offices of the Court (AOC), or

    d. County Jails System

B. MONITORING AND OVERSIGHT

1. The Division shall conduct an annual operational review of the AdSS to ensure the AdSS:

    a. Has policies and procedures that describe how Member care is coordinated and managed when other government

entities are involved.

b. Demonstrates evidence of collaborative work with the following:

i. Arizona Department of Child Safety (DCS)

ii. DCS Arizona Families F.I.R.S.T. (Families in Recovery Succeeding Together) (AFF) Program

iii. Arizona Department of Education (ADE), Schools, or other local Educational Authorities.

iv. Arizona Department of Economic Security (DES) Arizona Early Intervention Program (AzEIP)

v. Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA)

vi. Courts and Corrections

2. The Division shall conduct quarterly oversight meetings with the AdSS for the purpose of reviewing AdSS performance and addressing any Member access to care concerns.

3. The Division shall review data submitted by the AdSS

demonstrating ongoing compliance monitoring of their network of provider agencies through Behavioral Health Clinical Chart Reviews.

Signature of Chief Medical Officer: Anthony Dekker (Aug 29, 2023 14:52 PDT)
Anthony Dekker, D.O.

570 BEHAVIORAL HEALTH PROVIDER CASE MANAGEMENT

REVISION DATE: 11/9/2022, 7/3/2015
EFFECTIVE DATE: June 30, 1993
REFERENCES: A.R.S § 36-551; ACOM 407; AMPM Chapter 200; AMPM 320-O; AMPM 570

PURPOSE

The purpose of this policy is to outline requirements for Behavioral Health Provider Case Management services for Division of Developmental Disabilities (Division) members who are Arizona Long Term Care System (ALTCS) eligible.

DEFINITIONS

1. "Assertive Community Treatment Case Management" focuses upon members with severe and persistent mental illness that seriously impairs their functioning in community living, in conjunction with a multidisciplinary team approach to coordinating care across multiple systems.
2. "CALOCUS" is a standardized assessment tool that provides determination of the appropriate intensity of services needed by a child or adolescent and their family, and guides provision of

ongoing service planning and treatment outcome monitoring in all clinical and community-based settings.

3. "Connective Case Management" means to focus upon members who have largely achieved recovery and who are maintaining their level of functioning. Connective case management involves careful monitoring of the member's care and linkage to service. Caseloads may include both members with an SMI designation as well as members with a general mental health condition or Substance Use Disorder as clinically indicated.
4. "High Needs Case Management" means focus upon providing case management and other support and rehabilitation services to children with complex needs and multiple systems involvement for whom less intensive case management would likely impair their functioning. Children with high service intensity needs who require to be offered the assignment of a high needs case manager are identified as:
    a. Children 0 through five years of age with two or more of the following:

i. Involvement with Arizona Intervention Program (AzEIP), Department of Child Safety (DCS), and/or Division of Developmental Disabilities (DDD), and/or

ii. Out of home residential services for behavioral health treatment within past six months, and/or

iii. Utilization of two or more psychotropic medications, and/or

iv. Evidence of severe psycho-social stressors (e.g. family member serious illness, disability, death, job loss, eviction), and

b. Children six through 17 years of age: CALOCUS level of 4, 5, or 6.

5. "Member" means an individual who is receiving services from the Division of Developmental Disabilities (Division).

6. "Provider Case Management" means a collaborative process provided by a behavioral health provider which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through

communication and available resources to promote quality, cost-effective outcomes.

7. "Provider Case Manager" means the person responsible for locating, accessing, and monitoring the provision of services to clients in conjunction with a clinical team.
8. "Responsible Person" means the parent or guardian of a developmentally disabled minor, the guardian of a developmentally disabled adult or a developmentally disabled adult who is a client or an applicant for whom no guardian has been appointed.
9. "Substance Use Disorder" means a range of conditions that vary in severity over time, from problematic, short-term use/abuse of substances to severe and chronic disorders requiring long-term and sustained treatment and recovery management.
10. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551
11. "Supportive Case Management" means focus upon members for whom less intensive case management would likely impair their functioning. Supportive case management provides assistance,

support, guidance and monitoring in order to achieve maximum benefit from services. Caseloads may include members with an SMI designation as well as members with a general mental health condition or substance use disorder as clinically indicated.

POLICY

A. The Division shall ensure that members receive behavioral health case management services in addition to support coordination when requested by the member/responsible person and determined medically necessary for coordination of services. These services may be provided by:

1. A behavioral health provider for members enrolled in subcontracted health plans, or
2. A Tribal Regional Behavioral Health Authority (TRBHA) case manager for members enrolled in the Tribal Health Program.

B. The Division shall cover case management services provided by behavioral health providers involved with a member's care outside of the role of an assigned behavioral health case manager.

C. The Division shall ensure that Provider Case Managers monitor the member's current needs, services, and progress through regular and ongoing contact with the member/responsible person.

D. The DDD Support Coordinator shall participate as part of the Child and Family Team (CFT) or Adult Recovery Team (ART) in determining the frequency and type of contact during the treatment planning process, and adjust as needed, considering clinical need and member preference.

E. The DDD Support Coordinator shall participate as part of the CFT or ART in assessing the intensity level for one of the following types of Provider Case Management:

1. Connective Case Management
2. Supportive Case Management
3. High Needs Case Management
4. Assertive Community Treatment Case Management

F. The Division shall ensure that Provider Case Managers coordinate care on behalf of DDD members to ensure they receive the treatment and support services that will most effectively meet the member's needs by:

1. Coordinating with the member/responsible person, social rehabilitation, vocational/employment and educational providers, supportive housing and residential providers, crisis providers, health care providers, peer and family supports, other state agencies, and natural supports as applicable.
2. Obtaining input from providers and other involved parties in the assessment and service planning process.
3. Providing coordination of the care and services specified in the member's service plan and each provider/program's treatment plan, to include physical and behavioral health services and care.
4. Obtaining information about the member's course of treatment from each provider at the frequency needed to monitor the member's progress.
5. Participating in all provider staffing and treatment/service planning meetings.
6. Obtaining copies of provider treatment plans and entering them as part of the medical record.
7. Providing education and support to members/responsible persons, family members, and significant others regarding the

member's diagnosis and treatment with the member/responsible person’s consent.

8. Providing a copy of the member’s service plan to other involved providers and involved parties with the consent of the member/responsible person’s consent.
9. Providing medication and laboratory information to residential and independent living service providers or other caregivers involved with the consent of the member/responsible person.
10. Coordinating care with the member’s assigned care manager as applicable.
11. Utilizing the Behavioral Health Practice Tools located in AHCCCS Medical Policy Manual (AMPM) Chapter 200 for children.
12. In crisis situations:
    a. Identifying, intervening, and/or following up with a potential or active crisis situation in a timely manner,
    b. Providing information, backup, and direct assistance to crisis and emergency personnel, including "on-call" availability of case manager or case management team to the Crisis System

c. Providing follow-up with the member/responsible person after crisis situations, including contact with the member within 24 hours of discharge from a crisis setting,

d. Immediately assessing for, providing, and coordinating additional supports and services as needed to accommodate the individual's member's needs, and

e. Ensuring the member's annual crisis and safety plan is updated as clinically indicated, based on criteria as specified in AMPM Policy 320-O, and readily available to the crisis system, clinical staff and individuals involved in the development of the crisis and safety plan.

G. The Division shall ensure the AdSS develops a provider network with a sufficient number of qualified and experienced behavioral health case managers and meet the following requirements:

1. Behavioral health case managers are available to provide Case Management services to all enrolled members and shall meet the caseload ratios as specified in AMPM 570 Attachment A except as otherwise specified and approved by AHCCCS.

2. All DDD members with a Serious Mental Illness (SMI) designation are assigned to a Provider Case Manager in accordance with A.A.C. R9-21-101, and that all other individual members are assigned a Provider Case Manager as needed, based upon a determination of the individual's member's service acuity needs.
3. Providers are orienting new Provider Case Managers to the fundamentals of providing Case Management services, evaluating their competency to provide Case Management, and providing basic and ongoing training in the specialized subjects relevant to the populations served by the provider, and as specified in ACOM Policy 407.
4. Member/responsible person shall be provided adequate information in order to be able to contact the behavioral health case manager or AdSS for assistance. The AdSS shall also ensure that adequate information is provided to the member/responsible person for what to do in cases of emergencies and/or after hours.

5. Providers have a system of back-up Case Managers in place for members who contact an office when their assigned Provider Case Manager is unavailable and that members be given the opportunity to speak to the back-up provider Case Manager for assistance. The AdSS shall ensure when messages are left for Provider Case Managers that members/responsible persons are called back within two business days.
6. Case Managers are not assigned duties unrelated to member specific case management for more than 10% of their time if they carry a full caseload. (as specified in AMPM 570 Attachment A)
7. Providers establish a supervisor to Provider Case Manager ratio that is conducive to a sound support structure for case managers as per AMPM 570 Attachment A, including establishing a process for reviewing and monitoring supervisor staffing assignments in order to adhere to the AdSS's designated supervisor to Provider Case Manager ratio.
8. Provider Case Manager supervisors have adequate time to train and review the work of newly hired Provider Case Managers as

well as provide support and guidance to established Provider Case Managers.

9. In order to prevent conflicts of interest, ensure that a Provider Case Manager is not:

   a. Related by blood or marriage or other significant relation to a member or to any paid caregiver for a member on their caseload.

   b. Financially responsible for a member on their caseload.

   c. Empowered to make financial or health-related decisions on behalf of a member on their caseload.

   d. In a position to financially benefit from the provision of services to a member on their caseload.

   e. A provider of paid services (e.g., Home and Community Based Services (HCBS), privately paid chores, etc.) for any member on their caseload.

H. The Division shall ensure the AdSS establishes and implements mechanisms to promote coordination and communication between Provider Case Management and AdSS care management teams, with particular emphasis on ensuring coordinated approaches with the

AdSS's Chief Medical Officer (CMO), Medical Management (MM) and Quality Management (QM) teams as appropriate.

I. The Division shall ensure the AdSS submits a Case Management Plan that addresses how the AdSS will collaborate with other Contractors to implement and monitor Provider Case Management standards and caseload ratios for adult and child members, as well as including:

1. performance outcomes,
2. lessons learned, and
3. strategies targeted for improvement, and
4. evaluation of the AdSS's Case Management Plan from the previous year.

J. The Division shall oversee the AdSS utilizing the following methods to ensure compliance with policy:

1. Annual Operational Review of each AdSS
2. Review and analyze deliverable reports submitted by the AdSS
3. Conduct oversight meetings with the AdSS for the purpose of:
    a. reviewing compliance,
    b. address concerns with access to care or other quality of care concerns,

c. discuss systemic issues and

d. provide direction or support to the AdSS as necessary

4. Ongoing monitoring and evidence of compliance through Behavioral Health Chart Audits.

Signature of Chief Medical Officer: Anthony Dekker (Nov 1, 2022 11:06 PDT)
Anthony Dekker, D.O.

580 BEHAVIORAL HEALTH REFERRAL PROCESS

REVISION DATE: 6/15/2022
EFFECTIVE DATE: August 4, 2021
REFERENCES: A.R.S. § 8-512.01; CFR 45-164.520 (c)(1)(B)

PURPOSE

This policy applies to the Division of Developmental Disabilities (Division) with regard to ensuring that eligible ALTCS members enrolled in a DDD Health Plan, including the Tribal Health Program with behavioral health and substance use disorders, can gain prompt access to behavioral health services. For Division members enrolled in other AHCCCS health plans (i.e., targeted support coordination members), the Support Coordinator shall coordinate with the member's AHCCCS Complete Care plan for behavioral health services.

The Division delegates the responsibility to Administrative Services Subcontractor (AdSS) for the implementation of behavioral health services, whose contract includes this requirement, for eligible members enrolled in a DDD Health Plan. (Refer to AdSS Medical Policy 580.) The Division remains responsible for support coordination, care coordination for members enrolled in the Tribal Health Program and oversight of the AdSS. (Refer to Division Medical Policy 1620-G related to behavioral health referrals and service coordination.)

DEFINITIONS

Assessment means the ongoing collection and analysis of a member's medical, psychological, psychiatric, and social conditions in order to initially determine if a health disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensure that the member's planning

document is designed to meet the member's (and family's) current needs and long-term goals.

Intake means the initial evaluation and collection, by appropriately trained staff, of basic demographic information and preliminary identification of the member's needs.

Referral means, for purposes of this policy, a verbal, written, telephonic, electronic, or in-person request for behavioral health services.

Responsible Person means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed as cited in A.R.S § 36-551.

Serious Mental Illness (SMI) Determination means a determination as to whether or not an individual meets the diagnostic and functional criteria established for the purpose of determining an individual's eligibility for SMI services.

POLICY

A. GENERAL REQUIREMENTS FOR BEHAVIORAL HEALTH SERVICES REFERRAL

1. A referral may be made, but is not required, to initiate behavioral health services. A member/responsible person may directly outreach a behavioral health provider, the Division, or their health plan, to initiate services or to identify a contracted service provider. If behavioral health services are not available within the service array of an existing provider, a referral may

be made by any of the following:

a. A member or the member's responsible person,
b. The Division,
c. DDD subcontracted health plan,
d. Primary care provider (PCP),
e. Other providers within their scope of practice,
f. Hospital,
g. Jail,
h. Court,
i. Probation or parole officer,
j. Tribal entity,
k. Indian Health Services/638 Tribally operated facility,
l. School,
m. Other governmental or community agency, and
n. Members in the legal custody of the DCS, the out-of-home placement as specified in A.R.S. §8-512.01 and Division Operations Policy 449.

2. TRBHA responsibilities regarding referrals are specified in the TRBHA Intergovernmental Agreements (IGAs).

3. To facilitate timely access to behavioral health services, the Division shall ensure an effective referral process is in place for members seeking or screened as at-risk for needing behavioral health services including but not limited to general mental health/substance use services, members determined to have an SMI, and those seeking an SMI designation. The referral process shall include:

a. Engaging with the member/responsible person to communicate the process for making referrals, including

self-referrals, ensuring that the referral process maximizes member and family voice and a choice of service providers, as well as the allowance of THP members to see any AHCCCS registered provider;

b. Referrals are accepted for behavioral health services 24 hours a day, seven days a week. The processing of referrals shall not be delayed due to missing or incomplete information. An acknowledgement of receipt of a referral shall be provided to the referring entity within 72 hours from the date it was received.

c. Sufficient information is collected through the referral process to:

   i. Assess the urgency of the member's needs;

   ii. Track and document the disposition of referrals to ensure subsequent initiation of services. The Division shall ensure the AdSS comply with timeliness standard specified in AdSS Operational Policy 417; and

   iii. Ensure members who have difficulty communicating due to a disability, or who require language services, are afforded appropriate accommodations to assist them in fully expressing their needs;

d. Information or documents collected in the referral process are kept confidential and protected in accordance with applicable federal and state statutes, regulations, and

policies.

e. Providers offer a range of appointment availability and flexible scheduling options based upon the needs of the member.

B. REFERRALS FOR INDIVIDUALS ADMITTED TO A HOSPITAL

1. The Division shall ensure referrals involving members admitted to a hospital, who are identified as in need of behavioral health services, are responded to as follows:

   a. Upon notification of a member not currently receiving behavioral health services, the Division shall ensure a referral is made to a provider agency within 24 hours.

   b. The Division shall ensure the AdSS' provider agencies attempt to conduct a face-to-face intake evaluation with the member within 24 hours of referral and the evaluation occurs prior to discharge from the hospital.

   c. For members already receiving behavioral health services, the Division shall ensure coordination, transition, and discharge planning activities are completed in a timely manner as specified in Division Medical Policy 1021.

   d. TRBHA responsibilities regarding referrals are outlined in the TRBHA Intergovernmental Agreements.

C. DIVISION OVERSIGHT OF AdSS

1. The Division shall complete an Annual Operational Review of each AdSS in the following areas:

a. The AdSS has policies and procedures to ensure members receive behavioral health services.

b. The AdSS ensures the initiation and coordination of a referral when a behavioral health need has been identified and follows up to determine if the member received behavioral health services.

c. The AdSS ensures that training and education is provided to PCPs regarding the behavioral health referral process.

d. The AdSS informs PCPs of the ability and process to directly refer members with suspected diagnosis of autism or other DDD eligible diagnoses directly to a specialized Autism Spectrum Disorder, Cognitive/Intellectual Disability or other DDD qualifying diagnosing provider. For the purpose of eligibility, refer to the Division's Eligibility Policy 200-G and 200-H for a list of diagnostic and functional criteria.

e. The AdSS documentation reflects evidence that medically necessary behavioral services were determined by a qualified behavioral health professional.

f. Review and analyze deliverable reports submitted by the AdSS.

g. Conduct oversight meetings with the AdSS for the purpose of reviewing compliance; address concerns with access to care or other quality of care concerns; discuss systemic issues and provide direction or support to the AdSS as

necessary.

h. Ensure the AdSS conducts ongoing monitoring and evidence of compliance through Behavioral Health Chart Audits.

Signature of Chief Medical Officer: Anthony Dekker (Jun 14, 2022 17:35 PDT)
Anthony Dekker, D.O.

590 BEHAVIORAL HEALTH CRISIS SERVICES AND CARE COORDINATION

EFFECTIVE DATE: January 18, 2023
REFERENCES: AHCCCS Contract

PURPOSE

This policy describes the requirements related to the behavioral health Crisis system for Arizona Long Term Care System (ALTCS) eligible members.

DEFINITIONS

1. "Crisis" means an acute, unanticipated, or potentially dangerous behavioral health condition, episode, or behavior. A Crisis is self-defined and determined by the individual experiencing the situation. An individual is in Crisis if the individual finds they lack the skills or are unable to cope with a situation or event that is impacting them.
2. "Crisis Services" means services that are community based, recovery-oriented, and member-focused that shall work to stabilize members as quickly as possible so as to assist them in returning to their baseline of functioning.

3. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a member or an applicant for whom no guardian has been appointed.
4. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. The Division shall ensure medically necessary services and care are provided to members following a Crisis episode or discharge from a crisis stabilization setting.

B. The Division shall be financially responsible for services after the initial 24 hours of a Crisis episode, which is covered by the AHCCCS Complete Care Regional Behavioral Health Authority (ACC-RBHA), or discharge from a Crisis stabilization setting, whichever occurs first.

C. The Division shall ensure emergency transportation from Crisis receiving facilities is covered as a health plan benefit.

D. The Division shall ensure non-emergent transportation from Crisis receiving facilities is covered as a health plan benefit for members not

residing in community residential settings and Intermediate Care Facilities for the Intellectually Disabled.

E. The Division shall ensure community residential settings and Intermediate Care Facilities for the Intellectually Disabled provide non-emergent transportation from Crisis receiving facilities for members residing in those settings.

F. The Division shall publicize Crisis Services, including the statewide Crisis phone number, prominently on their websites, in their resource directories, and on the following relevant member and community materials:

1. Division website,
2. Member handbook, and
3. Member identification cards.

G. The Division shall ensure care coordination occurs between:

1. The member's health plan;
2. Behavioral health provider;
3. The Division;
4. Crisis providers; and
5. The member, if applicable.

H. The Support Coordinator shall follow up with the Responsible Person within two business days from receiving the focus global notification to gather information regarding what event occurred before the Crisis line was called and assess the following:

1. Whether additional support is needed from either the Division or behavioral health provider.
2. Whether the member is receiving the appropriate behavioral health services and:
    a. Make a referral within one business day, if needed; or
    b. Advocate if additional behavioral health services are needed.

I. The Support Coordinator shall:

1. Ensure all planning team members and/or Child and Family Team/Adult Recovery Team are aware of recent contact with behavioral health Crisis services.
2. Coordinate care with the planning team and/or Child and Family Team/Adult Recovery Team as needed to:
    a. Verify medications are taken as prescribed,

b. Verify the member is currently enrolled with a behavioral health provider,

c. Assess for additional behavioral health services, and

d. Ensure the member has a Crisis plan and/or update plan for current needs.

3. Request assistance from the District Behavioral Health Complex Care Specialist as needed.

4. Submit a referral to the Division's Behavioral Health Advocate as needed.

5. Request assistance from the District Nurse if medical concerns are presented.

6. Complete a referral for a Care Manager through the member's ALTCS health plan as needed.

J. The Division shall ensure the Administrative Services Subcontractors (AdSS) develop policies establishing post-Crisis care coordination expectations that provide the following:

1. Transfer of medical records of services received during a Crisis episode, including prescriptions.

2. Tracking of admission, discharge, and re-admissions, including admission setting.
3. Requirements for follow-up directly with the individual, within 72 hours, when discharged from a Crisis setting.
4. Engagement of peer and family support services when responding to post-Crisis situations.
5. The provision of ongoing care is done in an expedient manner in accordance with ACOM Policy 417.

K. The Division shall ensure the AdSS regularly evaluates post-Crisis care coordination activities and work to improve internal and external collaboration efforts. Care coordination activities shall include use of Health Information Technology, as available, to improve member outcomes.

L. The Division shall oversee the AdSS utilizing the following methods to ensure compliance with policy:

1. Annual Operational Review of each AdSS,
2. Review and analyze deliverable reports submitted by the AdSS, and
3. Conduct oversight meetings with the AdSS for the purpose of:

a. Reviewing compliance,

b. Addressing concerns with access to care or other quality of care concerns,

c. Discussing systemic issues, and

d. Providing direction or support to the AdSS as necessary.

Signature of Chief Medical Officer: Anthony Dekker (Jan 13, 2023 11:13 MST)
Anthony Dekker, D.O.

610 AHCCCS PROVIDER QUALIFICATIONS

EFFECTIVE DATE: November 17, 2017
REFERENCES: AHCCCS Medical Policy Manual Exhibit 610-1

All providers of services that are covered by the Division of Developmental Disabilities must:

A. Register with AHCCCS, which requires signing the Provider Participation Agreement or Group Biller Participation Agreement that includes all federal and state requirements as applicable.

B. Comply with all federal, state, and local laws, rules, regulations, executive orders, and agency policies governing performance of duties under the contract.

C. Sign and return attestations, found on the Provider Registration section of the AHCCCS website, that apply to their individual practices or facilities.

D. Meet AHCCCS requirements for professional licensure, certification, or registration, including current Medicare certification.

E. Complete all applicable registration forms.

Institutional and other designated providers are required to submit an enrollment fee (see AHCCCS Medical Policy Manual Exhibit 610-1).

Specific provider types require an AHCCCS Office of the Inspector General (AHCCCS-OIG) site visit prior to enrollment, and they are subject to unannounced post enrollment site visits (see AHCCCS Medical Policy Manual Exhibit 610-1).

AHCCCS Provider Registration Materials

AHCCCS-OIG Provider Registration materials are available on the AHCCCS web site. On the AHCCCS website, click on the “Plans/Providers” tab. In the resulting screen, click on the “New Providers” link and, in the resulting dropdown menu, click on the “Provider Reenrollment” link. The forms can be completed on the AHCCCS website, but they must be submitted by fax or mail.

AHCCCS Provider Types

AHCCCS providers are registered under a provider type (e.g., hospital, nursing facility, physician) established by AHCCCS. The AHCCCS-OIG “Provider Registration” section on the AHCCCS website will help providers to identify the most appropriate provider type, based on the provider's license/certification and other documentation.

Refer to the AHCCCS website for additional information regarding provider registration requests.

680-C PRE-ADMISSION SCREENING AND RESIDENT REVIEW

REVISION DATE: 11/15/23, 12/21/22, 9/25/19, 4/1/14
EFFECTIVE DATE: July 31, 1993
REFERENCES: 42 CFR 4 83.100 – 438.138, 42 CFR 447, 42 CFR 483.20

PURPOSE

This policy outlines the Division of Developmental Disabilities (Division) role in the Pre-Admission Screening and Resident Review (PASRR) requirements with the Intergovernmental Agreement.

DEFINITIONS

1. "Determination" means the outcome of the Level II assessment which ensures the nursing facility placement is, or continues to be, appropriate, and that services provided to individuals with a mental illness, intellectual disability, or related condition meet the individual's needs, including the need for specialized services.

2. "Health Care Decision Maker (HCDM)" means an individual who is authorized to make health care treatment decisions for the patient. As applicable to the situation, this may include a parent of an unemancipated minor or an individual lawfully

authorized to make health care treatment decisions as specified in A.R.S. §§ Title 14, Chapter 5, Article 2 or 3; or A.R.S. §§ 8514.05, 36-3221, 36-3231 or 36-3281.

3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

4. "Resident Review" means a subsequent Level II assessment and determination for existing nursing facility residents, triggered whenever an individual undergoes a significant change in status and that change has a substantial impact on their functioning as it relates to their mental illness/intellectual disability status.

5. "Significant Change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both (42 CFR 48 3.20).

POLICY

A. DIVISION REQUIREMENTS

1. The Division shall conduct Level II PASRR assessment for individuals suspected to have an Intellectual Disability (ID) or a related condition:

    a. Within nine business days from the date the completed Level I PASRR screening is received.

    b. Within five business days from the date the completed Level I PASRR screening is received when the Member is awaiting discharge from a hospital.

2. The Division shall ensure upon completion of Level II PASRR assessment, a Letter of Determination is sent to the following when applicable:

    a. Arizona Health Care Cost Containment System (AHCCCS);

    b. Social worker from the referring facility;

    c. Member and/or HCDM;

    d. Attending physician;

e. Support Coordinator; and

f. Social worker from a discharging facility.

B. RESIDENT REVIEW

The Division shall review resident review requests for individuals experiencing a significant change in condition within nine business days of the completed PASRR Level I screening being received.

C. ADMINISTRATIVE REVIEW PROCESS

1. The Division shall ensure an administrative review is provided for:

   a. Members to appeal a notice of intent to discharge or transfer the Member, and

   b. Members who have been adversely affected by a PASRR Determination in the context of:

      i. Preadmission screening, or

      ii. Annual resident review.

2. The Division shall ensure an appeals process is provided

as outlined in §483.15(h) and §431(e).

3. The Division shall ensure the following information is provided to the Member when filing an appeal:

   a. Statement of the Member's appeal rights;

   b. Name, address and telephone number of the entity receiving the request;

   c. How to obtain an appeal form;

   d. Assistance in completing and submitting the form for an appeal hearing request.

Signature of Chief Medical Officer: Anthony Dekker (Nov 9, 2023 11:53 MST)
Anthony Dekker, D.O.

700 School Based Claiming For Medicaid

REVISION DATE: 9/15/2014
EFFECTIVE DATE: June 30, 1994

The School Based Claiming Program through Arizona Health Care Cost Containment System (AHCCCS) covers both school-age children who are Medicaid Long Term Care eligible, and members supported by the Division's Targeted Support Coordination. The member must be at least three years of age but younger than 22 years of age, and have been determined by the school to be eligible for special education and related services. (See AHCCCS Medical Policy Manual Chapter 700.)

910 QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM SCOPE

REVISION DATE: 10/11/2023, 12/07/2022, 10/01/2020, 8/1/2018, 7/15/2016

EFFECTIVE DATE: May 27, 2016

REFERENCES: 42 CFR Part 438, 42 CFR 438.2, 42 CFR 438.208, 42 CFR 438.242, 42 CFR 438.310(c)(2), 42 CFR 438.320, 42 CFR 438.330, AMPM 910, AMPM 900,

PURPOSE

This policy establishes the requirements of the Division of Developmental Disabilities (Division) regarding the administration, management, and implementation of the Quality Management and Performance Improvement (QM/PI) Program. This policy sets forth roles and responsibilities of the Division to provide oversight and ongoing Evaluation of the Administrative Services Subcontractors' (AdSS) compliance with QM/PI Program requirements.

DEFINITIONS

1. "Administrative Services Subcontract/Subcontractor" means an agreement that delegates any of the requirements of the Contract with AHCCCS, including, but not limited to the following:
    a. Claims processing, including pharmacy claims,
    b. Pharmacy Benefit Manager (PMB),
    c. Dental Benefit Manager,
    d. Credentialing, including those for only primary source verification (i.e., Credential Verification Organization [CVO]),
    e. Management Service Agreements,
    f. Medicaid Accountable Care Organization (ACO),
    g. Service Level Agreements with any Division or Subsidiary of a corporate parent owner, and
    h. Comprehensive Health Plan (CHP) and DDD Subcontracted Health Plan.

A person, individual or entity, who holds an Administrative Services Subcontract is an Administrative Services Subcontractor. Providers are not Administrative Services Subcontractors.

2. "Corrective Action Plan " or "CAP" means a written work plan that identifies the root cause(s) of a deficiency. The CAP is made up of goals and objectives; actions and tasks to be taken to facilitate an expedient return to compliance; methodologies to be used to accomplish CAP goals and objectives; and staff responsible to carry out the CAP within the established timelines.
3. "Evaluation" or "Evaluating" means the process used to examine and determine the level of Quality or the progress toward improvement of Quality and performance related to Division service delivery systems.
4. "Executive Body" means ADES Director, ADES Deputy Director and ADES Chief Compliance Officer.
5. "Health Information System" means the data system that collects, analyzes, integrates, and reports data and can achieve

the objectives of 42 CFR Part 438. The system provides information in the following areas: utilization; claims; grievances and appeals; and disenrollments for other than loss of Medicaid eligibility (42 CFR 438.242).

6. "Long Term Services and Supports" or "LTSS" means services and supports provided to Members of all ages who have functional limitations or chronic illnesses that have the primary purpose of supporting the ability of the Member to live or work in the setting of their choice, which may include the individual's home, a worksite, a Provider- owned or controlled residential setting, a nursing facility, or other institutional setting (42 CFR 438.2).
7. "Member" means the same as "Client" as defined in A.R.S.§36-551.
8. "Monitoring" means the process of auditing, observing, Evaluating, analyzing, and conducting follow-up activities, and documenting results via desktop or on-site review.

9. "Outcomes" means changes in patient health, functional status, satisfaction, or goal achievement that result from health care or supportive services (42 CFR 438.320).
10. "Performance Improvement Project" or "PIP" means a planned process of data gathering, Evaluation and analysis to determine interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the Quality of care and service delivery. Formerly referred to as Quality Improvement Projects (QIP).
11. "Provider" means any individual or entity that contracts with the AdSS for the provision of covered services, or ordering or referring for those services to Members enrolled in an AdSS' health plan, or any subcontractor of a Provider delivering services pursuant to A.R.S 36-2901.
12. "Quality" as it pertains to external review, means the degree to which a contractor described in 42 CFR 438.310(c)(2) increases the likelihood of desired Outcomes of its Members

through:

a. Its structural and operational characteristics.

b. The provision of services that are consistent with current professional, evidenced-based knowledge.

c. Interventions for performance improvement (42 CFR 438.320).

POLICY

A. QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT (QM/PI) PROGRAM OVERVIEW

1. The Division shall include the following elements in the QM/PI Program:

   a. Performance Improvement Projects (PIPs),

   b. Collection and submission of performance measurement data,

   c. Mechanisms to detect both under and overutilization of services, and

d. Mechanisms to assess the quality and appropriateness of care furnished to Members with special health care needs.

2. The Division shall include the following elements for Long-Term Services and Supports (LTSS) in the QM/PI program:

a. Mechanisms to assess the quality and appropriateness of care furnished to Members using LTSS, including:

i. Assessment of Care between care settings; and

ii. A comparison of services and supports received with those set forth in the member's treatment or service plan, if applicable, and

b. Participation in efforts by the State to prevent, detect, and remediate critical incidents that are based, at a minimum, on the requirements of the State for home and community-based waiver programs.

B. QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM COMPONENTS

The Division shall adhere to the following QM/PI Program requirements:

a. Demonstrate that Members' rights and responsibilities are defined, implemented, and monitored;

b. Ensure that medical records and communication of clinical information for each member:

   i. Reflect all aspects of member care, including ancillary and behavioral health services; and

   ii. Are supported by policies and procedures for electronic signatures when electronic documents are utilized;

c. Conduct temporary or provisional, initial, and re-credentialing processes for individual and organizational providers in accordance with AMPM Policy 950;

d. Track and trend Quality of Care (QOC) concerns, service issue resolutions, and grievance and appeals that meets the standards as specified in AMPM Policy 960, 42 CFR 438.400, and 42 CFR 438.242 et seq.;

e. Develop and implement planned activities to meet or exceed AHCCCS-mandated Performance Measure

Performance Standards (PMPS), as specified in AHCCCS Contract and required by AMPM Policy 970, and PIP goals, as required by AMPM Policy 980;

f. Implement processes to review and Evaluate its quality improvement data for accuracy, completeness, logic, and consistency as well as trend quality improvement data to identify potential areas for improvement;

g. Evaluate performance measure and PIP results based on a number of demographics in order to reduce health disparities across demographics, to the extent practical;

h. Identify goals and objectives and implement interventions that are meaningful, specific, and applicable to the population(s) served;

i. Ensure ongoing communication and collaboration with other functional areas of the Division;

j. Demonstrate the obtainment and incorporation of input in matters related to program activities from:

   i. AHCCCS Members,

ii. Stakeholders,

iii. Advocates; and

iv. Contracted providers;

k. Monitor the quality and coordination between physical and behavioral health services, with procedures to ensure timely updates occur between Primary Care Physicians (PCPs) and behavioral health providers regarding a member's change in health status that shall include:

i. Diagnosis of chronic conditions,

ii. Changes in physical or behavioral health condition or diagnosis,

iii. Support for the petitioning process, if applicable,

iv. Transition to or from an ACC-RBHA, based on Serious Mental Illness (SMI) designation, when appropriate;

l. Promote timely engagement and appropriate service levels for adult Members, as well as enrolled youth and caregivers;

m. Identify, monitor, and implement interventions for High Needs/High Cost (HN/HC) Members to ensure appropriate and timely service provision for behavioral or physical health needs through developing processes to:

   i. Monitor appropriate use of methodologies for screening and identification of high needs adult Members; and

   ii. Maintain policies for Monitoring and documentation of ongoing implementation for AHCCCS review;

n. Identify standards for adults with an SMI diagnosis for all levels of service intensity;

o. Establish mechanisms to connect Members and families to family run organizations;

p. Provide training and Monitoring for provider use of Substance Abuse Mental Health Services Administration (SAMHSA) Fidelity Tools including:

   i. Assertive Community Treatment,

   ii. Supported Employment,

iii. Supportive Housing; and

iv. Consumer Operated Services;

q. Provide training of clinical and general staff on eligibility and use of services available for substance use prevention or treatment through funds available for individuals that are Non-Title XIX/XXI eligible, and as specified in AMPM Policy 320-T1.

r. Promote Evidence Based Practices in Substance Use Disorder (SUD) Treatment Services;

s. Develop a process to identify and refer youth and young adults to the behavioral health system when identified as having a diagnosed SUD;

t. Ensure implementation and completion of American Society of Addiction Medicine (ASAM) Criteria, utilizing the most current edition at the time of service in:

i. SUD assessments,

ii. Service planning,

iii. Level of care placement, and

iv. Monitoring fidelity of ASAM implementation in accordance with AHCCCS directed phased in approach;

u. Ensure AdSS has a process to increase and promote physical health care providers' knowledge of health-related topics including substance use screening, overdose reversal medications, and Medication Assisted Treatment (MAT) options available to Members;

v. Promote suicide prevention following the Zero Suicide Model to support the identification and referral of Members in need of behavioral health or crisis services considering of the following:

i. Community Members;

ii. Physical health providers;

iii. Behavioral health providers;

iv. Interested stakeholders; and

v. Agencies that serve individuals at increased risk for suicide (Veterans, individuals with Posttraumatic

Stress Disorder (PTSD), Native Americans, middle aged white males, Members of the Lesbian, Gay, Bisexual and/or Transgender Queer/Questioning (LGBTQ+) community, foster care, those age 65 and older, juvenile justice, and women post-partum);

w. Identify Veteran and service member enrollment within the behavioral health system to initiate referrals when behavioral health needs are identified;

x. Implement policies and procedures that require:

i. Providers to report the following incidents to the proper authorities as well as the Division, as soon as they become aware of the incident:

1) Incidents of abuse,

2) Neglect,

3) Injuries,

4) Exploitation,

5) Healthcare acquired conditions, and

6) Unexpected death.

ii. Providers to submit Incident, Accident, and Death reports to the Division as specified in 9 A.A.C. 10, AMPM Policy 960, and AMPM Policy 961;

y. Implement policies and procedures that:

i. Require providers to monitor and trend all suicides or suicides attempts;

ii. Ensure that all providers recognize signs and symptoms of suicidal ideation and at-risk behaviors for children and adults regardless of mental health status; and

iii. Ensure AdSSs identify requirements for care coordination between behavioral health providers and PCPs or other medical practitioners involved in member's care in the event that a physical health or behavioral health practitioner witnesses a patient with:

1) Suicidal ideation,

2) At-risk behaviors, or

3) Significant change in either the behavioral or physical health condition;

z. Develop a process to ensure a Health Risk Assessment (HRA) is conducted within 90 days of a new Member's effective enrollment date that consists of the following:

i. A "best effort" attempt is made to conduct an initial HRA of each member's health care needs;

ii. Follow up on unsuccessful attempts to contact a Member is made within 90 days of the effective date of enrollment;

iii. Each attempt is documented;

iv. Results of HRAs are used to identify individuals at risk for, or with special health care needs and coordinate care:

1) Refer to AMPM Policy 1620-A and AMPM Exhibit 1620-1 to obtain time frames for which ALTCS case managers shall have an initial contact with newly enrolled ALTCS Members; and

2) Refer to AMPM Policy 580 and ACOM Policy 417 to obtain time frames for which the Division shall have initial contact with referred Members for behavioral health services.

aa. Continuity of care and integration of services utilizing:

i. Programs for care coordination that include coordination of covered services with community and social services, generally available through contracted or non-contracted providers within the Division's service area;

ii. Monitoring of referral activities for both the PCP and the behavioral health provider during referral to, coordination of care with, and transfer of care between the PCP and the behavioral health provider;

iii. Monitoring to ensure that when a member is transitioning from the physical health provider to the behavioral health provider, or vice-versa, that bridge

medications are provided as specified in AMPM Policy 310-V and AMPM Policy 520;

iv. Monitoring of PCP's coordination of care with the Behavioral Health Medical Professional (BHMP), when PCPs are providing medical management services for the treatment of:

1) Mild depression;

2) Anxiety;

3) Attention Deficit Hyperactivity Disorder (ADHD); and

4) SUD, or Opioid Use Disorder (OUD) for Members with an SMI designation.

v. Monitoring to ensure that medication management by the PCPs is given within the PCP's scope of practice;

vi. Monitoring when PCP is providing treatment of mild depression, anxiety, ADHD, SUD, or OUD to ensure that medications are not contraindicated, based on

member's SMI designation or other behavioral health condition or functional status;

vii. Monitoring when a PCP is providing medical management services for a member to treat a behavioral health disorder, and it is subsequently determined by the PCP and Division that the member should receive care through the behavioral health system for Evaluation or continued medication management services, the Division's subcontracted providers shall assist the PCP with the coordination of the referral and transfer of care.

viii. Monitoring documentation of the care coordination activities and transition of care in the member's medical record from the PCP and the involved behavioral health provider;

ix. Utilizing Arizona's Controlled Substances Prescription Monitoring Program (CSPMP), in accordance with A.R.S. § 36-2606;

x. Monitoring of the behavioral health provider's referral to, coordination of care with, and transfer of care to PCP, as well as usage of Arizona's CSPMP, in accordance with A.R.S. § 36-2606; and

xi. Monitoring of coordination between behavioral health providers and PCPs or other medical practitioners involved in member's care in the event that a physical or behavioral health practitioner witness a patient with suicidal ideation or at-risk behaviors.

bb. Implement policies and procedures that specify:

i. The process for Members selecting, or the AdSS assigning, a PCP who is formally designated as having primary responsibility for coordinating the Members overall health care. The PCP shall coordinate care for the member including coordination with the BHMP or Behavioral Health Professional (BHP), and

ii. Processes for provision of appropriate medication monitoring for Members taking antipsychotic medication (per national guidelines):

1) Monitoring metabolic parameters for lithium, valproic acid, carbamazepine,

2) Renal function, liver function, thyroid function, glucose metabolism, screening for metabolic syndrome and involuntary movement disorders,

3) Provision of medication titration according to, drug class requirements and appropriate standards of care:

a) The circumstances under which services are coordinated by the Division, the methods for coordination, and specific documentation of these processes;

b) Specify services coordinated by the Division's Disease Management Unit; and

c) The requirements for timely and confidential communication of clinical information among providers, as specified in AMPM Policy 940.

cc. Implement measures to ensure that Members:

i. Are informed of specific health care needs that require follow-up;

ii. Receive, as appropriate, training in self-care and other measures they may take to promote their own health; and

iii. Are informed of their rights and responsibilities including, but not limited to the responsibility to adhere to ordered treatments or regimens.

dd. Develop and implement procedures for Members with special health care needs, as defined in the AHCCCS Contract, including:

i. Identifying Members with special health care needs, including those who may benefit from disease management;

ii. Ensuring an assessment by an appropriate health care professional of ongoing needs of each Member identified as having special health care need(s) or condition(s);

iii. Identifying medical procedures or behavioral health services, as applicable to address or monitor the need(s) or condition(s);

iv. Ensuring adequate care coordination among providers, including but not limited to, other Contractors or insurers and behavioral health providers, as necessary;

v. Ensuring a mechanism to allow direct access to a specialist as appropriate for the member's condition and identified special health care needs; and

vi. Implement processes and measures to ensure that Members receive Special Assistance, based on criteria as specified in AMPM Policy 320-R.

ee. Maintain a health information system that collects, integrates, analyzes, validates, and reports data necessary to implement its QM/PI Program (42 CFR 438.242). Data elements shall include:

i. Member demographics and designations;

ii. Encounter data and provider characteristics;

iii. Services provided to Members; and

iv. Other information necessary to guide the selection of, and meet the data collection requirements for:

1) Performance measures;

2) PIPs; and

3) QM/PI Program oversight.

ff. Include requirements, either in the AHCCCS Contract or as an extension of the AHCCCS Contract, for practitioners and providers to cooperate with quality improvement activities

and allow the Division to utilize their performance measure data.

gg. Ensure the inclusion of the following requirements related to data integrity:

i. Information and data received from providers is accurate, timely, and complete;

ii. Reported data is reviewed for accuracy, completeness, logic, and consistency, and the review and Evaluation processes used are clearly documented;

iii. Information that is rejected shall be tracked to ensure errors are corrected and the data is resubmitted and accepted; and

iv. Corrective actions are implemented with providers and vendors when data utilized for implementing and maintaining its QM/PI Program received from providers and vendors is not accurate, timely, or

complete, including data necessary to calculate and report performance measures.

hh. Results of the Division's quality improvement data review, analysis, reporting, and Evaluation are shared with Division staff and stakeholders, with internal corrective actions implemented when self-identified concerns and performance deficiencies are identified.

ii. Division staff and providers are kept informed of the following:

i. QM/PI Program requirements, activities, updates, or revisions;

ii. Study and PIP results;

iii. Performance measures and results;

iv. Utilization data; and

v. Profiling data results.

jj. All member and provider information are protected by Federal and State law, regulations, or policies is kept confidential; and

kk. Maintenance of records and documentation as required under State and Federal law.

ll. All QM/PI Program Components shall be supported through the development, implementation, and maintenance of policies and procedures.

C. QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM ADMINISTRATIVE STRUCTURE AND OVERSIGHT

1. The Division's QM/PI Program shall be administered through a clear and appropriate administrative structure that maintains the ultimate responsibility for the QM/PI Program.
2. The QM/PI Unit shall conduct all work of the QM/PI Program within the QM/PI Unit, adhering to requirements as specified in the AHCCCS Contract and AMPM Chapter 900.
3. The Division shall require that the Division's administrative structure for its QM/PI Program adheres to requirements of this section, which specify the roles and responsibilities of the following:
   a. The governing or policy-making body;

b. The Chief Medical Officer (CMO) or designated Medical Director, and the local DDD Assistant Director;

c. The QM/PI Committee;

d. The Peer Review Committee;

e. QM/PI Program Staff;

f. Delegated Entities; and

g. The Contractor's executive management.

4. The Executive Body and Executive Leadership Team (ELT) shall:

a. Oversee and be accountable for the QM/PI Program,

b. Review the QM/PI Program Plan, inclusive of the Work Plan and Work Plan Evaluation, and any applicable updates related to changes in the QM/PI Program scope prior to submission to AHCCCS; and

5. The Executive Body and Executive Leadership Team (ELT) shall:

a. Review and approve the QM/PI Program Plan, as demonstrated via an attestation of approval by the Executive Body and Executive Leadership Team (ELT);

b. Formally Evaluate and document the effectiveness of its QM/PI Program strategy and activities, at least annually, as demonstrated via an attestation of approval by the Executive Body and Executive Leadership Team (ELT);

6. The Division's Chief Medical Officer (CMO) and Division's Assistant Director shall:
   a. Oversee the implementation of the QM/PI Program Plan; and
   b. Have substantial involvement in the:
      i. Implementation;
      ii. Assessment; and
      iii. Resulting improvement of QM/PI Program activities;
   c. The CMO shall approve and sign all QM/PI policies.
7. The QM/PI Committee shall have an identifiable and structured QM/PI Committee within the state of Arizona that is responsible for QM/PI Program functions and responsibilities.
   a. Membership shall include:
      i. The CMO, serving as the chairperson:

1) The CMO may designate the local Associate Medical Director as their designee only when the CMO is unable to attend the meeting; and

2. The DDD Assistant Director may be identified as the co-Chair of the QM/PI Committee.

ii. The QM/PI Manager(s):

1) Representatives from the functional areas within the Division;

2) Contracted or affiliated providers serving AHCCCS Members; and

3) Clinical representatives of both the Division and the provider network.

b. The QM/PI Committee shall ensure that each of its Members are aware of the requirements related to confidentiality and conflicts of interest by having either:

i. Signed statements on file; or

ii. QM/PI Committee sign-in sheets with requirements noted.

c. The QM/PI Committee shall conduct meetings, at minimum, on a quarterly basis:

   i. The frequency of committee meetings shall be sufficient to monitor all program requirements and to monitor any required actions; and

   ii. The Division shall provide evidence of actual occurrence of these meetings through minutes and other supporting documentation.

d. The QM/PI Committee shall:

   i. Review the QM/PI Program objectives, policies, and procedures as specified in the AHCCCS Contract;

   ii. Update policies when processes or activities are changed substantially; and

   iii. Make available upon request for review by AHCCCS QM and/or Quality Improvement (QI) Teams, the QM/PI policies, procedures, and any subsequent modifications.

e. The QM/PI Committee shall also:

i. Review, Evaluate, and approve any changes to the QM/PI Program Plan;

ii. Develop procedures for QM/PI Program responsibilities and clearly document the processes for each QM/PI Program function and activity;

iii. Develop and implement procedures to ensure that Division staff and providers are informed of the most current QM/PI Program requirements, policies, and procedures; and

iv. Develop and implement procedures to ensure that providers are informed of information related to their performance;

f. The QM/PI Committee shall ensure meeting minutes clearly document discussions of the following:

i. Identified issues;

ii. Responsible party for interventions or activities;

iii. Proposed actions;

iv. Evaluation of the actions taken;

v. Timelines including start and end dates; and

vi. Additional recommendations or acceptance of the results, as applicable.

8. The Division shall have a peer review process with the purpose of improving the QOC provided to Members by both individual and organizational providers.

9. The Division shall ensure the peer review scope includes cases where there is evidence of deficient quality or the omission of the care or service provided by a physical or behavioral health care provider whether delivered in or out of state.

10. The Division shall define the peer review scope through specific policies and procedures which address the following requirements:

a. The Division shall not delegate functions of peer review to other entities;

b. The Peer Review Committee is scheduled to meet at least quarterly, or more frequently, as needed;

c. The Peer Review Committee may carry out activities as a stand-alone committee or in an executive session of the Division's QM Committee;

d. The Peer Review Committee consists of:

   i. The Division's CMO as Chair;

   ii. Contracted medical providers from the community that serve AHCCCS Members; and

   iii. Contracted behavioral health providers from the community that serve AHCCCS Members.

e. The Peer Review Committee also includes:

   i. Providers of the same or similar specialty in review and recommendation of individual peer review cases.

   ii. Peers of the same or similar specialty through external consultation, if the specialty being reviewed is not represented on the Division's Peer Review Committee;

f. Peer Review Committee Members:

i. Shall sign a confidentiality and conflict of interest statement at each Peer Review Committee meeting, electronic signature is permissible; and

ii. Shall not participate in peer review activities if they have a direct or indirect interest in the peer review outcome;

g. The Peer Review Committee shall Evaluate referred cases based on all information made available through the QM process;

h. The Peer Review Committee shall make recommendations to the Division's CMO or their designee, determining appropriate action.

i. The CMO or their designee shall implement actions recommended by the Peer Review Committee. Adverse actions taken as a result of the Peer Review Committee shall be reported to AHCCCS QM Team as specified in the AHCCCS contract;

j. The Peer Review Committee shall make recommendations to the Division's CMO or their designee regarding initiation of referrals for further investigation or action to:

   i. Division of Child Safety (DCS);

   ii. Adult Protective Services (APS);

   iii. Arizona Department of Health Services (ADHS) Licensure Unit;

   iv. The appropriate regulatory agency or board; and

   v. AHCCCS.

k. The Peer Review Committee shall notify the organizations listed in the previous section when the Committee determines care was not provided according to the medical community standards:

   i. To the regulatory agency as soon as possible, no later than 24 hours after the determination; and

   ii. Verbally or electronically, email or online, as determined by the specific organization(s) guidelines.

l. The Division shall develop a process to timely report the concern to the appropriate regulatory agency;

m. The Peer Review Committee shall maintain confidentiality with all information used within the peer review process, keeping reports, meetings, minutes, documents, recommendations, and participants confidential except for when implementing recommendations made by the Peer Review Committee;

n. The Peer Review Committee shall make documentation available upon request to AHCCCS for purposes of QM, Monitoring, and oversight;

o. The Peer Review Committee shall maintain high-level peer review summaries as part of the original QOC file,

p. The Division shall demonstrate:

    i. How the peer review process is used to analyze and address clinical issues;

    ii. How providers are made aware of the peer review process; and

iii. How providers are made aware of the procedure for grieving peer review findings.

q. Matters appropriate for peer review shall be outlined in the Division's Peer Review Charter.

11. The QM/PI Program shall have local personnel to carry out the functions and responsibilities specified in AMPM Chapter 900 in a timely and competent manner, with QM/PI positions performing work functions related to the AHCCCS Contract reporting directly to the local CMO and the CEO.

12. The Division is responsible for AHCCCS Contract performance, whether or not subcontractors or delegated entities are used. As part of the QM/PI Program Staffing requirements, the Division shall:

a. Maintain an organizational chart that shows the reporting relationships for QM/PI Program activities and the percent of time dedicated to the position for each specific line of business:

i. The QM/PI Program organizational chart shall be maintained and demonstrate the current reporting structures, including the number of full time and part time positions, staff names, and responsibilities;and

ii. This chart shall also show direct oversight of QM/PI Program activities by the local CMO.

b. Ensure all staff are trained on the process for referring suspected QOC concerns to the QM Team:

i. During employee orientation, no later than 30 days after the date of hire; and,

ii. At a minimum, annually thereafter.

c. Develop and implement policies and procedures outlining:

i. QM/PI Program staff qualifications including education, certifications, experience, and training for each QM/PI Program position; and

ii. Mandatory QM/PI Program Staff or Management attendance at AHCCCS Contractor meetings unless attendance is specified as optional by AHCCCS.

d. Attend or participate in, and maintain associated documentation for, applicable community initiatives and collaborations as well as implement specific interventions to address overarching community concerns.

13. The Division shall oversee and maintain accountability for all functions and responsibilities as specified in AMPM Chapter 900, which are delegated to other entities.

14. The methodologies for oversight and accountability for all delegated functions shall be integrated into the overall QM/PI Program with the requirements, specified in AMPM Chapter 900, being met for all delegated functions. Accredited agencies shall be included in the Division's oversight process:

    a. As a prerequisite to delegation, the Division shall provide a written analysis of its historical provision of QM/PI Program oversight function, which includes past goals and objectives. The level of effectiveness of the prior QM/PI Program oversight functions shall be documented.

Examples may include the number of claims, concerns, grievances, or network gaps;

b. The Division shall have policies and procedures requiring that the delegated entity report all allegations of QOC concerns and quality of service issues to the Division no later than 24 hours of awareness. QOC or service investigation and resolution processes shall not be delegated;

c. The Division shall Evaluate the entity's ability to perform the delegated activities prior to delegation. Evidence of such Evaluation includes the following:

   i. Review of appropriate internal areas, such as QM;

   ii. Review of policies and procedures and the implementation of them; and

   iii. Documented Evaluation and determination that the entity is able to effectively perform the delegated activities.

d. The Division shall establish a written contract prior to delegation, that specifies the delegated activities and reporting responsibilities of the entity to the Division;

e. The Division shall include in the agreement, the Division's right to terminate the contract or perform other remedies for inadequate performance;

f. The Division shall review annually and monitor performance of the entity and the quality of services provided on an ongoing basis.

g. The Division shall annually review a minimum of 30 randomly selected cases per line of business for each function that is delegated, keeping documentation on file for AHCCCS review.

h. The Division shall Monitor:

   i. Utilization;

   ii. Member and provider satisfaction;

   iii. QOC concerns; and

   iv. Complaints.

i. The Division shall review the performance and quality of services provided by entities that are accredited through the National Committee for Quality Assurance (NCQA) or another nationally recognized entity, reviewing a minimum of 10 randomly selected files per line of business for each function that is delegated.

j. The Division shall expand the sample to no less than 30 files in order to fully assess and identify issues and implement remediation efforts with the delegated service provider if any issues or concerns are noted within the files reviewed.

k. The Division shall submit Monitoring results to AHCCCS in accordance with ACOM Policy 438.

l. The Division shall keep the following documentation on file and available for AHCCCS review:

    i. Evaluation reports;

ii. Results of the Division's annual Monitoring review of the delegated entity utilizing AHCCCS required standards for the contracted functions;

iii. Corrective Action Plans, or CAPs; and

iv. Appropriate follow up of the implementation of CAPs to ensure that quality and compliance with AHCCCS requirements for all delegated activities or functions are met.

D. QM/PI PROGRAM MONITORING AND EVALUATION ACTIVITIES

1. The Division shall develop and implement mechanisms to Monitor and Evaluate its service delivery system and provider network that demonstrates compliance with all the requirements included within this Policy.
2. The Division's QM/PI Program QM staff shall directly oversee delegated entities conducting Monitoring activities.
3. The Division's QM/PI Program staff shall include the following Monitoring and Evaluation activities:

a. QM/PI Program scope of Monitoring and Evaluation be comprehensive and:

   i. Incorporate the activities used by the Division;

   ii. Demonstrate how these activities will improve the quality of services and the continuum of care in all services sites; and

   iii. Be clearly documented in policies and procedures.

b. If collaborative opportunities exist to coordinate organizational Monitoring, the lead Contractor coordinate and ensure that all requirements in the collaborative arrangement are met;

c. Monitor provider compliance with policies, training, and signage requirements aimed at preventing and reporting abuse, neglect, and exploitation as specified in AHCCCS Minimum Subcontract Provisions and Contract;

d. Information and data gleaned from QM/PI Program Monitoring and Evaluation that shows trends in QOC concerns are used in developing quality improvement

initiatives. Selection of specific Monitoring and Evaluation activities shall be appropriate to each specific service or site.

e. Development and implementation of methods for Monitoring PCP activities related to:

i. Referrals for behavioral health care,

ii. Coordination with the behavioral health system,

iii. Transfer of care, when clinically indicated, based on severity of behavioral health need, and

iv. Use of the CSPMP. Monitoring procedures for the CSPMP process shall include:

a) Assurance of communication between prescribers, when controlled substances are used;

b) Provider-mandated usage of the CSPMP; and

c) Integration strategies and activities focused on improving individual health Outcomes;

enhancing care coordination, and increasing member satisfaction.

f. Development and implementation of methods for Monitoring behavioral health provider activities related to:

i. Referrals for physical health care;

ii. Coordination with the physical health system;

c. Use of the CSPMP. Monitoring procedures for the CSPMP process shall include:

1) Assurance of communication between prescribers, when controlled substances are used;

2) Include provider-mandated usage of the CSPMP; and

3) Integration strategies and activities focused on improving individual health Outcomes, enhancing care coordination, and increasing member satisfaction.

g. Reporting of all QOC concerns including:

i. Incidents of abuse, neglect, exploitation, suicide attempts, opioid-related concerns, alleged human rights violations, and unexpected deaths to the AHCCCS QM Team as soon as the Division is aware of the incident and no later than one business day, as specified in Contract. The Division is expected to investigate and report case findings, including identification of organizational providers, individual providers, paid caregivers, or the specific individual rendering the service;

ii. Identified QOC concerns, reportable incidents, or service trends to the AHCCCS QM Team immediately upon identification.

1) Reporting shall include trend specifications such as providers, facilities, services, and allegation types;

2) Division QOC trend reports shall be incorporated into Monitoring and Evaluation

activities and presented to the QM/PI Committee; and

3) Policies and procedures shall be adopted to explain how the process is routinely completed.

h. Investigate all potential Health Care Acquired Conditions (HCAC) and Other Provider-Preventable Condition (OPPC) as QOC concerns within the AHCCCS QM Portal as described in AMPM Policy 960.

i. Incorporation of the ADHS licensure and certification reports and other publicly reported data in their Monitoring process, as applicable.

j. A process to ensure notification is made to the Division's QM clinical staff when a delegated auditing entity identifies either a Health and Safety Concern, Immediate Jeopardy situation, or other serious incident, which impacts the health and safety of a member.

i. On-site reviews related to Health and Safety Concerns, Immediate Jeopardy situations, or other

serious incidents are to be conducted in accordance with the requirements as specified in AMPM Policy 960;

ii. In working to ensure health and safety of Members in placement settings or service sites that are found to have survey deficiencies or suspected issues that may impact the health and safety of AHCCCS Members, the Division shall:

1) Actively participant in both individual and coordinated efforts to improve the QOC in placement settings or service sites; and

2) Utilize clinical quality staff trained in QOC investigations to conduct on-site reviews if there is a health or safety concern identified either by the Division, AHCCCS, or other party.

k. The Division QM staff conduct the Monitoring of services and service sites, in accordance to Attachment A. While the Division may also consider incorporating regulatory

agency licensing reviews, such as annual inspection surveys, as part of the Monitoring of services and service sites, the regulatory agency reviews shall not be used as the sole basis for the entire Monitoring Evaluation by the Division. Refer to Attachment A for the list of AHCCCS services, service sites, and Monitoring frequency;

l. Implementation of policies and procedures for ALTCS Contractors specific to the annual Monitoring of attendant care, homemaker services, personal care services, respite services and habilitation services. When deficiencies or potential deficiencies are identified, they shall be addressed from a member and from a system perspective; and

m. Coordination of mandatory routine quality Monitoring and oversight activities for organizational providers, including home and community based service settings, when the provider included is in more than one Contractor network. A collaborative process shall be utilized in counties when

more than one Contractor is contracted with and utilizes the facility as specified in Contract. The Division, or the lead Contractor if Contractor collaborative Monitoring was completed, shall submit the Contractor Monitoring summary to AHCCCS QM Team as specified in Contract.

n. A standardized and agreed upon tool shall be used and contain:

i. General quality Monitoring of these services are the review and verification of:

1) The written documentation of timeliness;

2) The implementation of contingency plans;

3) Customer satisfaction information;

4) The effectiveness of service provisions;

5) Mandatory documents in the services or service site personnel file as follows:

a) Cardiopulmonary resuscitation;

b) First Aid;

c) Verification of skills or competencies to provide care;

d) Evidence that the agency contacted at least three references, one of which shall be a former employer. Results of the contacts shall be documented in the employee's personnel record; and

e) Evidence that the provider conducted the pre-hire and annually thereafter search of the APS Registry as required in AHCCCS Minimum Subcontract Provisions.

iii. Specific quality Monitoring requirements for ALTCS Contractors are as follows:

a) Direct Care Services, as specified in AMPM Policy 1240-A (Attendant care, Personal Care and Homemaker services), Monitoring as specified in Attachment B. Monitoring shall

include verification and documentation of all of the following:

1) Mandated written agreement between the member/Health Care Decision Maker, and designated representative and the Direct Care Worker (DCW), as specified in AMPM Policy 1240-A, which delineates the responsibilities of each;
2) Evaluation of the appropriateness of allowing the member's immediate relatives to provide direct care services;
3) Compliance with ensuring DCWs meet competencies to provide care including training, testing, verifying/sharing of DCW test records and continuing education requirements in accordance with Attachment B; and

4) Timeliness and content of supervisory visitations as specified in AMPM Policy 1240- A.

b) Sampling methodology for Monitoring of direct care services shall assure that all provider agencies and all employees have an equal opportunity to be sampled (provider agencies shall be included in the sample frame even if the number of employees does not meet a statistically significant level. All employees shall be included in the sample frame including those who are in the pool of workers but are not currently assigned to a member;

4. The Division shall have mechanisms to assess the quality and appropriateness of care provided to Members receiving LTSS services including between settings of care and, as compared to the member's service plan 42 CFR 438.330 (b)(5)(i);

5. The Division shall monitor that the LTSS services a member receives align with those that were documented in the member's LTSS treatment or service plan 42 CFR 438.330 (b)(5)(i); and
6. The Division may also consider incorporating the use of surveys to assess the experience of Members receiving LTSS services as a key component of the Division's LTSS assessment process.

SUPPLEMENTAL INFORMATION:

1. Changes in the QM/PI Program scope include any alterations made to the Division's QM/PI Program structure from one year to the next. This may also include line of business, population, and geographic service area changes.
2. Matters appropriate for peer review shall include, but are not limited to:

a. Cases where there is evidence of deficient quality,
b. An omission of the care or service provided by a participating or non-participating physical health care or behavioral health care provider, facility, or vendor,
c. Questionable clinical decisions, lack of care and/or substandard care,

d. Inappropriate interpersonal interactions, unethical behavior, physical, psychological, or verbal abuse, neglect, and exploitation of a member or members, family, staff, or other disruptive behavior demonstrated by a provider,

e. Criminal or felonious actions related to practice,

f. Issues that immediately impact the member and that are life threatening or dangerous, and

g. Issues that have the potential for adverse outcome.

3. Documentation for participation in applicable community initiatives and collaborations, as well as implement specific interventions to address overarching community concerns including, but not limited to:

a. Quality Management and Quality Improvement,

b. Maternal child health,

c. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and Dental,

d. Chronic Disease management,

e. Long-Term Care

f. Behavioral health,

g. Justice Involvement,

h. Opioid and substance use,

i. Suicide,

j. Social determinants of health,

k. Veterans' resources and services, and

l. Specific community initiatives and collaborations, and as required by AHCCCS.

AHCCCS sponsored activities are not considered community initiatives or collaborations.

Signature of Chief Medical Officer: Anthony Dekker (Oct 4, 2023 16:50 PDT)
Anthony Dekker, D.O.

920 QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM ADMINISTRATIVE REQUIREMENTS

REVISION DATE: 8/16/2023, 4/20/2022, 10/1/2020
EFFECTIVE DATE: May 13, 2019
REFERENCES: CFR 42 CFR Part 438; 42 CFR 438.320; 42 CFR 438.310(c)(2); 42 CFR Part 457; 42 CFR 438.354; 42 CFR 438.358; AMPM 910; AMPM 920; AMPM 970; AMPM 980

PURPOSE

This policy specifies the Division's Quality Management and Performance Improvement (QM/PI) Program administrative requirements and explains how the Division monitors the performance of their Administrative Services Subcontractors (AdSS) for compliance with these requirements.

DEFINITIONS

1. "AHCCCS Division of Healthcare Management (DHCM), Quality Improvement (QI) Team" means AHCCCS staff who Evaluate the Division's Quality Management and Performance Improvement (QM/PI) Programs, monitors compliance with required Quality and Performance Improvement Standards Division Corrective Action Plans (CAPs) and Performance Improvement Projects

(PIPs) and provides technical assistance for QM/PI related matters.

2. "Corrective Action Plan (CAP)" means a written Work Plan that identifies the root cause(s) of a deficiency, includes goals and Objectives, actions, and tasks to be taken to facilitate an expedient return to compliance, methodologies to be used to accomplish CAP goals and Objectives, and staff responsible to carry out the CAP within established timelines. CAPs are generally used to improve performance of the Division and its providers, to enhance QM/PI activities and the Outcomes of the activities, or to resolve a deficiency.
3. "Evaluate" means the process used to examine and determine the level of Quality or the progress toward improvement of Quality and performance related to the Division's service delivery systems.
4. "External Quality Review (EQR)" means the analysis and evaluation by an External Quality Review Organization (EQRO), of aggregated information on Quality, timeliness, and access to

the health care services that the Division or AdSS furnish to Medicaid members [42 CFR 438.320].

5. "External Quality Review Organization (EQRO)" means an organization that meets the competence and independence requirements set forth in 42 CFR 438.354, performs EQR, and other EQR-related activities as specified in 42 CFR 438.358, or both [42 CFR 438.320].
6. "Measurable" means the ability to determine definitively whether or not a quantifiable Objective has been met, or whether progress has been made toward a positive outcome.
7. "Monitoring" means the process of auditing, observing, evaluating, analyzing, and conducting follow-up activities, and documenting results via desktop or on-site review.
8. "Objective" means a Measurable step, generally one of a series of progressive steps, to achieve a goal.
9. "Outcomes" means changes in patient health, functional status, satisfaction, or goal achievement that result from health care or supportive services [42 CFR 438.320].

10. "Performance Improvement Project (PIP)" means a planned process of data gathering, evaluation and analysis to determine interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the Quality of Care and service delivery.
11. "Performance Measure Performance Standards (PMPS)" means the minimal expected level of performance by the Division, previously referred to as the Minimum Performance Standard. Beginning Calendar Year End (CYE) 2021, official performance measure results shall be Evaluated based upon the National Committee on Quality Assurance (NCQA) HEDIS® Medicaid Mean or Centers for Medicare and Medicaid Services (CMS) Medicaid Median (for selected CMS Core Set-Only Measures) as identified by AHCCCS, as well as the Line of Business aggregate rates, as applicable.

12. "Quality" As it pertains to External Quality Review, means the degree to which Division increases the likelihood of desired Outcomes of its members through:

    a. Its structural and operational characteristics.

    b. The provision of services that are consistent with current professional, evidenced- based-knowledge.

    c. Interventions for performance improvement.

13. "Quality of Care (QOC)" means an expectation that, and the degree to which, the health care services provided to individuals and patient populations improve desired health outcomes and are consistent with current professionally recognized standards of care and service provision.

14. "Quality Management Unit (QMU), Quality Improvement (QI) Team" means Division staff who Evaluate AdSS Quality Management and Performance Improvement (QM/PI) Programs, monitor, and Evaluate compliance with required Quality and performance improvement standards through standardized Performance Measures (PM), Performance Improvement Projects

(PIPs), and Quality Improvement specific Corrective Action Plans (CAPs), as well as provide technical assistance for performance improvement related matters.

15. "Work Plan" means a document that addresses all the requirements of AMPM Chapter 900, and AHCCCS-suggested guidelines, as well as supports the Division's QM/PI goals and Objectives with Measurable goals (Specific, Measurable, Attainable, Relevant and Timely (SMART)), timelines, methodologies, and designated staff responsibilities. The Work Plan must include Measurable physical, behavioral, and oral health goals and Objectives.

16. "Work Plan Evaluation" means a detailed analysis of progress in meeting or exceeding the Quality Management and Performance Improvement (QM/PI) Program Objectives, strategies, and activities proposed to meet or exceed the performance standards and requirements as specified in contract and Division Medical Policy Chapter 900.

POLICY

A. QUALITY MANAGEMENT/PERFORMANCE IMPROVEMENT PROGRAM PLAN

1. The Division shall develop a written QM/PI Program Plan that specifies the Objectives of its QM/PI Program and addresses the Division's approaches to meet or exceed the performance standards and requirements as specified in Contract and AMPM Chapter 900.
2. The Division shall submit its QM/PI Program Plan as specified in the AHCCCS contract.
3. The Division shall include the following in its QM/PI Program narrative:
    a. Objectives and plans for the upcoming calendar year to meet or exceed the requirements as specified in contract and in compliance with Division Medical Policy Chapter 900.
    b. Division activities to identify member needs and to coordinate care. Follow-up activities to ensure appropriate

and medically necessary treatment is received in a timely manner.

c. Division participation in community and Quality initiatives.

d. AHCCCS defined checklist items and guidance.

4. The Division shall include the following in its QM/PI Program Work Plan Evaluation:

a. Evidence or documentation supporting continued routine Monitoring to Evaluate the effectiveness of the actions and other follow up activities conducted throughout the previous calendar year.

b. A description of how any sustained goals or Objectives will be incorporated into the Division's business practice and develop new goals or Objectives once a goal or Objective has been sustained.

c. Performance measure related Plan-Do-Study-Act (PDSA) cycles that have been initiated, updated, or refined as part of the Division's ongoing Corrective Action Plan (CAP) Monitoring and Evaluation activities.

d. Goals not met will be addressed and considered for possible internal Performance Improvement Projects (PIPs).

5. The Division shall include the following in its QM/PI Work Plan:

a. Goals and Objectives that are realistic, Measurable, clinical, or non- clinical, and based upon established Performance Standards and requirements as specified in the current AHCCCS contract and Division Medical Policy Chapter 900 series when appropriate.

b. Other nationally recognized benchmarks as available to establish minimum performance standards or when performance standards have not been published by AHCCCS.

c. Strategies and activities to meet or accomplish the identified goals and Objectives.

d. Identify responsible staff positions accountable for meeting the established goals and Objectives.

e. PIPs designed to address opportunities for improvement identified from both external and internal sources.

6. The Division shall include the following in its Health Disparity Summary and Evaluation Report:

a. The process utilized to conduct disparity analyses including the analytical tools and the methodology for identifying disparities.

b. Disparity analysis findings associated projects and activities meant to ameliorate the disparity(s)and related Measurable goals or Objectives.

c. An evaluation of the disparity analysis findings, progress on targeted strategies and interventions, and progress on identified goals or Objectives.

d. Member-specific data including targeted inquiries and other related ad hoc reports.

e. A detailed evaluation of performance measure rates specific to subpopulations.

f. An analysis of the effectiveness of implemented strategies and interventions in meeting the Division's health equity goals and Objectives during the previous calendar year.

g. A detailed overview of the Division's identified health equity goals or Objectives for the upcoming calendar year to address noted disparities and promote health equity.

h. Targeted strategies or interventions planned for the upcoming calendar year to achieve its goals.

7. The Division shall include the following in its Engaging Members Through Technology (EMTT) – Executive Summary:

a. An evaluation of the previous calendar year's EMTT activities including:

i. The percent of members engaged through telehealth services and through web and mobile-based applications in comparison to total membership, and

ii. Member-specific metrics including targeted inquiries and other related ad hoc reports, for member-related

Outcomes in comparisons to identified goals and Objectives.

b. Criteria for identifying and targeting members who can benefit from telehealth services and from web and mobile-based applications, including but not limited to:
   i. The identification of populations who can benefit from telehealth services to increase access to care and services, and
   ii. The identification of populations who can benefit from web and mobile-based applications.
c. A description of telehealth services and web and mobile-based applications in development and currently being utilized to engage members.
d. Strategies used to engage the identified members in the use of telehealth services and web and mobile-based applications.
e. A description of desired goals and outcomes for telehealth services and for each web and mobile-based application

currently being utilized to engage members, including how the desired outcome will be measured and directly impact the overall Quality of and Access to care for the identified population(s).

f. The percentage of members anticipated to engage through telehealth services and through web and mobile-based applications during the upcoming calendar year based on the identified strategies and related goals or Objectives.

8. The Division shall submit a completed AMPM Policy 920 QM/PI Program Plan Checklist, including any Division or AdSS policies relevant to the QMPI Program that are new or have been substantially changed, along with its QM/PI Program Plan

B. BEST PRACTICES AND FOLLOW UP ON PREVIOUS YEAR'S EXTERNAL QUALITY REVIEW REPORT RECOMMENDATIONS

The Division shall submit recommendations as specified in contract and include:

1. An overview of self-reported best practices submitted as a stand-alone document, highlighting a minimum of three

initiatives aimed at improving care and services provided to members.

2. A summary of the Division's efforts to date in completing the most current and Previous Year's EQR Report Recommendations, as a stand-alone document.
3. Best Practices and Follow Up on Previous Year's EQR Report and Recommendations Checklist

C. PERFORMANCE MEASURE MONITORING REPORT

The Division shall develop and submit the AHCCCS Performance Measure Monitoring Report & Work Plan Evaluation Template and AHCCCS Performance Measure Monitoring Report & Work Plan Attachment. The report includes the following:

1. The Division's progress in meeting, sustaining, and improving its performance based on contractual requirements in accordance with the AHCCCS template and report format.
2. The internal rates for each performance measure.

3. Identified barriers in implementing planned interventions and opportunities for improvement intended to support meeting identified goals or Objectives.
4. Detailed analysis of results that includes an evaluation of the Division's performance compared to the following:
    a. Performance Measure Performance Standards in accordance with Division Medical Manual Policy 970.
    b. Self-identified goals and Objectives.
    c. Historical performance.

D. PERFORMANCE IMPROVEMENT PROJECT REPORT

The Division shall include in its Performance Improvement Project (PIP) Report annual updates for both AHCCCS-mandated and Division self-selected PIPs, in accordance with the Division Medical Manual Policy 980, including the use of AMPM Policy 980 Attachment C, Performance Improvement Project (PIP) Report DDD Specific.

E. CORRECTIVE ACTION PLAN

1. The Division shall develop and implement a Corrective Action Plan (CAP) for taking appropriate steps to improve care when issues are identified.
2. The Division shall submit All CAPs to AHCCCS for review and approval prior to implementation and include:
    a. The concern(s) that require corrective action.
    b. Identification of any deficiency and remedial steps to be taken to facilitate a return to compliance.
    c. Documentation of proposed time frames for CAP completion.
    d. Entities responsible for making the final determinations regarding QM/PI Program concerns.
    e. Actions to be taken including, but not limited to:
        i. Education, training, technical assistance,
        ii. Follow-up Monitoring and Evaluation of improvement as well as implementing new interventions, approaches, when necessary,
        iii. Changes in process, structure, and forms, and

iv. Informal counseling.

f. Documentation of performance Outcomes identified barriers, opportunities for improvement, and best practices.

g. Internal dissemination of CAP findings and results to appropriate committees, staff, and network providers.

h. Submit information to AHCCCS and other stakeholders as required.

i. For QOC specific CAPs, information is submitted in accordance with Division Medical Manual Policy 960.

3. The Division shall submit CAPs as required in AMPM Policy 920, Attachment B AHCCCS Quality Improvement Corrective Action Plan Proposal Checklist, and AHCCCS Quality Improvement Corrective Action Plan Update Checklist.

4. The Division shall maintain documentation regarding CAPs development, implementation, the performance outcomes, identified barriers, opportunities for improvement, and best

practices.

F. REPORTING REQUIREMENTS

1. The Division shall submit deliverables as specified in the contract and in accordance with AHCCCS/Division of Healthcare Management (DHCM) QI Team instructions and guidance.

2. If a time extension is necessary, the Division shall submit a formal request in writing no later than two business days before the deliverable due date explaining the basis for request and timeline extension to the AHCCCS/DHCM, Quality Management (QM), or Quality Improvement (QI) team manager, as appropriate to the deliverable.

3. The Division shall submit the QM/PI Program administrative deliverables as specified in contract and subject to AHCCCS approval. The Division shall submit any significant modifications to the QM/PI Program Plan throughout the year to the AHCCCS/DHCM, QM and QI team managers for review and approval prior to implementation.

4. The Division shall provide the QM/PI administrative deliverables and other select deliverable submissions to the AHCCCS EQRO with Division supplied information included within the Division's annual EQR Report posted to the AHCCCS website.

G. DOCUMENTATION REQUIREMENTS

1. The Division shall maintain records that document QM/PI Program activities. The required documentation includes:

   a. Studies and PIPs

   b. CAPs

   c. All required reports

   d. All processes, standards of work, and desktop procedures

   e. Meeting agendas, minutes, and accompanying documents

   f. Worksheets (including but not limited to excel spreadsheets, graphs, diagrams, flowcharts)

   g. Other information and data appropriate to support changes

made to the scope of the QM/PI Plan or Program

2. The Division shall make the records available to AHCCCS/DHCM, QM and QI teams upon request.

H. DIVISION OVERSIGHT OF ADMINISTRATIVE SERVICES SUBCONTRACTORS

1. The Division monitors each of the AdSS for compliance with the QM/PI Program administrative requirements throughout the contract year by reviewing required reports, status updates reported by the AdSS at Division meetings and during an annual operational review.

2. The Division may require the AdSS to submit a CAP or initiate a PIP when areas of non-compliance are noted.

Signature of Chief Medical Officer: Anthony Dekker (Aug 11, 2023 10:56 PDT)
Anthony Dekker, D.O.

940 MEDICAL RECORDS AND COMMUNICATION OF CLINICAL INFORMATION

REVISION DATE: 9/6/2023
EFFECTIVE DATE: 5/18/2022
REFERENCES: A.R.S. §13-3620, 9 A.A.C. R9-10, 45, 9 A.A.C. 22-5, A.A.C. R9-22-503, 45 CFR 160, 162, and 164 ,42 CFR 431, 431.300 et seq., 438.2, 438.100(a)(1), 438.100(b)(2)(vi), 457.10, Part 2, 2.1-2.67, 42 U.S.C. §290 dd-2, Division Medical Manual Policy 320-O, 320-R, 410, AdSS Medical Manual Policy 940

PURPOSE

This policy applies to the Division of Developmental (Division) Service Providers. This policy establishes requirements for protection of Member information, documentation requirements for Member physical and behavioral health records, and specifies record review requirements including the use of Electronic Health Records (EHR) and external health information systems.

DEFINITIONS

1. "Adult Recovery Teams" or "ARTs" means A group of individuals that, following the Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, work in collaboration and are actively involved in a Member's assessment, service planning, and

service delivery made up of the following people:

a. The Member;

b. The Member's Health Care Decision Maker (HCDM), if one is in place);

c. Any assigned advocates;

d. A qualified behavioral health representative; and

e. Other individuals identified by the Member or HCDM such as. he Member's family, physical health, behavioral health or social service providers, other agencies serving the Member, and professionals representing various areas of expertise related to the Member's needs.

2. "Arizona Association of Health Plans" or "AzAHP" means an organization dedicated to working with elected officials, AHCCCS Health Care Plans, health care providers, and consumers to keep quality health care available and affordable for all Arizonans. AzAHP is involved in administration of the chart audit process for physical health plan sites and they collaborate with the contractors with regard

to the behavioral health chart audit process.

3. "Child and Family Teams" or "CFTs" means a group of individuals made up of the following people:

   a. The child and their family, orHCDM;

   b. A behavioral health representative, and

   c. Any individuals important in the child's life that are identified and invited to participate by the child and family.

4. "Designated Record Set" or "DRS" means a group of records maintained by the Provider that contain following:

   a. Medical and billing records maintained by the Provider;

   b. Case and medical management records; or

   c. Any other records used by the Provider to make medical decisions about the Member.

5. "Health Information Exchange" or "HIE" means the secure sharing of patient health information among authorized Providers.

   a. HIE is a process or action that can be facilitated by an HIO.

   b. HIE can also include the secure sharing of patient health information directly between providers .

6. "Health Information Organization" or "HIO" means an entity that facilitates the secure exchange of electronic patient health information between participating Providers .
7. "Medical Records" means all communications related to a patient's physical or mental health or condition that are recorded in any form or medium and that are maintained for purposes of evaluation or treatment, including records that are prepared by a health care provider or by other providers, in both hard copy and electronic form. Records do not include materials that are prepared in connection with utilization review, peer review or quality assurance activities as specified in A.R.S. § 122291.
8. "Member" means the same as "Client" prescribed in A.R.S. § 36.551.
9. "Multi-Specialty Interdisciplinary Clinic" or " (MSIC") - An means an established facility where specialists from multiple specialties meet with Members and their families for the purpose of providing interdisciplinary services to treat Members.
10. "Provider" means an individual or organization that contracts with the Division for the provision of covered services, or ordering or referring

for those services, to an eligible Division Member, or any subcontractor of a Provider delivering services pursuant to A.R.S 36-2901.

POLICY

A. GENERAL REQUIREMENTS

1. The Division shall require Providers to maintain comprehensive documentation related to care and services provided to Members.
2. The Division shall ensure, via regular monitoring activities, that documentation completed and is maintained by the Providers meets the requirements specified in this policy.

B. MEDICAL RECORDS REQUIREMENTS

1. The Division shall required Providers to maintain the following in their Medical Records:
    a. Up to date, well organized and comprehensive documentation, with sufficient detail to promote effective Member care and ease of quality review.
    b. Documentation of the following identifying demographic:

i. The Member's name,

ii. Address,

iii. Telephone number,

iv. AHCCCS identification number,

v. Gender,

vi. Age,

vii. Date of birth,

x. Marital status,

xi. Next of kin,

xii. Parent, guardian, or healthcare decision maker , if applicable.

c. The following Member identification information on the first page of the medical record:

i. Member name,

ii. Member AHCCCS ID,

iii. Member date of birth.

d. Member name and either AHCCCS ID or member date of birth on the subsequent pages of the Medical Record.

e. The following past medical history:

i. Disabilities,

ii. Any previous illness or injuries,

iii. Smoking,

iv. Alcohol/substance use,

v. Allergies,

vi. Adverse reactions to medications,

vii. Hospitalizations, to include discharge summaries,

viii. Surgeries,

ix. Emergent/urgent care received,

x. Immunization records: required for children, recommended for adult Members if available.

2. The Division shall require Providers to do the following regarding Medical Records:

a. Hard copy Medical Records be written legibly in blue or black ink, signed, and dated by the rendering provider for each entry.

b. Electronic format Medical Records contain the name of the Provider who made the entry and the date for each entry.

c. If revisions to information are made, a system is in place to track when, and by whom the revisions are made.

d. That a back-up system is maintained that tracks initial and revised information.

e. That if a Medical Record is physically altered:

   i. The stricken information be identified as a correction and initialed by the rendering Provider altering the record, along with the date when the change was made;

   ii. That correction fluid or tape is not used;

   iii. If Medical Records are kept in an electronic file, the Provider must establish a method for indicating the author; date; and time of added and revised information.

   iv. Ensure that information is not inadvertently altered.

f. That Providers in multi-Provider offices must have the treating provider sign their treatment notes after each appointment and procedure and occurs as close to the actual entry of treatment notes as possible, based on

either professional standards of care/or requirements specified within 9 A.A.C. R9-10.

g. That evidence of the use of the Controlled Substances Prescription Monitoring Program (CSPMP) database prior to prescribing a controlled substance or another medication that is known to adversely interact with controlled substances is documented in the Medical Record.

3. The Division shall require the Provider to document the following coordination of care activities when they occur:

a. Referrals to other Providers;

b. Transmission of the diagnostic, treatment, and disposition information related to a specific Member to the requesting Provider, as appropriate to promote continuity of care and quality management of the Member's health care;

c. Reports from referrals, consultations, and specialists for behavioral and physical health, as applicable;

d. Emergency and urgent care reports;

e. Hospital discharge summaries;

f. Transfer of care to other Providers;

g. Any notification when a Member's health status changes or new medications are prescribed;

h. Legal documentation that includes:

i. Documentation related to requests for release of information and subsequent releases,

ii. Documentation of a Health Care Power of Attorney or documentation authorizing a Health Care Decision Maker, and

iii. Copies of any Advance Directives or Mental Health Care Power of Attorney as follows:

a) Documentation that the adult Member was provided the information on Advance Directives and whether an Advance Directive was executed, as specified in AdSS Medical Policy 640;

b) Documentation of general and informed consent to treatment, as specified in AdSS Medical Policy 320-Q; and

c) Authorization to disclose information.

4. The Division shall refer to AMPM Policy 710 for Medical Record information regarding Members who receive Medicaid direct services through their school system.

C. PRIMARY CARE PROVIDERS PHYSICAL HEALTH MEDICAL RECORD REQUIREMENTS

1. The Division shall require any Provider delivering primary care services to a Member and acting as their Primary Care Provider (PCP) to maintains a comprehensive record that incorporates the following components:

    a. Initial history and comprehensive physical examination findings for the Member that includes family medical history, social history and preventive laboratory screenings.

    b. For Members under age 21, the initial history of prenatal care and birth history of the Member's mother while pregnant with the Member, if known;

    c. Documentation of any requests for forwarding of behavioral health and other Medical Record information;

    d. Behavioral health history and information when received

from a TRBHA or other the behavioral health Provider involved with the Member's behavioral health care;

e. If the Provider has not yet seen the assigned Member, Medical information detailed in this subsection may be kept in an appropriately labeled file until associated with the Member's Medical Record as soon as the Medical Record is established;

f. Documentation, initialed by the Provider, to signify review of the following diagnostic information:

   i. Laboratory tests and screenings,

   ii. Radiology reports,

   iii. Physical examination notes,

   iv. Medications,

   v. Last Provider visit,

   vi. Recent hospitalizations, and

   vii. Other pertinent data to the Member's health conditions;

g. Evidence that PCPs are utilizing and retaining AHCCCS approved developmental screening tools;

h. Current and complete Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Tracking forms or an equivalent including, at minimum all data elements on the EPSDT Tracking Form for:

i. All Members age 0 through 20 years;

ii. Developmental screening tools for children ages nine, 18, and 24 months;

iii. Dental history if available, and current dental needs and services;

iv. Current problem list;

v. Current medications list;

vi. Documentation to reflect review of the CSPMP database prior to prescribing a controlled substance or another medication that is known to adversely interact with controlled substances; and

vii. Evidence that obstetric Providers complete a standardized, evidence-based risk assessment tool for obstetric Members as detailed in AdSS Medical Policy 410.

D. BEHAVIORAL HEALTH MEDICAL RECORD REQUIREMENTS

The Division shall require the following elements to be included in all behavioral health Medical Records:

a. Initial behavioral health evaluation containing the following:

i. Documentation of the Member's choice for receipt of the Member Handbook, either hard copy or electronic format;

ii. Receipt of Notice of Privacy Practice;

iii. Contact information for the Member's PCP;

iv. Financial documentation for Non-Title XIX/XXI Members receiving behavioral health services, as outlined in AMPM Policy 650 occuring at the following:

a) At the initial evaluation appointment,

b) When the Member has had a significant change in their income, and

c) At least annually.

b. Behavioral health assessment documentation consisting of:

i. Documentation of all information collected in the

behavioral health assessment and any applicable addenda and required demographic information;

ii. Diagnostic information including psychiatric, psychological, and physical health evaluations;

iii. Evaluation of the need for reporting as required under A.R.S. §13- 3620;

iv. Copies of documentation related to the need for special assistance, if applicable, as detailed in. AdSS Medical Policy 320-R; and

v. An English version of the behavioral health assessment, Service Plan, and Treatment Plan, when applicable, if the documents are completed in any language other than English.

c. Service Plan documentation that contains:

i. The Member's Service Plan or Treatment Plan, as applicable;

ii. CFT documentation, based on Member's age (0 to

18 or up to 21 should Member choose to continue with Child & Family team after turning 18);

iii. ARTs documentation for adults 18 and older ; and

iv. Progress Reports, Service Plans, or Treatment Plans from all other Providers, as applicable.

d. Progress note documentation that includes:

i. Documentation of the type of services provided;

ii. The diagnosis, containing an indicator that identifies whether the progress note is for a new diagnosis or the continuation of a previous diagnosis;

iii. The progress note diagnosis code, if applicable;

iv. The date the service was delivered;

v. The date and time the progress note was signed;

vi. The signature of the staff that provided the service, including the staff Member's credentials;

v. Duration of the service (time increments);

vi. A description of what occurred during the provision of the service related to the Member's

Service Plan;

vii. Documentation of the need for the involvement of multiple Providers, including the name and roles of each Provider involved in the delivery of services, in the event that more than one Provider simultaneously provides the same service to a Member; and

viii. The Member's response to service.

e. The Notice of Extension (NOE) and any other documentation used for the processing of any applicable appeal that was sent to the Member and their legal guardian or authorized representative.

E. REQUIREMENTS FOR POLICIES AND PROCEDURES FOR ENSURING MEDICAL RECORD CONTENT

1. The Division shall implement and maintain policies and procedures to ensure that Providers have information required to monitor effective and continuous physical and behavioral health care for Members through accurate Medical Record documentation regardless of whether

records are hard copy or electronic via:

a. Onsite or electronic quality review;

b. Initial and on-going monitoring of Medical Records;

c. Review of health status, changes in health status, health care needs, and services provided;

d. Review of coordination of care activities;

e. Maintenance of a legible Medical Record for each Member who has been seen for physical and behavioral health appointments and procedures;

f. The Medical record shall also contain clinical records from other Providers who also provide care or/ services to the Member; and

g. Medical Record requirements for hard copy and electronic Medical Records.

2. The Division shall have policies and procedures in place that meet federal and state requirements including those related to security and privacy in accordance with 45 CFR 160, 162, and 164, 45 CFR 43142 CFR 431.300 et seq., and Medicaid Information Technology Architecture (MITA) for the use of

electronic Medical Records and for HIE via the state's HIO and digital (electronic) signatures that contain the following elements:

a. Signer authentication;

b. Message authentication;

c. Affirmative act (i.e. an approval function such as a signature which establishes the sense of having legally consummated a transaction);

d. Efficiency; and

e. Medical Record review.

3. The AdSS shall implement policies and procedures that:

a. Support Members' rights to request and receive a copy of their Medical Record at no cost and to request that the Medical Record be amended or corrected;

b. Ensure information from or copies of Medical Records are released only to the Member or their Health Care Decision Maker.

c. Ensure that unauthorized individuals cannot gain access to, or alter Member Medical Records;. and

d. Ensure Medical Records are maintained in a secure manner that maintains the integrity, accuracy, and confidentiality of Member medical information.

4. The Division shall have written policies and procedures addressing appropriate and confidential exchange of Member information among Providers.

5. The Division shall conduct reviews of Provider's policies and procedures to verify that they contain the following requirements:

   a. A Provider making a referral are to transmits necessary information to the Provider receiving the referral,

   b. A Provider furnishing a referral service reports appropriate information to the referring Provider,

   c. Providers request information from other treating Providers as necessary to provide appropriate and timely care, and

   d. Information about services provided to a Member by a non-network provider is transmitted to the Member's Provider:

e. Medical Records are transferred to the new Provider within 10 business days from receipt of the request for transfer of Medical Records to ensure continuity of care when a Member chooses a new Provider; and

f. Member information is shared when a Member enrolls with a new AdSS, in a manner that maintains confidentiality while promoting continuity of care.

F. METHODOLOGY FOR CONDUCTING MEDICAL RECORD REVIEW PROCESS

1. The Division shall require that the Medical Record audit process includes the Ambulatory Medical Record Review (AMRR) and the Behavioral Health Clinical Chart Audit.
2. The Division may, if they choose, utilize the AAzAHP to conduct Medical Record review and other Provider documentation review processes.
3. The Division shall utilize the following methodology when conducting a Medical Record review of Providers:
   a. Medical Record reviews using a standardized tool that has been reviewed by AHCCCS.

b. Review the following physical health records:

   i. EPSDT,

   ii. Family planning, and

   iii. Maternity components not otherwise monitored for Provider compliance by the Division.

c. Review the following elements of behavioral health Medical Records:

   i. Assessments; and

   ii. Service and treatment planning.

   iii. Ensure individual elements delineate which requirements pertain to:

      a) The unique needs of individual lines of business,

      b) The following special populations:

         1) General Mental Health/Substance Use (GMH/SU),

         2) Serious Mental Illness (SMI),

         3) Special Health Care Needs (SHCN),

4) Comprehensive Health Plan (CHP), or

5) Individuals receiving services under

d. Review to ensure Medical Record reviews are required to occur according to the following schedule:

i. At a minimum of every three years for physical health charts; and

ii. Yearly for behavioral health charts.

e. Review to ensure Medical Record reviews are required to occur according to the following schedule:

i. Conduct medical records reviews at a minimum of every three years for physical health charts (AMRR); and

ii. Yearly for behavioral health charts.

f. Use of AdSSThe Division staff with the appropriate licensure and experience necessary for completion of either clinical charts for behavioral health services or physical health services to conduct the Medical Record reviews.

i. The Division shall utilize licensed behavioral health professionals (BHPs) or behavioral health technicians (BHTs) with a minimum of three years' experience as a BHT and under the supervision of a BHP for behavioral health clinical chart audits; and

ii. The Division shall utilize a registered nurse (RN) or a licensed practical nurse (LPN) with current licensure under the Arizona State Board of Nursing for AMRR audits.

4. The Division shall make available the results of the Medical Record review to all contractors who utilize a consultant such as AzAHP, or in instances when multiple contractors share the same Provider for this process.
5. The Division shall share the deficiencies identified during a Medical Record review with all health plans contracted with the Provider.
6. If quality of care issues are identified during the Medical Record review process, the Division shall notify all

contractors which contract with the identified Provider within 24 hours of identification of the quality of care issue with specifics concerning the quality of care issue.

7. If the Division requests approval from AHCCCS to discontinue conducting the Medical Record reviews, the Division shall do the following prior to making the request:
   a. Conduct a comprehensive review the use of the Medical Record review process and how the process is used to document compliance with the Division and AHCCCS requirements;
   b. Document what processes will be used in place of the Medical Record review process to ensure compliance with the Division and AHCCCS requirements; and
   c. Submit the process the AdSS will utilize to ensure Provider compliance with the Division and AHCCCS Medical Record requirements to the AHCCCS/Quality Management/, Clinical Quality Management Administrator prior to discontinuing the Medical Record review process.
8. The Division shall include all PCPs that serve Members less

than 21 years of age and obstetricians/gynecologists in the AMRR process.

9. The Division shall review process shall consist of reviewing eight charts per practitioner and include the requirements specified in contract as a part of the AMRR.
10. The Division shall include in the behavioral health Medical Record review process:
    a. Behavioral Health Outpatient Clinics, and
    b. Integrated Health Homes and Federally Qualified Healthcare Centers (FQHCs) if they provide both behavioral health and physical health care.
11. The Division shall follow the medical review process for behavioral health records as specified in contract.
12. For changes in methodology or sampling, the Division shall submit to AHCCCS in advance for approval as specified in the contract.

G. MULTI-SPECIALTY INTEGRATED CLINIC

1. The Division shall implement written policies and procedures to require that MSICs have an integrated

electronic Medical Record for each Member that is served through the MSIC.

2. The Division shall require the MSIC's integrated electronic Medical Record:
   a. Be available, electronically through the HIE, for the multi-specialty treatment team and community Providers;
   b. Contains all information necessary to facilitate the coordination and quality of care delivered by multiple Providers in multiple locations at varying times; and
   c. For care coordination purposes, is shared with other care Providers, such as the multi-specialty interdisciplinary team.

H. COMMUNITY SERVICE AGENCY, THERAPEUTIC FOSTER CARE PROVIDERS, AND HABILITATION PROVIDER REQUIREMENTS

1. For Community Service Agencies (CSAs), Therapeutic Foster Care (TFC) Providers, and Habilitation Providers, the Divisions shall require that the Medical Records conform to the following standards:

a. Each record entry be:

1. Dated and signed with credentials noted;

2. Legible text, written in blue or black ink, or typewritten; and

3. Factual and correct.

2. If Medical Records are kept in more than one location, the Division shall require the agency Provider to:

a. Maintain documentation specifying the location of the Medical Records;

b. Maintain a Medical Record of the services delivered to each Member; and

c. Meet the following requirement for each Member's Medical Record:

i. The service provided and the time increment;

ii. Signature and the date the service was provided;

iii. The name, title, and credentials of the professional providing the service;

iv. The Member's Date of Birth and AHCCCS

identification number;

v. Documentation that services are reflected in the Member's Service Plan or Treatment Plan, as applicable;

vi. Maintain a copy of the Member's Service Plan or Treatment Plan, as applicable, in the Member's Medical Record; and

vii. Maintain a monthly summary of service documentation progress toward treatment goals.

d. The Division shall require Providers to transmit a summary of the monthly summary of service to the Member's clinical team for inclusion in the comprehensive Medical Record.

I. DESIGNATED RECORD SET

1. The Division shall treat the DRS as the property of the Provider who generates the DRS.
2. The Division shall require that Providers allow Members to:
   a. Review, request, and annually receive a copy, free of charge, of those portions of the DRS generated

by the Provider;

b. Request that specific Provider information is amended or corrected; and

c. Not review, request, amend, correct, or receive a copy of the portions of the DRS that are prohibited from view under Health Insurance Portability and Accountability Act (HIPAA).

3. The Division shall provide sufficient copies of records necessary for administrative purposes to AHCCCS free of charge for purposes relating to treatment, payment, or health care operations.

4. The Division shall not require the PCP to obtain written approval from the Member when:

a. Transmitting Medical Records to a Provider when services are rendered to the Member through referral to a Division subcontracted Provider,

b. Sharing treatment or diagnostic information with the entity or entities responsible for or directly providing behavioral health services, or

c. Sharing Medical Records with the Member's AdSS.

5. The Division shall require AHCCCS-registered Providers to forward Medical Records or copies of Medical Record information related to a Member to the Member's PCP within 10 business days from receipt of a request from the Member or the Member's PCP.
6. The Division shall provide access to AHCCCS to all Medical Records, whether electronic or hard copy, within 20 business days of receipt of a request.
7. The Division shall release information related to fraud, waste, or abuse against the AHCCCS program to authorized officials in compliance with Federal and State statutes and rules.
8. The Division shall demonstrate evidence of professional and community standards and accepted and recognized evidence-based practice guidelines as specified inDivision Medical Manual Chapter 500.
9. The Division shall require Providers to have an implemented process to assess and improve the content, legibility, organization, and completeness of Medical Records when

concerns are identified with the Providers Medical Records.

10. The Division shall require documentation in the Medical Record showing supervision by a licensed professional, who is authorized by the licensing authority to provide the supervision, whenever health care assistants or paraprofessionals provide services.

J. LEGAL REQUIREMENTS FOR RECORD MAINTENANCE

1. Consistent with 9 A.A.C. 22, Article 5, the Division, and Providers, and non-contracted entities providing services to Members shall safeguard the privacy of Medical Records and information about Members who request or receive services from AHCCCS or its contractors.
2. The Division shall require that tThe content of any Medical Record be disclosed in accordance with the prior written consent of the Member with respect to whom such record is maintained as allowed under regulations prescribed pursuant to 42 U.S.C. §290 dd-2 (confidentiality of records), 42 CFR Part 2, 2.1 – 2.67.
3. The Division shall release original and copies of Medical Records

shall only in accordance with Federal or State laws, and AHCCCS and Division policy and contracts.

4. The Division shall comply with HIPAA requirements and 42 CFR 431.300 et seq.
5. The Division shall align the Medical Records retention processes with AHCCCS and Division contract and TRBHA Intergovernmental Agreement (IGA) requirements.
6. The Division shall require that maintenance and access to Medical Records survive the termination of a Provider's contract regardless of the cause of termination.
7. The Division and Providers shall participate and cooperate in State of Arizona and AHCCCS activities related to the adoption and use of EHR and integrated clinical data sharing.
8. The Division shall encourage non-contracted entities that provide services to Members to cooperate and participate in State of Arizona and AHCCCS activities related to the adoption and use of EHR and integrated clinical data sharing.

K. UNITED STATES CORE DATA FOR INTEROPERABILITY

The Division shall incorporate United States Core Data for

Interoperability (USCDI) Data Elements as part of the DRS to facilitate the electronic exchange of an individual's Medical Record data as requested by the individual.

Signature of Chief Medical Officer: Anthony Dekker (Aug 30, 2023 16:22 PDT)
Anthony Dekker, D.O.

SUPPLEMENTAL INFORMATION

The requirements listed below are additional requirements under USCDI. The Division and AHCCCS strongly recommend these enhanced data elements be added to the existing Physical and Behavioral Health Medical Record requirements specified in this policy. Per the ONCs, disclosure of these additional data elements is subject to the confidentiality requirements of applicable state laws.

1. Medical Record requirements are applicable to both hard copy and electronic Medical Records. Medical Records may be documented on hard copy or in an electronic format. The AdSS' Providers shall include the following in their records:
2. Documentation of identifying demographics, including:

a. Any previous names by which the Member is known,

b. Previous address,

c. Telephone number with cell or home designation, and both if applicable,

d. Email address,

e. Birth sex,

f. Race,

g. Ethnicity, and

h. Preferred language.

3. For records relating to provision of behavioral health services, documentation including, but not limited to:

a. Behavioral health history,

b. Applicable assessments,

c. Service plans and/or treatment plans,

d. Crisis and/or safety plan,

e. Medication information if related to behavioral health diagnosis,

f. Medication informed consents, if applicable

g. Progress notes, and

h. General and/or informed consent.

4. Documentation, initialed by the Provider, to signify review of diagnostic information including vital signs data at each visit, to include:
    a. Body temperature,
    b. Diastolic and Systolic blood pressure,
    c. Body height and weight,
    d. BMI Percentile (two -20 years),
    e. Weight-for-length percentile (birth-36 months),
    f. Head occipital-frontal circumference percentile (birth-36 months),
    g. Heart rate and respiratory rate,
    h. Pulse oximetry,
    i. Inhaled oxygen concentration, and
    j. Unique device identifier(s) for implantable device(s), as applicable.
5. For Inpatient Settings – Clinical Note Requirements:
    a. Consultation notes,
    b. Discharge and summary notes,
    c. History and physical,
    d. Imaging narrative,

e. Laboratory report narrative,

f. Pathology report narrative,

g. Procedure notes, and

h. Progress notes.

950 CREDENTIALING AND RECREDENTIALING PROCESSES

REVISION DATE: 9/6/23, 5/18/22, 5/23/18, 5/05/17
EFFECTIVE DATE: May 3, 2016
REFERENCES: 42 CFR 8.11, 42 CFR 438, 42 CFR 455, Subpart B, 42 CFR 457.1208, 42 CFR 457.1233(a); A.A.C. 21, Article 1 through Article 4, A.A.C. R9-10-18, R9-10-115, R9-10-1803; A.R.S. §36- 2918.01, §36-2905.04, §36-2932, AMPM Policy 950

PURPOSE

This policy establishes the requirements for initial Credentialing, temporary/provisional Credentialing, and recredentialing of individual and Organizational Providers contracted with the Division of Developmental Disabilities (Division) and oversight of the Credentialing responsibilities delegated to the Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. "Adverse Action" means any type of restriction placed on a Provider's practice, including contract termination, suspension, limitations, continuing education requirements, monitoring, supervision.
2. "Completed Application" means when all accurate information and documentation is available to make an informed decision about the

Provider.

3. "Credentialing" means a process in which written evidence of qualifications are obtained in order for practitioners to participate under contract with a specific health plan.
4. Member" means the same as "Client" as defined in A.R.S. § 36-551.
5. "Organizational Provider" means a facility providing services to Members and where Members are directed for services rather than being directed to a specific practitioner.
6. "Primary Source Verification" means the process by which an individual Provider's reported credentials and qualifications are confirmed with the original source or an approved agent of that source.
7. "Provider" means any individual or entity that contracts with the Division for the provision of covered services, or ordering or referring for those services to Division Members, or any subcontractor of a Provider delivering services pursuant to A.R.S 36-2901.

POLICY

A. CREDENTIALING PROVIDERS

1. The Division shall verify Providers are properly trained, certified or licensed, and have the required experience to provide care

and services to Division Members.

2. The Division's Credentialing Unit shall credential and recredential individual and Organizational Providers contracted with the Division.
3. The Division shall credential Organizational Providers who have an agreement with the Division to provide residential placements, day and employment programs, Adult and Child Developmental Homes, home community-based services, and occupational, physical, and speech language therapies.
4. The Division shall delegate the Credentialing responsibilities of individual health care Providers to the Division's AdSS, except for occupational, physical, and speech language therapists that contract directly with the Division.
5. The Division shall retain the right to approve, suspend, or terminate any Provider credentialed by the AdSS.
6. The Division shall ensure the Credentialing and Recredentialing processes:
    a. Do not base Credentialing decisions on an applicant's race, gender, age, sexual orientation, or patient type in which the Provider specializes.

b. Do not discriminate against Providers who serve high-risk populations or who specialize in the treatment of costly conditions.

c. Comply with federal requirements that prohibit employment or contracts with Providers excluded from participation under either Medicare or Medicaid, or that employ individuals or entities that are excluded from participation.

7. The Division shall ensure Providers have capabilities to ensure physical access, reasonable accommodation, and accessible equipment for Members with physical and mental disabilities. [42 CFR.457.1230 (a), 42 CFR 438.206(c)(2) (3)].

8. The Division shall ensure that providers deliver services in a culturally competent manner, including to those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

B. CREDENTIALING COMMITTEE

1. The Division's Credentialing Committee shall be responsible for

the Credentialing process under the purview of the Quality Management Unit (QMU).

2. The Chief Medical Officer (CMO) or Quality Management Medical Director, in the absence of the CMO, shall oversee the Credentialing process and serve as chair of the committee.
3. The Credentialing Committee shall review and approve or deny Credentialing applications presented at each Committee meeting.
4. The Division's Credentialing Unit shall verify the completeness of the file and maintain an individual electronic or hard copy Credentialing/Recredentialing file for each credentialed Provider, including the final determination of the Committee for all initial, temporary/provisional, and recredentialed Providers reviewed by the Committee.
5. The Division's Credentialing Unit shall verify the information for presentation to the Credentialing Committee within 60 calendar days of receipt of all required documentation.
6. The Division shall notify the Providers of the Credentialing decision within 10 calendar days of the Credentialing Committee’s decision.

7. The CMO or Quality Management Medical Director's signature shall serve as evidence of the Credentialing Committee's final decision.
8. The Division shall enter the credentialed Providers in the claims payment system within 30 calendar days of Credentialing Committee approval with an effective date no later than the date the Provider was approved by the Credentialing Committee or the contract effective date, whichever is later.

C. TEMPORARY/PROVISIONAL CREDENTIALING

1. The Division shall grant temporary/provisional credentials when it is in the best interest of Members, as defined in this section, to have Providers available to provide care or services prior to the completion of the entire Credentialing process.
2. The Division may credential Providers using the temporary/ provisional Credentialing process, even if the Provider does not specifically request their application be processed as temporary/ provisional, if they meet any of the following criteria:

    a. Providers needed in medically underserved areas.

    b. Covering or substitute Providers rendering services to the

Division's Members during a contracted Provider's absence from the practice.

c. As directed by Arizona Health Care Cost Containment System (AHCCCS) during federal or state declared emergencies where delivery systems are, or have the potential to be, disrupted.

3. The CMO or Medical Director shall review the initial verified and validated Credentialing documents and make a determination within 14 calendar days from the date of request or identified need regarding temporary/provisional Credentialing.

4. If approved by the CMO or Medical Director, the Division's Credentialing Unit shall notify the Provider and the Division's Contract Management Unit of the service(s) approved for temporary/provisional Credentialing.

5. The Division's Contract Management Unit shall enter a service start date in order for the Provider to be uploaded into the claims system.

6. The Division's Credentialing Unit shall inform the Provider, in the Credentialing notification letter, that the entire initial

Credentialing process will be completed within 60 calendar days of issuance of the temporary/provisional Credentialing.

7. The Credentialing Committee shall consider the Provider's Credentialing information at the next Committee meeting for consideration of initial Credentialing.

D. INITIAL CREDENTIALING OF INDIVIDUAL PROVIDERS

1. The Division shall credential the following individual Provider when contracted directly with the Division:
   a. Occupational Therapist,
   b. Physical Therapist, and
   c. Speech and Language Pathologist.

2. The Credentialing Committee shall review a verified completed Credentialing file.

3. The Division's Credentialing Unit shall verify the completeness of the file and maintain an individual electronic or hard copy Credentialing/Recredentialing file for each credentialed Provider that contains:
   a. A Completed Application signed and dated by the Provider

that attests to the following elements:

i. Reasons for any inability to perform the essential functions of the position, with or without accommodation;

ii. Lack of present illegal drug use;

iii. History of loss of license or felony conviction;

iv. History of loss or limitation of privileges or disciplinary action;

v. Current malpractice insurance coverage;

vi. Attestation by the Provider of the correctness and completeness of the application; a copy of the signed attestation shall be included in the Provider's Credentialing file; and

vii. Minimum five-year history or total history if less than five years.

b. Drug Enforcement Administration and Chemical Database Service certification if a prescriber.

c. Verification from primary sources of:

i. Licensure or certification.

ii. Board certification, if applicable, or highest level of

credentials attained.

E. RECREDENTIALING INDIVIDUAL PROVIDERS

1. The Credentialing Unit shall recredential Individual Providers at least every three years and:

   a. Update the information obtained during the initial Credentialing process;

   b. Verify continuing education requirements are met, if applicable;

   c. Monitor Provider specific information related to:

      i. Member concerns and grievances;

      ii. Utilization management information;

      iii. Performance improvement and monitoring, if applicable;

      iv. Results of medical record review audits, if applicable;

      v. Quality of care issues including trend data;

      vi. Pay for performance and value-driven healthcare data and outcomes if applicable; and

      vii. Evidence that the Provider's policies and procedures meet Division requirements.

2. The Credentialing Committee shall make a Recredentialing decision within three years from the previous Credentialing approval date based on Primary Source Verification current within 180 days.

E. INITIAL CREDENTIALING OF ORGANIZATIONAL PROVIDERS

1. As a prerequisite to contract execution of an Organizational Provider, the Division shall ensure the Organizational Provider has established policies and procedures that meet AHCCCS requirements, including policies and procedures for Credentialing and recredentialing when those functions are delegated to the Organizational Provider and meet the requirements specified in this section.

2. The Credentialing Committee shall review a verified completed Credentialing file.

3. The Division's Credentialing Unit shall verify the completeness of the file and maintain an individual electronic or hard copy Credentialing/Recredentialing file for each credentialed Organizational Provider that contains:

a. The Completed Application and signed attestation by the Provider of the correctness and completeness of the application;

b. An executed qualified vendor agreement;

c. AHCCCS Registration;

d. The completed District-level readiness review;

e. Confirmation the Provider has met all the state and federal licensing and regulatory requirements;

f. A completed onsite quality assessment;

g. Central Registry check;

h. Criminal background check;

i. Electronic Visit Verification attestation, if applicable;

j. Office of the Inspector General List of Excluded Individuals or Entities check;

k. Social Security Administration Death Master File check;

l. Completed State of Arizona Substitute W-9;

m. System for Award Management registration;

n. Department of Economic Security, Office of Licensing, Certification, Regulation, and Home and Community Based Services Certificate;

o. Proof of insurance that includes general liability, professional liability, worker's compensation, and sexual abuse and molestation coverage;

p. Business license;

q. A maintenance schedule for vehicles used to transport Members and the availability of age-appropriate car seats when transporting children; and

r. Any other pertinent information used to determine that the Provider meets the Division's Credentialing and recredentialing standards.

F. RECREDENTIALING OF ORGANIZATIONAL PROVIDERS

1. The Credentialing Committee shall recredential Organizational Providers at least every three years.

2. The Credentialing Committee shall review a verified completed Credentialing/Recredentialing file that includes updated and verified status of the initial information.

3. The Division's Credentialing Unit shall verify the completeness of the file for each recredentialed Organizational Provider using the following components:

    a. Confirmation that the Organizational Provider remains in good standing with state and federal bodies by validating that the Organizational Provider:

        i. Is licensed to operate in the state and is in compliance with any other state or federal requirements as applicable; and

        ii. Is reviewed and approved by an appropriate accrediting body.

        iii. If an Organizational Provider is not accredited or surveyed and licensed by the state, an onsite review is conducted.

    b. Review of the following:

i. Current review conducted by the Arizona Department of Health Services (ADHS) or summary of findings;

ii. Hospital Compare Az Care Check, if applicable;

iii. Record of onsite inspection of non-licensed Organizational Providers to ensure compliance with service specifications;

iv. Supervision of staff and required documentation of direct supervision or clinical oversight as required in A.A.C R9-10-115, including, if applicable, review of a valid sample of clinical Member charts;

v. Most recent audit results of the Organizational Provider;

vi. Confirmation that the service delivery address is correct; and

vii. Verification that staff meet the Credentialing requirements.

c. Evaluation of Organizational Provider specific information related to:

i. Member concerns and grievances;

ii. Utilization management information;

iii. Performance improvement and monitoring;

iv. Quality of care issues;

v. Onsite assessment;

vi. Review of any Adverse Actions;

vii. Value-based purchasing results and level of Member satisfaction for recredentialing;

4. The Credentialing Committee shall review and approve all Credentialing decisions with formal documentation that includes discussion, review of thresholds, and complaints or grievances.

5. The Division shall reviewand monitor other types of Organizational Providers in accordance with the AHCCCS contract.

G. NOTIFICATION REQUIREMENTS

1. The Division's Contract Actions Unit shall report any issues that result in a Provider's suspension or termination from the network

to the AHCCCS/DHMC/QM within one business day of determination to take the Adverse Action.

2. If any issue is determined to have criminal implications, including allegations of abuse or neglect, the Division shall notify the appropriate law enforcement agency and protective services agency no later than 24 hours after identification.
3. The Division's Credentialing Unit shall report allegations of Provider misconduct or misuse of prescribing practices to licensing and other regulatory entities as appropriate.
4. The Division's Credentialing Unit shall report any adverse Credentialing decisions made on the basis of quality-related issues or concerns to AHCCCS/DHMC/QM within one business day of determination to take Adverse Action, and include the reason or cause of the adverse decision and when restrictions are placed on the Provider's contract.
5. The Division shall have an appeal process for Providers when restrictions are placed on the Provider's contract based on issues of quality of care or service and process to inform the Provider of the Quality Management dispute process through the QMU.
6. The Division shall report to AHCCCS/DHMC/QM in writing, any

final Adverse Action taken for any quality-related reason against a Provider, supplier, vendor, or practitioner within one business day of the final Adverse Action taken.

7. The Division shall not consider a final Adverse Action to be malpractice notices or settlements in which no findings or liability have been determined.

8. The Division shall consider the following to be a final Adverse Action:

    a. Civil judgments in federal or state court related to the delivery of a health care item or service.

    b. Federal or state criminal convictions related to the delivery of a health care item or service.

    c. Actions by federal or state agencies responsible for the licensing and certification of health care Providers, suppliers, and licensed health care practitioners, including:

        i. Formal or official actions such as restriction, revocation, suspension of license and length of suspension, reprimand, censure or probation.

ii. Any other loss of license or the right to apply for or renew a license of the Provider, supplier or practitioner, whether by operation of law, voluntary surrender, non-renewability or otherwise; or

iii. Any other negative action or finding by such federal or state agency that is publicly available information.

iv. Exclusion from participation in federal or state health care programs as defined in 42 CFR 455 Subpart B; and

v. Any other adjudicated actions or decisions that the Secretary of the U.S. Department of Health and Human Services shall establish by regulation.

vi. Any adverse Credentialing decision made on the basis of quality-related issues or concerns.

vii. Any Adverse Action from a quality or peer review process that results in denial of a Provider to participate in the Division's network, Provider termination, Provider suspension, or an action that

limits or restricts a Provider.

9. Submit to the NPDB and the Healthcare Integrity and Protection Data Bank (HIPDB) within 30 calendar days from the date the final Adverse Action was taken or by the close of the next monthly reporting cycle, whichever is later.

10. The Division shall immediately notify the AHCCCS Office of Inspector General (OIG) regarding any allegation of fraud, waste, or abuse of the AHCCCS Program, including allegations of fraud, waste, or abuse that were resolved internally but involved AHCCCS funds.

11. The Division shall provide notification regarding Credentialing denials to the applicable Provider(s) within 10 calendar days of the Credentialing Committee decisions.

12. The Division shall send a notice of final Adverse Action to AHCCCS/DHCM/QM within one business day and include the following information:

    a. The name and Tax Identification Number as defined in section 7701(A)(41) of the Internal Revenue Code of

1986[1121].

b. The name, if known, of any health care entity with which the health care Provider, supplier, or practitioner is affiliated or associated.

c. The nature of the final Adverse Action and whether such action is on appeal.

d. A description of the acts or omissions and injuries upon which the final Adverse Action was based, and such other information determined by regulation for appropriate interpretation of information reported under this section.

e. The date the final Adverse Action was taken, its effective date, and duration of the action.

f. Corrections of information already reported about any final Adverse Action taken against a health care Provider, supplier, or practitioner.

g. Documentation that the following sites have been queried:

   i. SAM, www.sam.gov, formerly known as the Excluded Parties List Syste;

ii. The Social Security Administration's Death Master File;

iii. The National Plan and Provider Enumeration System;

iv. List of Excluded Individuals or Entities; and

v. Any other databases directed by AHCCCS or CMS.

H. CREDENTIALING TIMELINESS

The Division's Credentialing Unit shall process Credentialing applications in a timely manner as shown in the following table:

CREDENTIALING ACTIVITY	TIME FRAME	COMPLETION REQUIREMENTS
Temporary/Provisional Credentialing	14 Days	100%
Initial Credentialing of Individual and Organizational Providers	60 Days	100%
Recredentialing of Individual and Organizational Providers	Every three years	100%
Load Times (Time between Credentialing Committee approval and loading into Claims System)	30 Days	95%

J. OVERSIGHT

1. The Division shall provide monitoring and oversight of the Division's Credentialing process through the following activities:

a. Review of quarterly performance data by the Quality Management/Performance Improvement (QM/PI) Committee.

b. Review of Credentialing data by the QM/PI Committee.

c. Recommendations by the QM/PI Committee regarding opportunities for improvement and monitor ongoing performance.

2. The Division shall monitor and provide oversight of the AdSS' Credentialing and recredentialing processes through annual operational reviews; review of quarterly reports submitted by the AdSS; and the internal quarterly health plan review meetings to ensure adherence to the requirements set forth in AdSS Medical Policy 950.

3. If there are any concerns regarding data reported in the quarterly reports by the AdSS, the Division may require the AdSS to report monthly until three consecutive months of compliance have been achieved.

Signature of Chief Medical Officer: Anthony Dekker (Aug 31, 2023 10:20 PDT)
Anthony Dekker, D.O.

960 QUALITY OF CARE CONCERNS

REVISION DATES: 8/16/23, 6/29/22, 9/02/20, 12/18/19,

EFFECTIVE DATE: May 20, 2016

REFERENCES: AHCCCS Contract, AMPM Policies 961, 960, 950, 910, 320-U; Division Medical Policy 966; Division Operations Policies 407, 446; 9 A.A.C. 34, A.A.C. R9-19-314 B (13) and A.A.C. R9-19-315(E), R9-21-4, R9-21-101(B), R9-21-401 et seq., A.R.S. §§8-412(A), 12-901 et seq, 13-3620 36-664(H), 36-517.02, 36-664, 41-3801, 41-3804, 46-454, 42 CFR Part 2, 42 CFR 447.26, 42 CFR 431.300 et seq, 42 CFR 482.13(e)(1), 45 CFR 16.103, 20 U.S.C. §1232g

PURPOSE

This policy sets forth the Division of Developmental Disabilities' (Division) standards and requirements for reporting, evaluating, and resolving Quality of Care and service concerns raised by internal and external sources, including systemic concern. This policy also sets forth the Division standards for providing oversight of Member and Service Provider concerns and Quality of Care (QOC) Concerns.

DEFINITIONS

1. "Adverse Action" means any type of restriction placed on a Service Provider's practice by the Division.

2. "Health Care Acquired Condition" means a hospital acquired condition which occurs in any inpatient hospital setting and is not present on admission.

3. "High-Profile Case" means a case that attracts, or is likely to attract, attention from the public or media.

4. "Immediate Jeopardy" means a situation in which the Service Provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a Member.

5. "Incident, Accident, or Death" or "IAD" means an incident report entered into the Arizona Health Care Cost Containment System (AHCCCS) Quality Management (QM) Portal by a Service Provider to document an occurrence that caused harm or may have caused harm to a Member, or to report the death of a Member.

6. "Internal Referral" or "IRF" means a report entered into the AHCCCS

QM Portal by an employee of a health plan to document an occurrence that caused harm or may have caused harm to a member and or to report the death of a member.

7. "Investigation" means a collection of facts and information for the purpose of describing and explaining an Incident.

8. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

9. "Other Provider Preventable Condition" means a condition occurring in an inpatient or outpatient health care setting which AHCCCS has limited to the following:

   a. Surgery on the wrong Member,

   b. Wrong surgery on a Member, and

   c. Wrong site surgery.

10. "Personally Identifiable Information" or "PII" means a person's name, address, date of birth, social security number, trial enrollment number, telephone or fax number, email address, social media identifier, driver's license number, places of employment, school identification or military identification number or any other distinguishing characteristic

that tends to identify a particular person as specified in A.R.S. § 41-3804(K).

11. "Protected Health Information" or "PHI" means individually identifiable information as specified in 45 CFR 160.103(5) about an individual that is transmitted or maintained in any medium where the information is:

    a. Created or received by a health care provider, health plan, employer, or health care clearinghouse; and

    b. Relates to the past, present, or future physical or mental health condition of an individual, provision of health care to an individual.

12. "Provider-Preventable Condition" means a condition that meets the definition of a Health Care Acquired Condition or an Other Provider Preventable Condition.

13. "Quality Management" or "QM" means the evaluation and assessment which can be assessed at a Member, Service Provider, or population level of Member care and services to ensure adherence to standards of care and appropriateness of services.

14. "Quality Management/Performance Improvement Team" or "QM/PI" means Division staff who:

    a. Oversee the QOC Concern process;

    b. Evaluate Administrative Services Subcontractors' Quality Management/Performance Improvement Programs;

    c. Monitor and evaluate adherence with required quality and performance improvement standards through standardized Performance Measures, Performance Improvement Projects, and Quality Improvement specific Corrective Action Plans ; and

    d. Provides technical assistance for performance improvement related matters.

15. "Quality of Care" or "QOC" means an expectation that, and the degree to which, the health care services provided to individuals and patient populations improve desired health outcomes and are consistent with current professionally recognized standards of care and service provisions.

16. "Quality of Care Concern" or "QOC Concern" means an allegation that any aspect of care or treatment, utilization of behavioral health services, or utilization of physical health care services that d:

a. Caused or could have caused an acute medical or psychiatric condition or an exacerbation of a chronic medical or psychiatric condition; and

b. May ultimately cause the risk of harm to a Member.

17. "Responsible Person" means the same as defined in A.R.S. § 36-551.

18. "Restraint" means personal restraint, mechanical restraint, or drug used as a restraint in a behavioral health inpatient setting as defined in 42 CFR 482.13(e)(1).

19. "Seclusion" means the involuntary confinement in a room or an area from which the person cannot leave.

20. "Seclusion of Individuals Determined to have a Serious Mental Illness" means the restriction of a behavioral health recipient to a room or area through the use of locked doors or any other device or method which precludes a person from freely exiting the room or area or which a person reasonably believes precludes the person's unrestricted exit as specified in A.A.C. R9-21-101(B).

a. In the case of an inpatient facility: confining a behavioral health recipient to the facility, the grounds of the facility, or a ward of the facility does not constitute seclusion.

b. In the case of a community residence, restricting a behavioral health recipient to the residential site, according to specific provisions of an individual service plan or court order, does not constitute seclusion, as specified in A.A.C. R9-21-101(B).

21. "Sentinel Event" means a Member safety event that results in death, permanent harm, or severe temporary harm.

22. "Service Provider" means the same as defined in A.R.S. § 36-551.

23. "Severity Levels" means the level of acuity of a QOC and which is described in the following ranking:

Level 0: (Track and Trend Only) - No Quality issue Finding

Level 1: Quality issue exists with minimal potential for significant adverse effects to the patient/recipient.

Level 2: Quality issue exists with significant potential for adverse effects to the patient/recipient if not resolved timely.

Level 3: Quality issue exists with significant adverse effects on the patient/recipient; is dangerous or life-threatening.

Level 4: Quality issue exists with the most severe adverse effects on the patient/recipient; no longer impacts the patient/recipient with the potential to cause harm to others.

POLICY

A. DOCUMENTATION OF QUALITY OF CARE AND SERVICE CONCERNS

Upon receipt of a Quality of Care (QOC) or other form of concern regarding a service provided to a Member, the Division shall:

a. Document each concern raised, including the time and location of the event, if available, when and from whom it was received, and the projected time frame for resolution.

b. Determine which of the following processes will be used to resolve the concern:

   i. Quality Management (QM) process,

   ii. Grievance and appeals process,

   iii. Both the grievance and appeals process and QM process if a rights violation also includes QOC,

   iv. Process for making initial determination on coverage and payment issues, or

   v. Process for resolving disputed initial determinations.

c. Provide written correspondence acknowledging receipt of the concern and explanation of the process to be used to resolve the QOC Concern.

d. If determined not to be a QOC Concern, provide an explanation of the process to be used to resolve the issue.

e. Provide assistance to the Member or Service Provider through the Office of Individual and Family Affairs, as needed, to complete forms or take other necessary actions to obtain resolution of the issue.

f. Maintain confidentiality of all Member information.

g. Inform the Member or Service Provider of all applicable mechanisms for resolving the concern external to the Division's processes.

h. Document all processes (including detailed steps used during the Investigation and resolution stages) implemented to ensure complete resolution of each complaint, grievance, or appeal, including:

   i. Corrective action plan or action taken to resolve the concern;

   ii. Documentation that education and training was completed, such as in-service attendance sheets and

training objectives;

iii. New policies and procedures; and

iv. Follow-up with the Member with the following as applicable to the situation:

1) Assistance to ensure that the immediate health care needs are met;

2) Closure or resolution letter that provides sufficient detail to ensure all covered, medically necessary care needs are met, and a contact name and telephone number to call for assistance or to express any unresolved concerns; and

3) Referral to the Division's Compliance Unit or AHCCCS Office of the Inspector General.

i. Enter QOC Concerns received outside of the AHCCCS QM Portal as an Internal Referral within:

i. one business day for Sentinel Events; or

ii. Within two business days for all other reportable

Incidents.

ii. Comply with 9 A.A.C 34, Division Operations Policy 446, and the AHCCCS Contract for the grievance and appeal system for Members and Service Providers.

B. PROCESS OF EVALUATION AND RESOLUTION OF QOC AND SERVICE CONCERNS

1. The Division shall:
   a. Complete the QOC Concern Investigation and documentation process within the AHCCCS QM Portal; and
   b. Include a summary of all applicable research, evaluation, intervention, resolution, and remediation, including details for each case as a part of the documentation process.
2. The Division shall complete the QOC Investigation and documentation process as a stand-alone process through the Quality Management Unit (QMU) with assistance from other units when necessary.
3. The Division shall not combine the QOC Investigation process with other Division meetings or processes.
4. Work units outside of the QMU:

a. Shall not solely conduct QOC investigations.

b. Shall provide subject matter expertise throughout the investigative process as requested by the QMU.

5. The QMU shall be solely responsible for and conduct its own QOC Investigations for services rendered under its direct responsibility, including conducting onsite visits for QOC Concerns.

6. The Division shall evaluate and resolve QOC and service concerns by:

a. Identification of the QOC Concerns.

b. Initial assessment of the severity of each QOC Concern.

c. Referral of QOC Concerns that involve the network of subcontracted health plans to the specific health plan for Investigation and remediation.

d. Prioritization of actions needed to resolve immediate care needs when appropriate.

e. Identification of trends related to Members, Service Providers involved in the allegations, considering types and frequency of allegations, severity, and substantiation

status.

f. Research:

i. Fact-finding in accordance with Division Operations Policy 6002-F,

ii. Medical records review,

iii. Mortality review in accordance with Division Operations Policy 6002-M, and

iv. Incident closure and corrective actions in accordance with Division Operations Policy 6002-I.

7. The Division may request copies of a Member's death Certificate from the Arizona Department of Health Services Vital Records and Statistics as specified in A.A.C. R9-19-314 B(13) and A.A.C. R9-19-315(E).

8. The Division's Quality Management clinical staff shall conduct onsite visits when there are identified health and safety concerns, Immediate Jeopardy, or at the direction of AHCCCS. .

9. The Division shall report onsite visits that are identified and

conducted by the Division after 5:00 p.m. on weekdays, or that occur during weekends or on holidays, to the AHCCCS Division of Health Care Management (DHCM), Quality Management Manager or Supervisor by telephone and follow up with an email to CQM@AZAHCCCS.GOV the following business day.

10. Clinical Quality Management staff shall:
    a. Be the lead responsible for the review and Investigation, and
    b. Participate in the onsite visits.
11. Subject matter experts outside of the QMU:
    a. May participate in onsite visits when necessary and appropriate; but
    b. Shall not take the place of Quality Management staff during reviews.
12. The QMU shall complete and submit the AMPM 960 Attachment C form for each Health and Safety Onsite Review conducted to AHCCCS DHCM QM within 24 hours of completing the review as specified in Contract..
13. The Division shall,based on the findings of the review:

a. Take immediate action to ensure the health and safety of all Members receiving services at the facility or Service Provider site;

b. Ensure Incident resolution and identify any immediate care or recovery needs;

c. Develop work plans and corrective action plans to ensure placement setting or service site compliance with Arizona Department of Health Services Licensure and AHCCCS requirements regarding policy, training, and signage requirements aimed at preventing and reporting abuse, neglect, and exploitation as specified in AHCCCS Minimum Subcontract Provisions.

d. Conduct scheduled and unscheduled monitoring of placement setting or service sites that are in an Immediate Jeopardy status, have serious identified deficiencies that may affect health and safety of Members, or as directed by AHCCCS.

e. Assist in identification of technical assistance resources focused on achieving and sustaining regulatory

compliance.

f. Determine, implement, and document all appropriate interventions including an action plan to reduce or eliminate the likelihood of the concern reoccurring.

g. Monitor and document success of interventions.

h. Monitor placement settings or service sites upon completion of activities and interventions to ensure compliance is sustained.

i. Implements new interventions and approaches when necessary.

j. Incorporate interventions into the Division's QM program plan if successful.

14. The QMU shall process investigations and resolution of Member and systemic concerns in a timely manner based on the nature and severity of each case or as requested by AHCCCS.

a. For high profile cases the QMU shall communicate initial reports of immediate findings to Division Executive

Leadership and AHCCCS DHCM QM immediately but no later than 24 hours of the QMU becoming aware of the concern and followed up by an initial findings report within seven business days.

b. For Member safety or placement concerns, the QMU shall schedule a due date for the resolution of the case for 30 calendar days from the date of opening.

c. For other concerns, the QMU shall schedule a due date for the resolution of the case within 60 calendar days from the date of opening.

d. The QMU shall track concerns that have aged to greater than 60 calendar days and develop action plans to address these cases.

e. The QMU shall coordinate with the Division Business Operations to review all paid claims within the last calendar year to identify the need to participate in systemic Investigations when notified of Service Provider concern related to:

i. Single case agreements, or

ii. Service Providers using subcontracted Service Providers.

15. The Division shall submit all requests for extensions of timelines associated with a QOC Investigation to AHCCCS DHCM QM for approval as soon as possible but no later than the assigned due date and include at a minimum:

    a. The Member's current placement and condition,

    b. The status of the Investigation, and

    c. The barrier to completing the Investigation within the assigned time frame.

16. The Division shall update the QM Portal due date after approval has been received from AHCCCS QM.

17. The Division shall, upon request from AHCCCS QM, provide additional information or attend a meeting to review the case and discuss barriers affecting the investigative process if more than one extension request is required to complete a QOC Investigation.

18. The QMU shall determine the level of severity of the QOC Concern initially based on the information received and the allegations involved, including whether Immediate Jeopardy is an issue.

19. The QMU shall ensure the case is updated to reflect changes in the Severity Level, as needed, during the Investigation as additional details and allegations are discovered and added to the QOC.

20. The QMU shall ensure that a final Severity Level is assigned to the case at the conclusion of the Investigation.

21. The QMU shall ensure that concerns are reported to the appropriate regulatory agency including:

    a. The Department of Child Safety,

    b. Adult Protective Services,

    c. Arizona Department of Health Services (ADHS),

    d. The Attorney General's Office,

    e. Law Enforcement,

f. AHCCCS Office of the Inspector General (OIG),

g. AHCCCS DHCM QM,

h. Other entities as necessary.

22. The QMU shall submit the initial report to the regulatory agency in the format required by the regulatory agency as soon as possible but no later than 24 hours of becoming aware of the concern.

23. The QMU shall submit all pertinent information regarding an Incident of abuse, neglect, exploitation, serious Incident including suicide attempts, and unexpected death including all unexpected transplant deaths, to AHCCCS DHCM QM as specified in Contract and Division Medical Policy 961.

    a. The QMU shall not limit pertinent information to autopsy results;

    b. The QMU shall include a broad review of all issues and possible areas of concern.

c. The QMU shall not delay the Division's Investigation of a QOC based on delays in receipt of autopsy results; Investigation of a QOC Concern.

d. The QMU shall, when available, use delayed autopsy results to confirm the resolution of the QOC Concern.

24. The QMU shall ensure qualified vendors follow procedures for reporting Incidents, Accidents and death as directed in Chapter 70 of the Provider Manual and Division Medical Policy 961.

a. QMU shall take any action necessary, upon receipt of an Incident, Accident, Death (IAD) Report from a Service Provider, to ensure the safety of the people involved in the Incident.

b. The QMU shall review the IAD Report within 24 hours of receipt and make a determination of whether the Incident includes a QOC Concern.

c. The QMU shall review the IAD Report to ensure it is fully and accurately completed.

i. If the IAD Report is not fully and accurately

completed, the QMU shall return the IAD Report to the Service Provider for correction.

ii. The QMU shall ensure that the Service Provider returns the corrected IAD Report within 24 hours of receipt.

25. The QMU Investigative Nurses shall determine the level of substantiation of the QOC during their Investigation.

26. The Division shall evaluate and resolve Service issues that do not rise to the level of a QOC Concern through the Customer Service Center or Support Coordination.

27. The QMU shall provide written notification to the appropriate regulatory board or licensing agency, and AHCCCS, when a health care professional, organizational provider, or other provider's affiliation with its network is suspended or terminated for any reason, including those related to QOC issues.

a. The QMU shall document all referrals made to a regulatory agency in the AHCCCS QM Portal and include, at minimum, the following information:

i. Name and title of the person submitting the report.

ii. Name of the regulatory agency the report was submitted.

iii. Name and title of the person at the regulatory agency receiving the report.

iv. Date and time reported.

v. Summary of the report.

vi. Tracking number, as applicable, received from the regulatory agency as part of the reporting process.

28. Division staff shall document in the QOC file all follow-up actions or monitoring activities, as well as related observations or findings.

29. In the event of a Service Provider suspension or termination, the Division Network and Support Coordination staff shall work in collaboration to assess and address Member needs impacted by the actionand work with Members to identify options and prepare for transition to new Service Providers.

C. TRAINING, INTER-RATER RELIABILITY FOR INCIDENT AND QOC REVIEW

1. The Division shall provide training to QMU staff on all new and updated policies and procedures.
2. The Division shall submit training documentation to AHCCCS that includes training materials, printed name and title of QMU staff, and date of training received.
3. QM clinical staff shall complete all required investigative training and achievement of competencies prior to performing Investigations.
    a. QM clinical staff responsible for conducting onsite investigations shall complete required training on how to conduct the Investigation and avoid interference with substantiation or prosecution.
    b. All QM clinical staff that may investigate alleged Incidents in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs), skilled nursing facilities, assisted living facilities, and group homes for Individuals

with Intellectual Disabilities shall complete training on how to conduct Investigations considering the specific needs of individuals with intellectual and developmental disabilities.

c. The Division shall incorporate AMPM Policy 960 Attachment D guidance in the content requirements for training on Investigations involving individuals with intellectual and developmental disabilities.

4. All QM staff responsible for making determinations related to Incidents and QOC Concerns shall meet the requisite competencies and complete routine Inter-Rater Reliability (IRR) testing with a passing grade of 90 percent or higher.

a. QM staff who do not receive a passing grade of 90 percent or higher shall retake the exam.

b. The Division shall develop and implement an education plan for staff who do not receive a passing grade of 90 percent or higher on the repeat testing until a passing grade is achieved or the staff member is reassigned to a different position for which the training requirement is not

pertinent.

D. TRACKING AND TRENDING OF QOC AND SERVICE CONCERNS

1. The QMU shall conduct oversight through tracking and trending of Member and Service Provider concerns and making appropriate referrals for independent review as described in this section.
2. The QMU shall track and trend Member and Service Provider issues to identify and address quality assurance issues and opportunities for quality improvement.
3. The Division shall provide training to QMU staff on the process for analyzing QM related data.
4. The Division shall submit training documentation to AHCCCS that includes training materials, printed first and last name of QMU staff, title, and date of training received.
5. The QMU shall document, track, trend, and evaluate complaints and allegations received from Members and Service Providers, or as requested by AHCCCS, inclusive of quality care, Immediate Jeopardy, deaths, quality of service, and immediate care need issues.

6. The QMU staff and QM/PI Committee shall analyze and evaluate the information from the tracking and trending system to identify and address any trends related to Members, Service Providers, the QOC process or services in the Division's service delivery system or Service Provider network.
7. The QMU shall incorporate trending of QOC issues in determining systemic interventions for quality improvement.
8. The QMU shall submit for review and consideration for action tracking and trending information to the Division's Quality Management Committee and Chief Medical Officer, or designated Medical Director, as Chairman of the Quality Management Committee.
9. The QMU shall develop performance improvement activities based on input from Division Executive Leadership, the Division Chief Quality Officer, and the Division Chief Medical Officer to respond to significant negative trends, including the issue resolution process itself, and address other system issues raised during the resolution process.
10. The QMU shall share tracking and trending information related to

Service Provider education, training and staff credentialing with the workforce development operations as specified in Division Operations Manual Policy 407.

11. The QMU shall refer QOC Concerns identified through tracking and trending to the following committees as appropriate:
    a. QM/PI Committee established in accordance with Division Medical Policy 910,
    b. Peer Review Committee established in accordance with Division Medical Policy 910,
    c. Mortality Review Committee, and
    d. Independent Oversight Committees established by A.R.S. 41-3801.
12. The QMU shall comply with federal and state confidentiality laws, including the Health Insurance Portability and Accountability Act (HIPAA) and 42 C.F.R. 431.300 et seq regarding Member record availability and accessibility.
13. The QMU shall maintain information related to coverage and payment issues for at least five years following resolution of the issue in accordance with Division Operations Manual Policy

6001-I, and is made available to the Member, Service Provider, and AHCCCS authorized staff upon request.

14. Support Coordination shall proactively facilitate care coordination for Members who have multiple complaints, regarding services or the AHCCCS Program. 15. Support Coordination shallwork with the Division's Office of Individual and Family Affairs or care coordination provided by the Administrative Services Subcontractors (AdSS) to facilitate and address Member complaints as a proactive measure to promote better service delivery and health outcomes.
15. QMU shall identify opportunities for improvement of care coordination in cases of multiple complaints from a single Member and monitor resolution of these complaints using tracking and trending data.

E. PEER REVIEW COMMITTEE

1. The QMU Chief Medical Officer shall refer cases, as appropriate, to the Division's Peer Review Committee.
2. The Peer Review Committee shall review the following:

    a. Cases where there is evidence of deficient quality by a

participating or non-participating physical or behavioral health care professional, or long-term services and supports (LTSS) Service Provider, whether delivered in or out of state.

b. Cases where there is omission of care or service that should have been provided by a participating or non-participating physical or behavioral health care professional, or Long Term Service and Support Service Provider, whether delivered in or out of state.

c. Oversight of the AdSS Peer Review Committee actions and remediations.

3. The Division shall not substitute referral to the Peer Review Committee for implementing interventions aimed at individual and systemic quality improvement.

4. The QMU shall document Peer Review referrals as well as high-level summary information in the QOC file within the AHCCCS QM Portal and include documentation of the specific credentials of the involved Committee members.

5. The Peer Review Committee may include the following recommendations as applicable:
   a. Education/training/technical assistance
   b. Follow-up monitoring and evaluation of improvement
   c. Changes in processes, organizational structures, forms
   d. Informal counseling
   e. Termination of affiliation, suspension, or limitation of the Service Provider
   f. Referrals to regulatory agencies
   g. Other actions as determined by the Division.
6. If an Adverse Action is taken with a Service Provider for any reason including those related to a QOC Concern, QMU shall report the Adverse Action, including limitations and terminations, to the AHCCCS DHCM Quality Management (QM) Unit as well as to the National Practitioner Data Bank as specified in Contract..
7. The QMU shall notify AHCCCS DHCM QM and take appropriate action with the Service Provider, including suspension or corrective action plans and referrals to appropriate regulatory Boards,when an adverse outcome including mortalities due to

prescribing concerns or failure of the Service Provider to check the Controlled Substance Prescription Monitoring Program (CSPMP), to coordinate care with other prescribers, or to refer for substance use treatment or pain management is identified.

8. The QMU shall present case findings ,as appropriate, to the Division's Peer Review Committee and Credentialing Committee for review and recommendations to the QM/PI Committee for discussion and recommendations to leadership.

9. QM/PI Committee shall monitor the following related to QOC Concerns:

    a. Trending

    b. Corrective Action Plans

    c. Resolution

10. The Division's Medical Director:

    a. Shall be a member of the AdSS' Peer Review Committee, and

    b. Shall provide quarterly summaries of Service Providers s reviewed by the AdSS' Peer Review Committees to the

Division's Peer Review Committee.:

11. The Division's Peer Review Committee shall review the quarterly summaries of Service Providers reviewed by the AdSS to determine whether:

    a. The action taken by the AdSS Peer Review Committee is sufficient to protect Division Members, and

    b. If further action from the Division is necessary.

F. REPORTING TO INDEPENDENT OVERSIGHT COMMITTEES

1. The Division shall provide IAD Reports, Internal Referral (IRF) Reports, and QOC Concerns, including reports of possible abuse, neglect, or denial of rights involving any Division enrolled Member, to the Division's Independent Oversight Committee (IOC) assigned to the region in which the IAD, IRF, or QOC occurred within three business days of closure of the Incident.
2. The QMU shall incorporate IADs and IRFs that are triaged as potential QOC Concerns into the QOC record and submit to the IOC as part of the QOC documentation upon completion of the QOC Investigationinstead of a standalone IAD or IRF as specified in (1) of this section.

3. The QMU shall redact in accordance with federal and state confidentiality laws all Personally Identifiable Information (PII) in all reports provided to the IOC.
4. The Division shall provide the following reports to the IOC:
    a. Seclusion and Restraint Reports,
    b. IAD Reports,
    c. IFR Reports, and/or
    d. QOC Investigations as applicable.
    e. Reports of possible abuse, neglect, or denial of rights involving any behavioral health provider as specified in the contract.
5. The Division and contracted Service Providers who receive an IOC request for additional or unaltered documentation, supplemental information, or an Investigation regarding an AHCCCS Member, shall submit the request to AHCCCS via email at: iocinquiries@azahcccs.gov.
6. The Division shall provide to the AHCCCS Independent Oversight Committee assigned to the region in which the IAD, IRF, or QOC occurred AD Reports, IRF Reports, and QOC

Concerns, including reports of possible abuse, neglect, or denial of rights, involving any behavioral health provider serving Members with a Serious Mental Illness designation, children, and anyone under court order for either Court-Ordered Evaluation or Court-Ordered Treatment, are provided within three business days of closure.

F. REQUESTS FOR PERSONALLY IDENTIFIABLE INFORMATION OR PROTECTED HEALTH INFORMATION

1. The Division shall do the following if AHCCCS or an IOC requests information regarding the outcome of a report of possible abuse, neglect, or violation of rights:

    a. Conduct an Investigation of the Incident if one has not been conducted.

        i. For Incidents in which a Member with an Serious Mental Illness (SMI) designation is the possible victim, the Investigation follows the requirements specified in A.A.C. Title 9, Chapter 21, Article 4, or

        ii. For Incidents in which a currently or previously

enrolled child or non-seriously mentally ill adult is the possible victim, the Investigation is completed within 35 days of the request and shall determine, from all information surrounding the Incident, whether the Incident constitutes abuse, neglect, or a violation of rights, and any corrective action needed as a result of the Incident.

b. If an Investigation has been conducted, and can be disclosed without violating any confidentiality provisions, provide the final Investigation decision to AHCCCS and the IOC with the following information:

i. The accepted portion of the Investigation report with respect to the facts found,

ii. A summary of the Investigation findings, and

iii. Conclusions and corrective action taken.

2. The Division shall only release PII or PHI concerning a currently or previously enrolled Member to the IOC if:

a. The IOC demonstrates that the information is necessary to perform a function that is related to the IOC's oversight of the behavioral health system, or

b. The IOC has written authorization from the Responsible Party to review requested PII and PHI.

3. If the Division determines that the IOC needs PII or PHI or that the IOChas obtained the Responsible Party's written authorization, the QMU shall first review the requested information and determine if it contains any communicable disease-related information, including confidential Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) information, or information concerning diagnosis, treatment, or referral from an alcohol or drug use program, or as described in A.R.S. §41-3804.

a. If no information detailed in (3) of this Section is found, the QMU shall provide the requested information to the IOC.

b. If information detailed in (3) of this Section is found, the

QMU shall contact the Responsible Person and ask if the Responsible Person is willing to sign an authorization for the release of communicable disease-related information, including confidential HIV information, or information concerning diagnosis, treatment or referral from an alcohol or drug use program, or as described in A.R.S. §41-3804, and provide the name and telephone number of a contact person with the IOC who can explain the Committee's purpose for requesting the protected information.

i. If the Responsible Person agrees to give authorization, a written authorization is obtained as outlined below and requested information provided to the IOC.

ii. If the Responsible Person does not agree to give authorization, the information is not included or it is redacted from any documentation which is authorized to be disclosed.

4. The Division shall accept authorization for the disclosure of

records of deceased Members made by the executor, administrator, or other personal representative appointed by Will or by a court to manage the deceased Member's estate. If no personal representative has been appointed, the Division shall upon request disclose PII and PHI to a family member, other relative, or a close personal friend of the deceased Member, or any other person identified by the deceased, only that PII and PHI directly relevant to such person's involvement with the deceased Member's health care or payment related to the individual's health care.

5. The Division shall provide requested information that does not require authorization within 15 working days of the request.

6. The Division shall provide the requested information that does require authorization within five working days of receipt of the written authorization.

7. The QMU shall include a cover letter when PII or PHI is sent to the IOC that states that the information is confidential, is for the official purposes of the Committee, and is not to be re-released

under any circumstances.

8. If the QMU denies the IOC's request for PII or PHI:

   a. The QMU shall notify the IOC within five working days of the decision that a request is denied, the specific reason for the denial, and that the Committee may request, in writing, that the Division's Deputy Director or designee review this decision.

   b. The Division shall only accept The Committee's request to review the denial if the request is received within 60 days of the first scheduled Committee meeting after the denial decision is issued.

   c. The Division's Assistant Director or designee shall conduct the review within five business days after receiving the accepted request for review.

   d. The Division shall consider the Division's Assistant Director or designee's decision the final agency decision pending any follow-up judicial review pursuant to A.R.S. Title 12,

Chapter 7, Article 6.

e. The Division shall not release related information or records related to the request during the timeframe for filing a request for judicial review or when judicial review is pending.

G. AUTHORIZATION REQUIREMENTS

1. The Division shall only accept a written authorization for disclosure of information concerning diagnosis, treatment, or referral from an alcohol or substance use program or communicable disease-related information, including confidential HIV information that contains the following information:

   a. The specific name or general designation of the program or person permitted to make the disclosure.

   b. The name or title of the individual or the name of the organization to which the disclosure is to be made.

   c. The name of the currently or previously enrolled Member.

   d. The purpose of the disclosure.

e. How much and what kind of information is to be disclosed.

f. The signature of the currently or previously enrolled Member/legal guardian, and if the currently or previously enrolled Member is a minor, the signature of a person authorized to give consent.

g. The date on which the authorization is signed.

h. A statement that the authorization is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it.

i. The date, event, or condition upon which the authorization will expire if not revoked before. This date, event, or condition must ensure that the authorization will last no longer than reasonably necessary to serve the purpose for which it is given.

j. A statement that this information has been disclosed to the recipient from records protected by federal confidentiality

rules (42 CFR Part 2) and state statute on confidentiality of HIV/AIDS and other communicable disease information (A.R.S. §36-664(H)) which prohibit further disclosure of this information unless further disclosure is expressly permitted by the written consent of the Member to whom it pertains, or as otherwise permitted by 42 CFR Part 2 and A.R.S §36-664(H).

2. The Division shall track in accordance with the Record of Access described in Division Operations Manual Policy 6001-C information released pursuant to a valid authorization.

H. DUTIES AND LIABILITIES OF BEHAVIORAL HEALTH PROVIDERS IN PROVIDING BEHAVIORAL HEALTH SERVICES

The Division shall require the Administrative Services Subcontractors to develop policies and procedures that provide guidance to behavioral health providers regarding their duty to warn under A.R.S. §36-517.02.

I. PROVIDER-PREVENTABLE CONDITIONS

1. The Division shall not provide payment for services related to

Provider-Preventable Conditions pursuant to 42 CFR 447.26

2. The Division shall review the AdSS' required report for evidence of Provider-Preventable Conditions quarterly as described in the AdSS Medical Policy 960.

3. If Provider- Preventable Conditions are identified, the Division shall open a QOC Investigation within the AHCCCS QM Portal and direct the AdSS to conduct an Investigation if it has not already done so.

Signature of Chief Medical Officer: Anthony Dekker (Aug 10, 2023 17:31 PDT)
Anthony Dekker, D.O.

961 INCIDENT, ACCIDENT, AND DEATH REPORTING

REVISION DATE: 8/9/2023

EFFECTIVE DATE: May 11, 2022

REFERENCES: Division Medical Policies 960, 962, 1020, 1230-A; Division Operations Policy 417; A.R.S. §8-201(2), §14-1501, §36.551.01, §46-451, §41-3801, §41-3803, §41-3804; A.A.C. R9-10-101, R9-21-105.

PURPOSE

The purpose of this policy is to establish the requirements for the reporting, reviewing, and monitoring of Incident, Accident, Death (IAD) of Members enrolled with the Division of Developmental Disabilities (Division).

DEFINITIONS

1. "Abuse" means the infliction of, or allowing another individual to inflict, or cause, physical pain or injury, impairment of bodily function, disfigurement or serious emotional damage which may be evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior. Such Abuse may be caused by acts or omissions of an individual having responsibility for the care, custody or control of a Member receiving behavioral health services or community services. Abuse shall also include sexual misconduct, assault, molestation,

incest, or prostitution of, or with, a Member under the care of personnel of a mental health agency. A.A.C. R9-21-101(B).

2. "AHCCCS" means Arizona Health Care Cost Containment System.
3. "Community Complaint" means a complaint from the community that puts a Member or the community at risk of harm.
4. "Death No Provider Present" means death of a Member living independently or with family and no Provider is being paid for service provision at the time of death.
5. "Expected Death" means a natural death, and may include deaths from long-standing, progressive medical conditions or age-related conditions.
6. "High Profile Case" means a case that attracts or is likely to attract attention from the public or media.
7. "Human Rights Violation" means a violation of a Member's rights, benefits, and privileges guaranteed in the constitution and laws of the United States and the state of Arizona. Human rights are defined in A.R.S. §36.551.01 as a violation of a Member's dignity or personal choice, violations of privacy, the right to open mail, send and receive phone calls, access to one's own money, choosing what to eat, etc.
8. "Incident, Accident, Death" means an unexpected occurrence that

harms or has the potential to harm a Member and is:

a. On the premises of a health care institution, or

b. Not on the premises of a health care institution and directly receiving physical health services or behavioral health services from a personnel member who is providing the physical health services or behavioral health services on behalf of the health care institution as specified in A.A.C. R9-10-101.

9. "Independent Oversight Committee" is a committee established by State Statute to provide independent oversight and to ensure the rights of certain individuals with developmental disabilities and persons who receive behavioral health services are protected as defined in A.R.S. §§41-3801, 41-3803, 41-3804, and A.A.C. R9-21-105.

10. "Internal Referral" means, for the purpose of this policy, a report entered into the AHCCCS Quality Management Portal by an employee of the Division to document an occurrence that harms or has the potential to harm a Member, and to report the death of a Member.

11. "Medication Error" means that one or more of the following has occurred:

a. Medication given to the wrong person,

b. Medication given at the wrong time or not given at all,

c. Wrong medication dosage administered,

d. Wrong method of medication administration, or

e. Inappropriate wastage of a Class II substance.

12. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

13. "Physical Abuse" means intentional infliction of pain or injury to a Member.

14. "Programmatic Abuse" means aversive stimuli techniques not approved as part of a member's plan. This can include isolation, restraints, or not following an approved plan or treatment strategy.

15. "Provider" means, for the purpose of this policy, any individual or entity that is engaged in the delivery of services to Division Members, or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services, as specified in 42 CFR 457.10 and 42 CFR 438.2.

16. "Sentinel Event" means an unexpected event that results in the death of a member, serious physical injury of a member, or severe psychological harm of a member, and requires an immediate investigation and response.

17. "Serious Injury" means any type of injury requiring medical care or treatment beyond first aid, such as assessment or treatment in an

emergency room, treatment center, physician's office, urgent care, or admission to a hospital.

18. "Sexual Abuse" means any inappropriate interactions of a sexual nature toward or solicited from a Member with developmental disabilities.
19. "Unexpected Death" means a sudden death and may include motor vehicle accidents, suicides, accidental drug overdoses, homicides, acute myocardial infarction or strokes, trauma, sudden deaths from undiagnosed conditions, or generic medical conditions that progress to rapid deterioration.
20. "Verbal/Emotional Abuse" means remarks or actions directed at a Member enrolled in the Division that are ridiculing, demeaning, threatening, derogatory, or profane.

POLICY

A. MINIMUM REQUIREMENTS FOR IAD REPORTING

1. The Division shall submit reportable Incident, Accident, Death (IAD), and Internal Referrals to AHCCCS via the AHCCCS Quality Management (QM) Portal within two business days of the occurrence or notification of the occurrence.

2. The Division shall submit Sentinel IADs to AHCCCS via the AHCCCS QM Portal within one business day of the occurrence or notification of the occurrence.

3. The Division shall notify AHCCCS of all Sentinel Events via email at CQM@ahcccs.gov as soon as possible, but within 24 hours of notification of the occurrence.

4. The Division shall consider the following to be reportable IADs:

    a. Allegations of abuse, neglect, or exploitation of a Member.

    b. Allegations of Human Rights Violations.

    c. Substance use disorders and opioid-related concerns.

    d. Death of a Member.

    e. Delays or difficulties in accessing care outside of the timeline specified in Division's Operations Policy 417.

    f. Healthcare acquired conditions and other provider preventable conditions as specified in Division Medical Policy 960.

    g. Serious Injury.

    h. Injury resulting from the use of a personal, physical, chemical or mechanical restraint, or seclusion as specified

in Division Medical Policy 962.

i. Medication Error occurring at a licensed residential Provider site including:

i. Division Group Home,

ii. Division Adult Developmental Home,

iii. Child Developmental Home,

iv. Assisted Living Facility,

v. Skilled Nursing Facility,

vi. Behavioral Health Residential Facility,

vii. Adult Behavioral Health Therapeutic Home,

viii. Therapeutic Foster Care Home, or

ix. Any other alternative Home and Community Based Service setting as specified in Division Medical Policy 1230-A.

j. Missing Member from a licensed Behavioral Health Inpatient Facility, Behavioral Health Residential Facility, Division Group Home, Assisted Living Facility, Skilled Nursing Facility, Intermediate Care Facility, Adult Behavioral Health Therapeutic Home, or Therapeutic Foster Care.

k. Member suicide attempt.

l. Suspected or alleged criminal activity involving or affecting a Member.

m. Community Complaint about a resident or the setting.

n. Provider or Member fraud.

o. Allegations of Physical, Sexual, Programmatic, Verbal/ Emotional Abuse.

p. Allegations of inappropriate sexual behavior.

q. Theft or loss of Member monies or property less than $1,000.

r. Property damage estimated to be less than $10,000.

s. Community disturbances in which the Member or the public may have been placed at risk.

t. Environmental circumstances which pose a threat to the health, safety, or welfare of Members, such as loss of air conditioning, loss of water, or loss of electricity.

u. Unplanned hospitalization or emergency room visit in response to an illness, injury, Medication Error.

v. Unusual weather conditions or other disasters resulting in an emergency change of operations impacting the health

and safety of a Member.

w. Illegal substance use by Provider or Member.

x. Any other incident that causes harm or has the potential to cause harm to a Member.

2. The Division shall consider the following to be reportable IAD Sentinel Events:

a. Member death or Serious Injury associated with a missing Member.

b. Member suicide, attempted suicide, or self-harm that results in Serious Injury while being cared for in a healthcare setting.

c. A 9-1-1 call due to a suicide attempt by a Member.

d. Member death or Serious Injury associated with a Medication Error.

e. Member death or Serious Injury associated with a fall while being cared for in a healthcare setting or any other setting where the Division has oversight responsibility.

f. Any stage 3, stage 4, or any unstageable pressure ulcers acquired after admission or presentation to a healthcare setting.

g. Member death or Serious Injury associated with the use of seclusion or restraint while being cared for in a healthcare setting.

h. Sexual Abuse or assault of a Member during the provision of services.

i. Death or Serious Injury of a Member resulting from a physical assault that occurs during the provision of services.

j. Homicide committed by or allegedly committed by a Member.

k. A circumstance that poses a serious and immediate threat to the physical or emotional well-being of a Member or staff.

l. Severe physical injury that does any of the following:

   i. Creates a reasonable risk of death,

   ii. Causes serious or permanent disfigurement, or

   iii. Causes serious impairment of a Member's or worker's health.

m. Reporting to law enforcement officials because a Member is missing and presumed to be in imminent danger.

n. Reporting to law enforcement officials due to possession or use of illegal substances by Members or Providers.

o. An incident or complaint from the community that could be or is reported by the media.

p. Property damage estimated in excess of $10,000.

q. Theft or loss of Member monies or property of more than $1,000.

B. QUALITY MANAGEMENT RESPONSIBILITIES

1. The Quality Management Unit (QMU) shall conduct an initial review of all IADs within one business day of Provider submission. An initial review shall include the following:

   a. Identification of any immediate health and safety concerns and ensure the safety of the individuals involved in the incident, which may include that immediate care and recovery needs are identified and provided.

   b. Determination if the IAD report needs to be returned to the Provider for additional information, to correct inaccurate information, or to provide missing information.

   c. Determination if the IAD report requires further

investigation through a quality of care investigation as specified in Division Medical Policy 960.

d. Determination if the IAD needs to be linked to a corresponding Seclusion and Restraint Individual Reporting Form.

e. Determination that the report does not need further documentation or review, and closure of the report.

2. The QMU shall follow up on all IADs returned to a Provider within one business day to ensure the Provider is aware that the report has been returned and is addressing the required corrections.

3. The QMU shall take immediate action to ensure the safety of Members where allegations of harm or potential harm exist, regardless of status assigned to the IAD, including those returned to the Provider.

4. The QMU shall report all suspected cases of abuse, neglect, or exploitation of a Member to the appropriate reporting authorities if not reported directly by the Provider, as specified in Division Operations Policy 6002-G.

5. The QMU shall track and trend IADs to identify and address

systemic concerns or issues within its Provider network.

6. The QMU shall provide IAD reports to the appropriate Independent Oversight Committees, as applicable, and as specified in Division Medical Policy 960 and A.R.S. 41-3801 et seq.

C. DIVISION OVERSIGHT AND MONITORING OF ADSS

1. The Division shall monitor the AdSS' compliance of the requirements set forth in AdSS Medical Policy 961 through AdSS' tracking and trending reports submitted to the Division.
2. The Division shall also conduct Annual AdSS Operational Reviews to ensure compliance to AdSS Medical Policy 961 and associated procedures.

Signature of Chief Medical Officer: Anthony Dekker (Aug 3, 2023 13:19 PDT)
Anthony Dekker, D.O.

962 REPORTING AND MONITORING OF SECLUSION AND RESTRAINT

REVISION DATE: 8/9/2023
EFFECTIVE DATE: September 14, 2022
REFERENCES: A.A.C. R9-10-101, R9-10-225, R9-10-226, R9-10-316, R9-10-1012, R9-21-101, R9-21-204; A.R.S. §36- 501, §41-3804 (K); 42 CFR 482.13(e)(1)(i)(B), AHCCCS Medical Policies 961 and 960

PURPOSE

To set forth the requirements applicable to the Division of Developmental Disabilities (Division) to provide oversight and monitoring of Seclusion and Restraint reporting for Members served by the Division, regardless of their health plan enrollment, in all state licensed Behavioral Health Inpatient Facilities, Mental Health Agencies, and out-of-state facilities providing behavioral health services to Division Members.

DEFINITIONS

1. "Behavioral Health Inpatient Facility" means, as defined in A.A.C. R9-10-101, a health care institution licensed by the Arizona Department of Health Services that provides continuous treatment to individuals experiencing behavioral health issues that causes that

individual to:

a. Have a limited or reduced ability to meet basic physical needs;

b. Suffer harm that significantly impairs judgment, reason, behavior, or capacity to recognize reality;

c. Be a danger to self or others;

d. Be persistently or acutely disabled as defined in A.R.S. §36-501; or

f. Be gravely disabled.

2. "Incident of Seclusion and Restraint" means an occurrence of Seclusion or Restraint that begins at the time a behavior necessitating Seclusion or Restraint begins and ends when the behavior has resolved for more than ten minutes.

3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

4. "Mental Health Agency" means a regional authority, service provider, inpatient facility, or outpatient treatment center licensed to provide behavioral health observation/stabilization services (Crisis Facility), licensed to perform Seclusion and Restraint as specified in A.A.C. R9-10-225, A.A.C. R9- 10-226, A.A.C. R9-10-316 and A.A.C. R9-10-1012.

5. "Personally Identifiable Information" means a person's name, address, date of birth, social security number, tribal enrollment number, telephone or fax number, email address, social media identifier, driver license number, places of employment, school identification or military identification number, or any other distinguishing characteristic that tends to identify a particular person as specified in A.R.S. §41-3804 (K).
6. "Restraint" means personal Restraint, mechanical Restraint, or drug used as a Restraint, and is the following:
    a. Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a Member to move their arms, legs, body, or head freely.
    b. A drug or medication when it is used as a restriction to manage a Member's behavior or restrict the Member's freedom of movement and is not a standard treatment or dosage for the Member's condition as specified in 42 CFR 482.13 (e)(1)(i)(B). Chemical Restraints shall be interpreted and applied in compliance with the Center for Medicaid Services (CMS) State Operations Manual, Appendix A at A-0160 for Regulations and

Interpretive Guidelines for Hospitals.

c. A Restraint does not include devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a Member for the purpose of conducting routine physical examinations or tests, or to protect the Member from falling out of bed or to permit the Member to participate in activities without the risk of physical harm. This does not include a physical escort.

7. "Seclusion" means the involuntary solitary confinement of a Member in a room or an area where the Member is prevented from leaving as specified in A.A.C. R9-10-101.

8. "Seclusion of Members Determined to Have A Serious Mental Illness" means the restriction of a Member to a room or area through the use of locked doors, or any other device or method which precludes a Member from freely exiting the room or area, or which a Member reasonably believes precludes their unrestricted exit.

a. In the case of an inpatient facility, confining a Member to the facility, the grounds of the facility, or a ward of the facility does

not constitute Seclusion.

b. In the case of a community residence, restricting a Member to the residential site, according to specific provisions of a service plan or court order, does not constitute Seclusion, as specified in A.A.C. R9-21-101(B).

POLICY

A. SECLUSION AND RESTRAINT

1. The Division shall require that the use of Seclusion and Restraint (SAR) be used to the extent permitted by and in compliance with A.A.C. R9-10-225, A.A.C. R910-316, and A.A.C. R9-21-204.
2. The Division shall require that any incident involving the use of SAR be reported as described in this policy to the Arizona Health Care Cost Containment System (AHCCCS), Division of Community Advocacy and Intergovernmental Relations, Office of Human Rights, and the appropriate Independent Oversight Committee (IOC) via collaboration with the AHCCCS Division of Health Care Management, Quality Management (QM) IOC Manager.

3. The Division shall require all interventions used during each incident of SAR be documented in a single individual report including all required components of each type of intervention used to manage the behavior.

B. DIVISION OVERSIGHT AND MONITORING OF REPORTING REQUIREMENTS

1. The Division shall require the AdSS to follow the reporting requirements as specified in this policy.

2. The Division shall require the AdSS utilizing any out-of-state facility to provide behavioral health services to Division Members, to ensure the facility agrees to and follows all reporting requirements as specified in AdSS Medical Policy 962 as a part of the contracted single case agreement.

3. The Division shall require the AdSS to submit individual reports of Incidents of SAR involving Division Members directly to the AHCCCS QM Portal within five business days of the incident using AMPM Policy 962 Attachment A or the agency's electronic medical record that includes all elements listed on AMPM Policy

962, Attachment A. If the use of SAR requires face-to-face monitoring, as specified in A.A.C. R9-21-204, a supplemental report shall be submitted as an attachment to the individual report.

4. The Division shall require the AdSS to have a process in place to ensure incidents of SAR that result in an injury or complication requiring medical attention are reported to the AdSS within 24 hours of the incident.

B. SUBMITTING INDIVIDUAL REPORTS OF SAR TO THE AHCCCS QM PORTAL

1. The Division shall review all individual reports of SAR submitted through the AHCCCS QM Portal by the AdSS and their service providers as specified in contract.

2. The Division shall ensure that the original AMPM 962 Attachment A or electronic medical record received from the service provider is attached to the record within the AHCCCS QM Portal.

3. The Division shall ensure individual reports of SAR are linked to any connected Incident, Accident or Death (IAD), Internal

Referral (IRF), or Quality of Care (QOC) Concern process within the AHCCCS QM Portal as specified in Division Medical Policy 960.

C. SUBMITTING INDIVIDUAL SAR REPORTS TO THE IOC

1. The Division shall ensure that all individual SAR Reports involving behavioral health service providers are uploaded within the AHCCCS QM Portal for IOC review as specified in contract.

2. The Division shall ensure that all reports uploaded for IOC review have all Personally Identifiable Information removed prior to submission as specified in A.R.S. §41-3804. If the use of SAR requires face-to-face monitoring, as outlined in A.A.C. R9-21-204, a supplemental report shall be submitted as an attachment to each individual report.

3. The Division shall ensure that the disclosure of protected health information is in accordance with state and federal laws.

D. OVERSIGHT, MONITORING, TRACKING AND TRENDING

1. The Division's Quality Management Unit (QMU) shall monitor the

AdSS' compliance to these reporting standards and AdSS Medical Policy 962 through review of SAR reports entered in the AHCCCS QM Portal and during the annual review process.

2. The Division's QMU shall track and trend the use of SAR for all Members, including Members at the Arizona State Hospital, and prepare quarterly reports for the Quality Management/Performance Improvement (QM/PI) Committee based on the data.

3. The QM/PI Committee shall review the quarterly reports, SAR incidents and recommendations for improvement, and develop recommendations to ensure Member safety and quality improvement.

4. The QM Medical Director shall review any QOC Concerns involving the inappropriate use of SAR on a monthly basis and identify opportunities for improvement and make recommendations to the Chief Medical Officer.

Signature of Chief Medical Officer: Anthony Dekker (Aug 3, 2023 12:37 PDT)
Anthony Dekker, D.O.

SUPPLEMENTAL INFORMATION

1. The AHCCCS OHR and the IOCs review SAR reports to determine if there has been inappropriate or unlawful use of SAR and to determine if SAR may be used in a more effective or appropriate fashion.
2. If the AHCCCS OHR or any IOCs determine that SAR has been used in violation of any applicable law or rule, the OHR or IOC may take whatever action is appropriate in accordance with their applicable regulation(s) and, if applicable, A.A.C. R9-21-204.
3. AHCCCS requires BHIFs and Mental Health Agencies providing services to FFS Members, except THP Members enrolled to receive behavioral health services with a Regional Behavioral Health Agency, submit individual SAR reports directly to the AHCCCS DCAIR OHR via email at OHRts@azahcccs.gov and to the AHCCCS DHCM QM IOC Manager using AMPM 962 Attachment A or the agency's electronic medical record that includes all elements listed on Attachment A concerning the use of SARs involving Members with a Serious Mental Illness designation within five business days of the occurrence of the incident. If the use of SARs requires face-to-face monitoring, a supplemental report shall be submitted as an attachment to each individual report.

966 IMMEDIATE JEOPARDY

EFFECTIVE DATE: April 20, 2022
REFERENCES: AMPM Chapter 900, Policy 960, Division Medical Manual Policy 960, 950, AdSS Medical Manual Policy 960

Purpose

This policy establishes the requirements applicable to the Division of Developmental Disabilities (Division) when the Arizona Health Care Cost Containment System (AHCCCS) notifies the Division with a report of immediate jeopardy (IJ), or the Division becomes aware of a situation that may elevate to the level of immediate jeopardy.

Scope

This policy applies to the Division's activities in investigating and resolving incidents involving allegations of immediate jeopardy.

Definitions

Immediate Jeopardy **-** A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a member. An immediate jeopardy situation is one that is clearly identifiable due to the severity of its harm or likelihood for serious harm and the immediate need for it to be corrected to avoid further or future serious harm.

Emergency Measure - The use of physical management techniques (Prevention and Support Intervention Techniques) in an emergency to manage a sudden, intense, or out of control behavior.

Policy

The Division ensures the health, well-being and safety of all members where a situation may present as immediate jeopardy. The Division takes action to remediate/remove any immediate jeopardy situation.

A. AHCCCS Notification of Immediate Jeopardy

1. During Normal Business Hours.

AHCCCS sends an email to the Division Quality Management Unit (QMU) mailbox and Chief Medical Officer, Chief Quality Officer and/or their designee, which details an immediate jeopardy situation. Notification of the immediate jeopardy situation requires the QMU team to conduct an investigation to determine member(s) status and remediate the IJ situation immediately but no later than 24-hours after the IJ notification. In the event other Division departments are involved with the Immediate Jeopardy situation, the QMU team holds ultimate accountability for resolving the IJ issue within the 24-hour timeframe. The following steps occur when an IJ is reported to the QMU:

a. QMU staff determines and verifies whether the situation impacts Division member(s) and/or provider(s).

b. Once verification is determined that Division member(s) are involved, QMU schedules an immediate health/safety monitoring visit within 24 hours. The Division notifies AHCCCS of the identity of the members involved.

c. QMU responds to AHCCCS on the member status based upon the monitoring report using the immediate jeopardy form (AHCCCS Medical Policy Manual [AMPM] 960 Attachment C Health and Safety Update Onsite Review Form) within the 24-hour timeline.

d. QMU notifies relevant Division staff and Department chain-of-command, as appropriate and required.

e. Information regarding any findings from the visit are forwarded to QMU as soon as the visit is completed using 960 Attachment C Health and Safety Onsite Review Form. The Incident Specific Health and Safety Assessment form is completed for each member identified in the incident report and in addition to other required information specifies the immediate steps taken to secure the safety of the resident.

f. If the immediate jeopardy situation affects Division member(s) in an acute care funded facility, the Division-contracted Administrative Services Subcontractor (AdSS) plan is notified to complete steps a, b, and e and send the response to the QMU to assess and respond to AHCCCS within 24-hours.

g. If the IJ situation arises late in the business day, the District on-call person is notified that they may be receiving a report after hours. In the event the District on-call person believes the immediate jeopardy team needs to convene, they will call the Chief Quality Officer (CQO) or designee and the CQO will initiate the call tree.

2. After Normal Business Hours.

The Division's After Hours staff contacts the District on call staff with any reports of immediate jeopardy that require follow-up within 24-hours. The designated staff on call in each District will contact the QMU Chief Quality Officer or their designee to initiate coordination of immediate jeopardy investigation and follow-up to include steps 1 a-e listed above.

B. Division Identification of Immediate Jeopardy

1. During Normal Business Hours.

When the Division becomes aware of an immediate jeopardy situation from any source involving Division members, QMU staff assume responsibility of the IJ situation/issue. In the event other Division departments are involved with the

Immediate Jeopardy situation, the QMU team holds ultimate accountability for resolving the IJ issue within the 24-hour timeframe. The following steps are completed within 24-hours of notification/identification of the immediate jeopardy situation:

a. QMU staff determines and verifies whether the situation affects Division member(s) and/or provider(s).

b. Once verification is determined that a Division member(s) are involved, QMU schedules an immediate health/safety monitoring visit within 24 hours. The Division notifies AHCCCS of the identity of the members involved.

c. QMU reports to AHCCCS the immediate jeopardy situation, on the members impacted and the member status based upon the monitoring report using the immediate jeopardy form (AMPM 960 Attachment C Health and Safety Update Onsite Review Form) within the 24-hour timeline.

d. QMU notifies relevant Division staff and Department chain-of-command, as appropriate and required.

e. Information regarding any findings from the visit are forwarded to QMU as soon as the visit is completed using 960 Attachment C Health and Safety Onsite Review Form. The Incident Specific Health and Safety Assessment form is completed for each member identified in the incident report and in addition to other required information specifies the immediate steps taken to secure the safety of the resident.

f. If the immediate jeopardy situation affects Division member(s) in an acute care funded facility, the Division-contracted AdSS is notified to complete steps a-c and send the response to the QMU to assess and respond to AHCCCS within 24-hours.

g. If the IJ situation arises late in the business day, the District on-call person is notified that a report may be sent after hours. In the event the District on-call staff believes the immediate jeopardy team needs to convene, the staff will call the Chief Quality Officer (CQO) or designee and the CQO will initiate the call tree.

3. After Normal Business Hours.

The District on call staff receives any reports of immediate jeopardy that require follow-up within 24 hours. The on-call staff in the District contacts the QMU CQO or their back-up to hand off coordination of follow-up for the immediate jeopardy notifications to include steps a-e listed above.

C. Member Relocation from Residential Facility

1. When certain serious conditions are present at residential facilities, the Division offers relocation options to members to ensure their health and safety. This section describes the following:

    a. The types of facilities where members reside that may be subject to relocation.

    b. The types of presenting circumstances that may support a decision to relocate member(s).

    c. The decision makers authorized to make the determination to relocate members.

2. The types of residential facilities from which members may be subject to relocation under this policy include the following:

    a. Group Homes

    b. Nursing Supported Group Homes

    c. Intermediate Care Facilities (ICFs)

    d. Adult Developmental Homes (ADHs)

    e. Child Developmental Homes (CDHs)

3. The Division may elect to relocate members for the following reasons including but not limited to:

    a. An individual is injured or ill and has not received medical attention.

    b. Air conditioning or heating units are not working and the thermostat at the facility is above 90 degrees Fahrenheit on high temperature days or below 60 degrees Fahrenheit on cold temperature days.

    c. The water or electricity is not working or has been shut off.

    d. The staff to client ratio is not adequate to meet the needs of the individuals in the home. For example, a resident requires a two person lift and there is only one staff on duty; a resident requires 1:1 staffing according to their Service plan and there is insufficient staffing to meet the requirement.

    e. On-duty staff is unable to meet the needs of residents due to being under the influence of alcohol or drugs.

    f. Staff lack required initial training or have not been oriented to client needs, placing residents at risk.

    g. Indications of physical abuse, sexual abuse and/or neglect of residents is evident.

h. Resident expresses fear about remaining in the facility.

i. Environmental health and safety risks are present. For example, fire damage, fire hazards such as exposed wiring, unsecured pool area, doors/windows cannot be secured, blocked doorways or unhealthy living conditions.

j. Food supplies are inadequate. There must be sufficient food to prepare a well-balanced dinner, breakfast the next morning and to pack lunches for the next day. Only if the provider is unable or unwilling to immediately remediate this issue would residents be relocated.

k. Provider license is suspended, expired, or voluntarily surrendered.

l. Serious infestation in the facility of insects or rodents.

m. The facility has non-working appliances such as a stove or refrigerator.

n. The residents do not have adequate furniture.

4. A Network Manager, District QI Manager, QMU Administrator, DDD Contracts Administration Unit staff or members of the Executive Leadership Team are responsible for making the determination to relocate members from residential facilities and documented in a summary note in FOCUS/Incident Management System (IMS).

D. Timeframes for Response

1. Below are standard expected response times for face-to-face visits with the member and/or purposeful site visits to the place of occurrence to determine whether there are site safety concerns related to allegations of immediate jeopardy. The types and categories below are not an exclusive list and the Quality Assurance Manager and/or Supervisor may exercise discretion to dispatch staff for a site visit that is not listed below.

2. Response within 24 hours of notification:

a. Unexpected death

b. Accidental injury with hospitalization

c. Neglect with imminent danger

d. Attempted suicide with serious injury

e. Physical or sexual abuse with serious injury

f. Emergency measures utilizing a prohibited restraint

g. Emergency measure with serious injury

h. Physical or sexual abuse (without serious injury)

i. Neglect with potential danger

j. Medication error with hospitalization

k. Human rights violation allegation

l. Injury of unknown origin

m. Programmatic abuse allegation

n. Verbal/emotional abuse allegation

o. Unapproved (but not prohibited) emergency measure without serious injury

E. Investigation, Evaluation and Resolution of Immediate Jeopardy Findings

1. The Division complies with Division Medical Policy 960 Quality of Care (QOC) Concerns for investigating, reviewing, evaluating, monitoring, and resolving all QOC concerns including concerns that involve allegations of immediate jeopardy.

2. The District nurse investigator takes prompt action to ensure the health, safety and well-being of the member(s) including remaining with the member(s) until the risk of harm or likelihood for serious harm is remediated.

3. Based on the findings of the investigation of an Immediate Jeopardy situation, in accordance with Division Medical Policy 960, the Division may implement any or all the following:

a. Actively participate in meetings focused on ensuring incident resolution and health and safety of members, as well as identifying any immediate care or recovery needs.

b. Actively participate in meetings scheduled to develop work plans and corrective action plans to ensure placement setting or service site compliance with Arizona Department of Health Services (ADHS) Licensure, Division contract requirements, and/or AHCCCS requirements, including, but not limited to, policy, training and signage requirements aimed at preventing and reporting abuse, neglect and exploitation as specified in AHCCCS Minimum Subcontract Provisions.

c. Participate in scheduled and unscheduled monitoring of placement setting or service sites that are in an immediate jeopardy status, have serious identified deficiencies that may affect health and safety of members or as directed by AHCCCS.

d. Assist in the identification of technical assistance resources focused on achieving and sustaining regulatory compliance.

e. Monitor placement setting or service sites upon completion of the activities and interventions to ensure that compliance is sustained.

f. Initiate corrective actions that may include sanctioning the provider or other appropriate contract actions to ensure client safety and provider response.

g. Take adverse action against the credentialing or contract status of a provider pursuant to Division Medical Policy 950.

4. The Division tracks immediate jeopardy incidents to identify trends and determine systemic interventions and opportunities for quality improvement.

a. The Division tracks the timeliness of its response to quality of care concerns and complaints involving allegations of immediate jeopardy. The timeframes for response set forth in this policy at Section D. 3-5 are tracked and trending to identify member/provider systemic issues. The following are tracked:

i. Number and reason for failure to respond within designated timeframes.

ii. Number and types of corrective actions per complaint type.

iii. Number and types of notifications to outside agencies including, but not limited, to law enforcement, Adult Protective Services, Department of Child Services, Arizona Department of Health Services.

b. Findings from investigations are also tracked and trended, including whether the allegations are substantiated, unsubstantiated, or unable to substantiate. Categories of findings that are tracked may include, but are not limited to:

i. Quality of care/treatment

ii. Member neglect

iii. Member rights

iv. Physical environment

v. Member abuse

vi. Other

c. The results of the Division's tracking and trending for immediate jeopardy related data are analyzed, reviewed, and discussed, at the monthly Quality Management subcommittee meeting, the monthly Performance Improvement Monitoring Subcommittee

meeting, and the quarterly Quality Management Program Improvement (QMPI) Committee for discussion and any decision-making with senior leadership.

Signature of Chief Medical Officer: Anthony Dekker
Anthony Dekker (Apr 15, 2022 13:15 PDT)
Anthony Dekker, D.O.

970 PERFORMANCE MEASURES

REVISION DATES: 9/6/23, 3/9/22, 07/29/20, 11/17/17

EFFECTIVE DATE: May 13, 2016

REFERENCES: 42 CFR 438 and AHCCCS Medical Policies 920 and 970

PURPOSE

This policy establishes the requirements of the Division of Developmental Disabilities (Division) to Evaluate, monitor, and report on performance measures; responsibilities related to performance measures specific to Long-Term Services and Supports; and oversight of physical and behavioral health services performance measures delegated to the Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. "Evaluate" means the process used to examine and determine the level of quality or the progress toward improvement of quality or performance related to service delivery systems.
2. "Health Information System" means a primary data system that collects, analyzes, integrates, and reports data to achieve the Objectives outlined under 42 CFR 438, and data systems composed of the resources, technology, and methods required to optimize the

acquisition, storage, retrieval, analysis, and use of data.

3. "Inter-Rater Reliability" means the process of ensuring that multiple observers are able to consistently define a situation or occurrence in the same manner, which is then recorded.
4. "Long-Term Services and Supports" means services and supports provided to Members who have functional limitations or chronic illnesses that have the primary purpose of supporting the ability of the Member to live or work in the setting of their choice as specified in 42 CFR 438.2.
5. "Measurable" means the ability to determine definitively whether or not a quantifiable Objective has been met, or whether progress has been made toward a positive outcome.
6. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
7. "Methodology" means the planned documented process, steps, activities, or actions taken to achieve a goal or Objective, or to progress towards a positive outcome.
8. "Monitoring" means the process of auditing, observing, evaluating, analyzing, and conducting follow-up activities and documenting results via desktop or onsite review.

9. "Objective" means a measurable step, generally one of a series of progressive steps, to achieve a goal.
10. "Official Rates" means Performance Measure results calculated by the Division that have been validated by the AHCCCS External Quality Review Organization for the calendar year.
11. "Outcome" means a change in patient health, functional status, satisfaction, or goal achievement that results from health care or supportive services [42 CFR 438.320].
12. "Performance Improvement" means the continuous study and improvement of processes with the intent to better services or outcomes, and prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent or systemic problems or barriers to improvement.
13. "Performance Measure Performance Standards" means the minimal expected level of performance based upon the National Committee for Quality Assurance, HEDIS® Medicaid Mean or Centers for Medicare and Medicaid Services Medicaid Median for selected Core Set-Only Measures, as identified by the Arizona Health Care Cost Containment System (AHCCCS), as well as the Line of Business aggregate rates, as

applicable.

14. "Plan-Do-Study-Act Cycle" means a scientific method for testing a change or intervention, designed to result in improvement in a specific area. The cycle is completed by planning the change/intervention, trying it, observing the results, and acting on what is learned. When these steps are conducted over a relatively short time period the approach is known as Rapid Cycle Improvement. The PDSA Cycle consists of the following steps:

    a. Plan: Plan the changes or interventions, including a plan for collecting data. State the Objectives of the interventions.

    b. Do: Try out the interventions and document any problems or unexpected results.

    c. Study: Analyze the data and study the results. Compare the data to predictions and summarize what was learned.

    d. Act: Refine the changes or interventions based on what was learned and prepare a plan for retesting the interventions

    e. Repeat: Continue the cycle as new data becomes available until improvement is achieved.

13. "Statistically Significant" means a result occurs that is unlikely due to chance or random fluctuation.

14. "Triple Aim" means a framework for optimizing health system performance consisting of the following three components:

    a. Improve the experience and outcomes of care;

    b. Improve the health of populations; and

    c. Reduce the per capita costs of healthcare.

POLICY

The Division's management of performance measures is focused on achieving the goals of the Triple Aim, providing integrated care, identifying and standardizing best practices, implementing targeted interventions, and tracking and trending outcomes to support quality improvement in member health and well-being.

A. PERFORMANCE MEASURES

1. The Division's Quality Management Unit (QMU) shall use standardized performance measures that focus on the following clinical and non-clinical areas reflective of the Centers for Medicare and Medicaid Services (CMS) Core Set domains of care:

    a. Primary Care Access and Preventive Care;

    b. Maternal and Perinatal Health;

c. Care of Acute and Chronic Conditions;

d. Behavioral Health Care;

e. Dental and Oral Health Services;

f. Experience of Care; and

g. Long-Term Services and Supports (LTSS).

2. The Division shall collect, monitor, and Evaluate Health Information System data relevant to the following performance measures:

a. Quality,

b. Timeliness,

c. Utilization,

d. Efficiency,

e. Member satisfaction,

f. Targeted investment, and

g. Performance Improvement.

3. The Division's Quality Management Unit (QMU) shall analyze, monitor, and Evaluate established performance metrics on an on-going basis and develop specific Measurable goals and Objectives aimed at supporting quality management and desired outcomes as well as enhancing the Quality Management/Performance Improvement (QM/PI) Program.

4. The QMU shall self-report the following performance metrics to AHCCCS:

   a. Quality Management/Quality of Care;

   b. Medical Management;

   c. Maternal and Child Health;

   d. Network Adequacy; and

   e. Waiver/Program Evaluation.

5. The Division shall include LTSS specific performance measures that examineMembers' quality of life, community integration activities [42 CFR 438.330©(1)(ii)], and any performance measures that are the responsibility of the AdSS.

B. PERFORMANCE MEASURE REQUIREMENTS

1. The QMU shall oversee activities delegated to the AdSS associated with performance measures.

2. The QMU shall work collaboratively with the AdSS to ensure that the AdSS are achieving performance measure standards as part of the quality management plan.

3. The QMU shall ensure compliance with AHCCCS QM/PI requirements and the utilization of applicable performance measure methodologies for internal Monitoring and evaluation of performance measure results.

4. The QMU shall provide oversight to ensure that the AdSS:

    a. Adhere to the requirements related to performance measures.

    b. Utilize the results of the Official Rates in evaluating the AdSS QM/PI Program.

    c. Achieve the Performance Measure Performance Standards (PMPS) identified by AHCCCS for each measure based on the rates calculated by AHCCCS.

    d. Establish how the Statistically Significant improvement can

be attributable to interventions undertaken by the AdSS, and that the improvement occurred due to the project and interventions, not another unrelated reason.

e. Maintain or increase the improvements in performance for at least one year after the performance improvement is first achieved.

f. Measure and report performance measures, and meet any associated standards mandated by the Division, AHCCCS, or CMS.

g. Achieve the PMPS outlined in the AdSS' contract for each measure using administrative and hybrid rates.

h. Demonstrate sustained and improved efforts throughout the performance cycle when PMPS have been met.

i. Develop an evidence-based Corrective Action Plan (CAP) for each measure not meeting the PMPS, including interventions to meet the specific needs of Division Members to bring performance up to the minimum standards required by AHCCCS while adhering to AMPM Policy 920, Attachment B.

j. Ensure each CAP includes a list of activities or strategies that the AdSS are using to allocate increased administrative resources to improve rates for a specific measure or service area.

k. Demonstrate and sustain improvement towards meeting PMPS.

5. The Division may take administrative action for PMPS that do not show Statistically Significant improvement in Official Rates.

6. The Division may take administrative action for Statistically Significant declines of rates or any rate that does not meet the PMPS or a rate that has a significant impact to the aggregate rate for the State.

7. The Division shall require the AdSS to report the status of any discrepancies identified in encounters submitted to and received by the Division for purposes of performance measure monitoring.

8. The Division is responsible for:

a. Monitoring encounter submissions by the Division's

subcontractors;

b. Demonstrating improvement from year to year, which is sustained over time, in order to meet goals for performance established by AHCCCS;

c. Complying with national performance measures and levels that may be identified and developed by CMS in consultation with AHCCCS; and

d. Ensuring the CAPs are approved by AHCCCS prior to implementation.

9. The Division shall internally measure and report to AHCCCS the Division's performance on contractually mandated performance measures using a standardized methodology established or adopted by AHCCCS.

10. The Division shall use the results of the AHCCCS contractual performance measures in evaluating the Division's QM/PI program.

C. PERFORMANCE MEASURE ANALYSIS

1. The Division shall conduct data analysis of performance measure

rates to improve the quality of care provided to Members, identify opportunities for improvement, and implement targeted interventions.

2. The Division shall evaluate performance for aggregate and subpopulations, inclusive of Members with special health care needs, as well as any other focus areas identified by AHCCCS.

3. The Division shall utilize proven quality improvement tools when conducting root-cause analysis and problem-solving activities.

4. The Division shall identify and implement targeted interventions to address any noted disparities identified as part of the Division's data analysis efforts.

5. The Division shall conduct Plan-Do-Study-Act (PDSA) Cycles to Evaluate the effectiveness of interventions, revise interventions as needed, and conduct repeat PDSA Cycles until improvement is achieved.

D. INTER-RATER RELIABILITY

1. The Division shall use the following process to collect data used to measure performance:

a. Assign qualified personnel to collect data,

b. Ensure Inter-Rater Reliability if more than one person is collecting and entering data, and

c. Submit specific documentation to verify that indicator criteria were met in accordance with AHCCCS instruction.

2. The Division shall ensure that data collected from multiple individuals is consistent and comparable through an implemented Inter-Rater Reliability process as specified in Medical Policy 960.

3. If requested by AHCCCS, the Division shall provide evidence of implementation of the Inter-Rater Reliability process and the associated Monitoring.

E. PERFORMANCE METRIC AND MEASURE REPORTING

1. The Division's QM/PI Committee shall review performance measure analytics and recommendations from subcommittees to improve the quality of the care provided to Members, identify opportunities for improvement, and implement targeted interventions on a quarterly basis.

2. The Division shall combine performance measure outcomes from the AdSS and submit those results to AHCCCS as specified in the AHCCCS contract.

3. The Division shall report on LTSS specific performance measures and outcomes managed by the Division, through qualified vendors, as well as the LTSS specific performance measures and outcomes managed by the AdSS.

4. The Division shall report the Division's QM/PI program performance to the AHCCCS Quality Improvement Team, as specified in the AHCCCS contract, utilizing the AHCCCS Performance Measure Monitoring Report & Work Plan Evaluation Template found on the AHCCCS website.

F. AdSS OVERSIGHT

1. The Division shall use the following methods to ensure the AdSS are in compliance with AdSS Medical Policy 970 and associated policies:

   a. Conduct annual operational reviews for compliance;

   b. Analyze deliverable reports and other data as required;

c. Conduct oversight meetings with each AdSS for the purpose of reviewing compliance and addressing any performance measures or other quality of care concerns; and

d. Review data submitted by the AdSS demonstrating ongoing compliance Monitoring of the AdSS' network and provider agencies through Behavioral Health Chart Reviews.

Signature of Chief Medical Officer: Anthony Dekker (Aug 31, 2023 10:18 PDT)
Anthony Dekker, D.O.

980 PERFORMANCE IMPROVEMENT PROJECTS

REVISION DATE: 9/6/2023, 12/7/2022, 9/15/2021, 07/29/2020, 11/17/2017, 05/13/2016
EFFECTIVE DATE: May 13, 2021
REFERENCES: 42 CFR 438.320, 42 CFR 438.330, AMPM 980 - Attachment A

PURPOSE

This policy establishes the requirements of the Division of Developmental Disabilities (Division) regarding the management and implementation of AHCCCS-mandated and Division self-selected Performance Improvement Projects (PIPs) within the Quality Management/ Performance Improvement (QM/PI) Program and its responsibilities to monitor, provide oversight and ongoing evaluation of the Administrative Services Subcontractors' (AdSS) performance.

DEFINITIONS

1. "Baseline Data" means data collected at the beginning of a PIP that is used as a starting point for measurement and the basis for comparison with subsequent remeasurement(s) in demonstrating significant and sustained improvement.
2. "Benchmark" means the process of comparing a practice's performance with an external standard to motivate engagement

in Quality improvement efforts and understand where performance falls in comparison to others. Benchmarks may be generated from similar organizations, Quality collaboratives, and authoritative bodies.

3. "Grievance" means a Member's expression of dissatisfaction with any matter, other than an adverse benefit determination.
4. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
5. "Methodology" means the planned documented process, steps, activities, or actions taken to achieve a goal or Objective, or to progress towards a positive Outcome.
6. "Monitoring" means the process of auditing, observing, evaluating, analyzing, and conducting follow-up activities, and documenting results via desktop or on-site review.
7. "Objective" means a measurable step, generally one of a series of progressive steps, to achieve a goal.
8. "Outcomes" means changes in patient health, functional status, satisfaction, or goal achievement that result from health care or supportive services [42 CFR 438.320].

9. "Performance Improvement Project" or "PIP" means a planned process of data gathering, evaluation and analysis to determine interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the Quality of care and service delivery.
10. "Plan Do Study Act Cycle" or "PDSA Cycle" means a scientific method for testing a change or intervention, designed to result in improvement in a specific area. The cycle is completed by planning the change/intervention, implementing it, observing the results, and analyzing results for Outcomes on the interventions. When these steps are conducted over a relatively short time period, i.e., over days, weeks, or months, the approach is known as Rapid Cycle Improvement.
11. "Plan Do Study Act Method" or "PDSA Method" means a four step model to test a change that is implemented. Going through the prescribed four steps utilizing one or more PDSA Cycles guides the thinking process into breaking down the task into steps and then evaluating the outcome, improving on it, and testing again.

12. "Quality" as specified in 42 CFR 438.320, pertains to external Quality review, means the degree to which an MCO increases the likelihood of desired Outcomes of its Members through:
    a. Its structural and operational characteristics.
    b. The provision of services that are consistent with current professional, evidence-based knowledge.
    c. Interventions for performance improvement.
13. "Statistically Significant" means a result occurs that is unlikely due to chance or random fluctuation.
14. "Validation" means the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias and in accord with standards for data collection and analysis.

POLICY

A. PIP REQUIREMENTS

1. The Division shall participate in AHCCCS-mandated and Division self-selected PIPs.

2. The Division shall select, with AHCCCS approval, additional PIPs based on self-identified opportunities for improvement, as supported by a root cause analysis, external and internal data, surveillance of trends and other information available to the Division.
3. The Division shall consider all populations and services covered when developing Quality assessments and PIPs.
4. The Division shall participate in performance measures and PIPs that are mandated by the Centers for Medicare and Medicaid Services (CMS).
5. The Division shall develop, design and implement PIPs to improve systemic and Member-focused Outcomes and demonstrate sustainable improvement in clinical care and non-clinical services, through:
    a. Measurement of performance using objective Quality indicators.
    b. Implementation of interventions to achieve improvement in access to and Quality of care.

c. Evaluation of the effectiveness of the interventions based on indicators collected as part of the PIP

d. Planning and initiation of activities for increasing or sustaining improvement (42 CFR 438.330(d)(2)).

B. PIPS DESIGN

1. The Division shall conduct PIPs that focus on either clinical or non-clinical areas.

   a. The Division may, when determined appropriate by the Division, include the following topics when selecting a clinical topic:

      i. Primary, secondary, or tertiary prevention of acute conditions;

      ii. Primary, secondary, or tertiary prevention of chronic conditions;

      iii. Primary, secondary, or tertiary prevention of behavioral health conditions;

      iv. Care of acute conditions;

      v. Care of chronic conditions;

      vi. Care of behavioral health conditions; and

vii. Continuity and coordination of care.

b. The Division may, when determined appropriate by the Division, include the following topics when selecting a non-clinical topic:

i. Availability, accessibility, and adequacy of Contractor's service delivery system;
ii. Cultural competency of services;
iii. Interpersonal aspects of care; and
iv. Appeals, Grievances, and other complaints.

2. The Division shall identify and implement clinical and non-clinical focused PIPs that are meaningful to the populations served and based on self-identified opportunities for improvement.

3. The Division shall support these PIPs by using:

a. Root cause analyses;

b. External and internal data;

c. Surveillance of trends; or

d. Other information available to the Division.

4. The Division shall adhere to the protocol in 42 CFR 438.330 when developing PIPs.

5. The Division shall adhere to and align with the protocol specified in AMPM Policy 980 – Attachment A, Protocol for Conducting Performance Improvement Projects, when selecting, designing, developing, and implementing self-selected PIPs.

6. The Division shall use the PDSA Method to test changes or interventions quickly and refine them, as necessary.

7. The Division shall utilize several PDSA Cycles within the PIP lifespan.

8. The Division shall include the following steps in the PDSA Cycle:

    a. Plan the changes or interventions, including a plan for collecting data.

    b. State the Objectives of the interventions.

    c. Try out the interventions and document any problems or unexpected results.

    d. Analyze the data and study the results.

e. Compare the data to predictions and summarize what was learned.

f. Refine the changes or interventions, based on what was learned, and prepare a plan for retesting the interventions.

g. Continue the cycle as new data becomes available until sustainable improvement is achieved.

9. The Division shall include all PDSA Cycles conducted as part of the PIP within the Division's PIP Report submissions.

C. PIP TIMEFRAMES

1. For AHCCCS-Mandated PIPs, the Division shall do the following:
   a. Initiate mandated PIPs on a date that corresponds with the calendar year established by AHCCCS.
   b. Collect and analyze Baseline Data at the beginning of the PIP.
   c. Implement innovative and-evidence-based interventions to improve performance based on an evaluation of barriers

and root cause analysis during the Intervention years or annual measurements.

d. Consider any unique factors such as:

i. The Division's membership,

ii. The provider network, and

iii. The geographic area(s) served.

e. Report at the intervals indicated within the associated PIP methodologies in cases where AHCCCS elects to implement Rapid Cycle PIPs.

f. Continue to participate in the PIP until the Division demonstrates significant and sustained improvement, as outlined in Section E, or as directed by AHCCCS.

2. For Division Self-Selected PIPs, the Division shall do the following:

a. Implement Rapid Cycle PIPs where applicable and appropriate, and

b. Continue to participate in the PIP until the Division demonstrates significant and sustained improvement, as outlined in Section E, or as approved by AHCCCS when

significant and sustained improvement has not been demonstrated.

D. DATA COLLECTION METHODOLOGY

1. The Division shall align their data collection Methodology, including project indicators, procedures, and timelines with the guidance and direction provided for all AHCCCS-mandated PIPs.
2. The Division shall evaluate their performance on the selected PIP indicators based on systematic, ongoing collection and analysis of accurate, valid, and reliable data as collected and reported by AHCCCS or as validated by the AHCCCS External Quality Review Organization (EQRO).
3. The Division shall ensure collected data are accurate, valid, and reliable through internal processes for self-selected PIPs that are not based on standardized performance measures.

E. INTER-RATER RELIABILITY

1. For PIPs that are not based on standardized performance measures as well as performance measures not included within AHCCCS Contract, the Division shall:

a. Submit specific documentation to verify that indicator criteria were met in accordance with AHCCCS instruction,
b. Have qualified personnel collect data,
c. Ensure inter-rater reliability if more than one person is collecting and entering data.

2. The Division shall ensure that data collected from multiple parties or individuals for PIP indicators is consistent and comparable through an implemented inter-rater reliability process.
3. The Division shall contain in their documented inter-rater reliability process:
   a. A detailed description of the Division's Methodology for conducting inter-rater reliability including:
      i. Initial training and retraining, if applicable;
      ii. Oversight;
      iii. Validation of data collection; and
      iv. Other activities deemed applicable.

b. The required minimum score that each individual shall obtain in order to continue participation in the data collection and reporting process;

c. A mechanism for evaluating individual accuracy scores and any subsequent accuracy scores, if applicable; and

d. The actions taken should an individual not meet the established accuracy score.

4. The Division shall monitor and track the inter-rater reliability accuracy scores and associated follow up activities.

5. The Division shall provide evidence to AHCCCS of implementation of the inter-rater reliability process as well as the associated Monitoring upon request.

F. MEASUREMENT OF SIGNIFICANT DEMONSTRABLE IMPROVEMENT

1. The Division shall implement interventions to achieve and sustain Statistically Significant improvement, followed by sustained improvement for one consecutive year, for each PIP indicator.

2. The Division shall initiate interventions that result in significant improvement, sustained over time, in its performance for the PIP indicators being measured.
3. The Division shall provide evidence to AHCCCS of improvement in repeated measurements of the PIP indicators specified for each active PIP.
4. The Division shall demonstrate significant improvement when the improvement in the PIP indicator rate(s) from one measurement year to the next measurement year is Statistically Significant.
5. The Division shall demonstrate sustained improvement when it:
    a. Establishes how the significant improvement can be attributable to interventions implemented by the Division; and
    b. Maintains, or increases, the improvements in performance for at least one year after the significant improvement in performance is first achieved.

G. PIPS REPORTING REQUIREMENTS

1. The Division shall refer to the AHCCCS Quality Management/Performance Improvement (QM/PI) Reporting

Templates & Checklists section of the AHCCCS website to locate the associated tools the Division shall utilize, as outlined in this section, when preparing and submitting the required deliverables.

2. The Division shall include baseline and annual remeasurements, inclusive of rates and results used as the basis for analysis, both quantitative and qualitative, and the selection or modification of interventions, within the Division's PIP report submissions.
3. The Division shall submit reports that contain population and line of business-specific data reflective of the Division's performance during the current and previous reporting periods in alignment with the associated PIP timeline.
4. The Division shall ensure the inclusion of subpopulation data and disparity analyses within its reporting, with the identification of targeted interventions to be implemented specific to findings, in alignment with the AHCCCS PIP Report Template and Attachment instructions.
5. For AHCCCS-mandated PIPs, the Division shall do the following:

a. Submit PIP reports for all AHCCCS-mandated PIPs, as specified in the AHCCCS contract.

b. Utilize the AHCCCS PIP Report Template and Attachment that is applicable to the population/line of business being reported.

c. Report rates and results, reflective of combined Title XIX and Title XXI populations, as applicable to the population/line of business.

d. Indicate if the interventions are applicable to Title XIX, Title XXI, or both populations.

e. Submit a final PIP report, as specified in the AHCCCS contract, following the year in which significant and sustained improvement is demonstrated.

f. Evaluate significant and sustained improvement based on PIP indicator rates that have been validated by AHCCCS' EQRO or considered as the AHCCCS official PIP indicator rates, as specified in the AHCCCS contract and the associated AHCCCS PIP Methodology.

g. Utilize its Remeasurement Year two (or subsequent year, if required) PIP report to serve as their final PIP report submission contingent upon the following:

i. The Division has met the AHCCCS contract and policy criteria related to significant and sustained improvement to support PIP closure, and

ii. The sections required as part of the final PIP report have been completed.

h. Keep AHCCCS-mandated PIPs open until formal notification of approval for PIP closure from AHCCCS is received.

i. Resubmit their final PIP report if the AHCCCS PIP Checklist requirements are not met.

6. For Division self-selected PIPs, the Division shall do the following:

a. Submit a Contractor Self-Selected PIP Initiation Notification, as specified in the AHCCCS contract.

b. Submit PIP reports for self-selected PIPs, active during the previous calendar year, as specified in the AHCCCS contract.

c. Utilize the AHCCCS PIP Report Template and Attachment, specific to population/line of business.

d. Indicate if measurements or rates and results are reflective of combined Title XIX and Title XXI populations, as applicable to population and line of business.

e. Indicate if the interventions are applicable to the Title XIX, Title XXI, or both populations.

f. Submit a final self-selected PIP report, as specified in the AHCCCS contract, following the year in which significant and sustained improvement is demonstrated.

g. Evaluate significant and sustained improvement based on PIP indicator rates that have been validated by AHCCCS' EQRO or considered as the AHCCCS official performance measure rates, as specified in the AHCCCS contract.

h. Evaluate significant and sustained improvement based on the Division's internally collected and validated data for self-selected PIPs that are not based on standardized performance measures and calendar year performance.

i. Utilize its Remeasurement Year two or subsequent year, if required, PIP report to serve as their final PIP report submission to AHCCCS contingent upon the following:
    i. The Division has met the AHCCCS contract and policy criteria related to significant and sustained improvement to support PIP closure, and
    ii. The sections required as part of the final PIP report have been completed.

j. The Division shall keep Division self-selected PIPs open until the Division has met criteria related to significant and sustained improvement.

k. The Division shall submit a PIP Closure Request for each PIP they are requesting to close for AHCCCS' review and approval.

l. The Division shall indicate the rationale for closing a PIP in cases where the Division has not met criteria related to significant and sustained improvement to support PIP closure.

m. The Division shall close the PIP when formal notification of approval for PIP closure has been received from AHCCCS.

n. The Division shall resubmit their final PIP report if the AHCCCS PIP Checklist requirements are not met.

Signature of Chief Medical Officer: Anthony Dekker (Aug 29, 2023 14:51 PDT)
Anthony Dekker, D.O.

1000 CHAPTER OVERVIEW

REVISION DATES: 09/30/2020, 11/22/2017
EFFECTIVE DATE: May 13, 2016
REFERENCES: 9 A.A.C. 34, 42 CFR 438.210

Purpose

The standards and requirements included in this chapter are applicable to the Division of Developmental Disabilities (Division) and its Administrative Services Subcontractors (AdSS). If requirements of this chapter conflict with specific contract language, the AHCCCS medical contract with the Division will take precedence.

At least annually, the Medical Management Unit will conduct reviews of each AdSS' compliance with the requirements of this chapter. The Division's Medical Management Unit is located within the Division's Health Care Services.

The chapter provides the necessary information to the Division and its AdSS to ensure compliance with federal, state, and AHCCCS requirements to Medical Management activities.

Definitions

The Division's words and phrases in this chapter have the following meanings, unless the context explicitly requires another meaning. Refer to AHCCCS policy for other applicable definitions.

Assess or Evaluate - To study or examine methodically and in detail, typically for purposes of explanation and interpretation.

Authorization Request (Expedited) - Under 42 CFR 438.210, a request for which a provider indicates the Division determines that using the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. The Division must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires no later than three working days following the receipt of the authorization request, with a possible extension of up to 14 days if the member or provider requests an extension or if the Division justifies a need for additional information and the delay is in the member's best interest.

Authorization Request (Standard) - Under 42 CFR 438.210, a request for which a the Division must provide a decision as expeditiously as the member's health condition requires, but not later than 14 calendar days following the receipt of the authorization request, with a possible extension of up to 14 calendar days if the member or provider requests an extension or if the Division justifies a need for additional information and the delay is in the member's best interest.

Care Management – A group of activities performed by AdSS to identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health care outcomes. Distinct from case management, care management does not include day-to-day duties of service delivery.

Case Management – A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.

Catastrophic Reinsurance - Stop-loss mechanism to provide the Division with partial reimbursement for specified service costs incurred by a member. This risk-sharing program is available when the provisions delineated in the Reinsurance Processing Manual, Medical Policy Manual, and contract are met.

Concurrent Review - Process of reviewing an institutional stay at admission and throughout the stay to determine medical necessity for an institutional level of care. The Division reviewers assess the appropriate use of resources, Level of Care (LOC) and service, according to professionally recognized standards of care. Concurrent review validates the medical necessity for admission and continued stay and evaluates quality of care.

Continuous Health Care Improvement - Integrated approach to health care delivery that seeks to improve health outcomes and reduce health care costs by:

A. Identifying and proactively monitoring high-risk populations,
B. Assisting members and providers in adhering to identified evidence-based guidelines,
C. Promoting care coordination,
D. Increasing and monitoring member self-management, and
E. Optimizing member safety.

Delegated Entity - Qualified organization, agency, or provider that holds a subcontract to perform delegated management/administrative functions or responsibilities for the Division.

Disease Management - An integrated approach to health care delivery that seeks to improve health outcomes and reduce health care costs by:

A. Identifying and proactively monitoring high-risk populations,
B. Assisting members and providers in adhering to identified evidence-based guidelines,
C. Promoting care coordination,
D. Increasing and monitoring member self-management, and
E. Optimizing member safety.

Goal - Desired result the Division envisions, plans, and commits to achieve within a proposed timeframe.

Grievance - Expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided or aspects of interpersonal relationships, such as rudeness of a provider or employee, or failure to respect the member's rights. Grievances do not include "Action(s)" as defined in 9 A.A.C. 34.

Measurable - A gauge to determine definitively whether a goal has been met or progress has been made.

Medical Management - Integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve the desired health outcomes, across the continuum of care (from prevention to end of life care).

Methodology - Planned process, steps, activities, or actions taken by the Division to achieve a goal or objective or to progress toward a positive outcome.

Monitoring – Process of auditing, observing, evaluating, analyzing, and conducting follow-up activities, and documenting results.

Retrospective Review - Process of determining the medical necessity of a treatment/service post-delivery of care.

Utilization Management - Applies to a Division process to evaluate, and approve or deny health care services, procedures, or settings based on medical necessity, appropriateness, efficacy, and efficiency. Utilization management also includes processes for prior authorization, concurrent review, retrospective review, and case management.

Monitoring

The Division monitors AHCCCS acute services, for the Division's members, with the following processes:

A. Contracts with acute health plan.

B. Operational Reviews with each Division contracted health plan.

C. Quarterly compliance meetings with each Division contracted health plan.

D. Annual Medical Management plans that include narratives, evaluations, completed work plans from the previous year and new work plans for the current year.

E. Quarterly AHCCCS deliverables (includes EPSDT reports) oversight for Division members.

F. Division contracted health plan quarterly Utilization Management (UM) reports.

G. The Division's Medical Management and Chief Medical Officer or designated Medical Director meetings to discuss data analysis, interventions, and corrective action plans (CAPs). Informal clarification may occur as well as defined CAPs coordinated through the Compliance Units of the Division and the AdSS.

H. Provider manual and member handbook oversight.

I. Health Care Services procedures.

1010 MEDICAL MANAGEMENT ADMINISTRATIVE REQUIREMENTS

REVISION DATE: 8/4/2021, 07/29/2020, 05/13/2016
EFFECTIVE DATE: May 13, 2016
REFERENCES: 42 C.F.R. 438.210(b)(3), 42 C.F.R. 438.406(a)(2)(i), A.R.S. § 36-2907, A.R.S. § 36-2907(B), A.A.C. R9-22-201 et seq, 9 A.A.C. 34, ACOM Policy 438, AHCCCS Contractor Operations Manual (ACOM)

PURPOSE

This policy outlines the Medical Management administrative requirements.

DEFINITIONS

Plan, Do, Study Act (PDSA) Method - A four step model to test a change that is implemented. Going through the prescribed four steps utilizing one or more PDSA cycles guides the thinking process into breaking down the task into steps and then evaluating the outcome, improving on it, and testing again.

POLICY

A. The Division of Developmental Disabilities (Division) shall develop a written Medical Management Plan that describes the methodology to meet or exceed the standards and requirements of contract.

B. The Division shall submit the Medical Management Plan, and any subsequent modifications, to the AHCCCS Medical Management for review and approval prior to implementation

C. At a minimum, the Medical Management Plan shall describe, in detail, the Medical Management program and how program activities assure appropriate management of medical care service delivery for enrolled members. Medical Management Plan components shall include:

1. A description of the Division's administrative structure for oversight of its Medical Management program, including the role and responsibilities of the following:

    a. The governing or policy-making body

    b. The Medical Management Committee

    c. The Division Executive Management

    d. Medical Management program staff

2. An organizational chart that delineates the reporting channels for Medical Management activities and the relationship to the Chief Medical Officer

(unless delegated to an associate Medical Director) and Executive Management.

3. Documentation that the governing or policy-making body has reviewed and approved the Medical Management Plan.

4. Documentation that appropriately qualified, trained, and experienced personnel are employed to effectively carry out Medical Management program functions.

5. The Division's specific Medical Management goals and measurable objectives as required by AHCCCS policy.

6. Documentation of how the following processes are implemented and monitored to ensure quality and cost-effective care is provided to members in compliance with state and federal regulations:

    a. Medical Management Utilization Data Analysis and Data Management

    b. Concurrent Review

    c. Discharge Planning

    d. Prior Authorization

    e. Inter-Rater Reliability

    f. Retrospective Review

    g. Clinical Practice Guidelines

    h. New Medical Technologies and New Uses of Existing Technologies

    i. Case Management/Care Coordination

    j. Disease/Chronic Care Management

    k. Drug Utilization Review

7. The Division's method(s) for monitoring and evaluating its service delivery system and provider network that demonstrates compliance with AHCCCS policy.

8. A description of how delegated activities are integrated into the overall Medical Management program and the methodologies for oversight and accountability of all delegated functions, as required by AHCCCS policy.

9. Documentation of input into the medical coverage policies from the Division or providers and members.

10. A summary of the changes made to the AdSS' list of services requiring prior authorization and the rationale for those changes.

Medical Management Work Plan

The Division is responsible for developing a work plan that identifies the goals, methodology for improvement, and monitoring efforts related to the Medical Management program requirements outlined in AHCCCS policy. The work plan shall:

1. Be submitted in an acceptable format on the template adopted by the Division and provided by AHCCCS.

2. Support the Medical Management Plan goals and objectives.

3. Include goals that are quantifiable and reasonably attainable.

4. Include specific actions for improvement.

5. Incorporate a Plan, Do, Study, Act (PDSA) methodology for testing an action designed to result in a desired improvement in a specific area. Refer to AdSS Medical Policy 970 for details related to PDSA methodologies.

Medical Management Evaluation

A. An annual narrative evaluation of the effectiveness of the previous year's Medical Management strategies and activities shall be submitted to AHCCCS Medical Management after being reviewed and approved by the Division's governing or policy-making body. The narrative summary of the previous year's work plan shall include, but is not limited to:

   1. A summary of the Medical Management activities performed throughout the year with the following:

      a. Title/name of each activity

      b. Desired goal and/or objective(s) related to each activity

      c. Staff positions involved in the activities

      d. Trends identified and the resulting actions implemented for improvement

      e. Rationale for actions taken or changes made

      f. Statement describing whether the goals/objectives were met

   2. Review, evaluation, and approval by the Medical Management Committee of any changes to the Medical Management Plan.

3. Necessary follow-up with targeted timelines for revisions made to the Medical Management Plan.

B. The Medical Management Plan and Medical Management Evaluation may be combined or written separately, as long as required components are addressed and easily located.

C. Refer to AHCCCS policy for reporting requirements and timelines.

Medical Management Administrative Oversight

A. The Division shall ensure ongoing communication and collaboration between the Division Medical Management program and the other functional areas of the Division (e.g., quality management, member, and provider services).

B. The Division shall have an identifiable and structured Medical Management Committee that is responsible for Medical Management functions and responsibilities, or if the Medical Management Committee is combined with the Quality Management Committee, the agenda items and minutes reflect that Medical Management issues and topics are presented, discussed, and acted upon.

C. At a minimum, the membership shall include the following:

1. The Chief Medical Officer or designated Medical Director, as the chairperson of the Medical Management Committee

2. The Medical Management Manager

3. Representation from the functional areas within the AdSS' organization

4. AdSS staff with experience with developmental disabilities, behavior health, and medically fragile physical health conditions

5. Representation of contracted or affiliated providers

D. The Chief Medical Officer, unless delegated to an associate Medical Director, as chairperson for the Medical Management Committee, or the chairperson's designee, is responsible for the implementation of the Medical Management Plan and has substantial involvement in the assessment and improvement of Medical Management activities.

E. The Medical Management Committee shall ensure that each of its members is aware of the requirements related to confidentiality and conflicts of interest (e.g., a signed statement on file or Medical Management Committee sign-in sheets with requirements noted).

F. The frequency of Medical Management Committee meetings is sufficient to demonstrate that the Medical Management Committee monitors all findings and

required actions. At a minimum, the Medical Management Committee meets quarterly.

G. Medical Management Committee meeting minutes include the data reported to the Medical Management Committee and analysis and recommendations made by the Medical Management Committee. Data, including utilization data, may be attached to the Medical Management Committee meeting minutes as separate documents if the documents are noted in the Medical Management Committee meeting minutes.

Recommendations made by the Medical Management Committee shall be discussed at subsequent Medical Management Committee meetings. The Medical Management Committee shall review the Medical Management program objectives and policies annually and updates them as necessary to ensure all of the following:

1. The Medical Management responsibilities are clearly documented for each Medical Management function/activity.

2. Division staff, administrative services sub-contractors (AdSS), and providers are informed of the most current Medical Management requirements, policies, and procedures in a timely fashion in order to allow for implementation that does not adversely impact the members or provider community.

3. The providers are informed of information related to their performance (e.g., provider profiling data).

4. The Medical Management policies and procedures, and any subsequent modifications to them, are available upon request by the AHCCCS Medical Management Unit.

H. The Medical Management program shall be staffed with a sufficient number of appropriately qualified personnel to carry out the functions and responsibilities.

I. Staff qualifications for education, experience, and training shall be developed for each Medical Management position.

J. The grievance process shall be part of the new hire and annual staff training, which includes:

1. What constitutes a grievance.

2. How to report a grievance.

3. The role of the Quality Management staff in grievance resolution.

K. A current organizational chart is maintained to show reporting channels and responsibilities for the Medical Management program.

L. The Division shall maintain records that document Medical Management activities and shall make the information available to AHCCCS Medical Management Unit upon request. The required documentation includes, but is not limited to:

1. Policies and procedures
2. Reports
3. Practice guidelines
4. Standards for authorization decisions
5. Documentation resulting from clinical reviews (e.g., notes related to concurrent review, retrospective review, and prior authorization)
6. Meeting minutes including analyses, conclusions, and actions required with completion dates
7. Corrective Action Plans (CAPs) resulting from the evaluation of any component of the Medical Management program such as inter-rater reliability
8. Other information and data deemed appropriate to support changes made to the scope of the Medical Management Plan

M. The Division shall have written policies and procedures pertaining to:

1. Verification that information/data received from providers is accurate, timely, and complete.
2. Review of reported data for accuracy, completeness, logic, and consistency (review and evaluation processes used shall be clearly documented).
3. Security and confidentiality of all member and provider information protected by Federal and State law.
4. Informing of appropriate parties of the Medical Management requirements and updates, utilization data reports, and profiling results.
5. Identification of provider trends and subsequent necessary corrective action regarding over/under utilization of services.
6. Quarterly evaluations and trending of internal appeal overturn rates.
7. Quarterly evaluations of the timeliness of service request decisions.
8. Annual review of prior authorization requirements that encompasses the analysis of prior authorization decision outcomes, including but not limited to, the rationale for requiring prior authorization for types of services such as high dollar, high risk, or case finding for care management.

N. The Division shall have processes that ensure:

1. Per 42 CFR 438.210(b)(3), qualified health care professionals, with appropriate clinical expertise in treating the member's condition or disease, render decisions to:

    a. Deny an authorization request based on medical necessity.

    b. Authorize a request in an amount, duration, or scope that is less than requested.

    c. Make a decision involving excluded or limited services under Arizona Revised Statute A.R.S. § 36-2907(B) and A.A.C. R9-22-201 et seq., as specified in this policy.

2. Per 42 CFR 438.406(a)(2)(i) qualified health care professionals, with appropriate clinical expertise in treating the members' condition or disease, and who have not been involved in any previous level of decision making, will render decisions regarding the following:

    a. Appeals involving denials based on medical necessity.

    b. Grievances regarding denial of expedited resolution of an appeal.

    c. Grievances and appeals involving clinical issues.

3. For purposes of this section, the following qualified health care professionals have the appropriate clinical expertise to render decisions based on previously established Division contractor standards and clinical criteria for skilled and non-skilled services within their scope of practice:

    a. Physician

    b. Podiatrist

    c. Optometrist

    d. Chiropractor

    e. Psychologist

    f. Dentist

    g. Physician assistant

    h. Physical or occupational therapist

    i. Speech-language pathologist

    j. Audiologist

k. Registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife)

l. Licensed social worker

m. Registered respiratory therapist

n. Licensed marriage and family therapist

o. Licensed professional counselor

4. Decision-making includes determinations involving excluded or limited services under A.R.S. § 36-2907 and A.A.C. R9-22-201 et seq.

5. Consistent application of standards and clinical criteria and consistent decisions that include inter-rater reliability criteria and monitoring of all staff involved in this process. A plan of action shall be developed and implemented for staff who fail to meet the inter-rater reliability standards of 90%.

6. Prompt notifications to the requesting provider and the member or member's authorized representative or medical power of attorney, as applicable, of any decision to deny, limit, or discontinue authorization of services. The notice includes information as specified in the AHCCCS Contractor Operations Manual (ACOM) and 9 A.A.C. 34

O. The Division shall maintain a health information system that collects, integrates, analyzes, and reports data necessary to implement its Medical Management Program. Data elements shall include, but are not limited to:

1. Member demographics

2. Provider characteristics

3. Services provided to members

4. Other information necessary to guide the selection of, and meet the data collection requirements for, improvement activities

P. The Division shall oversee and maintain accountability for all functions or responsibilities that are delegated to other entities. Documentation is kept that demonstrates:

1. A written agreement shall be executed that specifies the delegated activities and reporting responsibilities of the entity to the AdSS and include provisions for revocation of the delegation or imposition of sanctions for inadequate performance.

2. The Division evaluates the entity's ability to perform the delegated activities prior to executing a written agreement for delegation per ACOM Policy 438.

3. The performance of the entity and the quality of services provided are monitored on an ongoing basis and formally reviewed.

Q. The Division shall ensure:

1. Compensation to persons or organizations conducting prior or prospective authorization, and concurrent or retrospective review activities are not structured so as to provide inappropriate incentives for selection, denial, limitation or discontinuation or authorization of services.

2. Providers are not prohibited from advocating on behalf of members within the service provision process.

1020 UTILIZATION MANAGEMENT

REVISION DATE: 1/25/2023 7/20/2022
EFFECTIVE DATE: August 4, 2021
REFERENCES: A.R.S. § 13-3994, A.R.S. § 31-501, A.R.S. § 36-551, A.R.S. § 38-211, A.A.C. R9-22-101, A.A.C. R9-28-201, 42 CFR 412.87, 42 CFR Part 437, 42 CFR Part 438, 42 CFR 447.26, 42 CFR 456.125, 42, CFR Part 457, 45 CFR Parts 160 and 164

PURPOSE

This policy outlines the oversight responsibilities of the Division of Developmental Disabilities (Division) to ensure effective treatment services, coordination of care to achieve optimal health outcomes for members served by the Division and identify opportunities for improvement in utilization management. This policy is specifically targeted to the Division's roles and responsibilities related to utilization management and oversight of the AdSS.

DEFINITIONS

1. "Behavioral Health Inpatient Facility (BHIF)" means a health institution, as specified in A.A.C. R9-10-101, that provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual to:

a. Have a limited or reduced ability to meet the individual's basic physical needs;

b. Suffer harm that significantly impairs the individual's judgment, reason, behavior, or capacity to recognize reality;

c. Be a danger to self;

d. Be a danger to others;

e. Be an individual with a persistent or acute disability as specified in A.R.S § 36-501; or

f. Be an individual with a grave disability as specified in A.R.S. § 36-501.

2. "Behavioral Health Residential Facility (BHRF)" means, as specified in A.A.C. R9-10-101, is a health care institution that provides treatment to an individual experiencing a behavioral health issue that:

a. Limits the individual's ability to be independent, or

b. Causes the individual to require treatment to maintain or enhance independence.

3. "Care Management" means a group of activities performed to identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health outcomes. Distinct from Support Coordination, Care Management does not include the day-to-day duties of service delivery.

4. "Concurrent Review" means the process of reviewing an institutional stay at admission and throughout the stay to determine medical necessity for an institutional Level of Care (LOC). Reviewers assess the appropriate use of resources, LOC, and service, according to professionally recognized standards of care. Concurrent review validates the medical necessity for admission and continued stay and evaluates for Quality Of Care (QOC).

5. "Denial" means the decision to deny a request made by, or on behalf of, an individual for the authorization and/or payment of a covered service.

6. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:
   a. Placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
   b. Serious impairment to bodily functions;
   c. Serious dysfunction of any bodily organ or part as specified in 42 CFR 438.114(a); or
   d. Serious physical harm to another individual (for behavioral health conditions).

7. "Health Care Acquired Condition (HCAC)" means a Hospital Acquired Condition (HAC) which occurs in any inpatient hospital setting and is not present on admission (Refer to the current Centers for Medicare and Medicaid Services (CMS) list of Hospital-Acquired Conditions).

8. "Institution for Mental Disease (IMD)" means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases (including substance use disorders), including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases as specified in 42 CFR 435.1010.

9. "Institutional Setting" means:

   a. A nursing facility as specified in 42 U.S.C. 1396 r(a);

   b. An Institution for Mental Diseases (IMD) for an individual who is either under age 21 or age 65 or older;

   c. A hospice (free-standing, hospital, or nursing facility subcontracted beds) as specified in A.R.S. § 36- 401;

d. A Behavioral Health Inpatient Facility (BHIF) as specified in A.A.C. R9-10-101;

e. A Behavioral Residential Setting (BHRF) as specified in A.A.C. R9-10-101.

10. "Inter-Rater Reliability (IRR)" means the process of monitoring and evaluating qualified healthcare professional staff's level of consistency with decision making and adherence to clinical review criteria and standards.

11. "Other Provider-Preventable Condition (OPPC)" means a condition occurring in the inpatient and outpatient health care setting which the Division and AHCCCS has limited to the following:

a. Surgery on the wrong member,

b. Wrong surgery on a member,

c. Wrong site surgery.

12. "Peer-Reviewed Study" means prior to publication, is a medical study that has been subjected to the review of medical experts who:

a. Have expertise in the subject matter of the study,

b. Evaluate the science and methodology of the study,

c. Are selected by the editorial staff of the publication,

d. Review the study without knowledge of the identity or qualifications of the author, and

e. Are published in the United States.

13. "Prior Authorization (PA)" means a process by which the AdSS authorizes, in advance, the delivery of covered services based on factors including but not limited to medical necessity, cost effectiveness, compliance with this policy and as specified in A.A.C. R9-201, and any applicable contract provisions. PA is not a guarantee of payment as specified in A.A.C. R9-22-101.

14. "Provider Preventable Condition (PPC)" is a condition that meets the definition of a health care acquired condition or another provider preventable condition as defined by the State of Arizona.

15. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental

disability who is a client or an applicant for whom no guardian has been appointed. A.R.S. § 36-551.

16. "Retrospective Review" means the process of determining the medical necessity of a treatment/service post-delivery of care.

17. "Service Plan (SP)" means a complete written description of all covered health services and other informal supports which includes individualized goals, family support services, peer-and recovery support, care coordination activities and strategies to assist the member in achieving an improved quality of life.

18. "Special Health Care Needs (SHCN)" means serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by members generally; that lasts or is expected to last one year or longer and may require ongoing care not generally provided by a primary care provider.

19. "Subcontracted health plan" means an organization with which the Division has contracted or delegated some of its management/administrative functions or responsibilities.

20. Support Coordination" means a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.

21. "Telehealth" means healthcare services delivered via asynchronous , remote patient monitoring, teledentistry, or telemedicine (interactive audio and video).

POLICY

A. UTILIZATION DATA ANALYSIS AND DATA MANAGEMENT

1. The Division's Health Care Services (HCS) shall provide oversight and identifies trends, best practices and opportunities for improvement in utilization management through the following:
   a. HCS shall meet with the AdSS' Medical Management (MM) staff on a quarterly basis to review utilization data, trends, performance, and implementation of action plans.
   b. HCS shall review and approve annual AdSS' Medical

Management Program Plan, Work Plan and Evaluation to ensure goals, service quality and outcomes reflect member needs and Division goals.

2. The Division shall work in collaboration with AHCCCS Division of Fee for Service Management (DFSM) to monitor health outcomes of members enrolled in the Tribal Health Program (THP).

3. The Medical Management (MM) Committee shall review utilization data and findings to make recommendations to improve performance and achieve better outcomes. The MM Committee responsibilities include:

   a. The review of validated data provided by the Utilization Management (UM) subcommittee and any other relevant data;

   b. The review of tracking and trending utilization data on an on-going basis to:

      i. Identify under-utilization and/or over-utilization of services;

      ii. Identify opportunities for early intervention,

iii. Mitigate adverse outcomes;

iv. Identify opportunities for improvement and best practices;

v. Review of performance data related to integrated care, such as support coordination activities, access to services, and actions undertaken to resolve barriers to care; and

vi. Review of the utilization data, performance and opportunities for improvement with the AdSS at least quarterly.

4. The UM Subcommittee shall provide a quarterly tracking and trending report, including data provided by the AdSS, to the MM Committee.

5. The UM Subcommittee shall meet at least 10 times per year.

B. CONCURRENT REVIEW

1. The Division shall provide oversight of concurrent review services conducted by the AdSS. The Division shall monitor and review, at least annually, the AdSS' hospital and institutional stays to

ensure that treatment and lengths of stay meet member needs and are provided in accordance with clinical standards of care.

2. The Division shall provide oversight of the AdSS who are required to implement the following:
   a. Pre-certification prior to a planned hospital or institutional admission based on medical necessity and appropriateness of proposed care. After hospital or institutional admission occurs authorization of the continued stay is based on medical necessity established during the concurrent review process.
   b. Clinical documentation includes relevant medical information to be reviewed when making hospital length of stay decisions. Information may include: symptoms, diagnostic test results, diagnoses, and required services. The clinical review shall include the information used for determining the length of stay.
   c. The admission review and subsequent concurrent reviews shall occur within the timeframes and frequency set forth below:

i. Admission reviews shall be conducted within one working day after notification is provided to the AdSS by the hospital or institution (this does not apply to pre-certifications) as specified in 42 CFR 456.125;

ii. If the hospital or institution does not provide clinical information with the notification of admission, the AdSS shall request the member's medical records pertinent to the admission within one business day;

iii. Continued stay authorizations for hospital and institutional stays shall specify a date by which the next medical review shall be done based on the member's clinical information and criteria guidelines.

3. The Division shall notify providers of the option to request a peer-to-peer discussion with the appropriate AdSS or the AHCCCS DFSM Medical Director when additional information is requested or when the admission or continued stay is denied.

4. HCS shall ensure the concurrent review process is clearly documented and includes the following elements:

a. Medical necessity of admission, level of care and appropriateness of the service setting, criteria used for decision determination;
b. Quality of care, services and setting meeting the member needs;
c. Projected length of stay, based on approved clinical criteria;
d. Continued stay authorization with identification of next review date;
e. Denials or reduction in level of service;
f. Requests for peer-to-peer review and disposition of the request;
g. Proactive discharge planning starting on the day of admission and ongoing throughout the hospital/institutional stay to ensure continuity of care and linkage to required treatment services and supports at discharge;
h. Identification of utilization patterns, such as readmissions, extended length of stays.

5. The Division's support coordinator shall participate proactively in discharge planning for its members admitted to inpatient settings from the day of admission.

6. Support coordination shall manage discharge planning to ensure a safe discharge back to the community and facilitate active engagement from the health plans, health care and behavioral healthcare providers, allied treatment providers, supports and services to meet the comprehensive needs of the member.

7. The support coordinator shall collaborate with AHCCCS DFSM, as appropriate for THP enrolled members.

8. HCS shall review the AdSS' notification of an Institution of Mental Disease (IMD) placement exceeding 15 days and report it to AHCCCS.

9. The AdSS' Medical Management Committee shall annually approve the medical criteria used for concurrent review, which shall be adopted from the national standards. Subsequently it shall be approved by the Division's MM Committee.

10. The Division shall ensure criteria for physical health and behavioral health coverage and medical necessity decisions are clearly documented and based on reasonable medical evidence or the consensus of relevant health care professionals.
11. The Division shall review the AdSS submission of the quarterly Inpatient Hospital Showings Report and sends it to AHCCCS after ensuring the report is signed by the AdSS' Chief Medical Officer attesting that:
    a. A physician has certified to the necessity of inpatient hospital services,
    b. The services were periodically reviewed and evaluated by a physician,
    c. Each admission was reviewed or screened under a utilization review program, and
    d. All hospitalizations of members were reviewed and certified by medical utilization staff.
12. The Division shall collaborate with AHCCCS DFSM to review the Inpatient Hospital Showings Report for Division members enrolled in THP.

C. DISCHARGE PLANNING

1. The Division shall ensure the discharge planning process for members receiving inpatient services has proactive discharge planning to identify and assess the post-discharge bio-psychosocial and medical needs of the member to arrange necessary services and resources for appropriate and timely discharge from a facility.

2. The support coordinator shall proactively engage with the interdisciplinary planning team which includes the hospital/institutional staff, the AdSS UM staff, HCS nurses, health care and behavioral healthcare providers, allied treatment providers, supports and services in discharge planning to meet the comprehensive needs of the member.

3. The Division support coordinator shall engage within the interdisciplinary planning team to support discharge planning from the day of admission and during the inpatient stay and after discharge to ensure all the necessary treatment, services and supports are available to sustain recovery, health, wellness, and well-being upon discharge to the community.

a. If the discharge cannot be affected because of the lack of a resource including return to home or community-based setting, the support coordinator shall identify the needed resource to support discharge from the hospital or institutional setting or resolve member issues and service concerns timely at the lowest level through the identification of care coordination strategies, resources, and clinical consultation.

b. If a covered behavioral health service required after discharge is temporarily unavailable for individuals in an inpatient or residential facility who are discharge-ready, the member may remain in that setting until the service is available. The support coordinator shall work with the Behavioral Health Complex Care Specialist, as needed and/or seek assistance to elevate the issue for resolution of the barrier in accordance with established procedures.

4. The support coordinator shall ensure care management, intensive outpatient services, provider support coordination,

and/or peer service are available to the member while waiting for the appropriate covered physical or behavioral health services.

a. The HCS shall compile a census report identifying the number of members who remain in discharge pending status due to the lack of community resources for review by the MM Committee including the barrier, type of resources needed, date of projected discharge and date of discharge.

5. The Division shall ensure discharge planning is performed by a qualified healthcare professional and initiated on the initial concurrent review, updated periodically during the inpatient stay, and continues through post-discharge to ensure a timely, effective, safe, and appropriate discharge.
6. Division staff participating in discharge planning shall ensure the member/responsible person, as applicable:
   a. Is involved and participates in the discharge planning process;

b. Understands the written discharge plan, instructions, and recommendations provided by the facility;and

c. Is provided with resources, referrals, and possible interventions to meet the member's assessed and anticipated needs after discharge.

7. The Division shall ensure discharge planning, coordination, and management of care includes, but is not limited to:

a. Follow-up appointment with the PCP and/or specialist within seven business days;

b. Coordination and communication by the Division with inpatient and facility providers for safe and clinically appropriate discharge placement, and community support services;

c. Communication of the member's treatment plan and medical history across the various outpatient providers, including the member's outpatient clinical team, other entities/contractors, and FFS providers when appropriate;

d. Prescription medications;

e. Medical equipment;

f. Nursing services;

g. End-of-Life Care related services such as Advance Care Planning;

h. Practical supports;

i. Hospice;

j. Therapies;

k. Referral to appropriate community resources;

l. Referral to Disease Management or Care Management (if needed);

m. A post-discharge follow-up call is made by the District nurse to the member/responsible person within three business days of discharge to confirm the member's well-being and progress of the discharge plan;

n. Additional follow-up actions as needed based on the member's needs;

o. Proactive discharge planning when the Division is not the primary payer.

D. PRIOR AUTHORIZATION AND SERVICE AUTHORIZATION

1. The Division's support coordinator and Health Care Services staff shall work in conjunction with the Division's Network Administrator to provide needed support to homeless clinics to identify available providers and assist in obtaining PA to ensure timely delivery of services that are included in the member plan of care.

2. The Division shall not require PA for tribal members utilizing Indian Health Services (IHS)/638 Tribal providers and facilities. Non-IHS/638 providers or facilities rendering covered services shall obtain PA. PA is not a guarantee of payment as specified in A.A.C. R9-22-101.

3. The AdSS Medical Management committee shall determine PA criteria and is approved by the Division's Medical Management committee.

4. The Division shall provide oversight of the PA process conducted by the AdSS, including adherence to benefit coverage and timeliness of PA requests.

5. The Division shall provide oversight to ensure that all PA

activities are performed in accordance with AdSS Medical Manual Policy 1020 including, but not limited to:

a. The AdSS shall clearly document its criteria for decisions on coverage and medical necessity for both physical and behavioral health services and be based on reasonable medical evidence or a consensus of relevant health care professionals.

b. The AdSS shall utilize Arizona licensed PA staff that includes a nurse or nurse practitioner, physician or physician assistant, pharmacist or pharmacy technician, or licensed behavioral health professional with appropriate training to apply the AdSS' medical criteria or make coverage decisions.

c. The AdSS shall implement a system that allows providers to submit PA requests via telephone, fax, and/or electronically through email.

d. Any AdSS network provider who requests authorization for a service shall be notified of the option to request a peer-to-peer discussion with the AdSS Medical Director

when additional information is requested by the Division or when a PA request is denied.

e. The AdSS shall coordinate the discussion with the requesting provider when appropriate.

f. The AdSS shall identify and communicate to providers and members/Responsible Person the services that require and do not require PA and the relevant medical criteria required for authorization decisions.

g. The AdSS shall respond to requests for initial and continuous determinations for standard and expedited authorization requests as defined in Policy 1000, Chapter Overview of this Policy Manual, Division Operations Manual policy 414, 42 CFR 457.1230(d), and 42 CFR 438.210(b).

h. The AdSS shall respond as expeditiously as the member's condition requires but no later than 72 hours after receipt of an expedited service request pursuant to 42 CFR 438.210(d)(2)(i). The expedited authorization request shall meet federal standards, because a delay in processing could seriously jeopardize the member's life,

health, or ability to attain, maintain or regain maximum function. If the PA request does not meet the criteria for an expedited request, the requesting provider will be notified and given the opportunity to provide additional clinical information to support the expedited request status. However, if the additional clinical information does not support an expedited request, the PA request will be processed as a standard request within the specified timelines.

h. The AdSS shall communicate information to members/Responsible Person and providers in multiple ways including but not limited to newsletters, the AdSS' websites, the Member Handbooks, and provider manuals.

i. Medical criteria shall be available to members/Responsible Person upon request.

j. The AdSS shall consistently apply medical criteria through inter-rater reliability.

k. The AdSS shall authorize services in a sufficient amount,

duration, and scope to achieve the purpose for which the services are furnished.

l. The AdSS MM Committee and the Division MM Committee shall review and approve any changes to medical criteria and shall be communicated to providers at least 30 business days prior to implementation of the change.

6. The Division shall require PA for the following Medical and Behavioral Health Services:

a. Behavioral Health Residential Facility;

b. Non-emergency Acute Inpatient Admissions;

c. Level I Behavioral Health Inpatient Facility and RTC Admissions;

d. Elective Hospitalizations;

e. Elective Surgeries;

f. Medical Equipment;

g. Medical Supplies;

h. Home Health;

i. Home and Community Based Services;

j. Hospice;

k. Skilled Nursing Facility;

l. Therapies - Rehabilitative/Habilitative;

m. Medical and/or behavioral health services;

n. Nursing facility;

o. Emergency alert system services;

p. Rehabilitative/Habilitative Physical/Occupational Therapy for members twenty-one (21) years of age and older;

q. Behavior Analysis Services;

r. Augmentative and Alternative Communication (AAC) services, supplies, and accessories;

s. Non-Emergency Transportation;

t. Select Medications.

7. The Division shall not require PA for these services:

a. Services performed during a Retroactive Eligibility Period;

b. When Medicare or other commercial insurance coverage is primary;

c. Emergency Medical Hospitalization < 72 hours;

d. Emergency Admission to Behavioral Health Level 1 Inpatient facility, however, notification of the admission to the health plan shall occur within 72 hours;

e. Some Diagnostic procedures, e.g., EKG, MRI, CT Scans, X rays, Labs; check the member's health plan's prior authorization requirements;

f. Dental Care - emergency and non-emergency, check the member's health plan's PA requirements;

g. Eyeglasses for members < 21 years old;

h. Family Planning Services;

i. Physician and/or Specialty Consultations and Office Visits;

j. Behavioral Analysis Assessment;

k. Prenatal Care;

l. Emergency Transportation;

m. Non-Emergency Transportation of less than 100 miles;

n. Emergency room visit.

E. INTER-RATER RELIABILITY

1. The Division shall provide oversight of inter-rater reliability (IRR) done by the AdSS to ensure the consistent application of review criteria in making medical necessity decisions which require PA, concurrent review, and retrospective review. Each AdSS plan is monitored to ensure the following:
    a. Adoption of policy and procedures for conducting inter-rater reliability;
    b. All staff, including medical directors, making medical necessity decisions in PA, concurrent review and retrospective review shall have IRR testing as part of the orientation process and at least annually thereafter;
    c. A process for corrective action shall be developed and implemented for all staff who do not meet the minimum passing compliance standard of 90%.
2. The Division shall conduct IRR testing for the following HCS functions:
    a. Skilled Nursing Services,
    b. Second Level Medical Review.
3. At least annually, the IRR testing results from the AdSS plans,

the District Support Coordination and the Division medical directors are presented to the Medical Management Committee for review and approval.

F. RETROSPECTIVE REVIEW

1. The Division shall oversee the retrospective review of medical necessity of a treatment or service post-delivery of care done by the AdSS plans.

2. The AdSS plans shall be monitored for the following:

   a. Policy and procedure that reflect:

      i. The identification of health care professionals with appropriate clinical expertise who are responsible for conducting retrospective reviews,

      ii. Which services require retrospective review,

      iii. Timeframe(s) established by the AdSS plans for completion of the retrospective review.

3. The Division shall ensure criteria for making medical necessity decisions is clearly documented and based on reasonable

medical evidence or a consensus of relevant health care professionals.

4. The Division shall ensure there is a process for consistent application of review criteria.

5. Guidelines for Provider-Preventable Conditions (PPC), other Provider-Preventable Conditions (OPPC), Health Care Acquired Conditions (HCAC) include:

   a. Payment for services related to Provider-Preventable Conditions is prohibited, as specified in 42 CFR 447.26,

   b. A member's health status may be compromised by hospital conditions and/or medical personnel in ways that are sometimes diagnosed as a "complication." If it is determined that the complication resulted from an HCAC or OPPC, any additional hospital days or other additional charges resulting from the HCAC or OPPC will not be reimbursed.

   c. If it is determined that the HCAC or OPPC was a result of an error by a hospital or medical professional, the AdSS

shall conduct a Quality of Care (QOC) investigation and report it in accordance with AdSS Medical Manual Policy 960.

G. CLINICAL PRACTICE GUIDELINES

1. The Division shall collaborate with the AdSS to ensure the clinical practice guidelines (CPGs) developed by the AdSS meet the individualized needs of the Division members.

2. The AdSS shall develop, adopt and disseminate CPGs for physical and behavioral health services, in accordance with 42 CFR 457.1233(c) and 42 CFR 438.236 that:
   a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in that field;
   b. Have considered the individualized needs of the Division's members;
   c. Are adopted in consultation with contracted health care professionals and National Practice Guidelines or developed in consultation with health care professionals and include a thorough review of peer-reviewed articles in medical

journals published in the United States when national practice guidelines are not available;

d. Are disseminated by the AdSS to all their affected providers and, upon request, to members/Responsible Person and potential members;

e. Provide a basis for consistent decisions for utilization management, member education, coverage of services, and any other areas to which the guidelines apply.

3. The AdSS MM Committee shall evaluate the practice guidelines through a MM multi-disciplinary committee to determine if the guidelines remain applicable, represent the best practice standards, and reflect current medical standards every two years.

4. The Division shall review the AdSS' approved CPGs and document the review and adoption of the practice guidelines as well as the evaluation of efficacy of the guidelines in the MM Committee meeting minutes.

H. NEW MEDICAL TECHNOLOGIES AND NEW USES OF EXISTING TECHNOLOGIES

1. The Division shall collaborate with the AdSS to ensure new medical technologies and new uses of existing technologies to meet the individualized needs of the Division members. The AdSS shall be monitored for the following:

   a. Implementation written procedures for evaluating new technologies and new uses of existing technology that include an evaluation of benefits for physical and behavioral healthcare services, pharmaceuticals, and devices;

   b. The procedures shall include both a mechanism for MM Committee review on a quarterly basis and a timeframe for making a clinical determination when a time sensitive request is made. A decision in response to an expedited request shall be made as expeditiously as the member's condition warrants and no later than 72 hours from receipt of the request.

3. The AdSS shall include coverage decisions by Medicare

intermediaries and carriers, national Medicare coverage decisions, and Federal and State Medicaid coverage decisions in its evaluation.

4. The AdSS shall evaluate published or unpublished information sources that may establish that a new medical service or technology represents an advance that substantially improves the diagnosis or treatment of members, as specified in 42 CFR 412.87.

5. The AdSS shall have a process for documenting the coverage determinations and rationale in the MM Committee meeting minutes.

I. DIVISION OVERSIGHT RESPONSIBILITIES

1. The Division MM Committee shall monitor utilization management activities.

2. The MM Committee shall review relevant metrics and reports, and meet quarterly to discuss performance, outliers, and opportunities for improvement for HCS UM activities and AdSS UM activities.

3. HCS shall address the need for improvement of UM activities conducted by the AdSS through quarterly meetings with the AdSS and through the UM Subcommittee as well as the Division's Operational Review.

J. SUPPLEMENTAL INFORMATION

1. The Division is responsible for the oversight of the AdSS' administration of utilization management activities for all services provided to members of the Division.
2. AHCCCS DFSM is responsible for the administration of utilization management functions for acute physical and behavioral health services for Division members enrolled in the Tribal Health Program.
3. The intent of the discharge planning process is to improve the management of inpatient admissions and the coordination of post discharge services, reduce unnecessary hospital and institutional stays, ensure discharge needs are met, and decrease readmissions.

Signature of Chief Medical Officer: Anthony Dekker (Jan 20, 2023 08:46 MST)
Anthony Dekker, D.O.

1021 CARE MANAGEMENT

REVISION DATE: 11/8/2023
EFFECTIVE DATE: July 20, 2022
REFERENCES: A.R.S. § 13-3994; A.R.S. § 31-501; A.R.S. §§ 36-551; A.R.S. § 38-211; 42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(vi); 42 CFR 438.208(b)(2)(ii) and (iii); 42 CFR 438.208(b)(2)(iv); 42 CFR 457.1220; 42 CFR 457.1230(c); 45 CFR Part 160 and 164; AMPM 310-HH; AMPM 520; AMPM 570; AMPM 580; AMPM 940; AMPM 1010; AMPM 1021; AMPM 1620; ACOM 438.

PURPOSE

This policy sets forth roles and responsibilities of the Division of Developmental Disabilities (Division)for provision of Care Management services and collaboration with Support Coordination to improve health outcomes for Tribal Health Program (THP) Members who have physical or behavioral health needs or risks that require immediate Division intervention. This policy provides information on the Division's monitoring and oversight of the Administrative Services Subcontractors (AdSS) Care Management and High Needs/High Cost (HNHC) programs. The policy also provides details of the Divisions responsibilities for the High Needs/High Cost program.

DEFINITIONS

1. "Advance Care Planning" means a part of the End-of-Life Care concept and is a billable service that is a voluntary face-to-face ongoing discussion between a qualified health care professional and the member to:
   a. Educate the member about their illness and the health care options that are available to them.
   b. Share the member's wishes with family, friends, and his or her physicians.
   c. Develop a written care plan that identifies the member's choices for treatment.
2. "Arizona State Hospital" or "ASH" means the state hospital providing long-term inpatient psychiatric care to Arizonans with mental illnesses who are under court order for treatment.
3. "Care Management" means a group of activities performed to identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help

achieve better health outcomes. Distinct from Support Coordination, Care Management does not include the day-to-day duties of service delivery.

4. "Care Manager" means someone who provides Care Management services.

5. "Division Tribal Team" means for the purpose of this policy, the Tribal Liaison (Tribal Social Service referrals), Tribal Health Coordinator (general healthcare navigation inquires) and the Tribal RN Liaison (referrals to IHS 638 facilities programs), depending on the service need.

6. "End-of-Life Care" means a concept of care, for the duration of the member's life, that focuses on Advance Care Planning, the relief of stress, pain, or life limiting effects of illness to improve quality of life for a member at any age who is currently or is expected to experience declining health, or is diagnosed with a chronic, complex, or terminal illness.

7. "Informal Supports" means non-billable services provided to a member by a family member, friend, or volunteer to assist or

perform functions such as:

a. Housekeeping,

b. Personal care,

c. Food preparation,

d. Shopping,

e. Pet care, or

f. Non-medical comfort measures.

8. "Medication Assisted Treatment" or "MAT" means the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.

9. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

10. "Planning Document" means a written plan developed through an assessment of functional needs that reflects the Services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such Services and supports.

11. "Planning Team" means a group of people including the Member;

the Responsible Person; the Support Coordinator; other State of Arizona Department of Economic Security staff, as necessary; and any person selected by the Member; Responsible Person; or the Department.

12. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed.

13. "Social Determinants of Health" or "SDOH" means the social, environmental, and economic factors that can influence health status and have an impact on health outcomes.

14. "Special Health Care Needs (SHCN)" means serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by members generally, that lasts or is expected to last one year or longer and may require ongoing care not generally provided by a primary care provider.

15. "Support Coordination" means a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.

16. "Support Coordinator" means the same as "case manager" under A.R.S. § 36-551.

POLICY

A. COMPONENTS OF CARE MANAGEMENT

1. The Division shall have in place a Care Management process with the primary purpose of coordinating care and assisting in accessing resources for ALTCS eligible Members with multiple or complex conditions and who require intensive physical, or behavioral health support services.

2. The Division shall ensure the AdSS provides Care Management for members enrolled with the AdSS.

3. The Division shall provide Care Management for members

enrolled with the Tribal Health Program.

4. The Division shall have multiple methods for referring a Member to Care Management, including referrals from the Member or Responsible Person, internal sources, or provider.

5. The Division shall provide Care Management that is designed to be short-term and time-limited in nature.

6. The Division shall require the following Care Management services:
    a. Assistance in making and keeping needed physical or behavioral health appointments;
    b. Following up and explaining hospital discharge instructions;
    c. Health coaching and referrals related to the Member's immediate needs;
    d. Primary Care Provider (PCP) reconnection; and
    e. Offering other resources or materials related to wellness, lifestyle, and prevention.

7. The Division shall provide care coordination to ensure Members

receive the necessary services to prevent or reduce an adverse health outcome.

8. The Division shall ensure that clinical resources and assessment tools utilized are evidenced-based.
9. Care Managers shall establish a process to ensure coordination of Member physical and behavioral health care needs across the continuum, based on early identification of health risk factors or Special Health Care Needs (SHCN) consistent with the Planning Document.
10. The Division shall ensure the coordination ensures provision of physical and behavioral services in any setting that meets the Member's needs in the most cost-effective manner available.
11. Care Managers shall be expected to have direct contact with Members for the purpose of providing information and coordinating care.
12. The Division shall implement a Care Management system that automatically documents the staff member's name and ID and

the date and time the action or contact with the member occurred.

13. The Division shall implement a Care Management system that provides automatic prompts and reminders to follow-up with the member as specified in the member's care plan.

14. The Division shall provide Care Management as an administrative function.

15. The Division shall obtain approval by the Arizona Health Care Cost Containment System (AHCCCS) prior to delegating a portion of the Care Management functions to another entity.

16. The Division shall ensure the Care Managers are not performing the day-to-day duties of the Division Support Coordinator, the provider case manager, or the TRBHA case manager.

17. Care Managers shall work closely with case managers referred to in this section, to ensure the most appropriate service plan and services for Members.

18. The Division shall identify and refer members that meet criteria

for Care Management services, including:

a. Frequent use of the Emergency Department instead of seeing providers for ongoing issues (4 or more occurrences within the past 6 months);

b. Multiple physical or behavioral health hospitalizations (3 or more inpatient or readmissions within the past 6 months);

c. Discharged from an inpatient or skilled facility and requires coordination of post-acute services;

d. Missed 3 or more physical or behavioral health appointments within the past 3 months;

e. Having difficulty obtaining medical benefits or referrals ordered by providers;

f. Diagnosed with heart failure, diabetes, asthma, chronic obstructive pulmonary disease, or depression and requires assistance with management of the condition;

g. In the process of receiving a transplant or up to one year post-transplant;

h. Diagnosed with Human Immunodeficiency Virus (HIV);

i. Pregnant;

j. Diagnosed with a behavioral health disorder, the condition is not stable and requires assistance with management of the condition;

k. Needs exclusive provider restriction for overutilization of drugs with abuse potential;

l. Needs referral to or is currently receiving Medication Assisted Treatment (MAT) for opioid use;

m. Has Social Determinants Of Health (SDOH) needs that are impacting member's ability to obtain the appropriate care (e.g., basic needs not being met, safety issues in home environment, etc.);

n. Survivor of sex trafficking;

o. Recently been incarcerated or is transitioning out of jail or prison within the next 30 days;

p. Needs out of state services;

q. Requires assistance with Tribal Nations or providers;

r. Is a child with one or more of the following:

i. Newborn with neonatal abstinence syndrome or maternal drug exposure,

ii. Child and Adolescent Level of Care Utilization System (CALOCUS) level 4 or higher,

iii. Serious emotional disturbance,

iv. Recently removed from their home and placed in foster care.

s. Have multiple complaints regarding services or the Arizona Health Care Cost Containment System (AHCCCS) Program. This includes members who do not otherwise meet the Division criteria for Care Management as well as members who contact governmental entities for assistance, including AHCCCS.

19. The Division shall integrate data from medical and behavioral health claims or encounters, pharmacy claims, laboratory results, Health Risk Assessments (HRA)s, Electronic Medical Records (EMRs), health services programs within the organization, or other advanced data sources to develop the selection criteria.

20. The Division shall stratify Members for Care Management for targeted interventions, on at least an annual basis.

B. DIVISION CARE MANAGEMENT RESPONSIBILITIES FOR THP MEMBERS

1. Care Managers shall comprehensively assess the Member and develop and implement a care plan that has the following:
    a. Initial assessment of Members:
        i. Health status;
        ii. Physical and behavioral health history, including medications and cognitive function;
        iii. Activities of daily living; and
        iv. SDOH.

b. Life planning activities, including wills, living wills, advance directives, health care powers of attorney, End-of-Life Care and Advance Care Planning.

c. Evaluation of:

   i. Cultural and linguistic needs and preferences;

   ii. Visual and hearing needs and preferences;

   iii. Caregiver resources; and

   iv. Availability of services, including community resources.

d. Development of a Care Management plan, including self-management tools, prioritized goals that consider Member and caregiver preferences and desired level of involvement;

e. Identification of barriers;

f. Facilitation of referrals and a follow-up process to determine if Members act on referrals made;

g. Development of a schedule for follow-up and

communication with the Member;

h. A process and timeframe for monitoring the effectiveness of the Care Management plan.

2. Care Managers shall work with the Support Coordinator, the provider case manager, Division Tribal Team, the Primary Care Physician (PCP) or specialists to coordinate and address Member needs within 30 days after the member has been determined eligible to receive Care Management.
3. Care Managers shall continuously document interventions and changes in the care plan.

C. DIVISION RESPONSIBILITIES

1. The Division shall ensure integration of services and continuity of care by:
   a. Ensuring that in the process of coordinating care, each Member's privacy is protected in accordance with the privacy requirements including those specified in 45 CFR Part 160 and 164, Arizona statutes and regulations, and to the extent applicable in 42 CFR 457.1220, 42 CFR

438.100(a)(1), and 42 CFR 438.100(b)(2)(vi);

b. Allowing Member choice in selecting a PCP, TRBHA or a behavioral health provider who is formally designated as having primary responsibility for coordinating the member's overall health care.

c. Ensuring access to care that is appropriate to their individual needs as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(1);

d. Ensuring each Member receiving care coordination has an individual or entity that is formally designated as primarily responsible for coordinating services for the Member, such as the Support Coordinator, the provider case manager, or TRBHA case manager;

e. Ensuring the Care Manager provides the Responsible Person with information on how to contact their designated person or entity as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(1);

f. Specifying under what circumstances services are coordinated by the Division, including the methods for coordination and specific documentation of these processes;

g. Coordinating the services for Members between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(2)(i);

h. Coordinating covered services with the services the Member receives from another entity or FFS provider as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(2)(ii) and (iii);

i. Coordinating covered services with community and Informal Supports that are generally available through another entity or FFS provider in the Division's service area, as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(2)(iv);

j. Ensuring Members receive End-of-Life Care and Advance Care Planning;

k. Ensuring Care Managers establish timely and confidential communication of data and clinical information among providers that includes:

   i. The coordination of Member care among the PCP, AdSS, and tribal entities;

   ii. Working with the PCP to communicate all known primary diagnoses, comorbidities, and changes in condition to the Division or FFS provider and Tribal provider to include TRBHA when the PCP becomes aware of the Division, or TRBHA involvement in care.

l. Ensuring that the PCP is providing pertinent diagnoses and changes in condition to the Division:

   i. No later than 30 days from change in medication or diagnosis, or

   ii. No later than 7 days of hospitalization.

m. Facilitating this communication exchange as needed and establish monitoring activities such as record review to ensure that the exchange occurs;

n. Ensuring Care Managers provide consultation to a Member's inpatient and outpatient treatment team and directly engages the Responsible Person as part of Division Care Management;

o. Ensuring individuals admitted to a hospital who are identified as in need of behavioral health services, are responded to as specified below:

   i. Upon notification of an individual who is not currently receiving behavioral health services, the Division shall ensure a referral is made to a provider agency within 24 hours.

p. Ensuring that provider agencies attempt to initiate services with the individual within 24 hours of referral and that the provider agency schedules additional appointments and services with the individual prior to discharge from the

hospital;

q. Ensuring coordination, transition, and discharge planning activities are completed consistent with providers orders to ensure cost effectiveness and quality of care consistent with providers orders to ensure cost effectiveness and quality of care for Members already receiving behavioral health services;

r. Ensuring policies reflect care coordination for Members presenting for care outside of the Division's provider network;

s. Identifying and coordinating care for Members with Substance Use Disorder (SUD) and ensuring access to appropriate services such as Medication Assisted Treatment (MAT) and peer support services;

2. The Division shall develop policies and implement procedures for Members with SHCN, as specified in the contract with AHCCCS and AMPM Policy 520, including:

a. Identifying Members with SHCN;

b. Ensuring an assessment by an appropriate health care professional for ongoing needs of each Member;

c. Ensuring adequate care coordination among providers or TRBHAs;

d. Ensuring a mechanism to allow direct access to a specialist as appropriate for the Member's condition and identified needs (e.g., a standing referral or an approved number of visits); and

e. Additional care coordination activities based on the needs of the Member.

3. The Division shall implement measures to ensure that the Responsible Person is involved in Care Management:

a. Is informed of particular health care conditions that require follow-up;

b. Receives, as appropriate, training in self-care and other measures they may take to promote their own health; and

c. Is informed of their responsibility to comply with prescribed treatments or regimens.

4. The Division Care Management shall focus on achieving Member wellness and autonomy through:
   a. Advocacy,
   b. Communication,
   c. Education,
   d. Identification of service resources, and
   e. Service facilitation.

5. Care Managers shall also assist the Responsible Person in identifying appropriate providers, TRBHAs, or other FFS providers, and facilities throughout the continuum of services.

6. Care Managers shall ensure that available resources are being used in a timely and cost-effective manner in order to obtain optimum value for both the Member and the Division.

7. The Division shall proactively provide care coordination for Members who have multiple complaints regarding services or the AHCCCS Program. This includes Members who do not otherwise meet the Division criteria for Care Management, as well as Members who contact governmental entities for assistance,

including AHCCCS.

8. The Division shall report its monitoring of Members awaiting admission and those Members who are discharge-ready from Arizona State Hospital (ASH) utilizing the Arizona State Hospital Admission and Discharge Deliverable Template.

9. The Division shall demonstrate proactive care coordination efforts for all Members awaiting admission to, or discharge from ASH.

10. The Division's Health Care Services Complex Care team shall coordinate with ASH for discharge planning, including ensuring the Member with diabetes has appropriate diabetic monitoring equipment and supplies, and has been educated and trained to the use prior to discharge.

11. The Division shall not limit discharge coordination and placement activities based on pending eligibility for ALTCS.

12. The Division shall submit the following, in the case that a THP Member has been awaiting admission to, or discharge from ASH

for an excess of 90 days:

a. A barrier analysis report to include findings, performance improvement activities and implementation plan; and

b. A status report for each member who is continuing to await admission or discharge, as specified in the contract with AHCCCS.

13. The Division shall provide the AMPM 1021 Attachments A, B and E as specified in the contract with AHCCCS.

14. The Division shall arrange ongoing medically necessary nursing services consistent with providers orders to ensure cost effectiveness and quality of care in the event that a Member's mental status renders themself incapable or unwilling to manage their medical condition and the Member has a skilled medical need.

15. The Division shall identify, track and report Members who utilize Emergency Department (ED) services inappropriately four or more times within a six-month period.

16. The Division shall implement interventions to educate the Responsible Person on appropriate use of ED and divert Members to the right care in the appropriate place of service.

17. The Division shall ensure Care Management interventions to educate Responsible Person include:
    a. Outreach phone calls or visits,
    b. Educational letters,
    c. Behavioral health referrals,
    d. HNHC program referrals,
    e. Disease or chronic Care Management referrals,
    f. Exclusive pharmacy referrals, or
    g. SDOH resources.

18. HCS shall submit AMPM Attachment 1021-A as specified in the contract with AHCCCS, identifying the number of times the AdSS intervenes with Members utilizing the ED inappropriately.

19. The Division shall monitor the length of time Members remain in the ED while awaiting behavioral health placement or wrap-around services.

20. The Division shall coordinate care with the ED and the Member's treatment team to discharge the Member to the most appropriate placement or wrap-around services immediately upon notification that a Member who requires behavioral health placement or wrap-around services is in the ED.

21. The Division's Chief Medical Officer shall be involved when THP members experience a delay in discharge from institutional settings or the ED.

22. The Division shall submit the 24 Hours Post Medical Clearance ED Report utilizing Attachment B to the Division as specified in the contract with AHCCCS.

23. The Division shall develop a plan specifying short-term and long-term strategies for improving care coordination and Care Management as specified in the Medical Management (MM) Program workplan.

24. The Division shall develop an outcome measurement plan to track the progress of the strategies in the MM Program workplan.

25. The Division shall report the plan specifying the strategies for improving care coordination and the outcome measurement in the annual MM Program Plan, and submitted as specified in the contract with AHCCCS, utilizing AMPM Policy 1010 Attachment A and Attachment B.

26. The Division Tribal Team shall facilitate the promotion of services and programs to improve the quality and accessibility of health care to eligible American Indian and Alaskan Native Members.

27. The Division Tribal Team shall collaborate with Care Management to ensure communication with all tribal programs are actively engaged in the Member's care coordination process.

28. The Division's Behavioral Health Complex Care Specialist and Support Coordinator shall coordinate with the AdSS to provide assistance with care coordination for Members who are awaiting placement into ASH by communicating with the Responsible Person, Support Coordinator, facilities, providers, and ASH.

D. DIVISION MONITORING AND OVERSIGHT

1. The Division shall ensure the AdSS provides the following, in the case that a Member has been awaiting admission to, or discharge from ASH for an excess of 90 days:
   a. A barrier analysis report to include findings, performance improvement activities and implementation plan; and
   b. A status report for each member who is continuing to await admission or discharge, as specified in the contract with AHCCCS.
2. The Division shall review the deliverables received from the AdSS and submit the following reports to AHCCCS:
   a. Barrier analysis report,
   b. Status report for each member awaiting admission or discharge.
3. The Division shall ensure the AdSS provides the AMPM 1021 Attachments A, B and E as specified in the contract.
4. The Division shall review AMPM 1021 Attachments A, B and E

provided by the AdSS prior to sending to AHCCCS.

5. The Division HCS shall meet with the AdSS at least quarterly to provide ongoing evaluation including data analysis and recommendations to refine processes to optimize results.

6. The Division HCS shall meet with the AdSS quarterly to review the AdSS Medical Management Committee minutes, reports with data analysis and action plans, over and under-utilization, outliers, and opportunities for performance improvement.

7. The Division shall ensure the AdSS submit an overview of the Medical Management (MM) program plan checklist AMPM 1010 Attachment A and a MM workplan, AMPM 1010 Attachment B.

1. The Division shall monitor the overall performance of Care Management services including:
   a. Tracking and trending performance metrics and outcomes,
   b. Data analysis,
   c. Identifying successful interventions and care pathways to optimize results, and

a. Making recommendations to refine processes and provide reports to the Division Medical Management Committee.

2. The Division shall perform an Operational Review of the AdSS to review compliance on an annual basis.

3. The Division shall develop a plan specifying short and long term strategies for improving care coordination and the Care Management program as specified in the MM Program workplan.

E. DIVISION RESPONSIBILITIES FOR THE HIGH NEEDS/HIGH COST PROGRAM

1. Health Care Services (HCS) shall annually review the list of Members from each AdSS that are identified as meeting the criteria for the HNHC program and approve Members to be monitored through the HNHC program. This is also to be done by HCS upon the AdSS proposing changes to the list.

2. HCS shall request additional Members identified by the Division to be added to the HNHC program when Members have high needs or high costs due to Long Term Services and Supports

(LTSS) who also have high medical or behavioral needs.

3. The Division shall submit to AHCCCS an overview of the HNHC program in the Medical Management (MM) Program Plan submission, AMPM Attachment 1010-A as outlined in the contract.

4. The Division shall submit to AHCCCS counts of distinct members that are considered to have high cost behavioral health needs based on criteria developed by the AdSS and approved by the Division as outlined in the contract.

5. The Complex Care Manager shall annually review the High Cost Behavioral Health Reports (AMPM 1021 Attachment E) that the AdSS sends to the Compliance Unit, which is then forwarded to HCS.

6. The Complex Care Manager shall annually develop and submit an integrated High Cost Behavioral Health Report (AMPM 1021 Attachment E) reflecting data received from each AdSS to AHCCCS.

7. The Complex Care Manager shall annually send the High Cost Behavioral Health Report (AMPM 1021 Attachment E) to DDDAHCCCSDeliverables@azdes.gov.

8. HCS shall coordinate with the AdSS to ensure the assigned Support Coordinator and Behavioral Health Complex Care Specialist are invited to the monthly HNHC meetings.

9. The HCS Complex Care Nurse, assigned Support Coordinators and Behavioral Health Complex Care Specialists shall attend the monthly HNHC meeting to participate in the collaborative care coordination between the Division, AdSS, Care Manager, and provider case manager.

10. All attendees shall discuss the following care coordination activities during the monthly HNHC meetings:
    a. Identify Member specific interventions to be used to ensure:
        i. Relevant and timely access to care;
        ii. Care plan goals address the needs of the program

iii. Ineffective medical, behavioral health, and long-term care interventions are adjusted as needed; and

iv. Progress toward treatment goals is being achieved.

b. Address barriers to improvement, additional resources needed, and changes to treatment goals in the following areas:

i. Medical,

ii. Environmental,

iii. Behavioral Health, and

iv. Psychosocial.

11. The HCS Complex Care Nurse in collaboration with the AdSS, shall monitor Member outcomes to transition Members out of the HNHC program when they meet the following criteria:

a. The Member has met treatment goals, or

b. The Member's physical and behavioral needs have been stabilized, or

c. The Member no longer meets the AdSS HNHC criteria.

Signature of Chief Medical Officer: Anthony Dekker (Nov 2, 2023 08:16 PDT)

Anthony Dekker, D.O.

1022 JUSTICE REACH-IN

EFFECTIVE DATE: April 10, 2024
REFERENCES: 42 CFR § 438.62(b); A.R.S. § 36-551; AMPM 1022; AMPM 541.

PURPOSE

This policy sets forth roles and responsibilities of the Division of Developmental Disabilities (Division) when facilitating the transition of Members with chronic or complex care needs out of jails and prisons into communities.

DEFINITIONS

1. "Care Management" is a group of activities performed to identify and manage clinical interventions or alternative treatments for identified Members to reduce risk, cost, and help achieve better health outcomes. Distinct from Case Management, Care Management does not include the day-to-day duties of service delivery.
2. "Justice System Liaison" means a Division staff person who is located in Arizona and is the single point of contact for justice system stakeholders, such as jails, prisons, detention facilities,

courts, law enforcement, and community supervision agencies. This position is responsible for ensuring care coordination of justice-involved Members and for oversight and reporting of Justice System reach-in Care Coordination activities. This position also serves as the single point of contact for justice system stakeholders engaged programmatically in arrest diversion or incarceration alternative initiatives intended to reduce the number of individuals from entering the justice system.

3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

4. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

5. "Support Coordinator" means a "case manager" as defined in A.R.S. § 36-551.

POLICY

A. PROGRAM ADMINISTRATION REQUIREMENTS

1. The Division shall designate staff to serve in the role of Justice System Liaison who reach into the justice system to facilitate transitions for all Division Members out of justice facilities for the purposes of continuity of care.

2. The Justice System Liaison shall serve as the single point of contact when collaborating with justice system partners to identify, plan, and implement care coordination efforts for Members identified as requiring reach-in care.

3. The Justice System Liaison shall identify justice partners and their contact information, from the following:

    a. Jails;

    b. Sheriff's Offices;

    c. Correctional Health Services;

    d. Arizona Department of Corrections, Rehabilitation and

Reentry (ADCRR);

e. ADCRR Community Supervision;

f. Probation;

g. Courts; and

h. Other justice partners as determined by the Justice System Liaison.

4. The Justice System Liaison shall monitor the incarceration report, also known as the 834-file, in Focus in order to:

a. Identify Members who have been:

i. Incarcerated; or

ii. Otherwise released since the previous report.

b. Obtain length of Member incarceration from this report.

5. The Justice System Liaison shall collaborate with reach-in partners to determine Member care needs.

6. The Justice System Liaison shall collaborate with AdSSs through

the following measures:

a. Monthly meetings with each health plan to discuss mutual members;

b. Providing a Transition Notice Form to each MCO representative upon receiving notification of a member's justice involvement; and

c. Communicating with MCO's to address Member needs as identified.

7. The Justice System Liaison shall obtain the Member's criminal Justice Reach-In report from Focus in the quarter following the Member's release from the Justice System in order to:

a. Assess anticipated cost savings, including analysis of medical expenses prior to incarceration and subsequent to reach-in activities and release.

b. Report out in the Justice Quarterly Metrics the total amount saved or increased for all Members.

8. The Justice System Liaison shall notify AHCCCS upon becoming aware of a Member who becomes an inmate of a public institution, who is not identified in the 834 file, via email at MCDUJustice@azahcccs.gov.

B. REACH-IN CARE COORDINATION

1. The Justice System Liaison shall utilize the 834 file data provided by AHCCCS to identify Members who meet the Division's established parameters for reach-in care coordination, including identification of Medication Assisted Treatment (MAT) eligible Members prior to release.

2. The Justice System Liaison shall utilize additional data sources, if available for the purpose of identifying Members who meet the Division's established parameters for reach-in care coordination.

3. The Justice System Liaison shall utilize the 834 file provided By AHCCCS to identify incarcerated Members that may have missed their eligibility redetermination date while incarcerated, causing a discontinuance of benefits, in order to identify Members requiring assistance with reapplication for AHCCCS Medical

Assistance (MA) and other public benefits, in accordance with AMPM 541.

4. The Justice System Liaison shall complete the following activities upon identification of a Member's justice system involvement:

   a. Complete a Member intake utilizing Member data.

   b. Research the Member's legal case, utilizing jail or court websites to determine any pending court actions.

   c. Identify the Support Coordinator assigned to the justice involved Member to immediately inform the Support Coordinator of the justice involvement via email.

5. The Justice System Liaison shall coordinate with justice facility health care or subcontracted health plans in identifying Members requiring reach-in care for physical health, medication and behavioral concerns.

6. The Justice System Liaison shall begin reach-in activities for Members who have been incarcerated for 20 days or longer, and have a scheduled release date, to provide:

a. Member education regarding care, services, resources, appointment information; and

b. Subcontracted health plan case management contact information.

7. The Justice System Liaison shall communicate with incarceration facility health care and any subcontracted health plan to communicate the incarcerated Division Member's medication and behavioral concerns.

8. The Justice System Liaison shall contact and coordinate with Justice Partners and subcontracted health plans regarding status updates and anticipated release date or next court date, updating case file and entering shared notes into the database at least once weekly.

9. The Support Coordinator shall:

a. Acknowledge incarceration notification upon receipt from the Justice System Liaison, and update Member records.

b. Follow up with the Justice System Liaison to provide case

updates, including release or court date information.

c. Change Member status to "Suspend" in FOCUS when a Member has been incarcerated for 30 days or longer with no anticipated release date.

10. The Justice System Liaison shall monitor hearing information, noting date and type of hearing, entering this information into the database, and notifying Justice Partners of provided updates by email.

11. Division staff shall not appear on the Member's behalf, in the capacity of Division staff, in any court, unless a subpoena has been submitted through the Office of the Attorney General.

C. PRIOR TO RELEASE

1. The Justice System Liaison shall begin the release planning process upon receiving notification of the Member's anticipated release date.

2. The Justice System Liaison shall make Member education regarding care, services, resources, appointment information,

subcontracted provider and case management contact information available for the planning release meeting.

3. Division staff shall obtain from the Responsible Person a signed Authorization for Disclosure of Protected Health Information (DDD-1535A) that specifically identifies the person or organization intended to receive health information.

4. Justice System Liaison staff shall collaborate with Justice Partners to plan timeframes for appointments needed based on health status, to:

    a. Identify and address any barriers to accessing needed appointments; and

    b. Ensure initial appointments are scheduled to occur within seven days of Member release.

5. The Justice System Liaison shall communicate information regarding appointments to all Justice Partners and justice facility health care.

6. The Justice System Liaison shall review and address social

determinants of health prior to release through wrap-around services.

D. AFTER RELEASE

The Justice System Liaison shall continue reach-in activities post-release in effort to reduce recidivism to include:

a. Following up with the Responsible Person to support access to necessary services and appropriate service levels.

b. Following up with Justice Partners to communicate the status of appointments, within 30 days of release.

c. Monitoring the Member in the community until there is no longer any Justice involvement and the Member is reported to be stable in the community by the Planning Team.

E. OUTREACH TO COMMUNITY PARTNERS

The Justice Team shall provide specialized education to local law enforcement and other community partners to facilitate understanding

of developmental disabilities the populations served by the Division regarding the following:

a. Accommodating Division Members;

b. Safe interactions with Division Members;

c. Communicating with Division Members;

d. Effective engagement with Division Members;

e. Alternatives to the justice system for Division Members; and

f. De-escalation techniques.

F. REPORTING

1. The Justice System Liaison shall track data to be utilized by Division staff to create monthly, quarterly, and annual reports, identifying the number of Member transitions received, and other pertinent statistics, and trends.

2. The Justice Team designee shall provide data in the Division's Justice System Liaison reports at Medical Management meetings.

SUPPLEMENTAL INFORMATION

Division Members' AHCCCS health plan enrollment is suspended upon incarceration, and reinstated upon release.

Signature of Chief Medical Officer: Anthony Dekker (Apr 9, 2024 13:11 PDT)
Anthony Dekker, D.O.

1023 DISEASE/CHRONIC CARE MANAGEMENT

EFFECTIVE DATE: July 20, 2022
REFERENCES: A.R.S. §36-551; AMPM 1023

PURPOSE

This policy outlines the requirements for the Division of Developmental Disabilities (Division) Disease/Chronic Care Management Program. The program focuses on members with chronic conditions, and/or at high risk, and may benefit from a targeted intervention plan.

DEFINITIONS

1. "Care Management" means a group of activities performed by the Contractor to identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health outcomes. Distinct from Case Management, Care Management does not include the day-to-day duties of service delivery.
2. "Case Management" means a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes. Case Management for DES/DDD is referred to as support coordination.
3. "Disease/Chronic Intervention Plan" means a protocol targeted at

managing a disease/chronic condition and improving health outcomes.

4. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed A.R.S. §36-551.
5. "Person Centered Service Plan" means a written plan developed through an assessment of functional need that reflects the services and supports (paid and unpaid) that are important for and important to the member in meeting the identified needs and preferences for the delivery of such services and supports. The PCSP shall also reflect the member's strengths and preferences that meet the member's social, cultural, and linguistic needs, individually identified goals and desired outcomes, and reflect risk factors (including risks to member rights) and measures in place to minimize them, including individualized back-up plans and other strategies as needed.

POLICY

The Division Disease/Chronic Care Management Program focuses on members with high need/high risk and/or chronic conditions to improve health outcomes. Member participation is voluntary. The Disease/Chronic Care Management Program shall develop individualized intervention plans

that include early identification of potential members, coordination of treatment, and chronic disease management strategies including education and self-management of conditions. The program shall work with Support Coordination, and the Administrative Services Subcontractors (AdSS) to promote sustainable healthy outcomes, living well with chronic conditions, healthy lifestyles, coping and support strategies, and engagement in treatment.

A. CRITERIA FOR ENROLLMENT

A member is eligible for the program who:

1. Has been diagnosed with a chronic medical condition and complex care needs, requiring care from a multidisciplinary team;

2. Is identified as at risk or experiencing poor health outcomes by a health assessment, diagnostics or other relevant medical testing;

3. Has one or more of the Fatal Five (aspiration; bowel obstruction, gastroesophageal reflux disease [GERD], dehydration, or seizures) conditions considered preventable causes of death in people with intellectual/developmental disabilities;

4. Has been diagnosed with post- Covid-19 condition(s); or

5. Has exhibited high or low utilization of services for high need conditions.

B. PROGRAM COMPONENTS

The Disease/Chronic Care Management Program provides a focused assessment of opportunities and development of an intervention plan to better manage disease or conditions for targeted members, improve health outcomes and quality of life.

Program activities include:

1. Screenings and assessments to identify high risk behaviors or emerging health issues, coordination of treatment, as appropriate, with the AdSS including but not limited to:

    a. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for qualified members, including education and health promotion for dental/oral health services

    b. Substance use

    c. Depression

    d. Tobacco use

2. Development of an individualized Disease/Chronic Condition Intervention Plan that involves working closely with the member and/or responsible person and obtaining their agreement with the plan. The plan includes the following components:

   a. Goals.

   b. Opportunities, interventions and resources to improve long term health outcomes.

   c. Coordination with primary care provider/specialty care provider(s) and medical/behavioral treatment teams.

   d. Regular contact by Health Care Services with the member and/or responsible person.

   e. Evidence-based guidelines to enhance the health, wellness and quality of life of the member while reducing the need for hospitalization and other costly treatments. Individualized targeted interventions designed to improve and sustain member engagement in treatment.

   f. Actions to be taken by the member and/or responsible person.

g. Health education, resources and support tailored to the member's needs, including but not limited to:

i. Understanding chronic disease/conditions and improving health, wellness and quality of life

ii. Working with the care team, treatment/ services providers and allied supports

iii. Establishing and maintaining treatment relationships that foster consistent and timely interventions

iv. Understanding the member role in health and wellness

v. Healthy living and wellness programs

vi. Self-help resources/programs including digital, web based and/or community resources designed to improve health and wellness for specific disease/ chronic conditions

vii. Health risk-reduction and healthy lifestyle choices, including tobacco cessation.

viii. Preventative care may include but is not limited to:

1) Health screening

2) Annual health exams

3) Cancer screening

4) Dental/oral health services.

5) OB/Gyn care

6) Maternity care programs and services for pregnant women.

3. Engagement, ongoing support and technical assistance with Support Coordination and the AdSS to integrate the Disease/Chronic Condition Intervention Plan into the person-centered service plan to support sustainability and continuity of care.

4. Once the health care services team determines the member to be ready for discharge, the member may be discharged from the disease/chronic care program. The Team is available for technical assistance and consultation to Support Coordination and/or the AdSS to support the transition.

5. The member may be re enrolled based on the recommendation of Support Coordination, the AdSS and/or identified through HCS utilization reviews/reports.

C. OVERSIGHT

1. The Division collaborates with the AdSS to evaluate the effectiveness of the program by assessing the members' ability to self-manage their condition/disease and measuring other outcomes at predetermined points after enrollment. Other outcomes may include cost/utilization of services, clinical quality, and process measures.

2. The Division works in partnership with the AdSS to educate providers regarding the specific evidenced-based guidelines and desired outcomes of the program. The AdSS staff and providers may participate in the development of the Division specific evidence-based guidelines.

3. The Division monitors the AdSS to ensure provider compliance with the member Disease/Chronic Condition Intervention Plan and that appropriate corrective action is taken for any noncompliance.

4. Health Care Services shall track and trend performance metrics and outcomes identifying successful interventions and provide reports to the Division Medical Management Committee.

5. At least quarterly, the Division meets with the AdSS to provide ongoing evaluation including data analysis and recommendations to refine processes, identify successful interventions and care pathways to optimize results. On an annual basis, the Division performs an Operational Review of the AdSS that includes review of the Disease/Chronic Care Management Program compliance.

Signature of Chief Medical Officer: Anthony Dekker (Jul 11, 2022 14:17 PDT)
Anthony Dekker, D.O.

1024 DRUG UTILIZATION REVIEW

REVISION DATE: 3/27/2024
REVIEW DATE: 6/27/2023
EFFECTIVE DATE: July 13, 2022
REFERENCES: 42 CFR Part 457, 42 CFR Part 438, 42 U.S.C 1396r-8, A.A.C. R9-22-209, 42 USC 1396A(OO), Social Security Act Section 1927 (g) Drug Use Review, AHCCCS Contract, AMPM 310-FF, AMPM 310-V, AMPM 1024.

PURPOSE

This policy outlines the Division's responsibility for the oversight of the Drug Utilization Review (DUR) process that includes retrospective, concurrent and prospective drug utilization edits developed and implemented by the Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Division program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care, including beneficiary practices that result in unnecessary cost to the

Division Program.

2. "Drug Utilization Review" or "DUR" means a systematic, ongoing review of the prescribing, dispensing, and use of medications. The purpose is to assure efficacious, clinically appropriate, safe and cost-effective drug therapy to improve Member health status and quality of care.

3. "Exclusive Pharmacy" means an individual pharmacy, which is chosen by the Member or assigned by the Division to provide all medically necessary Federal and State reimbursable drugs to the Member.

4. "Exclusive Provider" means an individual provider, which is chosen by the Member or assigned by the Division to provide all medically necessary Federal and State reimbursable drugs to the Member.

5. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other

person, including any act that constitutes Fraud under applicable State or Federal law.

6. "Prescription Drugs" means prescription medications prescribed by an Arizona Health Care Cost Containment System (AHCCCS) registered qualified practitioner as a pharmacy benefit, based on medical necessity, and in compliance with Federal and State laws.

7. "Waste" means over-utilization or inappropriate utilization of services, misuse of resources, or practices that result in unnecessary costs to the Medicaid Program.

POLICY

A. DRUG UTILIZATION REVIEW REQUIREMENTS

1. The Division shall require reporting for the following:
   a. Concurrent Drug Utilization Review (DUR);
   b. Opioid monitoring;
   c. Antipsychotic prescribing in children; and
   d. Identification of Fraud, Waste, and Abuse by either DDD

Members or health care practitioners.

2. The Division shall require DUR is performed to ensure that Members are receiving medications appropriately with limited adverse drug reactions.

3. The Division shall require DUR that consists of retrospective, concurrent and prospective DUR.

4. The Division shall require use of Arizona Health Care Cost Containment System (AHCCCS) Prior Authorization (PA) clinical guidelines.

5. The Division shall require opioid monitoring based per Federal regulations.

B. CONCURRENT UTILIZATION REVIEW

1. The Division shall require a concurrent DUR process be implemented that occurs between the pharmacies and the Pharmacy Benefits Manager's (PBM) electronic DUR system at the Point of Sale (POS).

2. The Division shall require concurrent DUR edits that include:

   a. Preferred and non-preferred Federally and State reimbursable drugs prior to dispensing;

   b. Drug-drug interactions;

   c. Excessive doses;

   d. High and suboptimal doses;

   e. Over and underutilization;

   f. Drug-pregnancy precautions;

   g. Drug-disease interactions;

   h. Duplicate therapy; and

   i. Drug-age precautions.

C. RETROSPECTIVE UTILIZATION REVIEW

1. The Division shall require a retrospective DUR process is implemented to detect aberrant prescribing practice patterns, pharmacy dispensing patterns and medication administration patterns to prevent inappropriate use, misuse, or Waste.

2. The Division shall require retrospective DUR reviews are performed to evaluate the following edits:
    a. Clinical appropriateness, use and misuse;
    b. Appropriate generic use;
    c. Drug-drug interactions;
    d. Drug-disease contraindications;
    e. Aberrant drug doses;
    f. Inappropriate treatment duration;
    g. Member utilization for over and underutilization;
    h. Prescriber clinician prescriptive ordering and practice patterns; and
    i. Pharmacy dispensing patterns.

D. PROSPECTIVE UTILIZATION REVIEW

1. The Division shall require the prospective DUR process be implemented to promote positive health outcomes using PA clinical guidelines to ensure clinically effective medications are prescribed in the most cost-efficient manner.

2. The Division shall require prospective DUR edits during the adjudication of a claim be enabled by the PBM for the following:
   a. Drug-allergy interactions;
   b. Drug-disease contraindications;
   c. Therapeutic interchange;
   d. Generic substitution;
   e. Incorrect drug doses;
   f. Inappropriate duration of drug therapy;
   g. Medication Abuse or misuse; and
   h. Medications preferred on the AHCCCS Drug List.

E. PRIOR AUTHORIZATION (PA) CLINICAL GUIDELINES

The Division shall require AHCCCS PA guidelines be utilized for any medications that require PA or are non-preferred medications.

F. PROVIDER EDUCATIONAL INTERVENTIONS

The Division shall require educational interventions based on evaluations of practice patterns focused on drug therapy outcomes

with the aim of improving safety, prescribing practices and therapeutic outcomes and ensuring the interventions improve quality of care.

G. EXCLUSIVE PHARMACY OR EXCLUSIVE PROVIDER PROGRAM

1. The Division shall require Members that are assigned to an Exclusive Pharmacy or Exclusive Provider, or both are reported on form AMPM 1024 Attachment A.

2. The Division shall provide AMPM 1024 Attachment A to AHCCCS as a quarterly deliverable when aberrant pharmacy or aberrant provider utilization is identified.

H. OPIOID UTILIZATION

1. The Division shall require DUR activities be performed as part of Federal Opioid Legislation, and reported to AHCCCS in accordance with the Centers for Medicare and Medicaid Services (CMS) DUR requirements as specified in the Contract for the following:

a. Opioid utilization and concomitant use of benzodiazepines;

b. Opioid utilization and concomitant use of antipsychotics;

c. Buprenorphine utilization and concomitant use of opioids;

d. 7-day limits for opioid naïve adults;

e. 5-day limits for opioid naïve minors;

f. 50 Morphine Equivalent Daily Dose (MEDD) limits for opioid naïve Members;

g. Member utilization when the cumulative current utilization of opioids is a MEDD of greater than 90;

h. Antipsychotic prescribing for children; and

i. Fraud, Waste and Abuse by Members, pharmacies, and prescribing clinicians.

2. The Division shall require Members with a diagnosis of cancer, in hospice or palliative care be excluded from opioid safety edits and utilization management limitations associated with opioids.

I. DIVISION OVERSIGHT

1. The Division shall oversee the AdSS utilizing the following methods to ensure compliance with policy:
   a. Annual Operational Review of each AdSS;
   b. Review and analyze deliverable reports submitted by the AdSS; and
   c. Conduct oversight meetings with the AdSS for the purpose of:
      i. Reviewing compliance,
      ii. Addressing concerns with access to care or other quality of care concerns,
      iii. Discussing systemic issues, and
      iv. Providing direction or support to the AdSS as necessary.

Signature of Chief Medical Officer: Anthony Dekker (Mar 21, 2024 09:31 PDT)
Anthony Dekker, D.O.

1040 OUTREACH, ENGAGEMENT, AND REENGAGEMENT FOR BEHAVIORAL HEALTH

REVISION DATE: 10/28/2020
EFFECTIVE DATE: October 01, 2018
REFERENCES: AMPM Policy 320-R, AMPM Policy 320-U

Overview

The Division of Developmental Disabilities (Division) develops and implements outreach, engagement, and reengagement activities for members seeking and receiving behavioral health services. The Division develops and makes available to providers its policies and procedures regarding outreach, engagement, and reengagement, including any additional information specific to their operations.

Outreach includes activities designed to inform individuals of behavioral health services availability and to engage or refer those individuals who may need services. The activities described within this section are essential elements of clinical practice. Outreach to vulnerable populations, establishing an inviting and non-threatening environment, and re-establishing contact with persons who have become temporarily disconnected from services are critical to the success of any therapeutic relationship.

Definitions

Engagement - For purposes of this policy, the establishment of a trusting relationship, rapport and therapeutic alliance based on personal attributes, including empathy, respect, genuineness, and warmth.

Outreach activities - For purposes of this policy, activities designed to inform individuals of behavioral health services availability and to engage or refer those individuals who may need services.

Reengagement - For purposes of this policy, activities by providers designed to encourage the individual to continue participating in services.

Policy

The Division will incorporate the following critical activities regarding service delivery within the AHCCCS System of Care:

A. Establish expectations for the engagement of members seeking or receiving behavioral health services,

B. Determine procedures to reengage members who have withdrawn from participation in the behavioral health treatment process,

C. Describe conditions necessary to end reengagement activities for members who have withdrawn from participation in the treatment process, and

D. Determine procedures to minimize barriers for serving members who are attempting to reengage with behavioral health services.

Community Outreach

The Division provides and participates in community outreach activities to inform members of the benefits and availability of behavioral health services and how to access them. Outreach activities conducted by the Division may include the following:

A. Participation in local health fairs or health promotion activities;

B. Involvement with local schools;

C. Involvement with outreach activities for military veterans, such as Arizona Veterans Stand Down Coalition events;

D. Development of outreach programs and activities for first responders (i.e. police, fire, EMT);

E. Regular contact with AHCCCS contractor behavioral health coordinators and primary care providers, especially the Division's Administrative Services Subcontractors;

F. Development of outreach programs to members experiencing homelessness;

G. Development of outreach programs to persons who are at risk, identified as a group with high incidence or prevalence of behavioral health issues, or underserved;

H. Publication and distribution of informational materials;

I. Liaison activities with local, county, and tribal jails, prisons, county detention facilities, and local and county Department of Child Safety (DCS) offices and programs;

J. Regular interaction with agencies that have contact with substance abusing pregnant women/teenagers;

K. Development and implementation of outreach programs to identify members with co-morbid medical and behavioral health disorders and those who have been determined to have Serious Mental Illness (SMI) within the contractor's geographic service area; including persons who reside in jails, homeless shelters, county detention facilities or other settings;

L. Provision of information to behavioral health advocacy organizations; and

M. Development and coordination of outreach programs to Native American tribes in Arizona to provide services for tribal members.

Behavioral health providers shall participate in engagement, reengagement, and follow-up processes as described in this policy.

Engagement

The Support Coordinator and/or Case Manager of the TRBHA, IHS, Tribally Operated 638, or Urban Native Health Facility must ensure active engagement by providers in the treatment planning process with the following:

A. The member and/or member's legal guardian;

B. The member's family or significant others, if applicable and amenable to the person;

C. Other agencies or providers, as applicable; and

D. For persons with a SMI who are receiving Special Assistance (see AMPM Policy 320-R), the person (guardian, family member, advocate or other) designated to provide Special Assistance.

Reengagement

The Support Coordinator takes the lead in the coordination with the TRBHA, IHS, Tribally Operated 638, or Urban Native Health Facilities to ensure reengagement attempts are made with members who have withdrawn from participation in the treatment process prior to the successful completion of treatment, refused services, or failed to appear for a scheduled service based on a clinical assessment of need. Provider Case Managers are available to assist Support Coordinators with reengaging members as deemed beneficial to their care. All attempts to reengage members must be documented in the member's file.

A. The behavioral health provider shall attempt to reengage the member by:

1. Communicating in the member's preferred language.

2. Contacting the member/guardian/designated representative by telephone at times when the member may reasonably be expected to be available (e.g. after work or school).

3. When possible, contacting the member/guardian/designated representative face-to-face if telephone contact is insufficient to locate the member or determine acuity and risk.

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

5. Contacting the person designated to provide Special Assistance for his/her involvement in reengagement efforts for members determined to have a SMI who are receiving Special Assistance (see AMPM Policy 320-R).

B. If attempts to engage the member are unsuccessful, the Support Coordinator must ensure further attempts are made to reengage the member. Further attempts must include at a minimum, contacting the member or member's responsible person face to-face and contacting natural supports for whom the member has given permission to contact. All attempts to reengage members must be clearly documented in the member's case file.

C. If face-to-face contact with the member is successful and the member appears to be a danger to self, danger to others, persistently and acutely disabled, or gravely

disabled, the Support Coordinator must determine whether it is appropriate to engage the person to seek inpatient care voluntarily. If the member declines voluntary admission, the Support Coordinator must initiate the pre-petition screening or petition for treatment process described in AMPM Policy 320-U.

Follow-up After Significant and/or Critical Events

Discharge planning must begin upon notification that the member has been hospitalized. The Support Coordinator must ensure activities are documented in the member's case file and follow-up activities are conducted to maintain engagement within the following timeframes.

District nurses are available to assist Support Coordinators as considered beneficial to optimally meeting the needs of the individual member during their care transition:

A. Discharged from inpatient services, in accordance with the discharge plan and within seven days of the member's release to ensure member stabilization, medication adherence, and to avoid re-hospitalization;

B. Involved in a behavioral health crisis within timeframes based upon the member's clinical needs, but no later than seven days;

C. Refusing prescribed psychotropic medications within timeframes based upon the member's clinical needs and individual history; and

D. Changes in the level of care.

1200 OVERVIEW

REVISION DATE: 6/10/2016, 7/3/2015
EFFECTIVE DATE: June 30, 1994
REFERENCES: A.R.S. §§ 36, 32-1, 36-2939(B)(1), 36-591(G); A.A.C. R6-6-901 - R6-6-910; C.F.R. §§ 42, and, 42-456.1.

The following section contains information about services available either through the Arizona Long Term Care System (ALTCS) or the State only funded programs administered by the Division. Each eligible member will receive services in accordance with documented needs and availability of State funds.

The Arizona Long Term Care System (ALTCS) provides funding for certain services based upon assessed needs and medical necessity. ALTCS does not provide day care or educational services. Transitional Waiver services include all Home and Community Based Services under ALTCS and supported employment. The Transitional Waiver is a program for members who were eligible for the Arizona Long Term Care System and have improved either medically, functionally or both to the extent that they are no longer at risk of institutionalization at a nursing facility or Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID)level of care. The Transitional Waiver does not cover institutional services in excess of 90 days.

Based on assessed need, the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) drives what services, types and amounts of support a member may receive. The person with a disability may request the Planning Team to help them identify what their needs are, the best ways to meet those needs and what the primary caregiver(s) is willing and able to do. Often a person's services needs may be met through natural supports (such as relatives, friends, places of worship and local community resources). A contracted service provider may also be used. Though funding for services through ALTCS is not intended to replace what families currently provide, under certain circumstances parents or family members may be paid to provide services that support home and community living.

Although the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan planning documents processes identifies needed services, members who are eligible for ALTCS shall receive information regarding their right to receive services as authorized.

Members who are eligible for ALTCS shall also receive information regarding the appropriate Division staff to contact if services are not provided as scheduled. The Support Coordinator must assess with the member their needs, the risk to the member if a gap in services were to occur and develop a contingency plan in the event of a services gap. These needs and risk factors are determined at the time of the initial and quarterly (90 day review) assessments. The Support Coordinator shall also explain the guidelines regarding the Divisions process (including a time estimate) for providing services when there is a service gap. The Division tracks and trends these gaps in services per the Arizona Health Care Cost Containment Systems (AHCCCS) contract requirements. The Division also submits a semi-annual report and other necessary reports to the AHCCCS summarizing trends, services gaps, and related grievances.

Primary care givers are not required to be in the home during the delivery of services unless one of the following situations exists:

A. The primary care giver provides "skilled care" and the service being provided is non-skilled care. In this case, the primary care giver would need to perform any "skilled care" that the provider is not certified/licensed to do.

B. The intent of the service as documented on the Individual Support Plan/Individualized Family Service Plan/Person Centered Plan (Planning Documents) is to facilitate the primary care giver's ability to work with the member. As an example, the service is intended to directly train the family in learning how to respond to behavior problems.

Each person must be evaluated on a member basis to determine medical necessity as well as the cost effective level of care that will achieve the desired results. Only nurses or respiratory therapists can provide skilled care. For example, skilled care includes Jejunum tube insertion, catheter replacement, respiratory treatment such as small volume nebulizers suctioning, tracheostomy care.

Guidelines for services and evaluation criteria are found in the Service Approval Matrix (Prior Authorization). This information is available on the Division's website. https:/www.azdes.gov/main.aspx?menu=96&id=2470

The source information regarding each service is found in one of the following documents:

A. Chapter 42 Code of Federal Regulations. www.gpo.gov;

B. AHCCCS Medical Policy Manual. www.azahcccs.gov;

C. A.R.S. §36. www.azleg.gov/ArizonaRevisedStatutes.asp; or,

D. The Division Service Specifications.

1210 INSTITUTIONAL SERVICES AND SETTINGS

REVISION DATE: 8/15/2017, 7/15/2016, 5/13/2016, 2/12/2016, 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994
REFERENCES: A.R.S. §§ 36-2939(A)(1), (B)(1), 36-591(G); A.A.C. R9-10-101, 42 CFR 409.31-35, 438.6(e), 440.40, 440.155, 456.1, 456.436, 483.75, 483.100-138, 483.400, 483.440; Division Medical Policy Manual, Policy 6 0-C Pre-Admission Screening and Resident Review; Division Operations Policy Manual, Policy 2001 Planning Team Members

The Division of Developmental Disabilities (Division) covers medically necessary institutional services provided in an Arizona Health Care Cost Containment System (AHCCCS) registered long term care facility for members who are eligible for the Arizona Long Term Care System (ALTCS).

Institutional settings also include Behavioral Health Inpatient facilities, Institutions for Mental Disease (IMD), and Inpatient Behavioral Health Residential Treatment Facilities. ALTCS Contractors are responsible for ensuring that providers delivering institutional services to members must meet the requirements as specified in this Manual. The Division uses an acuity tool to determine the level of institutional placement prior to placement.

Members who are eligible for the ALTCS transitional program are not eligible for Nursing Facility (NF) services or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) services exceeding 90 continuous days per admission.

Nursing Facility

Service Description and Goals (Nursing Facility)

This service provides skilled nursing care, residential care, and supervision to persons who need nursing services on a 24-hour basis, but who do not require hospital care or direct daily care from a physician.

The goal of this service is to provide care that meets and enhances the medical, physical, and emotional needs of members residing in Nursing Facilities (NF).

Service Settings (Nursing Facility)

NFs must be Medicare and Medicaid certified and licensed by the Arizona Department of Health Services in accordance with 42 CFR 440.155 and 42 CFR 483.75 to provide inpatient room, board, and nursing services to members who require these services on a continuous basis. For the purposes of reimbursement by ALTCS funding, the facility must be Medicare/ Medicaid certified.

Service/Provider Requirements (Nursing Facility)

The provider must demonstrate the following before the service is authorized:

A. The NF must be licensed and certified by the appropriate Arizona state agencies.

B. The NF must comply with all applicable federal and state laws relating to professional conditions, standards, and NF requirements, including the conditions set forth in the 42 CFR 483 *et seq*.

C. The NF must also comply with all health, safety, and physical plant requirements established by federal and state laws.

D. The portion of the facility in which the member will be placed must be registered with AHCCCS.

Admission Criteria (Nursing Facility)

A. The NF service may be considered appropriate for a member if the member is in need of skilled nursing care on a 24-hour basis but does not require hospital care or direct daily care from a physician and is ordered by, and provided under, the direction of a physician, pursuant to 42 CFR 440.40.

B. Pursuant to 42 CFR 409.31-35 and 440.155, the member requires:

1. The skills of technical or professional personnel such as registered nurses, licensed practical nurses, or therapists

2. Daily skilled services that can only be provided in an NF, on an inpatient basis

3. Skilled services because of special medical complications

4. Services that are above the level of room and board.

C. The member must cooperate in a nursing assessment performed by the Division District Utilization Review Nurse prior to NF service being authorized.

D. The Pre-Admission Screening and Resident Review (PASRR) is completed pursuant to 42 CFR 483.100-138 (see Division Medical Policy Manual, Policy 6 0-C Pre-Admission Screening and Resident Review).

E. Prior to the authorization, the above criteria in this section must be met.

Exclusions (Nursing Facility)

A. The Division will authorize an NF placement only in a licensed and Medicare/Medicaid certified NF.

B. The Division will not pay for placement in an NF without prior authorization pursuant to 42 C.F.R 483.100 *et seq.* (see Division Medical Policy 6 0-C Pre-Admission Screening and Resident Review).

C. If the Primary Care Provider (PCP) or the Division District Utilization Review Nurse advises that the NF cannot meet the member's needs, the member shall be offered a choice of available alternatives, including less restrictive settings and/or Home and Community Based Services (HCBS), as medically necessary.

D. If the Division places an NF on termination status:

1. No new members will be admitted to the NF.

2. Members currently residing, or on leave from, the NF may remain or return to the facility and will have a special planning meeting scheduled. The planning meeting must identify contracted residential alternatives that are available to the member.

E. The member has exceeded 90 continuous days of acute services and is enrolled in the Transitional Program.

F. The member is in the Transitional Program and requests Long Term Care placement.

Therapeutic Leave and Bed Holds (Nursing Facility)

If the member exceeds allowable Therapeutic Leave and bed hold days, the Division will not pay the facility when the member is absent from the NF.

A. Therapeutic leave includes leave due to a therapeutic home visit to enhance psychosocial interactions, a trial basis, or as a part of discharge planning, and is limited to 9 days per calendar year.

B. A bed hold includes medically necessary short-term hospitalization and is limited to 12 days per calendar year.

Reassessment for Continued Placement (Nursing Facility)

A. Members residing in an NF must be reassessed by the Division for appropriateness (medical necessity) of placement, whenever a significant change in the physical or mental status of the member occurs (see PASARR section of this policy manual).

B. Physicians must order the continued need for NF placement not less than annually in accordance with 42 CFR 483.114.

C. The member must continue to meet the criteria in the Admission Criteria (Nursing Facility) section of this Policy.

Service Closure (Nursing Facility)

As determined by the PASRR, medical documentation, and the current needs of the member, NF services will be terminated when the criteria in the Admission Criteria (Nursing Facility) section of this Policy are no longer met. The discharge shall occur as follows:

A. Ten days prior to anticipated discharge, a Planning Team Meeting must occur to update the current Planning Document to include:

1. The member's health and abilities

2. Current medication

3. Identification of needed Durable Medical Equipment (DME)

4. An updated Service Plan

5. A completed Cost Effectiveness Study (CES) based on anticipated service needs

6. Needed follow up medical appointments.

B. The Planning Team includes the member and/or responsible person, the Division's Health Care Service (HCS) nurse, the Support Coordinator, and representatives from the NF. The Planning Team may also include a Division network representative, the HCBS provider, the PCP, or other representatives as needed per Division's Operations Manual, Policy 2001 Planning Team Members.

C. In the event the member's previous living arrangement needs to change, the Support Coordinator makes a request for residential services by completing a Placement Profile and submitting it to the Division's District Network Unit.

D. The member or responsible person, the PCP, attending Physician, and the Division's Medical Director shall resolve disagreements regarding discharge planning.

E. The Division's Chief Medical Officer has the final authority as delegated by the Assistant Director.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

Service Description (ICF/IID)

ICF/IID provides comprehensive and individualized health care, and habilitative and rehabilitative services, to members to promote functional status and independence for members who need, and are receiving, active treatment services that help the member obtain as much independence as possible.

Service Settings (ICF/IID)

An ICF/IID shall include the Arizona Training Program facilities, a state-owned and operated service center, state-owned or operated community residential settings, and private state-certified facilities that contract with the Department.

Service Provider/Facility Requirements (ICF/IID)

The provider must be state operated or contracted with the Division and demonstrate the following before the service is authorized:

A. The ICF/IID is registered with the Arizona Health Care Cost Containment System (AHCCCS).

B. The ICF/IID must be reviewed and certified annually by the Department of Health Services in accordance with 42 CFR 483.400.

C. The ICF/IID must comply with contract, all applicable federal and state laws, and DES and Division policies and procedures.

Admission Criteria (ICF/IID)

A. The ICF/IID service may be considered appropriate for a member who is in need of, or could benefit from, active treatment.

1. Active treatment includes continuous, aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services that are directed toward:

a. The acquisition of the behaviors necessary for the member to function with as much self-determination as possible and the ability to live in a more independent setting

b. The prevention or deceleration of regression or loss of current optimal functional status.

2. Active treatment is provided continuously based on an individual member's assessed developmental needs that prevent the member from living in a more independent setting.

3. A continuous active treatment program includes interaction, between ICF/IID staff and the member, in which the member receives aggressive and consistent training, treatments, and supports during the normal rhythm of the member's day, whenever the need arises or an opportunity presents itself, in both formal and informal settings.

4. Examples of active treatment may include:

a. The application of a specific stimulation technique, to the area of the mouth of an individual with severe physical and medical disabilities, that decelerates the individual's rate of reliance on tube feedings, and helps the individual retain ability to take food by mouth

b. Teaching the member to use an adaptive spoon and plate to eat independently

c. Acquisitions of behaviors for the member to function with as much self-determination and independence as possible

d. Teaching daily living skills.

5. Examples of what active treatment does not include:

a. Services to maintain generally independent members who are able to function with little supervision or in the absence of an active treatment program

b. Protective oversight for a member who is not in need of training for developmental deficits (e.g., a court placement to protect the community or the client from the client's behavior)

Programs to simply maintain a member's independence are not considered active treatment because the member is not learning to live in a more independent setting. If a member already possesses the skills that enables them to live in a less restrictive environment, and does not require the structure, support, resources, and services that only an ICF/IID can provide, the member is considered generally independent and not in need of active treatment.

B. Prior to any permanent or temporary admission, the Division will complete a preliminary evaluation. The preliminary evaluation will consider background information as well as currently valid assessments of functional development, behavioral, social, health, and nutritional status and assessed needs that are prohibiting the member from living in a more independent setting and which require intensive specialized supports, services, and supervision that only an ICF/IID can provide.

The Division will review all necessary medical or other documentation to support the need for admission into an ICF/IID. This information may include the Planning Document, Placement Profile and, if the member receives nursing or therapies, the Nursing Assessment and Therapy evaluations/reports. If any additional information (e.g., medical records) is required, the Division's HCS will contact the Support Coordinator.

C. The Division will determine whether there are alternative placements that are less restrictive and more cost effective than the requested ICF/IID placement. The alternative options shall be discussed with the member and/or their responsible person before a final decision is made by the Division.

D. A Cost Effectiveness Study must be completed prior to admission.

E. A written ICF/IID placement approval from the Assistant Director or the Assistant Director's Designee is required prior to authorization.

<u>Development and Implementation of the Active Treatment Plan (ICF/IID)</u>

A. Pursuant to 42 CFR 483.440, within 30 days after admission:

1. A comprehensive functional assessment of the member is completed.

2. As a result of the comprehensive functional assessment, specific objectives necessary to meet the member's needs will be identified.

3. A written active treatment program specific to the member will be designed and implemented.

B. Data documentation of the specific objectives must be in measurable terms.

C. The initial active treatment plan must be reviewed by a Qualified Intellectual Disability Professional/Support Coordinator, the Planning Team, and revised as necessary.

D. During the annual planning meeting the comprehensive functional assessment shall be reviewed for relevancy and updated as needed.

Exclusions (ICF/IID)

ICF/IID placements shall not be made when any of the following are true:

A. The member's needs can be met in a less restrictive and more cost-effective HCBS option.

B. The member does not need active treatment in an ICF/IID.

C. The member has exceeded 90 continuous days of acute services and is enrolled in the Transitional Program.

D. The member is in the Transitional Program and requests Long Term Care placement.

Therapeutic Leave and Bed Holds (ICF/IID)

If the member exceeds allowable Therapeutic Leave and bed hold days, the Division will not pay the facility when the member is absent from the ICF/IID.

A. Therapeutic Leave includes leave due to a therapeutic home visit to enhance psychosocial interactions or on a trial basis or as a part of discharge planning and is limited to 9 days per calendar year.

B. A bed hold includes when short-term hospitalization is medically necessary and is limited to 12 days per calendar year.

Continued Stay Reviews (ICF/IID)

A. The Division completes "Continued Stay Reviews" pursuant to 42 CFR 456.436 and "Active Treatment Reviews."

B. The "Continued Stay Reviews" and "Active Treatment Reviews" will be completed at least every six months, and the following will be considered:

1. The member no longer needs, and will not benefit from, continued active treatment in an ICF/IID.

2. The member requires protective oversight only.

3. The member is able to function with little supervision in the absence of an active treatment program.

4. A less restrictive and more cost effective level of service or living situation would meet the needs of the member as determined by the Planning Team.

Service Closure (ICF/IID)

ICF/IID services may be terminated:

A. As determined by the Continued Stay Review

B. As necessary for the member's welfare and when the needs of the member cannot be met in the ICF/IID

C. When the member has met their outcomes and no longer needs the services provided by the ICF/IID

D. At the request of the member/responsible person

E. When the member is no longer eligible for ALTCS

F. When the criteria in the Admission Criteria (ICF/IID) section in this Policy are no longer met

G. When the ICF/IID is no longer operating and a less restrictive or more cost effective level of service or living situation can meet the needs of the member.

The discharge shall occur as follows:

A. Ten days prior to anticipated discharge, a team meeting must occur to update the member's current Planning Document to include:

   1. The member's health and abilities

   2. Current medication

   3. Identification of needed Durable Medical Equipment (DME)

   4. An updated Service Plan

   5. A completed Cost Effectiveness Study based on anticipated service needs

   6. Needed follow up medical appointments.

B. The Planning Team shall include the member or responsible person, the Division's HCS nurse, the Support Coordinator, and representatives from the ICF/IID. The team may also include a Division network representative, the HCBS provider, the PCP, or other representatives as needed per Division's Operations Manual, Policy 2001 Planning Team Members.

C. In the event the member's living arrangement needs to change from what it was previously, the Support Coordinator makes the request for residential services by completing a Placement Profile and submitting it to the Division's District Network Unit.

D. The member or responsible person, the PCP, attending Physician and the Division's Chief Medical Officer shall resolve disagreements regarding discharge planning and service closure.

E. The Division's Chief Medical Director shall have the final authority as delegated by the Assistant Director.

Behavioral Health

Institutional settings also include Behavioral Health Inpatient facilities, Institutions for Mental Disease (IMD), and Inpatient Behavioral Health Residential Treatment Facilities.

Behavioral Health Inpatient Facility

A Behavioral Health Inpatient Facility is a behavioral health service facility licensed by ADHS, as defined in A.A.C. R9-10-101, to provide a structured treatment setting with 24-hour supervision, on-site medical services, and an intensive behavioral health treatment program. These facilities are the highest level of inpatient behavioral health services. Some Behavioral Health Inpatient Facilities are IMDs.

Institution for Mental Disease (IMD)

Services provided to members eligible for Title XIX (including members who receive behavioral health services through an Integrated/Tribal/Regional Behavioral Health Authority (IRBHA, RBHA, TRBHA) may be reimbursed in any behavioral health setting, regardless of age, as per AHCCCS Medical Policy Manual, Policy 1210.

An IMD is a Medicare-certified hospital, special hospital for psychiatric care, behavioral health facility, or nursing care institution which has more than 16 treatment beds and provides diagnosis, care, and specialized treatment services for mental illness or substance abuse for more than 50% of the members is considered an IMD. ADHS Office of Behavioral Health Licensure-licensed Inpatient facilities with more than 16 beds are considered IMDs.

Inpatient Psychiatric Residential Treatment Center (available to Title XIX members under 21 years of age)

An Inpatient Psychiatric Residential Treatment Center is a behavioral health service facility licensed by ADHS. Services must be provided under the direction of a physician and include active treatment implemented as a result of the service plan developed. The service plan must include an integrated program of therapies, activities, and experiences designed to meet the treatment objectives for the member. A member who turns age 21 and is Tribal ALTCS Title XIX while receiving services in an inpatient psychiatric facility considered to be an IMD may continue to receive services until the point in time in which services are no longer required or the member turns age 22, whichever comes first.

In addition, the following services must be available to members residing in a behavioral health institutional setting, but are not included in the service unit:

A. Speech, physical, and occupational therapies unless required as a part of the per diem for the service unit

B. Medical/acute care services as specified in this Policy Manual.

1230-A ASSISTED LIVING FACILITIES

REVISION DATES: 10/28/2020, 7/15/16, 7/3/15
EFFECTIVE DATE: June 30, 1994

PURPOSE

This policy establishes requirements for Assisted Living Facilities designed for ALTCS members who are physically or functionally unable to live in their own home, but do not need the care intensity of a nursing facility.

DEFINITIONS

Alternative Home and Community Based Services (HCBS) Setting means a living arrangement where a member may receive HCBS. The setting shall be approved by the director, and either 1) Licensed or certified by a regulatory agency of the state, or 2) Operated by the Indian Health Services (IHS), an Indian tribe or tribal organization, or an urban Indian organization, and has met all applicable standards for state licensure, regardless of whether it has actually obtained the license. The possible types of settings include:

- Community residential settings
- Group Homes
- State-operated Group Homes
- Developmental Homes
- Behavioral Health Therapeutic Homes
- Behavioral Health Respite Homes
- Substance Abuse Transitional Facilities

Assisted Living Center (ALC) means an assisted living facility that provides resident rooms or residential units to eleven or more residents. Assisted Living Centers may be licensed to provide one of three levels of care listed below, as defined by the Arizona Department of Health Services:

> **Supervisory Care Services** means general supervision, including daily awareness of resident functioning and continuing needs, the ability to intervene in a crisis, and assistance in the self-administration of prescribed medications.
>
> **Direct Care Services** means programs and services, including personal care services provided to persons who are incapable of recognizing danger, summoning assistance, expressing need, or making basic care decisions.
>
> **Personal Care Services** means assistance with activities of daily living that can be performed by persons without professional skills or professional training and includes the coordination or provision of intermittent nursing services and the administration of medication and treatments by a nurse who is licensed pursuant to Arizona Revised Statutes Title 32, Chapter 15, or as otherwise provided by law.
>
> **Assisted Living Home (ALH)** means a facility that provides resident rooms and services to ten or fewer residents.

Assisted Living Facility (ALF) means a residential care institution that provides supervisory care service, personal care services or direct care services on a continuing basis. All approved residential settings in this category are required to meet ADHS licensing criteria as defined in A.A.C R9-10 Article 8.

POLICY

A. CONSIDERATIONS

To ensure the appropriateness of a placement in a facility, the following shall be considered and documented:

1. Member is over the age of 60; however, the team can recommend exceptions for approval by the Assistant Director;

2. A nursing home is the only other alternative available or the team feels a facility best meets the needs, desires, and capabilities of the member;

3. Alternate placements were considered and the reason why they were not appropriate is documented. Facility placement cannot be the only placement option considered and cannot be used as an "emergency" placement alternative;

4. Member/responsible person clearly understands the alternative placement options;

5. Member/responsible person, and the Support Coordinator have visited the proposed facility;

6. Member will be placed with a similar age group as the other members living in the facility and not be segregated based on disability;

7. The supports identified in the Planning Document can be provided by the Center;

8. The member shall be given the choice to live with or without a roommate. The Support Coordinator will document this choice on the Assisted Living Facility/Single Occupancy Form. This form shall be filed with the Planning Document and be reviewed annually. At any time, the member may contact his/her Support Coordinator to revise the choice to live with or without a roommate. When this occurs the Support Coordinator shall update the form;

9. The Support Coordinator and others can monitor the facility at any time. Monitoring by the Support Coordinator, through on-site visits, will be conducted at least every 30 days for the first quarter and every 90 days thereafter; and

10. The District Program Manager/designee reviewed the required documentation and concurs the considerations have been met prior to the authorization of services.

B. CONDITIONS

When identifying potential facilities, the following conditions are recommended:

1. Private room (unless the member chooses to have a roommate as noted above),
2. Room includes a private in-room bathroom (unless the member chooses to have a roommate as noted above),
3. Space allows for separation of sleeping and living areas,
4. An inside door lock,
5. Food preparation space,
6. Doorbell or door knocker,
7. Individual mailbox,
8. Variety of on-site and off-site events from which to choose,
9. Transportation,
10. Indoor and outdoor common areas,
11. Weekly housekeeping service,
12. Weekly laundry service, and
13. Monthly newsletter or calendar of events.

C. EXCLUSIONS

1. Under no circumstance will a facility be used for Respite.
2. Although Assisted Living Facilities are required to provide room and board, room and board is not a Division-covered service for these facilities. The room and board amount shall be the responsibility of the member/ representative payee.

1230-C COMMUNITY RESIDENTIAL SETTINGS AND ROOM AND BOARD

REVISION DATE: 4/21/2023, 7/3/2015, 9/15/2014

EFFECTIVE DATE: June 30, 1994

PURPOSE

This policy establishes an overview of Community Residential Settings and Room and Board. This policy applies to ALTCS members.

DEFINITIONS

1. "Adult Developmental Home (ADH)" means the same as in A.R.S. § 36-551.
2. "Child Developmental Certified Home" means the same as in A.R.S. § 36-551.
3 "Child developmental home" means the same as in A.R.S. § 36-551.
4 "Community Residential Setting" means the same as in A.R.S. § 36-551.
5 "Group Homes" means the same as in A.R.S. § 36-551.
6 "Home and Community-Based Services Final Rule" means the final rule issued by the Center for Medicare and Medicaid

Services that ensures people receiving HCBS have full access to the benefits of community living and are able to receive services Community Developmental Disability Services are subject to this rule. The rule is also known as the HCBS Settings Rule.

7. "Member" means an individual who is receiving services from the Division of Developmental Disabilities (Division).
8. "Nursing-supported group home" means the same as in A.R.S. § 36-401.
9. "Room and Board" means a service that provides for the basic necessities that Members living in Community Residential Settings need to have in place to benefit from Community Residential Settings services, including a safe and accessible living environment, food, and utilities.
10. "Service Provider" means the same as in A.R.S. § 36-551.

POLICY

A. COMMUNITY RESIDENTIAL SETTINGS

1. The Division shall contract with service providers for Community Residential Settings to provide a safe, homelike family

atmosphere that meets the physical and emotional needs of DDD members.

2. The Division shall operate Community Residential Settings as outlined in A.R.S. § 36-558.
3. The Division shall cover Community Residential Settings when medically necessary and cost effective.
4. The Division assesses for and authorizes members for Community Residential Settings.
5. The Division shall ensure that Members who live in a Community Residential Settings have habilitation outcomes in their service plan to improve or learn new skills.
6. The Division shall cover physical health and behavioral health services by other providers when those services are not included in the scope of services provided by the Community Residential Setting.

B. ADULT AND CHILD DEVELOPMENTAL HOMES AND CHILD DEVELOPMENTAL CERTIFIED HOMES

1. The Division shall contract with service providers to develop and provide oversight to Adult and Child Developmental Homes.

2. The Division shall license providers of developmental home services for each Adult and Child Developmental Home.
3. The Division shall contract with Service Providers to develop and provide oversight to Child Developmental Certified Homes that are licensed by the Department of Child Safety and certified by the Department of Economic Security, Office of Licensing Regulation and Certification for up to three members.
4. The Division shall assess for Adult and Child Developmental Homes or Adult and Child Developmental Certified Homes when a member needs a licensed residential setting where:
    a. The provider(s) and other family members live in the home.
    b. Members need some help with daily care needs and learning, but do not need much support during sleeping hours.
    c. Transportation to day programs, work activities, and events outside the home is provided.

C. GROUP HOMES, NURSING SUPPORTED GROUP HOMES, AND ENHANCED BEHAVIORAL GROUP HOMES

1. The Division shall contract with service providers to develop and operate Group Homes, Nursing Supported Group Homes, and Enhanced Behavioral Group Homes.
2. The Division shall ensure the Group Homes, Nursing Supported Group Homes, and Enhanced Behavioral Group Homes are licensed by the Arizona Department of Health Services.
3. The Division shall assess for Group Homes, Nursing Supported Group Homes, and Enhanced Behavioral Group Homes when a member needs a licensed residential setting where:
    a. Staff rotate shifts 24-hours a day to meet a member's needs and help them learn skills.
    b. Members need more assistance with independent skills, including cleaning, hygiene, self-help, and behavioral support.
    c. Transportation to day programs, work activities, and events outside the home is provided.
4. The Division may assess for a Nursing Supported Group Home when a Member requires skilled nursing services as assessed by the Division's Healthcare Services staff.

5. The Division may assess for an Enhanced Behavioral Group Home when a Member requires time-limited intensive behavioral support as assessed by the Division's Healthcare Services staff.

D. ROOM AND BOARD

1. The Division shall assess and pay for the Community Residential Setting based on the Contracted Rate for the residential services using state funds.
2. The Division shall determine Member's responsibility for Room and Board, and bill the Member for their share of the cost per DDD Residency Agreement.
3. Support Coordinator shall complete the DDD Residency Agreement prior to a Member moving into a Community Residential Setting.
4. The Division shall ensure that providers comply with HCBS Settings rules requirements outlined in the Provider Manual Chapter 2.

Signature of Chief Medical Officer: Anthony Dekker (Apr 17, 2023 12:07 PDT)
Anthony Dekker, D.O.

1240-A ATTENDANT CARE AND HOMEMAKER (DIRECT CARE SERVICES)

REVISION DATE: 2/26/2016, 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994

Attendant Care

Description

This service provides assistance for a member to remain in their home and participate in community activities by attaining or maintaining personal cleanliness, activities of daily living, and safe and sanitary living conditions.

Barring exclusions noted in this section, Attendant Care (ATC) may include the following as determined by the member's assessed needs:

A. Meal preparation and clean up (e.g., meal planning, preparing foods, special diets, clean-up, and storing foods);

B. Eating and assistance with eating;

C. Bathing (e.g., washing, drying, transferring, adjusting water, and setting up equipment);

D. Dressing and grooming (e.g., selecting clothes, taking off and putting on clothes, fastening braces and splints, oral hygiene, nail care, shaving, and hairstyling);

E. Toileting (e.g., reminders, taking off and putting on clothes and/or undergarments, cleaning of catheter or ostomy bag);

F. Mobility (e.g., physical guidance or assisting with the use of wheelchair);

G. Transferring;

H. Cleaning;

I. Laundry (e.g., putting clothes in washer or dryer, folding clothes, putting away clothes);

J. Shopping (e.g., grocery shopping and picking up medications);

K. Attending to certified service animal needs; and,

L. General supervision for a member who cannot be safely left alone. (See Appendix A, B and C.)

Responsible Person's Participation (Attendant Care)

The member/family is responsible to provide:

A. Needed supplies (e.g., cleaning supplies) or money for supplies. Money must be provided in advance when the Attendant Care provider is expected to shop for food, household supplies, or medications; and,

B. Documentation required for the approval of this service.

Considerations (Attendant Care)

When assessing the need for this service, the following factors will be considered:

A. Due to advancing age, a temporary or permanent documented physical or cognitive/intellectual disability or documentation of other limitation, the parent or guardian cannot meet a child's basic care needs;

B. Due to the child's intensive medical, physical, or behavioral challenges, which are a result of the disability, the parent or guardian cannot meet the child's care needs;

C. The child, due to a medical condition or procedure related to the disability, is unable to attend their school/work/day program, and natural support(s) is/are unavailable to provide care;

D. The adult member is unable to meet specific, basic personal care needs;

E. The adult member lives alone and is temporarily unable to meet basic personal care needs due to a medical condition or illness;

F. The members' needs are not currently met due to unavailability of service. Attendant Care may be used as an alternative service;

G. The member has medical or physical needs, was living in a Developmental Home, Group Home, Intermediate Care Facility, Nursing Facility, or other out of home placement, and with Attendant Care, the member will be able to return home;

H. When a spouse provides Attendant Care, the total hours of Attendant Care may not exceed 40, regardless of who provides the care. In addition, the member may not receive any similar or like service (i.e., Homemaker). (Habilitation services are not a similar or like service.);

I. Attendant Care services are subject to monitoring and supervision as outlined in Arizona Health Care Cost Containment System (AHCCCS) policy; and,

J. When a family member requests to become the Attendant Care Provider for a member over the age of 18, the Support Coordinator/designee will conduct a personal interview with the member.

Settings (Attendant Care)

Attendant Care Services may only be provided:

A. In the member's home (unlicensed);

B. In an Independent Developmental Home when there is a specific issue, problem, or concern that is believed to be temporary or short term, and the service is approved by the Assistant Director/designee; and,

C. In the community:

1. While accompanying the member; or,

2. While shopping or picking up medications.

Exclusions (Attendant Care)

Exclusions to the authorization of Attendant Care service are indicated below. Exceptions shall be approved by the District Manager.

A. The Attendant Care Service:

1. Shall not substitute for private pay day care or a school program for children;

2. Shall not cover before and after school care needs, days when there is no school, half school days, holidays, or summer and winter breaks, or for 'babysitting' unless a child meets the criteria for supervision;

3. Shall not be provided for acute illnesses that prevent the child from attending private daycare or school;

4. Shall not be provided while the member is hospitalized;

5. Shall not substitute for Work, Day Program, Transportation, or Habilitation, unless those services are not available to the member;

a. When used as a substitute, Attendant Care shall be used only until an appropriate service is available; or,

b. When the appropriate service has been refused, Attendant Care cannot be used as a substitute.

6. Shall not substitute for Respite;

7. Shall not be received during the provision of a Division funded Employment or Day Program;

8. Shall not be used to avoid residential licensing requirements; and,

9. Shall not be used to take the place of care provided by the natural support system for children.

B. The tasks below are not included as part of the Attendant Care Service:

1. Cleaning up after parties (e.g., family celebrations and holidays);

2. Cleaning up several days of accumulated dishes;

3. Preparing meals for family members;

4. Routine lawn care;

5. Extensive carpet cleaning;

6. Caring for household pets;

7. Cleaning areas of the home not used by the member (e.g., parents' bedroom or sibling's bathroom);

8. Skilled medical tasks. (See Appendix D – Skilled Nursing Matrix.); and,

9. Shopping for a child living in the family home.

The Division will not authorize Attendant Care when the only tasks identified are cleaning, shopping and laundry.

Homemaker (Housekeeping)

Service Description and Goals (Homemaker)

This service provides assistance in the performance of activities related to routine household maintenance at a member's residence. The goal of this service is to increase or maintain a safe, sanitary, and/or healthy environment for eligible members.

Service Settings (Homemaker)

This service would occur in the member's own home or family's home. It would occur outside only when unsafe/unsanitary conditions exist and would occur in the community when purchasing supplies or medicines.

Service Requirements (Homemaker)

Before Homemaker can be authorized, the following requirements must be met:

A. Safe and sanitary living conditions shall be maintained only for the member's personal space or common areas of the home the member shares/uses.

B. Tasks may include:

1. Dusting;

2. Cleaning floors;

3. Cleaning bathrooms;

4. Cleaning windows (if necessary to attain safe or sanitary living conditions);

5. Cleaning oven and refrigerator (if necessary to prepare food safely);

6. Cleaning kitchen;

7. Washing dishes;

8. Changing linens and making beds; and,

9. Routine maintenance of household appliances.

A. Washing, drying, and folding the member's laundry (ironing only if the member's clothes cannot be worn otherwise).

B. Shopping for and storing household supplies and medicines.

C. Unusual circumstances may require the following tasks be performed:

1. Tasks performed to attain safe living conditions:

a. Heavy cleaning such as washing walls or ceilings; and,

b. Yard work such as cleaning the yard and hauling away debris.

2. Assist the member in obtaining and/or caring for basic material needs for water heating and food by:

a. Hauling water for household use;

b. Gathering and hauling firewood for household heating or cooking including sawing logs and chopping wood into usable sizes; and,

c. Caring for livestock used for consumption including feeding, watering and milking.

3. Provide or ensure nutritional maintenance for the member by planning, shopping, storing, and cooking foods for nutritious meals.

Target Population (Homemaker)

Members who are eligible for or are receiving assistance through the Supplemental Payment Program (SPP) will not receive Housekeeping. Members who are not eligible for Arizona Long Term Care Services (ALTCS) should be referred to the SPP. Needs are assessed by the Support Coordinator based upon what is normally expected to be provided by a member and/or his/her caregiver. It is important to remember that housekeeping services are based on "assessed need" and not on a person's or the family's stated desires regarding specific services.

Consideration should be made to age appropriate expectations of the member and his/her entire family (what can reasonably be expected of each member based on his/her age). The team should consider the natural supports available and not supplant them. In addition

to the guidelines found in this section, there may be a need for the SPP if any of the following are factors:

A. A member is living with his/her family and has intense medical, physical, or behavioral needs; and the family members are unable to care for the member and maintain a safe and sanitary environment;

B. A member is living with his/her family and the family members have their own medical/physical needs that prevent the family members from maintaining a safe and sanitary environment (documentation of the medical/physical needs may be required);

C. A member is living independently and has medical/physical needs that preclude him/her from maintaining/attaining a safe and sanitary environment;

D. A member is living independently and has demonstrated that he/she cannot maintain a safe and sanitary environment. Habilitation should be considered before using Housekeeping so the member's abilities may be maximized; and,

E. The family is experiencing a crisis that prevents them from maintaining a safe and sanitary environment. The situation would be documented in the member's progress notes and the service delivery would be of a time-limited nature.

Exclusions (Homemaker)

The following exclusions apply to the provision of Homemaker:

A. Homemaker is to be performed only for the members' areas of the home or common areas of the home used by the member, e.g., parents' or siblings' bedrooms or bathrooms would not be cleaned. Other examples of inappropriate use of Homemaker services include:

   1. Cleaning up after parties;

   2. Cleaning up several days of accumulated dishes;

   3. Preparing meals for the whole family; and,

   4. Routine lawn care.

B. Homemaker shall not be provided to members residing in group homes, vendor supported developmental homes, skilled nursing facilities, non-state operated Intermediate Care Facilities for Persons with an Intellectual Disability or Level I or Level II Behavioral Health Facilities.

Service Provision Guidelines (Homemaker)

Typical utilization of Homemaker would be two to four hours per week. Additionally:

A. The member or family is expected to provide all necessary supplies;

B. This service shall not be provided when the member is hospitalized or otherwise receiving institutional services. The service may only be provided at the end of hospitalization to allow the member to return to a safe and sanitary environment; and,

C. Members residing in Group Homes, Foster Homes or Adult Developmental Homes shall not receive this service.

Utilization of Homemaker will be in accordance with the Service Authorization Matrix.

Provider Types and Requirements (Homemaker)

Designated District staff will ensure all contractual requirements related to Homemaker providers are met before services can be provided. Additionally, all providers of ALTCS must be certified by the Division and registered with AHCCCS prior to service initiation.

Service Evaluation (Homemaker)

The Individual Support Plan/Individualized Family Service Plan/Person Centered Plan review (Plan Review) shall document appropriateness of this service based upon the Support Coordinator's observation and input from the member, family, and provider.

Service Closure (Homemaker)

This service is no longer appropriate when:

A. The member's medical, physical or behavioral needs have decreased;

B. The physical/medical needs of the family members have decreased;

C. The family is no longer experiencing crisis;

D. The member no longer resides at home, has moved out of state, or when the member is no longer eligible for ALTCS;

E. The member moves to a residential or institutional setting; or,

F. The family has adequate resources or other support to provide the service.

A Notice of Intended Action must be sent in accordance with the processes defined in of this policy manual.

Other Homemaker Services

A. The amount of Homemaker provided shall be determined based on the home requirements for a safe and sanitary environment. If more than one eligible member resides in the home, payment will not be made twice for cleaning common areas of the home.

B. If the family is receiving supplemental payments for other members in the home, the Support Coordinator shall determine if the Supplemental Payment Program (SPP) is meeting the family's needs.

1240-C COMMUNITY TRANSITION SERVICES

REVISION DATE: 3/2/2015
EFFECTIVE DATE: June 30, 1994

Description

The Community Transition Service (CTS) assists members eligible for Arizona Long Term Care System (ALTCS) to reintegrate into the community by providing financial assistance to move from an ALTCS setting to their own home or apartment, excluding licensed community settings.

An ALTCS setting includes one of the following:

A. Behavioral Health Level I facility;

B. Institution for Mental Disease;

C. Inpatient Psychiatric Residential Treatment Center (available to members under 21 years of age eligible for Title XIX.);

D. Nursing Facility, including religious non-medical health care institution; and,

E. Intermediate Care Facility (ICF).

The following items can be purchased using CTS funds:

A. Security deposits required to obtain a lease on an apartment or home (refunded deposits are the property of the Division);

B. Essential furnishings (new or gently used including items such as: bed, bedding, towels, table, chairs, window coverings, eating utensils, food preparation items, small electrical appliances);

C. Moving expenses; and,

D. Set up fees or deposits for utility or service access (e.g., telephone, electricity, gas). (Refunded deposits are the property of the Division.)

Considerations

The following factors will be considered when assessing the need for this service:

A. The member has been living in an ALTCS setting a minimum of 60 consecutive days regardless of ALTCS enrollment;

B. The member is within 30 days of being discharged into the community; and,

C. The LTC setting discharge plan identifies needs and assistance for which the member has no other source or support to move.

1. It is not intended to replace items or supports otherwise provided by the Division or community resources.

2. The members' needs shall be met upon discharge and discharge cannot be delayed in anticipation of receiving services from other sources (e.g., when coordinating with other community sources for the provision of this service).

Exclusions

Community Transition Services are:

A. Not available to members moving from an ALTCS setting to an alternate residential setting such as Assisted Living Facilities, Group, or Developmental Homes;

B. Limited to a one-time authorization (see exception letter C below) of up to $2,000 every five years per member;

1. The $2,000 includes all applicable administration fees.

2. The five year timeframe applies regardless of changes in Managed Care Contractors or the member transfers between fee-for-service and managed care.

C. Available 30 days prior to the planned discharge date and remain available for 90 days from the date of discharge from an ALTCS institutional setting. Exceptions to this timeframe for partially expended funds will be determined on a case-by-case basis.

D. Not dispersed to the member, the member's family, or friends.

1. Funds are paid directly to the vendor identified by the member or family.

2. Receipts for all purchases using CTS funds shall be retained for a minimum of five years.

3. The Support Coordinator will assist the member and family with prioritization of needs and facilitate the purchase of identified goods and services.

The following items cannot be purchased using CTS funds:

A. Cash payments to members or significant others;

B. Rent;

C. Leisure/recreational devices (e.g., television or cable access, internet access, stereo);

D. Aesthetics/decorative items (e.g., picture frames, rugs);

E. Remodeling improvements to any home or apartment; and,

F. Grocery items (e.g., food, personal hygiene, cleaning products).

1240-D EMERGENCY ALERT SYSTEM

REVISION DATE: 10/26/22, 3/2/15
EFFECTIVE DATE: June 30, 1994
REFERENCES: AMPM 1240-D

PURPOSE

This policy establishes requirements for the coordination and provision of emergency alert systems to Members eligible for the Arizona Long Term Care System.

DEFINITIONS

1. "Emergency Alert System" (EAS) means a service that provides monitoring devices/systems for members who are unable to access assistance in an emergency and/or live alone or would be alone for intermittent periods of time without contact with a service provider, family member, or other support systems, putting the member at risk.
2. "Member" means an individual enrolled with the Division.
3. "Planning Team" means a group of people including the Member; the Responsible Person; the Support Coordinator; other State of Arizona Department of Economic Security staff, as necessary;

and any person selected by the Member, Responsible Person, or the Department.

4. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. The Division of Developmental Disabilities (Division), shall cover EAS for Members who meet all of the following criteria:

1. The Member lives alone or is alone for intermittent periods of time without contact with a service provider, family member, or other support system;
2. The Member's community does not have reliable/available emergency assistance on a 24-hour basis;
3. The assessment of the Member's medical and/or functional level documents an acute or chronic medical condition;
4. The Primary Care Provider (PCP) has prescribed the EAS; and
5. The Member has the ability to use and operate the system.

B. The Division shall subcontract the management of EAS to the Administrative Services Subcontractors (AdSS) for Members enrolled in AdSS health plans.

C. The Support Coordinator, when a Member enrolled in a subcontracted health plan requests an EAS or the Planning Team identifies the need for one, shall:

1. Advise the Member to contact their PCP for a prescription.
2. Coordinate the service as per the subcontracted health plan's referral process.
3. Follow the Health Escalation Path if the Member experiences difficulty obtaining an EAS.

D. The Support Coordinator, when a Member enrolled in the Tribal Health Program requests an EAS or the Planning Team identifies the need for one, shall:

1. Advise the Member to contact their PCP for a prescription.
2. Coordinate the service as per the Arizona Health Care Cost Containment System referral process.

E. The Support Coordinator shall document all actions pertaining to the coordination of EAS in the Member's case file.

Signature of Chief Medical Officer: Anthony Dekker (Oct 19, 2022 10:25 PDT)
Anthony Dekker, D.O.

1240-E HABILITATION SERVICES AND DAY TREATMENT SERVICES

REVISION DATE: 5/31/23, 9/11/2019, 9/15/2017, 7/15/2016, 7/3/2015, 3/2/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994
REFERENCES: AMPM 1240-E, Division Medical Policy 1240-J

PURPOSE

This policy outlines the requirements for and describes covered hourly and daily Habilitation services and Day Treatment Services for Division Members who are eligible for Arizona Long Term Care Services (ALTCS).

For the purpose of this policy, Daily Habilitation is Habilitation provided in a Member's Own Home or community setting. Daily Habilitation may also be referred to as Supported Living or Independently Designed Living Arrangement (IDLA).

DEFINITIONS

1. "Community Residential Setting" means the same as in A.R.S. § 36-551.

2. "Competitive Integrated Employment" means work that is performed on a full-time or part-time basis for which an

individual is:

a. Compensated at or above minimum wage and comparable to the customary rate paid by the employer to employees without disabilities performing similar duties and with similar training and experience;

b. Receiving the same level of benefits provided to other employees without disabilities in similar positions;

c. At a location where the employee interacts with other individuals without disabilities; and

d. Presented opportunities for advancement similar to other employees without disabilities in similar positions.

3. "Day Treatment" means a service that engages Members in their communities to develop, or enhance skill development, for activities of daily living and employment while meeting their specialized sensorimotor, cognitive, communication, social interaction, and behavioral needs and foster the acquisition of skills explore their communities, to learn about their interests, to engage with others, and to gain skills needed for greater

independence.

4. "Direct Care Worker (DCW)" means An individual who assists an elderly individual or an individual with a disability with activities necessary to allow them to reside in their home. These individuals, also known as Direct Support Professionals, must be employed/contracted by DCW Agencies or, in the case of member-directed options, employed by ALTCS members in order to provide services to ALTCS members.

5. "Habilitation" means the process by which an individual is assisted to acquire and maintain those life skills that enable the individual to cope more effectively with personal and environmental demands and to raise the level of the individual's physical, mental, and social efficiency as specified in A.R.S. § 36-551 (18).

6. "Home and Community Based Services (HCBS)" means Home and community-based services, as specified in A.R.S. § 36-2931 and A.R.S. § 36-2939.

7. "Member" means a person enrolled with the Division of

Developmental Disabilities.

8. "Own Home" means a residential dwelling that is owned, rented, leased, or occupied by a Member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting, or an institution, or a portion of any of these that is licensed or certified by a regulatory agency of the state as a:

   a. Health care institution under A.R.S. § 36-401.

   b. Residential care institution under A.R.S. § 36-401.

   c. Community residential setting under A.R.S. § 36-551, or

   d. Behavioral health facility under 9 A.A.C. 20, Articles 1, 4, 5, and 6 (A.A.C. R9.101).

9. "Planning Document" means a plan which is developed by the planning team, such as an Individualized Family Service Plan (IFSP) or Person Centered Service Plan (PCSP).

10. "Planning Team" means a group of individuals that shall include the Member, Responsible Person, Support Coordinator, and a

representative from the agency for Member's living in a licensed setting and with the Member's consent, and any individuals important in the Member's life, including but not limited to, extended family members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems. The size, scope, and intensity of involvement of the team Members are determined by the objectives of the Planning Team to best meet the needs and individual goals of the Member.

11. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability, or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed as defined in A.R.S. §36.-551

12. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. HABILITATION SERVICES

1. The Division shall contract with service providers to provide Habilitation services to Division Members.

2. The Division shall cover Habilitation services when medically necessary and cost effective.

3. The Division shall assess for and authorize Habilitation services when a need for Habilitation services has been identified by the Planning Team.

4. The Division shall ensure that Members assessed for Habilitation have Habilitation outcomes, based on the Responsible Person's priorities and goals, identified in the Planning Document to improve or learn new skills.

B. HOURLY AND DAILY HABILITATION

1. The Support Coordinator may assess for Hourly or Daily Habilitation when the Member has outcomes in their Planning Document that require a service to support the Member in:

a. Independence and socialization skills

b. Safety and community skills

c. Member's health and safety.

d. Essential activities required to meet the Member's personal and physical needs

e. Alternative and/or adaptive communication skills

f. Self-help/living skills

g. Developing the Member's support system to reduce the need for paid services.

h. Helping family members learn how to teach the Member a new skill.

i. Developing skills for independent living in their home, including adaptive and self-determination skills, while offering supervision and assistance to assure their health and safety.

j. To socialize with their housemates, their family, their

friends, and community members.

2. The Support Coordinator shall consider the following when assessing for Hourly or Daily Habilitation:

   a. Existing community support systems have been exhausted and no other service is available.

   b. The Member's documented needs cannot be met by the Member's informal support system, employment program, or Day Treatment program.

   c. When the Member requires Habilitation to support their home program strategies for therapy services.

   d. Members want to live as independently as possible and develop or enhance their independence in their home, participation in their community, and relationships with others.

4. The Division shall authorize Habilitation Hourly or Daily Habilitation in the following settings:

   a. The Member's Own Home;

b. A community setting chosen by the Responsible Person;

c. The setting where the expected skills shall be applied;

d. In a Direct Service Provider's (DSP) residence when the residence is also the Member's Own Home.

5. The Division shall not authorize Hourly or Daily Habilitation in the following settings:

a. During the time the Member is attending Day Treatment and Training, or

b. To substitute for Day Treatment and Training services;

c. In a Qualified Vendor owned or leased service site;

d. When the Member is hospitalized;

e. To Members living in a Community Residential Setting, skilled nursing facilities, non-state operated Intermediate Care Facilities, or Level I or Level II behavioral health facilities;

f. Habilitation Hourly and Habilitation Daily shall not be

approved concurrently

g. In schools or while being transported by the school.

g. Substitute for Respite

h. Substitute for daycare

i. Be used in place of regular educational programs as provided under Public Law 108-446 IDEA Part B

j. Be used when another service is more appropriate

k. In a Direct Service Provider's (DSP) residence when the residence is not the Member's Own Home.

B. DAY TREATMENT SERVICES

1. The Division shall ensure that Day Treatment programs shall follow guidelines for language competency and provide rights and resources in a location that anyone can access at any time for reference or in the event they feel their rights are being violated.

2. The Support Coordinator shall consider the Member's ability to

gain Competitive Integrated Employment as part of the Employment First Initiative prior to assessing for Day Treatment services, refer to Division Medical Policy 1240-J.

3. The Support Coordinator, after consideration of any employment and educational services, may assess for Day Treatment services.

4. The Support Coordinator shall assess for Day Treatment Child for children through the age of 17 years old.

    a. Upon the age of 16 years old, transition plans may be individually developed, and may permit the inclusion into services with adults with consent from the Member's Responsible Person.

    b. The transition plan and consent shall be available to the Division upon request.

5. The Support Coordinator shall assess for Day Treatment Adult for Members who are 18 years old and older.

6. The Support Coordinator shall not assess for Day Treatment

services for Members to:

a. Substitute for Respite or day care

b. Be used in place of regular educational programs as provided under Public Law 105-17 (www.gpoaccess.gov/plaws/)

c. Be used to provide other related services that have been determined in the IEP to be educationally necessary

d. Be used when another service is more appropriate

e. Include wage-related activities that would entitle the member to wages.

5. The Division shall authorize Day Treatment services in the following settings.

a. A setting owned or leased by the Qualified Vendor that includes planned opportunities for interaction with community members and resources, and the home program allows for participation in community events; and

b. Is located in the community among other residential

buildings, private businesses, retail businesses, and

c. A community setting that offers opportunities for interaction with community members, and

d. Includes opportunities to learn about volunteer work in the community and referrals (resources and services) to prepare for, obtain and support volunteer work, and

e. Supports and facilitates social, recreational, skill-building, and community-based activities that do not regiment, individual initiative, autonomy, and independence in making life choices including but not limited to, daily activities, physical environment, and with whom to interact.

6. The Division shall not authorize Day Treatment services in the following settings.

a. A Community Residential Setting;

b. A contracted Intermediate Care Facility or

c. A Level I or Level II behavioral health facility;

d. In the same room at the same time as another service, except therapy services.

7. Responsibilities for Providers delivering Day Treatment services can be found in Provider Manual Chapter 2.

Signature of Chief Medical Officer: Anthony Dekker (May 26, 2023 13:45 PDT)

Anthony Dekker, D.O.

1240-F HOME DELIVERED MEALS

REVISION DATE: 08/30/23

EFFECTIVE DATE: August 09, 2023

REFERENCES: A.R.S. § 36-551; AMPM 1240-F

PURPOSE

This policy sets forth the Division of Developmental Disabilities (Division) guidance on Home Delivered Meals for ALTCS Members who live in their own home and are in jeopardy of not consuming adequate nutritious food to maintain good health.

DEFINITIONS

1. "Contactless Delivery" means once the package has reached its final destination, it is left outside the doorstep of the Member's home, or otherwise pre-designated location, without making any direct, in-person contact.
2. "Home and Community Based Services" means Home and community-based services, as specified in A.R.S. § 36-2931 and A.R.S. § 36-2939.
3. "Home Delivered Meals" means a service that provides a nutritious meal containing at least one third of the Federal

recommended daily allowance for the member, delivered to the member's own home.

4. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

5. "Nutritionist" means an individual who has a bachelor's or master's degree in Food and Nutrition.

6. "Planning Document'' means a written plan developed through an assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such Services and supports.

7. "Registered Dietician" means an individual who meets all the requirements for membership in the American Dietetic Association, has successfully completed the examination for registration and maintains the continuing education requirements.

8. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551

POLICY

A. ASSESSMENT AND DOCUMENTATION

1. The Support Coordinator may assess for Home Delivered Meals for ALTCS Members who live in their own home.
2. The Support Coordinator shall document the Member's assessed need for this service, including the Member's ability to:
    a. Prepare their own meal or have a meal prepared by a caregiver,
    b. Store meals in their refrigerator and freezer, and
    c. Complete preparation of meals which require:
        i. Heating from frozen state, or
        ii. Addition of dried ingredients.
2. The Support Coordinator shall document when meals are needed by documenting in the services section, noting:
    a. The number of days; and
    b. The specific days per week.
3. The Support Coordinator shall not assess service levels:
    a. At a rate exceeding one meal per day,

b. For Members who receive Attendant Care Services (ATC) on the same days the Member receives ATC, unless the Support Coordinator:

i. Identifies and documents an extenuating circumstance which prevents the ATC staff from completing meal preparation tasks; and

ii. Receives approval to proceed with the service authorization.

B. ESTABLISHING SERVICE

1. The Support Coordinator shall coordinate with the Responsible Person to complete paperwork to initiate meal delivery with the vendor.
2. The Support Coordinator shall confirm the Member's following information is current:
   a. Phone number for Responsible Person, and
   b. Physical address where meals will be delivered.
3. The Support Coordinator shall offer the option of Contactless Delivery to the Member, reviewing:
   a. Advantages and disadvantages; and

b. Individualized considerations of the member's needs and preferences.

4. The Support Coordinator shall document a summary of the discussion regarding Contactless Delivery in the Member's file.

5. The Support Coordinator shall follow up with the Responsible Person within two days of submitting the request to the vendor to verify the vendor has made initial contact to begin services.

C. ONGOING

The Support Coordinator shall notify the service provider immediately if the Member:

a. Needs the service to temporarily stop,

b. Changes their address, or

c. No longer needs this service.

D. SUPPLEMENTAL INFORMATION

Up to a maximum of 14 days (two weeks) worth of meals will be delivered to the Member at one time. No new meals will be delivered prior to the time the next meal is expected.

Signature of Chief Medical Officer: Anthony Dekker (Aug 22, 2023 10:05 PDT)
Anthony Dekker, D.O.

1240-G SKILLED NURSING AND LICENSED HEALTH AIDE SERVICES

REVISION DATE: 1/10/2024, 09/14/2022, 6/9/2021, 7/3/2015, 9/15/2014
REVIEW DATE: 9/6/2023
EFFECTIVE DATE: June 30,1994
REFERENCES: 42 C.F.R. 440.80, A.R.S. § 32-1601, A.R.S. §36- 2939, AMPM 1020, AMPM 1620-D, AMPM 1240-G, AMPM 1250-D, AMPM 310-I, AMPM 520.

PURPOSE

The purpose of this policy is to establish the requirements regarding medically necessary Home Nursing and Licensed Health Aide Services for Division Members who are eligible for Arizona Long Term Care System (ALTCS) services.

DEFINITIONS

1. "Activities of Daily Living" or "ADLs" means activities a Member shall perform daily for the Member's regular day-to-day necessities, including but not limited to mobility, transferring, bathing, dressing, grooming, eating, and toileting.

2. "H-NAT" means the Hourly Nursing Assessment Tool that is used to analyze and display the relationship between the Skilled

Nursing task and the necessary time to complete the task.

3. "Home" means the Member's place of residence, that is not a medical setting, which may include: a private home, group home, Adult Developmental Home (ADH), and a Child Development Home (CDH).

4. "Intermittent Nursing Services" means Skilled Nursing Services provided by either a Registered Nurse (RN) or Licensed Practical Nurse (LPN), for Visits of two hours or less in duration, up to a total of four hours per day.

5. "Inter-rater Reliability" or "IRR" means the process of ensuring that multiple observers are able to consistently define a situation or occurrence in the same manner, which is then recorded.

6. "Licensed Health Aide" or "LHA" means pursuant to A.R.S. § 32-1601, a person who is licensed to provide or assist in providing nursing-related services pursuant to A.R.S. § 36-2939 or:

   a. Is the parent, guardian, or family member of the Arizona

Long Term Care System (ALTCS) Member who is under 21 years of age and eligible to receive receiving Skilled Nursing or Skilled Nursing respite care services who may provide Licensed Health Aide (LHA) services only to that Member and only consistent with that Member's plan of care; and

b. Has a scope of practice that is the same as a Licensed Nursing Assistant (LNA) and may also provide medication administration, tracheostomy care, enteral care and therapy, and any other tasks approved by the State Board of Nursing in rule.

7. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

8. "Planning Team" means a defined group of individuals comprised of the Member, the Responsible Person if other than the Member, and, with the Responsible Person's consent, any individuals important in the Member's life, including extended family members, friends, service providers, community resource

providers, representatives from religious/spiritual organizations, and agents from other service systems.

9. "Pro Re Nata" or "PRN" means medications that are provided as needed and not on a regular basis.

10. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a member or an applicant for whom no guardian has been appointed.

11. "Skilled Nursing Care" or "Skilled Nursing Services" means a level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a Registered Nurse or a Licensed Practical Nurse).

12. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

13. "Visit" means one unit of LHA services. One unit is 15 minutes long. A Visit is usually two hours but may be greater or lesser

depending on the time it takes to render the procedure.

POLICY

A. SKILLED NURSING SERVICES

1. The Division shall cover medically necessary Skilled Nursing Services provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) in the Member's Home.

2. The Division shall ensure that if the Skilled Nursing Services are furnished by an LPN, the services are:
   a. Provided under the supervision and direction of an RN or Physician, and
   b. Provided by a LPN that is employed by a Home Health Agency (HHA).

3. The Division shall provide Skilled Nursing Services as an alternative to hospitalization or institutionalization when care cannot be safely managed within the scope and standards of Intermittent Nursing Services and when the Division determines the services to be cost-effective.

4. The Division shall ensure that Skilled Nursing Services are provided by a:
   a. Medicare certified HHA; or
   b. State licensed HHA if a Medicare certified HHA is not available per AMPM 310-I.
5. Support Coordinators shall identify Members who potentially need Skilled Nursing Services through the Person Centered Service Plan and shall submit a referral to Health Care Services for an assessment by the District Nurse when skilled nursing needs are identified.
6. The District Nurse, upon receipt of the referral from the Support Coordinator, shall complete a nursing assessment, which contains:
   a. A review of the current medical files, including all pertinent health-related information, to identify potential health needs of the Member related to the Division nursing assessment and;

b. Assessment of the health status of the Member by a review of the current medical data, communication with the Member, team members and families, and assessment of the Member in relation to physical, developmental, and behavioral dimensions.

7. The District Nurse shall determine allocation of Skilled Nursing Care hours based on the nursing needs identified on the Division nursing assessment and the H-NAT.

8. The District Nurse shall complete each section of the H-NAT to evaluate the needs of the Member requiring Skilled Nursing Services.

9. The Division shall not cover Skilled Nursing Services for the sole purpose of helping with ADLs.

10. The Division shall cover ADLs when nursing providers assist Members while they are on duty and providing authorized Skilled Nursing Services.

11. When PRN Skilled Nursing Services are assessed, the District

Nurse shall describe in detail the medical need in the nursing assessment.

12. The District Nurse shall ensure that assessed services are provided to the Member within 14 calendar days for an existing ALTCS Member or 30 days for a newly enrolled ALTCS Member.

13. The Division shall ensure Skilled Nursing Services are ordered by a Physician.

14. The District Nurse shall ensure the HHA obtains an order from the Physician to perform duties related to Skilled Nursing Care if an order is not already in place.

15. The Division shall require the HHA to ensure that the Physician reviews and recertifies the plan of care at least every 60 days and that it is reviewed at every Person Centered Service Plan meeting.

16. The Division shall require the HHA to ensure that a Physician prescribes the services and the Skilled Nursing Services follow a written nursing plan of care developed by the Division contracted

Home Health provider, in conjunction with the Division's Support Coordinator, the Member or Responsible Person, and the District Nurse that includes:

a. Specific services to be provided,

b. Anticipated frequency and duration of each specific service;

c. Expected outcome of services;

d. Coordination of these services with other services being received or needed by the Member;

e. Input of the Member or Responsible Person; and

f. Assisting the Member in increasing independence.

17. District Nurses shall ensure care is delivered by the Member’s Skilled Nursing Service providers.

18. District Nurses shall conduct ongoing assessment and monitoring of the nursing needs and Skilled Nursing Services of each Member assigned to their caseload every 90 days.

19. The Support Coordinator shall invite the District Nurse to all Planning Team meetings if a Member is receiving Skilled Nursing Services, unless otherwise requested by the Responsible Person.

20. District Nurses shall work in collaboration with the Member's Planning Team to ensure that all Skilled Nursing needs are met and all services are medically necessary and cost-effective.

21. The District Nurse shall document any contact made on behalf of the Member related to Skilled Nursing Services in the Member's progress notes.

22. At least annually, the Division shall train District Nurses and nurse managers on the H-NAT.

23. At least annually, Nurse Managers will conduct IRR testing to ensure consistent application of review criteria in making medical necessity decisions.

B. LICENSED HEALTH AIDE (LHA)

1. The Division shall cover medically necessary LHA services in the

setting where the Member's normal life activities take place when provided by an HHA**.**

2. The Division shall provide LHA services as an alternative to hospitalization or institutionalization when care cannot be safely managed within the scope and standards of Intermittent Nursing Services and when determined to be cost-effective.

3. The Division shall require Visits include at least one of the following components:

   a. Monitoring the health and functional level, and assistance with the development of the HHA plan of care for the Member;

   b. Monitoring and documenting of Member vital signs, as well as reporting results to the supervising RN or Physician;

   c. Providing Members with personal care;

   d. Assisting Members with bowel, bladder or ostomy programs, as well as catheter hygiene (does not include catheter insertion);

e. Administering, or assisting Members with self-administration of, medications;

f. Assisting Members with eating, if required, to maintain sufficient nutritional intake, and providing information about nutrition;

g. Assisting Members with routine ambulation, transfer, use of special appliances or prosthetic devices, range of motion activities or simple exercise programs;

h. Assisting Members in ADLs to increase Member independence;

i. Teaching Members and families how to perform home health tasks; and

j. Observing and reporting to the HHA Provider or the Support Coordinator of Members who exhibit the need for additional medical or psychosocial support, or a change in condition during the course of service delivery.

4. The District Nurse shall determine allocation of LHA services

based on the nursing needs identified on the Division nursing assessment and the H-NAT.

5. The District Nurse shall allocate LHA services in lieu of Skilled Nursing hours when skilled services fall within the scope of the LHA.

6. The Division shall ensure that Skilled Nursing Services, respite services provided by a RN or LPN, and LHA services are not provided concurrently.

7. The Division shall ensure that when LHA services are authorized for respite, the LHA is not the same individual for whom the respite is intended.

8. The Division shall ensure LHA services are provided under the supervision and direction of a RN or Physician.

9. The Division shall ensure the supervision of LHAs includes observing the LHA's competency in performing the necessary duties as required by the individual patient.

10. The Division shall ensure supervisory Visits occur within the

LHAs first week and:

a. Within the first 30 days,

b. Within the first 60 days, and

c. At least every 60 days thereafter.

11. The Division shall ensure that LHAs are employed by an HHA and licensed by the State Board of Nursing.

12. The Division shall ensure that LHA Services are provided through a Medicare Certified HHA.

13. The Division shall ensure that the Division rate book and claims manual reflect information on billing for LHA services.

Signature of Chief Medical Officer: Anthony Dekker (Jan 5, 2024 12:54 MST)
Anthony Dekker, D.O.

Exhibit 1240-G-1 Skilled Nursing Matrix

REVISION DATE: 9/14/2022, 1/31/2014
EFFECTIVE DATE: August 30, 2013

Condition or Need	Medical Definition	Skilled Nursing Task *This may result in Skilled Nursing Services being authorized
Head To Toe Assessment	A comprehensive Nursing assessment that reviews all major body systems	A clinical assessment of all body systems for changes in condition.
Anticoagulant Therapy Including but not limited to injectable anticoagulant therapy	Medications used to make the blood less likely to clot or form scabs	Assessment and monitoring for unstable anticoagulant therapy
Apical Pulse Check Including but not limited to prior to giving heart medication	Use of a stethoscope to listen to the heart beat at the level of the apex of the heart	Listening to heartbeat on chest for a full minute to assess the heart rate, rhythm and volume.
Ventilator/Respirator, Diaphragmatic pacing	A machine that breathes for a person who is unable to breathe enough on their own	Monitoring vital signs, cardiopulmonary status, monitor airway, monitor for work of breathing, oxygen saturations,monitor equipment settings and functionality

Bi-level positive airway pressure (BiPAP); Continuous Positive Airway Pressure (CPAP)with a trach	A machine that helps an individual breathe and prevents the airway from collapsing and blocking the breathing in people with sleep apnea or other breathing problems	Turning on and off, changing settings, respiratory assessment, circuit changes
Blood Pressure Checks	Assessment of Blood Pressure	Blood pressure monitoring and treatment when it is too high or too low
Chest Percussion Therapy (CPT)	Therapy by clapping on the chest either manually or with a machine	Application of the therapy techniques and assessment of effectiveness, respiratory assessment
Complex wound care	Assessment and treatment of wounds	Assessment and treatment of wound, including but not limited to wound cleaning and bandage changes
Complex/Unstable Seizure Disorder	A change in the way a person acts or moves that is not normal due to a brain problem	Neurological assessment and emergency medical intervention for unstable seizure activity

Coughalator/cough assist device	A machine that causes the member to cough	Application of machine and assessment of effectiveness of machine; respiratory assessment
Dialysis (occurring at home), including Peritoneal dialysis or hemo dialysis	Cleaning of blood through a machine or tube	Assessment and monitoring; starting and stopping of the treatment
Extremity edema checks when ordered by a physician	Assessment of extra fluid buildup in the extremities	Checking for fluid in the legs or arms; assessment
GJ Tube Gastrostomy/ Jejunostomy Tube	A feeding tube into the gastric (stomach) continuing to the Jejunum (small intestine)	Insertion of liquid food, water and/or medication into the tube
Injections	Medication given with a needle	Administering medication with a needle
Insulin Administration	Medications given with a needle to treat diabetes	Administering insulin with a needle
Intermittent Partial Pressure Breathing (IPPB)	A machine to assist with breathing all the time	Monitoring effectiveness of machine, changing settings on machine as ordered, respiratory assessment and

		intervention, circuit changes
Intravenous (IV) Therapy (For individuals living at home)	Administration of fluids and medications into the venous blood supply	Administering medications through an IV into the blood and any dressing changes needed
Central Venous Access (CVA)	A thin flexible tube inserted into a vein and guided into a larger vein above the right side of the heart. It is used to give Intravenous fluids, chemotherapy, TPN, Lipids, and other medications.	Assessment of insertion site, patency of catheter and for complications. Administration of IV medications or blood draws per physician orders. Includes TPN/Lipid administration and IV line maintenance.
J-Tube (Jejunum-tube)	A feeding tube through the Jejunum (small intestine)	Insertion of liquid food, water and/or medication into the tube
Nasogastric enteral feeding (NG tube)	A plastic tube that is used to deliver formula and medicine to the stomach. It is inserted through the nose, passes the throat, and placed into the stomach.	Insertion and removal of NG Tube, Monitoring for NG Tube placement, skin assessment to the area's/sites that the NG Tube enters, or is secured, starting/stopping NG Tube feedings,

		monitoring nutritional status tolerance of tube feedings

Nephrostomy	Surgically placed tubes used to flush fluid to clean the kidney(s)	Flushing fluid into tubes that cleans the kidney(s)
Ostomy irrigation	Flushing of an opening into the body with fluid	Cleaning out the organ with fluid
Ostomy Care	Care and maintenance to the Ostomy site and changing the ostomy wafer and pouch	Assessment of skin condition and ostomy site, assessment for signs of complications to include gastrointestinal complications, tissue integrity complications and for complications of the ostomy/stoma site
Oxygen Titration	Giving oxygen at an amount that changes dependent on the person's blood oxygen level	Changing the level of oxygen administration based on pulse oximeter readings
Postural drainage	A treatment to clear the lungs by moving the body in a downward position	Assessment and draining the lungs of fluids
Pressure Ulcer	An area of the skin that breaks down when	Assessment and monitoring of the care

	something keeps rubbing or pressing against the skin	and healing of the pressure ulcer
Pulse Oximeter	A machine that measures oxygen levels in the blood	Monitoring the amount of oxygen in the body
Sleep Apnea	The temporary stoppage of breathing during sleep	BiPAP machine or Vent used to treat the condition, respiratory assessment (the assessment for Apneic episodes)
Small Volume Nebulizer (SVN) (varied or unscheduled)	Medications given at varied times using a small-volume nebulizer, a device that holds liquid medicine which is then turned into a fine mist	Assessment of needed time for medicated breathing treatments
Sputum sample	Chest fluid sample test	Collection of fluid from chest
Straight catheterization (does not include catheter care and maintenance)	Insertion of a single use catheter to drain the bladder	Assessment of placement, drainage and skin integrity. Monitoring of urinary output and education
Suctioning (tracheal or deep through the nose or mouth)	The insertion of a suction catheter into the throat, and/or lungs through the mouth, nose or a tracheostomy to remove secretions	Inserting tube into the throat and/or lungs through the mouth or the nose to get fluid out

	from the lungs/airway.	

Tracheotomy	A surgery to make and opening through the neck into the windpipe to allow for breathing	All tracheotomy management and care

1240-I HOME MODIFICATIONS

REVISION DATE: 3/2/2015
EFECTIVE DATE: June 30, 1994
REFERENCES: A.R S. §§ 41-1491.19.D.1 and 32-1101.01.

Overview

Home Modification is the process of adapting the home to promote the independence and functional ability of persons with disabilities. Adaptations may include physically changing portions of the residence to create a living environment that is functional according to the member's specific needs. Terms often associated with this process include barrier removal, architectural access, assistive technology, retrofitting, home modifications, environmental access, or universal design.

Members who are eligible for the Arizona Long Term Care System (ALTCS) are also eligible for medically necessary home modifications for architectural access to and within his/her natural/private home. The goal of a home modification is to provide the person greater independence and ability with assistance for daily living in their home. Home modifications must be medically necessary, cost-effective, and reduce the risk of an increase in Home Community Based Services (HCBS) or institutionalization.

A Home Assessment will be done to develop an individualized home modifications plan. The plan will ensure that only appropriate diagnosis related modifications be completed in the home. This plan also provides for a cost-effective, predictable, medically beneficial, and measurable rehabilitative service for the member.

The Division must approve or deny requests for home modifications within 14 calendar days from the “identified need date.” A request that requires an additional extension for up to 14 days and is in the member’s best interest. Requires the member receive written notice including the reason for the extension. The Support Coordinator should request an assessment via the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process when attempting to identify the most appropriate modification for the member. The Planning Team identifies the need for a home modification assessment only. The assessment must be completed within 30 days. A certified staff person must conduct a home visit to make this assessment. The “identified need date” is determined at the time the team agrees to the recommendations as a result of the assessment.

When a request is for a specific home modification, such as a curbless shower, "handrails,” or widen doors, the Support Coordinator via the Planning Document can make a request for that specific modification. The “identified need date” starts at this time and the request for home modifications must be approved or denied within 14 days. A request that requires an additional extension for up to 14 days, and is in the member’s best interest, requires the member receive written notice including the reason for the extension. This method may result in a denial of service. The home modification unit would make a broad “contingent” recommendation if sufficient evidence is present to move forward with the request.

Scope of Home Modifications

The unit of service is one home modification project. Using the member’s primary and secondary diagnoses in conjunction with a home evaluation, a project plan to provide home

modification for the person will include, but not be limited to, the following areas of the home:

A. Member's bedroom;

B. Most appropriate, cost-effective bathroom;

C. Most appropriate, cost-effective entrance/exit to the member's home, i.e., a ramp; and,

D. Most appropriate, cost effective locations of the kitchen area, when determined to be medically necessary when the member lives alone.

The types of permanent installations for architectural barrier removal include:

A. Widening of doorways – entrance and exit to one bathroom and the member's bedroom;

B. Accessible routes to one bathroom and the member's bedroom;

C. One bathroom environment; (roll-in/curb-less) accessible shower, roll-under sink, high rise toilet with handrails, handrails and grab bars in accessible shower, as prescribed;

D. One wooden or concrete ramp/low inclined walkway; and,

E. Kitchen modifications; accessible cooking surface, minimum accessible pantry storage, accessible kitchen sink/faucet. Kitchen modifications are considered medically necessary when the member lives alone and cannot independently prepare necessary meals without modifications.

Home Modification recommendations (e.g., curb-less showers) will consider the use of durable medical equipment (e.g., shower chair) to be used; the Health Care Services Office can provide technical assistance on durable medical equipment. The member must request any new Durable Medical Equipment via their Primary Care Provider (PCP) who forwards the need to their contracted health plan.

Home Repairs, Home Improvement

General home repairs and maintenance are the responsibility of the homeowner. Home Modifications are for medically necessary environmental access and do not intend to include remodeling for home improvement or home safety. Although home safety is an outcome from architectural barrier removal when home modifications have been completed, it is the responsibility of the homeowner to ensure the home is safe; and to maintain important safe entrances from the home in case of emergency, for all inhabitants. Requests for home modifications that are determined to be for home repairs, home improvement, or home safety will be denied.
Repairs will be carried out to existing structures only when the approved modifications have begun and cannot be completed because of unforeseen circumstances. These repairs must

necessary for building code correction, thereby granting the building contractor the ability to achieve completion of approved medical environmental modifications.

New Construction

The service covers only modifications to existing structures of a member/family owned home where the person resides. Members/families that are planning for a new home are responsible for all the architectural access design/construction of a new home. The service does not cover the construction of additional rooms to the existing structure or provide for an additional bathroom. Technical assistance may be available to help with environmental access.

Homes Not Owned by the Member (Rental/Lease)

The owner of the residence must approve the modifications. When the home being considered for home modifications is not owned but is rented or leased by the family/member, documentation providing permission to allow for renovations on behalf of the member is required from the landlord/owner. Written confirmation must include agreement of participation, signature of the landlord/owner with indication of ownership, and address of residence requested for environmental access.

The Division will incur the cost to restore the home to the original condition prior to the renovation when the landlord/owner requires such after the member has vacated the property.

No Title XIX funds may be used to return a home to its pre-modification state as outlined in Arizona Health Care Cost Containment System (AHCCCS) policy (www.azahcccs.gov/Regulations).

It will be the responsibility of the landlord/owner to demonstrate that the removal of architectural barriers in the rented unit will result in the inability to negotiate a new rental agreement with another member or family. The landlord/owner must also demonstrate that it is a financial disadvantage to maintain environmental access to the rented unit. Additionally, the landlord/owner must demonstrate that the unit will not retain the retail value of a single family dwelling because of the removal of architectural barriers.

Requirements for Medically Necessary Environmental Modifications

Requests for the environmental access to the person's home must include all of the following:

A. The need for environmental access documented in the member's Individual Support Plan/Individualized Family Services Plan/Person Centered Plan;

B. ALTCS Primary Care Provider order;

C. An assessment by a qualified professional, e.g., Occupational Therapist, Physical Therapist, or Certified Environmental Access Consultant. The Division's Medical Director must be contacted to review the request if an assessment by a qualified professional cannot be obtained;

D. An authorization by the Home Modifications Manager; and,

E. The evidence that the member resides in a private residence. Members residing in alternative residential settings are not eligible to receive Home Modifications.

If the request is denied due to lack of medical necessity, it may be authorized, approved or paid by Assistance to Families funds. Medically contraindicated requests shall not be authorized.

Procedures

When a member has recognized a need for home modifications, a request for a home modification begins by contacting the member's Support Coordinator.

The Support Coordinator will forward the request to the Home Modifications Office using the "Initial Request for Home Visit" fax form upon receipt of a member's request for a home modification. This request must be made via the Individual Support Plan/Person Centered Plan process. A written order by a Primary Care Provider (PCP) is another way to make this request. Requests for a home modification may also be made using a home assessment from a Physical/Occupational Therapist. At the time of request for home modifications the Support Coordinator shall enter into the case file via the "Individual Support Plan" or the "Change of Individual Support Plan" form, the need for an assessment to determine specific modifications.

The date recorded in the member's Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) becomes the date for the request for an assessment. This request date determines the beginning of the required 30 days to complete a home visit and assessment. Once the assessment is completed, the team can request the specific modifications and the date of this request becomes the "need identified" date.

The Division must approve or deny requests for home modification within 14 days of the identification of need date. A request that requires an additional extension for up to 14 days and is in the member's best interest, requires the member receive written notice including the reason for the extension. Projects should be completed as soon as possible following approval, not to exceed 90 days. Extenuating circumstances that prevent project completion within 90 days of approval will be documented in the member's case record.

A scheduled home assessment will be conducted within 30 days after the Home Modification unit in Central Office receives a request. The Support Coordinator must be present during the home environmental assessment.

The purpose of a home modification is to increase a member's independence. The home visit will assess the relationship of the member's ability to function independently in the current environment as a result of the proposed home modifications. The home visit will also coordinate the Home Modification Packet production.
The home assessment will include:

A. Consideration for member's abilities and disabilities based upon aids to daily living;

B. Consideration of information that is obtained from the member, family or others in the household and members of the Planning Team;

C. Consideration of hazardous areas of the home based on physical and/or cognitive/intellectual disabilities;

D. Identification of the Planning Documents needs as they relate to delivering services to the member;

E. Identification of diagnosis-related modifications;

F. Provisions for necessary assistive devices and durable medical equipment;

G. Provisions for necessary architectural barrier removal; and,

H. Recording architectural measurements of floor plans and specification sheet.

Review the required documents for the Home Modifications Packet with the member's Support Coordinator. This includes:

A. Reviewing the Professional Assessment for environmental access. An Occupational Therapist, Physical Therapist, or Certified Environmental Access Consultant for the project can provide the professional assessment. A review may be requested from the Division's Medical Director if a professional assessment cannot be obtained at all or obtained in a timely fashion.

B. Obtaining the PCP order for the project using the prescription form approved by the AHCCCS at 15 days from the "need identified" date. After this 15-day period, the Home Modifications unit will send a second prescription form to the PCP with instructions that services will be denied if the prescription form is not received.

C. Obtaining the Project Specification Sheet and Floor Plans. The Home Modification Office will be responsible for the development and implementation of the Project Specification Sheet and drafting of floor plans for each Project. A bid request will be forwarded to the appropriate providers. The Home Modifications Unit will review and award the bid to the approved provider upon return of the proposal.

D. The following authorities will be used as reference for determining accessibility and defining a living environment that provides greater independence and architectural access for the member upon developing the Project Specification Sheet. These include Uniform Building Code Chapter 11 - Accessibility, and guidelines in accordance with the Americans with Disabilities Act. *Note:* The Division will only approve medically beneficial, cost-effective environmental access.

Obtain Home Modification Bids - (at least two (2) bids). The Division will use only a licensed, bonded/insured - B or B3 Contractor/Builder for the accessible renovation of the member's residence.
Complete the *Environmental Modifications Request Form* to track progress of the project. Ensure that member's identification information, Provider/Contractor name, cost of service, the signatures of the Support Coordinator, supervisor, and District Program

Administrator/District Program Manager or designee (cost of service must be indicated prior to submitting to the Lieutenant Program Manager/District Program Manager) are included. The project can be approved and started whether or not the form has been completed but must be completed to ensure everyone has knowledge of the project and the project costs.

Submit the project packet to the Home Modification Office for review/approval.

The packet will include the following:

A. Environmental Modifications Request;

B. Member's Planning Documents (Individual Support Plan/Individualized Family Services Plan/Person Centered Plan) indicating need for medical environmental access;

C. Professional assessment dated within time of request or review with signature from Division's Medical Director;

D. PCP order dated within time of request;

E. Project Specification Sheet and Floor plan (before and after, site plan); and,

F. Contractor bids.

Review Procedures

The Home Modifications Manager will ensure the District representative has reviewed costs and signatures are present upon receipt of the Project Packet.

The Home Modifications Manager will review and sign the request only upon verification that all necessary documents have been provided.

A second level of approval will be required if a Home Modification Project Packet has a total project cost greater than $9000.00. The Home Modifications Manager will forward the project packet to the Assistant Director or designee for review and a final decision. The second level review will be monitored as to avoid delay and maintain Project Packet progress with in required time frames.

1240-J EMPLOYMENT SERVICES

EFFECTIVE DATE: April 21, 2023
REFERENCES: AMPM 1240-J

PURPOSE

This policy establishes the requirements for and describes covered employment services and support services for Division members enrolled in the Arizona Long Term Care Services (ALTCS) program.

DEFINITIONS

1. "Competitive Integrated Employment" means work that is performed on a full-time or part-time basis for which an individual is:

    a. Compensated at or above minimum wage and comparable to the customary rate paid by the employer to employees without disabilities performing similar duties and with similar training and experience;

    b. Receiving the same level of benefits provided to other employees without disabilities in similar positions;

c. At a location where the employee interacts with other individuals without disabilities; and

d. Presented opportunities for advancement similar to other employees without disabilities in similar positions.

2. "Enclave" means a worksite of a competitive employer where a worker with a disability or group of workers with disabilities are working and supervised by staff from the qualified vendor. The workers remain on the qualified vendor's payroll and authorizations to pay subminimum wage is based on the work center's certificate.

3. "Mobile Work Crew" means a small crew of persons with disabilities that operates as a self-contained business that generates employment for their crew members by selling a service. The crew may work at several locations within the community, under the supervision of a job coach. This type of work may include janitorial, groundskeeping, or maintenance.

4. "Self Employment" means the following are met:

a. The person is directly involved in their own recognizable business, trade, or profession. This may include odd jobs or irregular and varied activities,

b. No employer-employee relationship exists and the person controls the hours worked and how the work is performed, or

c. The person works for someone else on a commission basis but pays their own federal taxes. In general, if taxes are deducted from the person's pay, the person is NOT self-employed.

POLICY

A. EMPLOYMENT FIRST

1. The Division shall participate as a partner in Arizona's Employment First initiative by:

a. Providing services and supports to implement Employment First principles and practices, and

b. Coordinating efforts to improve employment opportunities for working-age adults.

2. The Division shall adopt the following principles and ensure service planning and service delivery aligns with these principles:

   a. Employment shall be the first and expected outcome for all working-aged members.

   b. Members shall have access to competitive integrated work settings.

3. The Division shall provide members with the following information to help them make informed decisions about employment.

   a. Employment supports and services,

   b. Knowledge about the value of employment on their quality of life,

   c. Understanding of how work affects public benefits and resources so that employment remains an option without fear of losing essential benefits,

d. Focus on an individual's priorities, strengths, abilities, and interests, and

e. Appropriate supports and services such as supported and customized employment and assistive technology.

c. Long-term supports and services if needed to be successful in the workplace.

B. EMPLOYMENT SERVICES

1. The Division shall provide employment services and supports while applying this philosophy of empowerment and opportunity through the implementation of employment programs, measurement of outcomes, communication, and collaboration with all providers, subcontractors, and stakeholders.

2. The Division shall discuss employment with all members 14 years or older.

3. The Division shall provide a diverse range of employment services, from pre-employment services to post-employment supports, that are individualized to the member. The member's

employment services shall provide opportunities for them to participate in the range of pre-employment services based on their job goals, strengths, priorities, interests, and abilities.

4. The Division shall deliver pre-employment services, that shall be provided individually or in a group setting, to prepare members for engagement in meaningful work-related activities, such as volunteerism or services necessary to achieve full-or part-time competitive integrated employment, including self-employment. This may include the following:

   a. Vocational assessments to determine strengths, knowledge, skills, interests, and abilities,

   b. Career/educational counseling,

   c. Access to transportation training, including how to use public transportation and/or mobility training,

   d. Community trial work experiences, including volunteer work, career exploration, and job shadowing,

e. For Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) beneficiaries, benefits counseling on how working income may affect benefits,

f. Job training services, including vocational skill building and training related to soft skills necessary to be successful on the job,

g. Supervised supported employment in a group setting, including Enclaves and Mobile Work Crews,

h. Other training, including resume preparation, job interview skills, study skills, budgeting skills (when it pertains to employment), professional decorum, and time management, and

i. Assistance in job search.

C. PRE-EMPLOYMENT SERVICES

1. The Division shall assess and authorize Group Supported Employment when the member needs a service that shall provide the member with an on-site, supervised, paid work

environment in an integrated community setting.

2. The Division shall assess and authorize for Center Based Employment when the member needs a service:

   a. That shall provide the member with a controlled, protected, and supervised environment.

   b. That shall be provided in a Qualified Vendor-owned or leased setting.

   c. That shall provide the member with a goal to develop general, non-job-task-specific strengths and skills with a goal of integrated employment in the community including group and individual supported working environments

3. The Division shall assess and authorize Career Preparation and Readiness when the member needs assistance to obtain competitive and/or integrated employment.

   a. Members currently participating in Center Based Employment shall receive services and supports to assist them in making a progressive move into competitive

and/or integrated employment.

i. The Division shall assess and authorize Transition to Employment when the member needs a service that shall provide training in the meaning, value, and demands of work and in the development of positive attitudes toward work.

4. The Division shall assess and authorize for Employment Support Aide when the member needs additional supports to help them maintain successful employment. These supports may:
   a. Include personal care services, and behavioral intervention,
   b. Be provided in Group Supported Employment

D. POST EMPLOYMENT SERVICES

1. The Division shall assess and authorize for Individual Supported Employment when the member needs services to maintain, or obtain, employment and has exhausted services, services are not available, or is not eligible for services through Vocational Rehabilitation. The member shall receive the following services:

a. Job coaching at a competitive integrated job, or

b. Job search services

2. The Division shall assess and authorize for Employment Support Aide when the member needs additional supports to help them maintain successful employment. This support::

a. Includes "Job follow along" supports

b. May be provided with Individual Supported Employment

3. May be provided as a stand-alone service.

4. The Division shall ensure members are educated on the following:

a. Arizona Disability Benefits 101 (DB101), so that members:

i. Understand how disability benefits, such as SSI and SSDI, may change with working income and choose an employment goal based on that understanding, and

ii. May set up their own DB101 accounts and use it independently to make future employment decisions.

b. Rehabilitation Services Administration/Vocational Rehabilitation (RSA/VR), so that members understand:

i. RSA/VR, as the primary payer of employment services, must be offered to members interested in gaining employment,

ii. RSA/VR eligibility criteria,

iii. How the RSA/VR program can assist in their pursuit of becoming employed,

iv. The types of services RSA/VR may provide, and

v. Are able to make informed decisions about participation in the RSA/VR program and request a referral to RSA/VR when interested.

c. Community employment resources, including ARIZONA@WORK, so that members understand what is available in their community.

d. AHCCCS Freedom to Work (Medicaid Buy-In), so that members:

i. Understand it is affordable health insurance for individuals with disabilities who are employed, and

ii. Understand key concepts of the program, such as how to qualify, how to apply, what services are covered, and the cost of monthly premiums.

5. The Division may provide transportation services for eligible members when traveling to and from an employment service site. Employment service sites may be located at a Qualified Vendor site or at the location identified by the employer.

6. The Division shall ensure members receive employment services in an integrated community work setting. An integrated community work setting is a worksite that is located in a naturally occurring community of residential, business, social, or educational environments. Integrated work settings require that workers with disabilities shall have the choice and opportunity to:

a. Work alongside workers without disabilities, other than paid staff who are providing services to that individual,

b. Perform the same tasks with the same expectations that a non-disabled peer would perform for pay,

c. Freely participate in the social aspects common to the workplace, including but not limited to, having access to all common areas of the enterprise, eating lunch, and taking breaks together, and

d. With respect to facility-based services and these other standards for integrated work settings, members shall have the choice and opportunity to:

i. Develop products and services which are prepared in the facility but sold or provided out in the general community,

ii. Have alternate schedules for services and activities,

iii. Schedule activities at their own convenience,

iv. Have access to entrances and exits to the setting and any and all areas within the setting,

v. Engage in work and non-work activities that are specific to their skills, abilities, desires, needs, and preferences including engaging in activities with people of their own choosing and in areas of their own choosing (indoor and outdoor spaces), and

vi. Have access to food during breaks and lunch.

7. The Division shall ensure person-centered employment planning occurs with members interested in gaining or maintaining employment. Employment planning is, driven by the member, and the planning team, through informed choice, and shall include:

a. Members having an integrated employment goal (group or individual supported),

b. An annual readiness assessment is conducted for community-based employment and goals are developed to

address barriers when the member is not ready for the next step.

c. The duration of the service, as defined by the planning team,

d. Outline and prioritize the goals to be achieved,

e. DB101 and work incentive consultation to understand how working income may affect benefits, and

f. Opportunities for progressive moves.

8. The Division shall ensure members in facility-based, congregate employment programs prior to March 17, 2023, shall continue to receive those services without having a goal of working outside of the facility, however, providers shall continually assess and offer services geared toward these members obtaining a competitive job in the community.

9. The Division shall ensure members approved for facility-based, congregate employment programs after March 17, 2023 shall be

approved for no more than one year and reevaluated by the planning team at least one time annually.

10. The Division shall contract with a sufficient network of providers specializing in employment services covering all regions in the Geographical Service Area (GSA) and educate the providers on the importance and benefits of referring members interested in competitive integrated employment to RSA/VR.

11. The Division shall make all reasonable efforts to increase the number of providers who are mutually contracted with ADES/RSA for employment services.

12. The Division shall ensure any authorized attendant during the provision of pre- or post-employment services or at the employed member's workplace before and after work and/or during breaks is medically necessary. These services shall not substitute for the services or accommodations a member may be entitled pursuant to the Americans with Disabilities Act and/or the Rehabilitation Act of 1973 including reasonable accommodations rendered by an employer.

Signature of Chief Medical Officer: Anthony Dekker (Apr 20, 2023 11:52 PDT)

Anthony Dekker, D.O.

1250-D RESPITE

REVISION DATE: 12/18/2019, 7/15/2016, 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994
REFERENCES: Rate Book; AzEIP

Service Description and Goals (Respite)

This service provides short-term care to relieve caregivers. Members who are cared for by Respite providers must be eligible for supports and services through the Division. Respite providers may be required to be available on a 24-hour basis. Respite services are intended to relieve caregivers temporarily. Respite services are not intended as a permanent solution for placement or care. The number of hours authorized for Respite services must be used for Respite services and cannot be transferred to another service.

Service Settings (Respite)

Respite may be provided in any of the following settings:

A. The member's home

B. A Medicare/Medicaid certified Nursing Facility

C. A Group Home, Foster Home or Adult Developmental Home certified by the Division

D. A certified Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID.)

E. A provider's home that complies with the requirements of the Department of Health Services or the Division.

Service Requirements (Respite)

Before Respite can be authorized, the following requirements must be met:

A. Prior to initiating service, the provider shall meet with the primary caregiver to obtain necessary information regarding the member.

B. The provider shall:

1. Supervise the member and meet their social, emotional, and physical needs.

2. Ensure the member receives all prescribed medications in the ordered dose and time.

3. Administer First Aid and give appropriate attention to injury or illness

4. Supply food to meet daily nutritional needs, including any prescribed therapeutic diets.

5. Furnish transportation as needed to day-programs and appointments.

6. Carry out any programs as requested by the Planning Team.

7. Report any unusual incidents to the Division in accordance with policies and procedures.

8. Ensure appropriate consideration of member needs, compatibility, and safety when caring for unrelated members.

Target Population (Respite)

Respite, as a medically related social service, is appropriate based upon family needs, as written in the Individual Support Plan/Individualized Family Support Plan/Person Centered Plan (Planning Documents). Respite services are also, appropriate based on the following factors:

A. The primary caregiver is unable to obtain Respite and other supports from his/her immediate/extended family or other community resources.

B. The primary caregiver needs time to recover from abnormally stressful situations in order to resume his/her responsibilities.

C. A member with a developmental disability presents intense behavioral challenges or needs a high degree of medical care.

D. The primary caregiver is experiencing an emergency that temporarily prevents the performance of normal responsibilities.

E. The primary caregiver requires more frequent or extended relief from care responsibilities due to advanced age or disability.

F. The family is experiencing unusual stressors, such as care for more than one person who has a developmental disability.

Exclusions (Respite)

Exclusions to the provision of Respite services may include any of the following:

A. Respite shall not substitute for routine Transportation, daycare, or another specific service.

B. Respite shall not substitute for a residential placement.

C. Respite providers shall not serve more than three people at one time.

D. Child Developmental Homes and Adult Developmental Home providers shall not give services to more members than would exceed their Division license.

E. Child Developmental Homes and Adult Developmental Home Respite providers shall not give services to children and adults simultaneously. This is only allowed if stated on the license. Additionally, the provider shall not offer services to adults if the license is for children and vice versa.

F. Respite is not available for members living in Group Homes or an ICF/IID.

G. Assisted Living Centers, non-state operated ICF/IID, Skilled Nursing Facilities;

Level I or Level II Behavioral Health Facilities, and members living independently are not approved for Respite.

Service Provision Guidelines (Respite)

A. The federal government and the Arizona Heath Care Cost Containment System (AHCCCS) set the upper limit of 600 hours per year regarding Respite services for members who are eligible for Arizona Long Term Care (ALTCS). Respite Service hours are determined on a yearly basis by the initial Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process and periodic review of these documents.

B. Members who are eligible for Respite services funded by the state are subject to the availability of these funds. The continuation of Respite services is determined on a yearly basis through the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process and periodic review of these documents. Respite services are intended to allow primary care givers a break and, as such, the assessment for Respite hours will need to be reconciled with the amount of time a primary caregiver usually provides support.

C. All hours of Respite utilized by the member/family will be tracked and reported. Respite hours for members who are eligible for ALTCS will be reported to AHCCCS.

D. For Respite billing information see Department of Economic Security, Division of Developmental Disabilities Rate Book located on the Division's website at:

https://des.az.gov/services/disabilities/developmental-infant

E. A negotiated rate will be applied for families who have more than one person eligible for Respite. This negotiated rate will be reported by the provider, with the total actual hours of service given to each member on the Uniform Billing Document. This method of rate setting will be applied when these members receive Respite at the same time. The hours used will be deducted by the Division from the authorized level of Respite for each person.

F. Families receiving Respite for a member eligible for services from the Division who wish other non-eligible members to receive care will be responsible for the costs of serving the non-eligible member. The Division will only pay for services delivered to members authorized to receive such service and will pay the provider at a multiple client rate.

Provider Types and Requirements (Respite)

Designated District staff will ensure all contractual requirements related to Respite providers are met before service can be provided. Additionally, all providers of ALTCS services must be certified by the Division and registered with AHCCCS prior to service initiation.

Service Evaluation (Respite)

The Support Coordinator must continually assess the quality of the services provided to members with developmental disabilities in accordance with the mission statement.

Additionally:

A. The provider shall submit attendance reports summarizing the members served and the number of hours of service to the designated District representative. All incidents shall be reported to the Division within the required timelines.

B. The Support Coordinator and the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan team (Planning Team) shall determine the on-going appropriateness of the service based upon the input from the providers and the member's caregiver(s).

Service Closure (Respite)

A. Respite shall terminate when the member begins to live independently or in a Group Home, Vendor Supported Developmental Homes or, Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID) or Nursing Facility (NF).

B. Respite shall terminate when the family no longer desires the service.

C. Respite for members who are eligible for services through the ALTCS shall terminate when the maximum amount allowed has been used and there are no State funds available.

1250-E THERAPIES (REHABILITATIVE/HABILITATIVE)

REVISION DATE: 10/01/2021, 5/24/2021, 3/4/2020, 7/3/2015, 3/2/2015
EFFECTIVE DATE: June 30, 1994

Habilitative Therapy

Habilitative therapy directs the member's participation in selected activities to facilitate and/or improve functional skills. Additionally, habilitative therapy is described in terms of everyday routines and activities related to achieving the goals/outcomes described in the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) and is based on needs identified in the respective documents.

Habilitative therapy is available through the Division and some Health Plans through Early and Periodic Screening, Diagnosis, and Treatment Medicaid program. Habilitative therapy also provides for direct treatment by a licensed therapist.

Habilitative therapy may utilize direct treatment by a licensed therapist and is time limited and outcome driven. All therapy is consultative in nature.

Occupational, Physical and Speech Therapy

Descriptions (Occupational, Physical and Speech)

Therapy services require a prescription for an evaluation and then a certified plan of care for ongoing therapy services, are provided or supervised by a licensed therapist, and are not intended to be long term services.

Occupational therapy may address the use of the body for daily activities such as dressing, sensory and oral motor development, movement, and eating.

Physical therapy may address the movement of the body related to walking, standing, balance, transferring, reaching, sitting, and other movements.

Speech therapy may address receptive and expressive language (pragmatic language, social communication), articulation, fluency, eating, and swallowing.

Barring exclusions noted in this section, Therapy includes the following:

A. Evaluation of skills;

B. Development of home programs and consultative oversight with the member, family and other providers;

C. Assisting members to acquire knowledge and skills, increase or maintain independence, promote health and safety;

D. Modeling/teaching/coaching parents and/or caregivers' specific techniques and approaches to everyday activities, within a member's routine, in meeting their priorities and outcomes; and,

E. Collaboration with all team members/professionals involved in the member's life.

Responsible Person's Participation (Occupational, Physical and Speech)

To maximize the benefit of this service, improve outcomes and adhere to legal liability

standards, parents/family or other caregivers (paid/unpaid) are required to:

A. Be present and actively participate in all therapy sessions; and,

B. Carry out the home program.

Considerations (Occupational, Physical and Speech)

The following will be considered when approving this service:

A. Developmental/functional skills;

B. Medical conditions;

C. Member's network of support (e.g., family/caregivers, friends, providers);

D. Age; and,

E. Therapies provided by the school.

Settings (Occupational, Physical and Speech)

Therapy shall be provided in settings that support outcomes developed by the team. This includes:

A. The member's home;

B. Community settings;

C. Division funded settings such as day programs and residential settings for the purpose of training staff;

D. Daycare; and,

E. A clinic/office setting.

Exclusions (Occupational, Physical and Speech)

Exclusions to the authorization of Therapy services may include, but are not limited to the following:

Rehabilitative therapy (acute therapy) due to an accident, illness, medical procedure, or surgery. Rehabilitative therapy includes restoring former functions or skills due to an accident or surgery.

Funding for rehabilitative therapy shall be sought from:

1. Private/third party insurance;
2. Children's Rehabilitative Services (CRS);
3. DDD Tribal Health Program (THP);
4. Comprehensive Health Plan (CHP);
5. Arizona Health Care Cost Containment System (AHCCCS); or,
6. Division of Disabilities (DDD)/Arizona Long Term Care Service (ALTCS) Acute

Health Care Plan.

F. Physical therapy is provided by the DD/ALTCS Acute Health Care Plan for members 21 years and older and will not exceed 15 visits for developmental/restorative, maintenance, and rehabilitative therapy for the benefit year.

G. Therapy for educational purposes.

Respiratory Therapy

Service Description and Goals (Respiratory Therapy)

This service provides treatment to restore, maintain or improve respiration. The goals of this service are to:

A. Provide treatment to restore, maintain or improve respiratory functions; and,

B. Improve the functional capabilities and physical well-being of the member.

Service Settings (Respiratory Therapy)

The Division does not authorize rates for respiratory therapy as a stand-alone service that is separate from other services provided in a particular setting. Although, respiratory therapy may be provided to the member in any setting, it is part of the established rate for Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID) and Nursing Facilities (NF).

Service Requirements (Respiratory Therapy)

Before Respiratory Therapy can be authorized, the following requirements must be met:

A. The service must be prescribed by a qualified, licensed physician as part of a written plan of care that must include the frequency, duration, and scope of the therapy.

B. The provider must be licensed by the Arizona Board of Respiratory Care Examiners and be a graduate of an accredited respiratory care education program. This program must be accredited/approved by the American Medical Association's Committee on Allied Health Education and in collaboration with the Joint Review Committee for Respiratory Therapy Education.

C. The provider shall be designated for members who are eligible for ALTCS services and registered with the AHCCCS.

D. Tasks may include:

1. Conducting an assessment and/or review previous assessments, including the need for special equipment;

2. Developing treatment plans after discussing assessments with the Primary Care Provider, the District Nurse and the Planning Team;

3. Implementing respiratory therapy treatment as indicated by the assessment(s) and the member's treatment plan;

4. Monitoring and reassessing the member's needs on a regular basis;

5. Providing written reports to the Division staff, as requested;

6. Attending Planning Meetings (Individual Support Plan/Individualized Family Services Plan/Person Centered Plan meetings) if requested by the member and Division staff;

7. Developing and teaching therapy objectives and/or techniques to be implemented by the member, caregivers and/or other appropriate individuals;

8. Consulting with members, families, Support Coordinators, medical supply representatives, and other professional, and paraprofessional staff on the features and design of special equipment; and,

9. Giving instruction on the use and care of special equipment to themember and care providers.

Target Population (Respiratory Therapy)

This service is indicated for members who have a health condition that require respiratory therapy, as ordered by a physician, which is documented in the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents).

Exclusions (Respiratory Therapy)

Respiratory Therapy is prohibited without Physicians orders and prescriptions for certain medical procedures. This requirement does not apply to private or state- operated Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID).

Service Provision Guidelines (Respiratory Therapy)

Respiratory Therapy shall not exceed eight (8) fifteen (15) minute sessions per day.

Provider Types and Requirements (Respiratory Therapy)

Designated District staff will ensure all contractual requirements related to Respiratory Therapy providers are met before the service is approved. Additionally, all providers of ALTCS must be registered with the AHCCCS prior to service initiation.

Service Evaluation (Respiratory Therapy)

A. The Primary Care Provider (PCP) will review the plan of care at least every 60 days and prescribe continuation of service.

B. If provided through a Medicare certified home health agency, the supervisor will review the plan of care at least every 60 days.

C. The provider will submit progress notes on the plan of care on a monthly basis tothe Division Support Coordinator.

Service Closure (Respiratory Therapy)

Service closure should occur in the following situations:

A. The physician determines that the service is no longer needed as documented on the "Plan of Care";

B. The member/responsible person declines the service;

C. The member moves out of State;

D. The member requires other services, such as home nursing; and,

E. The member/responsible person has adequate resources or other support to provide the service.

The Division supports and encourages continuity of care among all therapy resources such as hospitals, outpatient rehabilitation clinics, and schools. The Division contracted therapists shall collaborate with other service providers and agencies involved with the member.

1250-Y SCHEDULED TRANSPORTATION

REVISION DATE: 2/7/2024, 7/15/2016, 7/3/2015, 9/15/2014
REVIEW DATE: 5/9/2023
EFFECTIVE DATE: June 30, 1994
REFERENCES: RFQVA DDD-2024

PURPOSE

The purpose of this policy is to outline the Division's requirements for covering Scheduled Transportation for ALTCS eligible Members to and from employment-related services, day services, and other Home and Community Based Services.

DEFINITIONS

1. "Community Residential Setting" means the same as A.R.S. § 36-551.

2. "Home and Community-based Services" or "HCBS" as defined in A.A.C. R6-6-1501, means one or more of the following services provided to Members:

    a. Attendant Care,
    b. Day Treatment and Training for Children or Adults,
    c. Habilitation,
    d. Home Health Aide,
    e. Home Health Nurse,

f. Hospice Care,
g. Housekeeping-Chore/Homemaker,
h. Non-Emergency Transportation,
i. Occupational Therapy,
j. Personal Care,
k. Physical Therapy,
l. Respiratory Therapy,
m. Respite services,
n. Speech/Hearing Therapy,
o. Supported Employment,
p. Other comparable services as approved by the AHCCCS Director.

3. "Member" means the same as "client" as defined in A.R.S. § 36-551.
4. "Scheduled Transportation" means regular, non-emergency, planned transportation provided to and from an HCBS service from a Qualified Vendor for an ALTCS-eligible Member.
5. "Planning Document" means a written plan developed through an assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important

to the Member in meeting the identified needs and preferences for the delivery of such services and supports.

6. "Planning Team" means means a defined group of individuals comprised of the Member, the responsible person if other than the Member, and, with the responsible person's consent, any individuals important in the Member's life, including extended family members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems.
7. "Qualified Vendor" means a provider of community developmental disability services that has applied for Qualified Vendor status, meets the criteria for Qualified Vendor status, and has entered into a Qualified Vendor Agreement with the Department.
8. "Qualified Vendor Agreement" means the valid, executed contract between the Department and a Qualified Vendor describing the services the Qualified Vendor is qualified to provide and the terms and conditions governing the relationship

between the Department and the Qualified Vendor including any amendments, attachments, schedules, or exhibits.

A. SCHEDULED TRANSPORTATION SERVICE REQUIREMENTS

1. The Division shall cover Scheduled Transportation when the Planning Team determines and documents in the Planning Document that the Member meets any of the following criteria:
    a. The Member is unable to provide their own transportation;
    b. The Member's natural supports cannot provide transportation; or
    c. The Member has no other community resources for transportation available.
2. The Division shall require the Planning Team to assess and document in the Planning Document the Member's needs associated with receiving Scheduled Transportation services, as applicable:
    a. Assistance with entering or exiting the vehicle;
    b. Supervision while waiting for transportation;
    c. Adaptations of the vehicle for accessibility;
    d. Accompaniment by an aide for health and safety; and

e. Special seating requirements if transported with other Members in the same vehicle.

3. The Division shall not cover Scheduled Transportation services if any of the following criteria apply to the Member:
   a. The transportation service is covered by the Member's health plan;
   b. The transportation service is school-related, covered by the local education agency, and documented in the Member's individual education plan;
   c. The Member is receiving habilitation services provided in Community Residential Settings;
   d. Transportation is included in the Home and Community Based (HCBS) service the Member is receiving; or
   e. The transportation is to a destination that is not to or from an HCBS service.
4. Network shall approve an extensive distance modified rate and a single person transport modified rate as outlined in the Division's rate book.

B. MONITORING AND SERVICE REVIEW REQUIREMENTS

1. The Planning Team shall review the Member's need for Scheduled Transportation services at each Planning Team meeting.
2. The Planning Team shall discontinue Scheduled Transportation services when:
   a. The Member no longer requires the service;
   b. The Scheduled Transportation meets the criteria in Section A.(3) of this policy; or
   c. Other transportation resources become available.

Signature of Chief Medical Officer: Anthony Dekker (Jan 30, 2024 10:19 MST)
Anthony Dekker, D.O.

1280 STATE FUNDED SERVICES

REVISION DATE: 3/2/2015
EFFECTIVE DATE: June 30, 1994

Member and Family Assistance

Member and Family Assistance is flexible support funding intended to enable families to care for children at home and for adult members to live independently in their communities. Member and Family Assistance is based on available funding and is not intended to replace natural or other means of support and assistance. They may be Emergency Support or Ongoing Support as described below.

General Guidelines

All payments from these funds must be made to a vendor, not the family or member unless extenuating circumstances prevent it. For instance, in the case of rent subsidy payable to a family member who is renting to a member all exceptions must be prior approved in writing by a Lieutenant and Program Manager Services that may be purchased with Member and Family Assistance funds include those listed in the Arizona Taxonomy of Services, as well as financial assistance for specific purposes. These services may include:

A. Automotive repairs (if the vehicle is unable to be driven and would put the member at risk if not repaired);

B. Clothing;

C. Corrective lenses;

D. Dental needs;

E. Diapers;

F. Equipment repairs;

G. Medication;

H. Moving expenses;

I. Rent and/or living subsidy;

J. Transportation; and,

K. Utilities.

Payments may produce a Federal Income Tax form 1099 that is sent to the recipient of these funds.

Receipts

Receipts must be obtained for all purchases/payments with few exceptions. Exceptions may include ongoing rent so long as an annual rental agreement is on file, showing monthly rent with beginning and end dates. Receipts may also be submitted in the form of a bill or invoice in the case of utility bills or monthly service fees. Receipts are to include the following information:

A. Vendor name/place of business;

B. Date of purchase;

C. Description of item(s) purchased;

D. Name of Member; and,

E. Name of Support Coordinator.

All disbursements from Member and Family Assistance funds shall be documented as expended by submission of the original itemized receipt(s) within 30 days. No further funds shall be granted to the vendor until the receipts are submitted, unless approved by the District Program Administrator/Manager or in case of health and safety concerns.

The funds may only be spent for the approved purchase and not for any other items. If there are any excess funds, they are to be returned to the Division.

Emergency Support

Emergency Support provides a one-time payment in emergent or extraordinary circumstances to eligible families on behalf of a member with a developmental disability living in the family home, or (for an adult) in either the family or her/his own home or in rare cases for a member living in a vendor operated setting with prior written approval by the Lieutenant Program Manager for health and safety purposes.

One-time payment amounts typically should not exceed $500 per member or family. Any amounts over $300 require Lieutenant Program Manager approval.

Eligible Services

Only authorized services may be purchased with Member and Family Assistance funds. Authorized services are those recommended by the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Team) and approved by the District Program Administrator/District Program Manager or designee. The Division will only approve services that can be purchased at a reasonable cost.

Emergency Support cannot be used to supplement the level of services already furnished to the family or member under Division contracts with service providers.

Emergency Support cannot be used to purchase services otherwise readily available to the family or members who are eligible for Arizona Long Term Care Service (ALTCS). Emergency Support is not available for Licensed Child Developmental or Adult Developmental Homes unless for health or safety matters not funded elsewhere members who have failed to take all reasonable steps to enroll in the ALTCS program are not eligible for Emergency Support.

Other service options must be explored in the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process and, if appropriate, applications for alternative services or benefits may be made a condition of eligibility to receive Member and Family Assistance. These alternatives might include:

A. ALTCS;

B. Income supplements such as Supplemental Security Income, Social Security Survivors Benefits, Social Security Disability Income, Railroad Retirement, Veterans Administration, Temporary Assistance to Needy Families, General Assistance and Emergency Assistance;

C. Food stamps, Arizona Supplemental Nutrition Program for Women, Infants & Children (WIC) and food banks;

D. Housing benefits available through Housing and Urban Development;

E. Vocational Rehabilitation Services and the Job Training Partnership Act Program;

F. Benefits rendered because of injury to persons or property;

G. Education programs;

H. Child support and adoption subsidies;

I. Arizona Health Care Cost Containment System (AHCCCS), Medicare, Indian Health Services and private health insurance; and,

J. Supplemental Payments Program and benefits furnished under the Older Americans Act.

Eligibility

All members/families must meet the following criteria to receive Emergency Support:

A. Enrolled in the Division service system.

B. Participation in the program by parent, other close relative, legal guardian or by the member. This participation usually takes the form of a co-payment for services.

C. Require funds for health or safety concerns for which no other funding is available.

Determination of Participation by Responsible Person

The Member and Family Assistance/Emergency Support funds are intended to form a partnership between families and the Division in meeting the needs of children or adults who live at home, or in independent or supported living arrangements not contracted as residential programs by the Division.

Emergency Support is "needs-based" and is not tied to a specific income eligibility level unlike the ALTCS. Families must demonstrate their co-pay participation related to cost for the service, item, or other purchase to be eligible for Emergency Support.

In the case of an adult with a developmental disability living in her/his own home, the member must be able to demonstrate how much income is devoted to shelter and food before Member and Family Assistance/Emergency support payment can be approved. The member must also demonstrate how much income is devoted to an Individual Support Plan Team-approved program before an Emergency Support payment can be provided. The member's remaining resources are available for personal and incidental expenses. Members with more than $3,000 in liquid assets (cash) are ineligible for Assistance to Families funds.

The Support Coordinator and member/responsible person shall complete the Member and Family Assistance Request Worksheet and Agreement when requesting participation in this program. The Planning Team shall review these documents and forward them, with a recommendation, to the District Program Manager/Lieutenant Program Manager or designee. The packet must reflect the items or services funded by Emergency Support dollars, the type and amount of support, and the level of participation by the member or family.

Guidelines for Approving Emergency Support

The District Program Manager/Lieutenant Program Manager (or designee) shall consider the following factors in evaluating requests for Emergency Support:

A. Age and/or health status of the parents/family members;

B. Complexity of the member's needs the stress that these place on the family, and the family's ability to respond to that stress;

C. Degree of member or family participation in the cost of services relative to their means;

D. Degree to which the member is already receiving other Division funded services;

E. Availability of funding from all sources; and,

F. Reason for the emergent or extraordinary request.

The District Program Manager/Lieutenant Program Manager should respond to a request for Emergency Support within five (5) working days of the recommendation by the Planning Team.

Payments

Services are authorized and participation/co-payments identified on the Member and Family Assistance Worksheet and Agreement. If approved, the payment will go directly to the vendor identified by the member or family.

Waivers

The District Program Administrator/Lieutenant Program Manager must approve any waivers for procedures or family participation. The waiver is only allowed if the goals and intent of the program are otherwise met.
The member, family, or Support Coordinator is permitted to initiate a written request for a waiver. The Individual Support Plan/Individualized Family Services Plan/Person Centered Plan Team may also initiate a written waiver request. The request must identify the specific requirements to be waived. The Lieutenant Program Manager/ Program Manager will determine whether approval of the requested waiver will enable the goals and intent of the program to be met. The Lieutenant Program Manager/District Program Manager will respond to the initiator of the request, in writing, within ten working days. Payments to other than a vendor must also be approved by the Division's Business Operations Administrator.

Ongoing Support

Ongoing Support is an on-going payment to a vendor intended to support the family's effort to maintain its family member with a disability in the family home, thereby preventing out-of-home placement; or to support an adult to live in their own home, thereby preventing placement in more restrictive settings. Payments are made directly to the vendor identified by the member or family or in the case of members living in Individually Designed Living Arrangements (IDLA), payments may be made to the provider who will make payments to landlords, utilities, and other living cost on behalf of a member.

When Ongoing Support payments are made to a provider for members living in an IDLA, the provider is required to maintain a detailed expenditures log for each member identifying all expenditures on behalf of the member, including:

A. Date;

B. Vendor;

C. Purchase/payment detail;

D. Amount; and,

E. Declining balance with all supporting documentation and receipts attached.

This expenditure log must be made available to the Division and/or the guardian upon request at any time.

Eligible Services – Ongoing Support

The Division will only approve services that can be purchased at a reasonable cost and that advance/meet the goals of the Member and Family Assistance program and the Division.

Ineligible Services

Ongoing Support cannot be used for the following:

A. Services available under ALTCS;

B. Members who live in Developmental Homes, Group Homes, Intermediate Care Facilities for Persons with an Intellectual Disability, Nursing Facilities, or Assisted Living Centers;

C. Members who have failed to take all reasonable steps to enroll in the ALTCS; and,

D. Families with income that exceeds 300% of the federal poverty level.

Alternative Options

The Individual Support Plan/Individual Family Services Plan/Person Centered Plan Team members must explore other service options and, if appropriate, applications for alternative services or benefits may be made as a condition of eligibility to receive Ongoing Support. These alternatives include:

A. The ALTCS;

B. Income supplements such as Supplemental Security Income, Social Security, Social Security Disability Income, Railroad Retirement, Veterans Administration, Temporary Aid to Needy Families, General Assistance, and Emergency Assistance;

C. Food stamps, WIC, and food banks;

D. Housing benefits available through Housing and Urban Development and other housing assistance;

E. Vocational Rehabilitation Services and assistance through the Job Training Partnership Act;

F. Education programs;

G. Child support and adoption subsidy;

H. AHCCCS, Medicare, Indian Health Services, and private health insurance;

I. Supplemental Payment Program and benefits furnished under the Older Americans Act; and,

J. Other community, and religious based services, and programs.

Eligibility

All members/families must meet the following criteria during any month wherein Ongoing Support is received:

A. Enrolled in the Division;

B. Participation in the program by parent, other close relative, legal guardian, or by the member. This participation usually takes the form of a co-payment for goods or services, although it may involve participation in the form of a contribution of labor. Members in an IDLA with no familial supports or source of other income or require extensive supports and medically or behaviorally unable to participate in their own service delivery may be exempt from this requirement.

Determination of Participation by Responsible Person

Whenever possible, families or members must demonstrate their participation in the cost of service, item or other purchase to be eligible for Community Living Support.

The member must be able to demonstrate how much income is devoted to shelter, food, and program cost. The Individual Support Plan/Individualized Family Services Plan/Person Centered Plan team must approve the programs referenced. The member's remaining resources are available for personal and incidental expenses. Members with more than $1,500 cash or $2,000 in liquid assets are ineligible for Ongoing Support. The member's Ongoing Support payment will be interrupted or terminated until they can demonstrate the need for continued or renewed support.

The Support Coordinator and the Planning Team shall review these documents, the family's resources, and any funds the member may have:

A. Savings and checking accounts;

B. Bonds;

C. Trust funds;

D. Tort-feasor (civil judgments) funds;

E. Annuities;

F. Estates;

G. Wages;

H. Benefits;

I. Child support payments; and,

J. Other financial resources and income.

The Support Coordinator shall then submit the request, including the items or services to be purchased and amount of family or member participation.

Guidelines for Approving Ongoing Support

In evaluating requests for Ongoing Support, the District Program Manager/Lieutenant Program Manager (or designee) shall consider the following factors:

A. Availability of funding;

B. The likelihood that Ongoing Support will enhance the family's integrity, prevent the need for residential placement, avoid a more restrictive placement, or foster a smooth transition to more independent living for an adult with a developmental disability;

C. The age and/or health status of the parents/family members;

D. The complexity of the member's needs, the stress that these place on the family and the family's ability to respond;

E. The degree of member or family participation in the cost of services relative to their means;

F. The anticipated duration of the need for service;

G. The degree to which the family/member is already receiving other Division funded services; and,

H. Other resources that may be available to the member/family.

The District Program Manager/Lieutenant Program Manager shall approve the response to a request for Ongoing Support funds within 14 working days of the recommendation by the Support Coordinator and Planning Team.

Payments

Authorized services, vendor payments and co-payments are identified on the Member and Family Assistance Request Worksheet and Agreement. They must be ongoing payments.

The Ongoing Support Payments may only be made when the initial/prior payment has been verified as expended for the authorized purpose (receipts, or when not available, then via a written, signed statement by the recipient member or family, or upon receipt of a bill, rental agreement, invoice, or quote from a vendor). In some cases, receipts totaling less than the advanced sum will result in a reduction of the subsequent payment of the Ongoing Support award and will require a return of the unspent supports.
Ongoing supports for food for members living in an Individually Designed Living Arrangement do not require an automatic reduction in the ongoing monthly support unless an ongoing trend in unspent Support is demonstrated, in which case the Support Coordinator shall make a re-determination regarding on the level on Ongoing Support required. Receipts exceeding the authorized amount will not result in an increase in the

subsequent payment. In-kind contributions including volunteer time must be documented in writing and submitted along with the receipts.

Waivers

Waivers of any Ongoing Support procedures, including member or family participation requirements, may be granted by the District Program Manager/Lieutenant Program Manager, if the goals and intent of the program are otherwise met.

The member, Support Coordinator, or Planning Team may initiate a written waiver request. The request must identify the specific requirements to be waived. The District Program Manager/Lieutenant Program Manager will determine whether approval of the waiver request will enable the goals and intent of the program to be met. The District Program Manager/Lieutenant Program Manager will respond to the initiator of the request, in writing within ten working of receipt of the request.

1290 BEHAVIORAL HEALTH ADVOCACY

EFFECTIVE DATE: July 19, 2023

REFERENCES: Behavioral Health Advocate Referral form (DDD-2093A), Behavioral Health Advocacy Plan (DDD-2092A).

PURPOSE

This policy sets forth guidance on how the Division of Developmental Disabilities (Division) the Division provides support to members who experience unique challenges of navigating systems of care while experiencing behavioral health challenges. This policy outlines when and how referrals are made to an Adult or Child Behavioral Health Advocate, explains the development of a Behavioral Health Advocacy Plan.

DEFINITIONS

1. "Behavioral Health (BH) Advocate" means for the purpose of this policy a Division staff member whose role is to offer independent support to members and families who feel they are not being heard, ensuring they are taken seriously, and that their rights are respected.

2. "Human Rights Advocates" means for the purpose of this policy, AHCCCS staff who assist and advocate on behalf of members determined to have a Serious Mental Illness with Service Planning, Inpatient Discharge Planning, and resolving appeals and grievances. Staff in this position are hired, trained, supervised, and coordinated through the AHCCCS Office of Human Rights-Special Assistance.

3. "Member" means an individual who is receiving services from the Division of Developmental Disabilities (Division).

4. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a member or an applicant for whom no guardian has been appointed.

5. "Special Assistance" means the support provided to a member designated as Seriously Mentally Ill who is unable to articulate treatment preferences and/or participate effectively in the development of the Service Plan, Inpatient Treatment, and Discharge Plan (ITDP), grievance and/or appeal processes due to

cognitive or intellectual impairment and/or medical condition. Special Assistance is offered through the AHCCCS Office of Human Rights.

6. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. ROLE OF A BH ADVOCATE

1. BH Advocates shall not represent their own views but amplify that of the person they are supporting.

2. BH Advocates shall offer support and guidance to assist members and their families to be empowered by having their voices heard and sharing in decisions regarding their health.

3. BH Advocates may work with a member for a short period of time to learn how to better advocate for themselves and navigate the Behavioral Health System. The BH Advocate has a non-adversarial role to support members and families to advocate for themselves through collaboration with system partners.

4. BH Advocates shall not perform the day-to-day duties of the Support Coordinator or the Behavioral Health Complex Care Specialist, however, the BH Advocates work closely with the Support Coordinator and the Planning Team to ensure the voice and expressed choices of the Member or Responsible Person is being heard, and barriers are being resolved so member's behavioral health needs are met.

B. REFERRALS FOR A BEHAVIORAL HEALTH ADVOCATE

1. The Support Coordinator shall review the need for a BH Advocate at the Planning Meeting for Division members of all eligibility types.

   a. The Support Coordinator shall attempt to advocate on behalf of the member and resolve a member's behavioral health care needs with the Division's function areas, the Health Plan, and providers before submitting a BH Advocate referral.

   b. Referrals for BH Advocates shall be made within three business days of an identified need for an Advocate.

2. The Support Coordinator or designee shall make a referral for a BH Advocate when:

   a. A member is exhibiting symptoms of a possible behavioral health disorder and may be in need of behavioral health services, or

   b. A member is diagnosed with a behavioral health disorder and the member or Responsible Person is willing to accept the assistance from an Advocate.

   c. Additionally, one of the following circumstances shall exist that impact the member's ability to receive needed care. The member or responsible person:

      i. Feels their voice is not being heard or their choice is not being respected regarding their behavioral health service needs.

      ii. Feels they are not actively involved in the service planning process.

      iii. Has limitations in the ability to communicate their

behavioral health needs.

iv. Is unable or does not know how to advocate for themself and would benefit from advocacy services.

v. May need assistance in navigating the behavioral health or other service systems of care.

vi. May need assistance in understanding the behavioral health grievance process.

3. The Division shall accept a request from a Responsible Person for a BH Advocate through:

a. Contacting the Member's Support Coordinator; or

b. Calling the Customer Service Center.

4. The Support Coordinator shall not make a referral for a BH Advocate through the Division's Office of Individual and Family Affairs (OIFA) when a member is assigned a BH Human Rights Advocate through the AHCCCS Office of Human Rights-Special Assistance, however, the BH Human Rights Advocate through the AHCCCS Office of Human Rights-Special Assistance may request to collaborate with a BH Advocate through the Division to assist

with meeting the member's needs.

5. The Support Coordinator may make a referral if a member has a guardian, and the guardian is willing to accept assistance from an Advocate.

C. BH ADVOCATE ASSIGNMENT

1. Division staff from other functional areas such as the Behavioral Health Administration, Nursing, OIFA, Support Coordination, or State Operations shall discuss an identified need for a BH Advocate with the Support Coordinator.

2. The BH Advocacy Supervisor shall request additional information if needed, to determine if a BH Advocate shall be assigned.

3. A BH Advocate shall contact the Responsible Person upon approval, to discuss the need for advocacy if the member is approved to receive a BH Advocate.

4. The Support Coordinator may request the OIFA Administrator to review the BH Advocate referral if a Member was denied a BH Advocate.

D. BEHAVIORAL HEALTH ADVOCACY PLAN

1. The BH Advocate shall contact the responsible person within three business days of approval for a BH Advocate, to discuss the Member's need for this support, and begin working on developing the Advocacy Plan by:

    a. Reviewing:

        i. Reasons for the BH Advocate request outlined in the referral, and

        ii. The Member's BH goals outlined in the Planning Document.

    b. Discussing with the Responsible Person the reason for the BH Advocate referral and goal(s) to be accomplished working towards ensuring the member's behavioral health needs are met.

    c. Developing action plan tasks, including:

        i. Persons involved with actions taken,

        ii. Targeted dates for task completion, and

iii. Dates of meetings the BH Advocate shall attend with the Member.

d. Discussing a targeted goal(s) for when BH Advocacy is no longer needed.

E. SUPPLEMENTAL INFORMATION

1. BH Advocate Roles and Responsibilities:

a. The BH Advocate shall contact the BH Complex Care Specialist, if one is assigned, to state the purpose of the BH Advocate involvement and to gather pertinent historical information.

b. Build relationships and knowledge of community resources in order to:

i. Support the member, and their family if applicable, to obtain and maintain needed services, including but not limited to Peer and Family Support Services when appropriate.

ii. Increase awareness of community resources for

children and adults and promote recovery, resilience, and wellness.

iii. Identify opportunities to inform and connect those seeking assistance to access programs and services to meet identified needs.

2. Support Coordinator Roles and Responsibilities:

a. Advocate for the member and continue to maintain the role of the member's primary case manager.

b. Identify when a member could benefit from a BH Advocate and inform the member how an Advocate can provide support.

c. Invite the BH Advocate to the Planning Meetings.

d. Maintain communication of any substantial changes that would impact the advocacy plan with the BH Advocate.

Signature of Chief Medical Officer: Anthony Dekker (Jul 13, 2023 09:04 PDT)
Anthony Dekker, D.O.

Exhibit 1240A-1 ATTENDANT CARE SUPERVISION REQUIREMENTS AGE 17 AND UNDER

EFFECTIVE: March 1, 2013

Overview

This information clarifies the criteria to meet medical necessity for **general supervision** for children age 17 and under as part of the Attendant Care service.

Age 17 and under: A child must meet the criteria indicated in one of the four categories outlined below:

A. Unsafe Behaviors

1. Documentation of behaviors placing the child at risk of injury to self or others; **AND,**

2. Documentation that the child is receiving or pursuing services through a behavioral health agency/professional; **or**,

3. Documentation of behaviors placing the child at risk of injury to self or others; **AND,**

4. Habilitation outcome to decrease unsafe behaviors has been unsuccessful in the past.

B. Medical

Documentation is required from a medical professional describing a severe medical need or physical condition that would place the child at risk if left alone.

C. Confused/Disoriented

Documentation indicating a loss of skills (e.g., due to accident or injury) that are unlikely to be regained.

D. Wandering risk (age 13 - 17 only)

1. Documentation of the child leaving a situation or environment neither notifying nor receiving permission from the appropriate individuals; **AND,**

2. The youth is at risk to self or others when alone in the community or may be unable to return safely.

When a child age 17 and under meets one of the criteria outlined above, **general supervision** is then based on age criteria. The requirements outlined below may be waived with District Program Manager approval.

For children age 12 and under, general supervision may be provided when **all** of the following are met:

A. The child cannot attend a typical day care center because

1. The child's health and safety would be at risk; **OR,**

2. The health and safety of others will be at risk; **OR,**

3. A fundamental alteration of a day care center would be required. This requires documentation from the day care center;

AND,

B. Child care in a private home or a before/after school program offered by the school/local city or county is not available or cannot meet the child's needs;

AND,

C. The parent, guardian, or other adult is not in the home;

AND,

D. Division funded summer or after school program is not available or cannot meet the child's needs (Only applies to age 3 and above.)

For children age 13- 17 **general supervision** may be provided when **all** of the following are met:

A. A Division funded program is not available or has been considered and is not appropriate;

AND,

B. The youth receives enhanced staffing (self-contained) or assistance from an aide at school as documented on the Individual Education Program (IEP);

AND,

C. The parent, guardian or other adult is not in the home;

AND,

D. The youth has received, is receiving or will receive Habilitation to minimize the need for supervision in the future, if a wandering risk or has unsafe behaviors.

Exhibit 1240A-2 ATTENDANT CARE SUPERVISION REQUIREMENTS AGE 18 AND ABOVE

EFFECTIVE: March 1, 2013

Overview

This information clarifies the criteria to qualify for general supervision for adults age 18 and above as part of the Attendant Care service.

Age 18 and above: An adult must meet one of the criteria outlined below:

A. Unsafe behaviors

1. Documentation that behaviors place the adult at risk of injury to self or others; and,

2. Documentation that the person is receiving or pursuing services through a behavioral health agency/professional;

3. Documentation that behaviors placing the adult at risk of injury to self or others; or

4. Habilitation outcome to decrease unsafe behaviors has been unsuccessful in the past.

B. Medical

Documentation is required from a medical professional describing a severe medical need or physical condition that would place the adult at risk if left alone.

C. Wandering risk

1. Documentation of the adult leaving a situation or environment neither notifying nor receiving permission from the appropriate individuals; and,

2. The adult is at risk when alone in the community and may be unable to return safely.

D. Confused/disoriented

1. Documentation of the presence of confusion or disorientation (prior to being diagnosed with dementia); or,

2. Documentation indicating a loss of skills (e.g., due to accident or injury) and are unlikely to be regained.

E. Unable to call for help even with a lifeline.

Documentation is available in the member's file that the adult is unable to use a telephone or press a button to alert the lifeline system.

When an adult 18 years of age and older meets one of the criteria outlined above, supervision is then based on the following age criteria. The requirements outlined below may be waived with District Program Manager approval.

For adults age 18 and above supervision may be provided when the first criteria and the others (if applicable) are met:

A. A Division funded employment/day program is not available or has been considered and not appropriate.

B. If still in school, the adult must receive enhanced staffing (self-contained) or assistance from an aide at school as documented on the Individual Education Program (IEP).

C. If appropriate, an adult who has an identified wandering risk or has unsafe behaviors must have received, is receiving or will receive habilitation to minimize the need for supervision in the future.

Exhibit 1240A-3 ATTENDANT CARE SUPERVISION DOCUMENTATION REQUIREMENTS

REVISION: 2/26/2016
EFFECTIVE DATE: March 1, 2014

Overview

Documents that may provide justification of medical necessity for supervision include, but are not limited to the following:

A. Individual Support Plan;

B. Individualized Education Program (IEP);

C. Multi-Disciplinary Education Team (MET);

D. Medical Documentation;

E. Psychiatric/Psychological Evaluation;

F. Clinical Notes;

G. Incident Reports;

H. Pre-Admission Screening (PAS);

I. Police Reports;

J. Inventory for Client and Agency Planning (ICAP); and,

K. Adaptive Mini-Mental (Pre-Dementia Screening Tool).

1100 RESERVED

1301 AGENCY WITH CHOICE

EFFECTIVE DATE: January 25, 2023

REFERENCES: AMPM Policy 1310-A

PURPOSE

The purpose of this policy is to outline requirements for the Agency with Choice (AWC) Member-directed service delivery model option as specified in A.A.C. R9-28-509. This policy applies to Members who have selected the AWC model and the Division staff supporting the Members.

DEFINITIONS

1. "Agency with Choice (AWC)" means a Member-directed service delivery model option offered to ALTCS Members who reside in their own home. Under the AWC option, the provider agency and the Member/IR enter into a partnership agreement. The provider agency serves as the legal employer of the Direct Care Worker (DCW) and the Member/IR serves as the day-to-day managing employer of the DCW.
2. "Direct Care Worker (DCW)" means an individual who assists elderly individuals or individuals with a disability with activities necessary to allow them to reside in their home. A DCW, also

known as Direct Support Professional (DSP), is employed/contracted by DCW Agencies or, in the case of Member-directed options, employed by ALTCS members in order to provide services to ALTCS members.

3. "Direct Care Worker (DCW) Agency" means an agency that registers with AHCCCS as a service provider of Direct Care Services that include Attendant Care, Personal Care, Homemaker or Habilitation.
4. "Electronic Visit Verification (EVV)" means a computer-based system that electronically verifies the occurrence of authorized service visits by electronically documenting the precise time a service delivery visit begins and ends, the individuals receiving and providing a service, and type of service performed.
5. "Individual Representative (IR)" means, for AWC only, a parent, family member, guardian, advocate, or other individual authorized by the individual to serve as a representative in connection with the provision of services and supports, as specified in A.A.C. R9-28-509.

a. If a Member is unable to fulfill the co-employment roles and responsibilities on their own, an IR may be appointed to assist the Member in directing their care.

b. The role of an IR is to act on the Member's behalf in choosing and directing care, including representing the Member during the service planning process and approving the service plan.

c. A.A.C. R9-28-509 and Section 1915(k) of the Social Security Act, prohibit an IR from serving as a Member's paid DCW.

6. "Member" means an individual who is receiving services from the Division of Developmental Disabilities (Division).

7. "Service Plan" or "Person Centered Service Plan (PCSP)" means a complete written description of all covered health services and other informal supports that includes individualized goals, peer-and-recovery support and family support services, care coordination activities and strategies to assist the Member in achieving an improved quality of life.

8. "Support Coordinator" means the same as "Case Manager" under

A.R.S. § 36-551.

POLICY

A. MEMBER'S ROLES AND RESPONSIBILITIES UNDER AGENCY WITH CHOICE

1. Members shall make decisions about who will provide their services, when those services will be provided, and how the services will be provided when selecting the Agency with Choice (AWC) model.
2. The Member and the provider agency shall share employment/day-to-day management, roles, and responsibilities of the DCW.
3. Members may opt in and out of the AWC at any time by notifying the provider agency and their Support Coordinator.
4. At a minimum, the Member shall have two responsibilities which they shall carry out, if necessary:
    a. Recruiting and selecting the DCW(s). This includes:
        i. Identifying the qualifications, skills, and characteristics of a DCW, over and above the minimum AHCCCS and provider agency

qualifications, that are necessary to meet the individual Member's needs, and

ii. Selecting the DCW from a pool of DCWs already employed by the provider agency or recruiting the DCW from the community to become an employee of the provider agency.

b. Dismissal of the DCW(s). This includes:

i. Identifying whether or not the Member is satisfied with the care provided by the DCW, and

ii. Making the decision to dismiss the DCW from providing their care only.

5. The Member may choose to carry out some or all of the following additional responsibilities:

a. Training the DCW(s), and

b. Identifying training needs, over and above the minimum required training by AHCCCS or the provider agency, that are necessary to meet their unique needs.

6. The Member shall manage the DCW(s) by:

a. Orienting the DCW to the manner in which they want the services provided;

b. Determining the schedule for the DCW, including the days/times when the specific tasks will be done; and

c. Verifying the dates and times the DCW provides the service.

7. The Member shall supervise the DCW(s) by:

a. Providing oversight and instruction to the DCW to ensure they are receiving quality care,

b. Communicating regularly with the provider agency about the DCW's performance, and

c. Providing feedback to the DCW regarding their performance.

8. The Member shall communicate with the provider agency regarding changes in service delivery by:

a. Notifying the provider agency when the DCW does not show up or cannot provide services that day, and

b. Notifying the provider agency when a service scheduling change has occurred.

B. SUPPORT COORDINATOR'S ROLES AND RESPONSIBILITIES

In addition to the Support Coordinator Standards specified in AMPM Chapter 1600, the Support Coordinator shall be responsible for the following for Members electing AWC:

1. Informing and educating Members about the AWC option including verifying that Members electing AWC understand required and optional roles and responsibilities;
2. Supporting the Member to assess whether or not they desire or need an IR to assist them in directing their care. The Support Coordinator shall use AMPM Policy 1310, Attachment B, to document the name and relationship of the IR to the Member and their respective roles and responsibilities;
3. Supporting the Member to recruit and select the DCW(s):
    a. Presenting options to the Member for recruiting and selecting the DCW(s):
        i. Selecting the DCW from a pool of DCWs already employed by the provider agency, and
        ii. Recruiting the DCW from the community to become an employee of the provider agency.

b. Assisting the Member in identifying qualifications, skills, and characteristics of a DCW that are necessary to meet their needs;

c. Assisting the Member in identifying how many DCW(s) they might need to provide their care;

d. Assisting the Member in identifying and initiating contact with a provider agency.

4. Supporting the Member to dismiss DCW(s):

a. Assisting the Member in utilizing conflict resolution strategies with the DCW and the provider agency in the event they are unsatisfied with the DCW(s) or the provider agency's performance, and

b. Assisting the Member to develop a transition plan to ensure there are no interruptions in the provision of care.

5. Supporting the Member, as needed, to receive training regarding their roles and responsibilities:

a. Assisting the Member in identifying whether or not they need training to fulfill their roles and responsibilities, and

b. Finding a provider to conduct the training and authorize the service.

6. Supporting the Member to train DCW(s):
   a. Assisting the Member in identifying whether or not additional training is required for the DCW in order to meet Member specific needs,
   b. Ensuring the requested training is within the service scope specifications for DCW training as specified in this policy, and
   c. Finding a provider to conduct the training and authorize the service.
7. Supporting the Member to manage DCW(s):
   a. Ensuring care provided is within the scope of services and the service hours authorized and specified in the Service Plan; and
   b. Ensuring Members understand what services need to be provided on a specific basis, versus services that are more flexible with regard to when they are provided.
8. Supporting the Member to supervise DCW(s):

a. Encouraging Members to communicate directly with the DCW and the provider agency particularly when it pertains to DCW's performance and/or quality of care concerns, and

b. Following up with Members to inquire about their progress in implementing AWC.

9. Obtaining and maintaining a current copy of AMPM Policy 1310-A, Attachment A, supplied by the DCWs.

C. PROVIDER AGENCY ROLES AND RESPONSIBILITIES

The roles and responsibilities of Provider Agencies shall be as outlined in Provider Policy Manual, Chapter 46.

SUPPLEMENTAL INFORMATION

AWC is a Member-directed option that allows Members to have more control over how certain services are provided, including services such as attendant care, personal care, homemaker, and habilitation. The Member-directed options are not a service, but rather define the way in which services are delivered and are available to ALTCS members who live in their own home. The options are not available to Members who live in an alternative residential setting or nursing facility. Member independence and personal choice are the primary objectives of the AWC Member directed option.

Members choosing to participate in the AWC Member-directed option shall be interested in actively taking responsibility for managing their own health care. Throughout the Policy, the term "Member" means the Member or the Member's IR. Member-directed options represent a philosophical approach to service delivery that maximizes a Member's ability to:

1. Identify their own needs.
2. Determine how and by whom their needs are met:
    a. Choose which tasks to receive from their DCW or ACW within the scope of the Service Plan;
    b. Select the days and times for service delivery; and
    c. Recruit, hire (select), manage, supervise, and terminate (dismiss) the DCW of his/her choice, including family members. Parents of minor children are prohibited from serving as a paid DCW.
3. Define what constitutes quality of care in the delivery of their services. ALTCS members can direct care for one or more services under the AWC option including, Attendant Care, Personal Care, Homemaker, and Habilitation (in-home/day). The DCWs serving Members under the AWC option shall be

employees of the Provider Agency, in order to fulfill the legal employer roles and responsibilities in partnership with the Member's managing day-to-day employer roles and responsibilities. If a Member is unable to fulfill the roles and responsibilities as specified in AMPM 1310-A, Attachment A, for the above listed services on their own, an IR may be appointed to assist the Member in directing their care. If a Member has a guardian, that guardian automatically serves in the capacity of an IR. The role of an IR is to act on the Member's behalf in choosing and directing care, including representing the Member during the service planning process and approving the Service Plan. A.A.C. R9-28-509 and Section 1915 (k) of the Social Security Act prohibit an IR from serving as a Member's paid DCW. The number and frequency of authorized services are determined through an assessment of the Member's needs by the Support Coordinator with the Member and/or the Member's family, health care decision maker, and their designated representative, in tandem with the completion of the cost-effectiveness study. Refer to the FFS Provider Billing Manual

for information regarding service codes and modifiers. Members are not precluded from receiving other medically necessary services. Refer to AMPM Policy 1240-A for more detailed information about the services ALTCS members can direct under AWC. Within AWC the Member, the provider agency, and the Support Coordinator are critical to the effective implementation of the Member's Service Plan. Each of these individuals has roles and responsibilities which shall be met in order for the Service Plan to be successful.

Signature of Chief Medical Officer: Anthony Dekker (Jan 20, 2023 08:47 MST)
Anthony Dekker, D.O.

1302 INDEPENDENT PROVIDER PROGRAM

EFFECTIVE DATE: November 9, 2022

PURPOSE

The purpose of this policy is to outline requirements for the Division's Independent Provider Program.

DEFINITIONS

1. "Direct Care Worker (DCW)" means an individual who assists elderly individuals or individuals with a disability with activities necessary to allow them to reside in their home.
2. "Electronic Visit Verification (EVV)" means a computer-based system that electronically verifies the occurrence of authorized service visits by electronically documenting the precise time a service delivery visit begins and ends, the individuals receiving and providing a service, and type of service performed.
3. "Employer of Record" means the responsible person enrolled with the Fiscal Intermediary services as the employer.
4. "Fiscal Intermediary" means a contracted provider that files state and federal paperwork required for a member to serve as the

employer and required for an Independent Provider to be an employee of the member and that provides payroll functions.

5. "Individual Independent Provider" means an individual who has a service agreement with the Division to provide Attendant Care (ATC), Homemaker (HSK), Respite (RSP), or Habilitation (HAH/HAI) and who is a DCW.

POLICY

A. The Division shall offer members and their families the ability to direct their care and give the member control over assigning duties and schedules for the Direct Care Worker including hiring, firing, and some training requirements through the Independent Provider Program.

B. An Individual Independent Provider shall not provide more than 40 hours per week in combination of all services to all members.

C. An Individual Independent Provider shall adhere to the Division's Provider Manual.

D. The Division shall allow the member or responsible person to change Individual Independent Providers at any time.

E. The member or responsible person shall:

1. Identify any training needs, over and above the minimum required training by the Division, that are necessary to meet their unique needs.
2. Select the Individual Independent Provider from a pool of Individual Independent Providers already contracted by the Division.
3. Orient the Individual Independent Providers to the manner in which they want the services provided.
4. Provide feedback to the Individual Independent Provider regarding the performance and dismiss or fire if the member is not satisfied with the care provided.
5. Provide oversight and instruction to the Individual Independent Provider to ensure they are receiving quality care.
6. Communicate regularly with the Support Coordinator about the Individual Independent Provider performance.
7. Enroll with the Division's Fiscal Intermediary agency as the Employer of Record and verify service visits using the fiscal intermediary's EVV system.

F. The Fiscal Intermediary shall:

1. Maintain an EVV system as required by AHCCCS.
2. Process payments to Individual Independent Providers.
3. Manage required withholdings.
4. Provide tax documentation of members and providers.

Signature of Chief Medical Officer: Anthony Dekker (Nov 1, 2022 12:25 PDT)

Anthony Dekker, D.O.

1400 RESERVED

1500 RESERVED

1601 ASSIGNMENT OF SUPPORT COORDINATORS

REVISION DATE: 8/9/2023, 4/17/2015

EFFECTIVE DATE: January 15, 1996

REFERENCES: AMPM 1630

PURPOSE

The purpose of this policy is to set forth the Division of Developmental Disabilities (Division) guidance on assigning a Support Coordinator to each Division Member.

DEFINITIONS

1. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
2. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.
3. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. ASSIGNMENT

1. The Division shall assign a Support Coordinator to each person eligible for Division membership.
2. Support Coordination Supervisors shall assign Support Coordinators to Members based on the Support Coordinator's current:
   a. Complexity of caseload, and
   b. Availability.
3. The Division shall honor the Responsible Person’s choice of Support Coordinator to the best of the ability of the District in which the Member lives.
4. The Division shall honor the Responsible Person’s request to be placed on a pending list for their first choice of Support Coordinator.
   a. If the Responsible Person chooses placement on a pending list, another Support Coordinator shall be assigned in the interim.

b. Support Coordinator Supervisors shall ensure the Responsible Person is assigned to the Support Coordinator of choice whenever possible.

5. The Division shall assign a Support Coordinator for Member's in the care of the Arizona Department of Child Safety in the District where the Member physically resides.

B. BACK-UP SUPPORT COORDINATOR

1. The Division shall designate a back-up Support Coordinator for each person eligible for the Division.
   a. Division staff shall refer a Responsible Person immediately to the Back-Up Support Coordinator, when the Responsible Person contacts an office and the assigned Support Coordinator is not available.
   b. The Support Coordination Supervisor shall act as the back-up Support Coordinator in instances where a back-up Support Coordinator is not available.
2. The Division shall notify the Responsible Person in writing and in advance when there is a change in Support Coordinator, whenever possible.

C. CASELOAD MANAGEMENT

1. The Division shall monitor caseload ratios at the Division district statewide level to ensure the average caseload size does not exceed the ratio standards set forth by AHCCCS.
   a. The Division shall request exceptions from AHCCCS' Division of Health Care Management, prior to implementing caseloads which exceed this ratio.
   b. The Division may establish caseloads at a lower ratio without prior approval from AHCCCS.

Signature of Chief Medical officer: Anthony Dekker (Aug 2, 2023 13:31 PDT)
Anthony Dekker, D.O.

1610 GUIDING PRINCIPLES AND COMPONENTS OF SUPPORT COORDINATION

REVISION DATE: 4/10/24, 7/6/2021
REVIEW DATE: 11/13/2023
EFFECTIVE DATE: July 31, 1993
REFERENCES: AMPM 1610

PURPOSE

This policy establishes an overview of the guiding principles and components of Support Coordination.

DEFINITIONS

1. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
2. "Planning Document" means a written plan developed through an assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such services and supports.
3. "Planning Team" means a defined group of individuals comprised of the Member, the Responsible Person if other than the Member, and, with the Responsible Person's consent, any individuals important in the member's life, including extended family

members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems.

4. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability, or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed as cited in A.R.S 36-551
5. "Support Coordination" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. GUIDING PRINCIPLES

1. The Division shall manage and deliver services and supports to Members in a manner which is consistent with the following guiding principles:
   a. Member-Centered Services
      i. The Member is the primary focus.
      ii. The Member and Responsible Person, if other than the Member, are active participants in the planning, identification and evaluation of physical, behavioral,

and long-term services and supports.

iii. Services are mutually selected through person-centered planning to assist the Member in attaining their goal(s) for achieving or maintaining the Member's highest level of self-sufficiency.

iv. Up-to date information about the Arizona Long Term Care System (ALTCS)-DD program, choices of options and a mix of services is readily available to Members and presented in a manner that facilitates the Member's ability to understand the information.

b. Employment First Philosophy:

i. Competitive integrated employment is the preferred daily service and outcome for all working age Arizonans who have disabilities.

ii. Employment First encompasses the belief that competitive integrated employment should be the primary day service and outcome for working age youth and adults with disabilities.

iii. Employment First supports an overarching goal that eligible individuals with disabilities will have access

to integrated work settings most appropriate for them, including the support necessary to help them succeed in the workplace.

iv. Employment First does not mean employment only and does not deny individual choice.

v. Employment First does not eliminate service options currently available but is intended to increase employment opportunities.

c. Member-Directed Options

i. Members are to be afforded the opportunity to exercise responsibilities in managing their personal health and development by making informed decisions about how best to have their needs met including who will provide the service and when and how the services will be provided.

d. Person-Centered Planning

i. Person-centered planning maximizes Member-direction, and supports the Member in making informed decisions, so that the Member can lead or participate in the process to the fullest extent

possible.

ii. The Planning Document developed through this process, safeguards against unjustified restrictions of Member rights and ensures Members are provided with the necessary information and supports in order to gain full access to the benefits of community living to the greatest extent possible.

iii. The Member's DDD Support Coordinator, in collaboration and coordination with the DDD Health Plans, ensures responsiveness to the Member's needs and choices regarding service delivery, personal goals, and preferences.

e. Consistency of Services and Supports

i. An accessible and consistently available network of services and supports is developed to ensure the delivery, quality, and continuity of services.

ii. Services and supports are provided in accordance with the Planning Document as agreed to by the Responsible Person and as authorized by the Division, consistent with coverage responsibility.

f. Accessibility of Network

i. Network sufficiency supports choice in individualized Member care and availability of services.

ii. Provider networks are developed to meet the unique needs of Members with a focus on accessibility of services for Members with disabilities, cultural preferences, and individual health care needs.

iii. Services are available to Members to the same extent that services are available to individuals who are not receiving services through the Medicaid system.

g. Most Integrated Setting

i. Members live in the most integrated and least restrictive setting and have full access to the benefits of community living.

ii. Members are afforded the choice of living in their own home or choosing an alternative Home and Community Based Setting (HCBS) rather than residing in an institution.

iii. Members receive comprehensive services in the most

integrated and least restrictive setting, allowing them to be fully integrated into their communities.

iv. Members are afforded the choice to receive HCBS in community settings where individuals who do not have disabilities spend their time.

h. Collaboration with Stakeholders

i. Ongoing collaboration with Members, the Responsible Person, if applicable, and other members of the Planning Team.

i. Alignment of Care

i. Alignment of care for Members is well-coordinated, integrated care.

ii. The Division and stakeholders have established that reducing or eliminating fragmentation of care for Members requires focused efforts to coordinate physical and behavioral health care with long-term services and supports and community support.

iii. To create greater alignment and care coordination, a single, shared person-centered plan, developed by the Division’s Support Coordinator with the

participation of the DDD Health Plans care management staff, as appropriate, serves as the foundation for care and shall be made available to all involved providers.

j. Integrated Services

i. An integrated care system operated to holistically assess and seamlessly to provide needed services within existing community programs.

ii. An integrated system that reflects that successful Member outcomes are a shared responsibility for all involved in the care and treatment of the Member, leveraging the strengths of the Division, the DDD Health Plans and respective provider disciplines.

B. COMPONENTS OF SUPPORT COORDINATION

1. The Support Coordinator, to provide person centered planning, shall:

a. Provide person-centered planning and coordination;

b. Identifies Cost Effective Services based on assessed need;

c. Develop and maintain the Member's Planning Document;

i. Development of the Planning Document shall be

coordinated with the Responsible Person to ensure mutually agreed upon approaches to meet the Member's needs.

d. Ensures the Responsible Person is informed on how to report the unavailability of services or other problems;

e. Coordinates acute, behavioral health, and long-term care services that will assist the Member in maintaining or progressing toward the Member's highest potential;

f. Reassesses needs and modifies the Member's Planning Document as needed;

g. Identifies appropriate non-ALTCS covered community resources and services for Members and families;

h. Obtains all funded services as assessed in accordance with the Planning Document;

i. Offers a substitute service when the assessed service is not available;

j. Provide facilitation and advocacy

   i. Timely addresses and resolves issues which impede the Member's progress and access to needed services (both ALTCS and non-ALTCS covered

services), and

ii. Ensure services provided are beneficial for the Member.

k. Monitors services for continuing appropriateness

i. Assess for medically necessary and cost effective ALTCS services for the Member.

ii. Evaluate the Member's placement, and authorized services, and taking necessary action to ensure that placement, services, and supports are appropriate to meet the Member's individual goals and needs.

l. Be a mandatory reporter

i. Identifies any instances or suspected instances of abuse or neglect of the Member, reports to the appropriate entities.

ii. Report to the Divisions Quality Assurance Unit all Quality Assurance issues related to non-compliance of contractual requirements related to services the Member is receiving from the Division.

2. The Support Coordinator shall:

a. Follow current Division policy;

b. Comply with all Arizona Health Care Cost Containment System (AHCCCS) requirements;

c. Complete Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) requirements and paperwork;

d. Document accurately;

e. Complete assigned tasks;

f. Be punctual and available.

C. NAVAJO NATION CONTRACTED SUPPORT COORDINATION

1. The Division shall have an Intergovernmental Agreement with the Navajo Nation to provide contracted Support Coordination services to Members that stipulates:

   a. Who are eligible for Arizona Long Term Services (ALTCS);

   b. Enrolled by the Department of Economic Security with the Navajo Nation to receive support coordination (case management) services;

   c. Affiliated as Members of the Navajo Tribe by virtue of being federally recognized Tribal members and who either live on the Navajo reservation or did live on the Navajo reservation prior to placement in an eligible ALTCS setting;

d. American Indians who are not affiliated members with the Navajo Nation by virtue of being federally recognized members, but currently physically reside on the Navajo reservation or did physically reside on the Navajo reservation but were subsequently placed off reservation in an eligible ALTCS setting.

2. The Navajo Nation contracted Support Coordinator, for Members receiving HCBS on the reservation or in a nursing facility on or off reservation, shall:
   a. Develop and implement a Person-Centered Service Plan;
   b. Coordinate medical needs with the Members' Primary Care Provider (PCP);
   c. Assist the Responsible Person with identifying qualified providers for ALTCS services when they are unable to choose a provider without assistance;
   d. Monitor and update the Person-Centered Service Plan in accordance with this Policy Manual;
   e. Assess the cost effectiveness of services and recommend the least most cost effective service alternatives;
   f. Inform Members of alternative services when the HCBS

services exceed 100% of the Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID) rate;

g. Implement necessary corrective action to bring services into compliance.

3. The Division shall retain various Support Coordination activities:

a. The intake process;

b. Determining and re-determining eligibility;

c. Authorizing services;

d. Monitoring service delivery.

D. SUPPLEMENTAL INFORMATION

Service Coordination responsibilities for the Arizona Early Intervention Program (AzEIP) can be found on the AzEIP Policy and Procedures website.

1620-A INITIAL CONTACT/VISIT STANDARD

REVISION DATE: 12/13/2023, 3/9/2022
REVIEW DATE:
EFFECTIVE DATE: September 7, 2021
REFERENCES: AHCCCS AMPM Chapter 1620-A and E; A.R.S. § 36-551. Division Medical Policy 1620-E

PURPOSE

This policy outlines the timeframe requirements for the initial contact and visit standards for Division Members enrolled in Arizona Long Term Care Services (ALTCS).

DEFINITIONS

1. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

2. "Planning Document" means a written plan developed through an assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such services and supports.

3. "Planning Team" means a defined group of individuals comprised of the Member, the Responsible Person if other than the Member, and, with the Responsible Person's consent, any individuals important in the Member's life, including extended family members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems.

4. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability, or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed as cited in A.R.S. § 36-551.

5. "Supports" means paid or unpaid resources available in the community, through natural or family relationships, or through service providers to assist Members.

6. "Support Coordination" means a collaborative process, which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet the Member's needs

through communication and available supports to promote quality, cost-effective outcomes.

7. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551

POLICY

A. INITIAL CONTACT WITH A MEMBER WHO IS NEWLY ENROLLED IN ALTCS

1. The Support Coordinator shall review all enrollment notifications received via Focus task, Focus Reports, telephonically, email from AHCCCS, or Pre Admission Screening (PAS) Report when a Member is newly enrolled in ALTCS.
2. The Support Coordinator shall contact the Responsible Person via telephone, in person, or by secure email within five (5) calendar days of enrollment notification to schedule a planning meeting, even if the Member is enrolled during a hospital stay.
3. The Support Coordinator shall conduct an in-person on-site visit to initiate the Person-Centered Service Plan within ten (10) working days of the Member's enrollment notification.

4. The Support Coordinator shall complete the in-person on-site visit as soon as possible if the information obtained during the initial contact or from the Pre Admission Screening (PAS) tool completed by AHCCCS during the ALTCS eligibility determination indicates the Member has more immediate needs for services.
5. The Support Coordination shall conduct the in-person on-site visit at the Member's place of residence, or institutional setting for Members who are enrolled during a hospital stay, in order to develop the Member's Planning Document.
6. The Member shall be present for, and be included in, the in-person on-site visit and at all planning meetings.
7. The Support Coordinator shall allow the Member to decide who should be part of the planning meeting unless participants are specified by rule or law, such as by guardianship.
8. The Support Coordinator shall assess for home and community based services, which shall be initiated within thirty (30) calendar days of the Member's enrollment.
9. The Support Coordinator shall explain the Member's rights and responsibilities including the procedures for filing a grievance or

appeal and have them sign and date the Acknowledgement of Publications indicating receipt and understanding of the Member's rights and responsibilities.

10. The Support Coordinator shall participate in proactive discharge planning and follow-up activities for members enrolled with ALTCS during a hospital stay. Refer to Division Medical Policy 1620-E for requirements regarding in-person on-site reviews following a member's discharge from an inpatient hospital stay.
11. The Support Coordinator shall create a Request to Schedule a Meeting to be left at, or sent to, the Member's residence requesting that the Member contact the Support Coordinator if the Support Coordinator is unable to locate or contact the Member via phone, email, mailed letter, or in-person visit.
    a. The Support Coordinator shall complete an Electronic Member Change Report (EMCR) for potential loss of contact if there is no contact from the Responsible Person within thirty (30) calendar days from the Member's date of ALTCS enrollment.
    b. The Support Coordinator shall continue attempts to reach

the Responsible Person until ALTCS disenrolls the member.

12. The Support Coordinator shall document in the Member's case file and Focus progress notes all contact, whether attempted or successful, regarding a Member who is ALTCS eligible.

1620-B NEEDS ASSESSMENT/CARE PLANNING STANDARD

EFFECTIVE DATE: 7/6/2021
REFERENCES: AHCCCS AMPM Chapter 1620-B; A.R.S. § 36-401; A.R.S. § 36-551; 9 A.A.C. 22 Article 1; 9 A.A.C. 20, Articles 1, 4, 5, and 6 (A.A.C. R9.101).

PURPOSE

This Policy establishes requirements regarding needs assessment and care planning.

DEFINITIONS

Own Home - A residential dwelling that is owned, rented, leased, or occupied by a member, at no cost to the member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting, or an institution, or a portion of any of these that is licensed or certified by a regulatory agency of the state as a:

1. Health care institution under A.R.S. § 36-401.
2. Residential care institution under A.R.S. § 36-401.
3. Community residential setting under A.R.S. § 36-551, or
4. Behavioral health facility under 9 A.A.C. 20, Articles 1, 4, 5, and 6 (A.A.C. R9.101).

Person-Centered Service Plan (PCSP) A collaborative process, which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet the member's needs through communication and available resources to promote quality, cost-effective outcomes.

Planning Document - A plan which is developed by the Planning Team, such as an Individualized Family Service Plan (IFSP), Person Centered Service Plan (PCSP). The member/Responsible Person (as defined in A.R.S. §36-551) has final decision-making authority unless there is legal documentation that confers decision-making authority to a legal representative.

Planning Team - A group of individuals that shall include the member, Responsible Person (when applicable), Support Coordinator, and a representative from the agency for member's living in a licensed setting and with the member's consent, their Health Care Decision Maker, Designated Representative and any individuals important in the member's life, including but not limited to extended family members, friends, service providers, community resource providers, representatives from religious/ spiritual organizations, and agents from other service systems. The size, scope, and intensity of involvement of the team members are determined by the objectives of the planning team to best meet the needs and individual goals of the member.

Prior Period Coverage (PPC) - For Title XIX members, the period of time prior to the member's enrollment, during which a member is eligible for covered services. The timeframe is from the effective date of eligibility to the day a member is enrolled with a Contractor. Refer to 9 A.A.C. 22 Article 1. If a member made eligible via the Hospital

Presumptive Eligibility (HPE) program is subsequently determined eligible for AHCCCS via the full application process, Prior Period Coverage for the member will be covered by AHCCCS Fee-For-Service and the member will be enrolled with the Contractor only on a prospective basis.

Responsible Person - Means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed as cited in A.R.S 36-551

Support Coordination - A collaborative process, which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet the member's needs through communication and available resources to promote quality, cost-effective outcomes.

Policy

A. Support Coordinators are expected to use a person-centered approach regarding the member assessment and needs identification, considering not only ALTCS covered services, but also other needed community resources as applicable. Support Coordinators shall:

1. Respect the member and the member's rights.
2. Support the member to have a meaningful role in planning and directing their own supports and services to the maximum extent possible.
3. Provide adequate information and education to support the member/Responsible Person to make informed decisions and choices.
4. Be available to answer questions and address issues raised by the member/Responsible Person, including between regularly scheduled Planning Meetings.
5. Provide a continuum of cost effective service options that supports the expectations and agreements established through the planning process.
6. Educate the member/Responsible Person, on how to report unavailability or other problems with service delivery to ensure unmet service needs can be addressed as quickly as possible. Refer to Division Medical Policy 1620-D and 1620-E, and 540 regarding specific requirements.
7. Facilitate access to non-ALTCS supports and services available throughout the community, ("natural supports") as well as Non-Title XIX services for members with a Serious Mental Illness (SMI) designation.
8. Advocate for the member and/or family/significant others as the need occurs.

9. Allow the member/Responsible Person to identify their role in interacting with the service delivery system, including the extent to which the family/informal supports will provide uncompensated care.

10. Provide member/Responsible Person with flexible and creative service delivery options.

11. Educate member/Responsible Person about member directed options for delivery of designated services. These options will be reviewed with the member/Responsible Person for members living in their own homes at every Planning Meeting.

12. Educate member/Responsible Person on the option to choose a spouse as the member's paid attendant caregiver.

13. Provide necessary information to providers about any changes in member's goals, functioning and/or eligibility to assist the provider in planning, delivering, and monitoring services.

14. Provide coordination across all facets of the service system in order to determine the efficient use of resources and minimize any negative impact on the member.

15. Educate the member/Responsible Person on End-of-Life Care and Advanced Care Planning, services and supports. See Division Operations Policy 1006 for additional guidance regarding health care directives.

16. Assist members to identify their independent living goals and provide them with information about local resources that may help them transition to greater self- sufficiency in the areas of housing, education, and employment, including volunteer opportunities (refer to the section below which outlines additional requirements for individualized member goals).

17. If a member's status has improved that s/he may no longer be medically eligible for ALTCS, the Support Coordinator shall complete an Electronic Member Change Report (EMCR), for a medical PAS Reassessment.

B. The involvement of the member/Responsible Person in strengths/needs identification as well as decision-making is a basic tenet of Support Coordination practices. For the Planning Meetings, the Planning Team may include anyone, as requested by the member/Responsible Person. The member/Responsible Person and Planning Team partner with the Support Coordinator in the development of the Planning Document, with the Support Coordinator generally functioning as the facilitator.

C. The Support Coordinator will complete the Division's Member Level of Care Tool (MLOC) based on information from the member's Planning Document to determine the member's current level of care.

D. Person-centered plan is based on face-to-face discussion with the member/Responsible Person and other members of the Planning Team in order to

develop a comprehensive Planning Document, as defined in this policy. The Planning Document will include recommendations of the member's Primary Care Provider (PCP), as well as input from service providers, as applicable. Support Coordinators will complete the (DDD-2039A) HCBS Member Needs Assessment Tool to determine the amount of service hours a member needs when Attendant Care/Homemaker, Habilitation Hourly, and/or Respite services will be authorized for members living at home. If the member has been assessed for Respite, the Respite Assessment Tool must also be completed.

E. In development of the member's Planning Document, Support Coordinators shall assist in identifying meaningful and measurable individualized goals for members, including long-term and short-term goals (e.g., in the areas of recreation, transportation, friendships, family and other relationships) to assist the member in attaining the most self-fulfilling, age-appropriate goals consistent with the member's needs, desires, strengths, and preferences.

1. Goals will include steps that the member will take to achieve the goal(s).
2. Goals will be written to outline clear expectations about what is to be achieved through the service delivery and care coordination processes.
3. Goals will be reviewed at each Planning Meeting.

F. For members who have been receiving Home and Community Based Services (HCBS) during the Prior Period Coverage (PPC) timeframe a retrospective assessment must occur to determine whether those services were:

1. Medically necessary,
2. Cost effective, and
3. Provided by a registered AHCCCS provider.

If all three of these criteria are met, the services are eligible for reimbursements specified in the member's Planning Document. Services that will be retroactively approved based on this assessment will be marked as "Retroactive" in the Planning Document. If any of the services provided during the PPC are not approved, the member must be provided a written Notice of Adverse Benefit Determination (NOA) and given an opportunity to file an appeal.

G. For new member residing in an Assisted Living Facilities (ALF) during PPC, the support coordinator shall inform the ALF that they are encouraged to bill/accept Medicaid payment for services for members who are eligible under PPC but are not required by regulations to do so. If the facility chooses to, or is required by contract to bill the Division, the facility must accept the Medicaid payment as full payment and is not permitted to bill the member or family for the difference between the Medicaid and private pay rate. The support coordinator shall ensure that the facility refunds private payments made by the member or family, less the amount of room

and board assigned by the Contractor, prior to billing the Division for Medicaid reimbursement.

H. In addition to the grievance and appeals procedures described above, Division of developmental Disabilities (DDD) will also make available the grievance and appeals processes described in Division Operations Policy 446.

1620-C COST EFFECTIVENESS STUDY

EFFECTIVE DATE: 7/6/2021
REFERENCES: A.R.S 36-551

DEFINITIONS

Home and Community Based Services (HCBS) - Home and community-based services, as defined in R6-6-1501.

Institutional Settings – Means a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF).

Planning Document - A plan which is developed by the Planning Team, such as an Individualized Family Service Plan (IFSP), Person Centered Service Plan (PCSP). The member/Responsible Person (as defined in A.R.S. §36-551) has final decision-making authority unless there is legal documentation that confers decision-making authority to a legal representative.

Planning Team - A group of individuals that shall include the member, responsible person (when applicable), Support Coordinator, and a representative from the agency for member's living in a licensed setting and with the member's consent, their Health Care Decision Maker, Designated Representative and any individuals important in the member's life, including but not limited to extended family members, friends, service providers, community resource providers, representatives from religious/ spiritual organizations, and agents from other service systems. The size, scope, and intensity of involvement of the team members are determined by the objectives of the planning team to best meet the needs and individual goals of the member.

Responsible Person - Means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed as cited in A.R.S 36-551.

Support Coordination - A collaborative process, which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.

POLICY

Cost Effectiveness Study

Home and Community Based Services (HCBS) provided under the ALTCS Program must be cost-effective when compared to the cost of providing care to the member in an institutional setting. It is the responsibility of the Planning Team to identify if the member will exceed 100% of the institutional cost and develop a plan to reduce ALTCS expenses. Written Cost Effectiveness Studies (CES) are also required by Arizona Health Care Cost Containment System (AHCCCS), for ALTCS eligible members whose costs exceed 80% of their approved rate.

The CES is a three-month projection of costs. The Support Coordinator shall complete a Cost Effectiveness Study (CES) Worksheet if the member's name appears on the quarterly report "Client_0060 – Individuals Exceeding 80% Cost Effectiveness" (CLT_0060). This report identifies members whose costs exceeded 80% of the institutional rate for one or more months during the prior quarter.

In addition to members on the CLT_0060 Report, there are other circumstances in which the Support Coordinator is required to complete a CES worksheet prior to implementation of services or change in placement. These include when a member's service assessment documents the need for:

A. Nursing services (including nursing respite) in excess of 200 hours monthly

B. Habilitation – Nursing Supported Group Home services

C. Residential Habilitation (Individually Designed Living Arrangement or Group Home) and Day Treatment and Training when the member needs a staff ratio of 1:1 or 1:2 in either setting.

D. Habilitation, Community Protection

E. A change in placement, staffing and/or services that could potentially put the member's costs above 80% cost effectiveness (e.g. move from home to a group home, move from one group home to another group home, adding Day Program with an enhanced staffing ratio, etc.) or discharge from an institutional placement in under consideration.

    1. The costs used for the CES should be those proposed for the new placement.

    2. The Support Coordinator is responsible for completing the CES worksheet and submitting to the Supervisor to check for accuracy and approval.

    3. The Discharge Plan from an institutional placement must be consistent with AHCCCS and Division policy and be developed prior to any move. As needed, the Support Coordinator will ensure coordination with the health plan occurs.

    4. If the costs of the proposed placement are projected to be below 100% of the appropriate institutional level and the move is approved, the Area Manager/designee will ensure the CES is entered in the AHCCCS computer system.

    5. If the costs of the proposed placement are above 100% of the institutional level, discharge cannot be approved.

COMPLETING THE COST EFFECTIVENESS STUDY

The following Home and Community Based Services must be included on the CES Worksheet:

A. Assisted Living Facilities

B. In-Home Support Services (e.g. Attendant Care, Habilitation Hourly, Respite, Homemaker)

C. Day Program (e.g. Day Treatment & Training Adult or Child, Employment Services) and Transportation - Scheduled

D. Emergency Alert Systems

E. Habilitation (Residential, Individually Designed Living Arrangement, etc.)

F. Home Delivered Meals

G. Nursing (continuous or "shift" nursing of 2 hours or more at a time, Nursing Respite)

H. Specific Behavioral Health Services provided through the member's integrated health plan:

1. Behavioral Health Respite

2. Behavioral Health Alternative Residential Settings

The following services are not included:

A. Occupational, Physical, Respiratory, and Speech Therapy

B. Room and Board

C. Therapeutic Day Program

D. Behavior Management (Behavioral Health Personal Care, Family Support, Peer Support)

E. Psychosocial Rehabilitation (Behavioral Health Living Skills Training)

F. Behavioral Health Services not Listed Above (e.g., medication management)

G. Home Health Aide

H. Nursing provided on an "intermittent" or "per visit" basis (not to exceed 2 consecutive hours per visit and no more than 4 visits per day)

I. Home Modifications

J. Community Transition Services

K. Physical health services provided by the health plan (e.g. Hospice services, customized DME, medical supplies and pharmaceuticals

L. Interpretation or translation services

The services, units, and costs projected on the CES Worksheet are for the upcoming quarter. Each CES Worksheet must be signed by the Support Coordinator. In addition, the Support Coordinator Supervisor is responsible for signing the Worksheet if the member's costs are projected to exceed 80% cost effectiveness. The Supervisor's signature indicates that the Worksheet has been reviewed for accuracy and costs are being monitored. Completed signed CES Worksheets must be maintained in the member's case record.

For CES' that are projected to exceed 100% cost effectiveness for one or more months of the quarter, a Cost Reduction Plan must be identified on the CES Worksheet. In addition to the Support Coordinator and Supervisor's signature, the District Program Manager must also sign the worksheet. This signature assures that all appropriate CES policies and procedures have been followed, including the identification of a Cost Reduction Plan and potential use of State dollars.

A revised CES should be completed and submitted by the Support Coordinator through their chain of command anytime during the quarter when there is a proposed change in placement or service costs that puts the member above 100% cost effectiveness (e.g. vacancy created in group home, staffing increase, enhanced ratio in the day program). Likewise, if there is a change in circumstances during the quarter that reduces costs below 100%, a revised CES should be completed.

The Support Coordinator is required to complete and submit a CES Worksheet quarterly until costs are demonstrated to fall below 80%. The Area Manager/designee will ensure the CES is entered into the AHCCCS computer system prior to the beginning of the quarter that is being projected or within 10 working days of any placement/service change, whichever is sooner.

The Area Manager/designee is responsible for tracking that CES' are completed at least quarterly. In addition, when a member who is over 80% cost effectiveness, transfers from one unit or district to another unit or district, the case transfer procedure will be followed.

SHARE OF COST

Prior to completing the CES worksheet, the Support Coordinator should verify s/he is using the member's most current CES Share of Cost (CES SOC). The CES SOC is the amount the member would have to pay monthly if placed in an institutional setting. The CES SOC amount is determined by AHCCCS and is based on the member's income and expenses. Members who only receive Supplemental Security Income (SSI) typically have $0 CES SOC. However, members who have other types of income (e.g. Social Security Survivors Benefits, VA, Adoption Subsidy, etc.) will have a CES SOC.

The CES SOC is subtracted from the member's approved institutional rate to determine the Net Institutional Cost. The Net Institutional Cost is used to determine whether the services provided to the member are cost effective when compared to an appropriate institutional placement.

WHEN THE CES IS OVER 100% COST EFFECTIVENESS

Once the member's costs have exceeded 100% of the Net Institutional Rate, the Support Coordinator should immediately consult with their supervisor, area manager, and other District personnel (nurse, Network staff, etc.) to develop a plan to reduce costs within six months and determine which options should be pursued.

AHCCCS allows up to six months from the time the member exceeds 100% cost effectiveness to implement a Cost Reduction Plan. If it is unlikely that costs can or will be reduced within six months, the Support Coordinator is responsible for initiating a review of other options.

District management is responsible for tracking and monitoring from the time the member exceeds 100% cost effectiveness until costs are reduced below the member's approved institutional rate.

Options the District may want to consider when a member exceeds 100% cost effectiveness include, but are not limited to:

1. Reconvene the Planning Team to review services and the member's level of support
2. Request a higher medical rate
3. Request a higher behavioral health rate
4. Consideration of possible institutional placement

A. Reconvene the Planning Team to Review Services and the Member's Level of Support

The Support Coordinator, in conjunction with their Supervisor/Area Manager, may need to call a special team meeting to address the high costs. Planning Team members, including providers, should be notified that current costs exceed institutional levels and overall costs must be reduced. Options the Planning Team could discuss include, but are not limited to:

1. Reduce service units
2. Reduce staffing levels
3. Alternative placements
4. Filling vacancies

B. Request a Higher Medical Rate

If the member has skilled nursing needs, a higher medical institutional rate may be considered by the team. The Support Coordinator must complete a packet that includes the following:

1. Narrative describing how the person meets the criteria

2. Current nursing assessment that identifies the need for skilled nursing care

3. Current CES Worksheet

4. Plan to Reduce Costs - The plan should identify the specific steps the team is taking to address the member's health and safety as well as how the team is monitoring and addressing costs.

Members who are ventilator dependent or authorized for a nursing supported medical group home have been determined to have skilled care needs. Thus, these members are pre-approved for a higher medical institutional rate and a packet does not need to be submitted. However, if the member's circumstances change (i.e. is weaned off the ventilator or no longer resides in a nursing supported medical group home), a Higher Medical Rate packet may be needed if the member continues to have skilled care needs and is over 100% cost effectiveness.

C. Request the Higher Behavioral Health Rate

If the member has a mental health diagnosis and significant behavioral health challenges, the Higher Behavioral Health Rate might be appropriate. These behavioral challenges by the member might include:

1. Behaviors that currently impact the member's functioning or ability to adapt to community life.

2. A substance abuse disorder and significant difficulties adapting to community life.

3. Charged with a crime of sexual violence, including but not limited to, rape, statutory rape, and child molestation.

4. Charged with acts directed toward strangers or individuals with whom a relationship has been established or promoted for the primary purpose of victimization

5. Has committed one or more violent crimes, such as murder, attempted murder, arson, first-degree assault, kidnapping, or use of a weapon to commit a crime.

The Support Coordinator must complete a packet that includes the following:

1. Narrative describing how the person meets the criteria. This narrative must contain the following:

   - Current psychiatric diagnoses

   - Current behaviors and frequency of these behaviors within the last six months. Include how the team is addressing these behaviors (e.g. Behavior Treatment Plan, Behavioral Health Treatment Plan, behavioral health services the member is currently receiving to address these behaviors).

- Description of how the member currently has difficulty adapting to community life
- Description of substance abuse issues (if applicable)
- Description of criminal offenses (if applicable)

2. Current CES Worksheet
3. Plan to Reduce Costs - The plan should identify the specific steps the team is taking to address the member's behaviors and reduce service costs.
4. The Division's Behavioral Health Administration may request additional documentation, such as current psychiatric and psychological evaluations or the member's approved Behavior Treatment Plan (BTP), to assist in evaluating the request.

RESPONSE FROM THE DIVISION'S HEALTH CARE OR BEHAVIORAL HEALTH SERVICES

DDD's Health Care or Behavioral Health Administration will notify the Operational Compliance Unit of the status of the request for the higher institutional rates (medical and/or behavioral). The Operational Compliance Unit will inform District Support Coordination of the outcome of the request.

- If approved, the notification will include the approval expiration date. If the member continues to need a higher institutional rate, a renewal request should be submitted 30 days prior to the expiration date.
- If denied, the Support Coordinator, in conjunction with the Supervisor/Manager will reconvene the team to consider other options.
- If the approval expires, the institutional rate will revert to the "Base ICF/ID" rate. The Support Coordinator, in conjunction with their Supervisor/Manager must initiate review of the other remaining options listed above if the member remains above 100% cost effectiveness.

D. Considerations for Possible Institutional Placement

When considering institutional placement, the Support Coordinator must first document all other options considered and the reasons why these options were not chosen by the team. The Planning Team must discuss the lack of appropriate, cost - effective alternatives for the member and discuss potential placements. The member/designated representative's decision regarding institutional placement shall be documented in the member's case record. Documentation shall be submitted to the District Program Manager for potential use of state dollars above 100% cost effectiveness.

Procedures for Reducing Cost Below 100%

The District Program Manager or designee is responsible for tracking and monitoring members who are identified as exceeding 100% cost effectiveness. This includes

identification and monthly reporting of members on the Expenditure Correction (EXCOR) Report.

- If costs have not been reduced within six months from the time the member began exceeding 100%, the District Program Manager must determine whether State funds will be approved.
- If there is no Cost Reduction Plan, Support Coordination will obtain approval from the District Program Manager for the use of state funds.
- If the District Program Manager approves home and community-based services above 100% of the cost of serving the member in an institutional setting, these costs must be paid with State funds.
- If State funds will be used, the Area Program Manager/designee will adjust the CES Worksheet calculation previously entered into the AHCCCS computer system to reflect Medicaid approved costs up to, but not exceeding 100% of the member's approved institutional rate. A copy of the AHCCCS computer screen prints showing adjusted CES costs below 100% will be sent to the Support Coordinator and filed in the member's case record.
- If the District Program Manager denies the use of State funds, Support Coordination shall initiate termination of service costs more than 100%. The Support Coordinator shall advise the member/designated representative of the cost effectiveness limitations and discuss other options. Support Coordination shall also follow the Notice of Adverse Benefits Action requirements.

If the member/designated representative chooses to have the member remain in his/her current placement, even though the Division cannot provide all of the services that have been assessed as medically necessary (including those ordered by the member's Primary Care Provider), a Managed Risk Agreement must be completed.

1620-D PLACEMENT AND SERVICE PLANNING FOR ALTCS ELIGIBLE MEMBERS

REVISION DATES: 8/2/2023, 2/16/2022, 9/8/2021

EFFECTIVE DATE: July 6, 2021

REFERENCES: Title 42 U.S. Code 1320a-7b, A.R.S. §36-551, AMPM Chapter 1600, Division Medical Policy 1620-B, Division Medical Policy 1620-C, Division Medical Policy Chapter 300, Division Medical Policy Chapter 1200, Division Operations Policy 4002

PURPOSE

This policy applies to Division Members who are eligible for Arizona Long Term Care Services (ALTCS) and all Division staff. It outlines the requirements for Member placement and service planning for Members eligible for ALTCS.

DEFINITIONS

1. "Electronic Visit Verification (EVV)" means a computer-based system that electronically verifies the occurrence of authorized service visits by electronically documenting the precise time a service delivery visit begins and ends, the individuals receiving and providing a service, and the type of service performed. Services subject to EVV include non-skilled in-home services and home health services pursuant to 42 U.S.C. §1396(b)(l).

2. "Gap in Services Subject to EVV" means the difference between the number of hours of these services documented in each Member's Planning Document and the hours of the type of these services that are actually delivered to the Member. The following situations are not considered gaps:

   a. The Member is not available to receive the service when the caregiver arrives at the Member's home as scheduled.

   b. The Member refuses the caregiver when she/he arrives, unless the caregiver is not able to do the assigned duties.

   c. The Member refuses services.

   d. The Member's home is seen as unsafe by the agency/caregiver, so the caregiver refuses to go there.

3. "Home and Community Based Services (HCBS)" means home and community-based services, as defined in R6-6-1501.

4. "Managed Risk Agreement" means a document developed by the Support Coordinator or District Nurse with the Responsible Person, which outlines potential risks to the Member's safety and well-being because of choices or decisions made by the

Responsible Person.

5. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

6. "Out-of-State Services" means services provided to Members outside of Arizona that are covered as provided for under Code of Federal Regulations (CFR) 42 CFR, Part 431, Subpart B. This includes services that, as determined on the basis of medical advice, are more readily available in other states and services needed due to a medical emergency. Services furnished to AHCCCS members outside the United States are not covered.

7. "Own Home" means a residential dwelling that is owned, rented, leased, or occupied by a Member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting, or an institution, or a portion of any of these that is licensed or certified by a regulatory agency of the state as a:

   a. Health care institution under A.R.S. § 36-401.

   b. Residential care institution under A.R.S. § 36-401.

c. Community residential setting under A.R.S. § 36-551, or

d. Behavioral health facility under 9 A.A.C. 20, Articles 1, 4, 5, and 6 (A.A.C. R9.101).

8. "Planning Document'' means a written plan developed through an assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such Services and supports.

9. "Planning Team" means a group of people including the Member; the Responsible Person; the Support Coordinator; other State of Arizona Department of Economic Security staff, as necessary; and any person selected by the Member, Responsible Person, or the Department.

10. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability, or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed as defined in A.R.S. §36.-551

11. "Share of Cost" means the amount an ALTCS Member is required to pay toward the cost of long term care services.

12. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551

13. "Temporarily Out of State" means A Member is considered temporarily absent from Arizona if

    a. Intends to return to Arizona when the reason for the absence is completed

    b. Has not become a resident of another state. For minors under the age of 18, residency is based on the custodial parent. A resident of another state includes, but not limited to applying for medical assistance in another state; renting or buying a home; getting a job; and/or applying for a driver's license or identification in another state.

POLICY

A. PLACEMENT AND SERVICE PLANNING STANDARDS

1. The Division shall identify placement goals through a

Member-centric planning process and cost effectiveness standards shall be met in the Home and Community Based setting.

2. The Support Coordinator shall facilitate placement and services based primarily on the Member's choice with additional input in the decision making process from the Planning Team, the Support Coordinator's assessment, and the Pre-Assessment Screening.

3. Support Coordinators shall not use referral agencies to identify placement options for Members in lieu of the Division's contracted network of providers.

4. The Support Coordinator shall discuss the cost effectiveness, as applicable, and availability of needed services with the Responsible Person as part of the Planning Meeting.

5. In determining the most appropriate service placement for the Member, the Support Coordinator and the Responsible Person shall discuss the following as applicable:

    a. The Member's placement choice and preferences,

b. Services necessary to meet the Member's needs in the most integrated/least restrictive setting. Refer to Division Medical Manual Chapters 300 and 1200 for information about the following types of services available:

   i. Home and Community Based Services (HCBS),

   ii. Institutional services,

   iii. Physical health (acute care) services, and

   iv. Behavioral health services.

c. The Member's interest in and ability to direct their own supports and services.

d. The availability of HCBS in the Member's community.

e. Cost effectiveness of the Member's placement and service choice.

f. Covered services that are associated with care in a licensed institutional setting compared to services provided in the Member's Own Home or an HCBS residential setting.

g. The risks that may be associated with the Responsible Person's choices and decisions regarding services, placements, caregivers, which would require the completion of a Managed Risk Agreement (Form DDD-1530A).

h. The Member's financial responsibility as specified in Division Operation Policy 4002.

i. The Member's Share of Cost (SOC) responsibility. The amount of the Member's SOC shall be determined and communicated to the Responsible Person by AHCCCS.

j. The room and board amount to be covered by the Member to be paid towards the cost of the Community Residential Setting.

i. For Members residing in other alternative residential settings including Community Residential Settings, this is the amount the Member is responsible for paying toward their room and board. Room and board is not an ALTCS covered service in these

settings.

ii. For vendor operated settings that contract directly with the Division, the amount is determined by the Division and shall be communicated to the Responsible Person.

iii. The behavioral health provider shall communicate the room and board amount directly to the Responsible Person for behavioral health residential settings.

iv. The Support Coordinator shall complete an Assisted Living Agreement (Form DDD-1747A) or a DDD Residency Agreement (Form DDD-2176A) for Members who live in Assisted Living or Community Residential Settings prior to the Member's entry into residential services and update the assessment when changes in the Member's income or the provider's rates occur.

6. The Division shall allow any Member who lives in their Own

Home to remain in their Own Home as long as HCBS are cost effective. The Division shall not require Members to enter a residential HCBS placement/setting that is "more" cost effective.

7. The Division shall inform Members that they have the choice to select their spouse to be their paid caregiver for medically necessary and cost effective services, provided the spouse meets all of the qualifications as specified in Division Medical Policy 1240.

8. The Support Coordinator shall complete the Spouse Attendant Care Acknowledgement of Understanding (Form DDD-1469A) with the Member and spouse prior to the authorization of the Member's spouse as the paid caregiver. The Spouse Attendant Care Acknowledgement of Understanding (Form DDD-1469A) form shall be completed at least annually.

9. The Support Coordinator shall coordinate services with the appropriate providers as identified and agreed to in the Member's Planning Document. The Member's assessed needs and corresponding authorization shall not be contingent upon the provider meeting the requirements of the U.S. Department of

Labor, Fair Labor Standards Act.

10. The Support Coordinator shall ensure that the Responsible Person understands that some services and medical supplies require a prescription by the primary care provider (PCP). These include home health services, therapies, and durable medical equipment (DME).

11. The Support Coordinator shall coordinate with the Member's ALTCS Health Plan to obtain a PCP when the Member does not have a PCP or to change the PCP when an ALTCS Member does not have a PCP or wishes to change PCP.

12. The Division shall make a decision regarding the provision of services requested within:

    a. 14 calendar days following the receipt of the request/order, or

    b. Three business days when the Member's life, health, or ability to attain, maintain or regain maximum function would otherwise be jeopardized

13. The Division shall provide appropriate placement and services to

meet the Member's needs within established timelines:

a. Services determined to be medically necessary and cost effective for a newly ALTCS enrolled Member shall be provided to the Member within 30 calendar days of the Member's enrollment.

b. Services for an existing ALTCS Member shall be provided within 14 calendar days following the determination that the services are medically necessary and cost effective.

14. The Support Coordinator shall verify the needed services are available in the Member's community and:

c. Shall substitute a combination of other services, when an assessed service is not currently available, to meet the Member's needs until the assessed service becomes available.

d. May assess a temporary alternative placement if services cannot be provided to safely meet the Member's needs.

15. The Support Coordinator shall ensure Members have access to transportation and support for the purpose of visiting potential

residential or non-residential settings prior to making a decision on where to live or receive services.

16. The Support Coordinator shall develop the Planning Document. The role of the Planning Team in developing the Planning Document is communicating and working towards the Member's vision for the future.

17. The Support Coordinator shall document the following in the Planning Document:

    a. The Member's strengths, goals, preferences, needs, and desired outcomes.

    b. The assessed services and supports identified to assist the Member in achieving their established goals. For each ALTCS covered service, the Planning Document shall document the frequency and quantity of the service including any change to the service since the last Planning Meeting.

    c. Every effort shall be made to ensure the Responsible Person understands the Planning Document, including their

agreement or disagreement with each service authorization. The Support Coordinator shall engage in reasonable conflict resolution efforts to resolve any issues when the Responsible Person disagrees with the service(s) authorized.

d. The Planning Document shall be reviewed according to the timeframes specified in Division Medical Policy 1620-A and Division Medical Policy 1620-E. The Planning Document shall be reviewed sooner when there is a change to the Member's functional needs, circumstances, individual goals, or at the Responsible Person's request.

e. The Support Coordinator shall document how the Member communicated their agreement or disagreement when the Member is physically unable to sign the Planning Document.

f. An adult Member enrolled with the Division shall be assumed legally competent to make decisions on their own behalf unless the Court has appointed a legal guardian. The Support Coordinator shall leave the Planning

Document unsigned and document the circumstances when the Member is unable to participate in the planning and decision making process and does not have a legal guardian. When appropriate, a referral to the County Public Fiduciary or resources shall be considered by the Planning Team.

g. The Support Coordinator shall provide a copy of the Planning Document to the Responsible Person and maintain a copy in the case file. The Support Coordinator shall also provide a copy of the Planning Document to the individuals selected by the Responsible Person, as specified in the Planning Document, and to all authorized service providers (vendors).

h. The Support Coordinator shall assess for risks while considering the Member's right to assume some degree of personal risk. The Planning Document shall also include measures available to reduce risks or identify alternative ways to achieve individual goals based on the Member's priorities outlined in the Planning Document.

18. The Division shall provide the Responsible Person with a Notice of Adverse Benefit Determination that explains the Member's right to file an appeal regarding the placement or service decisions within the Planning Document when the Responsible Person disagrees with the Planning Document and/or authorization of placement/services including the amount and/or frequency of a service.

19. The Support Coordinator shall provide a copy of the DDD-EVV Member Contingency/Back-Up Plan For the Independent Provider Program (Form DDD-2113A). The contingency plan shall be given to the Responsible Person when developed and at the time of each review visit.

20. For services delivered by an independent provider, the Member's contingency/backup plan shall direct the Responsible Person to contact the Support Coordinator or the Division's Customer Service Center when a Gap in Services Subject to EVV occurs during the Division's business hours. The Member's contingency/backup plan shall direct the Responsible Person to the Division's after-hours telephone number for a Gap in

Services Subject to EVV that occurs after regular business hours.

21. The Support Coordinator shall be responsible for completing the Member Contingency/Back-Up Plan with the Responsible Person when any of the following services will be provided by an Independent Provider (IP):

    a. Attendant care

    b. Respite

    c. Habilitation Hourly

    d. Habilitation Independent

    e. Homemaker (Housekeeping)

22. The Support Coordinator shall encourage and assist members who reside in their Own Home to have an emergency/disaster plan for their household that considers the special needs of the Member. Support Coordinators shall document the discussion in the Planning Document with the Responsible person and document the Member's plan on the Emergency/Disaster Plan (Form DDD-1621A) when the Responsible Person requests

assistance with developing an emergency/disaster plan.

23. The Support Coordinator shall regularly assess Members who reside in out-of-home residential placements to determine if they are in the most integrated setting possible for their needs. Members are permitted to change to a less restrictive placement, if needed services are available and cost effective in that setting.

24. The Support Coordinator shall inform the Responsible Person of the process for voluntary withdrawal and guide the Responsible Person through applying for AHCCCS Complete Care, or other programs, as needed, when the Member does not want or need long term care services.

    a. The Support Coordinator shall advise the Responsible Person that the Member may be disenrolled from the ALTCS program based on the Member's income.

    b. The Support Coordinator shall continue their attempts to meet with the Member and their Responsible Person until the Member is disenrolled from ALTCS.

25. The Support Coordinator shall include the date range and units

for each service authorized on the Planning Document and in the Member's case file according to the Division's system for tracking service authorizations.

26. The Division shall include the following types of services in its system for tracking authorized services for Members residing in an institutional setting as appropriate based on the Member's needs:

    a. Nursing facility services. The Planning Document shall indicate the Member's acuity (Level I, II, or III) based on the AMPM Exhibit 1620-3, completed by the District Nurse, and the need for specialty care.

    b. Hospital admissions (acute and psychiatric)

    c. Bed holds or therapeutic leave days, refer to AMPM Policy 100 for definitions and limitations

    d. Services in an uncertified nursing facility

    e. DME outside the institutional facility per diem (item/items with a value exceeding $300 regardless of if rented, purchased, or repaired). This requirement shall be waived

for ALTCS/DDD Members.

f. Hospice services

g. Therapies (occupational, physical, and speech)

h. Behavioral health services, refer to the Behavioral Health Service Matrix on the AHCCCS website.

i. ALTCS covered services noted above when provided by other funding sources.

B. TEMPORARILY OUT-OF-STATE HCBS SERVICES

1. The Division shall determine when HCBS Out-of-State Services are appropriate for the Member, medically necessary, and cost effective when requested.

2. The Division shall only cover HCBS Out-of-State Services when they are requested and approved prior to the Member traveling out-of-state.

3. The Division shall not authorize HCBS Out-of-State Services that are requested after the Member has traveled out-of-state.

4. The Support Coordinator shall assess the need for HCBS Out-of-State Services when requested by the Responsible Person. To assess for these services, the Planning Team shall:

   a. Determine if services currently assessed for the Member are appropriate and/or sufficient to meet the Member's needs while out-of-state.

   b. Determine the dates of departure and return.

5. The Division shall notify the Planning Team and the provider/qualified vendor agency of the outcome of the request.

6. The Division shall not authorize Licensed Health Aide (LHA) services for Members traveling Out of State as LHA providers are only licensed to practice in the state of Arizona.

7. The Division shall not cover services for Members who leave the United States and United States Territories.

C. AHCCCS NOTIFICATION REQUIREMENTS

1. The Support Coordinator shall not complete an electronic member change report (eMCR) when reporting a change in the

Member's PCP.

2. The Support Coordinator shall complete an eMCR for an evaluation of Long Term Care/Acute Care Only eligibility when the Member refuses long term care services that have been offered or refuses to allow the Support Coordinator to conduct a review visit in accordance with the required timeframes and locations but do not wish to withdraw from the ALTCS program.

3. The Support Coordinator shall complete and send an eMCR and documentation that further describes the circumstances of a Member's refusal to accept ALTCS services or allow a Support Coordinator to conduct a review visit to the AHCCCS Division of Health Care Management Medical Management Unit.

4. The Support Coordinator shall complete an eMCR to notify AHCCCS when the Member anticipates being out-of-state or has been out-of-state for more than 30 days.

5. The Support Coordinator shall complete an eMCR to notify AHCCCS when the Member has returned to Arizona when the Member has been out-of-state for more than 30 days.

Signature of Chief Medical Officer: Anthony Dekker (Aug 2, 2023 13:16 PDT)

Anthony Dekker, D.O.

1620-E SERVICE PLAN MONITORING AND REASSESSMENT STANDARDS

REVISION DATE: 07/19/2023
EFFECTIVE DATE: July 6, 2021
REFERENCES: A.R.S. §36-551, AMPM Chapter 1620-E

PURPOSE

This policy establishes the requirements for service plan monitoring and reassessment visits for Members who are eligible with Arizona Long Term Care Services (ALTCS).

DEFINITIONS

1. "Home and Community-Based Services (HCBS)" means home and community-based services, as defined in R6-6-1501.
2. "Member" means the same as "client" as defined in A.R.S. § 36-551.
3. "Own Home" means a residential dwelling that is owned, rented, leased, or occupied by a Member, at no cost to the Member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting, or an institution, or a portion of any of these that is licensed or certified by a regulatory agency of the state as a:

a. Health care institution under A.R.S. § 36-401.

b. Residential care institution under A.R.S. § 36-401.

c. Community residential setting under A.R.S. § 36-551, or

d. Behavioral health facility under 9 A.A.C. 20, Articles 1, 4, 5, and 6 (A.A.C.R9.101).

4. "Person-Centered Service Plan (PCSP)" means a written plan developed through an assessment of functional need that reflects the services and supports (paid and unpaid) that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such services and supports. The PCSP will also reflect the Member's strengths and preferences that meet the Member's social, cultural, and linguistic needs, individually identified goals and desired outcomes and reflect risk factors (including risks to Member)

5. "Planning Document" means a plan which is developed by the Planning Team, such as an Individualized Family Service Plan (IFSP), or Person-Centered Service Plan (PCSP).

6. "Planning Team" means a group of individuals that shall include the member, responsible person (as applicable), support coordinator, and a representative from the agency for Members

living in a licensed setting and with the Member's consent, and any individuals important in the Member's life, including but not limited to extended family members, friends, service providers, community resource providers, representatives from religious/ spiritual organizations, and agents from other service systems. The size, scope, and intensity of involvement of the team members are determined by the objectives of the Planning Team to best meet the needs and individual goals of the member.

7. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability, or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed as cited in A.R.S 36-551
8. "Serious Mental Illness (SMI)" means a designation as defined in A.R.S. §36-550 and determined in an individual 18 years of age or older
9. "Serious Mental Illness Determination" means a determination as to whether or not an individual meets the diagnostic and functional criteria established for the purpose of determining an individual's eligibility for SMI services.

10. "Special Assistance" means the support provided to a Member designated as Seriously Mentally Ill (SMI) who is unable to articulate treatment preferences and/or participate effectively in the development of the Service Plan, Inpatient Treatment, and Discharge Plan (ITDP), grievance and/or appeal processes due to cognitive or intellectual impairment and/or medical condition.
11. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. SERVICE PLAN MONITORING AND REASSESSMENT VISITS FOR MEMBERS ELIGIBLE FOR LONG TERM CARE SERVICES (ALTCS)

1. The Support Coordinator shall be responsible for the ongoing assessment and monitoring of the needs, services, and residential service setting of each Member they are assigned to assess including, but not limited to:
    a. The continued suitability and cost effectiveness of the services and residential service setting in meeting the Member's needs, and
    b. The quality of the care delivered by the Member's service

providers.

2. The Support Coordinator shall complete the Planning Meeting with the Member present as the Planning Document is about the Member being served.
3. The Support Coordinator shall encourage the Member to actively engage and participate in the development of their Planning Document to the greatest extent possible.
4. The Support Coordinator shall conduct the Planning Meetings where the Member receives services, including the Member's Own Home and other service settings.
    a. The Support Coordinator shall conduct the Planning Meetings with the Member and the Responsible Person, if applicable, in the Member's Own Home at least twice annually to evaluate the living environment, identify potential barriers to quality care, and assess for unmet needs.
    b. The Support Coordinator shall conduct the Planning Meeting once a year at one of the Member's service setting locations when a Member receives services in a setting outside of the home.

c. The Support Coordinator shall conduct the remaining Planning Meetings at an alternate location that is not a service setting when the Responsible Person chooses an alternate location for the Planning Meeting.

i. The Support Coordinator shall conduct the Planning Meeting at a service setting or an alternate service setting site, when it is convenient for the Responsible Person and not for the convenience of the Support Coordinator or providers.

ii. The Support Coordinator shall document the Responsible Person's choice of location in the Member's case file.

5. The Support Coordinator shall complete a Planning Document:

a. At the time of the initial Planning Meeting,

b. When there are any changes in services, and

c. At the time of each Planning Meeting, as specified in section B of this Policy.

6. The Support Coordinator shall provide a copy of the signed Planning Document that includes the Responsible Person's indication of whether they agree or disagree with each service

authorization.

B. TIMELINES FOR COMPLETING AND MONITORING THE PLANNING DOCUMENT

1. The Support Coordinator shall complete a Planning Meeting every 90 days for Members in the following scenarios:
    a. Living in their "Own Home".
    b. Residing in a Child or Adult Developmental Home.
    c. Residing in a group home and the Member is under the age of 12 years old.
    d. Residing in a group home and the Member is medically involved, regardless of age.
    e. Members receiving behavioral health services and/or medication monitoring from a behavioral health provider through their DDD health plan regardless of the Member's living arrangement.
2. The Support Coordinator shall complete a Planning Meeting every 180 days for Members in the following scenarios:
    a. The Member is 12 years or older, residing in a group home, and not receiving behavioral health services through the Member's ALTCS health plan, and not medically involved.

b. The Member is residing in a Skilled Nursing Facility (SNF), Intermediate Care Facility/Intellectually Disabled (ICF/ID), or other institutional setting, and not receiving behavioral health services from a behavioral health provider through their DDD health plan.

i. The Support Coordinators shall attend the facility's care planning meetings on a periodic basis to discuss the Member's needs and services jointly with the Responsible Person and the assigned District Nurse when the Member is in an SNF.

ii. The Support Coordinator shall consult with facility staff, the Responsible Person, the assigned District Nurse, and when appropriate, the Division's health plan representative during Planning Meetings to assess changes with the Member and whether discharge from the SNF should be considered.

iii. The Support Coordinator shall request a copy of the facility's Care Planning Meetings to be included as part of the Member's Planning Document and as part of the Member's file.

c. The Member is receiving hospice services in an institutional setting, even if it is a non-Medicare-certified institutional setting.

3. The Support Coordinator shall complete the 90-day Planning Meeting on-site or by telephone, as requested by the Responsible Person when the Member is in Long Term Care and Acute Care Only (LTC/ACO) status and is living in their Own Home and currently does not want or does not need Long-Term Services and Support in LTC/ACO status.

a. The Support Coordinator shall document in the Member's file the Responsible Person's request to conduct the meeting, other than in the Member's Own Home.

b. The Support Coordinator shall complete an on-site home visit with the Member at least once every 12 months.

C. ADDITIONAL MONITORING

1. The Support Coordinator shall respond to the Responsible Person's questions and requests, within 48 hours, not including holidays and weekends, when the Responsible Person contacts the Support Coordinator between regularly scheduled Planning Meetings to ask questions, discuss changes or needs, and to

request a meeting with the Support Coordinator.

2. The Support Coordinator shall take appropriate action when they identify or are notified of an urgent or a potential emergency situation.
    a. The Support Coordinator shall conduct an emergency visit when the situation is urgent and cannot be handled over the telephone.
    b. The Support Coordinator shall be required by law to report to a police officer or protective service worker, when the Support Coordinator identifies any instance of abuse or neglect during the course of a Planning Meeting or during any other contact with the Member.
    c. The Support Coordinator shall report urgent or potential emergencies to Support Coordination management to determine the level of intervention and appropriate action, including referral to quality management.
3. The Support Coordinator may provide more frequent case monitoring following the occurrence of an urgent or emergent need or change of condition, which may require revisions to the existing Planning Document.

4. The Support Coordinator, in conjunction with the Division's Health Care Services and Member's DDD health plan, shall assess and authorize adequate services prior to the Member's discharge to the Member's Own Home, community residential setting, or assisted living setting.
    a. The Support Coordinator shall conduct an on-site Planning Meeting within 10 business days following a Member's discharge from an inpatient setting or a change of placement type or from the date the Support Coordinator is made aware of such a change.
    b. The Support Coordinator shall conduct the Planning Meeting to ensure that appropriate services are in place and that the Responsible Person agrees with the Planning Document as authorized.
    c. The Support Coordinator shall conduct a post-discharge Planning Meeting within 10 business days when a Member is discharged from the hospital to a new SNF. A post-discharge Planning Meeting shall not be required for Members discharged from an inpatient hospital stay and returning to the SNF from which they were admitted.

d. The Support Coordinator shall conduct an on-site Planning Meeting within 10 business days post-discharge for Members who are enrolled with ALTCS during an inpatient stay in a hospital.

e. The Support Coordinator shall ensure the provision of services identified through the discharge planning, assess for any unmet needs, and ensure that the Responsible Person agrees with the Planning Document.

5. The Support Coordinator shall work in coordination with the District's Complex Care Specialist and the Member's behavioral health provider to assist with coordination of the Member's discharge needs when a Member has been admitted to a behavioral health inpatient facility.

a. The Support Coordinator shall participate in all scheduled Inpatient Treatment and Discharge Plan (ITDP) Meetings within three days of the Member's admission.

b. The Support Coordinator, with the facility's treatment team and representatives of the Planning Team, shall develop a preliminary ITDP within one day and a full ITDP within seven days of a Member's admission when a Member's

anticipated stay is less than seven days. Refer to A.A.C R9-21-312.

c. The Support Coordinator shall review and participate in the review of the ITDP as frequently as necessary, but at least once within the first 30 days of completing the plan, every 60 days thereafter during the first year, and every 90 days thereafter during any subsequent year that the Member remains in the inpatient facility. Refer to A.A.C R9-21-312.

6. The Support Coordinator shall conduct an on-site Planning Meeting within 30 calendar days when a Member:

a. Moves from a placement type to the same placement type.

b. Starts a new day treatment program or an employment program.

D. ADDITIONAL PLANNING MEETING REQUIREMENTS

1. The Support Coordinator shall meet with the Responsible Person, according to the established standards:

a. The Support Coordinator shall discuss the type, amount, and providers of authorized services.

b. The Support Coordinator shall take and document action taken, when issues are reported or discovered, to resolve

these issues as quickly as possible. The Division shall also be advised of Member grievances and provider issues for purposes of tracking and trending.

c. The Support Coordinator shall assess the Member's current functional, medical, behavioral, and social strengths and needs, including any changes to the Member's informal support system, in accordance with the Needs Assessment and Care Planning Standards as specified in Division Medical Policy 1620-B.

d. The Support Coordinator shall use the Division's, HCBS Member Needs Assessment Tool to review the service hours a Member needs when Attendant Care, Homemaker, and/or Habilitation services shall be authorized for the Member.

e. The Support Coordinator shall utilize the HCBS Member Needs Assessment (Form DDD-2039A) to assess and document the care that is provided and agreed upon by the Member's informal support system.

f. The Support Coordinator shall review the HCBS Member Needs Assessment (Form DDD-2039A) at each Planning

Meeting and include a discussion with the Responsible Person regarding the voluntary provision of informal support.

g. The Support Coordinator shall regularly assess the informal support systems to ensure that the individuals providing the support continue to be willing and able to provide uncompensated care to the Member.

h. The Support Coordinator shall use the Division's Member Level of Care (MLOC) Tool (Form DDD-2096A) to determine the level of care for all Members not residing in an institutional setting.

i. The Support Coordinator shall complete the Member Level of Care (MLOC) Tool (Form DDD-2096A) every 12 months and review the MLOC Tool at least every 180 days or more often as indicated by a change in Member's condition.

j. The District Nurse, in coordination with the Support Coordinator, shall review and complete the AHCCCS Uniform Assessment Tool (UAT) at least once every 180 days for Members residing in an SNF.

i. This review shall include a comparison with facility

documentation. In addition, for Nursing Facilities, this review shall include documentation from the Minimum Data Set (MDS) to determine changes in the Member's acuity level.

ii. The UAT may be updated more frequently than 180 days as requested by the provider for authorization purposes or when there has been a change in the Member's condition.

k. The Support Coordinator shall assess the continued appropriateness of the Member's current placement and services, including whether the Member is residing in the setting of their choice and whether there are any goals that need to be developed and/or risks to manage related to the Member's service or placement decisions and identify risks that may compromise the Member's general health condition and quality of life. The Support Coordinator shall:

i. Assess the cost effectiveness of services provided or requested,

ii. Discuss with the Responsible Person the progress

toward established goals

iii. Identify any barriers to the achievement of the Member's goals,

iv. Develop and prioritize new and/or existing goals as needed

v. Review service delivery options available to the Member, at each Planning Meeting for Members living in or preparing to transition to their Own Home from an institutional setting or to a community residential setting or Assisted Living setting.

vi. Review and document, at least annually, the Member's continued choice of the Member's spouse as the paid caregiver. Documentation shall include the Member's signature on the Spousal Attendant Care Acknowledgment of Understanding (Form DDD-1469A).

vii. Review, at least annually, the Division ALTCS Member Handbook to ensure the Responsible Person is familiar with the contents, especially as related to covered services and their rights and responsibilities.

2. The Support Coordinator shall coordinate with the Member's behavioral health provider for a referral to a qualified clinician, as specified in A.A.C. R9-21- 101(B) for assessment and evaluation when the Planning Team has identified the need for a Serious Mental Illness Determination. See the Division's Medical Policy 320-P for further details.
3. The Support Coordinator shall coordinate with the assigned advocate from the Office of Human Rights (OHR) assigned to provide the notification for Special Assistance Members with a Serious Mental Illness Determination in accordance with AMPM Policy 320-R.
4. The Support Coordinator shall coordinate with the behavioral health provider to review and discuss the following items for Members who have a Serious Mental Illness Determination:
    a. The outcome of the assessment, the need for further evaluations, as necessary, and any interim services provided.
    b. The existing Inpatient Treatment and Discharge Plan (ITDP), according to A.A.C. R9-21-312, when applicable.
5. The Support Coordinator shall be responsible for following up

with the behavioral health provider for Members receiving behavioral health services to ensure newly assessed services are initiated within 14 calendar days.

6. The Support Coordinator shall refer the case to the Public Fiduciary or other available resources, such as a Guardian ad Litem (GAL), Private Fiduciary, Tribal Government, or family members when the Member is not capable of making their own decisions, but does not have a guardian and is not capable of making their own decisions, The Support Coordinator shall document in the case file the reason a Responsible Person is not available.
7. The Support Coordinator shall regularly assess using the Planning Document, Members who reside in a community residential or Assisted Living setting to determine if it is possible to safely meet the Member’s needs in a more integrated setting.
8. The Support Coordinator shall review, at each Planning Meeting, with the Responsible Person, the process for immediately reporting any unplanned gaps in service delivery for Members receiving services in their Own Home.
9. The Support Coordinator shall reconvene the Planning Team to

address the gap and, if needed, identify additional strategies to prevent future occurrences when a gap occurs in one or more of the following services.

a. Attendant Care

b. Respite

c. Nursing

d. Homemaker

e. Habilitation Hourly, and

f. Habilitation – Individually Designed Living Arrangement

10. The Support Coordinator shall contact the appropriate provider to address problems or issues identified by the Responsible Person.

11. The Support Coordinator shall contact the Member's HCBS provider, at least annually, if they are not present at the time of the Planning Meeting, to discuss the ongoing assessment of the Member's needs and status.

    a. The Support Coordinators shall review Provider Progress Reports and follow-up if issues or concerns are identified.

    b. The District Nurse shall contact the Home Health Agency quarterly when the Member is receiving skilled nursing

care and document any input received from the Home Health Agency on the Quarterly Nursing Assessment.

c. The Support Coordinator may need to contact the service provider quarterly, for Members receiving behavioral health services, to complete the behavioral health consultation. Refer to Division Medical Policy 1620-G for further details.

12. The Support Coordinator shall refer the case to the Division's Medical Director for review when the Support Coordinator and PCP or attending physician disagree regarding the need for a change in acuity, placement, or physician's orders for medical services. The Medical Director shall be responsible for reviewing the case, discussing it with the PCP or attending physician if necessary, and making a determination to resolve the issue.
13. The Support Coordinator shall discuss with the Responsible Person any potential changes that may necessitate a change of placement or services, determined through the planning process, prior to the initiation of any changes.
14. The Division shall issue a Notice of Adverse Benefit Determination to the Responsible Person in the event of a denial, reduction, termination, or suspension of services, when the

Responsible Person has indicated, on the Planning Document, that they disagree with the type, amount, or frequency of services to be authorized. Refer to 42 CFR 438.404 and Division Operations Policy 414 for more detailed information and specific timeframes regarding the Notice of Adverse Benefit Determinations.

15. The Division shall provide Members who have a Serious Mental Illness Determination the option to choose between the appeal process for Members who have received a Serious Mental Illness Determination or the standard appeal process. Refer to Division Operations Policy 446.
16. The Support Coordinator shall be aware of the following regarding Members eligible to receive hospice services:
    a. The Responsible Person may elect for the Member to receive hospice services which may be covered by private insurance or Medicare, or by ALTCS if no other payer source is available.
    b. The Medicare hospice benefit shall be divided into two 90-day election periods. Thereafter, the Member may continue to receive hospice benefits in 60-day increments.

A physician shall recertify hospice eligibility at the beginning of each election period, and

c. The Responsible Person shall have the right to revoke the election of Medicare hospice care at any time during the election period and resume ALTCS coverage; however, any remaining days of coverage are then forfeited for that election period.

d. A Responsible Person may also, at any time, again elect to receive Medicare hospice coverage for any other hospice election periods for which they are eligible.

e. The hospice agency shall be responsible for providing covered services to meet the needs of the Member related to the Member's hospice-qualifying condition. Medicaid services provided to Members receiving Medicare hospice services that are duplicative of Medicare hospice benefits shall not be covered.

f. The Support Coordinator may assess and authorize attendant Care services in conjunction with hospice services.

i. The Division shall provide the attendant care service

when the hospice agency is unable or unwilling to provide or cover medically necessary services related to the hospice diagnosis. Refer to the Division's Medical Policy 310-J, for additional information regarding hospice services.

17. The Support Coordinator shall only complete a Member Change Report (eMCR) for Members who are ALTCS. The Support Coordinator shall be responsible for using the eMCR process to notify AHCCCS of a variety of changes in the Member's status. Refer to AMPM 1620-2 for a hard copy of the eMCR form and refer to the ALTCS Member Change Report User Guide on the AHCCCS website, for instructions on completing the eMCR.
18. The Support Coordinator shall update the information in Focus as the Division electronically transmits some data fields to AHCCCS.

E. RESPONSIBLE PERSON'S REFUSAL TO COOPERATE

1. The Division shall issue a Notice of Adverse Benefit Determination to the Responsible Person, indicating the reason(s) for the denial or discontinuance of services when a Support Coordinator is unable to conduct a Planning Meeting, as specified above, due to the Responsible Person's refusal to

cooperate with the provisions, services cannot be evaluated for medical necessity and therefore shall not be authorized.

2. The Support Coordinator shall send a letter to the Responsible Person requesting contact by a specific date within 10 business days to schedule a Planning Meeting.
3. The Support Coordinator shall contact the local ALTCS office to see if they have the Member's current contact information when there is no response by the designated date on the letter.
4. The Support Coordinator shall send an eMCR after 30 days of no contact with a Responsible Person indicating loss of contact to the local ALTCS Eligibility office for possible disenrollment from the ALTCS program.
    a. The Division shall not disenroll a member when the local ALTCS office is able to contact the Responsible Person and confirm the Responsible Person does not wish to withdraw from the ALTCS program.

Signature of Chief Medical Officer: Anthony Dekker (Jul 13, 2023 09:11 PDT)

Anthony Dekker, D.O.

1620-G BEHAVIORAL HEALTH STANDARDS

REVISION DATE: 12/22/21
EFFECTIVE DATE: March 3, 2021
SUPERSEDES: 5/13/16
REFERENCES: A.R.S. § 32-3251; A.A.C. R4-6-101, R9-10-101(25)

PURPOSE: This policy establishes Support Coordination requirements for DDD ALTCS eligible members needing or receiving behavioral health services.

The Division covers behavioral health services for members eligible for ALTCS and the Division regardless of the health plan they choose. The responsibilities of the Division for providing behavioral health services to members are outlined in this policy, including additional requirements for members that have chosen Tribal Health Program (THP) as their health plan. The Division is responsible for collaborating with tribal entities and behavioral health providers to ensure access to services for THP members.

DEFINITIONS

Behavioral Health Professional (BHP)

1. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:
    a. Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251, or
    b. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S.§32-3251 under direct supervision as defined in A.A.C. R4-6-101,
2. A psychiatrist as defined in A.R.S. §36-501,
3. A psychologist as defined in A.R.S. §32-2061,
4. A physician,
5. A behavior analyst as defined in A.R.S. §32-2091,
6. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or
7. A registered nurse with:
    a. A psychiatric-mental health nursing certification, or
    b. One year of experience providing behavioral health services.

POLICY

The following standards apply to members who are ALTCS eligible and need or receive behavioral health services.

A. Direct referrals for behavioral health services may be made by the member/responsible person, Support Coordinator, or a health care professional.

1. When the Support Coordinator receives a request for behavioral health services from the member/responsible person, the Support Coordinator shall send a referral to a behavioral health provider for an initial assessment.

2. When the Support Coordinator identifies the need for behavioral health services, the Support Coordinator shall document the member/responsible person's agreement to services prior to submitting a referral.

3. Referrals shall be made by the Support Coordinator within one business day from the day that the request for behavioral health services was received or the need identified.

B. As appropriate, the Support Coordinator will send a referral for serious mental illness determination to the behavioral health entity. See Division Medical Policy 320-P for further details regarding the behavioral health entity's responsibilities for serious mental illness determination.

C. The Support Coordinator shall ensure members receive behavioral health services in accordance with Behavioral Health Appointment Standards as delineated in Division Operations Policy 417.

1. Urgent need appointments: As expeditiously as the member's health condition requires but no later than 24 hours from identification of need.

2. Routine care appointments:

a. Initial assessment within seven calendar days of referral or request for service, and

b. The first behavioral health service following the initial assessment as expeditiously as the member's health condition requires but:

i) For members age 18 years or older, no later than 23 calendar days after the initial assessment, and

ii) For members under the age of 18 years old, no later than 21 calendar days after the initial assessment.

c. All subsequent behavioral health services as expeditiously as the member's health condition requires but no later than 45 calendar days from identification of need.

3. For psychotropic medication appointments, the behavioral health entity shall assess the urgency of the need. If clinically indicated, the practitioner shall provide an appointment that ensures that the member:

a) Does not run out of needed medications, or

b) Does not decline in his/her behavioral health condition prior to starting medication but no later than 30 days from the identification of need

4. The Support Coordinator shall follow-up with the behavioral health entity to ensure the member receives timely behavioral health appointments and services.

D. The Support Coordinator shall ensure there is communication with the member's primary care provider and behavioral health providers involved in the member's care and that care is coordinated with other agencies and/or other providers involved in the member's care.

E. For members exhibiting challenging behaviors (new or existing), additional or new interventions may be warranted to support the member in the current setting. The Support Coordinator shall ensure the timely involvement of a Behavioral Health Professional to assess, develop a care plan and preserve the current placement (if possible). For members residing in a non-behavioral health setting refer to AdSS Medical Policy 310-R for information on acute behavioral health situations.

F. Support Coordination for a member receiving behavioral health services shall be provided in collaboration with a qualified behavioral health professional in those cases where the Support Coordinator does not meet the qualifications of a Behavioral Health Professional as defined in A.A.C. R9-10-101. The consultation does not have to be with the provider of behavioral health services. It may be with a qualified designee within the Division.

G. The Support Coordinator shall make contact with the behavioral health professional prior to the initial behavioral health consultation for all members receiving/needing behavioral health services. At minimum, quarterly discussions (or more frequent, as warranted) between the Support Coordinator and the behavioral health professional are required as long as the member continues to receive/need behavioral health services.

H. Initial and quarterly discussions are not required for members who are stable on psychotropic medications and/or are not receiving any behavioral health services other than medication management.

1. The Support Coordinator shall document the content and results of the initial and quarterly discussions with the behavioral health professional. The

discussion must be a communication between the Support Coordinator and a behavioral health professional regarding the member's status and plan of treatment. A report received and placed in the member's case file by the Support Coordinator from the behavioral health professional does not meet the requirement for initial and quarterly discussions between the Support Coordinator and the behavioral health professional.

I. As part of the care planning and service plan monitoring, the Support Coordinator shall review the psychotropic medications being taken by the member. Only those medications used to modify behavioral health symptoms need to be included in this special monitoring. Examples of medication uses that do not require this monitoring are sedative hypnotics when used to treat insomnia or on an as needed basis prior to a procedure, anti-anxiety medications used for muscle spasms and anticonvulsants used to treat a seizure disorder.

J. Documentation of the medication review shall be evident in the member case file. The review shall take place at each Planning Meeting and include the purpose of the medication, the effectiveness of the medication, and any adverse side effects that may have occurred. Any concerns noted (for example, medication appears to be ineffective, adverse side effects are present, multiple medications apparently prescribed for the same diagnosis) shall be discussed with the behavioral health consultant and/or prescribing practitioner. The Planning Document and electronic progress notes shall reflect this discussion and include a plan of action to address these issues.

K. Support Coordinators are responsible for identifying, assisting with, and monitoring the special needs and requirements related to members who are unable or unwilling to consent to treatment (i.e., petitioning, court-ordered treatment and judicial review). The Support Coordinator shall document in the member's electronic progress notes a coordination with the behavioral health entity related to these activities.

L. The behavioral health code is updated in Focus at the time of each behavioral health professional consultation.

1620-K SKILLED NURSING NEED STANDARD

EFFECTIVE DATE: February 2, 2022
REFERENCES: AMPM 1620-K, Medical Policy Manual 1240-G, Medical Policy Manual Exhibit 1240G-1

PURPOSE

This policy establishes support coordination standards for members with skilled nursing needs.

DEFINITIONS

Division Contracted Nursing Agency is a Medicare Certified Home Health Agency (HHA) that is licensed by the Arizona Department of Health Services (ADHS), registered with AHCCCS, and contracted with the Division of Developmental Disabilities.

Institutional Settings are a long-term care arrangement in which skilled nursing services can be provided. Institutional Settings include:

- Nursing facility, including religious non-Medical Health Care Institution
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- Behavioral Health Inpatient Facility
- Institutions for Mental Disease (IMD) and
- Inpatient Behavioral Health Residential Treatment Facility

Non-Institutional (Home and Community Based/HCBS) Settings are a long-term care arrangement in which skilled home health nursing services can be provided. Non-Institutional Settings/HCBS settings include:

- A members "own home", as defined in A.A.C. R9-28-101(B)
- Assisted Living Facility
- DDD Group Home
- DDD Adult & Child Developmental Home
- Behavioral Health Residential Facility

POLICY

In conjunction with the Health Care Services (HCS), the Support Coordinator is responsible for ensuring that a member who has skilled nursing needs is provided with the monitoring and care necessary to meet the member's individual needs. District Nurses do not provide "hands on" direct nursing but are available to assist Support Coordinators with assessing and coordinating care related to the member's overall physical health.

A. Non-Institutional/HCBS Settings

1. A member who has skilled nursing needs (e.g., pressure ulcers, surgical wounds, tube feedings, and/or tracheotomy) shall be referred to the Division's Health Care Services (HCS) for the initial assessment. Refer to the Division's Medical Policy Manual, Exhibit 1240G-1 for a list of medical conditions and

needs that require skilled nursing tasks.

2. To assist with coordination of care and improve the member's overall health, there are other circumstances in which a referral for a nursing assessment shall be initiated by the Support Coordinator. These situations include, but not limited to:
   a. The member is at risk of compromised skin integrity (e.g., impaired circulation, obesity, extreme weight loss, difficulty shifting their weight in a bed or chair, autoimmune disorders, etc.)

   b. The member has a history of medical instability (e.g., frequent and/or uncontrolled seizures, unstable diabetes)

   c. The member has a change in behaviors not explained by a change in behavior treatment plan or behavioral medications, and consultation with a Qualified Behavioral Health Professional already occurred.

   d. Has multiple medical and/or behavioral challenges

   e. The member is over the age of 21 and has extensive dental concerns including decay, infection, or pain

   f. There has been a change in medical condition, a new skilled nursing need, or a change to an existing skilled nursing need

   g. There have been three or more trips to the Emergency Room in a six-month period

   h. Has multiple admissions to the hospital within 30 days

   i. Has been enrolled or will be enrolled in hospice care

   j. An enhanced ratio in Day Treatment and Training Program due to a medical condition is being considered by the member's Planning Team.

3. The Support Coordinator shall submit a referral to HCS for a skilled nursing assessment within two days of the date the potential need for nursing was identified. The Support Coordinator can also contact the District Nurse if they are unsure if a referral for a nursing assessment is needed.

4. The District Nurse will coordinate a meeting with the member/responsible person and Support Coordinator and complete the nursing assessment for skilled nursing services within 14 days of the referral. When possible, the Support Coordinator shall attend the nursing assessment and any follow up re-assessments. These joint meetings will assist with the coordination of care and services to meet the member's needs.

5. The member shall be monitored for skilled nursing needs by the District Nurse at least every 90 days and more frequently as needed. The District Nurse can make recommendations to the Primary Care Provider (PCP) and to the planning team for continued monitoring.

6. Upon receiving the authorization for nursing services, the Division contracted nursing agency shall obtain an order from the Primary Care Provider (PCP) to perform duties related to home nursing care. The plan of care shall be reviewed by the member's Planning Team and incorporated into the member's Planning Document. For further information regarding the details included in a nursing plan of care, see Medical Policy Manual 1240-G

7. If the member/responsible person refuses a nursing assessment or the skilled nursing service, the District Nurse and Support Coordinator shall inform the member/responsible person of the possible risks of refusing such care. The District Nurse shall utilize a Managed Risk Agreement (MRA) to document the reason given for refusing the recommended care and that the member/responsible person has been informed of the risks. The member/responsible person shall sign this agreement.

    a. If the member is requesting an alternative service be provided in lieu of skilled nursing (e.g., Attendant Care or Habilitation), the MRA shall document the member/responsible person's understanding that when the Attendant Care or other alternative service is utilized, skilled tasks shall not be provided and will not be paid for by the Division."

    b. The member's PCP shall also be informed by the District Nurse or Support Coordinator of the member/responsible person's refusal for skilled nursing care.

Refer to Division's Medical Policy 1240-G, for additional guidelines regarding medically necessary home health services for members.

B. Institutional Settings

1. The facility is responsible for providing appropriate care to meet the needs of each member who is at risk of compromised skin integrity (e.g., being bedridden, quadriplegia, or having a history of medical instability such as frequent seizures, unstable diabetes, COPD) and members who require skilled nursing for other conditions such as pressure ulcers, surgical wounds, and/or pain management.

2. Every 90 days, the District Nurse shall consult with the appropriate facility staff and review treatment record(s) and other Level of Care (acuity) documentation related to the member's condition and progress.

Refer to the Division's Medical Policy Chapter 1210, for additional information regarding services provided in these settings.

C. Documentation

1. The initial referral by the Support Coordinator for a nursing assessment shall be included as part of the member's case file. In addition, the date the referral was sent to HCS along with any communication regarding the referral shall be documented in the member's Focus progress notes.

2. All assessments and monitoring re-assessments completed by the District Nurse shall be sent to the Support Coordinator and included as part of the member's case file.

3. The District Nurse shall ensure the signed Plan of Care received from the Division contracted nursing agency is included in the member's case file and documented in the Focus progress notes.

4. If the member is residing in a Skilled Nursing Facility (SNF), the SNF Uniform Assessment Tool (aka acuity tool) completed by the District Nurse shall be included in the member's case file.

5. If the member is residing in an institutional setting, the member's progress related to specific skilled nursing needs, including compliance related to prescribed treatments, shall be documented in the member's case file.

Discussions regarding the member's needs, including action items and services identified to coordinate and meet the member's needs, shall be incorporated into the member's Planning Document, and documented in the member's file.

1620-L CASE FILE DOCUMENTATION

REVISION DATE: 11/8/2023, 3/9/2022
EFFECTIVE DATE: September 8, 2021
REFERENCES: 45 CFR Part 164, 42 CFR Part 2, A.R.S. § 12-2297, AMPM 1620-L, AMPM Exhibit 1620-3,, Division Medical Policy 680-C, 1620-B, and 1620-D

PURPOSE

This policy establishes the Division's requirements to maintain complete and accurate documentation in the Member's case file that details coordination of care activities. These requirements also ensure the Division's actions provide Members with effective and efficient coordination of care.

DEFINITIONS

1. "Health Insurance Portability and Accountability Act (HIPAA)" means the Health Insurance Portability and Accountability Act; also known as the Kennedy-Kassebaum Act, signed August 21, 1996 as amended and as reflected in the implementing regulations at 45 CFR Parts 160, 162, and 164.

2. "Member" means the same as "client" as defined in A.R.S. § 36-551.

3. "Planning Document'' means a written plan developed through

an assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such services and supports.

4. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed as defined in A.R.S. §36.

5. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

6. "Specialized Services" means these are recommended services resulting from the PASRR Level II evaluation that are beyond those normally provided and included in the nursing facility (NF) NF daily rate. These services have three key characteristics:

    a. They are individualized needs related to a person's Intellectual Disability and/or a related condition, as identified in the Level II evaluation.

b. They are provided to the individual during their residency in the NF.

c. They exceed the services a NF typically provides under its daily rate. Recall that PASRR applies to any individual applying for admission to a Medicaid-certified nursing facility, regardless of insurance type.

POLICY

A. MEMBER ELECTRONIC AND PAPER RECORDS

1. The Division shall maintain a system of record keeping that maintains Member case file documentation in a secure and organized manner.

2. The Division shall utilize electronic systems to track and maintain Member case files.

   a. The Division shall maintain the system which includes:

      i. The management of information regarding Member demographics, services plans, authorization, vendor calls, and claims.

ii. Documenting the beginning and ending dates of services listed on the Planning Document, and

iii. The renewal of services and the number of units authorized for services.

iv. Documentation of all actions related to the Member's coordination of care with the Division, the Division's contractors, community partners, or others involved in the Member's care unless otherwise restricted.

b. The Division shall maintain the system which stores the Member case file electronically.

3. The Division shall provide AHCCCS printed documents when requested by AHCCCS.

4. The Division shall adhere to the federal regulations for the Security and Privacy of Protected Health Information found at 45 CFR Part 164 (HIPAA) and for the Confidentiality of Substance Use Disorder Patient Records found at 42 CFR Part 2.

5. The Division shall keep Member case files secured with controlled access by authorized individuals.

a. The Division shall store paper documents in locked file cabinets or behind locked doors after normal business hours and in compliance with department record keeping confidentiality policies.

b. The Division shall ensure the integrity of electronic documentation by having safeguards like firewalls and encryption protocols for digital documents.

B. DIVISION STAFF RESPONSIBILITIES

1. Division staff shall be responsible for maintaining complete and comprehensive case file documentation for each Member.

2. Division staff shall provide documentation that is complete, accurate, timely, and reflective of the Member's programmatic, social, medical, behavioral, developmental, educational, or vocational status.

3. Division staff shall create all documentation in a professional, factual, and objective manner.

4. Division staff shall update the Focus Progress Notes to document Member information changes and completed activities.

5. Division staff shall indicate in the Focus Progress notes the name of the author and document all interactions with and about the Member, the services and supports the Member is receiving, and the status of the Member's case unless otherwise restricted.

6. Division staff shall maintain the Member case file information to the extent, and in such detail, as specified in A.R.S. § 12-2297.

C. SUPPORT COORDINATION RESPONSIBILITIES

1. The Support Coordinator shall, based on the Member's circumstances, document in the Focus Progress Notes, the following care coordination activities:

   a. Documentation of all actions related to providing the Member with coordination of care and benefits, unless otherwise restricted.

   b. Team discussion regarding the need for a new or revised Behavioral Plan (BP) needed for Home and Community Based Services (HCBS) provided by an independent provider or Qualified Vendor in response to the use of Emergency Measures two or more times within a 30-day period, or with an identifiable pattern.

c. The results of screening for side effects of behavioral modifying medication and tardive dyskinesia.

d. Referrals for Behavioral Health services, a Care Manager, a Behavioral Health Advocate. Referrals for community services.

e. The Support Coordinator's response to notifications of Member Emergency Room visits and Crisis Contacts.

f. Documentation of the outcome of initial and quarterly consultations with the Behavioral Health Professional.

g. Support Coordinator action regarding referrals to Health Care Services (HCS), Member hospitalization and discharge planning, and the use of Emergency Alert Systems.

h. Any other activities or correspondents that may be related to Member care coordination.

2. The Support Coordinator shall include and maintain the following in the Member case files.

a. Member demographic information, including residence address and telephone number, and the emergency contact

person and his/her telephone number.

b. Identification of the Member's primary care provider (PCP),

c. For Members residing in a nursing facility, the AHCCCS Uniform Assessment Tool (UAT)/(acuity tool) is completed at least annually by a Nurse, see AMPM Exhibit 1620-3.

d. The Member Level of Care Tool for all Members residing in a community-based setting at least annually by the Support Coordinator and when the circumstances of the Member changes.

e. Information from the Planning Meetings that addresses the following:

   i. Member's ability to be present and participate in the Planning Meeting and any needed accommodations for the Member to participate in the Planning Meeting.

   ii. Documentation describing the Member's involvement in their planning meeting including the support coordinator's interactions with the Member.

iii. Member's current medical, functional, and behavioral health status, including strengths and needs, in accordance with the requirements outlined in Division Medical Policy 1620-B,

iv. The appropriateness of the Member's current residential setting and services in meeting his or her needs, including the potential of the Member to move to a less restrictive setting.

v. The cost effectiveness of ALTCS services being provided,

vi. Identification of family, an informal support system, and community resources and their availability and willingness to assist the Member as uncompensated caregivers, including barriers to assistance,

vii. Identification of service issues and unmet needs, an action plan to address needs, and documentation of timely follow-up and resolution,

viii. A detailed description of the Member's objectives and

services for each behavioral health agency providing services to the Member,

ix. Documentation of the Member's progress toward identified goals and any strategies toward overcoming barriers as outlined in Division Medical Policy 1620-B,

x. Environmental details, which may include any safety concerns in the Member's home, or other special needs.

xi. Behavioral Plan developed by the Member's team in accordance with Article 9. See Behavioral Supports Manual Chapter 700.

xii. Documentation of all actions and information that is relevant to providing the Member with coordination of care unless otherwise restricted.

f. Copies of the Member's signed Cost Effectiveness Studies (CES) Worksheets, placement history, Planning Documents, and service authorizations.

g. Copies of the signed Planning Documents that are signed by the Responsible Person at each planning meeting.

h. A copy of the HCBS Member Needs Assessment (Form DDD-2039A) completed for all Members receiving Attendant Care, Homemaker, or Habilitation services that indicates how the service hours were assessed and which portions of care, if any, are provided by the Member's informal support system.

i. A copy of the Contingency/Backup Plan (Form DDD-2113A) and other documentation that indicates the Responsible Person has been advised regarding how to report unplanned gaps in services provided by an Independent Provider (IP) as outlined in Division Medical Policy 1620-D.

j. A copy of the Spouse Attendant Care Acknowledgement of Understanding (Form DDD-1469A) for any Member choosing to have his or her spouse as the paid caregiver, both before that service arrangement is initiated and annually to indicate the Member's continued choice for this option,

k. A copy of the Managed Risk Agreement (Form DDD-1530A), when indicated for the Member, that identifies potential risks associated with service or placement decisions the Responsible Person has madeor other risks identified whereby a Managed Risk Agreement was completed.

l. Notices of Adverse Benefit Determination along with any adjudication or decisions sent to the Responsible Person regarding denial or changes of services,

m. Member-specific correspondence

n. Evaluation and other records demonstrating eligibility and redeterminations of eligibility.

o. Physician’s orders for medical services and equipment,

p. Documentation that a Pre-Admission Screening and Resident Review (PASRR) Level I screening and PASRR Level II evaluation, if applicable, have been completed for Members in nursing facility placements. A copy of the PASRR Level II evaluation, if applicable, must also be

retained in the Member's case file. For further details regarding PASRR, see Division Medical Policy 680-C.

q. Documentation of recommended specialized services, as applicable, shall be coordinated and documented in the Member case file to ensure the provision of specialized services to the Member. For further details regarding this, see Division Medical Policy 680-C.

r. Provider evaluations and assessments or progress reports ,

s. Notifications of services not provided as scheduled and documentation of any follow-up conducted to ensure that Member's needs are met,

t. Documentation of the initial and quarterly discussion with a qualified behavioral health professional, when applicable,

u. All forms and documentation as required by the Division to provide the Member with coordination of care unless otherwise restricted.

3. The Support Coordinator shall include in the initial on-site

Planning for Members receiving Home and Community Based Services (HCBS already in place at the time of ALTCS enrollment) an assessment of the medical necessity and cost effectiveness of those services and a service plan that indicates which Prior Period Coverage (PPC) services will be retroactively authorized by the Division. For further information, see Division Operation Policy 302.

D. ENSURING MEMBER SPECIFIC PROGRESS NOTES

1. Division staff shall not cut and paste, or otherwise copy, Member correspondence into the Member's file.
2. Division staff shall not use templates, or other standardized templates, that are not specific to the Member.
3. Division staff shall not rely on system generated progress notes as the primary source of information when documenting in the Focus progress notes.

1620-N SERVICE CLOSURE AND CASE CLOSURE

EFFECTIVE DATE: September 8, 2021
REFERENCES: AMPM 1620-N

PURPOSE

The purpose of this policy is to identify the reasons an ALTCS covered service may be ended and to specify the steps needed when case closure should be pursued for a member currently enrolled with the Division.

DEFINITIONS

Arizona Health Care Cost Containment System (AHCCCS) – The state agency that is responsible for determining eligibility for Arizona Long Term Care Services (ALTCS).

Notice of Adverse Benefit Determination (NOA) – The written notice to the member regarding an Adverse Benefit Determination.

Office of Administrative Review (OAR) – The unit within the Division of Developmental Disabilities that processes and ensures adjudication of appeals and grievances.

POLICY

Service Closures

A. Closure of a member's service(s) may occur for various reasons, including, but not limited to:

1. The member is no longer ALTCS eligible as determined by AHCCCS.

    a. If the member has been determined ineligible for ALTCS, the member/responsible person will be informed of this action and the reason(s), in writing, by AHCCCS. This notification will provide information about the member's rights regarding that decision.

    b. The Focus task is the Division's "official" notification from AHCCCS that a change in the member's ALTCS eligibility has occurred. Thus, it is critical Support Coordinators review Focus tasks daily and take immediate action regarding services if notified that a member has been disenrolled from ALTCS.

2. The Support Coordinator has assessed a service as no longer necessary.

3. The Therapist, Division District Nurse or other clinician determines the goals have been met, the service is no longer medically necessary, or cost effective.

4. Physician has determined that a service is no longer necessary.

5. The member/responsible person requests discontinuance of a service.

6. The member/responsible person refuses to meet to re-assess the continuation of services currently authorized by the Division.

7. For members who are AzEIP eligible, non-ALTCS covered services shall be ended when the member ages out of the AzEIP program.

Case Closure

A. Closure of the member's eligibility with the Division may occur for a variety of reasons, including but not limited to the following situations:

1. The member has passed away.

2. The member moves out of state. If the member is a minor child, residency requirements are dependent upon the residency of the custodial parent.

3. The member/responsible person requests the member's case to be closed with the Division. If the member is ALTCS eligible and wishes to withdraw from the Division, the member/responsible person must first withdraw from ALTCS.

4. The member/responsible person has requested a voluntary withdrawal from the ALTCS program.

   a. A member who is disenrolling from ALTCS will generally remain enrolled through the end of the month in which the eligibility is terminated.

   b. If the member voluntarily withdraws and wants ALTCS benefits to stop immediately, the disenrollment will be effective with the processing of the withdrawal by AHCCCS.

   c. The Support Coordinator shall consult with his/her supervisor to determine if the member's eligibility shall be closed or placed in inactive status (e.g., involvement of protective service agencies, member likely to change his/her mind, request of the member/responsible person, etc.).

5. The member is no longer eligible for the Division. See the Division's Eligibility Manual for further details regarding eligibility criteria and redetermination requirements.

6. The member reaches the age of eighteen and does not wish to reapply for continuation of eligibility with the Division.

7. Contact has been lost with member and their responsible person. This includes members who have moved from the previous residence and the SC is unable to locate.

a. All communication methods available to the Support Coordinator (i.e., regular letter, certified letter/return receipt requested, telephone, email, text) have been unsuccessful.

b. Prior to pursuing case closure, the Support Coordinator shall consult with their Supervisor and ensure due diligence has been made to make contact and determine why attempts were unsuccessful.

c. If the member is ALTCS eligible, the Support Coordination shall continue attempts to schedule a meeting.

d. AHCCCS will not disenroll the member from the ALTCS program if they are able to contact the member/responsible person.

B. The member continues to be the responsibility of the Division until the member's disenrollment is processed by AHCCCS and the Division is notified via AHCCCS roster. The Support Coordinator shall be notified via a Focus task of the member's disenrollment.

1. Members are eligible to receive medically necessary services through their ALTCS disenrollment date.

2. The Support Coordination shall comply with all AHCCCS requirements, including scheduling and conducting Planning meetings until the member has been disenrolled from ALTCS.

C. For members who are DD only or Targeted Support Coordination eligible the member can be disenrolled at any time.

Notices

A. Notice of Adverse Benefit Action – If a previously authorized service is terminated, suspended, or reduced as no longer medically necessary or cost effective for an ALTCS eligible member, the member/responsible person shall be given a Notice of Adverse Benefit Determination (NOA) regarding the plan to discontinue the service. The NOA shall contain information about the member/responsible person's rights regarding the decision. A NOA is not required if the member/responsible person agrees to the reduction or termination. See Division Operations Policy 414 for additional details regarding NOA requirements.

B. No Show Letter (DDD-2066A) - If a member has a planning meeting scheduled, and does not show, and does not attempt to contact the Division in advance of the meeting to reschedule, then the Support Coordinator shall send a DDD-2066A No Show Letter by regular and certified mail.

C. Loss of Contact Letter (DDD-2065A) – If a member enrolled with the Division cannot be located, then the Support Coordinator shall send a DDD-2065A Loss of Contact Letter via certified and regular mail. If there is no response within required timelines, a Notice of DDD Closure shall be pursued.

D. Notice of DDD Closure (DDD-2028) – When a member is no longer eligible for the Division or chooses to be disenrolled from the Division.

E. The Office of Administrative Review

1. Except in a situation in which a member has passed away, the Division will send a notice to the member/responsible person advising that eligibility for the Division is ended. In addition, the Division will send a Notice of Action (NOA) when an ALTCS covered service is being terminated, suspended, or reduced. The notice shall include the right to request an Administrative Review along with the process for requesting an Administrative Review.

2. The Office of Administrative Review (OAR) will notify the Support Coordinator when a request for Administrative Review is received from the member/responsible person.

3. The Support Coordinator/Supervisor can also contact OAR if there are questions regarding the status of the Administrative Review.

F. The Electronic Member Change Report (eMCR) is the Division's notification to AHCCCS for ALTCS members when there is a change in the member's eligibility for the Division. The AHCCCS eMCR Guidelines provides instructions regarding completing an eMCR on the AHCCCS website.

1. Upon notification of the member's passing, the Support Coordinator shall immediately complete an eMCR.

2. If the member/responsible person requests voluntary withdrawal, the DDD-2083A shall be completed and signed by the member/responsible person. The voluntary withdrawal form shall be attached to the eMCR.

3. When an ALTCS eligible member has been redetermined no longer eligible for the Division, an eMCR shall not be completed until all appeal timeframes have been exhausted. The Support Coordinator/Supervisor can contact OAR if there are any questions regarding the status of any appeals.

a. Once all appeal timeframes have been exhausted, the Support Coordinator shall complete an eMCR requesting a PAS Reassessment. AHCCCS will then evaluate the member for the ALTCS/Elderly Physically Disabled (EPD) program.

b. If the member is determined eligible for the ALTCS/EPD program, the Support Coordinator shall work with the Division's Transition Coordinator to coordinate a transfer between the Division and the ALTCS/EPD Program Contractor. The purpose is to ensure a smooth transition from the Division to the other ALTCS program contractor. Refer to Division Medical Policy 520 for additional information regarding member transitions.

c. If a member is disenrolled from ALTCS, but remains eligible for AHCCCS benefits, the Support Coordinator shall direct the

member/responsible person to the AHCCCS website for information regarding available AHCCCS Complete Care (ACC) Contractors and encourage the member to convey their choice of health plans to the AHCCCS Communication Center at 1-800-962-6690.

Documentation

A. All attempts to contact the member/responsible person and actions taken shall be documented in the member's case record.

B. When the reason for termination is the member's death, the Support Coordinator shall end date the service authorization(s) with the date of death.

C. Upon notification from AHCCCS that the member has been disenrolled from ALTCS, the Support Coordinator shall "end date" the FOCUS authorizations. The Support Coordinator is responsible for notifying service providers when a service has ended, or the member is no longer eligible. Continuation of residential services using state funds shall be prior authorized by the District Program Manager and include a plan for re-applying for ALTCS.

D. The Support Coordinator shall ensure all notices along with any Administrative or Judicial resolution are uploaded into the member's case record in OnBase. All member records shall be stored in accordance with Division Record Retention Policies. For further details, see Division Operations Policy 6001-I and Division Medical Policy 1620-L.

E. The Support Coordinator shall provide the member/responsible person community referral information on available services and resources to meet the needs of members who are no longer eligible for ALTCS and/or the Division. This assistance shall be included as part of the member's case record.

F. The Focus progress notes shall reflect service and case closure activity, including but not limited to:

1. Reason for closure,

2. Member's status at the time of the closures, and

3. Referrals to community resources if the member is no longer ALTCS eligible.

G. The Support Coordinator shall ensure the member's record is complete prior to closing the member's case. This includes, but not limited to, ensuring the member records have been uploaded to OnBase (e.g., communication on behalf of the member, Planning Documents, and other records) and Focus progress notes are updated to reflect steps taken to close the record and the reason for closure.

1620-O ABUSE, NEGLECT, AND EXPLOITATION REPORTING STANDARD

EFFECTIVE DATE: October 6, 2021

REFERENCES: A.R.S. §§ 36-561(B), 13-3620, 46-454, 46-451. Division Operations Manual Chapters 6002-B, 6002-C, and 6002-G

DEFINITIONS

Abuse - Any of the following is abuse:

1. Intentional infliction of physical harm
2. Injury caused by negligent acts or omissions
3. Unreasonable confinement or unlawful imprisonment
4. Sexual abuse or sexual assault

Abusive Treatment - Any of the following is abusive treatment:

1. Physical abuse by inflicting pain or injury to a member. This includes hitting, kicking, pinching, slapping, pulling hair, or sexual abuse.
2. Verbal/Emotional abuse which includes ridiculing or demeaning a member, making derogatory remarks to a member or cursing directed towards a member.
3. Programmatic abuse which is the use of an aversive stimuli technique that has not been approved as part of such person's Planning Document and which is not contained in the rules and regulations adopted pursuant to A.R.S. § 36-561(B). This includes isolation or restraint of a member.

Adult Protective Services (APS) - A program within the Arizona Department of Economic Security that investigates allegations and provides service referrals to protect vulnerable adults from abuse, neglect, or exploitation.

Arizona Department of Child Safety (DCS) - The department established pursuant to A.R.S. § 8-451 to protect children and to perform the following:

1. Investigate reports of abuse and neglect.
2. Assess, promote, and support the safety of a child in a safe and stable family or other appropriate placement in response to allegations of abuse or neglect.
3. Work cooperatively with law enforcement regarding reports that include criminal conduct allegations.
4. Without compromising child safety, coordinate services to achieve and maintain permanency on behalf of the child, strengthen the family and provide prevention, intervention, and treatment services pursuant to this chapter.

Child, Youth, or Juvenile - A member who is under the age of eighteen years.

Exploitation - The illegal or improper use of an incapacitated or vulnerable adult or his/her resources for another's profit or advantage.

Incapacity - An impairment by reason of mental illness, mental deficiency, mental disorder, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication, or other cause to the extent that the person lacks sufficient understanding or capacity to make or communicate informed decisions concerning his/her person.

Neglect - The deprivation of food, water, medication, medical services, shelter, supervision, cooling, heating or other services necessary to maintain a member's minimum physical or mental health. Neglect is an intentional health and safety violation against a member, such as lack of attention to physical needs failure to report health problems or changes in health condition, sleeping on duty, abandoning the workstation, or failure to carry out a prescribed treatment plan.

Neglect of a child includes the substantial risk of harm due to inability or unwillingness of a parent, guardian, or custodian, to care for the child. This includes the inability or unwillingness to provide supervision, food, clothing, shelter, or medical care if that inability or unwillingness causes substantial risk of harm to the child's health or welfare, unless the inability of a parent or guardian to provide services to meet the child with a disability is solely the result of unavailability of reasonable services.

Physical Injury - The impairment of physical condition, including, but not limited to any of the following: skin bruising, pressure sores, bleeding, failure to thrive, malnutrition, dehydration, burns, fracture of any bone, subdural hematoma, soft tissue swelling, injury to any internal organ, or any physical condition which imperils health or welfare.

Serious Physical Injury - A physical injury which creates a reasonable risk of death or which causes serious or permanent disfigurement, serious impairment of health or loss, or protracted impairment of the function of any bodily organ or limb.

Sexual Abuse Any inappropriate interactions of a sexual nature toward or solicited from a member with developmental disabilities.

Vulnerable Adult - A member who is eighteen years of age or older who is unable to protect himself/herself from abuse, neglect, or exploitation by others because of a mental or physical impairment. This includes an incapacitated person as specified in A.R.S. § 14-5101.

POLICY

As designated by law, medical professionals, psychologists, social workers, Support Coordinators, peace officers, and other people who have the responsibility for the care of a child or a vulnerable adult are mandatory reporters. Mandatory reporters who have a reasonable basis to suspect that abuse or neglect or exploitation of the member has occurred must report such information immediately to a peace officer or protection services worker, (i.e., DES/Adult Protective Services (APS), Department of Child Safety, Tribal Social Services).

A. Reporting to the Arizona Department of Child Safety (DCS)

1. The Support Coordinator is a mandatory reporter. The Support Coordinator must immediately report to the Department of Child Safety (DCS) when they suspect abuse or neglect. Additionally, any allegation of abuse or neglect must be reported in accordance with A.R.S. §13-3620 as outlined below. Upon reporting, the Support Coordinator should provide sufficient information regarding the alleged abuse and/or neglect to allow the DCS worker to set the appropriate priority to the case. The Support Coordinator shall cooperate during investigations, and follow-up as required.

2. Reports made regarding American Indians will be in accordance with tribal procedures. Reports are to be made as soon as possible but no later than 24 hours of becoming aware of the concern. Reports shall include the following information:

   a. The names and addresses of the minor and his/her parents or person or persons having custody of such minor.

   b. The minor's age, and the nature and extent of his/her injuries, or physical neglect, including any evidence of previous injuries or physical neglect.

   c. Any other information that such a person believes might be helpful in establishing the cause of the injury or physical neglect.

3. The list of persons with a duty to report a reasonable belief that a minor has been the victim of abuse or neglect is expanded to include any person who is employed as the immediate or next higher-level supervisor to, or administrator of, a person who has a duty to report (other than the child's parent or guardian) and who develops the reasonable belief in the course of the supervisor's or administrator's employment. If the supervisor or administrator reasonably believes that the report has been made by the person with a duty to report, the supervisor or administrator is not required to report.

4. When the Support Coordinator reports alleged abuse or neglect to DCS, the Support Coordinator shall complete an Incident Call Report (DDD-1746A-FORFF) and submit to their District’s Incident Report email address. The Incident Call Report shall indicate the date and time DCS was notified.

   Additionally, if DCS notifies the Support Coordinator of alleged abuse or neglect report made by other than Division personnel, the Support Coordinator shall complete and submit an Incident Call Report.

5. It is the responsibility of DCS to determine whether an investigation of the allegation is necessary and to proceed with the investigation. If, after an investigation, DCS opens a case, the Support Coordinator shall participate in a team staffing to develop a collaborative plan.

B. Working with the Arizona Department of Child Safety (DCS)

1. The Support Coordinator shall work as expeditiously as possible with the DCS worker to resolve any concerns regarding a report or investigation made to DCS.

2. Whenever possible, the Support Coordinator shall meet in person with the DCS worker to review all aspects of the report including any information the Support Coordinator could provide regarding important historical information.

3. The Support Coordinator shall notify his/her immediate supervisor whenever issues cannot be quickly and satisfactorily resolved at the Support Coordination level. Supervisory and/or management staff must immediately pursue the steps necessary to resolve the issues.

4. The Support Coordinator shall collaborate with DCS Specialist and provide them with preliminary findings and recommendations on behavioral health risk factors, symptoms and service needs for court hearings.

C. Reporting to Adult Protective Services (APS)

1. In accordance with A.R.S. §46-454, as a mandatory reporter, the Support Coordinator, or other Division staff, shall immediately report any suspicions/allegations of abuse, neglect, or exploitation of an adult member to Adult Protective Services (APS). APS responds to allegations of abuse, neglect, or exploitation according to the following requirements below. The person:

   a. Is 18 years of age or older

   b. Is a vulnerable adult as defined in A.R.S. § 46-451.

2. Reports made to APS shall contain:

   a. The names and addresses of the adult and any persons having control or custody of the adult, if known

   b. The adult's age, and the nature, and extent of his/her incapacity or vulnerability

   c. The nature, and extent of the adult's injuries or physical neglect or of the exploitation of the adult's property

   d. Any other information that the person reporting believes might be helpful in establishing the cause of the adult's injuries or physical neglect or of the exploitation of the adult's property.

3. When the Support Coordinator reports alleged abuse or neglect to APS, the Support Coordinator shall complete an Incident Call Report (Form DDD-1746A-FORFF) and submit to their District’s Incident Report email address. The Incident Call Report shall indicate the date and time APS was notified.

4. When the member resides in his/her own home, a family residence, or an agency not funded by the Division, APS will take the lead for the investigation. APS will work together will with the Support Coordinator or other Division staff as appropriate. The APS worker will remain involved until the abuse or problem situation has been resolved.

5. When the adult resides in a DES/DDD operated or funded program, APS will investigate the complaint. DES/DDD is responsible for coordination with APS and notification of the fact-finding process. DES/DDD staff, as appropriate, will conduct a fact-find to determine programmatic and contract compliance issues.

D. Working with Adult Protective Services (APS)

1. The Support Coordinator shall work as expeditiously as possible with the APS worker to resolve any concerns regarding a report or investigation made to APS.

2. Whenever possible, the Support Coordinator shall discuss the situation with the APS worker and provide any relevant facts and important historical information.

3. The Support Coordinator shall elevate to their supervisor if there are additional concerns that cannot be resolved at their level.

4. The Support Coordinator shall collaborate with APS to ensure the member's needs are met. This includes but is not limited to identifying and obtaining behavioral health and medical services, and community resources as applicable. Some examples: identification of a Representative Payee, transportation to medical appointments, and a referral to HUD housing.

E. Quality of Care Concerns (QOC)

1. The Support Coordinator shall cooperate with and complete any follow up necessary for the Division to resolve a QOC.

1621 ENHANCED STAFFING RATIOS

EFFECTIVE DATE: March 20, 2024
REFERENCES: A.R.S. 42 CFR 438.400, A.A.C. R9-22-702, ACOM Policy 414

PURPOSE

This policy outlines the Division's requirements when assessing for and approving Enhanced Staffing Ratios (ESR) for Members who may need increased support in a specific setting.

DEFINITIONS

1. "Enhanced Staffing Ratio" or "ESR" means the number of paid supports, greater than currently provided to the Member in the service setting and ensures the Member's health, safety, and emotional, spiritual, and physical well-being.

2. "Member" means the same as "client" as defined in A.R.S. § 36-551.

3. "Planning Document'' means a written plan developed through an assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences

for the delivery of such services and supports.

4. "Planning Team" means a defined group of individuals comprised of the Member, the Responsible Person if other than the Member, and, with the Responsible Person's consent, any individuals important in the member's life, including extended family members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems..

5. "Reduction Plan" means a plan, that is outlined in the Planning Document, to decrease the service frequency, duration, or level of service and agreed to in writing by the Responsible Person.

6. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

7. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

8. "Staffing Ratio" means the number of Direct Care Workers that support a Member in a specific service setting.

POLICY

A. ENHANCED STAFFING RATIOS (ESR)

1. The Support Coordinator shall assess for and approve an ESR when:

   a. The Member has been determined to need increased supervision or increased care to provide for personal care, medical needs, or behavioral supports in a specific setting, and

   b. Requested by the Responsible Person.

2. The Support Coordinator shall assess and approve an ESR to support the Member in the least restrictive way possible and consider the Member's basic human rights to participate in the Member's daily activities. For additional information on a Member's basic human rights, refer to A.A.C. R9-22-702.

3. The Support Coordinator shall assess and document the request

for an ESR in the Planning Document.

4. The Support Coordinator shall request a Nursing assessment when a skilled nursing need is identified during the assessment for an ESR. Refer to Division Medical Policy 1240-G, Exhibit 1.

5. The Planning Team shall develop a Reduction Plan that clearly identify proactive and preventative strategies that will be used to reduce the need for an ESR.

    a. The support outlined in the Reduction Plan leads to personal growth and independence.

    b. The plan clearly outlines parameters to identify when the ESR needs to be reduced or is no longer needed.

    c. The Reduction Plan is documented in the Planning Document and Behavioral Plan as applicable.

    d. The Reduction Plan will include outcomes in the Planning Document to decrease or replace behaviors that require an ESR.

6. The Division shall require the Planning Team to provide

documentation that supports the Member's need for an ESR.

B. ASSESSING FOR PERSONAL CARE AND MEDICAL NEEDS

1. The Planning Team shall consider an ESR for a Member when the Member has personal care and medical needs that cannot be met in a standard Staffing Ratio.

2. The Support Coordinator shall consider the following when assessing the need for an ESR due to a Member's personal care and medical needs that impacts the Member's ability to complete activities of daily living.

    a. Seizures requiring rescue medications, emergency intervention, and close monitoring.

    b. Frequent Falling – A pattern of recent multiple falls in the last 60 days, which require staff to monitor the Member when standing or walking.

    c. Physical support needed for all personal care.

    d. Visual impairment or blindness that requires frequent intervention to support the Member in participating in

planned outcomes or activities.

e. Documentation of a medical diagnosis that impacts the Member's ability to complete activities of daily living;

f. Other medical or personal care needs that require frequent monitoring or interventions as determined by the Division.

C. ASSESSING FOR BEHAVIORAL NEEDS

1. The Support Coordinator shall consider an ESR for a Member when the Member has behavioral health needs that cannot be met in a standard Staffing Ratio.

2. The Support Coordinator shall consider the frequency, duration, and intensity of the Member's behaviors when assessing for an ESR for behavioral health needs.

3. The Support Coordinator shall consider the following when assessing the need for an ESR due to the Member's behaviors that pose a significant health and safety concern or a risk to themselves or others:

a. Documentation of behaviors placing the Member at risk or

injury to self or others;

b. Documentation that the Member is receiving or pursuing services through a behavioral health agency or professional;

c. Habilitation outcomes to decrease unsafe behaviors have been unsuccessful in the past;

d. Documentation from a medical professional describing a severe medical need or physical condition that would place the member at risk;

e. Documentation indicating a loss of skills that are unlikely to be regained;

f. Documentation of the Member leaving a situation or environment neither notifying nor receiving permission from the appropriate individual;

g. The Member is at risk to self or others when alone in the community or may be unable to return safely;

h. The Member cannot attend a typical day program because the Member's health and safety would be at risk or the

health and safety of other individuals may be at risk;

i. Documentation of the presence of confusion or disorientation;

j. Documentation that the member is receiving an ESR at school or daycare; and

k. A Member who has an identified wandering risk or has unsafe behaviors must have received, or will receive habilitation to minimize the need for an ESR;

l. Other behavioral health needs as determined by the Division.

D. DENIALS, TERMINATIONS, REDUCTIONS, AND SUSPENSIONS

If the Responsible Person disagrees with the assessment, the Division shall provide the Responsible Person with a Notice of Adverse Benefit Determination when the request for an ESR has been denied, terminated, reduced, or suspended. Refer to Division Operations Policy 414 for additional information on Notice of Adverse Benefit Determinations.

1630 ADMINISTRATIVE STANDARDS

REVISION DATE: 7/26/23
EFFECTIVE DATE: May 13, 2016
REFERENCES: 42 C.F.R. §441.555c, § 36-551, AMPM Chapter 1600, Division Medical Policy Chapter 1610, Division Medical Policy 680-C

PURPOSE

This policy establishes administrative responsibilities related to Support Coordination for Division Members who are eligible for the Arizona Long Term Care System (ALTCS) or Targeted Support Coordination (TSC).

DEFINITIONS

1. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

2. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

3. "Support Coordination" means a collaborative process, which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet the Member's needs

through communication and available resources to promote quality, cost-effective outcomes.

4. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

5. "Targeted Support Coordination (TSC)" means a covered service provided by the Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD) to Members with Developmental Disabilities (DD) who are financially eligible for the Title XIX and Title XXI acute care programs, but do not meet the functional requirements of the ALTCS program

POLICY

A. SUPPORT COORDINATOR QUALIFICATIONS

1. The Division shall hire individuals as Support Coordinators that shall:

   a. Be a licensed, registered nurse;

   b. Have a Bachelor's or Master's degree in Social Work;

   c. Have a degree in Psychology, Special Education, or

Counseling and at least one year of experience in case management;

d. Have two years experience in providing case management services to:

i. Persons who are elderly, and/or

ii. Persons with physical or developmental disabilities and/or persons who have been determined to have a Serious Mental Illness (SMI).

B. DOCUMENTATION

1. The Division shall use the following AHCCCS standardized forms:

a. Uniform Assessment Tool: Division District Nurse utilizes for Members residing in a Skilled Nursing Facility (SNF).

b. Person-Centered Service Plan (Form DDD-2089A) , for Members aged 3 years and up.

C. TRAINING

1. The Division shall maintain documentation of training dates and staff attendance, and copies of materials used, that are maintained for record-keeping.

2. The Division shall provide uniform training to all Support Coordinators including formal training classes and mentoring-type opportunities for newly hired Support Coordinators.

3. The Division shall provide newly hired Support Coordinators with an orientation and training in the following areas:

   a. The role of the Support Coordinator in utilizing a Member-centered approach to Arizona Long Term Care System (ALTCS) Support Coordination, including maximizing the role of the Member and their family in decision-making and service planning;

   b. The principle of most integrated, least restrictive settings for service delivery;

   c. Recognizing Member rights and responsibilities;

   d. Adherence to Support Coordination responsibilities as outlined in Division Medical Policy 1610.;

   e. Support Coordination procedures specific to the Division;

   f. An overview of the continuum of AHCCCS/ALTCS program

including available service delivery options, service settings, and service restrictions or limitations;

g. The Division provider network by location, service type and capacity, including information about community resources for non-ALTCS covered services.

h. Information on local resources for housing, education, and employment services/programs that could help Members gain greater self-sufficiency in the areas.

i. Responsibilities related to monitoring for and reporting of quality of care concerns, including, but not limited to, suspected abuse, neglect, and/or exploitation;

j. General medical information, such as symptoms, treatments, and medications, common to the Members served by the Division.

k. General social service information, such as family dynamics, care contracting, dealing with difficult situations, and risk management.

l. Behavioral health information, including identification of Member's behavioral health needs, covered behavioral

health services and how to access those services within the Division's network, and the requirements for initial and quarterly behavioral health consultations.

m. Support Coordination responsibilities, including processes for making referrals to the Member's behavioral health provider for SMI determination and standards related to the provision of services for Members determined to have an SMI.

n. The Pre-Admission Screening and Resident Review (PASRR) process as outlined in Division Medical Policy 680-C.

o. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for Members under the age of 21,

p. Member specific data from Focus is transmitted to AHCCCS bi-weekly and retained in the AHCCCS Pre-Paid Medical Management Information Systems/Client Assessment Tracking System (PMMIS/CATS) with the exception of Cost-Effective Studies which are directly entered into AHCCCS PMMIS.

q. Responsibilities related to monitoring for and reporting fraud, waste, and abuse.

r. Information and resources related to caregiver stress and burnout.

s. End-of-life person-centered planning, services, and supports including covered services and how to access those services within the Member's AHCCCS health plans.

6. The Division shall provide all Support Coordinators with regular ongoing training on topics relevant to the population served by the Division, in addition to the review of areas covered during orientation as outlined below:

a. Policy updates and new procedures.

b. Refresher training identified from internal monitoring reviews.

c. Interviewing, observation, and assessment skills.

d. Cultural competency skills.

e. Member rights.

f. Physical/behavioral health conditions.

g. Medications – side effects, contraindications, poly-pharmacy issues.

h. Article 9, and other relevant training.

7. The Division shall maintain staff who are designated as the expert(s) on housing, education, health care services, and employment issues and resources within the Division's service area. These staff shall be available to assist Support Coordinators with up-to-date information designed to aid Members in making informed decisions about their independent living options.

D. CASELOAD MANAGEMENT

1. The Division shall provide adequate numbers of qualified and trained Support Coordinators to meet the needs of enrolled Members.

2. The Division shall maintain protocols to ensure newly enrolled ALTCS Members are assigned to a Support Coordinator immediately upon enrollment.

E. ACCESSIBILITY

1. The Division shall provide the Responsible Person with adequate information to be able to contact the Support Coordinator or DDD office for assistance, including what to do in cases of emergencies and/or after hours.

2. The Division shall provide back-up Support Coordinators to the Responsible Person to contact when their primary Support Coordinator is unavailable.

3. The Division shall ensure the Responsible Person and providers are called back in a timely manner when messages are left for Support Coordinators.

F. TIME MANAGEMENT

1. The Division shall ensure that Support Coordinators are not assigned duties unrelated to Member-specific Support Coordination for more than 10% of their time if they carry a full caseload.

G. CONFLICT OF INTEREST

1. The Division shall ensure Support Coordinators are not:

a. Related by blood or marriage to a Member, or any paid caregiver of a Member, on their caseload;

b. Financially responsible for a Member on their caseload;

c. Empowered to make financial or health-related decisions on behalf of a Member on their caseload;

d. In a position to financially benefit from the provision of services to a Member on their caseload;

e. Providers of ALTCS services for any Member on their caseload;

f. Individuals who have an interest in, or are employed by, a provider of ALTCS services for any Member on their caseload.

2. Exceptions to the above shall be made under limited circumstances as described under 42 CFR 441.555c with prior approval from AHCCCS Administration.

H. SUPERVISION

1. The Division shall ensure a supervisor-to-Support Coordinator ratio is established that is conducive to a sound support

structure for Support Coordinators.

2. The Division shall ensure supervisors have adequate time to train and review the work of newly hired Support Coordinators and provide support and guidance to established Support Coordinators.

I. MONITORING

1. The Division shall ensure a system of internal monitoring of the Support Coordination program, including case file reviews and reviews of the consistency of Member assessments and service authorizations, has been established and applied, at a minimum, on a quarterly basis.

    a. The Division shall monitor the implementation of the ALTCS and Targeted Support Coordination (TSC) programs through a variety of tools. Data gathered through Focus and other systems are analyzed to ensure compliance with AHCCCS and Division standards. Support Coordination caseload ratios and other issues that may impact the timely delivery of services in meeting Member needs shall also be evaluated.

b. The Division shall utilize a case file review process to monitor the Support Coordination program.

i. Support Coordination: Supervisors, or designee, shall complete case file reviews on a quarterly basis to monitor the Division's compliance with its policies and procedures and contractual requirements with AHCCCS. The supervisor shall use this opportunity to provide feedback to the Support Coordinator regarding their work performance and provide training regarding various requirements of the ALTCS and TSC programs. The supervisor shall also use this opportunity to identify any issues and correct them for that case file and other case files on the Support Coordinator's caseload.

ii. The Division shall utilizecase file reviews and a survey to determine the Responsible Person's satisfaction with the services and supports received through the Division. If concerns are identified, The Support Coordinator's supervisor shalldevelop a plan to resolve any issues brought forth by the

Responsible Person.

iii. For questions below 95% compliance, the Division shall analyze the responses, at both a district and a statewide level, to determine root cause(s) and shall take appropriate action to improve compliance, including developing an improvement plan, as needed.

c. Support Coordination management shall:

i. Identify trends within their units and take appropriate steps.

ii. Trend the quarterly results to determine if additional action steps are needed to improve the District/Division's compliance with various requirements.

d. The Division shall monitor the timeliness of ALTCS planning meetings and TSC contacts in compliance with Division Medical Policy Manual Chapter 1600.

e. Support Coordination shall conduct Inter-Rater Reliability (IRR) reviews, on a quarterly basis, to ensure the

consistency of Member assessments and service authorizations.

f. Improvement plans shall be developed, as needed, to foster continuous improvement. The Division's leadership shall oversee these efforts.

g. The Division shall document and make available to AHCCCS, upon request, the results from this monitoring, including the development and implementation of continuous improvement strategies to address identified deficiencies.

J. INTER-DEPARTMENTAL COORDINATION

1. The Division shall establish and implement mechanisms to promote coordination and communication across disciplines and departments within their own organization, with particular emphasis on ensuring coordinated approaches with Medical Management (MM) and Quality Management (QM).

2. The Division's Medical Management Medical Director shall be available as a resource to Support Coordination and shall be advised of medical management issues as needed.

K. REPORTING REQUIREMENTS

1. The Division shall submit a Support Coordination Annual Plan to AHCCCS, on or before December 15th.

    a. The plan shall address how the Division shall implement and monitor the Support Coordination and administrative standards outlined in AMPM Chapter 1600, including specialized caseloads.

    b. An evaluation of the Division's Support Coordination Plan from the previous year is also included in the plan, highlighting lessons learned and strategies for improvement.

Signature of Chief Medical Officer: Anthony Dekker (Jul 21, 2023 11:58 PDT)
Anthony Dekker, D.O.

1640 TARGETED SUPPORT COORDINATION STANDARDS

REVISION DATE: 1/3/2024, 7/6/2021
REVIEW DATE: 8/18/2023
EFFECTIVE DATE: May 13, 2016
REFERENCES: AHCCCS AMPM Chapter 1640; A.R.S. § 36-551, Division Medical Policy 1650 DD Only Eligible

PURPOSE:

This policy outlines requirements related to Support Coordination for Members determined to be eligible for Targeted Support Coordination including Support Coordinator responsibilities, level of contact requirements, documentation standards, and Division responsibilities.

DEFINITIONS

1. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

2. "Planning Team" means a defined group of individuals comprised of the Member, the Responsible Person if other than the Member, and, with the Responsible Person's consent, any individuals important in the member's life, including extended family members, friends, service providers, community resource

providers, representatives from religious/spiritual organizations, and agents from other service systems.

3. "Planning Document" means a written plan developed through an assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such services and supports.

4. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability, an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed as cited in A.R.S 36-551.

5. "Supports" means paid or unpaid resources available in the community, through natural or family relationships, or through service providers to assist Members.

6. "Support Coordination" means a collaborative process, which assesses, plans, implements, coordinates, monitors, and

evaluates options and services to meet an individual's needs through communication and available supports to promote quality, cost-effective outcomes.

7. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

8. "Targeted Support Coordination" or "TSC" means a covered service provided by the Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD) to members with developmental disabilities who are financially eligible for the Title XIX and Title XXI acute care programs, but do not meet the functional requirements of the Arizona Long Term Care System (ALTCS) program.

9. "Title XIX" means the section of the Social Security Act which describes the Medicaid program's coverage for eligible persons, (i.e., medically indigent). Title 19 benefits are provided through the Medicaid federal entitlement program; benefits are delivered in Arizona through the Arizona Health Care Cost Containment System (AHCCCS). This includes individuals who receive Supplemental Security Income (SSI) or Temporary Assistance for

Needy Families (TANF).

10. "Title XXI" means the section of the Social Security Act that authorizes the State Children's Health Insurance Program known as KidsCare in Arizona.

A. TARGETED SUPPORT COORDINATION CASE MANAGEMENT ACTIVITIES

1. The Support Coordinator assigned to support the Member shall:
   a. Develop the planning document at the time of the initial visit for new Members eligible for TSC and review and update at each subsequent meeting.
   b. Annually explain the Member's rights and responsibilities including the procedures for filing a grievance and have them sign and date the Acknowledgement of Publications indicating receipt and understanding of the Member's rights and responsibilities.
   c. Inform the Responsible Person of the medical and behavioral health options available through the Member's AHCCCS Complete Care or ACC health plan and direct the

Responsible Person in coordinating these services.

d. Locate, assess, and coordinate social, educational, and other resources to meet the Member's needs.

e. As requested by the Responsible Person, provide necessary information regarding the Member's functioning level and any changes to assist the medical and behavioral health providers in planning, delivering and monitoring services.

   i. Provide Members, Member's family, or other caregivers, the support necessary to obtain benefits from available services or resources.

   ii. Create goals to strengthen the role of family as primary caregivers.

   iii. Provide assistance to reunite families with children who are in an alternative setting whenever possible.

   iv. Identify community resources to prevent costly, inappropriate, and unwanted out-of-home

placement.

v. If the Member has needs that cannot be met through community and natural supports, complete the Preadmission Screening or "Pre-Pas" and, if appropriate, submit a referral to ALTCS. **Note:** Members over the age of 3 receiving state-funded services must comply with the ALTCS application process.

vi. Provide contact with the Member at the requested type and frequency.

B. LEVEL OF CONTACT

1. The Support Coordinator shall conduct an in-person meeting with the Member and their Responsible Person within 10 business days upon notification of the Member's eligibility for TSC.

2. The Support Coordinator, after the initial meeting, shall schedule two additional in-person reviews at 90-day intervals from the date of the initial meeting with the Member and the Responsible

Person.

3. The Support Coordinator shall offer the Responsible Person the choice of type and frequency of contact at the second 90-day planning meeting.

   a. The type of contact may be in-person, by telephone, or by individualized letter.

   b. The Responsible Person may choose the frequency of contact – e.g., 30 days, 90 days, 180 days, 365 days. The frequency of contact cannot be more than 365 days.

   c. The choice will be given to the foster family and communicated to the legal guardian for a foster child in the custody of the Department of Child Safety or Tribal Social Services.

   d. The Responsible Person may change the type and/or frequency of contact at any time by contacting their Support Coordinator.

4. The Support Coordinator shall follow the minimum requirements of contact and planning meeting reviews established by rule,

policy, or procedure if the member is receiving services funded by the Division (i.e., "state-funded") or the Arizona Early Intervention Program (AzEIP).

5. The Support Coordinator shall allow the Responsible Person to choose more frequent contact if desired.

6. The Division shall require minimum contact in the following circumstances:

    a. Members receiving early intervention (AzEIP) services shall have in-person TSC visits every 90 or 180 days.

    b. Members receiving in-home support services (e.g., Attendant Care, Habilitation – Individually Designed Living Arrangement, Respite, etc.) or residing in a Child/Adult Developmental Home shall have in-person TSC visits at least every 90 days.

    c. Members residing in a licensed residential setting (e.g., group home, Skilled Nursing Facility, etc.) regardless of behavioral health services shall have TSC visits occur every 180 days from the date the placement began.

7. The Support Coordinator shall not be required to hold the initial 10-day and two 90-day meetings if the member loses TSC eligibility but becomes eligible again within 6 months.

8. The Support Coordinator shall treat the Member as newly TSC eligible if more than 6 months have lapsed.

C. DOCUMENTATION

1. The Support Coordinator shall update the Member's case record to include:
   a. The date the Support Coordinator was notified that the member is TSC eligible or the Focus task;
   b. Identification of Member as enrolled in TSC;
   c. A description of the type and frequency of contact chosen by the Responsible Person;
   d. Identification of all TSC contacts made and/or attempted including certified letter (when applicable);
   e. A description of the Member's abilities, supports and needs; and

f. Assistance provided to the Responsible Person

2. The Support Coordinator shall consult with their supervisor if the Responsible Person refuses to participate in the TSC program and based on this discussion, document the decision to move the Member to Inactive status or proceed to case closure as outlined in Division Medical Policy 1650.

D. DIVISION RESPONSIBILITIES

1. The Division shall ensure staff are qualified and employed in sufficient numbers to meet Support Coordination needs and responsibilities.

2. The Division shall ensure staff receive initial and ongoing training regarding Support Coordination responsibilities for the TSC program.

3. The Division shall identify new members who are eligible for TSC services and assign a Support Coordinator.

4. The Division shall ensure the Responsible Person is informed of the assignment of the Support Coordinator, when the Support Coordinator is changed, and how the Support Coordinator can

be contacted.

5. The Division shall establish and maintain an internal monitoring system of the TSC program and make results available at the time of annual review, to include a summary/analysis and corrective action plan, when applicable.

6. The Division shall follow prescribed timeframe requirements for the completion of the Planning Document.

7. The Division shall establish and maintain an internal monitoring system of the TSC program and make results available at the time of AHCCCS' Operational Review of the Division to include a summary/analysis and corrective action plan, when applicable.

1650 DIVISION ONLY (DD-ONLY) ELIGIBILITY SUPPORT COORDINATION STANDARDS

REVISION DATE: 12/13/2023
REVIEW DATE:
EFFECTIVE DATE: July 6, 2021

PURPOSE

This policy outlines the responsibilities Support Coordination has for members who are eligible for the Division but do not qualify for Arizona Long Term Care System, "ALTCS", or Targeted Support Coordination.

DEFINITIONS

1. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
2. "Planning Team" means a defined group of individuals comprised of the Member, the Responsible Person if other than the Member, and, with the Responsible Person's consent, any individuals important in the member's life, including extended family members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems.

3. "Planning Document" means a written plan developed through an assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such services and supports.
4. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability, an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed as cited in A.R.S 36-551.
5. "Supports" means paid or unpaid resources available in the community, through natural or family relationships, or through service providers to assist Members.
6. "Support Coordination" means a collaborative process, which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's needs through communication and available supports to promote

quality, cost-effective outcomes.

7. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551

POLICY

A. DD-ONLY CASE MANAGEMENT ACTIVITIES

1. The Support Coordinator assigned to support the Member shall:

   a. Develop the planning document at the time of the initial visit for new Members and review and update it at each subsequent meeting.

   b. Annually explain the Member's rights and responsibilities including the procedures for filing a grievance and have them sign and date the Acknowledgement of Publications indicating receipt and understanding of the Member's rights and responsibilities.

2. The Support Coordinator shall assist in identifying available resources to support the Member including:

a. School Programs

b. Employment (e.g., applying for a job, Vocational Rehabilitation)

c. Community/Recreational Center Programs

d. Day Care Services

e. Diagnostic and educational centers

f. Respite available through community or other grant programs

g. Therapy Services through a school, Third Party Insurance or other resources

h. AHCCCS insurance depending upon the member's income and resources

i. Other state or federal benefits

3. The Support Coordinator shall complete a Pre-PAS to determine if the member is potentially eligible for long-term care and assist with applying for the Arizona Long Term Care System

when the Member has service needs that cannot be met through community resources and natural supports.

B. LEVEL OF CONTACT

1. The Division shall defer to the Arizona Early Intervention Program Contractor for conducting Planning Meetings for Members under age three who are enrolled in the Arizona Early Intervention Program.
2. The Support Coordinator shall conduct an in-person planning meeting with Members who are age 3 years and older:
    a. Within 30 days of eligibility notification.
    b. Followed by two additional Planning Meetings to be held every 180 days.
    c. The Responsible Person shall determine the frequency and type of contact after the first three Planning Meetings.
    d. The Support Coordinator shall make contact with the Member at least annually based on the type of contact chosen.
3. The Support Coordinator shall update the Planning Document

at all Planning Meetings.

C. INITIAL PLANNING MEETING

1. The Support Coordinator shall
    a. Contact the Responsible Person within 10 days of Member eligibility notification to schedule the Planning Meeting;
    b. Conduct the Planning Meeting with the Member present within 30 days of eligibility notification; and
    c. Complete the Planning Document

D. INACTIVE STATUS

1. The Division shall allow a Member who is not actively being served by the Division to choose to be designated with inactive status.
2. The Division shall exclude the following members from inactive status:
    a. Arizona Long Term Care System (ALTCS) eligible;
    b. Targeted Support Coordination (TSC) eligible;
    c. Enrolled in Arizona Early Intervention Program (AzEIP);
    d. In the foster care system;

e. Currently authorized for services paid for by the Division; and/or,

f. Served by the Division as their Representative Payee.

3. When the Responsible Person selects to be inactive the Support Coordinator shall:

a. Update the Case Status Screen in Focus from Active to Inactive in consultation with the Supervisor; and

b. Manually add and edit an Annual Phone Contact Task in Focus; and

c. Contact the Responsible Person annually by phone and document this contact or all attempts to contact in the progress notes.

d. Annually conduct a file review of the member's case file of the following:

i. Current Planning Document

ii. Request a Re-determination of eligibility if one has not been done age at age 6 or 18;

iii. Obtain school records, if school age;

iv. Verify the status of referrals to community resources and document efforts to verify in Progress Notes, and if needed, complete any follow-up;

v. Review and update the Member's screens in Focus.

vi. Document in the electronic Progress Notes that the file review was completed, including any further follow-up that is needed, and update the PCSP Date History in Focus with the date the file was reviewed.

4. The Support Coordinator shall update the Case Status Screen in Focus according to the request when the Responsible Person requests services or elects to be active.

5. The Support Coordinator shall assist the Responsible Person if they request community resources.

   a. One time assistance shall be documented in the progress notes;

   b. On-going assistance shall be documented in the progress notes and the Case Status Screen in Focus shall be updated from Inactive to Active.